What's in Store for Older Adults (50-64) Under Health Care Reform

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March 13, 2013

National Elder Rights Training Project for the National Legal Resource Center.
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NLRC

Providing Legal Support to the Aging Advocacy Network

- http://www.nlrc.aoa.gov/
- Collaboration developed by the Administration for Community Living/ Administration on Aging between the National Consumer Law Center, National Senior Citizens Law Center, American Bar Association Commission on Law and Aging, Center for Elder Rights Advocacy, and the Center for Social Gerontology
- See upcoming trainings, conferences, and webinars
- Request a training
- Request consulting
- Request technical assistance
- Access articles and resources

Presenter – David Machledt

- David Machledt joined NHeLP in February 2012 as a policy analyst. His work at NHeLP centers primarily on health reform implementation.
- David has a Ph.D. in Anthropology from the University of California, Santa Cruz with a focus on medical anthropology, immigration and public health policy.
- David's dissertation work investigated the design of binational public health policy and access to care issues for vulnerable migrant populations at the US/Mexico border.
- In 2010-11, he taught courses on health and immigration at the College of the Atlantic in Bar Harbor, Maine.

Presenter – Leonardo Cuello

- Leonardo Cuello joined NHeLP in December 2009 and is the Director of Health Reform.
- Leonardo also leads NHeLP's work on health reform and the Campaign for Better Care (a coalition to improve care for older adults).
- Prior to joining NHeLP, Leonardo worked at the Pennsylvania Health Law Project (PHLP) for six years focusing on a wide range of health care issues dealing with eligibility and access to services in Medicaid and Medicare.

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NHeLP

- National non-profit public interest law firm committed to improving healthcare access and quality for low-income individuals
- Offices in Washington D.C., Los Angeles, and North Carolina
- Visit our website at: www.healthlaw.org
  - Medicaid Expansion Toolbox
  - Resources on Medicaid

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Affordable Care Act (ACA) Topics

- Medicaid expansion
- Health Insurance Exchanges, or Marketplaces
  - Subsidies to pay for private insurance
  - Essential Health Benefits
- Private market reforms and protections

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Why did we need Health Reform?

- Over 50 million people do not have health insurance
- Even if someone has insurance, it is often very expensive or does not cover the services needed
- Many individuals with chronic conditions or high healthcare needs stopped getting coverage if the services cost too much
- Health reform means millions more get quality health care that is affordable

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FDR
THE DOCTOR WILL SEE YOU NOW.
HEALTH CARE REFORM 2010
MILLIONS OF UNINSURED AMERICANS

Affordable Care Act (ACA)

- Starting in 2014, health reform is projected to newly insure 33 million
- 16 million people will gain coverage through the Exchange – four out of five with subsidies
- 17 million people will gain coverage through an expansion to the existing Medicaid program – aka the “Medicaid Expansion”

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MEDICAID & THE ACA

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Medicaid Today

- Medicaid is the nation's largest health program. In 2009, an estimated 63 million individuals enrolled for some period of time
- Medicaid is voluntary for states
- States and the Federal government share the costs
- Medicaid offers more benefits than most private insurance at lower costs to beneficiaries

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Medicaid Eligibility

- Medicaid eligibility has been based on 2 main concepts:
  - Being very low-income with few savings/assets
  - Fitting into a “category” (pregnant women, children, elderly, people with disabilities); and
- States must cover certain mandatory groups; states may take up optional categories or raise income thresholds
- Adults generally left out (Except parents with dependent children, who are covered at extremely low income levels in most states)

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Medicaid Changes in 2014: The Adult Medicaid Expansion

- Age 19-64, not pregnant, not Medicare eligible
  - No other category requirement
- Income up to 138% of FPL
  - No asset test
- Must meet Medicaid immigration status requirements
- States currently designing the "alternative Benefit Package" coverage, which must provide certain minimum benefits for those newly eligible
- Federal government pays 100% of costs for newly eligible individuals from 2014-2016 then phases down to 90%

