Health Reform Explained

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The Patient Protection and Affordable Care Act (PPACA)
Is this………

- A major step in the right direction & a framework for needed ongoing health reform?

    OR

- A government takeover of health care that deprives Americans of their freedom?
Health Reform discussed over past 20 years

- Expand public programs
- Private market reforms
- Shore up the safety net
- Individual mandate
The Patient Protection and Affordable Care Act (PPACA)

- Overview of health reform legislation
- Implementation timeline
- Key Provisions
- Winners & losers
- What does it mean for Missouri?
- Q & A
Overarching goals

- Cover (almost) everyone
- Improve the quality of care
- Begin to control health care costs
Hopes & Dreams……..
Overall, within the next year….

- Children with pre-existing conditions cannot be denied coverage.
- Young adults can stay on their parents’ insurance plan until age 26.
- People denied coverage due to health issues can obtain temporary insurance through new high-risk pool.
- $250 rebate to seniors to counter “donut hole” in drug coverage.
Within the next year….

- Tax credits available for small companies offering coverage
- Insurance companies can no longer arbitrarily cancel or limit coverage
- Preventive measures for patients covered
- Insurers are required to put a large % of premiums into benefits rather than profits
Starting 2014 ….

- All individuals can no longer be denied health insurance due to preexisting conditions
- 32 Million Americans who currently do not have insurance will be covered
- Individuals up to 133% of Federal poverty level (FPL) will be covered under Medicaid
- Sliding scale subsidies offered to those from 133%–400% of FPL
- State based Exchanges will begin operating
2014....

- Large employers not offering insurance will face a penalty
- Individuals not carrying health insurance will face a penalty
Overall…

- Increase in regulation & accountability
- Increase in federalization
- First steps toward paying for value rather than volume
How much will it cost?

- $788 Billion over 10 years
- Deficit reduction of $143 Billion over 10 years
Imposes taxes on

- Insurers
- Pharmaceutical and medical device industry
- High income individuals
- “Cadillac” plans

Assumes Medicare savings of $500B through 2019
Federal team for implementation

- Pete Rouse
- Nancy-Ann DeParle
- Kathleen Sebelius - Sec. of HHS – can expand promising provider payment reforms nationwide without Congress’ permission
- Donald Berwick – nominated CMS director - will oversee an Innovation Center in CMS
  - Health Care Innovation Zones (HIZs)
Jay Angoff – consumer advocate – will lead the regulation of insurers and insurance markets (defining “unreasonable”)

Jeanne Lambrew – veteran of the Clinton White House – will lead coverage expansions

Phyllis Borzi – Labor Dept. official – will police employers who provide benefits to over 150M Americans
There will be unintended consequences............
Nearly 4 in 10 people want the law repealed

When asked about specific aspects of reform, such as insurance reforms, the majority of respondents favored such action.

The individual mandate is unpopular.

59% of people supported the idea of a public option, which was not contained in the bill.
Health Reform legislation
Key Components
HEALTH CARE CONSUMERS
Establishes an Interim High Risk Pool Program $5B – 2010

- Provides access to health insurance for individuals who are uninsured for 6 months or longer due to a pre-existing condition
- Members will pay no more that 35% of the cost of covered benefits
- New state and federal based programs
- Will end when Exchanges become operable in 2014
Coverage Expansions

- Reduce the number of uninsured by 32 million in 2019
- 94% of legal residents to be covered
  - 16 Million will enroll in Medicaid
  - 24 Million through “Exchanges” including some who previously purchased coverage on their own in the individual market.
- 23 Million will remain uninsured
  - 1/3 of those are undocumented immigrants
Coverage expansions

- Medicaid expanded
  - Up to 133% of the federal poverty level (FLP) for all individuals < 65yr - 2014

- 100% Federal funding for the costs of the newly eligible for Medicaid 2014-2016
  - 95% in 2017
  - 94% in 2018
  - 93% in 2019
Premium subsidies to individuals 133%-400%FPL

