Affordable Care Act Update October 17, 2014

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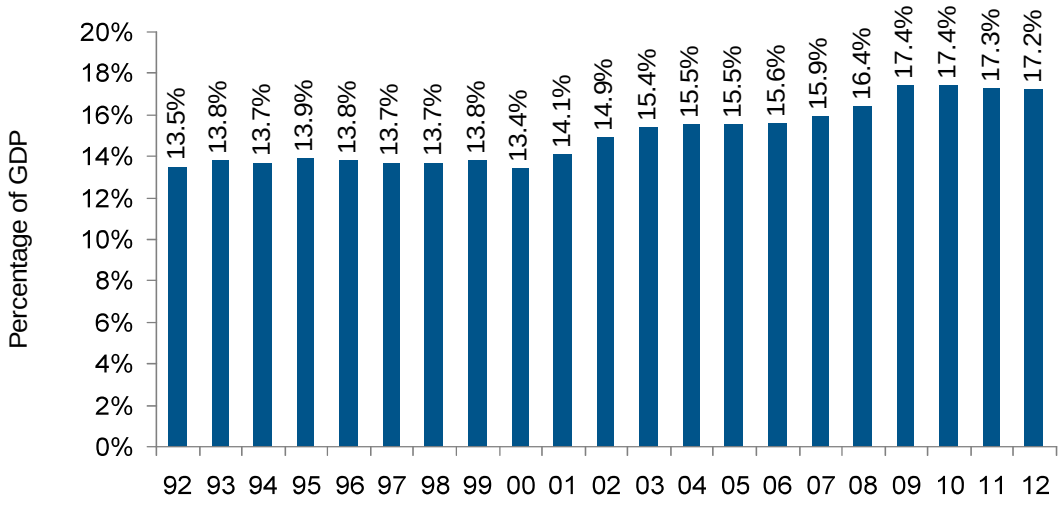
Outline of Discussion Topics

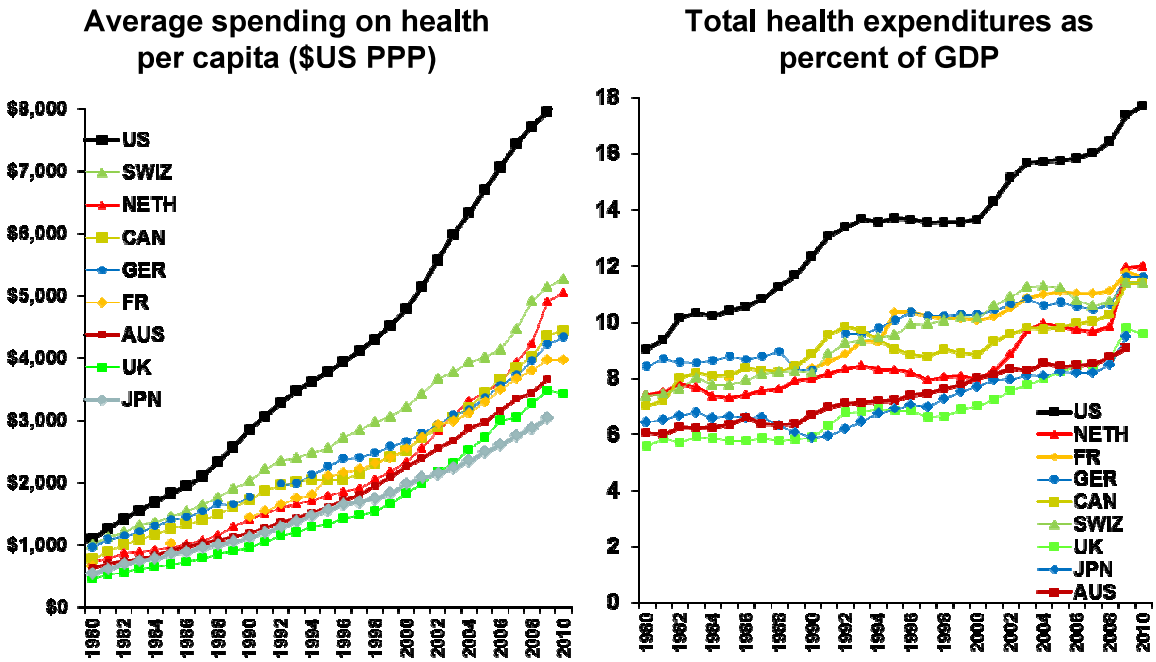
- Update on National Healthcare Expenditures and trends
- 40 years of ERISA
- Update on the Affordable Care Act – ACA
- Waivers issued to the Territories
- What applies and what does not to Guam
- Q&A

National Health Expenditures as a Percentage of Gross Domestic Product, 1992 – 2012[(1)]



