Federal Health Care Reform

A quick look at where we are
and selected issues of interest to state policymakers

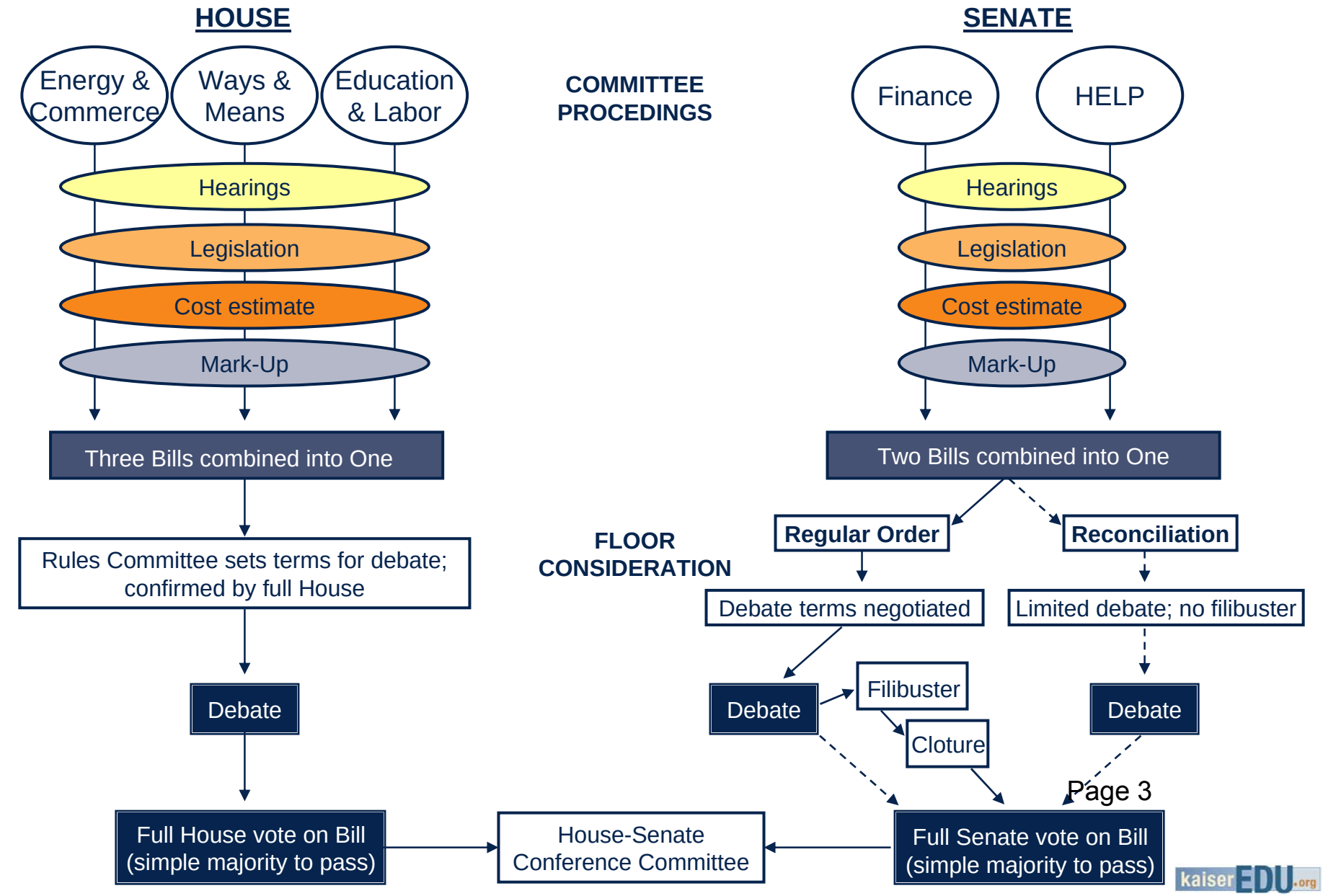
Bagels & Briefings for Legislators

Office of Legislative Research and General Counsel

August 19, 2009

Overview – Committees and Floor Debate

Source: "The Process of Health Reform Legislation," Alan Schlobohm, Senior Program Administrator, Kaiser Family Foundation. July 2009. Accessed at http://www.kaiseredu.org/tutorials/reformprocess/player.html, 8/6/09.



