The Academy and Healthcare Reform

CAS Annual Meeting, Session C-25
November 10, 2010
Washington, DC

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Overview

- Key provisions of the Affordable Care Act (ACA)
  - Near-term
  - 2014 and beyond
- Involvement of the American Academy of Actuaries
  - Legislative phase
  - Implementation phase

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Affordable Care Act

- Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010
- Health Care and Education Reconciliation Act of 2010, signed into law on March 30, 2010
  - Amended certain provisions in PPACA
- Together, these are typically referred to as the Affordable Care Act (ACA)

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Key Provisions of the Affordable Care Act
Near-Term

- New annual premium review process
- MLR reporting and rebate requirements
  - 85% for large groups
  - 80% for individual and small group markets
- Elimination of lifetime limits; restriction on annual limits
- Extension of dependent coverage to age 26
- Prohibits pre-existing condition exclusions for children<19
- First-dollar coverage of certain preventive services
- Prohibition of rescissions

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Key Provisions of the Affordable Care Act
Near-Term (cont.)

- Grandfathers existing plans (as of the date of enactment) from most reforms
- Temporary high-risk pool
- Temporary reinsurance program for early retirees
- Tax credits for small businesses
- Medicare provisions
  - Begins phasing in elimination of Part D coverage gap
  - Begins phasing down Medicare Advantage payments, relative to fee-for-service payments

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Key Provisions of the Affordable Care Act
2014 and Beyond

- Insurance market reforms
  - Guaranteed issue
  - Allowed premium rating factors: age (3:1), geography, family size, tobacco (1.5:1)
- Benefit tiers, based on actuarial value
  - Platinum (90%), gold (80%), silver (70%), bronze (60%)
  - Catastrophic plans available for individuals up to age 30 or exempt from mandate
- Individual and small group market exchanges (state-based)
- Risk-sharing mechanisms for private plans
  - Risk adjustment
  - Reinsurance (temporary 2014-2016)
  - Risk corridors (temporary 2014-2016)

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Key Provisions of the Affordable Care Act
2014 and Beyond (cont.)

- Individual mandate—penalty for those without coverage:
  - 2014: Greater of $95 or 1.0% of taxable income
  - 2015: Greater of $325 or 2.0% of taxable income
  - 2016+: Greater of $625 (indexed) or 2.5% of taxable income
- Premium and cost-sharing subsidies to individuals
  - Premium subsidies available for individuals with income up to 400% of the federal poverty line (FPL)
  - Cost-sharing subsidies available up to 250% FPL
- Medicaid expansions up to 133% FPL
- CHIP maintains current eligibility rules until 2019

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Key Provisions of the Affordable Care Act
2014 and Beyond (cont.)

- Employer responsibility
  - Penalties for employers with more than 50 employees who have at least one full-time employee who receives a premium tax credit through the exchange
- Cadillac plan tax (beginning 2018)
  - Excise tax on high-cost employer plans
  - Tax is 40% of the plan value that exceeds a threshold
    - $10,200 for individual coverage; $27,500 for family coverage
    - Thresholds indexed beginning 2020
    - Thresholds increased for certain high-cost groups

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Key Provisions of the Affordable Care Act
Select Cost and Quality Provisions

- Promote wellness and prevention
- New payment and delivery system initiatives
- Facilitate comparative effectiveness research and best practices
- Improve workforce training and development
- Creation of Medicare Independent Payment Advisory Board (IPAB)

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Key Provisions of the Affordable Care Act
Provisions Affecting Workers Compensation

- Provisions that have a direct effect
  - Repeals 1981 Black Lung Benefits Act reforms
- Provisions that may have an indirect effect
  - Frequency of workers compensation claims
  - New taxes on pharmaceutical and medical device manufacturers
  - Changes to Medicare's reimbursement levels
  - Comparative effectiveness research

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Actuarial Involvement with Implementation

- American Academy of Actuaries
- Actuarial involvement with other organizations (e.g., NAIC, NASI)
- Actuaries consulting for federal/state governments, employers, and insurers on implementation issues
- Actuaries working directly at carriers

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Academy Involvement
Legislative Phase

- Input to Congress
  - Comment letters to congressional leadership
  - Written testimony to congressional hearings regarding the keys to viable reform
  - Academy hill briefings and webcasts for congressional staff
  - Presentations at “off the record” forums for congressional staff
  - Meetings with congressional staff/response to congressional requests

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Academy Involvement
Legislative Phase (cont.)

