Affordable Care Act Overview: Insurance, System Change, & Public Health

Briefing for Social Services Advisory Board

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Objectives

- Provide an overview of the insurance provisions in the Affordable Care Act (ACA)
  - Background on current insurance coverage
  - Role of Medicaid
  - Basics of Covered California, CA's Health Benefit Exchange
  - Relationships between Covered California and Medi-Cal
- Highlight San Diego participation in ACA delivery system transformation initiatives
  - Community-Based Care Transitions Program (CCTP)
  - Dual Eligibles Demonstration (Cal MediConnect)
- Touch on ACA impacts on Public Health

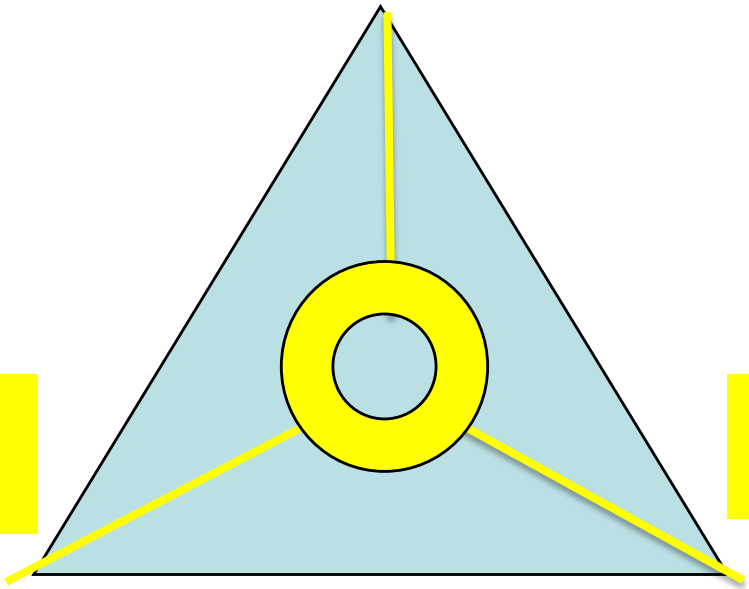
The Affordable Care Act (ACA) Overview

9 Titles, each addressing essential components of reform

I. Quality, Affordable Health Care for all Americans
II. The Role of Public Programs
III. Improving the Quality and Efficiency of Health Care
IV. Prevention of Chronic Disease and Improving Public Health
V. Health Care Workforce
VI. Transparency and Program Integrity
VII. Improving Access to Innovative Medical Therapies
VIII. Community Living Assistance Services and Supports
IX. Revenue Provisions

The Triple Aim

Better Health for the Population



Better Care for Individuals

Lower Costs per Capita

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Overview of ACA Insurance Provisions (Titles I and II)

- Require most US citizens and legal residents to have health insurance
- Create state-based Health Benefit Exchanges for the sale of individual and small business health coverage
- Provide premium and cost-sharing credits to individuals/families with income 139 – 400% FPL
- Require employers to pay a penalty if employees receive tax credits for insurance through the Exchange (except for small employers)
- Impose new regulations on health plans in the Exchange and in the individual and small group markets
- Change eligibility standards, enrollment processes, and outreach for current Medicaid
- Expand Medicaid eligibility to cover single adults <65 at or below 138% FPL

Essential Health Benefits Required

Health plans offered in the individual and small group markets, both inside and outside of the Exchanges, must include services within *at least* these 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Mental Health/Behavioral Health Benefits under ACA

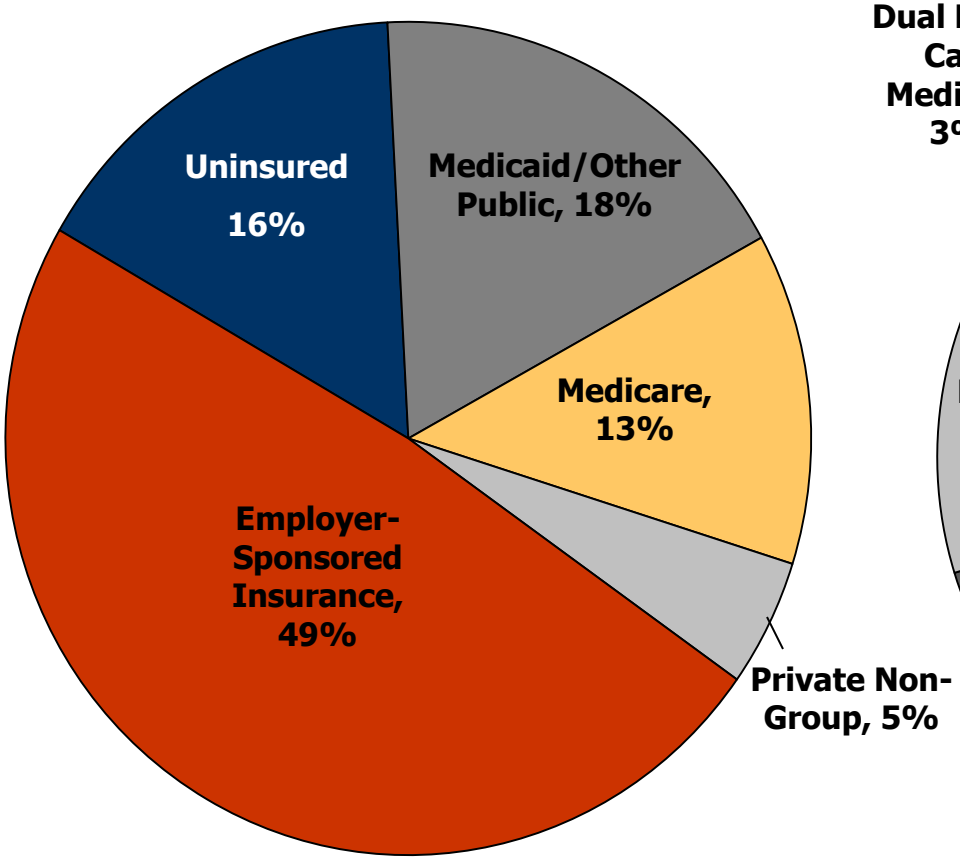
- The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 prohibits financial requirements and treatment limitations for mental health and substance abuse benefits in group health plans from being more restrictive than those placed on medical and surgical benefits.

