

What Next for Health Reform? Update

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For Osher Lifelong Learning Institute

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Outline

- Affordable Care Act Implementation
 - What's been done
 - What's upcoming
- Managing Medicare Costs

Affordable Care Act

What's been done

- 64 of 71 provisions scheduled for 2010-2013 implemented
- Notably
 - Employer coverage for family members under 26
 - Preventive services with no cost-sharing
 - Start of closing Medicare drug coverage gap
 - Minimum share of premiums paid in benefits or rebates

Complete list at: <http://healthreform.kff.org/timeline.aspx>

Affordable Care Act

January 2014

What's upcoming

- Health insurance changes
- Health exchanges/ marketplaces
- Medicaid expansion

What's not

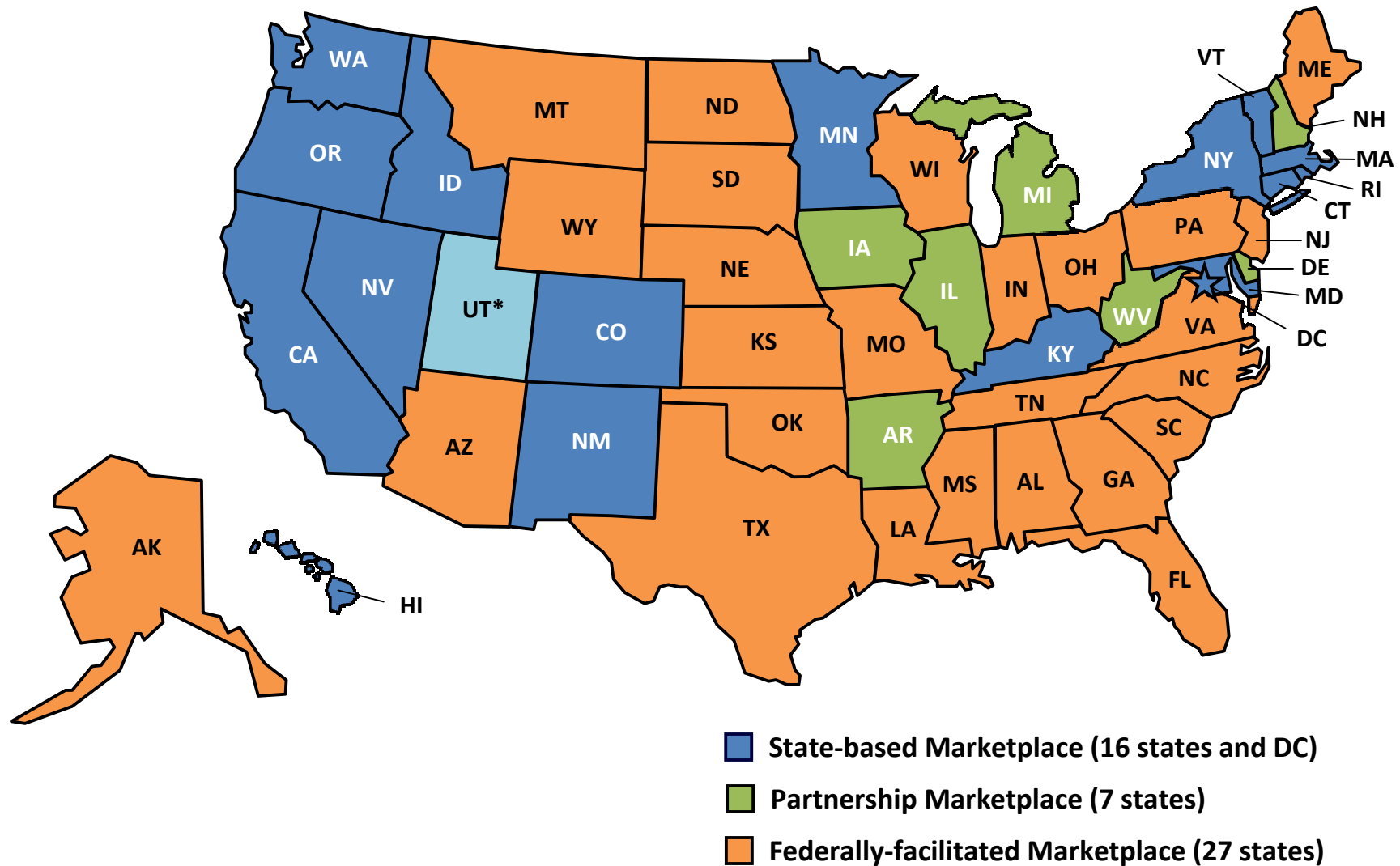
- Employer mandate

Affordable Care Act
What's upcoming
January 2014

Health Insurance Changes

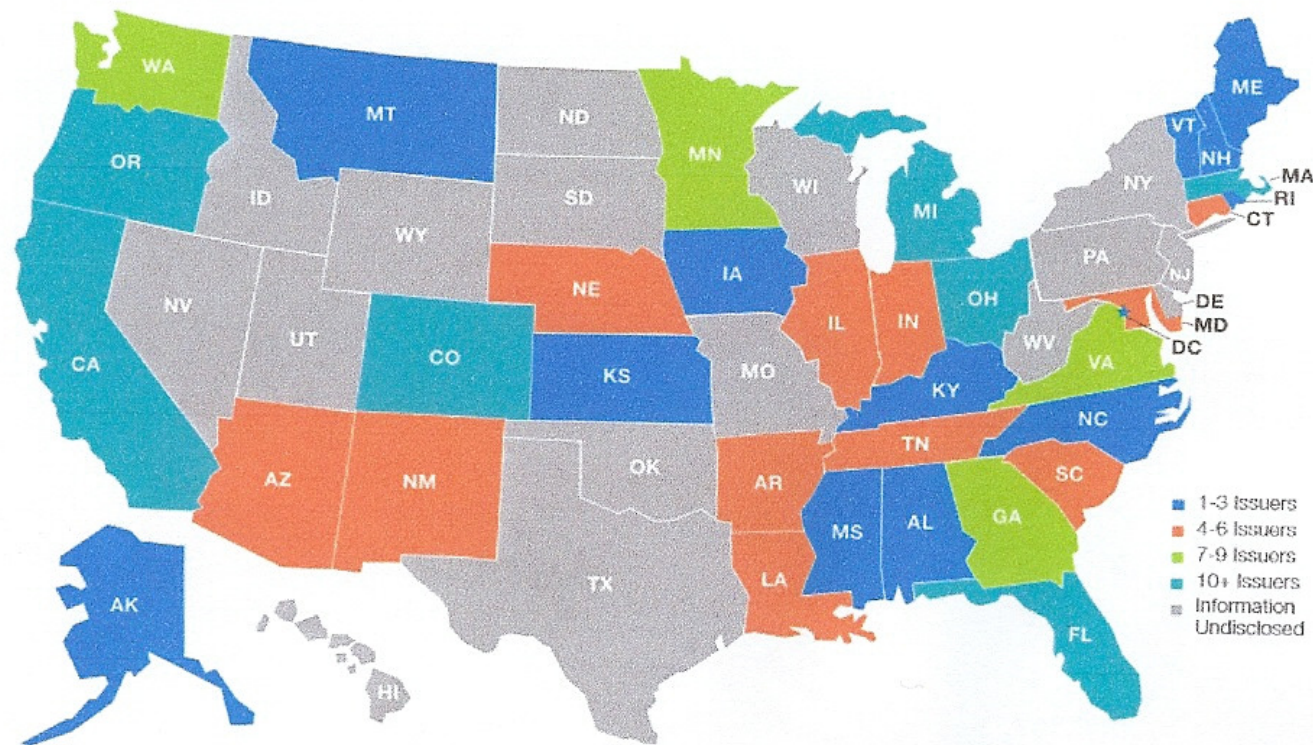
- Guaranteed offer of a policy
- No pre-existing condition exclusions
- Premiums
 - can not be based on health
 - can only vary 3 to 1 with age
 - can be 50% higher for smokers

States Health Insurance Marketplace Decisions, May 10, 2013



* In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.

