Health care reform:
WHAT YOU NEED TO KNOW AND DO

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Agenda:

- About health care reform
- Key provisions of the Affordable Care Act
- Health Insurance Marketplace
- Exchange navigators
- Health care reform timeline

About health care reform

- **March 23, 2010**—President Obama signed the Affordable Care Act (ACA), which is intended to provide affordable coverage options through Medicaid and Health Insurance Marketplaces.

- **October 1, 2013**—Health Insurance Marketplaces open.

- **January 1, 2014**—The individual mandate begins, and most Americans are required to have health insurance.

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Key provisions of the Affordable Care Act

- Individual mandate
- Employer mandate
- Guarantee issue
- Essential health benefits
- Qualified health plans
- Coverage tiers
- Medicaid expansion
- Premium tax credits
- Cost-sharing subsidies
- Prevention and wellness programs
- Fees and taxes
- Grandfathered plans

Individual mandate

- The mandate applies to Americans of all ages.
- Insurance companies are required to report certain information to the IRS and to individuals.
- Individuals may keep their active group or individual health insurance as long as the coverage:
  - –Qualifies for grandfathered status.
  - –Meets the definition of a qualified health plan.
  - –Provides the minimum essential benefits.
- The individual mandate does not apply to those who:
  - –Have a religious conscience exemption.
  - –Have a coverage gap of less than three months.
  - –Are incarcerated.
  - –Are in a hardship situation, as defined by Health and Human Services.
  - –Are undocumented aliens
  - –Reside outside of the U.S.
  - –Have a household income below the tax-filing threshold.
  - –Cannot afford coverage.*
  - –Are members of an Indian tribe.
  - –Are members of a Health Care Ministry

Individual mandate

- Effective January 1, 2014, individuals must have health insurance for themselves and each of their dependents.
- The ACA provides premium tax credits and subsidies for low-income individuals.
- The health insurance plan must meet the definition of "minimum essential" coverage.
- Minimum essential coverage may include:
  - Government-sponsored programs
  - Employer-sponsored plans
  - Health Insurance Marketplace plans
  - Other coverage approved by Health and Human Services and/or the Department of the Treasury (including self-insured student health coverage, the refugee medical assistance program, Medicare advantage plans and state high risk pools

Individual mandate penalty

- Individuals without minimum essential coverage will face a penalty.
- The penalty is the greater of a flat dollar amount or a percentage of the individual's household income.
- For minors, the penalty is half of the amount for adults.

	Flat dollar amount	Percentage of household income
2014	$95	1%
2015	$325	2%
2016	$695	2.5%
2017	$695	2.5%
2018 and beyond	Indexed to inflation	

* Dollar amount is per individual subject to a 300% limit.

Employer mandate and penalty

- Effective January 1, 2015, employers with 50 or more full-time-equivalent employees must provide coverage or pay a penalty.
- Employers must report certain information to the IRS and to individuals annually.
- The coverage must be "affordable" and provide "minimum value."

–Affordable: The employee's cost must be less than 9.5% of his or her income.

–Minimum value: The insurance must pay at least 60% of costs for covered services.

- Employers that violate the mandate:
  - –Are not penalized for the first 30 employees.
  - –Are charged a penalty if one or more employees receive a subsidy through the exchange.

Guarantee issue

- Insurers must provide health insurance to any person regardless of medical history or current health.
- Premiums for non-grandfathered plans in the individual and small group market must be based upon a single risk pool.
- Insurers are restricted in limiting the scope of coverage.
- Impact on health insurance premiums will vary by state
- Insurers cannot:
  - Deny coverage based on pre-existing conditions.
  - Exclude pre-existing conditions.
  - Charge a higher premium for individuals with pre-existing conditions.

Essential health benefits

- Effective January 1, 2014, fully insured small group and individual health plans must cover these essential health benefits:
  - Preventive and wellness services
  - Chronic disease management
  - Mental health and substance use disorder services, including behavioral services
  - Rehabilitative and habilitative services and devices
  - Pediatric services, including oral and vision care
  - Maternity and newborn care
  - Ambulatory patient services
  - Emergency services
  - Laboratory services
  - Prescription drugs
  - Hospitalization

Essential health benefits

- Each state must select an existing health plan as a “benchmark.”
- Benchmark plans will be selected from these options:
  - The largest plan based on enrollment in any of the three largest small-group products in the state
  - Any one of the three largest state employee health plans
  - Any one of the three largest federal employee health plan options
  - The largest HMO plan in the state’s commercial market
- The small-group plan with the state’s largest enrollment will become the benchmark is the state does not select one.