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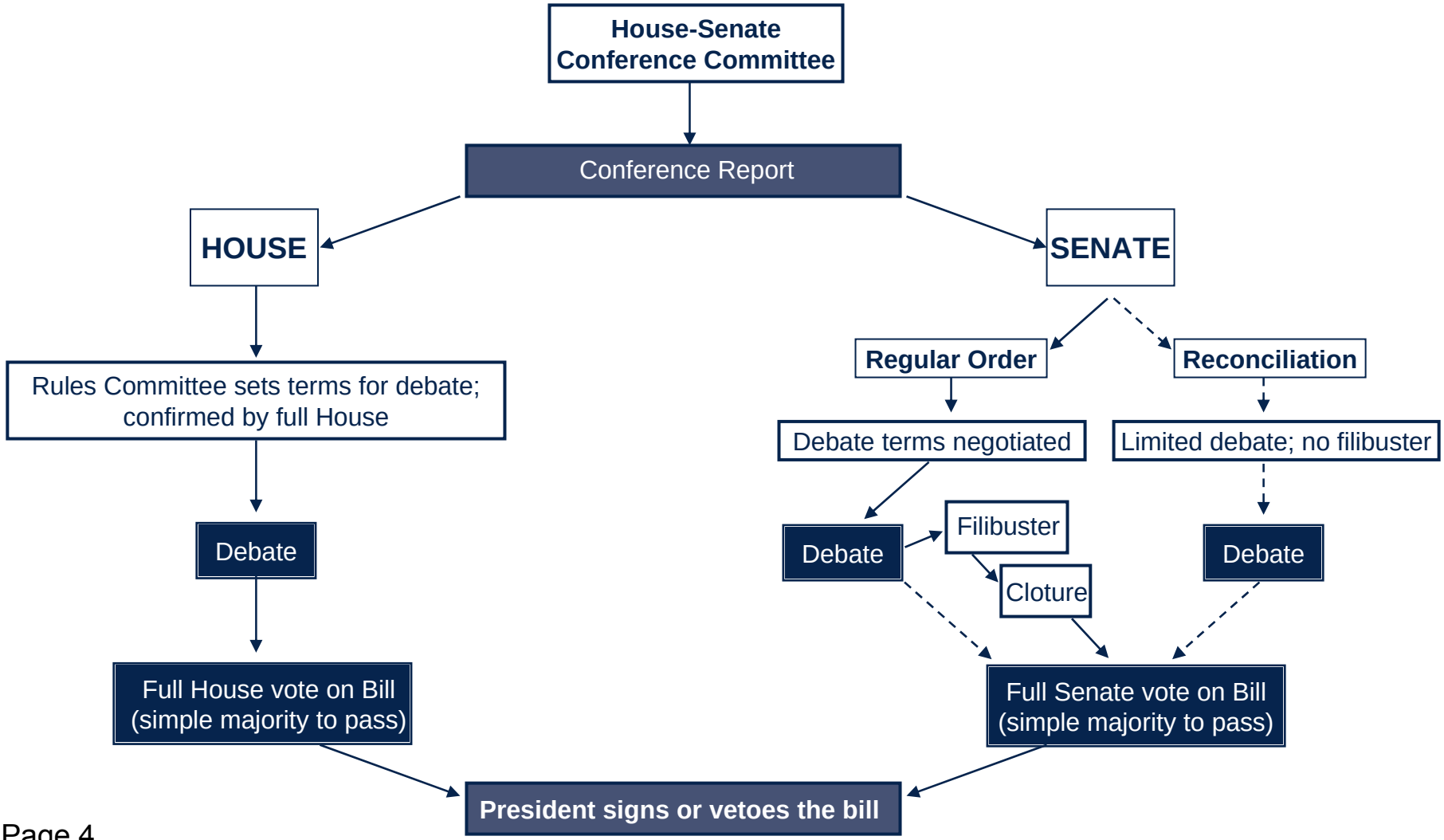
Overview – Conference

Source: "The Process of Health Reform Legislation," Alan Schlobohm, Senior Program Administrator, Kaiser Family Foundation. July 2009. Accessed at http://www.kaiseredu.org/tutorials/reformprocess/player.html, 8/6/09.