Insurance Companies and Exchanges



Source: Avalere Health State Reform Insights, July 10, 2013

Insurance Companies and Exchanges

- California
 - Kaiser and Blues offering policies
 - Aetna and United not participating for next 5 years
- United—not in Illinois or Missouri
- Humana—Will be in 14 unidentified states
- CIGNA---Will be in 5-10 unidentified states
- Mississippi
 - 36 of 82 counties (mostly rural and poor) have no plans offered

Insurance Companies and Exchanges

Premium Sticker Shock

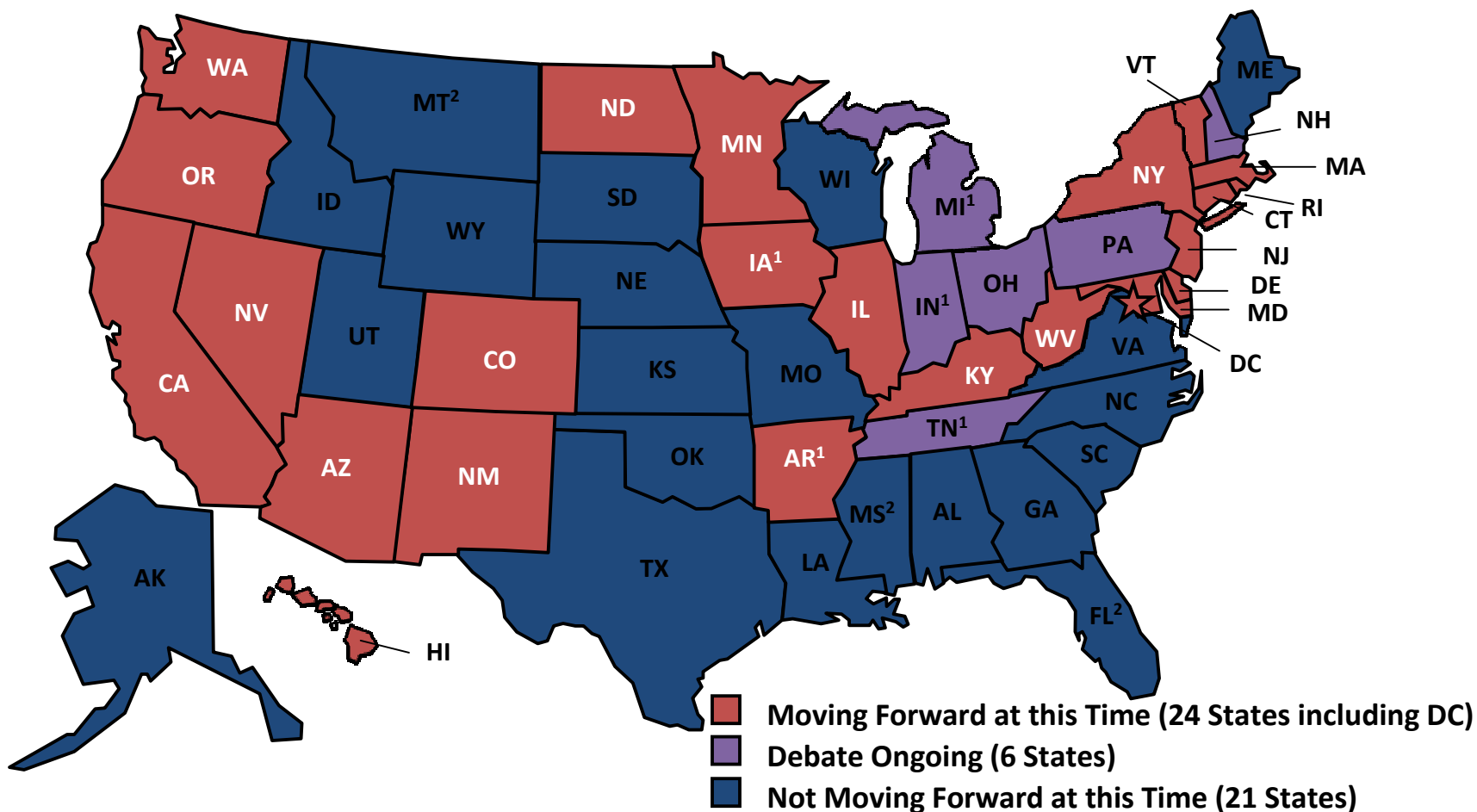
40 year old non-smoker Bronze plan (60% actuarial value)

	Monthly Premium
Nashville	\$149
Richmond	\$193
Columbus, OH	\$211
Hartford, CT	\$242

- Currently, \$5,000 deductible plan (50% actuarial value) is \$63 per month in Richmond for healthy 40 yr. old non-smoker

Source: Wall Street Journal, 7/1/2013

Current Status of State Medicaid Expansion Decisions, as of June 20, 2013



NOTES: 1 - Exploring an approach to Medicaid expansion likely to require waiver approval. 2- Discussion of a special session being called on the Medicaid expansion.

SOURCES: Based on KCMU analysis of recent news reports, executive activity and legislative activity in states. Data reported here are as of June 20. It is important to note that per CMS guidance, there is not deadline for states to implement the Medicaid expansion. Requirements for legislation to implement the Medicaid expansion vary across states.

Opting Out of Medicaid

Estimated Impact for States

- Study of 14 states*
 - 3.6 million fewer Insured
 - \$8.4 billion less in Federal payments
 - \$1 billion more in state spending on uncompensated care

*C.C. Price & C. Ebner, *Health Affairs*, June 2013.

Medicaid Expansion Virginia

- Legislature created commission to decide
 - 5 Senators and 5 Delegates
 - Related to reforming program to promote value
 - Met June 17; Scheduled Aug. 19 and Oct. 21
- Current eligibility
 - Childless adults—not eligible
 - Working parents—income below 30% of poverty
 - Non-working parents—income below 25% of poverty
 - Poverty for family of 3 = \$ 19,530

Employer Mandate


- Firms of over 50 full time workers (30+ hours per week) must offer coverage that is:
 - Minimum value (pays 60 percent of costs on average)
 - Affordable (Premium less than 9.5 percent of income)
- Penalty
 - Offering No Coverage
 - \$2,000 X (number of workers -30)
 - Offering Unaffordable Coverage
 - \$3,000 per employee who gets subsidy from health insurance exchange
- Enforcement delay until 2015 announced July 2

What Employers will do???

Why a Penalty May Look Tempting

Under the Affordable Care Act, many companies will be required to provide health care for employees.

Employer portion of family health benefit, average current cost:	\$11,429
Employer penalty for not providing benefits under Obamacare:	\$2,000



MINH UONG/THE NEW YORK TIMES

OFTEN, when the government wants you to do something, it makes you pay if you don't. That would seem to be the case with Obamacare, which penalizes companies for not providing health care. But in that penalty, there could be a par-

insurance and have unhappy employees," says Rick Wald, who heads Deloitte's employer health care consulting practice. Few experts see immediate, big changes to existing employer-sponsored coverage. But that may change in time. A generation

New York Times, June 23, 2013

- “Skinny” Plans
 - Example
 - Preventive services
 - 6 physician visits
 - Generic drugs
 - Xrays/ lab tests
 - No surgery
 - No hospital care

Managing Medicare Costs

Why is Medicare
a major focus of fiscal cliff/
federal deficit discussions?

What Happened to the Fiscal Cliff

Congressional Budget Office –May 2013

2013 Deficit drops to \$642 Billion

	Deficit as Percent of GDP
2009	10.1 %
2013	4.0%
2015	2.1%
2023	3.5%
1968- 2008	2.4%

