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## Wendell Potter

Analyst at MSNBC and the Center for Public Integrity

# Why Health Insurers Are Counting on the Supreme Court to Uphold ObamaCare

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If there is a group of people more anxious about how the Supreme Court will rule on the health care reform law than President Obama and the millions of Americans who are already benefiting from it, it is health insurance executives.

Not only have their companies been spending millions of dollars implementing the parts of the law that pertains to them -- and most of them do -- but they also have been counting on the law as very possibly the only thing that can preserve the free market system of health insurance in this country. This is why it is so ironic that defenders of the free market are the most vocal critics of the law and the ones hoping most ardently that the Court will declare it unconstitutional.

Health insurers have known for years that their business practices of excluding growing numbers of Americans from coverage and shifting more and more of the cost of care to policyholders are not sustainable over the long haul. That's why their top priority during the health care reform debate was to make sure whatever bill Congress passed included the much-vilified individual mandate. And it's also why the big insurance companies have been working almost frantically to reinvent themselves lately.

Cigna and Aetna recently became the latest of the biggest national firms to rebrand themselves and roll out new logos and self-descriptions. Cigna is now "a global health service company" while Aetna is now "one of the nation's leading health care benefits companies." What this means is that these companies and their competitors have come to understand that the very policies that enabled them to make Wall Street-pleasing profits over several years has led to a health insurance marketplace that is shrinking. And as it continues to shrink, so will their profit margins.

Cigna and Aetna and a handful of other companies got to be the giants they are today largely by acquiring scores of their smaller competitors in the 1990s and 2000s. Their acquisition strategy now is very different because they know the glory days of being able to report profits every quarter that are greater than what they reported a year earlier, which shareholders demand, are over. So instead of acquiring other insurers, the big firms are now diversifying by buying data and care management businesses and, to the alarm of many consumer advocates, hospitals and physician groups.

They are doing this because they have failed miserably at expanding coverage and controlling skyrocketing medical costs, as they promised they could do as they were torpedoing Bill and Hillary Clinton's health care reform bill two decades ago. Even though they hated many of the Clintons' proposals, they recognized even then that government intervention in the health insurance business would be necessary, that we couldn't rely solely on them or the free market to fix our broken system.

Here's what Karen Iagni, who heads America's Health Insurance Plans, the industry's largest PR and lobbying group, told a Congressional panel in the fall of 1993:

The need for national health care reform has been well documented... Universal coverage at broadly affordable cost becomes possible only when insurance risks are spread across a large community. Currently, most health coverage is priced using "experience rating," where high premiums are set for high cost groups and low premiums are set for low cost groups. Experience rating financially discriminates against populations that experience high costs: the very young, the very old, the chronically ill, and those with pre-existing conditions, such as diabetes.

And here's what Larry English, the former president of Cigna HealthCare, told that same Congressional committee:

There are many specifics in the President's plan we believe should be supported enthusiastically. Among them are universal coverage, portability, the elimination of pre-existing condition limitations, the elimination of cream-skimming and cherry picking underwriting practices, the use of community rating, a standard benefit plan and malpractice reform.

When it became clear, however, that some of the regulations the Clintons were proposing might curtail profits, the insurers began to disown what they had told Congress. They embarked on a campaign to persuade the public that the "invisible hand of the market," as English said in a speech the next year, would do a much better job of controlling costs and expanding coverage than the Clinton plan.

When the Clinton bill died in Congress, that invisible hand went to work. But it proved to be so ham-fisted that physicians and patients soon rebelled. As it turned out, people didn't like being required to change doctors, as many of them had to do. And women didn't like being forced out of the hospital within hours of having a baby or undergoing a mastectomy. So insurers had to ditch many of the practices that presumably would bring down health care costs.

The free-market solution the insurers came up with after the failure of managed care was to herd people into high-deductible plans, just as they herded us into restrictive HMOs 20 years ago. The problem, of course, is that the insurers have to keep increasing both premiums and deductibles to keep meeting Wall Street's profit expectations. It doesn't take a rocket scientist to see how that is not a sustainable strategy -- unless, of course, the government requires all of us buy coverage and gives subsidies to people who can't afford the premiums on their own.

Without the individual mandate, so loathed by free market lovers, the pool of people willing and able to buy coverage will continue to shrink, as will insurers' profit margins. Over the coming years, that pool will become increasingly older and sicker, meaning premiums will soar. Insurers will begin to desert the marketplace. They will not go out of business, but, as their acquisition strategy shows, they will be very different companies.

Insurance executives know they will have to transform their companies even more rapidly -- and get out of the risk business sooner rather than later -- if the individual mandate is struck down. They have run out of silver bullets. As for those who believe the free market can work in health care just as well as any other sector of the economy, they will see, if the Court declares the law unconstitutional, that it simply does not.

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The New York Times

## Economix

Explaining the Science of Everyday Life

MARCH 30, 2012, 6:00 AM

# The Supreme Court and the National Conversation on Health Care Reform

By UWE E. REINHARDT

*Uwe E. Reinhardt is an economics professor at Princeton. He has some financial interests in the health care field.*

Once again America is having one of its “national conversations” on health care reform. This time the buzz is over arguments before the Supreme Court on the constitutionality of certain provisions in the Affordable Care Act. The justices’ rulings will be landmark decisions, because they will indirectly go much beyond the act itself to our entire system of governance.

Today’s Economist

Perspectives from expert contributors.

A fine synopsis of the issues now before the court is provided in a report by the Henry J. Kaiser Family Foundation. The following decision tree illustrates the logical sequence of decisions.

The two major substantive decisions the Supreme Court has to make are:

1. Whether Congress has the constitutional authority to mandate every legal resident in the United States to have insurance coverage for a specified package of health benefits (hereafter the “mandate”) or whether that is an issue for the states to decide.
2. Whether Congress has the constitutional authority to expand eligibility for Medicaid benefits from the highly varied income thresholds that currently define eligibility to anyone under 133 percent of the federal poverty level (hereafter the “Medicaid expansion”).

**Severability:** If the court ruled that either the Medicaid expansion or the mandate, or both, were unconstitutional, it would then have to decide, for each provision, whether striking it down invalidated the entire Affordable Care Act or whether only the stricken provision was invalidated.

The legal jargon for this issue is “severability.” To avoid having entire laws invalidated over one provision that may be found unconstitutional by the

court, legislation typically includes an explicit severability clause. For either strategic reasons or inadvertently, such a clause was not included in the Affordable Care Act.

The Supreme Court devoted a session of argument on Wednesday to this issue, and the questioning by the justices suggested a range of opinions on the issue, so what the future of the entire law may be is uncertain.

**The Anti-Injunction Act:** To rule on the mandate, the court will first decide whether the Anti-Injunction Act of 1867 applies to the mandate. The crucial issue here is whether the penalty exacted from individuals who choose not to obey the mandate to be insured is to be construed as a mere penalty or a genuine tax.

