HEALTH REFORM
Affordable Care Act
GOALS OF THE ACT

1. Give Americans greater access to healthcare
   • Expanding insurance coverage and Medicaid

2. Rein-in healthcare costs
   • “Bend the cost curve”

3. Improve consumer protections
   • Pre-existing conditions; no lifetime limits

4. A smorgasbord of praiseworthy initiatives and pet projects
HEALTH INSURANCE: RADICAL CHANGES AHEAD

1. Today Most (But Not All) Americans Get Help Buying Health Insurance

2. Helping Those Who Need the Most Help

3. ObamaCare’s Impact on Different Groups
   a) Medicare recipients
   b) Individuals with employer-based insurance
   c) Individuals with private health insurance
   d) The uninsured
   e) Medicaid
History of US Insurance

Pre WWII: Health insurance limited in scope and availability

WWII: The institution of wage and price controls changed the health insurance market, dramatically expanding the role of employers

Post WWII: Tax-law changes and collective bargaining institutionalized the employer-based health insurance system

1963-1964: Medicare and Medicaid provided coverage to the “left-out” groups (poor and elderly) under the employer-based system
### US COVERAGE - 2010

<table>
<thead>
<tr>
<th>Source</th>
<th>Coverage</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>47 Million</td>
<td>15%</td>
</tr>
<tr>
<td>Employer</td>
<td>150 Million</td>
<td>48%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>27 Million</td>
<td>9%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>50 Million</td>
<td>16%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>40 Million</td>
<td>13%</td>
</tr>
</tbody>
</table>
1. Medicaid Expansion
   Coverage for all up to 133% FPL (Federal Poverty Level)
   ($9.20/hr. in Alaska)

2. Health Exchanges
   Sliding scale subsidies for purchasing coverage

3. Individual Mandate – The penalty

4. Incentives for Small Businesses
   Sliding scale tax credits for providing coverage
New eligibility category effective January 1, 2014

- Adults under 65 and not already in eligibility category
- 0-133% FPL (138% with adjustments)*
- Provides higher Federal funding match to state

*$9.20 / hour in Alaska - 2012
CORE MEDICAID EXPANSION

1. ACA made this new eligibility category “mandatory” for states.

2. The subsequent (June 2012) Supreme Court ruling made this group “optional” for states.

3. It is now at the option of each state whether to expand (or maintain) Medicaid up to 138% for adults.
Where the States Stand: February 13, 2013
What States are Saying About Medicaid Expansion

Note: Based on literature review as of 2/13/13. All policies possible to change without notice.


Learn more about the impact of the Supreme Court ruling at advisory.com/MedicaidMap

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1. Feds pay 90% - 100% of cost of expansion
   • Guaranteed through 2020

2. States fear the money will not last
   • Concerns over federal deficit spending

3. Dislike federal control over coverage levels
The ACA allows states to set eligibility at 138% FPL.

135,159 (w/ Alaskan natives)

- Infants (0-1): 150%
- Children (1-5): 150%
- Children (6-18): 150%
- CHIP: 175%
- Pregnant women: 76%
- Parents (Unemployed): 138%
- Parents (Employed): 81%
- Aged, Blind or Disabled: 109%
- Childless Adults: 138%
Through 2020, $1 State to $12 Federal

Figure 9. Funding of Alaska's Medicaid Expansion Option
2014 - 2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Federal funding</th>
<th>State funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$81.9</td>
<td>$3.0</td>
</tr>
<tr>
<td>2015</td>
<td>$127.4</td>
<td>$4.3</td>
</tr>
<tr>
<td>2016</td>
<td>$159.6</td>
<td>$5.2</td>
</tr>
<tr>
<td>2017</td>
<td>$174.8</td>
<td>$14.5</td>
</tr>
<tr>
<td>2018</td>
<td>$182.0</td>
<td>$17.1</td>
</tr>
<tr>
<td>2019</td>
<td>$188.2</td>
<td>$19.8</td>
</tr>
<tr>
<td>2020</td>
<td>$190.7</td>
<td>$26.7</td>
</tr>
</tbody>
</table>
ALASKA MEDICAID SUMMARY

1. Medicaid coverage for 40,000 uninsured Alaskans
2. $1.1 Billion in new federal revenue to Alaska
3. 4,000 new jobs
4. $1.2 Billion more in salaries and wages paid to Alaskans
5. $2.49 Billion in increased economic activity throughout Alaska
6. State spending: $90.7 million w/o offsets and $24 million with offsets
HEALTH INSURANCE EXCHANGE (HIX)

- A marketplace (think of Travelocity or Orbitz)
- Menu of private insurance plans
- Offering required minimum sets of benefits
- Manage subsidy eligibility
- Identify Medicaid eligibility
- Open to individuals w/o employer coverage
- Open to small businesses
HIX – PERHAPS THE KEY?