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BASIC GOAL

EXPAND COVERAGE

REFORM SYSTEM

BASIC APPROACH

MANDATED ENROLLMENT BY INDIVIDUALS

MANDATED OFFERING BY EMPLOYERS

SUBSIDIES TO INDIVIDUALS AND EMPLOYERS

EXCHANGE FOR PURCHASING SPECIFIED PLANS

PUBLIC PLAN OPTION IN THE EXCHANGE

EXPANSION OF MEDICAID

REINSURANCE FOR AGES 55–64

INSURANCE MARKET CHANGES

MEDICARE AND MEDICAID CHANGES

WHO WILL BE EFFECTED?

INDIVIDUALS

EMPLOYERS

PAYERS

PROVIDERS

MANY OTHERS

- Suppliers
- Third-party administrators
- Insurance brokers
- Etc.

INDIVIDUALS

REQUIRED TO HAVE ACCEPTABLE COVERAGE:

FEDERAL, OTHER COVERAGE

Medicare (65+), Medicaid, Federal Employees Health Benefits Plan, TRICARE (military), VA, retiree

GRANDFATHERED COVERAGE

Individual plan – indefinitely

Group plan – 5 years

QUALIFIED COVERAGE

From an employer (in or out of exchange)

From an exchange

INDIVIDUALS

QUALIFIED COVERAGE MUST INCLUDE:

BENEFITS Include essential benefits package determined by HHS Secretary with Health Benefits Advisory Committee input

COST SHARING Tiered packages, based on coverage

- Basic: ≥ 70% actuarial value
- Enhanced: ≥ 85% " "
- Premium: ≥ 95% " "

(Premium Plus includes additional benefits, e.g, oral health, vision)

Maximum annual cost sharing (indexed)

- $5,000 individual
- $10,000 family

RATING Adjusted Community Rating

Age (2:1 limit), rating area, family structure

LIMITS

No pre-existing condition exclusions
No annual or lifetime limits
Guarantee issue & renewability

INDIVIDUALS

PENALTY

2.5% modified adjusted gross income,
up to average national premium for a basic plan

EXEMPTIONS

Financial hardship, other

INDIVIDUALS

SUBSIDIES (available only in the exchange)

ELIGIBILITY

< 133% FPL: no subsidy (Medicaid eligible)
> 400% FPL: no subsidy
133% – 400% FPL: income-based subsidy
OR if premium > 12% modified AGI

PREMIUM CREDIT[1]

133% FPL: Enrollee pays no more than 1.5% modified AGI for premium

400% FPL: Enrollee pays no more than 12% modified AGI for premium

FEDERAL POVERTY LEVEL (FPL) GUIDELINES		
Family Size	133%	400%
1	$14,500	$43,500
3	$24,500	$73,000
5	$34,500	$103,000
7	$44,000	$133,000
9	$54,198	$163,000

COST SHARING CREDIT[1]

133% FPL: enrollee pays no more than 3% of plan value
400% FPL: enrollee pays no more than 30% of plan value

[1](Credit phases out over income range; based on three lowest cost basic plans in area)

EMPLOYERS

MUST OFFER QUALIFIED COVERAGE

- Grandfathered small group coverage (5 years)
- Qualified coverage
  - Essential benefits package, 70% of actuarial value, no pre-existing exclusions, adjusted community rating, $5,000/$10,000 cost sharing limit, etc.)

