University of Minnesota

The Healthcare Marketplace

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Overview

- Next unit up - Insurers
- Insurance theory & concepts
  - Risk & uncertainty
  - Insurance premiums
- Evolution of modern health insurance
  - Public insurance
  - Private insurance
- The state of health insurance today

Risky Business:
Making Decisions Under Uncertainty

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- **Uncertainty**: A situation when more than one event may occur but we don't know which one.
- Ex. 1: Invest in Intel without knowing how their newest processor will be received in 2 months.
- Ex. 2 Decide to not get a flu shot this year.

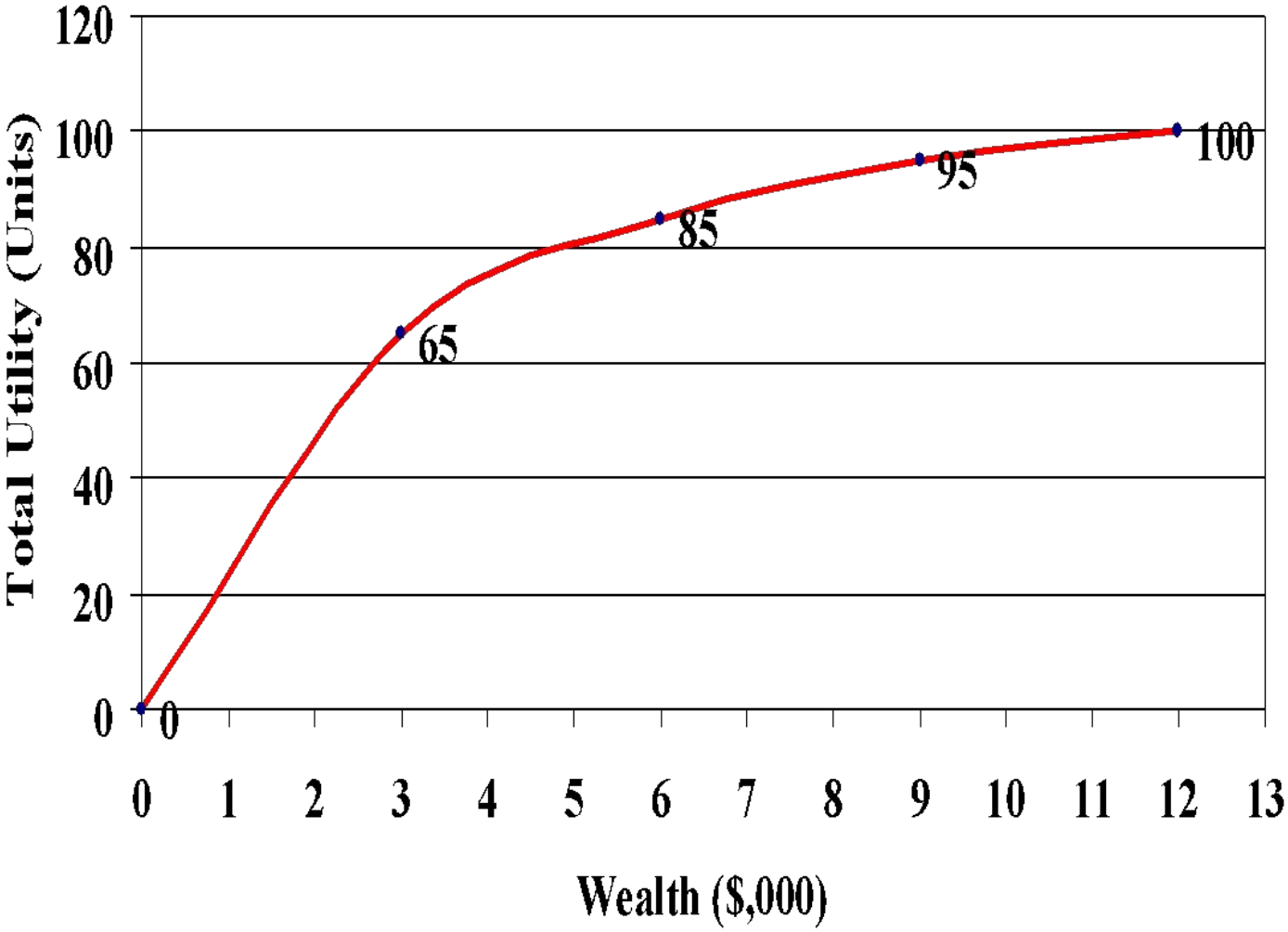
Risk Defined

- **Risk**: The probability of incurring a loss (or some other misfortune).
- More precisely, *risk is a situation in which more than one outcome may occur and the* ***probability*** *of each outcome can be estimated.*
- *Probability* is defined as a number between 0 and 1 that measures the chance of an event.

The Cost of Risk

- Some people are willing to bear more risk than others.
- In economics, people's attitudes towards wealth are measured using the ***utility of wealth*** schedules.
- **Utility of wealth** is the amount of utility a given person attaches to a given amount of wealth.

The Utility of Wealth



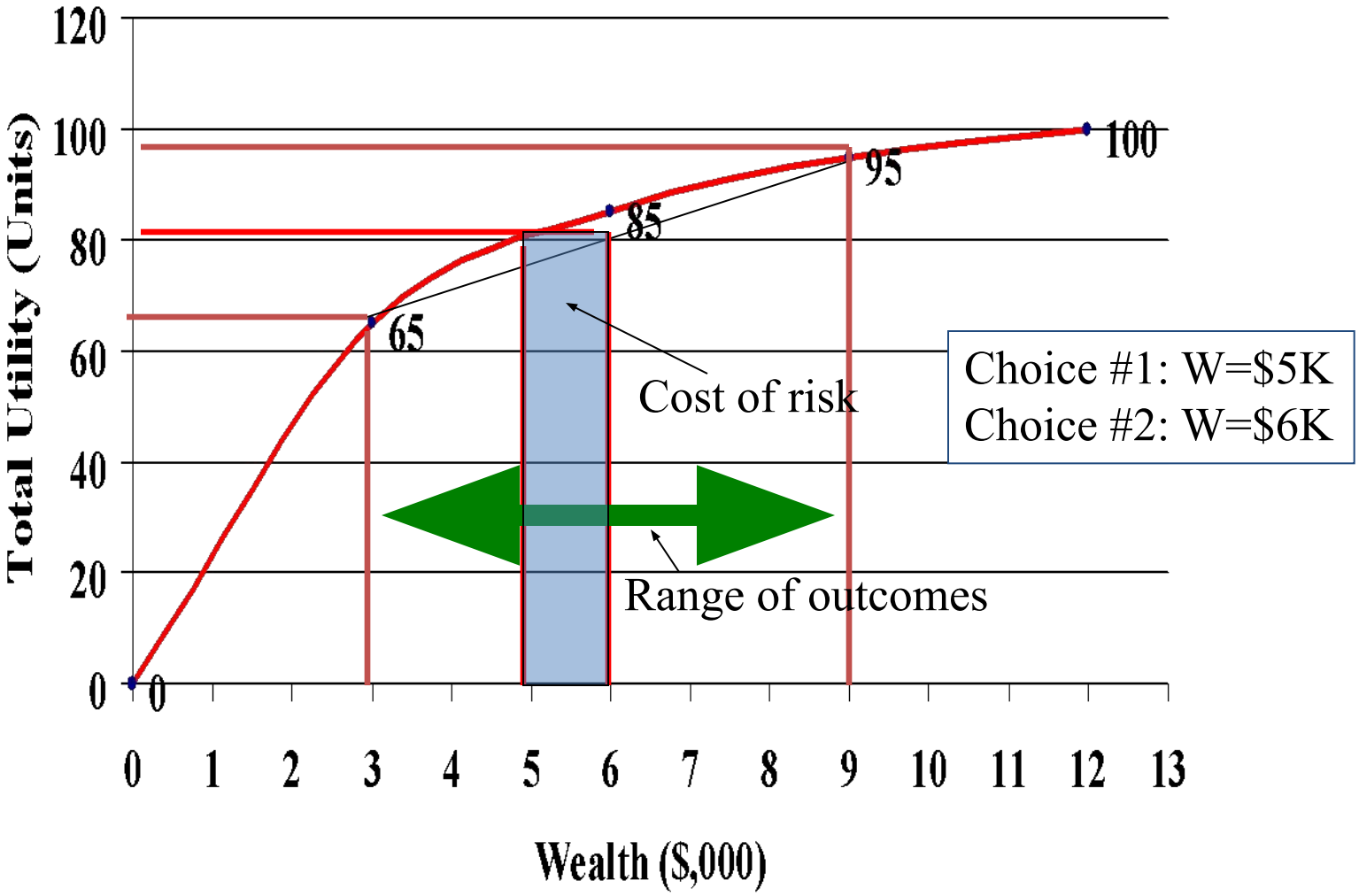
What can we observe from the Utility of Wealth Schedule?

- Utility increases as wealth increases.
- Change in utility decreases as wealth increases.
- Marginal utility of decrease as $$ increase:
  - From $0 to $3K, MU is 65
  - From $3K to $6K, MU is 20
  - From $6K to $9K, MU is 10
  - etc.

Translate Utility of Wealth into Expected Utility

- Due to uncertainty, people do not know the actual utility they will get from taking a particular action.
- An ***expected utility*** can be calculated by taking the average utility arising from all possible outcomes.

Choice Under Uncertainty



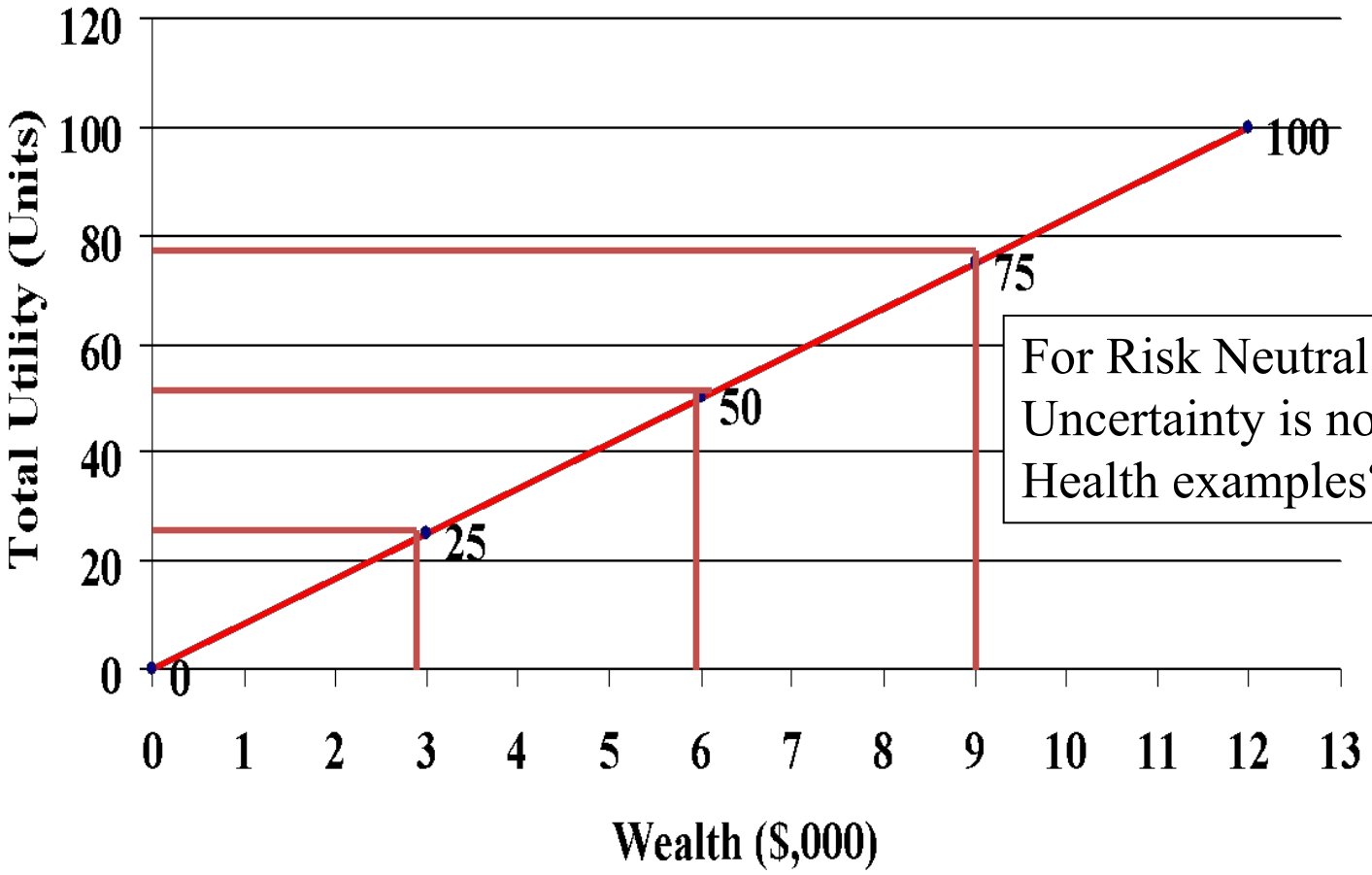
Interpretation of Choice under Uncertainty

- At Choice #1, Tania's wealth is $5K, U=80, no risk,
- At Choice #2, she faces an opportunity to have $9K with utility of 95 or $3K with utility of 65. What is her expected utility?
- At expected wealth of $6K, E(U)=80.
- Thus, she is indifferent the two alternatives.

Risk Aversion and Risk Neutrality

- Risk Averse: Someone who sees risk as not cost-less.
- The degree of risk aversion a person has will depend how fast their marginal utility of wealth diminishes.
- The cost of risk to an individual will depend on the extent of risk aversion.
- For a risk-neutral person, risk is costless.

Choice Under Uncertainty for Risk Neutral Person



For Risk Neutral Person, Uncertainty is not an issue. Health examples?

How do we reduce risk?

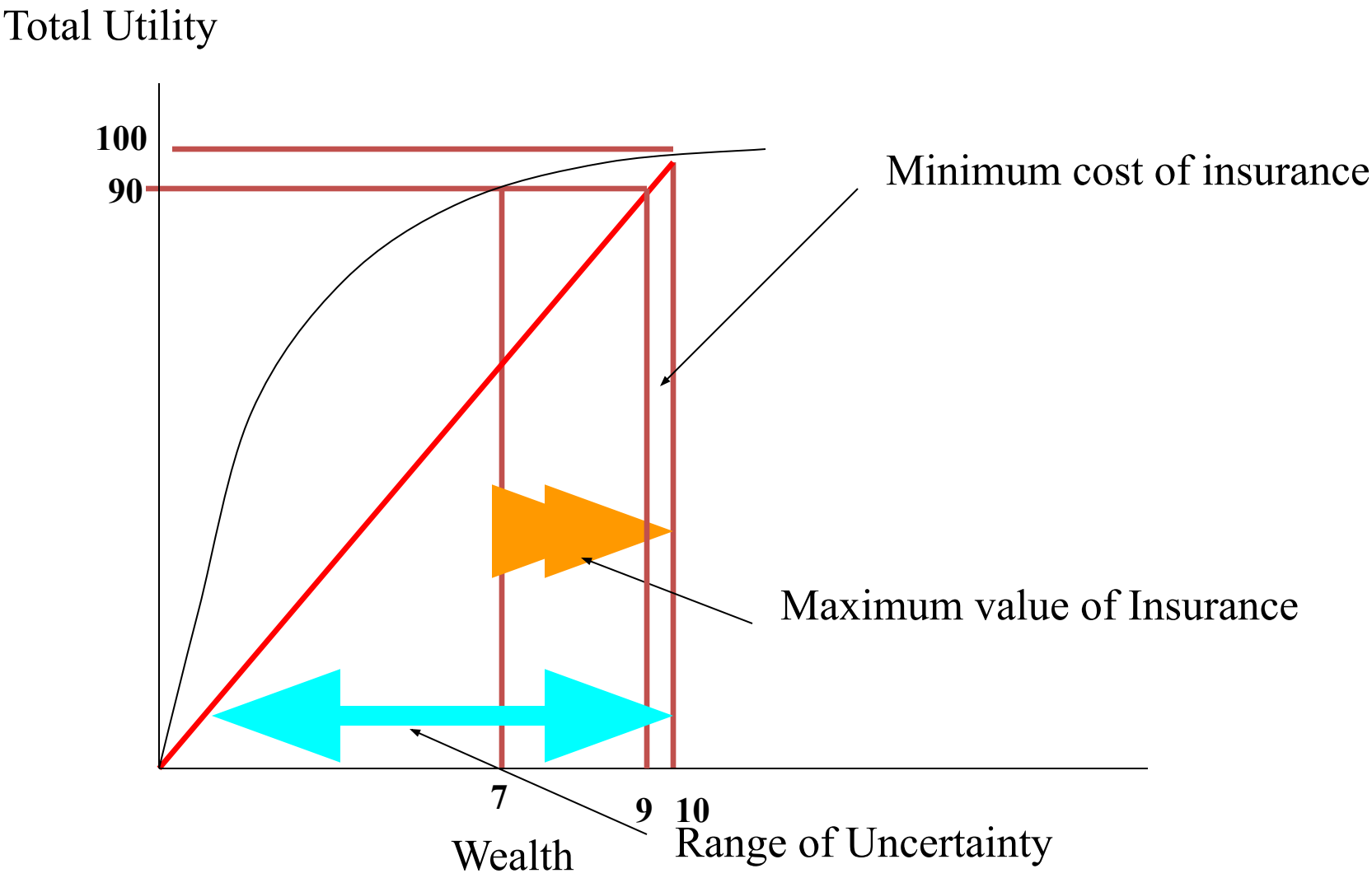
- Buy the 'the cost of risk' off. (similar to getting protection from the mob).

