

The Affordable Care Act: What Every Actuary Should Know

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Agenda

- Background on the uninsured and the pre-reform markets
- Key provisions of the Affordable Care Act (ACA)
 - Effective 2010-2013
 - Effective 2014 and beyond
- Current status of implementation



Background of Health Reform



Why Are People Uninsured?

- Cost
- Lack of employer-sponsored coverage
- Age



Why Are People Uninsured?

Uninsured Rate by Family Income Non-elderly Americans in 2010

Family Income as % of Federal Poverty Level	Uninsured Rate
0 – 99 %	33.4%
100 – 149%	32.6%
150 – 199%	28.6%
200 – 299%	20.7%
300% or more	8.5%

Source: Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey*, Employee Benefits Research Institute, September 2011.



Why Are People Uninsured?

Uninsured Rate by Work Status of Family Head Non-elderly Americans in 2010

Work Status of Family Head	Uninsured Rate
Full-time, Full Year Worker	13.9%
Full-time, Part Year Worker	30.7%
Part-time, Full Year Worker	28.0%
Part-time, Part Year Worker	24.6%
Non-Worker	28.8%

Source: Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey*, Employee Benefits Research Institute, September 2011.



Why Are People Uninsured?

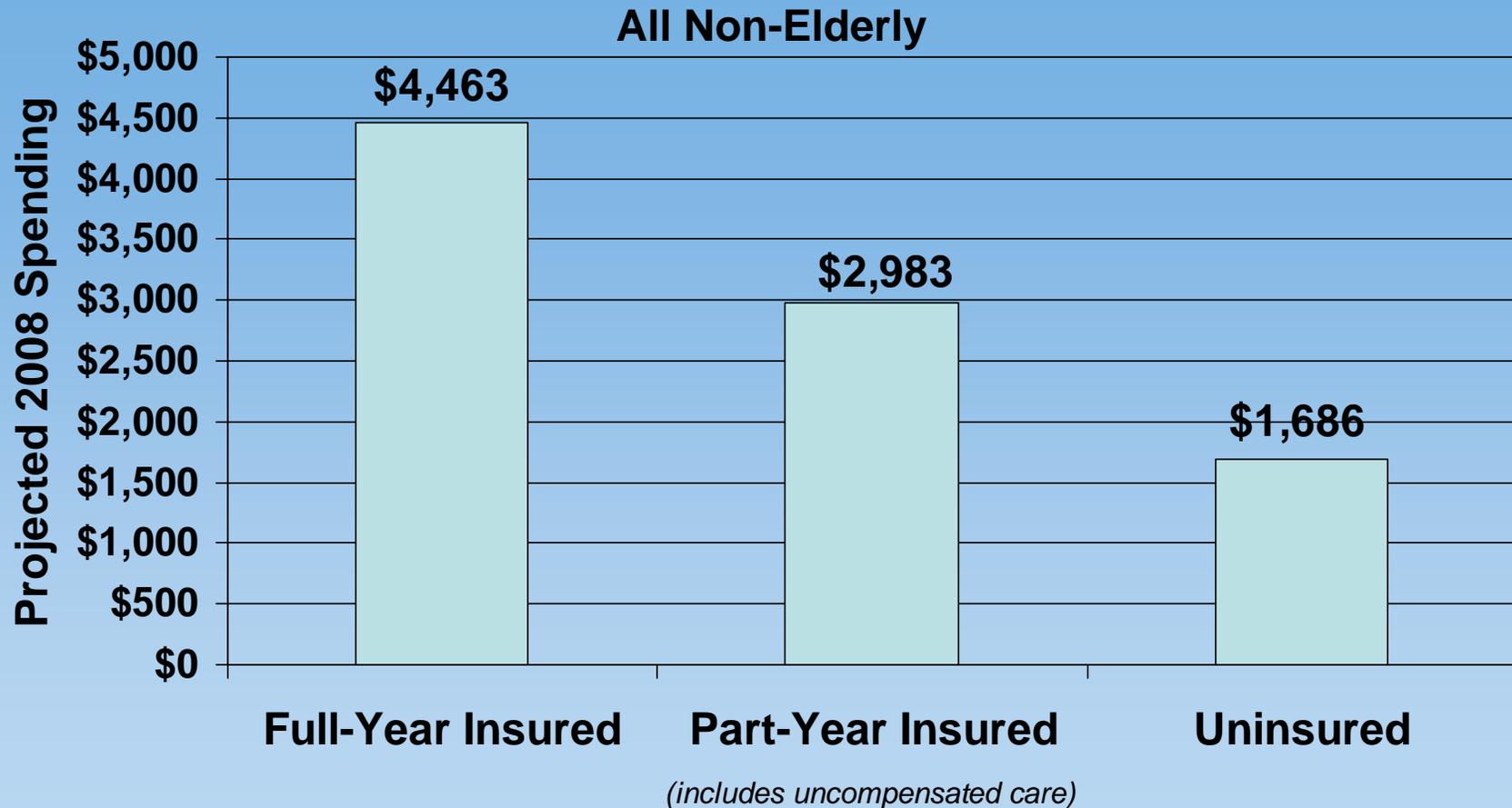
Uninsured Rate by Age 2010

Age	Uninsured Rate
Under 18	9.8%
18 to 24	27.2%
25 to 34	28.4%
35 to 44	21.8%
45 to 64	16.2%
65 and older	2.0%

Source: Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, U.S. Census Bureau, September 2011



Do the Uninsured Get Care?