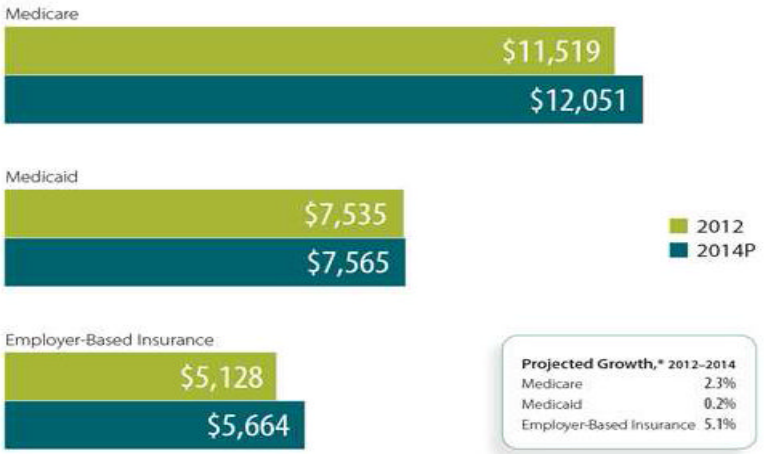
Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released January 7, 2014.
(1) CMS completed a benchmark revision in 2009, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.gov/nationalhealthexpenddata/downloads/benchmark2009.pdf.

International Comparison of Spending on Health, 1980–2010



Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.

Health Insurance Spending per Enrollee
United States, 2012 vs. 2014

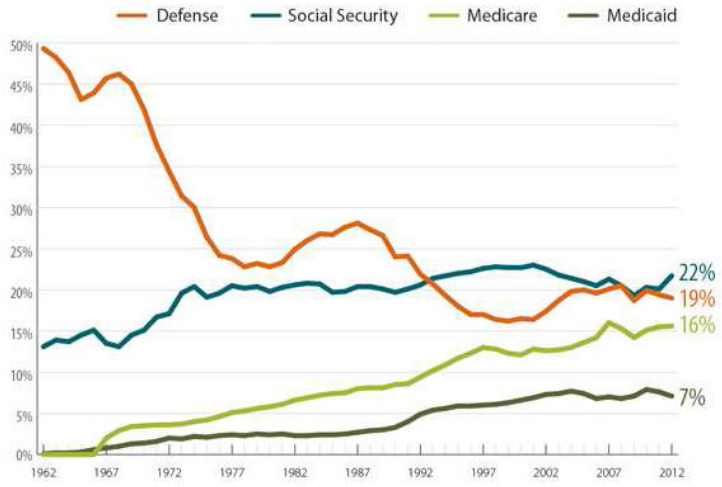


*Projected growth calculations are average annual figures per enrollee.

Note: Projections (P) include the impact of the Affordable Care Act.

Source: Author calculation based on Centers for Medicare & Medicaid Services (CMS), National Health Expenditures, 2014 release (historical) and 2013 release (projections), www.cms.gov.

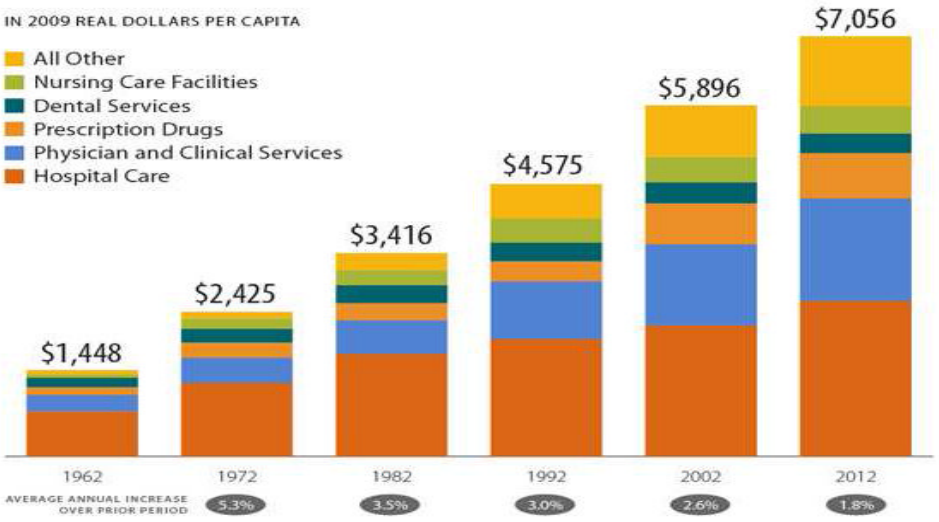
Major Programs as a Share of the Federal Budget
United States, 1962 to 2012



Notes: Spending shares computed as a percentage of federal outlays. All outlays reflect federal spending only (i.e., Medicaid outlays shown reflect federal portion). Annual changes in overall federal outlays — 2.8% (2007), 9.3% (2008), 17.9% (2009), –1.7% (2010), 4.2% (2011), –1.8% (2012) — show federal spending surge and then contract due to the recession. This activity impacted the share of government spending consumed by Social Security, defense, and other ongoing programs.

Sources: Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, February 4, 2014, www.cbo.gov and *The Budget and Economic Outlook: Fiscal Years 2003 to 2012*, January 2002, supplemental information: Historical Budget Data, www.cbo.gov.