- Buying insurance is another way of reducing risk (and the only one that needs to be mentioned on the exam).

How does Insurance work?

- Insurance works by 'pooling' risks.
- Insurance is possible and profitable because people are risk averse.
- Probability of bad events is small, but costs of such an event (e.g., prostrate cancer) are large.
- Can estimate probability of bad events and price the cost of risk to individuals.

The Gains from Insurance



Understanding the Graph

- At $10K, utility is 100.
- If one loses health (or a another valued good), utility drops to 0.
- If probability of adverse event is 0.1, what is expected utility?
- At $E(U)_{P=0.1,}$ what is wealth with no insurance?

Understanding the Graph - 2

- Up to what price will you buy insurance?
- What will insurance buy you?
- What is the minimum amount an insurance company will charge for insurance?
- If an insurance company offers a policy at $1,500 what will be it's expected profit?

Moral Hazard & Adverse Selection

- **Private information** is information that is available to one person but is too costly for anyone else to obtain.
- If you can't obtain the information you can be faced with a moral hazard or adverse selection problem.

Moral Hazard

- **Defined:** When one of two or more parities with an agreement has an incentive after the agreement is made to act in a manner that brings additional benefits to himself or herself at the expense of the other party.
- Examples?
- Why does moral hazard arise?

Adverse Selection

- **Defined:** The tendency for people to enter into agreements in which they use private information to their own advantage and to the disadvantage of the less informed party.
- General examples?
- Health examples?

Understanding the difference between the two

- People who face greater risks are more likely to purchase health insurance.
  - Moral hazard or adverse selection?

- A person with insurance coverage for a loss has less incentives than an uninsured person to avoid such a loss.
  - Moral hazard or adverse selection?

How do insurance companies overcome these problems?

- Find a ***signal*** to convey information from outside the market that can be used to detect these behaviors.
- An auto-insurance signal would be?
- A health insurance example would be?
- Another device is a deductible.

Examine Evolution of a Market

Using the "Time Machine" from Davey & Goliath

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Slow Day? Starr got you down? Consider….

http://www.awn.com/heaven_and_hell/DG/DG4.htm

Early Public Health Insurance

- First instance of public insurance is Germany's 1883 'compulsory sickness insurance'.
- Followed by:
  - Austria, 1888
  - Hungary, 1891
- Second Wave:
  - Norway, 1909
  - Serbia, 1910
  - Britain, 1911
  - Russia, 1912
  - Netherlands, 1913
- Mutual Benefit Society expansions or State Aid to voluntary programs:
  - French, 1910
  - Denmark, 1892
  - Switzerland, 1912

U.S. Public Health Insurance

- Failed proposals made in Congress for National Health Insurance:
  - 1918-19
  - 1935-36
  - 1948
  - 1974
  - 1993-94
- Successful Initiatives for Partial National Coverage
  - 1966, Medicare – National health insurance program for elderly & disabled
  - 1967, Medicaid – State sponsored programs for poor
  - 1972, Medicare inclusion of End Stage Renal Disease patients
  - 1997, State Children's Health Insurance Programs (SCHIP) – State sponsored expansion of Medicaid for kids, added 3 million uninsured kids out of 11.6 million total uninsured kids by 2000.
  - 2006, Part D, Senior coverage for drugs

Private Insurance – Two early models

- Fee-for-service insurance
  - Epitomized by Blue Cross plan started for Baylor University employees in 1929 in Texas.
  - Blue Cross – hospital insurance
  - Blue Shield – physician insurance
- Prepaid Group Practice
  - Epitomized by Kaiser Permanente (1937)
  - Others include:
    - Group Health Association (1937) eventually sold to Humana
    - Group Health Cooperative of Puget Sound (1947)

Four characteristics of Blue Cross/Blue Shield fundamentally shaped American health care.

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1. **Hospitals were reimbursed on a cost-plus basis.** If Blue Cross patients accounted for 40 percent of a hospital's total patient days, Blue Cross was expected to pay for 40 percent of the hospital's total costs. If Medicare patients accounted for one-third of patient days, Medicare paid one-third of the total costs. Other insurers reimbursed hospitals in much the same way. For the most part, physicians and hospital managers were free to incur costs as they saw fit. The role of insurers was to pay the bills, with few questions asked.

2. **The philosophy of the Blues was that health insurance should cover all medical costs—even routine checkups and diagnostic procedures.** The early Blue plans had no deductibles and no copayments; insurers paid the total bill and patients and physicians made choices with little interference from insurers. Therefore, health insurance was not really "insurance." Instead, it was prepayment for the consumption of medical care.

3. **Blues priced their policies based on what is called "community rating."** In the early days this meant that everyone in a given geographical area was charged the same price for health insurance regardless of age, sex, occupation, or any other factor related to differences in real health risks. Even though a sixty-year-old can be expected to incur four times the health care costs of a twenty-five-year-old, for example, both paid the same premium. In this way higher-risk people were under-charged and lower-risk people were over-charged.

4. **The Blues adopted a pay-as-you-go approach to insurance** instead of pricing their policies to generate reserves that would pay bills that weren't presented until future years (as life insurers and property and casualty insurers do). This meant that each year's premium income paid that year's health care costs. If a policyholder developed an illness that required treatment over several years, in each successive year insurers had to collect additional premiums from all policyholders to pay those additional costs.

Points of Inflection in Insurance Market -1

- 1930s – Great Depression reduces physician's opposition to third party payment as consumers become unable to pay cash for services.
- 1940s – During World War II, firms start providing health insurance as benefit to attract workers due to wage freeze. Employers wrote it off as an expense rather than a form of wages. Congress caught on and tried to stop the practice, but employers and unions fought back an institutionalized the practice.
- 1945 – The McCarran-Ferguson Act: All health insurance is regulated at the state, not the federal level.
- 1966 – Medicare administration is out-sourced to regional Blue Cross Blue Shield plans.
- 1974 – National Health Maintenance Organization (HMO) Act supports the creation of federal-sponsored managed care plans.
- 1974 - Employee Retirement Income Security Act (ERISA) exempts plans run by unions or single employers from state regulation.

Points of Inflection in Insurance Market - 2

- 1983 – Medicare institutes prospective payment for hospital inpatient payment.
- 1992 – Medicare institutes the Resource Based Relative Value Scale (RBRVS) for physician payment.
- 1990s – Benefits carved out to specialized firms: Mental Health and prescription drugs to Pharmaceutical Benefits Managements frims
- 1996 – Congress authorizes expansion of Medical Savings Accounts
- 2001 – Birth of Consumer Directed Health Plans
- 2003 – Congress Authorizes Prescription payment for seniors and Health Savings Accounts
- 2006 – Start of Medicare Part D

State of Health Insurance Today

- Insurance models
- Demand side control programs
- Supply side control programs
- Market successes & failures

Insurance Models in 2007

- 9% Conventional Fee for Service/Managed Indemnity
  - Payment is based on a fee-schedule or 'Usual, Customary or Reasonable" fees.
- 24% HMO
  - Payment by salary or 'capitation'
  - Insurer owns 'bricks & mortar'
- 65% Preferred Provider Organization & Point of Service Plan
  - Payment is based on set a fee schedule, usually indexed to Medicare's RBRVS schedule, with negotiated discounts
- 2% Consumer Driven Health Plans

2013: ACA Accelerated HDHP - Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2013

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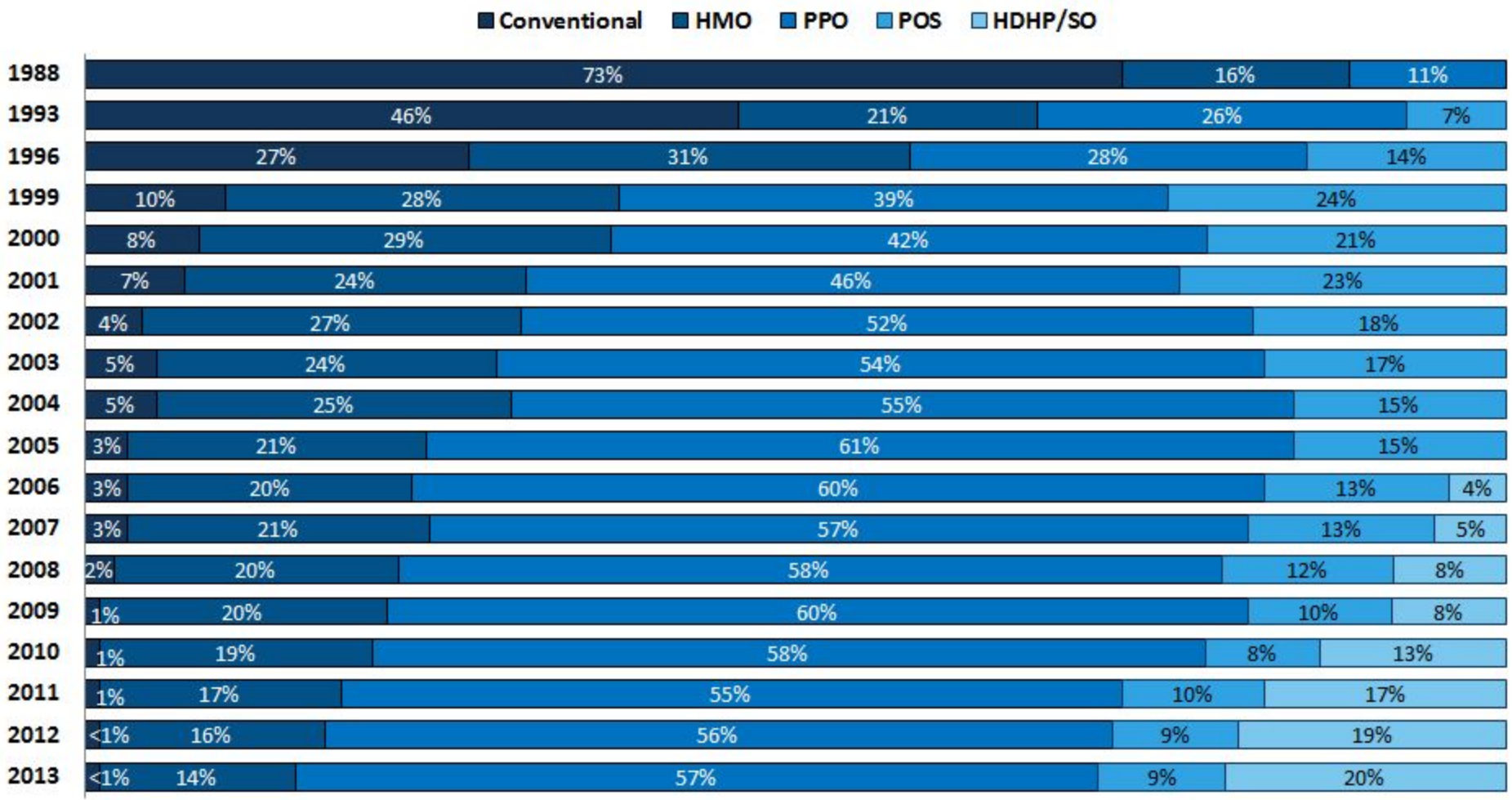

Source: Kaiser Family Foundation

Insurance Tower of Babel

- PPO: Preferred Provider Organization (Medica)
- IDS: Integrated Delivery System (Fairview)
- HMO: Health Maintenance Organization (HealthPartners)
- PHO: Physician Hospital Organization (Park Nicollet)
- IPA: Independent Practice Association (passe)
- POS: Point of Service – Patient gets choices at service time
- CDHP: Consumer Driven Health Plan
- HDHP: High Deductible Health Plan
- Gatekeeper: Physician, usually a primary care physician (general, family practitioner, internal medicine or pediatrician) who control's patient access to specialists and other services.

CDHP Business Enablers

- 'Ready to Lease' Components of Health Insurance:
  - Electronic claims processing
  - National panel of physicians
  - National pharmaceutical benefits management firms
  - Consumer-friendly health data web portals
  - Disease management vendors
- Internet
  - Transaction medium for claims processing
  - 2-way communication with members
- ERISA-exemption
  - Lack of state oversight
  - Half the US commercial health insurance market is self-insured.

CDHP Component Details

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Health Reimbursement Account (HRA)

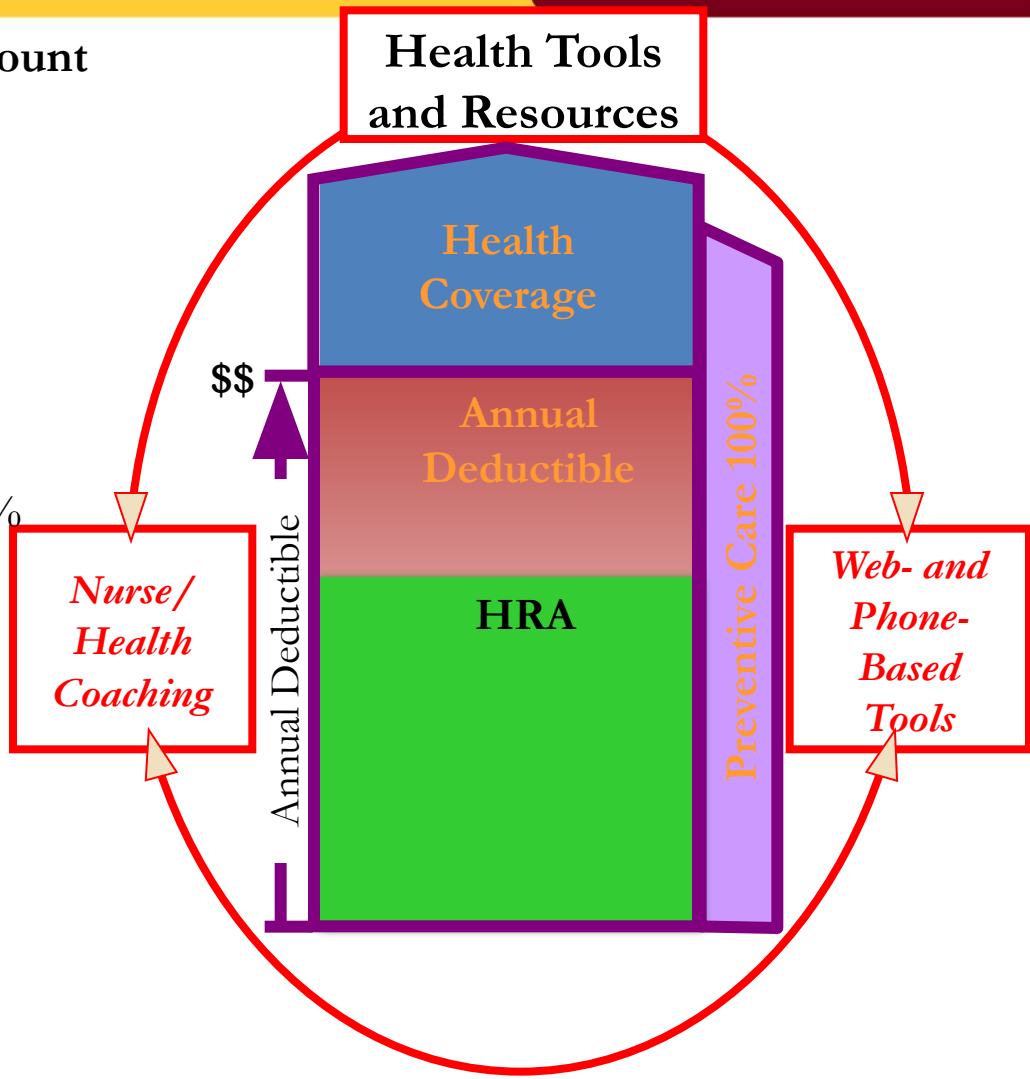
- Employer allocates HRA[1]
- Member directs HRA
- Section 213(d) "scope"
- Roll over at year-end
- Apply toward deductible[2]

Health Coverage

- Preventive care covered 100%
- Annual deductible
- Expenses beyond the HRA
- Nationwide provider access
- No referrals required

Health Tools and Resources

- Care management program
- Extensive easy-to-use information and services



[1] Employer selects which expense apply toward the Health Coverage annual deductible.
[2] Paid out of employer's general assets.

