Affordable Care Act and Adolescents and Young Adults
Overview of Summit

- Welcome and Introductions
- Affordable Care Act 101
- Affordable Care Act and Impact on Adolescents and Young Adults
- Federal Update on Affordable Care Act
- States Perspectives and Activities Panel
- Putting Together the Pieces
Healthcare Reform and AYA Summit

Participants will:
- Understand key provisions of ACA AND how they will impact adolescents and young adults
- Understand outlook for ACA implementation in 2013-2014
- Understand how other Adolescent Health Coordinators are addressing key issues in their states
- Identify potential roles Adolescent Health Coordinators can play during implementation in the states
- Identify next steps to take in finding out more about implementation in own state
Presenters

- Rachel Samsel, MSSW
  Director, Office of Healthcare Delivery Redesign
  Texas Department of State Health Services

- Jane Park, MPH
  National Adolescent and Young Adult Health Information Center
  Division of Adolescent and Young Adult Medicine
  Department of Pediatrics
  University of California, San Francisco

- Trina Anglin, MD, PhD
  Director of Adolescent Health
  Maternal and Child Health Bureau
  Health Resources and Services Administration
Who has joined us today?

- Adolescent Health Coordinators
- MCH Directors/Staff
- State health department or other state agency officials
- Family Delegates, Parents
- Youth
- Academia/Researchers
- Others?
Affordable Care Act

- Expansion of Public Programs
- Health Insurance Exchange
- Essential Health Benefits
- Employer Requirements
- Individual Mandate
- Premium and Cost-sharing subsidies
- Tax Changes
- Changes to Private Insurance
- Cost Containment
- Improving Quality and Health System Performance
- Prevention and Wellness
- Long-term Care
- Workforce
- Community Health Centers and School Based Centers
- Public Health and Disaster Preparedness

Health
Important Provisions & Key Terms
Affordable Care Act of 2010
Primary goals of ACA

- Redefine healthcare delivery
- Ensure healthcare quality
- Redefine healthcare financing

- In other words... changing the way we do business around healthcare delivery
Expansion of Public Programs

- States have an option to expand Medicaid
  - Expand coverage for up to 133% FPL
  - Newly eligible populations
    - Non-Medicare eligible individuals under age 65 up to 133% FPL
    - Newly eligible populations guaranteed benchmark benefit package
    - Children ages 6 to 18 from 100 to 133 percent of the federal poverty level (currently eligible for CHIP)
    - Former foster care youth up to age 26.

- CHIP - reauthorization needs to occur in 2015.
Health Insurance Exchange

Health Exchange: New organizations set up to create a more organized and competitive market for buying health insurance.

- Offer a choice of different health plans, certifying plans that participate and providing information to help consumers better understand their options.

Benefit Tiers – Precious Metal Scale (Bronze, Silver, Gold, Platinum and Catastrophic)

Basic Health Plans – state option for uninsured individuals with incomes from 133% to 200% FPL

Related site: www.healthcare.gov (healthcare marketplace website)
Community Navigators

- **Community Navigators** will do impartial public education on subsidies, plan selection, access hard-to-reach populations.

- The Federal government will:
  - Fund, train, and certify Community Navigators
  - Establish and enforce conflict of interest standards, as well as cultural and language competency standards*

*Opportunity for AHC
Essential Health Benefits

- Law ensures that health plans offer a core package of items and services
  - Must be offered in the individual and small group markets
  - Both inside and outside of Affordable Insurance Exchanges (Exchanges)
- The ACA is making sure that in 2014, all health insurance policies will cover 10 Essential Health Benefits.
10 Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care
No Co-pay Services for Women

- **Well Woman Visits:** Annual visits covered means women can receive preventive care when it matters most*
- **Lactation Counseling:** Pregnant and post-partum women have access to comprehensive lactation support and counseling from trained providers as well as breastfeeding equipment to give moms and little ones the best start*
- **DNA Testing for Cervical Cancer:** Women who are 30 or older will have access to HPV testing every 3 years, even if previous pap tests were normal
- **Contraceptive Counseling:** Women will have access to all FDA approved contraceptive methods and patient education/counseling*
- **STI and HIV Screenings & Counseling:** Women will have access to annual testing and counseling on HIV and Sexually Transmitted Infections (STI)*
- **Gestational Diabetes Screenings:** Screenings will be preformed at 24 - 28 weeks pregnant and for those at high risk*
- **Domestic Violence Screening:** Screening and counseling for domestic and partner violence will be provided for all women*

