Patient Protection and Affordable Care Act (PPACA) - Basics

Why does health reform matter?

- Health care expenses in the United States are much higher than in other countries, and health outcomes are worse
- Millions of people are uninsured or underinsured
- Health system is inefficient – does not deliver right care at the right time, is intervention focused
- Health costs are rising
- ACA attempts to address these systemic issues

Sources: Congressional Budget Office, *High-Cost Medicare Beneficiaries*, May 2005
AHRQ, The High Concentration of U.S. Health Care Expenditures,

U.S. ranked last in multiple studies

Country Rankings	
	1.00–2.66
	2.67–4.33
	4.34–6.00

	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	$2,876*	$3,165	$3,005*	$2,083	$2,546	$6,102

* 2003 data

Source: Calculated by The Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Health Reform

- There have been numerous health reform attempts in the U.S.
  - Prior to 2010, all attempts at national health reform to create universal or near-universal coverage have failed
  - Some successes at the state level

Health Reform Attempts

- Begins with Theodore Roosevelt
- Health insurance is left out of “new deal” under Franklin Roosevelt
- Truman abandons issue to focus on Korean war
- Medicare and Medicaid pass in 1965 under Lyndon Johnson
- Efforts made in following decades, attempts by Nixon and Edward Kennedy
- Clinton attempt fails
- ACA (Obamacare) passes – how?

The Patient Protection and Affordable Care Act (PPACA or ACA)

- Signed into law March 23, 2010 with *rolling implementation*
- Implementation slated to reach completion by January of 2014 but many delays and extensions
- Multiple complicating factors with implementation

The Affordable Care Act (ACA): Cause of controversy

- Disagreement over whether the government should drive reform efforts
- Question as to whether a **mandate to buy insurance** was constitutional
- State opposition to mandatory Medicaid expansion
- Unusual legislative process utilized to pass ACA
- Health care is highly personal
- Strong ideological differences about framing the problems and approaches to fixing those problems
- Serious problems with initial roll out this fall (exchange web sites)

Primary issues in challenge to ACA heard by SCOTUS

- Decided in June of 2012, two years after passage
  - 5-4 decision with Chief Justice Roberts writing for majority
- Challenge to mandate – is it constitutional?
  - **Result**: The mandate is constitutional because the penalty is a tax – and taxes are constitutional
- Challenge by states to mandatory Medicaid expansion
  - ACA said if states did not expand then ALL Medicaid funding would be taken away
  - **Result**: The Medicaid expansion could not be mandatory for states, contradicted the Medicaid statute itself. States must have CHOICE not to expand Medicaid.

ACA quality, efficiency and transparency provisions – focus on Medicare

Sources: Congressional Budget Office, *High-Cost Medicare Beneficiaries*, May 2005
AHRQ, The High Concentration of U.S. Health Care Expenditures,

Medicare spending reflects system-wide problems

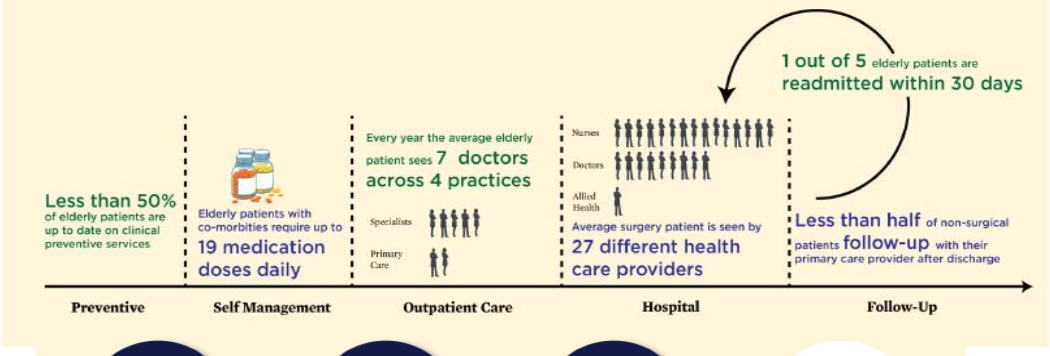
- Health care expenses in the United States rose from $1,106 per person in 1980 ($255 billion overall) to $6,280 per person in 2004 ($1.9 trillion overall).
- 5% of the U.S. population accounts for almost 50% of total health care spending.
- Costliest 5% of beneficiaries in Medicare FFS (traditional Medicare) account for 43 percent of total spending
- 25% of Medicare beneficiaries account for 85% of spending.

