# Healthcare Reform
# Implications for the Territories
# CNMI

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12.16.13

# Agenda

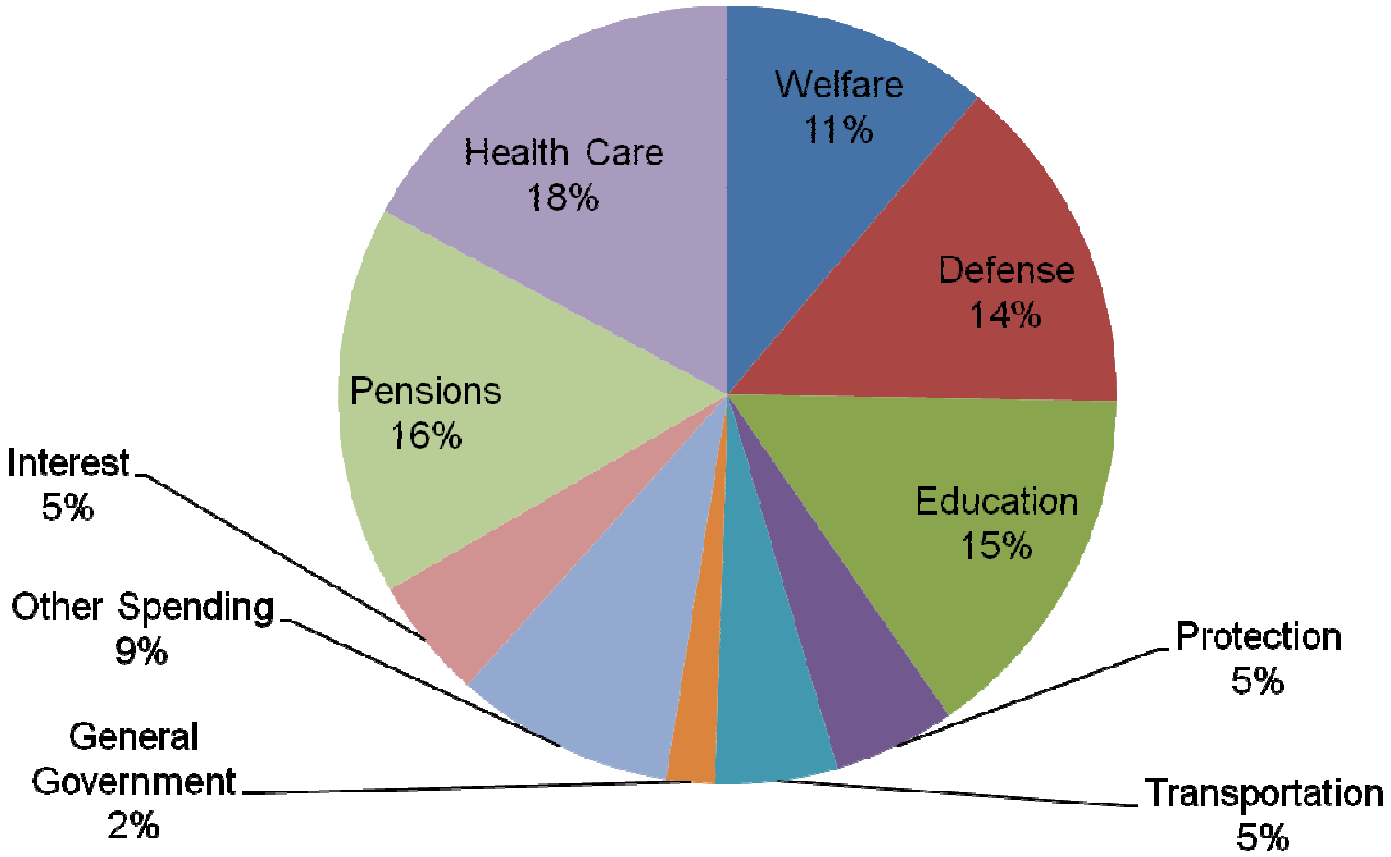
- Key Challenges to U.S. and CNMI Healthcare Systems
- Why reform
- Implications to CNMI

