The 2010 Patient Protection and Affordable Care Act (ACA): Overview and Implications for Risk Adjustment

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ACA Left Intact the Existing Federal System

Many diverse insurers	% of people, 2010
• Employment-based insurance	55.3%
• Medicare (elderly and disabled)	14.5%
• Medicaid/children (poor/children/high cost)	15.9%
• Military insurance	4.2%
• Direct insurance purchase (individual)	9.8%
• Uninsured	16.3%

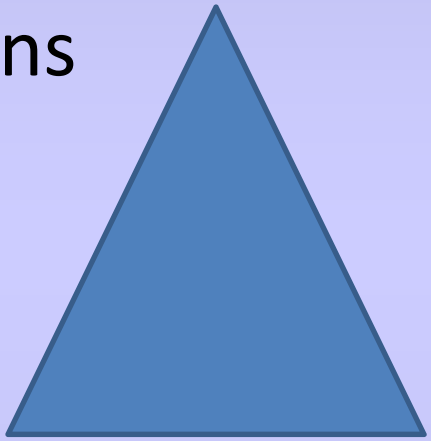
Note: numbers sum to more than 100% since many people have multiple coverage.

Source: http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/table10.pdf

Three Legs of the ACA Reforms

Insurers

No exclusions for pre-existing conditions



Consumers

Consumers must buy insurance

(or pay tax penalty)

Government

Subsidies for those who cannot pay

Jon Gruber, (2011)

Changes in Place in 2012

- Insurance companies can no longer **drop** people from coverage after getting sick
- Can't exclude children age < 19 with pre-existing conditions
- Young adults can stay on parents plan until age 26
- Creates high-risk pool for adults with pre-existing conditions without coverage *(small take up so far)*
- Temporary reinsurance program for early retirees aged 55-64
- $250 rebate given to seniors for high drug spending
- Tax credits for small businesses to offer insurance
- Insurers cannot pay out less than 80-85% of premium

Changes planned 2014-2017

- Expanded Medicaid programs for the poor.
- Impose tax penalties on individuals not purchasing coverage, tax subsidies for those that do
- Impose penalties on firms not offering insurance, offer subsidies for those that do IF they were not already offering insurance
- Raise revenue elsewhere

Medicaid expansion

- Expands Medicaid (for poor) to cover all individuals up to 133% of the federal poverty level (FPL) in 2014
- States receive large federal subsidies
- *Legislation in place but mandate that states must participate was ruled unconstitutional*

Children's Health Insurance Program

- Increased federal funding and eligibility

Individual “Mandate”

- Requires all U.S. citizens to have health insurance or pay tax penalty
- Exemptions granted for financial hardship, religious objections, American Indians, those without coverage for less than three months
- Penalties take effect beginning in January 2014

Individual Mandate (federal)

- Penalty for single coverage phased in:
  - $95 in 2014 (or 1% taxable income)
  - $325 in 2015 (or 2% taxable income)
  - $695 in 2016 (or 2.5% taxable income)
- Penalty up to three times this level for a family contract

Employer incentives in 2014

Penalties:

- 1-50 employees exempt from any penalty
- 50-199 employees must pay penalties of up to $3,000 per employee
- 200+ employees must enroll employees in a health insurance plan

Subsidies:

Premium credits and cost-sharing to legal US citizens purchasing through newly-created national exchange (not for existing insurance plans) for those between 100-400% FPL (about $88K for family of four)

Small Business Tax Credits

- Tax credits for businesses with fewer than 25 employees phased in 2014-2017
- Even more generous subsidies for non-profit (tax-exempt) firms

Limiting Out-of-Pocket Costs

(FPL = Federal Poverty Level)

Income level	Singles	Families
<100% FPL	Medicaid?	
100-200% FPL	$1,983	$ 3,967
200-300% FPL	$2,975	$ 5,950
300-400% FPL	$3,967	$ 7,933
> 400% FPL	$5,950	$11,900

Insurance Exchanges in 2014

- Encourages **state-based** insurance exchanges
- States not setting up their own exchange can use a **National Insurance Exchange**
- Exchanges only available to small businesses with fewer than 100 employees. Businesses with more than 100 employees are eligible after 2017
- Only for legal U.S. citizens
- Non-profit member-run insurance cooperatives also subsidized

Benefits Within National Exchange

- Some minimum benefits required but not standardized.
- Maximum deductibles of $2,000 for an individual and $4,000 for a family
- Out-of-pocket maximums cannot exceed $5,950 for individual and $11,900 for family.

