

Health Care Reform Cabinet May 3, 2010

High Level Summary of the Patient Protection & Affordable Care Act

- All individuals will be required to have health insurance by 2014
- Expands who qualifies for Medicaid
- Offers lower income residents a subsidy (tax credits) to be able to afford a plan
- Offers individuals and small employers a standardized web portal to purchase insurance (Exchange)

High Level Summary of the Patient Protection & Affordable Care Act

- Some employers will be eligible for tax credits (based on #FTEs & average salary)
- Specific health insurance reforms will be enacted – impact on premiums to be determined
- Opportunities to improve system performance and health status

Currently in Connecticut (Nonelderly population, 2009)

	Medicaid & Other Public	Employer & & non-group	Uninsured	Total
Population	508,000	2,133,000	305,000	2,947,000
% Total	17.2%	72.4%	10.4%	

Urban Institute (funded by RWJF)

Of the 305,000 nonelderly uninsured residents in Connecticut:

Eligible Subsidy	120,000	41.4%
Newly Medicaid Eligible	78,000	25.6%
Currently Medicaid Eligible	57,000	18.7%
Ineligible Sub/Medicaid	44,000	14.3%

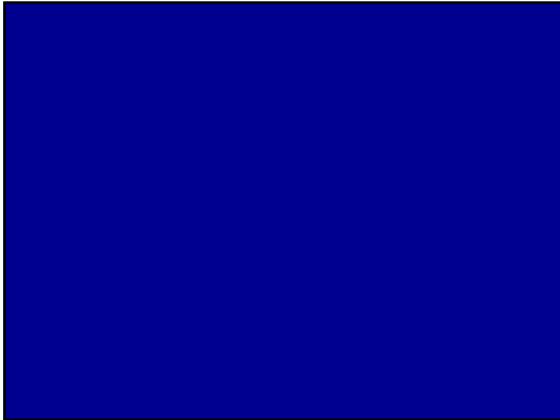
After reform, 47% of the nation's uninsured would be eligible for public insurance

Urban Institute (funded by RWJF)

Employers and Insurance

	# Firms	# Employees	% Offer
<50 ees	61,382	399,675	53.1%
50+ ees	19,140	1,062,563	97.4%

Source: MEPS



Affordable Care Act Implications for Medicaid and CHIP

Presentation to the Health Care
Reform Cabinet
May 3, 2010

Medicaid Expansion

- January 1, 2014 - new mandatory Medicaid coverage group
- Low Income Adults up to 133% of Federal Poverty Level
- Enhanced match depends on "expansion" status
 - 100% to 90% by 2020
 - 75% to 90% by 2020, plus 2.2% for 2 years
- Optional expansion
 - April 1, 2010
 - 50% FMAP
- CT applied for expansion effective April 1, 2010
 - Approximately 45,000 SAGA beneficiaries
 - Approximately 2,000 Charter Oak beneficiaries
- Additional 35,000(?) uninsured adults eligible January 1, 2014

Other Medicaid Provisions

- Maintenance of effort – no reduction in Medicaid eligibility
- Increased reimbursement of primary care physicians
 - 100% of Medicare in 2013 and 2014
 - 100% FMAP for increase in primary care expenditures
- DSH allotment reductions begin 2014
- Medicaid Drug Rebates –100% to feds; also managed care
- New premium assistance rules
- Mandatory coverage of former foster children to age 26
- Mandatory coverage – tobacco cessation, birthing cntrs
- Income standard
 - modified adjusted gross income (MAGI) –
 - reduced countable income by 5% of upper income limit
- Hospitals permitted presumptive eligibility
- Family Planning State Plan Amendment

New Grants & Demonstrations

- Bundled payments for integrated care during hospitalization
- Medicaid global payment system demonstration project*
- Medicaid emergency psychiatric demonstration project
 - Permits payment to private psychiatric hospitals
- Health homes for enrollees with chronic conditions
- Incentives for prevention of chronic diseases in Medicaid
- Community transformation grants*
- Other related CMS initiatives
 - Multi-Payer Advanced Primary Care Practice (MAPCI)
 - Federally Qualified Health Centers Advanced Primary Care Practice (FQHCAPC)

Long Term Care Rebalancing

- New federal oversight and coordination over all home and community-based services
- Expanding the Section 1915(i) state plan option
- Extending the Money Follows the Person Demonstration
- Applying Spousal Impoverishment Rules to HCBS Applicants
- New "Community First Choice Option," with increased FMAP
- New "Balancing Incentive Payment" Program, with increased FMAP
- Sense of the Congress regarding long-term care

