Health Care Reform Update

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Agenda

This will be an general session exploring the following topics:

- Why and how do I keep up with health care reform?
- Supreme Court Ruling
- Election Results – Did or will they impact current legislation?
- Timelines
  - Upcoming Changes
  - Beginning of Exchanges
- Essential Health Benefits and Actuarial Value
- Rating Changes as of January 1, 2014
- New competition – CO-OPs
Health Care Reform

- Why do I need to know?
- Where do I start?
- Basic resources

HCR – Why do I need to know?

- Duties of an actuary
  - CE requirements
  - Consulting actuaries need to stay up to date on topics affecting their clients
  - Company actuaries need to stay current on topics affecting their company and financial performance
  - Responsibility to the public

- Personal knowledge
HCR – Basic Resources

- http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act
- http://www.cbo.gov/
- http://cciio.cms.gov/
- http://www.ncsl.org/
- http://www.hhs.gov/
- http://www.naic.org/

Items Included in the Supreme Court Ruling

- Individual Mandate
  - Requirement that all individuals purchase a minimum level of health care coverage

- Medicaid Expansion
  - For many eligibility groups, coverage is currently based on income and that’s usually determined in relation to the Federal Poverty Level
  - Under ACA, coverage expanded from 100% of FPL to 133%
Supreme Court Ruling (June 28, 2012)

- Individual Mandate is upheld as Constitutional
  - upheld under the taxing power of Congress as the imposition of a tax on those who do not have insurance
  - could not be sustained under the Commerce Clause or the Necessary and Proper Clause
    - Commerce clause is the ability to regulate commerce
    - Even if the individual mandate is “necessary” to ACA’s other reforms, such an expansion of federal power is not a “proper” means for making those reforms effective.

- Medicaid Expansion
  - Medicaid expansion violates the Constitution by threatening States with the loss of their existing Medicaid funding if they decline to comply with the expansion

Tax Penalties

- Annual tax penalty for not having minimum essential coverage is the greater of:
  - Flat dollar amount per individual, or
    - After 2016, indexed to inflation
    - Penalty capped at 300% of flat dollar amount
  - A percentage of the individual’s taxable income
    - Equals percent of household income in excess of tax filing threshold
    - 1% in 2014, 2% in 2015, and 2.5% in 2016

- For any dependent under age 18, penalty is ½ of individual amount

- Annual penalty capped at amount equal to national avg prem for bronze level QHP available through State exchange
Funding of Health Care Reform

- Funded through additional taxes and expected savings
- Taxes
  - Increase Medicare tax rate
  - Annual fee for health insurers
  - Cadillac tax
  - Annual fee for drug manufacturers
  - Excise tax on medical devices
- Expected Savings
  - Reduce Medicare Advantage funding
  - Reduce Medicare home care payments
  - Reduce Medicare hospital payments

November Election Results

- Democratic Party retains the Presidency
- Republican Party retains control of the House of Representatives
  - 435 Total – 233 Rep, 194 Dem, 8 Undecided (as of 11/14)
- Democratic Party retains control of the Senate
  - 100 Total – 53 Dem, 45 Rep, and 2 Ind
November Election Results

- What does this mean for ACA?
  - No impact to current legislation
  - Are there going to be issues with the current timeline?

Current Timeline for ACA through 2015

- August 1, 2012 – Women’s Preventive Services (i.e., Contraceptive Mandate)
- November 16, 2012 – States declare intentions to run exchange
- December 14, 2012 – States must submit blue-print for exchange (Recent extension)
- January 1, 2013 – HHS approval of State-based exchanges
- August 1, 2013 – Religious Organizations must comply with Contraceptive Mandate
- January 1, 2014
  - Operational start of health insurance exchanges
  - Restrictions on individual and small group rating
  - Metal plans
  - Individual mandate
Progress of State Exchanges

- Currently, 12 states and the District of Columbia have enacted establishment legislation
  - Besides UT and MA, where some form of health care reform has been in place, CA has progressed more than the others in establishment of an exchange
- 4 states have pending legislation
- 9 states are not creating exchanges
- The remaining 25 states are somewhere in between

Exchange Timeline from Now until January 1, 2014 (Best Case Scenario)

- Let's Work Backwards:
  - January 1, 2014 – Exchanges become operational
  - October 1, 2013 – Open enrollment begins
  - August 1, 2013 – 60 days prior to open enrollment and probably the drop dead date for filing rates needed for approval for Oct. 1st; however, probably need at least 60 days for marketing and outreach
  - June 1, 2013 – 120 days prior to open enrollment and probably when most rate filings will need to be completed. Latest date carriers will need to start rate development.
  - April 1, 2013 – 180 days prior to open enrollment and probably the date carriers will need to start rate development
  - January 1, 2013
Essential Health Benefits