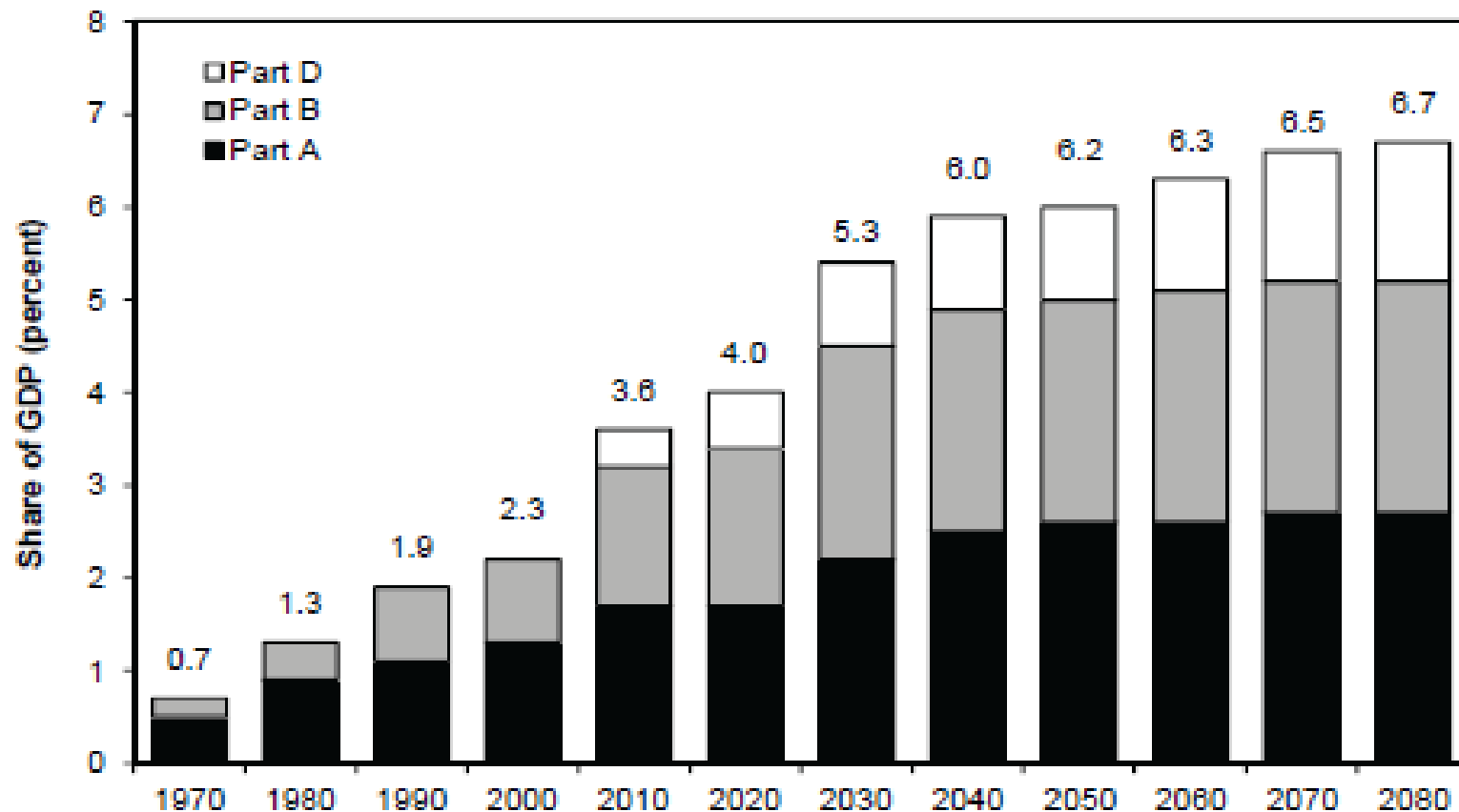
House Ways and Means Committee

July 11th

Chairman Camp seeking public input on Medicare reform

- Increase Medicare's eligibility age
- Reduce subsidies to high income seniors
- Revise Medicare cost sharing

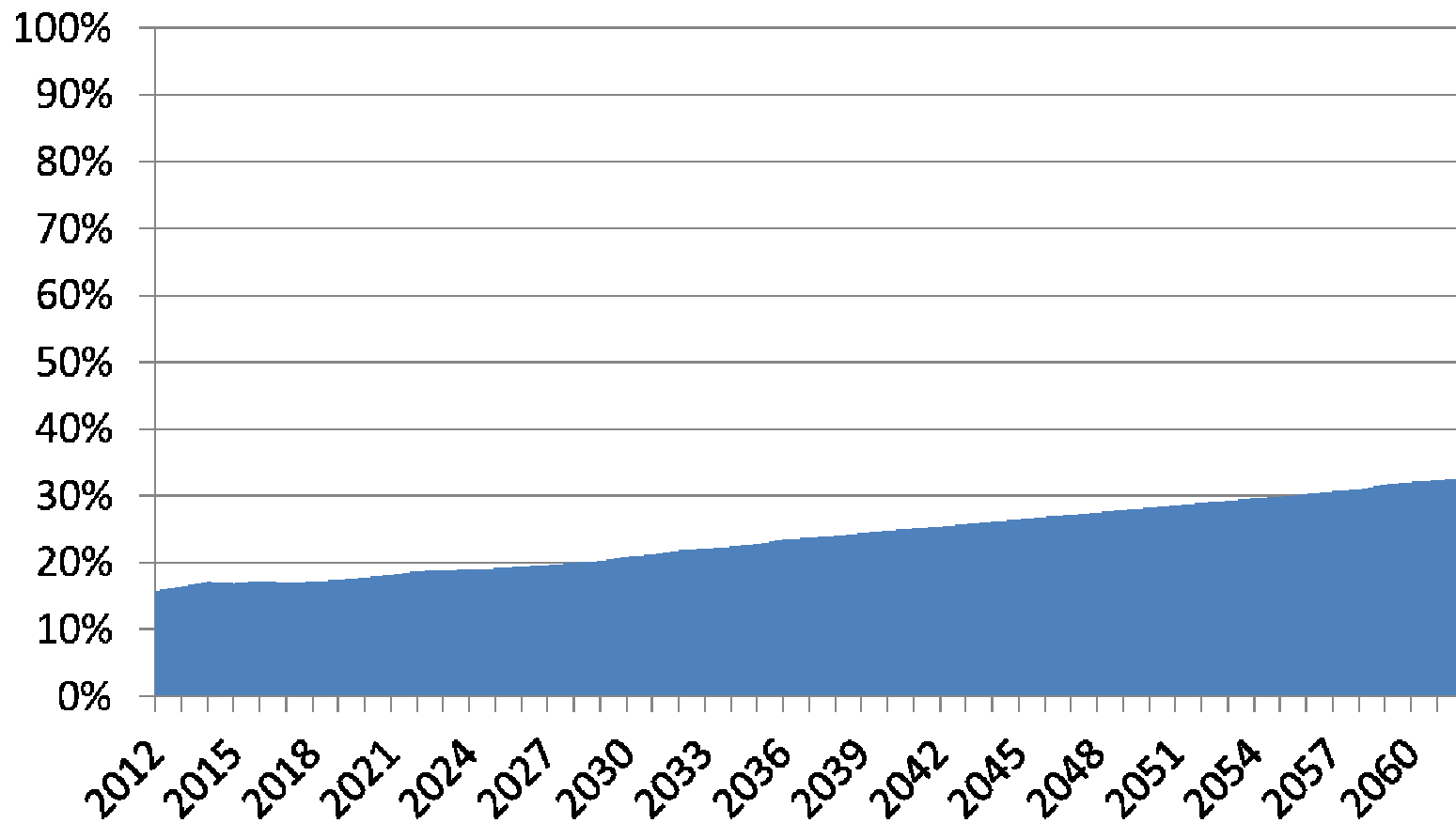
Medicare Trustees project Medicare spending to increase as a share of GDP



NOTE: GDP = gross domestic product. These projections are based on the trustees' intermediate set of assumptions.

SOURCE: MedPAC, based on 2012 annual report of the Board of Trustees of the Medicare Trust Funds

Medicare's Share of Federal Budget Doubles in 50 Years, Exceeds Social Security in 20 Years

