

Healthcare Reform Implications for the Territories/Guam

By:

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Calvo's SelectCare

Agenda

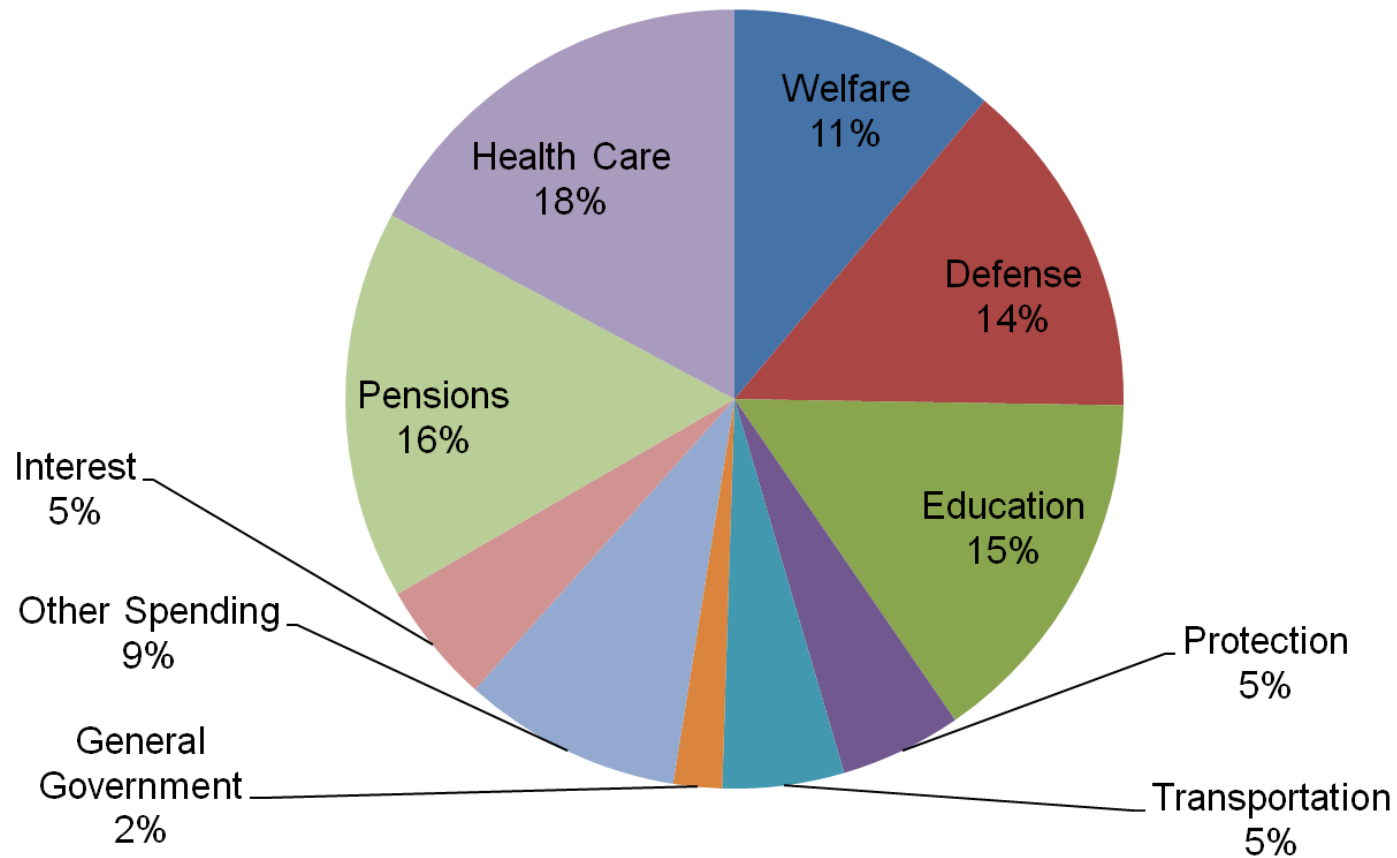
- Key Challenges to U.S. Healthcare System
- Why reform
- Implications to Guam