- Publications
  - *Critical Issues in Health Reform*—a series of 2-4 page papers providing an actuarial perspective on various health reform topics
  - Issue briefs and monographs
  - Collaborative projects with the SOA
    - Excise tax on high-cost employer plans
    - Start-up capital costs for health care co-ops and a public plan
    - Implications of the CLASS Act

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Academy Involvement
Legislative Phase (cont.)

- Other activities
  - Presentations and testimony at meetings of other organizations
  - Presentations at briefings for congressional staff organized by other organizations
  - Outreach to other health policy organizations
- Media outreach
  - Academy work on health reform-related issues has been featured in numerous media outlets

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Academy Involvement
Regulatory Phase

- Meetings with administration staff
  - White House Office of Health Policy
  - HHS Office of Consumer Information and Insurance Oversight (OCIIO)
- Meetings with congressional staff
- Presentations for congressional staff and other policy experts
- Webinars for actuaries (in conjunction with SOA and CCA)

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Academy Activities-Regulatory Phase
MLR Reporting and Rebates

- Provided input to HHS and NAIC, via comment letters, calls, and meetings
- Participated in congressional briefing on MLR issues
- Academy has stressed that regulations should be structured to:
  - Create fair comparisons between different types of health insurers
  - Minimize potential disruption in the individual market
- In particular, focused on issues related to credibility, aggregation, and what's included in the MLR numerator and denominator

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Academy Activities-Regulatory Phase
Premium Oversight

- ACA requires HHS in conjunction with States to establish a process for the annual review of unreasonable increases in health insurance premiums
  - Justification for unreasonable premium increases is required
  - "Unreasonable" needs to be defined
- Academy comments to HHS
  - Response to an HHS request for information
  - Forthcoming comment letter examines approaches for defining "unreasonable"
- Academy has stressed key principles for premium oversight:
  - Health insurance premiums must be adequate to pay projected claims, expenses, and supporting risk charges
  - Premium oversight should be done in conjunction with insurer solvency oversight
  - Premium oversight must incorporate actuarial principles

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Academy Activities-Regulatory Phase
Early Retiree Reinsurance Program

- Temporary reinsurance program for early retirees
  - Reimburse 80% of costs between $15,000 and $90,000
  - $5 billion to finance the program – first come, first serve
- Submitted comment letter to HHS responding to interim final rule (IFR)
  - Raised concerns regarding first come, first serve method, as funding could run out before 2014 and large employers could have an advantage
  - Also addressed some technical details

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Academy Activities-Regulatory Phase
Near-Term Benefit and Eligibility Changes

- Dependent coverage to age 26
  - Comment letter to HHS responding to IFR
  - Requested clarification on rules regarding age rating
  - Raised concerns regarding the disparity in treatment between grandfathered plans and non-grandfathered plans
- Prohibits pre-existing condition exclusions for children<19
  - Rules are expanding this to provide guaranteed issue
  - Comment letter to HHS responding to IFR
  - Raised concern that limited and uniform open enrollment periods would be needed to mitigate adverse selection (especially an issue with child-only plans)

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Academy Activities-Regulatory Phase
Near-Term Benefit and Eligibility Changes (cont.)

