

# Health Reform: An Overview and Implications for Michigan

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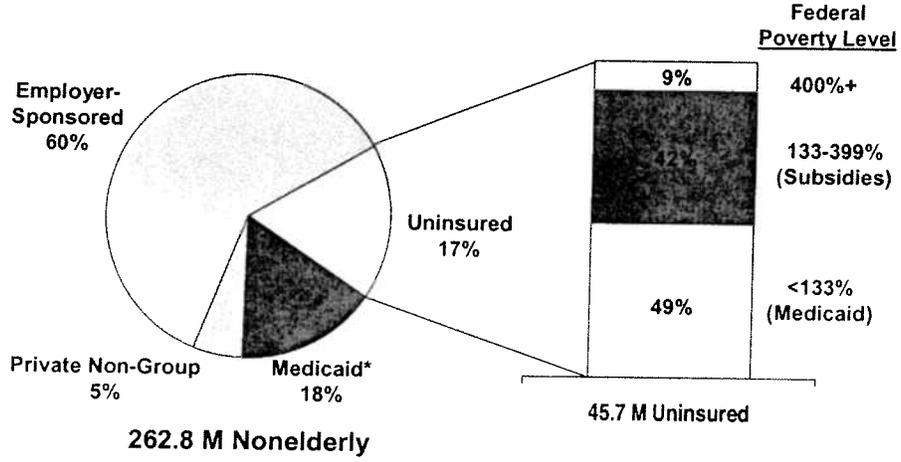
for

Health Policy Committee  
 Michigan House of Representatives  
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Figure 1

## The Uninsured -- As a Share of the Population and by Poverty Levels, 2008

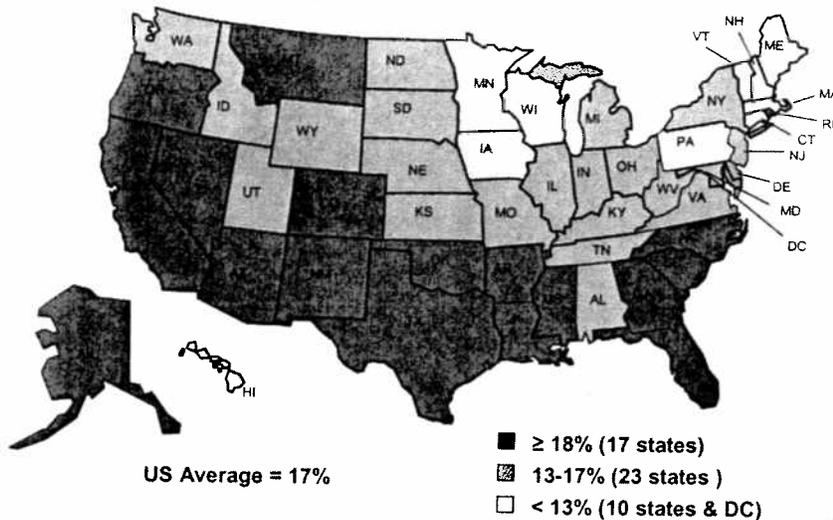


\* Medicaid also includes other public programs: CHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of four in 2008 was \$22,025.  
 SOURCE: KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS.



Figure 2

## Uninsured Rates Among the Nonelderly, by State, 2007-2008



SOURCE: Urban Institute and KCMU analysis of the March 2008 and 2009 Current Population Survey. Two-year pooled estimates for states and the US (2007-2008).



Figure 3

## Goals for Health Reform

- “Shared responsibility” in which employers, consumers, health plans, providers, and state and federal governments participate in and help pay for reform
- Make health insurance work for consumers
  - Insurance market reforms
  - Health insurance exchanges
- Make health insurance more affordable
  - Medicaid expansion
  - Federal premium and cost-sharing subsidies
- Reform delivery system to reduce health care cost growth and improve access to and quality of care



Figure 4

## Health Reform This Year

- Temporary high-risk pool
- Extend dependent coverage to age 26
- No lifetime limits or rescissions; restricted annual limits
- No pre-existing condition exclusions for children
- No cost-sharing for preventive services
- Review increases in health plan premiums
- Establish web portal to identify coverage options
- Tax credits for small businesses
- \$250 rebate for reaching Medicare Part D coverage gap
- Early retiree reinsurance program



Figure 5

## New Insurance Market Regulations

- Guarantee issue and renewability
  - Provide coverage to everyone regardless of health status
- Modified community rating
  - Prohibit insurers from charging people more based on gender, health status, or occupation
  - Variations in premiums based on age (3 to 1) and tobacco use (1.5 to 1) would be limited
- Benefit Standards
  - Provide uniform benefits packages within tiers of coverage
- These changes take effect in 2014



