PURPOSE AND BENEFITS OF THE AFFORDABLE CARE ACT

Congressman Elijah E. Cummings' Health Care Town Hall

July 22, 2013

Governor's Office of Health Care Reform

Carolyn A. Quattrocki, Executive Director

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What Problem Are We Working to Solve?

- ➢ **U.S. spends 1.5 times more on health care than any other developed country, and 2.5 times more than the average.**
  - ▪ $3,000 more per person than Switzerland, with comparable income.

- ➢ **Yet Americans die earlier and live in poorer health.**
  - ▪ Highest rates of infant and adult male mortality, and second highest mortality rate for women;
  - ▪ Second highest rates of death from heart, lung, and substance use; and
  - ▪ Lowest probability of living to age 50.

- ➢ **Growth in U. S. health care spending unsustainable.**
  - ▪ Health spending has doubled in past 30 years, rising from **9.2%** of GDP in 1980 to **17.9%** in 2011;
 - ▪ Health insurance premiums have increased 97% in the last decade.

Overarching Goal of Health Care Reform

BETTER HEALTH AT LOWER COST FOR ALL MARYLANDERS

Four Pillars of the Affordable Care Act

Stronger, Non-Discriminatory Insurance Coverage

Expanded Access to Health Insurance and Health Care

More Affordable Insurance Coverage

Cost Control and Improvement in Outcomes

Bringing These Benefits To Maryland
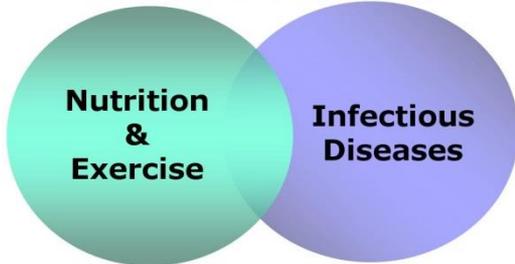
Health Care Reform Coordinating Council
Established by Executive Order, March 2010

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✓ **Executive and legislative leaders in health care**

✓ **Directed to examine Affordable Care Act and make recommendations to Governor and General Assembly on how State should implement reforms in ways that would work best for Maryland.**

Report: 16 Recommendations in 5 Categories

➢ **Health Benefit Exchange, Medicaid Expansion and Insurance Market Reforms**
➢ **Health Care Delivery and Payment Reform**
➢ **Public Health, Safety Net, and Special Populations**
➢ **Workforce Development**
➢ **Communications/Outreach and Leadership/Oversight**

Collaborative Approach

State Agencies, Local Jurisdictions, Non-Profits and Private Sector

Robust Stakeholder Process

Advisory Committees

Patients' Bill of Rights
Stronger, Non-Discriminatory Coverage
Chapter 4 2011 Laws of Maryland
Chapter 368 2013 Laws of Maryland

➢ Young adults can stay on parents' insurance plan until age 26; **52,000 in MD; 2.5 million nationwide**.

➢ No children denied coverage because of pre-existing condition.

➢ No lifetime limits on benefits and harder to rescind policies when people get sick; **2.25 million Marylanders benefiting, including over one half million children.**

➢ In **2014**, no exclusions for **pre-existing conditions** or **annual limits** on benefits.

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Patients' Bill of Rights
Stronger, Non-Discriminatory Coverage
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IO Reports:
Insurance,
Gender Rating
and Sex
Discrimination

➢ **Women** no longer paying higher premiums because they are women.

➢ **Preventive services:**

✓ ACA requires coverage of many preventive services at no cost;

✓ Examples include mammograms and other cancer screenings, flu shots and other vaccines, tobacco cessation programs;

✓ Services designed for women, like well visits, contraception, breastfeeding equipment, and domestic violence and counseling;

Break the habit!

✓ **1.2 million Marylanders covered** with no cost-sharing; **554,000 on Medicare** have received at no cost; 797,185 eligible.

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FOUNDED 1634

Patients' Bill of Rights
Stronger, Non-Discriminatory Coverage
Chapter 4 2011 Laws of Maryland
Chapter 368 2013 Laws of Maryland

➤ **Carriers' rating factors** limited to:

- ✓ Age bands no greater than 3:1
- ✓ Family size and geography
- ✓ Tobacco use no greater than 1.5:1
  - ▪ Maryland Health Progress Act directs State to study whether tobacco use rating should be eliminated or narrowed.

