# THE AFFORDABLE CARE ACT: WHAT IT MEANS FOR YOU AND YOUR FAMILIES

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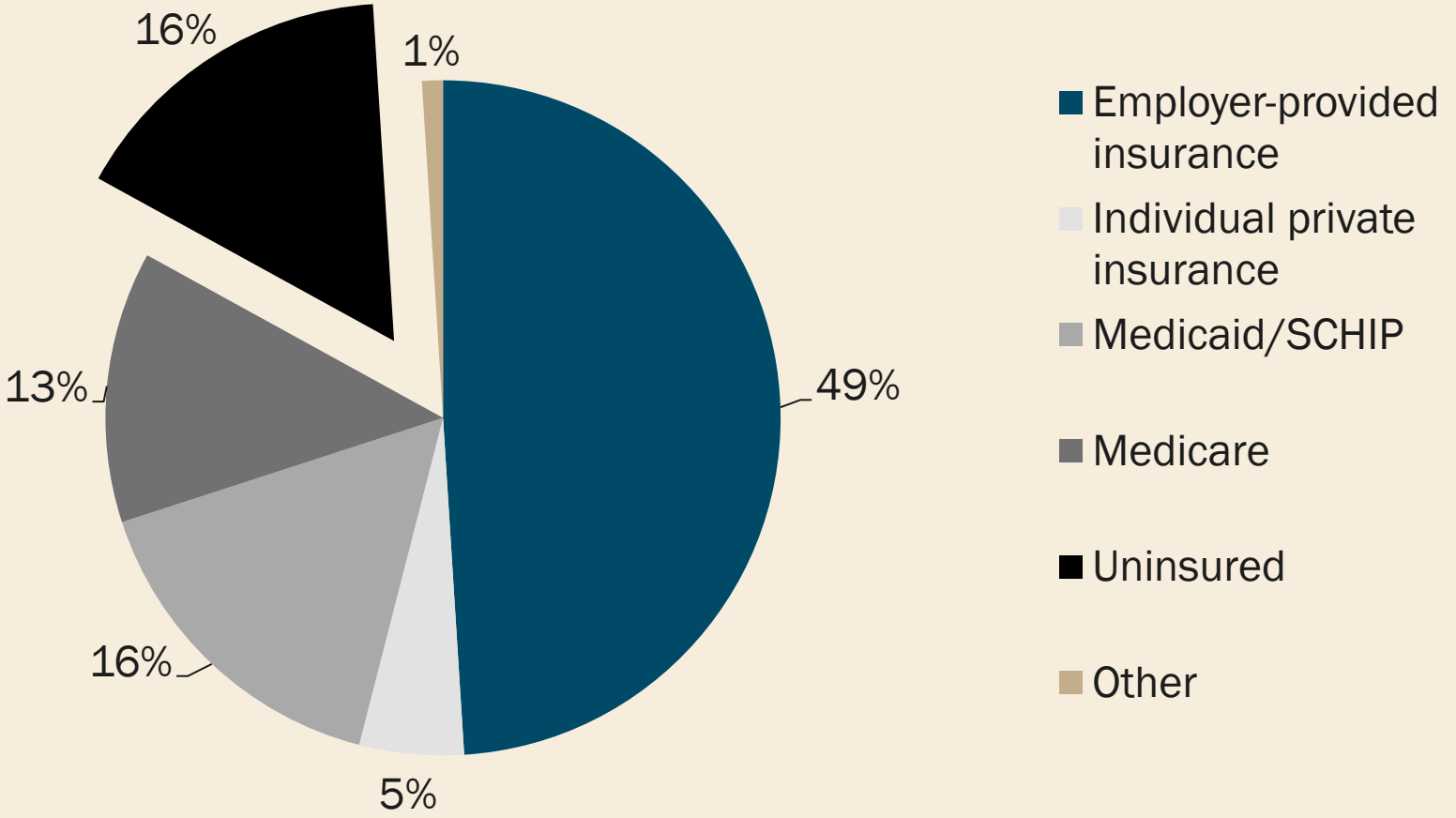
# OUR FRAGMENTED HEALTHCARE SYSTEM

