Connecting the Dots on Health Care Reform

The Law, The Policy, and What It Means for Associations

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Policy

THE HEALTH CARE CRISIS

- An American Journal of medicine report recently found 62 percent of all bankruptcies in 2007 were linked to medical expenses. An incredible 78 percent of those people had health insurance.
- The average family with health insurance is already paying $1,017 more each year in premiums to cover the cost of treating the uninsured.

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Policy

THE HEALTH CARE CRISIS

- According to a recent study by Harvard Medical School researchers, nearly 45,000 Americans die each year – 1 every 12 minutes – because they lack health insurance and access to medical care.

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GOAL OF HEALTH CARE REFORM

- Improving Quality
- Promoting Efficiency
- Controlling Costs
- Improved Access and Affordability
- Prevention and Wellness
- Shared Responsibility
- Workforce Investments to Address Shortages

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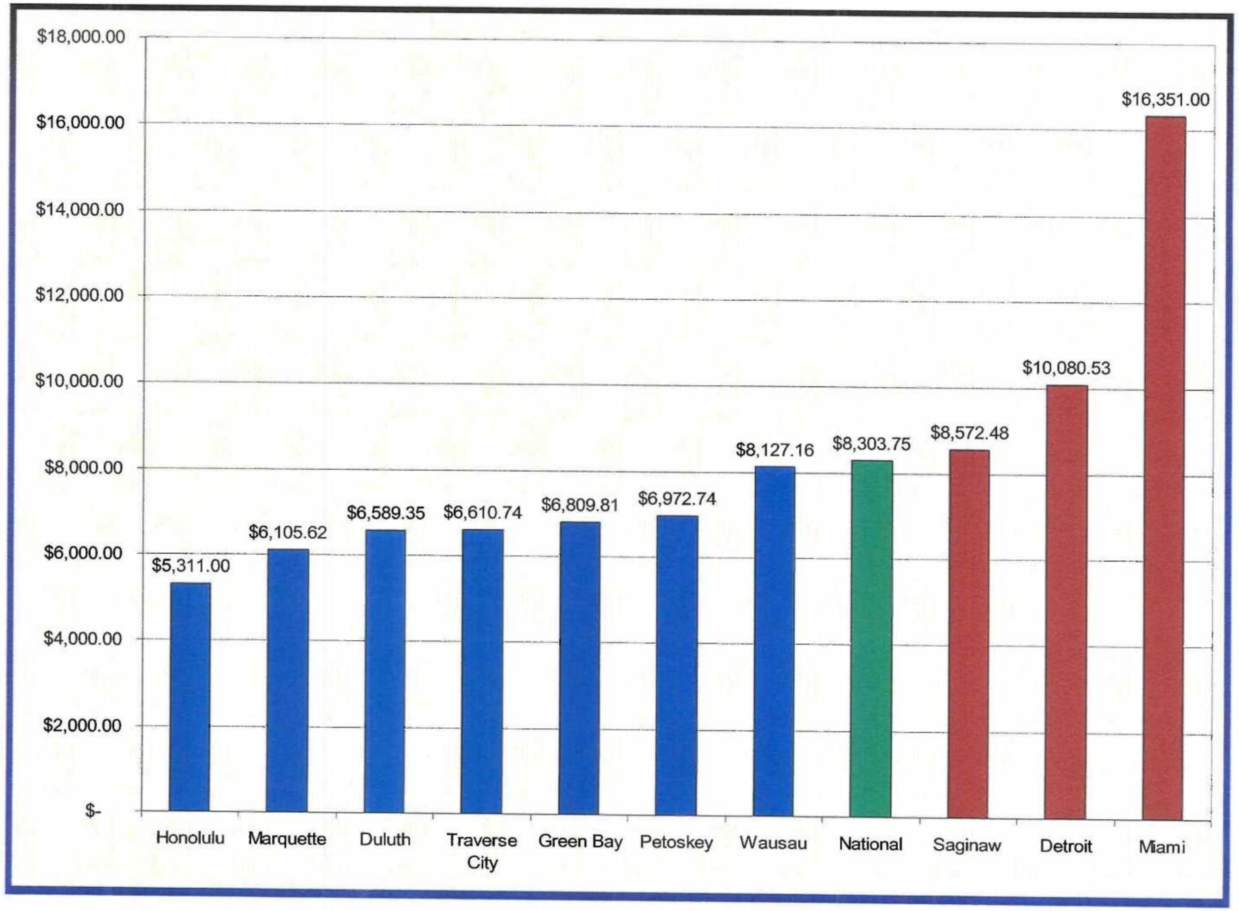

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The Drivers of Health Care Reform?

- Reform Insurance Laws
  - Mandate certain insurance standards
    - For example, "Essential Health Benefits," Cost-Sharing Limitations, and "Actuarial Value"
- Coverage - Priority #1
  - Expand Medicaid
  - Provide premium subsidies to help low- to middle-income people purchase health insurance
    - The new health insurance Exchanges created under PPACA became the mechanism through which these subsidies could be accessed

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The Exchange & Congressional Intent

- The original intent of the Exchange created under PPACA was not to deliver the subsidies, but rather to serve as a *marketplace*
  - It was believed that the Exchange would reduce administrative costs
  - In addition, it was believed that the Exchange would attract multiple insurance carriers, which would promote competition
  - Achieving these two goals could translate into lower premiums
- Early on in the drafting process, it was “private” exchanges that served as the model, not the Massachusetts Connector

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Two Kinds of “Public” Exchanges

- State-based Exchanges
  - The drafters never envisioned the level of resistance to the law and establishing an Exchange
- Federal Exchange (which includes the Federal-State Partnership)
  - Congress intended the “Federally-facilitated Exchange” to step in the shoes of the State-based Exchange and perform all of the same functions
  - Unsurprisingly, the statute is not “clean,” and therefore, questions have arisen
    - Can a Federal Exchange deliver the premium subsidies?

