Health Policy 201 –

Health Care Reform -- US and Connecticut

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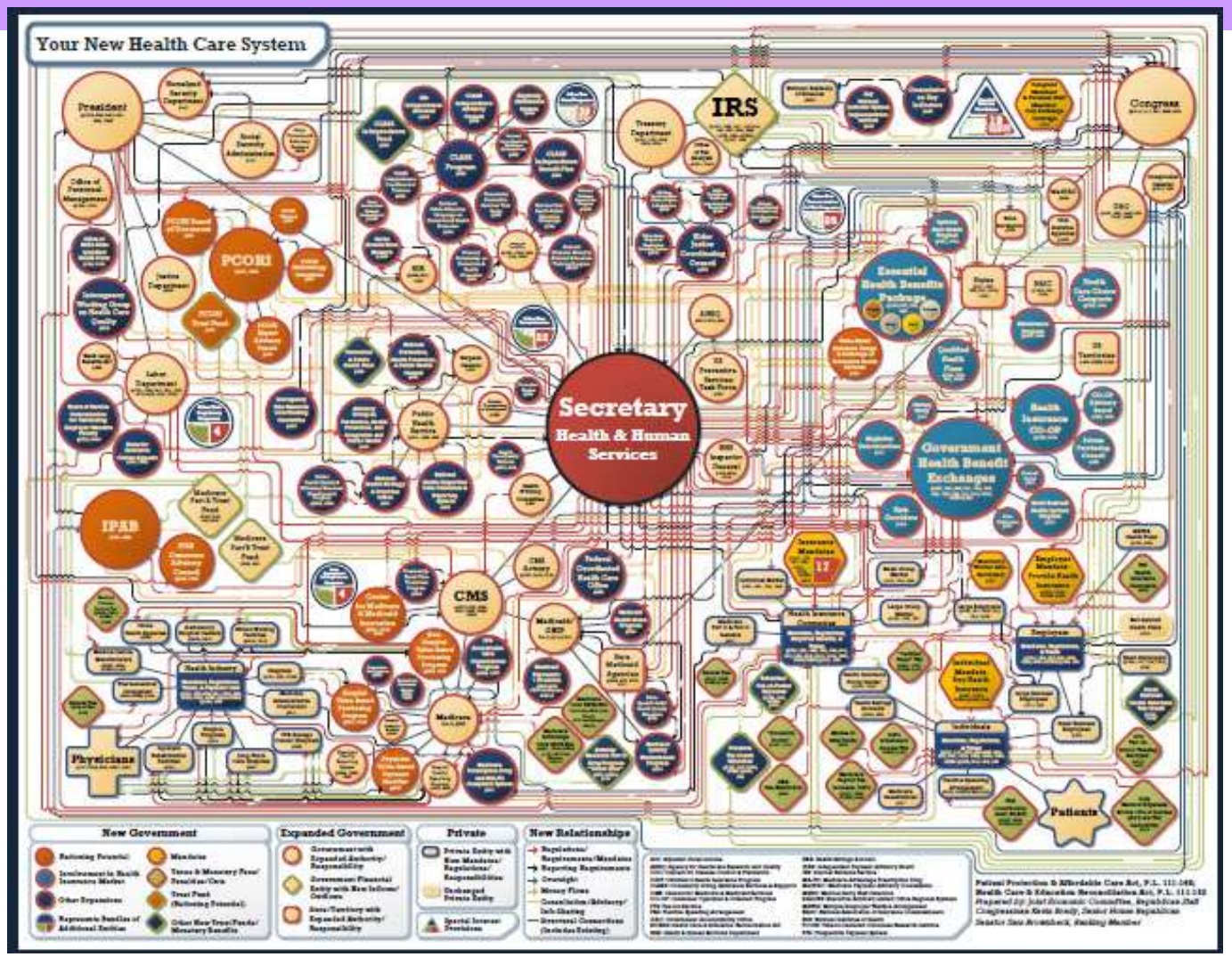
Connecticut Health Policy Project

Overview

- Frontline
  - http://www.pbs.org/wgbh/pages/frontline/obamasdeal/view/?utm_campaign=viewpage&utm_medium=grid&utm_source=grid
- Kaiser Family Foundation
  - http://link.brightcove.com/services/player/bcpid1875349721?bclid=0&bctid=608833805001