# Health Expenditures for Selected Services 2000–2015

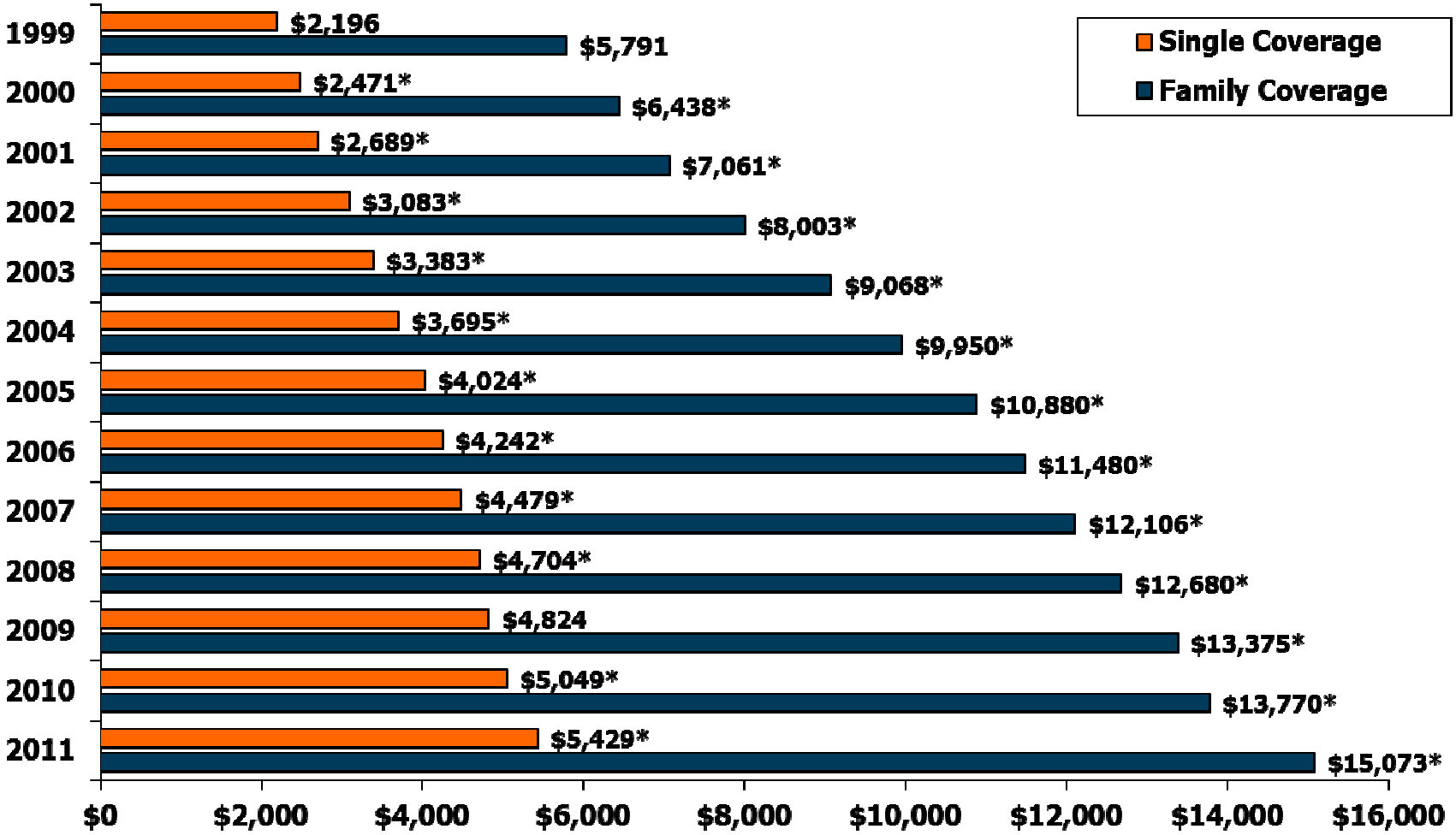
| | | | Projected | |
|---|---|---|---|---|
| **TOTAL** | **2000** | **2005** | ***2010*** | ***2015*** |
| **Billions** | $1,353.3 | $1,987.7 | $2,879.4 | $4,031.7 |
| **Percent GDP** | 13.8% | 16.0% | 18.0% | 20.0% |
| **BY TYPE OF SERVICE** | | | | |
| **Hospital care** | $417.0 | $611.6 | $882.4 | $1,230.9 |
| **Physician & clinical services** | 288.6 | 421.2 | 610.7 | 849.8 |
| **Other professional services (dental, etc.)** | 138.2 | 200.5 | 292.6 | 411.5 |
| **Nursing home care** | 95.3 | 121.9 | 160.5 | 216.8 |
| **Home health care** | 30.5 | 47.5 | 72.3 | 103.7 |
| **Prescription drugs** | 120.8 | 200.7 | 299.2 | 446.2 |
| **Other medical products** | 49.5 | 58.1 | 69.1 | 83.1 |
| **Program admin. & net cost of private health insurance** | 81.2 | 143.0 | 210.6 | 289.8 |
| **Investment** | 88.8 | 126.8 | 191.3 | 268.9 |

Source: The Commonwealth Fund; Data from A. Catlin et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):142–53; C. Borger et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web Exclusive (Feb. 22, 2006):w61–w73.

