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NCSL's Top Issues of 2013

February 4, 2013

Health Reform

Moving Ahead: What's Next for States?



Overview

- Health insurance exchanges
- Health insurance benefits, regulation and cost containment
- Medicaid expansion and other provisions
- Health Workforce
- Prevention and wellness provisions
- Flexibility options and remaining challenges to the law



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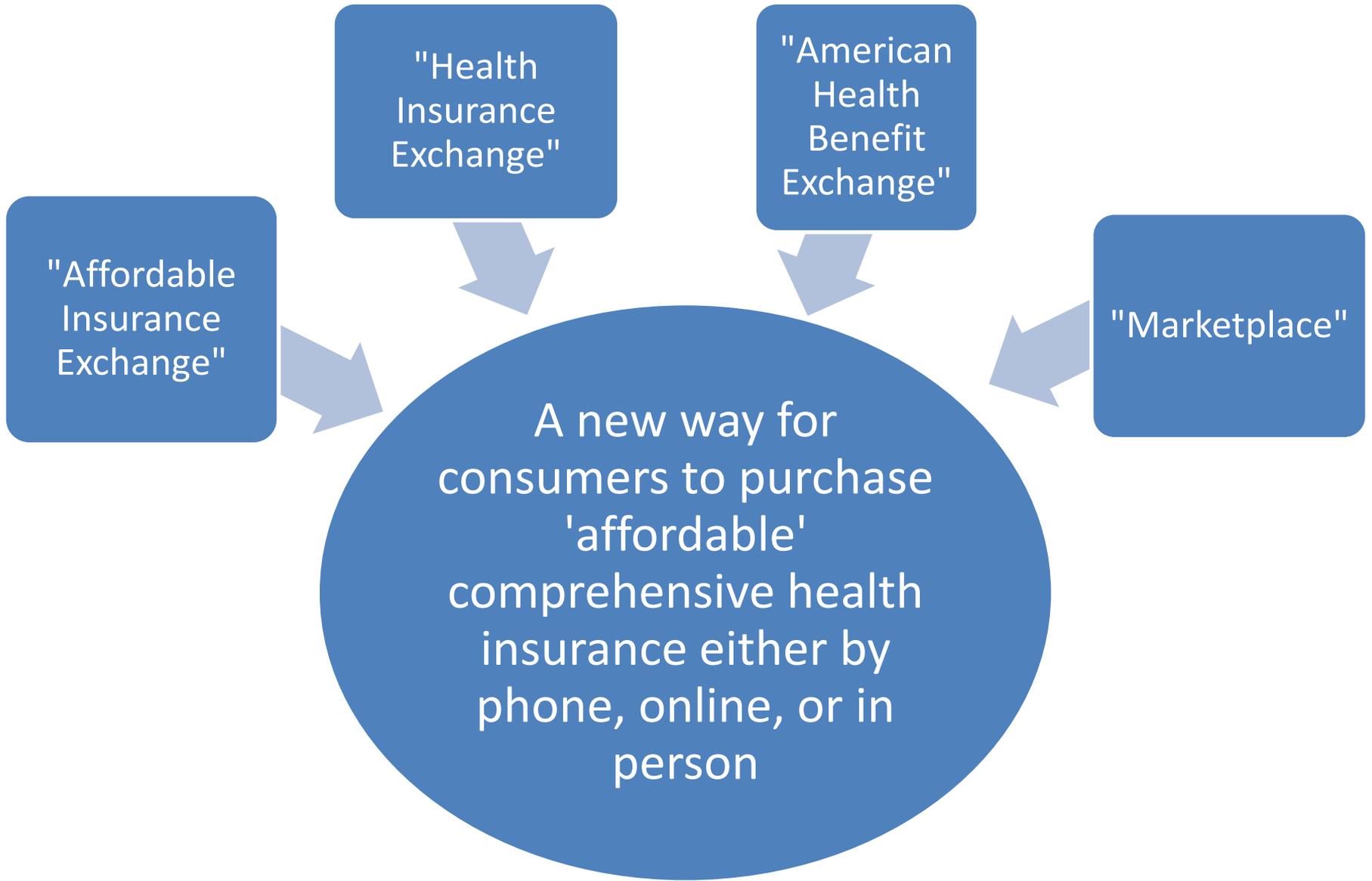
Patient Protection and Affordable Care Act (PPACA or ACA)

Coverage via insurance exchanges and Medicaid

Insurance coverage and regulations

Prevention and wellness

Controlling costs





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Will it be?

