OKLAHOMA STATE DEPARTMENT OF HEALTH · SEPTEMBER 2011

Summary of Patient Protection and Affordable Care Act (PPACA)

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PPACA Overall Approach to Expanding Access to Coverage

- Require most U.S. citizens and legal residents to have health insurance.
- Creates Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost sharing credits available to individuals & families with income between 133 - 400% of the federal poverty level (FPL). (The poverty level is $22,350 for a family of four in 2011)
- Create separate Exchanges through which small businesses can purchase coverage.
- Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers.
- Impose new regulations on health plans in the Exchanges and in the individual and small group markets.
- Expand Medicaid to 133% of the federal poverty level.

PPACA Individual Mandate to Have Coverage

- Require U.S. citizens and legal residents to have qualifying health coverage. Penalties will be phased in beginning in 2014 at $95.00 or 1% of taxable income. By 2016, those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income.

- Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants & incarcerated individuals.

- Assess a fee to employers with 50 or more full-time employees have at least one full-time employee who receives a premium tax credit. The penalty varies based on whether the employer offered health coverage. (Effective January 1, 2014)

- Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

PPACA Expansion of Public Programs

- Expand Medicaid to all non-Medicare eligible individuals under age 65 with incomes up to 133% FPL based on modified adjusted gross income (MAGI).

- All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.

- To finance the coverage for the newly eligible adults, states will receive 100% federal funding for 2014 through 2016, subsequent years will phase in state subsidy until federal financing decreases to 90% for 2020 and subsequent years.

- States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular Federal Medicaid Assistance Program (FMAP) until 2014.

- Increase Medicaid payments in fee-for-service and managed care 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. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014)

PPACA Expansion of Public Programs

Treatment of Children's Health Insurance Program (CHIP)

- Require states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law.

- Provide states with the option to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met.

- Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%.

- CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.

PPACA Premium & Cost Sharing Subsidies to Individuals

- Provides Premium Tax Credits and Subsidies Through Exchange. (Effective 1/2014)

Eligibility

- Limits availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits.

- Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.5% of income.

Premium Tax Credits

- Provide refundable and advanceable premium credits to eligible individuals and families with incomes between 133% - 400% FPL to purchase insurance through the Exchanges.

- The premium credits will be set on a sliding scale such that the premium contributions are limited from 2% of income (for 133% FPL) to 9.5% of income (300% - 400% FPL).

PPACA Premium & Cost Sharing Subsidies to Individuals

Cost Sharing Subsidies

Provide cost-sharing subsidies to eligible individuals and families. The cost sharing credits reduce the cost sharing amounts and annual cost-sharing limits based on a sliding scale up to 400% FPL.

Verification

Require verification of both income and citizenship status in determining eligibility for the federal premium credits.

Subsidies and abortion coverage

Ensure that federal premium credits or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or cases of rape or incest (Hyde amendment).

PPACA Premium to Employers

Small Business Tax Credit

Provide a tax credit to small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees.

1. Phase I: For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.

2. Phase II: For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years.

Reinsurance Program

Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000.

PPACA Tax Changes

- Impose a tax on individuals without qualifying coverage beginning in 2014.
- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA. (Effective January 1, 2011)
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20%. (Effective January 1, 2011)
- Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment. (Effective January 1, 2013)
- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes. (Effective January 1, 2013)
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% for higher-income taxpayers. (Effective January 1, 2013)
- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. (Effective January 1, 2018)

PPACA Tax Changes

- Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. (Effective January 1, 2013)
- Impose new annual fees on the pharmaceutical manufacturing sector. (Beginning 2012)
- Impose an annual fee on the health insurance sector. Discounts apply for non-profit insurers. (Effective January 1, 2014)
- Impose an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012)
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009)
- Impose a tax of 10% on the amount paid for indoor tanning services. (Effective July 1, 2010)
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. (Effective January 1, 2010)
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance. (Effective upon enactment)

Health Insurance Exchange

Creation & Structure of Health Exchange

- Create state-based Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. (State option, 1-50 employees through January 1, 2016)
- Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017.
- 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. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)

Eligibility to purchase in the exchanges

Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.

Public Plan Option

Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange.