Benefits Within National Exchange

- Coverage offered at four levels with actuarial value values defining how much insurers pay
- All cover “essential health benefits”
- Bronze plan covers 60% of the benefit costs
- Silver – 70%
- Gold – 80%
- Platinum – 90%

ACA: IMPLICATIONS FOR RISK ADJUSTMENT

(Ellis special interest)

Risk Adjustment Proposed for Health Exchanges

"(ii) SPECIFIC REQUIREMENTS.—The Secretary shall make the determination under clause (i) on a ***per enrollee basis*** *and shall take into account all relevant … (i), including the* ***age*** *and* ***income*** *of the enrollee, whether the enrollment is for* ***self-only or family*** *coverage,* ***geographic differences*** *in average spending for health care across rating areas, the* ***health status*** *of the enrollee* ***for purposes of determining risk adjustment payments*** *and reinsurance payments …through an Exchange, …" (ACA, p. 208)*

Risk adjustment proposed for high-risk conditions pool

- *"(i) a list of **at least 50 but not more than 100 medical conditions** that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or*
- *(ii) **any other comparable objective method** of identification recommended by the American Academy of Actuaries." (ACA, p 228)*

Revenue Provisions

- Tax on “Cadillac Plans” with premiums that exceed $10,200 annually for an individual, $27,500 for families in 2018
- Limits Flexible Spending Account contributions to $2,500 annually effective in 2013
- Excise taxes on pharmaceutical manufacturers beginning in 2011 on drugs whose revenue exceeds $2.5 billion annually.
- Excise tax on device manufacturers on devices with revenue exceeding $2 billion from 2011 – 2017, and $3 billion annually thereafter. A 2.3% sales tax on devices is also enacted effective in 2013

