The U.S. Health Care Landscape: Past, Present and Future

October 28, 2015
Epstein Becker Green
EBG Advisors
I. Timelines and Trends
   a. Medicare Managed Care
   b. Health Reform and ICD-10
   c. Mental Health Parity
   d. The Uninsured
   e. Medicaid Enrollment and Medicaid Managed Care
   f. Employers and Unions
   g. Payers
   h. Premiums
   i. State Policy
   j. Medical Loss Ratio
   k. Health Care Status

II. Key Dates Ahead

III. Political and Enforcement Landscapes

IV. Trends to Watch

V. Questions

VI. Appendix
I. Timelines and Trends

50th ANNIVERSARY OF MEDICARE AND MEDICAID
I. Timelines and Trends

**MEDICARE MANAGED CARE**

**Title XVIII**
Title XIX added to Social Security Act

**1965**
Medicare implemented and more than 19 million enrolled

**1966**
SS Amendments of 1972 added HMOs under a limited risk product or pre-paid cost reimbursement

**1972**
Tax Equity and Fiscal Responsibility Act adds the first realistic option for Medicare risk HMOs

**1982**
Medicare+Choice established under the Balanced Budget Act

**1997**
Part D and Medicare Advantage added under Medicare Modernization Act

**2003**
Sep. 2015 -- CMS announces Medicare Advantage Value-Based Insurance Design model test

**2015**
Sep. 2015 -- CMS announces Enhanced Medication Therapy Management model test

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*Medicare Prospective Payment and the American Health Care System, ProPAC, June 1988, p107


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**Total Medicare Beneficiaries (in millions)**

19 21 29 38 41 56

**Total Medicare Beneficiaries in Managed Care (in millions)**

No data No data 0.4* 5 5 18**

I. Timelines and Trends

MEDICARE PROGRAM - FISCAL PRESSURE FROM AGING BABY BOOMERS

Key fact: Former President George W. Bush’s birthday: July 6, 1946 & Former President Bill Clinton’s birthday: August 19, 1946

Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.
Source: CMS Office of the Actuary. 2014
I. Timelines and Trends

HEALTH CARE REFORM

1981 Reagan
1989 GHW Bush
1993 Clinton
2001 GW Bush
2009 Obama
2015

1988
Medicare Catastrophic Coverage Act adds outpatient prescription drug benefit

1989
Clinton Health Reform Initiative – Lessons learned: “faster, smaller”*

1995
Children’s Health Insurance Program/Balanced Budget Act

1997
Outpatient prescription drug benefit under Medicare Part D, Low income subsidy

2001
Affordable Care Act enacted

2009
The Supreme Court upholds the payment of subsidies under federal exchanges

2012
The Supreme Court upholds the constitutionality of the ACA’s individual mandate

I. Timelines and Trends

HEALTH CARE REFORM – WHAT’S NEXT?

2015

- Obama
- Jan. ’15 -- Burwell announces goal of moving 30% of Medicare FFS to value-based payment by 2018
- June 2015 -- CMS announces Chronic Care Joint Replacement bundled payment model
- Supreme Court upholds payment of subsidies in federal exchanges
- ICD-10 Implementation October 1
- CHIP Reauthorization, Through 2017
- 50th vote by the House of Representatives to repeal the ACA
- 50th Anniversary of Medicare and Medicaid

2016

- Health Care Choice Compacts
- Definition of Small Group, at state option, may expand to employers with 51-100 employees (pending President’s signature)

2017

- New President takes office in January
- New President
- Updated EHB Benchmark Plans in Effect
- Implementation of test of Value-Based Insurance Design in Medicare Advantage
- Argument/Decision in U.S. House of Representatives v. Burwell?
- Beginning of Independent Payment Advisory Board
- ACA Section 1332 Exchange Waiver authority takes effect

2021

- 2021

Second Term?