Children's Health Insurance Program (CHIP) or HUSKY B

- Retains current structure of the CHIP program
- States maintain income eligibility levels for currently eligible children until December 31, 2019
- Existing enhanced match rates (65%) remain through September 30, 2015
- Beginning FFY 2016 match rate will be increased by 23 percentage points
- Beginning January 1, 2014 income eligibility based on modified adjusted gross income

Temporary High Risk Pool

- \$5 billion – 7/1/10 through 1/1/14
- Administered by states or HHS; state option
- No state contribution; solely premium/federal subsidy
- No creditable coverage within 6 months
- No pre-existing conditions exclusions/no waiting period
- Individual standard rating
 - Actuarial value 65% of total allowed costs
 - OOP maximum \$5,950 for individual
- Connecticut Proposal
 - Health Reinsurance Association under contract with DSS
 - Charter Oak Health Plan; HUSKY B, Band 3
- CT penetration may be mitigated due to Charter Oak



Health Care Reform Enacted

May 3, 2010

Key Reforms – Early Implementation

- **High Risk Pool Grants** (\$5 billion – 2010-2013)
 - For individuals who currently do not have coverage and have a pre-existing condition
 - Challenge to provide grants to states without high risk pool and to guarantee issue states
- **Health Plan Reforms** (Plan years 6 mos. after enactment)
 - No lifetime limits; First-dollar coverage for preventive services
 - No rescissions; Appeals process
 - Dependent coverage up to 26 years of age
 - No Pre-existing Condition Exclusions for Children
- **Grants for State Ombudsman**
- **National Web Portal**

Key Reforms – 2014 Implementation

- **Market Reforms:**
 - Guarantee Issue and no Pre-existing Condition Exclusions in all markets
 - Rating Reforms limiting factors to age (3:1), geography, tobacco use and family composition
 - 4 Coverage Tiers based on coverage categories and cost-sharing
 - No annual limits
- **State-Based Exchanges** for Individual and Small Group markets that will provide standardized information on insurance choices and help consumers enroll in plans

Key Reforms (continued)

- **Individual Mandate** intended to ensure consumers do not wait until they are sick to seek coverage
- **Employer Responsibility** through a fine if employers with 50 or more employees do not offer coverage and an employee receives subsidies through the Exchange.
- **Subsidies** for lower-income persons and **Medicaid Expansion** (with enhanced federal match) to help make coverage available
- Limited provisions to address **Quality, Cost-Containment, and Fraud**

State Implementation

- States will need to act quickly to implement the reforms by 2014 – and very quickly to access high risk pool and ombudsman funds
 - Federal agencies will need to publish regulations
 - NAIC will develop model acts and regulations that comply with the federal regulations
 - State legislatures will adopt laws and state agencies will publish regulations and create new programs
 - Insurers will submit new forms and rates that comply with the new regulations, which must be approved by the states before they can be marketed
 - Insurers will market new plans that will become effective 2014

Insurance Department's Responsibilities

- Review all resubmitted rates and forms to ensure they conform with the law (varies between 6 months and 2014).
- Amend statutes, regulations, and bulletins consistent with the federal law.
- Approve benefit summaries based on standards set by HHS (12 months).
- Maintain copies of claims payment policies, enrollment and disenrollment data, financial disclosures, claims denials, rating practices, out-of-network payments and other information (6 months).
- Respond to increasing consumer complaints and inquiries.

Insurance Department Responsibilities (cont.)

- CID's role in regulating the Exchange is unclear. It is likely that we will have enforcement authority over plans operating within the exchange.
- "States" are also eligible for grants to operate the Exchange.
- CID must annually review "unreasonable" rate increases for all group and individual plans and report to HHS.
- CID must capture, analyze, manage, and report health insurance data to HHS. Specific data requirements and standards will be determined by HHS, Treasury, and DOL (July 2010).

Presentation to the Health Care Reform Cabinet

May 3, 2010



Impact on Businesses: Bottom Line

- Health care reform (HCR) produces benefits as well as costs to CT companies.
- DECD's preliminary analysis shows that the financial impacts of HCR on CT companies are difficult if not impossible to determine.
- The financial impact depends on choices companies and individuals make as they understand and search for the best and most cost-effective health care solutions for their specific circumstances under the new law.