Sources: Congressional Budget Office, *High-Cost Medicare Beneficiaries*, May 2005
AHRQ, The High Concentration of U.S. Health Care Expenditures,

ACA quality provisions – Medicare pilot provisions

- Extensive changes to Medicare to promote efficiency and effectiveness
- ACA established Center for Medicare and Medicaid Innovation (CMMI) to "test innovative payment and service delivery models to reduce program expenditures under [Medicare and Medicaid] while preserving or enhancing the quality of care . . .."
- National quality improvement strategy to set priorities to improve the delivery of health care services, outcomes, and population health, and to create processes for development of quality measures.

Systemic Inefficiency & Ineffectiveness



Institute of Medicine, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America (Sept. 6, 2012).
http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx

ACA sweeping legislation

- Includes
  - quality improvement provisions
  - Payment model reforms
    - Patient Centered Medical Homes
    - Accountable Care Organizations
- Primary focus of this session are ACA provisions related to:
  - Expanding coverage
  - Reforming insurance market
  - Ensuring access to affordable insurance

The Affordable Care Act (ACA): Major provisions

- Individual Mandate: most people required to purchase health insurance or pay a penalty starting in 2014
  - Exemptions for certain populations and based on affordability
- Prohibition on denying coverage for pre-existing conditions – January 2014
- Individual Mandate and ban on pre-existing condition exclusions *interlocking* provisions

Interlocking provisions:
Mandate and ban on pre-existing condition exclusions

- What is a pre-existing condition? What is a pre-existing condition exclusion?
- Individual mandate to purchase insurance and prohibition on denying coverage for pre-existing conditions are linked together
- Prevents individuals from *waiting until they get sick to purchase insurance*

ACA provisions: Private Health Insurance market wide reforms

- No pre-existing condition exclusion
- Dependent coverage to age 26
- Preventive services without cost sharing
- Prohibitions against lifetime and annual coverage limits
- No rescission (cancelling of policy) without fraud (lying) on application
- New appeals process (expansion to self-funded plans)
- Premium rate reviews (rate increases over certain amount must be approved by state or federal gov't)

Setting Premiums

- The ACA created new rules related to premium setting
- Applies to plans inside and outside of the exchanges (market wide)
- Premiums may be based on limited factors:
  - Age
  - Tobacco use
  - Geographic area
- Rate increase
  - States and federal government now have power to review and approve rate increases
  - All rate increases must be justified

ACA Provisions: Employer Mandate

- Referred to as “employer responsibility” provisions
- In 2015, employers with 50 or more employees must provide affordable health insurance or pay a penalty (*delayed from original 2014 date*)
  - Insurance is deemed “affordable” if it has an actuarial value of at least 60% or is not more than 9.5% of an employee’s income

“Employer Responsibility” (cont’d)

- Employers
  - Large businesses (over 50 full-time employees)
    - **Penalty** if the employer does not offer coverage, **and**
    - One or more employees receive premium tax-credit through the exchanges
  - Small Businesses
    - **No penalty** if employer does not offer insurance
    - May purchase coverage through health exchanges and receive tax credits

