Louisiana

The Health Insurance Market of 2023: Tracking the Changes in Louisiana and Nationally

By Mike Bertaut
Healthcare Economist, Exchange Coordinator
Spring 2023

DISCLAIMER

- All information in this presentation INCLUDING THE OPINIONS OF THE PRESENTER are solely for illustrative purposes. The information is based on certain assumptions, interpretations, and calculations that are not necessarily accurate with regard to provisions of PPACA, HCERA, HIPAA, COBRA, ERISA, ARPA, IRA and other rules, regulations, guidance and all other documents issued by relevant state and federal agencies with regard to these laws and any other relevant laws. **The information provided should not be considered as legal, financial, accounting, planning, or tax advice.** You should consult your attorneys, accountants, and other employees or experts of this type of this type of advice based on their own interpretations, calculations, and determinations of applicable laws, rules, regulations, guidance, and any other documents and information that they determine may be relevant. The authors make guarantees or other representations as to the accuracy or completeness of the data in this presentation.

- LHSIC/BCBSLA/HMOLA expressly disclaims any liability for information obtained from use of this presentation by any BCBSLA employee or by any other person. No warranty of any kind is given with regard to the contents of the presentation.

2023 Shaping Up to Be Eventful…

- The unwinding of the Public Health Emergency looms…
- The Family Glitch Fix is in play…
- Humana is exiting the Commercial Group marketplace.
- Carriers are buried in $9 Billion in CAA ‘21 work (transparency, advanced EOBs, etc.).
- Public Option plans are failing everywhere they are tried… They are failing to control costs.
- Governments, both state and federal, working hard to shift medical risk away from their own finances and onto carrier finances.
  - Adjustments in profitability are being called for in Washington.

In Exchange for More Money, States Stopped Screening their Existing Medicaid populations…

- Screening for income, residency and other eligibility criteria in Medicaid stopped in May 2020 as a reaction to COVID.
- As a result, Medicaid has grown by 22 MILLION people nationally since then. Louisiana is no exception.
- States estimate between 7% and 33% of their Medicaid populations will lose coverage in the next 12 months.
- Most states have already begun screening and will start notifying members in April of their new status.
- Those losing Medicaid will have three options:
  - Seek coverage through their/relative's employers
  - Seek coverage through their Marketplace (Healthcare.gov in Louisiana)
  - Allow themselves to become uninsured
- **In Louisiana, may affect 25-30,000 people per month.**

Reconnecting People to Coverage

- BCBSLA is making targeted investments in organizations that serve the affected community to help them add resources.
- Licensed agents all over the state will help the newly uninsured find new coverage without any cost for their services or any obligation to buy anything.
- The goal is a smooth transition.
- Complicating Factors:
  - Medicaid coverage is free. That is, participants don't pay premiums deductibles or copays, or have to worry about maximum out of pocket costs.
  - Private coverage, no matter what the source, will have costs associated with all of these areas.
  - The lowest premium plans on Healthcare.gov may have very high deductibles and maximum out-of-pocket costs.
  - Guidance is key! There are also plans that require almost NO out-of-pocket costs if income is just a bit above the Medicaid threshold.

What's the "Family Glitch" And Why Did It Need Fixing?

- In 2010 the passage of the Affordable Care Act put new obligations on larger employers, typically ones with 50 employees or more:
  - *One of those obligations was a requirement to offer their employees and dependents coverage at just 30 hours/week.*
  - That coverage had to meet both QUALITY and AFFORDABILITY standards for the employee.
  - *Once the employer met those standards, he could avoid federal fines that could get quite large.*
- Unfortunately, no affordability standard was established for DEPENDENT or SPOUSE coverage.
- *This meant employers could meet their obligations under the ACA by offering dependent/spouse coverage but putting $0 money into it.*

How Has It Been Fixed?

