Federal Health Reform
What the Future Holds

Health Access California
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Health Reform: Transforming America

- The Affordable Care Act is as important as
  - Social Security
  - Medicare
  - Minimum wage
  - Civil Rights
- These are not perfect—neither is ACA—but America is better because of all of them
- Health reform is a huge victory for those most in need—and for the middle class

Health Reform: Benefits

1. **Near-universal coverage:** health care as a basic benefit
2. **Medicaid/Medi-Cal Changes:** *Biggest reinvention of Medicaid since its creation*
3. **Medicare Improvements:** Part D, other changes
4. **Sliding scale subsidies**: Individuals who buy coverage as individuals will pay less if they make less
5. **The end of most bankruptcies** due to medical bills: a cap on out-of-pocket costs and decent basic benefits
6. **First-ever requirement for large employers** to provide coverage or pay a penalty
7. **New consumer protections**: New rules for insurers
8. **Cost containment and quality improvement** steps
9. **Workforce and capacity improvements**

Challenges: Myths Vs. Reality

The challenges are real but can be overcome:

1) **Repeal:** The House of Representatives passed repeal, but it failed in the Senate. President Obama has pledged to veto repeal efforts.
2) **Lawsuits:** Over a dozen legal challenges were thrown out of court. Of the five district court judges,
   - Three ruled the ACA was constitutional
   - One struck down a specific provision requiring individuals to have coverage, but upheld the rest.
   - Only one struck down the entire ACA.

   This is clearly going to Appeals Court and eventually the Supreme Court.
3) **Defunding:** 85% of ACA funding is already appropriated without further Congressional action. Some funds for cost-saving pilot programs and prevention need Congressional approval, and many items will be the subject of budget negotiations.

BOTTOM LINE: California can aggressively take advantage of the new funding, benefits, options, and consumer protections—and help build the momentum to overcome political obstacles.

Why CA Needs Reform

Why California Needs Health Reform More than Other States

- Over 7 million Californians are uninsured this year, and live sicker, die younger, and are one emergency away from financial ruin.
- Californians are less likely to get coverage from an employer.
- Two million Californians buy coverage as individuals, at a very high price with limited benefits.
  - Without reform, some cannot get coverage at all, due to pre-existing conditions.
  - With reform, almost 60% of individuals buying coverage on their own will be eligible for subsidized coverage.
- California is a high cost-of-living state with more low-wage workers.
- Almost eight million Californians rely on Medi-Cal and Healthy Families
- Californians need protection from inadequate coverage and discriminatory practices by insurers
- Big impact in under-served areas, like South Los Angeles and Central Valley

Los Angeles County

- *Census:* Los Angeles: 9,848,011 (10.6% 65+)
- *New numbers from UCLA (Feb 2011):*
- Just over 9 million below 65 years old.
    - Job-based coverage 47.2%
    - Medi-Cal and Healthy Families 19.1%
    - **23.7% uninsured** (higher than national average, higher than California average of 21.2%)
- **Over 2,154,000 uninsured in LA County**

Newly-Covered in LA County (Rough Estimates)**:**

- Over 800,000 newly eligible for Medi-Cal
- Over 900,000 eligible for subsidies in the Exchange (both uninsured and some currently insured but paying full cost of coverage)
- 350,000 newly covered by buying as individual or through employer
- 500,000 remaining uninsured
- Net Change: from 7 million insured to over 8.5 million with coverage

Preliminary Estimates of Insurance Coverage (in millions) for 2014, 2016, & 2019

Type of Coverage	Without ACA (2014)	With ACA (2014)	With ACA (2016)	With ACA (2019)
Employer-sponsored	19.1	19.2	19.0	18.9
Medicaid	5.7	6.6	7.0	7.5
Healthy Families	0.8	0.6	0.7	0.8
Other Public	1.3	1.2*	1.2*	1.2*
Individual/Exchange (with subsidies <400%)	N/A	1.6	2.0	2.4
Individual without subsidies	2.2	1.6	1.8	2.0
Uninsured	5.6	3.9	3.3	3.0