906 pages

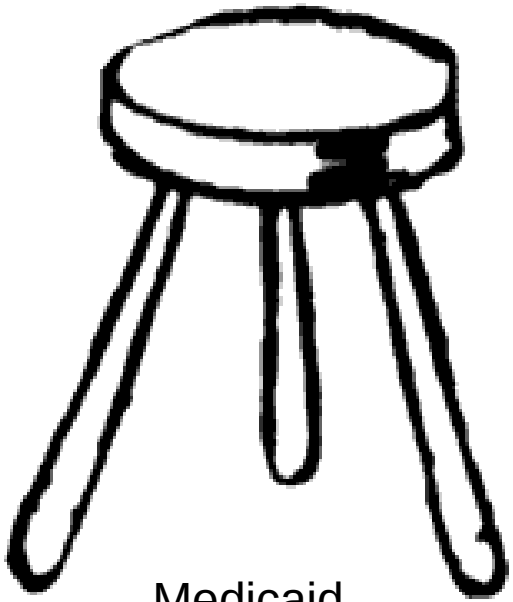


Source: Joint Economic Committee, Republican Staff Congressman Kevin Brady, Senior House Republican Senator Sam Brownback, Ranking Member

Not as complicated as all that

- Increases coverage to 32 million more Americans
  - 200,000 in CT by 2019
- Insurance reforms
- Improving quality of care
- Supports primary care, care coordination
- Reducing rate of cost increases
  - “bending the cost curve”
  - Payment reforms, value-based purchasing
- Stabilizing Medicare’s future
- Reforming Medicaid
- Reduces federal deficit by $143 to $400 billion by 2019
  - CT state government health spending down by 10%

Reform is a 3 legged stool



Medicaid

Employer sponsored coverage

Insurance exchange

Timeline

2010

- No pre-existing condition exclusions for children
- High risk pools
- Young adults can stay on parents' plans to age 26
- No insurance rescissions
  - Can't cancel coverage just when you get sick
- No lifetime limits on coverage
- Small business tax credits begin
- Medicare Part D rebates began
- Employer subsidies for early retiree coverage
- $$ to community health centers
- Tanning tax begins

Timeline

2011

- Medical Loss Ratio mandated
- Uniform health policy materials
- Drug discounts for Medicare Part D donut hole
- Coverage for preventive services in Medicaid begins
- Non-profit hospital accountability
- Non-profit Patient-Centered Outcomes Research Institute (CER)
- Enhanced $$ for Medicaid care coordination
- Menu labeling requirement

Timeline

2012

- Medicare Advantage rate caps start phasing in
- Quality bonuses in Medicare
- Reductions in payments for hospital readmissions

2013

- Medicaid primary care rates to Medicare levels
  - Fed.s pay the full cost for 2 years
- Higher health spending tax threshold begins
- Public reporting of physician performance starts
- Medicare taxes up for higher income filers
- Federal subsidies for Medicare donut hole begin

Timeline

2014

- Exchanges established and operational
- Guaranteed issue of insurance
- No annual caps on coverage
- No pre-existing condition exclusions for adults
- No rating based on health status
- Medicaid expansions effective
- Individual and employer mandates effective
- Individual subsidies begin
- Insurance company fees begin

Timeline

2015 & later

- Value-based purchasing programs to promote quality in Medicare
- 2018 “Cadillac tax” implemented
- Medicare Part D donut hole closed by 2020
- Federal support for Medicaid primary care rate increases end

What it means to the uninsured

- Affordable coverage options available
- Traps in policy fine print gone
- Subsidies for low income
- Basic benefit package
- Mandate to buy/get coverage
- Possible safety net capacity problem
- More options for coverage, more leverage in purchasing, can become a market driver
- Will need to change behavior i.e. ER use → PCMH
- Many/most will enter Medicaid

What it means to insured consumers

- More options
- Reductions in rising costs
- Insurance reforms
  - Rescissions
  - 26 year olds
  - No caps, pre-existing conditions
  - Guaranteed issue, renewal
  - Essential benefit package
  - Standard insurance documents
  - Community rating
- More information on options
- Consumer assistance programs
- Limits variation in rates, no variation for health status or gender

What it means to providers

- No more bad debt, or at least less of it
- More funding to medical care
- Pressure to coordinate care, join larger groups, ACOs
- More scrutiny on quality of care
- Support for care coordination, HIT → lower admin costs
- More Medicaid clients
- Higher primary care rates
- Workforce supports

What it means to employers

- Penalty if not covering workers for large companies
  - Level playing field for the 99% who provide coverage
- Lower health benefit cost increases
- Subsidies, options for small businesses
- Potential help for large businesses
- Wellness, prevention support
- Better information on value of benefits
- Need to work with other payers in data, delivery and payment reforms

What it means to government(s)

- Lower cost increases
- Far more oversight – state and federal
- New data and analysis needs
- Vigilance
- Create and monitor exchanges
- Less need for safety net
- Difficult role of enforcing mandates
- Massive Medicaid increases, 130,000 in CT, into already troubled program
- States get unprecedented federal subsidies, federal deficit reductions

What it means to insurers, drug companies, etc.

