



MAKING SENSE OF HEALTH REFORM

Paul Gionfriddo, September 2010

Presentation Outline



- How universal is coverage under reform?
- Some winners and losers.
- What will health reform cost and who pays?
- Expectations of consumers, insurers, employers, and states.
- Health reform and mental health.
- Health reform and long term care.
- Conclusion

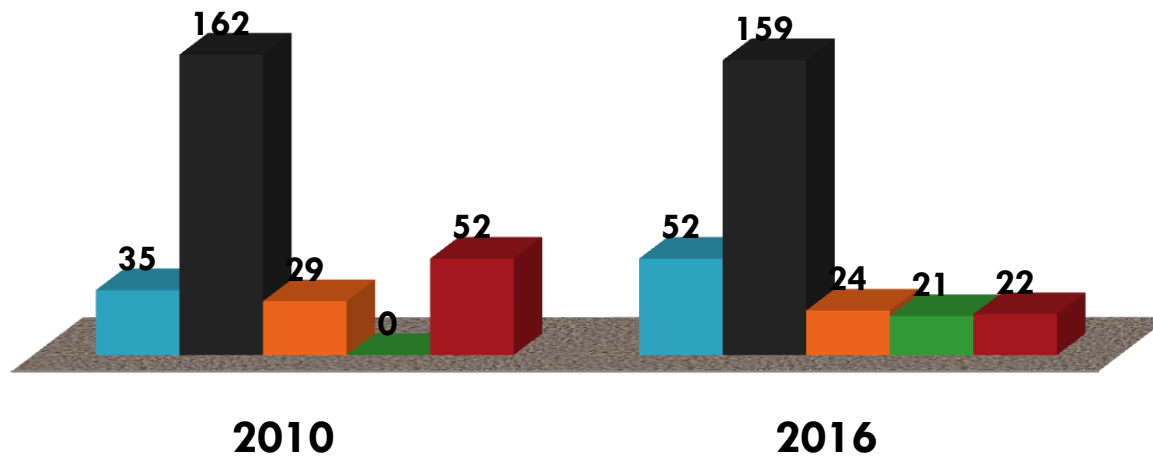
How Universal is Coverage?

...under health reform.

Reform moves 30 million uninsured to Medicaid/CHIP and Exchanges

non-elderly by insurance status, in millions

■ Medicaid/CHIP ■ Employer ■ Individual and Other ■ Exchange ■ Uninsured



WINNERS and LOSERS

...in health reform.



WINNERS

- ❑ **21 million currently uninsured people living in households making up to \$29,327 for a family of four, or up to 133% of poverty, will qualify for Medicaid or CHIP and pay nothing for health insurance.**



LOSERS

- ❑ **Up to 10 million people in the 4.7 million households in the upper income range –above \$200,000 for an individual and \$250,000 for a family – will pay more because they will pay a 0.9% increased Medicare tax on earned income and a new 3.8% Medicare tax on unearned income.**



WINNERS

- **Up to 200 million people in over 80 million households making up to 400% of poverty (\$43,320 for an individual, \$88,200 for a family of four in 2010) will save, because their health insurance premiums will be subsidized an average of \$5,300 per year.**



LOSERS

- ❑ **Households with Cadillac health plans (worth more than \$10,200 for an individual or \$27,500 for a family) will pay a new excise tax beginning in 2018 no matter what their income.**



WINNERS

- ❑ **Over 4 million Medicare recipients with high prescription drug costs will see the Donut Hole close over ten years, resulting in additional Medicare drug coverage worth up to \$1,300 or more by 2019.**



LOSERS

- ❑ **All households, regardless of income, refusing to buy insurance will pay, because they will be subjected to a new 2.5% penalty tax on income.**



What Will It Cost and Who Pays?

...when health reform is fully phased in.

What Will Health Reform Cost?

The total federal budget is \$3.5 trillion, of which \$2.1 trillion is fixed.

While the Congressional Budget Office projects the cost to be \$940 billion over the next ten years, in 2019, when Reform is fully implemented, the annual cost will be:

\$217,000,000,000, or 6.2% of the current federal budget

How Will the Money Be Raised?