Health Expenditures for Selected Services 2000–2015

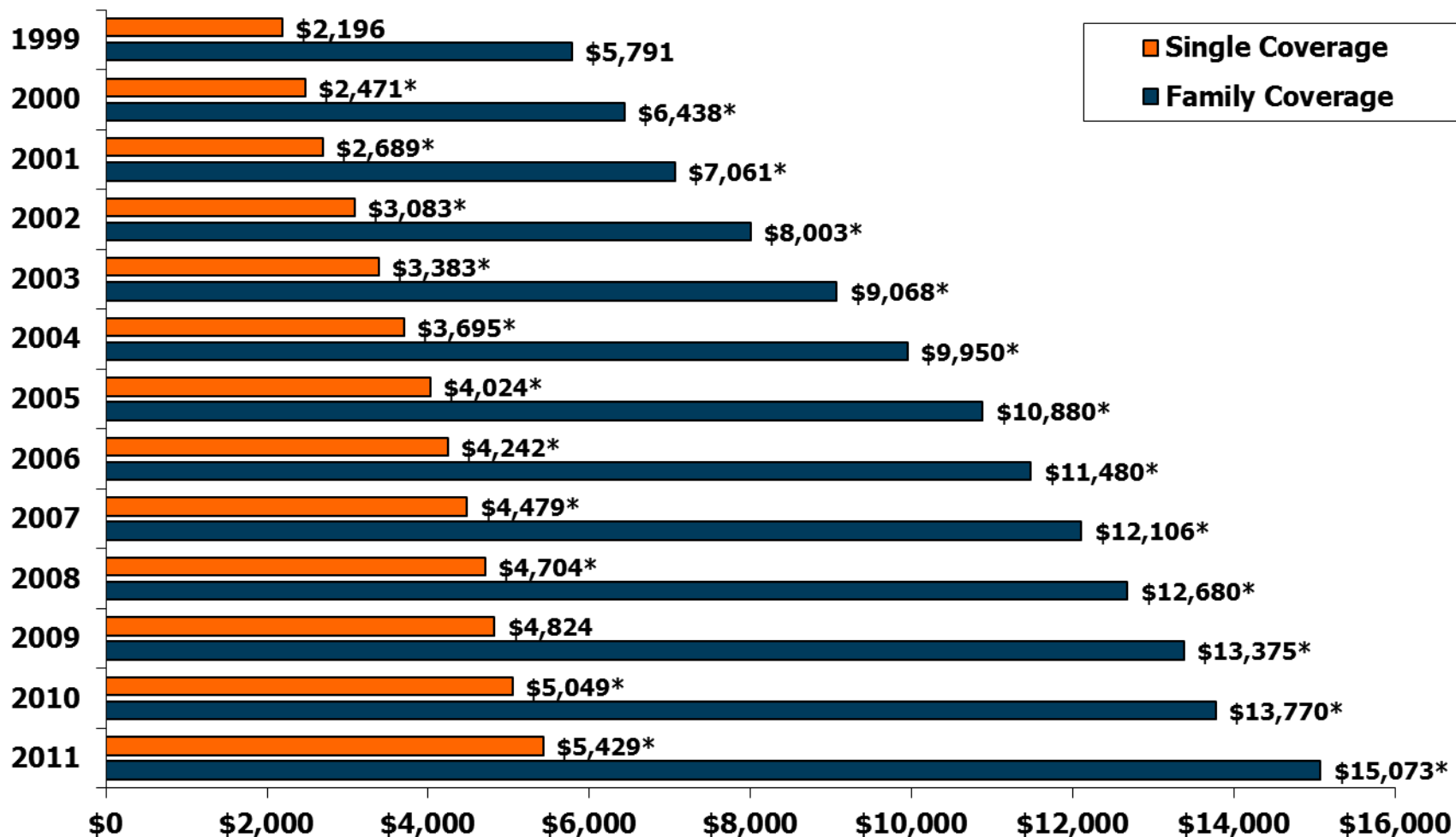
TOTAL	2000	2005	<i>Projected</i>	
			<i>2010</i>	<i>2015</i>
Billions	\$1,353.3	\$1,987.7	\$2,879.4	\$4,031.7
Percent GDP	13.8%	16.0%	18.0%	20.0%
BY TYPE OF SERVICE				
Hospital care	\$417.0	\$611.6	\$882.4	\$1,230.9
Physician & clinical services	288.6	421.2	610.7	849.8
Other professional services (dental, 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