2025

- ??
- 40% Excise Tax on employer-sponsored health coverage takes effect (Cadillac Tax)
- CHIP Reauthorization?
I. Timelines and Trends

HEALTH CARE REFORM – ACA CHALLENGE


- House of Representatives argues that Secretaries Burwell (Department of Health and Human Services) and Lew (Department of the Treasury) have
  - Spent billions of unappropriated dollars for cost sharing reduction payments, and
  - Through implementing regulations, have effectively amended the ACA’s employer mandate by delaying its effect and narrowing its scope

- The Secretaries moved to dismiss the case, arguing that the House of Representatives does not have standing to sue and that only the Executive branch can implement the law

- On September 9, 2015 the Court found that the House has standing to sue on the appropriations claim but not on the question of improperly amending the employer mandate:
  
  The genius of our Framers was to limit the Executive’s power “by a valid reservation of congressional control over funds in the Treasury.” *OPM v. Richmond*, 496 U.S. 414, 425 (1990). Disregard for that reservation works a grievous harm on the House, which is deprived of its rightful and necessary place under our Constitution. The House has standing to redress that injury in federal court.

- This decision enables the case to proceed on the merits of the appropriations claim.
I. Timelines and Trends: What’s Next?

ICD-10 – GOES LIVE OCTOBER 1, 2015

- Recent CMS ICD-10 test results show that 87% of submitted ICD test claims were accepted by CMS contractors during the final week of end to end testing.
  - Tested claims included:
    - 52.7% professional claims
    - 40.9% institutional claims
    - 6.4% suppliers claims
- Among the errors caught, .8 percent were rejected due to an invalid ICD-10 code, while 2.6 percent were rejected because they included an ICD-9 code.
- Additional rejections were unrelated to the use of ICD-10 codes, and included providers using incorrect National Provider Identifiers, invalid places of services and dates of services that did not qualify.
- Bottom line- no ICD 10 test claims were rejected due to problems with CMS processing systems and the testing did not uncover new ICD 10 problems.
- The original start date was supposed to have been October 2013.

I. Timelines and Trends

MENTAL HEALTH PARITY

1996
Mental Health Parity Act – Addressed aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits offered by group health plans

1997
Balanced Budget Act – Applied aspects of MHPA to Medicaid managed care organizations and CHIP benefits

1998
CMS issuance of guidance on application of MHPA to Medicaid and CHIP managed care

2008

2009

2010

2015

Mental Health Parity and Addiction Equity Act – financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits

CHIPRA – Applied MHPAEA to CHIP state plan services

ACA – Applied MHPAEA to Medicaid Alternative Benefit plans

HHS MHPAEA proposed regulations applicable to Medicaid managed care

HHS MHPAEA interim final regulations applicable to private health insurance
I. Timelines and Trends

THE UNINSURED

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC</td>
<td>14.8%</td>
<td>15.4%</td>
<td>16%</td>
<td>15.3%</td>
<td>14.7%</td>
<td>14.8%</td>
<td>11.9%</td>
<td>9.2%</td>
</tr>
<tr>
<td>Census</td>
<td>14.9%</td>
<td>16.1%</td>
<td>16.3%</td>
<td>15.7%</td>
<td>15.4%</td>
<td>13.4%</td>
<td>10.4%</td>
<td>No Data</td>
</tr>
</tbody>
</table>

CBO Projection* | 16.9% | 17.0% | 18.7% | 19.3% | 19.7% | 20.2% | 15.6% | 13% |

NOTE: CDC and Census numbers reflect uninsured of all ages. CBO data reflect author’s calculation of percentages based on CBO projections of effect of health reform on number of non-elderly uninsured for 2009-2015.
I. Timelines and Trends

WHERE WERE THE UNINSURED AND WHERE ARE THEY NOW

Uninsured, All Ages, By State, 2009, 2012, And 2013

<table>
<thead>
<tr>
<th>Top 6 States</th>
<th>2009</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Date of any Medicaid Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Uninsured</td>
<td>46.3 M</td>
<td>45.2 M</td>
<td>44.3 M</td>
<td>36.7 M</td>
<td></td>
</tr>
<tr>
<td>2. Texas</td>
<td>6.44 M</td>
<td>5.76 M</td>
<td>5.75 M</td>
<td>5.0 M</td>
<td>None</td>
</tr>
<tr>
<td>3. Florida</td>
<td>4.17 M</td>
<td>3.82 M</td>
<td>3.85 M</td>
<td>3.2 M</td>
<td>None</td>
</tr>
<tr>
<td>5. Georgia</td>
<td>1.93 M</td>
<td>1.80 M</td>
<td>1.85 M</td>
<td>1.6 M</td>
<td>None</td>
</tr>
</tbody>
</table>

