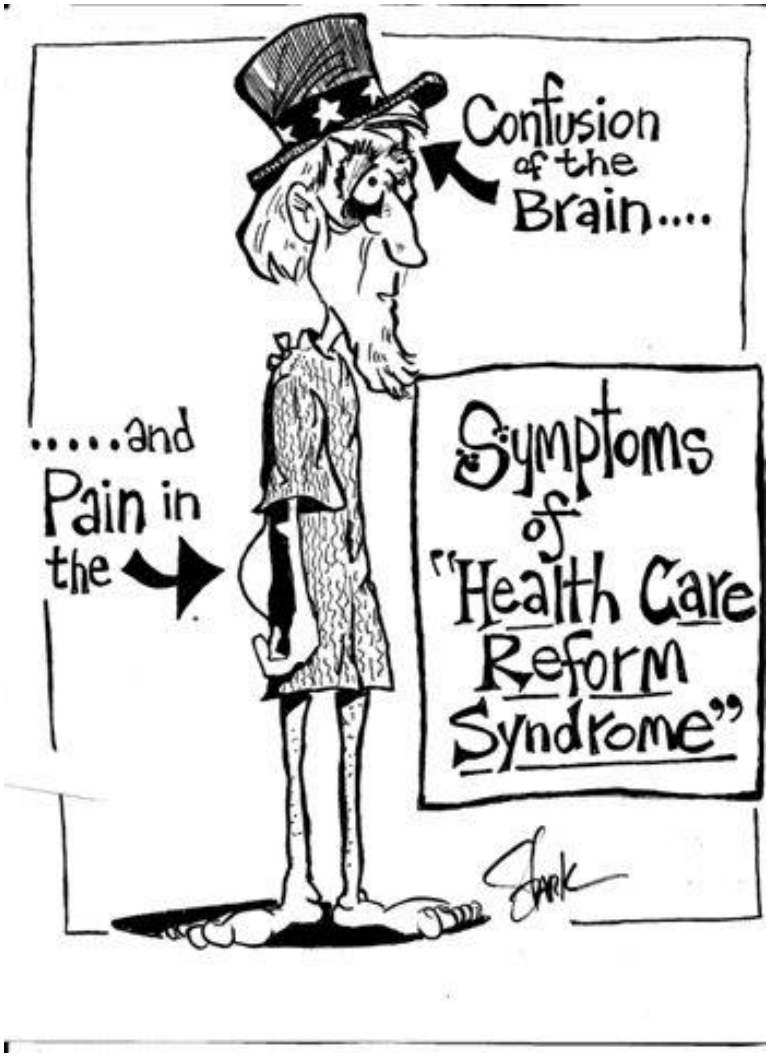
Overview of the Affordable Care Act

March 2013

Presentation Objective
Give you a high-level briefing on national health care reform and its impact

Wellmont Health System

Health Care Reform Syndrome



Wellmont Health System

Health Care Reform Basics

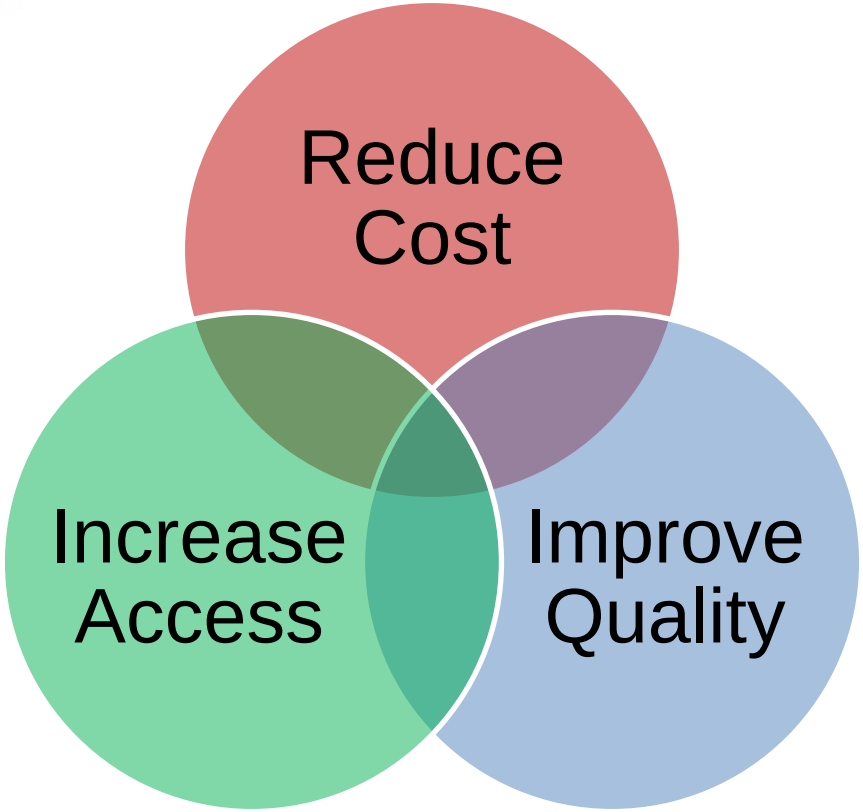
PPACA + HCERA = Final Health Reform Law (ACA)