➤ **Limits on out-of-pocket costs** - $6,350 for individual; $12, 700 for family; lower on sliding scale for consumers below 400% of federal poverty level.

➤ **New 80/20 Medical Loss Ratio**
- ✓ 141,000 Marylanders received $28 million in rebates in 2012;
- ✓ Average of $340 per family.

HEALTHCARE FACTS

Consumers *received*
$1.1 billion
in rebates from their
insurance companies.

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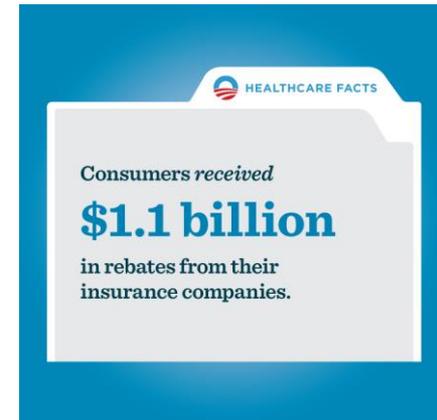
ESSENTIAL HEALTH BENEFITS: SELECTION OF STATE'S BENCHMARK

FEDERAL GUIDANCE – AFFORDABLE CARE ACT

➢ **Beginning in January, 2014, all plans offered in small group and individual markets inside and outside exchanges must cover "essential health benefits."**

Must cover 10 categories of mandated essential health benefits

- **Ambulatory patient services;**
- **Emergency services;**
- **Hospitalization;**
- **Maternity and newborn care;**
- **Mental health & substance use disorder services;**
- **Prescription drugs;**
- **Rehabilitative and habilitative services;**
- **Laboratory services;**
- **Preventive/wellness services & chronic disease management;**
- **Pediatric services, including oral and vision care**

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ESSENTIAL HEALTH BENEFITS: SELECTION OF STATE'S BENCHMARK

- **HCRCC** solicited stakeholder input and expert consultant's comparative analysis, and on December 17, 2012:
  - **Made selection of State's small group plan as benchmark**;
  - Retained all existing mandates in markets in which currently applicable;
  - Substituted more comprehensive and parity compliant federal employee behavioral health benefit;
  - Added adult component to existing child habilitative services benefit in parity with current rehabilitative services benefit.
- **HCRCC decision preserves stability in small group market while offering robust, comprehensive benefit coverage and open drug formulary.**

Medicaid Expansion

➢ **MAGI** - New eligibility rules based on "modified adjusted gross income" standard
- Uses income tax rules regarding household composition, income and deductions;
- Same standard in all states;
- Same standard used to determine eligibility for subsidies in Exchange.

2013 Federal Poverty Level Guidelines

➢ **Expanded eligibility** - All citizens at or below **138% of federal poverty level**
- No longer specific categories, *e.g.* pregnant women, parents, for income-based eligibility;
- About $16,000 for individual;
- $33,000 for family of four.

Household Size	138%	400%
1	$15,856	$45,960
2	$21,404	$62,040
3	$26,951	$78,120
4	$32,499	$94,200
Each additional add	$5,548	$16,080

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Medicaid Expansion

➢ **Primary Adult Care (PAC) program** – will convert to full Medicaid benefits 1/1/14.
  - 75,000 currently on PAC; outreach opportunity between now and January.

➢ **Foster care** – Children who age out of foster care can retain Medicaid to age 26.

➢ **Paradigm shift** – new assumption that all citizens qualify for health care;
  - Issue no longer preventing erroneous eligibility;
  - Instead, *in which program does the person qualify*?

➢ **Federal support** – for 2014-16, 100% federally funded; tapers to 90% by 2020.

➢ **One-stop eligibility and enrollment** through Health Benefit Exchange.

Projections
➢ 2014: **110,000**
➢ 2015: **135,000**
➢ 2020: **190,000** (including current PAC population)

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Health Benefit Exchange

➤ Transparent, competitive marketplace where consumers will compare private health benefit plans based on quality and price.

➤ Federal subsidies on sliding scale for low-income people between 133% - 400% FPL.