Individual Mandate - details

- Everyone must have health insurance (via employer, exchange, public program) or pay a penalty
- Penalty administered through IRS (tax code) and greater of:
  - $695/year (calculated monthly, per person, up to $2085 per family), or
  - Specified % of income, phased in up to 2.5% starting in 2016
- Exceptions for some such as American Indians; Religious objections; if lowest cost health plan available exceeds 8% of income; if very low income (annual income below $9,350 for individuals, $18,700 for family)

ACA focus: Expanding Access to Health Insurance

Health Insurance Coverage of the Total Population

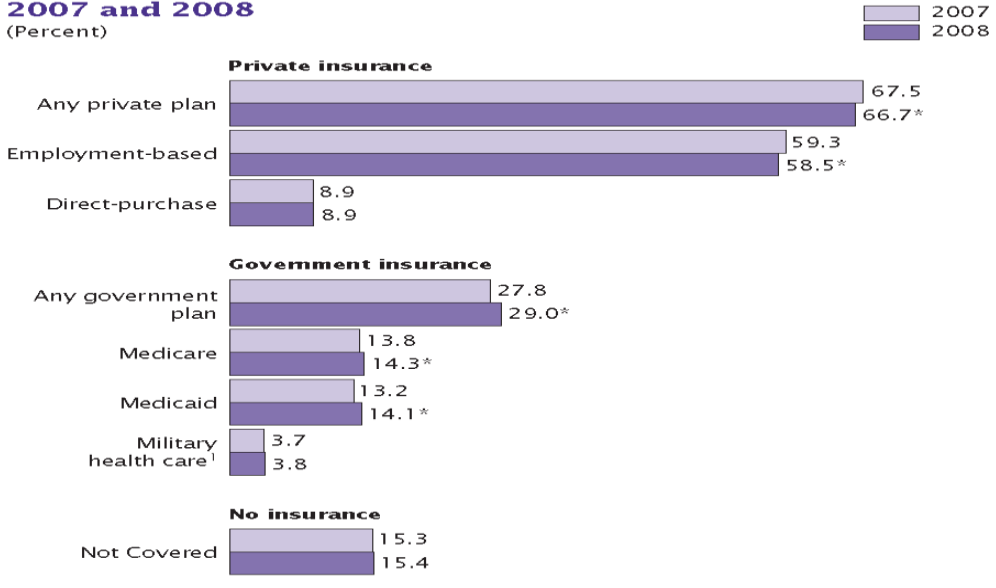
View Table in New Window

Location	Employer	Other Private	Medicaid	Medicare	Other Public	Uninsured	Total
United States	48%	5%	16%	14%	1%	15%	100%

Figure 7.

Coverage by Type of Health Insurance: 2007 and 2008

(Percent)



Insurance Coverage Overview

- In the U.S. insurance coverage = access
- The U.S. does not have a single national health insurance program that covers the entire population
- Approximately 15% of the US. Population is uninsured
- **Of those with insurance, most obtain coverage through their employer**
- Medicaid and Medicare are government health insurance programs that cover millions of people in the U.S.

Private Health Insurance Market Includes …

- Includes employer based coverage (approx 50%)
  - Self insured
  - Fully insured
  - Both are large group coverage (large risk pools)
- Includes “direct purchase” market (approx 10%)
  - Individuals, individual families
  - Small group (small business) market (e.g. hair salon)
  - Regulated at state level and “medically underwritten” prior to ACA

FPL levels

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$11,670	$15,521	$17,505	$23,340	$29,175	$35,010	$46,680
2	15,730	20,921	23,595	31,460	39,325	47,190	62,920
3	19,790	26,321	29,685	39,580	49,475	59,370	79,160
4	23,850	31,721	35,775	47,700	59,625	71,550	95,400
5	27,910	37,120	41,865	55,820	69,775	83,730	111,640
6	31,970	42,520	47,955	63,940	79,925	95,910	127,880
7	36,030	47,920	54,045	72,060	90,075	108,090	144,120
8	40,090	53,320	60,135	80,180	100,225	120,270	160,360