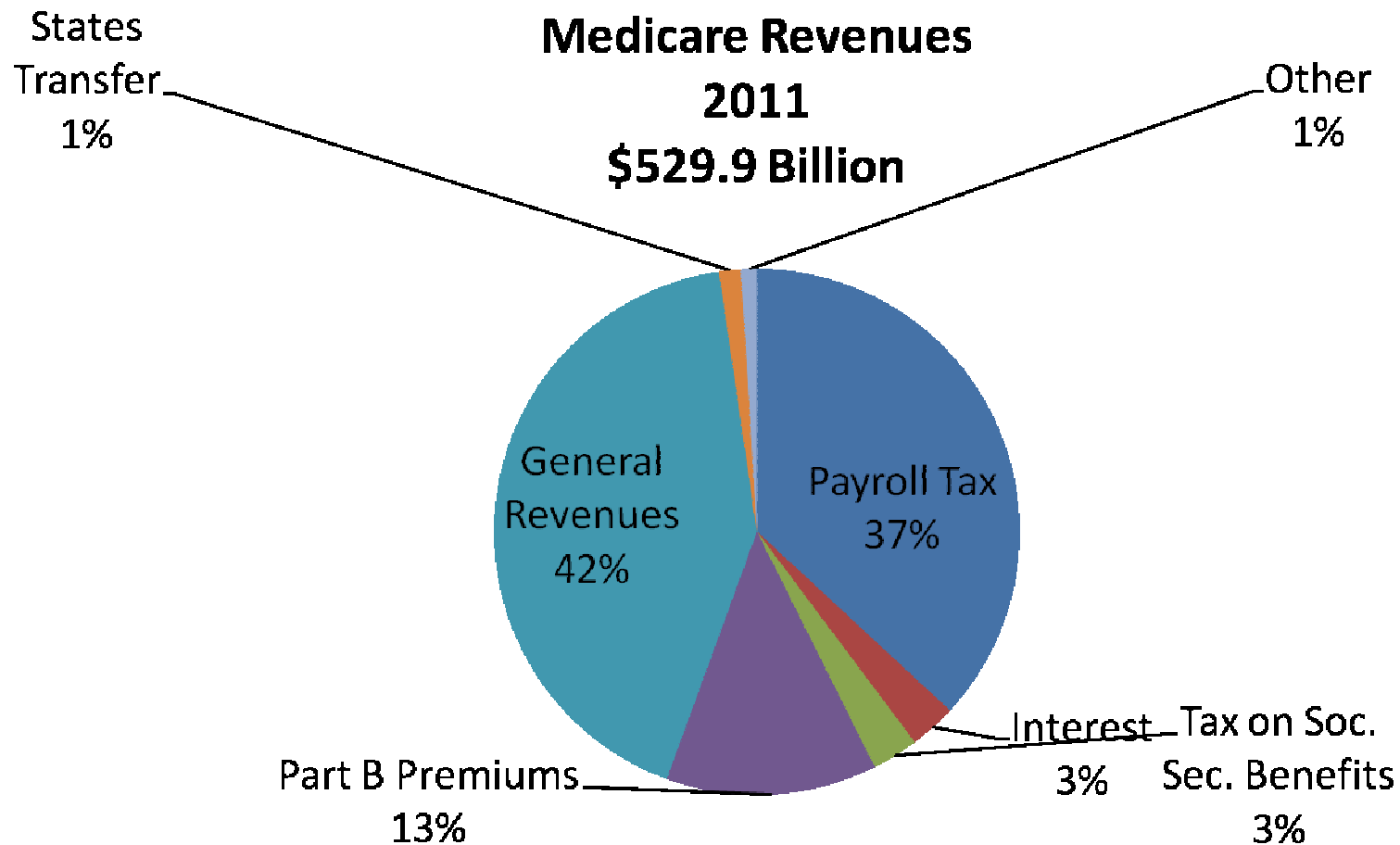


Source: CBO Long Term Budget Outlook

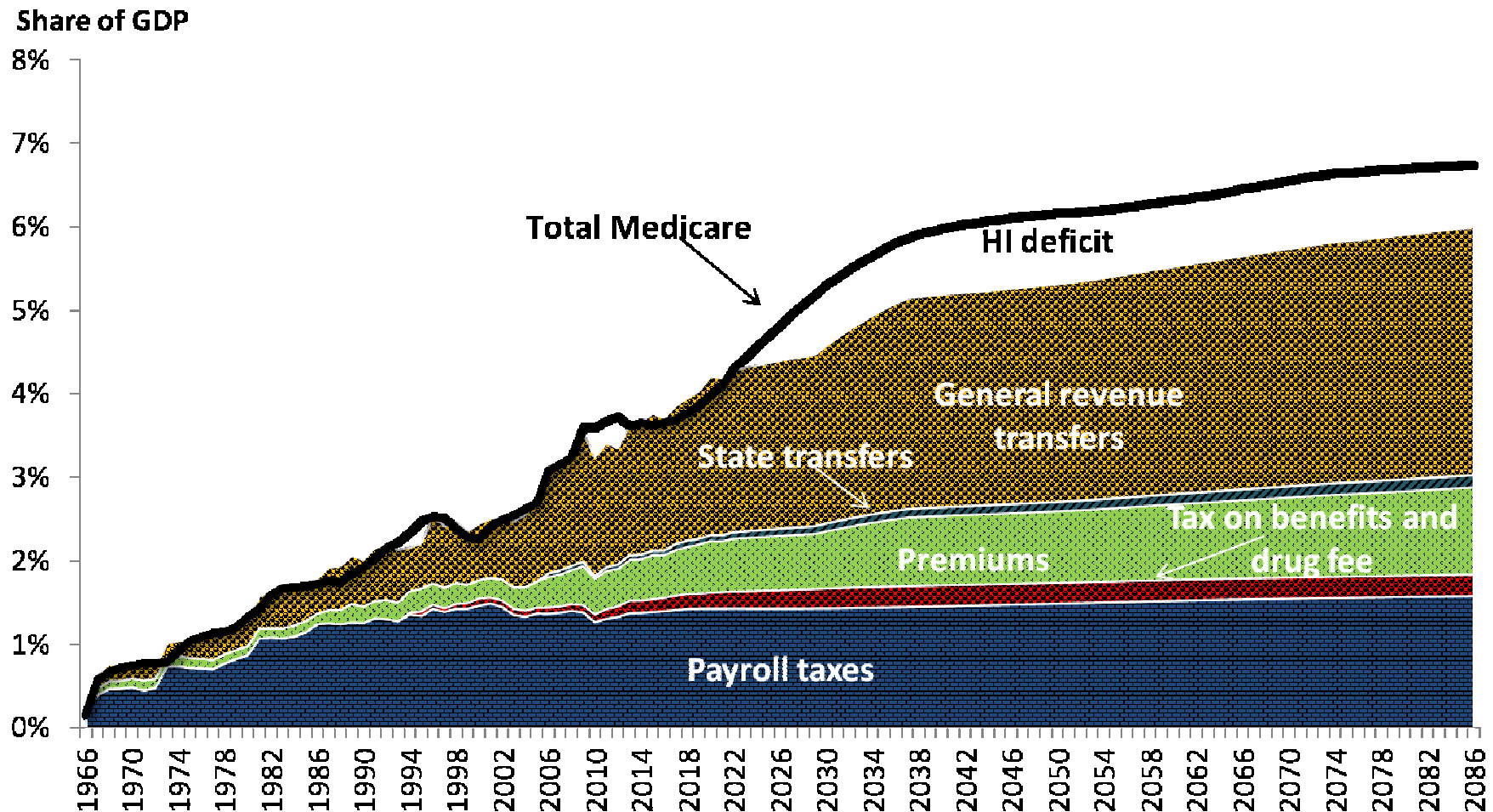
Why Medicare should not be a major focus of federal spending reductions?

- It's an entitlement
- Health care will suffer and beneficiaries will be harmed
- *Cutting Medicare spending cuts incomes*