- The ACA requires the inclusion of mental health and substance use treatment services in the 10 Essential Health Benefits.

- Parity provisions will apply to state Health Benefit Exchanges and to expanded Medicaid.

Health Insurance Coverage 2011

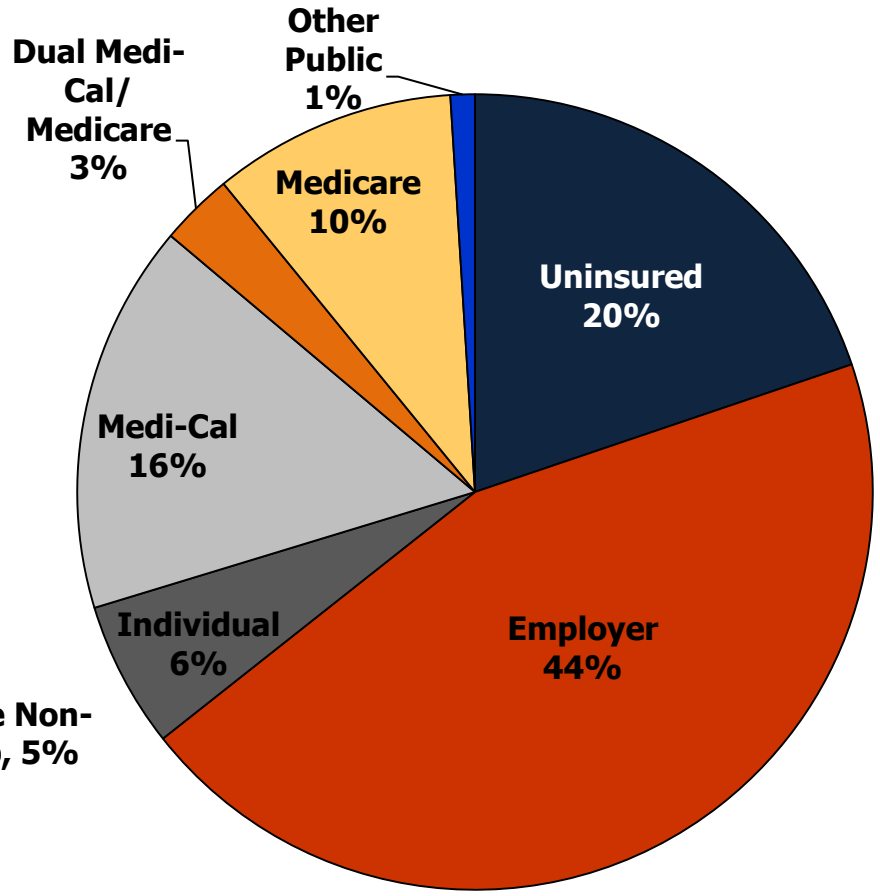
United States



Total = 307.9 million

SOURCE: KCMU/Urban Institute analysis of the 2012 ASEC supplement to the CPS.