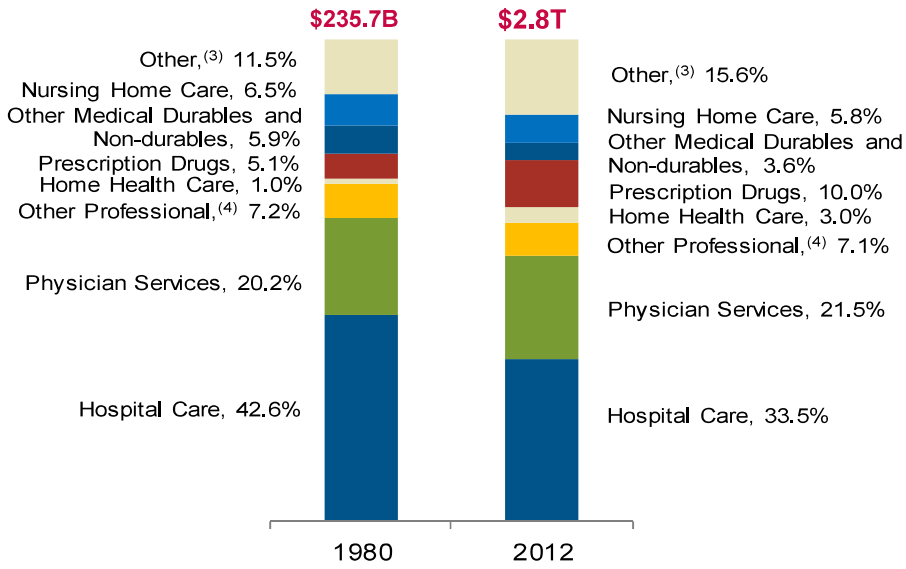
Personal Health Care Spending, Adjusted for Inflation
United States, 1962 to 2012, Selected Years



Notes: Personal health care spending measures the total amount spent directly on health care goods and services and excludes government administration, the net cost of health insurance, research, and investment. For additional detail on spending categories, see the appendix.

Source: Author calculation using Centers for Medicare & Medicaid Services (CMS), National Health Expenditures (NHE), 2014 release, including unpublished data (complete 1960–2012 series), associated with Table 23, "National Health Expenditures; Nominal Dollars, Real Dollars, Price Indexes, and Annual Percent Change: Selected Calendar Years."

National Expenditures for Health Services and Supplies[1] by Category, 1980 and 2012[2]



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released January 7, 2014.

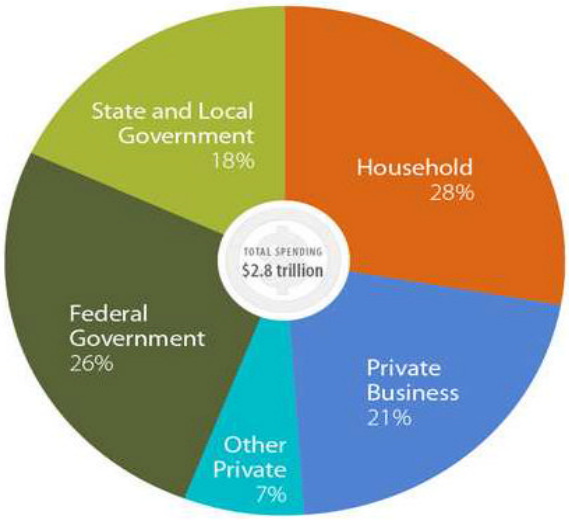
(1) Excludes medical research and medical facilities construction.

(2) CMS completed a benchmark revision in 2009, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.gov/nationalhealthexpenddata/downloads/benchmark2009.pdf.

(3) "Other" includes net cost of insurance and administration, government public health activities, and other personal health care.

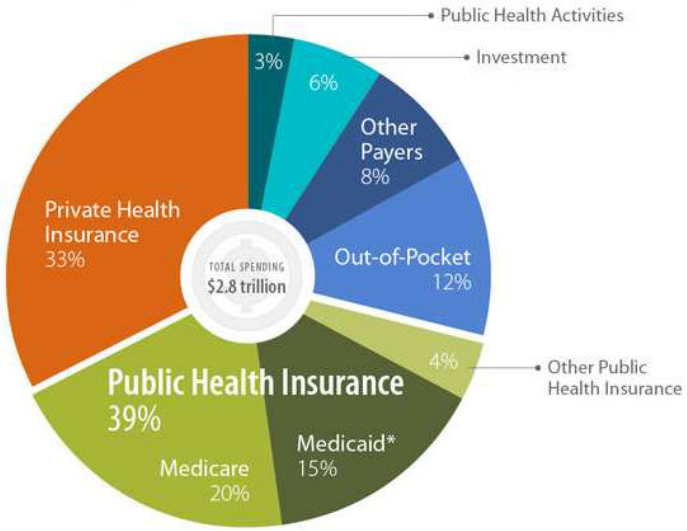
(4) "Other professional" includes dental and other non-physician professional services.