Sources of Medicare Revenues



Medicare is becoming more reliant on general revenues



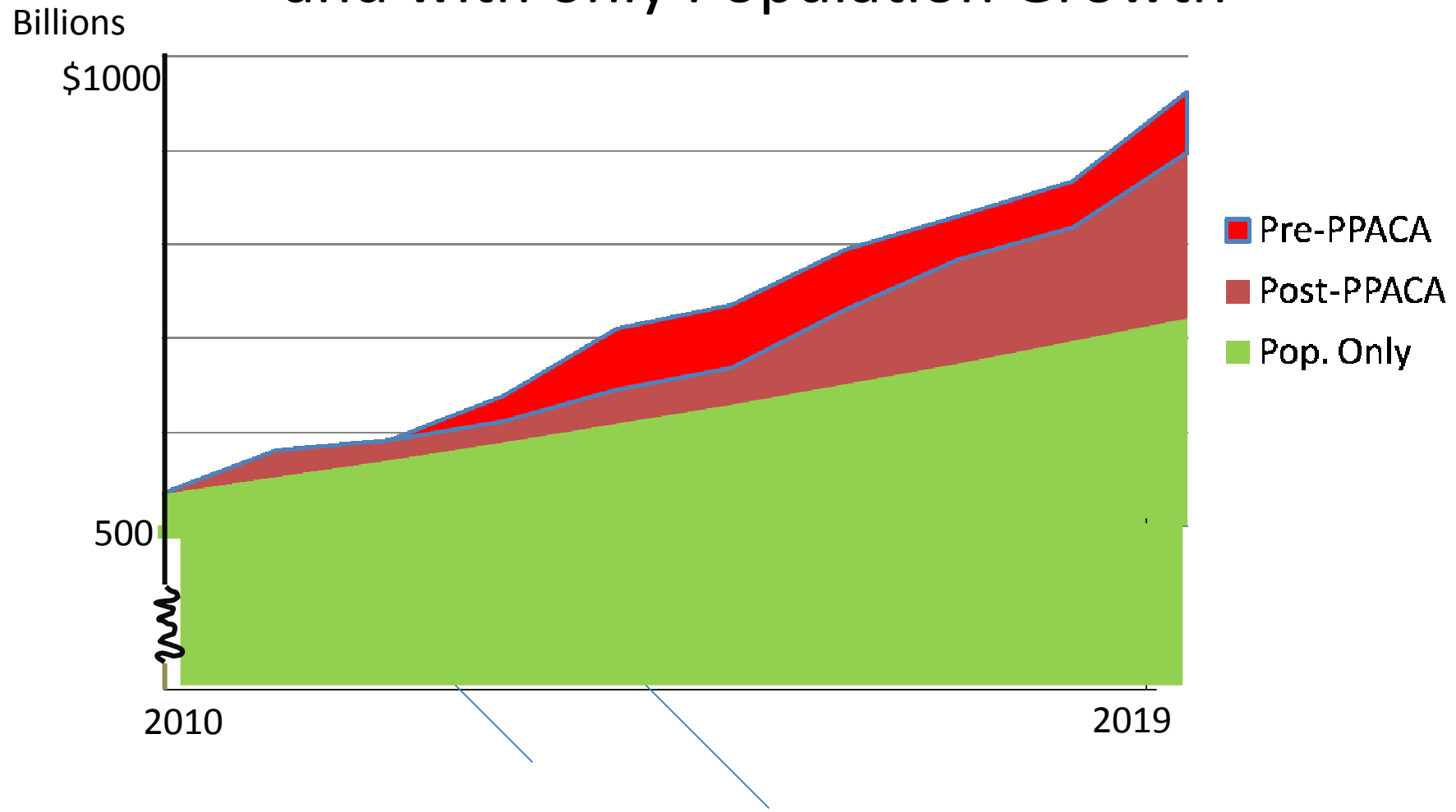
Source: Board of Trustees, 2012 Report of the Hospital Insurance and Supplementary Medical Insurance Trust Funds.

Medicare Benefits Compared to Taxes Paid

Turning 65 in	2010		2030	
	<u>Benefits</u> Contributions	Benefits	<u>Benefits</u> Contributions	Benefits
Average Income				
Single Female	3.39	\$207,000	3.92	\$353,000
Single Male	2.95	\$180,000	3.45	\$311,000
2 Earner Couple	3.17	\$387,000	3.68	\$664,000

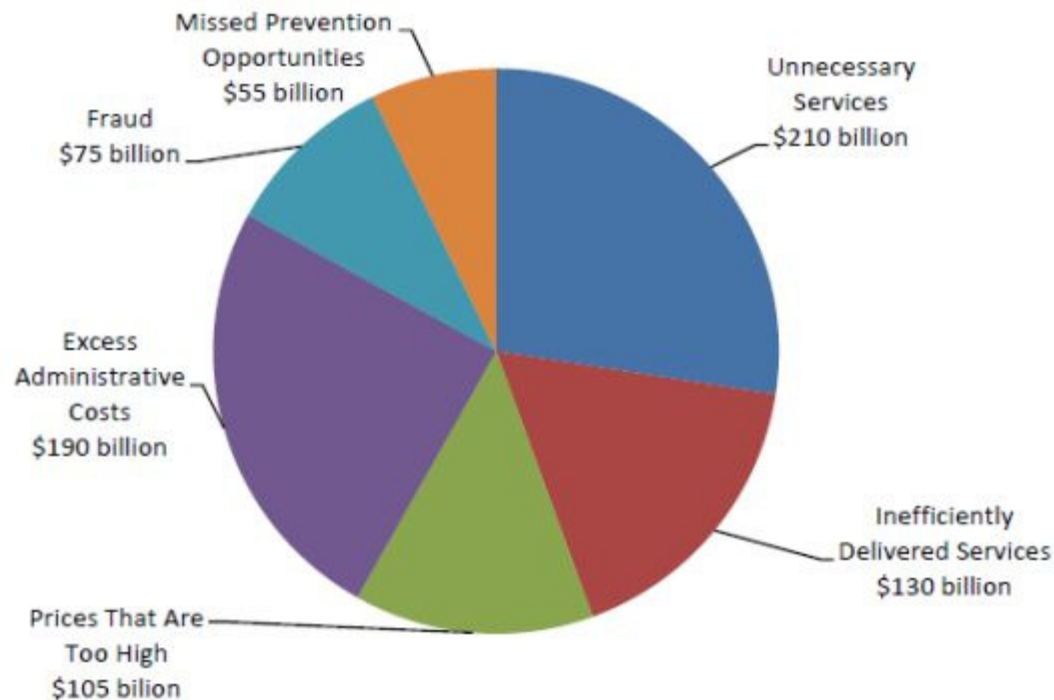
Source: C.E. Steuerle and C Quakenbush, *Social Security and Medicare Taxes and Benefits over a Lifetime: 2012 Update*, Urban Institute, October 2012

Projected Medicare Spending Pre and Post PPACA and with only Population Growth



Institute of Medicine Unnecessary Health Spending

\$750 Billion out of \$2.6 Trillion



Institute of Medicine: Best Care at Lower Cost, 2010

<http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx>

Choosing Wisely Campaign

- 26 Physician Specialty Societies have each identified 5 procedures that should not be done routinely
- <http://www.choosingwisely.org/doctor-patient-lists/>



October 11, 2011

Policy Analysis for the Real World--
Health Debates

Some Sources of Options to Reduce Medicare Spending

- Bipartisan Policy Center Debt Reduction Task Force (Domenici-Rivlin)--Nov 2010
- National Commission on Fiscal Responsibility and Reform (Bowles-Simpson)--Dec 2010
- House Budget Resolution--Apr 2011
- Senate “Gang of Six”--Jul 2011
- President’s Plan for Economic Growth and Deficit Reduction Sep 2011
- Premium Support (Ryan-Wyden)--Dec 2011
- President’s FY2013 Budget Proposal--Feb 2012

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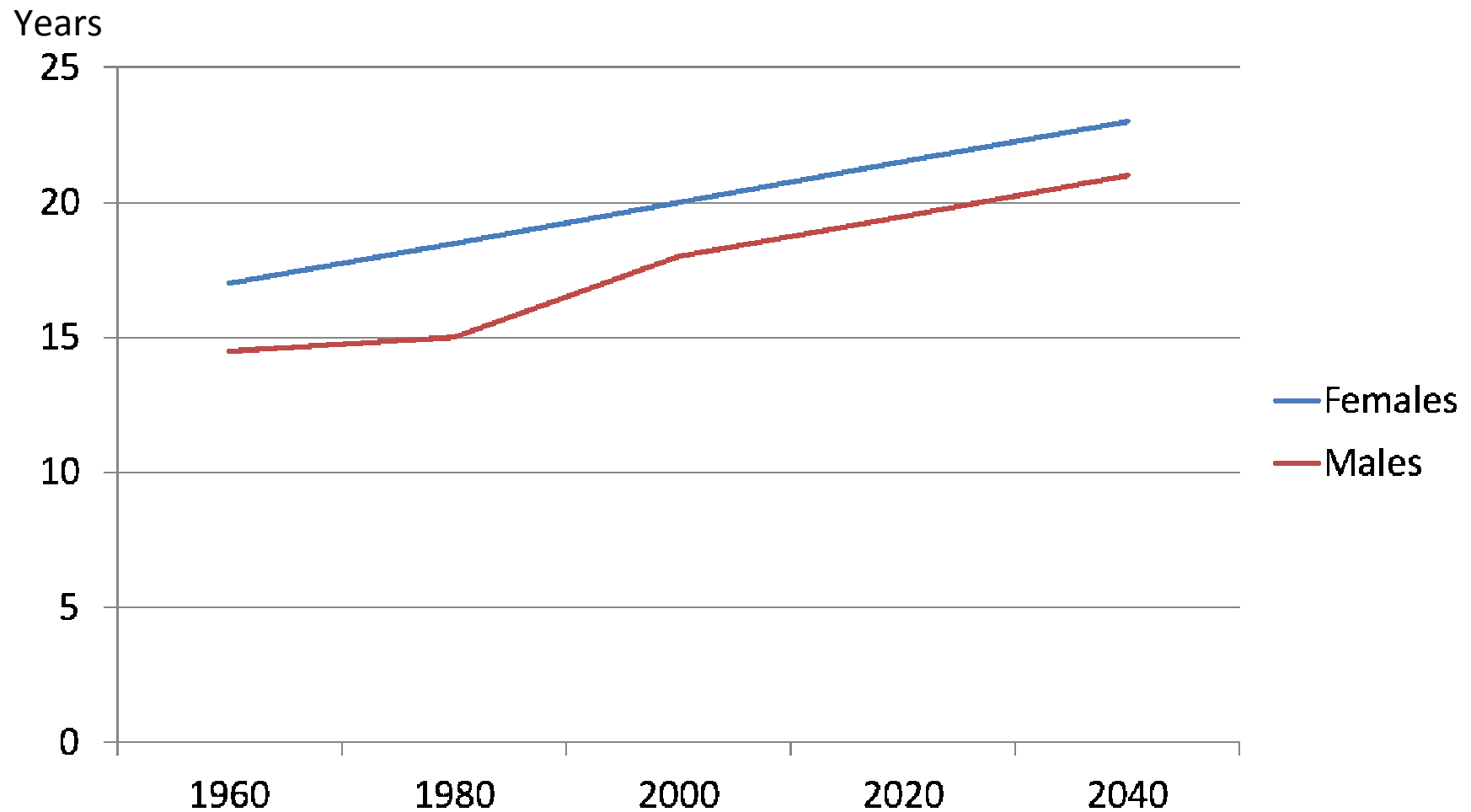
Subsidies to High Income Seniors