## I. Timelines and Trends

### MEDICAID ENROLLMENT

<table>
<thead>
<tr>
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<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Total Enrollment</strong></td>
<td>22</td>
<td>22</td>
<td>33</td>
<td>45</td>
<td>55</td>
<td>66</td>
<td>72</td>
</tr>
<tr>
<td><strong>Medicaid Managed Care</strong></td>
<td>No data</td>
<td>1</td>
<td>10</td>
<td>29</td>
<td>40</td>
<td>44</td>
<td>46</td>
</tr>
<tr>
<td><strong>Traditional Medicaid</strong></td>
<td>22</td>
<td>22</td>
<td>24</td>
<td>17</td>
<td>16</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td><strong>Medicaid Expansion</strong></td>
<td>None</td>
<td>None</td>
<td>1</td>
<td>0°</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

Affordable Care Act enacted

Health Insurance Exchanges and insurance subsidies available

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*Enrollment was above zero but under 500,000, thus was rounded down.
I. Timelines and Trends

MAP OF EXCHANGES AND EXPANSIONS (FEDERAL, STATE-RUN, FEDERAL PARTNERSHIP AS OF 9/1/2015)

Current Status of State Individual Marketplace and Medicaid Expansion Decisions

- **State-based Marketplace and Adopted the Medicaid expansion (16 States including DC)**
- **State-based Marketplace and Not Adopting the Medicaid expansion at this Time (1 State)**
- **Federally-Facilitated or Partnership Marketplace and Adopted the Medicaid Expansion (15 States)**
- **Federally-Facilitated or Partnership Marketplace and Not Adopting the Medicaid Expansion at this Time (19 States)**

**NOTES:** *NM, NV, and OR are federally-supported state-based Marketplaces in 2015. **MT legislature passed legislation adopting the expansion, it requires federal waiver approval.

I. Timelines and Trends

MEDICAID MANAGED CARE

- Section 1115 added to Social Security Act to allow for waiver of program requirements for pilot or experimental projects (1962)
- Medicaid Program enacted (1965)
- OBRA added 1915(b) freedom of choice waivers and replaced 50/50 with 75/25 rule (1973)
- Health Maintenance Organization Act (1976)
- Arizona granted the first statewide Medicaid managed care waiver under Section 1115 (1981)
- Balanced Budget Act allows for mandatory managed care without waiver and eliminates 75/25 rule (1991)
- Oregon statewide Medicaid managed care waiver approved, allowed for service prioritization (1994)
- CMS releases revisions to the Medicaid managed care rules (1997)
- CMS releases first Proposed comprehensive changes to the Medicaid managed care rules in 13 years (2002)
- ACA extends Medicaid drug rebate program to managed care, allows for expansion up to 138% of Poverty (2010)
- Balanced Budget Act allows for mandatory managed care without waiver and eliminates 75/25 rule (2015)
I. Timelines and Trends

EMPLOYERS AND UNIONS

- Direct contracting
  - Employers bidding directly with health systems

- Narrow networks
  - Being chosen by more employers to keep costs down
  - Added by NCQA to accreditation standards

- Medical tourism
  - According to the CDC, up to 750,000 US residents travel abroad for care each year
  - Some employers contract directly with specialty US facilities and pay for employees to travel to the relevant State/City for care

- Focus on drug costs
  - Employers directing employees to particular specialty pharmacies for expensive drugs

- Wellness programs*
  - Seventy-four percent of U.S. employers that provide health benefits offer at least one wellness program
  - For large firms with 200 or more employees, 98 percent offer at least one wellness program

I. Timelines and Trends

PAYERS

- Mergers
  - Largest managed care companies seek to expand their footprint through merger
  - Insurers claim mergers will create economies of scale and benefit provider organizations
  - Health systems and providers are opposed
    - E.g., AMA, AHA and the American Academy of Family Physicians wrote to Congress and the DOJ to express concern

- Narrow networks
  - Trying to keep costs down
  - Thirty nine percent of 2015 Exchange plan networks are narrow or ultra-narrow, based on hospital availability*
  - Forty one percent of 2014 Exchange silver plans were small or extra small based on the size of their physician network**

- Shifting of risk
  - Move to value-based payment and value-based insurance design


