



Navigating the ACA: What to Expect at the One Year Anniversary

Multiple Sclerosis Society

April 6, 2011

Dr. Andrew Allison, KHPA Executive Director



Brief Summary of the ACA



Federal Health Reform: Two New Laws

- **Patient Protection and Affordable Care Act of 2010 (ACA)**
 - Based on Senate health reform legislation
 - Passed March 23, 2010
- **Health Care and Education Affordability Reconciliation Act of 2010**
 - Added some elements of House reform proposals to the Senate version
 - Passed April 2, 2010



Affordable Care Act: Presumed Objectives

- **Define health insurance coverage**
 - Minimum coverage includes standard benefits and implies affordable cost-sharing
 - Includes prescription drugs and mental health parity
- **Secure access to an offer of group-like insurance coverage for everyone**
 - Eliminates differences in insurance premiums due to the health risks of individuals or co-workers
 - Private, portable insurance for those buying as individuals and employees
- **Get insurers to compete with each other rather than consumers**
 - New exchanges should facilitate price shopping and ease enrollment
 - Stabilize private insurance markets through required participation
- **Buy or subsidize minimum coverage to reduce the price to consumers**
 - Greatly expand Medicaid to cover the lowest-income Americans
 - Cost-sharing protections and Federal tax subsidies for premiums aid others



Detailed Provisions



Kansas Medicaid and CHIP at-a-glance

- Medicaid: Free coverage for very-low income families, elderly and disabled
 - Pregnant women and infants up to 150% FPL
 - Children: 100% or 133% of FPL, depending on age
 - Elderly and Disabled: income limits vary, 100 – 200% FPL
 - Adult Parents and Caregivers: appr. 30% FPL
 - “Medically Needy” – Adults with incomes above threshold with large medical bills
 - Childless adults are not covered
- CHIP
 - Income limit: 250% of 2008 FPL (appr. 241% current FPL)
 - Premiums: \$20 - \$75 per-family, per-month, depending on income (CMS will reject a state plan amendment to raise these by \$40-100 per month)
 - “HealthWave:” State contracts with MCO; pays flat, capitated rate for each beneficiary – also serves 141,000 Medicaid children and parents



Affordable Care Act: Private Insurance

- **Changes taking effect within six months**
 - New, temporary re-insurance pool for early retirees
 - Create new high-risk pools for those with pre-existing conditions
 - Provide dependent coverage for children up to age 26 for all policies
 - Eliminate lifetime limits on dollar value of coverage
 - Prohibit insurers from retroactively dropping coverage except for fraud
 - Prohibit pre-existing condition exclusions for children
 - Up to a 35% subsidy for small employers (under 25) to provide insurance
- **Changes taking effect in 2014**
 - Guaranteed offers of insurance to all eligible consumers
 - Eliminate any premium differences based on health risks or gender and limit age-rating to a premium ratio of 3-1
 - Income-related subsidies for both premiums and cost-sharing
 - Create new insurance marketplace through “exchanges”



Affordable Care Act: Health Insurance Subsidies

- **Sliding scale premium subsidies based on income**
 - Under 150% FPL: Max. of 2-4% of income
 - 150-200% FPL: Max . of 4-6.3%
 - 200- 400% FPL: Max . of 6.3-9.5%
- **Cost-sharing protections based on income**
 - Under 150% FPL: Max. of 6% of covered costs
 - 150-200% FPL: Max. of 15%
 - 200-400% FPL: Max. of 27-30%
 - Separate income-related out-of-pocket caps
- **Insurance reforms, subsidies, and cost-sharing protections interact**
 - Some out-of-pocket costs shift into premiums
 - Raw premiums for young adults will go up
 - Young adults are most likely to qualify for subsidies and protections
- **Federal government bears limited risk for premium increases**
 - After 2014, increases in subsidies will be limited to growth in income
 - After 2018, subsidy growth will also be tied to inflation



Affordable Care Act: Insurance Exchanges

- Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP)
- States may default to federal government to establish the exchange
- Administered by governmental agency or non-profit
- Subsidies available only through the new exchanges
- Available to individuals and small businesses (up to 100 employees)
- States can allow larger businesses to buy coverage in SHOP in 2017
- States may form regional exchanges with other states or within the state
- Federal funding available to establish exchanges through 1/1/2015



Affordable Care Act: Medicaid Expansion

- Maintenance of effort for Medicaid eligibility: current Medicaid eligibility rules are set in stone (only until 2014 for adult eligibility above 138% of poverty)
- Medicaid is expanded in 2014
- All non-disabled under 65, up to 138% FPL (includes childless adults)
- Feds cover 100% of cost for expansion group in 2014 through 2016
 - 2017: 95%
 - 2018: 94%
 - 2019: 93%
 - 2020 and thereafter: 90%
- Some state flexibility in covered benefits for newly-eligible
 - Must meet minimum standards set by Federal government
 - Minimum standards may entail new benefits like “habilitation” and “rehabilitation”
 - ACA language indicates that states can opt to provide additional benefits to the expansion population



Affordable Care Act: Children's Health Insurance Program

- Require states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019
- Extend funding for CHIP through 2019
- Benefit package and cost-sharing rules continue as under current law
- In October 2015, federal CHIP match rate increased by 23 percentage points
- Federal allotments for CHIP funding remain in place, limiting potential enrollment
- Eligible children who can't enroll due to limited funding will be eligible for tax credits in the state exchanges



Implementation



Affordable Care Act Implementation: State Responsibilities

- **Implement insurance reforms**
 - decide whether to accept the responsibility and opportunities that come with the establishment of an exchange
 - define what kind of competition they want inside the exchange
 - decide how to govern these new and potentially dominant health insurance markets
 - decide whether, and how, to use the buying power and regulatory influence they have been given in Federal legislation
- **Coordinate Medicaid and the new exchange(s)**
 - ensure access to coverage
 - seamless transitions between different sources of coverage
 - link Medicaid's insurance market with the new private insurance market?
- **Determine Medicaid's new role in the health care system**
 - simplify eligibility and select benefit package for Medicaid expansion group
 - set Medicaid payment rates and secure access to providers
- **Respond to numerous grant and demonstration project opportunities**



Analysis of Potential Impact on Kansas



Affordable Care Act: Impact on State Spending in 2020

State options regarding direct spending for the safety net*

	Maintain all state spending on the safety net	Reduce state spending on the safety net by half	Eliminate state spending on the safety net
Point estimate plus 5% provider rate increase	\$35 M	\$12 M	-\$8 M
Upper bound estimate of coverage	\$7 M	-\$16 M	-\$35 M
Point estimate	\$4 M**	-\$19 M	-\$39 M