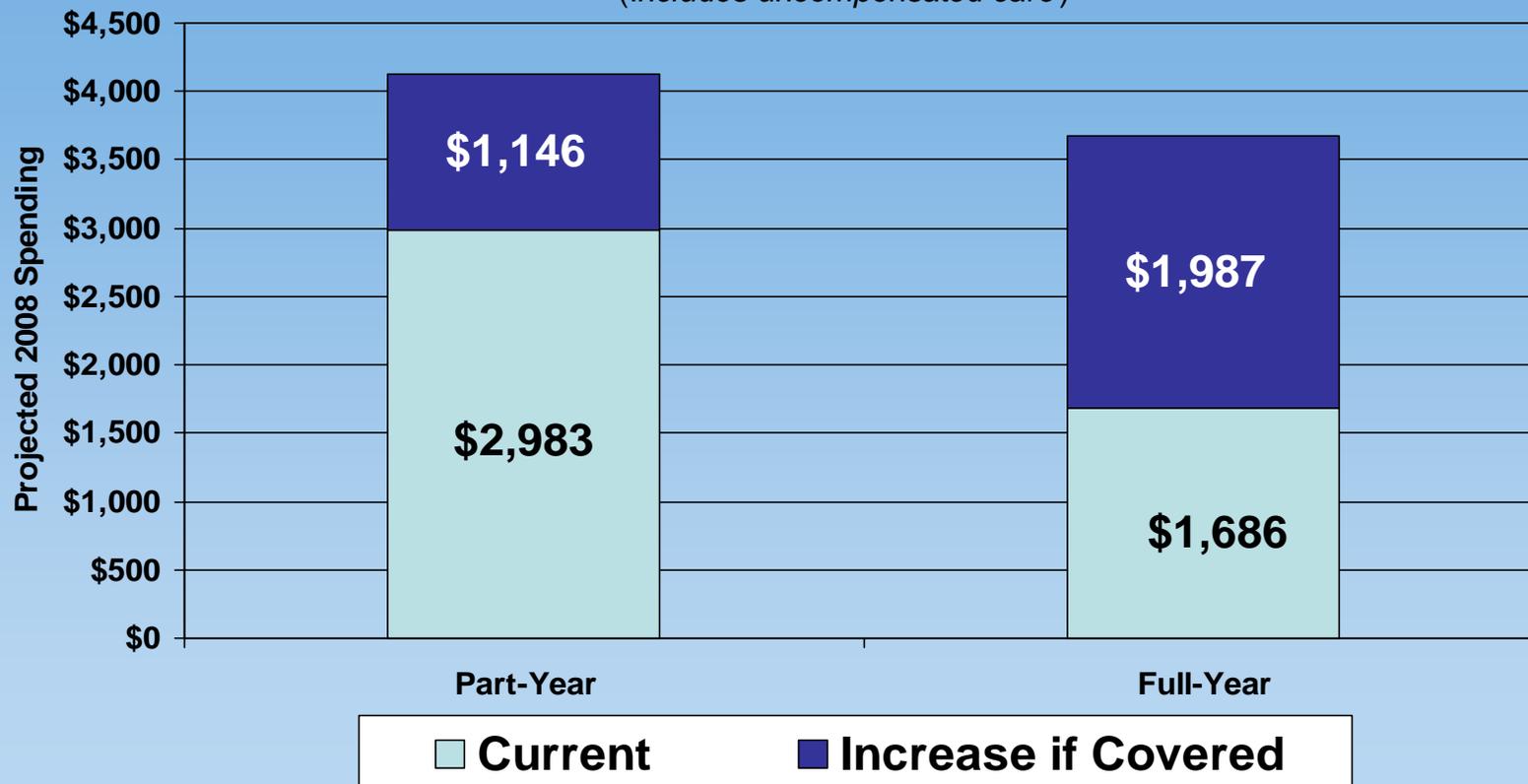


Source: *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage*, Kaiser Family Foundation, August 2008



Do They Get *Enough* Care?

All Non-Elderly Uninsured Effect of Coverage on Health Spending (Includes uncompensated care)



Source: *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage*, Kaiser Family Foundation, August 2008

