



National Health Care Reform and the Implications for States: Information from NASBO's 2010 Annual Meeting

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Overview. The National Association of State Budget Officers (NASBO) held a health care session during the recent 2010 Annual Meeting with several experts and state officials from around the country. The session provided an overview of the current Medicaid program, implications for national health reform, and an initial discussion about the state impact of national health care reform and how states are organizing for implementation. This brief provides information from that discussion and also highlights some of the critical fiscal issues states will be encountering as they implement national health care reform.

Current Trends in Medicaid. Medicaid currently provides comprehensive and long-term medical care to more than 60 million low-income individuals. According to the Centers for Medicare & Medicaid Services Office of the Actuary, total Medicaid spending in 2010 is estimated to be \$412 billion, representing approximately one-sixth of the nation's total health spending. Medicaid accounted for approximately 21 percent of total state spending in fiscal 2009 as reported in NASBO's 2008 State Expenditure Report.

Even before expansions under the new health care reform law, Medicaid spending and enrollment growth were accelerating in response to the severe economic downturn in states. As shown in the spring 2010 *Fiscal Survey of States*, total Medicaid spending increased by 6.6 percent in fiscal 2009 and is estimated to increase by 10.5 percent in fiscal 2010. Increases in total spending growth are primarily due to increased enrollment due to the economic downturn. About three-quarters of the states were planning to contain Medicaid costs in governors' proposed fiscal 2011 budgets, based on the spring 2010 *Fiscal Survey of States*. Many of these actions center on reducing provider reimbursement rates.

National Health Care Reform Overview. The President signed into law the comprehensive health reform measure known as the *Affordable Care Act*. Beginning in January 1, 2014, state Medicaid programs will be expanded to cover non-pregnant, non-elderly individuals with incomes up to 133 percent of the federal poverty level. The cost for those newly eligible for coverage will be fully federally funded in calendar years 2014, 2015, and 2016 with federal financing phasing down to 90 percent by 2020. States are required to apply a 5 percent income disregard when determining Medicaid eligibility, effectively bringing the new Medicaid minimum eligibility level to 138 percent of the federal poverty level.

The net fiscal impact on states will vary depending on many factors including the number of newly eligible, the enrollment of those currently eligible though not enrolled, and the impact of the prescription drug rebates.

The *Affordable Care Act* imposes a maintenance of effort (MOE) requirement on eligibility standards, methodologies, and procedures for adults until an exchange is fully operational (expected to be 2014) and for children in Medicaid and CHIP through 2019. There is a limited exception during the period January 1, 2011 through December 31, 2013 for a state that certifies it has a budget deficit on or after December 31, 2010.

While the major expansions to cover the uninsured will not be taking place until January 1, 2014, other changes under national health care reform will be affecting health care in states more immediately including: the maintenance of effort provisions for Medicaid and CHIP, a new option to cover childless adults in Medicaid using the regular Medicaid match, changes to drug rebates under the Medicaid program, new long-term care options for community based care, the establishment of temporary high risk pools in each state until the exchanges are operational, and changes in the insurance markets in every state.

Implications from National Health Care Reform. One of the most significant elements in national health care reform is the expansion of Medicaid to cover most individuals up to 133 percent of the federal poverty level and the development of health insurance exchanges. These exchanges will be developed as a mechanism for both individuals and businesses to purchase health insurance. Individuals between 133 percent and up to 400 percent of the federal poverty level will receive subsidies to purchase health insurance through the exchanges. Approximately 40 to 50 million individuals will be covered under the exchanges and approximately 16 to 18 million individuals will be newly enrolled under the Medicaid expansion.

States will play an increasingly major role in purchasers of health insurance through the interplay of the exchanges and the Medicaid program. This provides an excellent opportunity for states to leverage the buying power to move toward positive health outcomes and cost containment.

State Examples of National Health Care Implementation. States are organizing themselves in different ways to implement national health care reform. Many governors have signed executive orders to establish groups to advise and implement health care reform. Other states are using independent consultants to provide cost impacts. The following are some examples.

Oregon

Oregon established the Oregon Health Authority in 2009 to bring most health-related programs in the state into a single agency to maximize its purchasing power. In the public sector, the Oregon Health Authority will consolidate most of the state's health care programs, including employee benefits and public-private partnerships. This will give the state greater purchasing and market power to begin tackling issues with costs, quality, lack of preventive care and health care access. The consolidation of health programs in one entity helps with tracking and implementation of provisions under the *Affordable Care Act*.