Health Insurance Exchange

Consumer Operated & Oriented Plan (CO-OP)

Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government. (Appropriate $4.8 billion to establish CO-OPs by July 1, 2013)

Benefit Tiers

- Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets:
    1. *Bronze* plan represents minimum creditable coverage and provides the essential health benefits, covers 60% of the benefit costs of the plan.
    2. *Silver* plan provides the essential health benefits, covers 70% of the benefit costs of the plan.
    3. *Gold* plan provides the essential health benefits, covers 80% of the benefit costs of the plan.
    4. *Platinum* plan provides the essential health benefits, covers 90% of the benefit costs of the plan.
    5. *Catastrophic* plan available to those up to age 30 or those who are exempt from the mandate to purchase coverage. This plan is only available in the individual market.

- Reduce the out-of-pocket limits for those with incomes up to 400% FPL.

Health Insurance Exchange

Insurance Market and Rating Rules

- Require guarantee issue and renewability and allow rating variation based only on the following:
  - age (limited to 3 to 1 ratio)
  - premium rating area
  - family composition
  - tobacco use (limited to 1.5 to 1 ratio)
- Require risk adjustment (effective January 1, 2014)

Qualifications of Participating Health Plans

Require qualified health plans participating in the exchange to:

- Meet marketing requirements
- Have adequate provider networks
- Contract with essential community providers
- Contract with navigators to conduct outreach and enrollment assistance
- Be accredited with respect to performance on quality measures
- Use a uniform enrollment form and standard format to present plan information
- Require qualified health plans to report information on claims payment policies, enrollment, number of claims denied, cost-sharing, & out-of-network policies in plain language.

Health Insurance Exchange

Requirements of the Exchanges

- Maintain a call center for customer service.
- Establish procedures for enrolling individuals and businesses.
- Determine eligibility for tax credits.
- States develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail, or by phone.
- Permit exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the exchanges.
- Require exchanges to submit financial reports to the federal Secretary of Health and Human Services (HHS).

Basic Health Plan

Permit states 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.

Effective Dates

Provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.

PPACA Benefit Design

Essential Benefits Package

- Create an essential health benefits package that:
  - Provides a comprehensive set of services,
  - Covers at least 60% of the actuarial value of the covered benefits,
  - Limits annual cost-sharing to the current law HSA limits,
  - Is not more extensive than the typical employer plan, and
  - Requires the federal Secretary of HHS to define and annually update the benefit package through a transparent and public process.

- Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, to offer at least the essential health benefits package. (Exception - grandfathered individual and employer-sponsored plans)

Abortion Coverage

Prohibit abortion coverage from being required as part of the essential health benefits package.

PPACA Changes to Private Insurance

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions who have been uninsured for at least 6 months.
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.
- Establish a process to review increases in health plan premiums and require plans to justify increases.
- Adopt standards for financial and administrative transactions to promote administrative simplification.
- Provide dependent coverage for children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud.
- Prohibit pre-existing condition exclusions for children. (Effective within 6 months of enactment)
- Impose same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market. (Effective January 1, 2014)

PPACA State Role

State Role

- Create an Insurance Exchange for individuals and small businesses or federal government will create an Exchange.
- Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014, coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program.
- Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational.
- Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets.
- Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges.
- Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents. State health coverage must be at least as comprehensive as the coverage required under an Exchange plan and must not increase the federal budget deficit.

PPACA Cost Containment

Administrative Simplification

Adoption of single set of rules for health insurance administration.

Medicare

Restructure Medicare Advantage payments, freeze or reduce premiums & subsidies to certain individuals, withhold percentage of payment based on hospital readmission and healthcare acquired conditions.

Medicaid

Increase Medicaid drug rebates, prohibit payments for healthcare acquired conditions.

Prescription Drugs

FDA to approve generic for biologics.

Waste, Fraud, and Abuse

Enhanced oversight, capture and share data, increase penalties.

PPACA Improving Quality/Health System Performance

Primary Care

- Increase Medicaid payments in fee-for-service and managed care 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. States will receive 100% federal financing for the increased payment rates.
- Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015.

Develop Strategies, Grants, Plans & Research

- Comparative Effectiveness Research
- Medical Malpractice
- Bundled Payments
- Value-Based Purchasing
- Home Based Primary Care
- Dual Eligibles
- National Quality Strategy
- Financial Disclosure
- Disparities

PPACA Prevention/Wellness

Strategies, Funding, Grants, & Research

- Develop National Prevention Strategy.
- Establish a Prevention & Wellness Fund.
- Establish a grant program to support the delivery of evidence-based and community-based prevention especially in rural and frontier areas.
- 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.
- Provide grants for up to five years to small employers that establish wellness programs.
- Permit employers to offer employee incentives for participating in a wellness program and meeting certain health-related standards.