In 2019, the CBO projects that health reform will raise or save \$228 billion in the following way:

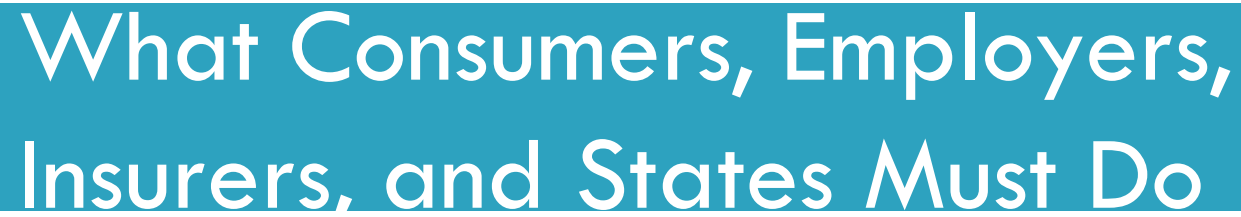
New Taxes and Fees	\$109,000,000,000
Spending Reductions	\$119,000,000,000

Some new taxes and fees

- **Penalty payments by uninsured individuals who don't buy insurance -- \$3 billion.**
- Penalty payments by businesses with over 50 employees -- \$10 billion .
- **40% excise tax on Cadillac plans will raise \$20 billion in 2019.**
- Increased Medicare taxes on wealthier people starting in 2013.
- **New 10% excise tax on indoor tanning services (effective 7/1/10) will raise \$2.7 billion over 10 years.**
- Raising the percentage after which people can deduct medical expenses from their taxes from 7.5% to 10% of Adjusted Gross Income phasing in starting in 2013.
- Limiting health flexible spending arrangements in cafeteria plans to \$2,500. (2013)
- Annual fee on health insurance providers that will raise \$14.3 billion by 2018 .
- Annual fee on brand drug importers and manufacturers -- \$3 billion annually by 2019.
- 2.3% excise tax on medical device manufacturers and importers. (2013)

Some Spending Cuts

- ❑ \$40 billion of annual savings by 2019, by lowering Medicare payments to hospitals and other providers.
- ❑ \$26 billion of annual reductions by 2019 to Medicare Advantage plans.
- ❑ Payment adjustments for home health care -- \$10 billion in savings in 2019.
- ❑ Reduced Medicaid drug payments to drug companies -- \$5 billion+ as of 2017.
- ❑ Reductions of \$5 billion each in Medicare and Medicaid “Disproportionate Share Hospital” payments as of 2018.
- ❑ Adjusting the calculation of Part B premiums -- \$5 billion per year by 2019.
- ❑ Reducing the Part D premium subsidy for higher income individuals -- \$2 billion by 2019.
- ❑ Readmission rate reductions for hospitals of \$1 billion or more as of 2015, to penalize hospitals for discharging people too early.

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What Consumers, Employers, Insurers, and States Must Do

... as of 2014 or beyond.

What Consumers Must Do



- ❑ Enroll in Medicaid if earning up to 133% of poverty.
- ❑ Once off parents' insurance, must purchase private individual or group insurance up age 65, subsidized up to 400% of poverty. Can purchase catastrophic-only coverage up to age 30.
- ❑ Enroll in Medicare if elderly, blind, disabled.

What Employers Must Do

- ❑ If they have 50 or more employees, employers must offer approved insurance, or pay fines.
- ❑ Existing plans can be grandfathered in, provided that benefits, co-pays, etc., are not significantly altered between 2010 and 2014.