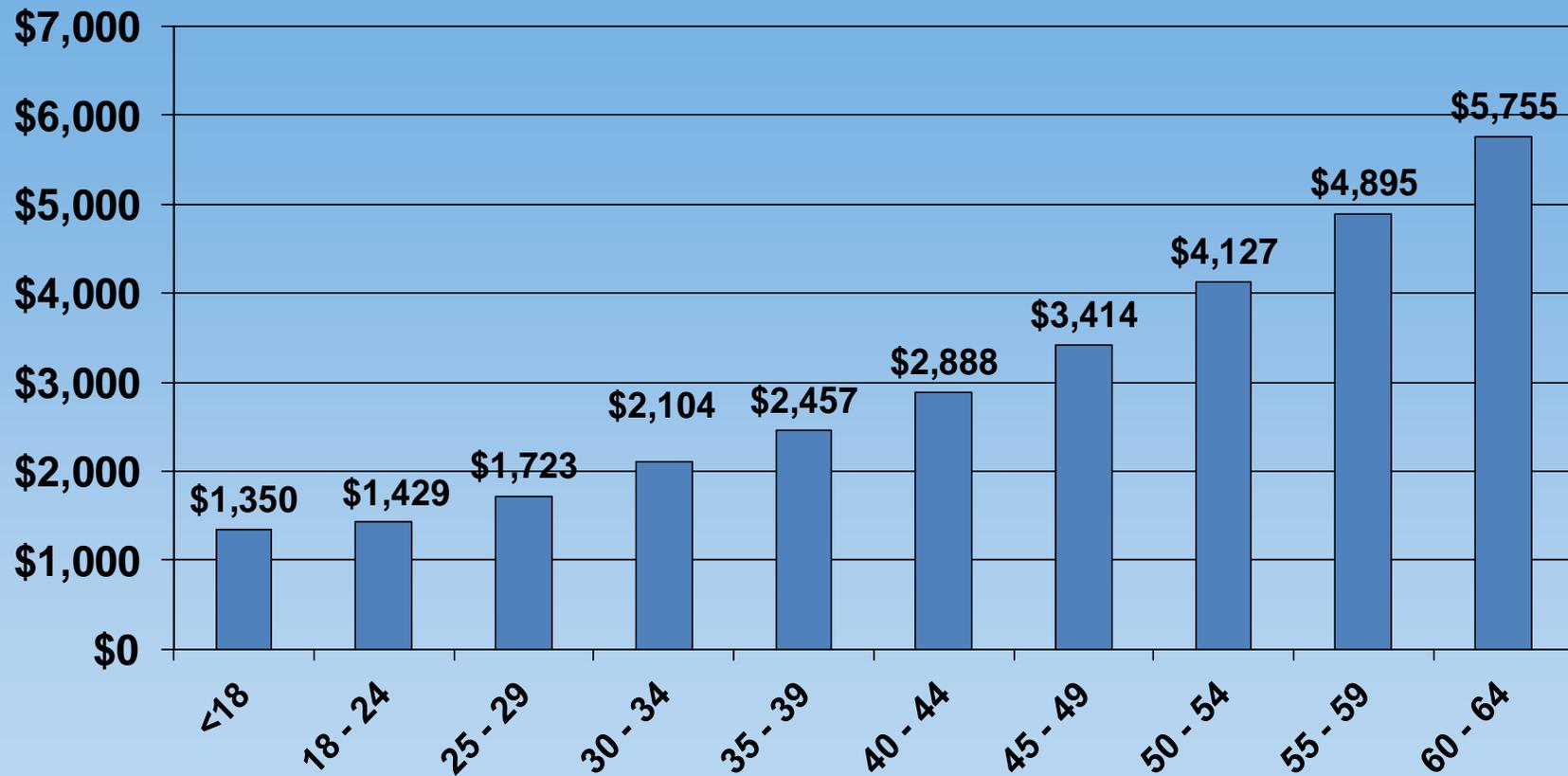


Pre-Reform Individual Market

- Roughly 1 of 10 non-elderly Americans with private coverage
- Coverage is voluntary
- Most states allow underwriting based on health status
- Premiums typically vary significantly by age
- Buyers are generally cost conscious (no employer subsidy)
- Same basic range of products is available as in the group market, *but* buyers typically choose higher cost-sharing to hold down premiums



Individual Market Premiums by Age



Source: *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits*, AHIP, October 2009



Effect of Medical Underwriting

(where allowed)

Age	Declination Rate	Offer Rate
< 18	4.8%	95.2%
18 – 24	10.0%	90.0%
25 – 29	12.2%	87.8%
30 – 34	11.7%	88.3%
35 – 39	12.8%	87.2%
40 – 44	14.1%	85.9%
45 – 49	16.4%	83.6%
50 – 54	19.6%	80.4%
55 – 59	24.0%	76.0%
60 – 64	29.2%	70.8%
Total	12.7%	87.3%

Source: 2009 AHIP Individual Market Survey



Pre-Reform Small Group Market

- Small firms do not have to offer coverage (many don't)
- Coverage is guaranteed issue
- Most states allow premiums to vary by:
 - Prior group experience
 - Average age of the group
 - Industry
 - Geographic location
- Often choose higher deductibles, co-payments, and out-of-pocket limits than larger firms



Key Provisions of the ACA



Affordable Care Act (ACA)

- Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010
 - Individuals and employer groups enrolled in plans in existence on this date are considered grandfathered and exempt from most reforms
