The Affordable Care Act: The Issues and Opportunities

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 was perhaps the most significant health care law passed in the U.S. since Medicare's passage in 1965. The purpose of the law is two-fold: to increase access to affordable health insurance; and to reduce inefficiencies and costs in the health care system. In this article, Tasha Barbour, Vice President, Director, Specialty Medical Programs, outlines the implications for employers and health care providers.

Following a number of legal challenges, the U.S. Supreme Court affirmed the ACA in June 2012 and the individual mandate was upheld as the hallmark of the law, meaning that if everyone purchases health insurance, healthy and sick alike, then the overall cost should decrease and be more affordable for all.

To aide this goal, the government is providing insurance subsidies to help those who can't afford coverage to pay for their insurance premiums, deductibles, and co-pays. Through health insurance marketplaces, called "insurance exchanges," uninsured people can choose from a variety of health plans on the exchanges.

The second aim of the ACA is to eliminate inefficiencies and reduce the cost of care. While access to the insurance marketplaces begins in 2014, cost containment efforts will be phased in gradually over the next several years. These include the Patient-Centered Outcomes Research Institute (PCORI), which provides physicians with standard guidance on treating patient illnesses, and the Center for Medicare and Medicaid Innovation (CMMI), which tests and funds new payment models and delivery system modifications that increase quality of care while reducing costs.

Many experts are speculating that the influx of people with varied and unknown health conditions into the health care system before efficiency measures are fully realized, will create huge cost and resource pressure on the system.

In May 2013, the Congressional Budget Office (CBO) released figures regarding health insurance exchange enrollment and the net budgetary impact upon the deficit. The CBO estimates that approximately 9 million people will access coverage in the Exchange in 2014. That figure grows to 15 million in 2015; 25 million in 2016; and peaks at approximately 29 million by 2018. Simultaneously, exchange subsidies will increase from $33MM in 2014; $57MM in 2015; to more than $120MM by 2018[1].

Given that health care currently represents 17.8% of the U.S. Gross Domestic Product (GDP)[2], this new era of U.S. health care is likely to produce both winners and losers. The race has begun to determine what products, services, and businesses will be sustainable in the future.

What it means…for government:

Roll out of insurance exchanges

One of the unexpected outcomes of the ACA was the rejection of insurance exchanges by some states. The assumption was that each state would set up its own insurance exchange. The federal government would supplement the start-up costs, and eventually the states would be left to manage and pay for the exchange. Currently, 16 states and the District of Columbia have agreed to run their own insurance exchanges. The remaining 34 are either doing a partnership exchange with the federal government or letting the federal government set up, fund, and run the insurance exchanges within their states. As we are now post-October 1, it is apparent that the federal exchanges have not met consumer expectations. Frequent system crashes and down time has made signing up for coverage challenging. Many of the federal exchanges are now turning to paper application forms.

A mixed welcome for Medicaid expansion

A second component to government involvement in health insurance reform is that of Medicaid expansion. Medicaid is a state-managed and funded program that receives federal dollars to supplement the program cost. The U.S. Supreme Court ruling in June 2012, gave states the option to participate in the Medicaid expansion project without being penalized regarding federal supplemental payments for the current/ongoing Medicaid efforts. Currently, 29 states and the District of Columbia have opted to expand from 100% of the federal poverty level (FPL) up to 138% of the FPL. The rest have either declared no program expansion or are still weighing their options. The implications are that individuals living

1 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage, CBO May 2013.
2 The Economic Case for Health Care Reform, whitehouse.gov.