ACA Medicaid Expansion

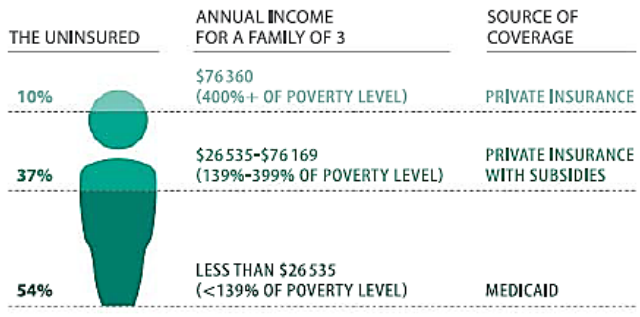
The ACA included major Medicaid expansion

- Expands income eligibility to national floor of 133% (technically 138%) of FPL
- For the first time Includes non-Medicare-eligible adults under age 65 **without dependent children**
  - Majority of uninsured adults < 133% FPL – **69%** – are adults without dependent children, 31% are parents
- Children currently covered by CHIP between 100-133% FPL will be transitioned to Medicaid
- Intended to be a uniform nationwide eligibility standard **but** the Supreme Court decision allows states to opt out
  - Existing Medicaid continues in states that don't expand

Important Changes in Medicaid Financing

- Phase-in changes to FMAP (federal reimbursement)
  - 100% federal financing for newly-eligible Medicaid for 2014-2016
  - 95% FMAP for 2017
  - 94% FMAP for 2018
  - 93% FMAP for 2019
  - 90% FMAP for 2020 and beyond.
- Cost Estimates
  - Adding 16 million new Medicaid enrollees by 2019 will add $434 billion in Federal coverage costs from 2010 to 2019
  - + $8.3 billion for enhanced payments to primary care physicians
  - State spending expected to increase by $20 billion

Medicaid's Role Under the Affordable Care Act (ACA)



Prior to the ACA, Medicaid eligibility varied widely by state and category. More than half of America's 49 million uninsured fall in the income range targeted by the ACA's Medicaid expansion which sets minimum eligibility levels at 138% of the Poverty Level across all states.

The ACA Medicaid expansion offers:



Coverage eligibility for 22 million uninsured adults



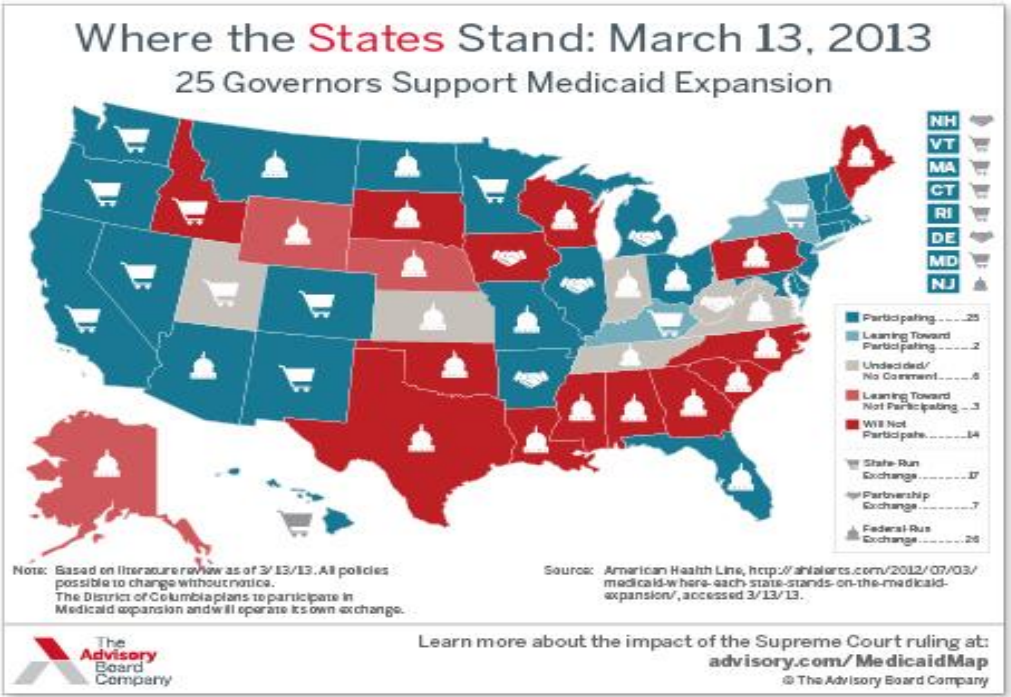
Substantial federal funds to states, covering more than 90% of the new cost over the next decade