Health Spending Distribution, by Sponsor
United States, 2012



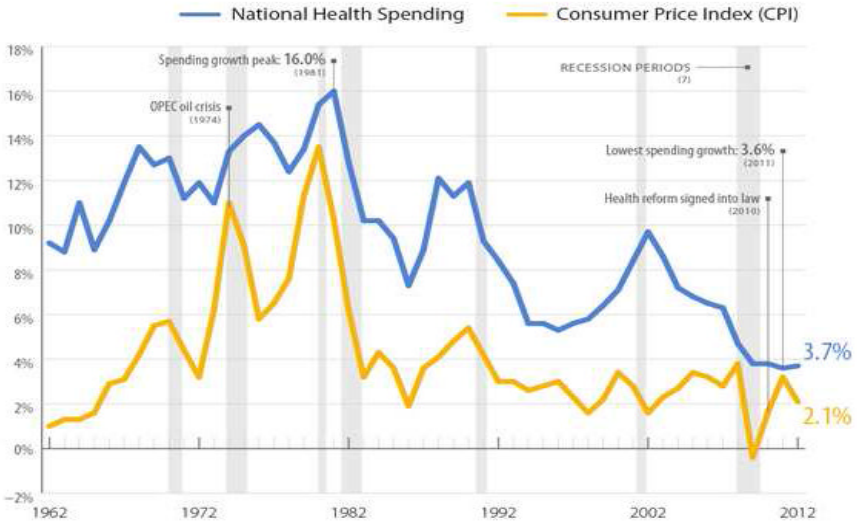
Notes: Health spending refers to National Health Expenditures. Sponsors are the entities that are ultimately responsible for financing the health care bill. In pre-2011 editions, this publication referred to sponsors as contributors. Figures may not sum due to rounding.
Source: Centers for Medicare & Medicaid Services (CMS), National Health Expenditures, 2014 release; www.cms.gov.

Health Spending Distribution, by Payer
United States, 2012



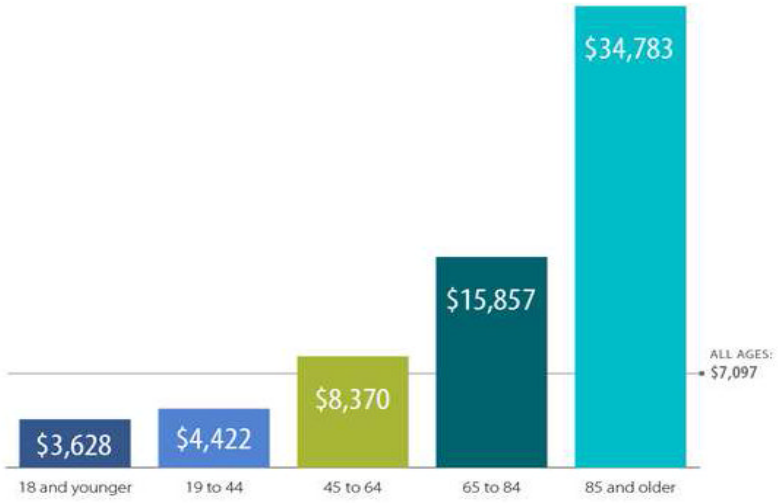
*The funding of Medicaid spending differed in 2012 (56% federal/44% state) compared to 2011 (61% federal/39% state).
Notes: Health spending refers to National Health Expenditures. See page 19 for historical distribution. Figures may not sum due to rounding.
Source: Centers for Medicare & Medicaid Services (CMS), National Health Expenditures, 2014 release; www.cms.gov.

Annual Growth Rates, Health Spending vs. Inflation
United States, 1962 to 2012

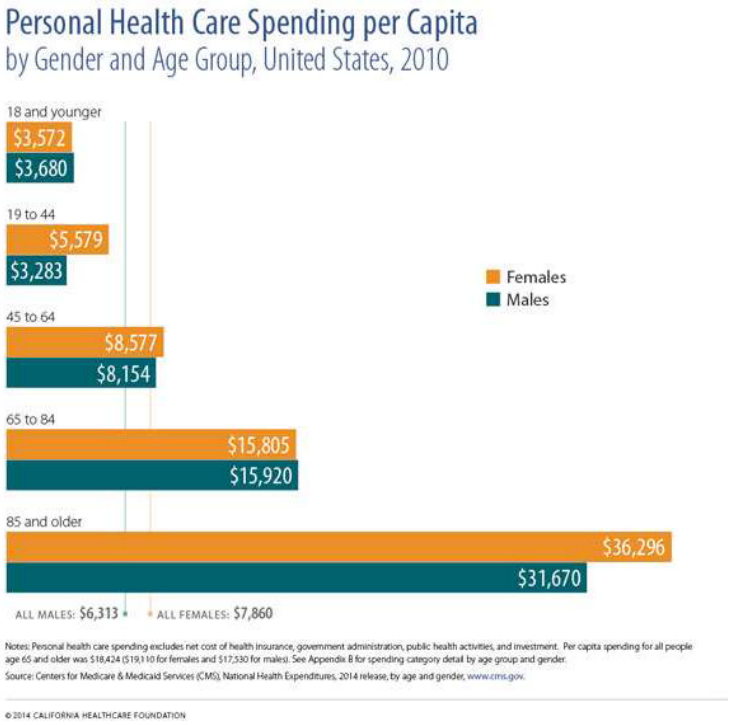


Notes: Health spending refers to National Health Expenditures. Per capita growth in health spending in 2012 (3.0%) was also greater than inflation's 2.1%.
Sources: Centers for Medicare & Medicaid Services (CMS), National Health Expenditures, 2014 release, www.cms.gov; Bureau of Labor Statistics, CPI-U, US city average, annual figures.