ACA Provisions Timeline	
2010	Elimination of lifetime dollar maximums
2010	Dependent coverage age 26 extension
2010	Elimination of pre-existing conditions exclusions on children < 19
2010	Prohibition of retroactive rescissions except for fraud
2010	Non-discrimination in plan design
2010	Prohibition on cost-sharing for preventive care services
2010	Coverage of ER treatment for emergency med conditions
2010	Coverage of ob/gyn care without pre-authorization or referral
2010/11	A new claims appeal process, including external review
2010	Temporary high risk pool (PCIP)
2011	Medical Loss Ratio standards
2012	Summary of Benefits
2012	W-2 Reporting
2013	$2,500 FSA cap; over-the-counter medication limitations
2014	Elimination of annual dollar maximum on Essential Health Benefit
2014	Elimination of waiting periods exceeding 90 days
TBD	Auto enrollment of employees where the employer has over 200 employees
2014	Required guarantee issue and renewability
2014	Coverage for clinical trials
2014	Health insurance mandate
2014	Health Insurance Exchanges
2014	Pre-existing conditions exclusions prohibition for all
2014*	Employer Pay-or-Play mandate *Now delayed until 2015
2018	Cadillac Health Plan tax

in states that do not expand the Medicaid program will incur higher costs to access health insurance.

Government-backed risk mitigation programs

A third component to federal government involvement is categorized as the "Three R's". In an effort to encourage new health plans to offer products on an insurance exchange platform, premium and risk stabilization programs have been created as follows: reinsurance; risk corridor and risk adjustment.

The reinsurance and risk corridor programs are temporary federal programs from 2014-2016. The purpose of these two programs is to limit a health plan's losses or gains against predicted costs during this initial start-up phase. The third program, risk adjustment, is a permanent state-run program, through which health plans in each state are actuarially equalized, resulting in a premium transfer between issuers. The main premise behind the Three R's is that no plan will "win" too big or "lose" too big.

However, the government efforts come with a hefty bill. Additional Medicare tax on high income earners is expected to be the largest funding mechanism for the ACA but, even with the addition of other taxes, it will only relieve 20-25% of the total cost. Overall, the ACA will create a net increase to the federal deficit, adding an additional $151 billion dollars by 2016 and an estimated $250 billion by 2023[3].

… for employers

Waning appetite for workplace health insurance

Since the World War II era of wage freezes, health care benefits have been tied to employment with labor unions traditionally negotiating very rich benefit packages on behalf of union members. However, increasing health premiums and a weak economy are putting pressure on employer benefit offerings, with the result that many employees fear a reduction in working hours to a level that would disqualify them from workplace health insurance. Worse, the concern is that employers will drop coverage altogether leaving employees to buy their own coverage on the insurance exchanges.

"Pay-or-play" tax

The federal government has anticipated the shift in employer appetite for offering health insurance coverage by creating the "pay-or-play" tax for employers with more than 50 full-time equivalent (FTE) employees. It stipulates that: 1) minimum essential coverage must be offered to 95% of the FTE's; and 2) minimum essential coverage must be affordable (<9.5% of household income) and provide value (covering 60% of the health care costs). If the employer does not meet these thresholds, various tax penalties are incurred.

The Cadillac tax

At the other end of the spectrum, the ACA will rein in employers who offer employees expensive health benefits. The "Cadillac tax" that goes into effect in 2018 represents a 40% excise tax on plans that cost more than $10,200 for individuals and $27,500 for families. The purpose of this tax is to encourage employers to move away from plans that insulate their employees from the costs of care and encourage employees to be more cost-conscious consumers.

… for individuals

In order for the ACA to be successful, premiums are needed from the young and healthy in order to subsidize the premiums and costs of the chronically ill. Survey data shows that approximately 45 million Americans were uninsured for the first nine months during 2012. Fifty-five percent of

3 Joint Committee on Taxation and CBO; Timetable of Taxes from Obamacare, wallstcheatsheet.com.
4 Center for Disease Control, National Health Interview Survey, 2012.

the uninsured were age 34 or younger, of which 72 percent of those younger uninsured were of a post-high school, working-eligible age. Per the ACA individual mandate, all people must carry health insurance. There is a tax penalty on those who do not purchase minimum essential coverage[4].