If the latter, under the Anti-Injunction Act the court should hear the case and rule on it only after someone has actually been forced to pay the penalty for violating the mandate, which could occur only in 2015 or thereafter.

The consensus among legal experts appears to be that the court will not feel bound by the Anti-Injunction Act and will rule on the mandate this year, most likely by the end of June.

**The Mandate:** I have discussed the mandate in several earlier posts, including this one. As explained there, a mandate on individuals to be insured is an actuarially necessary complement to two strictures on private insurers that seem to be popular with the public:

1. "Community-rated" premiums, that is, premiums divorced from the health status of any particular applicant for insurance and charged to all applicants for an insurer's coverage
2. "Guaranteed issue," that is, the requirement that an insurer must sell an insurance policy to any applicant willing to pay that insurer's community-rated premium for that policy.

For decades, Americans have lamented in vignettes published by various news organizations the families, stricken with serious illness, who find themselves unable to procure health insurance at premiums they can afford or are refused coverage altogether.

The Affordable Care Act was written to solve this problem by subjecting private health insurers to community rating and guaranteed issue.

But if Americans want the benefits of these two strictures, they must also be willing to countenance the mandate to be insured. It is not legislative hegemony. It is an actuarial necessity.

As I had noted in a post, that insight was shared during the 1990s by many Republican policy analysts and policy makers, including Senator Orrin Hatch of Utah, who now views the mandate as a violation of individuals' freedom. Republican legislators then openly countenanced the mandate and embodied it in federal legislation they proposed.

One can also view being insured for at least catastrophic health care a civic responsibility, as is the case in most other industrialized nations, including freedom-loving Switzerland. For example, asked in an interview in Health Affairs in August 2010 how he could defend the mandate to be insured to Swiss citizens, Switzerland's former secretary of health, Dr. Thomas Zeltner, responded:

That's easy. We will not let people suffer and die when they need health care. The Swiss believe that in return, individuals owe it to society to make provision ahead of time for their health care when they fall seriously ill. At that point, they may not have enough money to pay for it. So we consider the health-insurance mandate to be a form of socially responsible civic conduct. In Switzerland, "individual freedom" does not mean that you should be free to live irresponsibly and freeload from others, as you would put it.

Part of American exceptionalism, which we feel sets us apart from other nations, seems to be that Americans believe they have a moral right to critically needed health care, whether or not they can pay for it, but also believe that they should be free not to make financial provision for that event beforehand.

If the Supreme Court strikes down the mandate as unconstitutional — as it very well might, judging from the sharp and skeptical questions asked by the justices in arguments on Tuesday — it could lead to one of two distinct pathways.

First, as the Obama administration asserts, community rating and guaranteed issue would then have to be stricken from the Affordable Care Act. We would be back to the vignettes of Americans complaining about private insurers doing their actuarially sound and defensible thing, which can, however, be so devastating on American families.

An alternative would be to let these two provisions stand and force the insurance industry to live with them. As I explained in an earlier post, it would lead to what actuaries call the “death spiral” of individually purchased insurance, with shrinking risk pools of ever-sicker individuals and, naturally, ever-mounting premiums.

One could lambast the insurance companies for these ever-rising premiums, of course, but informed observers know better: the culprit would be the absence of a mandate to be insured. New York and New Jersey, which imposed community rating and guaranteed issue without a mandate to be insured, are living proof of that assertion. Risk pools there have shrunk and community-rated premiums have skyrocketed.

**The Medicaid Expansion:** As is shown in the chart above, the Anti-Injunction Act does not affect the court’s jurisdiction over the Medicaid expansion. If I had to bet, the court will rule this provision constitutional. After all, a state does not have to take part in Medicaid, which is heavily subsidized with federal money. The program is voluntary.

For the expansion, the federal government would pick up 100 percent of the cost in the first three years, which descends over time to 90 percent thereafter. For the existing enrollment, the federal government traditionally has picked up 50 to 80 percent of the program’s cost.

The opponents of the expansion appear to hold that for the federal government to make all of its generous Medicaid subsidies to a state conditional on that state’s agreement to expand Medicaid eligibility to 133 percent of the federal poverty level is so powerful a fiscal incentive as to be coercive and hence unconstitutional, even though participation in Medicaid is voluntary. It strikes me as a stretch.

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## Health-care changes may not all disappear even if justices overturn the law

By N.C. Aizenman, Published: March 22

Since the 2010 health-care bill became law two years ago Friday, it has launched fundamental changes to Medicaid, Medicare and the private health-insurance system relied on by millions of Americans.

Its most transformative — and controversial — provisions are not set to take effect until 2014, but a complex web of new rules has already extended coverage and expanded benefits across the country.

So what happens to the existing provisions if the Supreme Court, which will hear challenges to the law next week, ultimately decides to go with its most sweeping option: overturning the law in its entirety?

The answer depends on where you live, who you work for and how you get your insurance.

Take one of the law's most well-publicized provisions: the requirement that insurers allow parents to keep adult children on their health plans until age 26. The administration estimates that an additional 2.5 million young adults have been able to get health insurance coverage as a result.

Overturning the law would immediately release insurers from the federal rule. But it is hard to predict how many would actually exercise their right to revert to their original policies.

Compared with other provisions, the young-adults requirement proved fairly uncontroversial among insurers. Many even volunteered to comply well before the deadline set by the law, noted Robert Zirkelbach, spokesman for America's Health Insurance Plans, an industry group.

In addition, nearly all states, which regulate many forms of private insurance, have already codified the young-adult rule at the state level. In some cases this was done through actions that could be easy to undo. For instance, South Dakota's law adopting the young-adults requirement included the proviso that if the health-care law is found unconstitutional, the state statute would automatically be repealed as well.

But in plenty of other states, insurers would not be free of the rule unless state leaders rolled back the statutes or regulations they adopted to implement the health-care law.

The same is true of the host of other mandates the federal law currently imposes on insurers. These include prohibitions against imposing lifetime limits on insurance payouts or dropping someone's coverage after they get sick on the grounds that their insurance application contained inaccuracies.

There's also the requirement that private insurers cover preventive services such as mammograms and colonoscopies without imposing co-pays or other out-of-pocket charges. About 54 million Americans now have expanded coverage of at least one preventive service as a result, according to an analysis by the Kaiser Family Foundation.

Lawmakers are unlikely to unwind these rules in many states, predicted Sabrina Corlette, a Georgetown University professor and co-author of a study analyzing state actions to align their insurance rules with the health-care law. "These are market reforms that are really very popular," she said.

But Michael Cannon, director of health policy studies at the libertarian Cato Institute and an opponent of the law, argued that scrapping these requirements could actually benefit many Americans. They have driven up the cost of many insurance plans, he said. So without them, "there will be more affordable coverage options."

The likely impact of a court decision invalidating the law is more evident when it comes to another well-known feature: The discount that drug manufacturers must currently offer to seniors who fall into Medicare's prescription drug coverage gap — commonly referred to as the "doughnut hole."