- Part B and Part D Premiums are 25% of costs
- Surcharge applied to higher income beneficiaries

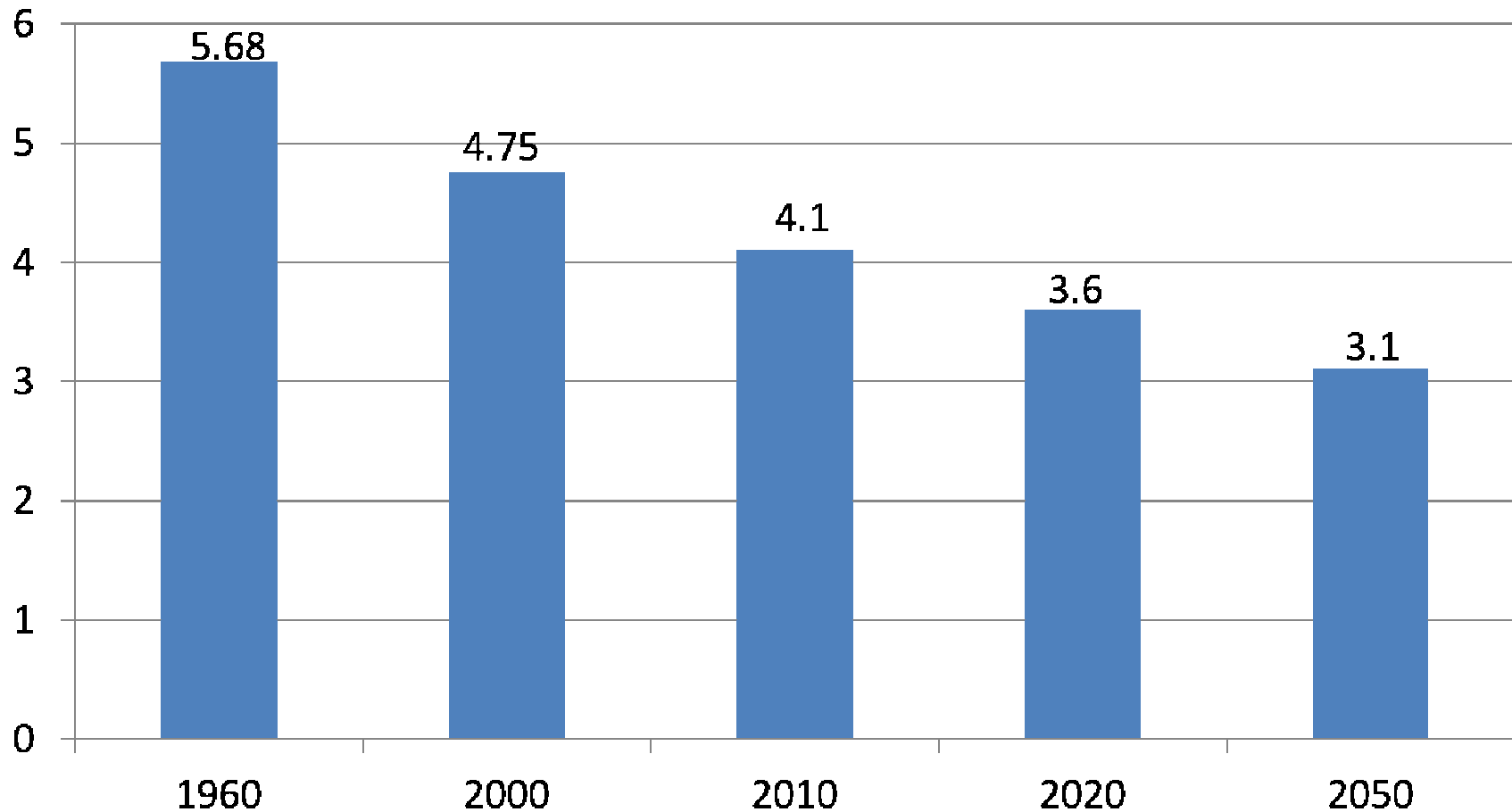
Individuals with incomes	Couples with incomes	2013 Part B premium per person
Less than \$85,000	Less than \$170,000	\$104.90
\$85,000-107,000	\$170,000-214,000	\$146.90
\$107,000-160,000	\$214,000-320,000	\$209.80
\$160,000-\$214,000	\$320,000-428,000	\$272.70
More than \$214,00	More than \$428,000	\$335.70

Increase Medicare's Eligibility Age to 67

Life Expectancy at 65



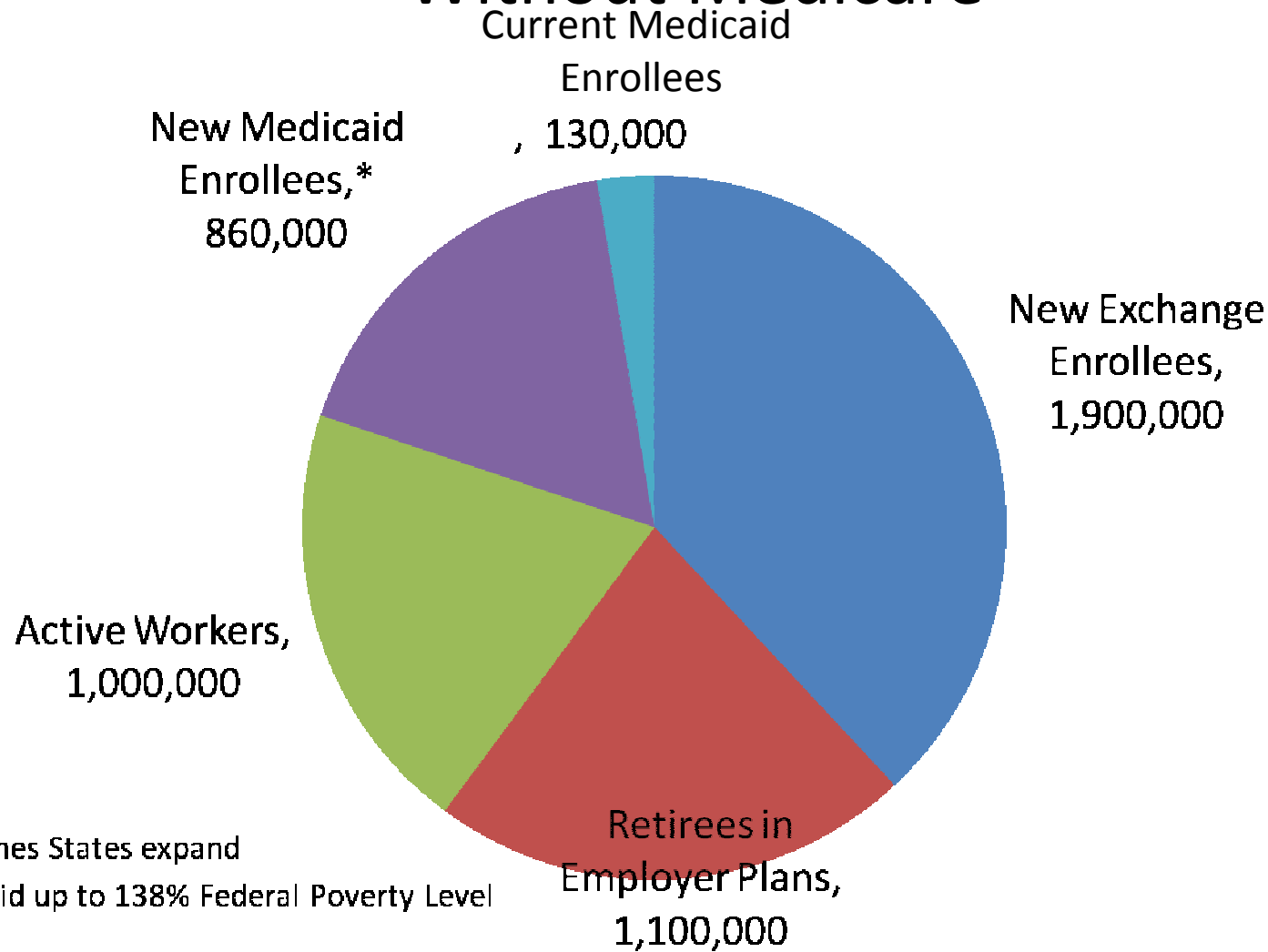
Number of Working Age Persons Per Person 65 +