Impact of Coverage Expansions

- Increase in demand of 10%-20% or more, depending on where in CA
- Fewer uninsured, as few as 2-3 million, instead of 6-7 million
- More Medi-Cal patients: 2 million plus
- “Exchange” coverage for 2-3 million
  - Individuals who do not get affordable coverage on the job today, some uninsured, some with really expensive individual coverage, some between jobs, etc
- Increase in demand for care from some of newly insured due to pent-up need
- Capacity, workforce demands: ACA also addresses both

Improving Public Programs: Medicaid

- **Medicaid** (Medi-Cal in CA) will be expanded to cover lowest-income families, including adults without dependent children
  - Expands Medicaid for all under 133% of the federal poverty level (excluding undocumented immigrants)
  - Before reform, adults without kids at home excluded
  - Up to two million additional Californians on Medi-Cal
  - For newly-eligible population, federal government will pay 100% of costs for 2014-2016; By 2020, will pay up to 90% of cost
  - Reduces paperwork and eligibility barriers
    - Example: Removes complicated “asset test” that is barrier to enrollment, and that prevents poor families from saving
  - SCHIP (Healthy Families in CA) intact
  - Newly-eligible get much higher than 50-50 matching rate
    - 2014-16: 100% Federally funded
    - 2017: 95%; 2018: 94%; 2019: 93%
    - 2020 and beyond: 90% (still a 9:1 match)

Fulfilling the Promise: The Medi-Cal Waiver

California's "Medicaid waiver" was negotiated in 2010 to:

- Be ready for health reform: through early enrollment and other efforts, have over one million in Medi-Cal on Day 1: January 1, 2014
- Help bring in additional federal funds to California, for the state budget and for our safety-net institutions, especially public hospitals
- Incorporate other delivery system reforms through coordination of care
- Ensure key consumer protections for seniors and people with disabilities, before any patient is mandatorily shifted

Health Insurance Exchange

“Exchanges are bad for [insurer] margins, because it makes price the most important variable in selecting a plan”- Citigroup investment analysis on California exchange law, Oct 2010

What is an “Exchange”?

1) A place to get health insurance for those who don’t get affordable coverage on the job but who make too much for Medi-Cal.

2) A place to get health insurance for those between jobs, just divorced or lost coverage for any other reason

Health Insurance Exchange

- Subsidies for Individuals, 2014
  - Under 400% FPL ($88,000 family of four, $44,000 for an individual); subsidies based on family income.
  - Available to individuals not eligible for Medi-Cal and not offered affordable job-based coverage
  - Unaffordable job-based coverage: employee contribution more than 9.5% of family income or less than 60% actuarial value
  - Undocumented immigrants not eligible for individual coverage through the Exchange
- Exchange coverage: by design, better than individual coverage today but not as good as job-based coverage

Actuarial Value

Definition: Percentage of covered medical costs paid by an insurance plan, averaged across a population.

Benefit Package	Summary	Estimated Actuarial Value
Traditional Medicaid	No cost sharing for “necessary” health services	100%
Typical employer-sponsored HMO	No deductible, $20 copay for office visits, $250 hospital copay, no cost sharing for lab and x-ray	93%
Typical employer-sponsored PPO (large firm)	$400 deductible, 20% coinsurance, $2,000 out-of-pocket max	84%
Sample “Bronze” plan	$3,000 deductible, 20% coinsurance, $5,950 out-of-pocket max	60%

Sources: Congressional Research Service, “Setting and Valuing Health Insurance Benefits,” April 6, 2009; sample Bronze plan developed and estimated by Towers Watson

Premium subsidies in exchange

	Maximum monthly premium spending		
Federal Poverty Level	% of family income	$ (single)	$ (family of 4)
100-133%	2.0%	$18-24	$37-49
133-150%	3.0-4.0%	$36-54	$73-110
150-200%	4.0-6.3%	$54-114	$110-232
200-250%	6.3-8.05%	$114-182	$232-370
250-300%	8.05-9.5%	$182-257	$370-524
300-400%	9.5%	$257-343	$524-698

Note: Federal Poverty Level is $10,830 for a single individual and $22,050 for a family of 4.