Nutritional Information

Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

PPACA Prevention/Wellness

Coverage of Preventive Services

- Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests.

- Provide a one percentage point increase in the FMAP to states that offer Medicaid coverage of recommended immunizations, preventive services, and removes cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force.

- Authorize Medicare coverage of personalized prevention plan services, including a comprehensive health risk assessment, annually.

- Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.

- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.

PPACA Long Term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out.
- Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September of 2016.
- Provide states with new options for offering home and community-based services through a Medicaid state plan.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program.
- Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services.
- Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures.
- Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities.

PPACA Other Investments

Medicare

Medicare Part D coverage gap, bonus payments for primary care & surgeons in Health Professional Shortage Areas (HPSA), payments to hospitals in counties with low Medicare spending .

Workforce

Increase Graduate Medical Education (GME) by redistributing GME slots, health and public health training & loan repayment, support nurse training programs .

Community Health Centers and School-Based Health Centers

Funding for Community Health Centers & National Health Services Corps.

Trauma Care

Strengthen emergency department & trauma center capacity.

Public Health and Disaster Preparedness

Establish commissioned Regular Corps and Ready Reserve Corps.

Requirements for Non-Profit Hospitals

Impose requirement to conduct community needs assessment every three years and impose a penalty of $50,000 per year for failure to comply.

American Indians

Reauthorize and Amend the Indian Health Care Improvement Act.

Cost Associated with Implementation

Cost Implications Associated with Implementation of PPACA

Congressional Budget Office Estimates

- 32 million (of 55 million uninsured) will gain insurance
- 50% through Medicaid expansion
- 50% through Insurance Exchange
- Cost of implementation $938 Billion over 10 years
- Costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which will raise $32 billion over ten years
- Net federal deficit reduction $143 Billion through 2019

Cost Implications Associated with Implementation of PPACA

Medicaid Expansion

- Costs associated with expansion of newly eligible persons at enhanced federal match rates.
- Costs associated with persons already eligible seeking Medicaid due to mandate and current state match requirements.
- Costs associated with upgrading Medicaid systems and integrating the Health Insurance Exchange (whether or not the State builds an Insurance Exchange).
- Current estimates on Oklahoma's increased cost for Medicaid vary but majority of increase is intended to be borne by federal government.
- Potential for increased administrative cost/operational cost due to expansion & pending federal regulations.

Cost Implications Associated with Implementation of PPACA

Insurance Exchange

- Cost **?**
- Dependencies (whether or not Oklahoma chooses to run an Insurance Exchange)
  - Policy decisions
  - How integrated will the system be with Medicaid?
  - What functionality will the federal government provide or require of states?
  - Will the Exchange be able to leverage existing infrastructure?
  - Vendor availability
  - Timing

Cost Implications Associated with Implementation of PPACA

Cost Avoidance/Incentives

- Provides more consistency in the application and administration of Medicaid & insurance.
- Potential to avoid cost due to uncompensated care.
- Focus on Preventive Services.
  - Reduce cost through early detection and treatment
  - Promote evidence based practices in clinical settings
  - Increase FMAP 1% on Medicaid for recommended clinical preventive services & immunizations