Source: Census Bureau

Where 65 and 66 Year Olds Would Get Insurance

Without Medicare



Source: Actuarial Research Corporation

Change in Out-of-Pocket Spending for 65 and 66 Year Olds if Medicare Eligibility Age is 67

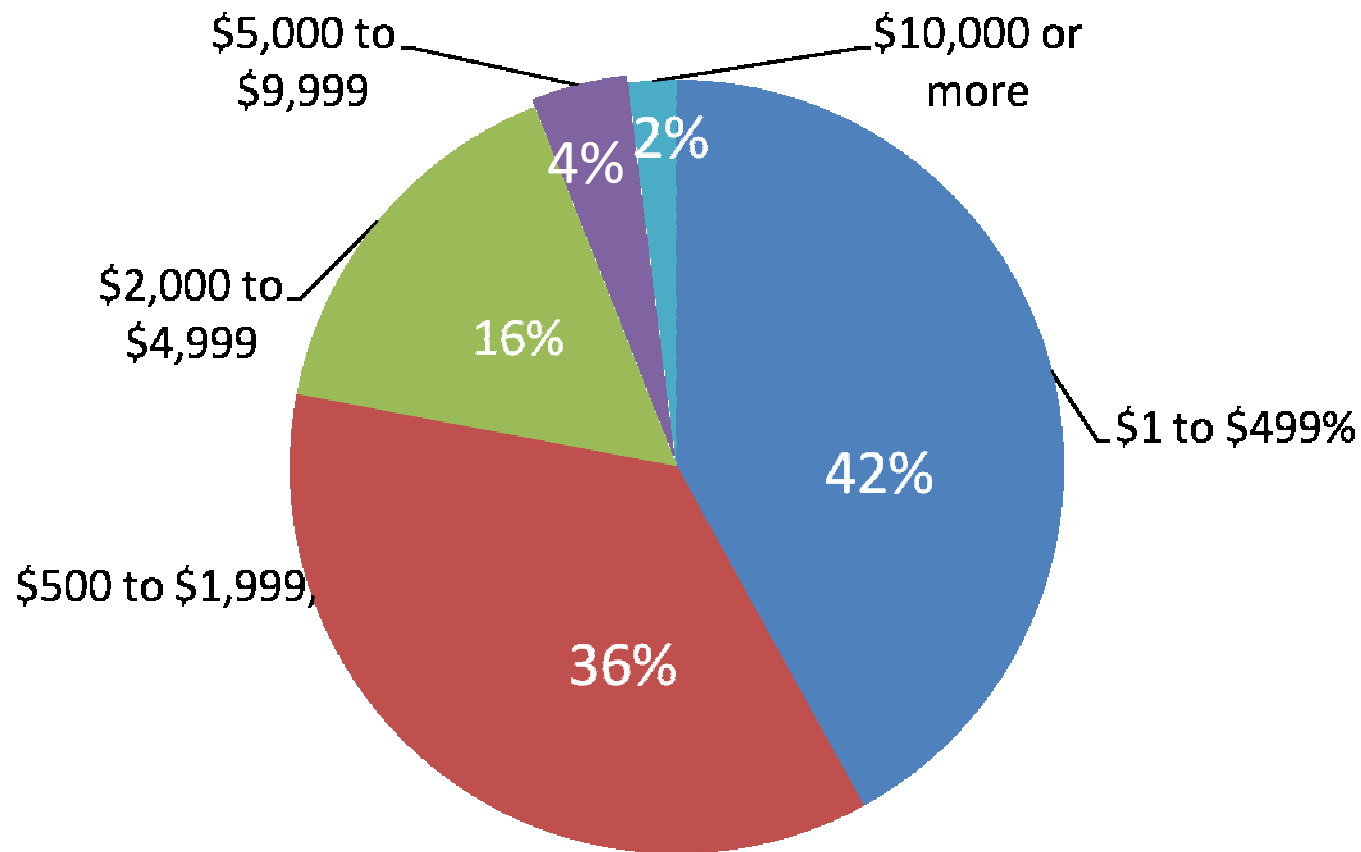
- Average Person spends \$700 more
- Persons with incomes less than 300% of Poverty spend less in either Medicaid or exchange
- Active workers spend more (\$500 on average)
- Retired persons with incomes greater than 300% of Poverty spend more (\$1200-4300)

Change Medicare Cost Sharing and Reduce Supplementary Coverage

Current Medicare cost sharing

- Deductible payment for each hospitalization \$1184
- \$148 per day for days 21-100 in skilled nursing facility
- Deductible for physician and other Part B services of \$147 and 20 percent thereafter
- No catastrophic coverage—i.e., no limit on out of pocket costs

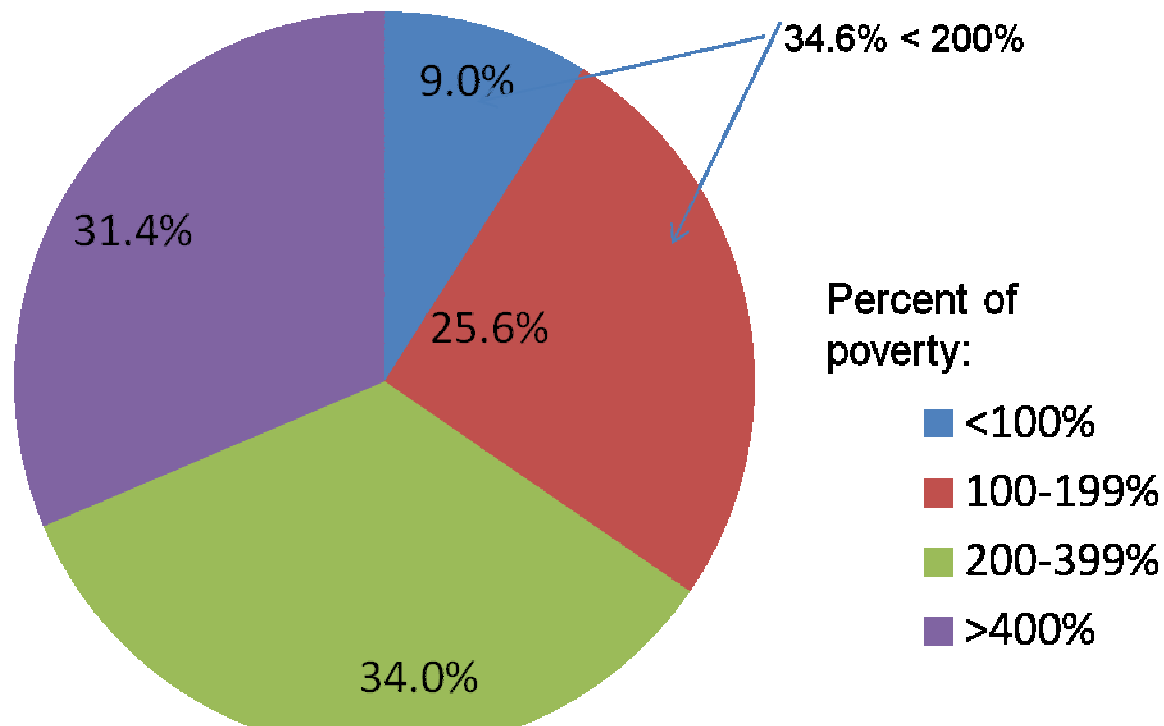
Cost-Sharing Liability for Medicare Fee-for-Service Beneficiaries, 2008



Note: The amounts reflect Medicare beneficiaries' liability but do not reflect what Medicare beneficiaries actually paid out of pocket because most beneficiaries have supplemental coverage that covers all or some of their Medicare cost sharing.