State
Exchange

Federally
Facilitated
Exchange
(default)

Partnership
(hybrid of the two)



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State Exchange

- Develop, operate and manage all functions and components of an exchange
- Meets certain criteria outlined in law, rules, guidance
- State needs federal approval

Federal Exchange

- Federal government runs all functions of the exchange
- State Role?
 - State still regulates insurance
 - States know consumers best...outreach, etc.
 - Integrating Medicaid/Exchange for seamless enrollment

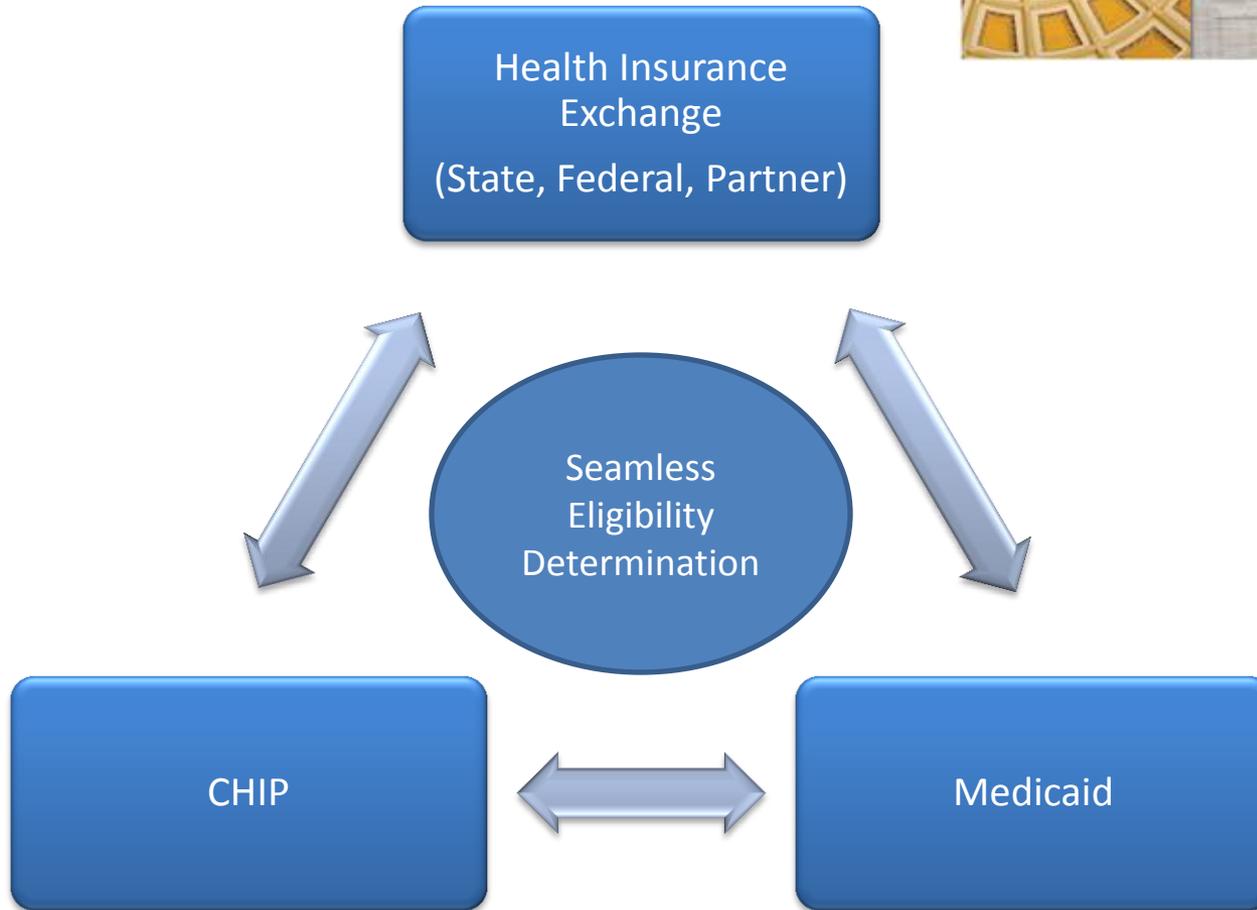
Partner Exchange

- Plan Management
- Consumer Assistance
- Both
- Federal government still running most functions and facilitating exchange
- State needs federal approval



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Key Dates

Submit State Exchange Blueprint

- December 14, 2012

Submit Partner Exchange Blueprints

- February 15, 2013

Open Enrollment Begins

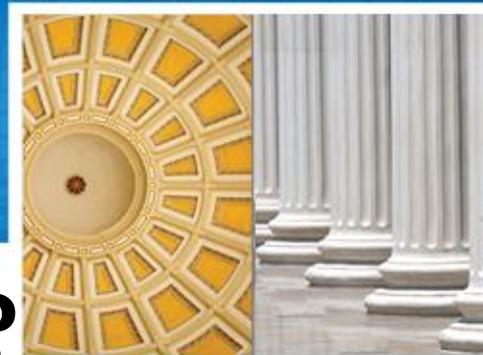
- October 1, 2013

Coverage Begins

- January 1, 2014

Federal Funding Expires

- December 31, 2014



Who pays for it now & later?

Federal Grants to States

- **49 states** and DC received up to \$1 million in exchange **planning grants**. Four territories received similar grants on March 21, 2011.
 - **FL, LA, NH, TX returned grants**, AK did not apply.
- **6 states and a multi-state consortium** led by the University of Massachusetts Medical School received over \$241 million in **Early Innovator grants** to develop model Medicaid/Exchange IT systems.
 - **KS, OK and WI** returned grants.
- **34 States** received establishment grant funds and can receive these until Dec. 31, 2014.

Establish Fees to Insurers, Consumers, etc.

- Federal Exchange will assess a 3.5 percent fee on carriers
