



# The Obama Health Reform Proposal Impact on Payers

Seeing the big picture to solve the biggest problems in health care.

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# Agenda

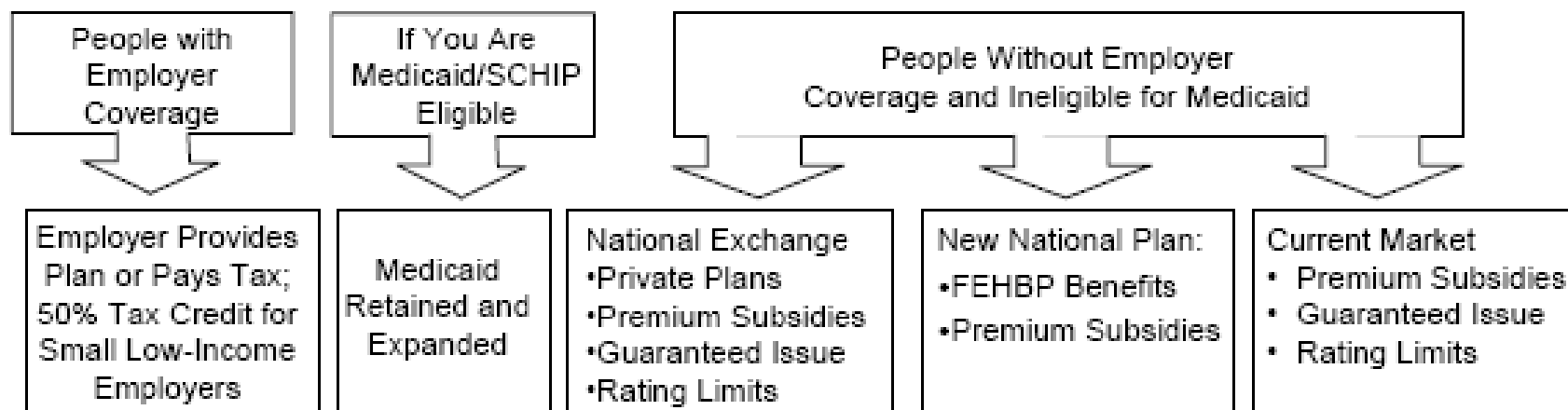
- • General overview of Obama's proposed health reforms
- • Impacts on Medicare payers
- • Impacts on Commercial Payers
- • Q&A

# Key Impacts of the Obama Health Reform Proposal

	Change under Obama Plan
Reduction in Uninsured (2010)	-26.6 million
Change in Public Coverage (2010)	48.3 million
Change in Private Coverage (2010)	-21.6 million
Change in Employer Coverage (2010)	4.7 million
Net Federal Cost (2010-2019)	\$1.17 trillion
Medical Underwriting	Prohibited
Cost Containment	Modest

# Obama Health Proposal – “Plan for a Healthy America”

- All Children Must Have Coverage – Enforcement not Specified
- Voluntary Subsidized Coverage for Low-Income – Not Specified
- New National Exchange as Alternative to Current Market



## Other Proposal Features

- Guaranteed Issue and No Health Status Rating in Exchange
- Funds Health Information Technology
- Funds Clinical Effectiveness Research
- Disease Management
- Funds Minimum Loss Ratio (in non-competitive areas)
- Negotiate Part D Drug Prices Directly With Manufacturers
- Permit Re-importation of Drugs
- Reduced Medicare Advantage Rates

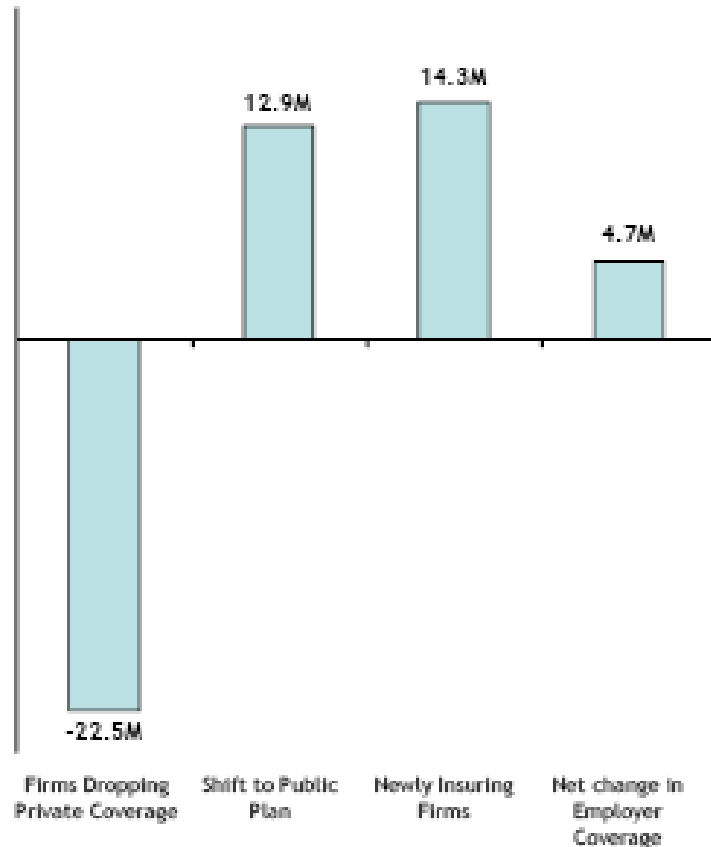
# Transitions in Coverage Under the Obama Plan

		Coverage Under Obama Plan (millions)						
Coverage Under Current Law	Total	Public Plan		Private Coverage		Medicaid & SCHIP Only	Uninsured	Medicare & Other
		Employer	Individual	Employer	Individual			
Employer Coverage	157.4	12.9	1.5	134.9	0.9	5.7	1.5	--
Individual Coverage	14.3	0.8	7.8	1.2	3.4	0.8	0.2	--
Medicaid & SCHIP <sup>a/</sup>	41.5	1.2	--	1.9	--	38.3	--	--
Uninsured	48.9	3.6	3.8	5.4	2.1	13.4	20.6	--
Medicare & Other	45.0	--	--	--	--	--	--	45.0
<b>TOTAL</b>	<b>307.1</b>	<b>18.6</b>	<b>13.1</b>	<b>143.5</b>	<b>6.5</b>	<b>58.1</b>	<b>22.3</b>	<b>45.0</b>