EMPLOYER CONTRIBUTION

- 65% individual coverage
- 72.5% family coverage

PENALTY (play or pay)

- < $500,000 payroll: 0%
- = $500,000 payroll: 2%
- > $750,000 payroll: 8%
- $500,000 – $750,000: phased in

EMPLOYERS

SUBSIDIES

< 10 employees and average wage < $20,000: credit = 50% of premiums paid by employer

Credit phases out for employers with 10 – 25 employees and average wages of $20,000 – $40,000

(wage amounts indexed; wages > $80,000 exempt)

PAYERS

MEDICAID/CHIP

Expansion of Medicaid eligibility

- All individuals up to 133% FPL
- Newborns otherwise uninsured
- Other individuals and services

Potential mandatory Medicaid expansion of preventive services required by HHS Secretary

Increase primary care provider payments

- 2010: 80% of Medicare rates
- 2011: 90% of Medicare rates
- 2012: 100% of Medicare rates

Move CHIP enrollees into the exchange as capacity permits

Accountable care and medical home pilot programs

MEDICARE

Many payment changes

PAYERS

PRIVATE PAYERS

Standards for claims transactions: claims processing, denials, etc.

Medical loss ratio limits for qualifying plans determined by Health Choices Commissioner

Many adjustments due to qualified plan requirements

PROVIDERS

Increased payment for primary care from Medicaid (to 100% of Medicare) and Medicare (5%)

Medical home pilots

Accountable care organization pilots in Medicare and Medicaid

Payments tied to health-care-provider acquired infections

Medicare incentive payments for physicians in most cost-efficient areas

Reporting by manufacturers and distributors of payments to providers

SELECTED ISSUES

MEDICAID

Federal match for expansions/rate increases

2013–14:	100%
2015 and after:	90% for 133% expansion
	Only an "increase" in FMAP for provider rate increases and newborns expansion?

Increased enrollment of Medicaid eligibles not previously enrolled

Potential crowd-out of employer coverage

Reporting of provider payment rate methodology and determination by HHS Secretary of whether adequate

Waivers may need to be addressed individually

CHIP

How long will CHIP continue?

SELECTED ISSUES

HIPUtah

What role will it play, if any?

OTHER PAYERS

Viability of grandfathered plans

- Group plans (5 years)
- Individual plans (indefinitely)

Impacts of risk adjusting inside the exchange

Addressing risk outside the exchange

Net effects of individual and employer mandates, subsidies, penalties, and qualified plan requirements

Impact of qualified plans loss ratio limit defined by Health Choices Commissioner

