Connecticut Health Reform in the Wake of Federal Action: Federal Reforms & SustiNet

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Office of the Healthcare Advocate
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Overview of the Patient Protection and Affordable Care Act (PPACA), as amended

- Overall architecture of the new federal law
- Suggested changes to state law because of reform
- A basic approach for adjusting SustiNet to the new federal law
- Policy design issues under this basic approach
Part I

Overall structure of the new federal law
Basic architecture: 2014

- Health insurance exchanges
  - Run by state agency, nonprofit, or federal government
  - Consumers can choose among multiple health plans
  - Access by
    - Consumers not offered employer-sponsored insurance (ESI),
    - Small firms (and at state option, large firms)
- Subsidies
  - Medicaid up to 133% of federal poverty level (FPL)
  - Tax credits, other subsidies up to 400% FPL
- Shared responsibility
  - Individuals must buy coverage (with exceptions)
  - Employers with >50 FTE workers pay a penalty if ESI not offered
- Insurance reforms
- Delivery system reform encouraged in many ways
Other policy features: “Early deliverables” effective in 2010:

- **Immediate for Connecticut:**
  - Reinsurance for early retirees
  - High-risk pool dollars
  - Grants for independent state offices of health insurance consumer assistance
  - “Backstop” rate review provisions-$1M grant to Insurance Dept.
  - Medical loss ratio reporting – Final guidance given by NAIC
  - Early adopter Medicaid expansion for SAGA
  - Required Medicaid coverage of tobacco cessation for pregnant women
  - Planning grants for Medicaid coverage of patient centered home services for chronically ill
  - Grants for work force programs with a focus on primary care and the underserved
  - No preexisting condition exclusions for children
  - Begin Medicare Part D donut hole assistance with $250 rebate

- **Effective six months from enactment (September 2010):**
  - Dependents on parental policies to age 26
  - Independent appeals process
  - Rescissions limited to fraud and intentional misrepresentation
  - Bar on lifetime limits & annual limits limited to reasonable limits
  - First dollar coverage for preventive services.
Federal health reform: covered services and benefit design

- No lifetime or annual limits
- Required “essential benefits” are defined by the Secretary of HHS
- Must be like a “typical employer plan”
- Plans in small group and non-group must offer plans that are 60, 70, 80 and 90 percent of actuarial value of essential benefits
Federal reform: Benefit Design (continued)

- Limits on out-of-pocket expenses
- Lower out-of-pocket limits for low-income
- New Medicaid eligible population: essential benefits, plus drugs and mental health (could be different from current CT Medicaid)
Grandfathered Plans

- Part of promise to allow folks to keep current plans. To retain grandfathered status under PPACA, plan:
  - Cannot Significantly Cut or Reduce Benefits.
  - Cannot Raise Co-Insurance Charges.
  - Cannot Significantly Raise Co-Payment Charges.
  - Cannot Significantly Raise Deductibles.
  - Cannot Significantly Lower Employer Contributions. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points.
  - Cannot Add or Tighten an Annual Limit on What the Insurer Pays.
Grandfathered plans are NOT exempt from:

- **No lifetime limits on coverage for all plans;**
- **No rescissions of coverage when people get sick and have previously made an unintentional mistake on their application;**
- **Extension of parents’ coverage to young adults under 26 years old;** and the
  
  For the vast majority of Americans who get their health insurance through employers, additional benefits will be offered, irrespective of whether their plan is grandfathered, including:

- **No coverage exclusions for children with pre-existing conditions;** and
- **No “restricted” annual limits (e.g., annual dollar-amount limits on coverage below standards to be set in future regulations).**
Federal reform: preventive services

- Plans must cover preventive services recommended by the US Preventive Services Task Force
- Medicare will cover an annual wellness visit providing a personal prevention plan
- No cost sharing for prevention in all plans, except grandfathered plans
- Grants to state for healthy lifestyle incentives in Medicaid
Federal health reform: prevention and public health investments

- Prevention and public health investment board with dedicated, stable funding for prevention, wellness and public health activities
- National prevention and health promotion outreach and education campaign
- Grants for school-based health centers
- Oral health prevention
- Nutrition labeling at chain restaurants
- Pilot program for health risk assessments at CHCs
Federal Funding Opportunities

- PPACA includes a number of funding opportunities for preventive care, including:
  - 10 state wellness demonstration (Secs. 1201 and 4206)
  - Grants for incentive programs to help Medicaid recipients quit smoking, control/reduce weight, lower cholesterol and blood pressure (Sec. 4108)
  - Grants for community preventive health activities (Sec.4201)
  - Pilots to promote healthy aging (Sec.4202)
  - Demonstration to increase immunization of high risk populations (Sec. 4204)
  - Support community-based collaborative care networks of providers to provide comprehensive coordinated and integrated health care services for low-income populations (Sec. 10333)
  - Workplace wellness grants for small employers (Sec. 10408)
Some Medicaid/CHIP PPACA Provisions

