

**Health Care Reform  
Presentation to  
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# Health Care Reform

## PART 1

Why Did It Happen?

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## PART 2

What's In The Bill?

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## PART 3

What's Next?

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# PART 1

## Why Did It Happen?

# Why Did It Happen? – Part 1

## Part 1 Agenda

1. The Rhetoric versus the Reality
2. Insurance Industry Practices
  - a) Non-Group (Individual) Underwriting
  - b) Small Group Underwriting

# Why Did It Happen?

## The Rhetoric

1. To “Bend the Cost Curve”
2. To stop insurance companies from dropping you when you get sick
3. To end pre-existing exclusions
4. To cover the uninsured

## The Reality

MOST ACKNOWLEDGE WHAT WE GOT WAS:

- (i) HEALTH *INSURANCE* REFORM (items 2 & 3); PLUS
- (ii) A HUGE EXPANSION IN ENTITLEMENTS (item 4); NOT
- (iii) HEALTH *CARE* REFORM – item 1;

# Why Did It Happen?

## Insurance Industry Practices

### The Actuary (April / May 2010 Edition)

“Because of HIPAA, any person who is covered for at least 18 months under a group or individual health care plan *has a right to maintain continuous coverage without ever again being required to undergo assessment of health status (underwriting) or facing a new limit on pre-existing conditions.*”

*(emphasis Added)*

**If only this were true . . .**

# Why Did It Happen?

## Non-Group (Individual Insurance) Underwriting (Actual / Perceived “Fairness” Issues)

1. New Business Underwriting Practices and Results
  - a) Issue as Standard Risk
  - b) Issue as Substandard Risk with higher premiums
  - c) Issue with exclusion for pre-existing conditions
  - d) Deny coverage
  - e) “Post-Claim” underwriting and policy rescission
  - f) “Cherry Picking” and “Lemon Dropping”
  - g) Target Marketing
  - h) Product design initiatives (e.g. benefit limitations and/or healthy benefit enhancements)

# Why Did It Happen?

## Non-Group (Individual Insurance) Underwriting (Actual / Perceived “Fairness” Issues – Cont’d)

2. Renewal Business “pseudo” underwriting
  - a) Durational Rating – largely (universally?) prohibited
  - b) Close blocks of business
  - c) “New” products require “re-underwriting”
  - d) Target renewal underwriting offerings – use Predictive Risk Modeling?
3. Managing Risk versus Managing Care
4. Is this really “insurance”??

# Why Did It Happen?

## Small Group (2 to 50 employees) Underwriting

1. New Business Underwriting Practices and Results
  - a) HIPAA requires Guarantee Issue
  - b) But HIPAA does not impose premium or group medical underwriting restrictions (many States do impose restrictions)
  - c) Rate band limitations (e.g. compression by Age/Gender)
  - d) Employer contribution requirements
  - e) Employee participation requirements
  - f) Payroll audits to confirm employment
  - g) Multiple benefit plan or carrier choice limitations
  - h) Geographic limitations (e.g. out-of-area limitations)
  - i) Coverage waiting periods (especially for transient employees)
  - j) Pricing COBRA impact
  - k) List Billing versus Composite Rates

# Why Did It Happen?

## Small Group (2 to 50 employees) Underwriting

### 2. Renewal Underwriting

#### a) NAIC Model Bill concepts

- 1) Limit rate variation from block of business “Midpoint”
- 2) Maximum increase over “Base Rate” (i.e. New Business Rate)
- 3) Rate increases often limited to +15% per year; but sometimes confusing as to +15% over what?