- PPACA = Patient Protection and Affordable Care Act
  - Original legislation
  - Senate version of PPACA formed the basis for the final ACA
  - Signed into law on March 23, 2010
- HCERA = Health Care and Education Reconciliation Act
  - Made numerous significant changes to PPACA
  - Signed into law on March 30, 2010
- ACA = Affordable Care Act
  - Final health reform law as amended by the Reconciliation Act

Source: John E. McDonough. *Inside National Health Reform.* 2011. University of California Press, pp. 5-6

Wellmont Health System

Triple Aim of Health Care Policy



3 Overlapping Problems to Solve

- Lack of access to timely and affordable healthcare for large segments of the population
- Rising healthcare costs and inflation that threatens the sustainability of our legacy financing structures.
- Quality of care delivered across the country is highly variable.

Rare for policies to accomplish all three objectives. Most policies involve a trade-offs with at least one objective.

Wellmont Health System

Key Provisions of Health Care

Primary Goals

Expand Access

1. **Changes to Private Insurance:** New regulations prevent denying coverage to people for any reason and from charging higher premiums based on health status and gender.
2. **Medicaid Expansion:** Encourages and pays for states expand Medicaid eligibility to 133% of federal poverty level.
3. **Health Exchanges:** New “marketplaces” for individuals and small businesses to purchase affordable coverage
4. **Individual Mandate:** Requirement that most individuals have health insurance beginning in 2014
5. **Employer Requirements:** Penalties to employers that do not offer affordable coverage to their employees, with exceptions for small employers.

Improve Quality

6. **Delivery System Reforms:** Various programs, incentives, and grants to improve quality, health system performance, and reduce costs

Reduce Costs

7. **Cost Containment & Financing of Health Reform:**

Wellmont Health System

1. Changes to Private Insurance and Market Regulations

Policy Objective: Maintain and Expand Access, Expand Risk-Pool

- New regulations prevent health insurers from denying coverage for any reason, including health status.
- Prohibits charging people more based on their health status and gender. Health plan premiums allowed to vary only based on age, geographic area, tobacco use, and number of family members.
- Require health plans provide comprehensive coverage that includes at least a minimum set of services (Essential Health Benefits) and caps annual out-of-pocket spending.
- Young adults allowed to remain on parent's health insurance up to age 26.
- Health insurers prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.
- New health plans required to cover certain preventive services with no cost-sharing.
- Increases in health plan premiums will be subject to review.
- Insurers required to spend at least 80% of premiums on medical costs or pay rebates back to consumers.
- Note: Some **"grandfathered plans"** at small businesses will be exempt from **some** of these new requirements.

Wellmont Health System

Source: Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." April 11, 2011.

