



The Patient Protection and Affordable Care Act of 2010 Presentation to the Legislative Committee on Health Care April 21, 2010

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Overview

- Background
- Key provisions of the Act
- Timeline for major provisions
- Issues and policy decisions
- State planning & implementation
- Estimated costs for the Medicaid Expansion
- Questions?



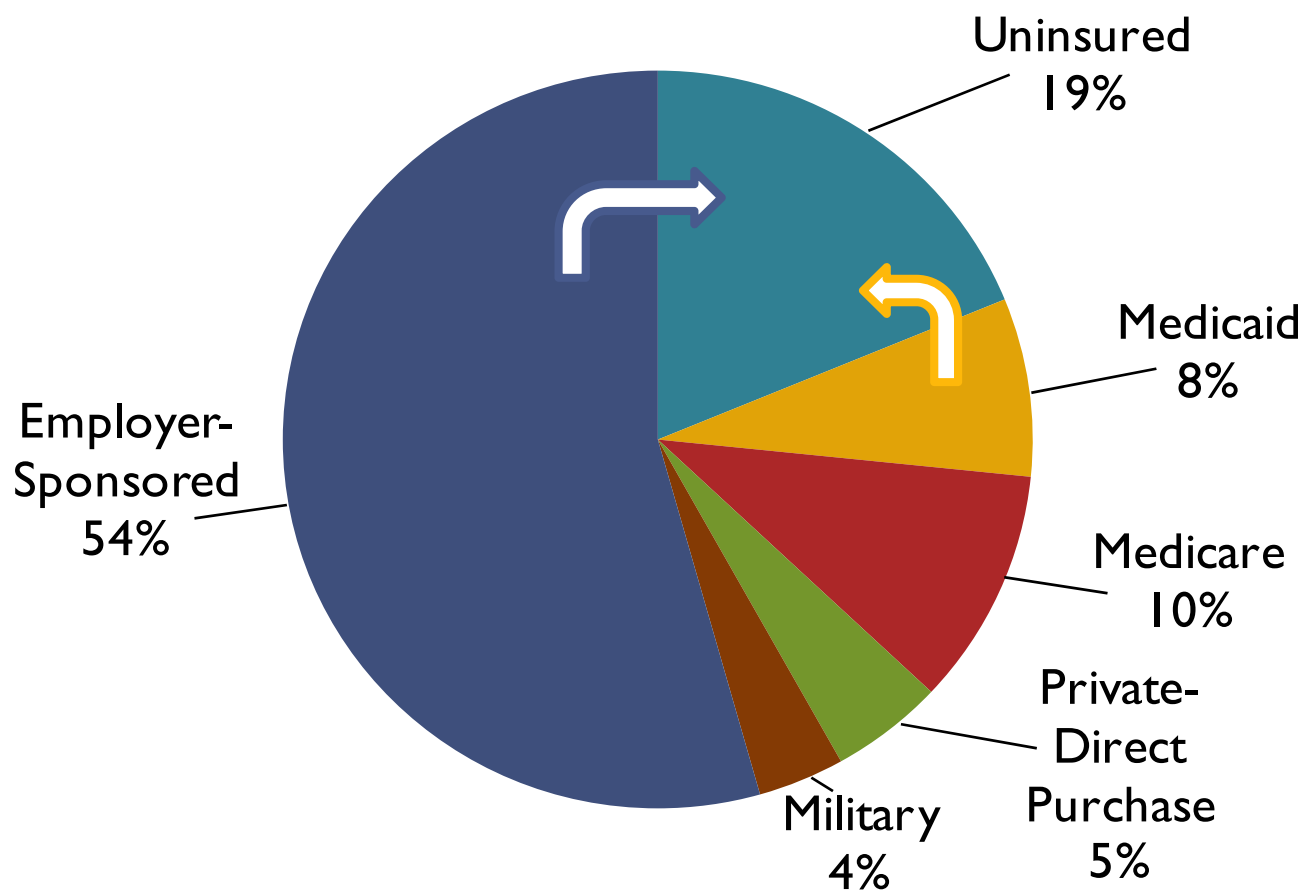
Background

- Sources of health coverage in the U.S. for 2007 *(Source: Employee Benefit Research Institute analysis of 2007 CPS data)*
 - Assured sources
 - 45M Medicare
 - 38M Medicaid/CHIP
 - 8M CHAMP/VA/Tricare
 - Less “assured” sources
 - 163M employer or unions
 - 18M individual plans
 - Others have no coverage or “assurance” at all – 45M uninsured
- Health Reform – Seeking greater assurances on coverage
 - Individual and group
 - Uninsured → Individual, group & Medicaid/CHIP