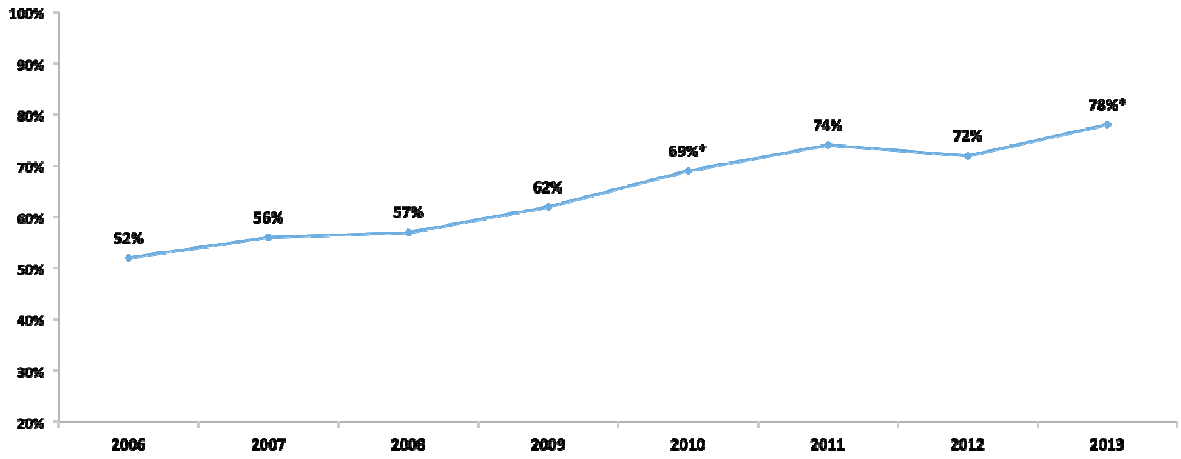
Personal Health Care Spending per Capita, by Age Group
United States, 2010



Notes: Personal health care spending excludes net cost of health insurance, government administration, public health activities, and investment. Per capita spending for all people age 65 and older was $18,424. See Appendix B for spending category detail by age group and gender.
Source: Centers for Medicare & Medicaid Services (CMS), National Health Expenditures, 2014 release, by age and gender, www.cms.gov.



Percent of Covered Workers Enrolled in a Plan That Includes a General Annual Deductible, 2006-2013



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

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Between 2012 and 2013 we did not collect information on the attributes of conventional plans, to be conservative, we assumed conventional plans did not have a deductible. Because of the low enrollment in conventional plans, the impact of this assumption is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2013.

Pharmaceuticals Spending

- **Global spending on medicines will grow annually to nearly $1.2 trillion by 2016, as the emerging markets, biologics and generics contribute a greater share of spending**
- Developments in target areas of research where some therapies have already launched including hepatitis C, multiple sclerosis and prostate cancer.
- **Sovaldi the $90K for 3 months treatment drug**

Pain Management: Market Trends

- **US accounts for 80% of worldwide Rx opioid use**
- **Pain management products focus on abuse deterrence**
  - **New products available-Opana ER, Oxycontin**
  - **Older formulations removed from market**
- **2011 FDA requirement to reduce APAP content to 325 mg in combination products within 3 years**
- **Top Medications by market share 2011:**
  - **Pain-Hydrocodone/APAP, oxycodone/apap, tramadol, amitriptyline, oxycodone**

Advances in Biotechnology…

Biologic/Specialty Drugs

- Medications called "specialty drugs" – *including biologics* – are made from variety of natural sources including human, animal or micro-organisms
- Derived from a biotechnology process that can change the course of a disease instead of just treating the symptoms
- Development of these drugs is a long, complex and costly endeavor

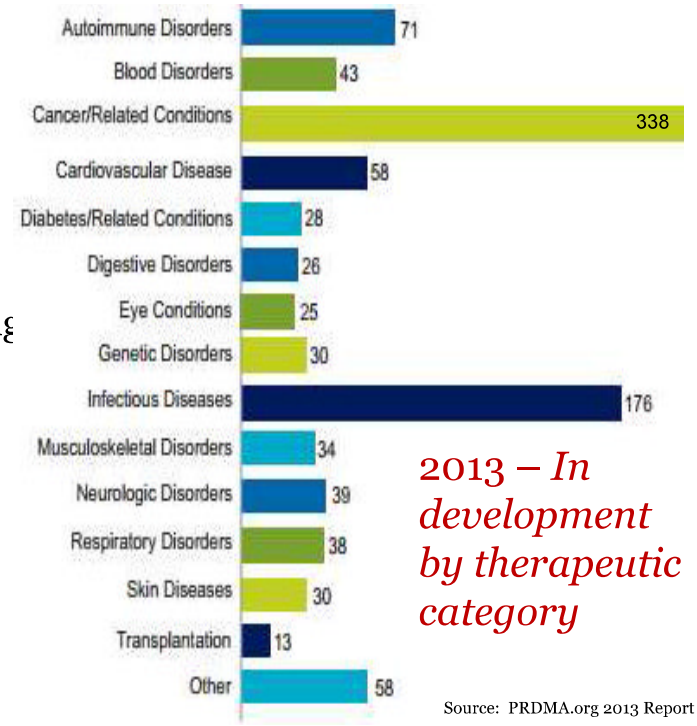
- Average of 10-15 years to bring a medicine to patients
- Average R&D investment today for each drug is $1.2 B