Department of Economic and Community Development

Impact on Pharma

- Nationwide, industry fee is
 - \$2.5 billion in 2011,
 - \$2.8 billion in years 2012-2013,
 - \$3.0 billion in 2014-2016,
 - \$4.0 billion in 2017,
 - \$4.1 billion in 2018 and
 - \$2.8 billion in 2019 and years thereafter.
- Fee is allocated across the industry according to market share with a reduction in share for companies with annual sales of branded pharmaceuticals of less than \$400 million.
- The fee is assessed based on a company's market share of government sales (to Medicare, Medicaid, Tricare and the Veterans Administration) in the prior year and is non-deductible for federal tax purposes.
- 173 pharma firms in CT.



Department of Economic and Community Development

Impact on Medical Device Mfg.

- National excise tax on domestic sales of medical devices by the manufacturer or importer equal to 2.3% of the sales price.
- Tax is deductible for federal corporate income tax purposes.
- Certain medical devices are exempt.
- Sales for export and sales of devices for use in further manufacturing would be exempt from the excise tax.
- Included in the medical device manufacturing industry are companies that make in vitro diagnostic substances or appliances and companies that make prosthetics.
- The provision is effective for sales after December 31, 2012.
- 121 medical device mfrs. in CT.
- Impact depends on product line sales.



Department of Economic and Community Development

Impact on Health Insurance Providers: Annual

- U.S. industry annual fee of
 - \$8.0 billion in 2014,
 - \$11.3 billion in years 2015-2016,
 - \$13.9 billion in 2017 and
 - \$14.3 billion in 2018.
- After 2018, annual fee is the amount for the preceding year increased by the rate of premium growth for the preceding calendar year.
- Exemptions from the fee include non-profits that receive more than 80% of their gross revenues from government programs that target low-income, elderly or disabled populations.
- Only 50% of net premiums written by entities exempt from federal income tax are included for purposes of determining their market shares.
- Effective for years after December 31, 2013.
- What insurers pay depends on the firm's share of net premiums plus 200% of their administrative costs.



Department of Economic and Community Development

Additional Impact on Health Insurance Providers: 2014-2016

- Third party administrators & health insurers must pay a 3-year aggregate industry fee (\$25 billion) to fund a reinsurance program:
 - \$12 billion in 2014,
 - \$8 billion in 2015 and
 - \$5 billion in 2016.
- HHS will set the precise formula determining the amount each insurer owes in 2014-2016.
- Basic concept seems to be that market share determines an insurer's liability.
- Administered at the state level.
- Fees will be assessed on each insurer covering residents of a particular state and paid to a reinsurer operating within the state to cover the costs of the state's high-cost insured.



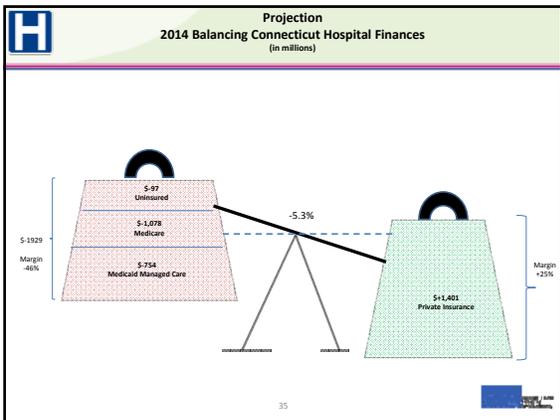
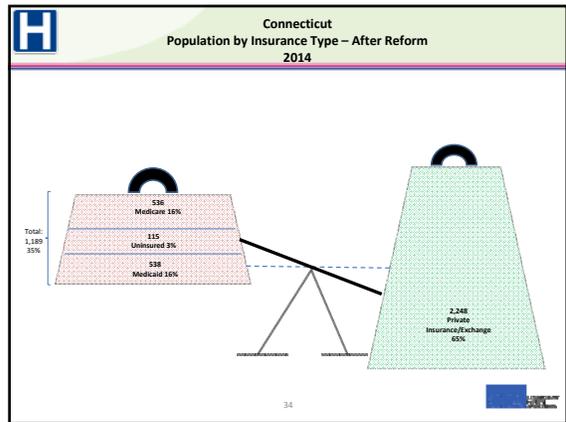
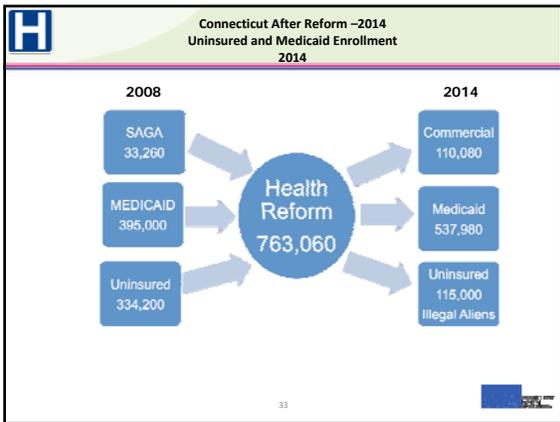
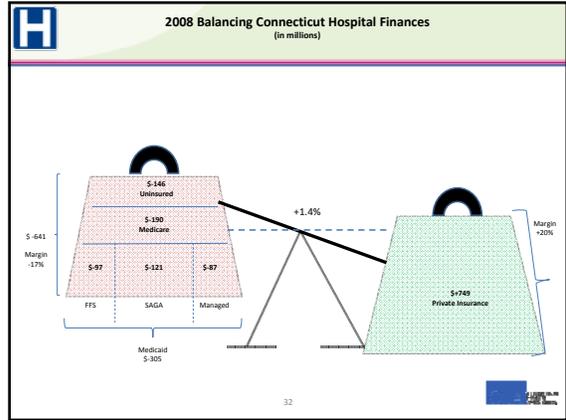
Department of Economic and Community Development



