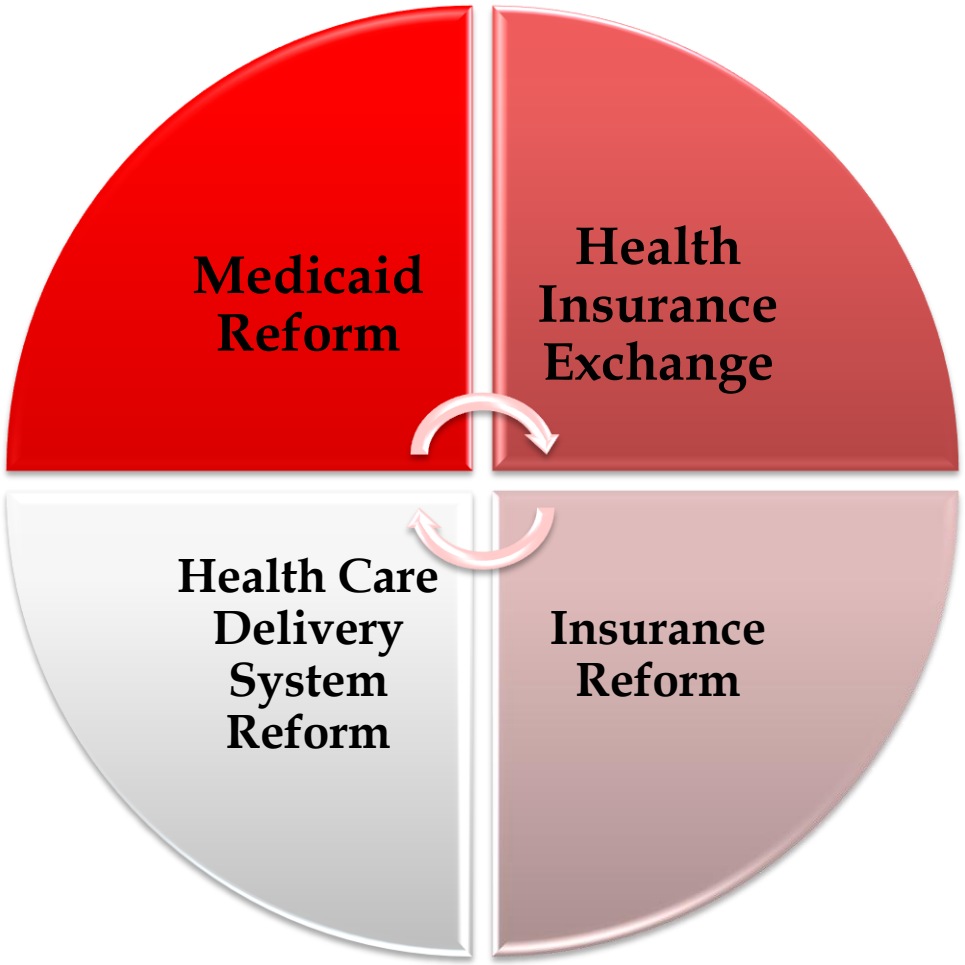
Patient Protection and Affordable Care Act

Planning & Implementation in New Mexico

Presentation to the
New Mexico Public Health Association
7th Annual Health Policy Legislative Forum

Katie Falls
Cabinet Secretary, Human Services Department
December 1, 2010

Patient Protection and Affordable Care Act (PPACA)



Medicaid Today in New Mexico

- Medicaid -553,698 enrolled and growing (July 2010 enrollment data)
  - Medical Assistance for Women, Children, and Families
  - Foster Care/Adoption
  - SSI/Institutional/Waiver/Working Disabled Individuals/Breast & Cervical Cancer
  - Emergency Medical Services for Aliens
  - Medicare Savings Program
  - Children's Health Insurance Program (CHIP)
  - *Insure New Mexico!*
    - State Coverage Insurance (SCI)
    - Premium Assistance for Kids (PAK)
    - Premium Assistance for Maternity (PAM)
  - Uninsured = 444,000 total uninsured in NM (82,000 children 0-18 and 362,000 adults 19+).