Figure 6

### Applicability of New Plan Requirements

	New Individual Plans	New Group Plans	Grandfathered Plans
No pre-existing condition exclusions (kids 2010, adults 2014)	Yes	Yes	Yes
No lifetime or annual limits	Yes	Yes	Yes (annual limits for group plans only)
Extend dependent coverage to 26	Yes	Yes	Yes
Coverage of preventive services	Yes	Yes	No
Minimum Loss Ratios/rebates	Yes	Yes	Yes (except self-insured plans)
Premium rating rules	Yes	Yes (except large group and self-insured plans)	No
90-day limit on waiting periods	Yes	Yes	Yes
Essential benefit package	Yes	Yes (except large group and self-insured plans)	No
Limits on cost-sharing	Yes	Yes (except self-insured plans)	No



Figure 7

### Temporary High-Risk Pool

- Individuals with pre-existing conditions who have not had creditable coverage for 6 months
- No pre-existing condition exclusions
- Benefits: Actuarial value of at least 65%
  - Secretary will determine minimum benefit package
- Premiums set as if for a standard population
  - Variations in premiums based on age (4 to 1) & tobacco use
  - Limit out-of-pocket costs
- \$5 billion in federal funding (\$141 million for Michigan)
- Implemented on June 21, 2010, terminates on January 1, 2014



Figure 8

## The Health Insurance Exchange

- States to create and administer exchanges (can form regional exchanges)
- Open to U.S. citizens and legal immigrants and small employers (<100 employees; states can expand to larger employers in 2017)
- Premium and cost-sharing subsidies available
- Four tiers of coverage: bronze, silver, gold, platinum plus catastrophic plan
- No public option—multi-state plans administered by the Office of Personnel Management and CO-OPs
- Standardized information to facilitate plan comparisons and uniform enrollment form



Figure 9

## Premium and Cost-Sharing Subsidies

- Premium tax credits for eligible individuals and families without access to other coverage and with incomes up to 400% FPL
  - Premium payments range from 2% of income up to 133% FPL to 9.5% of income 300-400% FPL
  - Those with access to employer coverage eligible for subsidies if employee share of premium exceeds 9.5% of income
- Cost sharing subsidies increase the actuarial value of the plan and reduce out-of-pocket costs
  - Available to those with incomes up to 250% FPL
- Applicants must verify income and citizenship status



Figure 10

## Family Premiums Under Health Reform

Family of 4 with Annual Plan Premium of \$11,321

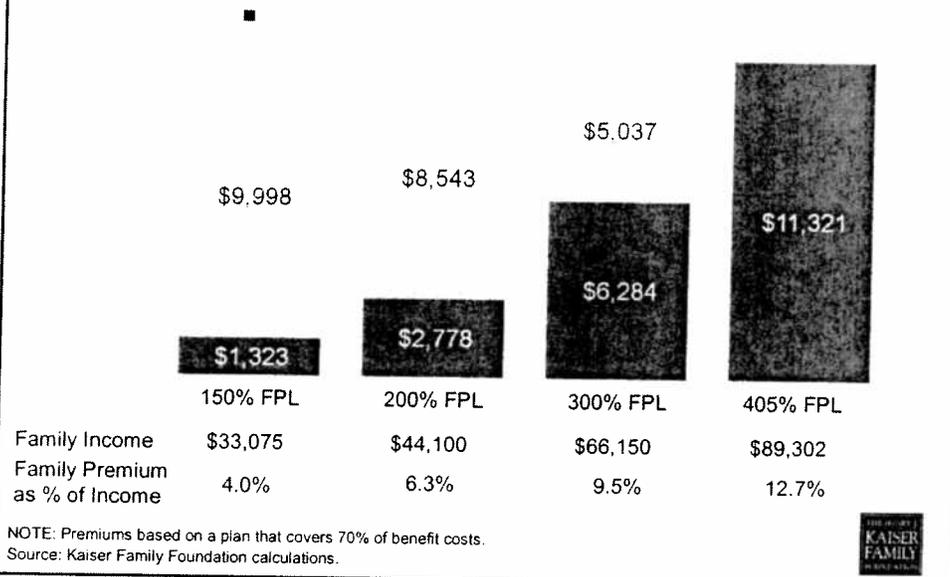


Figure 11

## Basic Health Plan Option

- State option to create separate health plan for those with incomes 133-200% FPL in lieu of coverage through exchange
  - Contract with one or more plans
  - Offer benefits at least as good as exchange and premiums and cost-sharing no higher than required in exchange
  - Encourage plan innovation and care coordination and incentives for preventive services
  - Coordinate enrollment with Medicaid/CHIP and Exchange
- State will receive 95% of subsidies that would have been paid to enrollees

