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State Health Access Data Assistance Center

ACA 101: Presentation to MNsure Advisory Committees

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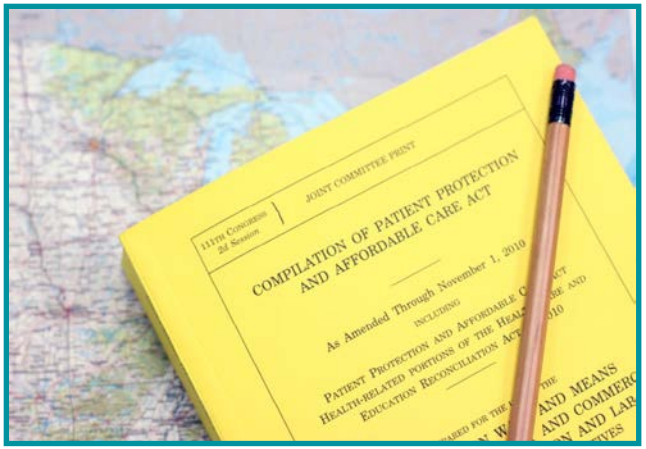
Overview

1. What problem is the ACA trying to solve?
   - Minnesota and National Context
2. Access Expansions in the Affordable Care Act
   - Medicaid Expansion
   - Health Insurance Exchange
3. Policy Issues for the Exchange
4. What's next?
5. Q&A

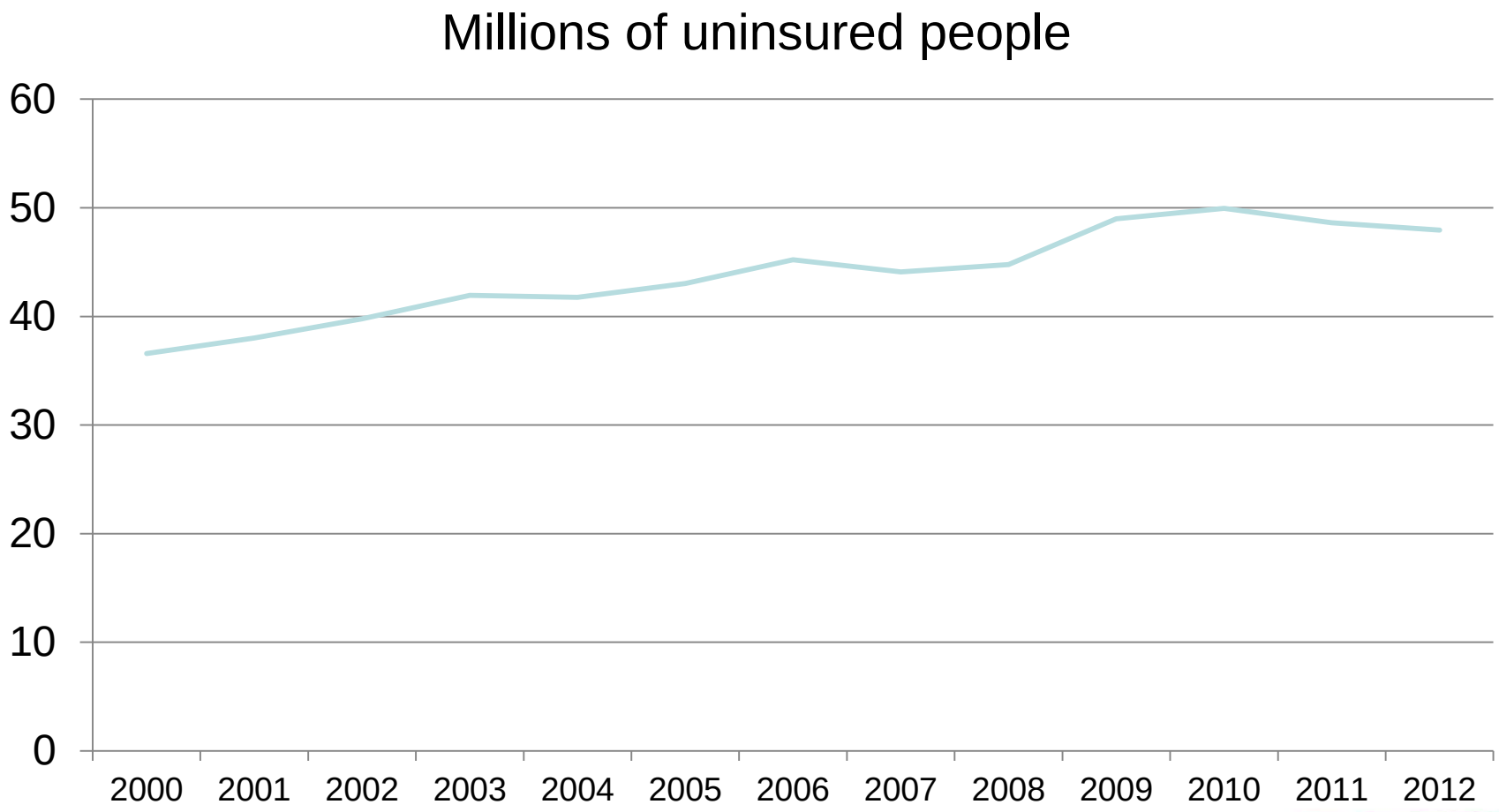


What policy problems is the Affordable Care Act trying to solve?

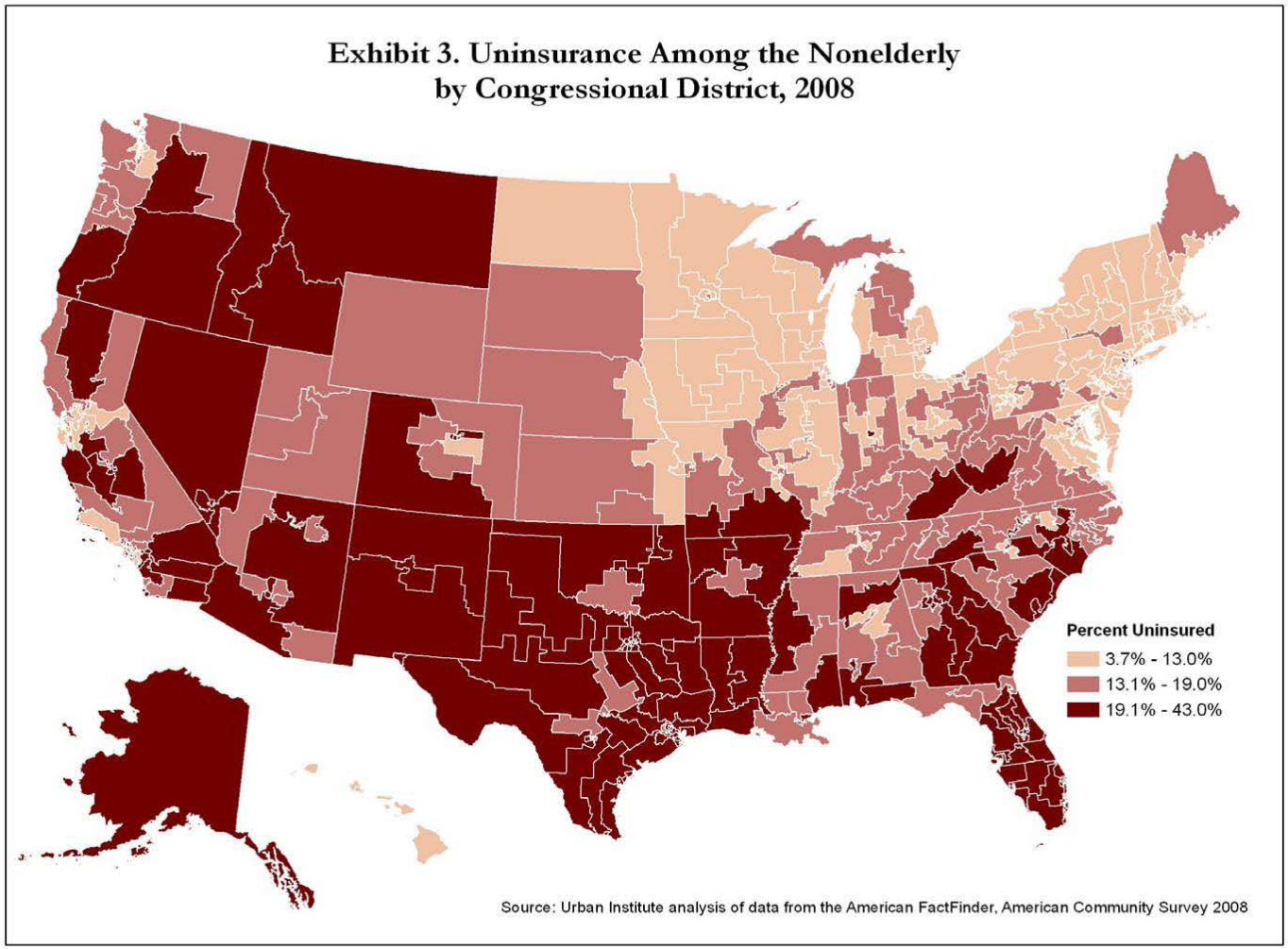
- 50 million uninsured
  - Erosion of employer sponsored insurance
- Unsustainable cost growth
- Adverse selection in insurance markets
- Lack of consumer info to compare options