Coverage tiers

- The ACA establishes health insurance coverage tiers:

Tier	Paid by the plan	Paid by the insured	Typically offers…
Bronze	60%	40%	Lowest premium, highest cost-sharing
Silver	70%	30%	Lower premium, higher cost-sharing
Gold	80%	20%	Higher premium, higher cost-sharing
Platinum	90%	10%	Highest premium, highest cost-sharing
Catastrophic coverage			

- Tiers serve two main purposes:
  - To create standardized levels of insurance for individuals and small businesses
  - To serve as benchmarks for premium credits and cost-sharing subsidies

*AV calculation is different for ER mandate

Medicaid expansion

- Effective January 1, 2014, states have the option to expand Medicaid.
- Americans 65 or younger with a household income of less than 133% of the federal poverty level may enroll.
- States will receive 100% federal funding for the first three years.
- States must create a simplified eligibility process for individuals to enroll.
- Medicaid eligibility is not being changed for:
  - Aged, blind or disabled individuals
  - Foster care children
  - SSI cash recipients

Premium tax credits

- Individuals who enroll in coverage through the Health Insurance Marketplace may be eligible for a premium tax credit.
- Premium tax credits:
  - –Assist with payment of premium for health insurance.
  - –Are available only to individuals who purchase insurance through the Marketplace.
  - –Are determined on an income-based sliding scale, drawing on the taxpayer's last tax return.
  - –Are based on the premium cost for the second lowest cost silver plan in the Marketplace servicing the individual.
  - –Are available to people with incomes between 100% and 400% of the federal poverty level.

Premium tax credits

The amount of tax credit varies with income:

Income level as a percentage of the federal poverty level	Health care costs as a percentage of income
Up to 133% FPL	2.00%
133%–150% FPL	3.00%–4.00%
150%–200% FPL	4.00%–6.30%
200%–250% FPL	6.30%–8.05%
250%–300% FPL	8.05%–9.50%
300%–400% FPL	9.50%

ACA Tax Credit Income Guidelines

Persons in Household	2018 Federal Poverty Level	Medicaid Eligibility (138% of FPL)	200% of Poverty Level	300% of Poverty Level	Premium Subsidy Threshold (400% of FPL)
1	$12,060	$16,643	$24,120	$36,180	$48,240
2	$16,240	$22,411	$32,480	$48,720	$64,960
3	$20,420	$28,180	$40,840	$61,260	$81,680
4	$24,600	$33,948	$49,200	$73,800	$98,400
5	$28,780	$39,716	$57,560	$86,340	$115,120
6	$32,960	$45,485	$65,920	$98,880	$131,840
7	$37,140	$51,253	$74,280	$111,420	$148,560
8	$41,320	$57,022	$82,640	$123,960	$165,280

Cost sharing subsidies

- Individuals may be eligible for a federal subsidy, which:
  - Helps protect lower-income individuals from high out-of-pocket costs.
  - Are available to those with a household income of up to 250% of the federal poverty level.
- The subsidy amount is determined by a sliding scale based on:
  - The federal poverty level
  - The insured's benefits, including state-mandated benefits
- Health and Human Services through the Marketplace notifies the insurer if an enrollee is eligible for the subsidy.
- Individuals can determine their potential eligibility using this calculator: kff.org/interactive/subsidy-calculator. This tool is not approved or sponsored by the federal government or [INSERT COMPANY NAME] and is intended for illustrative purposes only.

Cost sharing subsidies

- The federal subsidy amount is based on the individual's household income and the plan's actuarial value.