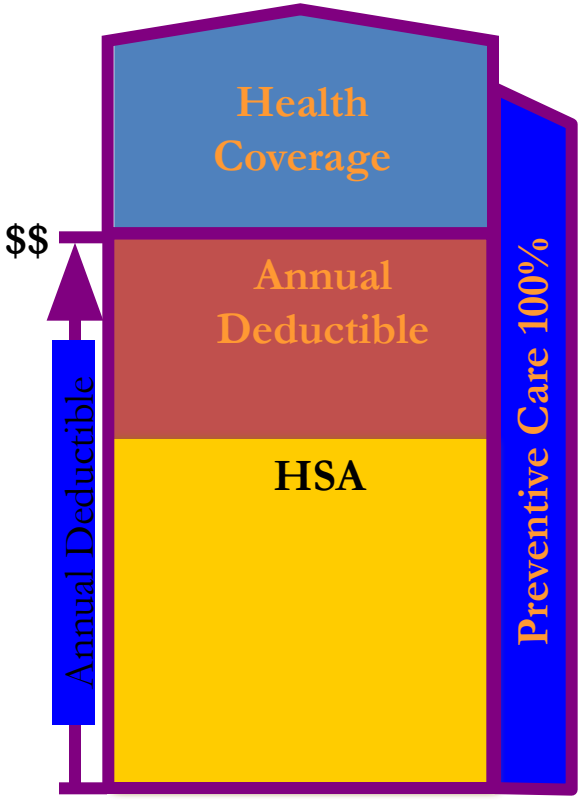
…The HSA Model

Health Care Account (HSA)

- Consumer/Employer allocates HSA
- Consumer directs HSA
- Owned by consumer and portable
- Roll over at year-end
- Many deposited pre-tax
- Consumer can withdrawal with penalty

Health Coverage

- Can apply toward deductible
- Purchased by 'Qualified' Plans
- Annual deductible
- Expenses beyond the HSA
- No managed care provisions
- Nationwide provider access
- No referrals required



Demand Side Controls

'Affect the consumer to mitigate moral hazard'

- Coinsurance, Copayments, Deductibles
- Specialist access through 'gatekeeper' physicians.
- Disease management
- Pricing differentials to consumers:
  - Preferred providers in PPO & POS
  - Formularies: Reimburse only cost of generic drug if generic substitute is available.

Supply Side Controls

'Reduce the probability of provider induced demand'

- Fee schedules
  - Diagnosis Related Groups
  - RBRVS
  - Outpatient DRGs
- Utilization management
  - Deny claims payment for unnecessary services
  - Deny authorization for treatment
  - Redirect patient care to less expensive options
- Case management
  - Organize care for patient
  - Streamline care process – look for efficiencies that improve outcomes or at worst have a neutral effect.

Insurance 'Market Success'

- Primary funding source of medical innovation in the United States.
- Consumers have more provider and treatment choices and less rationing than other industrialized firms.
- Flexible market that creates workarounds for changing health economy and politics.

Insurance 'Market Failures'

- 50+ million uninsured (at any point in time) prior to ACA
- 120% health insurance premium increase from 2000 to 2011
  - Moral hazard not checked?
  - Medical technology driving moral hazard?
  - Defensive medicine?
- Issue commands national attention along with economy, defense, and taxes as being at a crisis point.

Average Annual Premiums for Single and Family Coverage, 1999-2013

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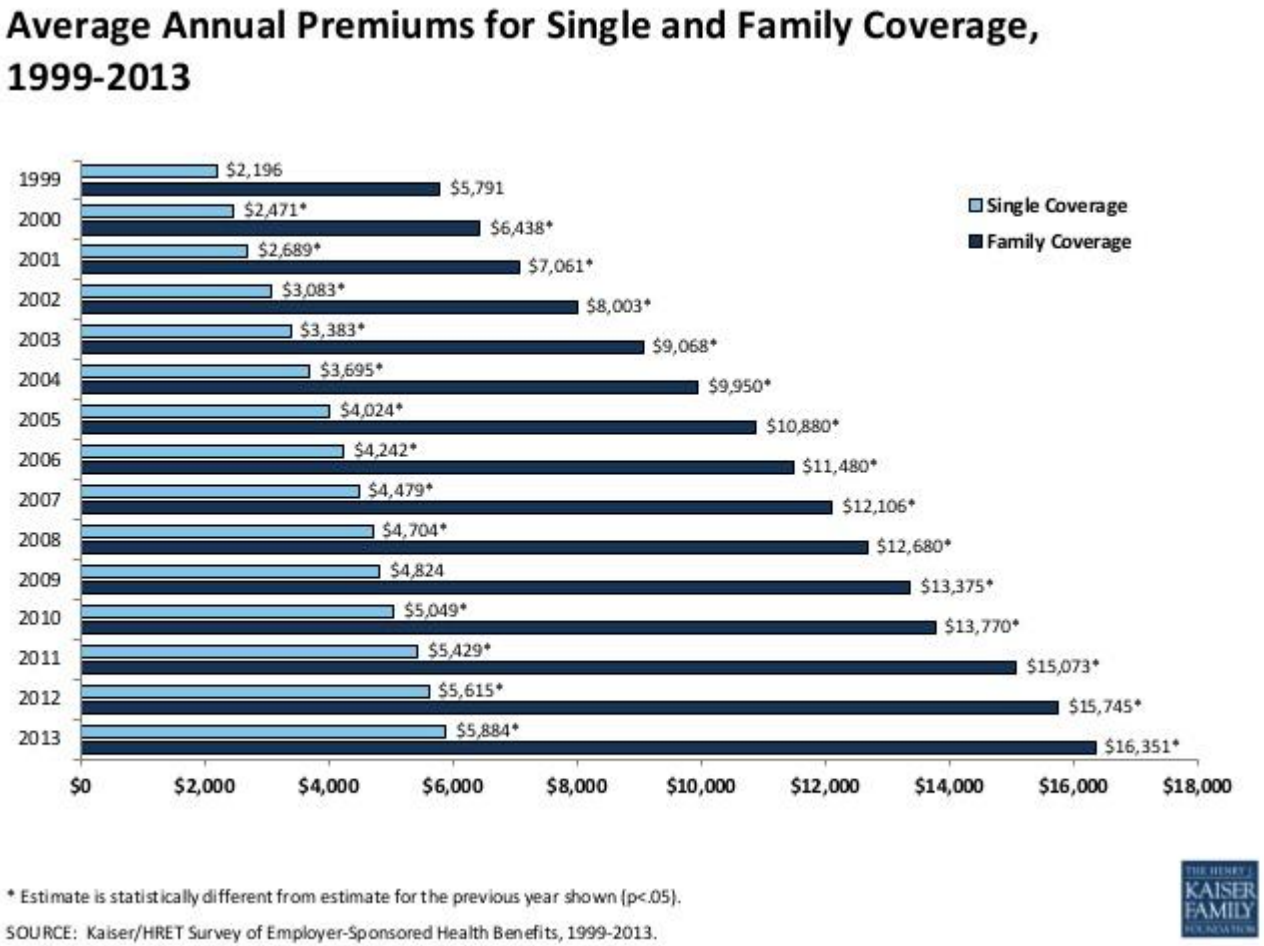


* Estimate is statistically different from estimate for the previous year shown (p<.05).

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

THE HENRY J. KAISER FAMILY FOUNDATION -AND- HRET HEALTH RESEARCH & EDUCATIONAL TRUST

Question for Reflection

- How uniquely American is evolution of the insurance market in the 20th century? Name three unique historic moments that uniquely shaped the insurance market by 2015?

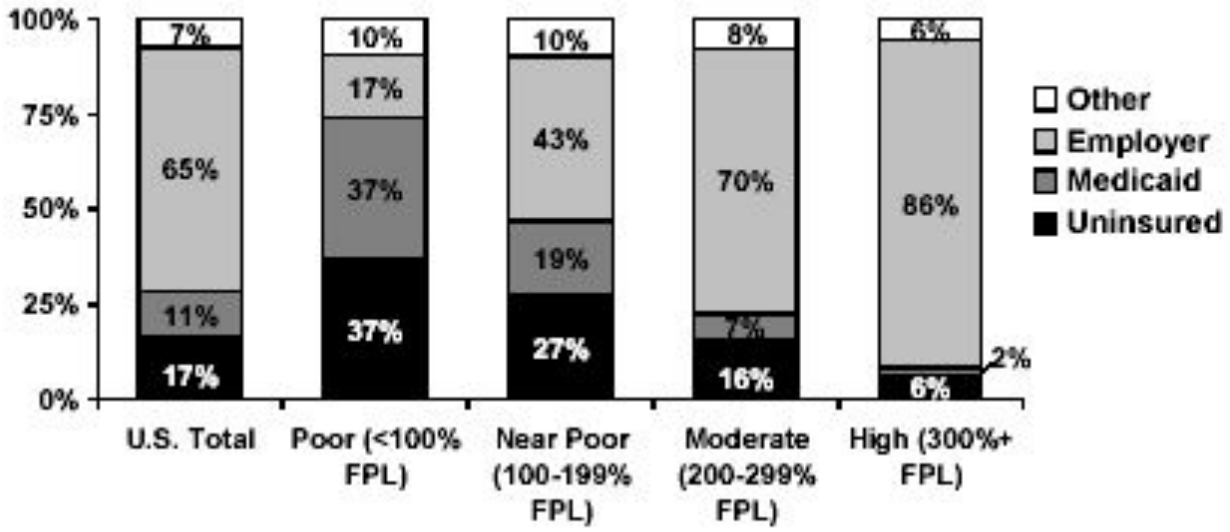
The Uninsured Problem

- Who are the uninsured?
- Why is this a 'market failure'?
- If government were to prioritize, who among the uninsured you would extend coverage too would you?
  - Easiest to hardest to 'enroll' get maximum 'person effect'
  - Reach people with greatest utility from insurance first
  - Another strategy
- Why are the number of uninsured growing?
- Is this a federal problem?
- Should it have a federal or state solution?

Who Are the Uninsured?

Figure 2

Health Insurance Coverage by Poverty Level, 2001



Note: The federal poverty level was $14,128 for a family of three in 2001.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey, 2002.

Types of Uninsured *(Over 4 Years)*

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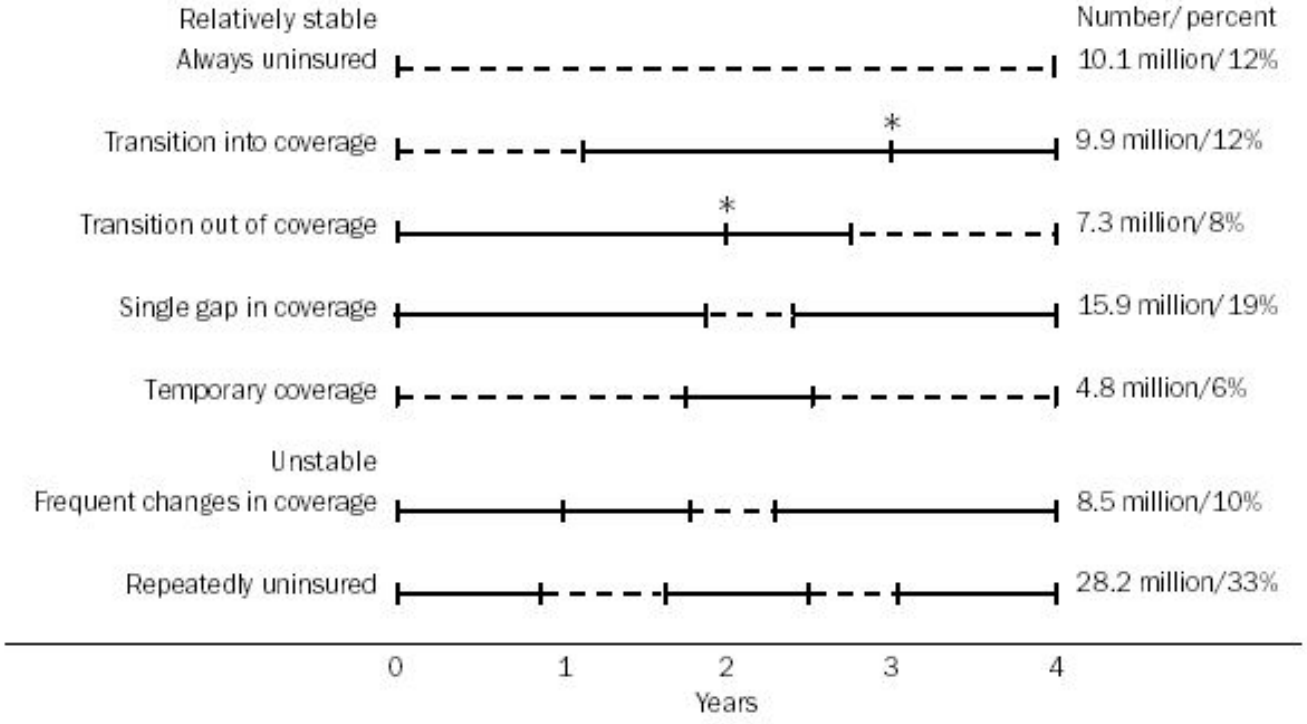
From Pamela Farley Short and Deborah R. Graefe, 2003, Health Affairs

EXHIBIT 1
Patterns Of Health Insurance Coverage Over Four Years, U.S. Uninsured Population Under Age 65, 1996–1999



SOURCE: Authors' tabulations of the 1996 panel of the Survey of Income and Program Participation (SIPP).
NOTES: Dashed lines denote periods of uninsurance; solid lines, periods of insurance. Asterisks denote transitions experienced by some, but not all, of the people with the specified pattern. Total number of people ever uninsured: 84.8 million.

