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E2: The Affordable Care Act: An Update and an Irish Perspective

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The Affordable Care Act

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History – US Health Care System
(percentages from 2010-pre ACA*)

Multiple-payer structure

- Federal and state government programs
  - Medicare – 14.5%
  - Medicaid – 15.9%
  - Military – 4.2%
- Private plan – 64.0%
  - Employment-based – 55.3%
- **Uninsured – 16.3% (49.9 million)**

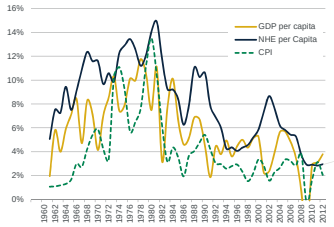
* The estimates by type of coverage are *not* mutually exclusive; people can be covered by more than one type of health insurance during the year.

Sources: US Census Bureau;
http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2014/Table1.pdf
http://www.census.gov/prod/2011pubs/p60-239.pdf


„Obamacare" steht auf der Kippe

Source: Börsen-Zeitung, December 15, 2010

Pre-ACA:
Healthcare costs vs GDP growth and inflation

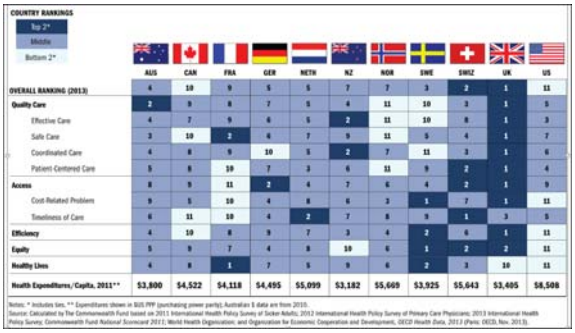


CAGR	GDP per capita	CPI	National health expenditures (NHE) per capita
1960-1970	5.7%	2.8%	9.2%
1970-1980	9.1%	8.2%	11.9%
1980-1990	6.6%	4.7%	9.9%
1990-2000	4.3%	2.8%	5.3%
2000-2007	4.0%	2.7%	6.6%
2007-2012	1.5%	2.1%	3.1%
1960-2012	**5.6%**	**4.1%**	**8.1%**

- 2012 value 3.0%
- NHE in 2012: $2.8 tr (17.2% of GDP)
- NHE per capita in 2012: $8,900

Sources: Centers for Medicare and Medicaid Services, Bureau of Economic Analysis, bureau of Labor Statistics, US Census Bureau

US Healthcare System – Ranking



Sources: The Commonwealth Fund: Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally; http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

Goals of the Affordable Care Act (ACA)

- Provide **greater access** to health coverage and reduce the number of uninsured
- Bring down **healthcare cost** increases by encouraging a shift toward more **efficient** delivery and payment models
- Add new **consumer benefits and protection**

WHO Health System Performance Framework defines the goals of health systems as:

- Improving the health of the population they serve
- Fair financing, i.e., providing financial protection against the costs of ill-health.
- Responsiveness, i.e., responding to people's legitimate expectations

ACA – Background and a long journey

The campaign, gathering consensus and democratic votes

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Signed into law on March 23, 2010

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In June 2012, Supreme Court decided in favor of ACA

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14 States and DC signed up to run own exchange

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Months before launch deadline

↓

Launch on October 1, 2013 and the Crash

↓

Rescue and 8 Million sign-ups

Key provisions of the ACA

- **Individual health insurance mandate**
  - Requires individuals to have insurance or pay a tax penalty
- **Employer health insurance mandate**
  - Requires employers to offer health benefits to employees or pay a fine (small employers are exempt)
- **Public insurance exchanges for individuals and small businesses**
  - Either state-based, a state-federal partnership, or a federally-facilitated exchange run by the Department of *Health and Human Services* (HHS)
- **Consumer Operated and Oriented Plans (CO-OPs)**
  - To increase affordable options to individuals and small businesses
  - 23 CO-OPs created with $ 2.4 billion in federal funding support.

Key provisions of the ACA – cont'd

- **Expansion of Medicaid eligibility**
  - Up to the states whether or not to participate; federal government to cover most of the expansion costs
- **Consumer Protection**
  - No pre-existing condition rejection, no rating for health conditions, and modified community rating
  - Essential health benefits mandate
  - Medical loss ratio (MLR) thresholds
  - No annual or lifetime cap on benefits
  - Young adults can remain on parent's plan (until age 26)

Key provisions of the ACA – cont'd

- **Provisions to improve system performance**
  - Promotion of Accountable Care Organizations
  - Funding for 'comparative effectiveness research'
  - Pilot programs to test new payment systems (pay-for-performance, bundled-payments systems)
- **Premium stabilization programs (the 3Rs)**
  Goal: Provide certainty and protect against adverse selection while stabilizing premiums in the individual and small group markets
  - Reinsurance program
  - Risk adjustment
  - Risk corridor

Premium stabilization programs (the "3Rs")