According to the Obama administration, last year 3.6 million Medicare beneficiaries saved more than \$2.1 billion on prescription drugs — an average of \$604 per person — as a result of the discount. And it would no longer be available if the law were overturned.

Seniors would also lose access to the law's requirement that Medicare cover preventive services, including an annual physical, with no out-of-pocket charges — an option about 32.5 million took advantage of in 2011.

There are also large categories of people who would likely lose their insurance coverage altogether.

These include approximately 50,000 Americans currently insured through temporary "high risk" pools set up for people unable to obtain private insurance because they have a pre-existing health condition. The pools were intended to tide such people over until 2014, when the law will bar insurers from discriminating against them.

Many of the pools are run by states with federal dollars. And the states could choose to maintain them at their own expense. But it's hard to say how many would opt to do so amid the financial pressure the sluggish economy has put on state budgets.

Budget concerns could also prompt states to respond to an invalidation of the health-care law by dropping millions of residents from their Medicaid rolls.

Currently the law bars states from tightening their eligibility rules for Medicaid before 2014, when the program will be expanded to cover a larger share of the poor, almost entirely at the federal government's expense.

State leaders across the country have complained that this "maintenance of effort" requirement has imposed a crushing burden, forcing them to shortchange other priorities such as education.

"I would think almost all of them would want to revisit their eligibility rules," said Cannon, "and they should because there's a lot of people in Medicaid who don't need to be there."

That assessment was hotly contested by Ronald Pollack, executive director of the advocacy group Families USA, which supports the law.

"People in Medicaid today are the poorest of the poor," he said. "In many cases their total annual income is less than the average premium for a family insurance plan. So there is no way in the world they can afford insurance."

Still, Pollack said his concern over the issue was lessened by his conviction that even if the Supreme Court strikes down part of the law it will leave the bulk of it — including the Medicaid provisions — in place.

"To invalidate all provisions of the [law] would require a Herculean effort to avoid decades of precedents," he said.

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# ISSUE SPOTLIGHT

## Affordable Care Act's Medicaid Expansion: Reduces Low Income Uninsured by 41% in California

March 28, 2012

With the Supreme Court hearing oral arguments on the Medicaid provisions in the Affordable Care Act this week, the following spotlights the impact the Medicaid expansion will have in California.

### The Great Recession's impact in California

While enrollment in private health coverage declined as unemployment rates increased, Medi-Cal enrollment increased by almost a half-million people between December 2007 and December 2009.

### More low income residents eligible for Medi-Cal in 2014 under ACA

- 2 million Californians below 133% FPL will become eligible to enroll in Medi-Cal, 1.4 million of whom were previously uninsured.
- This will reduce California's low-income uninsured population by 41.5%.
- Nearly 94% of funding will come from the federal government.
- The federal matching funds that help fund Medi-Cal will increase from 50% to 55.4%.

### The ACA's Medicaid expansion (beginning in 2014):

- Raises income eligibility to \$14,000 for individuals (133% of the federal poverty level, FPL);
- Extends eligibility to childless adults (currently ineligible in California regardless of income);
- Provides 100% federal funding for those newly eligible for 2014-2016, to be phased down to 90% by 2020;
- And, maintains Medicaid federal-state funding match rate for those currently eligible.

Funding for Medi-Cal Expansion Will Come Mainly from Federal Government	
Increase in Spending, 2014-2019	
State Spending	1.5%
Federal Spending	23.0%
Total Spending	12.3%

Source: [statehealthfacts.org](http://statehealthfacts.org)

Source: Kaiser Family Foundation. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." May 2010.

Please contact Sunshine Moore at [smoore@calhealthplans.org](mailto:smoore@calhealthplans.org) or 916.558.1545 with any questions about this research highlight.

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The California Association of Health Plans (CAHP) is a statewide trade association representing 40 full-service health care plans. Through legislative advocacy, education, and collaboration with other member organizations, CAHP works to sustain a strong environment in which our member plans can provide access to products that offer choice and flexibility to the more than 21 million Californians they serve.

## The Dangers of Guaranteed Issue & Community Rating without an Individual Mandate

March 2012

*"The enforcement of [guaranteed issue and community rating] without a minimum coverage provision would restrict the availability of health insurance and make it less affordable - the opposite of Congress' goals in enacting the Affordable Care Act."*

- Department of Justice brief to the United States Supreme Court, October 2011

**Individual mandate/ minimum coverage:** requires all Americans, with limited exceptions, to purchase health insurance or face a financial penalty.

**Guaranteed issue:** requires health plans to issue coverage to all applicants regardless of health status or preexisting conditions.

**Community rating:** prohibits health plans from varying premiums based on factors such as health status, preexisting conditions, and gender.

**Modified community rating:** allows limited band-rating for factors such as age, region, and tobacco use.

**Adverse selection:** occurs when younger, healthier individuals — who have lower health expenditures — choose to forgo coverage until they really need it.

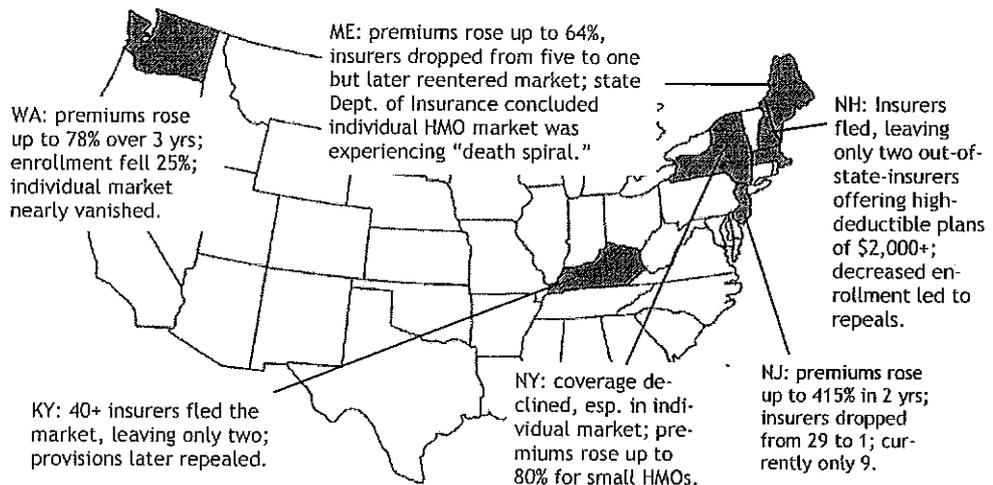
**"Death spiral:"** As a result of adverse selection, there are fewer people among whom to spread the costs for those with higher health expenditures. Premiums go up, further driving out those willing to risk forgoing coverage, which in turn further drives up premiums.

If the individual mandate were eliminated and guaranteed issue and community rating remained in place:

- Premiums would increase in order to offset the costs anticipated by adverse selection.
- Individuals may be forced to switch to plans with less coverage or drop coverage altogether.
- Federal subsidies to help pay for insurance in the Exchange would decrease by \$39 billion;<sup>1</sup> yet government spending per newly insured enrollee would more than double.<sup>2</sup>
- An estimated 7.8-24 million Americans would not have coverage.