Income level	Plan's actuarial value
100%–150% FPL	94%
150%–200% FPL	87%
200%–250% FPL	73%

- Individuals with incomes at or below 400% of the federal poverty level have limited out-of-pocket costs:

Income level	Out-of-pocket limit
100%–200% FPL	Two-thirds of the HSA limit
200%–300% FPL	One-half of the HSA limit
300%–400% FPL	One-third of the HSA limit

Prevention and wellness programs

- The ACA provides for HHS to offer a limited program of wellness grants funded by the federal government.
- To qualify, a business must:
  - Have less than100 employees working 25 hours or more per week.
  - Not have had a wellness program in place in March 2010.
  - Use the grant to create a comprehensive wellness program for employees.
- The ACA also increases the permissible health-contingent wellness program reward under an employer wellness program up to 30% of the cost of employee-only coverage (the program must also meet certain other standards).

Prevention and wellness programs

Participatory wellness program	Health-contingent wellness program
Do not offer rewards	Offer rewards to individuals who meet defined standards
Do not make rewards that require an individual to make lifestyle changes	Program must meet additional criteria
Reward examples: • Reimbursement for a gym membership • Rewards for participating in diagnostic testing • Rewards for attending free educational seminars	Reward examples: • Requiring tobacco users to take a smoking cessation program to avoid a surcharge • Rewarding participants who obtain health screening values (e.g., BMI) within healthy ranges; requiring participants outside of healthy ranges to work to improving their numbers.

Fees and taxes for insurers

- Patient-Centered Outcomes Research Institute (PCORI) Fee
  - Used to fund Patient-Centered Outcomes Research Institute
  - Determines which treatments work best when applied to patients
  - 2012-2019
- Health insurance industry fee
  - $8 billion in 2014, increases annually to $14.3 billion in 2018
  - Continues to increase in line with premium growth after 2018
  - Based on each insurer's share of taxable premium base
- Reinsurance assessment
  - Totals $25 billion
  - Collected from 2014 through 2016
  - Used to fund a reinsurance program intended to lessen the impact of high-risk insureds in the individual market

Grandfathered plans

- Plans in force before the Affordable Care Act can be grandfathered.
- To earn "grandfather" status, a plan must:
  - –Be in force before March 23, 2010.
  - –Not be changed in any material way that:
    - Reduces benefits or employer contributions.
    - Increases employee-paid deductibles.
    - Increase the employee's coinsurance or copayment costs.
- Grandfathered plans:

– May have lower rates initially compared to plans sold through health insurance exchanges.
– May not include some ACA benefit reforms.
– Are exempt from certain reform provisions.
– Employer plans that are grandfathered, may change insurance companies.

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Health Insurance Marketplace

- The Health Insurance Marketplace is intended to help individuals find and purchase health insurance to fit their budget.
- The Marketplace will open for enrollment on October 1, 2013.
- Every health insurance plan available in the Marketplace will offer essential health benefits.
- All costs are stated up front.

