

Americare: the Affordable Care Act

An Overview

Five Main Topics

- Expansion of health insurance.
- Changes in Medicare
- Strong regulations of the insurance industry
- Employers' responsibility
- Cost containment, particularly for Medicare

Expansion of Health Care

- Beginning in 2014:
 - Expands Medicaid an estimated 122,000 low-income West Virginians. Federal government pays almost all of the cost (95.9%)
 - Creates state health exchanges for individuals and small businesses
 - Significant tax credits for individuals and small businesses to make insurance premiums more affordable. 24 million Americans will purchase health insurance in the exchanges.

Medicaid by the Numbers

- \$2.6 Billion health and LTC Program in WV – 75% Federal/25% State
- Serves 390,000 people
- About 20% of all Health Spending in WV
- Serves about half of all children in WV

WHO Is Served by Medicaid

- CHILDREN – about 185,000 annually
- People with DISABILITIES – about 90,000
- Pregnant Women – about 10,000
- Elderly in LTC and Dual Eligibles
- Parents – very low income women, women on TANF – about 50,000
- Current eligibility is about 35% of FPL

WHO is not served

- Single Adults
- Low Income Parents
- Never been a poor people's insurance program
- Primarily a program for
 - health insurance and prevention program for poor children
 - LTC program for people with disabilities and elderly
 - 2/3 of spending in Medicaid is for elderly and people with disabilities.

Medicaid Under Reform

- Eligibility increased to 133% of FPL
 - \$25,000 for family of three
- First time ever for single adults
 - \$16,000 for one person
- Estimate that 122,000 to 157,000 additional West Virginians will be in Medicaid
- 45-55% of all uninsured covered by Medicaid

Health Exchanges

- Essential benefits mirrors the Federal Employees Health Benefits program – what Congress has -- and includes oral and vision care for children.
- Office of Personnel Management contracts with at least two multi-state plans in each exchange.
- Catastrophic plan for young adults.

An Example of Tax Credits for Individuals in the Exchanges

- Family of four with annual income of \$55,000 pays \$370 a month in premiums and the tax credits equal \$560 a month*.
- Additional tax credits to assist with deductibles and copayments.
- Plus out-of-pocket maximum protection.

*Source: Kaiser Family Foundation's Subsidy Calculator: www.kff.org

Tax Credits for Small Businesses: \$40 Billion Buys

- 2010 through 2013, employers with 10 or fewer employees and average wages of \$25,000 or less get tax credits for 35% of the employer's contribution. Phased out for employers with 25 employees and average wages of \$50,000.
- 2014 and beyond, very similar program, but tax credits are raised to 50% of the employer's contribution. Tax credits are limited to 2 years.

For People Who Are on Medicare

- Guaranteed Medicare benefits protected
- Expands wellness and preventive care coverage

For People Who Are on Medicare Continued

- Lowers out-of-pocket prescription drug costs
- Closes in the dreaded coverage gap known as the “doughnut hole” by 2020

For People Who Are on Medicare Continued

- What the law means for those with Medicare Advantage plans
- Changes in how Medicare Advantage plans are paid
- What this could mean for your Medicare Advantage plan

For People Who Are on Medicare Continued

- Reduces waste, fraud and abuse
- Health Care Fraud – Who pays?

Reduction in the Growth of Medicare

- The reductions in Medicare reduces the annual growth from 6.8% to 5.5%, according to the Commonwealth Fund

Commonwealth Fund: The Impact of Health Reform on Health System Spending, May 2010

Grandfathered Insurance Plans

- Any health insurance policy in existence on March 23, 2010 is grandfathered.
- Grandfathered plans must comply with most of the 2010 insurance reforms, but are exempt from almost all of the 2014 insurance reforms.

Interim Final Regulation on Grandfathered Plans

- To maintain grandfathered status employers cannot
 - Significantly cut benefits
 - Increase co-insurances
 - Significantly increase copayments: The greater of \$5 or the medical rate of inflation plus 15%
 - Significantly increase deductibles: medical rate of inflation plus 15%
 - Significantly lower employers' premiums: reduce the employers' percentage of payment to premiums by more than 5 percentage points

Interim Final Regulation on Grandfathered Plans

- Employers must notify employees that they are maintaining a grandfathered plan. Keep this year's Summary Plan document.