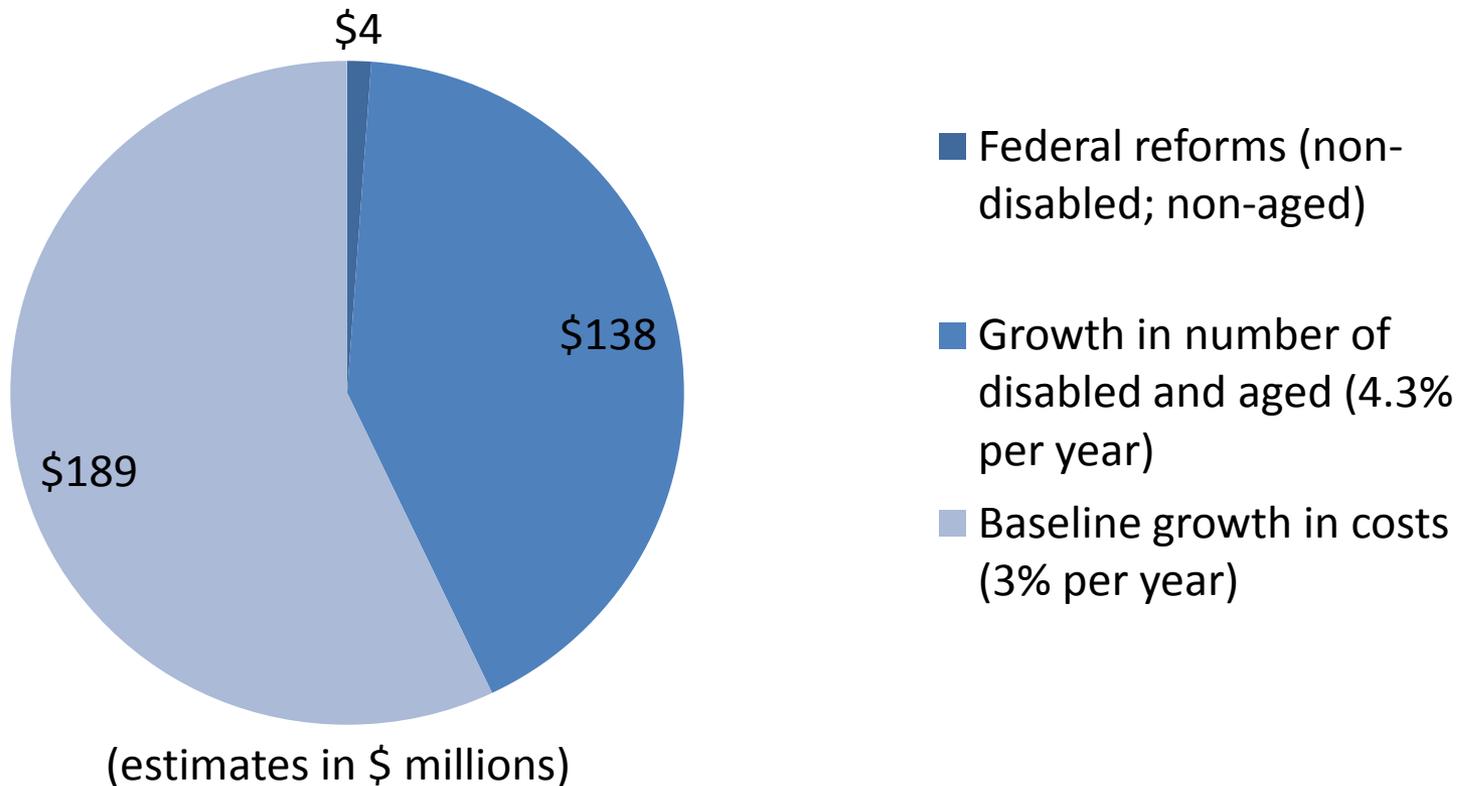
Additional risk: +/- \$15 million variance in true cost of Medicaid benefit package. Impact subject to state choice and federal regulation over covered benefits.

*Options are illustrative and do not reflect the opinions of KHPA staff, nor the KHPA Board. State spending totals for the uninsured through the safety net are preliminary (\$40-\$45 million annually) .

**To the estimate from the actuaries model, this adds new administrative costs and reductions in DSH spending.



Sources of Growth in Medicaid Spending 2011 vs. 2020



Note: Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.



Affordable Care Act: Implications for Medicaid

- **Expanded role for Medicaid in funding the safety net**
 - Medicaid will become the major payer for some providers
 - Approach to payment and cost control will be more important
- **States will need to re-evaluate programs designed for the uninsured**
 - The state helps mitigate uncompensated care through Medicaid disproportionate share hospital (DSH) payments, direct state subsidies to health care and mental health clinics, special Medicaid reimbursements to clinics and critical access hospitals, etc.
 - Health reform will bring at least \$150 million in new health spending in the state
 - Many of the remaining uninsured will be eligible for subsidized coverage
 - Cultural expectations for coverage and individual responsibility may change
 - Key questions:
 - ❖ How much of current state spending on the safety net is devoted to the uninsured?
 - ❖ How much uncompensated care will remain?
 - ❖ What is the state's ongoing responsibility for those costs?



The Affordable Care Act: What It Does Not Do

- **Change individual *health behaviors***
 - Directly confront the true cost drivers in health care: smoking, over-eating, inactivity
 - Make sure individuals face the right incentives as consumers of health care
- **Reduce *health care prices* for consumers**
 - Expand the number of providers (and insurers) to create more price competition?
 - Fill in “missing” provider markets with changes in training and/or licensing?
 - Enact malpractice reforms?
- **Reduce *public spending* on health care**
 - Public spending on health care is unsustainable at the present rate of growth
 - In Kansas, increases in public spending will be driven by the existing program
 - Will require changes in the delivery of care, e.g., technology and coordination
 - Federal reform created new opportunities, but leaves concrete steps to states