Source: PRDMA.org 2013 Report

Advances in Biotechnology

Biologic/Specialty Drugs

- Used to treat more than 100 life-threatening diseases and complex chronic conditions that previously had no therapeutic options
- Very effective in decreasing debilitating effects of a disease
- As of 2013, there are 907 biologic drugs in development



2013 – In development by therapeutic category

Source: PRDMA.org 2013 Report

Impacts to Employers

- Specialty drugs account for more than 20% of the average employer's overall pharmacy costs
- Increase in number of diagnostic and genetic tests, lab diagnostics and biomarkers required
- Site of care cost issues

- Three account for more than half of all spend:
  - Cancer – Arthritis – Multiple Sclerosis
- Approximately 50%-60% of specialty drugs are represented by the oncology category

40 Years of ERISA

- Employee Retirement Income Security Act
- Passed in 1974
- It provides the frame work for employer sponsored retirement plans and sets forward rules for all types of fringe benefits including heath insurance plans

WHAT IT DID FOR EMPLOYEES

- Created vesting for Retirement Plans
- Prohibited discrimination in employee benefits
- Allowed small employers to offer benefits

LATER:

- HMO mandate
- COBRA/HIPAA for continuation and portability
- ACA Amendments

ObamaCare or ACA

PRIOR TO THE ACA

- ERISA covered retirement and health plans
- Originally no substantive ERISA protections for health plans
- Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")
- Health Insurance Portability and Accountability Act of 1996 ("HIPAA")
- Other specific health benefits added (e.g., WHCRA)

The ACA and ERISA

- ACA added one new provision: ERISA § 715
- ERISA § 715 incorporates all of ACA's coverage requirements
- What does this mean?
- Employer sponsored health coverage (non-grandfathered) must comply with ACA
- ERISA's remedial provisions (§ § 502 & 510) can be used to enforce ACA

ERISA
CLAIM PROCEDURES

FOR CLAIMS THAT ARE APPEALED TIME FRAMES VARIES BASED ON TYPE OF CLAIM:

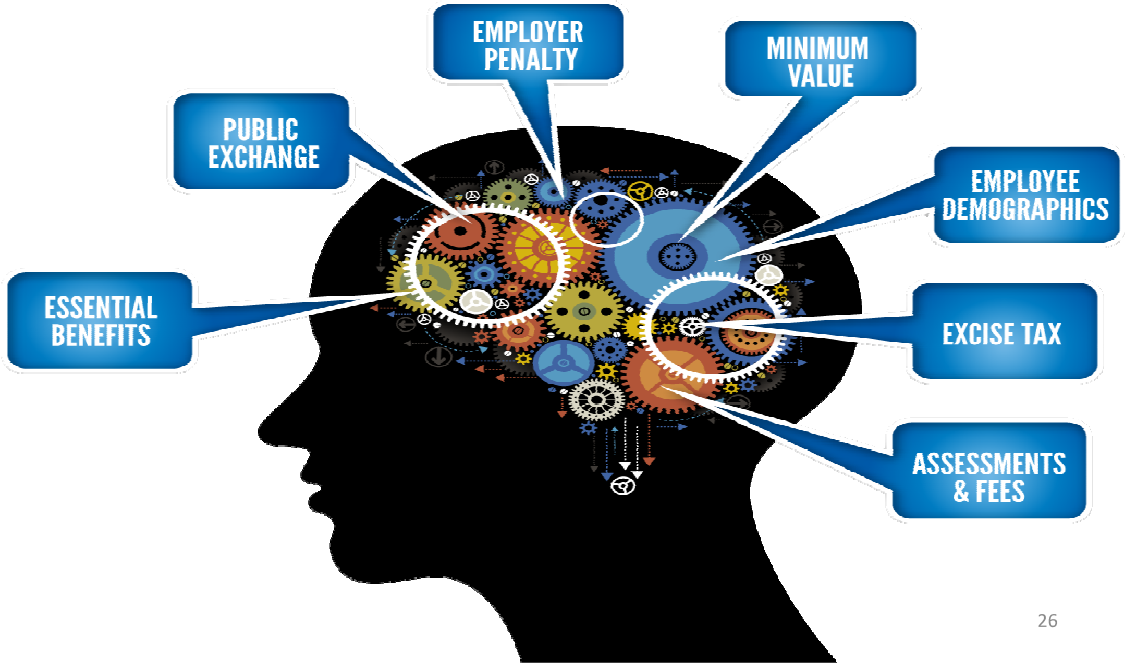
•Urgent care claims, as soon as possible but not later than 72 hours after the plan receives the request to review a denied claim;

•Pre-service claims, within a reasonable period of time not later than 30 days after the plan receives the request to review a denied claim;

•Post-service claims, as soon as possible but not later than 60 days after the plan receives the request to review a denied claim; and

•Disability claims, within a reasonable period of time but not later than 45 days after the plan receives the request to review a denied claim.