According to the U.S. House Committee on Commerce and Energy, in New Mexico, the health care reform bill will extend coverage to 273,000 New Mexicans

Expanding Medicaid is a Key Component of the PPACA

- Expands eligibility to 133% Federal Poverty Level (FPL) for all non-pregnant, non-disabled individuals between the ages of 19 and 64 years – "newly eligible"
  - 133% FPL - $14,404 for an individual and $29,327 for a family of four (2009)
  - Establishes a standard 5% income disregard (effective income threshold of 138% FPL)
  - Begins January 1, 2014
  - States have the option of expanding Medicaid coverage as early as April 2010 using regular Federal Medical Assistance Percentage (FMAP)
- By 2019, health care reform is expected to achieve coverage for 92 percent of the nation's residents
  - Increased Medicaid coverage of 16 million people
  - Reduction in the number of insured by 32 million people

PPACA Standardizes Most Medicaid Eligibility

- Eligibility for Medicaid will be based on a uniform definition of income.
- Modified Adjusted Gross Income (MAGI) used to determine eligibility
  - Based on Taxpayers IRS Returns
  - Eliminates all asset tests and other income disregards
  - Establishes uniformity for Medicaid eligibility across the states
  - Much more straightforward eligibility determination

Exemptions from use of MAGI

- Eligible w/o income determination (e.g. foster care, SSI)
- 65 and older
- Blind or disabled
- Medically needy
- Qualified Medicare Beneficiaries
- Eligible for Part D subsidies
- Eligible for Long Term Care services
- Eligible through an Express Lane option
- Enrollees who would lose coverage solely on the basis of applying MAGI
  - Grandfathered coverage until the later of 3/31/14 or next eligibility redetermination date

Federal Government will pay for much of the costs of Medicaid Expansion

- Federal government will assist states in costs of covering the newly eligible
- FMAP
  - 100% FMAP 2014 through 2016
  - 95% FMAP 2017
  - 94% in 2018
  - 93% in 2019
  - 90% in 2020 and beyond
  - States can expand Medicaid to individuals up to 133% FPL prior to 2014 at the State's regular FMAP rate
- Additional federal funding such as 100% CHIP match in 2016-2019 for kids over 185% FPL

Maintenance of Effort Requirements (MOE)

- Health reform includes a MOE requirement that requires states to maintain eligibility levels for adults through 2014 and children through 2019
- Must also maintain eligibility and enrollment procedures
- Violation of the MOE requirement would eliminate all federal funding for the state's Medicaid program
- New Mexico has established generous disregards as a way of increasing health care coverage for low-income individuals so maintenance of effort will have an impact on the state's budget

Basic Health Plan

- States have the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- If choosing this option, States will contract with at least one health plan to provide at least the essential health benefits (as defined by the federal government)
- Restrictions on how much individuals in the Basic Health Plan can pay in premiums and cost-sharing
- States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan.

Benefit Plan for Newly Eligible Adults

- PPACA requires that newly eligible adults be covered by a benchmark benefit plan. The federal government will define what constitutes benchmark coverage. States can choose to provide benefits beyond those identified as part of a benchmark plan.
- Currently, guidance from Health and Human Services (HHS) indicates that benchmark coverage is defined as follows, but it is expected that this definition will be broadened in the future:
  1. Federal Employees' Health Benefits Program (FEHBP) -equivalent coverage: the standard Blue Cross Blue Shield (BCBS) preferred provider option plan that is offered to federal employees, or
  2. State employee coverage, or
  3. The coverage plan offered by the Health Maintenance Organization (HMO) with the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by such a HMO in the state,
  4. HHS Secretary approved coverage: Any other health benefits coverage approved by the HHS Secretary upon application by the State.