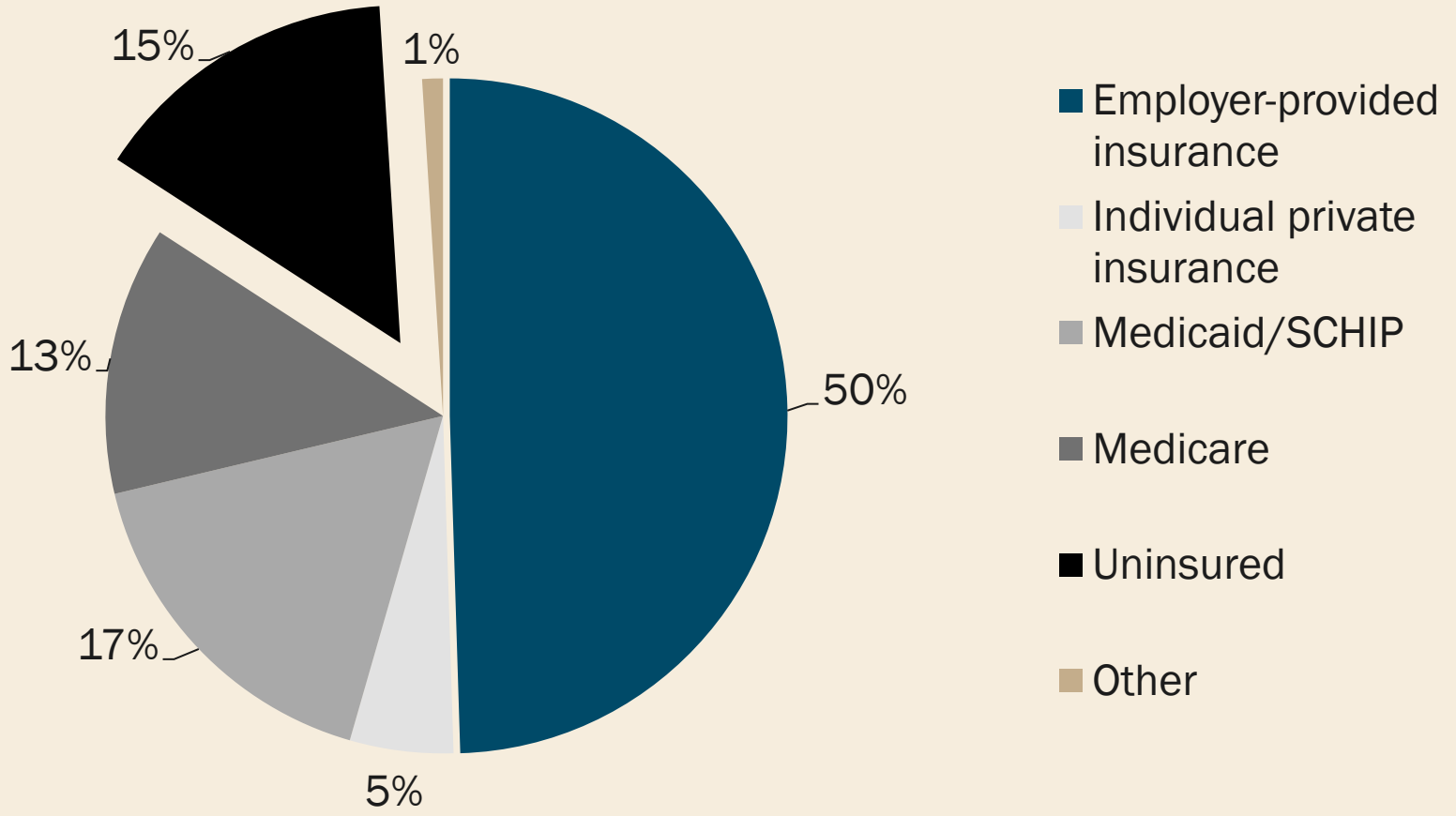
| Program | Who it covers | How it's funded |
|---|---|---|
| Medicare (1965)<br>(Part D: 2003) | People over 65 who are eligible for Social Security; people with permanent disabilities | Financed and controlled by federal government (12% of total federal spending) |
| Medicaid (1965) | Categories of people below certain income levels: children, pregnant women, elderly (for some services), disabled, adults on welfare | Costs and decisionmaking shared by federal and state governments (state share in Illinois: 50%) |
| State Children's Health Insurance Program (SCHIP) (1997) | Children in families not poor enough to qualify for Medicaid | Costs and decisionmaking shared by federal and state governments (state share in Illinois: 35%) |
| Employer-provided health insurance | Workers who receive it as a job benefit | Costs are shared by employers and employees |
| Private Health Insurance: Self-insured | Those who purchase it on the private, individual market | Costs are borne by individuals |