#### b) Health Status (e.g. Predictive Risk Modeling) and Claim Underwriting; often restricted by regulation

#### c) Cannot single out individuals; another HIPAA requirement

# PART 2

## What's In The Bill?

**CAVEAT: ALL SUBSEQUENT SLIDES REFLECT ACTUARIAL MODELING'S SUMMARY UNDERSTANDING OF THE COMPLEX REGULATORY HEALTH REFORM BILL AND VARIOUS SUMMARY INTERPRETATIONS.**

**ACTUARIAL MODELING'S INTERPRETATIONS ARE NOT COMPLETE NOR COMPREHENSIVE AND SHOULD NOT BE RELIED UPON WITHOUT INDEPENDENT VERIFICATION.**

# What's In The Bill? – Part 2

## Part 2 - Agenda

1. General
2. Individual Mandate / Penalties
3. Employer “Play or Pay” Penalties
4. Medicaid Expansion
5. Premium Subsidies for Individuals
6. Cost Sharing Subsidies for Individuals
7. Premium Subsidies for Employers
8. New and Increased Taxes and Other Revenue
9. Pre-Exchange Provisions
10. Health Exchange Provisions
11. Medicare Advantage and Part D Provisions
12. Bending the Cost Curve
13. Long Term Care (CLASS Program)
14. CBO / JCT Projections; 2010 thru 2019

# What's In The Bill?

## General

1. Bills
  - a) Senate Bill H.R. 3590; “*Patient Protection and Affordable Care Act*” (906 Pages; Single spaced version of 2,409 page draft); signed into law on 3/23/2010
  - b) Reconciliation Bill H.R. 4872; ‘*Health Care and Education Affordability Reconciliation Act of 2010*’ (55 Pages); signed into law on 3/30/2010
2. Mandates coverage for most U.S. citizens and legal residents
3. Create, no later than January 1, 2014, state-based Health Benefit Exchanges – one Risk Pool for individuals and a separate Risk Pool for small groups; State can elect to combine individual and small group Risk Pools
4. Provide premium credits for low income individuals
5. Provide cost-sharing credits for low income individuals
6. “Pay or Play” provision for most employers with over 50 employees

# What's In The Bill?

## General (Cont'd)

7. Impose regulations on health insurers
8. Increase or create new taxes to fund health care reform
9. Expand Medicaid to 133% of federal poverty level (“FPL”)
10. Funds various programs and demonstrations designed to “bend the cost curve”
11. Creates a federal Long Term Care Insurance Program; Community Living Assistance Services and Supports (“CLASS”)
12. Makes the federal government the sole provider of student loans backed by the federal government – we will not be discussing this.

# What's In The Bill?

## Individual Mandate / Penalties

1. Must maintain “minimum essential coverage”; at least 60% Actuarial Value – the “Bronze” Plan
2. Penalty limit of 3 per family
3. 50% Penalty for children under age 18
4. Certain exemptions for low income, religious objection, American Indians, and the incarcerated

<u>Calendar Year</u>	<u>Penalty equal to greater of:</u>	
	<u>Dollar Amount</u>	<u>% of Income</u>
2014	\$95	1.0%
2015	\$325	2.0%
2016	\$695	2.5%
2017 and Later	CPI Indexed	2.5%

## What's In The Bill?

### Employer ‘Play or Pay’ Penalties

1. Impacts employers with more than 50 employees effective January 1, 2014
2. If do not offer coverage and at least one employee receives premium or cost-sharing subsidy: \$2,000 for EACH full-time employee in excess of 30 (Note: not just those receiving the subsidy)
3. If offer coverage: Lesser of:
  - a) \$3,000 for each employee who receives a premium tax credit; or
  - b) \$2,000 for each full-time employee in excess of 30
4. Certain exemptions for low income, religious objection, American Indians, and the incarcerated
5. Waiting periods in excess of 90 days are prohibited

# What's In The Bill?

## Medicaid Expansion

1. All individuals up to 133% of FPL eligible effective January 1, 2014
2. Benchmark package greater than or equal to “essential health benefits”
3. Federal Medical Assistance Percentage (“FMAP”) to States are increased for “newly eligible” Medicaid enrollees

Calendar Year	FMAP for All States & D.C.
2014 - 2016	100.0%
2017	95.0%
2018	94.0%
2019	93.0%
2020	90.0%

# What's In The Bill?

## Premium Subsidies for Individuals

1. Premium credits tied to second lowest-cost silver plan in the area
2. Income between 133% and 400% of FPL; Premium contributions limited via linearly interpolation in below table
3. Premium credits only available through the Exchanges
4. No Premium credits if covered by employer unless:
  - a) Employer plan has actuarial value less than 60%; or
  - b) Employee's share of premium exceeds 9.5% of employee's income
5. Effective 1/1/2014