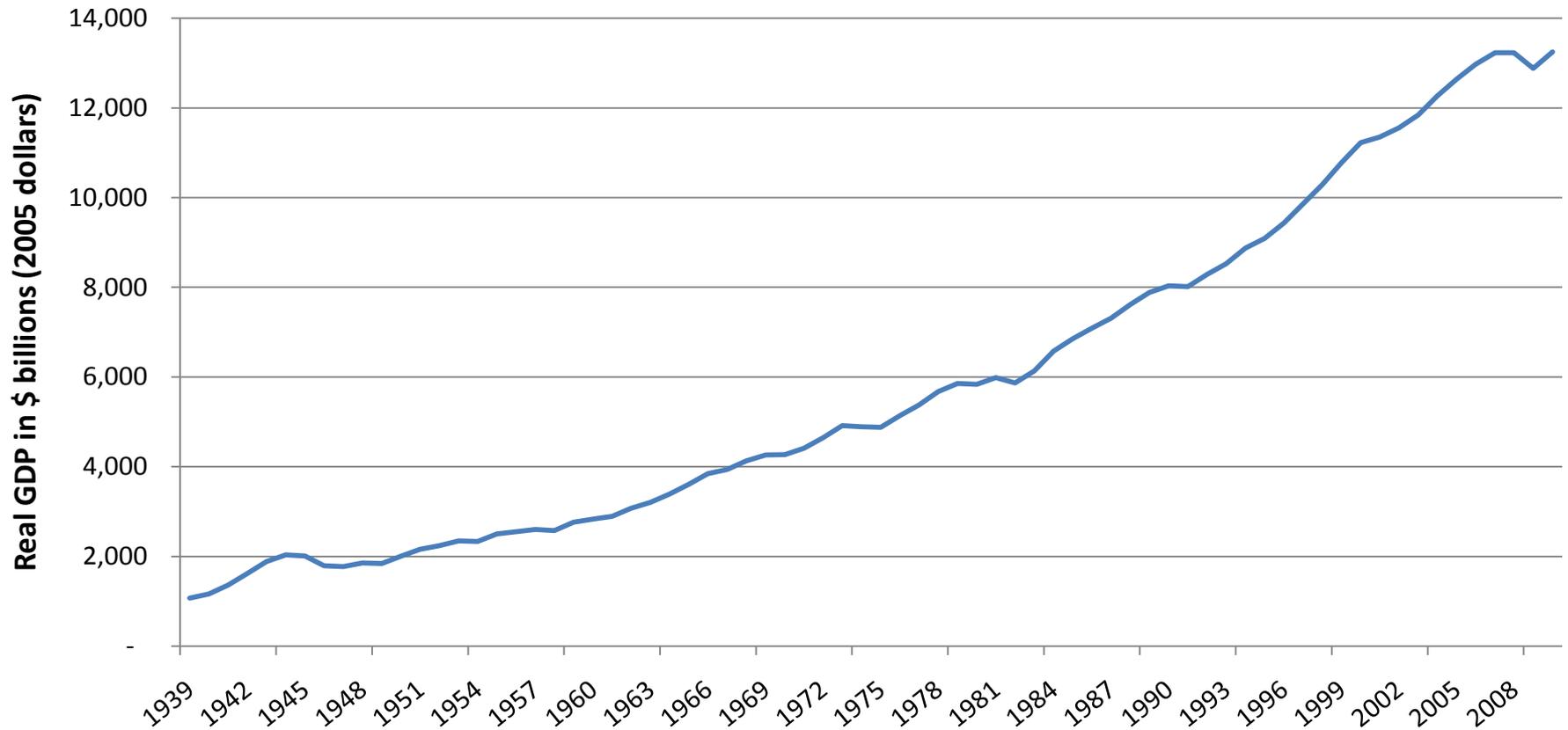


The New Economy

Fundamental Shifts in the US Economy

US Real Gross Domestic Product

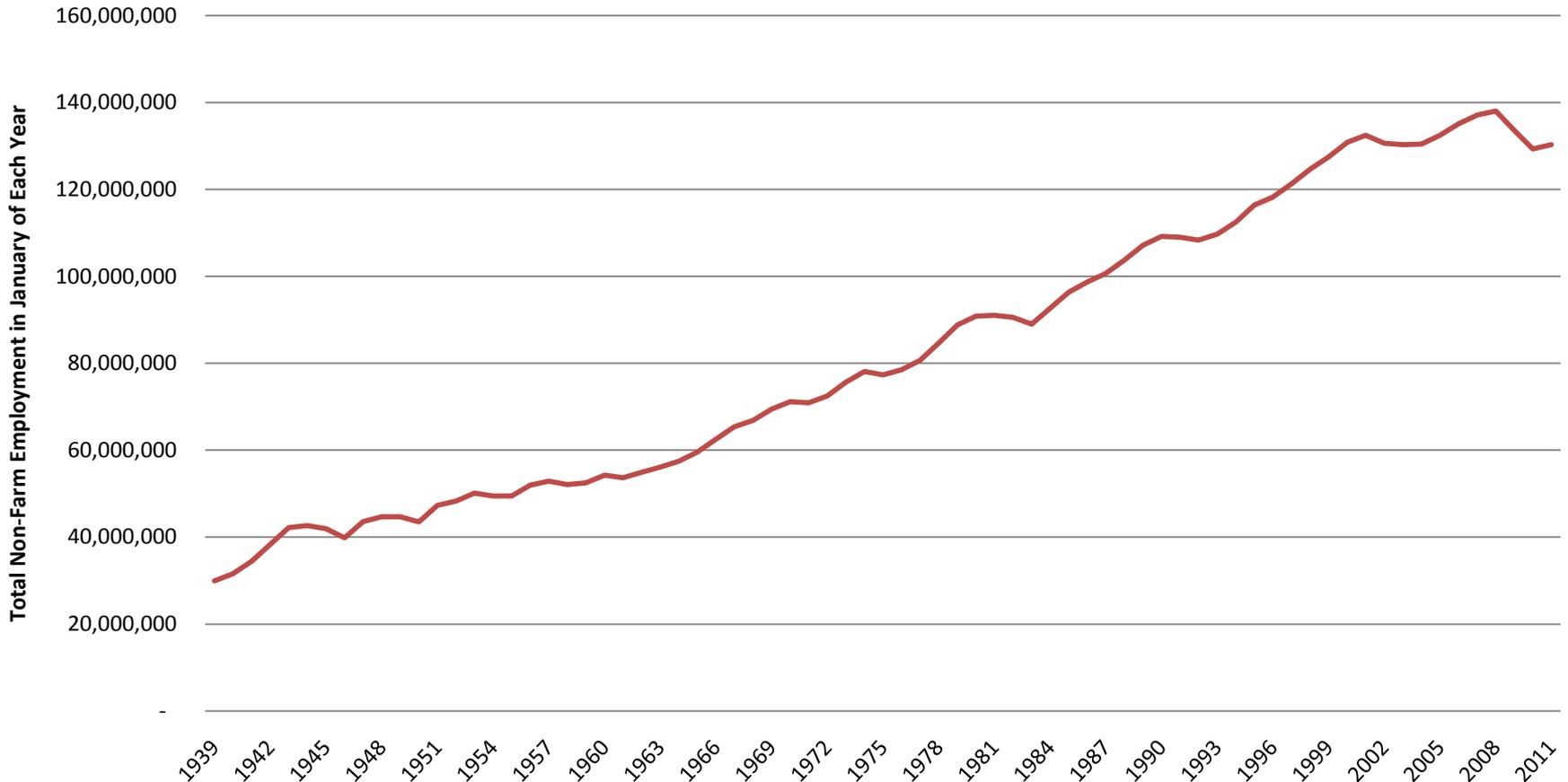
Source: US National product and Income Accounts, BEA