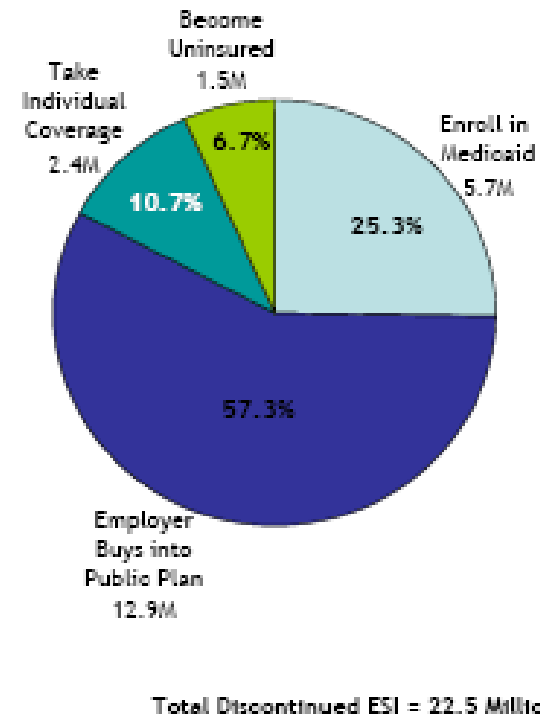
a/ Excludes Dual eligible Medicaid beneficiaries, who are counted as Medicare covered.

# Change in Workers and Dependents With Employer Health Insurance under Obama Plan: 2010 (millions)

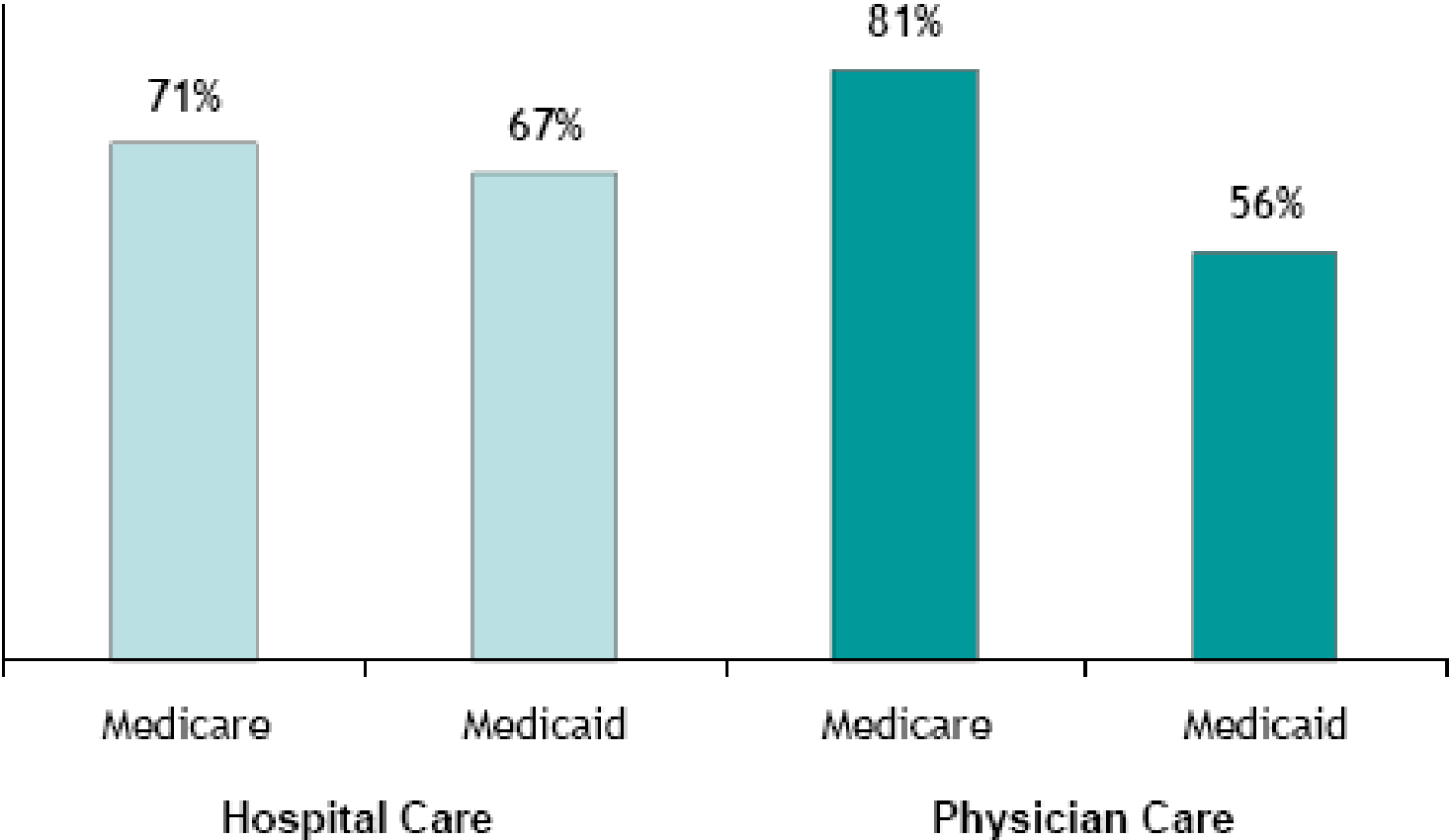
Changes in Employer Coverage



People Losing Private Employer Coverage



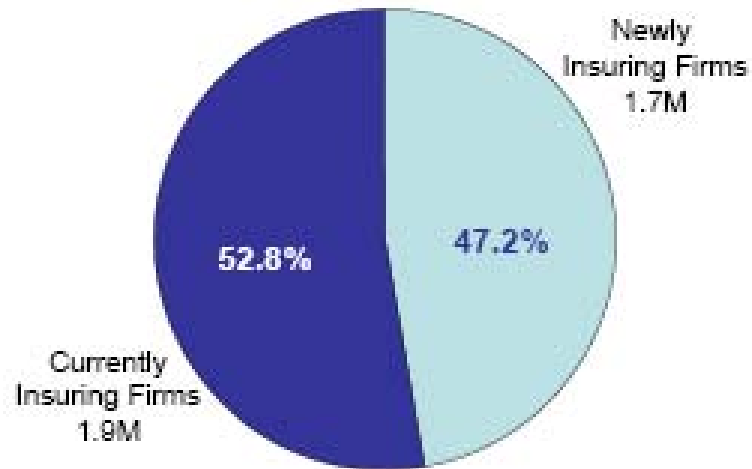
# Public Program Provider Payments as a Percent of Private Payments for Similar Services