FPL	% of Income Limit
Up to 133%	2.0%
133% - 150%	3.0% - 4.0%
150% - 200%	4.0% to 6.3%
200% - 250%	6.3% to 8.05%
250% - 300%	8.05% to 9.5%
300% - 400%	9.5%

## What's In The Bill?

### Cost Sharing Subsidies for Individuals

Cost Sharing Subsidy only available through the Exchanges

Federal Poverty Level (FPL)	Maximum Cost Sharing
100 – 150%	6.0%
150 – 200%	13.0%
200 – 250%	27.0%
250 – 400%	30.0%

# What's In The Bill?

## Premium Subsidies for Employers (Small)

1. For following employers:
  - a) Less than 26 employees and average wage less than \$50k
  - b) Employer contributes at least 50% of “benchmark premium” for Phase I and 50% of Exchange Premium for Phase II
2. Phase I; tax years 2010 through 2013
  - a) Tax credit up to 35% of employer’s contribution (25% credit for tax-exempt businesses)
  - b) Full credit for employers with less than 11 employees and average wage less than \$25k (grades down as employees / average wage increases)
3. Phase II; tax years 2014 and later
  - a) Tax credit up to 50% of total premium cost for up to two years (35% credit for tax-exempt business)
  - b) Full credit for employers with less than 11 employees and average wage less than \$25k (grades down as employees / average wage increases)

## What's In The Bill?

### Premium Subsidies for Employers (All)

1. Temporary reinsurance program for employees over 55 not eligible for Medicare
2. Reimburse benefit plan for 80% of retiree claims between \$15k and \$90k
3. Effective 90 days after effective date through earlier of January 1, 2014 and when total payments may reach \$5.0 billion.

## What's In The Bill?

### New and Increased Taxes and Other Revenue (Cont'd)

1. 40% excise tax on “Cadillac” Plans; over \$10.2k Individual / \$27.5k Family
  - a) Indexed to CPI or greater if health care costs rise “more than expected”
  - b) Increased for (i) non-Medicare over 54 and (ii) high-risk professions; limits also increased for Age and Gender
  - c) Tax imposed on issuer of the policy
  - d) Includes FSA, HRA, HSA employer contributions, and other supplementary health insurance coverage; dental and vision excluded
  - e) Effective 1/1/2018
2. Eliminate employer tax deduction for Medicare Part D retiree drug subsidy; effective 1/1/2013
3. Over-the-counter Rx not prescribed by a doctor ineligible as tax-exempt expenses for HRA, FSA, or HSA accounts; effective 1/1/2011
4. Non-medical HSA withdrawals taxed at 20% versus current 10% ; effective 1/1/2011

## What's In The Bill?

### New and Increased Taxes and Other Revenue (Cont'd)

5. FSA medical expenses limited to \$2,500 per year; effective 1/1/2013; increased annually by COL
6. Itemized deduction threshold for medical expenses increased from 7.5% to 10.0% of adjusted gross income; effective 1/1/2013
7. For individuals with wages over \$200k (\$250k for married); effective 1/1/2013:
  - a) Increase Medicare Part A payroll tax from 1.45% to 2.35% for earned income in excess of the wage threshold
  - b) 3.8% tax on 100% of net investment income (or, if less, 3.8% of amount by which gross income exceeds the wage threshold)
  - c) Wage thresholds are not indexed
8. Freeze income limits for means-tested Part B premiums and reduced Part D premium subsidies; incomes above \$85k individual and \$170k couple; frozen from 1/1/2011 through 12/31/2019

# What's In The Bill?

## New and Increased Taxes and Other Revenue (Cont'd)

### 9. Taxes on health care sector

#### Medical Device Industry

2.3% Tax effective 1/1/2010

(Excludes eyeglasses, contact lenses, hearing aids, and "other retail devices")