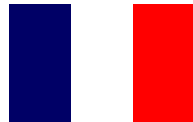
Average Annual Premiums for Single and Family Coverage, 1999-2011



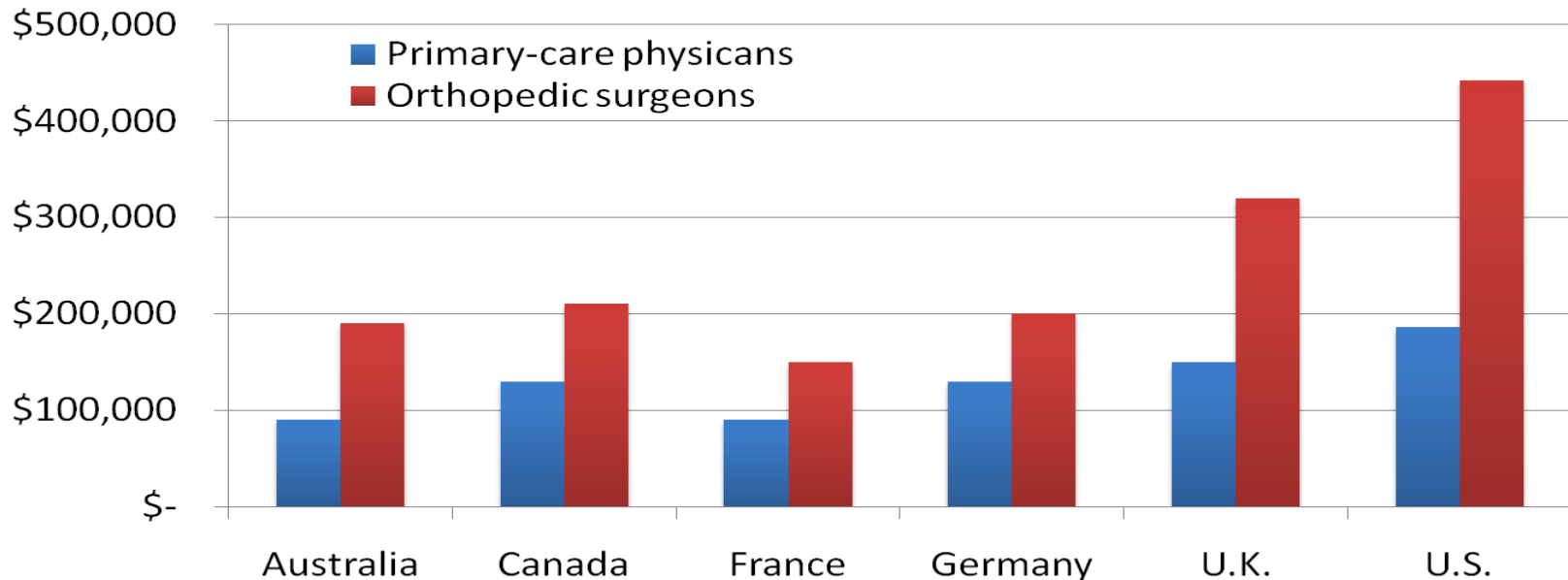
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