But following the Supreme Court decision, some states may choose not to implement the Medicaid expansion.

Excerpted from: Kaiser Family Foundation, "Medicaid: Its Role Today and Under the Affordable Care Act," JAMA. 2012;308(8):752. doi:10.1001/2012.jama.10159. http://jama.jamanetwork.com/article.aspx?articleid=1352118

Policy Implications of Medicaid Reforms

- If state does not expand:
  - Funding at old match rate; burden of uninsured population on state
- If state does expand:
  - Challenge to design coherent Medicaid programs that permit transitions for "churn" (incomes changes that alter eligibility: ineligible for Medicaid but eligible for Health Benefit Exchanges or CHIP - and back again)
  - Must choose between providing the traditional, full Medicaid package or provide a "benchmark" benefit package with essential health benefits
  - Have to distinguish between newly eligible and previously eligible.


Where the States Stand: March 13, 2013
25 Governors Support Medicaid Expansion
NH
VT
MA
CT
RI
DE
MD
NJ
Participating.....25
Learning Toward Participating.....2
Undecided/ No Comment.....6
Learning Toward Not Participating...3
Will Not Participate.....14
State-Run Exchange.....17
Partnership Exchange.....7
Federal-Run Exchange.....26
Note: Based on literature review as of 3/13/13. All policies possible to change without notice.
The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.
Source: American Health Line, http://ahlalerts.com/2012/07/03/medicaid-where-each-state-stands-on-the-medicaid-expansion/, accessed 3/13/13.
The Advisory Board Company
Learn more about the impact of the Supreme Court ruling at:
advisory.com/MedicaidMap
© The Advisory Board Company

ACA Health Exchanges (Marketplaces)

Private Health Insurance: Legal Framework

- States have traditionally had the authority to regulate insurance companies and their actions
- A range of Federal laws also govern some private health insurance plans:
  - ERISA (Employee Retirement Income Security Act)
  - COBRA (Consolidated Omnibus Budget Reconciliation Act)
  - HIPAA (Health Insurance Portability and Accountability Act)
    - Health privacy as well
  - ADA (American with Disabilities Act)
  - MHPAEA (Mental Health Parity and Addiction Equity Act)
  - Civil Rights laws
  - **PPACA (Patient Protection and Affordable Care Act – aka "Obamacare")**