- Provides refundable, advanceable, and sliding-scale premium credits for individuals and families incomes up to 400% of the federal poverty level (FPL)
FPL

- $10,830 for an individual
- $22,050 for family of 4
Premium subsidies for insured through exchanges

- A 40-year-old earns $21,660 (200% FPL)
  - annual premium is $3,500
  - subsidy of $2,135, goes directly to the insurer
  - he or she pays $1,365

- A family of four with an income of $44,100
  - Family would pay $2,778
  - Subsidy would be $6,656
• The proportion of income people at this level have to pay for insurance is capped at no more than 6.3 percent of their earnings
Families earning 300 to 400% of FLP
- expected to pay up to 9.5% of their income - from $6,284 to $8,379 per year
- the federal subsidy is from $3,150 to $1,056

Anyone who cannot find a premium that costs less than 8 percent of their income is exempted from the penalty
New rules on Flexible Spending Accounts

- Cannot use to cover over the counter medications unless directed by a doctor (2011)

- Limited to $2500 per year (2013)
Preventive Services

- Requires new plans to provide 100% coverage for recommended preventive care, all plans by 2018
  - such as immunizations and cancer screening

- Medicare will do so starting in Jan 2011
  - Level A & B recommendations of the US Preventive Services Taskforce (USPSTF)
Medicare

- “Donut hole” gradually closed

- Private Medicare Advantage (managed care) government subsidy cuts phased in
Help for Seniors with prescription drug costs

- For those in the donut hole:
  - $250 rebate 2010
  - 50% discount on brand-name drugs 2011

- The donut hole will be phased out over time and completely eliminated by 2020
Closes the Medicare Prescription Donut Hole

Occurs between the $2,700 initial limit & when catastrophic coverage kicks in at $6,154
Cuts in the Medicare Advantage plans - $136B by 2019

- Private plans that administer Medicare benefits - paid 14% more than the per-patient cost of the traditional Medicare program

- Lower premium costs or extra benefits not normally paid for by Medicare, such as vision care or better prescription drug coverage
"Over time, there will be less rich benefits or higher premiums, but it's going to be gradual," noting that the largest cuts do not begin until 2015.

Marsha Gold, Mathematica
Individual Mandate

Most individuals will be required to have health insurance beginning in 2014
Penalties for those without coverage

- $95 for an individual in 2014, $325 in 2015
- Raises in 2016 to $695 per individual up to a maximum of $2,085 per family, or 2.5% of household income, whichever is greater
- Exemptions
  - financial hardship or
  - can't find coverage costing less than 8% of income.

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University of Missouri
High income earners

- Medicare payroll tax will increase from 1.45% to 2.35% for individuals earning more than $200,000 and married filing jointly above $250,000 – 2011

- The same taxpayers face a 3.8% tax on unearned/investment income, starting in 2013
EMPLOYERS
Impact of health reform on business

- **Large (>50) Employer mandate**
  - $2,000 penalty per employee for no coverage

- **Mid-sized (26-50) employers**
  - No penalty, no tax credits

- **Small (<26) employees**
  - Tax credits for offering coverage
Companies with <50 Employees

- Make up 96% of U.S. businesses

- Are exempt from the mandate that requires larger enterprises to provide health benefits by 2014 or pay a $2,000 penalty per employee
Tax credits for small business (<26 workers)

- Small businesses that cover at least 50% of their workers' premiums will get tax credits up to 35% of their cost of providing coverage to their workers.

- In 2014, the tax credit increases to 50% for coverage purchased in the insurance 'shopping mall,' or exchange, for two years.
The full 35% to 50% credit will be available to employers of 10 or less with average annual wages below $25,000

The credit phases out as firm size and average wage increase
New rules for large businesses (>50 FTEs)

- Will pay a $2,000 fee for each full-time employee not offered health coverage (except for the first 30 FTE)

- This fee would then help cover the cost of buying a policy in the insurance exchange
More fees.........