- States using various methods to reach financial sustainability for their operational exchange starting 2015

State Funds



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Keeping health coverage; defining how it works

1. Maintains an employer-based system & private market
2. Combines state regulation and federal regulation
3. Enacts health insurance consumer reforms
4. Requires most people to have insurance ("individual mandate")



ACA Health Insurance Reforms

Examples

Prohibits:

- Preexisting condition exclusions
- Discrimination based on health status
- Dropping people from coverage ("rescinding" coverage)*
- Annual and lifetime* caps on coverage costs

Requires:

- Young adults up to age 26 can be included on Family plans*
- Guaranteed issue/guaranteed renewal
- Premium rate review: rules and rebates*
- Lower drug costs in Medicare coverage gap*

**Includes "Early Market Reforms" already in operation.*



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"Essential Health Benefits (EHB)"

(The new name for mandated benefits)

- 10 broad categories of health care that must be included in health insurance
- Will apply to all individual and small employer health policies, 2014
- In 2012 states were given the power to define and add other existing benefits, called "benchmark plans"



10 Required Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Prescription drugs
- Laboratory services
- Mental health and substance use disorder services, including behavioral health treatment (equal to other benefits, or "parity")
- Maternity and newborn care
- Rehabilitative and habilitative services and devices
- Preventive and wellness and chronic disease management
- Pediatric services, including oral and vision care.