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

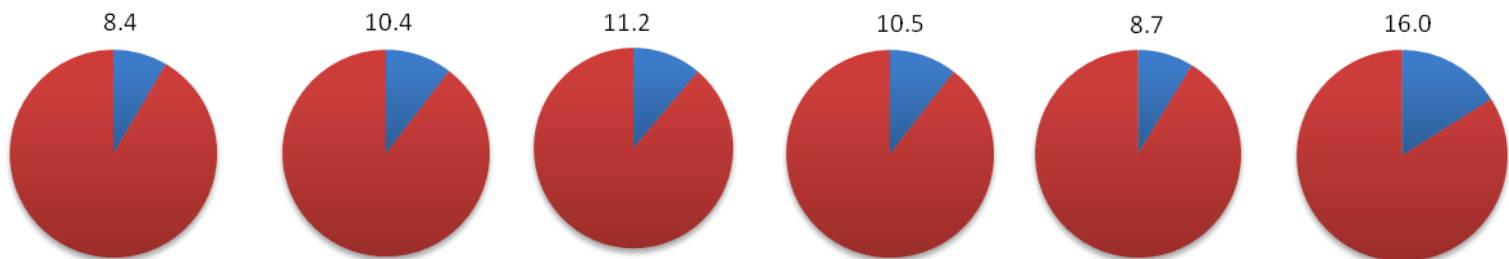
Global Payments



PRE-TAX EARNINGS

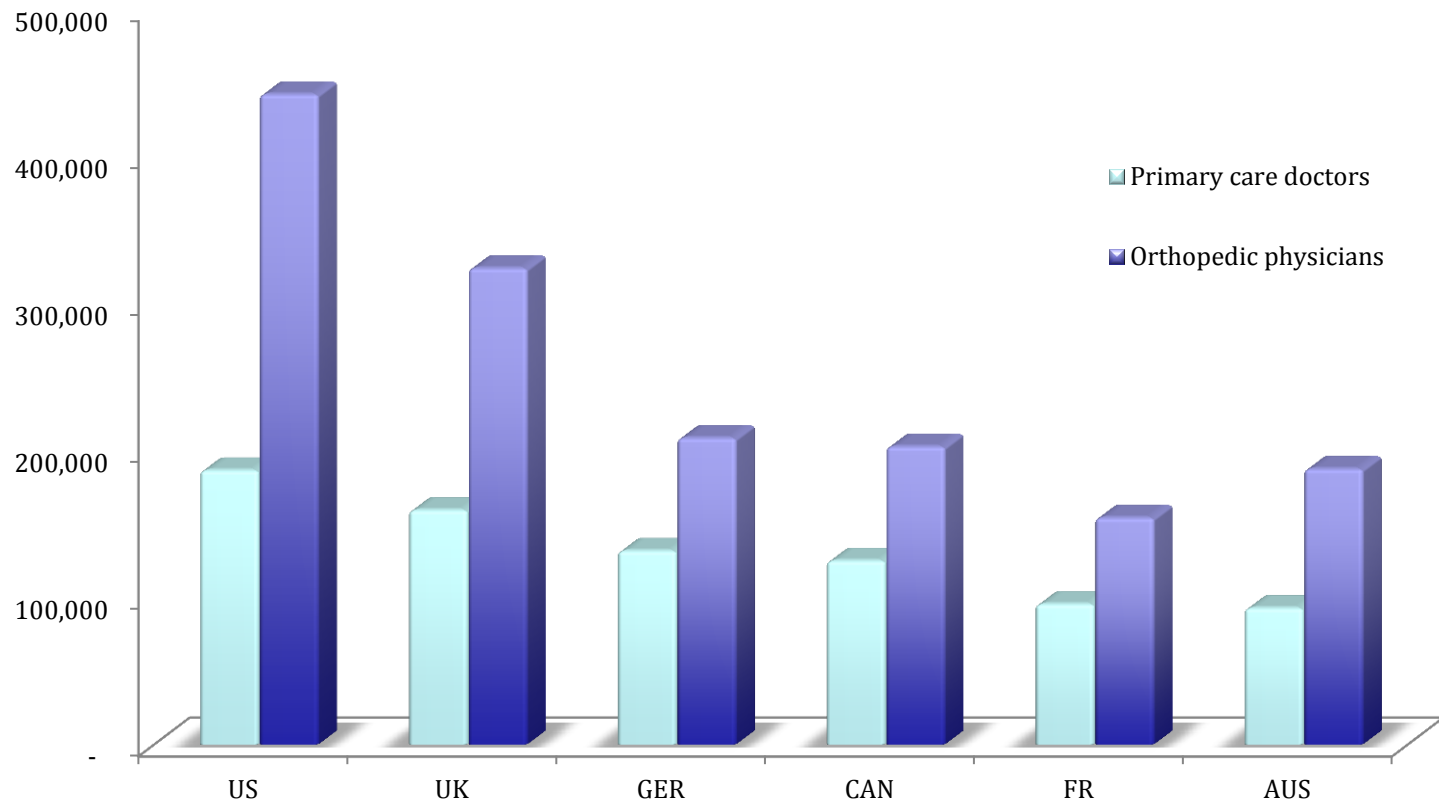