Fundamental Shifts in the US Economy

Total US Non-Farm Employment since 1939

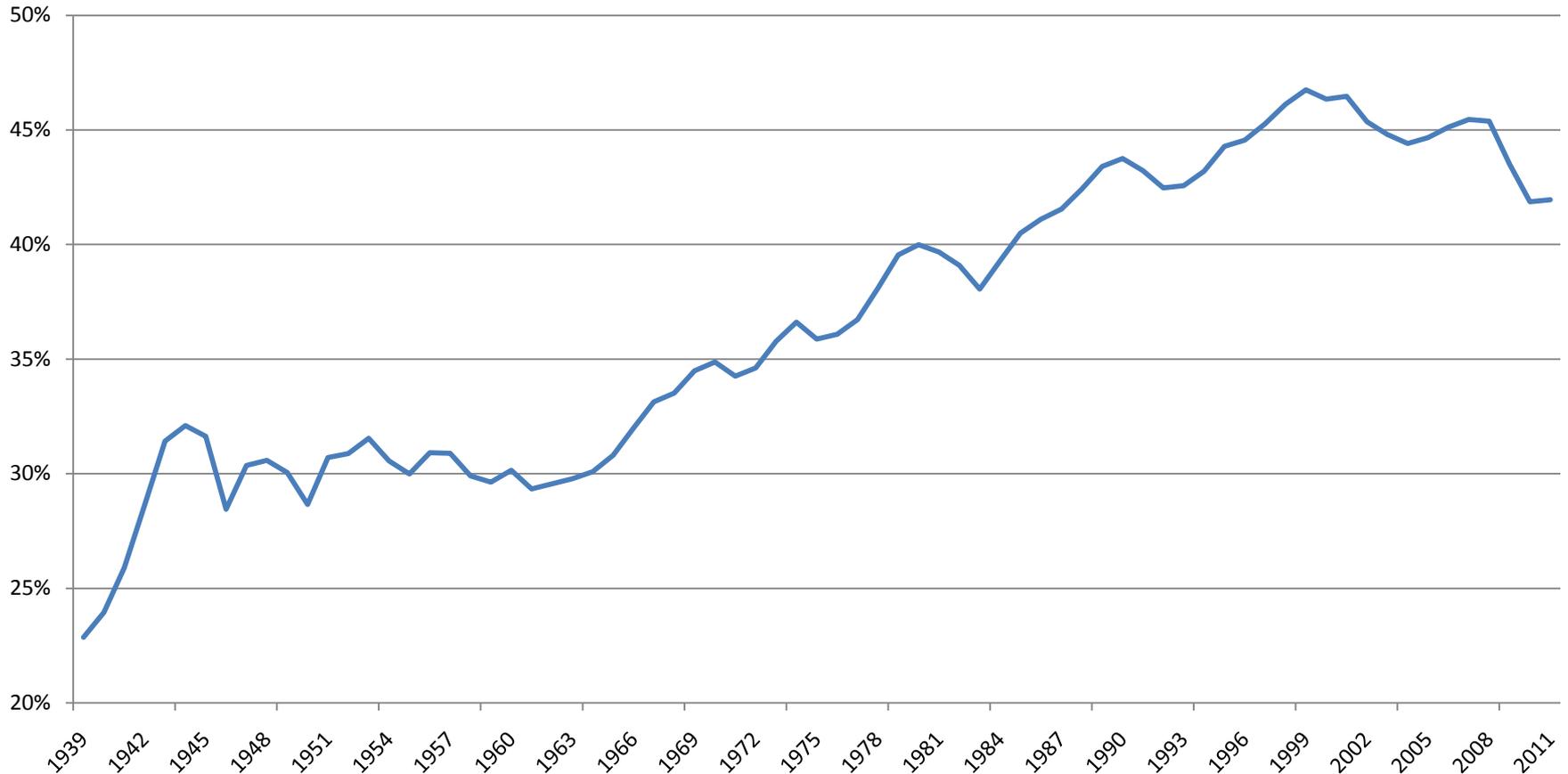
Source: Current Employment Statistics Survey, BLS



Fundamental Shifts in the US Economy

Percentage of US Population with Non-Farm Employment

Source: Current Employment Statistics Survey, BLS





Impact of the New Economy on State Budgets

- States across the country are facing enormous deficits
- Possibility of credit default and “bankruptcy” is receiving serious consideration in economic policy circles
- Future economic growth is uncertain
- Projections of state deficits in Kansas range into the hundreds of millions as soon as FY 2013
- Will Medicaid costs continue to drive state spending and exacerbate deficits?