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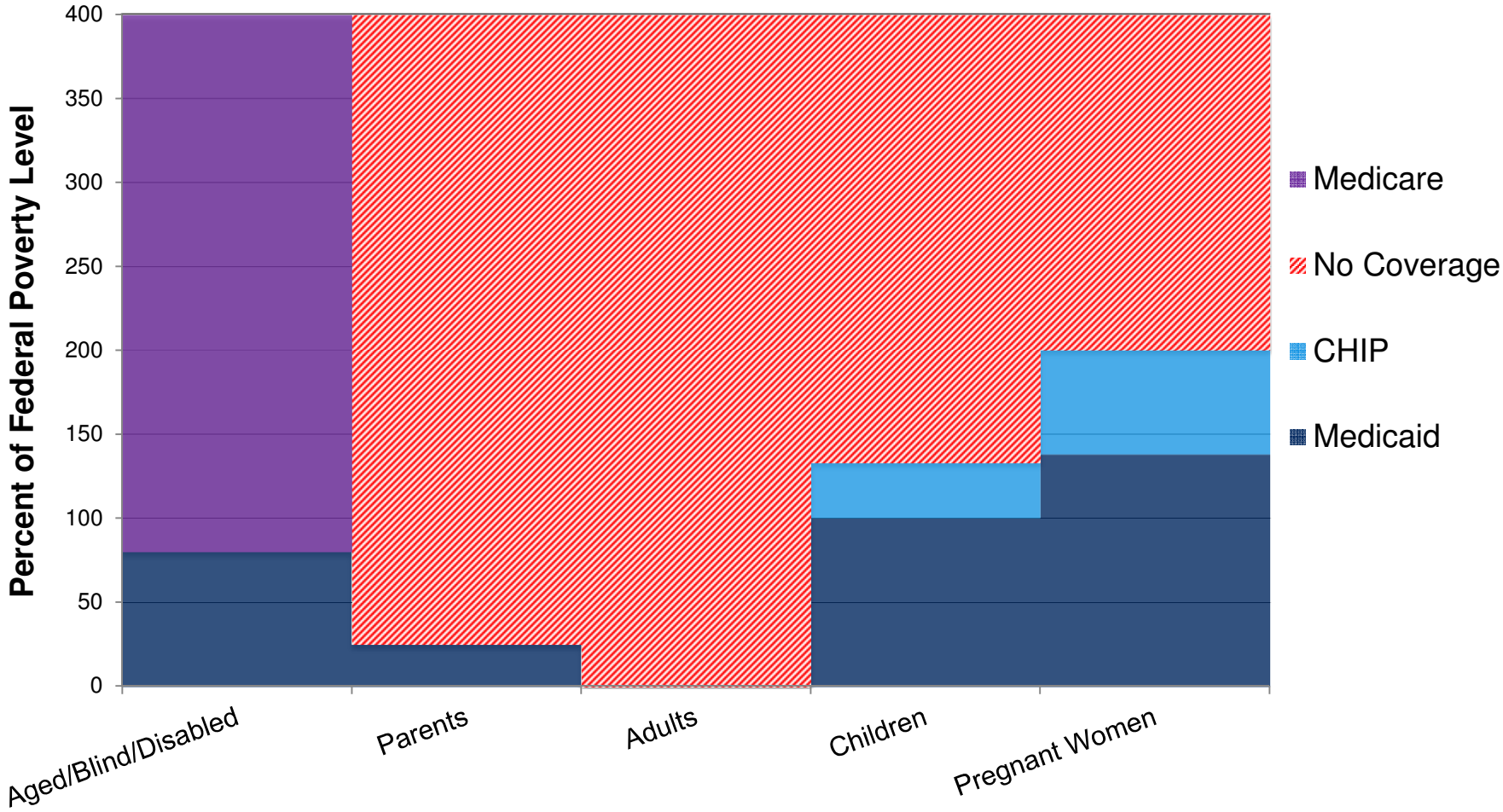
Pre-ACA Coverage: Virginia today



