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Healthcare Reform: Impact on States

The large scale changes to the basic organization of healthcare legislated by the Patient Protection and Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act (Reconciliation Act), collectively referred to as "healthcare reform," have a profound effect on the resources and policies of every state. Each state will be affected by health reform to a different degree based on their economic and demographic profile, yet there is some debate whether the total cost burden for states in general will be stifling, especially considering assistance from federal funds.[1] This is the last article in Health Capital Topic's series: *Impact of Healthcare Reform on Various Stakeholders*.

MEDICAID

Several provisions of the ACA specifically affect Medicaid, forcing states to implement new policies and drastically change how they manage their low-income populations. The most significant provision is the Medicaid State Plan Amendment, which expands Medicaid eligibility to all non-elderly, non-pregnant adults up to 133 percent of the poverty level.[2] States have the option to phase in newly eligible Medicaid participants starting in 2010 under a state option program, but the process must be complete by 2014.[3] From 2014-2016 the federal government will reimburse states for newly eligible Medicaid participants. [4] After 2016, federal funds will cover a steadily decreasing percentage of reimbursement – 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 on - with states being responsible for the difference. States are required to cover any new Medicaid enrollees who are not defined as newly eligible.[5]

The Congressional Budget Office does not predict these costs to be substantial, with the main burden being administrative.[6] States may potentially see savings from new Medicaid mandates. Increased Medicaid coverage funded by the federal government will encompass many individuals who previously received state-covered health insurance or uncompensated care through state hospital charity care. A 2008 study estimated that uncompensated care for the uninsured totaled $17.2 billion.[7] By strategically shifting costly patients into federally matched Medicaid groups, states could save approximately $70-80 billion from 2014 to 2019.[8] In addition, as a result of tax credits associated with the individual mandate, many individuals that would have been using Medicaid resources will now be able to afford insurance through state exchanges.[9]

The largest financial burden for state Medicaid programs will be the requirement to raise Medicaid provider reimbursement to Medicare levels for primary care providers, including: pediatricians: internists: and, general and family practitioners, by 2014.[10] While the difference in provider payout will initially be supplied by the federal government, states could see costs of approximately $8.2 billion between 2013 and 2017.[11] Smaller changes to state Medicaid policies will continue to go into effect before states feel the full burden of ACA provisions in 2014. Many provisions affecting state regulation and reimbursement of pharmaceuticals began in 2010 and required states to: (1) increase the drug rebate percentage for brand name drugs up to 23.1 percent (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1 percent); (2) increase the drug rebate percentage for non-innovator, multiple-source drugs up to 13 percent of the average manufacturer price; and, (3) extend the drug rebate to Medicaid managed care plans. In 2010, the federal government also provided additional funding for the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission to include assessments of adult services (including those persons who are dually eligible for Medicare and Medicaid).[12] Access and quality of care provisions continue to go into effect in 2011 including: (1) prohibition of federal payments to states for Medicaid services related to healthcare acquired conditions; (2) creation of a new Medicaid state plan option to permit enrollees with at least two chronic conditions, one condition and a risk of developing another, or at least one serious and persistent mental health condition, to designate a provider as a health home (and provide states taking accepting the option with 90 percent FMAP for two years for health home related services such as care management, care coordination and health promotion); (3) creation of the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long term care services; and, (4) establishment of the Community First Choice Option

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in Medicaid to provide community-based attendant support services to certain people with disabilities.[13]

CHIP

Regarding CHIP, healthcare reform provisions require states to maintain current income eligibility levels until 2019 and to extend funding levels for CHIP through 2015.[14] Beginning in 2015, states will have the option to receive a 23 percent increase in the CHIP match rate up to a cap of 100 percent.[15] Additionally, children who are eligible for CHIP but who are unable to enroll in the program due to enrollment caps will be eligible for certain tax credits. Another option requires states to provide CHIP coverage for children of state employees who are eligible for health benefits, for certain conditions. [16] The Children's Health Fund estimates that by 2019, when the ACA is fully implemented, 4.3 million children will be insured due to ACA provisions through CHIP and Medicaid.[17]

