Federal Health Care Reform, So Far: Overview and Reflections

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Disclosures

• I have no actual or potential conflicts of interest in relation to this presentation.

• Any comments or views expressed are strictly my own and do not represent the views of my employer, the university, or any sponsoring entity for this webinar.
Topics

• Goals of Federal Reform
• Components of the federal law
• Mechanisms for Coverage
• Insurance reforms
• Individual Mandate (and challenges to it)
• Financing mechanisms
• Other Medicaid Options
• State specific Considerations
• Questions
GOALS of the Patient Protection and Affordable Care Act (ACA)

• Significantly reduce the number of uninsured
• Improve value of insurance benefits
• Improve access to insurance coverage
• Improve health care quality and reduce disparities*
• Contain cost growth
Who are the Uninsured?

- In 2009, over 50 million (~16% of) Americans were uninsured:
  - poor (<133% FPL),
  - young (19-25 years) or
  - older with pre-existing medical conditions (ages 50-64)
- Affordability and insurance policy exclusions are main obstacles to coverage
- Uninsured numbers growing steadily
- Medical debt is leading cause of personal bankruptcy

“There’s a fundamental lack of economic security in our country,” Gruber said. “If you don’t get insurance from your employer, you are one bad gene, or one bad car accident away from losing everything.”

Jonathan Gruber, MIT Professor of Economics; architect of MA and Fed health reform model; quoted in “Comic Treatment for Health Plan”, The Pulse, Feb 8, 2011.
Components of the Patient Protection and Affordable Care Act

- Mechanisms for coverage of uninsured
- Insurance Reforms
- Financing of the Reform
- Cost containment, quality improvement and innovation*
- New Medicaid Options and Roles for States

*See Resources slide for Report detailing these
Mechanisms for Coverage

• Medicaid Expansion and expanded CHIP funding*

• Employer sponsored insurance –
  • penalties for large employers who do not offer coverage
  • incentives to certain small employers who do offer coverage
  • affordability standards for employees

• Exchanges - to enhance affordable options and transparency for individuals and small businesses

• Tax credits - to subsidize cost of private purchase (133-399% FPL)

• Insurance Reforms and the Individual Mandate
Mechanisms for Coverage: Medicaid Expansions

- Medicaid coverage of Adults up to 133% FPL
  - 100% federally-funded for 3 years; from 2017 on, State share at 10%
  - Requirement has been upheld by federal courts, to date
  - *Option* to add now (without waiver processes) at standard FMAP rate
  - States already covering, pre-ACA, get phased-in FMAP enhancements, if maintain eligibility levels at July 2008 levels (narrow hardship exceptions)

- Medicaid for Former Foster Children up to age 26

- Medicaid Premium Assistance: all enrollees with access to ESI

- Impact on hospital and health industry
  - Uncompensated care reduced
  - Medicaid rates become larger portion of payer mix
  - State can leverage new federal revenues for state’s health industry

- Indirect benefits to employers and insurers
  - Insurers risk pools – many low income now on Medicaid
  - Medicaid revenues for payment of ESI premiums

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<th>State</th>
<th>Medicaid Enrollment</th>
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Source: Holahan and Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. Kaiser Commission on Medicaid and the Uninsured, May 2010.
Mechanisms for Coverage: Employer-Sponsored Insurance (ESI)

- **2010 - Small employer tax credits** for insurance offers
  - < 25 employees; average annual wages <$50K
  - Effective 2010 - 2013; after 2013, credits available for two years

- **2014 - Large employer (> 50 workers) penalties**
  - Up to $2000 per employee per year for not offering benefits
  - ESI affordability –
    - if employee share of premium is more than 8% of income, employee can go to Exchange; if income-eligible, can get tax credits too, and
    - if costs for employees > 8-9.8% of income, employers must provide vouchers for purchase of Exchange products

- Small employers (< 50) are **exempt** from penalties
Health Insurance Exchanges

• For all without access to affordable ESI and small employers
  • Open, transparent marketplace for eligible purchasers
  • Standardization of benefits and actuarial value of health plans allows “comparison shopping” and furthers competition
  • Coordination of enrollment and Medicaid eligibility

• Subsidies (Tax Credits) for incomes 133% - 400% FPL; amount to be indexed on sliding scale basis

• More Options:
  • Federal Govt exchange - states can opt to use federal Exchange
  • Multi-state exchanges
  • Option to operate “Basic Health Plan” for those at 133-200% FPL, subject to high value plan criteria and competitive procurement