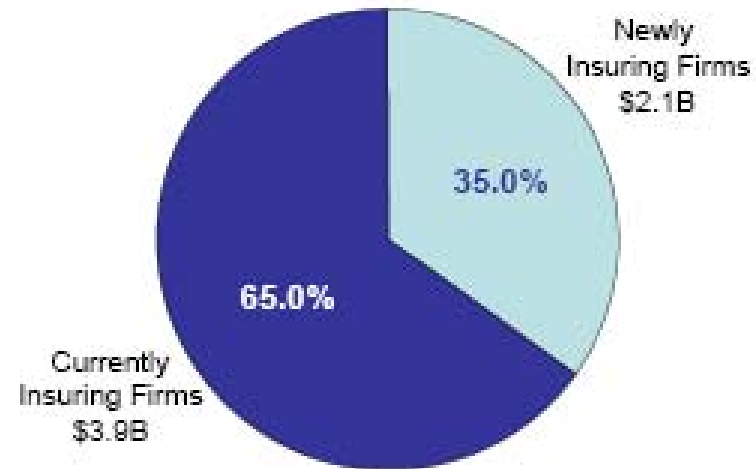
# Impact of Using Medicare Provider Payment Levels in the National Plan: 2009

	Eligible Groups	
	Small Firms, Self-employed and Individuals Only	All Firms, Self-Employed and Individuals
Public Plan Premiums as Percent of Private premiums	-40 percent	-32 percent
<b>Coverage Effects</b>		
Reduction in Uninsured	27.4 million	28.2 million
Enrollment in National Public Plan	42.7 million	130.5 million
Change in Private Coverage	-31.8 million	-118.5 million
Percent Change in Private Coverage (Now 171.5 million)	-18.6 percent	-69.4 percent
<b>Change in Provider Revenues</b>		
Hospitals	\$7.8 billion	-\$36.5 billion
Physicians	-\$8.7 billion	-\$36.4 billion

# Coverage and Costs for the Obama Small Employer Tax Credit



People in Recipient Firms = 3.6 million

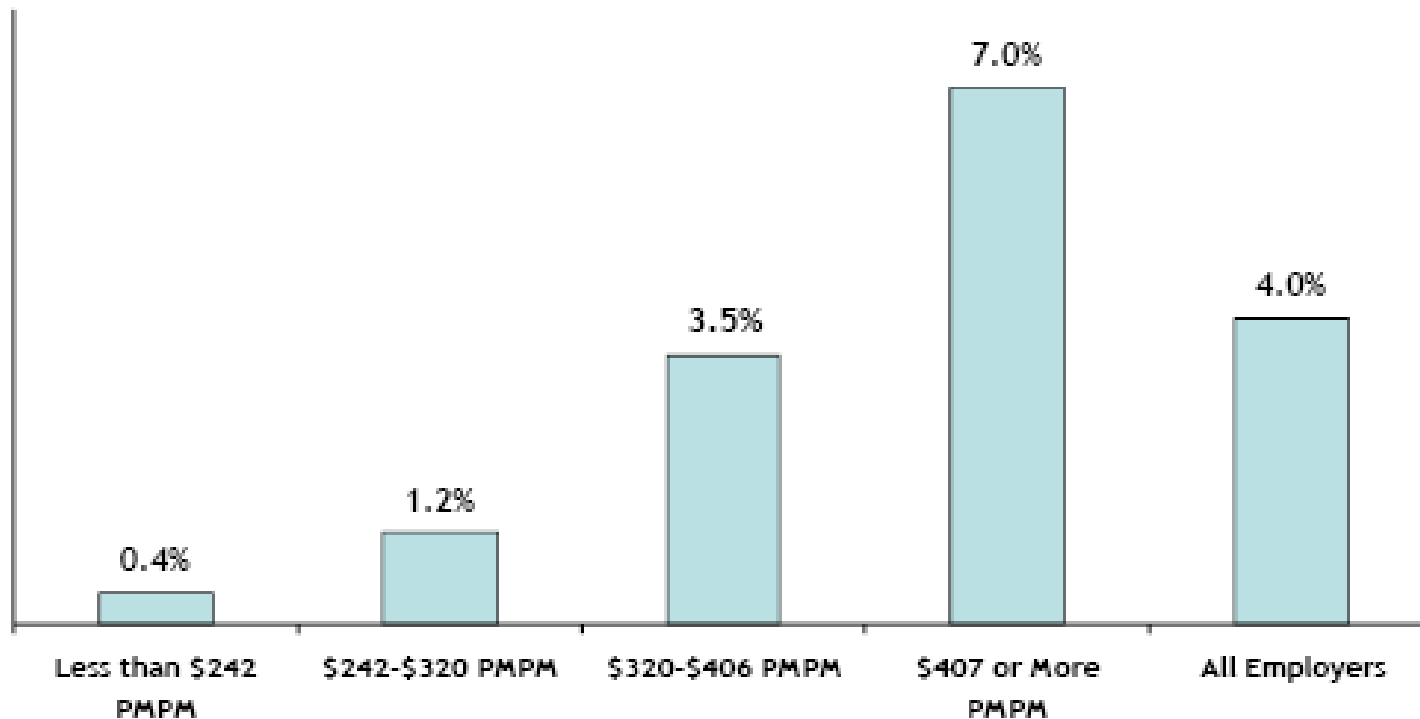


Tax Credit Expenditures = \$6.0 billion

a/ Estimates assume that the tax credit is available to low-wage firms with under 10 workers only.