INSURANCE EXCHANGES

By January 1, 2014, all states are required to establish an American Health Benefit Exchange. These exchanges will facilitate the purchase of qualified health plans and establish a Small Business Health Options Program (SHOP), which will assist small employers with obtaining coverage for their employees. Employers with 100 or less employees may enroll in the exchange. Effective 2017, employers with over 100 employees may obtain coverage through an exchange at the discretion of the state.[18] States have several options when designing their health benefit exchange: states may design their exchange after existing model, such as Utah's (went into effect in 2009) or Massachusetts's (went into effect in 2006); states can develop their own design; or, states can chose to have a federally operated exchange. There are a myriad of pros and cons to each option, particularly: cost, ensuring the exchange is self-sustaining, risk, coordination of various agencies, and time.[19]

Given the current economic climate, many states may be unable to raise sufficient funding to establish an exchange.[20] To lessen this burden, in 2010 HHS announced that $49 million ($1 per grant) in federal funding would be given to 48 states and the District of Columbia for the implementation of state insurance exchanges.[21] Federal funding for state exchanges will become unavailable after December 2014, increasing the importance of the ACA provision that exchanges be self-sustaining by 2015.[22] In addition to funding opportunities, exchanges present some potential cost savings for states. States whose pre-ACA Medicaid eligibility included individuals between 133 and 200 percent of the federal poverty line (well beyond the eligibility required under the ACA) will be able to shift these individuals into the Basic Health Program, where states will convert ACA tax credits to fund contracts with health plans for adults in this income range.[23]

CONCLUSION

States govern the organization and implementation of many aspects of healthcare, namely Medicaid, CHIP, and the regulation of insurance markets. Despite federal funding, administrative cost will be saddled by the states leading to diverse approximations as to the total financial burden on states.[24] Currently 38 states have officially filed legislation that opposes or seeks to limit the ACA.[25] Even though current political debates threaten the existence of possible state requirements set to go into effect in 2014, most states have taken it upon themselves to begin the process of implementation for many of the health reform mandates on some level.

This is the final article in a series of five regarding health reform and the impact on various stakeholders, including individuals, hospitals, physicians, and employers. In the May 2011 issue, we will begin a new series on implications of Accountable Care Organizations.

1 "State Variation and Health Reform: A Chartbook" By Caryn Marks, et al., Kaiser Family Foundation, October 2009.
2 "Patient Protection and Affordable Care Act" Pub. L. 111-148, Section 2001,124 STAT. 271 (March 23, 2010).
3 "New Option for Coverage of Individuals Under Medicaid" Center for Medicaid and Medicare Services, To State Medicaid Director, April 9, 2010.
4 "Variation in Analyses of PPACA's Fiscal Impact on States" By Evelyne Baumrucker and Bernadette Fernandez, Congressional Research Service (September 8, 2010), p. 4.
5 "What Is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States? Timely Analysis of Immediate health policy Issues" By John Holahan and Stan Dorn, Robert Wood Johnson Foundation and Urban Institute, June 2010, p.1-2.
6 "What Is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States? Timely Analysis of Immediate health policy Issues" By John Holahan and Stan Dorn, Robert Wood Johnson Foundation and Urban Institute, June 2010, p.1.
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9 "What Is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States? Timely Analysis of Immediate health policy Issues" By John Holahan and Stan Dorn, Robert Wood Johnson Foundation and Urban Institute, June 2010, p.2.
10 "Patient Protection and Affordable Care Act" Pub. L. 111-148, Section 2303, 124 STAT. 293 (March 23, 2010).
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12 "Health Reform Implementation Timeline" Kaiser Family Foundation, March 31, 2010, http://www.kff.org/healthreform/upload/8060.pdf, (Accessed 4/19/2010).
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[16] "Health Reform Implementation Timeline" Kaiser Family Foundation, March 31, 2010, http://www.kff.org/healthreform/upload/8060.pdf, (Accessed 4/19/2010).

[17] "Children Under Siege: Safeguarding Provisions for Children in the New Health Law: A Children's health Fund Special Report" Children's Health Fund, March 2011, p.3.

[18] "Patient Protection and Affordable Care Act" Pub. L. 111-148, Section 1321, 124 STAT.186 (March 23, 2010).

[19] "Health Insurance Exchanges: Key Issues For State Implementation" By Robert Carey, State Coverage Initiatives Robert Wood Johnson Foundation, September 2010, p.1.

[20] "Health Insurance Exchanges: Key Issues For State Implementation" By Robert Carey, State Coverage Initiatives Robert Wood Johnson Foundation, September 2010, p.3.

[21] "Health Insurance Exchanges: State Planning and Establishment Grants" Centers for Medicare and Medicaid Services: The Center for Consumer Information and Insurance Oversight, http://cciio.cms.gov/resources/files/grant_award_faq.html (Accessed 4/14/11).

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