Figure 12

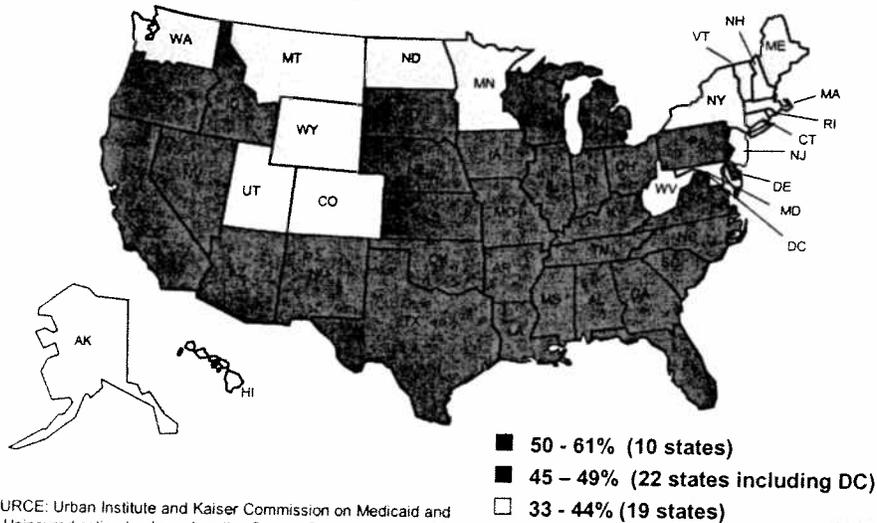
## Medicaid Expansion

- Expand Medicaid to all individuals with incomes up to 133% FPL in 2014
  - Maintain Medicaid eligibility until 2014
  - Provide states option to expand Medicaid to childless adults at regular FMAP starting April 1, 2010
- Enhanced federal funding for new eligibles
  - Full federal funding for 2014-2016; phases down to 90% by 2020
- Fund CHIP program until 2015; maintain Medicaid/CHIP coverage for children through 2019
- Simplify enrollment processes and coordinate eligibility determinations with Exchanges



Figure 13

## Share of the Nonelderly Uninsured At or Below 133% FPL by State, 2007-2008



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements).



Figure 14

## Improving Access and Quality in Medicaid

- Increase Medicaid payments for primary care (fully federally funded 2013-2014)
- Promote coordinated primary care for high need Medicaid beneficiaries
- Increase FMAP for preventive services rated A or B by USPSTF if states cover with no cost sharing
- Create the Center for Medicare and Medicaid Innovation to test new payment and delivery system models
- Pay bundled payments for episodes of care
- Provide incentives to shift to home and community-based long-term care services



Figure 15

## Individual Mandate

- Individuals required to have health coverage that meets minimum coverage standards beginning 2014
- Enforced through tax system
  - Penalty greater of \$695 (up to \$2,085 for a family) or 2.5% of income, capped at the lowest cost Bronze plan in the area
  - Will have to report insurance coverage on taxes
- Exemptions:
  - Undocumented immigrants; incarcerated individuals; those for whom lowest cost plan exceeds 8% of income; those with income below the tax filing threshold; American Indians; religious objections; and financial hardship



Figure 16

## Employer Requirements and Incentives

- Requirements for larger employers (50+ employees)
  - If don't provide coverage or provide coverage that is unaffordable and at least one employee receives a premiums tax credit, pay penalty of up to \$2,000 per full-time employee (excluding first 30 employees)
  - Employers offering coverage can avoid by paying "free choice voucher"
  - Employers with more than 200 employees must automatically enroll workers in health plan
- Provisions for small employers
  - Small employers with fewer than 50 workers exempt from fees
  - Tax credits for small businesses offering health benefits
    - Phase I: 2010-2013 up to 35% of premium costs
    - Phase II: 2014+ up to 50% of premium costs if purchased through the Exchange; available for two years



Figure 17

## New Opportunities for States

- Prevention
  - Education and outreach, oral health, community health, wellness
- Workforce development
  - Focus on primary care, increasing capacity in rural and underserved areas
- Emergency and trauma care
  - Regional emergency care systems, enhancing trauma care in underserved areas
- Long-term care
  - CLASS Act, options to promote home and community-based services in Medicaid



Figure 18

## Implementation: What Will It Take?

- Early strategic planning
  - Identification of goals and priorities
  - Operational plan including authorizing legislation and appropriations
- Investments in administrative capacity and infrastructure
- Coordination across Medicaid and private insurance
  - Integrated eligibility and enrollment systems
  - Health care service delivery
- Expansion of provider and health system capacity
- Federal assistance and leadership with funding, systems development, regulatory and other guidance
- Engagement from the public and other stakeholders



Figure 19

## Early Federal Guidance

- HHS interim final rules and letters to states
  - Extending dependent coverage to age 26
  - Web portal requirements
  - Early retiree reinsurance program
  - Temporary high risk pool
- CMS letters to State Medicaid Directors
  - Early option to receive FFP for covering low-income adults beginning April 1, 2010
  - Medicaid Drug Rebate changes
- IRS guidance
  - Small business tax credits



Figure 20

## Looking Ahead

- Health reform, if done right, provides opportunities to improve our health care system
  - Reduce the number of people who are uninsured
  - Make the health insurance system work better for all consumers
  - Transform delivery and payment systems to get better value for our health care dollars
  - Reorient health care to focus on prevention and primary care
- States will play pivotal role in implementation
- Preparing for 2014 begins now



Figure 21

For more information on health reform  
and additional resources for states:

[www.healthreform.kff.org](http://www.healthreform.kff.org)

[www.statehealthfacts.org](http://www.statehealthfacts.org)