Financial Implications of Healthcare Reform for Connecticut Hospitals

Presentation to Health Care Reform Cabinet

Stephen A. Frayne
Senior Vice President, Health Policy
Connecticut Hospital Association
May 3, 2010



 **How Federal Health System Reform May Impact Physicians In Connecticut**

Matthew C. Katz
Executive Vice President
Connecticut State Medical Society

 **Medicare payment changes**

- 10 percent incentive payments for primary care physicians
- 10 percent incentive payments for general surgeons performing major surgery in health professional shortage areas
- 5 percent incentive payment for mental health services
- Geographic payment differentials.
- Medicare quality reporting incentive payments extended

 **Medicaid payment changes**

Medicaid payments increases

- to family physicians, general internists and pediatricians for E/M services to at least Medicare rates in 2013 and 2014.

 **Other Areas of Potential Benefit**

- Health Insurance Market Reforms
- Administrative simplification
- Employer requirement to offer coverage
- Preventive and screening benefit expansions
- Medicare prescription drug coverage
- Medical liability protection and grants

 **What wasn't addressed**

- Flawed Medicare sustainable growth rate (SGR)
- Medical liability situation in CT



The New Insurance Marketplace & Other Insurance Market Reforms

The Patient Protection and Affordable Care Act fundamentally reforms the insurance market, both in providing access to coverage for those previously uninsured and in changing the system for those who already have coverage

The New Insurance Marketplace

- States health insurance Exchanges (for individuals and small employers up to 100 employees) estimated to provide coverage to 24 million
- New coverage alternatives, such as CO-OPs and benefit plan levies
- Individual responsibility requirement and employer requirements/penalties for not offering coverage
- Subsidies and tax credits to offset insurance premiums
- Temporary high-risk pool established until 2014 to provide coverage to those who can't obtain insurance due to health status or pre-existing conditions
- New voluntary long-term care insurance program for individuals with functional limitations

...and Other Insurance Market Reforms

- Effective 2010:
 - Children up to age 26 covered on their parents' policies and up to age 19 obtain coverage with no pre-existing condition exclusions
 - 16-state cap on out-of-pocket expenses
 - Prohibition on rescissions except in the case of fraud or intentional misrepresentation
 - New state review authority process established
- Effective 2011:
 - Establishment of standard MHPs for all plans
 - Uniform health plan documents created
- Effective 2014:
 - Guaranteed issue coverage for all
 - No exclusions for pre-existing conditions
 - Minimum, essential benefits and standard benefit differences
- Effective 2018:
 - Insurance industry annual tax standards
 - High-value plan issuer tax begins