1. Practical Implications of Changes to Private Insurance

Individuals

- **(+) Cannot be denied coverage due to pre-existing conditions**
- **(+) Young people have greater access**
- **(+) Increased free access to preventative services**
- **(-) Likely to face some premium increases due to inclusion of "higher-cost" patients**
- **(-) Likely to face some premium increases due to increased minimum plan requirements (Essential Health Benefits)**

Providers

- **(+) Less uninsured "higher-cost" patients**

Insurers

- **(-) Cannot deny coverage to "higher-cost" patients**
- **(-) Cannot completely "pass-thru" costs to beneficiaries due to 80% requirement**

Businesses

- **(-) Larger businesses may face increased costs due to increased minimum plan requirements (Essential Health Benefits)**
- **(+) Some small businesses that are permitted to "grandfather" current plans will be exempt from some requirements**

Government/Taxpayer

- **(+) Less uncompensated care**
- **(-)**

Overall Market/System

- **(+) Increased free access to preventative services likely to reduce some costs**
- **(+) First steps of moving to more effective risk-pooling**

Wellmont Health System

Source: HVMC Internal Analysis

2. (Voluntary) Medicaid Expansion

Policy Objective – Expand Access

- Expand Medicaid to all individuals under 65 with incomes up to 133% of the poverty level.
- In 2012, poverty level was $11,170 for individuals and $23,050 for a family of four.
- Expansion would create uniform minimum Medicaid eligibility across states.
- Expansion would allow most adults without dependent children to enroll in Medicaid (they currently do not qualify). Undocumented immigrants would not qualify.
- People with incomes above 133% of poverty level without employer-sponsored insurance would obtain coverage in the new state exchanges.
- Federal government provides 100% of costs for those newly eligible from 2014 – 2016; 95% of costs for 2017; 94% in 2018; 93% in 2019; 90% for 2020 and beyond.
- Medicaid payments to primary care doctors for primary care services increased to 100% of Medicare payment rates in 2013-2014 with 100% federal financing.
- In June 2012 , Supreme Court ruled that Medicaid expansion was voluntary for states. The court ruled that the federal government could not withhold all federal Medicaid spending if a state did not expand Medicaid.
- Governor Haslam has not yet made a decision whether TN will pursue expansion.

Wellmont Health System

Source: Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." April 11, 2011.

How Would the Medicaid Expansion Affect Tennessee

- Who is eligible for TennCare today?
  - Adults with out dependent children are ineligible regardless of income level
  - Adults with dependent children are eligible if they are jobless and at 69% of the federal poverty level
  - Adults with dependent children are eligible if they are working and at 126% of the federal poverty level
- How many uninsured would be eligible for TennCare if expanded?
  - 459,000 uninsured adults (Of these, 361,000 would be newly eligible and 98,000 are eligible under the current rules but not enrolled)
- How much would it cost Tennessee to expand?
  - During the first six years between $716M to $1.5B depending on enrollment
  - This is a 2.5% to 5.4% increase in State expenditures in TennCare excluding the Federal funds

Wellmont Health System

Source: John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, Urban Institute and Kaiser Family Foundation, May 2010.

2. Practical Implications of Changes to Medicaid

Individuals

- **(+) Increased access for individuals without employer-sponsored insurance**
- **(+) Increased access for childless adults who are currently denied Medicaid in most states**
- **(-) Likely to face some premium increases due to inclusion of "higher-cost" patients**

Providers

- **(+) Less uninsured/self-pay patients**
- **(+) Medicaid reimbursement for primary care services increased to 100% of Medicare rates**

Insurers

Businesses

- **(+) Employers who pay low wages can shift health care responsibility to Medicaid/public payers**

Government/Taxpayer

- **(-) Increased state budget costs to cover increase in reimbursement rate for primary care services**
- **(-) Increased pressure on state budgets to cover 10% of costs associated with newly eligible beneficiaries**
- **(-) Increased pressure on federal budget to cover 90% of costs associated with newly eligible beneficiaries**

Overall Market/System

- **(+) Increased free access to preventative services likely to reduce some future health care costs**

Wellmont Health System

Source: HVMC Internal Analysis

3. State Health Exchanges

Policy Objective: Create a new "marketplace" for individuals and small businesses to purchase health insurance.