Cost Sharing in the Exchange

Federal Poverty Level	Max-Out of Pocket Individual/Family
100-133%	$1,983 / $3,967
133-150%	$1,983 / $3,967
150-200%	$1,983 / $3,967
200-250%	$2,975 / $5,950
250-300%	$2,975 / $5,950
300-400%	$3,967 / $7,933
400%+ (no cost sharing subsidy)	$5,950 / $11,900

Immigrants

- Lawfully present
  - Eligible for exchange subsidies.
  - 5-year Medicaid waiting period maintained.
- Undocumented
  - 1.2 million uninsured undocumented in California.
  - Ineligible for exchange and subsidies.
  - Documentation requirements for employers purchasing coverage in the exchange not yet clear

Individual Responsibility

- Tax penalty if individual does not have coverage.
- Hardship waiver if cost greater than 8% of income or income below tax filing threshold.
- Effective 2014
- What Counts as Minimum Essential Coverage?
  - Employer-sponsored coverage
  - Coverage under a government-sponsored plan, Medicare, Medi-Cal, Healthy Families, Tricare, Veterans Health
  - Plans in the individual market;
  - Grandfathered health plans; and
  - Any other health benefits coverage recognized by HHS.

Employer Responsibility

- Sets minimum standards for job-based coverage for the first time
- Establishes floor for negotiations, similar to minimum wage
- Free Rider Penalty, 2014
  - Firms with 50 or more Full Time Equivalents
  - $2,000 per full-time, non-seasonal employee if employer does not offer coverage
  - $3,000 per full-time employee receiving a subsidy in the exchange if employer provides coverage to some
- Full-time defined as 30 or more hours/week. Seasonal, as working fewer than 120 days/calendar year.
- Limit on waiting periods to 90 days, effective 2014
- Automatic enrollment with opt-out for firms with 200 or more employees

Employer Responses

- Use of part-time workers.
  - 9.4% of workforce (12 million national) work between 30-36 hours a week.
  - 10.9% of workforce (14 million national) work less than 30 hours per week.
  - Highest in Restaurants, Building Services but also applies in health care
- Reliance on part-year workers: under 120 days for same employer in a year
- Reduces incentive to provide coverage to lower-income workforces.

Financing Health Reform

- Health reform will cost money upfront, but is **an investment to achieve savings in the long run**.
- Cost is half **Medicaid expansion** and half **affordability subsidies** for low- and moderate-income families.
- Congressional Budget Office estimates that reform will cost $950 billion over 10 years. CBO says **it will be paid for**, and actually **reduce the deficit** by $150 billion in the first ten years, and by a trillion in the 2nd ten years.

- Over half of the financing is **savings in the existing health system** (e.g., reducing the overpayments to insurers in Medicare Advantage program).
- Based on **"shared responsibility"** mandates, sliding-scale contributions for individuals, and an employer requirement.
- **Additional financing** for health reform include: upper-income Medicare tax; an excise tax on high-cost insurance products; and other revenue sources (e.g., a 10% tanning salon tax).

Fulfilling the Promise: California Acts

- California Health Benefits Exchange,
  - Already Law, Operational by 2014, Meeting Now
- Rate Review: Already Law, premiums reviewed Now
- Guaranteed Issue for Kids: Ended Denying Kids for Pre-existing Conditions
- Medi-Cal Reforms: Bridge to Reform in 58 Counties
- More to do:
  - Public Option: SB222(Alquist)
  - Easy Enrollment: AB714 (Atkins), AB792 (Bonilla), AB1296 (Bonilla)
  - Maternity Coverage in Individual Market: SB155 (Evans)
  - Another dozen pieces of legislation

Securing the Safety-Net

- **The Need for Transformation**
  - For hospitals, community clinics, and others, this a challenge and opportunity
  - Potential new resources: Direct funds for clinics, newly insured consumers with dollars attached to them.
  - Will their consumers stay with clinics and county hospitals? Are safety net providers ready to compete?
  - **Goal: Not Just Surviving, but Thriving**

Assessing the Entire Community's Capacity

- With many more insured, we need the capacity of the existing safety-net to provide the care.
- The newly-insured will have specific needs, such as language access
- The safety-net will still need strategy and support to provide care to the remaining uninsured.
- How can we provide care better, and more cost-effective? How can a county's health system-public & private-be ready in 2014?
- Overall reforms of delivery systems…

For more information

Health Access:

Website: http://www.health-access.org

Blog: http://blog.health-access.org

UC Berkeley Labor Center:

http://laborcenter.berkeley.edu/healthcare/resources.shtml