- Health Care and Education Reconciliation Act of 2010, signed into law on March 30, 2010
 - Amended certain provisions of PPACA
- Together, these are typically referred to as the Affordable Care Act (ACA)
- Generally, the ACA does not apply to Med Supp, LTC, DI, dental/vision, limited benefit plans



Strategy for Expanding Coverage

- Medicaid for everyone below 133% poverty
- Premium subsidies from 133% to 400% of poverty
- Individual and small group market reform
- Create exchanges to simplify purchasing process
- Encourage employers to continue providing coverage
- Individual mandate



What ACA Does Not Do

- The ACA builds/expands current public and private sources of coverage. It does NOT create a new public program.
- Although the traditional Medicare program (not private Medicare Advantage plans) sets provider payment rates, there are no price controls for private plan provider payments. The ACA does NOT impose new provider price controls for private plan payments.



Key Provisions of the ACA

2010–2013

- New annual premium review process
 - HHS review of “unreasonable” rate increases (does not apply to grandfathered plans)
 - States retain rate review authority if deemed by HHS to have an effective rate review program (vast majority of states have this)
- MLR reporting and rebate requirements
 - 85% for large groups
 - 80% for individual and small-group markets
 - 18 states have applied for exemption from individual MLR; 10 have been denied, 6 have been modified, 2 are still under review



Key Provisions of the ACA

2010–2013 (cont.)