Geo-variation in the Uninsured

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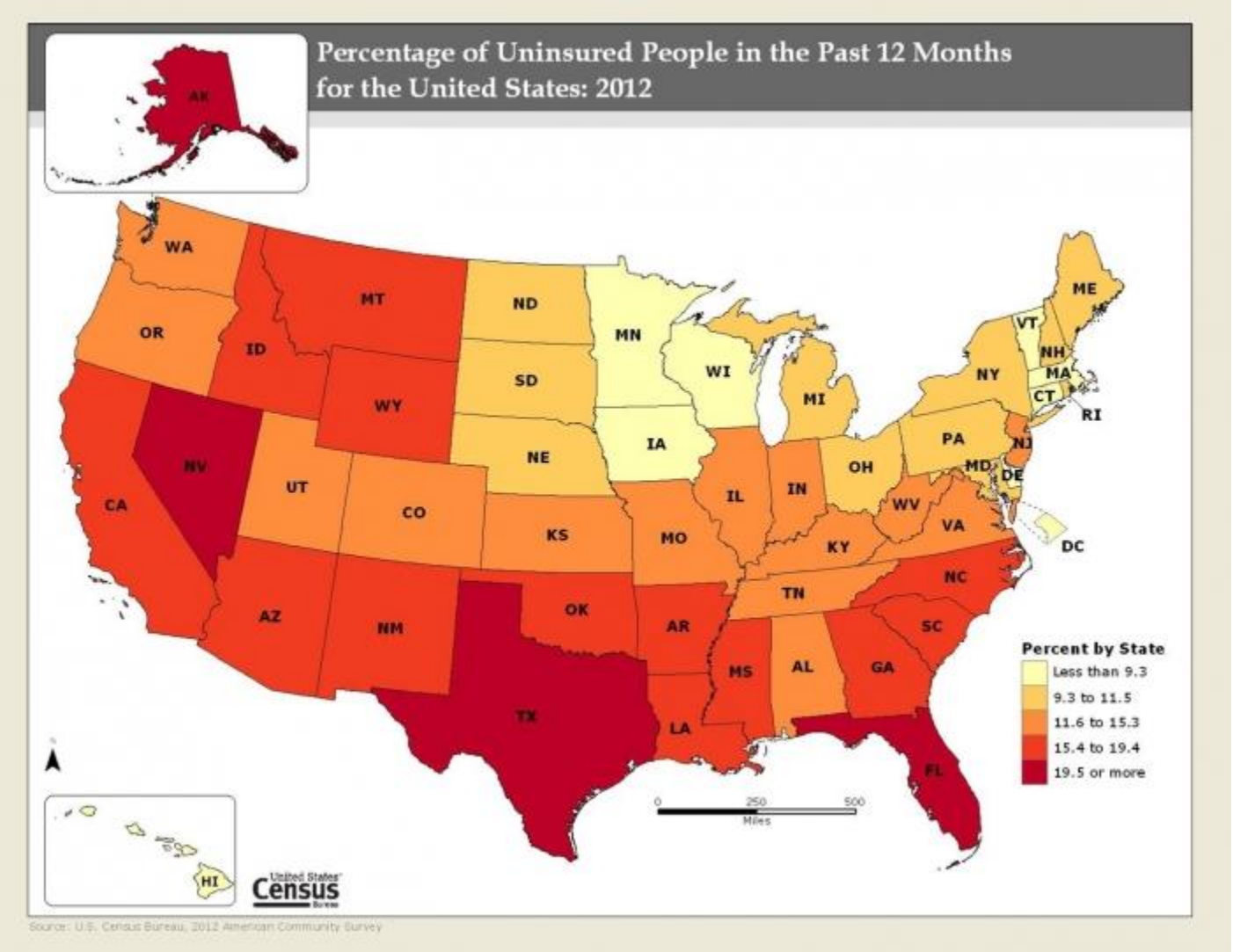
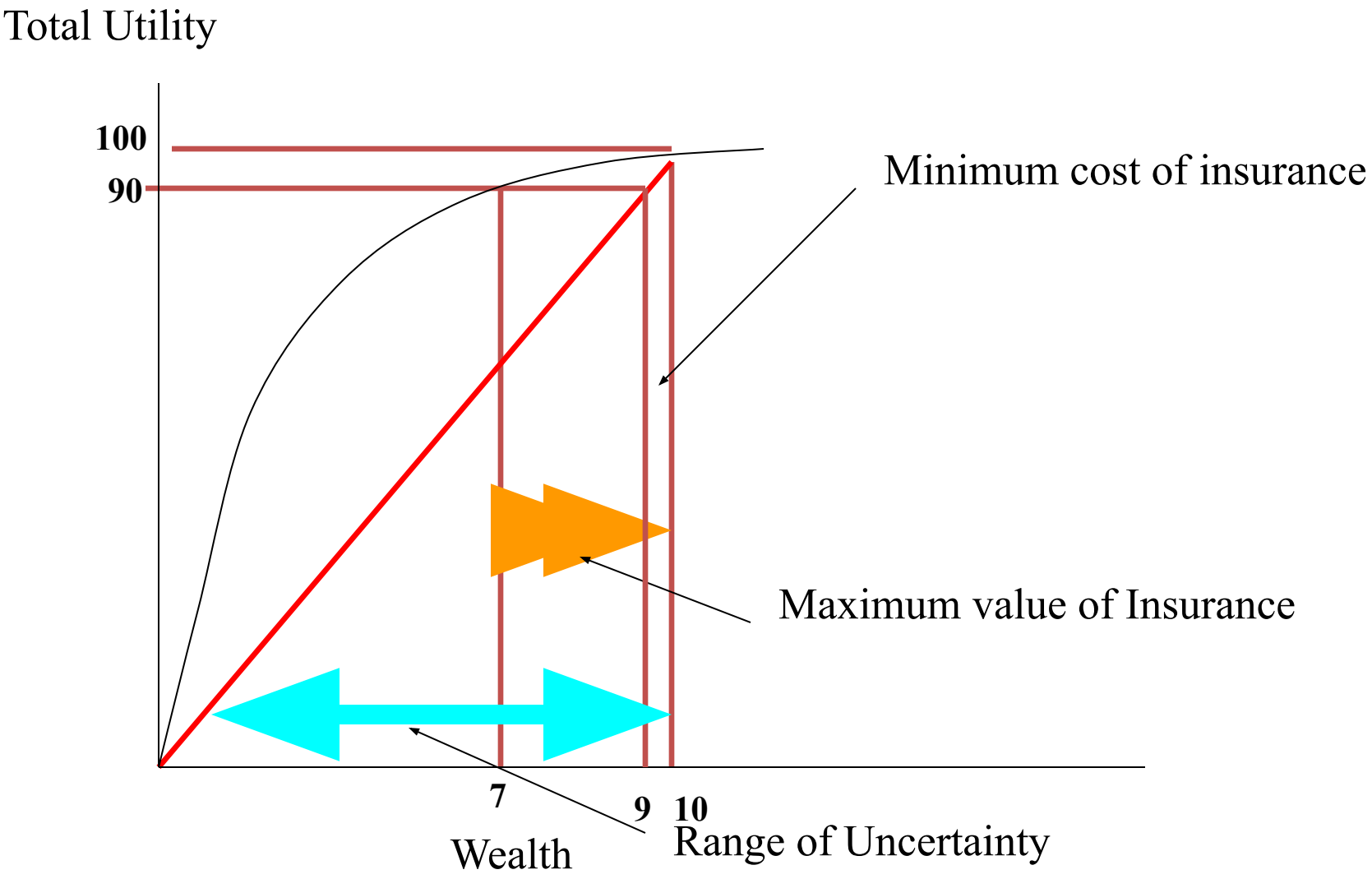


Does theory square with health insurance today?

- What is the purpose of insurance?
- How is modern health insurance like general insurance?
- How is it different?
- Is it different for an idiosyncratic reason or is it tied back to the theory of insurance?
- What example of a pure form insurance is available in the health insurance market today?

Insurance: In Theory



What is the Effect of Uninsurance?

EXHIBIT 1
Costs Consequent To Uninsurance

Internal or private costs (for individuals, families, and firms)	External or spillover costs
Greater morbidity and premature mortality	Diminished quality and availability of personal health services
Developmental losses for children	Diminished public health system capacity
Family financial uncertainty and stress, depletion of assets (resource and transfer costs)	Diminished population health (such as higher rates of vaccine-preventable disease)
Lost income of uninsured breadwinner in ill health	Higher taxes, budget cuts, loss of other uses for public revenues diverted to uncompensated care (primarily transfer costs, except for administrative costs)
Workplace productivity losses (absenteeism, reduced efficiency on the job)	Higher public program costs connected with worse health (Medicare, disability payments) (primarily transfer costs)
Diminished sense of social equality and self-respect	Diminished workforce productivity
	Diminished social capital; unfulfilled social norms of caring, equal opportunity, and mutual respect

SOURCE: Adapted from Institute of Medicine Committee on the Consequences of Uninsurance, *Hidden Costs, Value Lost: Uninsurance in America* (Washington: National Academies Press, 2003), 31, Figure 2.2.

One Insurance Reform Option

(G.H.W. Bush '92, M. Romney '06, and H.R. Clinton & B. Obama '08)

'Pay or Play'

Firms pay worker's premium into insurance pool
or
Firms play by covering workers

What has the Uninsured Problem been Proposed to be Addressed?

- Pay or play
  - Federal effort failed in 1992.
  - States options depend on economic strength of states.
  - Hilary and President Obama's proposal in 2008; Rodney's MA policy in 2006 – NOW our current law.
- National health insurance
  - Proposed: 1918;1935;1948;1965;1974;1994
  - DOA: Always What's changed now? Two World Wars, a depression and two recessions couldn't provide a catalyst.
- Incremental coverage additions
  - Medicare (1966), Medicaid (1967), ESRD (1974), SCHIP (1997)
  - Track record of success, but goes incrementalism cost more in the long run?

What is the minimal form of health insurance you can live with?

1. High-deductible catastrophic
2. Service-specific coverage only (long term care, dental, pharmacy)
3. Health savings accounts
4. Kaiser-style HMO
5. PPO
6. Fee-for-service

The Free-Rider Problem

- Free-rider is a person who consumes a good without paying for it.
- The problem is that quantity of the good that a person is able to consume is not influenced by the amount a person pays for the good.

Break

Health Insurance Market Today

- Health Economist Health Reform Priors
- Current Law Overview
  - Coverage and Financing
  - Insurance Markets
  - Exchanges
  - Payment Reform
- Projected Financial Impact on US Economy
- Medicaid Expansion Twists

Priors as a Health Economist

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- Health economists find that technology is both good for society and huge cost driver.
- Nothing in the Bills passed will measurably bend the cost curve down.
- Health insurance actuaries find the best way to keep costs within general inflation is through catastrophic/high-deductible insurance.
- Advocating catastrophic insurance for all might be the surest way to a two year House of Representatives visit.

Coverage and Financing

- **Coverage:** 32 of 54 million uninsured covered
  - 24 million in Exchange
  - 16 million in Medicaid
  - Loss of 8 million from individual and group coverage
- **Financing:** Half from reduced spending in Medicare and Medicaid and half from tax provisions
  - **Medicare/Medicaid:** Medicare FFS payments, Medicare Advantage, Part D pharmaceutical discounts, Medicaid drug rebates, DSH, and small amount from payment reform
  - **Tax Provisions:** Medicare FICA tax, insurer and pharmaceutical assessments, medical device tax, "Cadillac" tax, FSA and HSA tax changes, tax deductibility of medical expenses to 10%, and tanning bed tax

Insurance Market: 2010

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- **Effective Immediately:** Annual process set by HHS and States for premium rate review. $250 million available to States from FY 2010 through FY 2014
- **Effective Within 90 Days:** Temporary High Risk Pool through December 2013 for those uninsured for at least 6 months with a pre-existing condition. Premiums not to exceed 100% of standard individual rate, with 4 to 1 rating range allowed for age.
- **Effective Plan Years on or After 6 Months Post Enactment:** (Provisions apply to fully-insured and self-insured)
  - No lifetime benefit limits and "restricted" annual benefit limits
  - Dependent coverage to age 26
  - Coverage of preventive services without cost-sharing
  - No pre-ex for kids under 19
  - No rescissions, except in cases of fraud

NAIC Health Reform Committees

- HHS is required to consult with the National Association of Insurance Commissioners (NAIC). The NAIC has developed the following committees to provide recommendations to HHS on:
  - Medical Loss Ratio (MLR)
  - Premium Rate Review
  - Rescission Procedures
  - Medigap Reform
  - Exchanges
  - Individual Market Reform
  - Group Market Reform
  - Uniform Fraud Reporting
  - Reinsurance and Risk Adjustment
  - Interstate Compacts
  - HHS and State Data Collection
  - Uniform Enrollment, Standard Definitions, and Disclosures
  - MEWA Fraud Provisions
  - Cost Containment

Insurance Market: 2011

- **Effective January 2011:** 80% MLR for individual and small group, 85% MLR for large group.
  - NAIC is to develop definition and methodologies for MLR calculation.
  - Clinical to include "activities that improve health care quality." Taxes and regulatory fees excluded from non-clinical.

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New Federal Health Reform Structure -2010

- New "Office of Consumer Information and Insurance Oversight" established within HHS on April 19th, with four programs:
  - Office of Oversight
  - Office of Insurance Programs
  - Office of Consumer Support
  - Office of Health Insurance Exchanges
- Established to implement private market reforms and work with CMS to ensure coordination between public and private market reforms

Exchanges: 2010

- **Effective July 2010:** HHS with States to establish internet portal to identify coverage options.
  - Information to be provided for individual and group plans, Medicaid, CHIP, and high risk pools
  - By **June 2010**, HHS to develop format for comparison of options including MLR, eligibility, availability, premium rates, and cost-sharing.

The new HHS "Office of Consumer Information and Insurance Oversight" will compile and maintain information for the internet portal. Rule will require information on insurers (from Commerce), HMOs (from Health) and public plans (from DHS). **Will be moved under CMS from fear of budget cuts from GOP House members.**

Exchanges: 2014

- **Effective 2014:** States to establish Exchange to facilitate comparison shopping, enrollment, and subsidy administration for qualified health plans or HHS will establish.
  - **Standards: "As soon as practical,"** HHS to set standards for plan certification, marketing, network adequacy, plan rating, "Navigators", and risk sharing. **States to create electronic interchange for eligibility for Medicaid and subsidies.**
  - **Funding: Within 1 year of enactment,** $2 billion to States for Exchange start-up.
  - **Structure: State may create separate or combined Exchange for individuals and small groups. Regional and subsidiary Exchanges for distinct State geographies also allowed.** Operated by governmental or non-profit entity (not Medicaid agency or health plan).
  - **Eligibility:** Individuals not eligible for "affordable" employer coverage and small groups. States may allow large groups starting 2017.
  - **Outside Market:** Benefit rules, rating rules, and risk sharing apply inside and outside Exchange. Subsidies only available for plans inside Exchange.
  - **Section 125:** May only be used by employers offering "group plan" through Exchange.