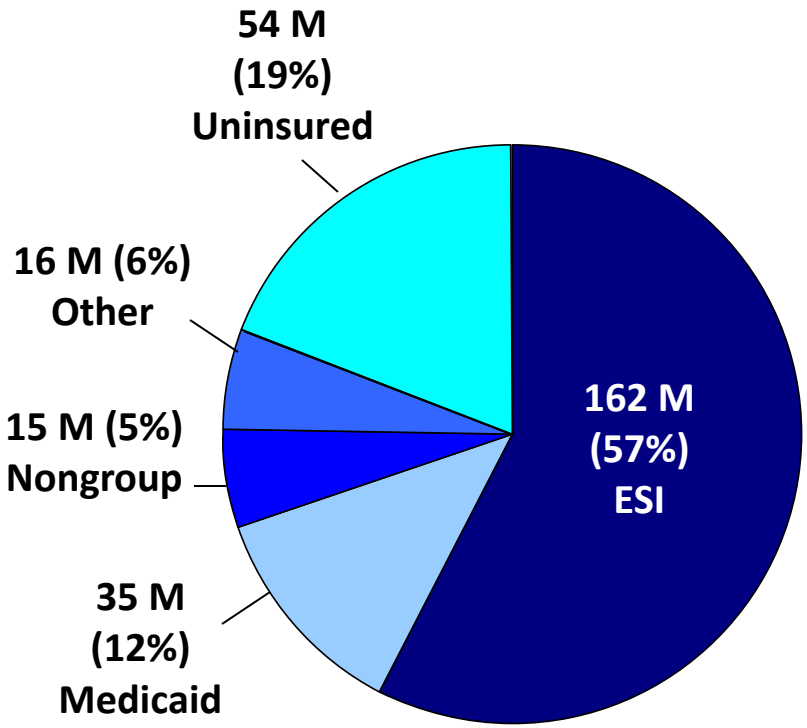
California



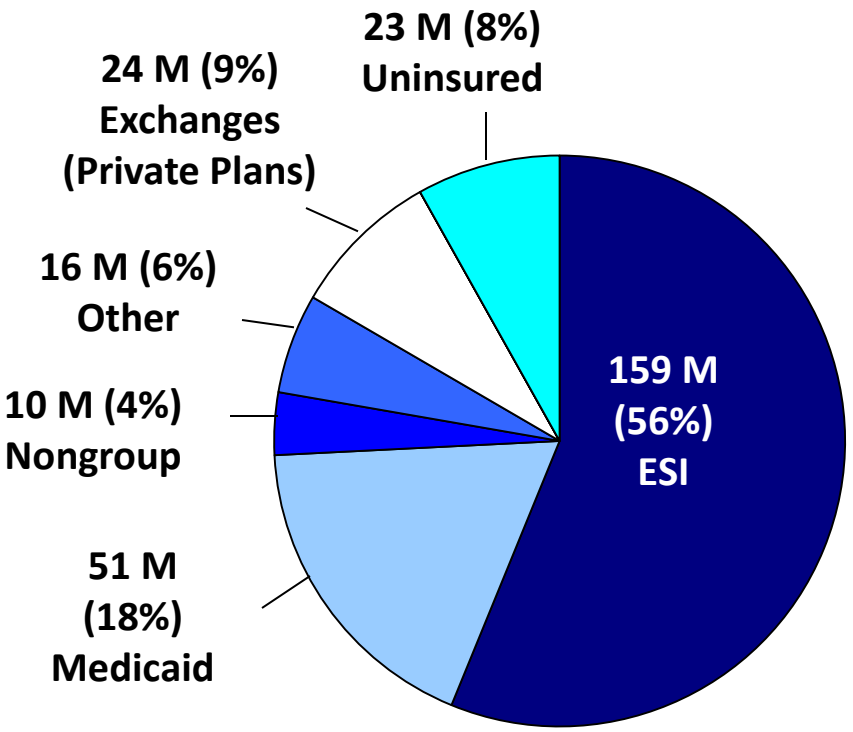
Total = 32.9 million

SOURCE: 2013 CALIFORNIA HEALTHCARE FOUNDATION

Source of Insurance Coverage Pre-Reform and ACA 2019: US under Age 65



Pre-Reform



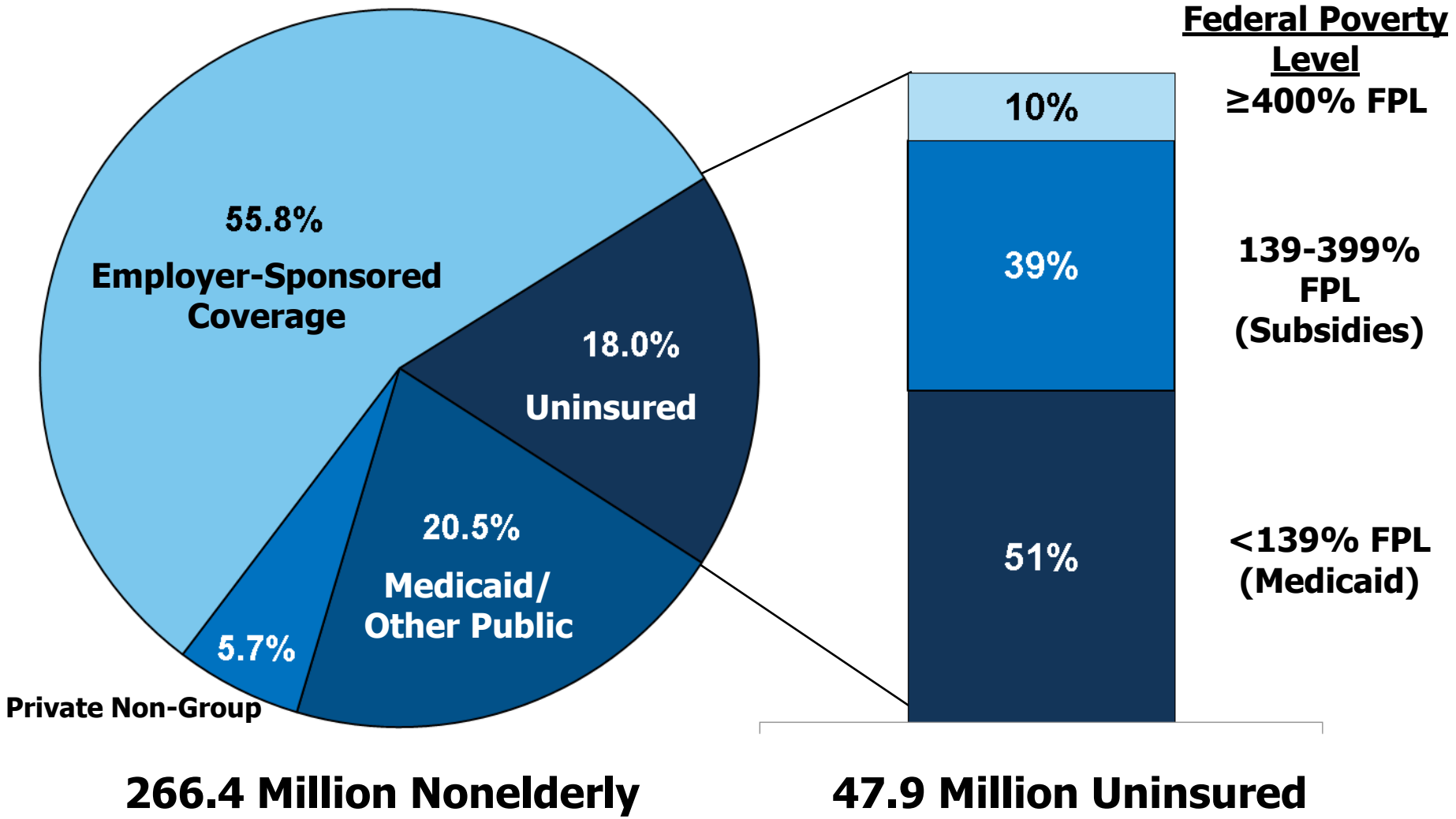
Affordable Care Act

Among 282 million people under age 65

* Employees whose employers provide coverage through the exchange are shown as covered by their employers (5 million), thus about 29 million people would be enrolled through plans in the exchange. Note: ESI is Employer-Sponsored Insurance.

