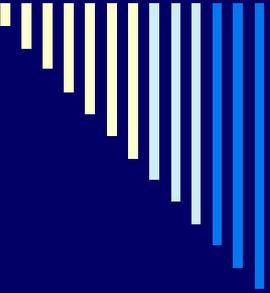


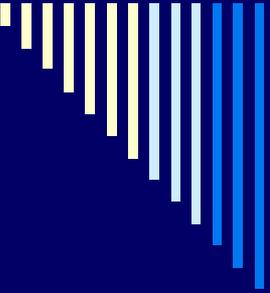
PPACA Basics

By the Hawaii Insurance Division



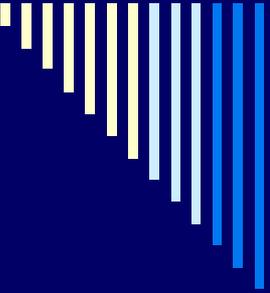
3 health insurance issues

- Access to coverage (uninsured)
 - Quality of coverage (underinsured)
 - Cost of coverage
-



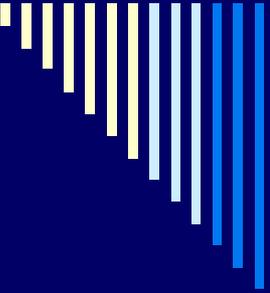
Insurance 101

- Risk transfer
 - Risk pooling
 - Premiums from the many subsidize the losses of a few
 - 80% of healthcare costs driven by 20% of policyholders
 - 50% driven by 5%
-



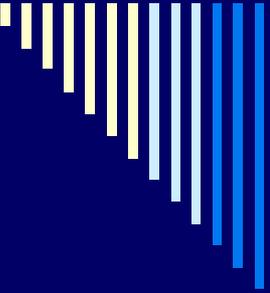
Insurance 101 (cont)

- ❑ Insurance is a pass through
 - ❑ Insurance is middleman
 - ❑ Insurance aggregates and disburses money
 - ❑ Not a bank account
-



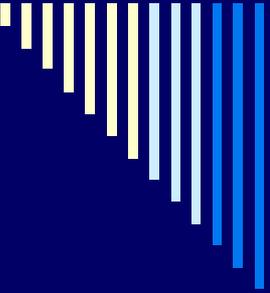
Insurance 101 (cont)

- Adverse selection: people only buy what they need
 - People will buy insurance only when they need it; healthy people stay out; driving up premiums
-



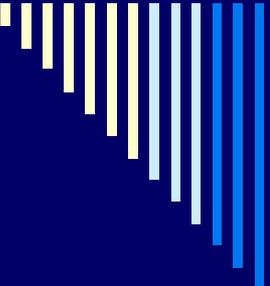
What is ACA trying to solve?

- ❑ Pre-existing condition exclusion in individual policies
 - ❑ Not applicable to group policies
-



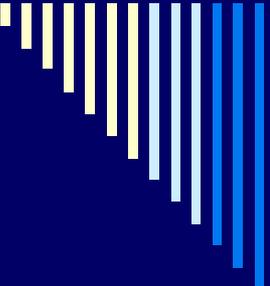
ACA solution

- ❑ Guaranteed issuance
 - ❑ Individual purchase mandate
 - ❑ Subsidies for those between 100% and 400% of FPL
 - ❑ Subsidies on a sliding scale
-



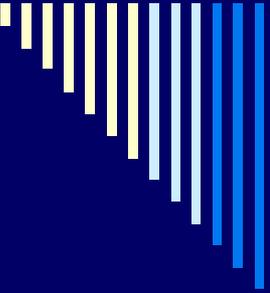
Problem: penalties too low

- If the penalties for the individual mandate are too low, then you get adverse selection and an upwards rate spiral
-



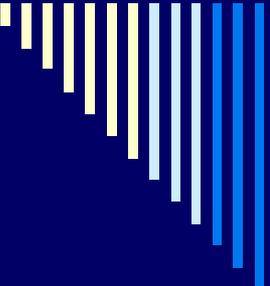
ACA and access to coverage

- ❑ Exchanges to buy on a website
 - ❑ Theory: competition reduces prices (not costs)
 - ❑ Metal levels based on cost-sharing
 - ❑ You must use the exchange to get your subsidy
-