I. Timelines and Trends

**PREMIUMS**

- State regulators approving large premium increases for 2016 Exchange plans
  - Florida – approved average 9.5 % increase
  - Iowa – approved 19.8% average increase for state’s largest carrier
  - Montana – approved average 23 % increase
  - Kansas – Premiums could rise as much as 25.4 %
- Other analyses show more moderate increases
- Increases driven by*
  - Increase in health care costs
  - Reduction in reinsurance payments
  - Resolving assumptions as to risk pool from 2015 rates
  - CMS pressing states to be more strict in granting premium increases

I. Timelines and Trends

STATE POLICY TRENDS

- Transparency – States requiring:
  - Providers to report on price and quality
  - Payers to include more comprehensive information on prescription drug formularies

- Consumer Protections for
  - “Surprise bills”
    - Disclosure on provider participation
    - Negotiated dispute resolution between provider and enrollee
  - Narrow Networks
    - Increased disclosure and requirements regarding access
      - See, e.g., recent Texas legislation protects a preferred provider’s ability to inform patients about their out-of-network provider choices
  - Participating Provider Directory
    - Include information such as provider gender, acceptance of new patients
I. Timelines and Trends

MEDICAL LOSS RATIO

Medical Loss Ratio (MLR) Formulas:
Traditional MLR and Affordable Care Act (ACA) MLR

- Traditional MLR = Health Care Claims / Premiums
- ACA MLR = Health Care Claims + Quality Improvement Expenses / (Premiums - Taxes, Licensing & Regulatory Fees)

- Applies to all types of licensed health insurers, on and off of the Exchanges, EXCEPT self-funded
- Applies to all of an insurer’s underwritten business (i.e., when risk is transferred to the insurer in exchange for premium), including grandfathered plans
- Individual/Small Group Markets – 80%
- Large Group Market – 85%
- Medicare plans – 85%
- Medicaid plans – 85% (proposed)
I. Timelines and Trends

MEDICAL LOSS RATIO

<table>
<thead>
<tr>
<th></th>
<th>CY 2012</th>
<th>CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Amount of MLR Refunds</td>
<td>$504,157,712</td>
<td>$332,152,474</td>
</tr>
<tr>
<td>Paid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Consumers who</td>
<td>8,517,869</td>
<td>6,816,423</td>
</tr>
<tr>
<td>Received MLR Refunds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average MLR Refund Paid</td>
<td>$98</td>
<td>$80</td>
</tr>
</tbody>
</table>


- GAO study:
  - In 2011 and 2012, more than ¾ of insurers met or exceeded the MLR standards
  - Insurers in large group market had higher median MLRs and spent a higher share of their premiums on enrollees’ claims and less on non-claims costs when compared with insurers in the individual and small group markets

I. Timelines and Trends

HEALTH CARE STATUS TRENDS

- 2014 study indicates that since 2010, young adults ages 19 to 25 are now:
  - 7.2% more likely to have health insurance;
  - 6.2% more likely to report “excellent physical health”; and
  - 4% more likely to report “excellent mental health”


- Increase in personal health information tracking
- Emphasis on consumer engagement using game theories and other social science theories
II. Key Dates Ahead

- ICD-10 Implementation – Oct. 1, 2015
- OIG Work Plan – Oct./Nov. 2015
- Definition of small employer expands to include those with up to 100 employees – Jan. 1, 2016
- CMS CCJR bundling demonstration proposed implementation – Jan. 1, 2016
- Premium filings for new 2017 commercial plans – Second Quarter 2016
- MLR reporting for 2015 – Due July 31, 2016
- Presidential election – Nov. 2016
- Presidential swearing in – Jan. 21, 2017
- Cadillac Tax becomes effective – Jan. 1, 2018
### III. Political Landscape

<table>
<thead>
<tr>
<th></th>
<th>113(^{\text{rd}}) Congress</th>
<th>114(^{\text{th}}) Congress</th>
<th>115(^{\text{th}}) Congress Beg. 1/3/17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Senate</strong></td>
<td>55 Democrats* 45 Republicans</td>
<td>46 Democrats* 54 Republicans</td>
<td>??</td>
</tr>
<tr>
<td><strong>House of</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Representatives</strong></td>
<td>233 Republicans 205 Democrats 3 Vacant</td>
<td>246 Republicans 188 Democrats 1 Vacant</td>
<td>??</td>
</tr>
</tbody>
</table>