➤ Small business tax credits: 50% of employer's contribution to premium

Projections

➤ 2014: **147,000**
➤ 2015: **170,000**
➤ 2020: **284,000**

Single Person FPL	Annual Income	Maximum Premium (as % of income)	Enrollee Monthly Share
133%	$15,281	2.00%	$25.47
150%	$17,235	4.00%	$57.45
200%	$22,980	6.30%	$120.65
250%	$28,725	8.05%	$192.70
300%	$34,470	9.50%	$272.89
400%	$45,960	9.50%	$363.85

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Pillars II and III
Expanded Access to Care and More Affordable Coverage

Effect on Maryland's Rate of Uninsured

➢ **750,000** Marylanders currently uninsured (12.7%); 13th among states;

➢ **By 2020, uninsured rate cut in half;**

➢ Medicaid expansion and Exchange enrollment will cover 350,000, or about 6.5%;

➢ Remaining uninsured will be undocumented immigrants, individuals with affordability exemption, those choosing penalty, *etc*.

Closing the Donut Hole
Prescription Drug Savings to Maryland Seniors

➢ **55,107** Maryland seniors received **$250** rebate in 2010.

➢ **49,000** saved **$37.5 million** in 2012.

➢ Overall savings to date: **$84.1 million.**

➢ Projected savings through 2020: **$400 million.**

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ECONOMIC BENEFITS OF EXCHANGE AND MEDICAID EXPANSION

Economic Stimulus

➢ Independent analysis by Hilltop Institute at University of Maryland Baltimore County found that full implementation of the Affordable Care Act will:

- **generate $3 billion in additional economic activity annually;**
- **create 26,000 new jobs by end of decade;**
- **have net positive impact on State's budget through 2020;**
- **protect safety net and other health care providers; and**
- **reduce hidden uncompensated care tax in insurance premiums.**

Source : "Maryland Health Care Reform Simulation Model" Hilltop Institute, University of Maryland Baltimore County (July 2012)

# ECONOMIC BENEFIT OF EXCHANGE AND MEDICAID EXPANSION

Economic Benefit	2104	2015	2020
Federal Subsidies	$254 Million	$607 Million	$1.3 Billion
Increase in Funds to Providers	$682 Million	$1.2 Billion	$2.3 Billion
Increase in Health Expenditures	$1.06 Billion	$2.08 Billion	$3.9 Billion
Number of New Jobs	9,000	16,000	26,000
Reduction in Uncompensated Care	$118 Million	$306 Million	$714 Million
Additional State and Local Taxes	$61 Million	$140 Million	$237 Million

Pillar IV
Cost Control and Quality Improvement: Save Money While Making People Healthier

Keeping people healthy: Investments in wellness and prevention
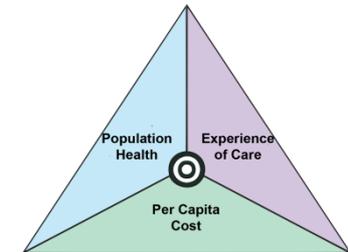
Higher quality and more efficient care delivery models: Pilots and demonstration projects with leadership from health care providers

Health Information Technology: Support ongoing efforts to develop Health Information Exchange and meaningful use of Electronic Health Records

IHI Triple Aim

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Workplace Wellness and Health Care Reform

✓ **ACA creates new incentives and builds on existing wellness program policies.**

✓ **Increases maximum permissible reward under health-contingent wellness programs from 20% to 30% of the cost of health coverage;**

✓ **Further increases maximum reward to as much as 50% for programs designed to prevent or reduce tobacco use.**

Health Care Delivery and Payment Reform

Progress

- ✓ **HCRCC's Health Care Delivery and Payment Reform Subcommittee**
    - ▪ **Identifies and supports successful clinical innovations, financial mechanisms and integrated programs underway in private sector to promote delivery system reform**
    - ▪ **Website, www.dhmh.maryland.gov/innovations**

- ✓ **Health Quality & Cost Council**

    - ▪ **Public-private Partnership to address chronic disease management, wellness and prevention, and other quality and cost control measures**
        - ▪ Healthiest Maryland
        - ▪ Cultural Competency
        - ▪ Evidence-based medicine

Health Care Delivery and Payment Reform

✓ **Health Enterprise Zones** (Health Improvement and Disparities Reduction Act of 2012)

- **Community (or contiguous cluster) of 5,000 or more residents with economic disadvantage and poor health outcomes;**

- **4-year, $4 million/year pilot to invest in local community plans to improve primary care and address underlying causes of health disparities using direct grants, property and income tax incentives, loan repayment, and other tools;**

- **5 HEZ designations:**
  1) MedStar - St. Mary's Hospital – Greater Lexington Park; 2) Dorchester, Caroline County Health Dept.; 3) Prince George's County Health Dept. – Capitol Heights; 4) Anne Arundel Health System – Annapolis; and 5) Bon Secours West Baltimore Primary Care Collaborative.