Insurance Reforms for Plan Year Beginning After September 23, 2010

- End pre-existing conditions for children
- Young adults can stay on their parent's policy until age 26
- Prohibits lifetime caps on dollar value of benefits and limits annual caps

Insurance Reforms in 2010 Continued

- All new insurance plans must cover preventive services that are clinically effective, and without cost sharing
- Prohibits rescissions, except for fraud

Insurance Reforms in 2010 Continued

- Patient Protections for new plans:
 - Selection of a primary care provider and pediatrician
 - Selection of an OB/GYN provider with no prior authorization needed
 - Use of out-of-network for emergency services with in-network deductibles and copays

Insurance Reforms in 2010 Continued

- Requires the reporting of medical loss ratios in 2010, and in 2011 requires rebates if a medical loss ratio is below 80% and 85% for large group market.

Insurance Reforms in 2010 Continued

- Establishes a process for the Secretary of HHS to review insurance companies premium increases. States are required to report on trends and recommend whether certain companies should be excluded from the exchanges based on unjustified premium increases.

Insurance Reforms in 2010 Continued

- National high-risk pool for uninsured Americans with pre-existing conditions
- Creates a temporary (until 2014) reinsurance for employers with early retiree insurance program

Insurance Reforms for Plan Year Beginning After January 1, 2014

- Guarantee issuance and renewal
- End pre-existing conditions for adults
- End to medical and gender underwriting

Individual Mandate

- Beginning in 2014 individuals must have health insurance or pay a penalty.
- The annual penalty in 2014 is \$95 per adult or 1% of income. Increases to \$695 per adult or 2.5% of income whichever is higher by 2016.
- Exemptions for religious objections, financial hardship and those making less than the IRS filing threshold.

Employer Responsibility

- Free rider provision: If an employer with 50+ employees does not provide health insurance; **and** at least one employee goes to the health exchange and receives tax subsidies; then the employer pays a penalty. Penalty is \$2,000 times the number of FTE minus the first 30 employees.

Employer Responsibility Continued

- Beginning in 2011, employers must report the value of an employer sponsored health insurance on the employees W-2. This is informational only. The value of the employer sponsored health insurance is not taxable income.

Cost Containment

- “The current (payment) system, based on volume and intensity, does not disincentivize, but rather **pays more for overuse and fragmentation.**” Mark McClellan

Cost Containment

- Comparative effectiveness studies and the establishment of the Patient-Center Outcome Research Institute
- Health information technology
- Administrative simplification
- Generic biologic agents

Cost Containment Continued

- Payment reform – moving from fee-for-service to payment that promotes quality and reduces costs
 - Establishes an Independent Payment Advisory Board to make recommendations to reduce Medicare cost
 - Creates an Innovation Center within CMS to test, evaluate and promote payment reform