# Distribution of Coverage – National (2011)



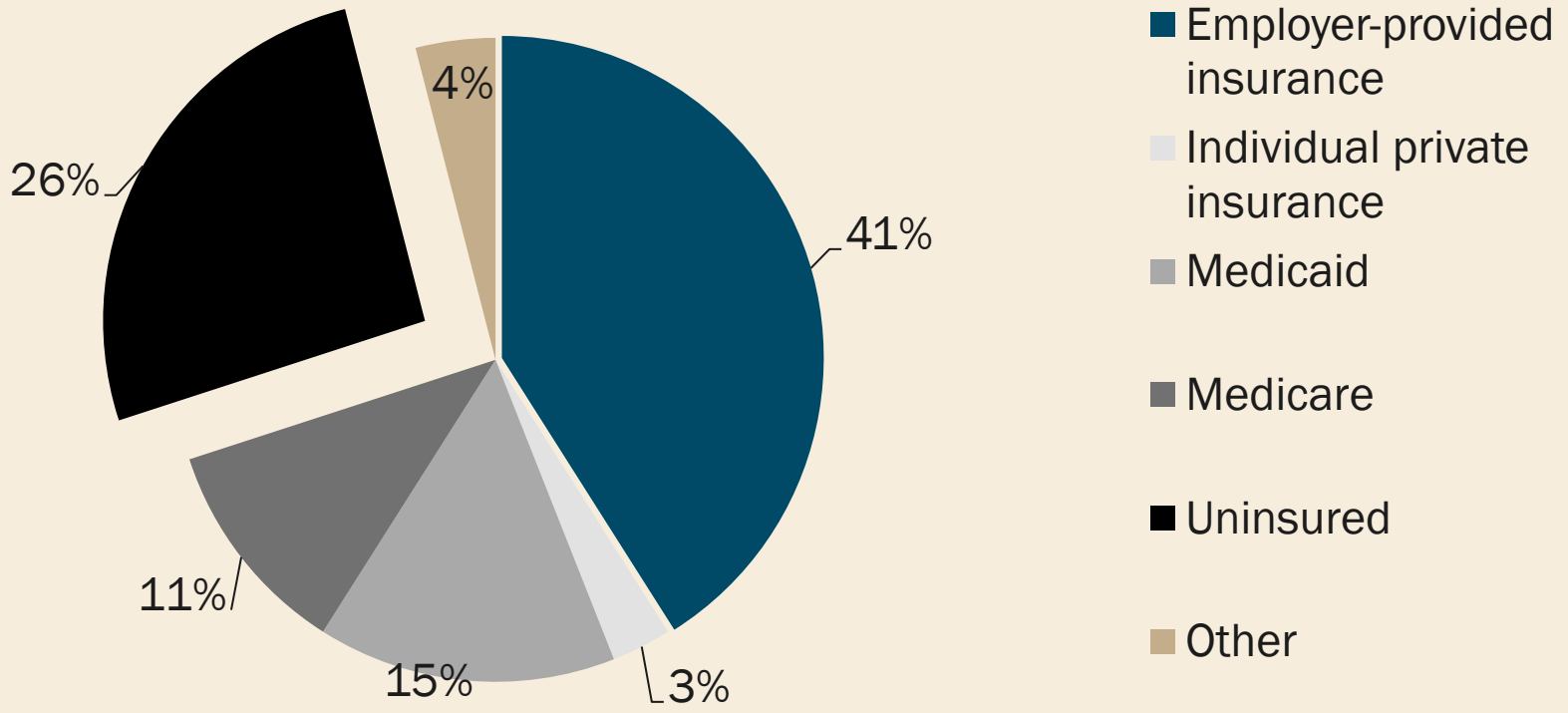

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Available at statehealthfacts.org.