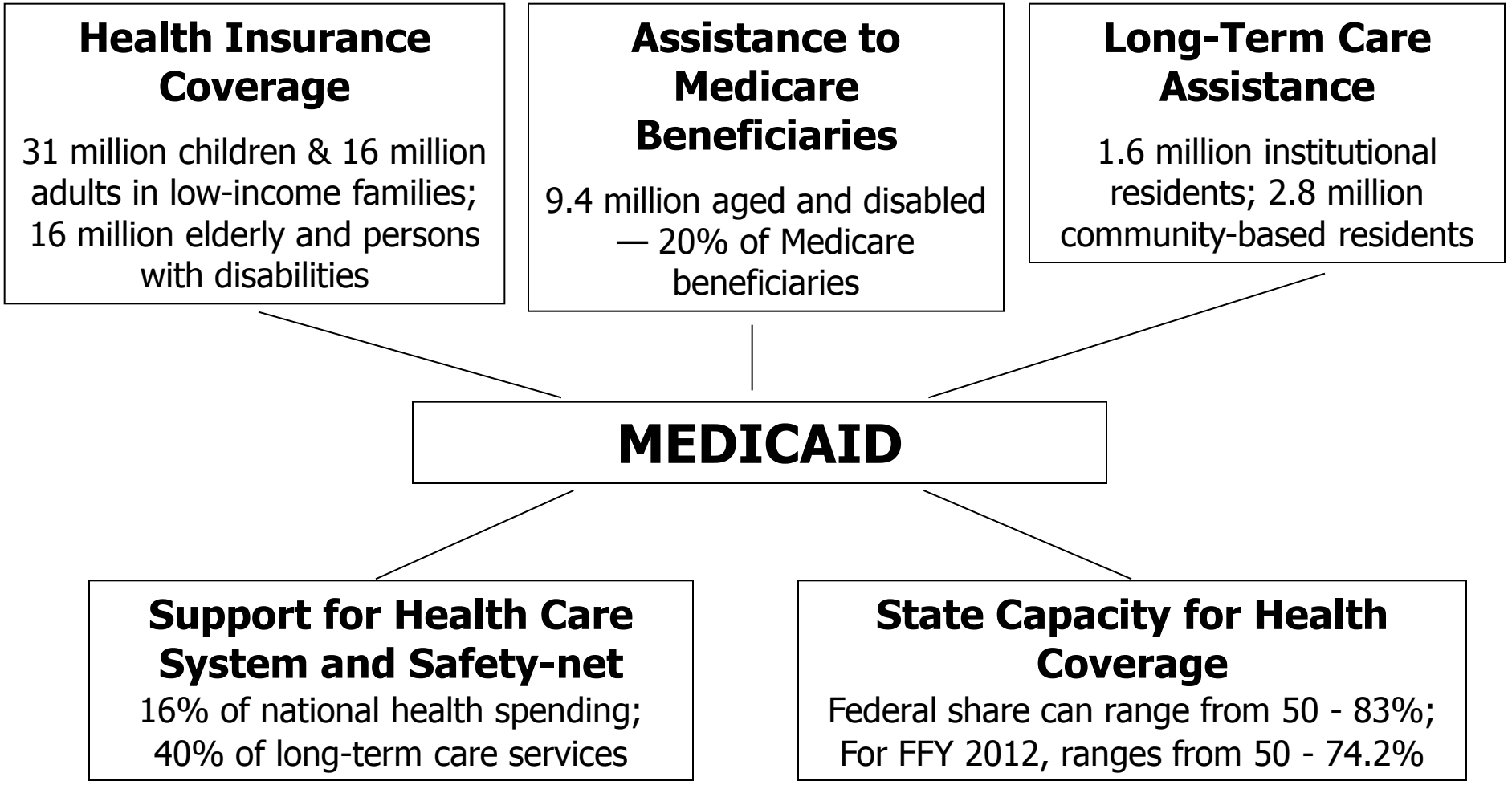
Source: S. R. Collins, K. Davis, J. L. Nicholson, S. D. Rustgi, and R. Nuzum, The Health Insurance Provisions of the Affordable Care Act: Implications for Coverage, Affordability, and Costs, The Commonwealth Fund, *(forthcoming)*.

Health Insurance Coverage of the Nonelderly, 2011



*Medicaid also includes other public programs: CHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of four in 2011 was $22,350.
Numbers may not add to 100 due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Medicaid Roles in Our Health Care System