Health Insurance Marketplace

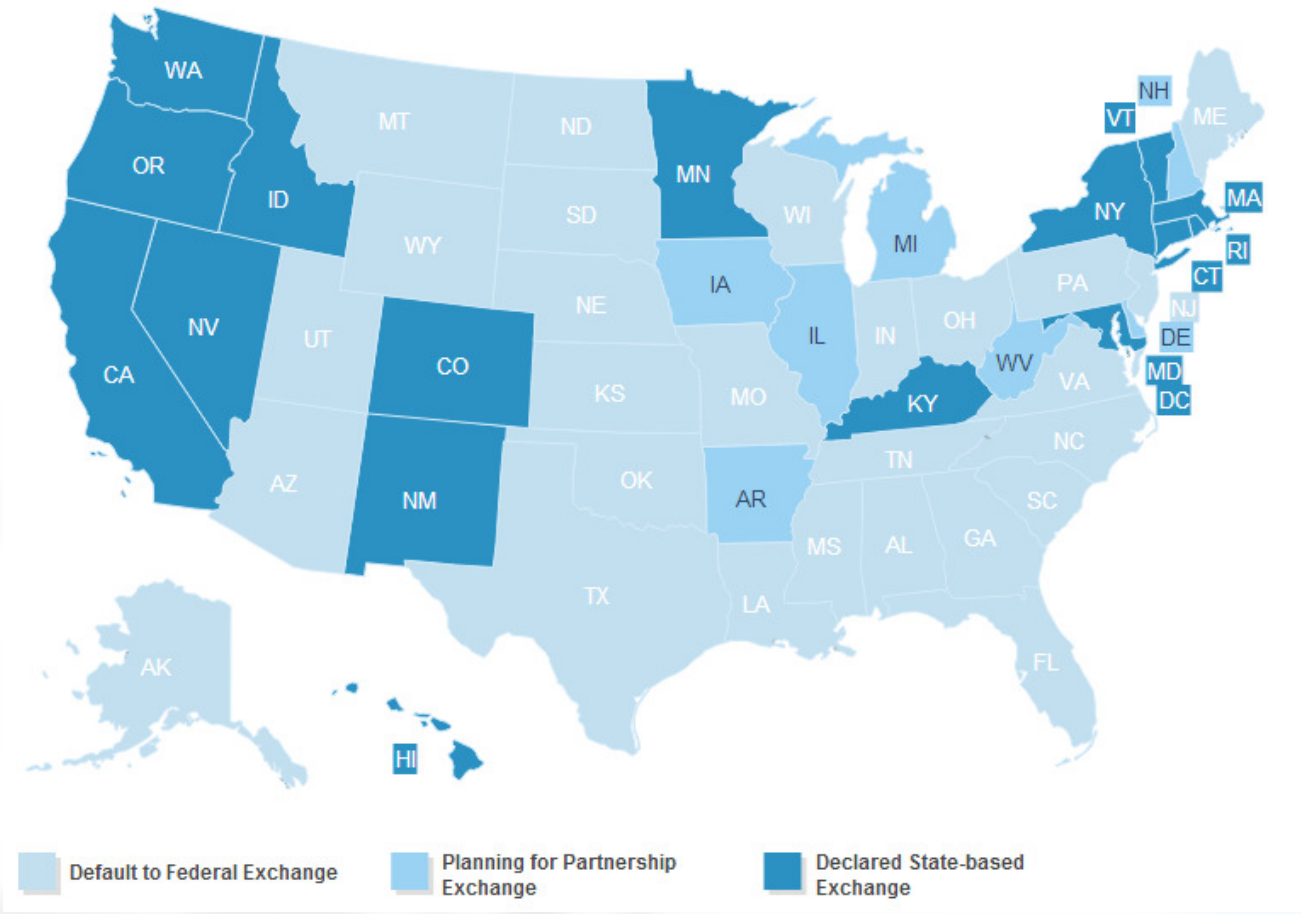
States can choose to offer one of three types of Marketplace:

1. **State-based Marketplace**
   The state assumes all functions.

2. **State partnership Marketplace**
   The state shares operational functions with the federal government.

3. **Federally facilitated Marketplace**
   Health and Human Services assumes all functions.

Health Insurance Marketplace



Status by state, available at kff.org/state-health-exchange-profiles

Health Insurance Marketplace

- The individuals most likely to enroll through the Health Insurance Marketplace include 29 million Americans who are:
  - Uninsured
  - Unemployed
  - Self-employed
  - Insured today in the individual market
- Of these individuals, 19 million may be eligible for a premium tax credit.

Source: Congressional Research Service, Health Insurance Premium Credits in the Affordable Care Act

Small Business Health Option Program (SHOP)

- Beginning in 2014, small employers may offer insurance through the Small Business Health Option Program (SHOP) Marketplace.
  - The **employer-choice** SHOP Marketplace. Eligible employers can select one or more plans; their employees can choose coverage from these options.
  - The **employee-choice** SHOP Marketplace. Eligible employers can select from four options: bronze, silver, gold and platinum. Employees can select any plans offered at that level in their state. Delayed until 2015 in the Federally facilitated SHOP.
- Employers offering insurance through SHOP must offer the coverage to all full-time-equivalent employees.
- Small-employer tax credit requirements:
  - Coverage must be purchased through the SHOP Marketplace.
  - The employer must cover at least 50% of the cost for single (not family) coverage for each employee.
  - The employer must have no more than 25 full-time equivalent employees.
  - Employees' average annual wages can be no more than $50,000.

