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Agenda Item 6

November 15, 2011

TO: MEMBERS OF THE HEALTH BENEFITS COMMITTEE

I. SUBJECT: Health Care Reform Quarterly Update

II. PROGRAM: Benefit Programs Policy and Planning

III. RECOMMENDATION: Information

IV. ANALYSIS:

This agenda item contains information on the following health care reform categories:

1. Implementation Activities—Provisions staff have reviewed and are in the process of implementing
2. Federal Regulatory Provision Updates—Provisions staff are reviewing and/or are monitoring
3. California Health Benefits Exchange Board Updates—Significant meeting activities
4. Other Health Care Reform News

1. Implementation Activities

Early Retiree Reinsurance Program

The Early Retiree Reinsurance Program (ERRP) reimburses participating employment-based plans for a portion of health benefit costs for early retirees age 55 and older and who are not eligible for Medicare. The reimbursement also extends to their spouses, surviving spouses, and dependents.

To date, CalPERS has received $98,700,419 in ERRP funds. In September, CalPERS submitted its third quarter 2011 ERRP reimbursement request to the U.S. Department of Health and Human Services (HHS) for $32.7 million for self-funded plan claims. In late October, CalPERS received the full requested reimbursement from HHS. Our December reimbursement request will include health maintenance organization plan claims as well as self-funded plan claims.

2. Federal Regulatory Provision Updates

Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

HHS released proposed regulations addressing reinsurance, risk corridors, and risk adjustment in July 2011. HHS designed these programs to mitigate potential adverse selection and stabilize premiums in the individual and small group markets as the Affordable Insurance Exchanges are implemented in 2014. Below is a brief summary of each program:

- The transitional, state-administered Reinsurance Program serves to reduce the uncertainty of insurance risk in the individual market by making payments to health plans for high-cost cases.
- The transitional, federally-administered Risk Corridor Program serves to protect against uncertainty in the Exchange by limiting health plan losses (and gains).
- The ongoing, state-administered Risk Adjustment Program serves to provide adequate payments to health plans that attract high-risk populations.

CalPERS submitted comments to HHS, via the Centers for Medicare and Medicaid Services (CMS), regarding the preferred method for calculating the Reinsurance Program health insurance issuer contribution rate. Under the Reinsurance Program, all health plans must contribute a nationwide total of $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. A state reinsurance entity will then make payments to non-grandfathered, individual market plans inside and outside of the Exchange to cover high-cost individuals.

In developing the rule, CMS proposed a percent of premium method, as opposed to a per capita amount, as the preferred way in which to determine health plan contribution rates. Staff articulated to CMS a concern that if CMS uses a percent of premium to calculate the contribution rate, it sets a precedent using a formula that could adversely impact the market. For example, contributions for plans with higher risk populations may drive premiums higher, encouraging lower risk plan members to migrate to lower cost plans, potentially creating a premium spiral effect from the adverse selection.

Please see Attachment 1 for a copy of these comments.

Summary of Benefits and Coverage and the Uniform Glossary

In August 2011, the Departments of Labor, Treasury, and HHS issued proposed regulations on the Summary of Benefits and Coverage (SBC) and Uniform Glossary to help consumers understand their health insurance choices and compare health plans. Specifically, the proposed regulations ensure consumers

have access to a:

- Summary of Benefits and Coverage; and
- Uniform glossary.

The rule requires health plans and issuers to provide these forms to individuals upon request, before they purchase coverage, and if the SBC information changes. The SBC summarizes key health plan features, such as covered benefits, cost-sharing provisions, coverage limitations and exceptions, and examples of plan benefit scenarios. CalPERS already provides nearly identical information to members. The uniform glossary defines health care industry terms. All plans will use the glossary in their SBC, creating consistency for consumers. The proposed rule is effective March 23, 2012.

CalPERS submitted comments to the Department of Labor, recommending that employers and plans have the flexibility to implement these provisions during open enrollment on or after March 23, 2012 within the same calendar year. This flexibility would create less confusion for existing employees who typically make enrollment decisions during open enrollment and mitigate the cost of producing these materials off-cycle.

Please see Attachment 2 for a copy of these comments.

Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers

In August 2011, HHS released proposed regulations establishing Exchange eligibility standards for individual enrollment in qualified health plans and insurance affordability programs (including premium tax credits, cost-sharing reductions, Medicaid, the Children's Health Insurance Program, and the Basic Health Plan, if applicable) in the Exchange. The regulations also establish standards for employer participation in the Small Business Health Option Program (SHOP), paralleling the Exchange standards for SHOP in a previous rule. These regulations create a central role for the Exchange to provide streamlined and coordinated eligibility determinations and enrollment processes.

Staff have reviewed the proposed regulations and while they do not initially impact CalPERS operationally or strategically, we will continue to monitor its implementation to more clearly determine any impacts.

Health Insurance Premium Tax Credit

In August 2011, the Department of Treasury released proposed Health Insurance Premium Tax Credit regulations that provide guidance to individuals who enroll in qualified health plans through Affordable Insurance Exchanges and claim a premium tax credit, and to Exchanges that make qualified health plans available

to individuals and employers. Beginning in 2014, people with incomes between 100 and 400 percent of the federal poverty level, not eligible for Medicaid or other public coverage, and not offered minimum essential health coverage by their employer will be eligible for tax credits.