Impact of public plan

SELECTED ISSUES

UTAH HEALTH INSURANCE EXCHANGE

Criteria to become an approved state exchange

PROVIDERS

Net effect or increased enrollment and DSH payment reductions

Potential loss in payment due to health-care-associated infections

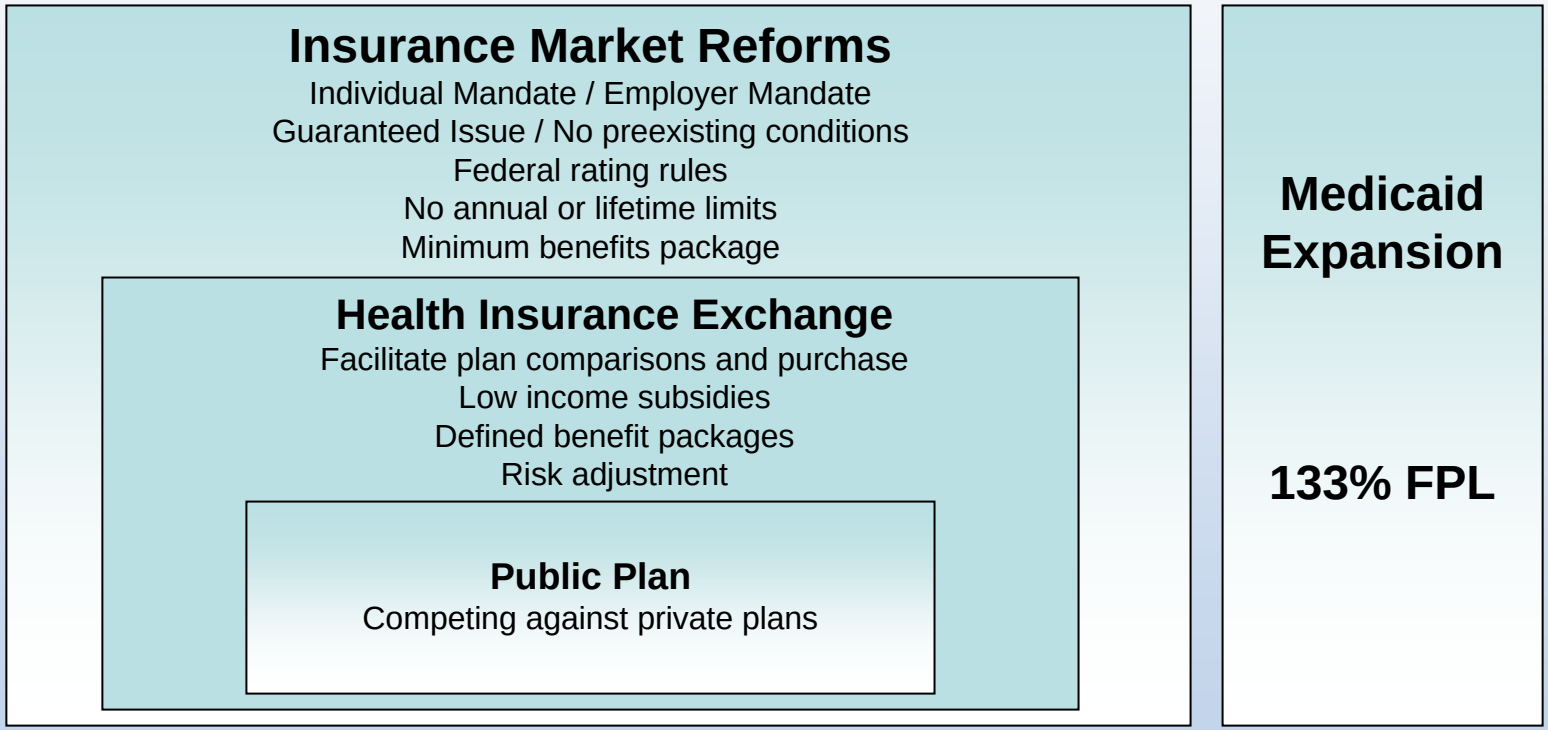
STATE REGULATION

Extent of dual (state/federal) oversight of qualified plans in and out of the exchange

Extent to which Health Choices Commissioner will determine that certain consumer protection standards established by the Commissioner for plans inside the exchange will apply to plans outside the exchange

State can mandate benefits in exchange but will have to reimburse federal government for federal subsidies paid due to cost of those mandates

Building Blocks of Reform



NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

SCI Health Reform Bracket (As of July 31, 2009)

Directions: 1) Copy your selected answer into the blank answer slot after each pair for the first three sections