- If an employer offers coverage but has at least one employee who is entitled to a premium tax credit because the employer's plan is too costly, the penalty is $3,000 for each employee receiving a credit or $2,000 for each full-time employee, whichever is less
For employees of big business

- If share of health insurance is too costly (to 8% of salary), one could buy a policy in the exchange in 2014
  - The employer must give a voucher for the amount they would have spent on one’s health insurance

- If the cost of coverage exceeds 9.5% of income, and one’s total income is under a certain amount, tax credits to purchase coverage in the exchange are available
Wellness

- Employers may offer rewards of up to 30 percent of the cost of a health insurance plan to employees who participate in a wellness program and meet certain health-related standards.
HEALTH CARE INSURERS
Health insurance market reforms

- Within six months….

  - Requires public disclosure of overhead/benefit spending by health insurance issuers
  - Eliminates lifetime limits on benefits and restrictions on annual limits on benefits
  - Requires development of uniform explanation of coverage documents for enrollees
Allows states to form compacts for the interstate sale of insurance
Significant Health Insurance Reforms

- New regulations prevent
  - Denying coverage or charging higher premiums for gender or health status (but can for age, geography, and tobacco use)
  - Imposing exclusions on children (2010) and adults (2014) with pre-existing conditions
  - The practice of rescission – (dumping pts when they get sick)
  - Life time and annual limits on coverage
New rules for insurance companies

- Insurers must devote at least 80% of premiums to paying medical claims - 2010
  - 85% for insurers serving large groups

- Otherwise they have to give money back to consumers next year as a rebate – 2010

You could get a check from your insurance company in 2011!
Establishes a new independent appeals process

- For consumers in new plans
- To have access to effective internal and external appeals process to appeal decisions made by their health insurer
Health Insurer

Your excuses for not providing me coverage have been denied...
The Secretary of HHS has made it clear that the feds will be watching and will “do battle” if health insurers adopt practices that harm consumers between now and 2014.
Senate discussing……..

- New legislation that would provide a check on “unjustified” premium hikes

- 22 states in the individual market and 27 states in the small group market do not require a review of premiums before they go into effect
By 2013

- Health plans must implement uniform standards for electronic exchange of health information to reduce paperwork and administrative costs.

- Contributions to flexible savings accounts will be limited to $2,500 per year.
Insurance exchanges

- Creates state-based and administered health insurance exchanges (marketplaces) for the individual and small group market by 2014

- Only qualified health benefit plans meeting specific criteria can be sold in the exchange

- Large employers to be phased into the exchanges in 2017
- Allows qualified health plans to provide coverage through a qualified primary care medical home that meets certain requirements

- Requires health plans to publicly disclose information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing and enrollee rights
Requires health plans to take steps to reduce health disparities, including the use of language services, community outreach and cultural competency trainings
Cultural competency

- Requires improvements in the collection and standardization of data for public programs, including data on:
  - Race
  - Ethnicity
  - Primary language

- Requires the exchanges to provide linguistically appropriate information on health insurance options
Requires health plans seeking certification as qualified for the Exchange to use **plain language** in writing:

- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment
- Data on the number of claims that are denied
Insurance companies required to use plain language on insurance forms!!!!
Health Literacy

- The average adult reads at an 8th grade level
- Nearly 1 in 5 adults read at or below the 5th grade level
Applied to net premiums of all health insurers based on their market share.

For non-profit insurers, only 50 percent of net premiums will be taken into account in calculating the fee.