Missouri

Missouri is organizing along cabinet lines to coordinate the state's response to the *Affordable Care Act*. The state is using a three tiered approach with tier one for issues needing the Governor's involvement, tier 2 for issues needing decisions from the health care cabinet, and tier 3 for issues best dealt with the normal departmental structure, such as applying for grants.

The state has developed a tool to track all components of the *Affordable Care Act* and has developed strategic areas for the health care cabinet which are health insurance exchanges, other

insurance reforms, Medicaid expansion, delivery system reform, prevention and wellness, workforce expansion and training, and the small business employer.

Minnesota

Minnesota is organizing along cabinet lines with inter-agency work groups which include the Governor's Health Cabinet, the Legislative Commission on Health Care Access, and the Health Care Reform Task Force made up of both private and public sector individuals. The state is currently focusing on developing infrastructure to study and make decisions about the health insurance exchanges. Issues under consideration with the exchanges include the definition, financing, streamlining state law on eligibility, and administration and regulation.

Planning and Implementation for Health Care Reform. States currently have been making decisions including whether or not to operate a Pre-Existing Condition Insurance Plan (high risk cost pool) and whether to apply for the Early Retiree Reinsurance Program. States as regulators and as employers are also preparing to implement national insurance reforms such as providing dependent coverage for adult children up to age 26, eliminating preexisting conditions, and covering certain preventative services without requiring a co-payment. Currently, states are assessing their authority as insurance regulators to approve health insurance rate increases and whether or not additional authority through the state legislative process for that authority will be needed.

To prepare for the coverage expansions in 2014, states will need to be ready for both the Medicaid expansion and making decisions about health insurance exchanges. Among issues to consider include the following:

Preparing for Medicaid Expansion. With new individuals becoming eligible for Medicaid beginning in 2014, states are beginning to start preparations for eligibility processes and costly systems that will integrate Medicaid with health insurance exchanges. How these costs are shared between the federal and state governments is a significant issue. While the eligibility will be the same across the nation, states are currently at different eligibility levels and therefore Medicaid expansion will have differential impacts across states.

Planning for and Establishing State-Based Insurance Exchanges. One of the most far reaching issues is the establishment of a health insurance exchange that will serve as a portal for individuals and business to purchase insurance. Although the expansion of coverage will not begin until January 2014, many decisions and actions need to take place before that time.

Administrative Costs and the Administrative Capacity. National health reform requires implementation dollars and staff to implement national health care reform. To implement these coverage expansions, states will face fiscal and administrative challenges associated with the Medicaid expansion and with developing new health insurance exchanges that are to be operational in 2014.

Capacity of the Provider Network and the Impact on Provider Rates. With the passage of health care reform, provider reimbursement rates for certain primary care providers will be raised to match the rate paid to Medicare for 2013 and 2014 with federal funds paying for the increase in only 2013 and 2014.

States as Employer. With the increasing constrained resources, states may be adjusting co-payments, deductibles, and employer contributions that may affect the "grandfather status" of employees' health insurance plans. State will need to determine if these changes affect the

“grandfather” status of their plans. If plans lose their “grandfather” status, they will have to conform to additional requirements under the *Affordable Care Act*, such as providing what are deemed “essential health benefits” specified by the federal government.

Uncompensated Care. Under the *Affordable Care Act*, national disproportionate share payments (DSH) will be reduced beginning in 2014 and reduced by about half by 2019. States will need to assess the impact at both the state and local levels of savings from not providing uncompensated care. The challenge will be how do you achieve these saving and identify them.

Workforce Demands for Health Services. With the increase in individuals that will be covered by health insurance, the expectation is for the need for additional health services.

New Opportunities. The *Affordable Care Act* has many opportunities for changes in health care delivery and also additional flexibility to provide long-term care services. These include numerous grant opportunities and demonstration programs to test new payment and delivery system methodologies as well as new long-term care options and incentives intended to increase the availability of home and community-based care options.

Conclusion. While there are many changes in the *Affordable Care Act* to affect the delivery and payment of health care services, at least in the short-term, the expectation is that health care costs will continue to outpace economic growth and continue to strain government budgets.

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