

WHO GOES WHERE & WHY—THE NUTS AND BOLTS OF THE NEW HEALTH LAW”

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The Laws

- The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010.
- The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law on March 31, 2010 and amended some of the provisions of P.L. 111-148.
- The **package** is now referred to as... "The Affordable Care Act"

Access - Overview

- Maintains an employer-based health care system
 - Imposes a penalty on employers that fail to provide coverage or whose employees go to the health insurance exchange for coverage
- Expands and modifies the Medicaid to become the foundation for the reformed health care system
 - All individuals with incomes at or below 133% of the federal poverty level (FPL) are eligible
- Requires individuals to obtain qualified coverage
 - Imposes a tax on individuals who fail to comply
- Establishes health care exchanges to help individuals and small businesses (initially) to purchase qualified coverage
 - Establishes subsidies for premiums and cost-sharing for individuals with incomes between 133% and 400% of the federal poverty level (FPL)

Medicaid Expansion

- Establishes a national minimum eligibility level at 133% of FPL (\$14,400)
- Eligibility based on income (SSI, child welfare, SSDI, medically needy, Medicare Savings Programs beneficiaries are exempt)
- Adds new **mandatory** categories of Medicaid-eligibles: (1) Single, childless adults who are not disabled; (2) Parents; (3) Former Foster Care Children (aged-out of foster care)

Medicaid Expansion

- Option for states to begin expansion for certain non-elderly individuals with incomes up to 133% of FPL effective 4/1/2010. Coverage would be reimbursed at the state's regular Medicaid FMAP.
 - Connecticut and Washington, D.C. have expressed interest in this option.

Enhanced FMAP for Newly Eligibles

- Enhanced FMAP for Newly Eligibles 2014 – 2020

Year	Federal Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

There are special provisions for "expansion states"

Medicaid Expansion Features

- Temporary Maintenance of Effort/Eligibility
 - Prohibits eligibility changes that are more restrictive than those in place on date of enactment (March 23, 2010)
 - Expires in 2014 when the health care exchanges become effective
- State Financial Hardship Exemption from Maintenance of Effort
 - Governor **must certify that state is in deficit or will be in deficit** to qualify for the hardship exemption (12/31/2010)

What Does the Medicaid Expansion Mean for States

- Fundamentally changes the state role in Medicaid by changing the status of Medicaid in relation to the rest of the health care system in the United States.
 - State budget issues
 - Underfunding of the underlying program
 - No coverage for undocumented immigrants
 - No statutory countercyclical trigger
 - Implications of reduction in federal assistance in the future
 - Long term care
 - State flexibility
 - The transformation of the Medicaid program left largely to state governments

Challenges

- Show me the money
 - New Eligibles v. others
 - Systems upgrades
 - Eligibility
 - Interoperability with Health Insurance Exchanges
 - Staffing
 - State and local government
 - Workforce/Infrastructure
 - Provider reimbursement
 - Training & recruitment
 - Infrastructure Improvements

Challenges cont.

- Marketing the new Medicaid
 - Mainstream health care v. welfare
 - New networks/service delivery models
- Maintaining public support
- Improving quality

Remember....with every challenge there is an opportunity!!!

Employer Responsibility

- Requires employers with more than 200 employees to automatically enroll new full-time equivalent employees in coverage (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in.

Employer Responsibility

- **Penalties for Failure to Provide Coverage**
 - Requires an employer with more than 50 full-time equivalent employees that does not offer coverage and has at least one full-time equivalent employee receiving the premium assistance tax credit to make a payment of \$2000 per full-time equivalent employee.
 - Excludes/disregards the first 30 full-time employees.
 - Requires an employer with more than 50 full-time equivalent employees that offers coverage and has at least one full-time equivalent employee receiving the premium assistance tax credit to make a payment of \$3000 per full-time equivalent employee.
 - Excludes/disregards the first 30 full-time employees.
- **Large Employers with Waiting Periods**
 - Amends the employer shared responsibility policy such that a large employer requiring a waiting period before an employee may enroll in coverage of longer than 60 days will pay a fine of \$600 per full-time equivalent employee.

Individual Responsibility

- Requires individuals to maintain minimum essential coverage beginning in 2014.
- **Penalties for Failure to Maintain Coverage**
 - Failure to maintain coverage will result in a penalty that is the greater of a flat fee \$95 in 2014; \$325 in 2015; and \$695 in 2016 **OR** the following percent of the excess household income above the threshold amount required to file a tax return----1% of income in 2014; 2% of income in 2015; 2.5% of income in 2016 and subsequent years.
 - For those under the age of 18, the applicable penalty will be one-half of the amounts listed above.
 - Families will pay half the amount for children up to a cap of \$2,250 for the entire family.
 - After 2016, dollar amounts will increase by the annual cost of living adjustment.

Individual Responsibility

- **Exceptions** to the individual responsibility requirement to maintain minimum essential coverage are made for:
 - religious objectors;
 - individuals not lawfully present; and
 - incarcerated individuals.
- **Exemptions** from the penalty will be made for those who:
 - cannot afford coverage (where the lowest cost premium available exceeds 8% of income) , thereby qualifying for a “hardship waiver”;
 - taxpayers with income under 100 percent of the federal poverty level;
 - members of Indian tribes; and
 - individuals who were not covered for a period of less than three months during the year.