# Distribution of Coverage – Illinois (2011)




Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Available at statehealthfacts.org.

# Distribution of Coverage – UIHHSS Primary Service Area (2012)




Source: 2012 PRC-MCHC Community Health Survey. Professional Research Consultants Inc. [Item 202]. Includes adults ages 18-64.

# THE AFFORDABLE CARE ACT

- The Patient Protection and Affordable Care Act (known as the ACA, or “Obamacare”) was passed in March 2010

- Some provisions are already in place, while others will be phased in over the next few years. The “big bang” will be January 2014.

# SUMMARY OF THE ACA

| MAIN GOAL | MAIN COMPONENTS |
|---|---|
| 1. Make insurance coverage accessible for the uninsured | • Medicaid expansion<br>• Creation of subsidized insurance marketplace |
| 2. Reduce “free riders” | • Mandate that all individuals have insurance coverage<br>• Penalize employers that don’t offer coverage |
| 3. Regulate/reform insurance plans | • No lifetime limits<br>• Offer preventive services at no cost<br>• No denials for pre-existing conditions |
| 4. Improve quality of care | • Grants and pilot projects related to integration, accountability, and care coordination |

# GOAL 1: EXPAND INSURANCE COVERAGE

## *MEDICAID EXPANSION (2014)*

- Expands eligibility to all people below 133% of poverty (~$30,600 for a family of 4)
- Federal government pays 100% of costs for newly eligible, decreasing to 90% by 2020
- Supreme Court Decision upheld the entire ACA, but ruled that the Medicaid expansion must be voluntary for states

# MEDICAID EXPANSION: ILLINOIS

- ~500,000 people will enroll in Medicaid in 2014: 350k newly eligible, 150k currently eligible but not enrolled
- IL state legislature will need to vote to authorize expansion. Passed Senate; now in House (House Bill 106/Senate Bill 26)
- Expect passage, though it will be a battle because of substantial added state costs and future uncertainties

# GOAL 1: EXPAND INSURANCE COVERAGE: *HEALTH INSURANCE MARKETPLACE (2014)*

- Online marketplace for health insurance (like Expedia or Travelocity)
- Subsidies for people below 400% of the Federal Poverty Level (income up to $92,200 for a family of 4)
- Health plans allowed to sell on the exchange have to meet state standards for benefit coverage, doctor availability, and quality

# MARKETPLACE: ILLINOIS

- State options: state-based, partnership, federal
- Illinois will have a partnership marketplace for plan year 2014
- State views partnership as a bridge to a state-based marketplace for 2015 (will require legislative action)

# GOAL 1: EXPAND INSURANCE COVERAGE: *OTHER PROVISIONS*

- Allows children under age 26 to be covered under their parents' plans

- Helps small businesses that choose to offer coverage by providing tax credits to firms with fewer than 25 full-time equivalents (FTEs) and average wages below $50k

# GOAL 1: EXPAND INSURANCE COVERAGE: *EXPECTED RESULTS*

- Starting in 2014, these combined provisions will extend health insurance coverage to an estimated 30 million Americans at a cost of approximately $940 billion.