"Individual Mandate"

Required coverage; multiple definitions

- Requirement for coverage applies to "most taxpayers"
- "Coverage" includes employer, Medicaid, CHIP, Medicare, state-local programs, new exchange-based subsidized insurance, individual purchase, others.
- Categories of exemptions from coverage or fines:
 - **Cannot afford coverage (cost too high)**
 - **Income below the IRS filing threshold**
 - **Short gaps in coverage; hardship**
 - **Undocumented, incarcerated or tribe**
 - **Religious conscience exemption**
 - **Below Medicaid expansion level if state does not adopt the expansion**
- Non-compliance can mean a fine or "shared responsibility payment" via IRS.
- Maximum annual payment to IRS: 2014 = \$95; 2015 = \$325; 2016 and beyond = \$695 or 2.5% income with inflation increases. (examples only; see full list)



Employer-Based Coverage

- **Small Employers (<50 workers)**
 - No requirement to offer; but Incentives - premium tax credits up to 50%
 - SHOP “Small Business Health Options Program”
 - CO-OP plans for private, non-profits
- **Large Employers (50+ workers)**
 - Required to offer health insurance; fee/penalty for non-compliance
 - 95.7% of these employers already offer coverage



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PPACA Medicaid Related Provisions

Medicaid
Expansion

Interoperability
with Exchange

Fraud and
Abuse
Prevention

Dually Eligible

Home and
Community-
based Services



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Optional Medicaid Expansion



The ACA expands Medicaid to adults aged 19–64 with incomes at or below 138% FPL



States will receive 100% FMAP rates for the newly eligible population from 2014 through 2016

*Declines and
stays at 90 % FPL*

FMAP rates decline gradually, reaching 90 percent in 2020.



Supreme Court did not change the Medicaid provision, but effectively allows states to opt out.



Recent CMS answers

Is there a deadline for expanding Medicaid?

NO

Can states “partially” expand Medicaid?

NO

Once expanded, can states roll back?

YES

Will there be flexibility in cost sharing and benefit packages?

YES

And Remaining Questions

The Woodwork Effect and the Uninsured

- How many of these people WILL enroll?
- What will happen to disproportionate share hospital (DSH) payments?

Who will the newly eligible be?

- What are their medical needs?
Costs?
- What about provider capacity?

What other costs will states face?

- Personnel and expertise
- Other program & administrative functions
- Will the enhanced match last?

PPACA Program Integrity Provisions

Increases **provider screening** and enrollment requirements

Mandates Medicaid **provider termination** if billing privileges have been revoked by another state Medicaid program or Medicare

Requires states **suspend Medicaid payments** to individuals or entities where there is a “credible allegation of fraud”

Allows a temporary **payment freeze** on new providers

Mandates the use of the **National Correct Coding Initiative (NCCI)** to minimize improper coding

Mandates establishment of state **Recovery Audit Contractor (RAC)** programs to audit payment to providers

Requires that **physicians document a face-to-face encounter** with a Medicaid beneficiary before ordering home health services

PPACA and Dually Eligible



Currently 9 million dually eligible people (low-income seniors and others with disabilities who are enrolled in both **Medicaid and Medicare**).