What's on the Minds of Employers?



ACA here to stay!

- Passed into law on March 2010
- SCOTUS ruled on challenge June 2012
  - Mandate requiring individuals to insured upheld
  - Medicaid Expansion not upheld
- As with any law, there may be future challenges or changes

Just recently a Federal judge ruled against the subsidies

- Most provisions already in effect.
- Major implementation effective on January 1, 2014
- Waivers from some of the 2014 insurance provisions issued to Territories

ACA Goal: Decrease the uninsured

- Consumers are mandated to purchase insurance.
- Creates Marketplaces (Exchanges) where consumers can choose among affordable plans, offering tax credits to some
- Builds on the current employer-employee fringe benefit insurance arrangement and mandates that large employer offer adequate and affordable health care plans
- Expands states' Medicaid programs to include all individuals and families under 138% FPL ($15856 for individual, $32,499, family of four)

Framework of PPACA or ACA

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

- Insurance Market Reforms – Applies with some waivers
- Individual and employer mandates – Does not apply to Guam
- Premium and cost sharing subsidies – Does not apply to Guam

The Three Legged Stool Approach

Individual and Employer Coverage

Marketplace Reforms

Premium and Cost Subsidies Expansion Medicaid/CHIP/Medicare

ACA and Insurance Reforms

- **Preventive Aspects**
  - Insurance (including Medicare) must provide **free preventive care**
- **Financial Aspects**
  - **Financial assistance for seniors** for prescription drugs
  - **No lifetime limits on coverage** of essential benefits
  - **No annual maximums on coverage of essential benefits** (Jan 2014)
  - **No cancellation of policies**
  - **Tax breaks for small businesses** to provide coverage (2010-2016)
  - **Tax credits for purchasing in Marketplaces <400% FPL** (Jan 2014)
  - **Tax subsidies on out of pocket payments <250% FPL**
- **Access to insurance**
  - **Young adults** can stay on parent's private insurance family plans until age 26
  - **Children** cannot be denied coverage for **pre-existing** condition (Adults Jan 2014).

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

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

- 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 Waiver Issued

- 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 to Guam

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

Long-Term (2014) Reforms: Benefit Requirements

Essential Health Benefits Package* for small groups Waiver Issued

- 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.

Guam 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.

Essential Health Benefits

Qualified Health Plans in the Marketplace must cover:

ambulatory patient services	maternity and newborn care
emergency services	prescription drugs
mental health and substance use disorder services	laboratory services
rehabilitative and habilitative services and devices	chronic disease management
preventive and wellness services	pediatric services, including oral and vision care

Exchanges

- Requires states to establish an Exchange for the individual and small group markets **no later than January 1, 2014**. Not available for Guam or territories
  - 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

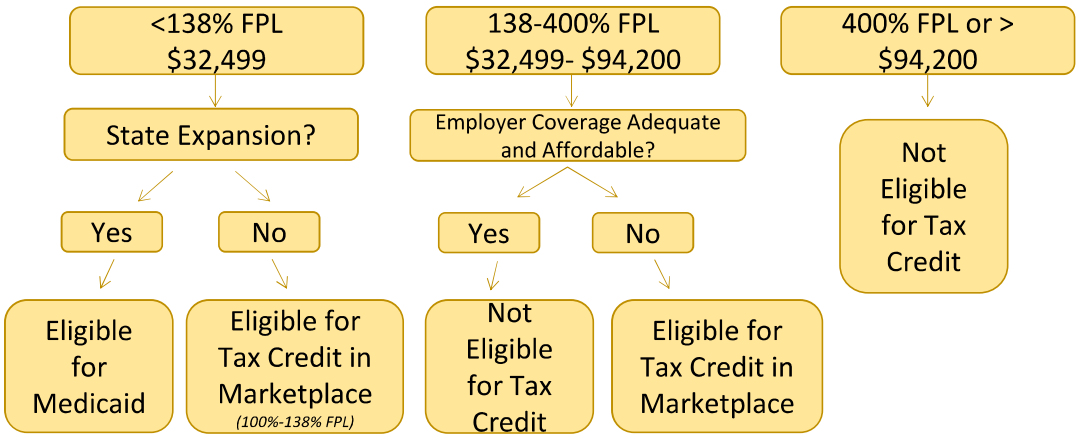
What is Medicaid Expansion

- ACA was set to change minimum eligibility criteria to include all adults under 138% (133%) of the FPL
  - $15,856 individual (2013)
  - $ 32,499 family of four (2013)
  - Elsewise state could not participate at all in Medicaid
    - This “enforcement” is what SCOTUS said was un-Constitutional.
- Feds were to pay
  - 100% of cost for first 3 years
  - Phase down to 90% of costs by 2020