- Sadly, even the OFFER of unsubsidized, potentially very expensive coverage to a spouse or dependent would freeze them out of tax credits to help with premiums on Healthcare.gov! (2013 IRS ruling)
- *In October 2022, the IRS changed its mind and issued a final rule that potentially solves the problem without putting a direct cost on the employer:*
  - *Re-compute affordability using the entire family (tax household) as the basis.*
  - *Allow non-employee family members with premiums above a certain income threshold (9.12% of HH income for 2023) to pass on the employer offer and access advanced premium tax credits to purchase individual coverage on Healthcare.gov.*
  - *Keep the same standards as before for the employer/employee relationship.*
  - ***The Determination of Unaffordable Coverage triggers a special enrollment period (newly unaffordable)***
  - ***Affordability MUST be computed on the cheapest plan available, even for spouse/dependents.***

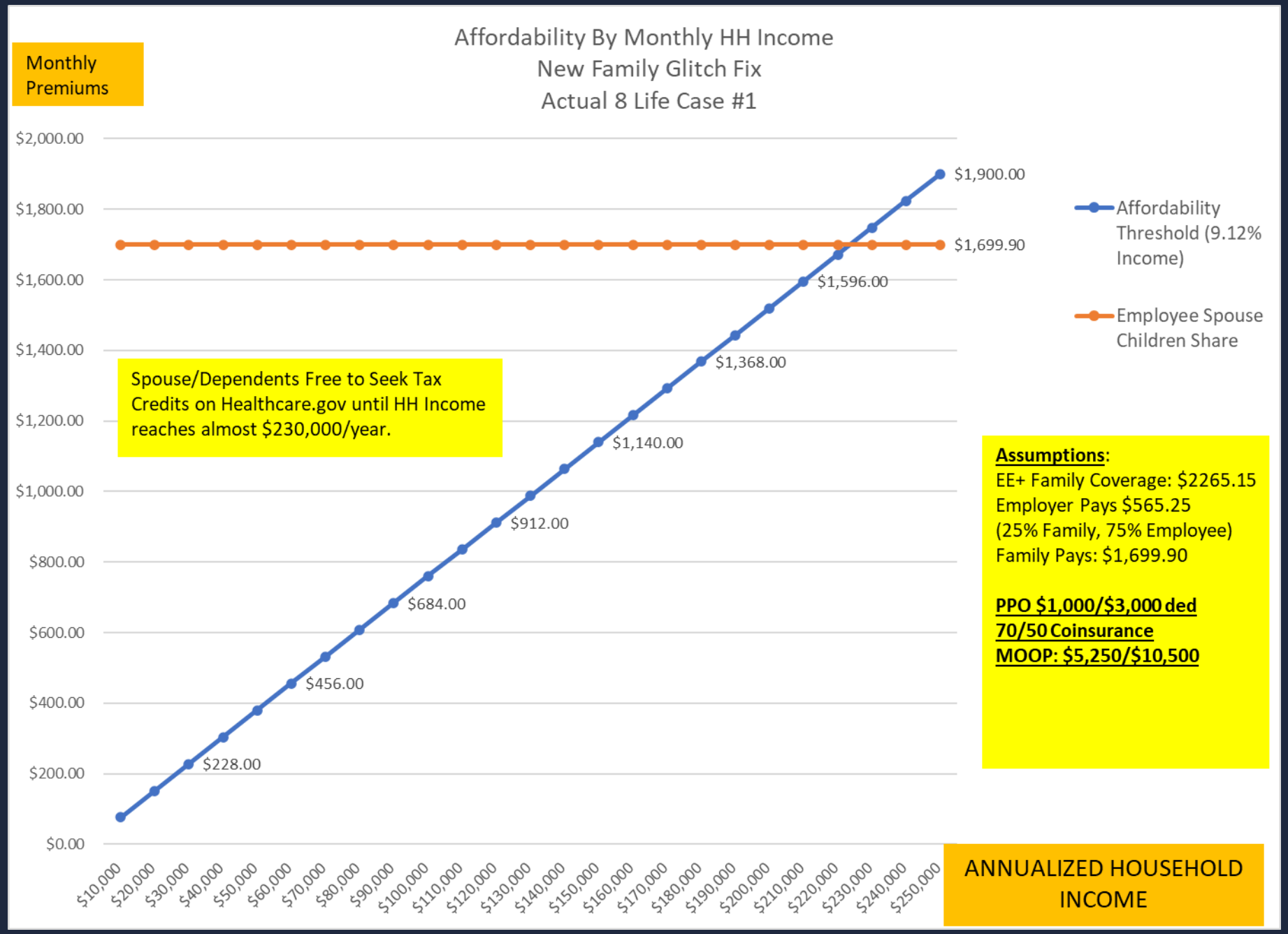
Louisiana Employer Offers are Highly Likely to Trigger this Benefit