What Insurance Companies Must Do

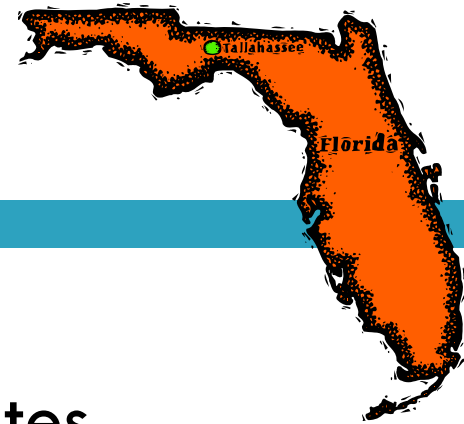
- Cover people regardless of pre-existing conditions, including mental illness. (Eff. 10/1/2010 for children, 1/1/14 for adults, applies to grandfathered group policies).
- Cover children up to age 26 on parents' policies unless they have an employer insurance option, including children with mental illness. (Eff. 10/1/2010, first day of new plan year)
 - As of 4/1/10, pre-tax treatment available up to age 27.
- Not rescind when people get sick, including physical and mental illness. (Eff. 9/23/2010, first day of new plan year)
- Eliminate annual and lifetime coverage caps, for all conditions. (Eff. 9/23/2010, lifetime; 1/1/14, annual)
- No individual right to sue to enforce this.

What if You Have a Pre-Existing Condition, Like MI, Today?

Pre-Existing Condition Insurance Plan (PCIP)

- As of 2010, states and federal government now offer a PCIP for adults.
- 29 states and DC run their own plans.
- Feds run plan in 21 other states, including mostly southern states, Florida, MA, MN, and Hawaii.
- Rates are controlled; no higher than individual health insurance premiums.
- Temporary program, expires in 2014.

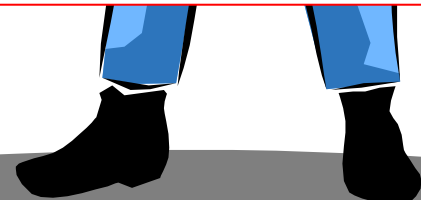
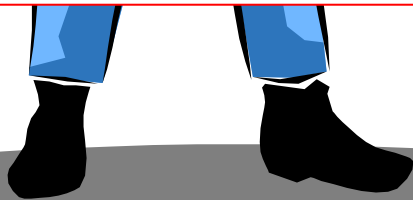
What States Must Do



- ❑ Enforce federal coverage mandates.
- ❑ Set up regulated exchanges through which health insurance will be offered to groups and individuals.
- ❑ Require mandatory minimum benefit packages.
- ❑ **Require insurance products to have minimum loss ratios of 80-85%.**
- ❑ Approve insurance products for sale through single state or multi-state exchanges.



July, 2010: Insurers Ask Obama to Add Sales Costs to Loss Ratio Calculation. NAIC unanimously opposes this! (8/2010)
August, 2010: State Insurance Commissioners in FL and Elsewhere Claim Not to Have Authority to Enforce Key Consumer Provisions of PPACA.



Health Reform and Mental Health

...over the coming decade.



Health Reform and Mental Health: 5 Areas of Improvement

- Maternal and Infant Mental Health
- Enhanced Drug Availability under Medicaid and Medicare
- Drug Parity in Mental Health Parity
- Inpatient Mental Health
- Community Mental Health

Maternal and Infant Mental Health

- Encourages treatment, research, and education for women with post-partum depression and psychosis.
- Ten-year longitudinal postpartum depression study to be carried out by the National Institute of Mental Health (NIMH).
- Health and Human Services (HHS) report in two years on the benefits of screening for post-partum conditions.
- \$3 million in funding for community programs.

Enhanced Drug Availability Under Medicaid and Medicare

- Beginning in 2014, benzodiazepines (such as xanax and valium), barbiturates, and smoking cessation drugs will no longer be excluded from Medicaid's drug lists.
- Medicare Part D will be required to cover these drug classes (it already covers smoking cessation drugs), to benefit older adults with depression.



Drug Parity



- Under the Medicaid expansion in 2014, mental health and prescription drug services are included in the basic benefits package and must be valued in the same manner as other basic benefits package provisions.
- Plans including mental health benefits under the current parity laws will be less likely to reduce other benefits provided in the plan to “make up” for this required inclusion.

