



# **State Choices and Challenges in the Wake of Federal Health Reform Legislation**

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# 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**



# Affordable Care Act Implementation: KHPA Priorities

- **Closely monitor and work with federal agencies**
  - Federal health reform panels
  - National Association of Medicaid Directors
- **Understand and describe reform**
  - Estimate Potential Impact on Kansas (May 2010)
- **Coordinate information system changes**
  - Build a new platform for Medicaid and the Exchange (RFP released October 2010)
- **Detailed analysis of state policy choices under the ACA**
  - \$250,000 in grants from five Kansas grant makers (matched 1-for-1)
  - Create options for Medicaid benefit packages and to simplify Medicaid eligibility (RFP for contract analysis pending; analysis due mid-2011)
- **Coordinate planning for the exchange with Kansas Insurance Department**
  - Develop Innovator Grant application with KID (submitted December 21, 2010)
- **Solicit input from stakeholders and inform policymakers**



# **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

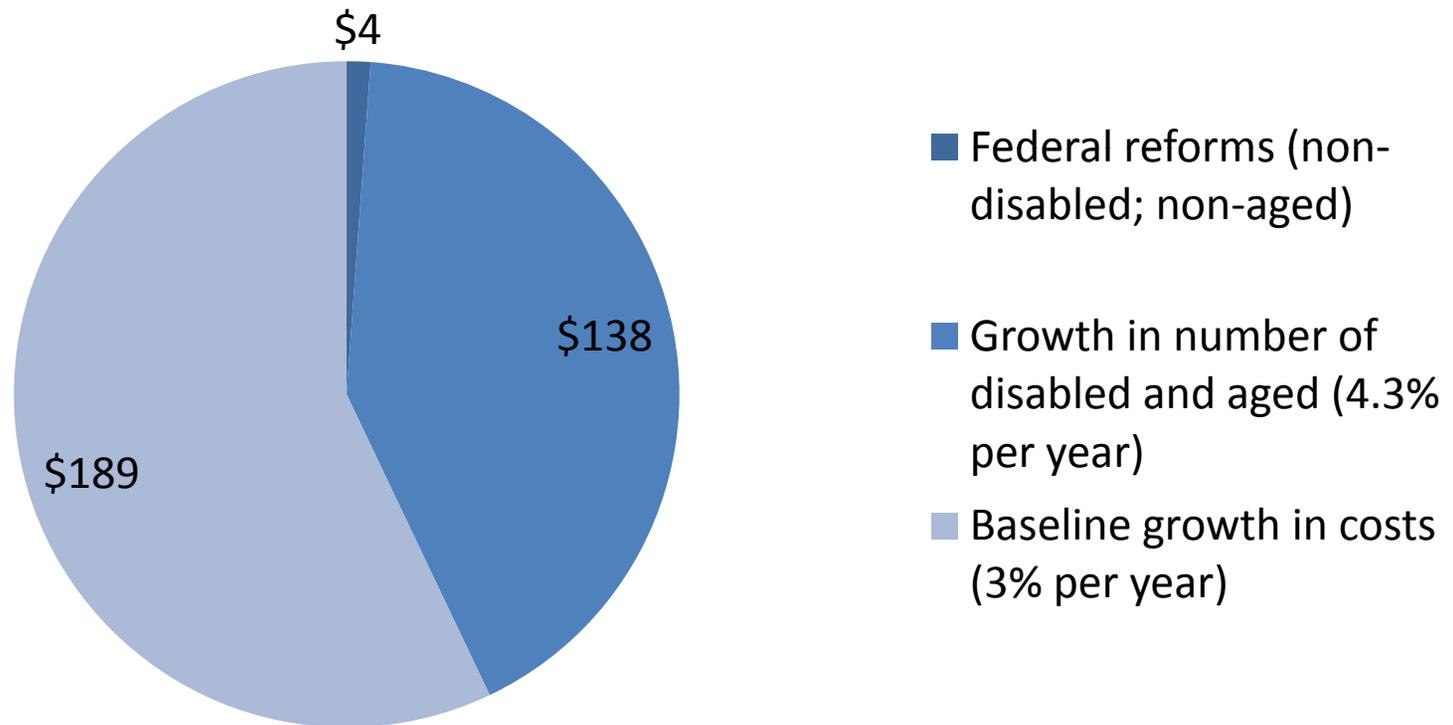
Additional risk: +/- \$15 million variance in true cost of Medicaid benefit package. Impact subject to state choice and federal regulation over covered benefits.