Impact of Eliminating the Individual Mandate Only		
Coverage Loss	Premium Increase	Source
24 million	27%	Gruber <sup>3</sup>
16 million	15-20%	CBO <sup>4</sup>
12.5 million	9.3%	RAND <sup>5</sup>
13.4 million	10%	Urban Institute <sup>6</sup>
7.8 million	12.6%	Lewin Group <sup>7</sup>

### Other States' Experience in the Individual & Small Group Markets After Passing Guaranteed Issue / Community Rating *without* an Individual Mandate<sup>8</sup>



When Massachusetts instituted guaranteed issue and modified community rating *without* an individual mandate, insurance premiums skyrocketed and the market shrunk as insurers fled the nongroup and individual markets. After passing an individual mandate in 2006, the number of uninsured dropped 60% and nongroup premiums fell by 40%.

Please contact Sunshine Moore at [smoore@calhealthplans.org](mailto:smoore@calhealthplans.org) or 916.558.1545 with any questions about this issue brief.



# ISSUE BRIEF

## What They're Saying...The Dangers of Guaranteed Issue & Community Rating without an Individual Mandate

March 2012

**Senator Joe Lieberman:** "Unless you have a mandate, the insurance companies will not have the money to cover all the things in the Affordable Care Act...If the Supreme Court finds the mandate unconstitutional, the Affordable Care Act has to change." (*The Connecticut Mirror*, 03/19/2012)

**Paul Krugman, columnist:** "Yet simply requiring that insurers cover people with pre-existing conditions, as in New York, doesn't work either: premiums are sky-high because only the sick buy insurance." (*The New York Times*, 03/18/2012)

**Joel Cantor, Rutgers University:** "If there is guaranteed issue and no mandate, I think it essentially spells the end of the health insurance industry as we know it... Eventually, the insurance market would become so dysfunctional that carriers would pull out, premiums would go through the roof, and enrollment would collapse. That's certainly consistent with what happened in New Jersey." (*Kaiser Health News*, 3/20/12)

**CBS News:** "The mandate is central to the law...The mandate is designed to solve a problem: If you're going to require that insurance companies cover people with pre-existing conditions, how do you keep people from just waiting until they get sick to buy insurance? If the mandate is struck down, the requirement that insurance companies cover those with pre-existing conditions would become unworkable, since the pool of insured would have far fewer healthy people in it to offset the costs of those who need expensive medical care." (03/19/2012)

**Kaiser Health News:** "The consternation over the individual mandate stems from the fact that it is intertwined with all the other parts of the health law...Insurers would have to take all comers, regardless of their health status, and would be limited in how much more they could charge the very sick. But keeping the premiums affordable – for both individuals and the government – hinges on making sure healthy people enroll in insurance too, contributing premiums that are above what they consume in health care. Hence the argument for a mandate." (03/16/2012)

**Kaiser Health News:** "Still, the economists all believe that the mandate, as envisioned by the law, will make a significant difference in reform's impact. Gruber has suggested that removing the mandate from the law would diminish the number of newly insured by nearly two-thirds and raise premiums overall by 30 percent." (3/20/12)

### SOURCES

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3. Gruber, Jonathan, "Health Care Reform Is a Three-Legged Stool," Center for American Progress, August 2010.
4. "Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care," Urban Institute, February 2012.
5. "Without the Individual Mandate, the Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted," Health Affairs, October 2011.
6. "The Impact of Guaranteed Issue on Community Rating Reforms on Individual Insurance Markets," Milliman, August 2007.

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# RESEARCH HIGHLIGHT

## Understanding High-Cost Patients

March 2012

An analysis of the IMS Institute for Healthcare Informatics – using nationwide data from 10 million privately insured individuals under age 65 – provides key insights as to who high-cost patients are and just how greatly they affect overall health care costs.

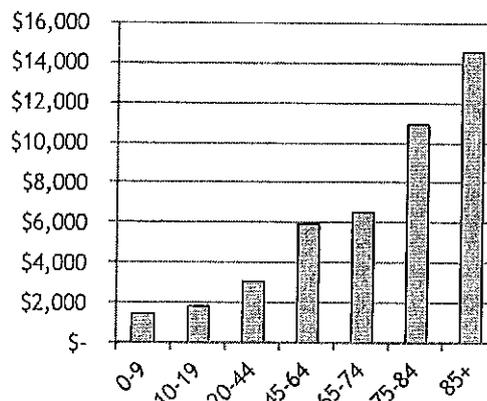
### Concentration of Spending in Private Insurance Population under Age 65

The greatest costs are concentrated among a very small segment of the privately insured population:

- The top 1% of privately insured account for 25% of overall costs in that pool;
- The top 5% account for 50% of total cost;
- The bottom 50% account for only 3% of total health care spending.

*The average annual cost for the top 1% of the privately insured population is more than \$100,000 - compared to less than \$4,000 per member overall.*

### Annual Health Care Spending by Age



### Characteristics of High-Cost Patients

High-cost patients tend to be those suffering from chronic conditions, cancer, and auto-immune or specialty disorders. Spending among high-cost patients (those in the top 1%) with these diagnoses, however, is significantly greater than other patients with the same conditions:

- Diabetes care and management was almost nine times higher;
- Cost for patients with history of heart attack was more than five times higher;
- Care for chronic renal failure was almost four times higher;
- Care for rheumatoid arthritis was six times higher;
- Treatment for Multiple Sclerosis was three times higher.

### Utilization Among Privately Insured

Population	Inpatient	Outpatient	Pharmacy
All Members	20%	59%	21%
Top 1%	45%	45%	10%
Chronic Conditions	21%	55%	24%
Cancer	21%	65%	14%
Auto-Immune/ Specialty Diseases	16%	45%	39%

### Implications for the Future of the Private Insurance Market

As the number of individuals enrolled in the private insurance market is expected to grow by an estimated 17 million people in the coming years, it will be important to understand the drivers of overall health care costs.

Source: IMS Institute for Healthcare Informatics, "Essential Health Benefit Packages Explained: Understanding High-Cost Patients," February 2012.

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merges the individual and small-group markets. Similarly, Maryland's pending legislation builds on Board recommendations around carrier participation, contracting with health plans, and keeping small-group and individual markets separate.

Although much attention has been focused on state legislative activity, a number of states have taken steps to implement exchanges without legislation. In all cases, states have used enacted laws or previously established government entities to anchor the exchange. In the case of Rhode Island, where the legislature failed to enact establishment legislation in 2011, the Governor issued an Executive Order to establish an exchange utilizing the authority of a previously established health care fund. Mississippi is utilizing an existing non-profit high risk pool association. New Mexico began building a state-based exchange using the New Mexico Health Insurance Alliance, which appears to provide sufficient legal authority for planning and development activities though additional legislation or an executive order may be needed to fully comply with federal regulations. For states that cannot anchor their exchange on prior legislation, an executive order may not be a viable option and new legislation may be the only mechanism to establish an exchange.