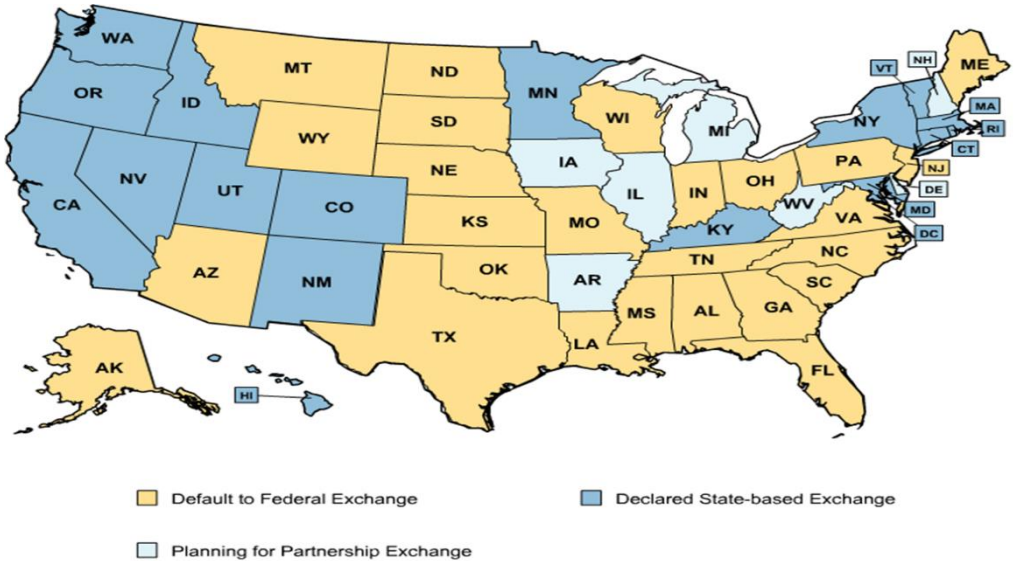
State Insurance Exchanges

- Exchanges are web based marketplaces where health plans are sold
- Focus on “direct” purchase market
  - Individual health plans purchased on open market
  - Small group health plans
- Intention to mimic structure of employer based insurance system by “pooling risk”
- Hope is that “pooling risk” will lower premiums
- Minimum standards now required in this market
- Premium and cost sharing assistance available through exchanges
- Additional insurance reforms required for plans sold in exchanges

State Insurance Exchanges

- ACA requires exchanges be established in each state to facilitate access and purchase of health insurance for qualified individuals and small employers.
  - **3 models:** State based marketplaces (SBMs), federally facilitated marketplaces (FFMs) and State Partnership Marketplaces (SPMs)
  - In State Partnership Marketplaces (SPMs) the state can handle consumer assistance, plan management or both – but authority over the exchange remains with the federal government
  - Currently 17 states & D.C. are SBMs; 26 states are FFMs; and 7 states are SPMs

State Decisions For Creating Health Insurance Exchanges in 2014, as of April 23, 2013



http://www.statehealthfacts.org/comparemapdetail.jsp?ind=962&cat=17&sub=205&yr=1&typ=5

Who can buy insurance in exchanges?

- To be eligible to purchase insurance through the exchange in your state you must be a U.S. Citizen or lawfully present (green card holders), not incarcerated, and meet residency standards (live in the U.S.).
- Generally, individuals with employer based insurance cannot access premium **subsidies** through exchanges unless they meet one of the exceptions:
  - Your employer based plan is not "affordable" – meaning it costs more than 9.5% of your income
  - Your employer based plan must cover at least 60% of medical services (60% actuarial value)

Tax Credits for Premiums

- Federal premium tax credits for exchange plans are available for people with income between 100 and 400% FPL
- 100-133% FPL – for those not eligible for Medicaid (in states that do expand Medicaid
  - 133-400% FPL – Available on a sliding-scale basis
  - Tax credit amount varies based amount by which the premium exceeds a certain percentage of an individual's income
  - Amount of tax credit based on premium of second lowest cost silver plan in your state exchange
  - **NOTE: people with incomes under 100% FPL in states that <u>do not expand Medicaid</u> will be excluded from premium assistance**

Cost sharing subsidies etc.

- Limits on out-of pocket spending
  - In addition to premium subsidies, additional cost-sharing subsidies are available for those with incomes below **250 % FPL** for out-of-pocket costs (such as deductibles, co-pays, and co-insurance).
- Premium tax credits are provided upfront, but must be reconciled in tax return
- Even with assistance, plans may remain unaffordable for some, and some may choose not to buy coverage

Congressional Budget Office Estimate of Premiums and Subsidies for Exchange Enrollees in 2016