# U.S. National Healthcare Expenditures



# Average Annual Premiums for Single and Family Coverage, 1999-2011




* Estimate is statistically different from estimate for the previous year shown (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011.

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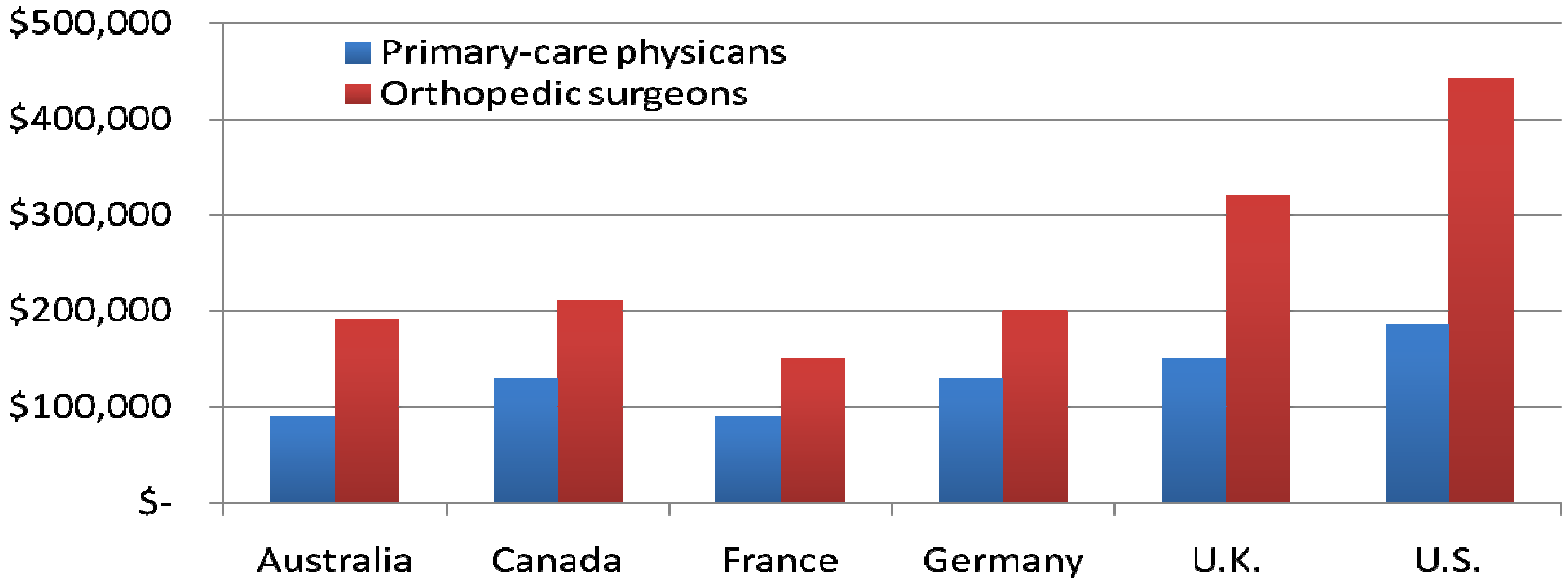
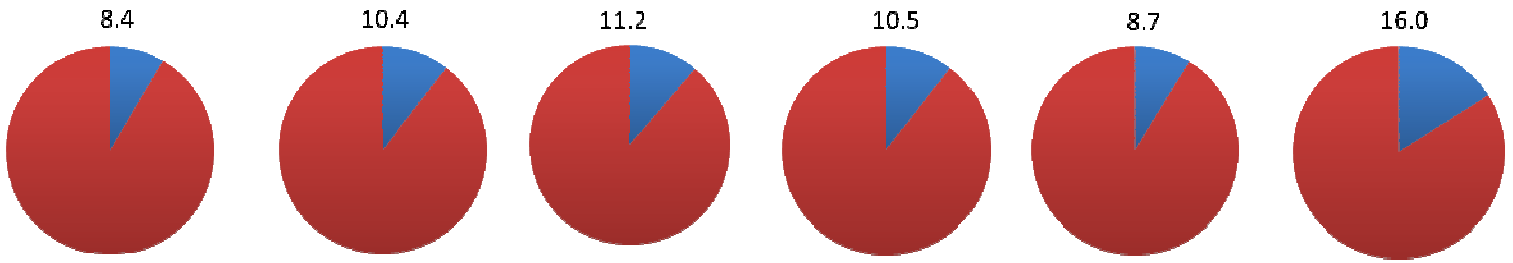
# Global Payments