Payment Reform & Care Coordination

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- **CMS Innovation Center:** Created in 2011 to test and expand Medicare and Medicaid payment models, including State all-payer models and other state proposals.
- **Medicaid and Medicare efforts, pilots and demonstrations, for example**:
  - Medicaid Global Payment Demonstration (5 states) for capitation payments for safety net hospitals. (2010)
  - 90% FMAP for Medicaid "medical home" for those with chronic conditions. States to develop payment method. (2011)
  - Medicaid Bundled Payment Demonstration (8 states). (2012)
  - Value-Based Purchasing for a variety of Medicare providers with percent of payment tied to quality (Development starting in 2011)
  - Medicare payment incentives/penalties to reduce hospital readmissions. (2012)
  - Medicare Bundled Payment Pilot. (2013)

National Impact of Health Reform

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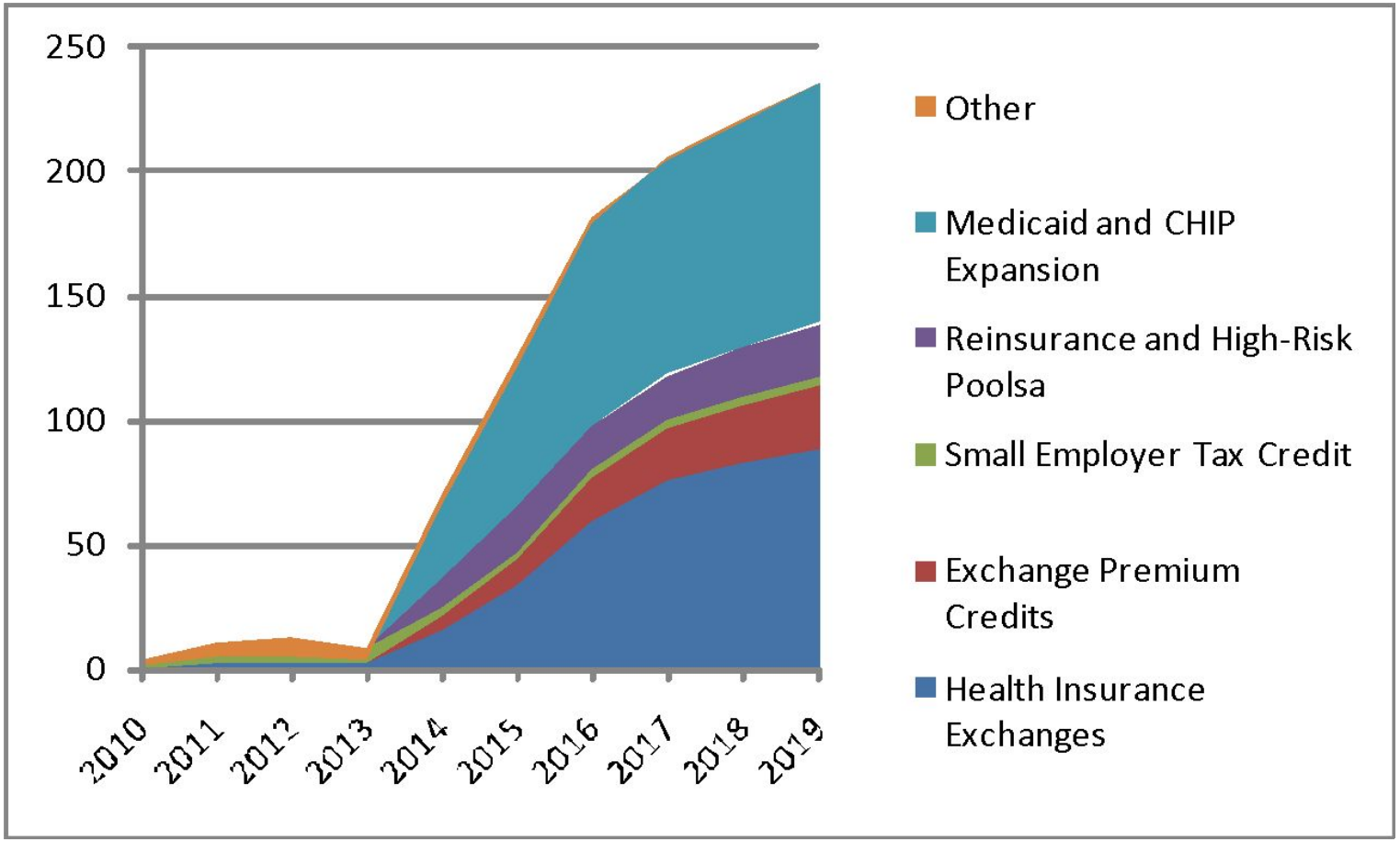
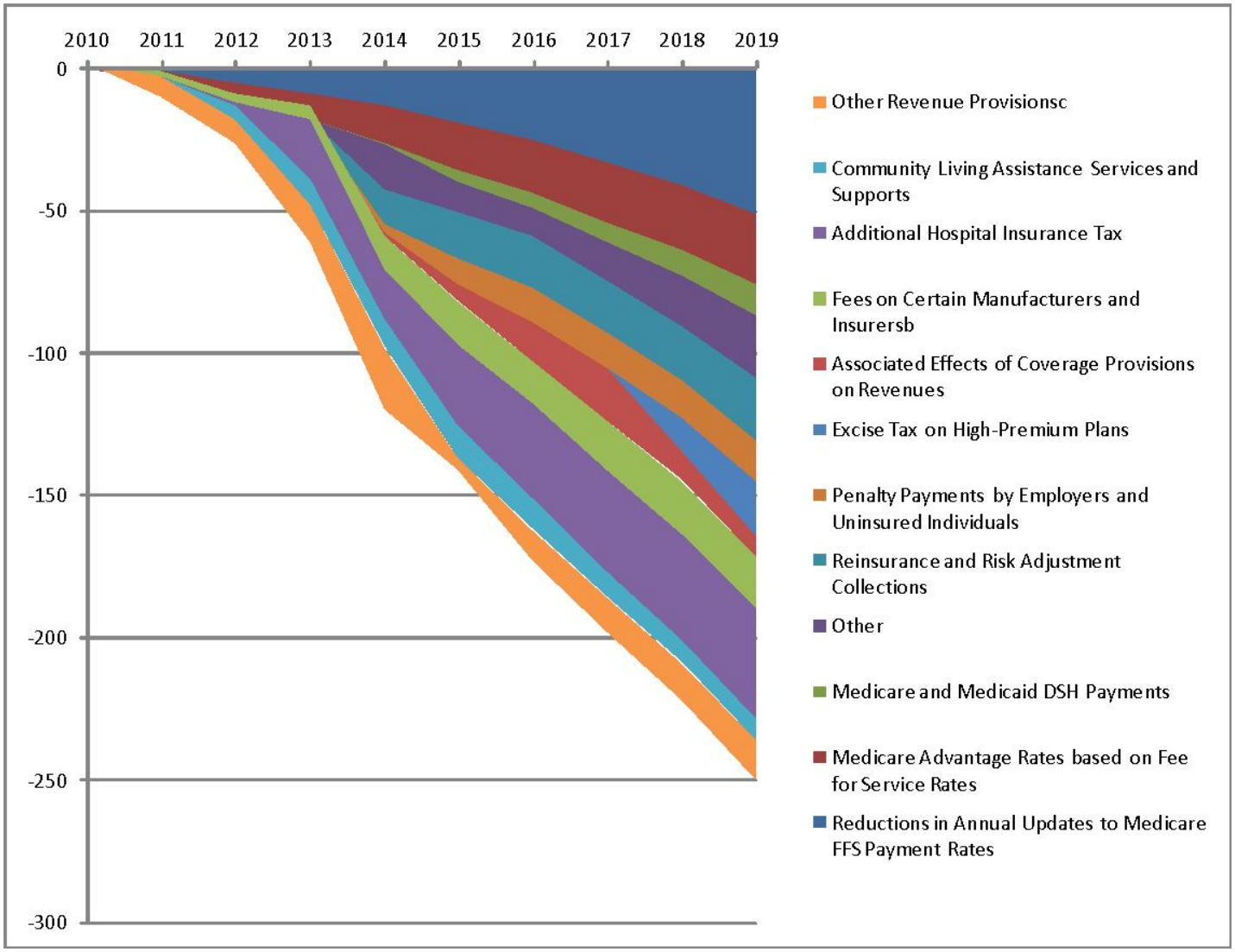
- Uninsured status is reduced by **59.8%** (81% if base is US citizens only) to newly cover approximately **30.7 million people**
- CBO Estimates – 3/18/2010
  - CBO 10 year cost: $940 billion
  - CBO deficit savings $130 billion
- Parente/HSI Estimates – 3/19/2010
  - 10 year cost: $1.36 trillion
- Summary: Additional costs will eliminate deficit savings and add to deficit by $287 billion

CBO: 2010-2019 Spend



CBO: 2010-2019 Tax/Save



CBO: Projected Savings on Vote Eve, March 21, 2010

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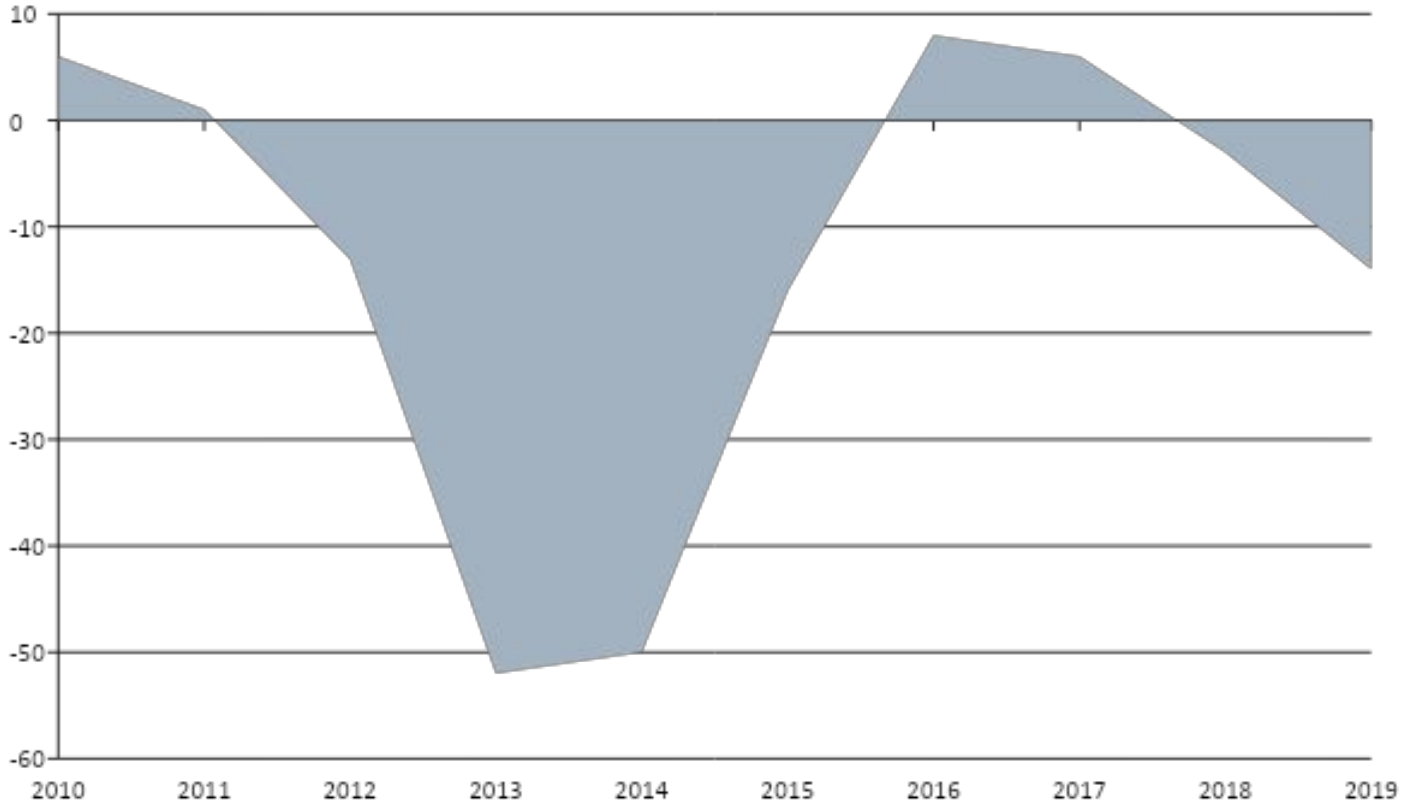

By 2019, $122 billion deficit savings

CBO: Projected Additional Cost/Savings of Pending Changes

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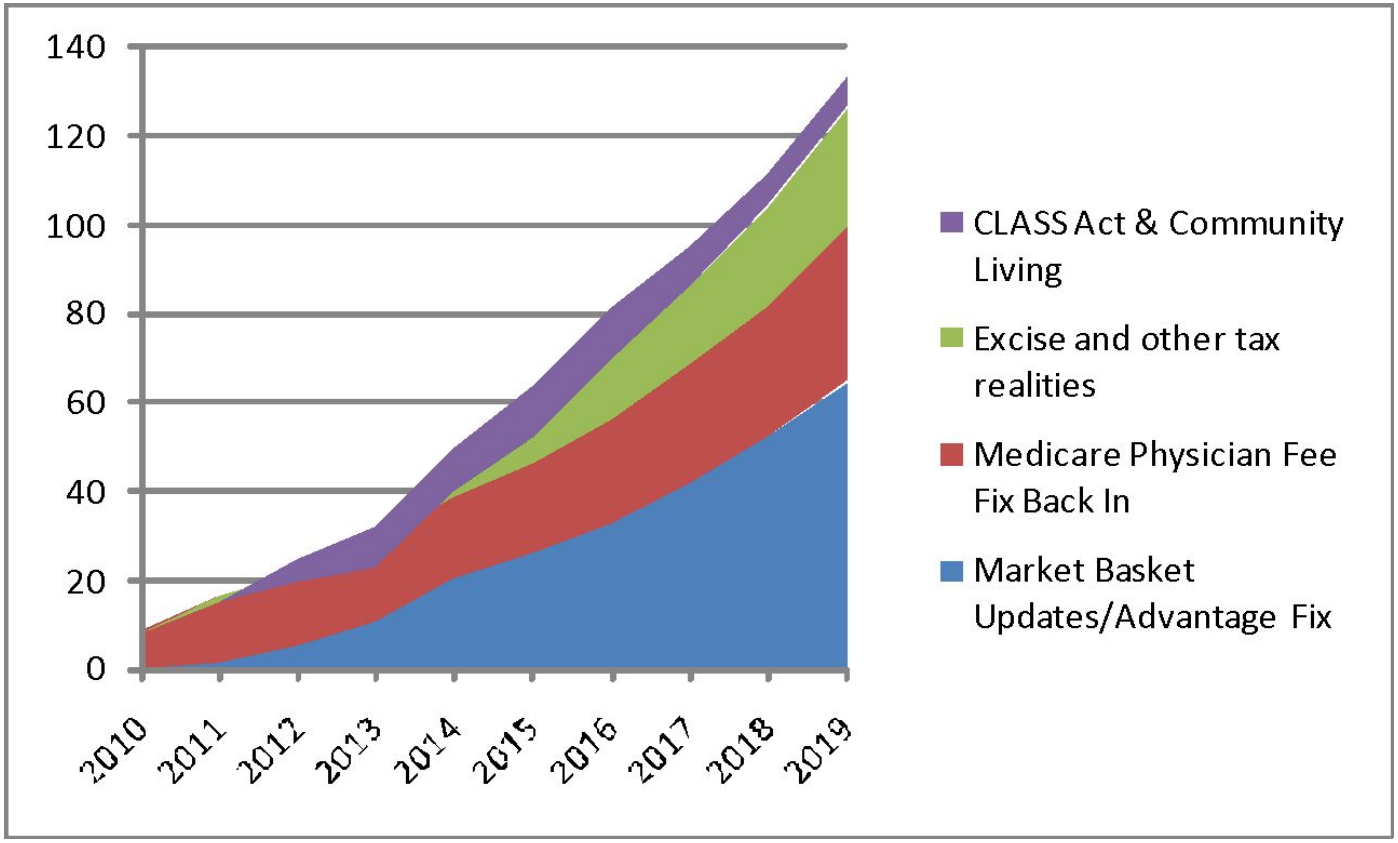