Single Policy



Income Relative to Federal Poverty Level	Premium Cap as a Share of Income[1]	Middle of Income Range[2]	Enrollee Premium for the 2nd Lowest Cost Silver Plan[3]	Premium Subsidy[4]
100–150%	2.1%–4.7%	$14,700	$300	94%
150–200%	4.7%–6.5%	$20,600	$1,200	77%
200–250%	6.5%–8.4%	$26,500	$2,000	62%
250–300%	8.4%–10.2%	$32,400	$3,000	42%
300–350%	10.2%	$38,300	$3,900	25%
350–400%	10.2%	$44,200	$4,500	13%
400–450%	NA	$50,100	$5,200	0%

Family Policy (Family of Four)



Income Relative to Federal Poverty Level	Premium Cap as a Share of Income[1]	Middle of Income Range[2]	Enrollee Premium for the 2nd Lowest Cost Silver Plan[3]	Premium Subsidy[4]
100–150%	2.1%–4.7%	$30,000	$600	96%
150–200%	4.7%–6.5%	$42,000	$2,400	83%
200–250%	6.5%–8.4%	$54,000	$4,000	72%
250–300%	8.4%–10.2%	$66,400	$6,100	57%
300–350%	10.2%	$78,300	$7,900	44%
350–400%	10.2%	$90,100	$9,200	35%
400–450%	NA	$102,100	$14,100	0%

Source: Congressional Budget Office, Letter to the Honorable Evan Bayh, 2009; Staff of the Joint Committee on Taxation

Exchange Plans

- Only qualified health plans (QHPs) may be sold in the exchanges
- "QHPs" must meet certain certification criteria from ACA statute and implementing regulations
- QHP criteria includes:
  - Insurance Carriers must offer plans that adhere to actuarial value requirements represented by metal tiers Bronze, Silver, Gold, Platinum
    - Bronze = 60% AV Silver = 70% AV
    - Gold = 80% AV Platinum = 90% AV

About Exchange Plans

- Health insurance carriers decide whether or not to sell plans in the exchanges (subsidies are big incentive!)
- For issuers to sell in the Exchange they must offer at least one silver-level plan (covering 70 percent of expenses), one gold-level plan (covering 80 percent of expenses), and a child-only plan.
  - Catastrophic plans also for sale
  - for "young invincibles" (under 30 only)
  - No financial assistance available
  - Available with "hardship waiver"
  - Available for those who had plans cancelled
- Fed. govt. will contract to offer at least two multi-state plans in each Exchange (at least one non-profit plan)

QHP criteria continued

- Exchange required to sell one plan that is member owned and operated (CO-OP plan)
- States can allow all plans meeting "qualified" standards to be sold in exchanges, or be more selective
- **All plans sold in exchanges must:**
  - Meet **network adequacy** and service area standards.
  - Be in good standing and licensed in the state.
  - Premiums are based on adjusted **community rating**.
  - Plans must submit to rate reviews.
  - No abortion coverage with public money (may offer if paid separately with private money, or state may prohibit coverage altogether)
  - **Offer Essential Health Benefit (EHB) package**

Essential Health Benefits - categories

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Wellness services and chronic disease management
- Pediatric services, including oral and vision care

State Benchmarks and EHBs

- All non-grandfathered individual and small group plans sold inside and outside exchange must cover EHBs
- States required to define EHBs for policies sold in their state.
- To meet this requirement, each state selected an existing health plan as a "benchmark" to establish services and items included in that state's EHB package.
  - The largest plan, based on enrollment in any of the three largest small group products in the state
  - Any of the three largest state employee health plans
  - Any one of the three largest federal employee health plan options
  - The largest HMO plan offered in the state's commercial market

State Benchmarks and EHBs

- States had to "supplement" their benchmark plans for benefits generally not covered prior to the ACA
  - Pediatric dental and vision plans
  - Habilitative care
- States insurance mandates are considered EHB in that state if included in the benchmark
- Mental health and substance abuse benefits must meet mental health parity standards

Questions?

Feel free to email ACA questions related to this presentation to juliette@HCRI.org