- Exchanges are new organizations to create a more organized and competitive market for buying health insurance.
- Provides consumers and small businesses with information to compare and choose plans
- Two separate exchanges: Individual and Small Employer (1-100 employees)
- Exchanges will certify and offer choice of different health plans that must offer benefits with a minimum set of standards
  - Insurers must offer 4 levels of coverage that vary based on premiums, out-of-pocket costs, benefits beyond minimum, plus catastrophic coverage plan
  - Guaranteed issue = participating plans cannot deny coverage based on health status
- Insurers willing to accept constraints on pricing, capping, and enrollment because individual mandate increases risk-pool and spreads the financial risk
- Sliding-scale subsidies and tax credits for those at 100-400% of the poverty level.
  - 100%-400% of federal poverty level in 2012 = $23,050 to $92,200 for a family of four
  - Premium costs limited to between 2% of income for those up to 133% of the poverty level and 9.5% of income for those between 300-400% of the poverty level.
- Federal funding provided to establish and operate exchanges in 2014. State exchanges must be self-sustaining by 2015 by assessment or fee on participating plans
- TN Governor Haslam in December of 2012 announced TN will not operate its own state exchange, opting to let the federal government run it.

Wellmont Health System

Source: Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." April 11, 2011.

3. Practical Implications of New State Health Exchanges

Individuals

- **(+) Increased access and affordable coverage for individuals without employer-sponsored insurance**
- **(+) Increased ability to navigate individual insurance options and compare plans**

Providers

- **(+) Less uninsured/self-pay patients**

Insurers

- **(+) New market and potential customers (reliant on individual mandate)**
- **(-) Guaranteed issue in individual market, meaning participating insurers cannot "cherry-pick" individuals**

Businesses

- **(+) Small business can pool purchasing power to lower insurance costs**

Government/Taxpayer

- **(-) Major federal subsidies/tax credits provided to make coverage affordable for those up to 400% poverty level**
- **(-) State costs to maintain operations of exchange**
- **(-) States who let federal government operate exchanges will have less autonomy in plan design and shaping market**

Overall Market/System

- **(+) Coupled with individual mandate, increased efficiency in risk-pooling**
- **(+) Increased access to preventative services likely to reduce some future health care cost**

Wellmont Health System

Source: HVMC Internal Analysis

4. Individual "Mandate"

Policy Objective: Expand risk pool to spread financial risk

- All individuals will be required to have health insurance beginning in 2014
- Exceptions given for:
  - Financial hardship and religious objection
  - American Indians
  - People who have been uninsured less than three months
  - Those for whom the lowest cost exceeds 8% of income
  - Individuals with income below tax filing threshold; $9,350 for individual, $18,700 for married couple in 2009
- Those without coverage will be subject to yearly penalty of the greater of 2.5% of household income or $695 per person (up to a maximum of $2,085) per family.
- The individual mandate requires that all individuals purchase health insurance. This requirement of the ACA allows insurers to spread the financial risk of newly insured people with pre-existing conditions among a larger pool of individuals.
- Supreme Court upheld the individual mandate in June 2012. The decision agreed that the mandate's penalty functions as a tax.

Wellmont Health System

Source: Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." April 11, 2011.

4. Practical Implications of Individual Mandate

Individuals

- **(-) Mandates individuals to purchase insurance**

Providers

- **(+) Less uninsured/self-pay patients**

Insurers

- **(+) New market and potential customers**
- **(-) Guaranteed issue in individual market, meaning participating insurers cannot "cherry-pick" individuals**

Businesses

Government/Taxpayer

- **(-) Major federal subsidies/tax credits provided to make coverage affordable for those up to 400% poverty level**
- **(-) State costs to maintain operations of exchange**

Overall Market/System

- **(+) Coupled with individual mandate, increased efficiency in risk-pooling**
- **(+) Increased access to preventative services likely to reduce some future health care cost**

Wellmont Health System

Source: HVMC Internal Analysis

5. Employer Requirements

Objective: Preserve employer-based system as primary method of ensuring health access

There continues to be no employer mandate, but businesses with 50+ employees may be subject to fees/penalties if they do not offer coverage.