HEALTH SPENDING AS GDP% AND PER CAPITA



Physician Incomes, 2008

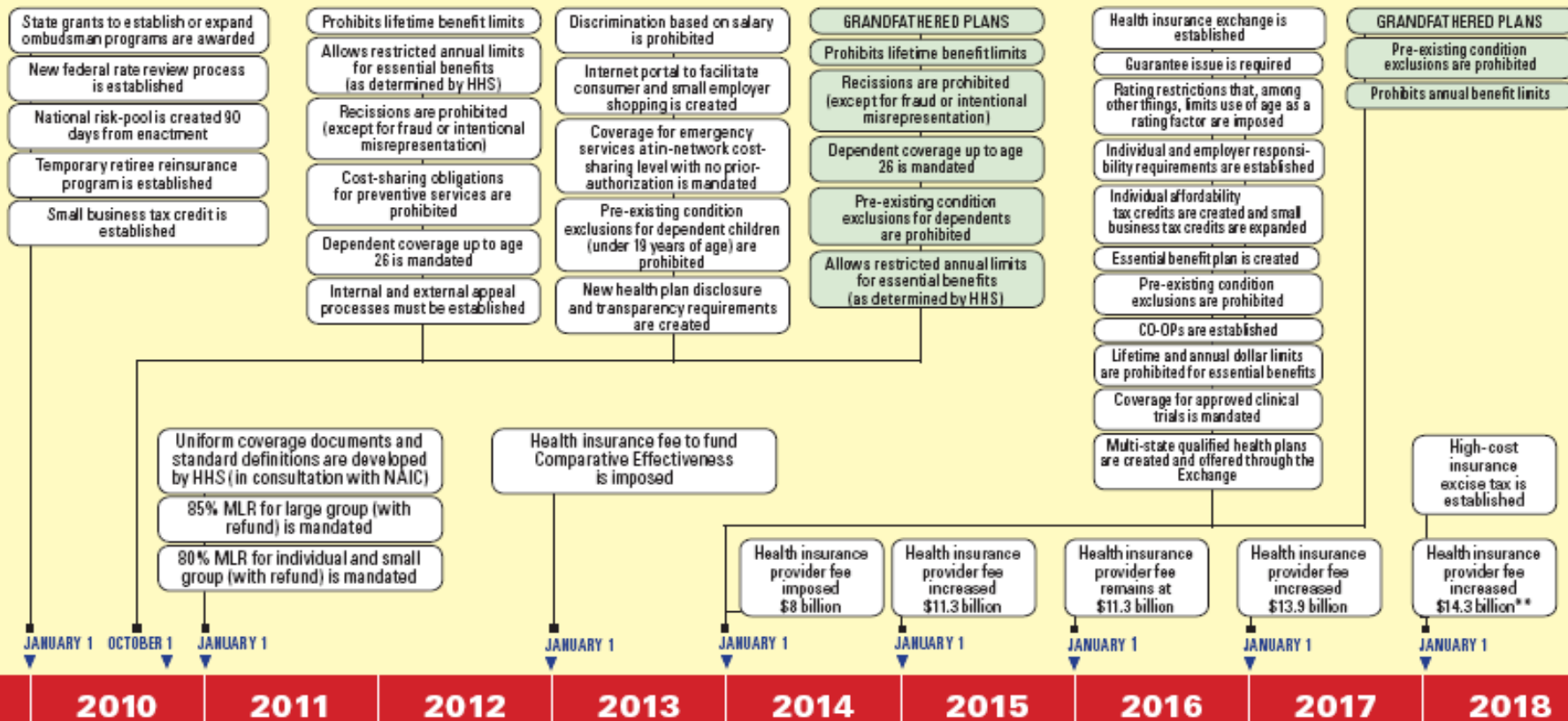
Adjusted for Differences in Cost in Living