Implications for the State Concerning Public Health

Public Health Infrastructure
Clinical Services

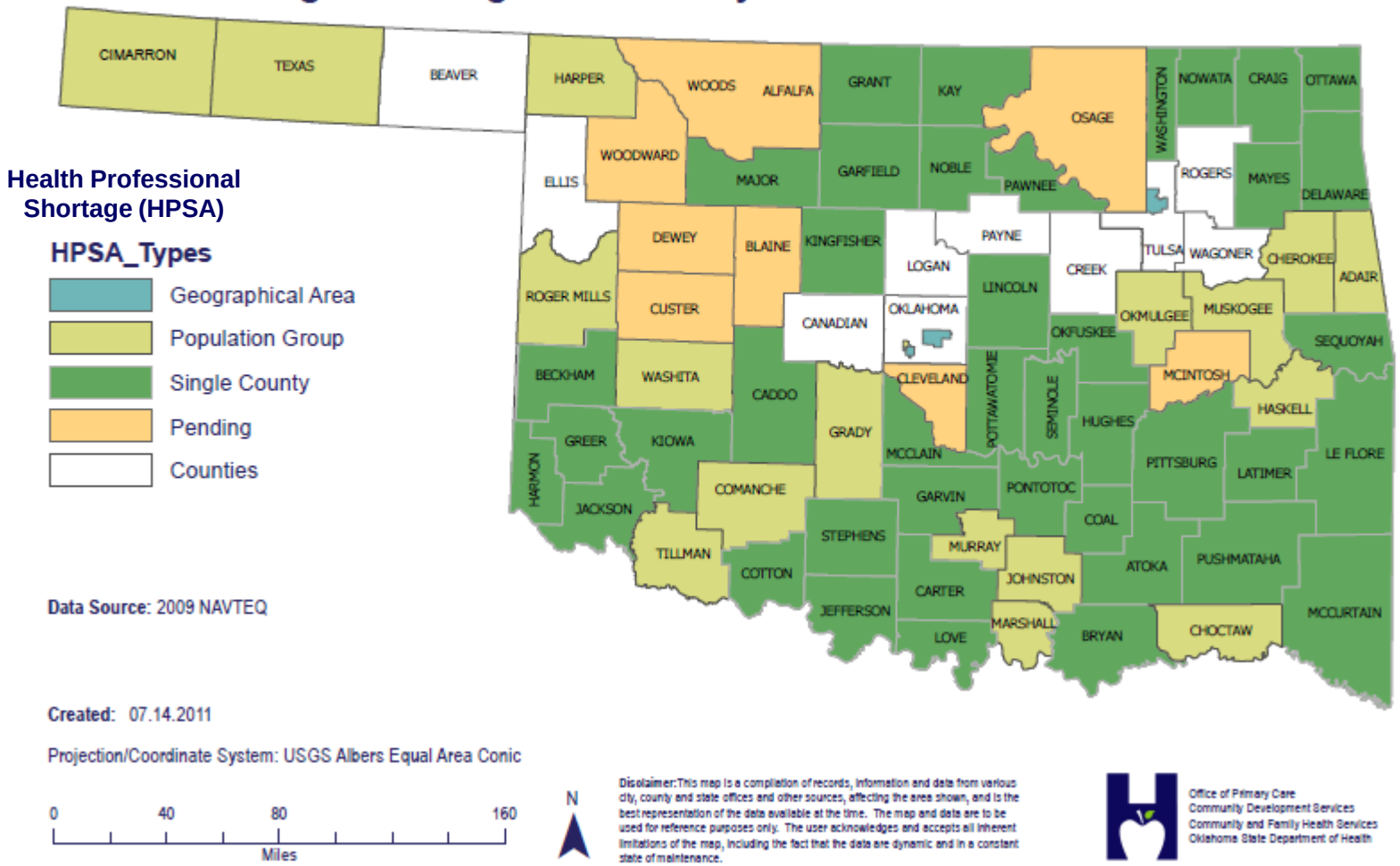
Public Health Clinical Services

- Infrastructure necessary for core public health functions
  - Infectious Disease Control
  - All Hazards Emergency Response
- Identified Community Gaps
  - Children's Behavioral Health
  - Medically Underserved Areas
- Effective, non-medical interventions to protect community health