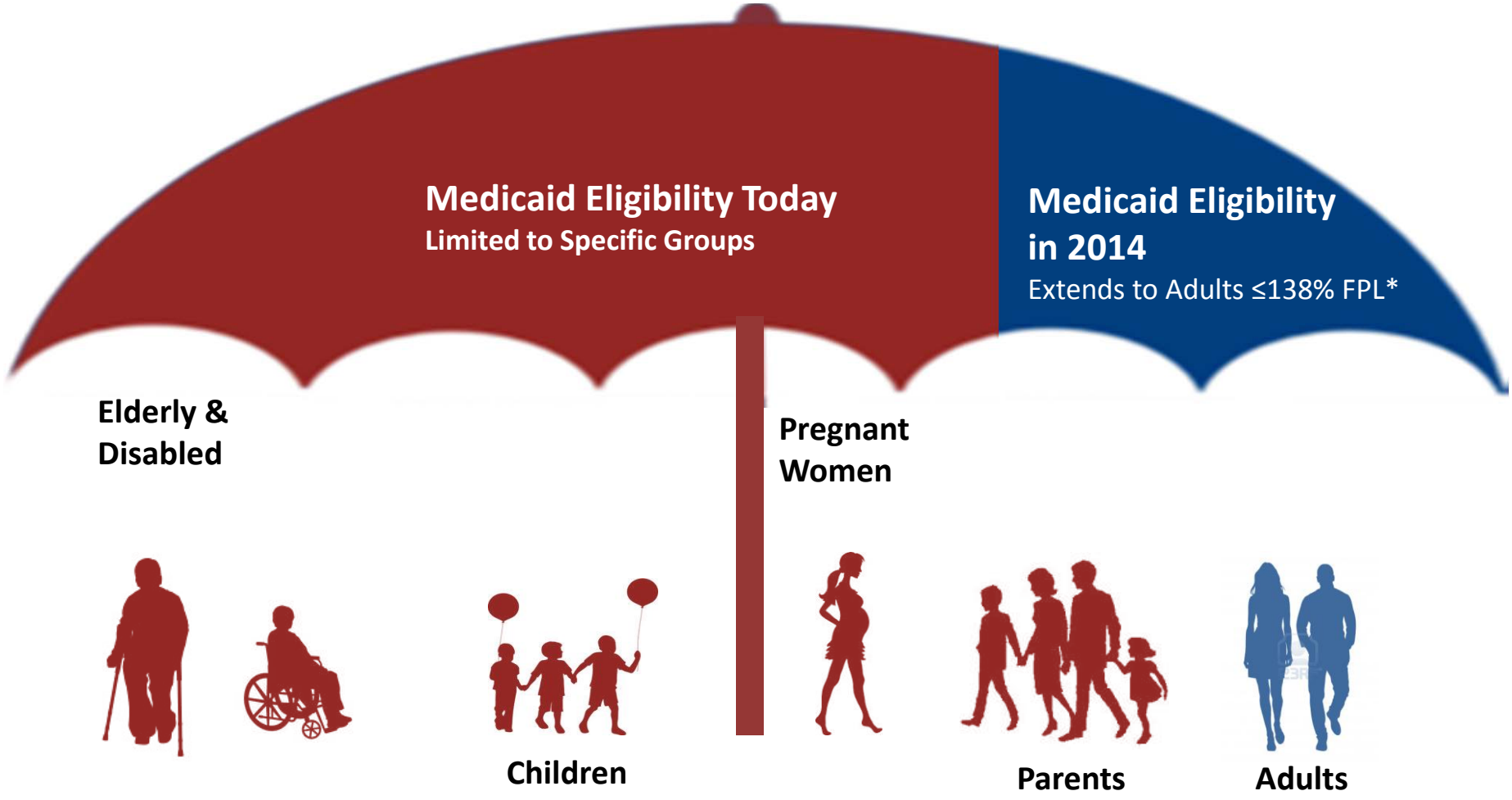
Medicaid Changes ***Required*** by ACA

- Starting 1/1/2013
  - Federal Medicaid payments in fee-for-service and managed care for primary care services increased to 100% of Medicare rates (in process)
- Starting 1/1/2014
  - Simplified eligibility determination based on MAGI (Modified Adjusted Gross Income); no asset test
  - Streamlined enrollment process
  - Coordination with Health Exchange
  - Enhanced outreach activities to encourage participation in health insurance and Medicaid

Medicaid Expansion Under the ACA

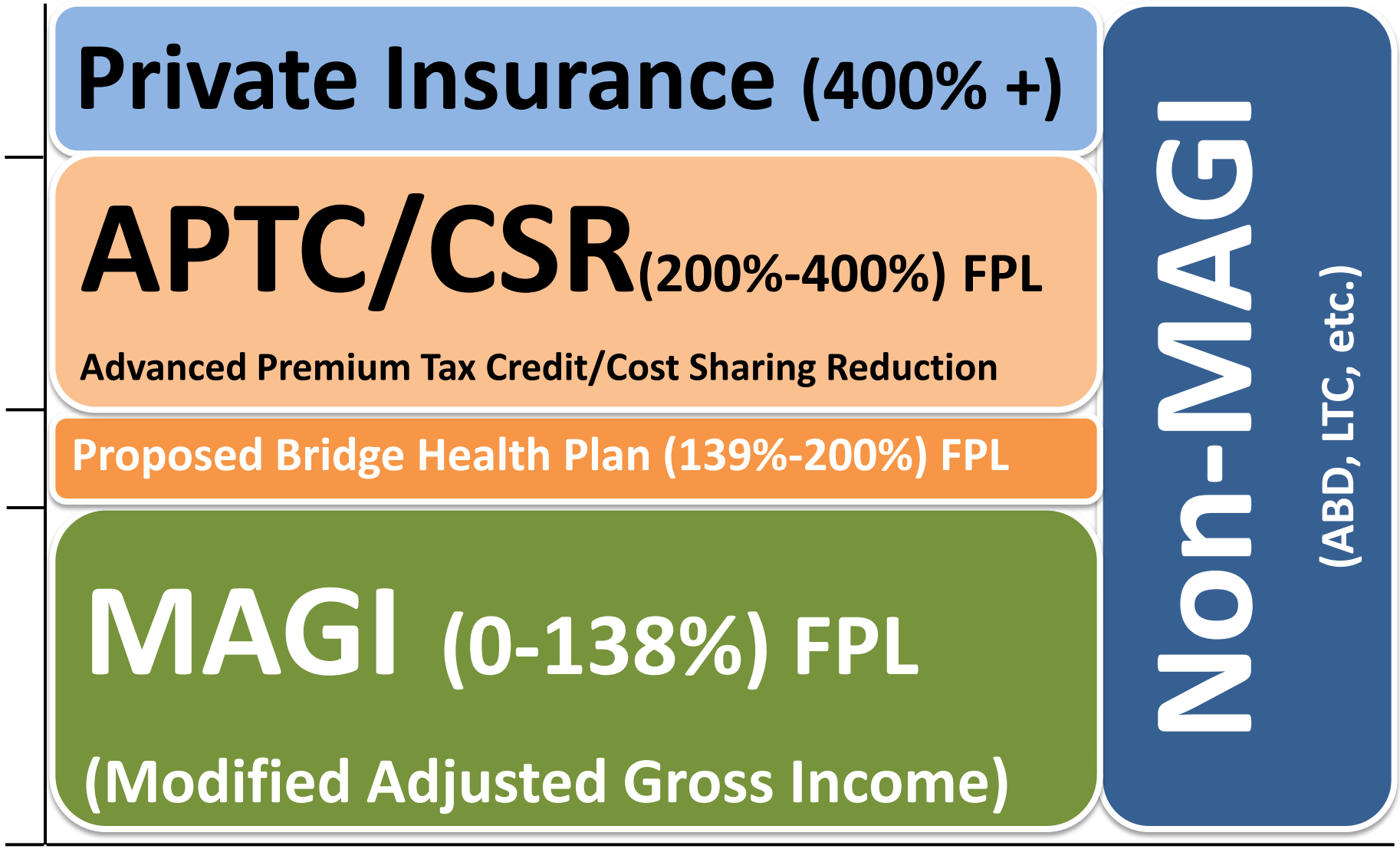
- ***Optional*** for States under Supreme Court's 6/28/2012 decision
- California has committed to expansion, but details are still TBD
- As of 1/1/2014
  - Covers adults <65 with incomes at or below 138% FPL
  - For 2014 – 2016, federal matching rate (FMAP) will be 100% (cf. 50% for existing Medi-Cal population, including current eligible but not enrolled)
  - Federal matching gradually declines 2017 – 2020 to 90% for 2020 and beyond
  - States must provide Essential Health Benefits to expansion population
  - Only US citizens and legal immigrants with >5 years of residence in US are eligible