Source: International Foundation “Health Care Reform Update”



Health Coverage in Nevada



Source: U.S. Census Bureau, Current Population Survey, Table HIA-4, 2008



Nevada Health Coverage Facts



- **19% of Nevadans are uninsured. The US average is 15%. (*U.S. Census, Current Population Survey (CPS)*)**
- **Nevada has the highest percentage of uninsured children, 19%, compared to 10% nationwide. (*U.S. Census, CPS*)**
- **8% of Nevadans receive Medicaid. The US average is 14%. (*U.S. Census, CPS*)**
- **In 2008, 63% of Nevada's private businesses offered health insurance to employees. The national average was 56%. (*Kaiser Family Foundation, State Health Facts*)**
- **In 2008, the average premium for employer-sponsored health insurance in Nevada was \$3,927 for individual coverage and \$11,487 for family coverage. This is 7%-10% below the national average. (*Kaiser Family Foundation, State Health Facts*)**
- **On average nationwide, the unreimbursed cost of health care for the uninsured contributes \$368 to annual individual premiums and \$1,017 to family premiums. (*Families USA, "Hidden Health Tax: Americans Pay a Premium", 2009*)**
- **Employees in Nevada pay a higher percent of the total premium for employer-sponsored health insurance—22% of the premium for individual coverage and 31% for family coverage compared to 20% and 28% nationwide. (*Kaiser Family Foundation, State Health Facts*)**



Background (continued)



- On March 23, 2010, the President signed the Patient Protection and Affordable Care Act (PPACA) passed by the House on March 21, 2010.
- On March 30, 2010, the President signed the Health Care and Education Act of 2010, making changes to the Patient Protection and Affordable Care Act.
- According to the CBO, the Act is estimated to cost \$938 billion over the next ten years, covering 32 million uninsured individuals, while reducing the deficit \$124 billion during this time period.



PPACA Key provisions

- Individual Mandate
 - Almost all individuals will be required to have health insurance by 2014.
 - Those without insurance will be required to pay an annual financial penalty phased-in from 2014-2016.
 - Exceptions:
 - Financial hardship and religious objections;
 - Native American;
 - Those for whom the lowest cost health plan exceeds 8% of income; and
 - If the individual has income below the tax filing threshold (In 2009, \$9,350 for an individual and \$18,700 for a married couple).



Key provisions (continued)

- **Employer Requirements**

- Employers with more than 50 employees will be assessed a fee of \$2,000 per FTE (in excess of 30 employees) if they do not provide coverage AND if they have at least one employee who received a premium credit through the exchange.
- Employers that do offer coverage but have at least one employee who received a premium credit through an exchange, are required to pay the lesser of \$3,000 per employee receiving a premium credit, or \$2,000 for each FTE.
- Employers that offer coverage will be required to provide a exchange voucher to employees with incomes below 400% of poverty if their share is between 8-9.8% of income.
- Large employers that offer coverage are required to enroll employees into their lowest cost premium plan if the employee does not sign up for coverage, or does not opt out of employer coverage.



Key provisions (continued)

- **Changes to Private Insurance**

- Establish temporary high risk pool.
- Create temporary reinsurance program for companies covering early retirees ages 55-64.
- Young adults can stay on parent's plan to age 26.
- Establish Minimum Loss Ratios for insurance plans.
- Limits on health plan premiums for age, tobacco use, geographic area and number of family members.
- Prohibit lifetime limits on coverage.
- No rescission of coverage, except for enrollee fraud.
- Premium increases subject to review.
- States allowed to form health care compacts to allow insurers to sell policies in any compact state.
- Waiting periods for coverage limited to 90 days.



Key provisions (continued)

- American Health Benefit Exchanges – States will create a virtual marketplace where individuals can purchase insurance and separate exchanges for small employers. Premium and cost-sharing subsidies will be determined as well as eligibility for Medicaid and CHIP.
 - Plans in the exchanges will be required to offer benefits that meet a minimum set of standards, including: four levels of coverage that vary by premiums; out-of-pocket costs and benefits; plus a catastrophic plan.
 - Premium subsidies will be provided to families with incomes between 133-400% of poverty (\$29,327 to \$88,200 for a family of four in 2009). Subsidies will be provided on a sliding scale.
 - Cost sharing subsidies will also be available to people with incomes between 133-400% of the poverty level.



