Patient Protection and Affordable Care Act (PPACA): Impacts for Minnesota

Lynn A. Blewett, PhD
State Health Access Data Assistance Center
University of Minnesota
School of Public Health
Division of Health Policy and Management

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Short-Term Impacts of Reform

1. Public program expansion and eligibility
2. Private insurance market
3. High-risk pool
4. Health insurance exchange
5. Employer Provisions
6. Delivery system and payment reform
1. Public Program Expansion and Eligibility

Coverage Expansion Categories

- Medicaid Expansion 133%
  - Family of Four: $29,326
- Premium Subsidy 400%
  - Family of Four: $88,000

Federal Poverty Level
Public Programs: Immediate

- As of April 1, 2010, states can provide early coverage for low-income adults up to 133% of poverty through Medicaid
  - State match required at current rate – 50%
  - Phase in of FMAP starting in 2014
- States must maintain current Medicaid eligibility levels until health insurance exchange is operational (and for children, until 2019)
  - States will receive a 23 percentage-point increase in the CHIP match rate (65+23=88% FMAP for MN)

Covering the Cost of Expansion

- Percent of costs covered by Federal Medicaid for newly-eligible:

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent of Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-2016</td>
<td>100%</td>
</tr>
<tr>
<td>2017</td>
<td>95%</td>
</tr>
<tr>
<td>2018</td>
<td>94%</td>
</tr>
<tr>
<td>2019</td>
<td>93%</td>
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<tr>
<td>2020+</td>
<td>90%</td>
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</tbody>
</table>
Federal Premium Subsidies

Maximum Premium Contribution based on sliding scale as a percent of income*

<table>
<thead>
<tr>
<th>Percent of Income</th>
<th>≤ 133% FPL</th>
<th>133-150% FPL</th>
<th>150-200% FPL</th>
<th>200-250% FPL</th>
<th>250-300% FPL</th>
<th>300-400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>2%</td>
<td>3.4%</td>
<td>4.6-8.05%</td>
<td>8.05-9.5%</td>
<td>9.5%</td>
<td></td>
</tr>
<tr>
<td>$2,000</td>
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<tr>
<td>$4,000</td>
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<tr>
<td>$6,000</td>
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<tr>
<td>$8,000</td>
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</tbody>
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*Based on Income for Family of Four (133% FPL = $29,320)
Average Annual Family Premium = $13,375

Estimated MN Impact

- 5.6% of non-elderly population newly eligible for Medicaid* - 260,000
- Eligible but not enrolled
  - About 60% of Minnesota’s 480,000 uninsured are estimated to be eligible for public programs under current law
  - These would not qualify newly eligible
- 31.3% of non-elderly population eligible for premium and cost-sharing subsidies* – 1.4 million

Who is not covered by expansions/subsidies

- People with incomes above 400% of poverty
- Undocumented immigrants
- Exemptions from Individual Mandate
  - Financial hardship, religious objections, American Indians, incarcerated individuals, people for whom the lowest cost plan option exceeds 8% of income, and people whose income is below the tax filing threshold.

Individual Responsibility

• Effective January 1, 2014
• U.S. citizens and legal residents and their dependents
• Exempt:
  – Those for whom lowest-cost plan exceeds 8% of income
  – Financial hardship and low-income
• Young adults:
  – Up to age 30, individuals can purchase a catastrophic plan and
    be in compliance
• Penalty for non-compliance
  – $325 in 2015
  – $695 in 2016 and beyond (indexed by a COLA)
  – Penalty will be applied for any uninsured dependents as well

Private Insurance Market Regulation: Short-Term Issues

• Effective 6 months after enactment:
  – Young adults may be covered as dependents up to
    age 26 (non-married)
    • 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”)
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

Regulatory Changes

Rate Regulations

- Ban on rate variation by health or gender
  - Effective 2014
- Limit on rate variation by
  - age (3:1 ratio max.),
  - tobacco use (1.5:1 ratio max.),
  - family composition, and
  - geographic area
- Effective 2014

National Temporary High-Risk Pool

- 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

<table>
<thead>
<tr>
<th></th>
<th>MCHA</th>
<th>National Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums</td>
<td>Up to 125% of individual market average</td>
<td>Based on standard population; 4:1 rating allowed for age</td>
</tr>
<tr>
<td>Maximum out of pocket</td>
<td>Up to $10,000, depending on plan selected</td>
<td>$5,950 individual/$11,900 family</td>
</tr>
<tr>
<td>Actuarial value</td>
<td>None</td>
<td>At least 65%</td>
</tr>
<tr>
<td>Waiting period</td>
<td>None</td>
<td>6 months uninsured</td>
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Minnesota Impact