Minority Health and
Health Disparities
Maryland Department of Health
and Mental Hygiene
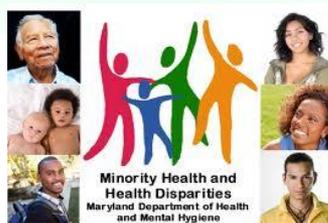
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Maryland's Patient-Centered Medical Home Pilot Programs
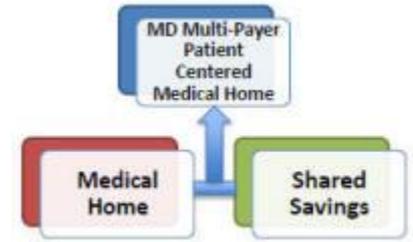
- ❑ **State multi-payer and private single payer authorized by 2010 legislation.**

- ❑ **State multi-payer:**
    - 5 commercial carriers, 6 MCOs, some self-funded employees, and TRICARE (7/13);
    - 52 practices with 250,000 "attributed" patients; 330 providers;
    - Practice transformation through Maryland Learning Collaborative;
    - Practices must deliver team-based care with care coordinator, obtain NCQA recognition as PCMH, and report on quality and performance;
    - In 2012, approximately $900,000 in shared savings issued to 23 practices;
    - Model to be evaluated to determine whether achieves savings, increased patient and provider satisfaction, and reduced health disparities.

- ❑ **Two single payers authorized as of 3/13; 1.1 million patients.**

ACA Promotion of Accountable Care Organizations
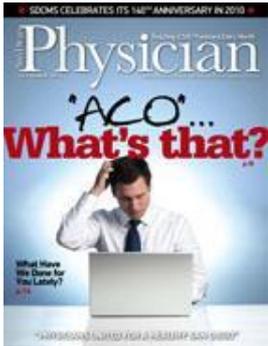
❑ **New health care delivery model where groups of doctors, hospitals, and other providers work together to:**
   ▪ provide coordinated, high quality care to their Medicare patients which:
      o ensures care at the right time and place; and
      o avoids duplication or services and medical errors;
   ▪ reduce the rate of growth in health care spending.

❑ **Medicare Shared Savings Program**
   ▪ Uses 33 performance measures for patient safety, preventative health services, care for at-risk populations, care coordination, and patient experience;
   ▪ If the cost of care is below the anticipated cost, ACO receives portion of savings.

❑ **Maryland ACOs** – 9 approved by CMS to date covering every region of State

MARYLAND ACOs

APPROVED JULY 2012

- **Accountable Care Coalition of Maryland,** Hollywood, MD, 109 physicians

- **Greater Baltimore Health Alliance Physicians,** partnerships between hospital and ACO professionals, 399 physicians.

- **Maryland Accountable Care Organization of Eastern Shore,** National Harbor, 15 physicians.

- **Maryland Accountable Care Organization of Western MD,** National Harbor, ACO group practices and networks of individual ACO practices, 23 physicians.

APPROVED JANUARY 2013

- **AAMC Collaborative Care Network**

- **Lower Shore ACO - Med-Chi Network Services**

- **Three ACOs overseen by Universal American**
  - **Maryland Collaborative Care LLC,** serving Carroll, Montgomery, Frederick, Calvert and Anne Arundel.
  - **Northern Maryland Collaborative Care LLC,** serving Baltimore and Washington metro areas.
  - **Southern Maryland Collaborative Care LLC,** serving Montgomery, Prince George's, and Anne Arundel.