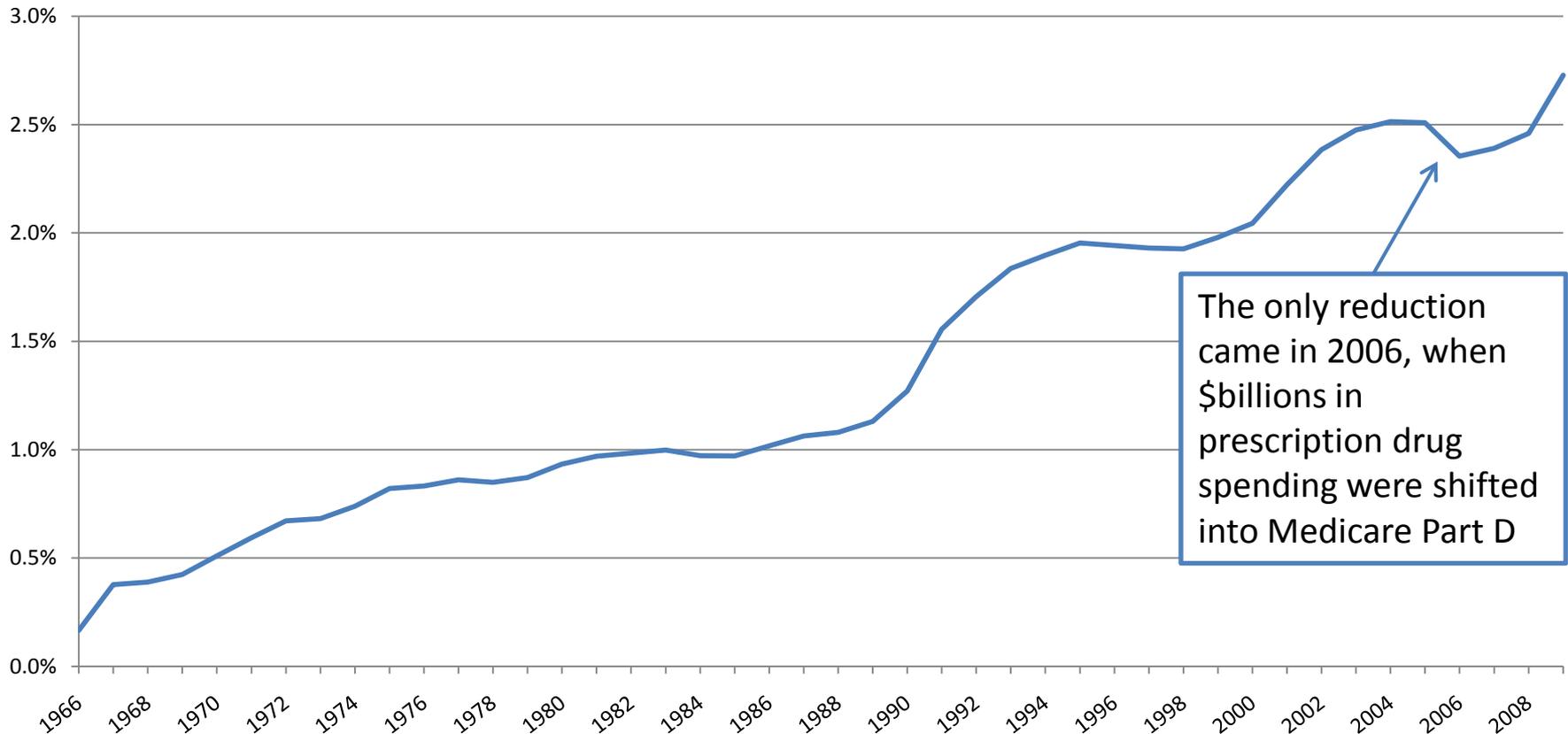


Growth in Medicaid Spending Nationally

Medicaid's Growth Outpaces the National Economy

Total Medicaid and CHIP Spending as a Percentage of GDP

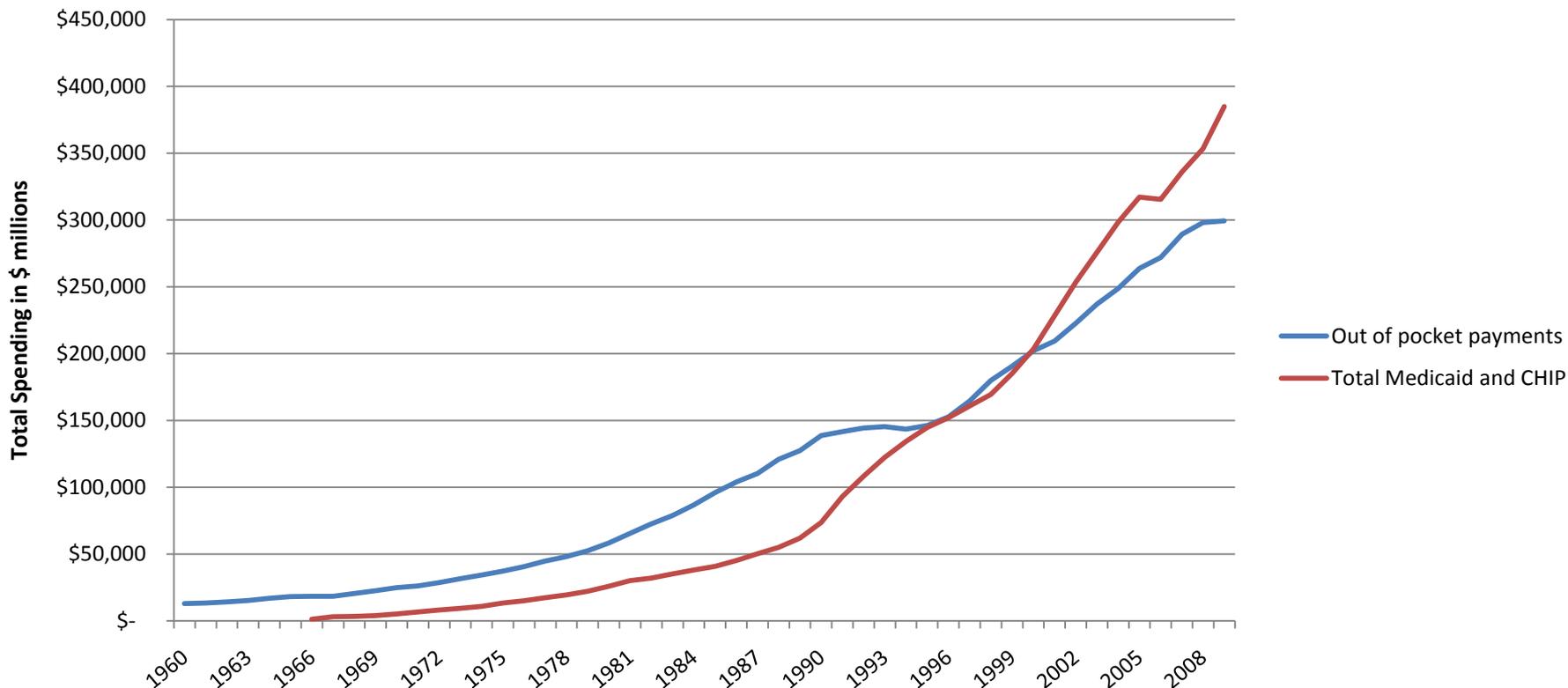
Sources: National Health Accounts, HHS; US National product and Income Accounts, BEA