- Minimum insurance benefits people will be entitled to in 2014
- Defined on a state-by-state basis
- Apply to individual and small group plans sold within and outside the state-based exchanges scheduled to launch in 2014.
- Many states have begun to define what benefits must be covered
- Nearly all have selected as a benchmark for minimum coverage one of the three most popular small group health plans available to residents now
- Can find a listing of current plans by state here:
  - [http://www.statereforum.org/analyses](http://www.statereforum.org/analyses)
  - Refer to “State Progress on Essential Health Benefits”

Requirements for Offering Health Insurance Inside vs. Outside of an Exchange

- Must be a Qualified Health Plan to offer coverage in the Exchange
- QHP Basic requirements
  - Licensed and in good standing in each State where coverage is offered
  - Offer at least one silver level and one gold level plan in exchange;
  - Charge the same premium rate for each qualified health plan of the issuer whether offered in or out of the exchange
  - Comply with all applicable requirements for the exchange
    - For example, offer sufficient choice of providers or have a quality improvement program
What is “Silver and Gold”? 

- Benefit levels in the individual and small group market 
- 4 “Metallic” levels available 
  - Bronze – Actuarial value of 60% 
  - Silver – 70% 
  - Gold – 80% 
  - Platinum – 90% 
- Must offer at least 1 silver and 1 gold 

Actuarial Value 

- Measures the percentage of expected medical costs that a health plan will cover 
- Used to categorize health plans sold in the individual and small group markets into coverage tiers 
- Will help consumers compare coverage choices based on a relative value 
- HHS will publish a calculation tool 
  - Based on a standard population 
  - Uses their claims data to develop value of cost sharing 
  - Based on a practical approach 
- Valuation of HSA and HRA plans assume employer contributions are first dollar coverage
Rating Restrictions for Individual and Small Group Health Benefit Plans

- Begin January 1, 2014
- Guaranteed issue and renewal
- No pre-existing condition exclusions (i.e., no prospective underwriting)
- Rates for a specific plan of benefits can vary by:
  - Age (not gender) and is limited to 3:1 for adults
  - Smoking status (limited to 1.5:1)
  - Individual versus Family
  - Geographic area (established by each state)
- No other rating characteristics allowed

Two Items to Think About

- No prospective underwriting
  - Influx of uninsured
    - Young invincibles
    - Those that can afford to fund health care costs
    - Unhealthy
  - 20% of the people are responsible for 80% of the costs

- Restrictions on the use of age as a rating variable
Age Slope: A Closer Look

- Ratio of highest to lowest
  - Actual Claim Costs – 7:1 (Based on Milliman HCGs)
  - Permissible by Law – 3:1

- What do these rating changes mean?
  - Subsidies
  - Health of underlying population
  - Number of uninsured
New Competitors – CO-OPs

Definition (Consumer Operated and Oriented Plans)
- CO-OP is a new type of nonprofit health insurer that is directed by its customers, uses profits for customers’ benefit, and is designed to offer individuals and small businesses affordable, customer-friendly, and high-quality health insurance options. CO-OPs may operate locally, State-wide, or in multiple States. CO-OPs must be licensed as issuers in each State in which they operate and are subject to State laws and regulations that apply to all similarly-situated issuers.

- Exchange focused
  - 66% of contracts (i.e., groups) must be sold through exchanges

- Most have a unique strategy or focus in their market

- If approved, qualify for a 5 year start-up loan and a 15 year solvency loan

As of October 12, 2012
- 23 CO-OPs have been funded
- Cover business in 23 different states
  - 2 in the State of Oregon, but
  - 1 CO-OP covers Iowa and Nebraska
- Have been awarded $1.8 B in loans of the $3.8 B committed under ACA
- Loans only made to private, non-profit entities
- Quarterly application process
  - Next deadline is December 31, 2012
- A list of the current CO-OPs is found here:
**Premium and Cost Sharing Subsidies**

- **Premium subsidies**
  - Depends on income level and number of family members
  - Provided as advanceable, refundable tax credit
  - Subsidize premiums for individuals in households with income up to 400% of FPL

- **Cost Sharing Subsidies**
  - Depends on income level and number of family members
  - Serves to reduce out-of-pocket expenses
  - Increases actuarial value of plan
  - Enrollee must be in a silver plan

**What We Do Not Know?**

- Still lots of unanswered questions
- Federal exchange
- Actuarial value model
- Essential benefits
- State regulations
Questions?