Staff reviewed the proposed regulations and determined that the penalty assessed on the employer to offset the tax credit may impact some contracting agency employers, depending on future premiums, contributions, and salaries. Staff will coordinate Health Benefits Purchasing Review efforts to ensure we bring to the Board a benefit design and premium point that allows the Board to mitigate this potential impact to employers.

Medicare Shared Savings Program

On October 20, 2011, HHS released final regulations on the Medicare Shared Savings Program to help doctors, hospitals, and other providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings (e.g., doctor's offices, hospitals, and long-term care facilities). The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care. Patient and provider participation in an ACO is voluntary. The final rule makes it easier for doctors and hospitals to participate in the program. Some of the changes to the proposed rule include:

- Allowing providers to participate in an ACO and share in Medicare savings without risk of losing money. ACOs can also begin sharing in savings earlier;
- Reducing the number of quality measures that ACOs must meet to qualify for performance bonuses from 65 to 33;
- Telling ACOs up front which Medicare beneficiaries are likely to be part of their system; and,
- Allowing community health centers and rural health communities to lead ACOs.

These regulations impact ACOs in the Medicare program and not the existing CalPERS integrated health care programs, such as the Catholic Healthcare West and Hill Physicians Medical Group (CHW/Hill) Pilot Program with Blue Shield of California. We believe, however, that coordination with CMS is critical to ensuring and minimizing confusion for our members participating in our supplemental plans.

3. California Health Benefit Exchange Board

The California Health Benefit Exchange Board recently appointed Peter Lee as Executive Director of the California Health Benefit Exchange. On November 1, 2011, CalPERS staff met with Mr. Lee and his staff to discuss the CalPERS call center, our member enrollment, employer billing, and online enrollment processes, and the data warehouse.

In October, the Health Benefit Exchange Board met for the ninth time and adopted its Vision, Mission, and Values. The Board also discussed Exchange-related health care reform regulations and comments for HHS, and the Exchange information technology (IT) procurement solicitation scope. Exchange staff hope to have draft IT specifications out for public comment in the next six weeks and a Request for Proposal by the end of 2011.

4. Other Health Care Reform News

Essential Health Benefits

On October 7, 2011, the Institute of Medicine (IOM) released a report recommending criteria and methods to guide HHS in developing and updating the essential health benefits (EHB) package. Plans sold inside state Exchanges, and individual and small group plans sold outside the Exchanges, must provide EHBs to enrollees (large group, self-insured, and grandfathered plans are not required to provide EHBs). The report is a critical milestone, but does not comment on whether specific benefits should be included or excluded, as this was beyond the Institute's charge.

Below is a summary of IOM's recommendations to HHS on the EHB package:

- Adjust EHBs so the expected national average premium for a "silver" plan is actuarially equivalent to the average premium that small employers with a typical plan would have paid in 2014;
- Establish a framework for monitoring implementation and updating EHBs to account for changes in provider payment rates, financial incentives, practice organizations, and other matters by 2013;
- Update the EHBs to make it more evidence-based, specific, and value-promoting, and incorporate costs and a public process for input on updates beginning 2016;
- Allow states to adopt variations to EHBs, provided that modifications are consistent with the federal package, not significantly more or less generous, and are subject to public input; and,
- Establish a nonpartisan National Benefits Council to oversee EHBs and make annual recommendations on updates.

The IOM also recommends HHS develop the EHB package by May 2012.

Community Living Assistance Services and Supports (CLASS) Act

On October 14, 2011, HHS announced that the Obama Administration will suspend work on the CLASS Act, the long-term care program created under the ACA. The CLASS Act intended to provide insurance to workers if they could no longer take care of themselves due to injury or illness. In a letter to Congressional leaders, HHS determined there was not a "viable path forward" to implement CLASS, while keeping it affordable and financially solvent. Prior to implementing CLASS, HHS was required to certify fiscal solvency for 75 years, without federal tax dollars. After 19 months of research, actuaries decided this was not possible within the framework provided by the law.

The underwriting requirement and funding mechanism are the two most distinct differences between the CLASS program and the CalPERS long-term care program. Employment status was the only underwriting requirement for the CLASS program. In contrast, the CalPERS long-term care program has always maintained some level of underwriting and has tightened these requirements over time. The CLASS program was funded through premium contributions and investments in treasuries. CalPERS funds its long-term care program through premiums and investment returns, which are typically much higher than treasury returns.

V. STRATEGIC PLAN:

This directly relates to Goals X, XI, and XII of the Strategic Plan which state:

- "Develop and administer quality, sustainable health benefit programs that are responsive to and valued by enrollees and employers."
- "Promote the ability of members and employers to make informed decisions resulting in improved lifestyle choices and health outcomes."
- "Engage and influence the healthcare marketplace to provide medical care that optimizes quality, access, and cost."

VI. RESULTS/COSTS:

This is an information only item.

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Attachments