Exemptions are granted for programs receiving >80% of income from serving low-income, elderly, &/or disabled.
Annual fee on pharmaceutical companies
- Based on annual sales and set to reach a certain revenue target each year – 2011

Annual fee on medical device manufacturers
- Annual excise tax of 2.3% on medical devices including the vast majority of orthotics and prosthetics, as well as durable medical equipment – 2013
Tax on High-Cost “Cadillac” Health Plans - 2018

- If value of the plan exceeds $10,200 for individual coverage and $27,500 for family coverage
- The tax is equal to 40 percent of the value of the plan that exceeds these threshold amounts
- Imposed on the coverage provider – insurer, plan administrator or employer
HEALTH CARE PROVIDERS
Primary Care

- Increases Medicaid primary care pay to 100% of Medicare rates in 2013 & 2014
- Boosts funding for Community Health Centers
- Provides 10% Medicare bonus from 2011-2015 for primary care and general surgery in health professional shortage areas
Over five years, nearly doubles funding for Federally qualified Community Health Centers
Healthcare Workforce Provisions

- Training programs for primary care doctors, nurses, and public health professionals
- Commission to advise Congress on future health care workforce needs – Sept. 2010
- Grants to create or expand primary care residency programs – in FQHCs, etc.
- Grants to provide scholarships for mid-career health care professional training
New physician owned hospitals are barred from participating in Medicare

Hospitals must have a process in place for physicians to disclose any financial interest in the hospital to patients by 2013
Independent Payment Advisory Board (IPAB)

This provision divisive for the House of Medicine
Establishes the Independent Payment Advisory Board (IPAB)

- 15 full-time, Senate confirmed members
- 6 year terms
- Can put proposals in place nationwide unless Congress objects within 30 days
- Even then…… the President can veto the disapproval resolution and it takes 2/3s of both the House and the Senate to override the veto
“a very muscular provision”

Peter Orszag, director of Office of Management & Budget (OMB)
IPAB

- Expected to save at least $15.5B of the $500B in savings projected from the Medicare program through 2019.
- After 2014, IPAB can alter payment for doctors but not hospitals until 2019!
- Cannot change benefits and out of pocket costs for Medicare recipients.
Health Care Quality

- A plan to establish a national strategy for improving health care delivery, patient outcomes and overall population health
  - HHS must submit to Congress by Jan 1, 2011

- Grants to community-based networks of hospitals and health centers to improve coordination of services to low-income people
“bundled payments that encourage each patient’s various caregivers to coordinate care for a fixed sum……..”

Demos in up to 8 States
“Takes the first steps toward breaking the link between pay and volume of services.”

Frederick E. Turton, MD, Chair of the ACP Board of Regents
By March 23, 2010, federal agencies managing health programs and conducting surveys will have to start collecting statistics by demographic characteristics such as race, ethnicity, sex, language and disability status by narrow geographic areas to determine quality of and access to health care.
To examine the comparative effectiveness of different medical treatments by evaluating existing studies and conducting its own

- 19-member board chosen by Comptroller General - includes doctors, hospitals, drug makers, device manufacturers, insurers, payers, government officials and health experts
Patient-Centered Outcomes Research Institute

- Cannot mandate or even endorse coverage rules or reimbursement for any particular treatment

- Medicare may take the institute’s research into account when deciding what procedures it will cover, so long as the new research is not the sole justification and the agency allows for public input
Reductions in Disproportionate Share Payments (DSH)

- Medicare DSH - $22 Billion over 10 years – starting in 2014

- Medicaid DSH - $14 Billion over 10 years

  - To reduce payments that are “not empirically justified”

- $7.1 Billion over 10 years
- Payment reductions for 30 day readmission rates for
  - Heart attack
  - Heart failure
  - Pneumonia
- If the rates exceed “risk-adjusted expected rates”
The Patient Protection and Affordable Care Act

- Unexpected provisions
  - Require chain restaurants (>20 stores) and food sold from vending machines to disclose the nutritional content of each item (2011)

- The Student Aid and Fiscal Responsibility Act-making the government the main student loan lender
My favorite provision?

A tax of 10% on amount paid for indoor tanning services – July 1, 2010
My least favorite provision?