STATE	AVERAGE ANNUAL EMPLOYER CONTRIBUTIONS TO FAMILY COVERAGE	TOTAL AVERAGE ANNUAL FAMILY PREMIUMS
ARKANSAS (50th in Nation)	$11,837	$18,339
LOUISIANA (49th!)	$12,574	$19,305
HAWAII	$12,589	$18,539
OKLAHOMA	$12,886	$20,108
ARIZONA	$13,026	$20,117
UTAH	$13,071	
ALABAMA	$13,293	
IDAHO	$13,473	
KANSAS	$13,568	
MISSISSIPPI	$13,830	$20,373

Note that if we remove the contributions of government and union groups, the Louisiana contribution drops to less than $6,000/year.

Important Considerations!

- If the HH is just employee + spouse, the employee rate + the spouse rate are included to test affordability.
- If the HH includes tax dependents, then the “Family” coverage, including the employee + spouse + dependent coverage, is tested.
- An employee who receives ANY offer of affordable coverage is still blocked from Tax Credits on Healthcare.gov.
- IF an employer offers multiple plans or if plans are offered to both spouses, ONLY the least expensive qualified health plan must be tested for affordability.
- *The IRS has created some ability for willing employers to let employees out of unaffordable coverage and cafeteria plans early to take advantage of an affordable offer on Healthcare.gov. See IRS Bulletin 2022-41 & 2022-43*


Monthly Premiums
Affordability By Monthly HH Income
New Family Glitch Fix
Actual 8 Life Case #1
$2,000.00
$1,800.00
$1,600.00
$1,400.00
$1,200.00
$1,000.00
$800.00
$600.00
$400.00
$200.00
$0.00
$1,900.00
$1,699.90
$1,596.00
$1,368.00
$1,140.00
$912.00
$684.00
$456.00
$228.00
Affordability Threshold (9.12% Income)
Employee Spouse Children Share
Spouse/Dependents Free to Seek Tax Credits on Healthcare.gov until HH Income reaches almost $230,000/year.
Assumptions:
EE+ Family Coverage: $2265.15
Employer Pays $565.25
(25% Family, 75% Employee)
Family Pays: $1,699.90
PPO $1,000/$3,000 ded
70/50 Coinsurance
MOOP: $5,250/$10,500
$10,000
$20,000
$30,000
$40,000
$50,000
$60,000
$70,000
$80,000
$90,000
$100,000
$110,000
$120,000
$130,000
$140,000
$150,000
$160,000
$170,000
$180,000
$190,000
$200,000
$210,000
$220,000
$230,000
$240,000
$250,000
ANNUALIZED HOUSEHOLD INCOME

Major New Regulatory Work: The No Surprises Act Provisions

- Prohibit providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing) in certain circumstances (emergencies);
- Require providers and facilities to provide good-faith estimates of charges for care to uninsured (or self-pay) individuals upon scheduling care or on request, and for individuals with certain types of coverage, to submit good-faith estimates to the individual's plan or issuer;
- Create a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate;
- Require certain providers and facilities to publicly disclose restrictions on balance billing; and limit billed amounts in situations where a provider's network status changes mid-treatment or individuals act on inaccurate provider directory information.

Major New Regulatory Work: The Transparency In Coverage Act

- All Carrier Wholesale Network Agreements must be provided online in a machine-readable file, in a federally specified data language including both in-network agreements and out-of-network payment amounts.
- By 1/1/2024, a consumer pricing tool via which carriers are required to disclose personalized pricing information for all covered items and services to their participants either online, by phone, or in paper form upon request.
- Cost estimates must be provided in real-time based on cost-sharing information that is accurate at the time of the request (Time Travel EOB).

Cost Versus Benefit of Changes?