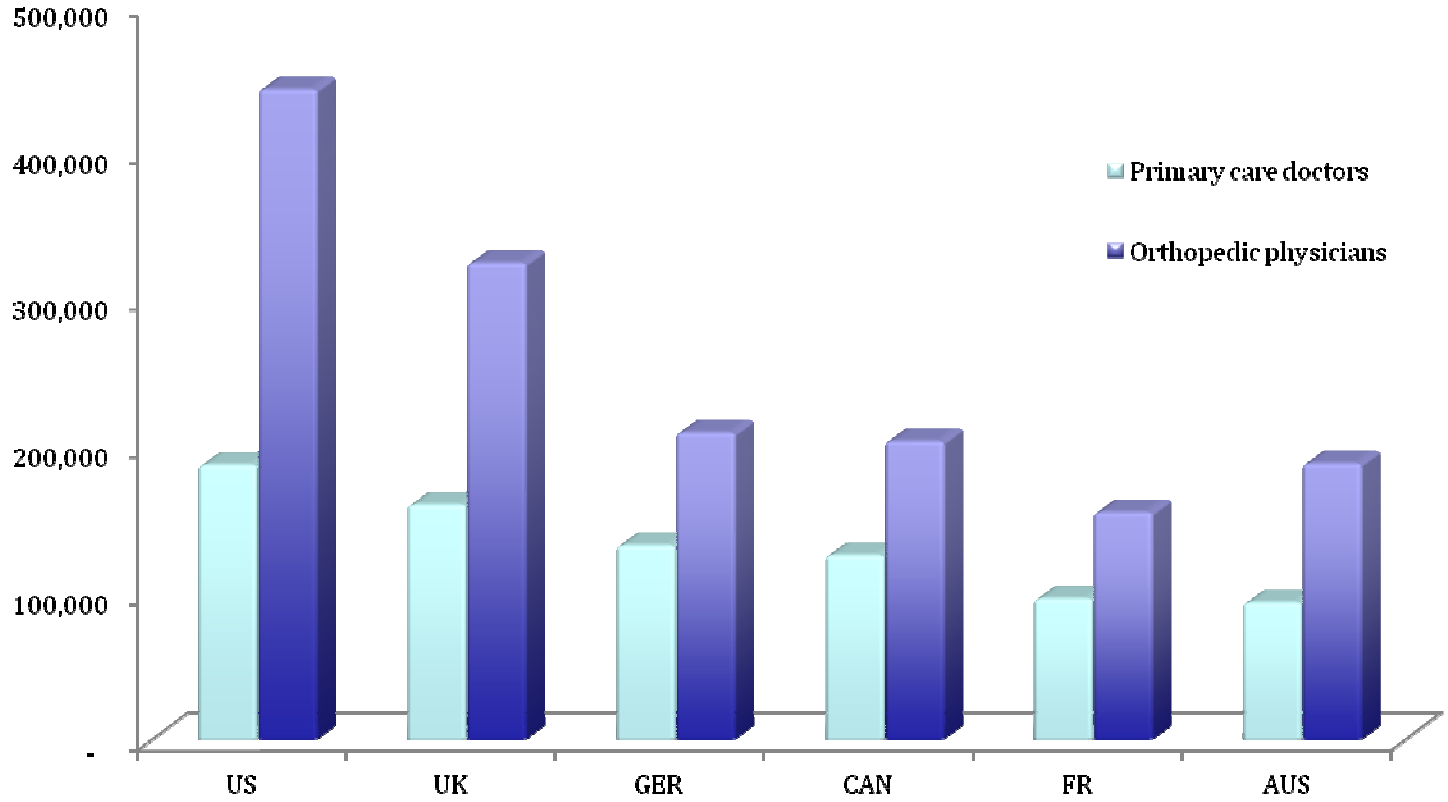
## PRE-TAX EARNINGS




## HEALTH SPENDING AS GDP% AND PER CAPITA

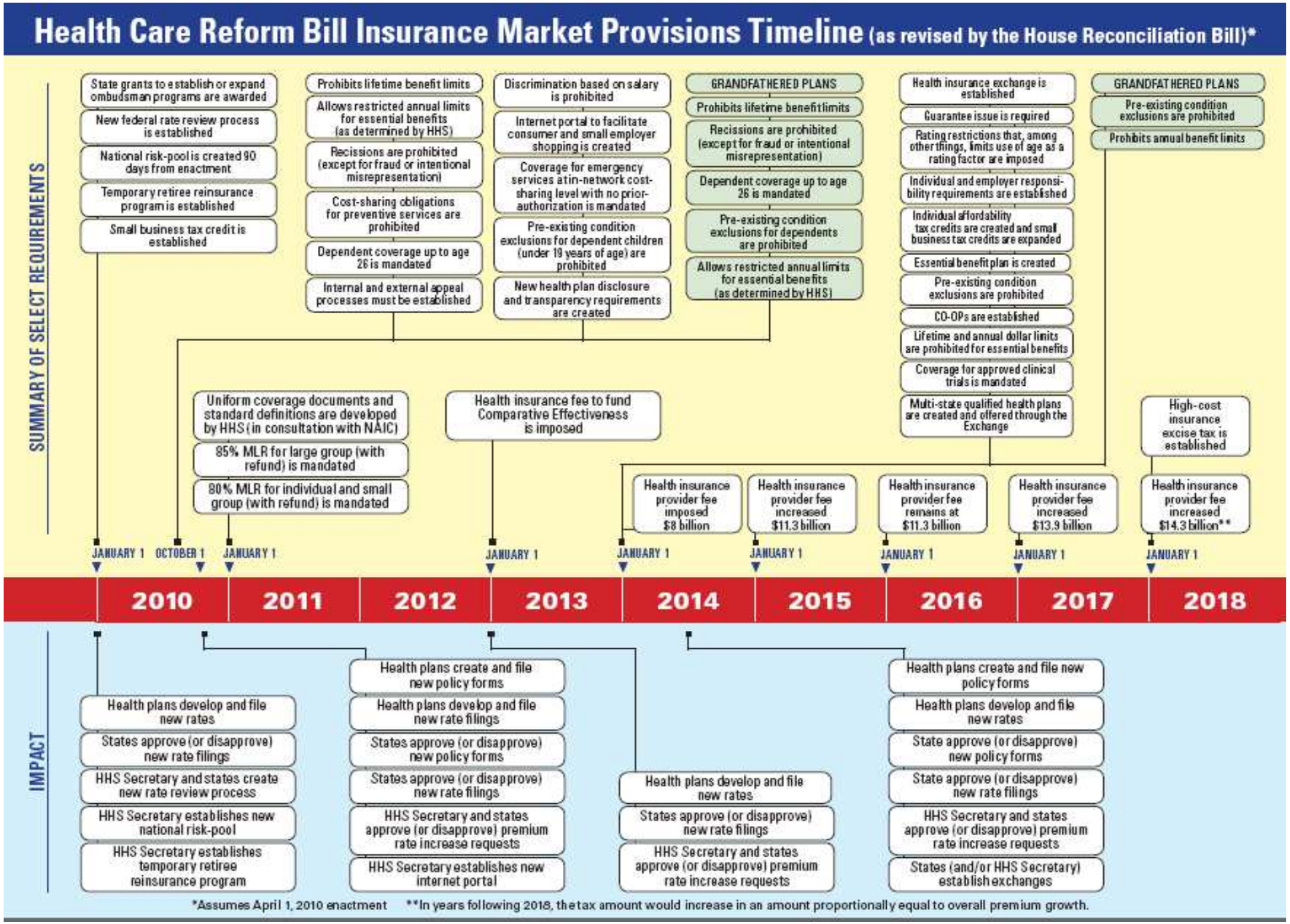


# Physician Incomes, 2008
# Adjusted for Differences in Cost in Living




Source: MJ Laugesen and SA Glied, "Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs*, Sept. 2011 30(9):1647-56

# Health Care Reform Bill Insurance Market Provisions Timeline (as revised by the House Reconciliation Bill)*




*Assumes April 1, 2010 enactment **In years following 2018, the tax amount would increase in an amount proportionally equal to overall premium growth.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# How the justices ruled on key PPACA provisions

| |  Breyer |  Ginsburg |  Kagan |  Sotomayor |  Roberts |  Alito |  Kennedy |  Scalia |  Thomas |
|---|---|---|---|---|---|---|---|---|---|
| Mandate legal as tax | X | X | X | X | X | | | | |
| Mandate legal under commerce clause | X | X | X | X | | | | | |
| Mandate unconstitutional | | | | | | X | X | X | X |
| Illegal to put all Medicaid funding at stake to force expansion | X | | X | | X | X | X | X | X |