- ***Increase access to affordable, comprehensive coverage through targeted subsidies***
- ***Improve overall affordability of coverage***
- ***Spread risk more broadly across the population***
- ***Organize/present plan comparisons***

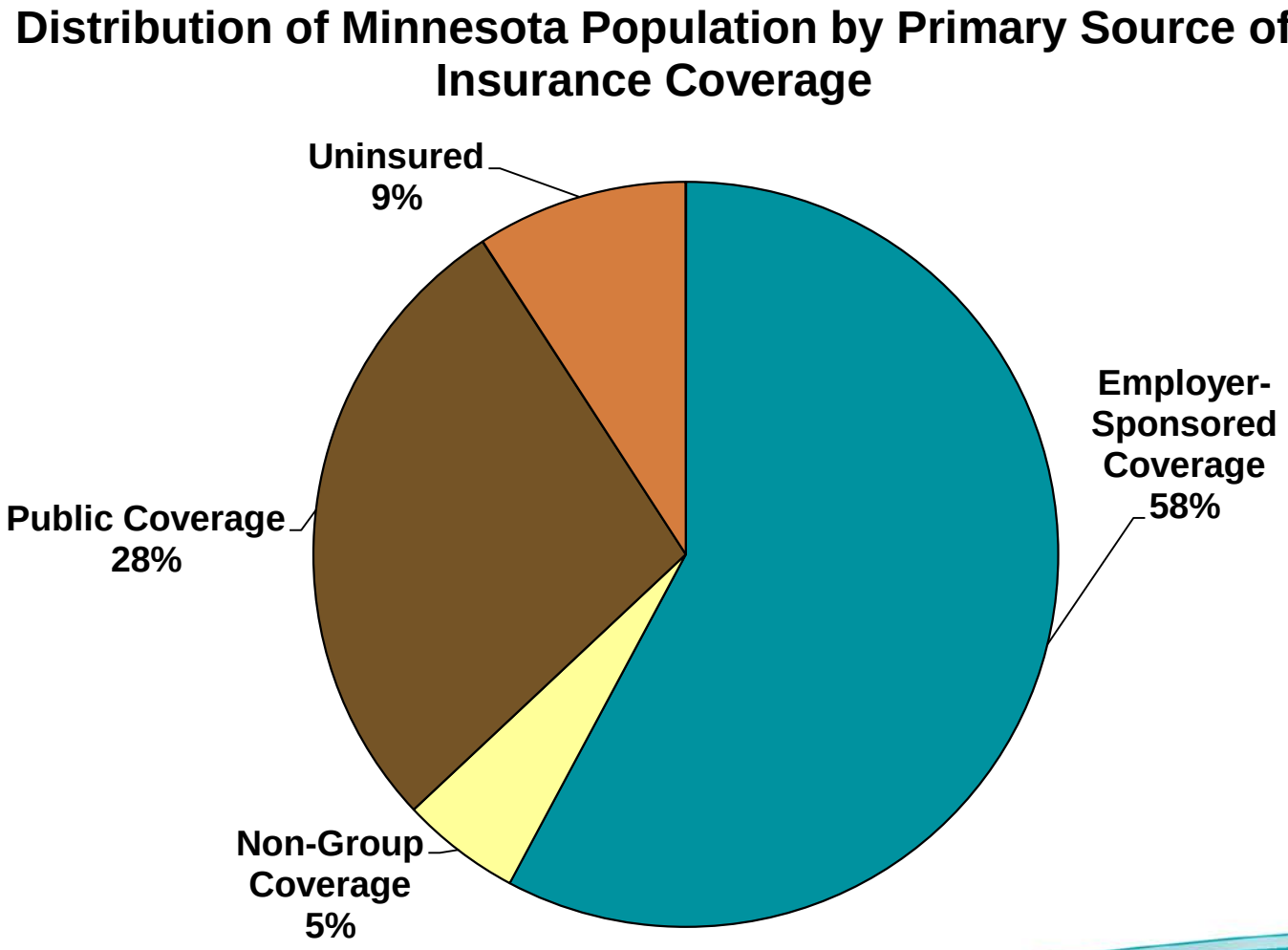
Uninsured population increased by 13.3 million between 2000 and 2010