In the absence of legislation, a number of states continue to make progress in planning for an exchange. In some states establishment legislation is pending but has been stymied by ongoing political disagreements. Such has been the case in New York and Minnesota where the Governors' offices have moved forward to organize significant planning efforts around exchange structure, governance, and information technology systems without establishment legislation in place. While not on the same scale, Tennessee, a state in which establishment legislation has yet to be proposed, has steadily gathered together the necessary stakeholder input to inform the exchange planning process.

As of March 1, 2012, a growing number of states show no significant planning activity. Some of these states had been making significant progress in 2011, but ended their exchange planning efforts due to increasing political pressure. In Kansas, Oklahoma, and Wisconsin significant planning momentum was halted when the Governors announced the return of Early Innovator grant funding. Others states such as Texas, Florida, and New Hampshire never began planning for a state exchange, citing the uncertainty created by ongoing legal challenges to the law.

Louisiana and Arkansas are the only two states to have announced their intention to stop pursuing a state-based exchange. However, both are moving in very different directions. Louisiana returned federal planning grant funds and relinquished control of its exchange to the federal government in early 2011; since then there has been no significant planning activity. Arkansas on the other hand, announced it was ending state-run exchange planning in December 2011, and then moved quickly to begin defining their role in a federal-state partnership exchange. Arkansas intends to maintain control over the exchange's plan management and consumer assistance functions while having the federal government control the eligibility and enrollment portal.

### **Key Design Areas**

The ACA allows for flexibility over exchange design so that states can tailor exchanges to their specific populations and insurance markets. As states proceed with establishing their exchanges, they must make a number of important decisions, including how their exchange will be structured and governed, how it will contract with health plans, and how it will be financed (Table 1).

### **Exchange Structure**

The ACA gives states options for how to structure their exchanges, including establishing within an existing or new state agency, as an independent public entity, or as a non-profit. There are various considerations associated with each option.<sup>2</sup> Basing the exchange within an existing state agency enables the entity to efficiently leverage established administrative systems and procedures. An exchange that is a state agency is more closely tied to the government and accountable to elected officials. However, there may be value in maintaining independence and having the ability to define the administrative processes that best meet the needs of the exchange. Depending on the structure and governance, an exchange that is established as a quasi-governmental or non-profit entity may

be more insulated from political influence and particular interest groups. Unlike a quasi-governmental exchange, a non-profit exchange may find it challenging to perform functions that are typically viewed as governmental.

Eight states plus the District of Columbia have chosen a quasi-governmental structure, four will house the exchange within a state agency, and one has opted to create the exchange as a non-profit corporation. Most exchanges to date have been created with some independence from state government. For example, Washington's exchange is "a public-private partnership separate and distinct from the state,"<sup>3</sup> while Maryland's exchange is a "public corporation and independent unit of state government."<sup>4</sup>

#### ***Contracting Relationship with Qualified Health Plans***

Another important consideration for states is defining the relationship between the exchange and participating qualified health plans (QHPs). States can opt to require the exchange to contract with all QHPs which meet specified criteria, commonly referred to as the clearinghouse model, or states can require the exchange to be an active purchaser and selectively contract with only certain QHPs, possibly to achieve stated goals around plan choice, quality or value. The Board may choose, for example, to require plan certification criteria beyond what is defined in the ACA or may negotiate with plans for better pricing or different product offerings. Boards can also use selective contracting to improve plan quality or can encourage plans to implement strategies to better coordinate health care services.<sup>5</sup> Of the 14 established exchanges, seven have decided to act as active purchasers while three others will serve as clearinghouses. The remaining states have yet to define the contracting relationship.

#### ***Exchange Governance***

Exchanges established as independent state agencies or as non-profit entities, must have a clearly-defined governing Board overseen by the state.<sup>6</sup> Nearly all states with established exchanges have created independent governing Boards to direct their exchanges, and most have appointed members to these Boards. The Boards range in size from 5 to 15 members, often representing both stakeholders and subject matter experts in an attempt to balance the political interests and management skills needed to operate an exchange.<sup>7</sup> Common subject matter experts include health economists, health actuaries, and people with experience purchasing or managing health benefits. Exchanges that require stakeholder representation on the Board may specify the number of representatives of individual consumers or small employers, insurers, brokers, and/or health care providers. Some states without stakeholder representation on the Board have included a provision in the legislation requiring the Board to create advisory groups to facilitate feedback on issues ranging from plan certification to consumer protections.

#### ***Conflict of Interest***

Whether to allow representatives of insurers and brokers to serve on the Board has been a contentious issue in some states. Nearly all states included conflict of interest provisions for Board members in the legislation that establishes the exchanges, though some are more restrictive than others. The Boards are responsible for planning and operating the exchanges, as well as implementing the certification process to identify QHPs that may participate in the exchanges.

Conflict of interest provisions are important when entities that might financially benefit from contracting with an exchange are represented on the Board and may gain unfair advantage over competitors.<sup>8</sup> These provisions are even more important when the Board is expected to behave as an active purchaser and negotiate with plans. Typically, states with active purchaser exchanges prohibit industry representation. For example, the conflict of interest provisions are among the most restrictive in Maryland, California, and Connecticut, where the exchange Boards are meant to act as active purchasers. In these states, Board members cannot have relationships with a variety of players in the health care sector, such as carriers, insurance producers, third-party administrators, managed care organizations, health care providers, facilities or clinics, and/or entities contracting with the exchange. Seven states explicitly prohibit representation of health insurance carriers and brokers on their Exchange Board, one state prohibits health insurers but not brokers, and an additional three states limit the number of industry representatives that can be appointed to the Board.

**Exchange Financing**

States must be able to fully finance the costs of exchange operation by January 1, 2015. Various financing options in any combination are available to states including, assessing fees on participating health insurance carriers, appropriating state funds to the exchange, or allowing for other public or private funding sources. Nearly all exchanges were authorized to apply for public or private grants. Nine states allow for fees to be collected from insurance carriers operating in their exchanges. One state, Colorado, explicitly prohibits the appropriation of state funds for the exchange, while others have opted to allow for state funding, if necessary. Maryland’s exchange is authorized to collect fees from plans within the exchange, but not to the extent that the fees create a competitive disadvantage with plans offered outside the exchange.

**Information Technology**

The ACA requires states to create a seamless, user-friendly interface which allows for eligibility determinations and health insurance enrollment for anyone up to 400% of the federal poverty level. To accomplish this goal, states must coordinate exchange and Medicaid/Children’s Health Insurance Program (CHIP) eligibility determination and enrollment functions. Many states will perform significant upgrades to their Medicaid eligibility systems as well as build new information technology (IT) systems necessary to support exchange functions. A few states envision building an integrated eligibility system that will make determinations for the Exchange, CHIP, Medicaid and eventually other public programs. Many states have already started to solicit subcontractors to upgrade or build the necessary IT infrastructure.