- Hoover Institute Study pegs the cost of all the previous initiatives at $9 Billion across all carriers.
- CBO says consumer benefit from all changes will be $100-$125m a year maximum.
- All listed work must be done in the federally regulated “overhead” category of carrier finances.
- Is this possible without raising rates?

Will Regulatory Work Drive Rate Increases for the First Time? Or Do We Miss Deadlines?

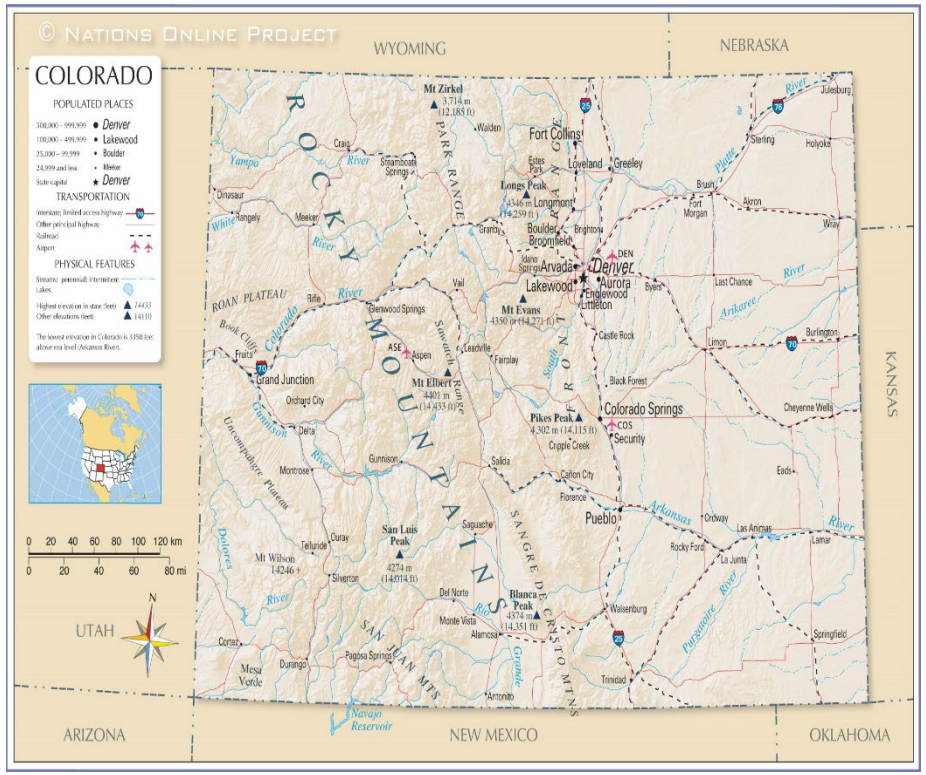
In 2019, Our Members trusted us with ~$3.5B in premiums. Here's how we spent it:

$1.3B (37%)	$770M (22%)	$980M (28%)	$455M (13%)
Hospital	Physician Services	Drugs	Allowable Overhead

- **Drugs are consistently today more than 25% of the total spend (up from 11% in 2005),** physicians and their services down to 22% (From 30%+ a decade ago).
- **Overhead/Gross Margins federally capped (by ACA) at 15% for all groups over 50 lives. 20% for individual and small group offerings**
- **Total Salaries, administrative, benefits, IT upgrade, compliance costs BELOW 6% OF PREMIUMS year after year.**

All figures are estimates based on Blue Cross and Blue Shield of Louisiana actuarial, claims and membership data. Represents fully insured group and individual members of both Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. Includes the cost of prescription drugs administered in physician offices and for outpatient hospital care. Drug costs are net of all discounts and rebates. All other expenses include operating costs, commissions, taxes/fees and reserves.