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Exchange navigators

- A navigator is a health insurance adviser paid by the government, a government-funded entity or an exchange to support individuals and businesses.
- Navigators at a Health Insurance Marketplace can provide information and facilitate the enrollment process.
- The federal and state governments and commercial health insurance exchanges may redefine the navigator's role.
- Training and certification requirements for navigators include:
  - Completing a 30-hour training program.
  - Earning a passing grade on an examination.
  - Annual recertification and continuing education.

Exchange navigators

A navigator's responsibilities include:

- Educating the public about available qualified health plans.
- Distributing fair, impartial information about enrolling in qualified plans.
- Describing the available premium tax credits and subsidies.
- Facilitating enrollment in qualified plans.
- Referring people who have problems with their health plan or premium tax credits to appropriate entities for grievance resolution.
- Communicating appropriately with individuals served by the exchange.

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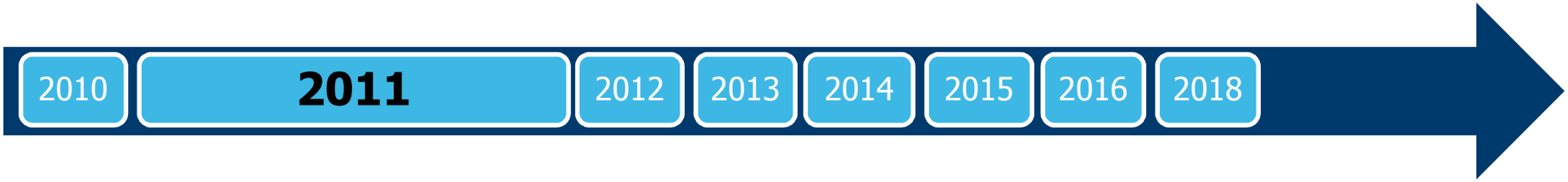
Key effective dates—2010

- Cost-free preventive services began for many Americans.
- In April 2010, states may expand Medicaid to cover more people.
- Effective June 2010, Medicaid coverage was expanded for early retirees.
- Effective July 2010, insurance was extended to uninsured Americans with pre-existing conditions, through the Pre-Existing Condition Insurance plan.
- Effective in September 2010:
  - Coverage cannot be denied to children based on pre-existing conditions.
  - Insurance companies cannot rescind coverage.
  - Lifetime limits are eliminated on insurance coverage for essential health benefits.

Key effective dates—2011



- People with Medicare can get key preventive services at no cost to them and receive a 50% discount on brand-name drugs inside the Medicare "donut hole."
- In January 2011, reforms to Medicare include:
  - Prescription drug discounts
  - Preventive care at no cost to seniors
  - Health care quality and efficiency improvements
  - Reduced health care premiums
  - Stronger Medicare Advantage program
- As of October 2011, Medicare includes increased access to services at home and in the community.

Key effective dates—2012

- Accountable care organizations and other programs are working to help doctors and other providers deliver better care.
- In January 2012, integrated health systems were launched.
- For Medicare, in October 2012, efforts took effect to:
  - Link provider payments to quality outcomes through value-based purchasing program.
  - Reduce paperwork and administrative costs.

Key effective dates—2013

- For Medicare, effective January 2013, efforts began to:
  - Improve preventive health coverage.
  - Expand authority to bundle payments.
  - Increase Medicaid payments for primary care doctors.
- In October 2013, open enrollment in the Health Insurance Marketplace begins.

Key effective dates—2014

- Effective January 2014, these health care reform provisions take effect:
  - Prohibiting discrimination due to pre-existing conditions or gender
  - Eliminating annual limits on insurance coverage for essential health benefits
  - Ensuring coverage for individuals participating in clinical trials
  - Offering tax credits and subsidies for individuals
  - Establishing the Health Insurance Marketplace
  - Increasing access to Medicaid for states who elect expansion
  - Charging penalties for individuals who violate the individual mandate

Key effective dates—2015

- The employer mandate is expected to take effect on January 1, 2015.
- For Medicare, effective January 2015, physician payments are to be based on value, not volume.
- In January 2015, Federally Facilitated SHOP Marketplace expected to offer employee choice.

Key effective dates—2016

- Effective January 2016:
  - The ACA permits states to form health care choice compacts and allows insurers to sell policies.
  - The definition of a small employer for SHOP rises to 100 full-time-equivalent employees.
- Federal funding to states ends.

Questions