**TABLE 1: Key Characteristics of Established State Exchanges**

State	Structure of Exchange	Contracting Type of Exchange	Governance
California	Quasi-governmental	Active purchaser	5- member Board
Colorado	Quasi-governmental	Clearinghouse	12- member Board
Connecticut	Quasi-governmental	Active purchaser	14- member Board
District of Columbia	Quasi-governmental	Active purchaser	7-member Board
Hawaii	Non-profit	Clearinghouse	15-member Board*
Maryland	Quasi-governmental	To be decided by the Board of Directors	9-member Board
Massachusetts	Quasi-governmental	Active purchaser	11-member Board
Nevada	Quasi-governmental	Not addressed in legislation	10-member Board
Oregon	Quasi-governmental	Active purchaser	9-member Board
Rhode Island	Operated by State	Active purchaser	13-member Board
Utah	Operated by State	Clearinghouse	NA**
Vermont	Operated by State	Active purchaser	5-member Board
Washington	Quasi-governmental	Not addressed in legislation	11-member Board
West Virginia	Operated by State	Not addressed in legislation	10-member Board

\*Description of Hawaii’s Interim Board, which will be replaced on June 30, 2012. The ultimate Board of Directors will include eleven members.  
 \*\*Although Utah’s exchange doesn’t have a formal Governing Board, the state has created an Executive Steering Committee to advise exchange staff on operations and transparency issues and a Defined Contribution Risk Adjuster Board to manage risk sharing mechanisms.

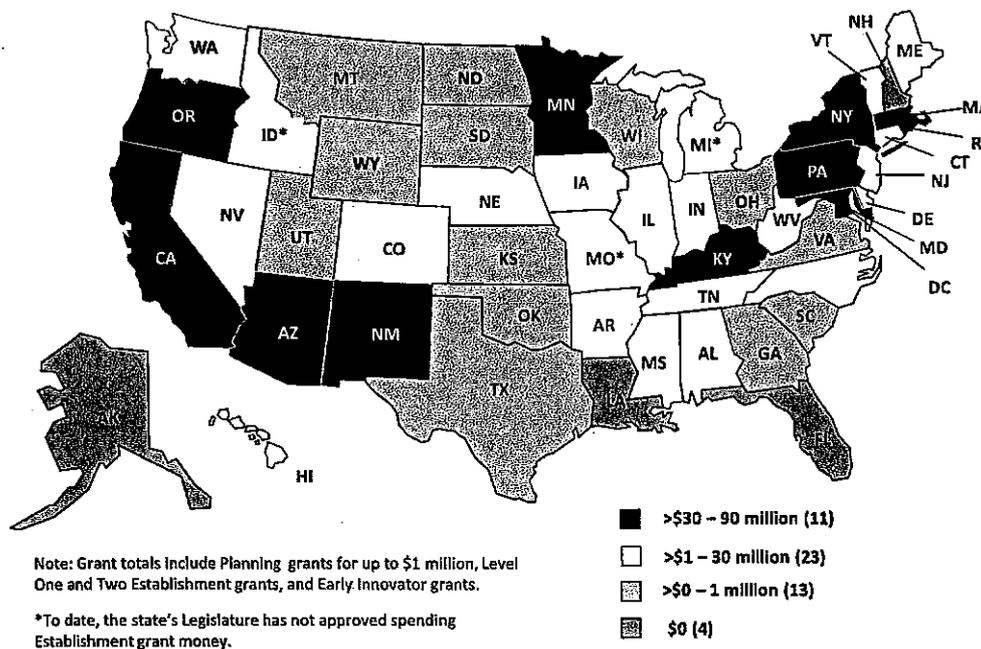
**Federal Funding**

As of March 2012, over \$830 million has been distributed to states through federal Exchange Planning grants, Establishment grants, and Early Innovator grants (Figure 2). Almost every state received some amount of funding to study exchange implementation. Thirty-four states have received Level One Establishment grants, which provide up to one year of funding for states that have made some progress under their planning grant. States may reapply for a second year of Level One funding and to date five states have taken advantage of this option. One state, Rhode Island, has received a multi-year Level Two Establishment grant that can only be awarded to states with established exchanges. Level Two grants can provide funding through the first year of a state’s exchange operation.

While the deadline to apply for federal funds was previously set for June 29, 2012, states now have the opportunity to submit applications on a quarterly basis through the end of 2014. At this time, states have allocated a sizable portion of federal grant money towards building the IT infrastructure necessary to support exchange functions.

In a handful of states, the Governor or Legislature has pushed back against the use of federal grant money for exchanges. While Alaska was the only state which did not apply for a federal Exchange Planning grant, three additional states, Florida, Louisiana, and New Hampshire, returned their Planning grant money in 2011. For some states that have been awarded Level One Establishment grants, tension over spending has created significant deadlock, in effect, halting exchange planning. For example, Governors in Missouri, Michigan, and Idaho have yet to receive approval from their legislatures to begin spending awarded Level One Establishment grant funds.

Figure 2  
**Total Federal Grants for Health Insurance Exchanges**



**Future Exchange Prospects**

Many states have demonstrated a strong commitment towards establishing a state-based exchange. Of those with established exchanges, the majority have appointed Boards, hired staff, and solicited subcontractors to begin planning and building their exchange infrastructure. However, significant work remains for many states aiming to be ready by 2014. Even a state like Maryland, which has been moving aggressively to implement an exchange, has delayed making certain fundamental decisions around exchange financing and health plan contracting.

While a sizeable number of states have established or plan to establish an exchange, others are moving much more cautiously and continue to study their options. Reasons for the slow pace are numerous, but a critical issue is the uncertainty that continues to surround the ACA. The Supreme Court is scheduled to address multiple issues, including the constitutionality of the individual mandate and its severability from the rest of the health reform law in March 2012. A ruling by the Court is expected by late June. Some states are reticent to take any steps toward creating an exchange until the legal challenges have been resolved. Currently, 26 states are involved in the lawsuits to be argued before the Supreme Court.

However, a majority of states' legislative sessions will end before the Supreme Court ruling. States that elect to wait until after June 2012 to begin exchange planning may find there are few legislative options remaining given the short timeline. On January 1, 2013, HHS will certify state exchanges as fully or conditionally operational. If not approved, the federal government will assume responsibility for running a health insurance exchange in those states. Once a state's regular legislative session has concluded, it will have to weigh alternative strategies to establish an exchange, including exploring non-legislative options (e.g., executive order), a special legislative session, or a federal-state partnership.

The 2013 deadline to demonstrate an operational exchange is fast approaching, and even those states moving more aggressively may find it difficult to put all the pieces into place in time to meet it. Recognizing this challenge, HHS has offered several strategies to promote the formation of state-based exchanges.<sup>9</sup> One option is the federal-state partnership model, which would allow for combined state and federal business functions, such as eligibility and enrollment, financial management, and health plan management systems and services.<sup>10</sup> While few states have explored the possibility of a partnership, it may be an increasingly viable option for states that have delayed establishing an exchange. HHS will also grant conditional approval for state exchanges that may not be able to demonstrate complete readiness on January 1, 2013, but that are expected to be operational by January 2014. Finally, states not ready to run their own exchanges beginning in 2014 may transition from a federal exchange to a state exchange when they have the capability, though they must receive approval for their exchange at least 12 months prior to the start of coverage.