• Robust use of Exchange can include competitive procurement of high value insurance plans for consumers and business
Insurance Reforms

• No pre-existing condition clauses (2010 for children)
• No annual or lifetime caps
• No price increases or rescissions due to sickness
• Access to dependent coverage up to age 26
• Other Consumer protections
  • Uniform explanation of benefits
  • Appeals of coverage denials
  • Limits on out-of-pocket spending; no co-pays for prevention
• Constraining price variation and excess
  • State review of premium increases
  • Price variation subject to community rating (3:1-age; 1.5:1 tobacco)
  • Medical Loss Ratios: 80% -small group; 85% - large group
Individual Mandate

• Applies to adults and children

• Tax Penalty – Greater of 2.5% of income above tax filer’s threshold, or $695 ($2085 for family)

• Exemption from Mandate if insurance is not “Affordable”; i.e., premium costs > 8% of income

• All ESI, Individual market products, grandfathered plans satisfy federal mandate

• Tax credits (subsidies) for those with income less than 400% FPL
Insurance Mandate - Challenges

• Why the mandate?
  • Primarily to allow costs of insurance reforms to be spread (“pooled”)
  • Once it begins (2014), risk pool is improved - costs are spread
  • Moderates adverse selection and premium price pressure, but…

• Interim Effects - Insurance reform comes years before mandate
  • Adverse selection and premium increases
  • Unaffordability: medical debt burden may worsen
  • Loss of support for law ? or
  • Increased understanding of why a mandate is needed?

• Constitutionality and the Commerce Clause
  • Two decisions in support; two against, so far
  • Consider: Mandate is a tax policy favoring those who purchase
  • Regardless of legal outcome, legal challenges will affect public opinion
  • Again, will this lead to improved understanding or loss of support?
Financing mechanisms: 2010-2019

• Funding Sources:
  • Excise tax on high-cost health plans (not until 2018)
  • Taxes on high-income earners (>200K ; $250K for couple)
  • Health care sector industry fees
  • Reductions to Medicaid DSH payments
  • Slower growth of increase for Medicare rates (“market basket update”)
  • Independent Payment Advisory Board and related savings
  • Revenues from Individual and Employer Penalties

• Total Cost = $938 Billion
• Savings to Federal Deficit = $124 Billion

Source: Congressional Budget Office, 2010
New State Options for Long Term Care

- Nationally, largest portion (52%) of long term supports and services (LTSS) expenditures are covered by State governments (Medicaid – 49%; other state programs – 3%)

- CLASS - provides private, individual funding mechanism for future LTSS needs
  - employers opt to offer and employee opt in or out
  - actuarial soundness is debated
  - use of administrative regulatory authority may fix issues

- Several Medicaid options, with enhanced FMAP, for community based services options without a waiver, or at higher income and asset levels, or for transitioning individuals to the community
Timeline for Implementation

- **2010**
  - Immediate insurance reforms
  - Tax credits for small employers
  - Begin to close doughnut hole
  - Medicaid expansion option
  - Funding opportunities
  - Early planning

- **2011**
  - System improvement initiatives
  - Promotion of ACOs, Pay Reform
  - Comparative Effectiveness Studies
  - Insurance reforms
  - Medicare reforms
  - CLASS

- **2013**
  - Medicaid expansion
  - Exchanges launched
  - Employer requirements/assessments
  - Premium & cost sharing subsidies
  - Insurance reforms
  - Medicare reforms
  - Individual Mandate

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- **2016**
  - Excise tax on high-cost health plans

- **2018**
  - Option for multi-state compacts
Some Further Considerations for States

• Leveraging federal funds to economic advantage
• Using Exchanges to improve competitive market
• Consider *indirect* economic benefits of
  • Medicaid expansion for adults ≤ 133% FPL
  • Other options under Medicaid for FMAP enhancement and Federal Grants
• Challenge - state share funds for Medicaid expansions
• New State Roles in Cost Containment: What works?
  • Robust or Minimal approach to Exchange development
  • Balance: Regulating costs/premiums vs. facilitating market competition
• Leading by example: State roles in leading reform
Resources

- Kaiser Family Foundation: www.healthreform.kff.org
- National Governors Association: www.nga.org
- National Association of Insurance Commissioners www.naic.org

- Summary of federal support and funding in the ACA for innovations and improvements in health care delivery, quality and pay reform: See “PPACA – Pilot Programs, Demonstration Projects and Grants”, posted at www.umassmed.edu/chle
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