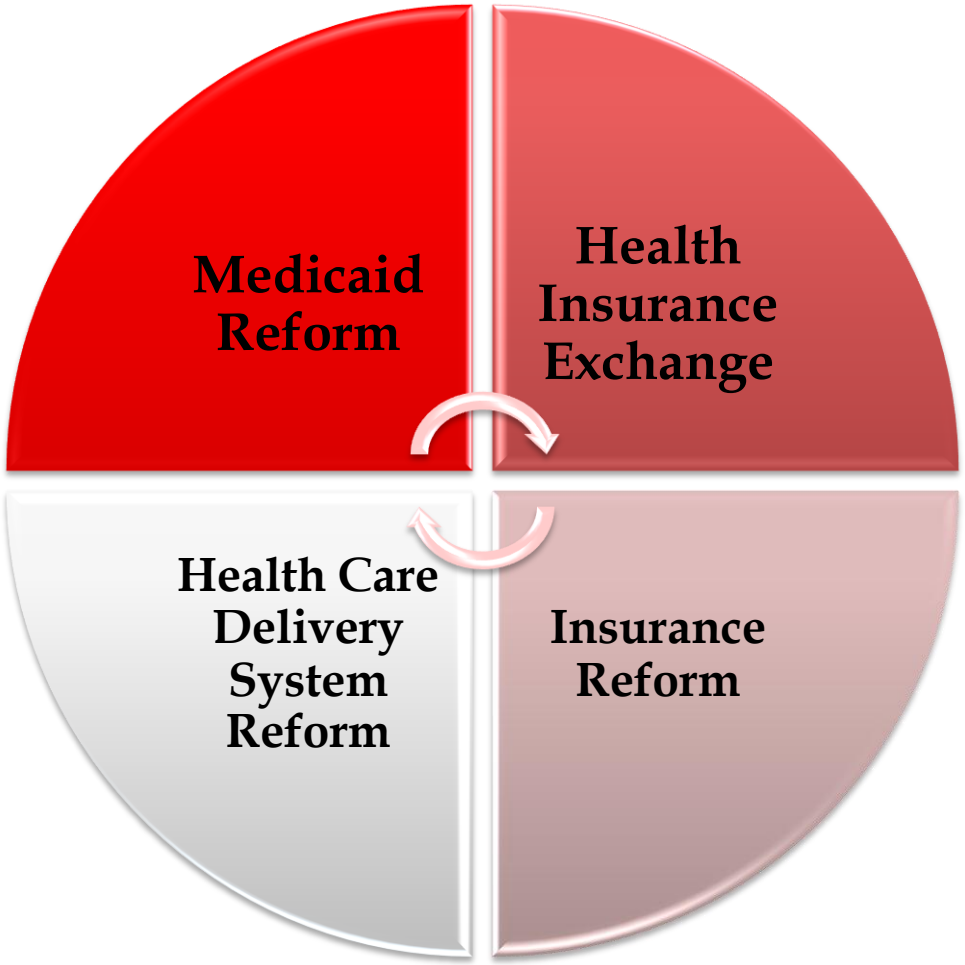
Other Medicaid Provisions in PPACA

- Creates an option to provide Medicaid coverage for family planning services through a State Plan Amendment (SPA), rather than a waiver, to certain low-income individuals up to the highest level of eligibility for pregnant women (effective immediately)
- Requires coverage of free-standing birth centers (effective immediately)
- Requires coverage of smoking cessation for pregnant women without cost-sharing (Oct. 1, 2010)
- Provides states with a 1% increase in the FMAP for certain preventive services and immunizations, if offered with no cost-sharing (2013)
- Increases Medicaid payments for primary care services provided by primary care providers to 100% of Medicare, and provides 100% FMAP for the increase (2013-2014)
- Increases drug rebates to states & Managed Care Organizations (MCOs) that provide drug coverage

Future Opportunities for Medicaid

- Medicaid Health Home for Enrollees with Chronic Conditions
  - Medicaid State Option to provide coordinated care to enrollees with chronic conditions (January 2011)
  - HHS to establish minimum standards for health homes
  - Planning grants to states to develop SPAs ($25 million maximum per state)
  - 90% FMAP for health home services during the first 8 fiscal quarters of SPA implementation
  - State contribution required for planning grants
- Medicaid Global Payments System Demonstration Project
  - Allows states to test paying a safety net hospital system or network using global capitated payment models (2010-2012)
- Medicaid Chronic Disease Incentive Payment Program
  - Grants to states to test approaches that may encourage behavior modification for healthy lifestyles among Medicaid enrollees with chronic diseases (2011-2016)
- Medicaid Integrated Care Hospital Demonstration Program
  - Demonstration program to allow states to use bundled payments to promote integration of care around hospitalization (2012-2016)