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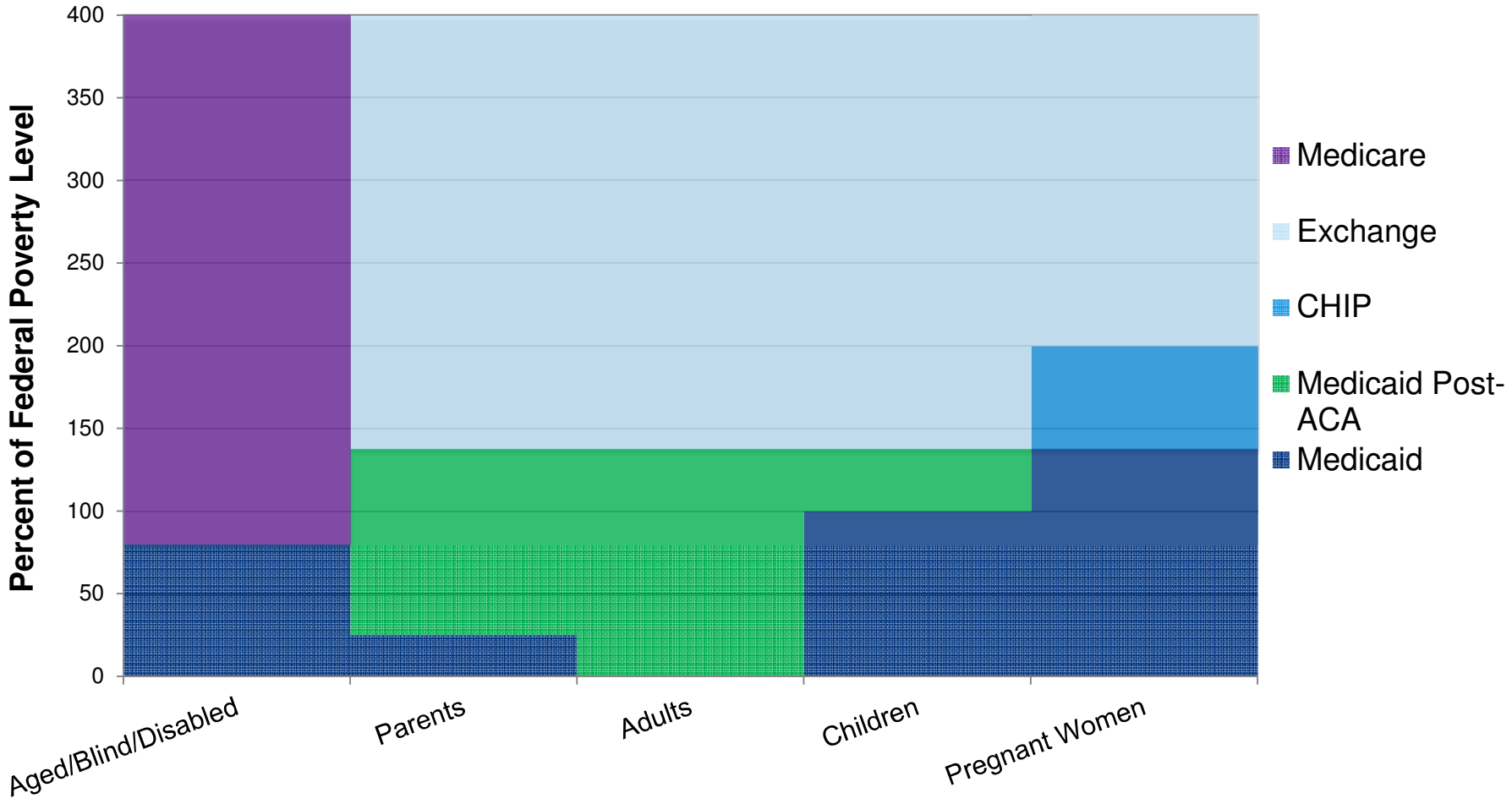
ACA Seamless Coverage: Virginia in 2014, with Expansion



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"Supreme" Headache

- The ACA made the Medicaid expansion a mandatory part of health reform for every state
- The Supreme Court ruled that health reform was valid, but that there can be no punishment of a state that refuses to do the Medicaid Expansion
- So now each of your states can decide (i.e., play politics) about whether and when to expand
  - Enter or leave anytime