Medicaid Eligibility Expanded to Fill Coverage Gaps for Adults



*138% FPL =$15,856 for an individual and $26,951 for a family of three in 2013

Covered California: CA's Health Benefits Exchange



Insurance Affordability Programs (IAP) under the ACA

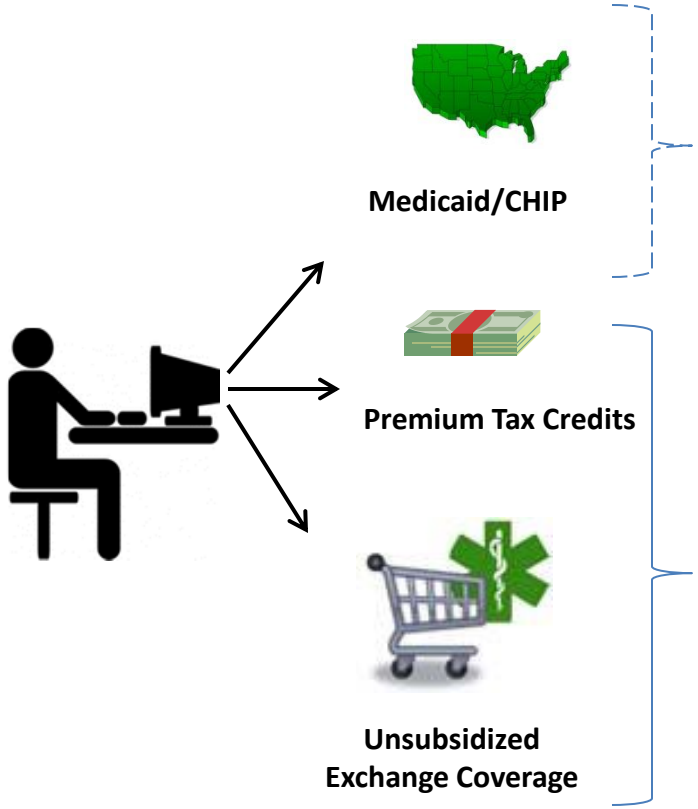
Advanced Premium Tax Credit/Cost Sharing Reduction (APTC/CSR):

- Small Business Health Options Program (SHOP) and Individual Insurance markets
- Modified Adjusted Gross Income (MAGI) – income methodology used for determination
- Applies to population 139-400% FPL

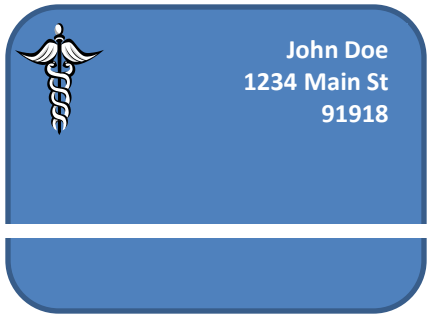
Medi-Cal MAGI Groups

- Children (infants to 18 yrs) – age and income determine with or without premiums (up to 250% FPL)
- Parents/Caretaker Relatives (138% FPL)
- Pregnant Women (138% FPL for full scope/ 139-200% FPL for pregnancy services)
- Adults (19-64 yrs) – (138% FPL)

Health Insurance Marketplaces Will Facilitate Enrollment into Coverage by Individuals and Small Employers



Plan A	Plan B	Plan C
X	X	
X	X	X
	X	X
X	X	X



Eligibility for multiple Programs Determined in Real Time

Information Provided on Available Plans for Comparison

Enrollment Into Selected Plan

Medi-Cal Non-MAGI Groups

- Aged (65+ yrs), Blind or Disabled (ABD) individuals
- Long-Term Care (LTC) individuals
- Medicare eligibles (Part A/B) for Medicare Savings Programs (QMB/SLMB/QI-1)
- Individuals eligible for SSI, Foster Care, or Adoption Assistance programs
- Individuals/Families eligible as Medically Needy (AFDC-MN) with a dependent child (Absent/Deceased/Incapacitated/Unemployed parent)

Covered California: Major Activities 2013 - 2014

- **Health Plan Selection:** evaluate, select, certify, and contract with Qualified Health Plans (QHPs) to be offered on the Exchange
- **California Health Eligibility, Enrollment & Retention System (CalHEERS):** being jointly developed by Covered California and Department of Health Care Services; must be online October 2013
- **Marketing, Outreach, Education:**
  - Community-based grants ($43 M over 2013 – 14)
  - Training of in-person assisters and navigators
  - Paid media campaign

Covered California Impacts on San Diego County

- Enrollment through Covered California begins October 1, 2013
  - First open enrollment period extends to March 31, 2014
- Coverage effective January 1, 2014.
- Counties are expected to:
  - Conduct eligibility for MAGI Medi-Cal (0-138% FPL) and mixed household (139-400% FPL) Health Exchange products
  - Serve Family Resource Center (FRC) walk-in customers and direct calls to HHSA ACCESS for MAGI Medi-Cal and Covered California health coverage products

Covered California Impacts to San Diego County

Workflow:

- Individuals who call the Covered California Call Center will be screened for Health Exchange coverage eligibility
    - San Diego residents screened as MAGI Medi-Cal or mixed household will be transferred to San Diego's HHSA ACCESS call center
    - Covered California expectation: Transferred calls are to be answered by counties within 30 seconds, 80% of the time
- CalHEERS (Exchange Database) web portal and US mail applications for MAGI and mixed cases for San Diego residents will be forwarded to San Diego for eligibility processing

Covered California Impacts to San Diego County

County of San Diego's Planning Activities:

- Participating in State-wide and CalWIN Automation Planning workgroups
- Working with County legislative office, California Welfare Directors' Association (CWDA), and CalWIN on operational strategies
- Assessing workload/staffing impact