Patient Protection and Affordable Care Act (PPACA)



Goals of the Health Insurance Exchange

- Passage of the Patient Protection and Affordable Care Act mandates establishment of the Exchange
- The goals of the Exchange include:
  - Promoting competition;
  - Simplifying shopping for insurance;
  - Enforcing consumer protections;
  - Standardizing consumer information;
  - Centralizing enrollment;
  - Market Reform Policy—shift the market from **competition based on avoiding risk into competition based on price and quality;**

Currently only Massachusetts and Utah have state-based insurance exchanges

Key functions of the Exchange

- Maintain an on-line portal where consumers can obtain standardized information on insurance products
- Make comparison shopping for insurance easy (like Orbitz or Insurance.com)
- Centralize enrollment and screen individuals for Medicaid and link to Medicaid system for enrollment
- Provide customer service and call center
- Transition between commercial and government programs
- Determine eligibility for and administer subsidies
- Provide electronic calculator to determine the cost of coverage after tax and cost sharing
- Enroll individuals and businesses into plans through standardized electronic forms
- Maintain customer confidentiality
- Enforce consumer protections
- Promotes competition

Plans Sold on the Exchange

Qualified Plans & Essential Benefits

- New Individual Market and Small Group Plans must offer qualified plans and essential benefits as defined by HHS.
- Plans that offer essential benefits can offer varying levels of coverage known as Bronze, Silver, Gold and Platinum levels.
- A qualified health plan must:
  - Agree to offer at least one Silver and one Gold Plan
  - Agree to charge the same premium whether the plan is sold through the Exchange or outside of the Exchange
- Plans can offer to individuals under the age of 30 “catastrophic plans” that cover essential benefits but have very high deductibles.

Enrollment and eligibility issues in the Exchange

- PPACA requires simplified application and enrollment procedures
- Individuals purchasing through the Exchange will be
  1. Screened for Medicaid eligibility
  2. Complete a simple, streamlined application to determine eligibility for both Medicaid and Premium Tax Credits
  3. Able to apply and renew Medicaid coverage through a website with electronic signature
  4. Determined eligible for Medicaid and tax credits by either the Exchange or HSD or both
  5. Determined eligible for Medicaid and amount of Premium Subsidies by using IRS data

Sort plans by Benefits Package

You've Selected:

Benefits Package
- [x] YAP
- [x] Bronze
- [x] Silver
- [x] Gold

Narrow Your Plans by:

Monthly Cost
- Less than $300 (40)
- $301 - $400 (19)
- $401 - $500 (2)
- Greater than $500 (1)

Annual Deductible
- None (12)
- $250 - $500 (16)
- $500 - $1,000 (6)
- $1,000 - $2,000 (6)
- $2,000 - $4,000 (22)

Insurance Carrier
- Carrier A (11 Plans)
- Carrier B (7 Plans)
- Carrier C (11 Plans)
- Carrier D (11 Plans)
- Carrier E (11 Plans)

Show Plans. Then choose up to 3 to compare. Click **Continue** at bottom.

