Atlanta Actuarial Club
Impact of Healthcare Reform on Healthcare Financing and Delivery
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Topics

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- Public and Private Plan
- The Co-op Alternative
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Catch Your Breath

- Understand really what and how rhetoric is being said
- 17% of the economy – true change will happen slowly
- The tenets of HC reform have been on the table for a year via "white papers" and position papers

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Prefacing Observations

- Admittedly, HC financing and delivery mechanism is a very difficult issue to solve, change or unwind
- Unfortunately, political sound bites do not bring clarity to issues

Prefacing Observations – contd.

- HC reform attempts to fill in the gaps where private insurance has not been able to provide effective coverage
- Lots of public policy issues embedded within bills
- Delivery system does not change
- Aimed primarily at those who have difficulty securing insurance
  - Low-income individuals
  - Employees working for a smaller-sized employer
  - Individuals with chronic conditions
- Senate and House bills are an attempt to crystallize concepts from previous position papers

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Major Tenets of HC Reform

- Brokerage entity through which individuals can purchase insurance (aka Exchange/Connector/Gateway)
- Guaranteed issue coverage
- No pre-existing coverage exclusions
- Mandates a minimum benefit plan containing preventive care benefits
- Put responsibility on individual to secure insurance – presumably monitored through Treasury
- Subsidies for individuals in lower income brackets
  - Subsidies contained in a number of various places in the two bills
- Medicare expansion for low income people

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Two Bills

- House bill (HR 3200)
  - One bill with 3 variations
- Senate Committee – Health, Education, Labor, and Pensions (HELP) bill (no number)
- Both bills have very similar components
  - Each may have different details on specific issue

Specific Components: Individual Mandates

- Individuals responsible for securing own insurance
- Penalty for not complying
  - Lesser of 2-1/2 % of income or actual premium cost (HR3200)
  - $750 maximum (HELP)
- Policed through Treasury Dept
- Premium credits and cost sharing reductions for low income (not Medicaid-eligible)
  - 133% to 400% of Federal Poverty Limit (FPL)
  - 2009: 100% of FPL is $10,830 for one person, and $22,050 for family of four
- Tax credits if individual with employer coverage is unaffordable (11% or 12% of income in HR 3200, 12.5% AGI in HELP)

Specific Components: Employer Role

- Bills specify minimum contribution levels for employers
- If employee declines employer coverage and obtains coverage through Connector, the employer must contribute to Connector (HR 3200)
  - 8%, with decreases for smaller sized employers (payroll-based)
- Employers with more than 25 employees that do not offer coverage or who pay less than the minimum contribution level (HELP)
  - $750 per full-time employee above 25 employees
- Subsidies for small employers

Specific Components: Benefit Plans

- Minimum benefit plan
  - House: 70% to 95% of first dollar plan; four plans
  - Senate: 76% to 93%; three plans
  - In other words, minimum plan has an actuarial value of 70% of a plan that provides coverage with no coinsurance.
  - A plan with 20% coinsurance with no deductible or out of pocket maximum would have an actuarial value of 80%.
  - Minimum benefit plans are richer than a number of plans currently in force
- Existing group and individual plans may be grandfathered
  - 5 years for employment-based plans (HR 3200)
  - forever" for employment-based and individual plans (with some restrictions) in HELP
  - limited grandfathering for individual plans (but no new enrollment) in HR 3200

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Specific Components: Underwriting & Rating

- Guaranteed issue
- No pre-ex condition exclusions
- Rating variables limited to family composition, geographic area, and age of individuals
  - Age limited to ratio of 2:1
  - Milliman Guidelines show a ratio of upwards of 5:1

Public and Private Plans

- Biggest source of contention between insurance industry and Democratic lawmakers
- Private public plans offered alongside each other to individuals
- Public plan payment rates
  - HR 3200 Version 1: Bases payments on Medicare allowable reimbursement levels or just above that level
  - HR 3200 Version 2: Negotiates to produce rates that are not lower than Medicare (in the aggregate) or higher than average rates (in the aggregate) paid by other Connector plans
  - HELP: Negotiates to produce rates no higher than average of all Gateway reimbursement rates
- Private plans will negotiate reimbursement rates with providers in the same way that its done now – nothing will change

Public and Private Plans – contd.

- Would put public plans at tremendous advantage over private plans and essentially put private plans eventually out of business
  - If public plans set reimbursement at 100% to 105% of Medicare allowable levels, and
  - Average reimbursement levels of private plans are at 130% to 150% of Medicare allowable, with wider ranges from 110% to 175% of Medicare allowable
  - Then there is a 30% advantage in fee levels

The Co-op Alternative

- Really a mechanism to address the pushback on the public plan
- Co-op plan is a non-profit, consumer owned and operated plan that does not force providers to participate in the public plan and therefore does not have to accept Medicare allowable reimbursement levels for services

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Regulatory Authority

- **Currently,** the federal government has a dual regulatory oversight with the State. Until the McCarran-Ferguson act is overturned, the State DOI's will still have regulatory authority over the rating rules of the health insurance products.
  - The Federal government can dictate who is eligible and what benefit provisions have to be offered.
  - The states, however, dictate the rules for the actual rating of the group or individual
- **Future,** combination of federal and state oversight
  - Federal government is establishing the framework and rule and "inviting" the states to assist in regulation and oversight

Thinking Points to Frame Thoughts

- Various components of HC reform that will impact individual and small group insurance markets

1. Individual mandate of purchasing insurance
2. Preventing individuals from purchasing products with benefit levels below the minimum
3. Insurers' inability to decline coverage or determine rates based on health status
4. Limits on ability to rate insurance by age and family composition
5. Coverage of pre-existing conditions
6. Combining of individual and small group markets into single rating pool

Impact on Current Insurance Market

- Magnitude of rate impact will depend upon how “well” the coverage mandate works
  - There will be people not participating in the insurance pool
  - Need a strong coverage requirement to reduce adverse impact
  - Need mechanism to ensure that both healthy and unhealthy people enroll
- Minimum benefit plan levels provide more coverage than those being sold today; rates will increase will meet minimum plan levels

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Impact on Current Insurance Market – contd.

- Both the compression of rates based on health status and guaranteed issue provision will raise rates for individual and small group markets
- Rate band compression resulting from socialized rating variables will increase rates for younger individuals and younger families
- Pre-existing conditions will increase rates
- Large rate increases for many individual and small groups as average health status with insured block worsens

Thank You

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