#### Insurance Industry <sup>(1)</sup>

Calendar Year	Annual Fee
2014	\$8.0 Billion
2015 - 2016	\$11.3 Billion
2017	\$13.9 Billion
2018	\$14.3 Billion
2019+	Prior Year + % Prem Growth

<sup>(1)</sup> Plus \$2 PMPY effective 10/1/2012; \$1 PMPY for Year 1

#### Pharmaceutical Industry <sup>(2)</sup>

Calendar Year	Annual Fees
2011	\$2.5 Billion
2012 - 2013	\$2.8 Billion
2014 - 2016	\$3.0 Billion
2017	\$4.0 Billion
2018	\$4.1 Billion
2019+	\$2.8 Billion

<sup>(2)</sup> Also increasing the Medicaid brand drug rebate percentages; effective 1/1/2010

## What's In The Bill?

### New and Increased Taxes and Other Revenue (Cont'd)

10. Limit deductibility of executive and employee compensation to \$500k per individual for health insurers; for remuneration paid in tax years beginning after 2012, with respect to services performed after 2009.
11. 10.0% tax on amount paid for indoor tanning services; effective 7/1/2010

# What's In The Bill?

## Pre-Exchange Provisions

1. Minimum Medical Loss Ratio (“MLR”)
  - a) 1/1/2011 thru 12/31/2013: 80% for Individual / Small Group Plans and 85% for Large Group Plans
  - b) 1/1/2014: Annual rebate based on average of prior three years
2. Temporary national high risk pool:
  - a) Effective within 90 days of enactment through earlier of 1/1/2014 and when total payments may reach \$5.0 billion
  - b) For all non-covered individuals with pre-existing medical condition
  - c) Premiums set equal to standard population
  - d) Age variation no more than 4 to 1 ratio
  - e) Issuer's share of total cost must be at least 65%
  - f) Maximum cost sharing set equal to HSA deductible limits (2010 limits: \$5,950 Single / \$11,900 Family)
  - g) Dumping prohibited; closing a block, health underwriting, and anything else state decides

## What's In The Bill?

### Pre-Exchange Provisions (Cont'd)

3. States to review and approve premium increases; prior approval required for “unreasonable” increases; silent as to whether limited to individual and small group policies; effective 1/1/2010 with no sunset;
4. States to establish ombudsman advocate for Individual and Small Group markets; federal funding to commence in 2010
5. Effective 6 months after enactment (i.e. 9/23/2010):
  - a) “Children” must be covered until the child turns age 26
  - b) Debate ended as to whether Children have “guarantee issue” rights
  - c) Lifetime limits and “unreasonable” annual limits prohibited; annual limits prohibited effective 1/1/2014
  - d) Preventive Services must be covered at 100% (i.e. no cost sharing)
6. Benefit Plan Description standardized within 12-months of enactment; 24 months for implementation

# What's In The Bill?

## Health Exchange Provisions

1. Health Exchange Provisions effective 1/1/2014 unless otherwise stated
2. Individual and Small Business Health Options Program (SHOP) Exchanges
3. For individuals and small groups with up to 100 employees
4. States can permit participation by larger employers effective 1/1/2017
5. Community health insurance option (i.e. the “Public Plan”)
  - a) States can opt out of the Public Plan offering
  - b) Public Plan subject to same standards as private plans
  - c) Public Plan must “negotiate” payment rates with providers
  - d) Public Plan can pool national experience for pricing and financial reporting
  - e) Start-up funding as requested by Secretary of Health & Human Services
6. Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies

## What's In The Bill?

### Health Exchange Provisions (Cont'd)

7. Create four benefit categories of plans plus a catastrophic plan:
- a) Bronze Plan: 60% actuarial value; OOP max equal to HSA deductible limits (\$5,950 Individual and \$11,900 Family for 2010)
  - b) Silver Plan: 70% actuarial value; same OOP limits as Bronze Plan
  - c) Gold Plan: 80% actuarial value; same OOP limits as Bronze Plan
  - d) Platinum Plan: 90% actuarial value; same OOP limits as Bronze Plan
  - e) Catastrophic Plan: Deductible set at HSA deductible limits (but prevention benefits and three primary care visits excluded from deductible); only available to those up to age 30
  - f) Reduce OOP Limits up to 400% of FPL; w/o increasing actuarial values:

FPL Range	Fraction of HSA Limits	OOP Limits
100 – 200%	One-third	\$1,983 / \$3,967
200 – 300%	One-half	\$2,975 / \$5,950
300 – 400%	Two-thirds	\$3,967 / \$7,933

## What's In The Bill?

### Health Exchange Provisions (Cont'd)

8. Small Group deductible limits; \$2,000 Individual / \$4,000 Family
9. Guarantee Issue and Renewability
10. Only permissible rating factors are:
  - a) Age; Health & Human Services (HHS) and NAIC to establish permissible age bands
  - b) Area; rating areas to be defined by the State
  - c) Individual / Family coverage
  - d) Tobacco use
11. Single or Family age rate variation limited to 3 to 1 ratio
12. Tobacco use rate variation limited to 1.5 to 1 ratio
13. “Essential Health Benefits Package”: at least equal to the “Bronze Plan”
14. All qualified health benefits plans (inside or outside the Exchange) must offer at least the Essential Health Benefits Package (unless grandfathered)

## What's In The Bill?

### Health Exchange Provisions (Cont'd)

15. Effective 1/1/2014, HHS and States to review premium increases inside and outside of Exchanges; excess increases outside of Exchanges considered in determining whether to offer large groups inside the Exchanges
16. Temporary reinsurance program
  - a) Collect payments from Individual and Group markets
  - b) Covers high-risk individuals in the Individual market
  - c) Funded with \$25 billion of mandatory contributions by health insurers
  - d) Effective 1/1/2014 through 12/31/2016
17. Require risk-adjustment for individual and small group markets; effective 1/1/2014

# What's In The Bill?

## Medicare Advantage and Part D Changes

1. Medicare Advantage (MA) payments; create benchmark payments at various percentages (by area) of Medicare FFS; payment to also reflect “quality and enrollee satisfaction”; adjust payments for health status coding to achieve additional savings; 3-6 year phase in (No increase for CY 2011).
2. 85% MLR; effective CY 2014; suspend new enrollment if over 85% for 3-consecutive years; terminate contract if over 85% for 5-consecutive years.
3. No cost-sharing permitted for qualified preventive services; effective CY 2011
4. Reduce Part D donut hole
  - a) \$250 rebate for CY 2010 to those hitting the donut hole
  - b) Beneficiary coinsurance reduced from 100% to 25% by 2020
    - 1) Brand Drugs: 50% from Rx Manufacturer (effective 1/1/2011); + 25% from Government by 2020
    - 2) Generic Drugs: 75% all from Government by 2020
5. Medicare physician fee schedule: offset of 21% fee reduction not addressed; on 4/15/2010 extended, for 3<sup>rd</sup> time this year, reduction delay until 6/1/2010

## What's In The Bill?

### Medicare Advantage and Part D Changes

6. 10% bonus physician payment for general surgeons practicing in shortage areas and primary care physicians
7. Prohibit MA plans from imposing cost-sharing requirements greater than those for traditional Medicare FFS benefits

# What's In The Bill?

## Bending the Cost Curve - Selected Programs

1. Accountable Care Organizations (“ACO”): groups of providers (e.g. Hospitals and Doctors) and suppliers (e.g. Ambulatory Surgical Centers) paid via original Medicare Part A and Part B reimbursement mechanisms that can share in savings as defined and determined by the Center of Medicare and Medicaid Services (“CMS). Established by 1/1/2012.
2. Bundling of Payments: single payment made for medical care services related to a defined “episode of care”. Pilot program to be established by CMS by 1/1/2013.
3. Comparative Clinical Effectiveness: establishes Patient-Centered Outcomes Research Institute funded by Patient-Centered Outcomes Research Trust Fund (“PCORTF”); cannot deny coverage “solely on the basis of comparative clinical effectiveness research”; annual funding starts in 2010.
4. Prevention and Wellness Programs: e.g. 100% coverage and permit wellness programs.