	$ Monthly Cost	Annual Deductible	Annual Out of Pocket Max.	Doctor Visit	Generic Rx	Emergency Room	Hospital Stay
YAP Low no Rx Benefits Package 5 plans available Show Plans | About YAP Low no Rx	as low as **$136**	STANDARD BENEFITS FOR ALL YAP LOW WITHOUT Rx PLANS					
		$2,000	$5,000	$25 copay	Not applicable	$250 copay	annual deductible, then 20% co-insurance
YAP Low with Rx Benefits Package 5 plans available Show Plans | About YAP Low with Rx	as low as **$163**	STANDARD BENEFITS FOR ALL YAP LOW WITH Rx PLANS					
		$2,000	$5,000	$25 copay	$15 copay	$250 copay	annual deductible, then 20% co-insurance
YAP High no Rx Benefits Package 5 plans available Show Plans | About YAP High no Rx	as low as **$168**	STANDARD BENEFITS FOR ALL YAP HIGH WITHOUT Rx PLANS					
		$250	$5,000	$25 copay	Not applicable	$250 copay	annual deductible, then 30% co-insurance
YAP High with Rx Benefits Package 5 plans available Show Plans | About YAP High with Rx	as low as **$191**	STANDARD BENEFITS FOR ALL YAP HIGH WITH Rx PLANS					
		$250	$5,000	$25 copay	$15 copay	$250 copay	annual deductible, then 30% co-insurance
Bronze Low Benefits Package 6 plans available Show Plans | About Bronze Low	as low as **$219**	STANDARD BENEFITS FOR ALL BRONZE LOW PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	annual deductible, then $25 copay	annual deductible, then $15 copay	annual deductible, then $100 copay	annual deductible, then 20% co-insurance
Bronze Medium Benefits Package 6 plans available Show Plans | About Bronze Medium	as low as **$224**	STANDARD BENEFITS FOR ALL BRONZE MEDIUM PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	$30 copay	$10 copay	annual deductible, then $150 copay	annual deductible, then $500 copay
Bronze High Benefits Package 6 plans available Show Plans | About Bronze High	as low as **$229**	STANDARD BENEFITS FOR ALL BRONZE HIGH PLANS					
		$250 (ind.) $500 (fam.)	$5,000 (ind.) $10,000 (fam.)	$25 copay	$15 copay	$150 copay	annual deductible, then 35% co-insurance
Silver Low Benefits Package 6 plans available Show Plans | About Silver Low	as low as **$272**	STANDARD BENEFITS FOR ALL SILVER LOW PLANS					
		$1,000 (ind.) $2,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$20 copay	$15 copay	annual deductible, then $100 copay	annual deductible, then no copay
Silver Medium Benefits Package 6 plans available Show Plans | About Silver Medium	as low as **$288**	STANDARD BENEFITS FOR ALL SILVER MEDIUM PLANS					
		$500 (ind.) $1,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$20 copay	$15 copay	$100 copay	annual deductible, then no copay
Silver High Benefits Package 6 plans available Show Plans | About Silver High	as low as **$311**	STANDARD BENEFITS FOR ALL SILVER HIGH PLANS					
		None	$2,000 (ind.) $4,000 (fam.)	$25 copay	$15 copay	$100 copay	$500 copay
Gold Benefits Package 6 plans available Show Plans | About Gold	as low as **$380**	STANDARD BENEFITS FOR ALL GOLD PLANS					
		None	None	$20 copay	$15 copay	$75 copay	$150 copay

Federal statutory requirements for the Exchange

- States must establish a Health Insurance Exchange by 2014 or allow the federal government to establish one for the state
  - State must be ready to stand-up an exchange in 2013
- There will be 2 types of Exchanges
  - American Health Benefit Exchange, or Health Exchange
  - Small Business Health Options Program, or SHOP Exchange
  - States can choose to establish a single Exchange serving both individuals and small businesses, or offer options through separate entities
- States can operate the Exchange directly, contract with a nonprofit entity, enter into agreements with other states to jointly provide an exchange, or allow the federal government to run the Exchange for the state
- States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area
- Plans must meet certain qualifications to be sold on the exchange
  - Those plans can sell policies at the same price outside of the Exchange

Qualified Plans

- New Individual Market and Small Group Plans must offer the following essential benefits.
  - Ambulatory patient services
  - Emergency Services
  - Hospitalization
  - Maternal and Newborn Care
  - Mental Health and substance abuse disorder services
  - Prescription Drugs
  - Rehabilitate and Habilitative services and devices
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

HHS will further define what must be covered within these categories, and the scope of coverage will be equal to the scope of benefits provided under typical employer plans.