What Should You Know About the "Public" Exchanges?

- Initially, the Exchanges will service (1) individuals and families in the individual market and (2) employees of small employer
  - In 2017, a State may elect to permit the sale of fully-insured large group plans through the Exchange, but a State is not required to do so
- An Exchange may be structured as (1) a governmental agency or (2) an independent non-profit entity
- The Exchange is directed to perform specific functions
  - Determine eligibility for the premium subsidies
  - Establish and maintain a web site
  - Set up a call-center to field questions from consumers
  - Screen for Medicaid eligibility and enroll people in Medicaid if eligible

What Have the States Decided?

- Generally, you can put the States into 3 categories
  - Category #1 – Federal Exchange
    - AK, AL, AZ, FL, GA, IN, KS, LA, ME, MO, MS, MT, NE, ND, NH, NJ, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY (26)
  - Category #2 – Federal-State Partnership
    - AR, DE, IA, IL, MI, NC, WV (7)
  - Category #3 – State-based Exchange
    - CA, CO, CT, DC, HI, ID, MD, MA, MN, NV, NM, MN, NY, OR, RI, UT, VT, WA (18)

The Subsidies Offered Through the Exchange

- GENERAL RULE – An individual is NOT eligible for subsidies offered through the Exchange if he or she is "eligible" for employer-sponsored coverage
  - So, even if your employees are subsidy-eligible, they CANNOT go to the Exchange and access the subsidies
- EXCEPTION – The employer-sponsored coverage (1) is "unaffordable" (i.e., the *employee's* contribution for the lowest cost for self-only plan exceeds 9.5% of the employee's household income (or certain other "safe harbor" measures)) or (2) does NOT provide "minimum value" (i.e., the employer coverage does not pay for at least 60% of the benefits provided under the plan)

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The "Employer Mandate"

- Beginning in 2014, an employer with 50 or more "full-time equivalent" employees would be subject to a penalty tax if:
  - The employer is NOT offering health insurance coverage to at least 95% of its full-time employees and their child dependent(s) (under age 26)
  - The employer offers coverage, but the coverage (1) is "unaffordable" (i.e., the required *employee* contribution for self-only coverage exceeds 9.5% of, for example, the employee's household income or W-2 income) or (2) does NOT provide "minimum value" (i.e., the employer coverage does not pay for at least 60% of the benefits provided under the plan)
- The penalty tax is ***only*** triggered if the employee purchases health insurance through the Exchange and accesses the premium subsidy

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Association Health Plans

- In general, States can no longer define coverage sold to individuals and small employers through an association as "large group" coverage
  - Premium rating rules applicable to individual and small group will apply, not large group
  - Small groups will be part of the same risk pool – pooled by carriers (same for individuals)
- EXCEPTION – But, if your association is a "bona fide association," you may avoid this treatment
  - You may not satisfy the technical definition of a "bona fide association"

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QUESTIONS?

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Success v. Failure
Financing of “Public” Exchanges

- By the time 12/31/2014 rolls around, the Administration will have issued nearly $5.8 billion in grants to States
- In 2015, State-based Exchanges must be self-sustaining
  - Cost of operating an Exchange is arguably significant
    - DC – Around $20 million per year
    - MD - $37 million per year
    - WA – $50 million per year
    - NY’s estimated operating budget is $428 million between 2011 and 2015 (roughly $85.6 million per year)
- How to finance the Federal Exchange?
  - In general, there are no appropriations in the ACA to finance the Federal Exchange
  - HHS recently said the Federal Exchange will cost $2 billion next year

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Success v. Failure
Financing of "Public" Exchanges

- Where will the money come from?
  - The statute allows the Exchange (State-based or Federal Exchange) to impose "user fees" on insurance carriers selling products through the Exchange
  - States are also considering imposing user fees on all carriers in the State
  - Other States are looking to other revenue sources
    - Charging for advertising
    - Selling supplemental insurance products (e.g., dental, disability)
    - Increasing taxes on cigarettes, soda, health claims

Success v. Failure
Cost of Plans

- Cost of insurance will go up
  - "Guarantee issue" and the new premium rating rules will increase the cost of plans – CBO says so
  - Other costs include:
    - "Grandfather" rules (e.g., coverage for adult children and no cost-sharing for preventive services) – actuaries estimate 1% to 3% increase in 2011
    - "Fee" on health insurance providers – 2% to 2.5% increase in 2016, according to JCT and CBO
    - "User fees" on carriers – 3.5% of the monthly premium increase in 2014, according to HHS and some States
    - Reinsurance assessment – $63 per head for 2014, according to HHS

Success v. Failure
Cost of Plans

- Individual Market Exchanges
  - While the cost of plans will go up, the increased cost is generally not borne by the consumer. Federal government will pick up tab
    - For example, subsidized individuals only pay up to a specified percentage of income. The Federal government pays the rest
    - So, as costs of plans go up, in general, the cost to the subsidized individual does not (their cost only goes up as their income increases)
  - End result is increased government spending
    - Not the right time for increased government spending
- SHOP Exchanges
  - In general, there is no government assistance to defray the cost (the small business tax credit is too small, to complex, and is available to too few small businesses for it to make an impact)