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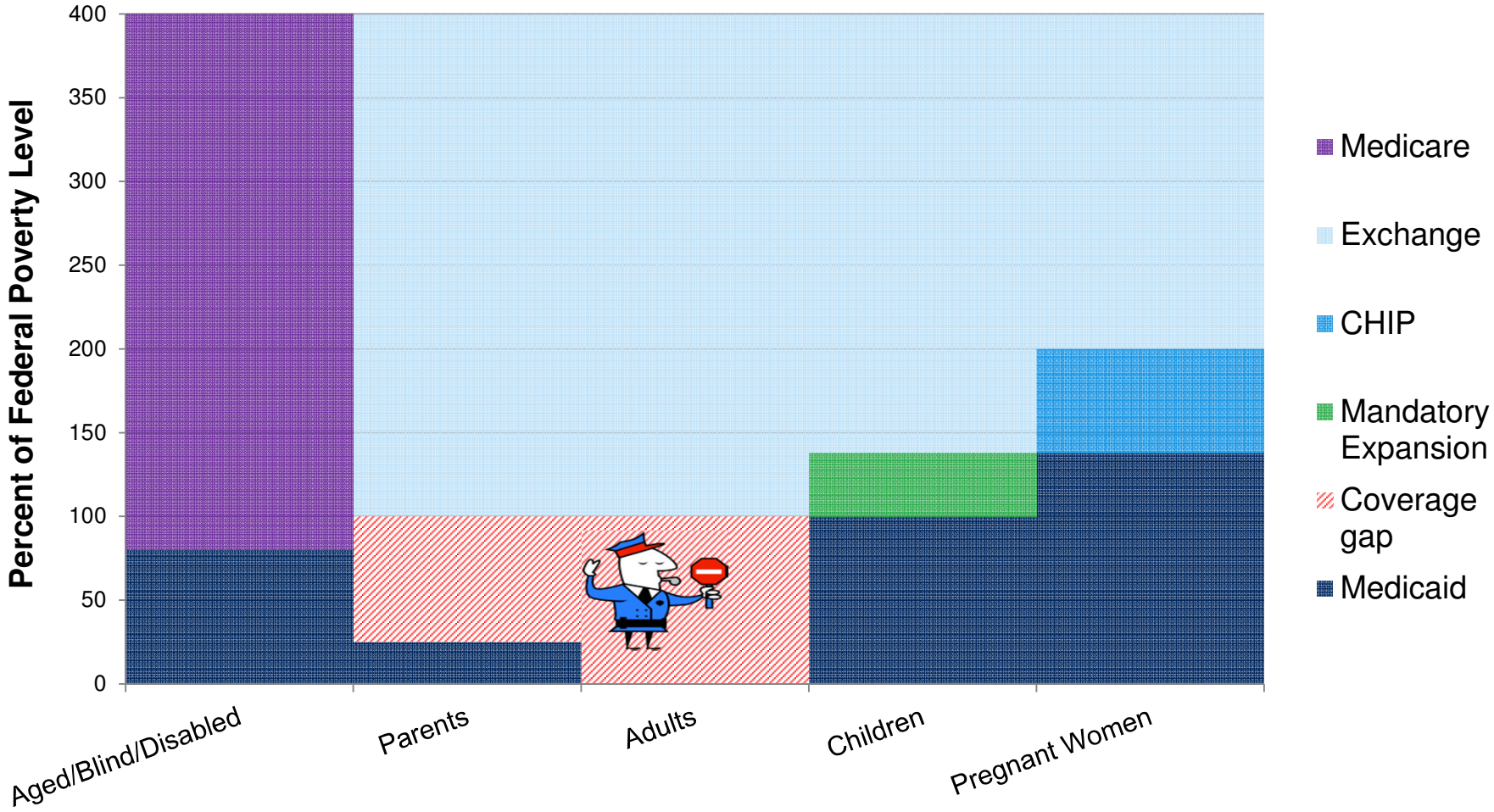
Coverage Gap: Virginia without Expansion, 2014