Substantial regional variation in uninsurance

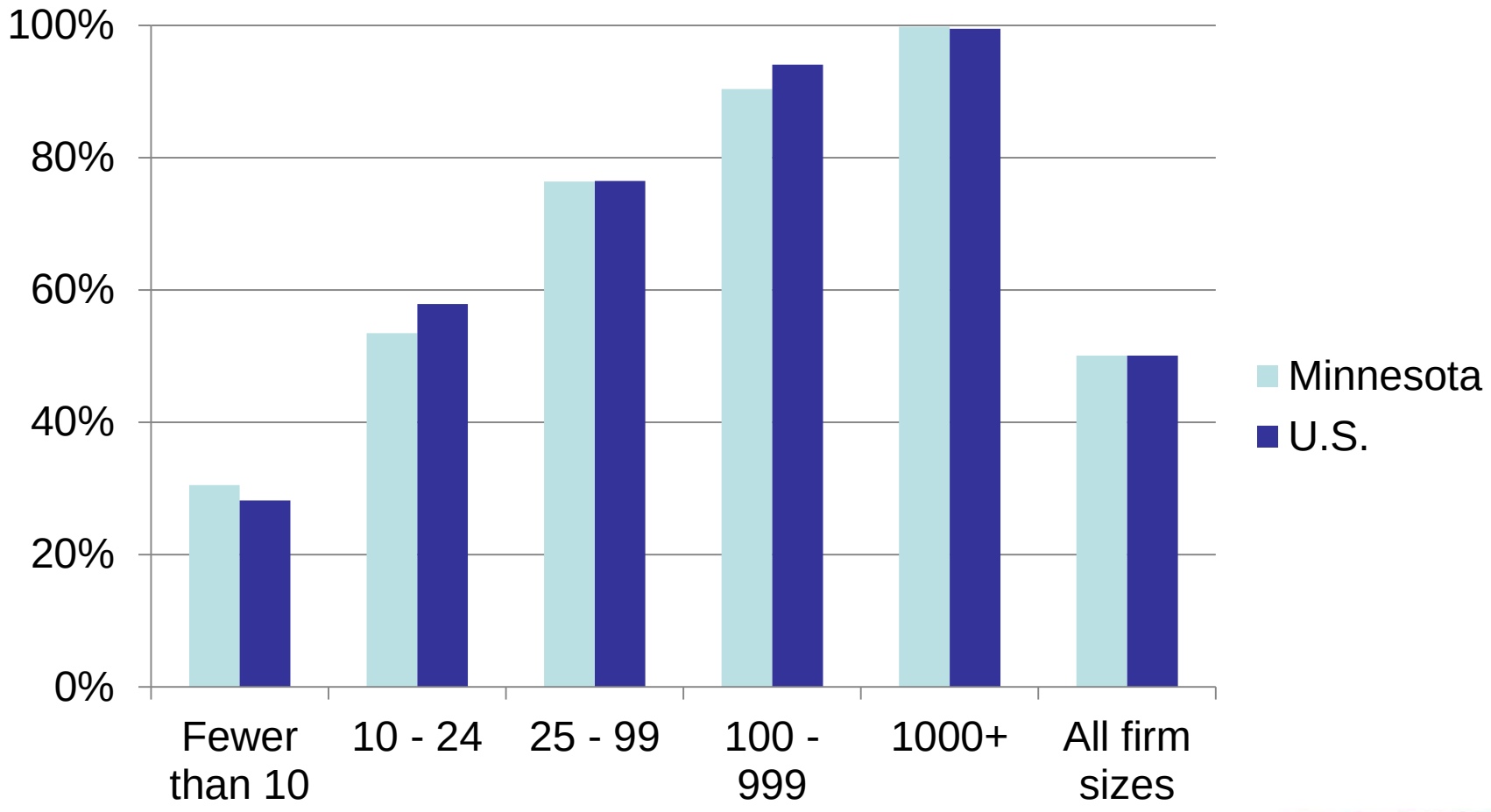


Most people get their health insurance coverage through an employer



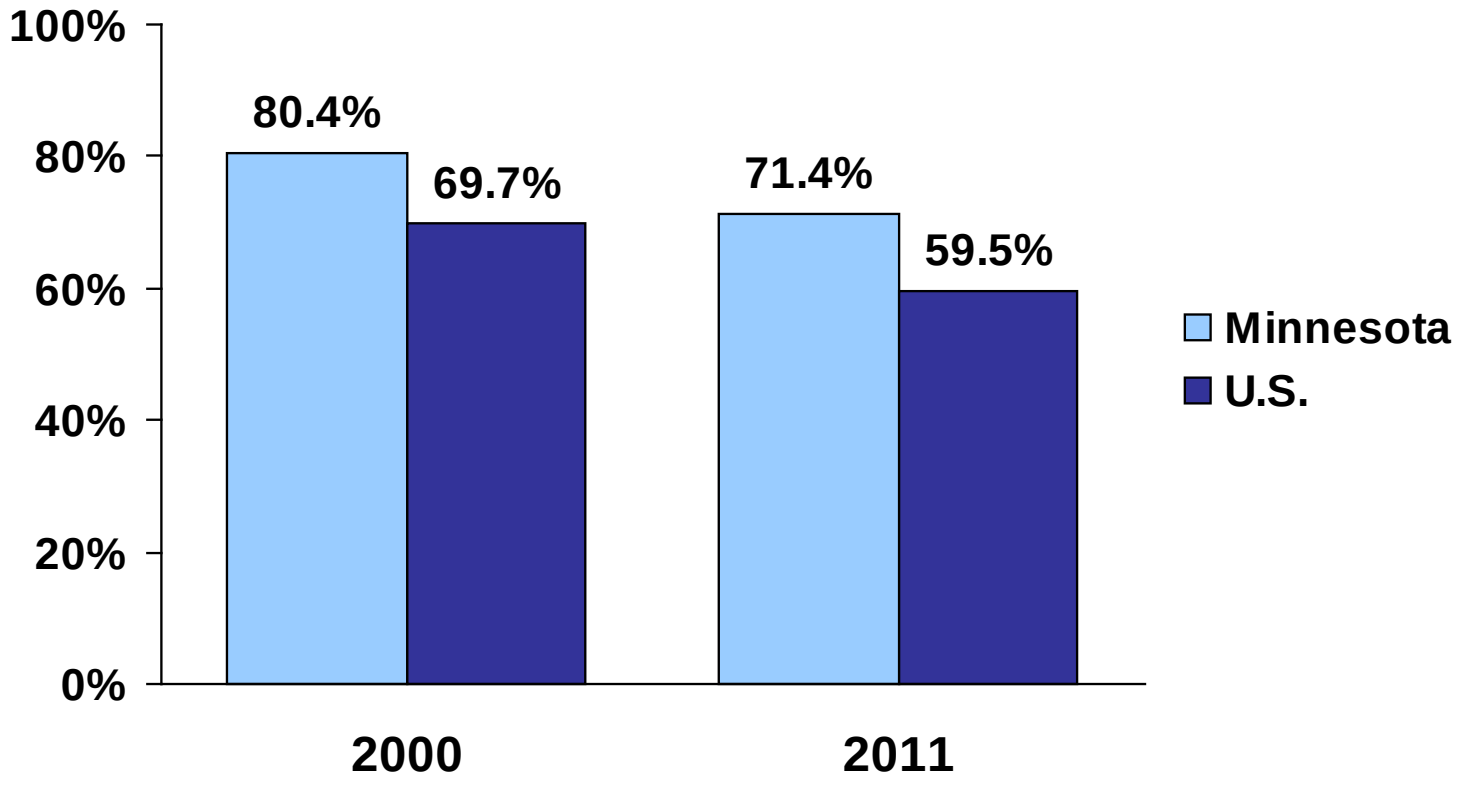
MDH Health Economics Program (data for 2010)

But small employers are less likely to offer coverage



Source: 2012 MEPS-IC, Table IIA2

Long-term downward trend in ESI coverage



Source: SHADAC, State-Level Trends in Employer-Sponsored Health Insurance: A State-by-State Analysis. April 2013.