*Includes 2 independents who caucus with the Democrats

**White House**

Bush – 8 Years R | Obama – 8 years D | ?? 4 years ?
III. Enforcement Landscape

- Focus on medical record documentation and risk adjustment data
  - Qui Tam suits regarding plan sponsors’ lack of sufficient documentation of diagnoses submitted to CMS for use in risk adjustment
    - One case is pending against plan sponsor as well as against certain of its downstream vendors (See Appendix)
  - OIG work plan includes a focus on risk adjustment documentation and use of external risk adjustment consultants

- Increase in severity of enforcement actions by CMS in MA/Part D

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015 (through Aug.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans subjected to CMPs</td>
<td>10</td>
<td>35</td>
<td>16</td>
</tr>
<tr>
<td>Total value of CMPs</td>
<td>$956,505</td>
<td>$5,089,750</td>
<td>$3,906,920</td>
</tr>
<tr>
<td>Average CMP imposed</td>
<td>$95,651</td>
<td>$145,421</td>
<td>$244,183</td>
</tr>
</tbody>
</table>

- State enforcement activities on mental health parity beginning to increase
- **On Sep. 9, 2015, DOJ announced a new initiative to hold more individuals liable for corporate misconduct**
- Move towards having Corporate Compliance Officer report directly to the Board of Directors
IV. Trends to Watch in 2016 & Beyond

- Increased plan reliance on narrow networks
- State efforts to protect consumers from “surprise bills”
- Expansion of value-based purchasing
- Increased plan use of Value-Based Insurance Design
- Additional mergers/provider consolidation
- Growing acceptance of telehealth
IV. Trends to Watch in 2016 & Beyond

- Shifts in the health status of the population
- Changes in the way health services are delivered
- Payment methods that bundle payments; pay for efficiencies or “savings”; aggregate payments
- Malpractice reform
- Changes in consumer engagement and consumer preferences (e.g., end-of-life services)
- Advances in medical technology (disruption and adoption)
- Advances in timely access to quality and cost data/Transparency/Individual responsibility
- Health care workforce
- Political/fiscal discipline (e.g., Independent Payment Advisory Board)
EBG As A Resource For Clients

- Visit the www.ebglaw.com website for the various alerts we have published on a wide range of issues related to health reform and the Medicare and Medicaid programs
VI. APPENDIX

MEDICARE – PAY FOR VALUE

- Comprehensive Care for Joint Replacement Model
  - Bundled payment for hip and knee replacement
  - Mandatory participation
  - All hospitals in 75 Metropolitan Statistical Areas
  - Comment period closed Sep. 8, 2015
  - Additional information at http://innovation.cms.gov/initiatives/ccjr/

- Accountable Care Organizations
  - Pioneer ACO Model – for health care organizations and providers with experience in coordinating care for patients across care settings
    - Must accept risk for 15,000 Medicare beneficiaries (5,000)
    - Involves greater risk than the Medicare Shared Savings Program but allows for larger rewards
    - Participation dropped from 32 entities in 2012 to 20 entities in 2015
  - Medicare Shared Savings Organizations – Participants in the Shared Savings Program receive advance payments to be repaid from the future shared savings they earn.
  - In 2014, 20 Pioneer and 333 Shared Savings Program ACOs generated more than $411 million in savings, which includes all ACOs savings and losses, see https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-25.html
    - Additional information at http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/
VI. APPENDIX

MEDICARE – PAY FOR VALUE

- Bundled Payment Initiative – Four models
  - Model 1 – Episode of care defined as the inpatient stay in the acute care hospital. Medicare pays hospital a discounted amount based on rates under the Inpatient Prospective Payment System and continues to pay physicians separately for their services under the Medicare Physician Fee Schedule.
  - Models 2 and Model 3 – Both involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care.
    - Model 2 – Episode of care includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge.
    - Model 3 – Episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency.
    - Under both models, Medicare continues to make FFS payments; the total expenditures for the episode are later reconciled against a bundled payment target amount, with Medicare then making a payment or recoupment to reflect the aggregate expenditures as compared to the target amount.
  - Model 4 – Bundle includes all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay, for which CMS makes a single, prospectively determined bundled payment to the hospital. Physicians and other practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled payment.
  - First phase participants do not bear risk; more than 2100 transitioned to phase 2 risk bearing.
  - Additional information at http://innovation.cms.gov/initiatives/Bundled-Payments/
VI. APPENDIX