- Purpose of temporary risk pool is to provide coverage for people who have been unable to obtain insurance coverage because of a pre-existing condition, prior to 2014 when health plans will no longer be able to deny coverage to this group.
- It is not meant to replace or supplement existing high-risk pools.
- Given the 6 months waiting period MN might not be able to shift current MCHA enrollees to the new pool.
- New pool might be cheaper for some people.
4. Health Insurance Exchange

Basic Components

- State-based “American Health Benefit Exchanges”
  - For purchase of individual coverage
  - Premium and cost-sharing credits available to individuals/families between 133% and 400% FPL
- Separate exchanges (also state-based) for small businesses (≤ 100 employees)
  - “Small Business Health Options Programs” (SHOP) Exchanges
  - States can combine the individual and SHOP exchanges
  - States can open exchanges to businesses with more than 100 employees beginning in 2017
- At least two national or multi-state plans will be offered in each exchange
Additional Exchange Provisions

• Funding
  – HHS will provide grants to states to establish exchanges
  – Exchanges must be self-sustaining, effective 2015

• Benefit Packages
  – All plans must provide basic services
  – Four benefit categories will be available, based on actuarial value (60%, 70%, 80% and 90%)
  – States may require additional benefits to be covered
  – Catastrophic coverage available to individuals under 30 years of age

Role of State in Setting up the 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
5. Select Employer Provisions

Employer Sponsored Health Insurance

- Effective January 1, 2014
- “Free-Rider” penalty
  - Penalties if no coverage offered and at least one employee receives tax credits through an Exchange
  - $2,000 multiplied by the # of workers employed (minus first 30 workers)
  - Exceptions for small businesses (≤ 50 workers)
- Employers with > 200 employees must automatically enroll them into ESI
  - Employees can opt-out of the coverage
Premium Subsidies to Employers

- Tax credits for small employers (≤ 25 employees) and average annual wages below $40K who provide ESI
  - For 2010-2013: Up to 35% of employer’s premium contribution, depending on employer’s size and average annual wage
  - For 2014 and beyond: Up to 50% of employer’s premium contribution for employers that purchase coverage through Exchange, depending on employer’s size and annual wage

Employer Free Choice Voucher

- Require employers that offer coverage to their employees to provide a free choice voucher
  - employees with incomes less than 400% FPL and
  - whose share of the premium is 8% - 9.8% of their income and
  - who choose to enroll in a plan in the Exchange.
- The voucher
  - equal to what the employer would have paid to provide coverage to the employee under the employer’s plan
  - used to offset the premium costs
- Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange
6. Delivery System and Payment Reform

Delivery System and Payment Reform: Value-Based Purchasing

- “Value index” added to Medicare physician payment methodology (combined measure of quality and cost) – beginning in 2015

- Hospital payment based in part on quality – beginning in 2013

- Planning for value-based purchasing of nursing facility and home health services

- Reduced Medicare payment rates to hospitals with high rates of hospital-acquired conditions and high rates of readmissions
Delivery System and Payment Reform: Quality Measurement and Reporting

- Stronger incentives for participation in Physician Quality Reporting Incentive program – reduced payment rates in 2015 for non-participation
- Comparative reports to physicians on resource use and quality (Medicare) – reports not made public
- Expanded public reporting of provider-specific quality
  – Examples include hospital-acquired conditions and readmission rates
- Funding for development of new quality measures

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Delivery System and Payment Reform: Care Coordination

- Bundled payment demonstration projects in Medicare/Medicaid - beginning in 2013
- 90% Medicaid match (2 years) for care coordination services in a health care home (2013 and 2014)
- Improve care coordination for Medicare/Medicaid dual eligibles by more effectively integrating benefits

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Delivery System and Payment Reform: Improving System Accountability

- Accountable Care Organization (ACO) demonstration projects with shared savings for ACOs meeting quality standards - beginning in 2012
- 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

Provider Payments

- Reduction in disproportionate share payments (DSH) beginning in 2014
- Increase in Medicaid payment rates to 100% Medicare rates for primary care
  - (100% match for 2013 and 2014 only)
- Increase in Medicare physician payment rates in areas with below average practice expense payment rates
- Increase payments to hospitals in counties in bottom quartiles of risk-adjusted spending per Medicare enrollee (PPS hospitals only)
Summary

- Access and Affordability: the new law will have a significant impact in MN and elsewhere
- Initiatives on delivery system & payment reforms to improve the cost and quality of care
  - *Minnesota is ahead of most other states and should be well-positioned to take advantage of these initiatives*
- Many details related to implementation remain to be clarified through rules, regulation and administrative directives
- Significant work ahead in short and long term to implement health reform

Contact Information

Lynn A. Blewett, PhD
State Health Access Data Assistance Center
University of Minnesota, Minneapolis, MN
www.shadac.org
blewe001@umn.edu
612-624-4802