1. Insurance Exchanges - Critical to success of the Affordable Care Act

2. Represent the potential to truly reform the marketplace (in the long run)
HIX – 4 STANDARD PLANS

• Bronze - 60% Coverage plan
• Silver – 70%
• Gold – 80%
• Platinum – 90%
• All will offer defined minimum benefits
• At this point – we have no information on plan design or cost
1. If income at or above 100% FPL can join Exchange
2. If income below 100% FPL can not join Exchange
3. 47,000 currently uninsured Alaskans with incomes <100% FPL would not be eligible for the Exchange
4. A good portion of the 47,000 are not eligible for Medicaid under current rules
1. Is the Individual Mandate Really Necessary?
   a) Strengthen the nation’s health insurance “risk pool”
   b) Pre-existing condition rejections
   c) Offset increased costs from other ObamaCare rules
1. Insurance mandate starts January 1, 2014
2. Tax penalty for failure to maintain coverage
   - 2014: $95 or up to 1% of income
   - 2015: $325 or up to 2% of income
   - 2016: $695 or up to 2.5% of income (Max $2085)
   - Penalty increases by annual COLA each year thereafter.
3. Exceptions for religious and hardship reasons, and individuals who are not required to file taxes
4. AI/AN may opt out of individual mandate
1. Premium subsidies for individuals with income between 100% and 400% FPL to purchase insurance through the new Health Insurance Exchanges

2. ~ $380 million in premium subsidies will be available in Alaska

### Premium Subsidies

<table>
<thead>
<tr>
<th>Income</th>
<th>100%-133% FPL</th>
<th>133-150% FPL</th>
<th>150-200% FPL</th>
<th>200-250% FPL</th>
<th>250-300% FPL</th>
<th>300-400% FPL</th>
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</thead>
<tbody>
<tr>
<td>(Proj. 2016)</td>
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<tr>
<td>Premium Cap as a</td>
<td>2 – 3% of income</td>
<td>3 – 4% of income</td>
<td>4 – 6.3% of income</td>
<td>6.3 – 8.05% of income</td>
<td>8.05 – 9.5% of income</td>
<td>9.5% of income</td>
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<tr>
<td>% of income</td>
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<tr>
<td>Cap</td>
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</tbody>
</table>
1. Employers with more than 50 employees that do not offer insurance must pay a $2,000 free rider assessment (penalty) for each FTE, minus 30, who receives a premium subsidy.

2. Employers with more than 50 employees that do offer coverage but it is not affordable must pay a $3,000 penalty for each employee who receives a premium subsidy or a $2,000 free rider assessment for each FTE minus 30.

3. Small employers with less than 26 employees with average wage of $50k or less can receive a tax credit for providing health insurance.

4. Must notify employees about the Health Insurance Exchange and premium subsidies.

5. Employers must report whether they offer coverage and the names and numbers of employees who are enrolled.

6. Employers with more than 200 employees must auto-enroll new employees in their coverage plan and continue coverage of current employees.
1. Companies of low-income, homogenous employees may opt to pay the penalty and drop coverage.

2. Companies with diverse workforces likely will keep coverage.

3. Unless the exchanges surpass expectations, employer-based coverage will still be competitively desired.
ACA includes numerous pilot programs

- Bundled payments
- ACOs (Accountable Care Organizations)

- Few are binding at this point
- Within this work is where industry is paying close attention
Current Healthcare Economic Environment
1. The health industry is in a major cycle of change
2. Providers (Doctors, Hospitals, Etc.) and Employers/Employees likely can’t sustain existing economic models
3. Care models and business models are changing
4. Outcome based care and population health are the “buzz words”
WHAT DO WE EXPECT?