Inpatient Mental Health

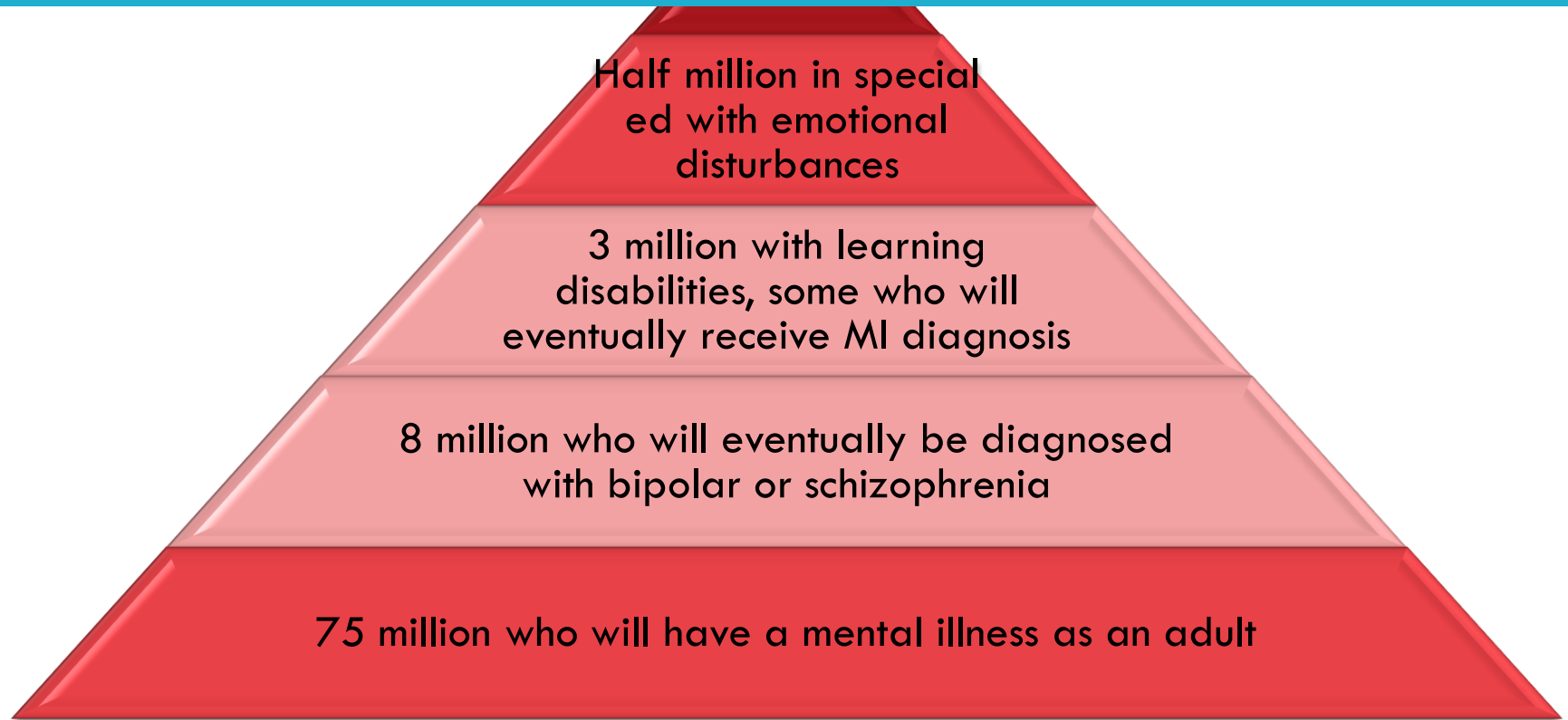
- A mandatory 3-year, 8-state demonstration project to reimburse Institutions for Mental Disease (or “IMDs,” which are inpatient and residential treatment facilities with more than 16 beds primarily treating people with mental illness and/or substance abuse) for services to adult Medicaid beneficiaries in need of medical assistance to stabilize a psychiatric emergency.
- Pre-reform provisions applied only to children in 49 states (except Arizona).

Health Reform Promotes Community Mental Health Care

- Grants to states to **prevent and manage chronic conditions** in the Medicaid population, including depression.
- “Community transformation grants” for CBOs that **promote individual and community health and prevent or reduce the incidence of chronic diseases associated with obesity, tobacco use, or mental illness.**
- Grants to educational institutions for **training programs in social work, graduate psychology, and professional and paraprofessional training in child and adolescent mental health.**
- **Primary care extension program**, with grants to state hubs providing training to primary care providers in preventive medicine, health promotion, chronic disease management, and mental health.
- \$50 million in grants for **coordinated and integrated services through the co-location of primary and specialty care** in community-based mental and behavioral health settings.