There is no single path toward establishing state-based exchanges, as is evidenced by the myriad approaches states have taken to date. For those states interested in running their own exchanges, the next two years provide a unique opportunity to plan a health insurance exchange tailored to the needs of their state with the support of federal funding.

For more information on state's health insurance exchange implementation please visit <http://healthreform.kff.org/tags/exchanges.aspx>

<sup>1</sup> In 2012, 133% of the Federal Poverty Level (FPL) was \$14,856 for an individual and \$30,657 for a family of four; 400% of FPL was \$44,680 for an individual and \$92,200 for a family of four.

<sup>2</sup> Van de Water P and Nathan R. "Governance Issues for Health Insurance Exchange." Georgetown University Health Policy Institute and the National Academy of Social Insurance. January 2011. [www.nasi.org/research/2011/governance-issues-health-insurance-exchanges](http://www.nasi.org/research/2011/governance-issues-health-insurance-exchanges)

<sup>3</sup> Washington Senate Bill 5445, 2011.

<http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Senate%20Passed%20Legislature/5445-S.PL.pdf>

<sup>4</sup> Maryland Health Benefit Exchange Act of 2011. Senate Bill 182. [http://mlis.state.md.us/2011rs/chapters\\_noln/Ch\\_1\\_sb0182T.pdf](http://mlis.state.md.us/2011rs/chapters_noln/Ch_1_sb0182T.pdf)

<sup>5</sup> Corlette S and Volk J. "Active Purchasing for Health Insurance Exchanges: An Analysis of Options." National Academy of Social Insurance. June 2011. [www.nasi.org/research/2011/active-purchasing-health-insurance-exchanges-analysis-option](http://www.nasi.org/research/2011/active-purchasing-health-insurance-exchanges-analysis-option)

<sup>6</sup> Department of Health and Human Services. Notice of Public Rulemaking. 45 CFR 155 and 45 CFR 156: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. July 15, 2011. (CMS-9989-P)  
[www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf)

<sup>7</sup> Jost T. "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues." The Commonwealth Fund. September 2010. [www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx](http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx)

<sup>8</sup> Ibid.

<sup>9</sup> Department of Health and Human Services. Notice of Public Rulemaking. 45 CFR 155 and 45 CFR 156: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. July 15, 2011. (CMS-9989-P)  
[www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf)

<sup>10</sup> Bachrach, D and Boozang, P. "Federally-Facilitated Exchanges and the Continuum of State Options." National Academy of Social Insurance. December 2011. [www.nasi.org/sites/default/files/research/Federally-Facilitated-Exchanges-and-the-Continuum-of-State-Options.pdf](http://www.nasi.org/sites/default/files/research/Federally-Facilitated-Exchanges-and-the-Continuum-of-State-Options.pdf)

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#### THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

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FOCUS *on* **Health Reform**

THE ROLE OF THE BASIC HEALTH PROGRAM  
IN THE COVERAGE CONTINUUM:  
OPPORTUNITIES, RISKS, AND CONSIDERATIONS  
FOR STATES

MARCH 2012

Deborah Bachrach and Melinda Dutton  
Manatt, Phelps, and Phillips, LLP

and

Jennifer Tolbert and Julia Harris  
Kaiser Family Foundation

The full report can be found at:

<http://www.kff.org/healthreform/8283.cfm>

## EXECUTIVE SUMMARY

The Basic Health Program (BHP) is an optional coverage program under the Patient Protection and Affordable Care Act (ACA) that allows states to use federal tax subsidy dollars to offer subsidized coverage for individuals with incomes between 139-200% of the federal poverty level (FPL) who would otherwise be eligible to purchase coverage through state Health Insurance Exchanges. States can use the BHP to reduce the cost of health insurance coverage for these low-income consumers, a highly price-sensitive population with high rates of uninsurance. Depending on how it is designed, the BHP also can help consumers to maintain continuity among plans and providers as their income fluctuates above and below Medicaid levels.

As states weigh whether to implement a BHP, they face significant questions and challenges. Critical among these are how to design the BHP to enhance continuity of coverage as people move among Medicaid, the BHP, and coverage through qualified health plans (QHPs) in the Exchange; how to assess the BHP's impact on the viability and effectiveness of state Exchanges; and how to estimate revenues and costs to evaluate the financial feasibility of the BHP. Building on a roundtable discussion of state and federal officials and policy makers convened by the Kaiser Family Foundation to explore these issues, this paper provides a framework for assessing the BHP option and exploring the advantages and risks associated with a BHP. It also offers strategies for states to manage and reduce those risks.

***The BHP delivery model will influence both the BHP cost and the program's success at bridging Medicaid and QHP coverage.*** States with Medicaid managed care programs may look to Medicaid managed care plans and networks as the delivery system for the BHP. These plans offer an existing infrastructure and also accept lower reimbursement rates than commercial plans, which will enable states to offer coverage through the BHP with the available federal funding. States may, however, need to enhance provider rates above Medicaid levels to ensure the plans are able to offer robust provider networks.

***It is estimated that the BHP could reduce the size of the Exchange population by about one-third, which could impact the risk profile, weaken the purchasing power, and undermine the administrative viability of the Exchange.*** The risk profile of the BHP eligible population will affect the premiums in the Exchanges, driving them up if the BHP population is healthier than those remaining in the Exchange or lowering the premiums if the BHP population is sicker. Similarly, reducing the size of the population purchasing coverage through the Exchange by creating a BHP may reduce the leverage of the Exchange to promote innovations that improve quality and lower costs. Further, by drawing participants away from the Exchange, a BHP reduces the financing base for Exchange operations.

States may consider a number of different strategies for minimizing the impact of the BHP on the Exchange. To avoid adversely affecting the risk profile of the Exchange, states can combine risk across the markets or include the BHP in the Exchange risk adjustment and reinsurance

systems. States may also consider integrating the BHP procurement with that of the Exchange to pool market leverage across the programs and align quality standards and program features. Finally, integrating BHP functions with those of the Exchange, and potentially with certain functions of public programs, will allow states to achieve economies of scale to promote efficiency and spread program costs across a larger pool of beneficiaries.