Title III: Delivery System Transformation

- Center for Medicare and Medicaid Innovation (CMMI)
  - Created by Section 3021 of ACA to
    - Test new payment and service delivery models
    - Evaluate results and advance best practices
    - Engage a broad range of stakeholders
  - $10 billion over 10 years
  - Secretary of HHS has authority to expand scope and duration of any model if it reduces spending without reducing quality of care or improves quality without increasing spending
- Community-Based Care Transitions Program (CCTP)
- Dual Eligibles Demonstration

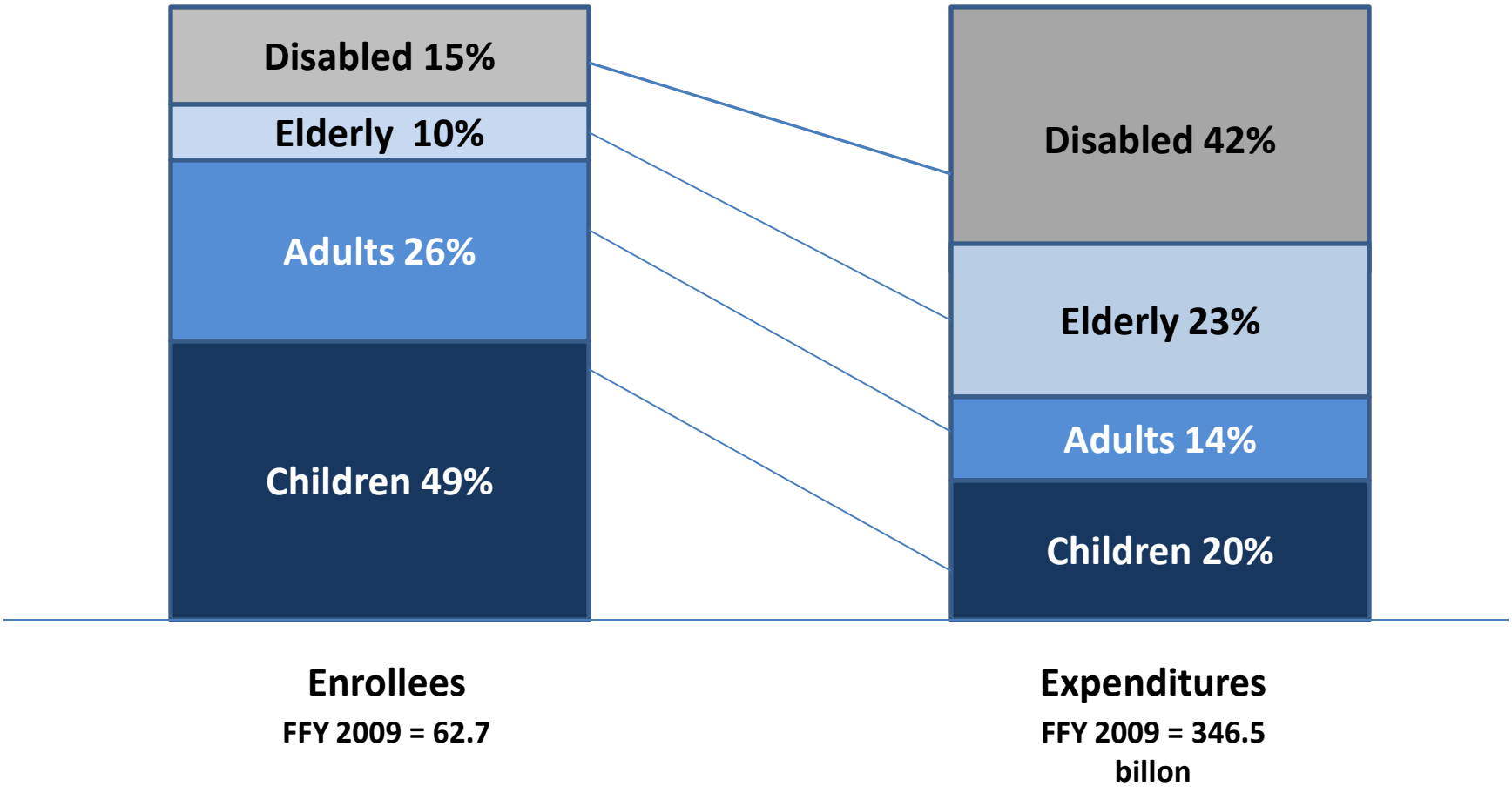
Community-Based Care Transitions Program (CCTP)

- Section 3026 of the ACA
  - $500 million over 5 years to test models for improving care transitions from inpatient hospital to home or other settings
  - Link Community-Based Organizations to hospitals
  - Goal: reduce readmissions for fee-for-service (FFS) Medicare patients by 20% in 2 years
- San Diego Care Transition Partnership (SDCTP)
  - Partnership between HHSA Aging & Independence Services (AIS) and Palomar Health, Scripps Health, Sharp HealthCare, and UC San Diego Health System – 11 hospitals/ 13 sites
  - Cooperative agreement announced by CMS January 2013
  - Will serve almost 21K FFS Medicare patients per year
  - Began January 2013 at UCSD; as of April 17th operational at 12 of 13 locations