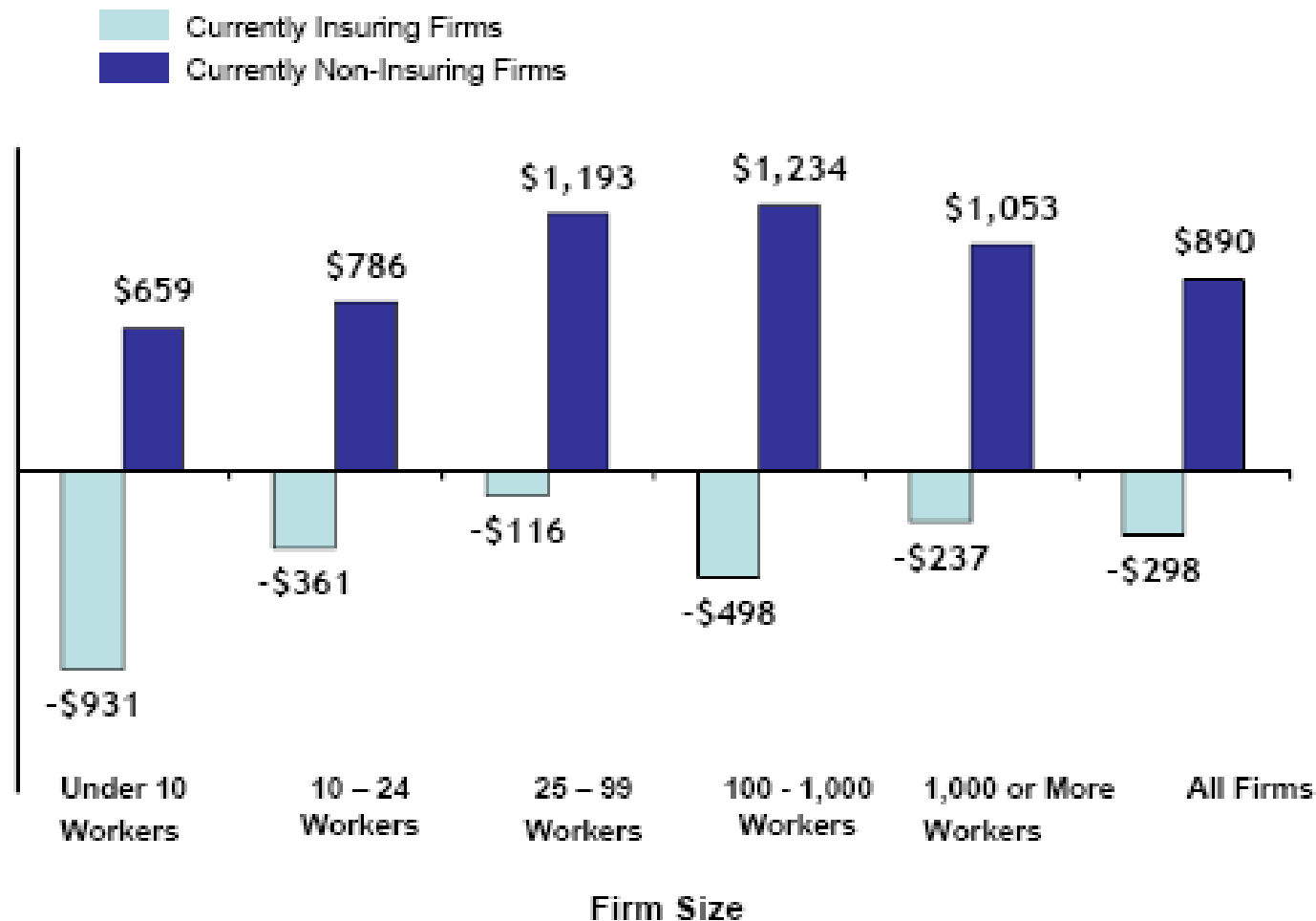
# Impact of the Obama Employer Reinsurance Program for Costs over \$140,000

Percent Reduction in Costs from Reinsurance

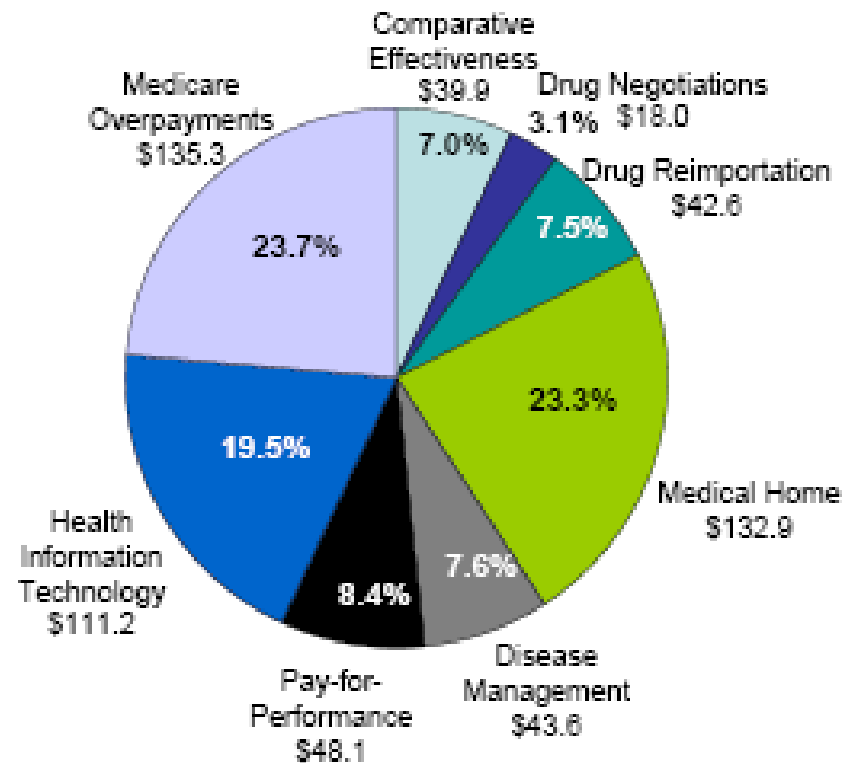


Firms by Current Law Costs Per-Member-Per-Month (PMPM)