By 2019, $676 billion additional deficit burden

Current vs. Pending Budget Effect – CBO's Own Numbers

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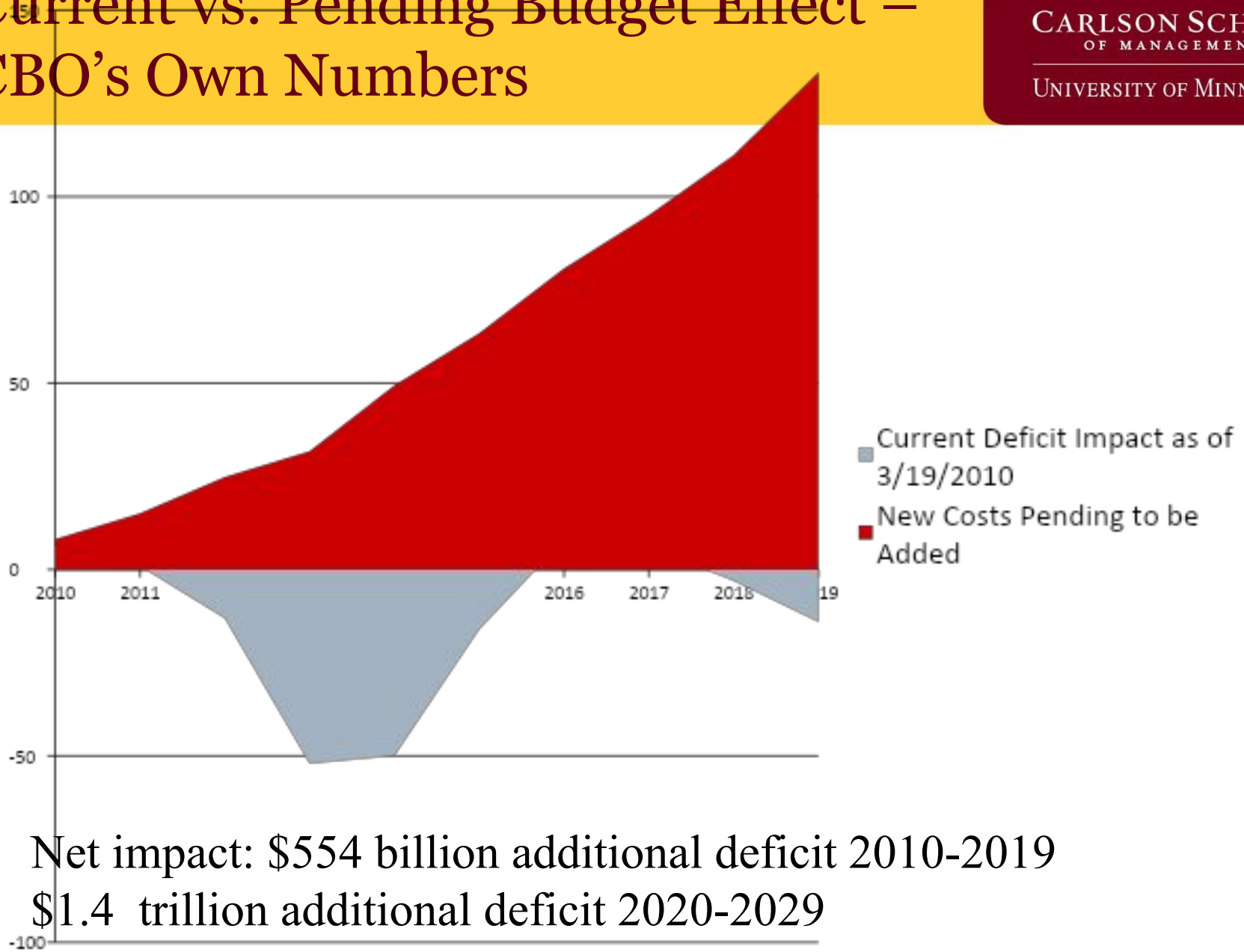

Net impact: $554 billion additional deficit 2010-2019
$1.4 trillion additional deficit 2020-2029

Train Wrecks Do Happen In DC

But, to be fair, who's train wreck is it?

Does this Look Familiar?

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PART 2—ELECTRONIC MEDICAL DATA STANDARDS

Sec. 261. Medical data standards for hospitals and other providers.
Sec. 262. Application of electronic data standards to certain hospitals.
Sec. 263. Electronic transmission to Federal agencies.
Sec. 264. Limitation on data requirements where standards in effect.
Sec. 265. Advisory commission.

PART 3—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION

Sec. 271. State comparative value information programs for health care purchasing.
Sec. 272. Federal implementation.
Sec. 273. Comparative value information concerning Federal programs.
Sec. 274. Development of model systems.

Or This?

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TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE COVERAGE

Subtitle A—Increased Affordability and Availability for Employees

Guess the Year? Guess the Authors?

Guess the Year? Guess the Authors?

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102D CONGRESS
2D SESSION

H. R. 5325

To improve access to health insurance and contain health care costs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 4, 1992

Mr. MICHEL (for himself, Mr. GINGRICH, Mr. LEWIS of California, Mr. EDWARDS of Oklahoma, Mr. HUNTER, Mr. MCCOLLUM, Mr. WEBER, Mr. VANDER JAGT, Mr. ARCHER, Mr. GRADISON, Mr. MCDADE, Mr. MCMILLAN of North Carolina, Mr. SOLOMON, Mr. BILIRAKIS, Mr. BLILEY, Mr. CHANDLER, Mr. GOSS, Mr. GRANDY, Mr. GUNDERSON, Mr. HASTERT, Mr. HOBSON, Mrs. JOHNSON of Connecticut, Mr. KASICH, Mr. LENT, Mr. MCGRATH, Mr. ROBERTS, Mr. WALKER, Mr. BAKER, Mr. BALLENGER, Mrs. BENTLEY, Mr. BROOMFIELD, Mr. BUNNING, Mr. CAMP, Mr. CLINGER, Mr. DOOLITTLE, Mr. EWING, Mr. FRANKS of Connecticut, Mr. GALLEGLY, Mr. GEKAS, Mr. GILCHREST, Mr. GILLMOR, Mr. GILMAN, Mr. HAMMERSCHMIDT, Mr. HEFLEY, Mr. HENRY, Mr. HOLLOWAY, Mr. HOPKINS, Mr. HOUGHTON, Mr. INHOFE, Mr. JOHNSON of Texas, Mr. KOLBE, Mr. LAGOMARSINO, Mr. LEWIS of Florida, Mr. LOWERY of California, Mr. MCCRERY, Mr. MARLENEE, Mrs. MEYERS of Kansas, Mr. MILLER of Ohio, Mr. MYERS of Indiana, Mr. OXLEY, Mr. PETRI, Mr. PURSELL, Mr. RAMSTAD, Mr. RHODES, Mr. RIGGS, Mr. RITTER, Mr. ROTH, Mr. SANTORUM, Mr. SCHULZE, Mr. SENSENBRENNER, Mr. SHAW, Mr. SKEEN, Ms. SNOWE, Mr. SPENCE, Mr. SUNDQUIST, Mr.

Implementation Iceberg Cometh?

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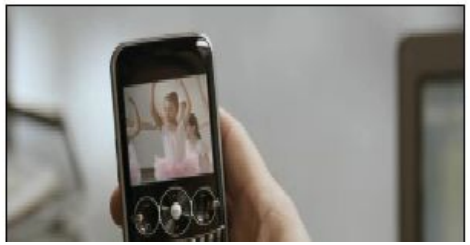
REAL CLEAR POLITICS

ObamaCare Faces the Implementation Iceberg

By Paul Howard and Stephen Parente - November 26, 2012

Defenders of the Patient Protection and Affordable Care Act, aka Obamacare, can be forgiven for some post-election triumphalism. But their joy is likely to be short lived. Because the law put off implementation of most key provisions until after the 2012 election, voters cast their ballots on November 6 without knowing what Obamacare's true effect will be on their tax bills, insurance costs, or access to care.

Delaying implementation until 2014 helped the president win re-election, but now the bill is coming due. The administration can't forestall Obamacare's massive regulatory impact any longer, and the result will keep Congress and the media occupied for months and years to come.



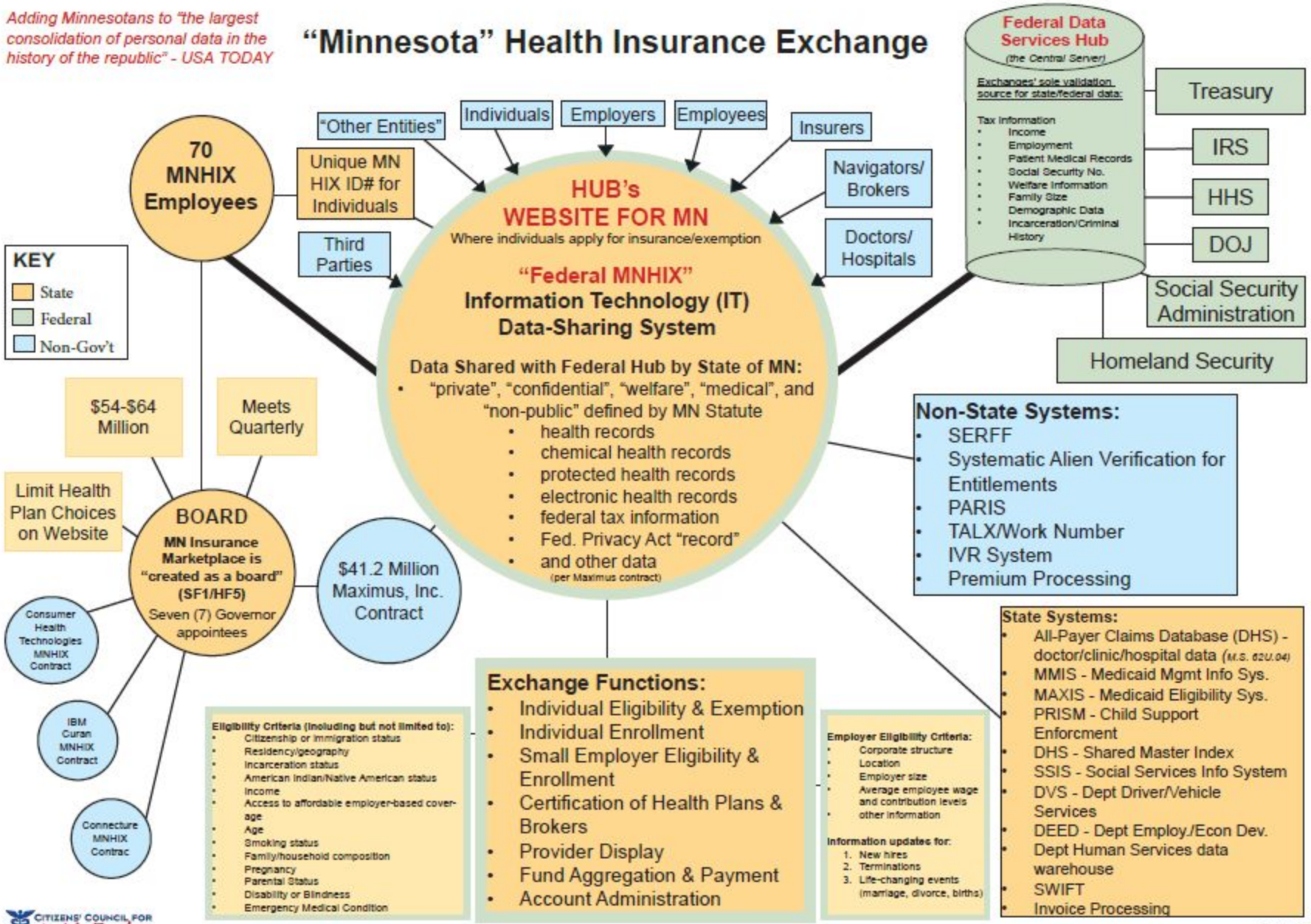
The administration has just begun to issue guidance (proposed rules) to the insurance industry on Obamacare's most important (and expensive) insurance market "reforms." Insurance plans must have clarity on these issues if they are to develop and price plans for the individual and small group markets both inside and outside of the exchanges.

Right now, insurance companies don't have answers

Paul Howard and Stephen Parente
Author Archive

Adding Minnesotans to "the largest consolidation of personal data in the history of the republic" - USA TODAY