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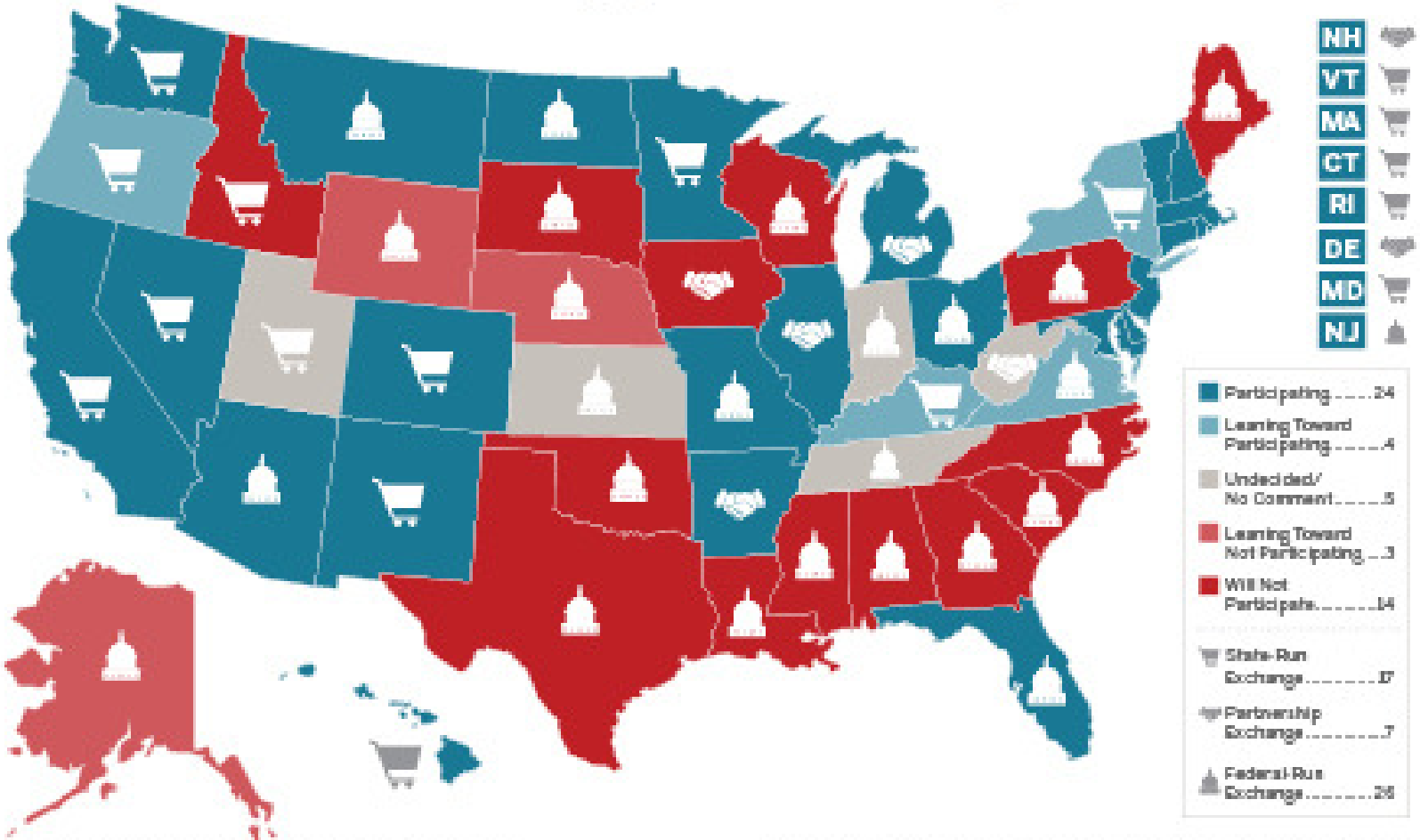
Where the States Stand: March 1, 2013

24 Governors Support Medicaid Expansion



Note: Based on literature review as of 3/1/13. All policies possible to change without notice.
The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.

Source: American Health Line, http://ahlalerts.com/2012/07/03/medicaid-where-each-state-stands-on-the-medicaid-expansion/, accessed 3/1/13.

The Advisory Board Company

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

Short break for questions…

HEALTH INSURANCE EXCHANGES

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Health Insurance Exchanges

- "Marketplaces" will coordinate the new eligibility and enrollment for individuals and small group market
- Individuals between 100 to 400% FPL will qualify for subsidies to help pay premiums.
- Individuals between 100 to 250% will get reduced cost sharing (deductibles, co-pays and other out-of-pocket costs)
- Three types:
  - State-operated
  - Fed/State Partnership
  - Federally-facilitated

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Applying

- Single application for Medicaid, CHIP and private insurance coverage (unless you get insurance through your employer)
- Can apply in person, over the phone, by web or mail to the Health Exchange
- Uniform summary of benefits and coverage – apples to apples comparisons of plans
- "Navigators" will help individuals understand their options during the application and enrollment process