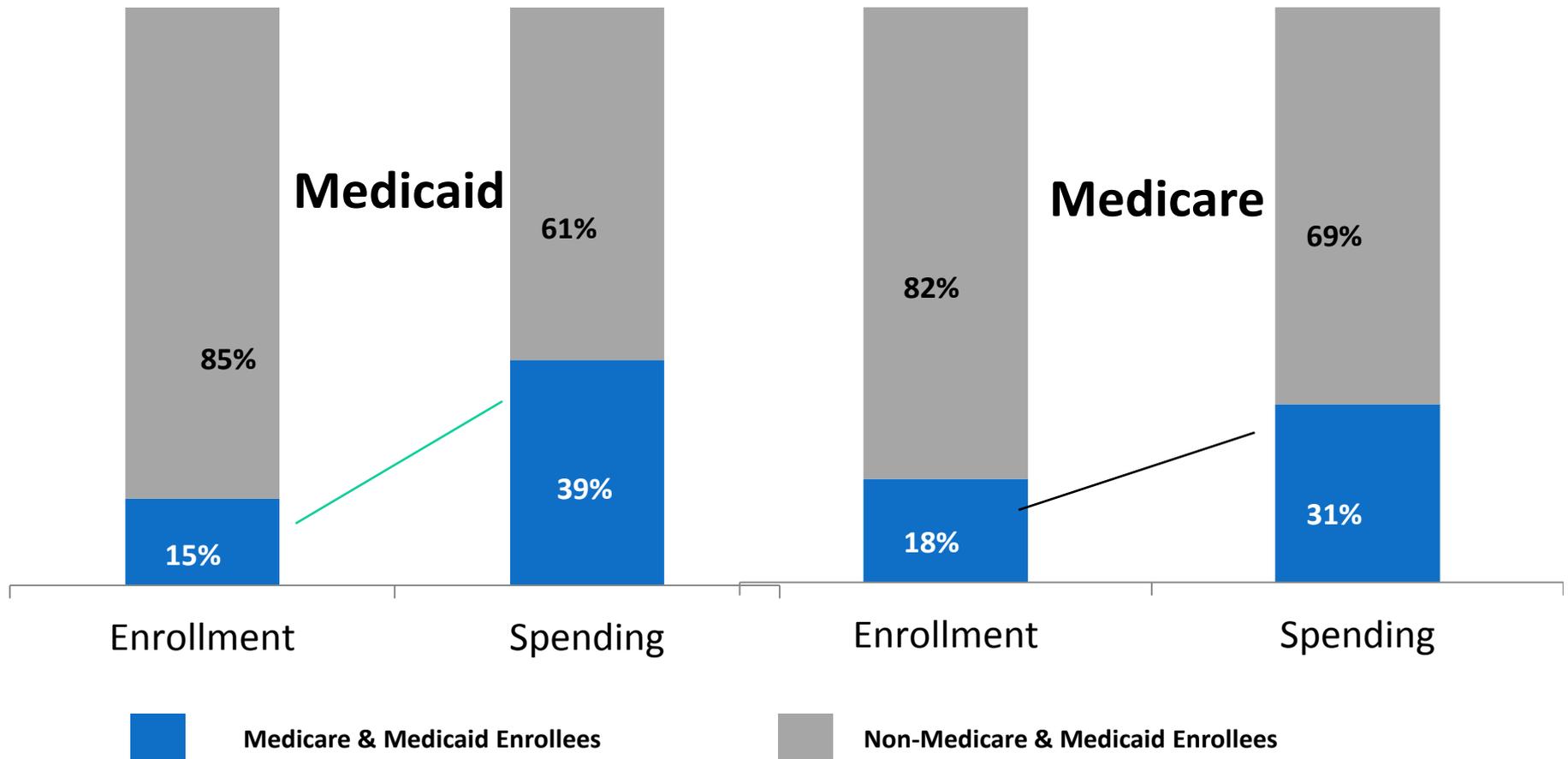


PPACA established the Medicare-Medicaid Coordination Office to help states design integrated care programs.



Federal funding available to states to develop infrastructure.

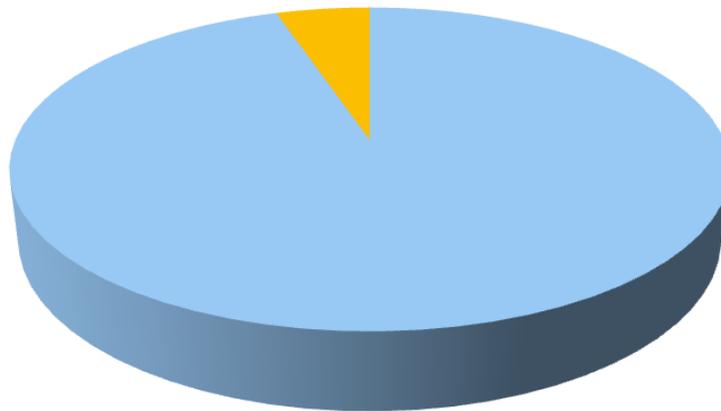
Dually eligible account for a significant amount of both Medicare and Medicaid spending





Health Care = "Medical Model"

Primary focus on **fixing** health problems
rather than **preventing** them



■ Medical Care
■ Public Health

95% of U.S. "health" spending pays for medical care
5% is spent on "public health"