Medicaid's Growth Outpaces Individual Spending

Medicaid Spending vs. Total Out-of-Pocket Payments by Individuals

Source: National Health Accounts, HHS

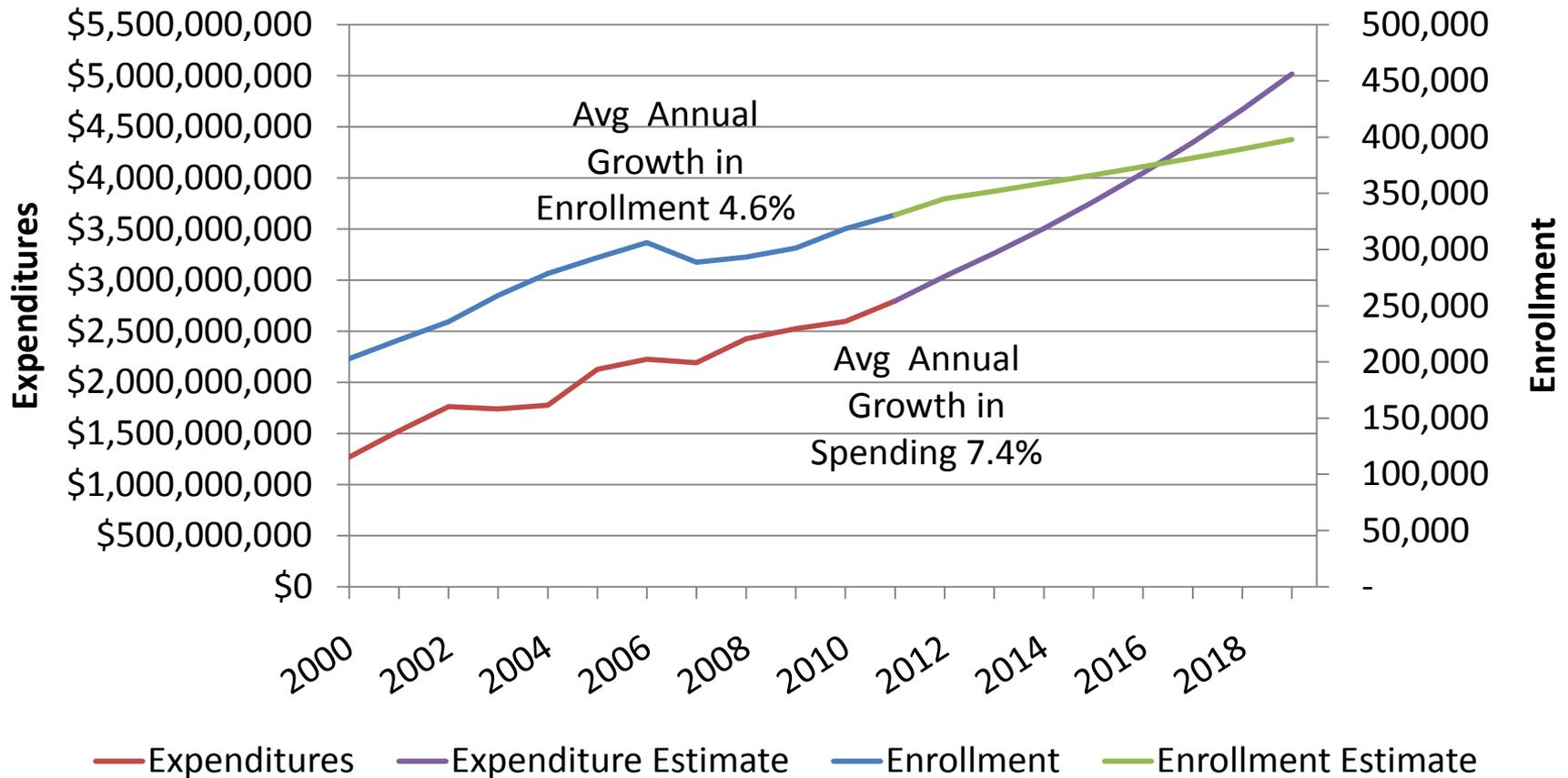




Growth in Medicaid Spending in Kansas

Potential Growth in Kansas Medicaid

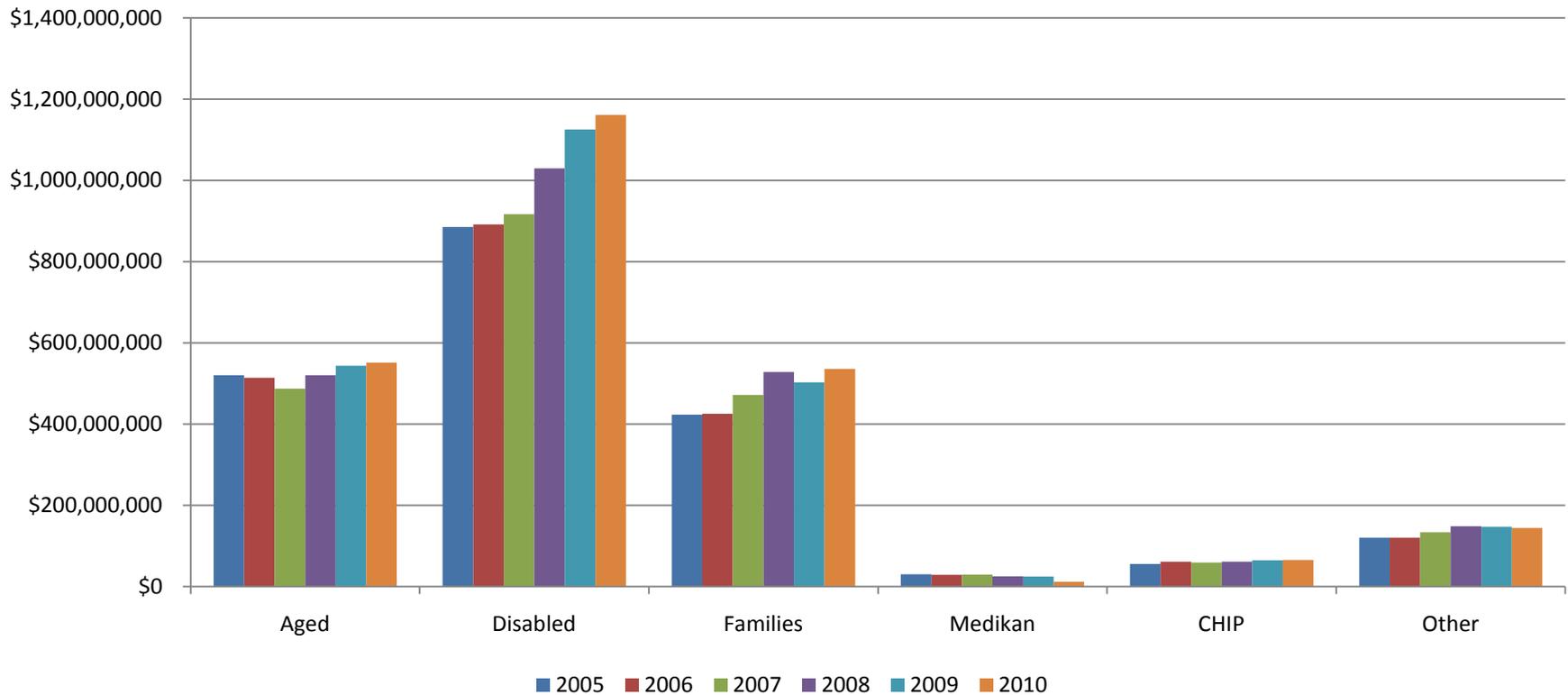
Total Medicaid (*without federal reforms*)



*Preliminary estimates. New projections will follow consensus caseload process in April 2011.