- An estimated 23 million (~6%) U.S. residents will remain uninsured, including:
  - Undocumented immigrants
  - Young adults who choose not to purchase insurance (tax penalties less than the cost of coverage)
  - Inmates

# GOAL 2: ELIMINATE FREE RIDERS
## *INDIVIDUAL MANDATE (2014)*

- All individuals must prove enrollment in health insurance on tax return or receive a penalty (greater of $695 per person or 2.5% of taxable family income)

- Exceptions: religious objection, financial hardship

# GOAL 2: ELIMINATE FREE RIDERS
## *EMPLOYER PENALTIES (2014)*

- Larger employers that do not provide coverage will be assessed a penalty if any of their employees receives a subsidy when buying a plan in the marketplace
- Applies to all employers with 50 or more employees
- Intended to keep employers from dropping employees
- Employers argue that it discourages small business growth

# GOAL 3: REGULATE INSURANCE
## *INSURANCE MARKET REFORMS*

- Applies to all group health plans:
  - Bans lifetime and annual dollar limits
  - Cannot deny insurance because of pre-existing conditions
  - Bans recissions
  - Dependent coverage (children up to age 26)
  - Medical Loss Ratio (MLR) requirements—insurers are required to spend 80% of premiums on medical care
- Applies only to “new” health plans that didn’t exist in 2010:
  - No co-payment for preventive services (e.g., annual checkup, screenings, vaccinations, contraception)
  - Bans “rating” based on gender or pre-existing conditions, limits age rating

# GOAL 4: IMPROVE QUALITY

- Value-based programs that tie some provider reimbursement to quality outcomes (hospital readmissions, hospital acquired conditions, etc.)
- Establishes the Center for Medicare and Medicaid Innovation (CMMI), which creates pilot, demonstration, and grant programs to test integrated models of care, including:
  - Accountable care organizations (ACOs)
  - Medical homes
  - Bundling payments for acute care episodes
- Increases funding for community health centers and the National Health Service Corps to expand access to primary care services in rural and medically underserved areas and reduce health care disparities.

# THE AFFORDABLE CARE ACT: *OTHER PROVISIONS*

- Closing of Medicare donut hole
- Reimbursement cuts or fees to hospitals, medical device companies, drug companies
- Workforce development

# UNINTENDED CONSEQUENCES?

- Will employers drop workers from coverage?
  - Why? Health insurance too expensive, and penalties would be lower than costs of insurance.
    - It is always in the best interest of employers to have insured employees, but does the employer have to be the source of that coverage?
  - In 2012, a nationwide survey found that 6% of employers planned to drop coverage as a result of law
- Will companies raise prices on goods?
  - Five Guys example: ACA costs (e.g., increased labor costs) will require raising prices on burgers
  - May see some small price increases, though impact likely exaggerated

# UNINTENDED CONSEQUENCES?

- Will insurance costs increase?
  - Why? Insurance companies will be hit with new fees and mandates, which they may pass on to enrollees
    - 2013 report by Independent Society of Actuaries found that the ACA will lead to an average of a 32% increase in the costs to plans from 2014-2017
  - Insurance costs for enrollees WILL likely increase, though not just from the ACA. Costs were already trending upwards quickly due to increased use of medical care, improved technology, more expensive drugs, etc.
    - Dec 2012: United Health Care (largest in US) estimated that premiums would increase 116% in individual market; 25-50% in small group market; 20-25% in large group market, but each of these would have seen at least 12-15% rate increase in the absence of the ACA

# IMPACT OF ACA ON RETIREE HEALTH BENEFITS IN ILLINOIS

- It appears that Illinois state public health plans are "grandfathered," meaning they are currently only subject to certain requirements for health plans under the ACA.
  - State employee plans will NOT have to provide free preventive care
  - State employee plans WILL have to abide by restrictions against lifetime or dollar limits, put 80% of premiums toward medical services, and remove any exclusions related to pre-existing conditions. This could possibly lead to cost increases that would be passed on to retirees.
- Greater impact will be state laws (e.g., SB1313, which required that SERS and SURS retirees contribute to the costs of their premiums)

# WHAT'S NEXT?

- Spring 2013: Illinois legislature will vote on Medicaid expansion
- October 2013: Enrollment in marketplace begins
- January 2014: Newly eligible enrollees in marketplace and Medicaid can begin receiving coverage; individual mandate effective; employer penalties begin