"Minnesota" Health Insurance Exchange



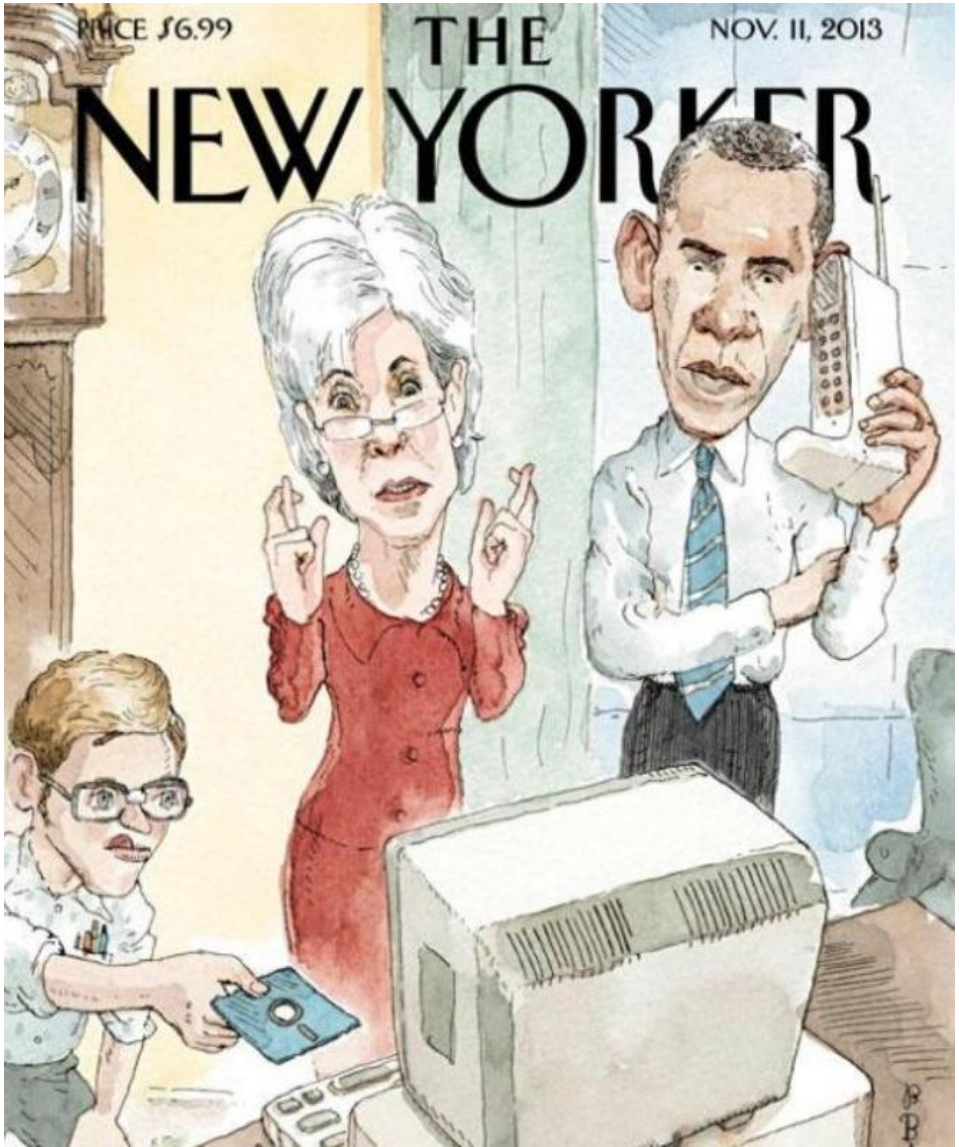
CITIZENS' COUNCIL FOR Health Freedom

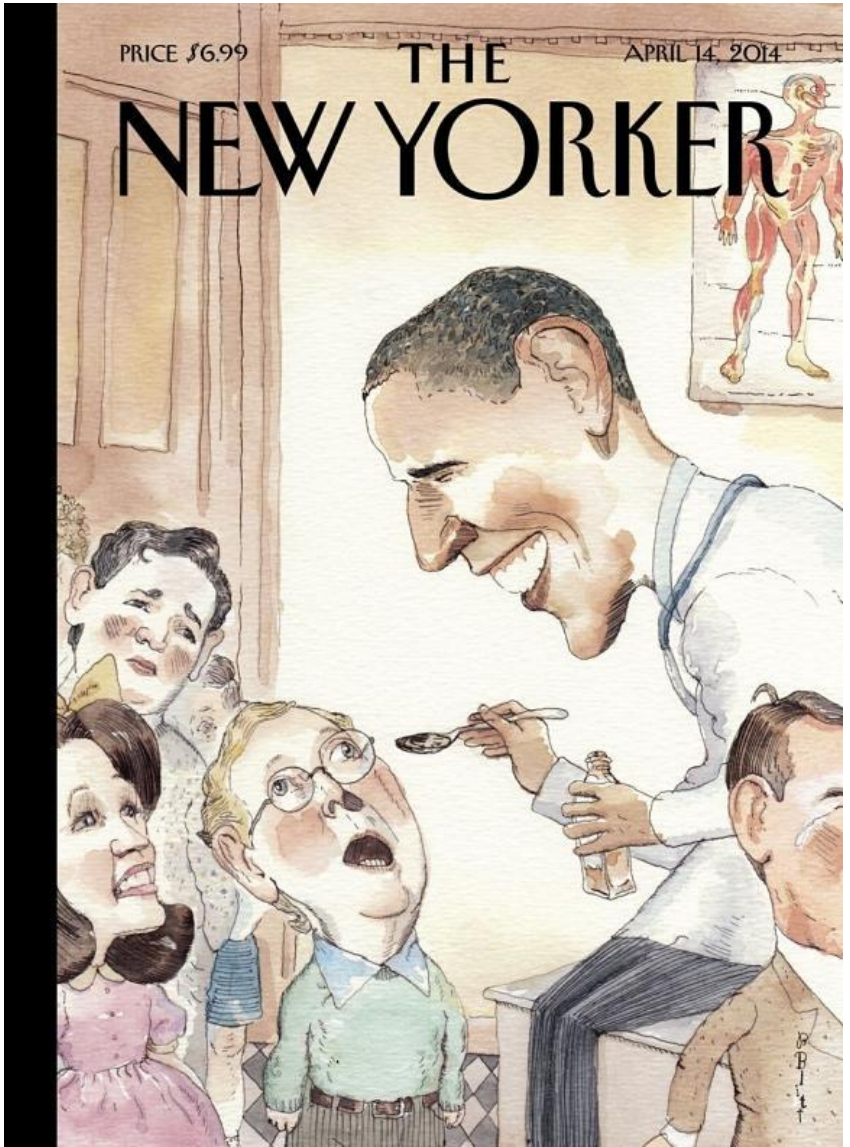
www.cchfreedom.org

1/22/13

News Source: "Potential Obamacare Privacy Nightmare," USA TODAY, December 6, 2012; State sources include: SF 1/HF 5 and MNHIX RFP and MN Exchange Contracts
Federal sources include: Federal PPACA Risk-Adjustment Rules, and *"Federal Exchange Program System Data Services Hub Statement of Work," CMS,HHS, July 15, 2011.*

Even Friends can Wound if Implementation Poor





ACA Privacy Nightmare?

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www.usatoday.com/story/opinion/2012/12/06/column-potential-obamacare-privacy-nightmare/1752211/

john entwistle

USA TODAY | NEWS | SPORTS | LIFE | MONEY | TECH | TRAVEL | OPINION | 46°

This story is part of COLUMNISTS' OPINIONS

Opinionline: West Virginia goes 'Buckwild'?

Column: When even Santa has to dive for cover

Grover Norquist: Tax pledge means accountability

Column: Potential ObamaCare privacy nightmare

Stephen T. Parente and Paul Howard

6 Comment | Share

Collecting personal data from across government opens door to abuse.

(Photo: Lisa Nipp, for USA TODAY)

6:51PM EST December 6. 2012 - By mid-December, the federal government is planning to quietly enact what could be the largest consolidation of personal data in the history of the republic. If you think identity theft is a problem now, wait until Uncle Sam serves up critical information on 300 million American citizens on a platter.

Hyperbole? Unlikely. Here's why: As the Patient Protection and Affordable Care Act lurches toward full implementation on Jan. 1, 2014, only a handful of states (California, Massachusetts, Maryland, Oregon

STORY HIGHLIGHTS

- The health care exchanges will collect information from

Not all data hacked – just the parts that let you create a fake credit card account

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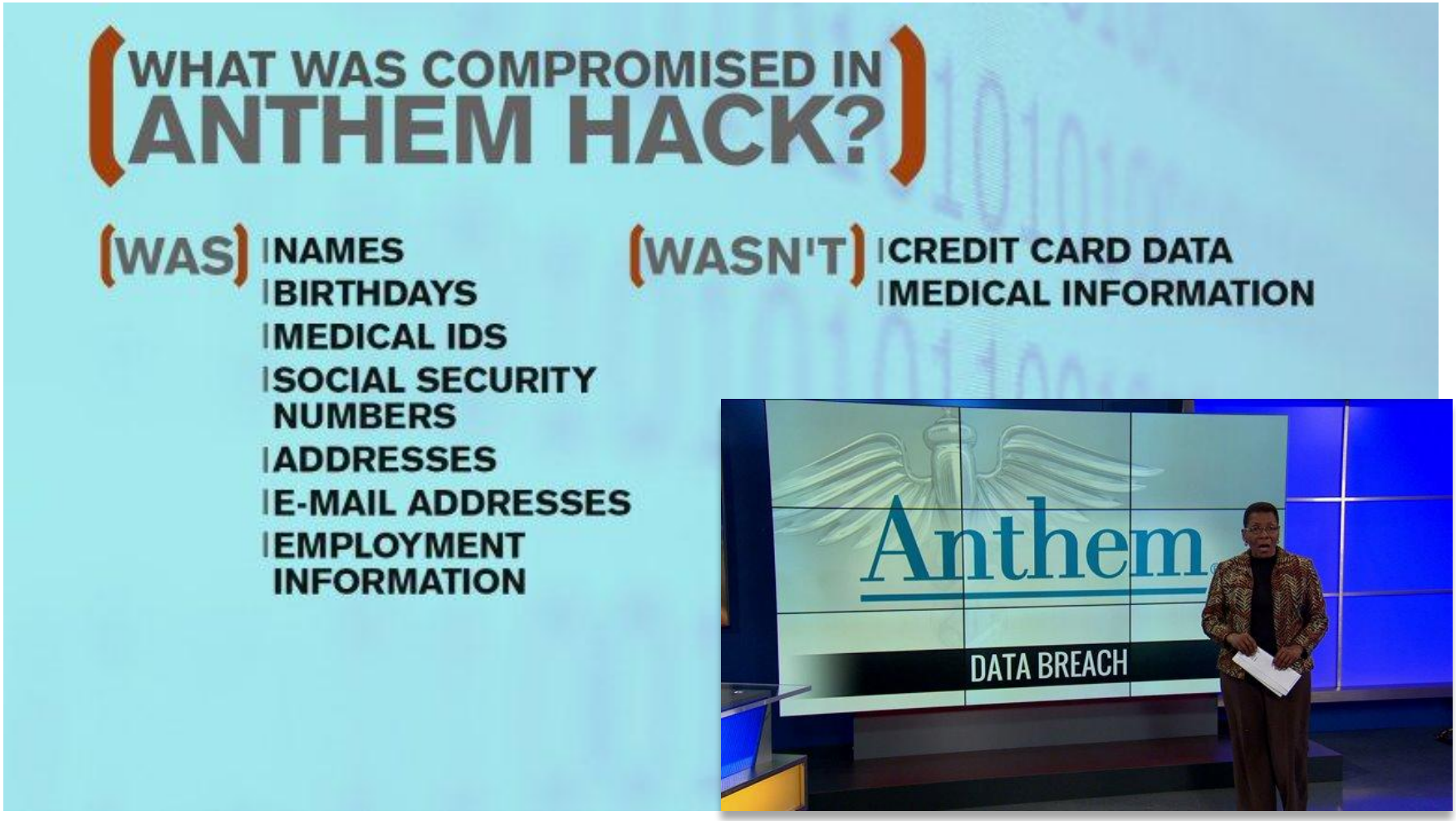

Major Reform Component – Medicaid Expansion

The Act transforms Medicaid into a program to meet the health care needs of the entire non-elderly population with income below 133% of the FPL. Estimate: 18 M additional individuals would be eligible for Medicaid.

Post-ACA: If individual states accept this provision to expand Medicaid, the federal government will cover the 100% of the cost for Medicaid expansion through 2016. In 2017, match is 95%; in 2020, match is 90%

The Act gives HHS has the authority to penalize States that choose not to participate in the Medicaid expansion by taking away their existing Medicaid funding.

Decision: Medicaid expansion violates Congress' spending clause power as unconstitutionally coercive.

Supreme Court Ruling "Gun to the Head"

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Rationale:

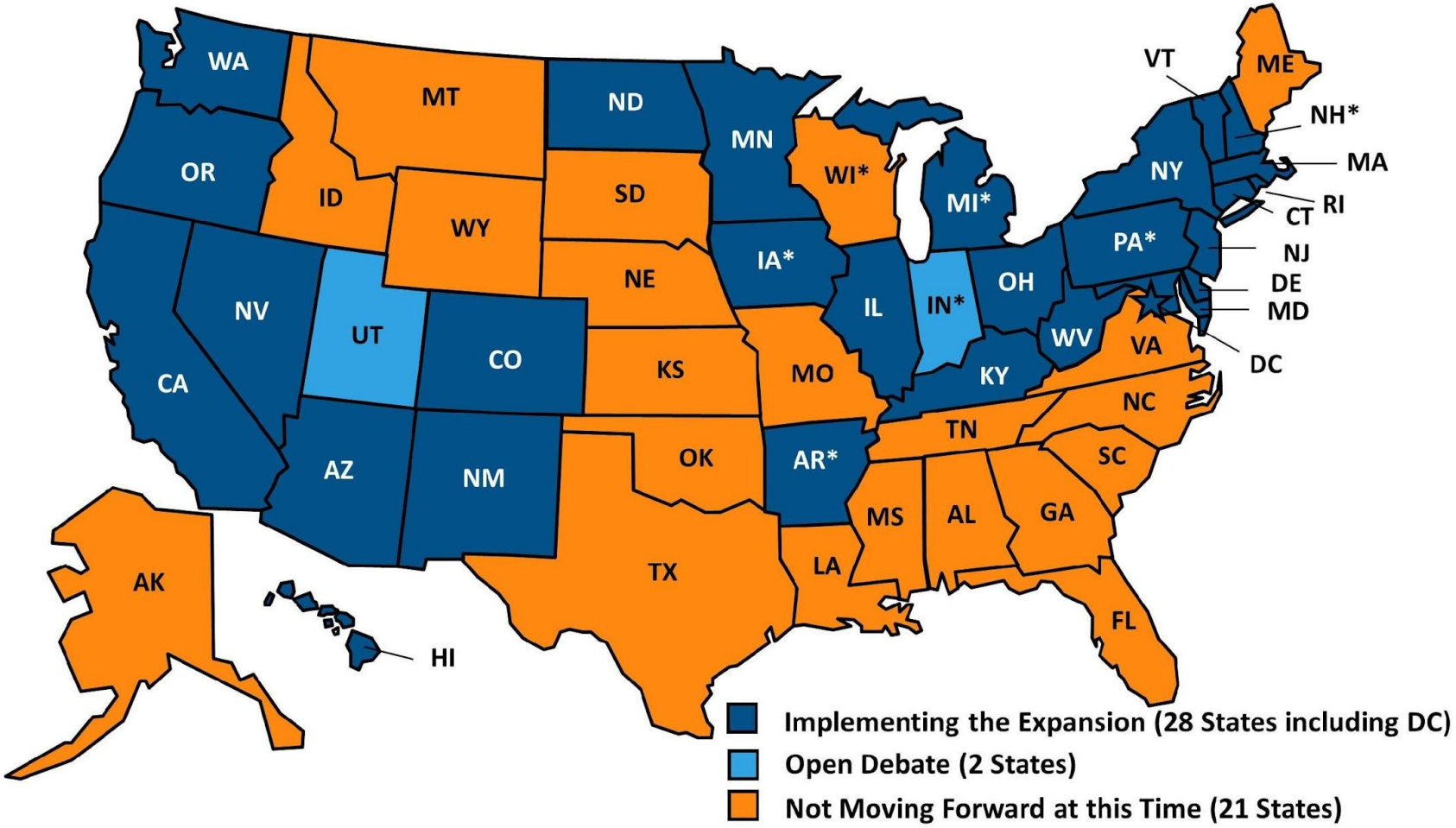
"…the financial "inducement" Congress has chosen is much more than "relatively mild encouragement"—it is a gun to the head. A State that opts out …stands to lose not merely "a relatively small percentage" of its existing Medicaid funding, but all of it. Medicaid spending accounts for over 20 % of the average State's total budget, with federal funds covering 50 to 83 % of those costs."

"*The threatened loss of over 10 percent of a State's overall budget is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion."*

Remedy (to preclude severability):

The constitutional violation is fully remedied by precluding the Secretary of HHS from making all of a state's existing Medicaid funds contingent upon the state's compliance with the ACA Medicaid expansion.

Current Status of State Medicaid Expansion Decisions



NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available here, and KCMU analysis of current state activity on Medicaid expansion.

What if 'Vocal' Republican 6 States Opt out? Covered Lives – FL, LA, MS, NE, SC, TX

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Post-SCOTUS Ruling

INDIVIDUAL COVERAGE	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Insured	32.6	31.3	46.9	48.1	47.3	44.7	42.2	39.3	36.5	33.9
Medicaid	31.7	32.1	38.9	39.6	40.5	41.7	42.8	44.2	45.6	47.1
Uninsured	48.9	50.9	29.6	28.9	29.9	32.6	35.1	37.9	40.4	42.7

GROUP COVERAGE	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Insured	152.6	152.4	145.8	138.6	132.8	133.2	133.9	135.0	136.4	138.1
Take Medicaid Coverage	3.2	3.8	8.7	9.9	11.0	12.0	12.9	13.7	14.4	15.0
Refuse Coverage	5.9	7.2	5.6	6.0	6.5	7.0	7.3	7.5	7.5	7.2
Take Individual Coverage	0.1	0.1	4.9	12.2	18.2	17.8	17.6	17.2	17.0	16.7

TOTAL COVERAGE	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Insured	185.4	183.7	197.7	198.9	198.2	195.8	193.8	191.5	189.9	188.7
Medicaid	34.9	35.9	47.7	49.5	51.5	53.7	55.7	57.9	60.0	62.1
Uninsured	54.8	58.1	35.2	34.9	36.4	39.5	42.5	45.4	47.9	50.0
	275.0	277.7	280.5	283.3	286.1	289.0	291.9	294.8	297.8	300.7

Net Impact	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Insured	0.0	0.0	3.2	2.7	1.9	1.0	0.2	-1.0	-2.2	-3.2
Medicaid	0.0	0.0	-4.4	-4.6	-4.7	-4.9	-5.2	-5.1	-5.0	-4.8
Uninsured	0.0	0.0	1.1	1.9	2.8	3.9	5.0	6.1	7.2	7.9

What if 'Vocal' Republican 6 States Opt out? $$$ Impact – FL, LA, MS, NE, SC, TX

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Post-SCOTUS Ruling

INDIVIDUAL FEDERAL $$	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Insured	$0.0	$0.0	$236.0	$236.0	$237.3	$237.4	$237.7	$227.6	$214.4	$202.1
Medicaid	$105.4	$108.9	$135.9	$141.1	$147.2	$154.3	$161.3	$169.7	$178.7	$188.3
Uninsured	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

GROUP FEDERAL $$	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Insured	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Take Medicaid Coverage	$10.7	$13.1	$31.0	$35.7	$40.4	$45.1	$49.3	$53.5	$57.2	$60.8
Refuse Coverage	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Take Individual Coverage	$0.0	$0.0	$30.6	$30.6	$31.2	$31.1	$31.0	$30.2	$30.2	$30.1

TOTAL FEDERAL $$	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Insured	$0.0	$0.0	$266.7	$266.6	$268.5	$268.5	$268.7	$257.8	$244.6	$232.3
Medicaid	$116.1	$122.0	$166.9	$176.8	$187.6	$199.4	$210.6	$223.1	$235.9	$249.1
Uninsured	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	$116.1	$122.0	$433.6	$443.5	$456.0	$467.9	$479.4	$480.9	$480.5	$481.3