# Average Change in Spending Per Worker under the Obama Plan by Firm Size: 2010



# Reduction in National Health Spending under Cost Containment Provisions of the Obama Proposal: 2010-2019 (billions)

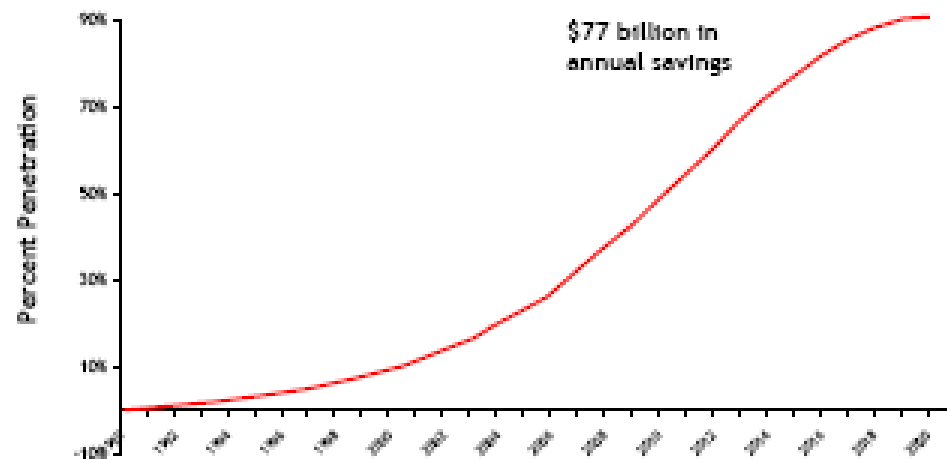


Public Program Savings = \$321.6  
 Private Insurance Savings = \$250.0  
 Total System Savings = \$571.6

# \$50 Billion to Fund Health Information Technology under Obama Proposal

- Electronic Medical Records (EMR) – Access to all patient care
- Computer Assisted Clinical Decision Support – Evidence Based Medicine
- Computerized Practitioner Order Entry (CPOE) Systems – Reduced errors
- Interoperable EMR – access to EMR across patient caregivers

## Savings Under Current Trends (i.e., in baseline)



Adoption rate base on Bower (2005), "Diffusion and Value of Healthcare Information Technology", Rand corporation 2005, MG-272.

# Wyden Health Proposal – “The Healthy Americans Act”

- Employers Must “Cash-Out” All Health Benefits as Wages
- All Americans are Required to have Insurance (99 percent covered)
- Premium Subsidies and Enforcement Through Withholding

If You Are Happy With Your Employer Health Coverage, and Your Employer Continues to Offer

- Still has Cash-out
- Pays Premium via Withholding
- Plan Paid Risk-adjusted Amt. Through area HHA

If You Are Uninsured or Want to Change Coverage

Area “Connector” called “Health Help Agencies (HHA)”

- Enroll in FEHBP Like Private Health Plans
- All Pay Premium Amount less Subsidies Through Withholding
- Additional Benefits/Co-pays for Medicaid/SCHIP Eligible

If You Are Medicaid/SCHIP Eligible

## Other Features

- People select from FEHBP like options
- Provides subsidies for people through 400% of FPL (\$80,000 for a family of four)
- Pools Risk across Entire Population
- Promotes Price Competition

## Estimated Program Impacts

- All but 2.5 million of the Uninsured get Coverage
- Private Non-group Coverage Increases by 113 Million People
- Program is Fully Funded
- Competition designed to Reduce Spending Growth

# Cost Control Under the Health Americans Act

- Employers would convert their health benefits to wages
- People would then pay the full cost of their insurance
- Area health plans would submit bids for the FEHB based minimum benefits package
- All people are guaranteed coverage in the lowest cost health plan regardless of income
- People may buy more but must pay the full additional cost
- The tax exclusion for employer benefits is replaced with fixed health deduction so taxes do not encourage high-cost coverage
- Health Savings Account (HSA) plans are available
- The premium payments are administered through withholding, which is reduced by the income-based subsidy they receive