***Although federal funding is available to finance the costs of the BHP, it is essential for states to accurately estimate the amount of funding they will receive and the costs of the program to ensure that funding will be sufficient.*** The federal funding for the BHP is tied to premium and cost-sharing subsidies BHP enrollees would have received if they had purchased coverage in the Exchange (states will receive 95% of premium subsidies and either 95% or 100% of the cost-sharing subsidies). Therefore, to estimate the funding that will be available, states must first use actuarial modeling to estimate the value of the benchmark plan in the Exchange and then subtract individual contributions to the premiums, which are based on enrollees' incomes. Any funding states receive is then subject to a year-end reconciliation, which adjusts the payments based on enrollee characteristics, such as age and health status, and changes in enrollee income that occurred during the year. States may want to reduce revenue projections to account for these adjustments. They should also factor in whether any state funding will be available. Once the BHP revenue is estimated, states must compare the funding to anticipated program costs. States have broad flexibility to determine BHP benefits, consumer premiums and cost-sharing levels, and provider networks and payment rates, all of which can be altered to impact costs. Further federal guidance will be needed on how to calculate the value of the premium and cost-sharing subsidies and the mechanism for implementing the annual financing reconciliation in order for states to fully assess the financial feasibility of the BHP.

***States must plan for the administrative infrastructure of the BHP and the financing of planning and operations costs.*** States must make important decisions regarding who will be responsible for designing, implementing, and operating the BHP. Another important consideration is how the administrative functions of the program will be financed. Federal guidance will be needed to resolve how BHP operating costs can be financed and whether this financing can be similar to or integrated with the financing of the Exchange.

### **Conclusion**

Federal officials have yet to provide details about how the program will be financed, administered and certified, and states are struggling to evaluate the BHP's impact on the viability and effectiveness of state Exchanges. Federal regulations will inform state deliberations, but are unlikely to fully resolve the complexity or eliminate the risk. Ultimately, states that opt for a BHP will want to design BHP programs so as to minimize the state's financial exposure and address any negative impacts on the Exchange. States in which a BHP is not a viable option may want to consider alternative strategies to advance affordability and continuity goals.



# THE AFFORDABLE CARE ACT IN CALIFORNIA

## After Two Years - Big Benefits, More Work to Do

This 2012 report marks the second anniversary of the federal health reform law, and highlights the work that has been done in California, the benefits that Californians are already enjoying, and the outstanding issues that need to be addressed. Each section of the report looks at the Affordable Care Act from the perspective of one key California constituency. The appendix section also includes a section that highlights the personal stories of Californians who have benefited from health reform.

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The full report can be found at:

<http://www.health-access.org/files/advocating/HA%20ACA%20Two-Year%20Report%203-20-12.pdf>

## HOW THE AFFORDABLE CARE ACT BENEFITS CALIFORNIANS WITH PRE-EXISTING CONDITIONS

People who are living with diseases such as cancer often must fight more than their illness. Individuals with "pre-existing conditions" such as cancer, heart disease, diabetes, etc. have been shut out of the health insurance market—either denied coverage, charged exorbitant premiums, or left with coverage that excludes benefits for their health conditions. The result has been thousands of individuals with serious health conditions who are uninsured—unable to afford health insurance or pay out of pocket for their own medical care. They delay or forego needed care, or go deeply into debt to pay for treatment. It's a situation that puts lives at risk.

### PROBLEM

The uninsured are more likely to be diagnosed with cancer at later stages, and are less likely to survive the disease<sup>1</sup>. Approximately 6,487,000 California adults under age 65 and 576,500 children under age 18 have pre-existing conditions<sup>2</sup>. More than 300,000 people in this country die from cancer each year because they lack access to appropriate care and treatment. In California, it is estimated that 144,800 people will be diagnosed with cancer this year and 55,415 will die from the disease<sup>3</sup>.

### SOLUTIONS

In the two years since its passage, the Affordable Care Act has transformed the outlook for thousands of cancer patients and others with pre-existing conditions, taking them from "uninsurable" to enrolled, and providing newfound hope and health security.

Because of the ACA, uninsured patients with pre-existing conditions now have access to affordable health coverage (Pre-Existing Condition Insurance Program (PCIP) in California) and the worst insurance industry practices that left patients without viable options for accessing care are now history.

- PCIP is helping to fill a void in the insurance market for those who have been uninsured for six months or more, and have a pre-existing condition or have been denied coverage. It is a temporary federally-funded high risk pool that will continue until January 1, 2014 when insurers will be prohibited from denying coverage or charging them more because of a pre-existing condition. PCIP provides comprehensive coverage including primary and specialty care, hospital care, prescription drugs, home health and hospice care, skilled nursing care, preventive health and maternity care. There is no waiting period; health care costs are covered from the first day that PCIP coverage begins. PCIP enrollees are not charged a higher premium because of their medical conditions; rates are comparable to those charged for healthy people in the individual insurance market. However, because premiums are not based on income, they may still be unaffordable for some. PCIP greatly expands the state's capacity for covering "uninsurable" individuals—the Major Risk Medical Insurance Program (MRMIP), a state-run program has been providing limited benefits at a higher cost.

- Because of the ACA, health plans can no longer impose a lifetime dollar limit on benefits for patients with cancer and other illnesses; caps can cause the sudden termination of much needed coverage.
- The ACA puts a stop to the practice of insurers rescinding insurance coverage in response to a diagnosis such as cancer.
- The ACA prohibits insurers from denying coverage to children because of a pre-existing condition.

### **IMMEDIATE IMPACTS**

- Over 8,600 previously uninsured Californians are enrolled in the Pre-Existing Condition Insurance Program as of January 31, 2012<sup>4</sup>.
- Estimated 8,837,000 California adults and 3,255,000 California children are benefitting from the prohibition on lifetime limits on health benefits<sup>5</sup>.
- Approximately 576,500 children under age 18 and 6,487,000 adults under age 65 in California with pre-existing conditions are now protected from being denied coverage<sup>6</sup>.

### **MORE WORK TO DO**

- California will need to transition people with pre-existing conditions enrolled in PCIP and MRMIP to plans in the California Health Benefits Exchange in 2014 when insurers will no longer be able to deny coverage for individuals with pre-existing conditions, or charge them different rates.
- The California Health Benefits Exchange must be implemented and operated so that it improves access to care for people with chronic diseases by decreasing cost, increasing competition, and offering consumers the peace of mind that they are buying a quality health plan.
- Minimum essential benefits must be established to ensure coverage of proven ways to prevent and treat diseases such as cancer.
- Medi-Cal eligibility must be expanded so that low income people with cancer can get access to the quality care they need.



<sup>1</sup>CA: *A Cancer Journal for Clinicians* (2007); 110: 395-402 and 403-411)

<sup>2</sup>Families USA, "Health Reform: Help for Americans with Pre-existing conditions, May 2010, <http://www.familiesusa.org/resources/publications/reports/health-reform/pre-existing-conditions.html>

<sup>3</sup>American Cancer Society, California Department of Public Health, California Cancer Registry. *California Cancer Facts and Figures 2012*. Oakland, CA: American Cancer Society, California Division, September 2011.

<sup>4</sup>MRMIB.

<sup>5</sup>ASPE Issue Brief, March 5, 2012

<sup>6</sup>Estimates based on pre-existing conditions diagnosed or treated in 2007, prepared by The Lewin Group for Families USA.