

Federal Health Reform: Short-Term Implications

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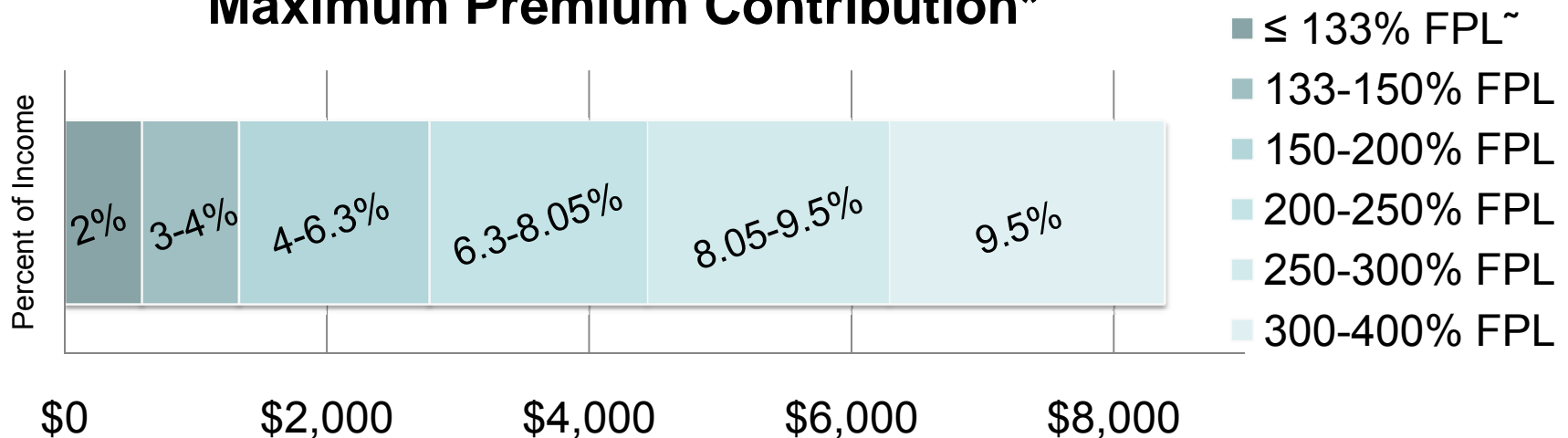
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SHADAC

- Independent research center located at the University of Minnesota School of Public Health
- Support states in their data, survey, policy and evaluation activities
 - Help states monitor rates of insurance coverage and understand factors associated with uninsurance
 - Provide assistance to states on policy development, program evaluation and assessment
- Disseminate research findings in a manner that is meaningful to state and national policy-makers

Impact of Reform Law on Coverage and Affordability

Federal Subsidies: Maximum Premium Contribution*



*Based on Income for Family of Four (FPL = \$22,050 through March 31, 2010)

Estimated Minnesota Impact:

- 5.6% of nonelderly population newly eligible for Medicaid
- 31.3% of population eligible for premium and cost-sharing subsidies

Source: Holahan, J., and L. Blumberg. January 2010. "How Would States Be Affected by Health Reform?" Urban Institute Report

Short-Term Impacts of Reform

- Public program enrollment and eligibility
- Private insurance market:
 - Eligibility
 - Benefits
 - Pricing
- High-risk pool
- Health insurance exchange
- Delivery system and payment reform

Public Programs: Short-Term Issues

- Eligible but not enrolled
 - About 60% of Minnesota's 480,000 uninsured are estimated to be eligible for public programs under current law
- As of April 1, 2010, states may choose to cover adults up to 133% of poverty through Medicaid
 - State match required at current rate
- States must maintain current Medicaid eligibility levels until health insurance exchange is operational (and for children, until 2019)

Private Insurance Market Regulation: Short-Term Issues

- Effective 6 months after enactment:
 - Young adults may be covered as dependents up to age 26
 - Current MN law is to age 25, and applies to fully-insured market only
 - Pre-existing condition exclusions prohibited for children
 - No lifetime limits on coverage; annual limits regulated (beginning in 2014, no annual limits)
 - First-dollar coverage for preventive services
 - No dropping coverage (“rescission”)

Private Insurance Market: Short-Term Issues Related to Premiums

- Process for state/federal review of “unreasonable” premium increases
 - Grant funding for states to review/approve premium rates
 - States must report to HHS on premium trends
- Minimum loss ratio 85% for large group plans, 80% for small group, and 75% for individual
 - Current MN law is 82% for small group market, 72% in individual market
 - Minimum loss ratios in MN are lower for carriers with small share of the market – federal reform may have a bigger impact on them
 - Although federal standard is higher than MN:
 - States may establish lower standards
 - In recent years, MN health plan companies have reported loss ratios well in excess of the minimum

High-Risk Pool: Short-Term Issues

- Temporary high-risk pool established 90 days after enactment, with \$5 billion appropriation
 - May be implemented by contracting with states or with private non-profit entities
 - Eligibility: individuals with pre-existing conditions, uninsured for at least 6 months
- In states that already have high-risk pools, the existing pool can operate alongside the new pool

Temporary High-Risk Pool: Comparison to MCHA

	MCHA	National Pool
Premiums	Up to 125% of individual market average	Based on standard population; 4:1 rating allowed for age
Maximum out of pocket	Up to \$10,000, depending on plan selected	\$5,950 individual/\$11,900 family
Actuarial value		At least 65%

Health Insurance Exchange

- Within one year, grants to states for start-up cost of exchanges
 - Must be self-sustaining by 2015
- Primary roles of exchange:
 - Certify plans to be offered for sale through the exchange, and rate them on cost and quality
 - Minimum benefit standards to be developed by HHS; states may require benefits beyond the minimum, but must pay extra costs for individuals who receive subsidies
 - Facilitate comparison/purchase by individuals and small employers
 - Help eligible individuals enroll in public insurance coverage
 - Certify individuals who are exempt from the mandate to purchase health insurance

Delivery System and Payment Reform: Short-Term Issues

- Accountable Care Organization (ACO) demonstration projects with shared savings for ACOs meeting quality standards - beginning in 2012
- Newly created Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models to improve quality and reduce cost
 - List of potential models includes allowing states to test and evaluate systems of all-payer payment reform
- Demonstration projects for bundled payments
- Payment for care coordination services in a health care home (90% match for 2 yrs)
- Value-based purchasing

Contact Information

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