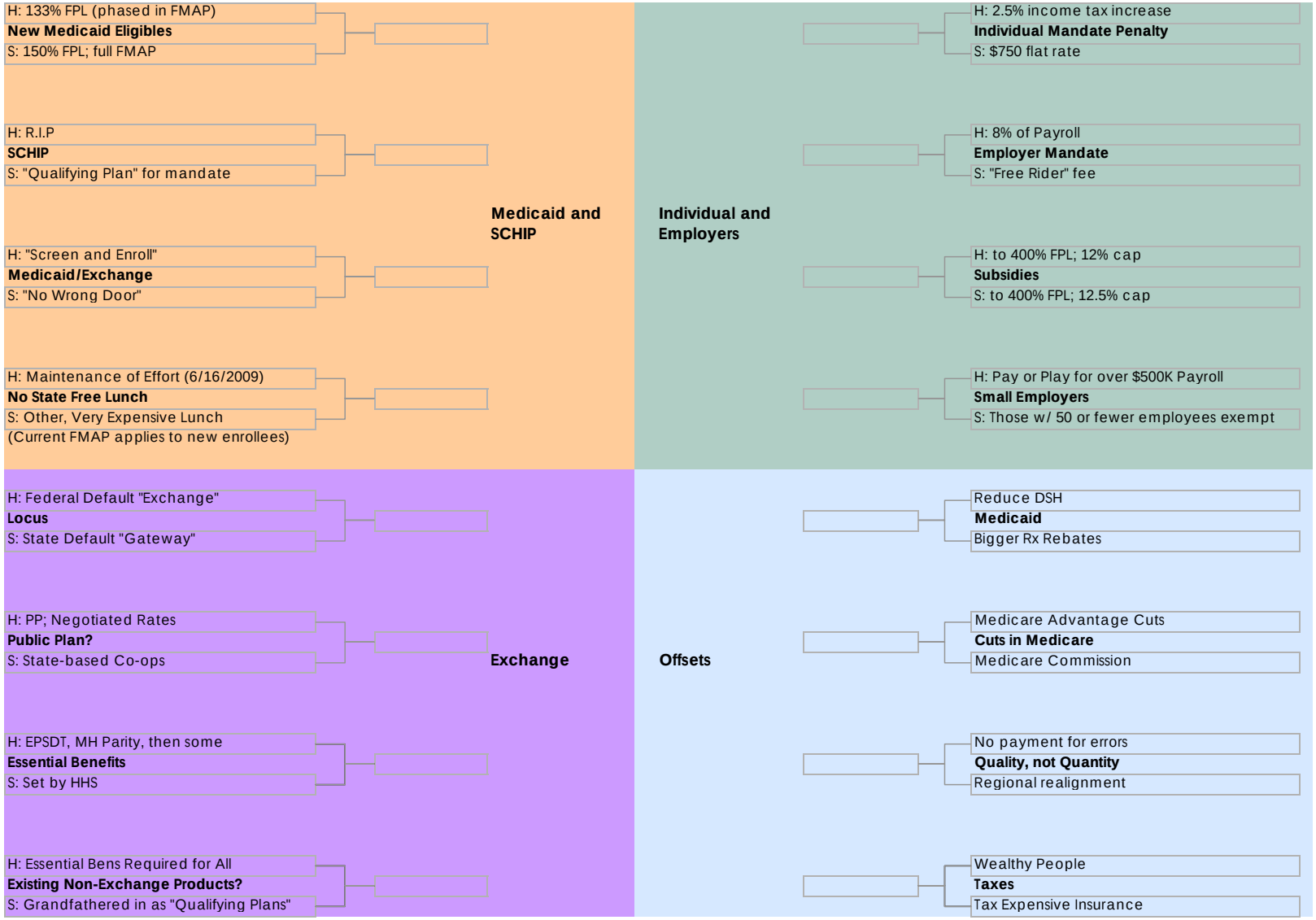
2) For the Offsets section, choose any four from the entire section; the four biggest off-sets win

3) H: means House, S: means Senate

4) Answer the tie-breaker questions at the bottom

5) Save the bracket

6) Send it as an attachment to sci@academyhealth.org; direct any questions to the same address



Tie-Breaker Questions:

What date will the reform bill pass (never is an option)?

How many vote in Congress for and against (out of 535)?

Source: Charles Milligan, Executive Director, The Hilltop Institute, University of Maryland, Baltimore County, Maryland. Presented at State Coverages Initiatives Annual Meeting for State Officials, Robert Wood Johnson Foundation, Albuquerque, New Mexico, July 30, 2009. Accessed 8/14/09 at http://www.statecoverage.org/node/1982.

NOTES AND CONTACTS

Note:

Information in this presentation reflects the language of the original House Tri-committee bill, "America's Affordable Health Choices Act," and available information about various amendments made to the bill, as summarized in various secondary sources. The information is not comprehensive.

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