- Elimination of lifetime limits (all plans); restriction on annual limits (non-grandfathered only)
- Extension of dependent coverage to age 26 (all plans)
- Prohibits pre-existing condition exclusions for children < 19
- First-dollar coverage of certain preventive services
- Temporary high-risk pool
- Temporary reinsurance program for early retirees
- Tax credits for small businesses



Key Provisions of the ACA

2014 and Beyond

- Insurance market reforms
 - Guaranteed issue (GI)
 - Allowed premium rating factors: age (no more than 3:1), geography, family size, tobacco (up to 1.5:1)
- Individual and small group market exchanges (state-based)
- Benefit tiers, based on actuarial value
 - Platinum (90%), gold (80%), silver (70%), bronze (60%)
 - Catastrophic plans available for individuals up to age 30
 - Plans must cover essential health benefits (EHB) encompassing 10 categories of services
- Risk-sharing mechanisms for non-grandfathered plans
 - Risk adjustment
 - Reinsurance (temporary 2014–2016)
 - Risk corridors (temporary 2014–2016)



Key Provisions of the ACA

2014 and Beyond (cont.)

- Individual mandate
 - Penalty for those without coverage (greater of):
 - 2014: \$95 per person or 1.0% of family income
 - 2015: \$325 per person or 2.0% of family income
 - 2016+: \$695 per person (indexed) or 2.5% of family income
 - Legal challenge and [amicus brief](#)
- Premium and cost-sharing subsidies to individuals
 - Premium subsidies available up to 400% FPL
 - Cost-sharing subsidies available up to 250% FPL



Key Provisions of the ACA

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



Key Provisions of the ACA

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



Key Provisions of the ACA

Voluntary Long-Term Care Insurance (CLASS Program)

- Voluntary program to support community living assistance services and support
- Financed through voluntary payroll deductions
- No underwriting
- Funding for CLASS withheld and program put “on hold” due to concerns with severe adverse selection



Understanding the Implications

- Important to remember that it isn't the size of the pool that determines cost, it's who's in the pool.
- Will the mandate be enough to offset the increase in average premiums from GI and modified community rating? Depends on whether the mandate, combined with the subsidies, is strong enough to bring in the young and healthy.
- “Winners” and “losers” will depend on current state rules relative to new rules
 - States that have GI without a mandate likely will see lower premiums
 - States that allow medical underwriting will likely see higher premiums
 - Young adults likely will see the largest increases in premiums



Understanding the Implications

Congressional Budget Office “Score”

- Net reduction in deficit of \$124 billion over 10 years
 - Driven by \$455 billion in Medicare spending reductions over 10 years (helps to offset premium subsidies)
- Reduce the number of uninsured by 32 million in 2019
 - Coverage rate of legal residents rises from 83% to 94%
 - Roughly half the increase in coverage is in Medicaid and CHIP

Note: Figures reflect original CBO final score. Subsequent estimates may differ somewhat, but not materially.



Status of ACA Implementation



Status of Implementation

Rules and Regulations

ACA established a framework for the reformed markets

Detailed requirements developed through regulation or guidance

HHS is charged with developing most regulations

Public comments requested

- Notice of Proposed Rulemaking (NPRM)
- Interim Final Regulation (IFR)



Status of Implementation

Today's Areas of Focus

- Unreasonable rate increase review
- Medical loss ratio (MLR) and rebates
- Essential health benefits
- Risk mitigation programs
- Actuarial value



Status of Implementation

Rate Increase Review Final Rule

- Academy [comments](#) to HHS
 - Response to an HHS request for information
 - Public statement that examines approaches for defining “unreasonable”
- Academy stressed key principles for premium oversight
 - Premiums must be adequate to pay projected claims, expenses, and supporting risk charges
 - Premium oversight should be in conjunction with solvency oversight
 - Premium oversight must incorporate actuarial principles



Status of Implementation

Rate Increase Review Final Rule

- HHS, with input from the NAIC, established a process for the review of “unreasonable” health premium increases
- Applies to small group and individual (excluding grandfathered plans) rate increases
 - Threshold of 10% beginning 2011
 - For 2012 and after, state-specific thresholds to be set by HHS
- Those exceeding the threshold are *subject to review*
- Insurers must submit a preliminary justification for all proposed rate increases subject to review