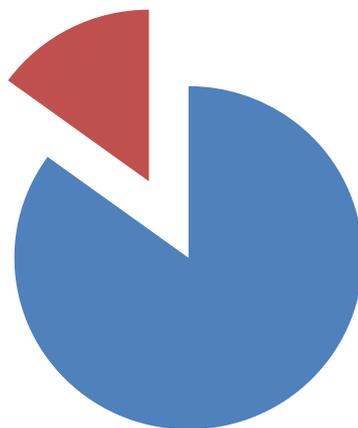
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Health Care Spending for People with Chronic Conditions

**People with Chronic Conditions Account for
85 Percent of All Health Care Expenditures**



■ Chronic Conditions
■ Other



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ACA Prevention of Chronic Disease and Improving Public Health - 4 Areas

- Modernizing Disease Prevention & Public Health
- Increasing Access to Clinical Preventive Services
- Creating Healthier Communities
- Support for Prevention & Public Health Innovation



Opportunities for Prevention Savings in Medicare and Medicaid

Medical spending linked with obesity, 2008

- Medicare
8.5% of expenditures
- Medicaid
11.8% of expenditures
- All U.S. obesity-related health care costs, (2008 estimate)
\$147 billion

Medical spending linked with tobacco use, 2004

- Medicare
\$27.4 billion
- Medicaid
\$30.9 billion, includes:
federal share: \$17.6 billion
state share: \$13.3 billion



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National Prevention Strategy

Four Strategic Directions

- Healthy and Safe Community Environments.
- Clinical and Community Preventive Services.
- Empowered People.
- Elimination of Health Disparities.





National Prevention Strategy

Seven Priority Areas and state examples

- Tobacco Free Living - smoke-free laws, programs to reduce youth access to tobacco
- Preventing Drug Abuse and Excessive Alcohol Use - minimum legal drinking age
- Healthy Eating - incentives for retail access to fresh foods, school nutrition standards
- Active Living - complete streets (e.g., sidewalks, bike lanes), school physical education
- Injury and Violence Free Living - seat belt laws, graduated driver's licensing for teens
- Reproductive & Sexual Health - evidence-based STD & teen pregnancy prevention
- Mental and Emotional Well-Being - access to mental health services.





Prevention and Public Health Fund

- To provide an expanded and sustained national investment in prevention.
- Fund has also been tapped for other purposes.

Clinical and Community Preventive Services

- Expanding U.S. Preventive and Community Services task forces to coordinate evidence-based prevention recommendations (§4003)



Clinical Preventive Services

- Evidence-based preventive health services insurance coverage in new health plans - no co-pay (§1001\2713)
- Medicaid incentives - weight loss, lowering cholesterol, improving blood pressure, preventing diabetes and stopping tobacco use (§4108)
- Funding school-based health center grants (§4101)
Appropriation - \$50 million annually, FY 2010 – FY 2013

<http://www.healthypeople.gov/2020/LHI/clinicalPreventive.aspx>



Adult Preventive Services Covered under the PPACA

- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Screening
- Aspirin Use
- Blood Pressure Screening
- Cholesterol Screening
- Colorectal Cancer Screening
- Depression Screening
- Type 2 Diabetes ScreeningDiet Counseling
- HIV Screening
- Immunization Vaccines
- Obesity Screening
- Sexually Transmitted Infection Prevention Counseling
- Tobacco Use Screening and Tobacco Cessation Interventions
- Syphilis Screening

Additional preventive services are covered for women, children and Medicare beneficiaries.



Creating Healthier Communities

- Menu Labeling at chain restaurants (§4205)
- Break time for nursing mothers (§4207)

Community Transformation Grants

- Expected to improve the health of more than 4 out of 10 Americans—about 130 million Americans.
- 2011, CDC awarded \$103 million to 61 state and local government agencies, tribes and territories.
- 2012, CTG was expanded to support areas with fewer than 500,000 people.





Support for Prevention & Public Health Innovation

- Workplace Wellness Programs (§4303)
- Childhood Obesity Demonstration Project (§4306)
Appropriation - \$25 million, FY 2010 – FY 2014





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Health Workforce Shortages...