1. More “insured” people accessing a crowded system
2. Potential shortage of physicians, nurses, other clinicians
3. Uncertain payment mechanisms
4. Changing delivery models
   • “Higher quality at lower cost”
There likely will be:

• Intensifying pressures to control costs, leading to new payment arrangements that place hospitals and health systems at greater risk

• Uncertain(?) number of uninsured; uncompensated care and collection problems may increase or decrease

• Declining payment/support from Medicaid at the same time that number of Medicaid patients increases

• Increasing price sensitivity on part of consumers

• More pressure from purchasers for price and quality transparency

• Continued (possibly worsening) differential funding by payer
WHAT DOES THE FUTURE HAVE IN STORE FOR HEALTHCARE?

• Continued bifurcation of hospitals by financial status seems highly likely: hospital haves and have not's

• Continued increase in hospital/physician integration via partnerships and other cooperative arrangements
Volume Based vs. Value Based Models

**Volume Based**

- The more care and services we provide, the more we are reimbursed
- Managing one patient at a time
- Fragmented Care

**Value Based**

- It's not how many patients that are seen but how well we care for them
- Population Management
- Accountable Care
WHAT IT MEANS FOR YOU

• Beneficiaries of coverage expansion
  – Uninsured
  – Self employed
  – Pre-existing conditions
  – Unemployed
  – Poor
  – Young adults 18 – 29
  – Some small businesses and employees
WHAT IT MEANS FOR YOU

• Medicare recipients – reduction in Medicare payments to doctors (this is how the expansion is funded) may make it harder to get appointments.

• Employer-based insured – if your employer doesn’t drop coverage you should be ok...for now. Critics believe costs may increase in long run?
WHAT IT MEANS FOR DOCTORS (And Other Health Providers)

- Shrinking payments from Medicare.
- Potential new patients from newly insured?
- No-one knows what type of rates the HIX products will pay.
- If Medicaid expands – new patients may overwhelm the system?
- If Medicaid doesn’t expand – Providers still have “Bad Debt” from patients that can’t pay.
WHAT IT MEANS FOR DOCTORS
(And Other Health Providers)

• The push to deliver higher quality care at a lower cost may greatly stress the healthcare system.

• 40% of Physicians surveyed in a 2010 poll said they would retire or otherwise leave clinical practice. (Physician’s Foundation, 2010)
1. Controlling Costs: The Great Weakness of ObamaCare
2. More Benefits Mean Higher Costs
3. Why Did the Insurance Industry Support the ACA?
4. How about prescription drug companies?
5. Are Healthcare Costs Rising Because of the ACA?
5. A Review of the New ObamaCare Mandates
   a) No pre-existing condition rejections
   b) Temporary “high-risk pool” in each state
   c) Children can be insured on their parents’ plan up to age 26
   d) No annual or lifetime cap on benefits
   e) No rescissions
   f) “Essential health benefits” covered
   g) “Medical-loss ratios” tightened
   h) Restrictions on premium discrimination
TURNING THE SCREWS ON MEDICARE

1. Closing the “Donut Hole”
2. More Retirees May Need to Use Medicare’s Prescription Drugs
4. Medicare Spending Cuts
5. Medicare Payment Rate Cuts
6. Medicare Advantage Cuts
7. Independent Payment Advisory Board (IPAB)
OBAMACARE: THE FINE PRINT
MAKING AMERICANS HEALTHIER

1. No Co-Pays for Approved Preventive Services
2. Prevention as a Guaranteed “Essential Health Benefit”
3. Employer-Based Personal Wellness Reward Programs
4. Nutritional Information in Restaurants
5. Increased Funding for Preventive Services in Medicaid
6. Prevention Counseling in Medicare
7. Additional Costs for a Healthier America
1. Check Your Eligibility for Medicaid
2. Don’t Pay the Individual Mandate Penalty Unless You Have To
3. Get OTC Prescriptions if You Use a Health Savings Account
4. Get Approved Preventive Tests Without Being Charged Co-Pays
5. Check to See if Your Employer Has a Personal Wellness Reward Program
6. Use the Government’s “High-Risk” Insurance Pool if You Need To
7. If You’re an Early Retiree Under Age 65, Prepare to Lose Your Insurance in 2014
8. Medicare Advantage Enrollees Might Need to Find an Alternative
9. If You’re a High Earner, Talk to Your Accountant
10. Small Business Owners Should Calculate Health-Related Costs of New Hires
11. Stay Informed