# What's In The Bill?

## Long Term Care (CLASS Program)

1. CLASS = Community Living Assistance Services and Supports
2. Must pay premiums for at least 60 months to be eligible / vested
3. Premiums to be determined; Age rated only
4. Guaranteed Issue
5. Benefit payable not less than \$50 per day
6. Financed through voluntary payroll deductions (auto enrollment encouraged but not mandated)
7. Premiums not guaranteed unless:
  - a) Attained age 65;
  - b) Paid premiums for at least 20 years;
  - c) Not actively at work; or
  - d) Below the poverty line or full-time student under age 22
8. Effective 1/1/2011

## CBO / JCT Projections; 2010 thru 2019

Outlays (\$Billions)	
Exchange Subsidies, etc.	\$358
Reinsurance/Risk Adj.	\$106
Medicaid/CHIP Expansion	\$434
Medicare FFS Payment Rates	(\$196)
Medicare Advantage Cuts	(\$136)
Medicare/Medicaid DSH Pymts <sup>(1)</sup>	(\$36)
CLASS (Pre-Benefit Premiums)	(\$70)
Education (Student Loans/Grants)	(\$19)
<u>Other</u>	<u>(\$59)</u>
<b>Total Outlays</b>	<b>\$382</b>

Offsets (\$Billions)	
Medicare Payroll & Unearned Inc. Tax	\$210
Reinsurance/Risk Adj.	\$106
Individual Penalties	\$17
Employer Penalties	\$52
“Cadillac” Plans Tax	\$32
Rx Manufacturer Fees	\$27
Medical Device Fees	\$20
Insurance Co. Fees	\$60
RDS Part D Taxes	\$5
Exclude biofuel credit	\$24
Exchange Prem Credits	(\$107)
Small Er Tax Credits	(\$37)
<u>Other Taxes</u>	<u>\$116</u>
<b>Total Offsets</b>	<b>\$525</b>

**Net Change in Deficit = \$382 - \$525  
= (\$143 Billion)**

<sup>(1)</sup> DSH = Disproportionate Share Hospital Payments

All figures from 03/20/10 Analyses by Congressional Budget Office (CBO) Analysis & Joint Committee on Taxation (JCT)

## CBO / JCT Projections; 2010 thru 2019

“The reconciliation proposal and H.R. 3590 would maintain and put into effect a **number of policies that might be difficult to sustain over a long period of time**. Under current law, payment rates for **physicians’ services in Medicare would be reduced by about 21 percent in 2010 and then decline further in subsequent years**; the proposal makes no changes to those provisions. At the same time, the legislation includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, **increases in payment rates for many providers would be held below the rate of inflation** (in expectation of ongoing productivity improvements in the delivery of health care). The projected longer-term savings for the legislation also reflect an assumption that the Independent Payment Advisory Board established by H.R. 3590 would be fairly effective in reducing costs beyond the reductions that would be achieved by other aspects of the legislation.”<sup>(1)</sup>

<sup>(1)</sup> Excerpt from CBO Scoring Report of 3/20/2010

## CBO / JCT Projections; 2010 thru 2019

“Under the legislation, CBO expects that Medicare spending would increase significantly more slowly during the next two decades than it has increased during the past two decades (per beneficiary, after adjusting for inflation). It is unclear whether such a reduction in the growth rate of spending could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or through reductions in access to care or the quality of care. The long-term budgetary impact could be quite different if key provisions of the legislation were ultimately changed or not fully implemented. If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.”<sup>(1)</sup>

<sup>(1)</sup> Excerpt from CBO Scoring Report of 3/20/2010

# PART 3

**What's Next?**

# What's Next? – Part 3

## Part 3 Discussion Topics

1. “Repeal and Replace” – what are the prospects?
2. Positives and Negatives of Health Care Exchanges
3. Massachusetts – a precursor?
4. Health insurance industry survival / autonomy at risk?
5. Impact on Individual and Small Group Markets?
6. Impact on Large Group Market?
7. Impact on Medicare Advantage Plans?
8. Which way will the “Cost Curve” bend?