Key provisions (continued)

- Medicare Changes
 - Provide \$250 rebate to Medicare beneficiaries who reach the Part D “donut hole.” Later, require drug makers to provide 50% discount on brand drugs to enrollees who fall into the Part D “donut hole.”
 - Restructure payments to Medicare Advantage plans to 95% of the traditional Medicare program.
 - Establish pilot programs for: accountable care organizations; and, bundled payments for hospital, physician and post-discharge services.



Key provisions (continued)



- Medicaid
 - Starting 2014, expand Medicaid to all individuals under 65 years of age with incomes up to 138% of the FPL (133% of the FPL with a 5% income disregard).
 - Changes to the Medicaid drug rebate program.
 - Prohibit payments for hospital acquired conditions.
 - Option to create a medical home program for recipients with multiple chronic conditions.
 - Increase payments for primary care services for 2013 and 2014 at 100% federal funding.
 - Reduce states' DSH allotments.



Timeline for Major Provisions



- 2010
 - Insurance reforms
 - Establish temporary high risk pools
 - Allow coverage of adult children up to age 26
 - No lifetime limit on benefits.
 - Establish review process for health insurance rate increases.
 - Medicare
 - Provide \$250 rebate for Part D “donut hole.”
 - Medicaid
 - Increase drug rebates.



Timeline (continued)

- 2011
 - Medicare
 - Drug-makers to provide 50% discount for brand drugs to Medicare beneficiaries in the donut hole.
 - Provide 10% bonus to doctors in health professional shortage areas.
 - Medicaid
 - Prohibit payments for hospital acquired infections.
 - Medical home model for patients with chronic conditions.
 - Long-term care
 - Establish Community Living Assistance Services and Support program (CLASS).



Timeline (continued)

- 2012
 - Medicaid
 - Create demonstration for Medicaid for bundled payments to hospitals and physicians.
- 2013
 - Insurance reforms
 - Simplify health insurance administration by adopting a single set of rules for: eligibility verification and claims status; electronic remittance and payments; and health care encounter data.
 - Medicare
 - Begin brand subsidies for the Part D donut hole.
 - Establish bundled payment pilot.
 - Medicaid
 - Increase payments for primary care physician services.



Timeline (continued)

- 2014
 - Insurance provisions
 - Individual mandate begins.
 - Health Insurance Exchanges operational.
 - Employers with more than 50 employees subject to assessments.
 - Limit on deductibles for small group market.
 - Limit on waiting periods to 90 days.
 - Medicaid
 - Expand Medicaid to all individuals under 65.
- 2015 and beyond
 - Permits states to develop health insurance compacts



Issues and Policy Decisions

– Timing Issues

- Short IT planning and funding horizons including:
 - Replacement or enhancement of NOMADS before 2014
 - Development of Health Information Exchange
 - Medicaid management information system changes
- Need for federal guidance now.
- Coordination with ongoing HIT initiatives.

– Policy Issues

- Should Nevada run its own Health Insurance Exchange? Partner regionally? Let the feds run it?
- Develop a Health Care governance structure for cross-cutting policy issues?
- Which options, grants and pilot programs should the State pursue?



Issues and Policy Decisions (continued)



– Funding Issues

- 2012-2013
 - Staff and technology improvement requests for multiple agencies.
 - Additional funds for staff, consultants and IT contracts for multiple agencies.
- 2014-2015
 - Implementation and operations funding for Health Insurance Exchange
 - Go live with Individual Mandate and Medicaid Expansion
- 2016 and beyond
 - Continued operational funding