... already exist, but will be magnified by:

- Future expansions in public and private coverage
- Aging and retiring workforce
- Americans growing older and requiring more care
- Poor health status of Americans
- Workforce maldistribution
- Traditional methods of delivering care



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PPACA provisions to address workforce shortages:

National Workforce Commission

Primary Care Reimbursement Increases

Community Health Centers

Nat'l Health Service Corp.

Education and Training Grants

Three Fundamental Approaches

Building
the
Supply

Reforming
the
delivery
model

Improving
the
public's
health

Source: Keith Mueller presentation at NCSL Legislative Summit, 2010.



Challenges & Alternatives to ACA

- Multiple federal court challenges (March 2010 - June 2012).
- Final result: U.S. Supreme Court upheld all but one provision: Medicaid expansion to 138% of Federal Poverty cannot be mandatory; it is now an option for each state.
- 20 state legislative laws and constitutional amendments passed opposing mandates to offer & to purchase insurance; bar state agency enforcement



Latest court challenges, 2013-

Specific provisions still subject to opposition

- Requirement for employers to offer contraception coverage:
 - 45+ lawsuits filed, business owners or employers and religious leaders objecting on religious freedom grounds
 - Some federal injunctions (specific to paying for birth control)
 - New proposed federal rule issued Feb. 1
- Tax law question: Do premium subsidies for low/moderate income apply only to state Exchanges or also federal health exchanges.



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The Future: Other Alternatives

- State Coverage Waivers (2017 or sooner?)
- Cross-state purchasing & Interstate Health Compacts
- Future funding



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What's Next for States?

How will insurance exchange(s) evolve?

Will states expand Medicaid? What will it cost?

Will states align their insurance laws with
new federal insurance provisions?

How will states address workforce shortages?

Will states do a better job keeping people healthy?



Medicaid Expansion

Established a minimum eligibility level at 133% of Federal Poverty Guidelines (FPL).

(Estimated to add 17 million Americans)

Using the required "modified adjusted gross income, (MAGI)" most new enrollees will qualify with incomes up to 138% FPL--in 2013:

- Individual -- \$15,856
- Family of 4 -- \$32,499

No asset test, no resource test

New mandatory categories of eligibility

- Childless adults
- Parents
- Former Foster Care Children to age 26

Law, as passed, allowed the DHHS Secretary to "punish" states by withholding regular federal match





Court Ruling on Medicaid

The Medicaid expansion is a "gun to the head" because the "threatened loss of over 10 percent of a State's overall budget ... is economic dragooning that leaves the States with no real option but to acquiesce."

Federal Medicaid share in FY 2010:

Alabama:	\$3,637,309,545
New York:	\$31,740,661,884
Texas:	\$19,089,295,649
Wyoming:	\$331,008,563