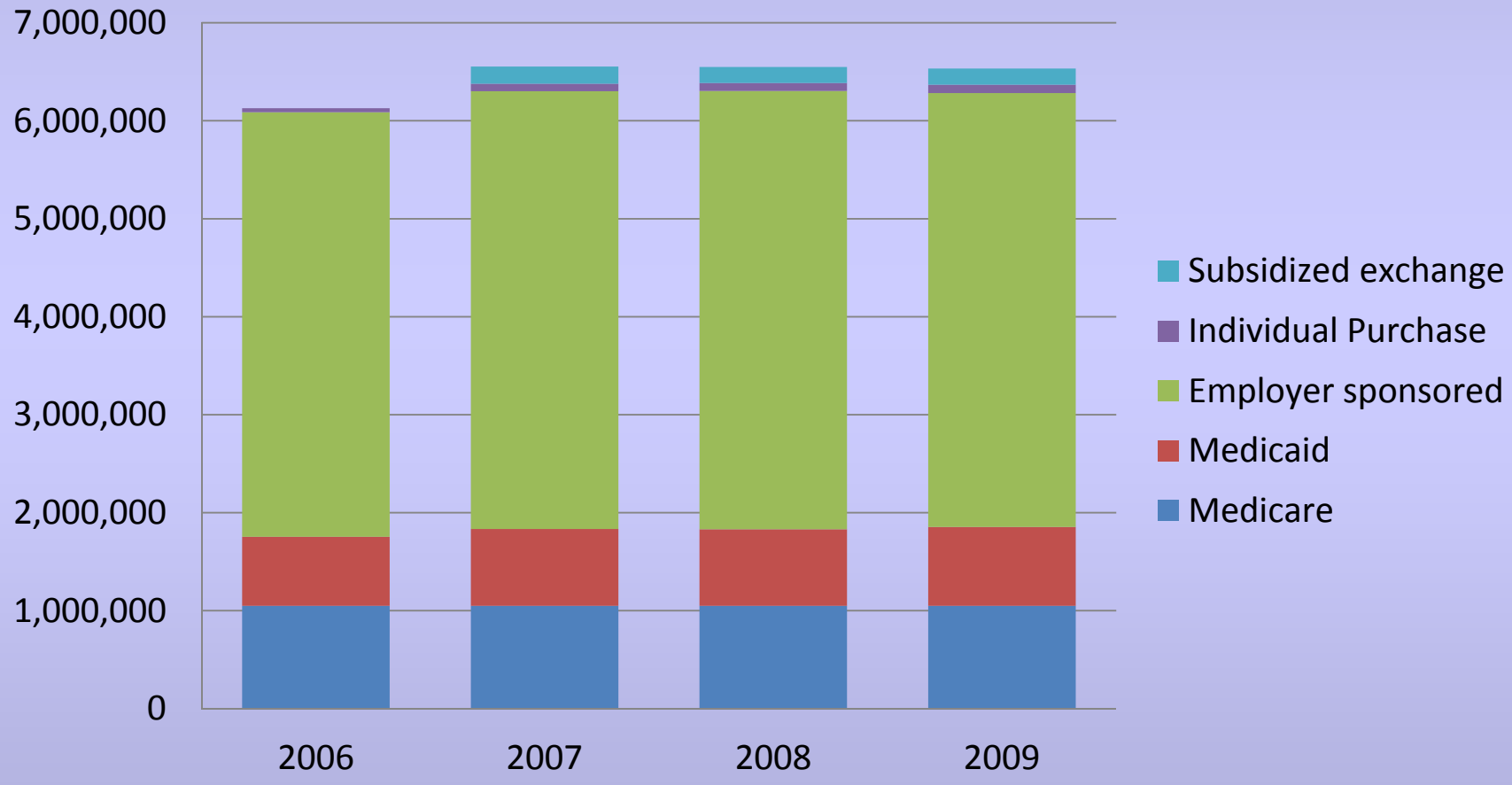
Revenue Provisions

- 0.9% tax on earned income for households earning over $200K for individuals ($250K for joint filers)
- 3.8% Medicare tax on unearned income (interest, dividends, annuities, royalties, and rents) for households earning over $200K for individuals ($250K for joint filers)
- 10% tax on tanning services

Only incremental effects occurred in Massachusetts

- Massachusetts mandated insurance in 2006, and has gradually ramped up relatively modest subsidies and penalties, and has over 98% insurance so far.
- MA started out with only 9-10% uninsured, versus national average of 16%
- Increases in coverage were balanced between increased employer-sponsored insurance, subsidized and unsubsidized insurance through the exchanges.
- In MA, increases in Medicaid were modest, affected more by the recession in 2008 than by RomneyCare

Massachusetts Insurance Enrollment 2006-2009



Exchanges will require RA

- RA not yet done in Mass., required for national exchanges.
- Exchanges offered by governments or nonprofit orgs, so less incentive to try to select.
- Different plan generosity (bronze-silver-gold-platinum) increases importance of RA
- Premium rate bands and create systematic profits and losses
- Incentives within exchanges less serious than between exchanges and conventional insurers
- Main government focus of RA is on Medicare
- RA also used in 15 state Medicaid programs

Medicare has continually made adjustments to offset MA coding pattern differences.

- Initially, Medicare built in an assumed 5% coding intensity change.
- For 2011, CMS applied a 3.41% reduction to each Part C beneficiary's risk score to correct for the observed pattern that MA plans have had coding creep at a rate of 1.75% faster than FFS plans on which model is calibrated.
- FFS plans have had coding creep at the rate of 4.1% per year

2011-12 Huge years for risk adjustment research in US

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