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Major Health Insurance Coverage Provisions of the ACA

- Medicaid expansion
- Subsidies for private insurance – through health insurance exchanges
- Requirement for individuals to have health insurance ("individual mandate")
- Employer provisions – incentives and penalties
- Changes to private insurance market rules

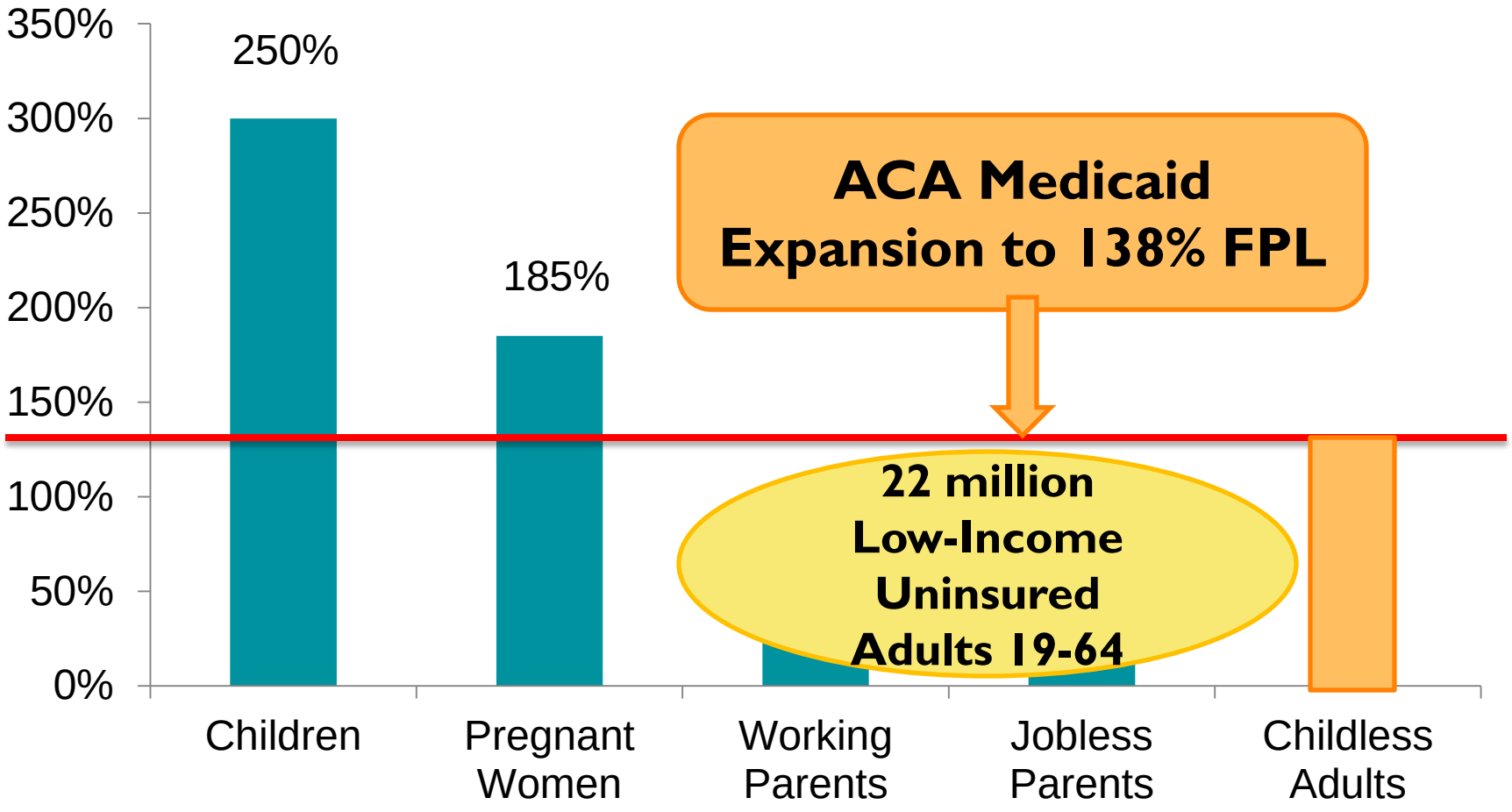
MEDICAID EXPANSION

Expanded Medicaid coverage

- People with family incomes below 138% of poverty guidelines* are eligible for Medicaid as of January 2014
  - 2012 Supreme Court decision made this optional for states
  - Goal was to simplify eligibility – no more variation by family status, age
- ACA expansion of eligibility mostly affects adults, since children are already eligible for Medicaid or CHIP at this income level in all states
- Only applies to U.S. citizens and legal immigrants in the country for more than 5 years

*The poverty level for a family of four is currently $23,550

ACA Access Expansion Categories



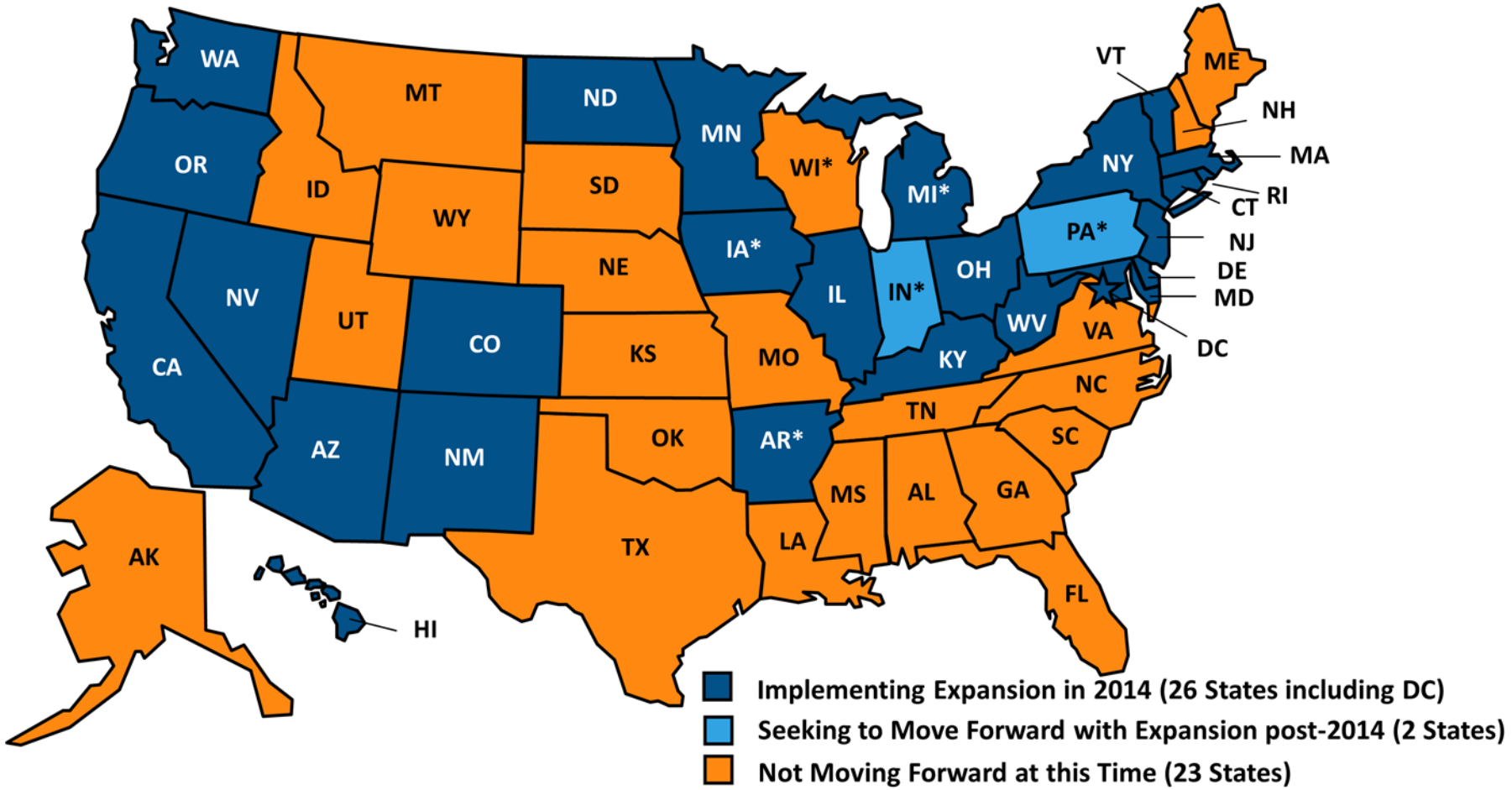
Source: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Impact of the Medicaid Expansion will Vary By State

The following are differences across states that will affect enrollment:

- Medicaid expansion is now optional for state
- Current Medicaid enrollment and eligibility
- Current Levels of Private Coverage
- Levels of outreach and enrollment activities
- Attitudes toward government programs

Status of State Medicaid Expansion Decisions, as of December 11, 2013



NOTES: *AR and IA have approved Section 1115 waivers for Medicaid expansion; MI has a pending waiver for expansion and plans to implement in April 2014; IN and PA have pending waivers for Medicaid expansion plans that would be implemented post-2014; WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.
SOURCES: State decisions on the Medicaid expansion as of December 11, 2013. Based on data from CMS, available at: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html. Data have been updated to reflect more recent activity.