Net Impact	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	
Insured	$0.0	$0.0	$20.1	$22.4	$23.2	$25.8	$31.4	$29.3	$24.0	$19.2	
Medicaid	$0.0	$0.0	-$12.5	-$13.6	-$14.3	-$15.2	-$16.3	-$16.3	-$16.0	-$15.4	
Uninsured	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	
TOTAL	$0.0	$0.0	$7.5	$8.8	$8.9	$10.6	$15.1	$13.0	$8.0	$3.8	$75.8

A Lot of Money to Walk Away From….
Probably Won't in Long Run

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Post SCOTUS PPACA Cost Impact (Billions), Confidential, 7-18-2012

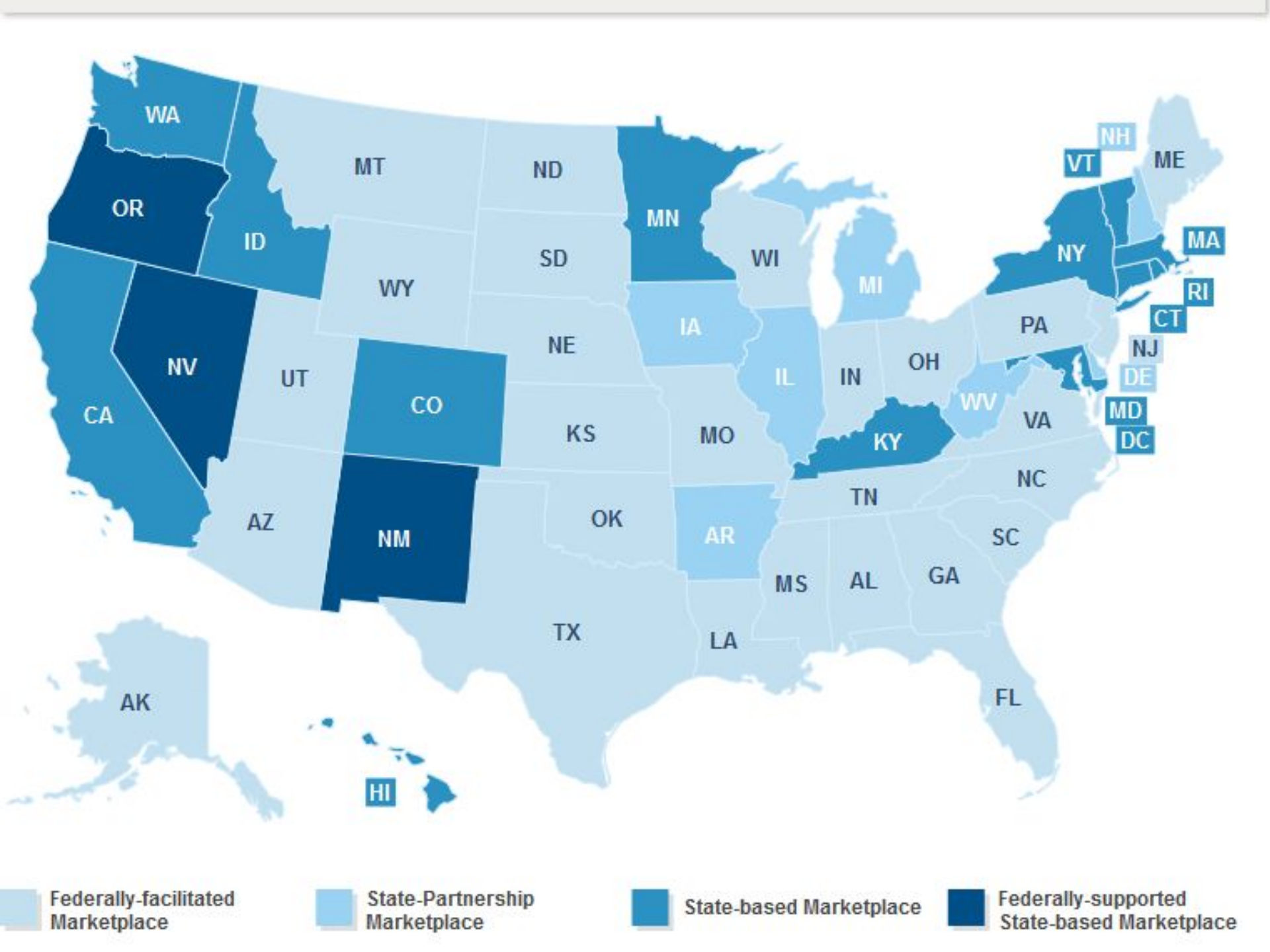
Scenario: All States drop expansion. Medicaid expands through 100% Subsidized Exchanges

	Post SCOTUS Federal Exchange to State $$								Drop in Medicaid $$ to States if they don't Accept Expansion										
									100%	100%	100%	95%	94%	93%	90%	90%	Federal	Drop	Net
STATE	2014	2015	2016	2017	2018	2019	2020	2021	2014	2015	2016	2017	2018	2019	2020	2021	Exchange	Medicaid	Federal
AK	$0.39	$0.38	$0.35	$0.33	$0.32	$0.30	$0.30	$0.27	-$0.04	-$0.05	-$0.07	-$0.04	-$0.11	-$0.13	-$0.17	-$0.16	$2.65	-$1.79	$0.86
AL	$3.35	$3.29	$3.27	$3.32	$3.38	$3.30	$3.30	$3.16	-$0.50	-$0.62	-$0.71	-$0.63	-$0.85	-$0.95	-$1.06	-$1.08	$26.37	-$7.40	$18.97
AR	$2.46	$2.47	$2.50	$2.52	$2.53	$2.41	$2.41	$2.13	-$0.18	-$0.22	-$0.26	-$0.23	-$0.33	-$0.36	-$0.40	-$0.41	$19.42	-$3.40	$16.02
AZ	$3.70	$3.48	$3.43	$3.28	$3.23	$3.08	$3.08	$2.31	$1.57	$1.47	$1.34	$1.51	$1.00	$0.92	$0.56	$0.93	$25.58	$8.30	$33.88
CA	$24.94	$23.95	$23.76	$23.04	$23.19	$21.91	$21.91	$19.03	-$1.28	-$1.53	-$1.85	-$1.55	-$2.51	-$2.77	-$3.16	-$3.01	$181.72	-$18.66	$163.07
CO	$3.77	$3.73	$3.67	$3.52	$3.40	$3.13	$3.13	$2.78	-$0.28	-$0.40	-$0.54	-$0.43	-$0.79	-$0.94	-$1.15	-$1.22	$27.13	-$6.76	$20.36
CT	$1.26	$1.23	$1.18	$1.16	$1.16	$1.12	$1.12	$1.09	-$0.46	-$0.55	-$0.64	-$0.59	-$0.80	-$0.89	-$0.96	-$0.99	$9.33	-$6.86	$2.47
DE	$0.37	$0.36	$0.35	$0.33	$0.31	$0.28	$0.28	$0.21	$0.09	$0.08	$0.06	$0.08	$0.03	$0.03	$0.00	$0.02	$2.48	-$0.60	$1.88
FL	$14.38	$14.09	$13.77	$13.13	$12.57	$11.42	$11.42	$10.34	-$2.53	-$2.90	-$3.21	-$2.77	-$3.79	-$4.17	-$4.74	-$4.84	$101.13	-$29.95	$71.18
GA	$6.82	$6.72	$6.77	$6.77	$6.83	$6.63	$6.63	$6.36	-$2.15	-$2.54	-$3.00	-$2.68	-$3.55	-$3.80	-$4.25	-$4.39	$53.53	-$27.37	$26.16
HI	$0.79	$0.78	$0.74	$0.69	$0.64	$0.56	$0.56	$0.46	$0.25	$0.23	$0.21	$0.24	$0.16	$0.15	$0.10	$0.15	$5.23	$0.50	$5.73
IA	$1.66	$1.60	$1.57	$1.60	$1.63	$1.55	$1.55	$1.46	-$0.22	-$0.28	-$0.34	-$0.30	-$0.44	-$0.49	-$0.53	-$0.54	$12.62	-$4.14	$8.48
ID	$1.14	$1.11	$1.10	$1.06	$1.04	$0.99	$0.99	$0.85	-$0.17	-$0.19	-$0.23	-$0.17	-$0.31	-$0.35	-$0.42	-$0.41	$8.27	-$3.25	$5.03
IL	$7.98	$7.69	$7.22	$6.77	$6.47	$6.13	$6.13	$5.52	-$2.01	-$2.38	-$2.73	-$2.43	-$3.23	-$3.54	-$3.84	-$3.90	$53.92	-$25.06	$28.85
UT	$1.96	$1.88	$1.86	$1.81	$1.77	$1.58	$1.58	$1.30	-$0.06	-$0.08	-$0.10	-$0.05	-$0.18	-$0.19	-$0.28	-$0.25	$13.74	-$2.18	$11.55
VA	$5.82	$5.82	$5.81	$5.84	$5.94	$5.79	$5.79	$5.59	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$46.40	N/A	$46.40
VT	$0.25	$0.23	$0.24	$0.23	$0.23	$0.22	$0.22	$0.17	$0.05	$0.04	$0.03	$0.03	$0.01	$0.01	-$0.01	$0.00	$1.79	-$0.84	$0.95
WA	$4.37	$4.22	$4.14	$3.93	$3.84	$3.61	$3.61	$3.26	-$0.36	-$0.52	-$0.69	-$0.49	-$1.01	-$1.17	-$1.45	-$1.42	$30.98	-$8.11	$22.87
WI	$3.11	$3.02	$2.94	$2.83	$2.74	$2.57	$2.57	$2.33	-$1.06	-$1.27	-$1.50	-$1.38	-$1.81	-$1.96	-$2.09	-$2.14	$22.11	-$14.21	$7.91
WV	$1.63	$1.58	$1.56	$1.51	$1.47	$1.37	$1.37	$1.20	-$0.35	-$0.44	-$0.51	-$0.44	-$0.60	-$0.65	-$0.74	-$0.75	$11.69	-$5.48	$6.21
WY	$0.38	$0.37	$0.36	$0.34	$0.32	$0.30	$0.30	$0.27	$0.01	-$0.01	-$0.02	$0.00	-$0.04	-$0.06	-$0.08	-$0.08	$2.64	-$1.29	$1.35
																	$1,420.95	-$458.83	$962.12

Next Supreme Court Ruling, June 2015

Are Insurance Subsidies Legal in 34 States using Federal Exchange?

- Something like this can be modelled.
- How should I and my merry modelers complete the analysis?
  - Which states sit out?
  - For how will they sit out (years)?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CT
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MD
DC
AK
HI
Federally-facilitated Marketplace
State-Partnership Marketplace
State-based Marketplace
Federally-supported State-based Marketplace

Some Insights from themorningconsult.com (2/11/2015)

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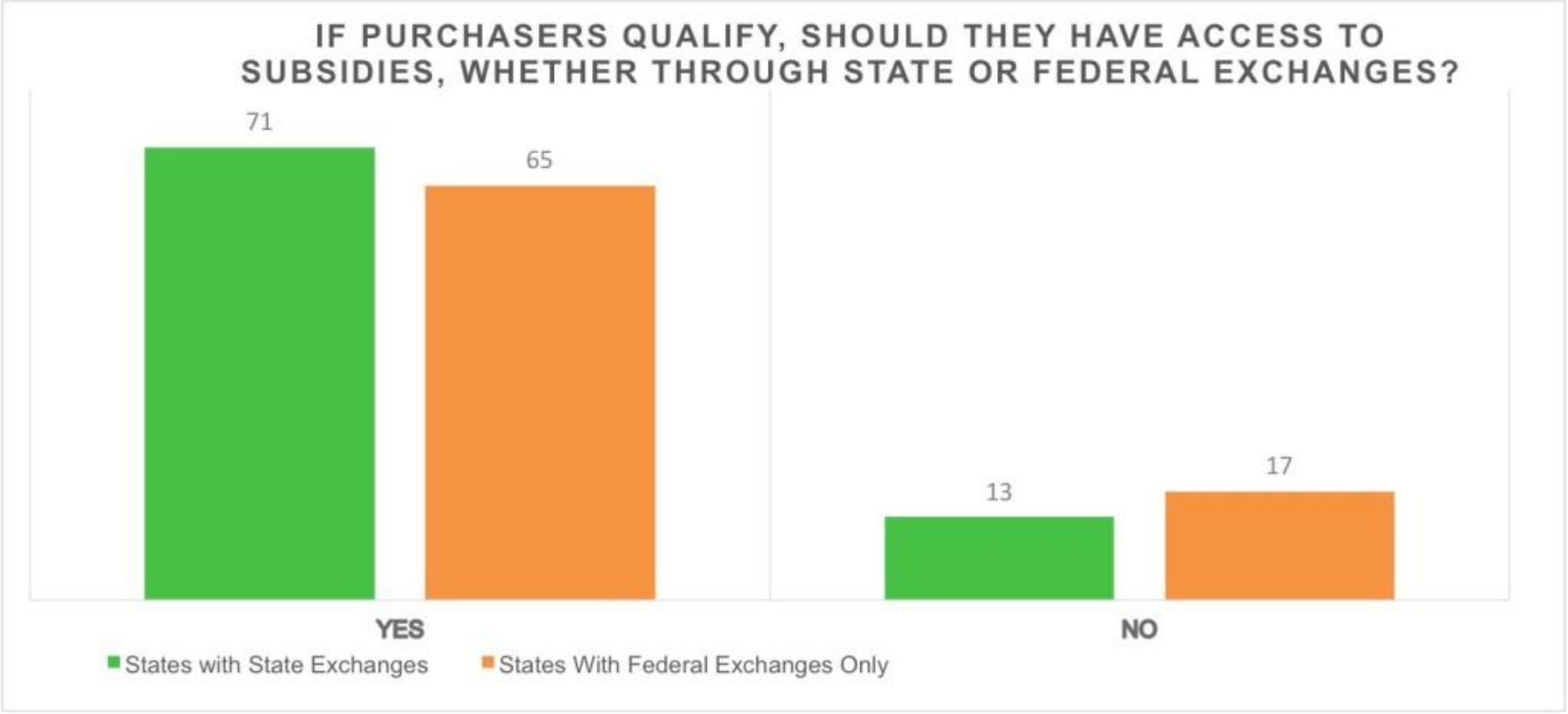

If Asked: A 21st Century Version of Health Insurance Reform

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- Get actuarially certified risk profiles for all insured based on existing data
  - Let people get them like they would a credit report
  - Equifax and Experian are standing by and waiting for the go-switch
- Government and private federal exchanges portals
  - Take risk profiles from (1) and provide a 'lock in' by Internet click
  - Target the younger population not buying coverage today through the web. Brokers handle the rest. Gives brokers time to get a Plan B.
- Where the market fails from (2), auction off the high risk
  - Given (1) and (2), who are the vulnerable and why
  - Target resources to fill the insurance gaps using federal and state resources
- Let the Employer-sponsored market evolve; it's not broken

Details worth watching in Health Reform evolution 2015-16

- Supreme Court Decision in June, 2015 on State Exchanges
- The GOP Unicorn / Replace Plan
- Trojan Horse National Health Insurance / Medicare 4 All
  - Mandate tax ☐ FICA tax for under 65s
- Medical Device Tax repeal
- What States will Take Medicaid expansion
- Benefit inclusions from ACA regs for minimum coverage
- Device manufacturers, Hospital bundled payment and Jedi : (‘these are not the device costs you are looking for”).

Closing Thoughts

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- We are going to get a great natural experiment in economics, political science and law.
- Expansion could become a political football subject to state elections for years to come until an equilibrium is reached.
- 2016 election obviously key for future policy trajectory. But, it just one data point in 100+ year evolution.

Midterm Exam

- Covers materials on PowerPoints
- Short Answer (40%)
- Definitions (30%)
- Essay (30%)
- Extra Credit (up to 10%)