Reinsurance programs

- Temporary program from 2014 through 2016
- Protects in the individual market from specific high-cost individuals within and outside exchange
- Health insurance issuers and third party administrators make contributions
  2014: $63; 2015: $44; 2016: $27 per enrollee
- Administered by State or HHS
- Reinsurance funds
  2014: $10bn; 2015: $6bn; 2016: $4bn
- Attachment points, coinsurance rate, reinsurance caps
  Published by HHS each year depending
  2014: $45,000 – 80% (adjusted to 100%) - $250,000
  2015: $70,000 – 50% - $250,000
  2016: $70,000 – 50% - $250,000
- Payments net to zero

Premium stabilization programs (the "3Rs")

Risk adjustment

- Permanent program that began in 2014
- Protects in the individual and small group markets from attracting higher than average health risks within and outside exchange
- Administered by State or HHS
- Plans' average actuarial risk will be determined based on enrollees' individual risk scores (based on age, sex, diagnoses)
- Adjustments are made for actuarial value, allowable rating, induced demand, geographic cost variation
- Payments within a given state net to zero
- (Up)coding and risk adjustment auditing

Premium stabilization programs (the "3Rs")

Risk corridor

- Temporary program from 2014 through 2016
- Protects against inaccurate rate-setting by sharing gains and losses in ACA's initial phase
- Applies to Qualified Health Plans (QHP) within exchange or plans similar to an exchange QHP outside of the exchange
- Administered by HHS
- Payments:
  Claims less than 3% of target => payment to HHS
  Claims exceed 3% of target => reimbursement from HHS
  a) Claims below / above its target by 3% – 8% => 50% payment / reimbursement
  b) Claims below / above its target by more than 8% => a) + 80% payment / reimbursement
- Payments not required to net to zero
  (or rather administered over the 3-year life of program)

Current Status of ACA

- **Consumer Operated and Oriented Plans**
  => 12 of 23 CO-OPs have closed
- **Risk Corridor**
  => 12.6% of insurers' request of $2.9 billion were paid
- **Uninsured Population**
  => 2013: 13.3% (41.8 million)*
  2014: 10.4% (33.0 million)*
  2015: 9.2%**
- **National Health Expenditures**
  => 2014: $3.0 trillion ($9,523 pp) or 17.5% of GDP – (was 17.3% in 2013)
  2024: 19.6% of GDP by 2024***
- **Private Exchanges**
  => Market expected to grow to about 40 million by 2018

Sources:
* US Census Bureau; http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2014/Table1.pdf
** http://obamacarefacts.com/uninsured-rates/
*** https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf

Outlook

November 8, 2016:

"Defend and build"

or

"Repeal and Replace"

Facts:

- **ACA's provisions are entering their fourth to seventh year**
- **Uninsured population down**
- **100+ Million now used to free preventive care, no pre-existing conditions, …**
- **Exchanges well established**

=> Modifications and adjustments

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An Irish Perspective

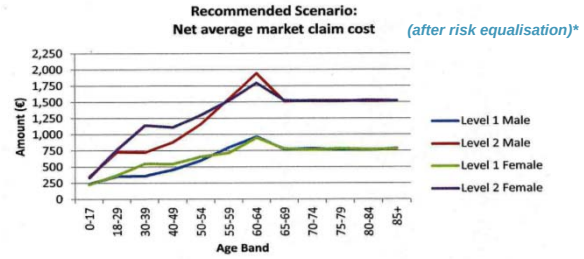
Private medical insurance in Ireland

- **Consumer protection**
  - No pre-existing condition rejection, no rating for health conditions, and community rating (1957)
  - No annual or lifetime cap on benefits (1957)
  - Prescribed minimum medical benefits (1996)
  - Discounts for young adults (2015)
- **Lifetime community rating (2015)**
  - New joiners over the age of 34 are subject to a premium loading
  - 2% for each year above age 34 up to a maximum of 70%

Risk adjustment (equalisation)

- **Timelines**
  - Legislative provision (1996)
  - Commencement triggered (2005)
  - Overturned (2008)
  - New scheme (2009)
  - Provisions to claw back “overcompensation” (2012)
- **Structure**
  - Administered by the Health Insurance Authority (HIA)
  - Levy applies to each adult and child; credits paid for each person over age 60 (credits vary by gender)
  - Further credits paid for each hospital bed night and day case procedure
  - Levies and credits intended to net to zero

Risk equalisation



HIA report to the Minister for Health, September 2015

*Credits are set so that the net claims cost does not exceed 130% of the market average

Context and outlook

- Private health insurance supplements an NHS-type public hospital system
- 47% of the population is insured (peak was 51% in 2008)
- Motivations are speed of access and choice of provider
- Typically provided as an employee benefit by multinationals
- Universal health insurance?

"A system of Universal Health Insurance is still our preferred model to achieve universal healthcare. However, the high costs for the particular model of health insurance analysed in the new ESRI report are not acceptable, either now or any time in the future. The ESRI report therefore vindicates the Government's decision not to rush the implementation of UHI."


Varadkar rules out implementation of original universal health insurance plan