"Grandfathered" Group Health Plans

- ACA permits small businesses (1-100 workers) that wish to keep their current plan to do so. Plans must have been in place before March 23, 2010 and employers cannot make major changes to the benefits and costs to employees.
- These "grandfathered plans" are subject to fewer requirements than new plans purchased under ACA. For example, grandfathered plans are not required to:
  - Cover preventive services without cost sharing
  - Cover essential Health Benefits

Purchasing Insurance

- Small businesses have option to purchase insurance through an exchange (Called SHOP, Small Business Health Options Program)
- Until 2016, states decide whether small businesses defined as 1-50 employees or 1-100 FTEs
- After 2016, businesses with 1-100 FTEs permitted to purchase insurance through exchange
- However, employees have the option of purchasing insurance through individual exchange

Wellmont Health System

Source: Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." April 11, 2011.

5. Employer Requirements (continued)

Penalties related to Coverage

- **1-50 Employees:** Exempt from any penalties or requirements.
- **50+ Employees:** Assessed penalty beginning in 2014 if any one of their workers receives tax credit when buying insurance from health exchange. To avoid penalties, employers with 50+ employees must:
  - Offer insurance that covers at least 60% of the actuarial value—the percent of covered medical expenditures that a plan is *likely* to pay across a "typical" covered population with the rest covered by enrollees.
  - Offer insurance that is affordable. Individual's premium cannot exceed 9.5% of household income
  - If coverage does not meet affordability standard, employees may receive tax credit to purchase insurance on their own from the exchange. Workers with income up to 400% of the poverty level are eligible for tax credits.
  - If tax credits are utilized, employer will pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each fulltime employee (in excess of 30 employees).

Wellmont Health System

Source: Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." April 11, 2011.

5. Employer Requirements (continued)

Automatic Enrollment Into Insurance Plans

- Employers with more than 200 employees must automatically enroll employees into health insurance plans that are offered by the employer
- Employees can opt out.

Tax Credits to Assist in the Cost of Health Insurance

- Small businesses with fewer than 25 FTE employees may be eligible for tax credits to help defray cost of providing coverage
- To qualify, such businesses must have average annual wages below $50,000 and must pay at least 50% of the cost of their employees' health insurance

Grants for Wellness Programs

- Small businesses with less than 100 employees who work 25+ hours/week on average that did not have a workplace wellness program in effect as of March 2010 are eligible for grants to start one.

Wellmont Health System

Source: Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." April 11, 2011.

5. Practical Implications of Employer Requirements

Individuals

- •(+) Employees of small businesses have greater opportunities to be insured via employer
- •(?) If businesses "outsource" coverage to exchanges or public programs, individual may face higher costs, less benefits

Providers

- •(+) Less uninsured/self-pay patients

Insurers

- •(?) If businesses "outsource" coverage to exchanges or public programs, commercial business could decrease

Businesses

- •(+) No increased costs and potential tax credits for businesses with fewer than 50 employees
- •(?) Will businesses absorb penalty costs and shift costs and risk to exchanges or public programs?

Government/Taxpayer

- •(-) Major federal subsidies/tax credits provided to make coverage affordable for those up to 400% poverty level
- •(-) State costs to maintain operations of exchange
- •(?) Will businesses absorb penalty costs and shift costs and risk to exchanges or public programs?

Overall Market/System

- •(?) Will businesses absorb penalty costs and shift costs and risk to exchanges or public programs?
- •(+) Coupled with individual mandate, increased efficiency in risk-pooling
- •(+) Increased access to preventative services likely to reduce some future health care cost

Wellmont Health System

Source: HVMC Internal Analysis

6. Delivery System Reforms

Objective: Move toward pay-for-performance

ACA contains numerous programs that focus on:

- **Encourage health information technology adoption**
- **Strengthen primary care and care coordination**
- **Reform provider reimbursement**
- **Emphasize prevention**
- **Support research that identifies most effective treatments and interventions**
- **Promote cost and quality transparency**

Wellmont Health System

Source: Shelia Burke and David Stevenson. "Brief History of Health Reform in the U.S. and Overview of the New Law," PowerPoint presentation as part of graduate course titled Introduction to U.S. Health Care Policy, Harvard Kennedy School of Government, September 14, 2010.