- Elimination of lifetime/restriction on annual limits
  - Comment letter to HHS responding to IFR
  - Requested clarification regarding whether non-dollar limits (e.g., limits on number of visits) are allowed
- First dollar coverage for certain preventive services
  - Comment letter to HHS responding to IFR
  - Requested clarification regarding the frequency and scope of services included
    - Subsequently, HHS released an FAQ clarifying that carrier can use reasonable medical management techniques and relevant evidence to determine coverage limitations (if not already specified in a recommendation or guideline)

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Academy Activities-Regulatory Phase
Grandfathering Provisions

- Comment letter to HHS responding to IFR
- Transition rule allows plans/carriers that made changes that would trigger loss of grandfathered status to revert to acceptable grandfathered levels (prior to end of 2010)
  - Academy raised concerns that IFR focuses on actions taken by plans/carriers, but not actions taken by individuals

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Academy Activities-Regulatory Phase
Risk-Sharing Provisions

- Reinsurance
  - ACA vests the Academy with providing recommendations to HHS regarding the law's reinsurance provisions
    - identifying high-risk individuals
    - determining reinsurance payment amounts
  - Letter to HHS outlines potential approaches
    - Subsequent letters and meetings with HHS will refine the potential approaches
- Risk adjustment
  - Academy represented at a Commonwealth Fund sponsored meeting on risk adjustment
  - More in-depth work expected on risk adjustment and risk corridors

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Academy Activities-Regulatory Phase
Exchanges

- Response to an HHS request for information focused on issues related to:
  - Plan minimum standards and bidding process
  - Plan quality metrics
  - Open enrollment period options
  - Employer participation
  - Risk-sharing provisions
- Forthcoming letter on actuarial value issues

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Academy Activities
Communicating with Members

twitter Actuary_Dot_Org

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Health Reform: Implications for Workers Compensation

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November 10, 2010

Potential WC Impacts

- Changes to Federal Black Lung Benefits
- Changes to Medicare's Reimbursement Rates
- Increase in Healthcare Coverage
- Other Potential Frequency/Severity Impacts

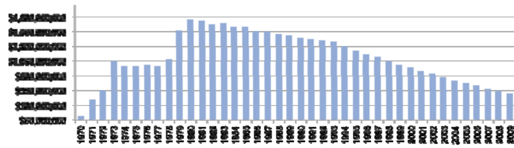
Federal Black Lung Benefits

Repeals of 1981 Black Lung Benefit Act reforms:

- **Automatic survivor benefit** - paid upon death of miner without requirement to show that death was due to black lung disease
- **15 year presumption** - reinstates rebuttable presumption that black lung is the cause of disability/death if miner worked for 15 or more years in underground mines

Federal Black Lung Benefits

Historical Paid Benefits 1970-2009



- $44 billion of benefits paid under the Black Lung program from 1970-2009
- Entitlement ratios for black lung claims decreased from 60-70% in the 1970's to 10-15% in recent years
- Concern that Health Care Bill's repeal of the 1981 reforms could increase entitlement ratios closer to former levels
- Impacts all claims filed after January 1, 2005; concern that no premium has been collected for the potential retroactive impact

Medicare's Reimbursement Rates

TITLE III:

Improving the Quality and Efficiency of Health Care

- **Medicare's Reimbursement Rates** – may change as a result of provisions of Title III
- **Workers Compensation Connection** – many states have medical fee schedules that are directly or indirectly tied to Medicare Reimbursement Rates
- **Workers Compensation Impact** – medical represent nearly 60% of the costs to the workers compensation system countrywide. There could be a significant impact to workers compensation costs if Medicare's Reimbursement Rates change.

Increase in Healthcare Coverage

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TITLE I:
Quality, Affordable Health Care for All Americans

- **Expanding Healthcare Coverage** – the primary impetus for the Health Care Bill
- **Workers Compensation Impact** – many potential effects, including:
  - **More healthcare coverage = less access to Workers Compensation system for non-work related injuries?**
  - **More healthcare coverage = less access to physicians?**

Other Potential Impacts

Deloitte.