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Eligibility

- Eligibility basics – an individual must:
  - Live in the state
  - Be a citizen or a lawfully present immigrant
- Subsidies and cost sharing reductions
  - Individuals and families up to 400% FPL can get tax credits to help paying monthly premiums
  - Individuals from 100 to 250% FPL can get plans with reduced cost sharing
  - Only available if individual has no access to affordable insurance through employer, Medicare or Medicaid
- Older beneficiaries below 400% FPL do not pay more; instead their tax credits increase to cover higher premiums

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Paying for Marketplace Insurance

Income Level	Premium Cost as Percent of Household Income	Average Cost-Sharing Paid by Individual
Up to 133%FPL	2%	6%
133% up to 150%	3% to 4%	6%
150% up to 200%	4% to 6.3%	13%
200% up to 250%	6.3% to 8.05%	27%
250% up to 300%	8.05% to 9.5%	30%
300% up to 400%	9.5%	30%

NOTE: The premium cap is based on the cost of the second-lowest cost silver plan available to the individual. An individual who enrolls in a more expensive gold plan would pay more. An individual who enrolls in a cheaper bronze level plan would have lower or no premium costs. Cost sharing reduction is only available with silver plans.

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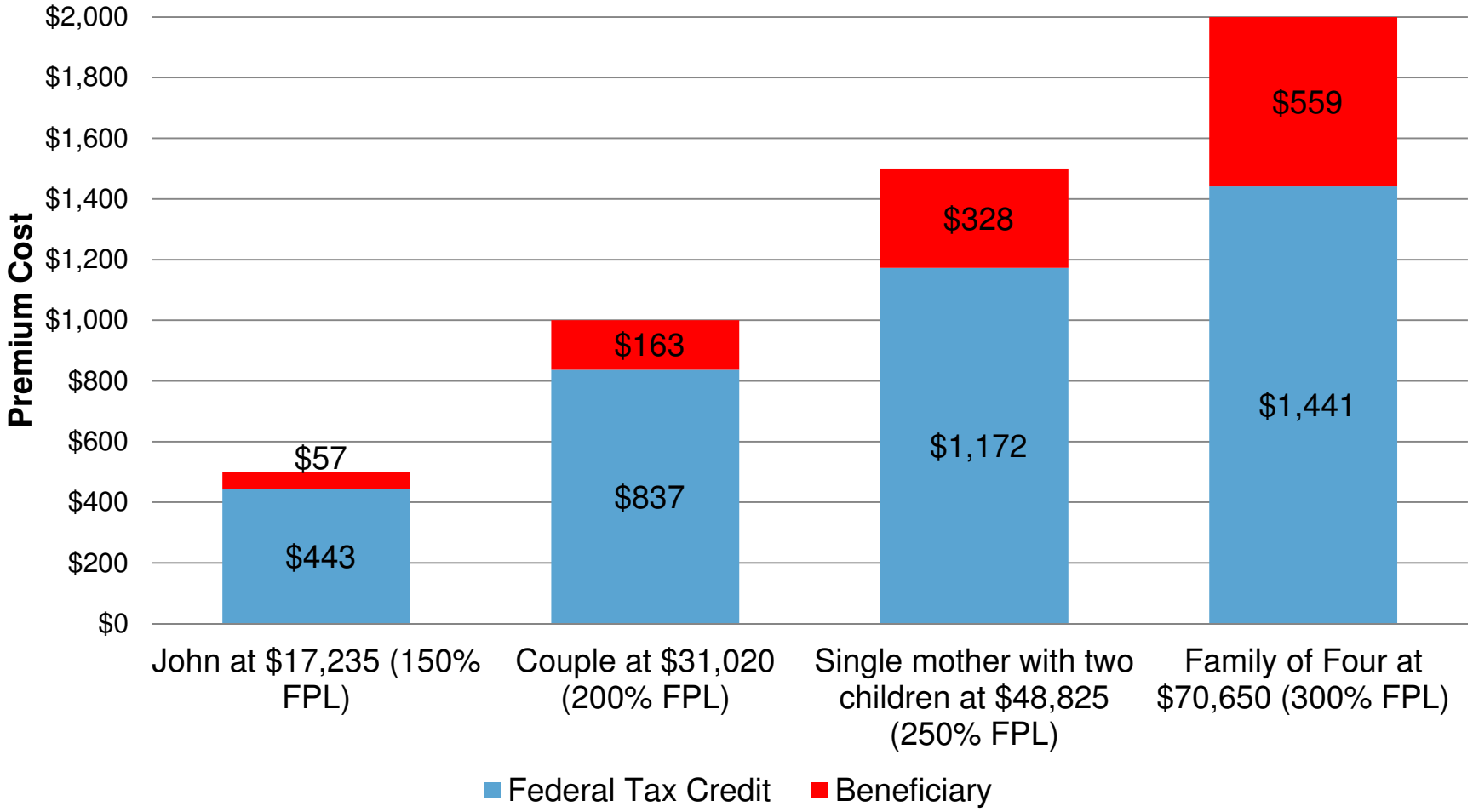
Monthly Premium Costs on the Exchange*