Premium Assistance Tax Credits: Help Paying with Costs (Not Applicable to Guam)

Federal Poverty Level	% of income premium costs	Maximum income for an individual (salary), 2013 FPL	Maximum income for an individual (hourly) – [40 hour work week]	Approx. maximum annual premium (before tax subsidy)
Up to 133% FPL	2% of income	$15,282	$7.35/hr	$306
133 - 150% FPL	3 - 4% of income	$17,235	$8.28/hr	$690
150 - 200% FPL	4 - 6.3% of income	$22,980	$11.04/hr	$1448
200 - 250% FPL	6.3 - 8.05% of income	$28,725	$13.81/hr	$2312
250 - 300% FPL	8.05 - 9.5% of income	$34,470	$16.57/hr	$3274
350 - 400% FPL	9.5% of income	$45,960	$22.10/hr	$4366

Health Plan Enrollment Eligibility in the Marketplace: Family of 4



Consumers can always choose employer coverage if available, or purchase in the private market. To be eligible for tax credits, though, consumers must purchase through the Marketplace.

Employers with over 50 employees: Two Potential Penalties

- Penalty for not providing health care coverage
  - $2,000 per year for each full time employee starting at employee #31
  - Example: 60 employees: 60 – 30 = 30 x $2,000 = $60,000 per year penalty for not providing health coverage
  - Penalty will increase with rising insurance premiums
- Penalty for not providing *affordable and adequate* health care coverage
  - If any employee has a pay > 9.5% of income for employer's coverage AND/OR
  - If coverage does not pay at least 60% of covered health care expenses
  - $3,000 per year for each full time employee receiving a tax credit up to maximum of $2,000 per year x number of full time employees starting at employee #31
  - Penalty will increase with rising insurance premiums

Delayed till Jan. 2015

- **Resource:** http://kaiserfamilyfoundation.files.wordpress.com/2013/04/employer__penalty_flowchart_1.pdf

Transitional Reinsurance Program

- Section 1341 of the Affordable Care Act provides that:
  - A transitional reinsurance program must be established in each State to help stabilize premiums for coverage in the individuals market from 2014-2016
  - All health insurance issuers and third party administrators on behalf of self-insured group health plans, must make contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market
- Reinsurance is a critical element in helping to ensure a stabilized individual market in the first years of Exchange operation.

3Rs Background

- The Affordable Care Act establishes State-based reinsurance and risk adjustment programs, and a Federal risk corridors program.
- The overall goal of these programs is to provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets as market reforms and Exchange being in 2014.
- This final rule establishes standard to ensure effective program implementation while providing significant State flexibility and imposing minimal burden on States and issuers.

3Rs – Insurers Protections – N/A for Guam

Program	Reinsurance	Risk Corridors	Risk Adjustment
What:	Provides funding to issuers that incur high claims costs for enrollees	Limits issuer losses (and gains)	Transfer funds from lower risk plans to higher risk plans
Who Participates:	All issuers and third party administrators on behalf of group health plans	Qualified health plans	Non-grandfathered individual and small group market plans, inside and outside the Exchange
When:	Throughout the year	After reinsurance and risk adjustment	Before June 30 of the calendar year following the benefit year
Time Frame:	3 years (2014-2016)	3 years (2014-2016)	Permanent

Waiver or Specific Exemptions for the Territories

- Guaranteed availability
- Community rating
- Rate Review
- Medical Loss Ration Requirements
- Essential Health benefits
- Single Risk Pool

BASED ON CURRENT INTERPRETETION - SUBJECT TO CHANGE ON CMS RULING

Provisions Still Applicable for Territories

- No pre-existing condition exclusions or other discrimination in benefits based on health status
- No discrimination in eligibility based on health status
- No waiting period of more than 90 days
- Dependent children must be allowed to be covered to age 26
- Uniform explanation of coverage and benefits documents must be used documents must be used
- Coverage of emergency services must be covered, even if out-of-network
- Covered person must be allowed to choose own primary care provider
- Child's primary care doctor can be a pediatrician
- Woman must be allowed to consult obstetrician or gynecologist
- Coverage for clinical trials
- Non-discrimination in favor of those more highly paid – discrimination will be prohibited once the Agencies figure out how it is supposed to work and issue regulations

WHY WAIVERS WERE IMPORTANT

While the territories are working to be compliant with the new health care reform, the fragmentary extension of ACA provisions to the territories could result in the weakening of health insurance coverage in the territories and the industries that provide that coverage, thus undermining the original intent of Affordable Care Act.

The above exert is from the NAIC group that issued a white paper on the effects of reform on the Territories.

Provisions Still Applicable for Territories

- Annual lifetime coverage limits prohibited
- Rescissions prohibited
- Coverage of preventive health services is required
- Revised internal and external appeals processes must be followed

Taxes and Fees Applicable

- Insurance Industry Fee
- PCORI

Final Reflections

- Where do we go from here?
- Do we need full reform on Guam?
- Should individuals and employers on Guam be required to purchase health insurance
- What parts of the ACA should we keep?
- How will health premiums be affected in the future
- Emerging threats – Ebola
- Bill 402-32
- GMHA and GRMC

Questions