- More people have coverage, more business
- Insurers required to cover everyone who signs up and pays
- Everyone legally required to buy their product
- Limits on administration/profit
- Limits on marketing
- Insurance rate review process
- More scrutiny on business practices
- Better informed consumers
- Health from government in reducing escalating costs
- New taxes

Coverage expansions

- 32 million fewer uninsured Americans by 2014, 95%
  - 23 million remain uninsured in 2020
- Medicaid to 138% FPL
  - 15 million Americans newly eligible for the program
  - 133,000 new eligibles in CT
  - Mainly childless adults, more men, many young, working
  - Lower cost than current enrollees
- Subsidies to 400% FPL
  - To purchase only through insurance exchange
- Individual mandate
- Employer mandate, exempts small businesses
- Small business subsidies
- Private coverage more affordable, easier to get

Individual mandate

- Citizens and legal residents over tax filing level
- Tax penalty of $695 to $2,085/family/year
- Phased in to 2016, COLA increases annually after
- Exemptions
  - financial hardship
  - religious objections
  - people without coverage 3 months
  - undocumented immigrants
  - Incarcerated
  - those for whom the lowest cost available plan is over 8% of income
- Implemented through withhold on tax refunds

Individual subsidies

Estimated Premium Credits for Insurance Purchased in the Exchange Based on 2010 Federal Poverty Levels

- **Affordable Premium Credit—Individual**

Annual Income:	Premiums/Income:	Annual Premiums:	Monthly Premiums:
$14,404 (133% FPL)	no more than 2%	$288	$24
$16,245 (150% FPL)	no more than 4%	$650	$54
$21,660 (200% FPL)	no more than 6.3%	$1365	$114
$27,075 (250% FPL)	no more than 8.05%	$2180	$182
$32,490 (300% FPL)	no more than 9.5%	$3087	$257
$43,320 (400% FPL)	no more than 9.5%	$4115	$343

- **Affordable Premium Credit—Family of Four**

Annual Income:	Premiums/Income:	Annual Premiums:	Monthly Premiums:
$29,327 (133% FPL)	no more than 2%	$587	$49
$33,075 (150% FPL)	no more than 4%	$1323	$110
$44,100 (200% FPL)	no more than 6.3%	$2778	$232
$55,125 (250% FPL)	no more than 8.05%	$4438	$370
$66,105 (300% FPL)	no more than 9.5%	$6280	$523
$88200 (400% FPL)	no more than 9.5%	$8379	$698

- Source: Office of Congressman Joe Courtney, CTHPP Webinar 3/21/2010

Employer mandate

- Only applies to firms >50 workers, where at least one accessed subsidies in the exchange
- Penalty for those who offer but have workers who take federal subsidies
  - Lesser of $3,000/FT worker receiving a subsidy or $2,000/FT worker total
- Penalty for those who don't offer benefits at all
  - $2,000/FTE, first 30 workers exempted from fines
- Provide vouchers to low income workers with high costs who choose to get coverage in the exchange
- Firms >200 workers must automatically enroll employees into benefits
- Small businesses get tax credits to offer benefits
- Can access coverage through health insurance exchange

Medicaid

- To 138% FPL regardless of family circumstances
  - $15,028 now single, $30,843 family of four
- Effective Jan. 1, 2014
- Fed.s pay full cost of new enrollees 2014 - 2016, tapers down to 90% by 2020 and on
- States have option to increase to childless adults earlier
  - CT moved former SAGA program into Medicaid under this option last year
  - LIA – low income adults
  - Saved at least $53 million
  - Better care for clients, no asset test
- Primary care rate increase to Medicare level, feds pay full cost 2013-2014
  - Will be intense pressure to continue their support
- Pilots for community based care, payment reforms
- $$ for care coordination, chronic disease management

Insurance changes

- Temporary High Risk Pool
- Medical Loss Ratio standards
  - At least 80% for individual and small group policies
  - At least 85% for large groups
- States must create a process to review rates
- Must cover children to age 26 on parents' plans
- No lifetime or annual limits on coverage
- No rescissions

Insurance changes

- No pre-existing condition exclusions
- Guaranteed issue and renewal
- Limit small group deductibles to $2,000 individuals, $4,000 families
- Limit waiting period for coverage to 90 days
- Essential benefit package
- Limits on rate variation
  - Can only base on age, tobacco use, geography
  - Only 3:1 based on age
  - 1.5:1 for tobacco use
  - Cannot use gender, health status