VALUE-BASED INSURANCE DESIGN MODEL TEST IN MEDICARE ADVANTAGE

- To begin Jan. 1, 2017 and run for 5 years
- Will operate in seven pilot states – Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee
- Participating plans will choose one of the following interventions targeting MA enrollees with one or more specific chronic conditions:
  - Reduced Cost Sharing for High-Value Services
  - Reduced Cost Sharing for High-Value Providers
  - Reduced Cost Sharing for Enrollees Participating in Disease Management or Related Programs
  - Coverage of Additional Supplemental Benefits
- Targeted conditions may include:
  - Diabetes
  - Chronic Obstructive Pulmonary Disease (“COPD”)
  - Congestive Heart Failure
  - Patient with Past Stroke
  - Hypertension
  - Coronary Artery Disease
  - Mood Disorders
- Award process is not competitive – all qualified plans in the pilot states can participate
VI. APPENDIX

UPDATED EHB BENCHMARKS

- Current State EHB Benchmarks apply for the 2014 to 2016 plan years
- Through an information request published on Feb. 27, 2015, CMS requested that states submit form filings for their updated benchmark plan selection
- Comment period on proposed benchmark plans closed Sept. 30, 2015
- Updated benchmark plans will be effective starting plan year Jan. 1, 2017
- Because EHB benchmark plans will be based on plans that were sold in 2014, some of the benchmark plan designs may not comply with current federal requirements, which could include the requirements on:
  - Annual and Lifetime Dollar Limits
  - Coverage Limits
  - EHB Benchmark Plan Prescription Drug Coverage by Category and Class
  - Excluded Benefits
  - Habilitative Services and Devices
  - Mental Health Parity
  - Preventive Services
  - State-Required Benefits
VI. APPENDIX

THE THREE RS – RISK ADJUSTMENT, REINSURANCE AND RISK CORRIDORS

- Risk Adjustment (Permanent)
  - To combat overall adverse selection since health insurance is now guaranteed issue, carriers cannot impose pre-existing conditions limitations, and cannot vary premiums based on individual’s health status
  - Compares insurers within a state based on the average financial risk of their enrolled population; payments are made to insurers who cover a higher-risk population (e.g., people who are older, sicker or have more chronic conditions)

- Transitional Reinsurance Program (2014-2016)
  - To stabilize premiums in the individual market during the first 3 years of Exchange operations, because higher-cost (sicker) individuals are more likely to enroll early
  - Once insurer has paid up to an attachment point in claims for an individual, the insurer is reimbursed for a percentage of costs above the attachment point and up to an upper limit
    - 2014: Attachment point of $45k after which the insurer was reimbursed for 80% of costs between $45k & $250k/person
    - 2015: Attachment point of $45k after which the insurer will be reimbursed for 50% of costs between $45k & $250k/person
    - 2016: Attachment point of $90k after which the insurer will be reimbursed for 50% of costs between $90k & $250k/person

- Temporary Risk Corridor Program (2014-2016)
  - To limit QHP issuer gains and losses in first 3 years, due to lack of data on which to set prices
  - If actual claims are:
    - within 3% of expected claims, insurers in Exchanges keep the profits or bear the risks
    - 3-8% more (or less) than expected, insurer pays/is reimbursed by the gov’t 50% of the gains (losses) and keeps (or bears the loss of) the other 50%
    - at least or > 8% more (or less) than expected, insurer pays the gov’t (or is reimbursed by the gov’t) 80% of the gains (losses) and keeps (or bears the risk of) the other 20%
VI. Appendix

ENFORCEMENT RESOURCES

VI. Appendix

RISK-ADJUSTMENT CASES

- **Graves v. Plaza Medical Centers, et al., Case Number: 1:10-cv-23382, Florida Southern District Court**
  - Against plan sponsor, individual physician and physician practice

- **United States v. Walter Janke, MD, et al. (2012)**
  - Government sued under FCA for submission of upcoded diagnoses codes to increase risk adjustment scores
  - Settled with DOJ = $22.6 million

- **United States and State of California ex rel. Swoben v. SCAN Health Plan (2012)**
  - Relator alleged ScanHealth inflated risk adjustment scores
  - Settled with DOJ = $3.82 million