PRIVATE INSURANCE

Individual Mandate - 2014

- Individuals are required to maintain minimum essential coverage for themselves and their dependents.
- Rationale: other changes to market rules (guaranteed issue, no lifetime benefit limits, ect.) will not work unless healthy people participate.
- Those who do not meet the mandate will be required to pay a penalty for each month of noncompliance:

Once fully phased in, annual penalty of $695 per person or 2.5% of income, whichever is greater

Exemptions to the Individual Mandate

- Financial hardship
- Religious objections
- American Indians and Alaska Natives
- Incarcerated individuals
- Those for whom the lowest cost plan option exceeds 8% of income, and
- Those whose income is below the tax filing threshold

And the Undocumented

Tax subsidies for small employers

- Tax credits for small employers (≤ 25 employees) and average annual wages below $40K who provide health insurance
  - 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
    - Can only receive credit for 2 years

Employer requirements

- Employers subject to penalties if no coverage offered and at least one employee receives tax credits through an Exchange
  - $2,000 multiplied by the # of full-time workers employed (minus first 30 workers)
  - Does not apply to businesses with fewer than 50 full-time workers
  - Delayed to 2015
- Employers with > 200 employees must automatically enroll them into health insurance
  - Employees can opt out of the coverage

Other employer provisions

- Employers also have the option to buy insurance through an exchange
  - Limited to employers with fewer than 100 workers through 2016 (States can choose to limit employer size to 50 initially)
  - States can expand to all employers beginning in 2017
  - States can choose to combine the individual and employer exchanges, and/or merge these 2 insurance markets
- Beginning in 2014, small employer tax credits available only to employers that purchase through the exchange

Comprehensiveness of coverage pre-ACA

- Reviewed nearly 6,000 health insurance plans marketed to individuals and families across US
- Out of 285 plans in Minnesota, no coverage for
  - Labor and delivery in 195 (apx 70%),
  - Mental health services in 170, and
  - Specialty drugs in 80
- The median deductible in Minnesota - $5,000, five times as high as in Massachusetts

Source: US World News and Report http://bit.ly/TH1ldF

Essential Benefits in the ACA

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management, and
- Pediatric services, including oral and vision care

Other ACA changes to benefits

- No pre-existing condition exclusions
- No lifetime or annual limits on coverage
- First-dollar coverage for preventive services

HEALTH INSURANCE EXCHANGES

Exchange Basics

- What is an Exchange under the ACA?
  - A (primarily) web-based marketplace
  - Organizes information on health insurance coverage options
  - Provides comparison across plans with respect to premiums, cost-sharing, coverage and quality ratings
  - Consumers can select and enroll in coverage through the Exchange
  - Vehicle for administering premium tax credits and cost sharing subsidies

Target Population for Exchange

- Those who purchase in coverage
  in the individual and small group market
  - <50 employees
- Don't have same leverage as large employers when purchasing coverage
- Apx 12% of MN population gets coverage in small group or non-group markets pre-ACA

Tax credits (subsidies) for private nongroup insurance

- Amount of credit is a sliding scale based on income
  - Premium subsidies for families with incomes up to 400% of poverty
  - In addition, cost sharing subsidies up to 250% of poverty
    - Reduces deductible and other enrollee out of pocket costs
    - Available in silver level plans only

ACA's Sliding Scale Premiums

Maximum premium contribution, based on income for family of four in 2013:

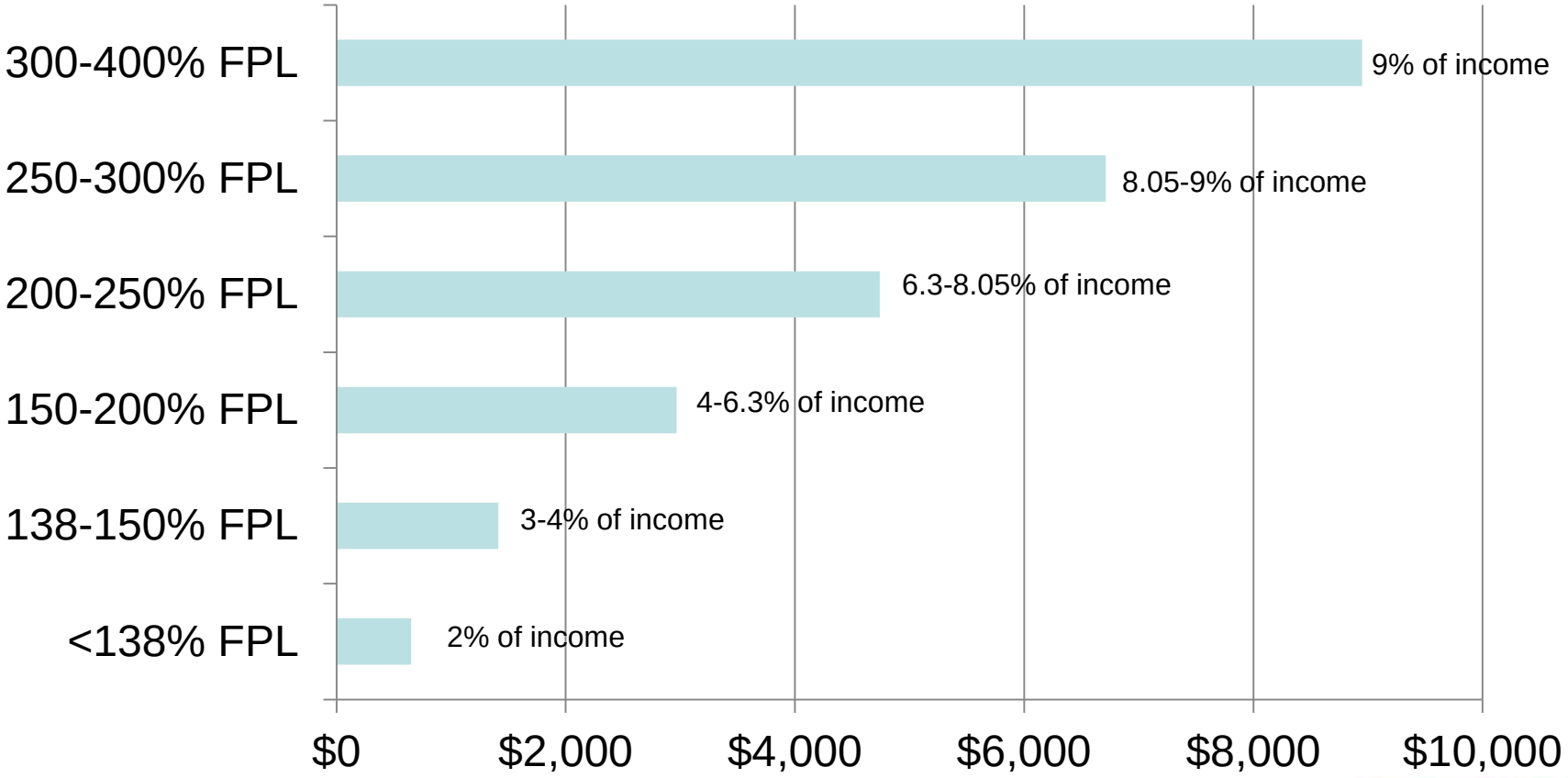
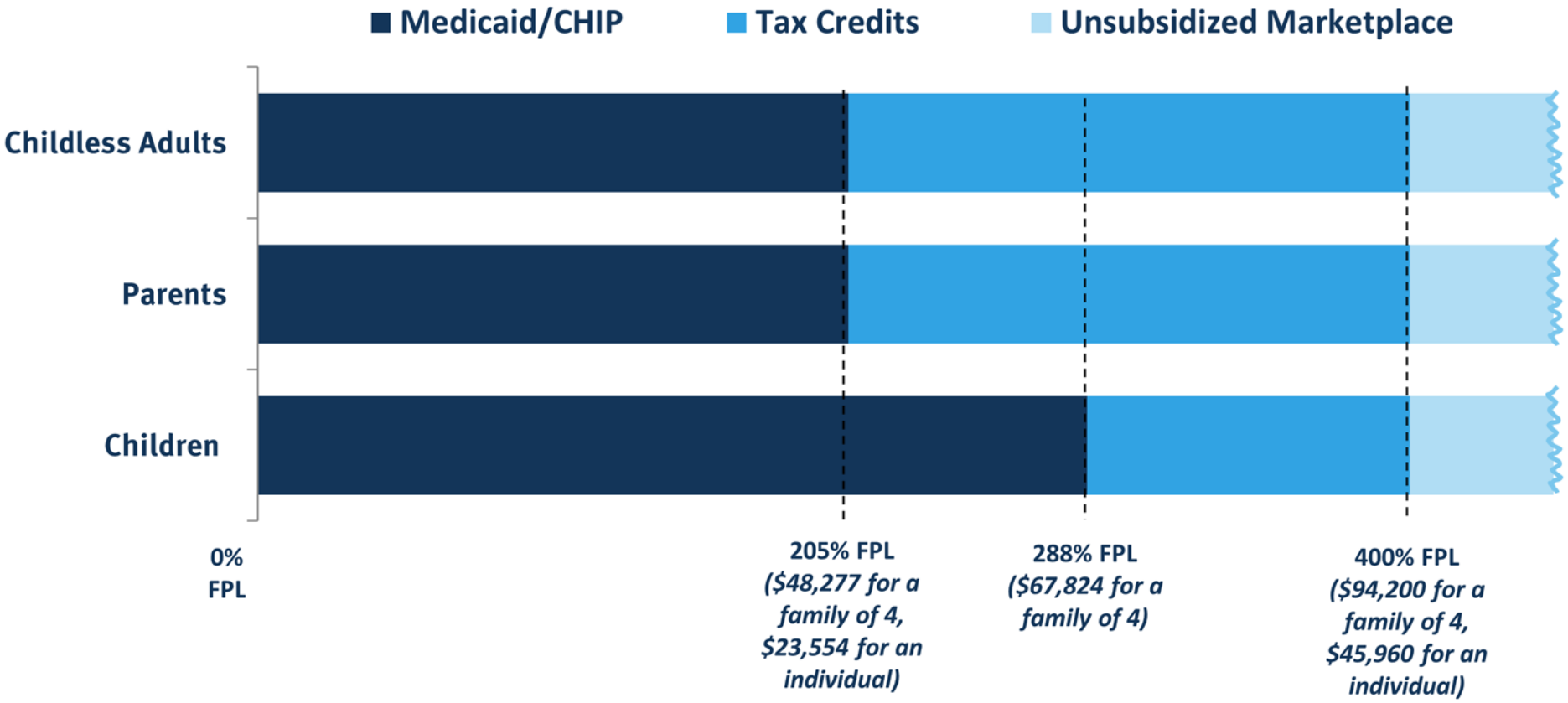


Figure 1

Income Eligibility Levels for Medicaid/CHIP and Marketplace Tax Credits in Minnesota as of 2014

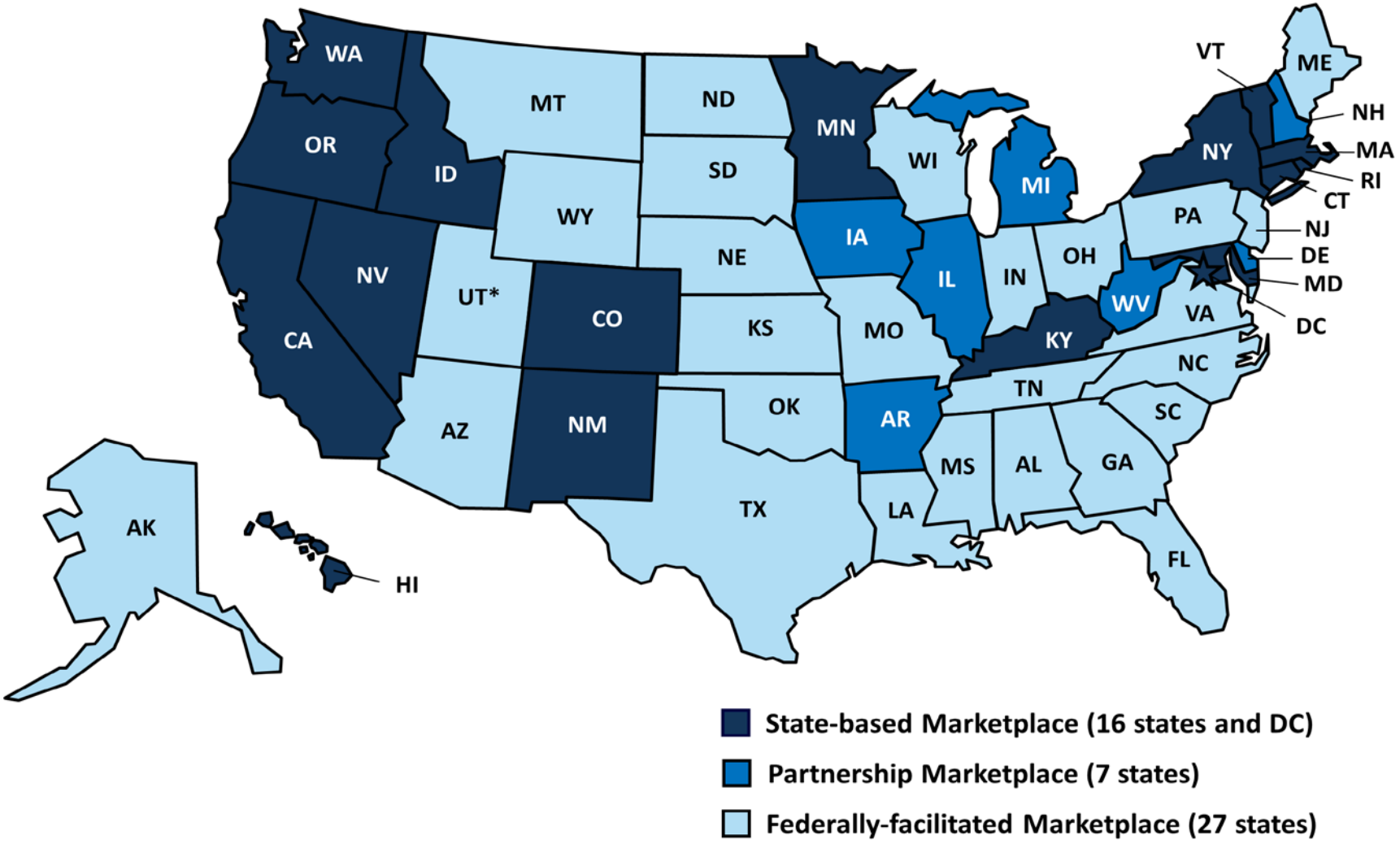


Notes: Medicaid eligibility is based on current Medicaid eligibility rules converted to MAGI. Applies only to MAGI populations. Medicaid eligibility levels as a share of poverty vary slightly by family size; levels shown are for a family of four. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels.