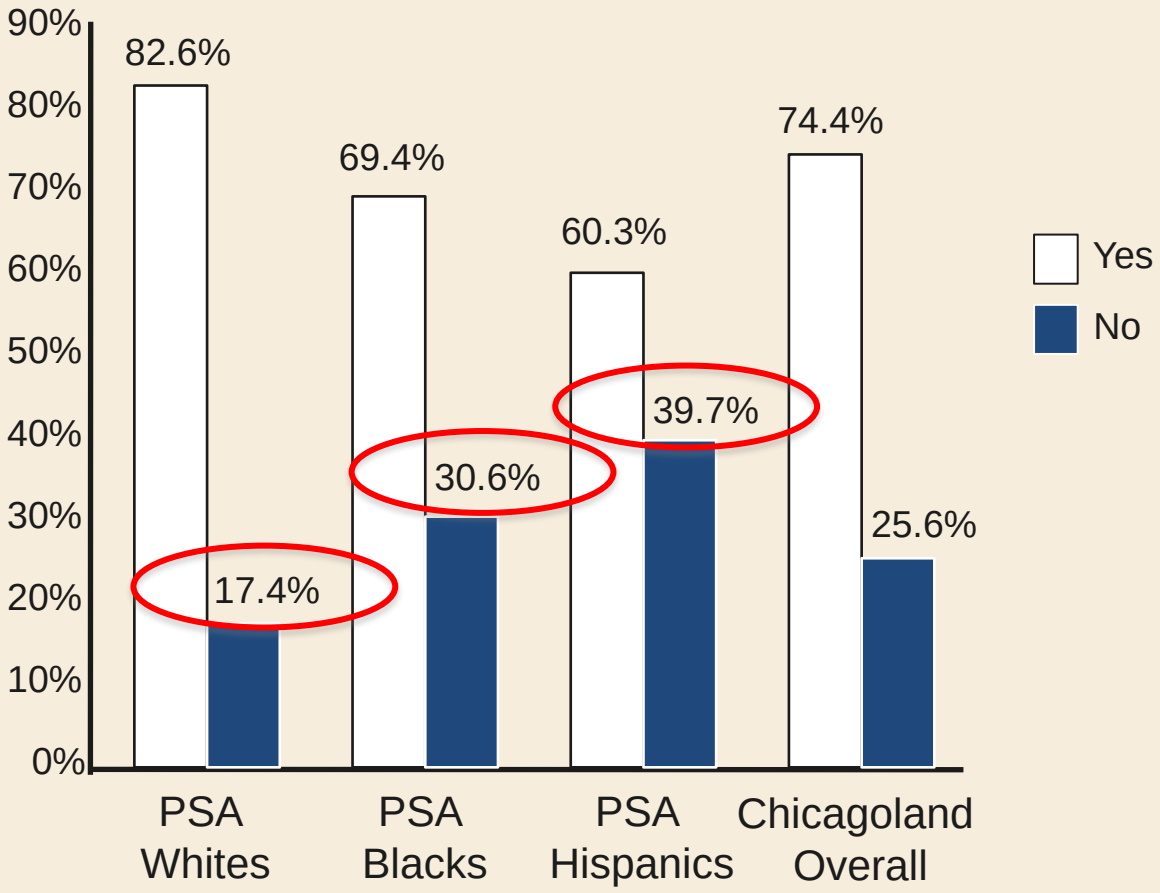
- For more information: www.healthcare.gov

# MARKETPLACE: EXAMPLE OF ACA SUBSIDY

- Person with income of $25,000 – approximately 166% of FPL
- Purchases Silver Plan
- Total cost: $6000 (includes premium and out-of-pocket maximums)
  - Premium: Total premium is 70% of cost, or $4200
    - ACA says maximum premium cost for this individual is $1250 per year, so federal government will pay almost $4000
  - Out-of-pocket cost: $1,800 per year
    - ACA says maximum cost sharing is $750, so federal government will pay over $1000
- Total maximum annual cost for person is $2,000
  Federal government subsidy is $4,000

# HEALTH DISPARITIES:

## RESIDENTS IN THE UNIVERSITY OF ILLINOIS HEALTH SYSTEM SERVICE AREA (2012): DO YOU HAVE A SOURCE OF ONGOING MEDICAL CARE?

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