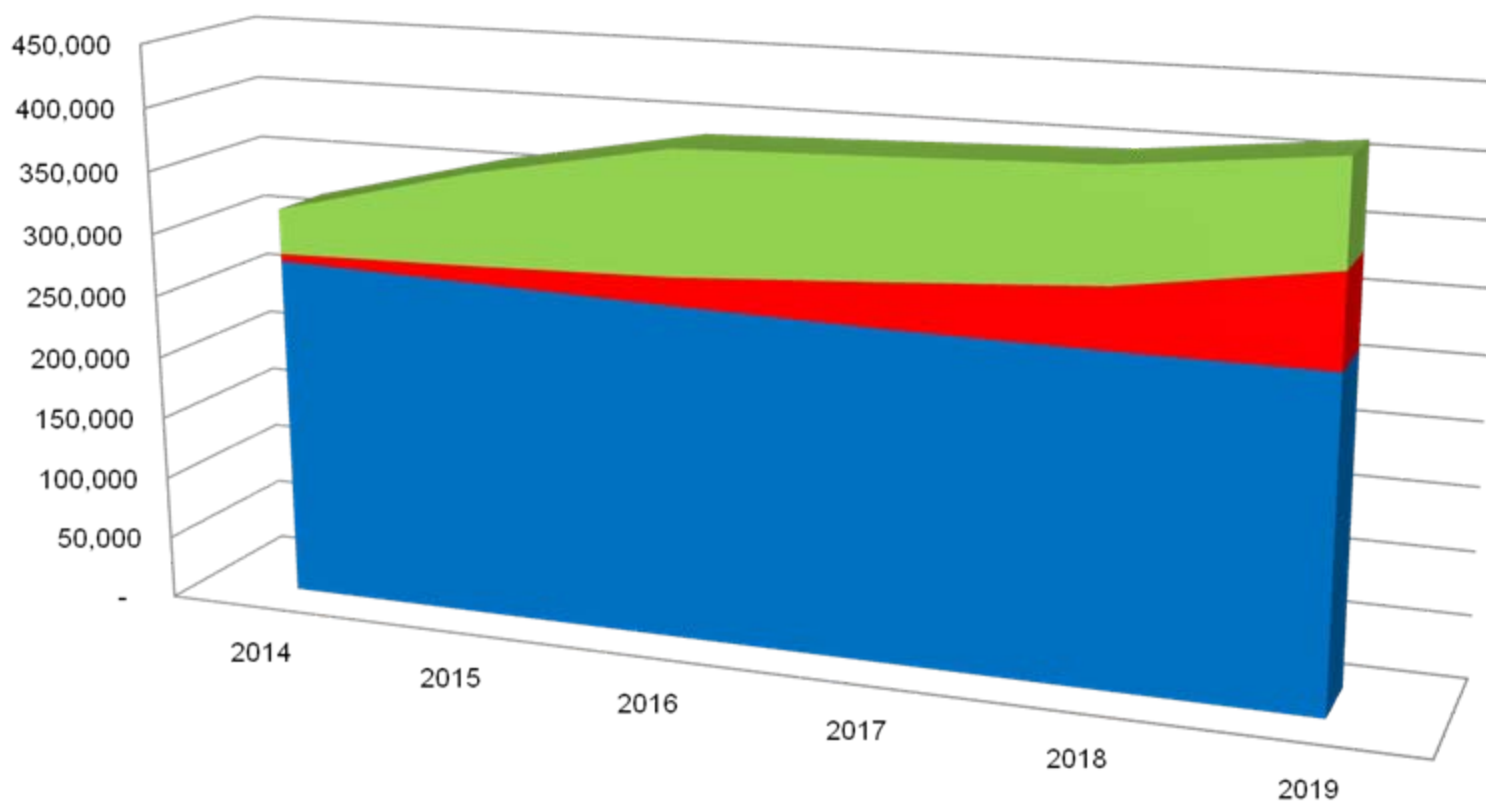


State Planning Efforts

- Health Reform Core Group
 - Includes: Insurance Division; DHHS;PEBP; Risk Management; and Attorney General's Office
 - Weekly meetings to discuss key issues and deadlines.
 - Work with national associations and federal partners – NGA, NAIC, NASMD, NASHP, CMS and HHS.
- DHHS Planning Teams established
- Establish Medicaid Health Reform Planning Group
 - ASO III and SSPS III
 - Contract Services
 - Request \$279,119 State General Fund