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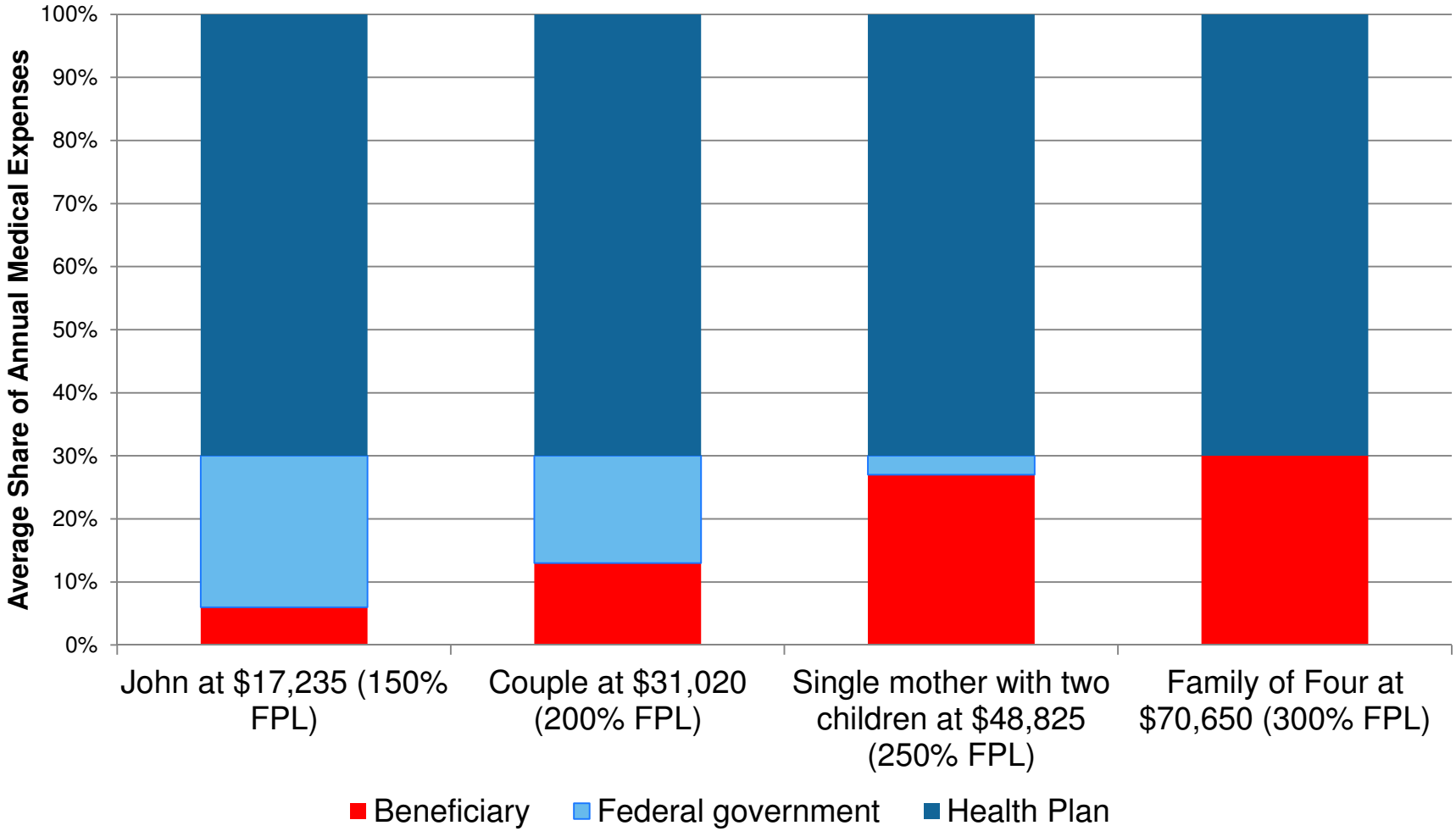
* Based on second cheapest silver plan at $500/month per person.