*Opportunity for AHC
Pre-existing Conditions

- No Pre-existing Conditions
  - As of 2010: children (ages 0-18) can not be denied coverage based on pre-existing conditions.
  - Starting in 2014: **No one** can be denied insurance due to pre-existing conditions.
  - Starting in 2014: **No one** can be charged more because of health history or condition.
  - Only 3 things lead to higher premiums: age, tobacco use, and geography

- **Related terms: high-risk pool:** State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market.
Pre-existing Condition Exclusions

- Illness or medical condition diagnosed or treated within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.
Individual Mandate

- Effective January 2014
- Individuals (US citizens and legal residents) are required to obtain qualifying coverage that meets federal standards
  - Certain exemptions apply
- Individual or group plan
- Financial penalties for not having insurance coverage
  - Assessed through tax returns
The Requirement to Buy Coverage Under the Affordable Care Act

Do any of the following apply?
- You are part of a religion opposed to acceptance of benefits from a health insurance policy.
- You are an undocumented immigrant.
- You are incarcerated.
- You are a member of an Indian tribe.
- Your family income is below the threshold requiring you to file a tax return ($9,350 for an individual, $18,700 for a family in 2010).
- You have to pay more than 8% of your income for health insurance, after taking into account any employer contributions or tax credits.

Start here.

Yes → There is no penalty for being without health insurance.

No → Were you insured for the whole year through a combination of any of the following sources?
- Medicare.
- Medicaid or the Children’s Health Insurance Program (CHIP).
- TRICARE (for service members, retirees, and their families).
- The veteran’s health program.
- A plan offered by an employer.
- Insurance bought on your own that is at least at the Bronze level.
- A grandfathered health plan in existence before the health reform law was enacted.

Yes → The requirement to have health insurance is satisfied and no penalty is assessed.

No →
There is a penalty for being without health insurance.

2014
Penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1.0% of family income, whichever is greater.

2015
Penalty is $325 per adult and $162.50 per child (up to $975 for a family) or 2.0% of family income, whichever is greater.

2016 and Beyond
Penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater.

The penalty is pro-rated by the number of months without coverage, though there is no penalty for a single gap in coverage of less than 3 months in a year. The penalty cannot be greater than the national average premium for Bronze level coverage in an Exchange. After 2016, penalty amounts are increased annually by the cost of living.

Key Facts:

- Premiums for health insurance bought through Exchanges would vary by age. The Congressional Budget Office estimates that the national average annual premium in an Exchange in 2016 would be $4,500-$5,000 for an individual and $12,000-$12,500 for a family for Bronze coverage (the lowest of the four tiers of coverage that will be available).

- In 2010 employees paid $899 on average towards the cost of individual coverage in an employer plan and $3,997 for a family of four.

Employer Requirements

- **Large employers** (more than 100 employees)
  - Must either offer insurance that meets certain cost requirements, or pay penalties
  - Employers with 200 or more workers who offer coverage must automatically enroll new employees and continue enrollment of current employees;
  - Employees may choose to opt-out
Employer Requirements

- **State Business Health Options (SHOP) program**: State health insurance exchanges that will be open to small businesses up to 100 employees.

- **Small employers** (50 or fewer full-time employees)
  - Not required to offer insurance
  - Not required to offer coverage to part-time workers
  - Some small employers that provide insurance may be eligible to receive tax credits
Accountable Care Organizations

- A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get.

- ACO receive payments for all care provided to a patient.

- Payments are tied to achieving health care **quality** goals and outcomes that result in cost savings.
Patient Centered Medical Home Model

- One of the most promising approaches to care, especially for people with chronic health conditions
  - higher-quality
  - cost-effective primary care
- Prompt access to primary care
- Ongoing relationship with a primary care provider or team
- Adoption of health information technology (IT)
- Improved coordination of care
Healthcare Financing Terms

- **Actuarial Value**: measure of the average value of benefits in a health insurance plan. It is calculated as the percentage of benefit costs a health insurance plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions. Placing an average value on health plan benefits allows different health plans to be compared.

- **Capitation**: A method of paying for health care services under which providers receive a set payment for each person or “covered life” instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.

- **Cost Containment**: A set of strategies aimed at controlling the level or rate of growth of health care costs that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency in the health care system.

- **Cost-Sharing**: A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.
Healthcare Financing Terms

- **FMAP (Federal Medical Assistance Percentage):** The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears.

- **Pay for performance:** A health care payment system in which providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

- **Payment bundling:** A mechanism of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service. Total care provided for an episode of illness may include both acute and post-acute care.

- **Tax Credits:** amount that a person/family can subtract from the amount of income tax that they owe.
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Questions?
Next: ACA Implementation: What does it mean for adolescents and young adults?

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