Note: X means ruled in favor of the provision

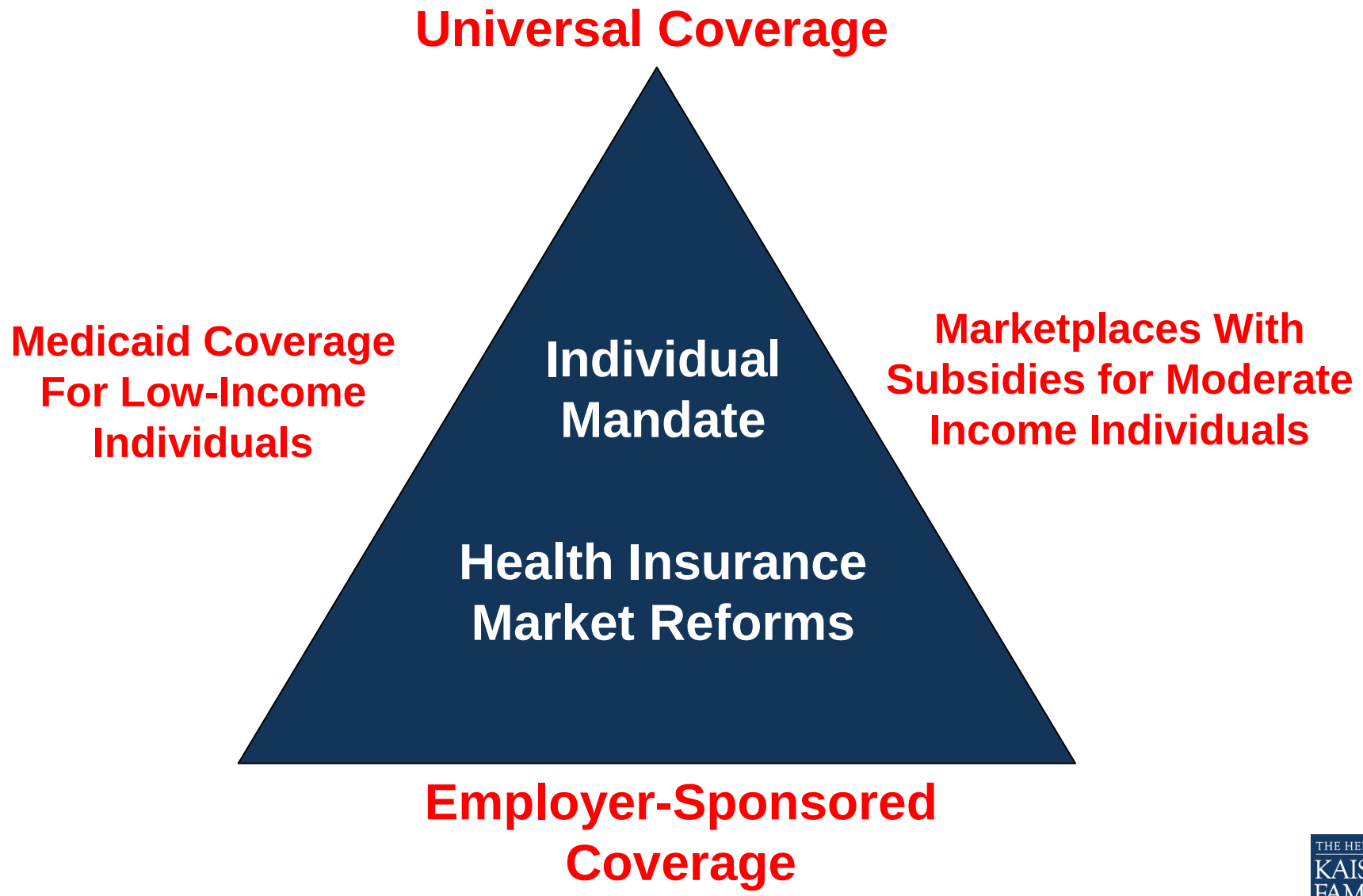
MODERN HEALTHCARE GRAPHIC

# Framework of PPACA or ACA

ACA frame work has been compared to a three-legged stool

- Insurance Market Reforms – Applies to CNMI
- Individual and employer mandates – Does not apply to CNMI
- Premium and cost sharing subsidies – Does not apply to CNMI
- Market stabilizers such as the 3Rs – Does not apply or not available in CNMI

# Promoting Health Coverage through the ACA



# Long-Term Reforms (2014): Underwriting and Rating Requirements

**Guarantee Availability/Guarantee Issue – Applies** Mandates that health insurance issuers accept every employer and individual that applies for coverage.

- Allows the HHS Secretary to establish open and special enrollment periods to mitigate the potential for adverse selection.

**Prohibition on Pre-existing Condition Exclusions – Applies**

- Prohibits the imposition of pre-existing condition exclusions

**Risk Pooling**

- Requires health insurance issuers to consider all enrollees in all individual market health plans (other than grandfathered plans) as a single pool.
- Requires health insurance issuers to consider all enrollees in all small group health plans (other than grandfathered plans) as a single pool.