Exchanges: State vs. federal roles

- States have a lot of control over how to establish and run the exchange – for example, whether to be selective about what health plans can be sold through the exchange
- In states that do not establish their own exchanges, the federal government will establish and operate an exchange

States Health Insurance Marketplace Decisions, May 10, 2013

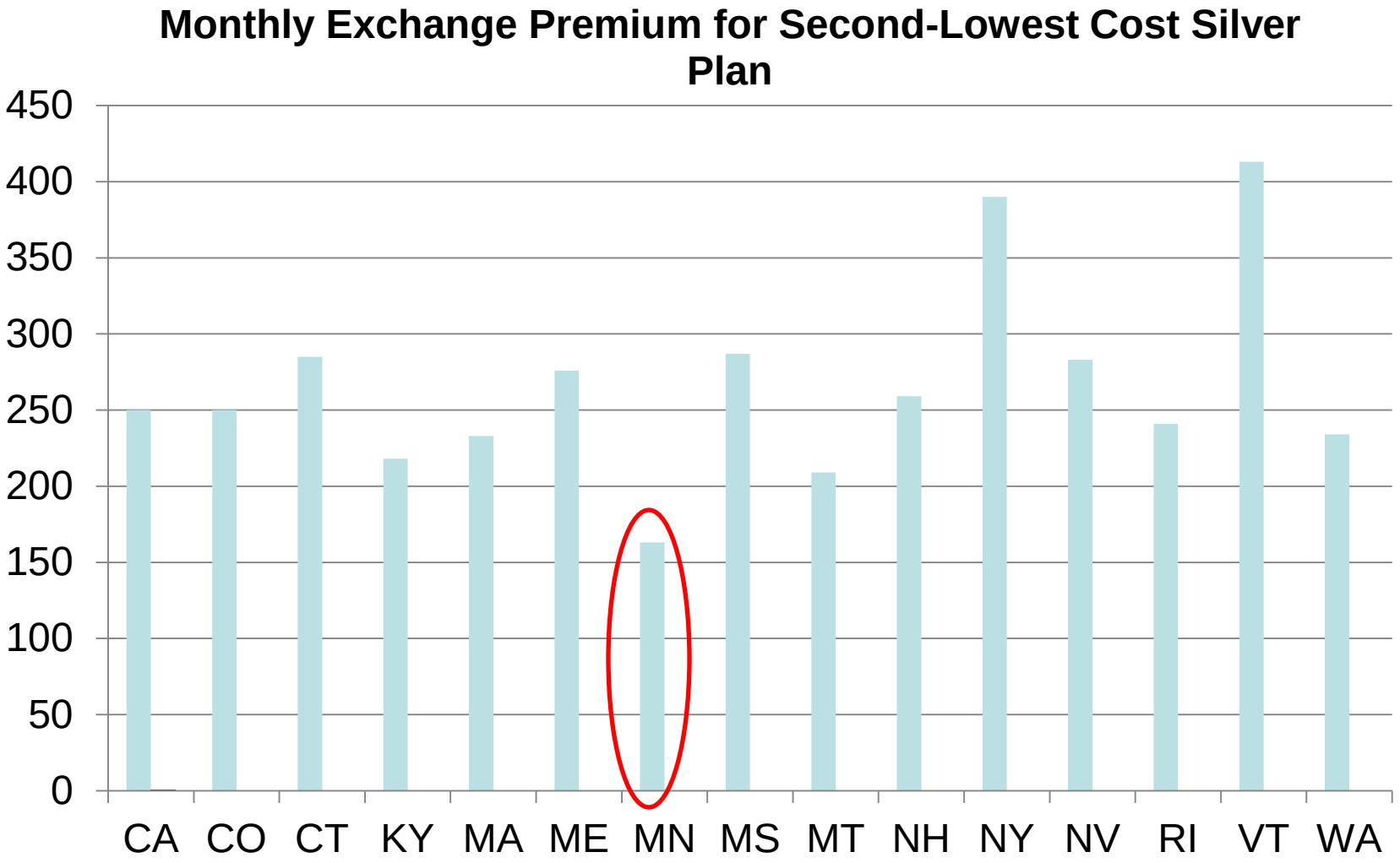


* In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.

Levels of coverage

- Levels of coverage (bronze, silver, gold, platinum) correspond to enrollee cost sharing requirements
  - Deductibles
  - Coinsurance
  - Rx copays, etc.
- Tradeoffs between premiums and cost sharing depend on individuals' expectations about how much care they will need

Minnesota compared to other states



Source: Breakaway Policy Strategies and the Robert Wood Johnson Foundation, "Looking Beyond Technical Glitches: A Preliminary Analysis of Premiums and Cost Sharing in the New Health Insurance Marketplaces," November 2013.