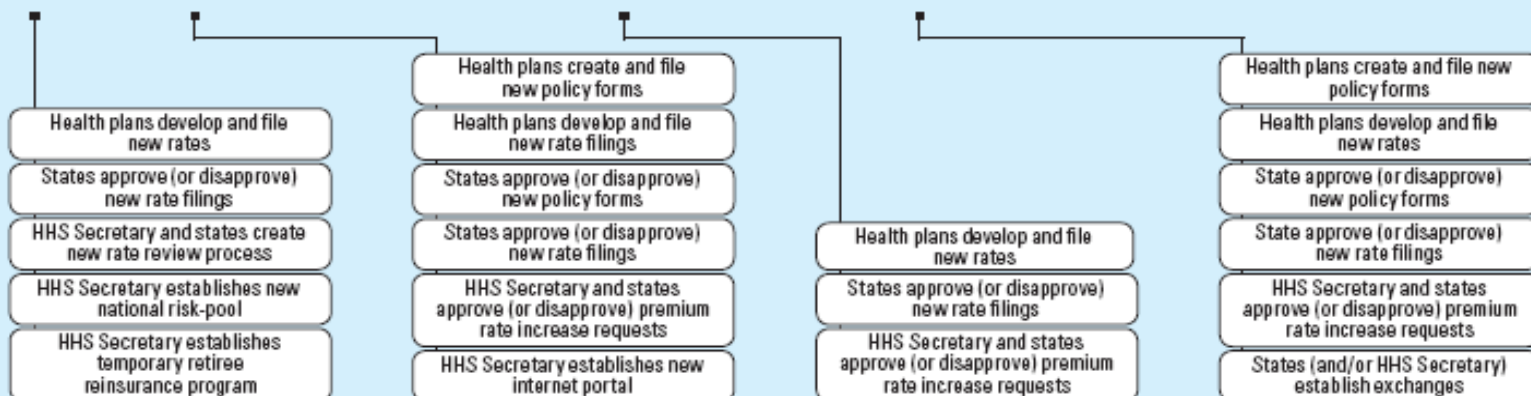
Source: MJ Laugesen and SA Glied, "Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs*, Sept. 2011 30(9):1647-56

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

SUMMARY OF SELECT REQUIREMENTS



IMPACT












*Assumes April 1, 2010 enactment

**In years following 2018, the tax amount would increase in an amount proportionally equal to overall premium growth.



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

IMMEDIATE AND LONGER TERM INSURANCE MARKET REFORMS

2010 > 2011 > 2012 > 2013 > 2014 > 2015 > 2016 > 2017 > 2018 > 2019

Upon Enactment: **FEDERAL GUIDELINES FOR REASONABLENESS OF RATES PROCESS**

IMMEDIATE REFORMS

**Within 60–90-Days
of Enactment:**

- ▶ National High Risk Pool Established
- ▶ Internet Portal Created

**For Plan Years That
Begin on or After
180 Days of Enactment**

- ▶ Prohibition on Lifetime Limits for Essential Benefits
- ▶ No Pre-Existing Condition Exclusions for Children Under 19
- ▶ Restricted Annual Limits for Essential Benefits
- ▶ Internal/External Appeals Process
- ▶ Rescission Restrictions
- ▶ Dependent Coverage Extended up to Age 26

By January 1, 2011:

- ▶ Mandatory Minimum Loss Ratio Requirement

LONG-TERM REFORMS

**Beginning
January 1, 2014:**

- ▶ Co-Ops and Multi-State Qualified Plans Are Created
- ▶ Guarantee Issue Required, No Health Status Rating and Limited Age Rating, No Pre-Existing Condition Exclusions, Annual Dollar Limits Prohibited
- ▶ Individual and Employer Responsibility Requirements Established
- ▶ Individual Affordability Tax Credits Are Created
- ▶ Health Insurance Provider Fee Imposed
- ▶ Establishment of Exchanges

**Beginning
January 1, 2018:**

- ▶ High Cost Insurance Excise Tax Imposed

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 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 **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.

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.

Exchanges

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

- 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 or 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

Framework of PPACA or ACA

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

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

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 Guam

- Only \$3.7M in additional Medicaid money
- Other States get 100% subsidies for new Medicaid eligibles
- Insurance reforms apply to Guam but mandates do not
- The three legged stool becomes a one legged one for Guam

Questions