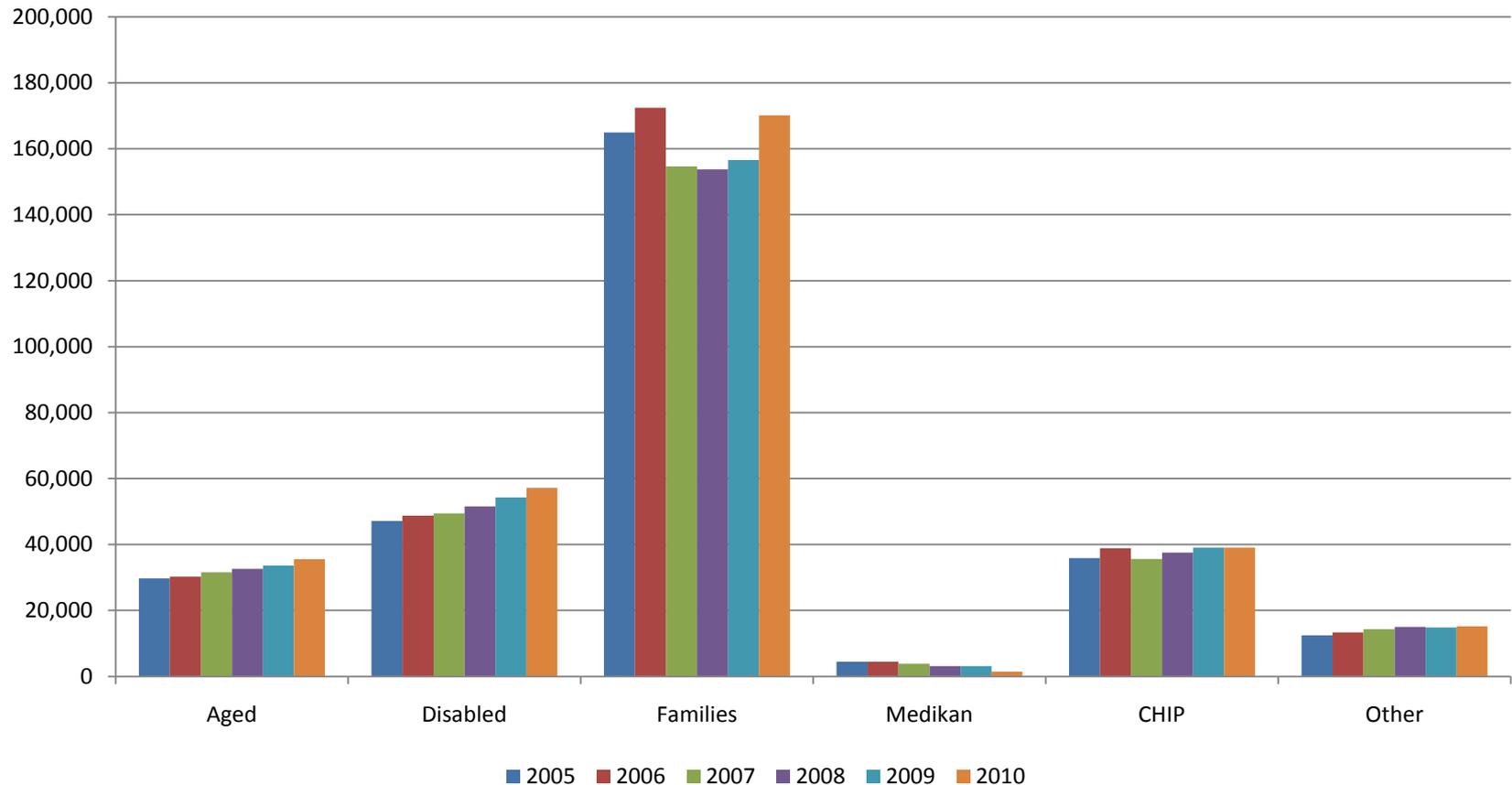
Recent Growth in Spending by Population

Population Expenditures 2005-2010



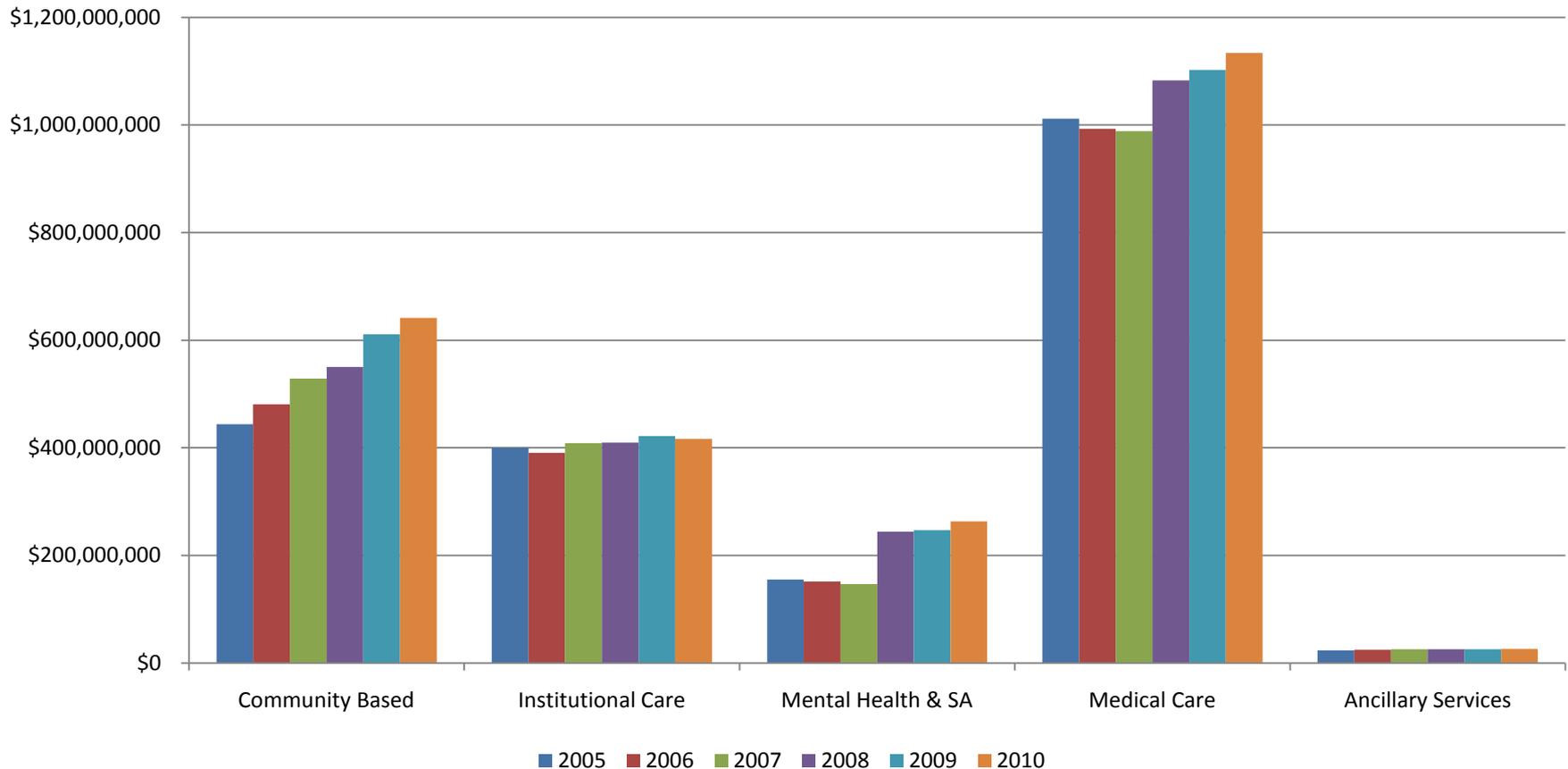
Recent Growth in Enrollment

Population Enrollment 2005-2010



Recent Growth in Spending by Type of Service

Service Expenditures 2005-2010





Concentrations of Program Dollars Across Populations and Services

Service	Population						
	Total Spending (SFY 10; \$ millions)	XXI-Children in CHIP	XIX-Adults and children	Disabled	Elderly	Other & MediKan	Total
Physical health		61	494	450	107	76	1,187
Behavioral health		4	33	102	12	32	184
Substance abuse		NA	8	7	0	7	22
Nursing facilities		NA	0	111	312	1	424
HCBS		NA	NA	479	121	8	608
Total		65	535	1,149	552	124	2,425



Existing Silos in Medicaid Service Delivery

		Population					
Service	Purchasing Program	XXI-Children in CHIP	XIX-Adults and children	Disabled	Elderly	Other & MediKan	Managing Agency
	Physical health	HealthWave MCOs	HealthWave MCOs; HealthConnect PCCM	HealthConnect PCCM and FFS	FFS	FFS	KHPA
	Behavioral health	CHIP MCO	PAHP	PAHP	PAHP	PAHP	SRS, KHPA
	Substance abuse	CHIP MCO	PIHP	PIHP	PIHP	PIHP	SRS, KHPA
	Nursing facilities	N/A	FFS	FFS	FFS	FFS	SRS, KDOA
	HCBS	N/A	N/A	PD, DD, TBI, SED, TA, Autism, and CBA waivers	FE waiver	TA,DD waivers	SRS, KDOA



Trends in State Medicaid Spending

- Long-run trends in Medicaid spending are driven by widespread increases in enrollment and spending per person
- Most spending, and most of the growth in Medicaid spending, is attributable to the aged and disabled populations
- The Medicaid cost crisis cannot be addressed without reducing growth in spending across all Medicaid populations, but especially among the disabled
- The state is in the midst of a sustained period of accelerated growth in the number of newly-disabled recipients as baby boomers reach the age of onset of acquired disability
- Medicaid spending is spread widely across service types, funding streams, and state agencies – often for the same population



Medicaid Cost Containment — Remaking the Program



Medicaid Cost Containment: Options

Avoiding unnecessary spending

- Available approaches to reduce Medicaid spending
 - Reduce payments
 - Reduce eligibility
 - Reduce range of services offered
 - Lower utilization through appropriate management and improved services
- Limitations on state flexibility
 - Eligibility maintenance of effort (MOE) requirement began in ARRA and was made permanent in the ACA
 - Potential legal restrictions on state flexibility to reduce payments
 - Vast majority of optional spending is for services that either improve health , lower overall costs, or could be protected by the MOE
- Remaining options are to redesign program payments, coordinate care, address unnecessary utilization and ensure positive incentives for both consumers and providers to achieve high quality care