6. Delivery System Reforms - Medicare

Objective: Medicare seeks to increase value, improve quality, and reduce cost

- **Establishes Center for Medicare/Medicaid Innovation.**
  - Tests new payment and service delivery models that reduce cost without decreasing quality
  - Evaluates results and disseminate best practices
  - Engages a broad range of stakeholders to develop additional models for testing
- **ACOs/Accountable Care Organizations (Medicare Shared Savings Program)**
  - ACO is an entity that will be 'held accountable' and paid collectively for providing comprehensive health services to a population
  - Voluntary grouping of primary care physicians, specialists, hospitals and other organizations to better coordinate care and reduce costs
  - Wellmont launched ACO in early 2013
- **Value-based Purchasing Program**
  - First performance period: July 2011-March 2012
  - Links Medicare hospital reimbursement to 17 clinical outcome metrics on common high cost conditions such as Cardiac disease, Surgical care, Pneumonia care
  - Links payment to 8 metrics for customer satisfaction
  - VBP will expand to Long Term Care Hospitals, Inpatient Rehabilitation facilities and Hospice care in 2014 creating a payment link to quality and service
  - Physician Quality Report Initiative does the same for physician practices. Incentives in 2013-2014. Penalties start in 2015 for performance in 2013.
- **Payment reduction for hospital-acquired conditions**
- **Hospital Readmissions Reduction Program**
  - Initial focus on Pneumonia, Congestive Heart Failure, Heart Attack
  - Hospitals face hefty penalties for readmission rates higher than national average
  - Penalties began in October 2012

Wellmont Health System

Sources: HVMC Internal Analysis; Shelia Burke and David Stevenson. "Brief History of Health Reform in the U.S. and Overview of the New Law," PowerPoint presentation as part of graduate course titled Introduction to U.S. Health Care Policy, Harvard Kennedy School of Government, September 14, 2010.

6. Practical Implications of Delivery System Reforms

Individuals

- **(+) Greater value and care coordination**

Providers

- **(-) Payment reductions for not meeting established quality and performance metrics**
- **(-) Hospitals tagged "leader" or "coordinator" of many quality improvement efforts**
- **(-) Hospital and physician incentive, unless integrated, not yet financially aligned**

Insurers

- **(+) Private payors will eventually follow Medicare's lead on linking payment to performance**

Businesses

- **(+) Greater value for health care dollars spent**

Government/Taxpayer

- **(+) Greater value for health care dollars spent**
- **(+) Reduce unnecessary and duplicative services, thereby reducing cost**

Overall Market/System

- **(+) Greater value for health care dollars spent**

Wellmont Health System

Source: HVMC Internal Analysis

7. Financing of Health Reform and Cost Containment

Summary of Key Tax Increases

- Increase Medicare tax rate by .9% and impose added tax of 3.8% on unearned income for high-income taxpayers
- Charge an annual fee on health insurance providers
- Impose a 40% excise tax on health insurance annual premiums in excess of $10,200 for an individual or $27,500 for a family (Cadillac plans)
- Impose an annual fee on manufacturers and importers of branded drugs
- Impose a 2.3% excise tax on manufacturers and importers of certain medical devices
- Raise the 7.5% Adjusted Gross Income floor on medical expenses deduction to 10%
- Limit annual contributions to flexible spending arrangements in cafeteria plans to $2,500

Summary of "Savings"