**Transitional Reinsurance/Risk Corridors/Risk Adjustment Programs - Not available in CNMI**

- Implements various risk spreading mechanisms in individual and small group markets

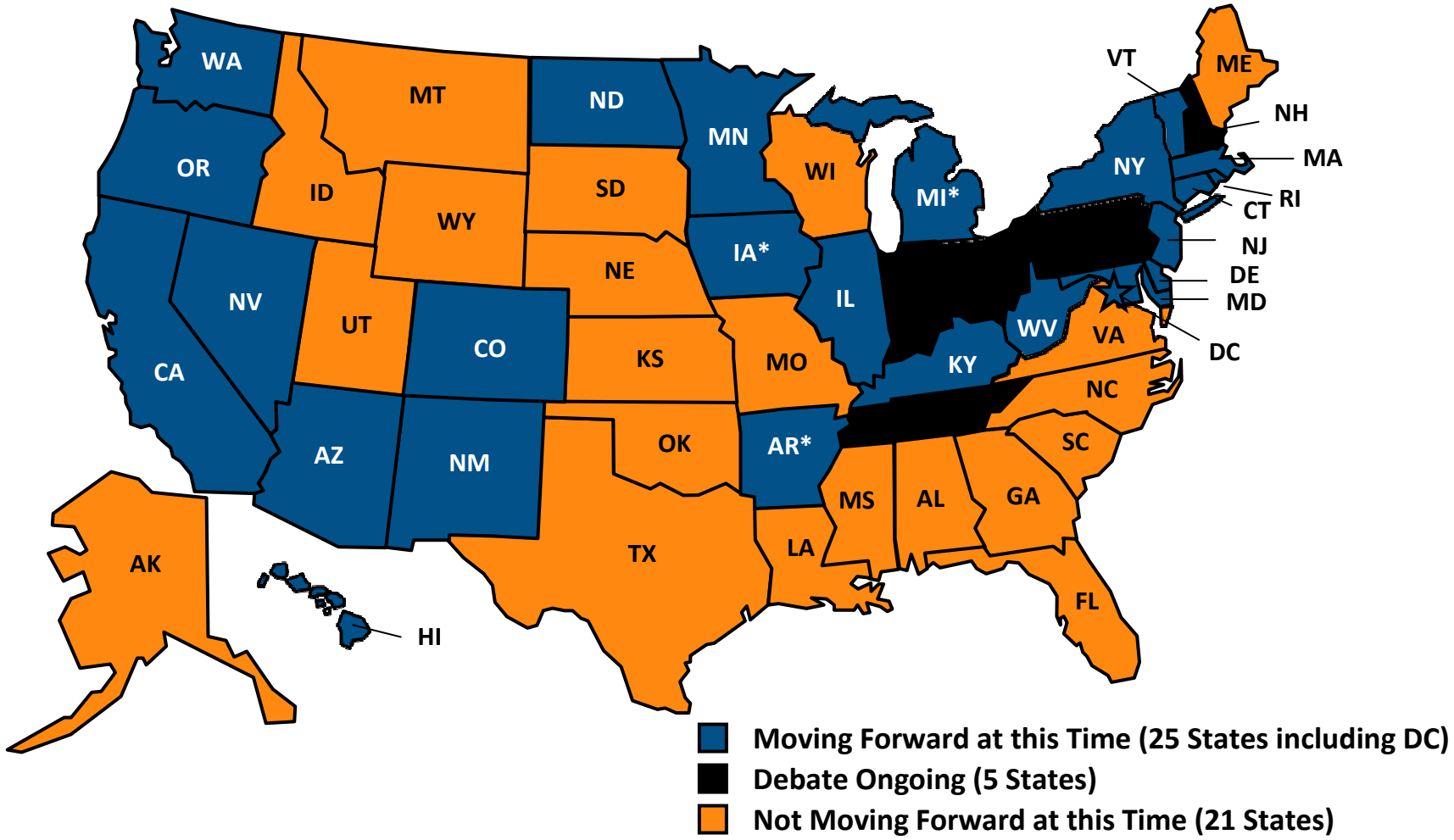
# Long-Term (2014) Reforms: Benefit Requirements

**Essential Health Benefits Package* for small groups Applies**

- Requires the Secretary to define an essential health benefits package (EHBP) that includes coverage for at least the following general categories:
  - ambulatory patient services;
  - emergency services;
  - hospitalization;
  - maternity and newborn care;
  - mental health/substance use disorder services;
  - prescription drugs;
  - rehabilitative and habilitative services and devices;
  - laboratory services;
  - preventive and wellness services and chronic disease management; and
  - pediatric services, including oral and vision care.

CNMI and other territories did not select a plan, so a default plan was assigned. The most popular FEHB plan, which single rate is in excess of $500/month.

# Current Status of the Medicaid Expansion Decision, as of August 28, 2013




* These states are exploring an approach to the Medicaid expansion that is likely to require waiver approval.