# Other Congressional Health Care Bills 2005-2008

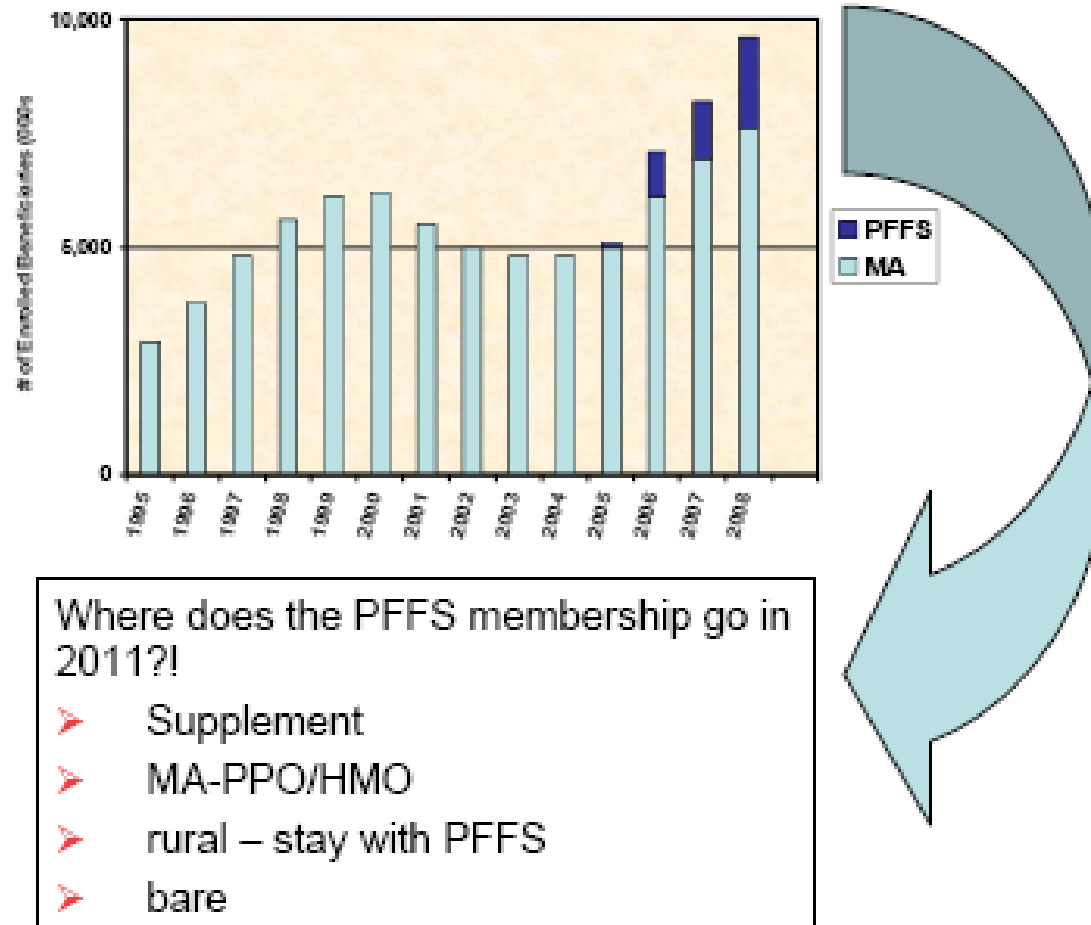
Congressional Bill	Key Provision
Health Partnership Act/Health Partnership Through Creative Federalism Act/State-Based Health Care Reform Act, S325,HR506, S1169	Promote State reforms to increase coverage. Minimum benefit package mandated
AmeriCare Health Act of 2006/Medicare for All Act	Open Medicare to everyone with choice of a health plan.
Kids Come First Act of 2007, S 95/HR 1111	Provides states with incentives to expand coverage for children up to age 21 in families with incomes up to 300 percent of poverty through Medicaid and SCHIP.
Family Care Act of 2005	Provides states with incentives to expand coverage for parents of Medicaid and SCHIP eligible children and pregnant women.
The Small Business Health Fairness Act of 2007, HR241	Allow associations to form association health plans (AHPs), which could provide health benefits to employees of businesses that are members of the associations.
The Small Business Health Plans Act of 2007, HR2132	Provides new group options for small employers to purchase coverage for their employees.
Ten Steps to Transform Health Care in America, S1783	Changes the Tax Treatment of Health Insurance and Merges Group and Non-Group Markets.
Universal Health Care Choice And Access Act, S1019	Provide Individual Tax Credits for the Purchase of Private Insurance. Reform Medicaid into a Block Grant Program
HSA Improvement and Expansion Act of 2007, HR 3234	Expands limits on HSA Contributions and Increases Flexibility

# Anticipated Impact to Medicare Insurers

## 2008 Legislation – MIPPA. It's just a start.

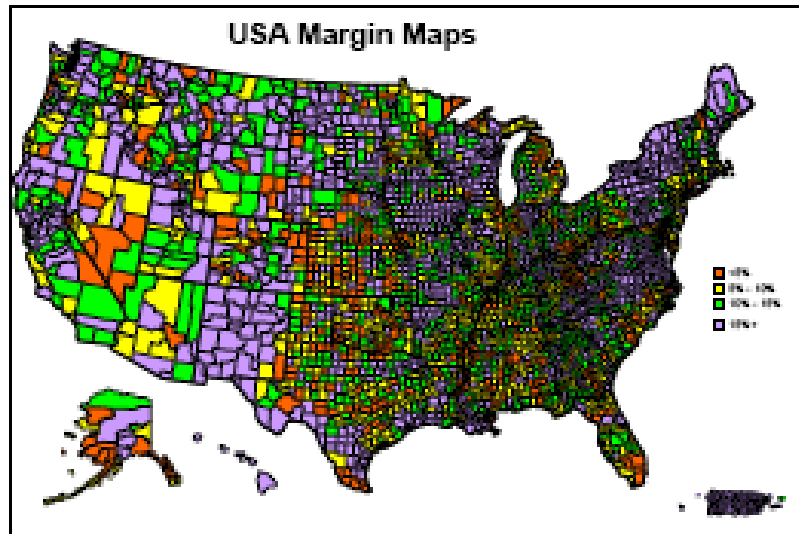
- Changes Physician Fees 0% 7-12/2008, 1.1% 2009, will impact 2010 MA benchmarks (1 ½ prior years' catch-up)
- Reduces MA rates: phases out IME from MA Capitation, eliminates RPPO stabilization funds
- Requires PFFS plans to have provider networks
- Adds new marketing/compliance requirements
- Lifts SNP moratorium and extends SNP authority to 2010. Restricts enrollment criteria for SNPs
- Expands Medical Home demonstration

# Reform may heighten changes to MA enrollment

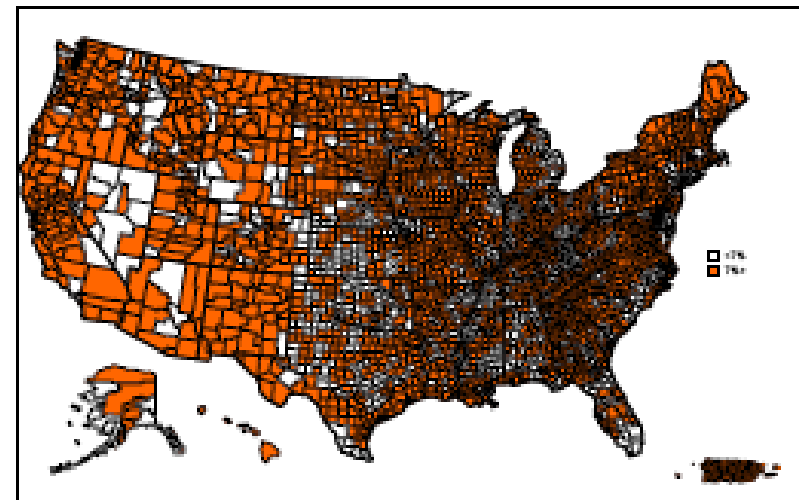


# The Issue: MA payment rates in many counties are very high compared to fee for service costs.

## 2009 benchmarks



## Projected 2010 counties above 107%



# Payment Changes Under Consideration

- **Reduce MA to lower percent of FFS**
  - > Somewhere between 100% and 110%
  - > Phase-in over 4 years
- **Decrease size of rebate**
  - > Some talk of 50% savings to CMS
  - > May not be quite as negative as benchmark ceiling (?)
- **Competitive Bid**