# State Innovation Models Award Community-Integrated Medical Home

- ❑ CMS initiative to develop, implement and test new payment and delivery models;
- ❑ Maryland received **$2.37 million "Model Design,"** 6-month planning award;
- ❑ Opportunity for "Model Testing" award up to $60 million over 4 years.
- ❑ **Community-Integrated Medical Home** **(analogous to "Accountable Care Community")**
    - ▪ Integration of multi-payer medical home with community health resources;
    - ▪ Four components – primary care, community health, strategic use of new data, and workforce development;
    - ▪ Governance structure and public utility to administer payment and quality analytics processes (**analogous to concept of "wellness trust"**);
    - ▪ Use of expanded Local Health Improvement Coalitions, community health workers, and data and mapping resources for "hot-spotting" high utilizers.

- ❑ **Stakeholder engagement planning process** with payers, providers, and local health improvement coalitions from April to September, 2013.

Maryland's Health Information Exchange

Architecture

Hospitals

Clinics

Registries

Health Information Exchange

Labs

Home care

Tertiary care

Primary care
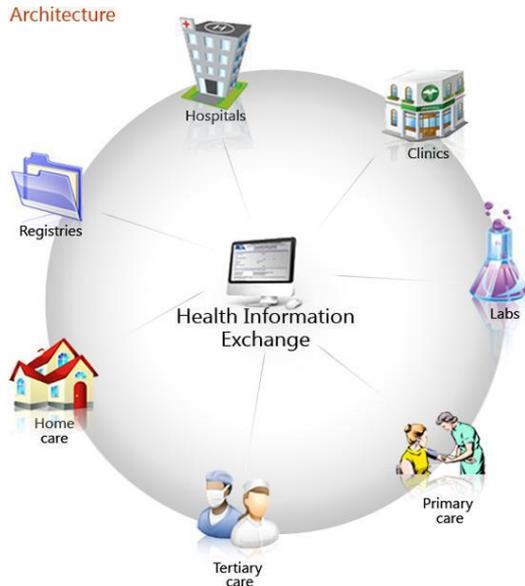
Goal: Interconnected, consumer-driven electronic health care system aimed at enhancing quality and reducing costs.

- ❑ **Chesapeake Regional Information System for our Patients (CRISP) is State-designated HIE;**

- ❑ **State invested $10 million in startup costs to leverage $17.3 million in federal assistance;**

- ❑ **Maryland is first state to connect all 46 acute care hospitals to common platform; 41 hospitals providing some clinical data;**

- ❑ **Launched ENS (patient hospital encounter notifications system) in late 2012;**

- ❑ **sends out 12,000 notifications a month to primary care clinicians when patients seen in hospital;**

- ❑ **State also using HIE to map hot spots of preventable hospitalizations and poor outcomes.**

CRISP

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Workforce Development

- ❑ **EARN program (Employment Advancement Right Now)**
    - ▪ 2013 bill which provides grant dollars to match Marylanders seeking new or better jobs with the workforce needs of Maryland employers.
    - ▪ Businesses, government, and educational institutions will create training programs for jobs in high-demand fields, including health care.

- ❑ **SIM Model Design planning**
    - ▪ Use of community health worker
    - ▪ Identification of best practices and inventory of training models

- ❑ **Workforce Advisory Committee**
    - ▪ Educators, practitioners, and other stakeholders to recommend and help support workforce development initiatives, including:
        - o Training to increase diversity and align with new care delivery models;
        - o Workforce data collection, analysis, and reporting.
        - o Licensing and credentialing – identify opportunities to streamline, reduce barriers, and make more efficient.
    - ▪ **Upcoming analysis of supply and distribution of allied health professionals** in addition to physicians, *e.g.* psychologists, physical therapists, physician assistants, nurse practitioners.

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TELEHEALTH

❑ **Telehealth:** use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

❑ **Leading challenges include:**

- Developing interoperable networks capable of communicating/connecting to CRISP;
- Determining actual cost-effectiveness and appropriate Medicaid reimbursement.

❑ **Telemedicine in Maryland**

- Medicaid reimburses for telemental health services in rural geographic areas;
- 2013 legislation expanded Medicaid reimbursement to cardiovascular or stroke emergencies, where procedure is medically necessary and specialist is not on duty;
- Bill also directed continued study of telemedicine through Telemedicine Task Force to identify opportunities to use telehealth to improve health status and health care delivery, with final report and recommendations due December, 2014;
- DHMH supports expanding to "hub and spoke" model that connects primary care to specialists, and continues to study "store and forward" and "home health telemonitoring" for cost-effectiveness.

QUESTIONS

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