Qualified Plans, continued

- Plans that offer essential benefits can offer varying levels of coverage, known as bronze, silver, gold and platinum levels. These levels are distinguished by the percentage of costs that will be paid for by the plan.
  - Bronze plan will be for 60 percent of the cost of covered benefits
  - Silver plan will pay for 70 percent
  - Gold plan will pay for 80 percent and,
  - Platinum plan will pay for 90 percent of the cost of covered benefits.
- In addition to the above, plans can offer to individuals under the age of 30 “catastrophic plans” that cover essential benefits but have very high deductibles - $5,950 for an individual in 2010, to be updated annually by premium inflation. Catastrophic plans are only required to cover three primary care visits before a person satisfies the deductible. The other plans noted above must cover all recommended preventive care before a person satisfies the deductible. The catastrophic plan may also be available for purchase by individuals exempt from the mandate because no affordable plan is available to them or because of a hardship.

Interface between Medicaid and the Exchange – Issues to Consider

- The Health Insurance Exchange and the Medicaid eligibility system must be able to interface with each other. States will be required to:
  - Create a single, streamlined application for persons applying (Medicaid, CHIP, subsidies, commercial)
  - Enable individuals to apply or renew Medicaid coverage through a web site with electronic signature; and
  - Apply for Medicaid, CHIP, or the Exchange through a state-run web site by Jan. 1, 2014
- Individuals will be screened for Medicaid before purchasing insurance through the Exchange
- Individuals will move back and forth between the Medicaid program and purchasing health care coverage through the Exchange
  - How do we facilitate people moving between the Exchange and the Medicaid program with no lapse in health care coverage?
  - How will the benefit package they receive in Medicaid compare to what they purchase on the Exchange?
  - How will the issue of co-pays be coordinated?
- **HCR will change both the way Medicaid eligibility is determined AND the way HSD does business**

Questions for the Exchange need to be addressed

Exchange

1. Does NM Want One or Two Exchanges?
2. Which Model below should we choose?

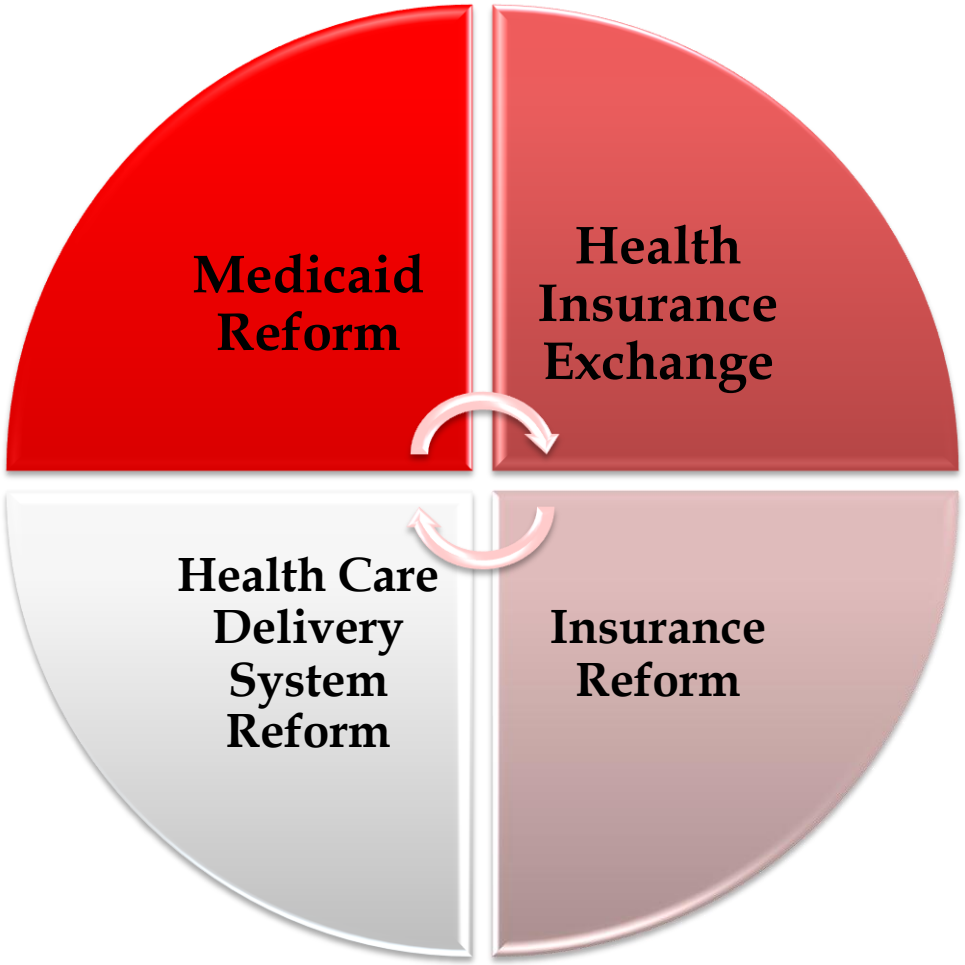
Exchange Operated by the Feds	Exchange operated by a non-profit agency	Exchange operated within a state agency	Join in a Regional Exchange with other States	Create regional exchanges within NM