Medicaid Cost Containment: Initiatives

Avoiding unnecessary spending

- KHPA solicited Medicaid cost-saving ideas in an open call in February 2010. Dozens of ideas were summarized in a Medicaid savings options report submitted to the legislature.
- KHPA hosted a Forum on Cost Drivers in Medicaid April 26, 2010 for stakeholders, providers, state agencies and legislators to identify sources of growth and discuss potential solutions.
- KHPA developed a Request for Information (RFI) to seek products and services from vendors that could reduce Medicaid costs (responses were due October 29, 2010). *See attached summary of responses.*
- Governor Brownback has identified Medicaid spending as unsustainable, and one of three fiscal priorities to address the state's structural deficit
- Lt. Governor Dr. Jeff Colyer is leading an effort to be spearheaded by the HHS Sub-Cabinet to remake Medicaid. The Administration is soliciting ideas for pilot programs and reforms to curb growth, achieve long-term reform, and improve the quality of services in Medicaid. (Responses are due to Dr. Barb Langner at KHPA February 28)



Medicaid Cost Containment: Keys to Success

- Recognizing the need for change
- Understanding the cost drivers and potential solutions
- Political ownership of the program and its challenges
- Strong leadership and a sustained effort
- Active engagement with Kansas health care community
- Timely action and fundamental changes
- Coordinating care across multiple conditions and services

What if it isn't enough?

- Medicaid was created in the fifth straight year of job growth, and during a 10-year stretch of continuous job growth
- Medicaid was expanded over 45 years of relative economic growth, including a few recessions
 - Passage of the ACA is a major exception
- Previous discussions about the role of Medicaid in economic downturns focused on the short-term nature of recessions, unemployment and enrollment spikes
- Supporting state (and Federal) spending growth in Medicaid would require a new level of tax burden
- May require revisiting Federal limits, requirements and mandates

Next Steps

- Senate version of reform transferred the health reform debate to states, who now face many key decisions
- The fiscal base for both the ACA and Medicaid is weak
 - States are approaching fiscal crisis at varying speeds
 - Federal government is approaching a practical debt ceiling
 - Sustainability of Title XIX (Medicaid) is now in jeopardy
- Legal footing of the ACA is also uncertain
- States will need to explore the relationship between Medicaid's costs, needed reforms, and the ACA
- States will need either more money or more flexibility in order to balance their budgets
- Deadlines for tough state decisions are fast approaching

*Coordinating health & health care
for a thriving Kansas*



<http://www.khpa.ks.gov/>