Status of Implementation

Rate Increase Review Final Rule

- States with effective rate review programs decide if rate increase is unreasonable
- For HHS reviews, increase is unreasonable if:
 - Excessive—causes the premium to be unreasonably high in relation to the benefits provided;
 - Unjustified—data or documentation is incomplete or inadequate to provide a basis for reasonableness; or
 - Unfairly discriminatory—results in differences between insureds within similar risks that do not reasonably correspond to differences in expected costs.
- HHS does not have actual rate approval authority
- If insurer implements “unreasonable” increase, must submit final justification to HHS and post information on its website



Status of Implementation

MLR and Rebate Final Rule

- Federal reporting including administrative expenses
- Rebate thresholds (applied by legal entity, state, and market)
 - 80% for individual and small group markets
 - 85% for large group market



- Additional state reporting developed by NAIC



Status of Implementation

Continuing MLR Developments

- Ongoing review of state exemption requests
- NAIC to update model regulation for 2014
 - Incorporate transfer of funds for risk mitigation programs
 - Consider timing issues
 - Forms also will need to be updated
- NAIC's process
 - Working group calls are open
 - Comments requested from all interested parties
 - Academy's MLR and Risk Sharing work groups will comment from an actuarial perspective
- HHS has to re-certify updated regulation



Status of Implementation

Essential Health Benefits Bulletin

- Institute of Medicine charged with developing policy foundations, criteria, and methods for defining and updating
 - Issued report in October 2011
 - Key message of balancing coverage with cost
- CCIIO released EHB bulletin in December
 - Addresses scope of covered services
 - Not benefit or cost-sharing levels
- Gives states flexibility to select benchmark plan for 2014–15
 - Identifies four options for benchmark plans for 2014 and 2015
 - Evaluation by HHS for 2016



Status of Implementation

Essential Health Benefits Bulletin

- Academy task force [comments](#)
 - Balance between scope of benefits, limitations, and cost of coverage
 - Treatment of dollar and visit limits v. 100% coverage
 - Need to define pediatric age limits, “medically necessary” orthodontia
 - Cost impact of expanding habilitative to “maintaining”
 - Caution on scope of benefit flexibility
 - Clarification of range of services in each EHB category
 - Impact on certain risks
 - How specific exclusions in benchmark plan will be addressed
 - Clarification of “actuarial equivalence” and “substantially equal”
 - Implementation complexity for reinsurance and risk adjustment if plans within a state define EHBs differently



Status of Implementation

Risk Mitigation Programs

- CCIIO risk adjustment white paper
 - Potential methods
 - Prospective versus concurrent approach
 - Use of pharmacy data
 - Effects of different benefit levels
 - Transitional versus steady-state model
 - Calculating payments and charges
 - Establishing baseline premium
 - Balancing payments and charges
 - Permissible rating variations
 - Age
 - Tobacco
 - Geographic area
 - Family size

“The aim of the risk adjustment methodology is to result in plan premiums that differ due to benefit levels and efficiency, but not the risk of their enrolled population.”

- CCIIO Risk Adjustment white paper



Status of Implementation

Risk Mitigation Programs

- Reinsurance program
 - Law included requirement for Academy input
 - Provided HHS pros and cons of various structures
 - Input reflected in proposed program
 - Likely a percentage of claims over attachment point
 - All claims, not condition based

- Risk corridor program
 - Proposed to be similar to Medicare Part D
 - More guidance and clarification needed

- Academy Risk Sharing Work Group
 - Importance of coordination of three programs
 - Also integrate with MLR and rating requirements



Status of Implementation

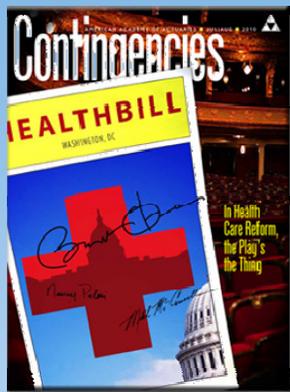
Actuarial Value Issues

- No proposed regulation or guidance to date
- Options for method
- Academy Actuarial Value Work Group released [issue brief](#) discussing
 - Options to define a standard population
 - Healthcare utilization assumptions
 - Geographic variations affects calculation
 - Year-to-year changes in actuarial values
- Proposed rule expected later this year



Academy Activities

Communicating with Members



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