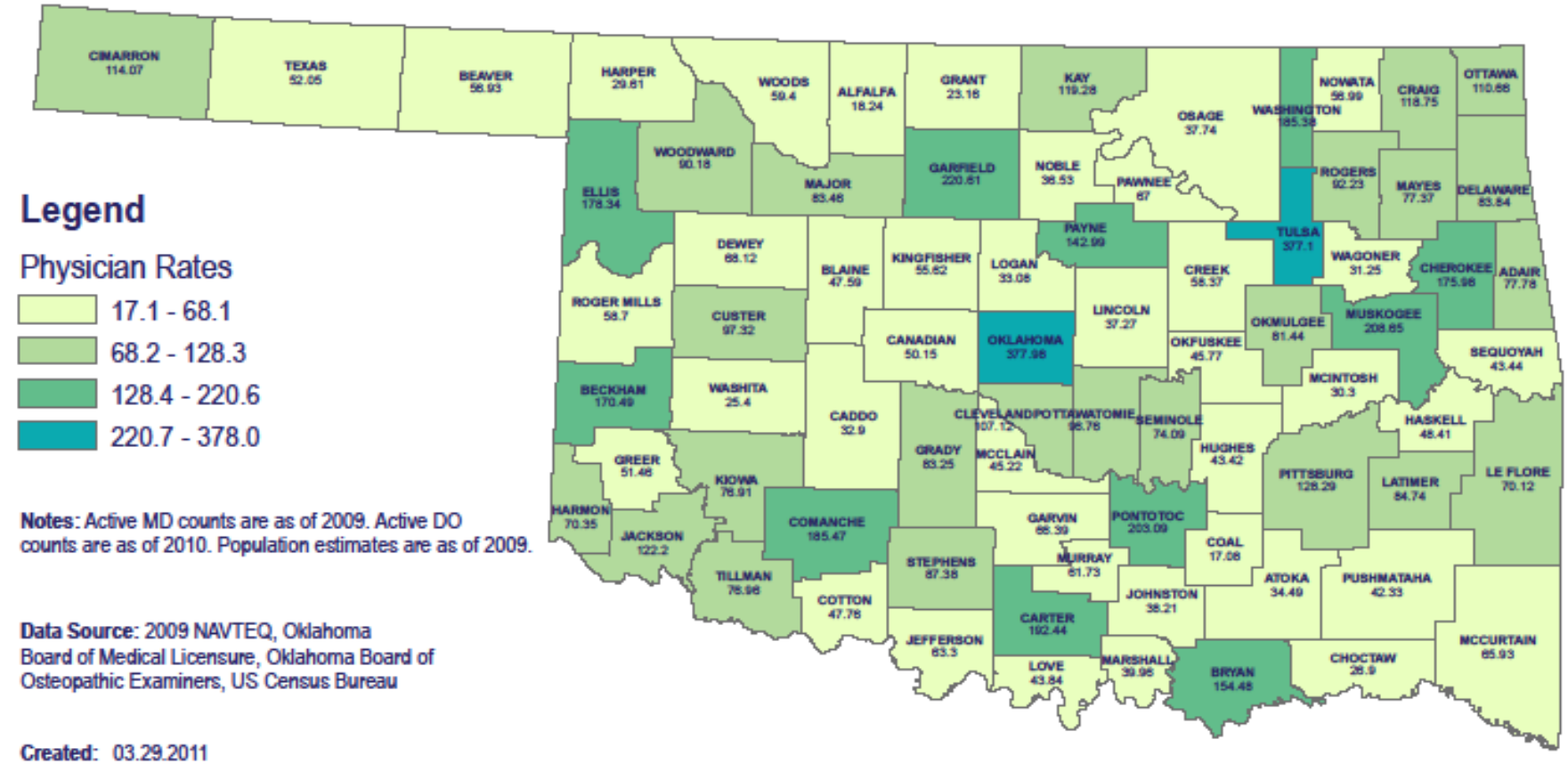
Access to Primary Care Services

- United Health Foundation Ranks Oklahoma 49th in the number of Primary Care Physicians.
- Access to care issues are worse in rural areas of the state.
- Unclear if PPACA programs will significantly improve access to primary care.
- The OSDH is currently trying to assess the impact of limited access to primary care.

Oklahoma State Department of Health
Office of Primary Care
Pending and Designated Primary Care HPSAs as of 07.14.2011



Physician Rates to 100,000 Population



Legend

Physician Rates

- 17.1 - 68.1
- 68.2 - 128.3
- 128.4 - 220.6
- 220.7 - 378.0

Notes: Active MD counts are as of 2009. Active DO counts are as of 2010. Population estimates are as of 2009.

Data Source: 2009 NAVTEQ, Oklahoma Board of Medical Licensure, Oklahoma Board of Osteopathic Examiners, US Census Bureau

Created: 03.29.2011

Projection/Coordinate System: USGS Albers Equal Area Conic

0 37.5 75 150

Miles

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Disclaimer: This map is a compilation of records, information and data from various city, county and state offices and other sources, affecting the area shown, and is the best representation of the data available at the time. The map and data are to be used for reference purposes only. The user acknowledges and accepts all inherent limitations of the map, including the fact that the data are dynamic and in a constant state of maintenance.

Office of Primary Care
Community Development Service
Community & Family Health Services
Oklahoma State Department of Health

Health Outcomes

- The current state of Oklahoma's poor health outcomes will likely influence the cost insurance coverage.
- While Clinical Preventive Services and limited Public Health Activities are included they aren't sufficient to create significant behavior change and improve health status.
- A coordinated system of health and public health interventions are required to make significant improvements in Oklahoma's health status.

Questions?