12 years of exclusivity for the makers of biologic medications
Winners

- Uninsured and Currently Uninsurable
- Health care providers – doctors, nurses, etc.
- Hospitals and Clinics
- Pharmaceutical industry
- Private Insurers
- Employers – esp. small
- Primary Care Providers
- Young people
- Seniors who take medication
Losers

- Private insurers
- High income Americans
- Specialty providers
- Employers – esp. large
- Young people
- Older Americans using Medicare managed care plans
- Generic drug makers
Not included……..

- Public plan
- Significant liability reforms
- Provider payment reform
- A fix for the 21% Medicare cut for physicians
- Major cost controls
Fear of Lawsuits

Gallup recently conducted the six-week, nationwide survey across all specialties of physicians. Those doctors reported that 26 percent of overall healthcare costs can be attributed to the practice of defensive medicine.
Medical malpractice provision

- Beginning in fiscal 2011, the HHS secretary is authorized to spend $50 million over five years on grants to states intended to design alternative methods of resolving medical malpractice claims, and to encourage more detailed and complete reporting of medical errors.
Missouri
Missouri Health Insurance Pool (MHIP) (existing high-risk pool)

- Provides health coverage to medically uninsurable Missouri residents who are unable to obtain private health insurance
- Deductibles range from $500 to $5,000
- Out-of-pocket maximums range from $2,500 to $5,000
- Does not cover any costs incurred during the six months preceding the effective date of MHIP coverage
Missouri

- Deadline for submitting a letter of intent to apply HHS to administer the federal pool is April 30
- Must be operated completely separately from the existing state high risk pool
- Cannot be used to cover patients currently covered by the state pool
- Estimate that as many as 20,000 Missourians will qualify for the federal pool
Impact for Newly Medicaid-Eligible Adults (MO Health Net)

- Raise the eligibility to 133% of the poverty level on January 1, 2014
- Will cover an additional 255,000 Missouri adults
- The federal government will pay 100% of the cost of covering this new population for the first three years beginning in 2014
## Cost of Expanding Medicaid Eligibility to 133% FPL: 255,000 Missouri Adults

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**Notes:**

- In the above chart, “M” denotes “millions”, “B” denotes “billion”
- Estimates include an inflation rate of 4.5%
Missouri Cost of Newly Medicaid-Eligible Adults for the Next 10 Years (2010-2019), $11.68 Billion

Will cover an estimated 255,000 adults starting in 2014

- Federal: $11.3 Bil, 96.80%
- State: $0.38 Bil, 3.20%

Center for Health Policy
University of Missouri
Health Literacy Missouri

Established through funding from Missouri Foundation for Health (MFH):

- to increase awareness of the role health literacy plays in the health of Missourians.
- to foster collaboration and coordinate resources and efforts among diverse organizations located across the state
- to provide a clearinghouse of resources, technical assistance, policy analysis, education, and outreach to improve the health literacy of Missourians.
Status of Missouri Legislative action regarding health reform:

- House Joint Resolution passed the house on March 16. It has been referred to the Senate Government Accountability and Fiscal Oversight Committee, which held a hearing on it on April 22.

- Senate Joint Resolution 25 is currently on the Senate’s Informal Calendar. Last taken up on March 24, but placed onto the informal calendar with an amendment pending.
Peter Kinder, Missouri’s Lt. Governor – has joined a lawsuit challenging the constitutionality of the individual mandate on behalf of Missourians - using private money
In review, within the next year....

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2014....

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- Individuals not carrying health insurance will face a penalty
In summary.....

- This is comprehensive health reform
- There will be changes as it rolls out
- Provider payment reform will be messy
- Politics/elections will continue to influence
8th Annual Health Policy Summit

Friday, Oct. 29, 2010, Hilton Garden Inn, Columbia, MO

This year’s Summit will deal with “The Future of Health Care” and “The Social Determinants of Health” featuring the following speakers:

Louis Sullivan
Uwe Reinhardt
Gary Schwitzer

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