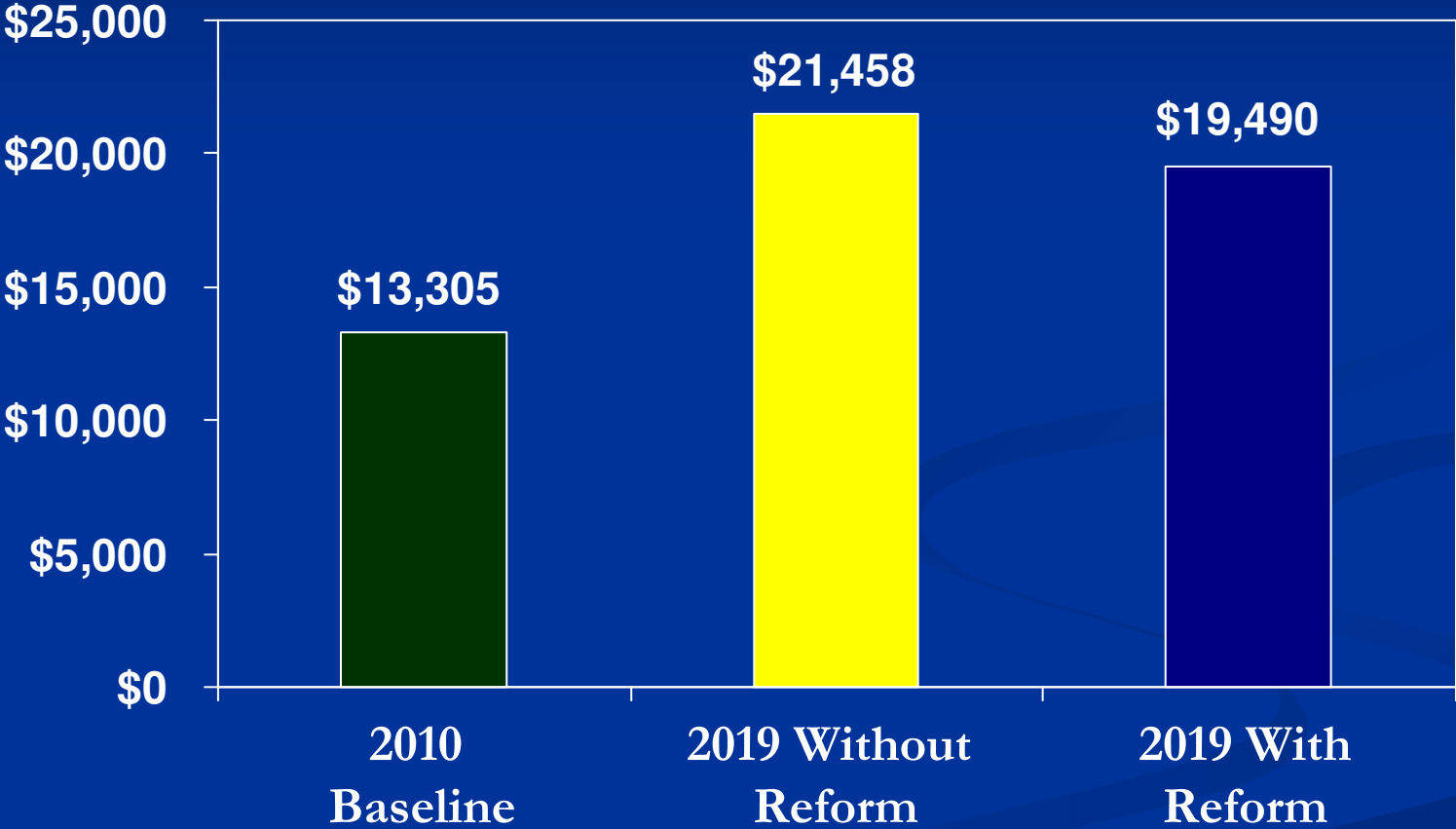
Cost Containment Continued

- Pilot projects for episode of care and accountable care organizations
- Value-based purchasing of hospital services based on quality
- Reduced payment for hospital acquired conditions (e.g. infections) and preventable hospital readmissions

Emphasis on Primary Care and Public Health

- Increases appropriations to community health centers and National Health Service Corp and increases appropriations for public health
- Increases payment to primary care doctors that treat Medicaid patients
- Increases Medicare payment by 10% for primary care providers and general surgeons practicing in under-served areas

\$2,000 Savings in Total Family Premiums with Reform



Source: Commonwealth Fund, The Impact of Health Reform on Health System Spending, May 2010

Under the Radar Gems

- Calorie information posted on menus and menu boards by chain restaurants (2011)
- Non-profit hospitals must do a community needs assessment, implementation plan to meet these needs; and adopt and publicize a financial assistance program that limits charges for low-income patients
- Establish a national, voluntary CLASS program to fund community base assistance program as an alternative to nursing homes.

Other Gems Continued

- Public disclosure of payments made by pharmaceutical companies to doctors, hospitals and other providers. This is physician level data.
- Racial disparities: elevates the Office of Minority Health at the NIH, requires enhanced data collection, promotes training of diverse workforce, and promotes cultural competency training.

Health Care Reform Summit

- August 30 and 31st at the Charleston Marriot
- Register at <http://wvhealthreform.wordpress.com/>
- Presenters include: Ken Thorpe, Jocelyn Moore, Brian Rosman, Kathleen Stoll, Nora Super, Dr. Fred Ralston, Richard Hamburg, Nancy Atkins, and many more.

Contact Information

AARP West Virginia at www.aarp.org/wv

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www.wvpolicy.org

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www.wvahc.org