A Policy Opportunity

New community programs to enhance early detection of mental health problems in children could reduce the cost of providing educational, clinical, social and other services to the:



Health Reform and Long Term Care

...over the coming decade.

The Medicare Donut Hole



The Basic Part D Benefit in 2010:

- ❑ The consumer pays the first \$310 of prescription drug costs.
- ❑ 25% consumer co-pay on total drug costs from \$310 up to \$2,830 (the plan pays 75%).
- ❑ **100% consumer co-pay after total drug costs are above \$2,830 until the consumer's out-of-pocket costs hit \$4,550** (at which time total drug costs to the consumer and plan combined will be approximately \$6,469);
- ❑ 5% consumer co-pay (often as a small flat co-pay) after the \$4,550 out-of-pocket line is crossed.

Closing the Donut Hole



- In 2010, everyone who reaches the donut hole (the \$2,850 threshold in total drug costs) is entitled to a \$250 tax free drug rebate.
- Beginning in 2011, consumer co-pay after entering the donut hole will decrease by 7% per year until 2020 when it will go down to 25%. In 2011, e.g., the consumer will pay 93% of the cost in the donut hole and the plan will pay 7%; in 2012, the consumer will pay 86%, etc., until 2020, when the consumer will pay 25% and the plan will pay 75%.
- 2011 Medicare drug prices: \$1 /month average premium increase, but 99% will have access to lower cost programs, and drug prices will be discounted up to 50% for generics.

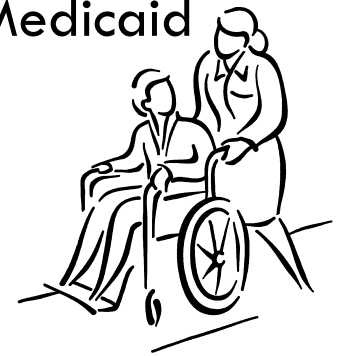
Rebate Update: 1,000,000th Donut Hole Check Mailed Out



- **“We hit a major milestone: the millionth check was sent out over the weekend.”**
Don Berwick,
CMMS
Administrator,
White House
Blog, 8/30/10

Long Term Care: New “Community Living Assistance Services and Supports” LTC Insurance Program

- ❑ CLASS, a national voluntary LTC insurance program for individuals and groups, begins October 2012.
- ❑ Eligible for cash benefits after 5 years of premium payments. Can miss 3 payments.
- ❑ Benefit of \$50/day after limits in 2+ Activities of Daily Living (ADLs).
- ❑ CLASS plans will be solvent and self-sustaining for at least 75 years.
- ❑ Premium freeze when 65, retired, and paying premiums for 20 years. Discounts for students and people living below poverty.
- ❑ If beneficiaries need Medicaid, they keep 5% of their benefit in a nursing home, 50% if they stay in the community.
- ❑ CLASS benefits not counted as income in determining Medicaid eligibility.



Community Living Supports in Reform

- New “Community First Choice” Medicaid Option for states to provide care attendants for people with MR, MI, or in a nursing home, available 10/1/11. States will not have to apply for waiver.
- More Home and Community-Based Services (HCBS) available through state plan amendments, as opposed to waivers.
- “Money Follows the Person Rebalancing Demonstration” extended through 9/2016, for the 30 states (not FL) awarded \$1.4 billion+ over 5 years in 2007 to transition over 30,000 people from institutional to community services.
- From 2014-2019, states must protect spouses against impoverishment by extending impoverishment rules from nursing homes to HCBS.
- New Medicaid option for states to enroll people with chronic conditions into health homes and include care coordination under reimbursement.

Conclusion



- Reform will insure 30 million more people, some through Medicaid, some through private insurance.
- Reform is revenue and cost neutral, though almost \$1 trillion are moved around.
- Reform preserves and regulates private insurance market.
- Reform includes significant mental health and long term care benefits.



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