Medicare Reforms

Medicare Advantage (MA) Reforms

- Starting in 2012, MA payment benchmarks will be phased in relative to local Medicare fee-for-service costs, and quality bonuses will be phased in based on a five star rating system
- Starting in 2016, MA plans are subject to a new minimum medical loss ratio (MLR) requirement of 70%
- MLR and Prescription Drug Plan (PDP) enrollment period changes
 - In 2011, the January - March MA open enrollment period (OEP) for beneficiaries is eliminated and replaced with an opportunity to move to a fee for service plan from January 1 - February 15
 - In 2012, the MA and PDP annual election period (AEP) is moved up to October 15 - December 7
- Medicare beneficiaries are entitled to an annual wellness visit with no copayment or deductible. Cost sharing is also removed for annual wellness, screening tests and preventative services
- A new Independent Payment Advisory Board is established to present proposals to the President and Congress to reduce excess cost growth, improve quality of care for Medicare beneficiaries, and slow the growth in national health expenditures

Part D Coverage Gap ("Donut Hole" Coverage)

- A 50% rebate will be given to beneficiaries who enter the coverage gap in 2010
- The donut hole will be closed by 2020 by reducing coinsurance to 25% for all spending between the deductible and the catastrophic limit for both generic and brand name drugs
- In 2011, pharmaceutical manufacturers whose drugs are covered in Part D must provide a 50% discount for off-invoice drugs
- A generic drug discount in the form of a federal subsidy is also provided to eligible beneficiaries in the donut hole beginning in 2011

Medicare Drug Plans

- Starting in 2012, the deduction for expenses allowable to the Medicare Part D subsidy for "qualified prescription drug 2007" is eliminated

Medicaid Expansion and Medicaid, CHIP, & SNPs Reforms

Medicaid Expansion

- Expands the Medicaid program in 2014 to individuals and families with incomes up to 133% of the federal poverty level
- Enables children, adults and parents to enroll in the program. States will receive an enhanced federal match for this expansion (100% federal match in 2014 - 2016, phasing down in 2017 and beyond)
- Newly-created exchanges will act as national enrollment vehicles starting in 2014

Federal Statutory Prescription Drug Rebates & Medicaid Managed Care

- As of January 2010, drug manufacturers are required to provide statutory Medicaid drug rebates in states for drugs provided in managed care
- Provides an immediate savings opportunity for states that currently deliver their drug benefit through managed care

Primary Care Payments in Medicaid

- In 2013 and 2014, states are required to pay primary care providers equivalent to Medicare rates

Children's Health Insurance Program (CHIP)

- Expands the CHIP program through 2015
- Beginning in 2014, states receive a 23% increase in their federal CHIP match rate
- States have flexibility to provide CHIP eligibility coverage in the Exchanges in 2015

Special Needs Plans (SNPs)

- Extends the authorization for Medicare SNPs through 2015
- Extends the current state contracting requirement for dual SNPs through December, 2017

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Fraud and Abuse, Health IT, and Prevention & Wellness Initiatives

Fraud and Abuse

- Increased funding for fraud and abuse prevention, enforcement and control
- Updated fraud and abuse rules for HMOs, PPOs, Medicare, and Medicare Part C and D
- Increases penalties for violations
- Streamlines procedures for Medicare administrative contractors to conduct Medicare enrollment audits

Comparative Effectiveness Research

- In 2010, the Patient-Centered Outcomes Research Institute is established
- Facilitates and supports health outcomes and the shared interventions, data, and benefits of non-or non-medical treatments, services, and forms. Does not allow comparisons based on cost

Administrative Simplification

- HR to promote uniform adoption of electronic transaction standards, including standards for patient insurance eligibility and payment financial requirements
- Electronic funds transfer rules are imposed by July 2014, effective July 2014
- Beginning in 2015, all payments made by Medicare must use EFT

Prevention & Wellness

- Promotion of healthier eating habits and increased physical activity through increased funding for Community Transformation Grants
- All health plans to provide coverage for preventive benefits with no coinsurance or cost sharing
- Grants to states or local health departments to conduct pilot programs in the 35-to-64 year-old population for prevention and wellness programs designed to reduce Medicare costs
- New front labeling requirements for child restraints and window machines



The modernization of health care is just beginning.

All Americans should have access to quality, affordable health care coverage.

Each day, UnitedHealth Group applies the broad capabilities and experiences of our 78,000 employees to improve the health care system through innovations and proven best practices.

UnitedHealth Group will continue to work with physicians, nurses, hospitals, government officials, policy-makers, thought leaders, customers, industry partners, and others to develop solutions to modernize the health care system and address the challenge of rising health care costs.