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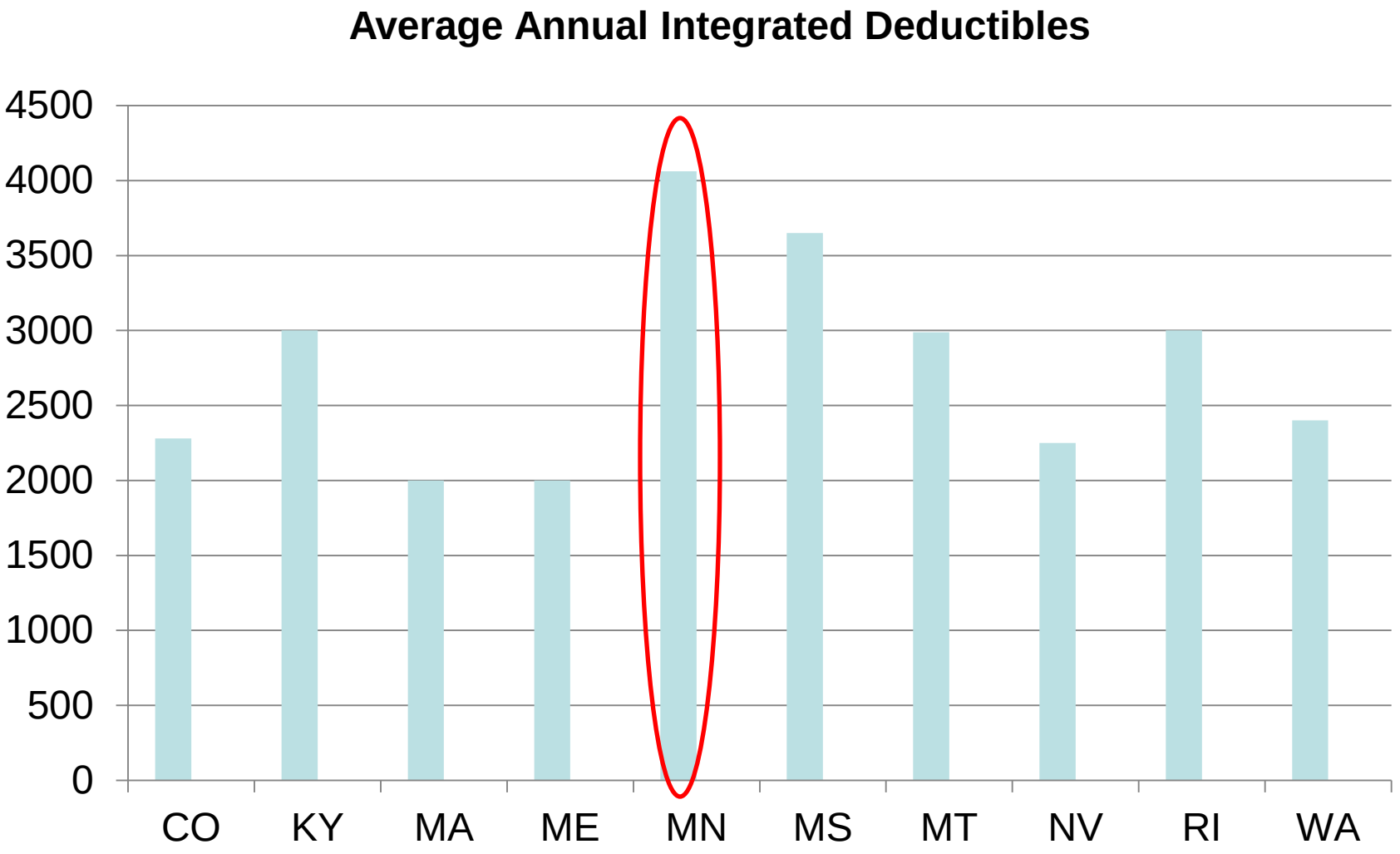


Source: Breakaway Policy Strategies and the Robert Wood Johnson Foundation, "Looking Beyond Technical Glitches: A Preliminary Analysis of Premiums and Cost Sharing in the New Health Insurance Marketplaces," November 2013. (Policies with a single deductible for medical and rx expenses combined

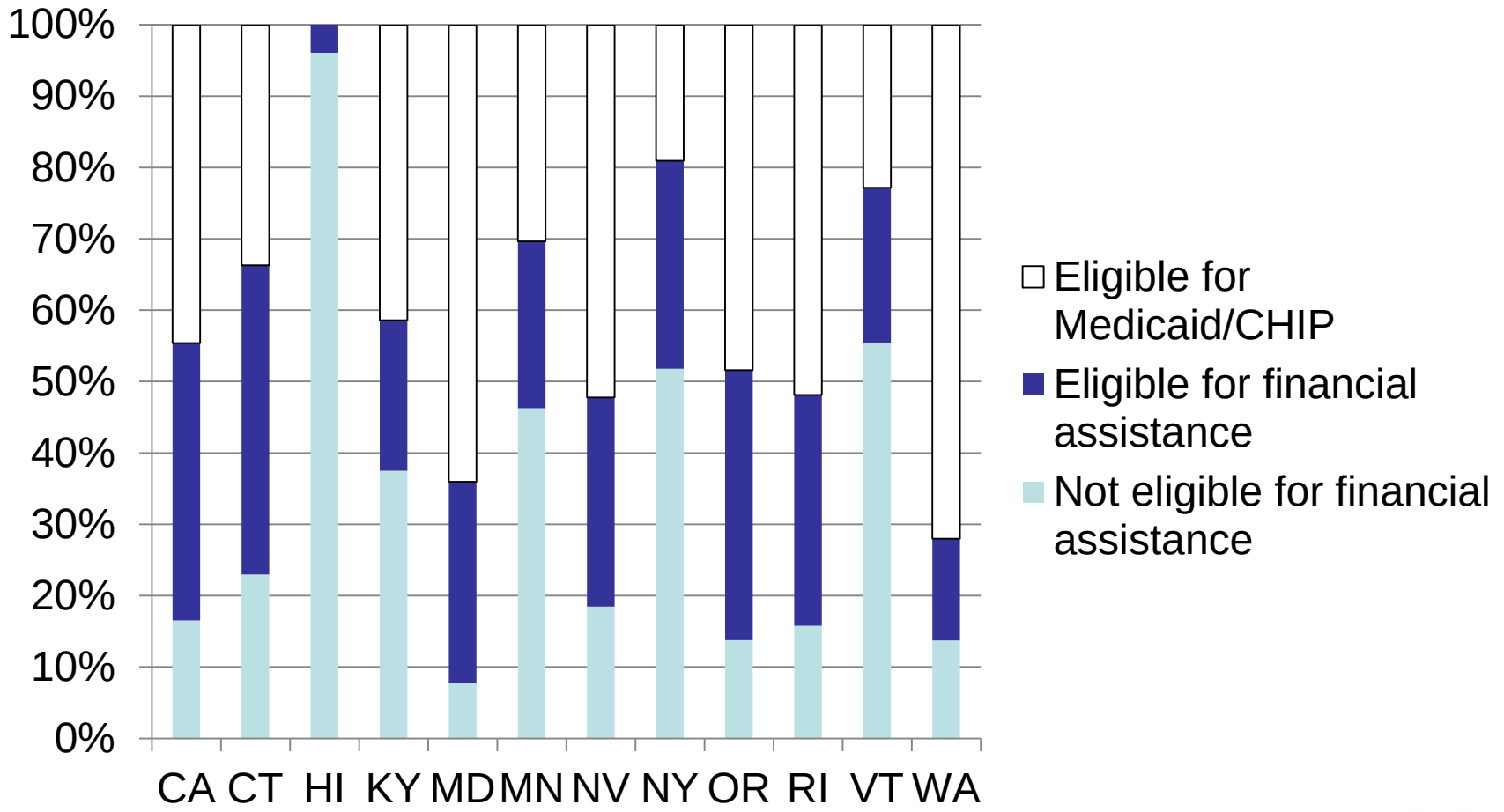
Minnesota vs other states: Premiums and deductibles

- Too early to draw conclusions from this preliminary data on premiums and cost sharing
  - Need to know what consumers **actually buy** in the exchanges vs. what is being offered for sale
- Will likely take some time for markets to sort out in both Minnesota and other states over the next couple of years

Other policy issues exchanges will need to consider

- Churn & continuity of providers
  - States are especially concerned about churn between Medicaid and the exchange
- Breadth of provider networks (related to continuity of providers)
- Demographics of exchange population and market stability
- Degree of standardization in health plan choice/design

State-based exchange enrollment stats



Source: Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, "Health Insurance Marketplace: December Enrollment Report for the period: October 1 – November 30," December 11, 2013.

SUMMARY/CONCLUSION

Summary Points

- Access expansions of the ACA are targeted to a relatively small segment of the population in Minnesota
  - Those with low incomes
  - Those without employer-sponsored insurance
  - Small employers
- Comprehensiveness of benefits in the individual market has improved – but comes at an additional cost
- Tradeoffs between premium cost, enrollee cost sharing, and provider networks are an issue that warrants attention and monitoring

Still more to do

- Payment reform
  - Transforming the way we receive and pay for care
- Immigrant Populations
  - Not covered by Medicaid expansion but represent almost 1/5 low-income non-elderly adult
- Baby boomers retiring
  - Growth of federal entitlements with continued deficit spending
- Incremental reform in political battlefield

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