- **Wellness Programs** – could reduce workers compensation frequency and severity
- **Taxes** – pharmaceutical and medical equipment manufacturers face several billion dollars in new taxes; a portion of these costs could be passed along to the workers compensation system
- **Fraud Reduction** – could improve compliance
- **Workers Compensation Impact** – some areas where workers compensation costs will clearly increase, but potential for savings as well from improvements to the healthcare system

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Member of
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Medical Loss Ratio

PPACA Requires:

- Beginning January 1, 2011, issuers shall, each plan year, pay rebates to enrollees if the Medical Loss is lower than:
  - 80% in the non-group market
  - 80% in the small group market
  - 85% in the large group market

  NOTE: A state may set a higher percentage – The Secretary may set a lower percentage in a state if the non-group market is destabilized or adjust the rates due to volatility caused by the Exchanges.
- By December 31, 2010, the NAIC shall establish uniform definitions and standardized methodologies for calculating the components included in the Medical Loss Ratio. This is subject to Secretary certification.

Medical Loss Ratio

Components of the Medical Loss Ratio:

Reimbursement for clinical services +
Expenditures to improve health care quality

———————————————

Total premium revenue –
Federal and State taxes and licensing or regulatory fees
(and accounting for risk adjustment, risk corridors and reinsurance)

- The issuer must provide an annual report to the Secretary on the above expenditures/revenues and other non-claims costs, including and explanation of the nature of such costs.

Medical Loss Ratio

NAIC Considerations:

- The NAIC Health Reform Solvency Impact (E) Subgroup developed a "blank" to capture the information required to be reported to the Secretary and to calculate the MLR. The Subgroup also developed instructions that will include the definition of "activities that improve health care quality."
- The "blank" and instructions were adopted by the NAIC in Seattle (Aug 2010)
- The NAIC PPACA Actuarial Subgroup developed the final model that includes the methodologies for calculating the MLR and the definitions, many of which were taken from the "blank" instructions.
- The final regulations was adopted by the NAIC in Orlando (October 2010) and was submitted to HHS on October 27th.

Medical Loss Ratio

Key Issues in Regulation:

- Definition of Plan Year (calendar year)
- Definition of "Small Group" and "Large Group" (state law)
- Definition of "quality improvement activities"
  - improve health outcomes
  - prevent hospital readmissions
  - improve safety and reduce medical errors, lower infection and mortality rates;
  - increase wellness and promote health activities
  - enhance the use of health care data to improve quality, transparency, and outcomes
- Definition of taxes (all except for income tax on investment income)
- Aggregation (calculated at state level, by market, by legal entity)
- Credibility (confidence level of 50%)

Medical Loss Ratio

Other Issues:

- Special Considerations for Expatriate Plans
- Transition to 2014 (avoid market disruption)
- Address Agent Compensation
- Payment of Rebates

➢ NAIC sent a letter to Secretary Sebelius on October 13th addressing these issues

Rate Review

- "Unreasonable" rate increases must be filed with Secretary and state, and posted for public review
- Plans with "excessive" rate increases may be excluded from the Exchange
  - HHS working on regulation that will define "unreasonable" and "excessive"
  - NAIC working on uniform disclosure form for filing with feds and state, and posting for the public

Questions?

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Actuarial Implications – Health Reform

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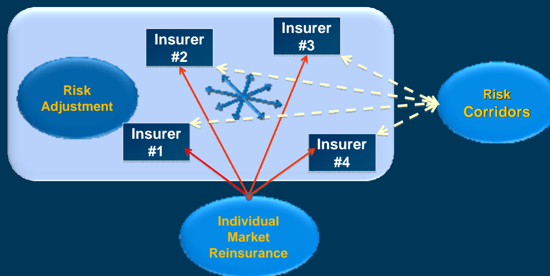
Engineering Sustainable Financing and Business Models

- Broad implications affecting 15% to 20% GDP
- New risk environments
  - Guarantee issue, pre-existing conditions
  - What is covered?
  - Cash flow and pricing risks
  - Solvency
- Provider payment and financing
- Casualty impacts
- Professionalism

Risk Stabilization Programs – Complicated Business Issues



Solvency

- Full cost accounting, balance sheet
- Insurers – Adequate premiums, risk charge and capital/surplus
- Government sponsored – Adequate premium and revenue sources, stabilization funds
- Health care providers – Risk recognition and management, capital/surplus and stop loss

Questions?