Health Insurance Reforms - Now

- Temporary high-risk pools
- Minimum medical loss ratios
- Prohibition on rescissions (exception for fraud)
- Extension of dependent coverage for young adults (expires at the 26th birthday)
- Limits preexisting condition exclusions for children
- Limits lifetime and/or annual caps
- Reinsurance for early retirees (applies to state and local government plans)

Health Insurance Reforms - Later

- **Prohibition on preexisting condition exclusions**
- **Guaranteed issue/Guaranteed renewal**
- Premium rating rules
- Non-discrimination in benefits
- Mental health and substance abuse services parity
- Prohibits discrimination based on health status
- Prohibits annual and lifetime caps

State Grants - Rate Review

- Secretary Sebelius announced the availability of \$51 million in Health Insurance Premium Review Grants on June 7, 2010. These funds are the first round of grants available to states through a new \$250 million grant program to create and strengthen insurance rate review processes.
- All states and the District of Columbia are eligible for the first round of rate review grants.
- To receive a grant, a state must submit a plan for how it will use grant funds to develop or enhance its process of reviewing and approving, disapproving, or modifying health insurance premium requests.
- States with successful applications will receive a \$1 million grant during the first round.

Medical Loss Ratio

- Large group plans that fail to have a medical loss ratio (MLR) of 85 percent and individual and small group plans that fail to have a MLR of 80% by January 1, 2011, will be required to provide rebates to plan participants.
- HHS is authorized to adjust these rates to avoid market destabilization.
- HHS is working closely with the National Association of Insurance Commissioners (NAIC) and other stakeholders to develop a plan.

Small Business Tax Credit

- Small employers with fewer than 25 full-time equivalent employees and average annual wages of less than \$50,000 that purchase health insurance for employees are eligible for the tax credit.
- The maximum credit will be available to employers with 10 or fewer full-time equivalent employees and average annual wages of less than \$25,000.
- To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost.
- Businesses that receive state health care tax credits may also qualify for the federal tax credit.
- Dental and vision care qualify for the credit as well.

Small Business Tax Credit cont.

- 2010 - 2013
 - For 2010 through 2013, eligible employers will receive a small business credit for up to 35 percent of their contribution toward the employee's health insurance premium.
 - Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution.
- 2014 and thereafter
 - For 2014 and beyond, small employers who purchase coverage through the new Health Insurance Exchanges can receive a tax credit for two years of up to 50 percent of their contribution.
 - Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

Health Insurance Exchanges

- **American Health Benefit Exchanges**

- Requires states, by 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a Exchange for small businesses.
- Requires the Secretary to:
 - ✦ Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
 - ✦ Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange's Internet portal.
 - ✦ Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.

Health Insurance Exchange

- Provides premium and cost-sharing assistance to individuals, who obtain coverage through the exchange, with incomes up to 400% of FPL.
- Establishes Multi-State Plans modeled after Federal Employees Health Benefits Program (FEHBP) and administered by the federal Office of Personnel Management (OPM).
 - This was adopted in lieu of the "Public Option".
- Cooperatives
 - Non-profit entities, operated by a board of directors, contracts established by the HHS Secretary.

Health Insurance Exchanges

- **State Planning Grants**
 - Requires the Secretary to award grants, **available 3/23/2011** until 2015, to states for planning and establishment of American Health Benefit Exchanges.
- **States must declare intention to administer the exchange or to permit the federal fall-back by the end of 2012.**

Key Issues - Health Insurance Exchange

- **State Options**
 - Interstate Compacts
 - Basic Health Plan
 - Waiver (available in 2017)
- **Creating a seamless Exchange/Medicaid connection**
 - **Financing**
 - Technical Assistance
 - Staff Recruitment/Training
- **Essential benefits/Affordability**
 - Treatment of state mandated benefits
 - States must **pay (individuals or plans)** for mandated benefits not included in the essential benefit package.

Other Key Provisions

CLASS Act

- Creates a new national insurance program, **Community Living Assistance Supports and Services (CLASS)**, to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.
- Financed through voluntary payroll deductions (**with opt-out enrollment** similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living.
- Could result in Medicaid savings.

Maternal & Child Health

- **Maternal, Infant, and Early Childhood Home Visiting Programs**
 - Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s).
 - Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.
 - Establishes competitive grants appropriated at \$100 million in 2010, \$250 million in 2011, \$350 million in 2012, \$400 million in 2013 & 2014
 - A maintenance of effort (MOE) applies and prohibits grants from supplanting existing funding for these services.
 - First grants were awarded on July 21, 2010 to 49 states, the District of Columbia, and five territories.

Medicare Provisions

- ✓ Ensuring Access to Physician Care & Other Services
- ✓ Rural Protections
- ✓ Improving Payment Accuracy
- ✓ Improving Prescription Drug Coverage
- ✓ Ensuring Medicare Sustainability
 - ✓ **Independent Payment Advisory Board******
- ✓ Quality Improvements
- ✓ Protecting and Improving Guaranteed Benefits

Other Key Provisions

- ✓ Improving Quality/Efficiency
- ✓ Public Health/Chronic Disease Prevention
- ✓ Health Care Workforce (NHSC)
- ✓ Transparency and Program Integrity
- ✓ Improving Access to Innovative Medical Therapies
- ✓ Revenue Provisions
- ✓ Indian Health Care Improvement
- ✓ Elder Justice Act
- ✓ Menu Labeling (Chain Restaurants)

Other Provisions of Note

- Grants to Support School-Based Health Clinics
- Increased Community Health Center Funding
- National Health Service Corps Improvements
- Workforce Grants/Initiatives
- Public Health Initiatives
- Medicare Improvements for Rural Areas
- Medicare Rate Improvements/Medicare Rate Reductions
- Indian Health Service Reauthorization