<http://www.statehealthfacts.kff.org/comparemactable.jsp?ind=636&cat=4>





Medicaid at a Glance

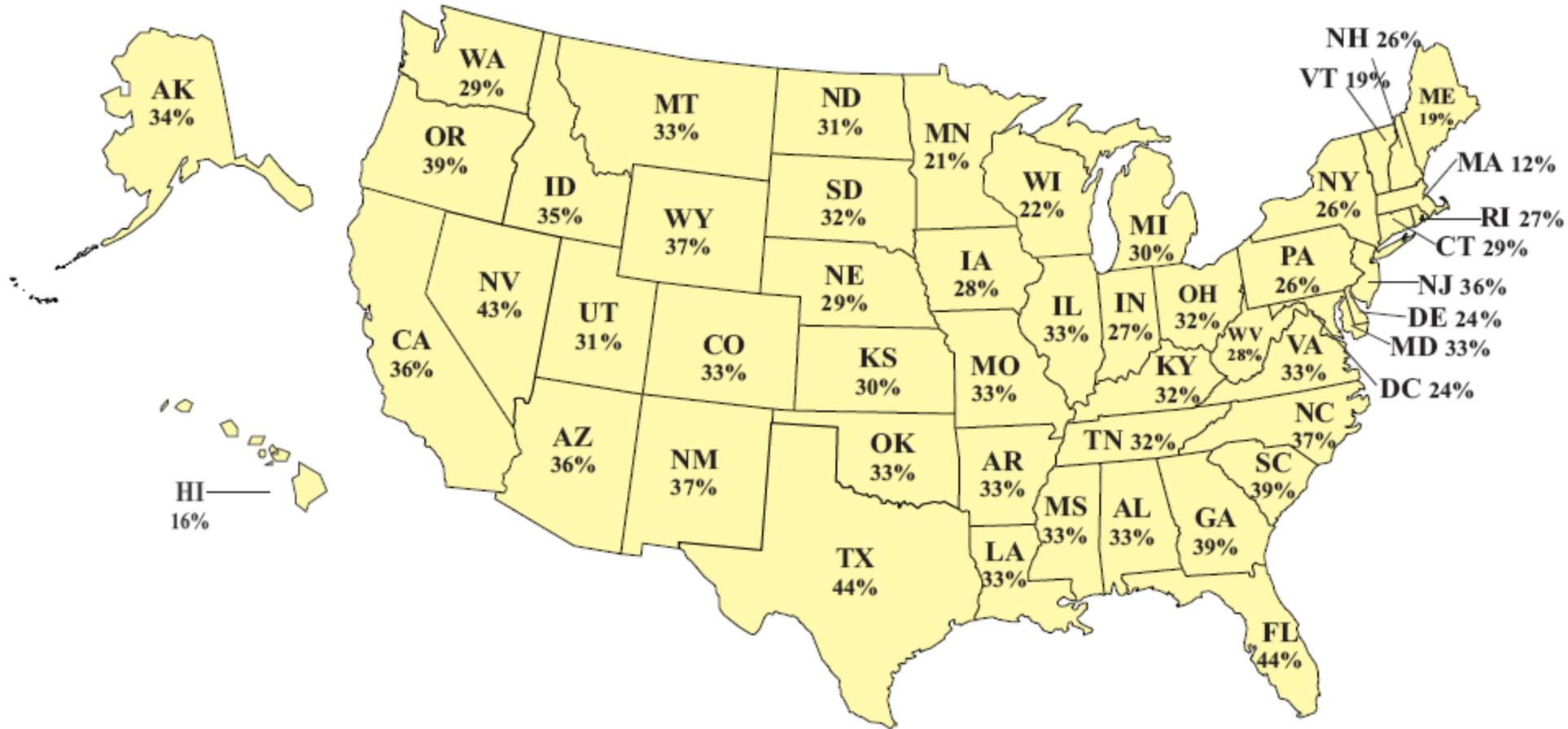
Three programs in one:

- A health insurance program for low-income parents (mostly mothers) and children
- A funding source to provide services to people with significant disabilities (nation's "high-risk" pool)
- A long-term care program for the elderly
"Medicaid makes Medicare work"

Virtually no one else



Uninsured rates for nonelderly (0-64) with incomes up to 139% of poverty



Source: statehealthfacts.kff.org

Note: State data = 2009-10; U.S. = 2010



Enhanced FMAP* for Newly Eligible 2014 – 2020

Year	Federal Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

***Federal medical assistance percentage = federal share or "match" rate**





Medicaid: What Next?

Many more questions than answers!

- HHS declared there's no deadline for states to expand
- Once they expand, states can roll back eligibility
- States that expand must cover everyone with incomes <133%
- What assistance is available to those with incomes <100%
- Just who ARE the current "Medicaid eligible" people (and therefore won't qualify for the enhanced federal match)?
- What will happen to disproportionate share hospital (DSH) payments?
- Etc. ...



More Questions ...

- Who are the currently eligible, but not enrolled?
- Who will the newly eligible be?
- What are their medical needs? Costs?
- What other costs will states face?
 - Personnel for enrollment
 - Other program & administrative functions
- What about provider capacity?
- What savings might states/local gov'ts experience?
 - Less ER use?
 - Less cost-shifting?
 - Less indigent care?
 - Fewer hospitalizations?
- Etc.