- Medicaid eligibility increases to 133% FPL for individuals < 65 years old
- Clarifies that “medical assistance” means “payment for services”
- Extends Premium Assistance Option for ESI
- Enhanced FMAP for CHIP in 2015
- Requires simplification of enrollment and coordination with insurance exchanges
- Allows participating hospitals to make presumptive eligibility determinations.
- State plan option to Provide Community and Home Based Services
Major Caveats

– The law is huge and complex
  • PPACA & reconciliation sections
– We’re receiving and can shape guidance on implementation provisions
– Many provisions already binding
– Many grants are authorized but not yet appropriated
  • Multiple opportunities to bring in federal $ while addressing access and cost issues
  • Many private and public non-profit grant options
• Connecticut’s Public Option
• Structure similar to federal exchange
  – Administered by entity TBD
  – Includes reforms- HIT, PCMH, wellness, etc.
  – Includes provision of direct services
• Populations include:
  – State employees
  – Public programs
  – Individuals and small businesses
Elements of SustiNet & Federal Reform

• Newly available federal resources to implement delivery system reforms, starting NOW. E.g.:
  – $5 billion in reinsurance for early retiree coverage, premised on slowing cost growth for the chronically ill
  – $10 billion for care innovation demonstrations
  – 90 percent Medicaid match for medical home demonstrations
  – SustiNet as state/regional hub for primary care, med. home

• SustiNet embodies an integrated strategy for implementing delivery system reforms favored by federal law to “bend the cost curve”
Current state employee and Medicaid benefits

• Similar in breadth to SustiNet offerings
• Do not cover tobacco cessation--except for pregnant women up to 250% FPL--nutritional counseling or wellness programs
• Low or no cost sharing for preventive services
• Benefits subject to collective bargaining
## Comparison of covered services

### Selected Covered Services in Sustinet Plans

<table>
<thead>
<tr>
<th>Service</th>
<th>Sustinet Act</th>
<th>Husky A and Medicaid LIA</th>
<th>Husky B</th>
<th>Charter Oak Plan</th>
<th>State Employees &amp; Retirees (in-network care)</th>
<th>Municipal Employee HIP</th>
<th>Under 100% FPL</th>
<th>200%-300% FPL</th>
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### MA Commonwealth Care Covered Services

- Under 100% FPL
- 200%-300% FPL
Part II

Key policy design issues for SustiNet
Implementation before 2014

- Not in question: applying delivery system reforms to existing SustiNet populations before 2014 (SustiNet plan begins in 2012)

- Issues before 2014
  - Expanding HUSKY to currently ineligible consumers
  - Offering SustiNet to employer groups (small firms, non-profits, municipalities)
  - Offering SustiNet to individuals
  - Compliance with other federal laws
    - Mental Health Parity and Addiction Equity Act of 2008- regulations now in effect
SustiNet Reforms

• Three core components:
  • Patient-centered medical homes serve SustiNet members
  • Health Information Technology supports practice transformation
  • Incentives provided for evidence-based medicine
New Model of Care

**Benefits**
- Comprehensive services
- Integrated physical and behavioral health

**Payment**
- Range of models, but all include set payment for broader array of services, most with some provider risk sharing
- Increased payments for primary care

**Incentives**
- Reduced incentive for overtreatment (provider risk-sharing)
- Reduced incentive for undertreatment (quality standards and monitoring)

**Care Delivery**
- Primary care medical home coordinates care
- Increased emphasis on patient management through primary care
- Flexibility for providers to change/substitute care
Additional benefits and services that affect health status

– Early evaluation and diagnosis
  • Health needs assessments
  • Evidence-based screenings
  • Identification of developmental delays
  • Consumer choice

– Support for lifestyle modifications
  • Smoking cessation
  • Substance abuse cessation
  • Nutritional counseling and weight loss coaching
  • Stress management

– Chronic conditions
  • Improving medication compliance
Relationship between SustiNet and the Exchange

- 60-day report recommended modifying CT licensure rules so SustiNet can be offered in the exchange
- Independence of SustiNet and the Exchange
  - Should a non-profit or the federal government run the exchange, instead of a state agency?
  - Should something other than a state agency run SustiNet?
- Supplementing federal subsidies for SustiNet and exchange plans that reform health care delivery
SustiNet Board Activities

• October: administration and governance (includes presentation on implications of offering SustiNet as an option in the exchange)
• November: costs and financing (includes implications of pursuing the federal Basic Health Program option)
• December: draft report
• Update information available at www.ct.gov/sustinet
Conclusion - SustiNet

• SustiNet
  – Fits comfortably within the federal reform framework
  – Positions CT to access newly available federal resources
  – Carefully flesh out answers to key questions in response to 60 day report, available at:
Conclusion for CT

Generally

• CT needs to:
  – Act now to implement early deliverables and pull down federal funds
  – Respond to requests for comments on how HHS, DOL, DOT should implement sections
    – OHA has submitted comments on multiple regulations
  – Continue to educate Connecticut residents on landmark federal legislation & SustiNet
  – Be vigilant and ready for opportunities