Public Option Plans: Colorado

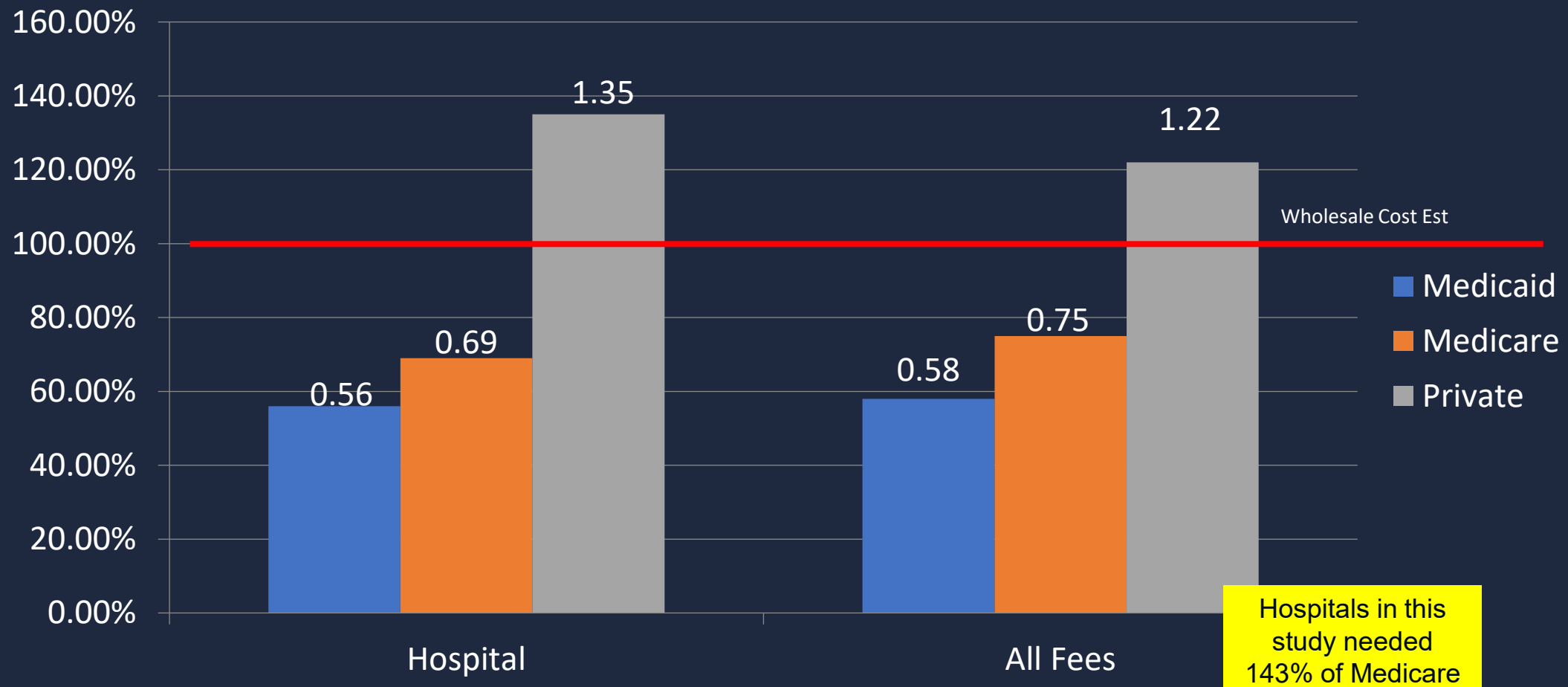


Colorado

- "Hybrid" model with private carriers operating individual plans under strict state rules and controls.
- Open Enrollment 2022 was the first one, only a few thousand people enrolled.
- Pricing was actually 10% HIGHER than most private coverage.
- 90% of participating carriers did not hit state pricing targets.
- Bright and Oscar have both left the market.
- "Plan benefit requirements are so rich no carriers will hit the arbitrarily created premium levels." (Colorado Association of Health Plans)

15

Colorado Spent Years Determining Fair Prices for Reimbursement in their Public Option Plan



Hospitals in this study needed 143% of Medicare to BREAK EVEN on existing care.

https://www.modernhealthcare.com/payment/colorado-unveils-hospital-rates-its-public-option-plan? 00