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# ACA Includes New Rules for Coverage in the Non-group Market

| Pre-ACA | Post-ACA |
| --- | --- |
| • Policies are medically underwritten<br>• Many policies exclude benefits such as prescription drugs and maternity care<br>• Policies typically have high cost sharing<br>• Premiums are unsubsidized leaving them unaffordable for many | • Insurers are prohibited from discriminating based on health status<br>• Policies must cover the essential health benefits<br>• Consumer out-of-pocket spending is limited<br>• Premium and cost-sharing subsidies are available |

# Coming Changes to Employer-Sponsored Insurance

- Large employer requirement to offer coverage or pay a penalty. *Delayed to 2015* *Does no Apply to CNMI*
- Maximum limit on annual out-of-pocket cost sharing for essential benefits limited to $6,350/person or $12,700/family. *Partially delayed to 2015* *Applies*
- No annual dollar limits on covered benefits Applies
- Small group, fully insured plans must cover essential health benefits Applies
- Already in effect: No lifetime limits on covered benefits, dependent coverage to age 26, 100% coverage for preventive services Applies

# Exchanges

- Requires states to establish an Exchange for the individual and small group markets **no later than January 1, 2014**. Not available for CNMI
  - Defines “small group” as employers with at least one full-time employee and no more than 100 full-time employees.
  - State option for plan years before January 1, 2016, to define "small group" between 1 and 50 FTEs.
  - State option to expand access to large groups beginning in 2017.
  - 27 States chose not to set up an exchange and allow the Federal Government to run it
  - Federal funding is provided to create and operate state-based Exchanges by January 1, 2014.
  - States exchanges must be self-sustaining beginning on January 1, 2015, by placing an assessment or user fee on participating health insurance issuers or another funding mechanism.
    - $250 Million in HHS Grants available from 2010-2015

# Incentives to Purchase Coverage

**Personal Coverage Requirement – Not applicable to CNMI**

- The penalty charged for failing to maintain coverage is the greater of:
  - a flat fee of $695/year, or
  - 2.5% of income, phased in over time in the following manner

| Year | Penalty Amount |
|---|---|
| 2014 | The greater of $95 or 1% of income |
| 2015 | The greater of $325 or 2% of income |
| 2016 | The greater of $695 of 2.5% of income |
| 2017 and thereafter | The greater of $695 (+ COLA) or 2.5 % of income |

# Incentives to Purchase Coverage

**Tax Credits for Health Insurance Cost-Sharing Obligations**

- Increases cost-sharing subsidies for individuals with household incomes between 100 and 400% of the federal poverty level (FPL), as follows

| FPL Percent | Amount of Subsidy Percent |
|---|---|
| 100 – 150 | 94 |
| 151 – 200 | 87 |
| 201 – 250 | 73 |
| 251 – 400 | 70 |

# Items of Interest - The 3 Rs

- HHS released Standards and Proposed Rules Related to the 3 Rs
  - Permanent Risk Adjustment
  - Temporary Reinsurance
  - Temporary Risk Corridors
  - Proposed Approaches by HHS follow traditional NAIC Model methodology
- Transitional Issues for each State:
  - How and Why to quickly establish a State Reinsurance Program?
    - The markets thrive or at least they survive
  - What might happen if a State  does not?
    - The markets may fail!

# Three New "Risk Sharing" Mechanisms- Not in CNMI

1. Permanent Risk Adjustment will compensate insurers when they write high risk business in the individual or in the small employer market either inside or outside the exchange(s);

2. Temporary Reinsurance will compensate insurers when they pay claims for individual high risks either inside or outside the exchange(s);

3. Temporary Risk Corridors will limit the extent of issuer gains or losses inside the exchange

# Worst Case Scenario

- **A STATE NON-PROFIT REINSURANCE PROGRAM IS NOT ENABLED (FEDERAL FALLBACK)**
  - However, the Wild Cards appear
  - Adverse Selection runs rampant
  - Federal market mechanisms and their related market controls are not flexible enough to balance the markets
  - Health Plans exit the markets
  - Overall supply decreases and adverse selection tightens its grip in the death spiral
- **AND THE MARKETS MAY FAIL!**

# Tax Changes Related to Financing Health Reform

- Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule:
  – $2.8 billion in 2012-2013; – $3.0 billion in 2014-2016; – $4.0 billion in 2017;
  – $4.1 billion in 2018; and
  – $2.8 billion in 2019 and later.
- Impose an annual fee on the health insurance sector, according to the following schedule:
  – $8 billion in 2014;
  – $11.3 billion in 2015-2016; – $13.9 billion in 2017;
  – $14.3 billion in 2018
  – For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth.

  For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer. (Effective January 1, 2014)

- Impose an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012)
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009)
- Impose a tax of 10% on the amount paid for indoor tanning services. (Effective July 1, 2010)
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. (Effective January 1, 2010)
- Clarify application of the economic substance doctrine and increase penalties for underpayments

# Concerns for CNMI

- Only $2.3M in additional Medicaid money for expansion
- Other States get 100% subsidies for new Medicaid eligibles
- Insurance reforms apply to CNMI but mandates or other market stabilizers do not
- The three legged stool becomes a one legged one for CNMI
- Concerns with market destabilization

# Questions