# Obama Transition Team Goals

- Prevention – access for children and low income adults
- Wellness – personal responsibility
- EDI/EMR
- Stimulus: Health Corps (?)
- Medical education of primary care providers
  - > Nurse Practitioners, Physician Assistants
  - > General Medicine
- Portability – individual, group
- “Real, effective cost containment”
  - > Doesn't this sound like the promise of managed care?!

# Obama Transition Team Focus (in order)

## 1. Stimulus

- > How to get dollars quickly to the market
- > Increased Medicaid funding
- > National Health Corps

## 2. Budget

- > Medicare Advantage payment changes/reductions
- > Provider fee schedule discussions and changes in methodology
- > Increased emphasis on primary care services

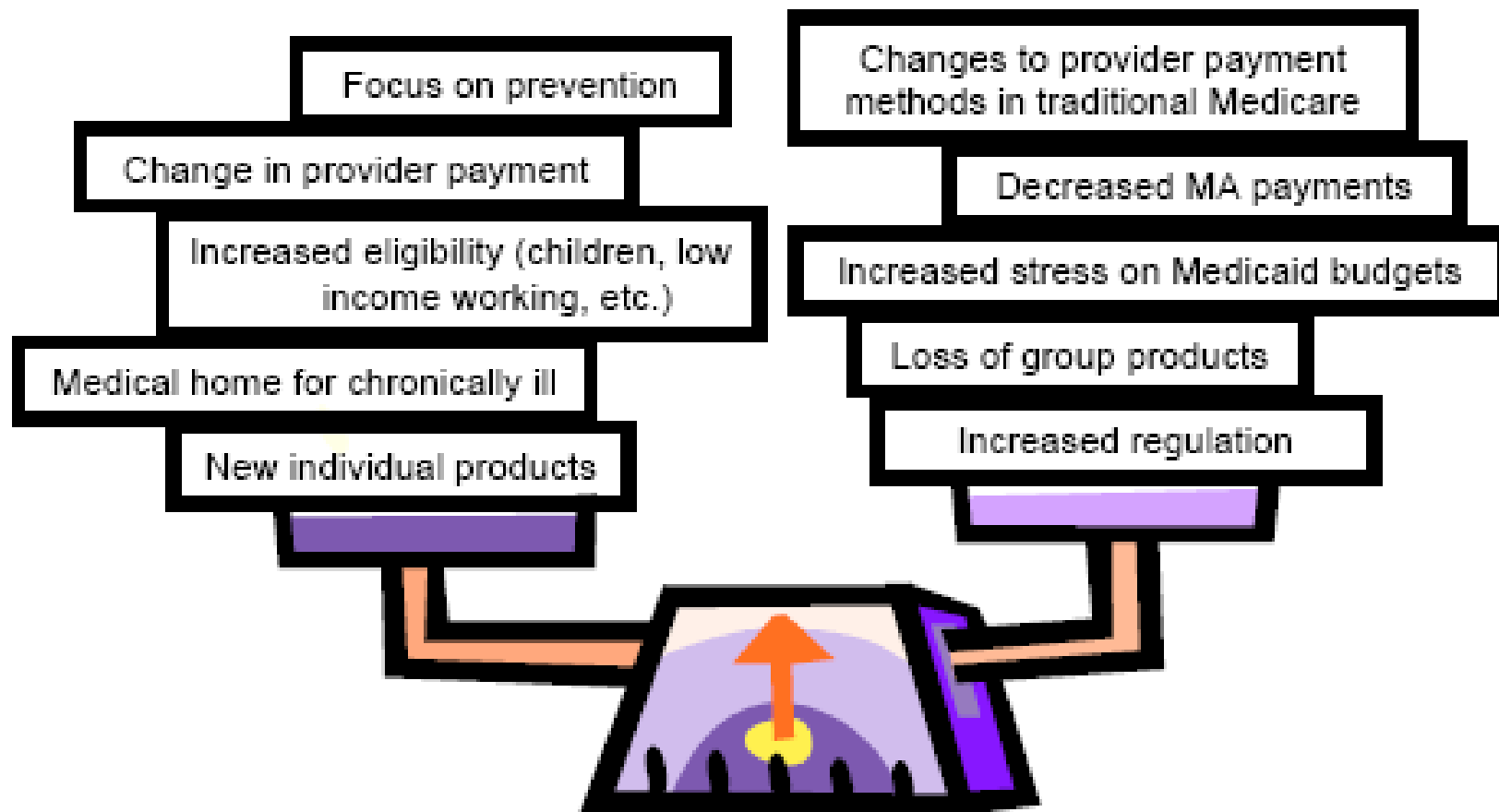
## 3. Overall Reform in Medicare and Medicaid

- > Expanded Medicare eligibility to pre-65 populations
- > Expanded Medicaid eligibility

# Immediate Plan Response

- New member enrollment push
  - > MA commissions in the range of \$500/\$250
- Attention to future administrative costs
- Reduced benefits/increased premiums
- Shift to cost-based plans (!)
- Resurgent Medicare Supplement programs
- Review additional product opportunities such as MLTC
- Reduction of group potential
  - > Increased individual product opportunities
- Medicaid managed care program development
- Renewed interest in medical management programs