Public Option Plans: Washington State

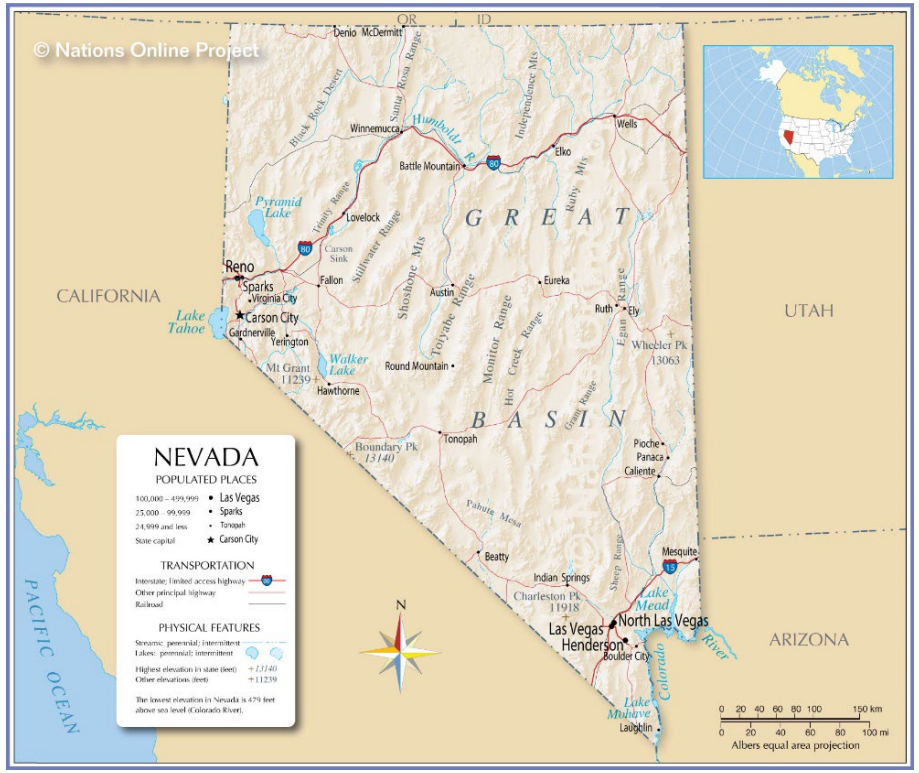
Washington

- "Cascade Select" was designed to lower premiums by putting hard caps on what providers can be paid by carriers.
- Most state hospitals refuse to participate in plans, network in only half of counties (2023).
- Not cheaper than regular plans, only 2,600 people enrolled during 2022 Open Enrollment.

Legislators are debating FORCING hospitals to participate for 2024…

17

Public Option Plans: Nevada



Nevada

- Legislation passed in 2021; target date of launch 2026.
- Requires all MCOs in state to offer a public option plan.
- Premiums must be reduced by 4% annually for the first three years of the plan.
- Carriers will not be allowed to “skinny” networks to hit the premiums.
- Carriers will be REQUIRED to pay providers Medicare plus 10%.

<u>Requirements will be very difficult to hit, carriers still debating participation, providers silent.</u>

18

The Great “Risk Shift” Continues….

- Medicaid
  - 41 states (and Washington, D.C.) are now using Managed Care Organizations for at least some of their Medicaid populations.
  - They cover almost 80% of all people on Medicaid.
  - States typically pay a flat, predictable fee each month per Medicaid recipient to private carriers to assume all medical risk.
  - Carriers agree to operate with a gross margin cap (typically 15%).
  - Trend is INCREASING, not decreasing.
- Medicare
  - Of the 65m people on Medicare, roughly 30 million of them are now enrolled in a Medicare Advantage plan. Enrollment is GROWING…
  - MA plans receive a flat payment per month for each Medicare recipient enrolled in their plan and are at risk for all healthcare costs (beyond copays and coinsurance payments).
  - MA plans have a federal gross margin cap (15% with some allowance for extra services).
  - MA payments can vary based on federal quality ratings (star ratings) of the plans.

Michael Bertaut,
Healthcare Economist
Blue Cross and Blue Shield of Louisiana
225-573-2092
Michael.Bertaut@bcbsla.com
"Mike Bertaut" on Linked-In
@mikebertaut on Twitter
Sign Up for Our Blog!
www.straighttalkla.com

That's a Lot of Spouses and Dependents!