Dual Eligibles Demonstration – Cal MediConnect

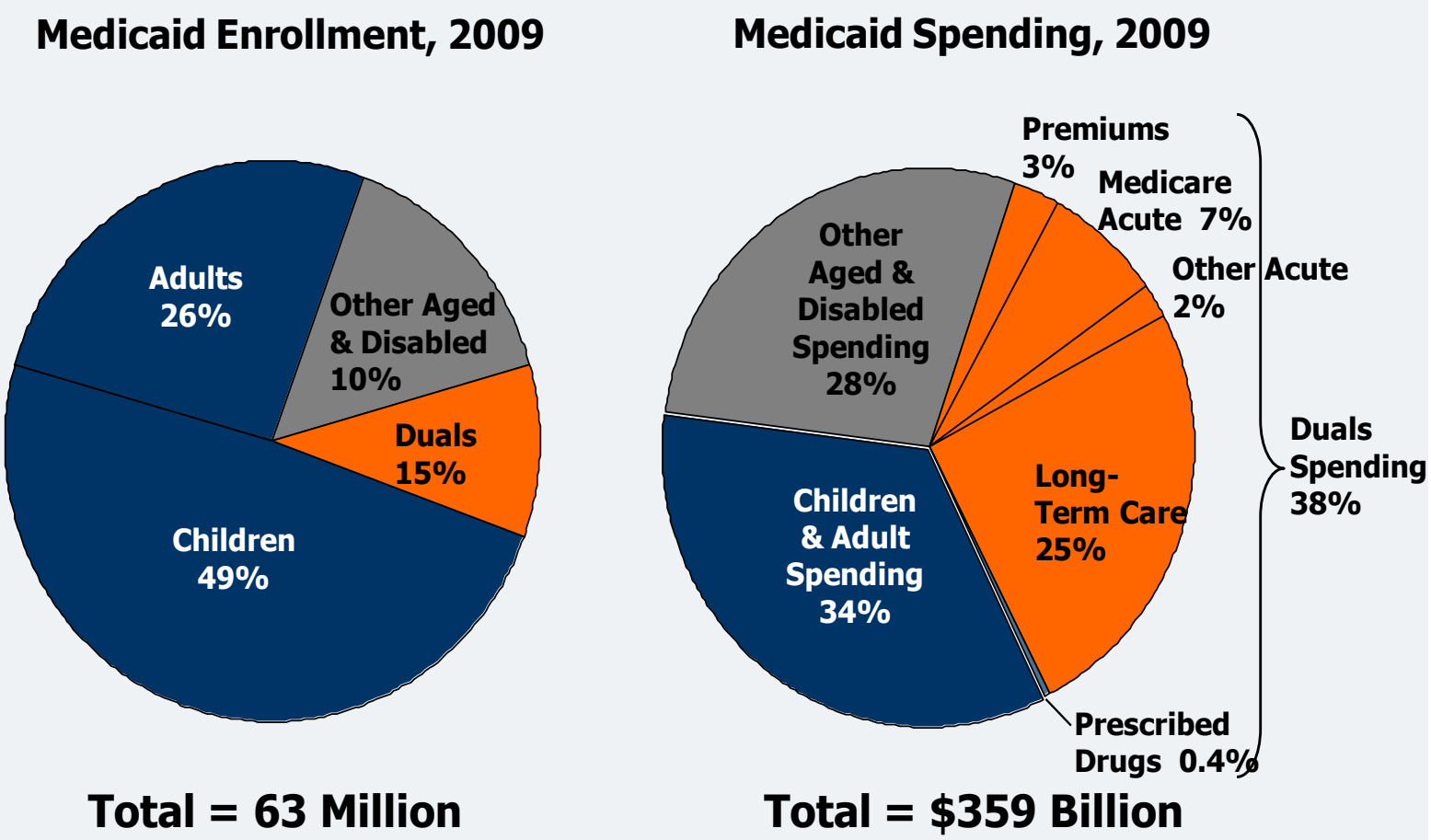
- Dual Eligibles a high priority for CMS
  - Medicare-Medicaid Coordination Office created by ACA
  - With CMMI testing new approaches to care coordination
- California one of ~15 states participating
  - Part of larger Coordinated Care Initiative (CCI) proposed by Governor in FY 2012-13 budget released January 2012
  - Goal: integrate Medicare, Medi-Cal, and Medi-Cal long-term services and supports (LTSS) to create patient-centered coordinated care delivery that will improve quality while reducing fragmentation and cost
  - MOU signed with CMS on March 27, 2013; California is 5th state to sign
  - ~456,000 beneficiaries will participate
  - Enrollment begins no earlier than January 1, 2014
- San Diego one of 8 counties participating
  - 4 health plans: Care First, Community Health Group, Health Net, and Molina
  - ~50,000 beneficiaries

Medicaid Spending: Elderly and People with Disabilities



NOTE: Percentages may not add up to 100 due to rounding.
SOURCE: KCMU/Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64, 2012.
MSIS FFY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64

Medicaid Spending: 38% for Dual Eligible Beneficiaries



SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012. MSIS FY 2008 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.

Title IV: Prevention and Public Health

- Improve the Public Health System (infrastructure)
- Increase access to clinical preventive services (develop school-based clinics, education campaigns, Medicare coverage for wellness visits)
- Provide funding for research in public health services to determine best prevention practices
- Create healthier communities (e.g., Restaurant Calorie labeling, grant awards to communities and national organization) prevention grants

The Prevention and Public Health Fund

Designed to:

- Expand and sustain the capacity to prevent disease
- Manage conditions before they become severe
- Provide states with resources to promote healthy living
- Originally funded at $15 billion over 10 years
  - Reduced by $5 billion to extend payroll tax "holiday" for a 2nd year

Funds are dedicated to four critical priorities:

- Community Transformation Grants (CTG)
- Clinical Prevention
- Public Health Infrastructure and Training
- Research and Tracking

The Prevention and Public Health Fund

Community Transformation Grants

- $145 million appropriated and allocated in FY 2011 to support the reduction of tobacco use, increase healthy eating and activity, and reduce inequities
- Support the implementation of community prevention activities that have broad impact
- Use of evidence-based prevention programming
- Available from the CDC by competitive process
- San Diego awarded a CTG in 2011 - $3.05 million/year for 5 years

The Prevention and Public Health Fund

Clinical Prevention

- Increase awareness of preventive benefits
- Expand immunization services and activities
- Strengthen employer participation in wellness programs

The Prevention and Public Health Fund

Public Health Infrastructure and Training

- Advance health promotion and disease prevention at local level through information technology, workforce training, and policy development
- Build state and local capacity to prevent, detect, and respond to infectious disease outbreaks
- National Public Health Improvement Initiative – $1.1 million grant to San Diego over 5 years

The Prevention and Public Health Fund

Research and Tracking

- Increase resources for the guidance and evaluation of preventive services
- Fund data collection and analysis to monitor impact of ACA
  - Collection of race/ethnicity and language data approved March 2012
- Fund public health research studies
  - CMS Innovation grants

Questions?