Average Share of Medical Expenses on the Exchange*



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* Based on second cheapest silver plan at $500/month per person.

Confusion!

- Enrollees in the Exchange can choose between qualified health plans. They will select between four levels of health plans that cover different percentage of average health costs (Bronze, silver, gold, platinum) as well as catastrophic. However, the best option for most low income individuals will be silver plan because they can get extra help paying the cost-sharing. Huh?
- “Bronze trap”
- This is why navigators and consumer advocates will be critically important!

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Essential Health Benefits

- All health plans must cover certain “essential health benefits”
  - 10 categories, such as prescription drugs,
  - Mental health parity
- Preventive services without cost-sharing:
  - Recommended screenings and counseling
  - Preventive care and screening for women (e.g. mammograms (Age 40+), osteoporosis (Age 60+))
  - Regular immunizations and some preventive care for children and adolescents
- Health plans must also provide wellness services and chronic disease management

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PRIVATE MARKET REFORMS & OTHER ACA CHANGES

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Private Market Reforms

- If you get insurance through your employer, things should mostly stay the same
- Guaranteed issue
- Pre-existing conditions may not be excluded (adults in 2014, children now)
- Limitations on rating
  - Insurers cannot charge higher rates based on beneficiary health status or gender
  - ACA establishes federal limits on insurers' ability to charge higher premiums based on a beneficiary's age
- Elimination of annual and lifetime caps on coverage
- Parents can insure their children up to age 26
- Insurer accountability to consumers
  - Insurers must spend at least 80% of your premiums on services or provide a rebate
  - Insurers cannot raise their rates without explaining why

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Mike Luckovich
Health Insurer
YOUR EXCUSES FOR NOT PROVIDING ME CONERAGE HAVE BEEN DENIED...
HEALTH CARE REFORM

Medicare and the ACA

- Medicare reforms
  - “Donut hole” closed
  - Spending growth slowed (no benefit cuts)
  - Annual wellness visit and preventive screenings without cost-sharing
- Better coordination for Medicare/Medicaid enrollees
- Transition to Medicare at 65

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COVERAGE FOR 30 MILLION UNINSURED. THOSE WITH PRE-EXISTING CONDITIONS COVERED. CAN'T BE DROPPED IF THEY GET SICK. FREE PREVENTIVE CARE...
OBAMACARE UPHELD
MIKE LUCKOVICH
I'm BUMMED.
OBAMACARE UPHELD

Health Reform: Getting Involved

- Congress may try to cut Medicaid or introduce per capita caps
- States are currently debating Medicaid expansion
- States are now defining their benefit packages for Medicaid expansion and for the Exchanges
- States are implementing eligibility and enrollment systems
- Some states are looking to do things in the name of "flexibility" that will hurt consumers, such as raising cost-sharing on beneficiaries

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Additional Resources

- National Health Law Program: www.healthlaw.org
  - Medicaid Expansion Toolbox
  - Resources on Medicaid
- Federal government sites:
  - www.cms.gov
  - www.healthcare.gov
- National Senior Citizens Law Center: www.nsclc.org
  - Information on Dual eligible demonstrations
  - Resources on long term care

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THANK YOU

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Bonus Slide:
Other ACA Medicaid Changes

- Medicaid raises payments to some primary care providers to increase their participation
  - Equivalent to Medicare levels for 2013-2014
  - No cost to beneficiaries
- Reductions in Disproportionate Share Hospital (DSH) payments
- New options for Long Term Services and Supports

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