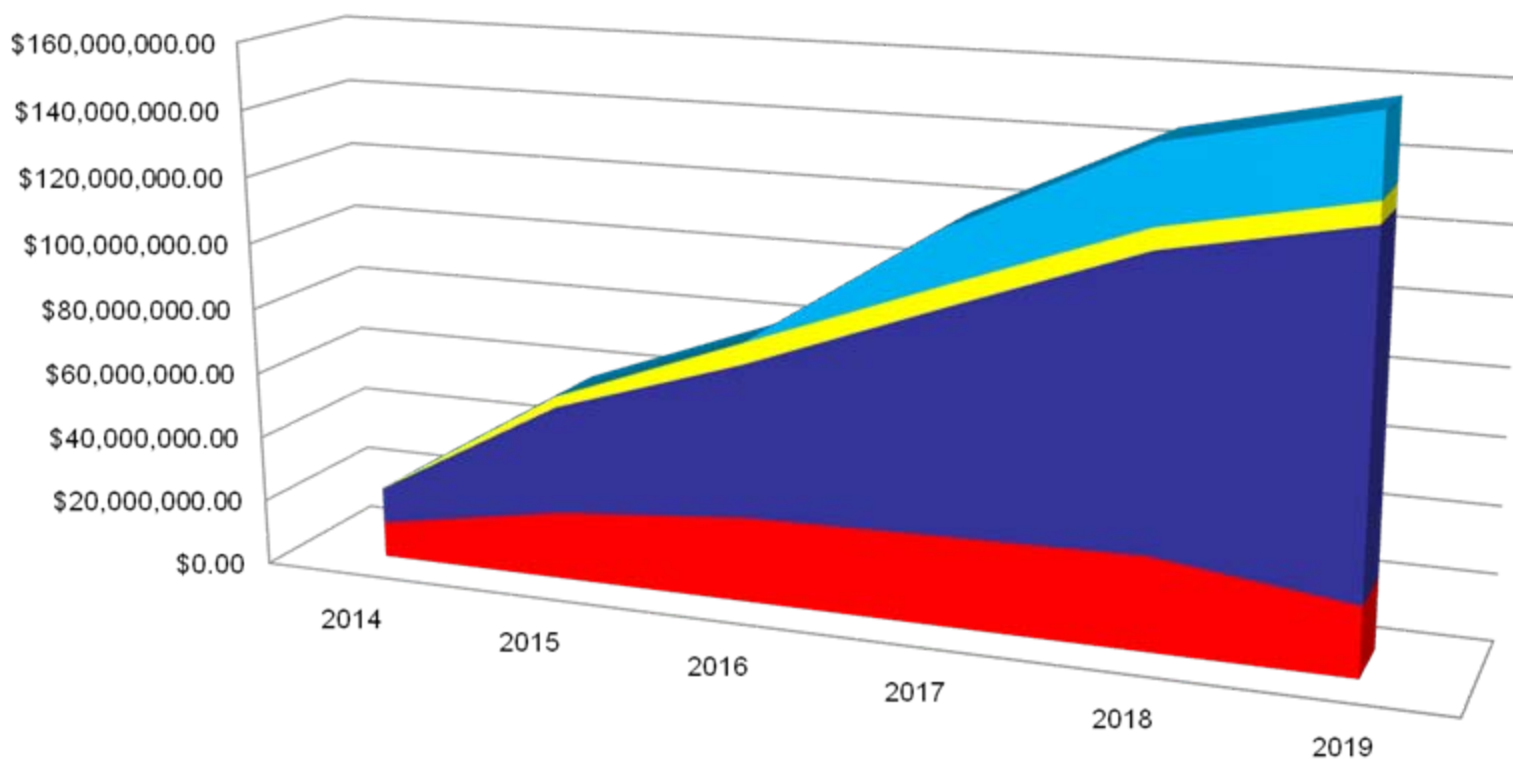
Health Care Reform – Nevada Medicaid Caseload Estimate 2014-2019



	2014	2015	2016	2017	2018	2019
New Eligibles	35,891	72,930	98,472	93,561	88,163	80,950
"Woodwork"	5,869	13,410	22,360	35,490	47,779	72,621
Normal Caseload	274,442	269,794	265,029	261,332	259,350	258,741



Health Care Reform – Nevada Medicaid SGF Incremental Cost Estimate 2014-2019



	2014	2015	2016	2017	2018	2019
■ New Eligibles Cost	-	-	-	16,190,164	23,122,041	23,950,232
■ Physician's Rate Increase		3,298,296	6,414,791	6,362,506	6,378,781	6,359,894
■ Woodwork Costs	11,019,800	32,868,938	46,247,963	66,605,345	86,645,134	105,206,785
■ Administrative Costs	10,782,442	20,644,186	25,814,711	27,112,099	28,238,271	21,076,097



Questions?