However, a poll in April 2013 that surveyed individuals inquiring about their knowledge of the ACA, indicated that of people whose annual family income was $30,000 or less, 59% were unaware of the status of ACA implementation5. It is yet to be seen if the ACA will have its intended impact; however, one thing is for certain – we are at a crossroads where the inefficiencies and cost inflation produced in the current health care delivery system are unsustainable for the government, employers and individuals.

New risks and opportunities for stakeholders

Health insurance companies have been evolving payment mechanisms for health care providers for years. This concept has accelerated, as "pay-for-performance" has emerged. No consumer wants to overpay for low-value goods or services, or pay for multiple services that may be unnecessary. A transition from volume-based payments to value-based purchasing is now underway.

Pay-for-performance

Current trends in payment reforms include pay-for-performance, shared savings and loss models, bundled payments /case rates and capitation6. Many of these trends are wrapped around the term "accountable care organization," otherwise known as an ACO. ACOs are forming under the guidance of Medicare, as well as large payer companies, that put health care providers at risk for providing quality, low-cost, high-value services.

The trends in payment reform appear to be leading to the riskier model of capitation which failed in most parts of the U.S. during the 1990's. However, with today's analytic tools, accountable care coupled with capitation appears to have a much higher likelihood of success. All of the new payment mechanisms work under the same premise: that all businesses must operate under budget – including health care. Risk positions under payer contracts must be protected to ensure continuity of the business. Only adapters will prosper.

Changing trends in health care

The current trend for health care providers is one of mergers and acquisitions. As new payment mechanisms evolve, new partnerships are forming. Hospitals are increasingly purchasing physician practices as part of an integrated delivery system and new trends in telemedicine, predictive modeling and nanotechnologies are starting to take hold.

Meanwhile, the evolution of "patients" into "consumers" will drive the biggest change. As employers shift a greater burden of the cost of health care to employees, a generation of cost-conscious consumers will emerge. Individuals will be at the forefront of the change as they "vote with their feet" and providers will need to ensure that their delivery system is of the highest quality and financially stable to serve their new customers.

With these changes come new risks and opportunities. It is essential that all parties – employers, health care providers and other risk-bearing entities – have access to the right insurance products for their specific needs.

How PartnerRe solutions can help

On December 31, 2012, PartnerRe expanded its specialty capabilities by acquiring Presidio Reinsurance Group. Presidio's deep understanding of and commitment to the health care market – particularly the reinsurance and stop-loss markets – coupled with PartnerRe's strong, financial capability, means we can offer our clients a variety of creative and effective risk programs tailored for each client.

Our solutions can help quantify, manage and limit the risk of health insurance companies, HMOs/health plans, self-insured health plans, insurance exchange health plans, accountable care organizations, integrated delivery systems, at-risk provider groups and employers. They include:

- **Excess of loss programs** available to our employer groups, health plans and capitated providers through our reinsurance and insurance solutions.
- **Specialty products**, which may include aggregate solutions, available to accountable care organizations, bundled payment providers, and other health providers that participate in value-based reimbursement and pay-for-performance arrangements.
- **Quota share reinsurance** arrangements and other carve-out solutions.
- Along with our products, we provide a **suite of service offerings**, including our medical management program - ***PULSE*** + Plus™, as well as private label products and underwriting and actuarial support for captives and risk retention groups.

Since health plans are now required to be guaranteed-issue, annual and lifetime limits may no longer be imposed and pre-existing condition exclusions and limitations are becoming a thing of the past, now more than ever, insurers, health care providers and self-insured plans need the kinds of reinsurance and stop-loss products made available by PartnerRe through PartnerRe America Insurance Company, a Delaware-domiciled insurer.

Through our extensive industry knowledge and unique combination of analysis and innovation, we design risk programs tailored to the exposure type and risk-tolerance profiles of our clients. If you would like to find out more about the programs we offer, please contact us at: www.partnerre.com/contacts.

5 Kaiser Health Tracking Poll, April 2013.
6 Capitation is a fixed fee payment model, whereby the health plan pays the provider a flat fee per plan member per month, to take care of all health needs of its plan members.