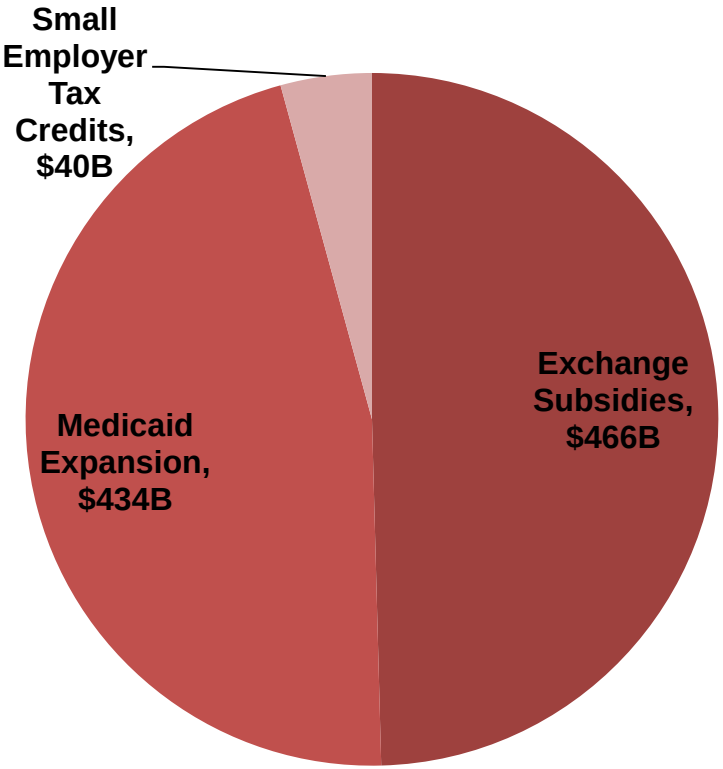
- Productivity Adjustment and other update reductions – VBP, HACs, Readmissions
- Reduce funding for Medicare Advantage policies
- Reduce Medicaid prescription drug payments
- Reduce Medicare home health care payments
- Reduce DSH Medicare hospital payments

Wellmont Health System

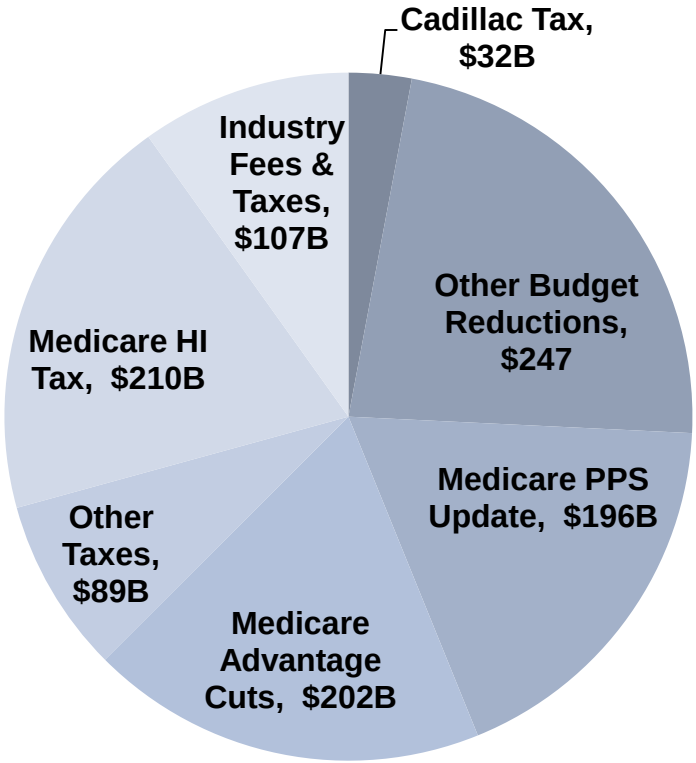
Source: CBO Letter to Speaker Nancy Pelosi, March 20, 2010;
Wikipedia, http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act

ACA 10-year Financing Estimate, 2010-2019

Spending on health reform, $940 Billion



Paying for health reform, $1,083 Billion



Source: CBO Letter to Honorable House Speaker Nancy Pelosi, March 18, 2010

Source: Shelia Burke and David Stevenson. "Brief History of Health Reform in the U.S. and Overview of the New Law," PowerPoint presentation as part of graduate course titled Introduction to U.S. Health Care Policy, Harvard Kennedy School of Government, September 14, 2010.

Wellmont Health System

Questions?

Troy Clark
Chief Operating Officer
Holston Valley Medical Center
423-224-5263
troy.clark@wellmont.org

Wellmont Health System