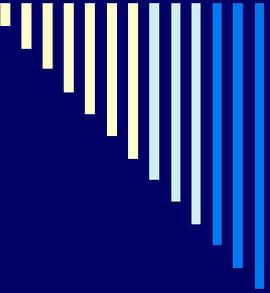
ACA and quality of coverage

- ❑ Essential health benefits—benchmark plan
 - ❑ Increased preventive care coverage
 - ❑ No lifetime limits
 - ❑ No unreasonable annual limits
 - ❑ No rescissions unless fraud
 - ❑ Children up to age 26 can stay on parents' plan
-



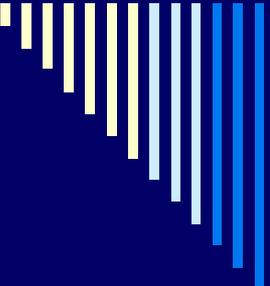
Focus: EHB versus PHCA

- ❑ Prescription drugs
 - ❑ Habilitative services
 - ❑ Pediatric dental
 - ❑ Pediatric vision
 - ❑ Other than that, prevalent plan is the same as the benchmark plan
 - ❑ EHB not applicable to large group
-



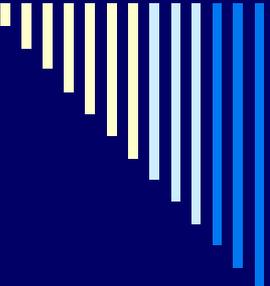
ACA and cost reduction theory

- Reduce emergency room care
 - Broaden risk pool to include more healthy people
 - Increase preventive care to reduce long term chronic care
 - Increase market competition
 - Control administrative costs (maximum loss ratio)
-



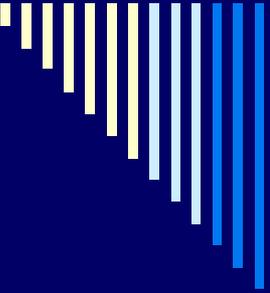
ACA and cost reduction theory

- Accountable care organizations that coordinate care
 - Encouraging use of primary care physicians to cut down on expensive and unnecessary care by specialists
 - Encourage use of electronic medical records
-



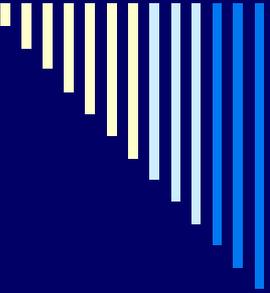
Rating rules: small group and individual markets

- Rating factors: age, family, geographic, smoker
 - Large risk pools: individual vs. small group
 - No utilization rating—means lower rate volatility
-



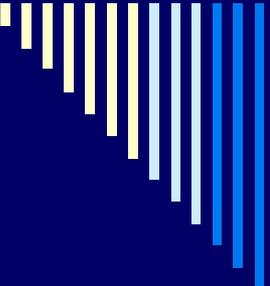
Insurers

- Medical loss ratio (MLR) of 85% for large groups and 80% for small groups and individuals
 - The idea is to keep a lot of money going to healthcare as opposed to administrative costs.
 - Minimum network adequacy standards
-



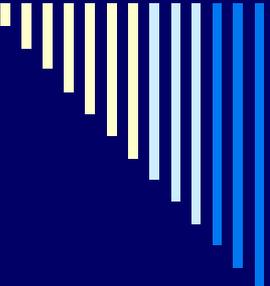
Businesses

- PHCA probably survives
 - On the mainland, large business with 50 employees have to provide health insurance or pay a penalty
-



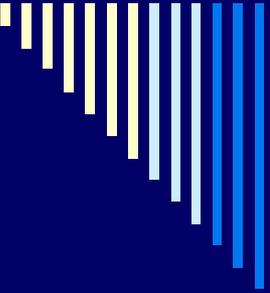
Medicaid expansion

- 133% of FPL
 - Hawaii already there, but a big burden for other States going forward
-



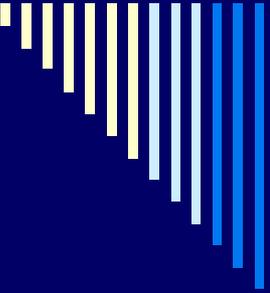
Medicare

- ❑ Cuts in Medicare Advantage
 - ❑ Creation of Independent Payment Advisory Board (IPAB) to do comparative effectiveness decisions and promote cost control
 - ❑ Various healthcare cost control pilot projects
-



Taxes and fees

- Needed to pay for the subsidies
 - About 2% of premium
-



ACA not affordable?

- ❑ Subsidies make it affordable for some
 - ❑ But there will be premium increases due to richer coverage, adverse selection, paying for the subsidies, loading more people onto the system
 - ❑ Healthcare cost increases will continue to be a problem
-