# Proposed Reforms have profound impact that need to be balanced by organizations serving the public markets.



# **Anticipated Impact to Commercial Insurers (Non-Medicare)**

# Health Insurance Exchange

- An alternative to the non-group market
- Offers individuals a choice of health plans including private plans meeting federal regulations and the Public Plan
- All insurer's benefits (actuarial value) must be at least as great as the Public Plan's benefits
- Guaranteed issue and community rating
- Must meet quality and efficiency standards
- Exchange would evaluate plans and make differences among them transparent
- "Above average" rate increases require approval

# Health Insurance Exchange – Impact

- More regulatory requirements on the private market
  - > All but 11 states allow premium variation based on health status
- Choice of Public Plan's minimum benefit is key
  - > Higher benefit standard would ensure better coverage (initially)
  - > But would lock-in a higher cost structure and reduce the range of insurance options (potentially introduces moral hazard)
  - > Premium trends would be affected by benefit buy-ups
  - > Will affect parity regulations
  - > Size of employer, to which mandate is applied, is not defined
- Healthy pay more; sick pay less
- No purchase mandate increases chance of risk selection
- Administrative efficiency becomes a differentiator
- Public Plan will become “the” competition

# New Public Plan

- Made available through the Health Insurance Exchange
  - An alternative to private coverage
  - Guaranteed issue to anyone that does not have access to ESI or existing public programs<sup>1&2</sup>
  - No exclusions due to pre-existing conditions
  - No differentiation in premium due to health status
  - Subsidies available to income-challenged not eligible for public programs
  - Benefits must be at least as great as one of the national plans offered by the FEHB program
  - By 2010, premium rates must assume Medicare reimbursement levels in rate-making calculations
- 
- ESI = Employer-sponsored insurance; FEHB = Federal Employees Health Benefits
  - 1 Medicare, Medicaid and State Children's Health Insurance Program.
  - 2 Available to small employers that do not currently offer their own plan.

# New Public Plan – Impact

- Difficult to compete against the Public Plan
  - > Premiums low due to Medicare provider payment requirement
  - > Consumers attracted to lower-cost, higher-benefit program
- No mandate to purchase opens the door to risk selection
- If high option benefit is chosen as the minimum benefit standard, lower-option plans cannot be offered in HIE
  - > May numb consumer's sensitivity to cost
- Insurer's investment in HSAs/HRAs may be for naught

# Governmental Reinsurance

- Partially reimburses employers for costs related to catastrophic patients
- Subsidies must be used to reduce worker's premiums
- Policy shifts cost to federal budget

# Governmental Reinsurance – Impact

- Cost shift will reduce employer's core medical costs
  - > Anomalies may result in certain cases (large NICU cases)
  - > Future premium rates and cost trends will be affected
  - > Period of uncertainty as insurers assess employer-specific impact
- Insurers and providers may be encouraged to provide more services to catastrophic patients
- Reinsurers, TPAs and insurers that offer employer stoploss may contemplate market exit
- More regulation (and cost) may result as the government vocationally re-trains

# Mandate: Employer Play-or-Pay

- All large employers required to contribute towards either:
  - > Health coverage for their employees in a high quality plan,
- OR
- > Cost of the new Public Plan (a health tax)
- Contribution must be “meaningful”
- Some very small businesses would be exempt from the mandate and would further receive a subsidy (tax credit)

# Mandate: Employer Play-or-Pay - Impact

- Level of tax payment relative to the cost of insurance will be critical
  - > Dictates the participation level in the new Public Plan
  - > If tax payment is low, employers may “pay” rather than “play”
  - > Employer will offer coverage only if better benefits and lower cost than the new Public Plan
- Subsidy will likely increase enrollment in private insurance plans
- Some argue employer mandate will ultimately come out of employee’s total pay or via loss in jobs
  - > Could affect insurer membership levels

# Mandate: Child Coverage

- All children must have health care coverage
- Technically, mandate is on parents to cover all children in private or public program
- Expands the number of options for young adults to obtain coverage (up to age 25)
- Lower eligibility requirements for Medicaid and SCHIP

# Mandate: Child Coverage - Impact

- Generally low cost cohort, but significant variation
- NICU cases
- Increased numbers should help stabilize risk pools
- Mandated coverage will limit risk selection
- Enforcement of mandate is not clearly defined (penalty?)

# Other Policy Provisions

- Require health plans to disclose the percentage of their premium that actually goes to paying for patient care
- In market areas where there is not enough competition, require insurers to pay out a “reasonable share” of premiums on patient care benefits
- Maintain existing state health reforms if they meet minimum standards of the national plan

# Other Policy Provisions - Impact

- Minimum cost ratio may create additional pressure on insurer margins and administrative cost increases
  - > Definition of minimum health cost ratio will be key (CMS def'n?)
  - > State ins. depts. require profits to meet solvency requirements
  - > May affect GAAP and stat calculations
- Federal mandates will increase standardization of regulations across states, simplifying insurer attainment
- No definition of “not competitive”; difficult to assess

# Cost Containment

- Adoption of Health Information Technology (HIT)
- Disease management
- Coordinate and integrate care (medical home)
- Require full transparency regarding cost and quality
- Promote patient safety
- Align provider incentives for excellence
- Comparative effectiveness reviews
- Reduce disparities in health care treatments for same illness
- Antitrust insurance reform

# Cost Containment - Impacts

- Insurers will likely make similar HIT investments that will increase administrative costs in the short-term
- HIT will likely decrease costs in the long-term (paperless)
- Current outcomes studies are unclear whether disease management programs actually reduce costs
- Insurers will continue to develop systems that will identify their best providers in terms of cost efficiency and quality
- Pay-for-performance and network tiers will increase number
  - > Participation requirement in Public Plan, Exchange and Medicare
  - > Insurers will need to allocate performance funds as part of budgets
  - > Disparity reduction will require new information to report parity

# Key Variables That Drive Extent of Impact

- Health Insurance Exchange minimum benefit standard
- Mandate to purchase in non-group environment
- Public Plan premium rates assume Medicare reimbursement levels – extreme competition
- Level of tax payment in Employer Pay-or-Play
- Definition of “competitive” market
- Governmental reinsurance application
- Speed to value of cost containment efforts