Insurance Exchanges

- Utah vs. Massachusetts models
- Expect to cover 24 million Americans
  - One in ten CT state residents
- Run at state level or default to federal plan
- For individuals and businesses up to 100 workers
  - States can allow larger businesses in 2017
- Only citizens and legal immigrants
- Out of pocket cost limits
- Four benefit tiers
  - Platinum covers 90% of population medical costs
  - Gold covers 80%
  - Silver covers 70%
  - Bronze covers 60%
- Catastrophic option for young adults to age 30

Medicare

- Donut hole gone by 2020
- Ends Medicare Advantage Plan overpayments
  - No cuts in rates, just reduces increase
  - Phased in over three years
  - Quality incentives
- Creates an independent board to set payment levels
- ACO shared savings model
- Innovation Center created to test payment reform pilots
- Reduce payments for readmissions, hospital acquired infections
- Increase provider rates in underserved areas

Quality, delivery reform

- Over 100 demo projects and >$22 billion for innovation
- Medical malpractice demos
- Comparative Effectiveness Research support
- Medicare and Medicaid pilots of basing payments on quality rather than volume – bundling, ACOs
- Care coordination for dual Medicare/Medicaid eligibles
- Enhanced Medicaid match for care coordination
- Increase Medicaid primary care payments – 2 years
- National quality strategy
- New data and reporting on disparities

Workforce

- Develop a national workforce strategy
- Shift residency slots to primary care and underserved areas
- Promote training in outpatient areas
- Scholarships and loan repayment, target primary care and underserved areas
- Include prevention in training professionals
- Include Nurse Practitioners and Physician Assistants as clinicians in patient-centered medical homes
- Promote diversity and cultural competence
- Support nursing education
- Support training in patient-centered medical homes, teams, chronic disease management, integration of physical and mental health
- $$$ to community health centers and Nat Health Services Corp

Public option

- Came from concerns that individuals would be required to buy private insurance, often from for-profit companies
- Concern that government oversight will not protect consumers
- Offers a transparent, accountable, affordable, comprehensive, voluntary option
- Competition of public option with private insurers would keep private plans honest and make both better
- Rejected at national level due to insurance industry pressure
  - SustiNet in CT

Concerns from the Right

- “Government takeover” of health care
- Limits on profits will hinder innovation
- Not enough cost control in bill
- Individual mandate
- Costs too much
- Too little flexibility for states

Concerns from the Left

- Insurance and drug industry “wrote the bill”
  - Too many deals
- No public option
- No discussion of single payer
- Not universal
- Subsidies are too weak to be meaningful
- Too much reliance on states
- Leaves out undocumented immigrants

Public opinion

- Public divided, confused on reform
- Don’t understand the parts of it
- Generally reinforce underlying political views
- Sick of the incivility, but responding to it
- Fading into the background now, far behind the economy and jobs

CT impact of ACA

- Uninsured rate from 11% to 5%
  - Reduce uninsured by 200,000 by 2019
- Medicaid roles will increase by 31%
  - Up by 130,000
  - One in six state residents will be covered through the program
- Total state government spending on health care will drop by 10% 2011-2020
  - Mainly due to federal subsidies

CT impact of ACA

- Little change to employer-sponsored or state employee coverage
- Insurance Exchange will cover one in ten state residents by 2016
  - 140,000 will receive federal subsidies
  - 40,000 small business employees

CT status

- Insurance exchange board announced, meeting
  - Despite strong conflict of interest law, dominated by insurance interests
  - No voting consumer rep.s, despite federal regulations that consumer rep.s should be a majority of voting members
  - Advocates mounting challenges to insurance domination
- SustiNet/Governors Health Reform Cabinet starting work
- Medicaid reforms beginning
  - Move to ASO, Jan. 1st, CHN will administer
  - Patient-centered medical homes
  - Improvements to provider relations, recruitment
- State employees shift to non-risk last year
  - Wellness/value based purchasing being implemented Jan. 1st

SustiNet

- Was to be CT's public option
- Merge (in some form) Medicaid with state employee plan
  - Then include municipalities, nonprofits, and individuals – in that order
  - Completely voluntary
- Emphasizes, supports team-based patient-centered medical homes
- Emphasizes prevention
- Public health initiatives – tobacco, obesity prevention and treatment, disparities
- Rejected by Malloy administration
  - After supporting during the campaign
- SustiNet Health Reform Cabinet now meeting

Future, politics

- Many new Congressmen elected on platform of repeal, reverse ACA
- Republicans gained control of House, not Senate in 2010
- Another election for Congress and President next year before this is implemented
- Court challenges down to individual mandate, Medicaid expansion
  - Supreme Court will decide before elections
- Several states refuse to implement
  - But still taking federal funds

More info

Senate bill

http://democrats.senate.gov/reform

Kaiser Foundation site

http://healthreform.kff.org

CT Impact: RAND study

http://www.rand.org/pubs/technical_reports/TR973z1.html

For more information

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