3. What legislation is needed to create the Exchange?
4. Determine functions within the Exchange and relationship to Medicaid

Medicaid ⟷ Exchange

5. How will Medicaid eligibility be determined?
6. Who will determine eligibility for the tax subsidies?
7. How will consumer education and protection be coordinated?
8. How will individuals move between the Exchange and Medicaid without loss of health care coverage?
9. How will individuals maintain some consistency in health care benefits when they move back and forth from the Exchange to Medicaid?

Patient Protection and Affordable Care Act (PPACA)



More on Insurance Reform

- No lifetime limits on coverage
- No dropping of coverage except in cases of fraud
- Requires guarantee issue and renewability
  - Effective for children on 9/23/10
  - Effective for adults on 1/1/14
- Extends adult dependent coverage through age 26 (current NM law is 25) for all individual and group policies
- Allows variation in rates based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchange. Can no longer set rates based on health or gender.
- Mandates premium rate disclosure and transparency

Insurance Reform, continued

- At least 85% of the premiums in the large group market must be spend on direct services and 80% of the premiums in the small group and individual market (Medical Loss Ratio or MLR)
  - NM law requires health insurers to meet minimum MLR levels for the individual and group markets; with the amount to be spent on direct services in the group market set at 85%, and at 80% in the individual market.
- Requires coverage of certain preventive services
- Creates health insurance consumer office and ombudsman
- Eliminates cost sharing for Indians under 300% FPL
- Established a federal high risk pool - $37 million for New Mexico

Individual and Employer Responsibility

- **INDIVIDUAL RESPONSIBILITY (2014)**

Year	Penalty	Percent of Income*
2014	$95	1%
2015	$325	2%
2016	$695**	2.5%

* In lieu of the flat penalty if greater

** Indexed for inflation thereafter

- In 2014, businesses employing more than 50 employees will be required to offer affordable coverage to their employees or pay penalties. Provides tax credits for businesses.