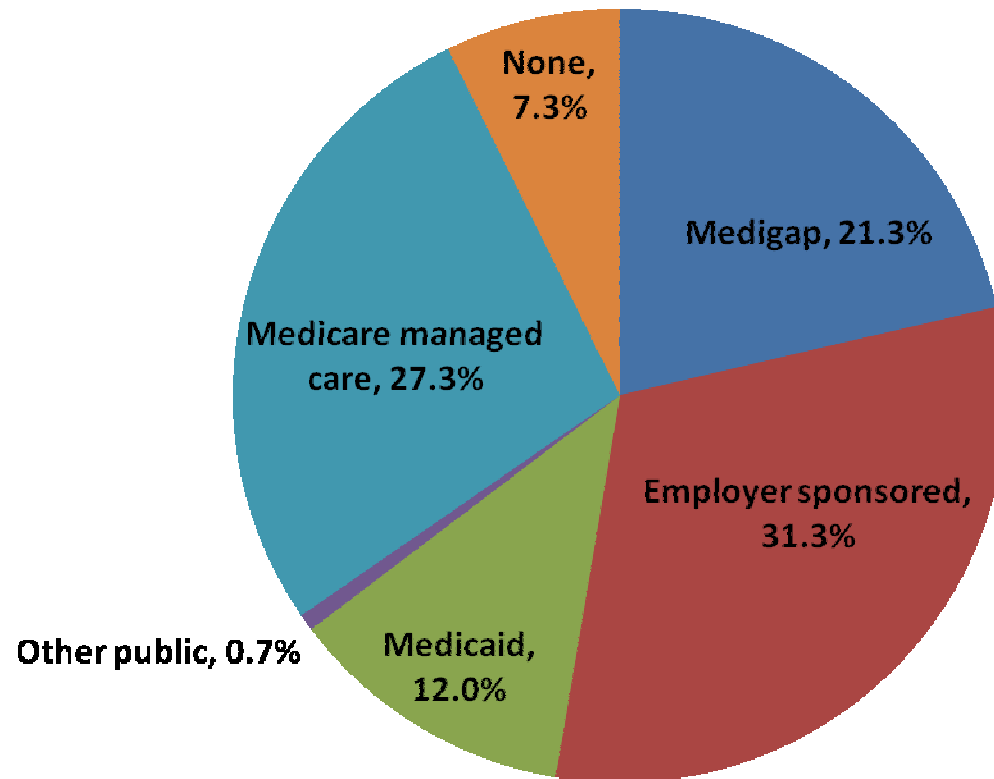
Source: Medicare Payment Advisory Commission, Report to the Congress: Aligning Incentives in Medicare, June 2010, p. 54, available at www.medpac.gov/chapters/Jun10_Ch02.pdf.

Income Distribution of Persons 65 and older, as percent of poverty, 2010



Source: Federal Interagency Forum on Aging-Related Statistics,
Older Americans 2012: Key Indicators of Well-Being, June 2012.

Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2009

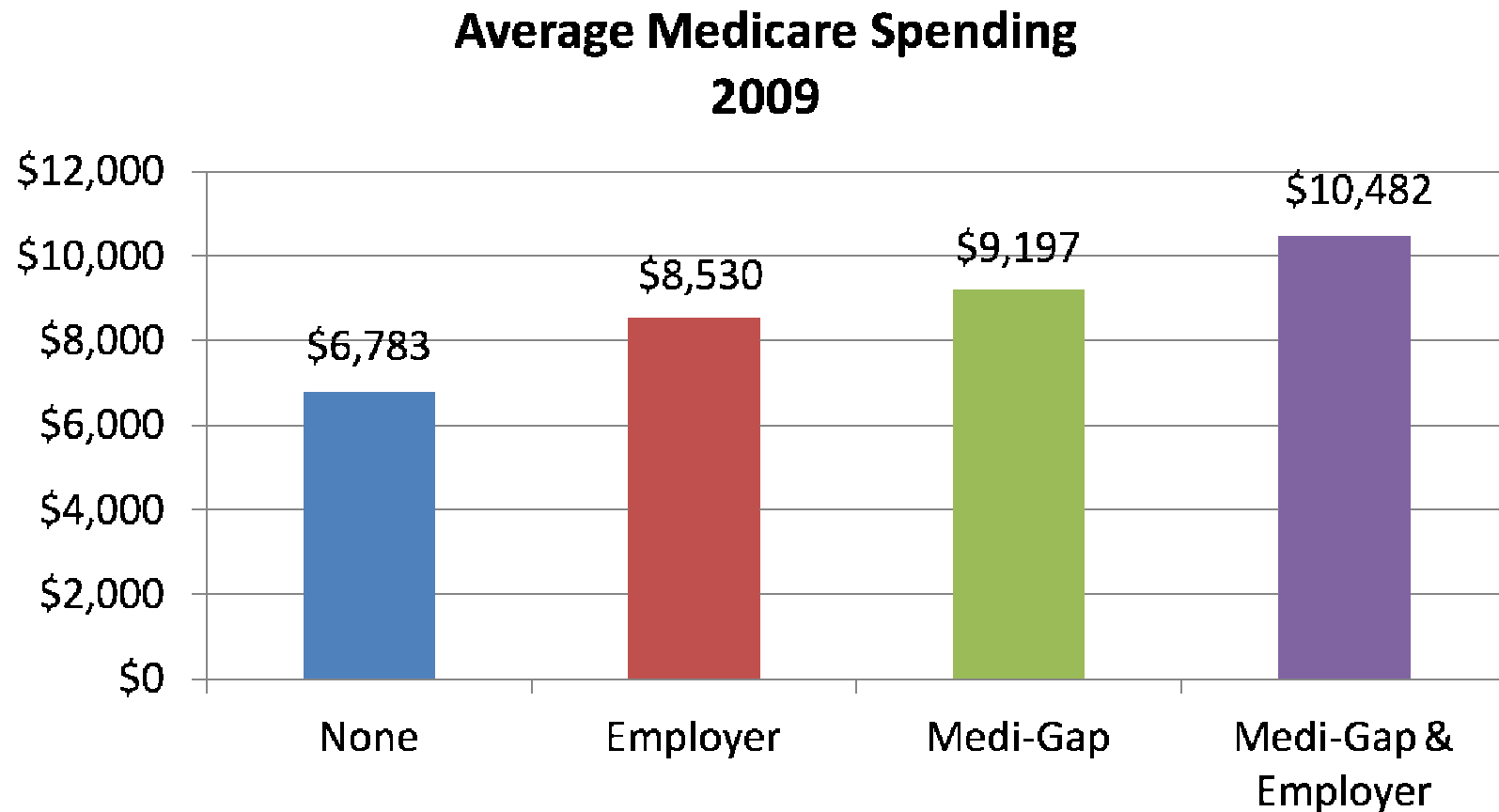


Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.
From: *Data Book: Health spending and the Medicare Program*, June 2012.

Supplementary Coverage

- Medi-Gap Plans
 - 65% cover all cost sharing (No out of pocket)
 - 4 % include beneficiary paying some cost sharing on ambulatory services
- Employer Retiree Plans
 - Often do not cover the Medicare deductible
 - Have co-pays or cost sharing on ambulatory services

Variation in Medicare Spending with Type of Supplemental Coverage



Source: Medicare Payment Advisory Commission

Proposals to Change Cost Sharing and Supplementary Coverage

- Cost Sharing
 - Combine the Part A and Part B deductibles
 - Add a catastrophic cap so Medicare pays all or almost all expenses beyond some amount
- Supplementary Coverage
 - Prohibit plans from covering Medicare deductible and some cost sharing (akin to True Out of Pocket requirement in Part D)
 - Impose a surcharge on Part B premiums for those with first dollar supplemental coverage

Questions