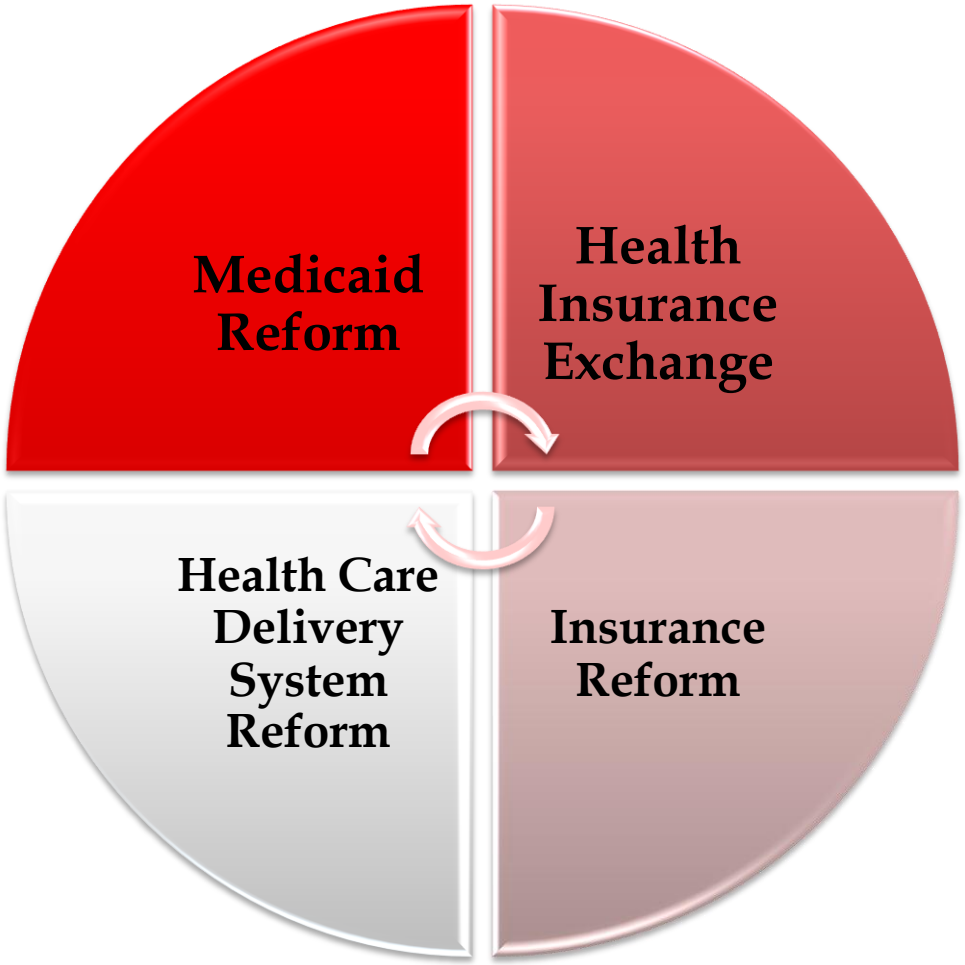
Exchange - Role in tracking compliance and penalties

- Individuals must acquire health care coverage or pay a tax penalty
- Some people are exempt from the individual mandate including:
  - Tribal members
  - Individuals with low incomes who are not required to file taxes
  - Members of certain religions that are exempted for religious reasons
  - Incarcerated individuals
  - Undocumented immigrants
  - Those without coverage for less than three months
  - People who do not have an affordable offer of coverage, either through the Exchange or through their employer

Consumer Education and Protection

- New Mexicans need a coordinated education and outreach plan
- Need to determine roles, partnerships and coordination across state agencies, the Exchange, community partners, providers and others
  - Need to think about creating new partnerships and developing web-based tools, such as community and technical colleges, kiosks in retail stores, etc.
- Simple procedures and educated consumers will help expand health care coverage in New Mexico

Patient Protection and Affordable Care Act (PPACA)



Health Care Delivery System Reform

Recognizes the importance of prevention services and the primary care delivery system and provides incentives to expand that network

- Grants for workforce development; expansion of scholarships and loans;
  - Example: Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)
- Increase Medicaid payments for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014.
- Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015.
- Includes several payment and health delivery system reforms, including a pilot program to bundle payments for post-acute care, value-based purchasing for providers, and the establishment of accountable care organizations.

Health Care Delivery System Reform

- Establishes the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities.
- Creates a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs.
- Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.

Health Care Delivery System Reform

- Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and immunization programs. Appropriate $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015.
- Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)

Coverage of Prevention Services

- Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective January 1, 2011)
- Increase federal funding for states that provide Medicaid coverage for certain preventative services including recommended immunizations
- Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011)

Coverage of Prevention Services

- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan.
- Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010)
- Require qualified health plans to provide at a minimum coverage without cost-sharing for certain preventive services, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)

Wellness & Nutrition Programs

- Provide grants for up to five years to small employers that establish wellness programs.
- Provide technical assistance and other resources to evaluate employer-based wellness programs.
- Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

PPACA and next steps—Overall implementation in New Mexico

- See Health Care Reform Leadership Team's Strategic Plan, ***Implementing Federal Health Care Reform—A Roadmap for New Mexico***, at

http://www.hsd.state.nm.us/pdf/hcr/NM%20Federal%20Health%20Care%20Reform%20Strategic%20Plan%207-12-10%20FINAL.pdf

- Further Information Available at

http://www.hsd.state.nm.us/includes/nhcrlao.htm

AND

http://www.hsd.state.nm.us/