\*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



(estimates in \$ millions)

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

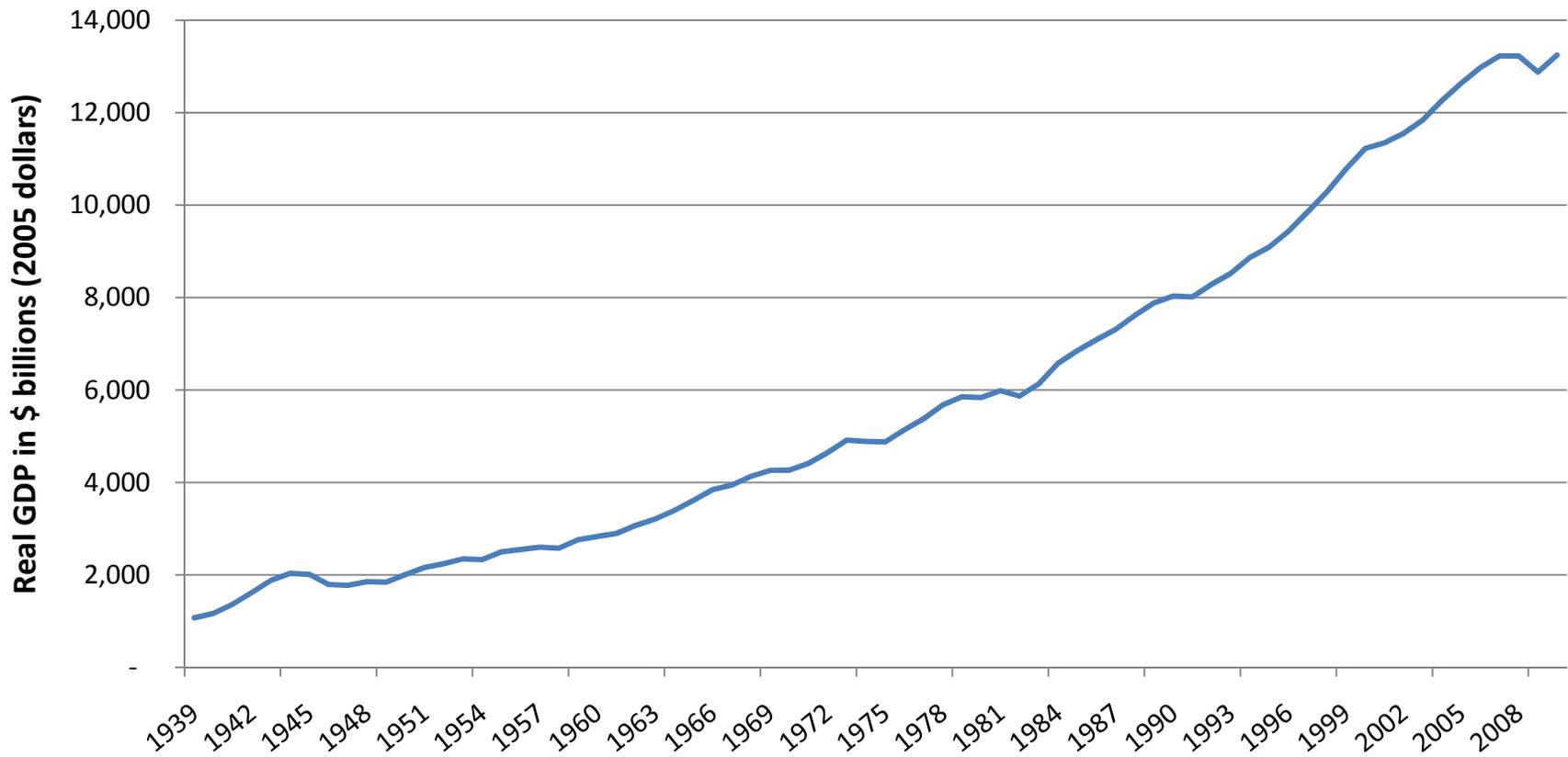


# The New Economy



# Fundamental Shifts in the US Economy

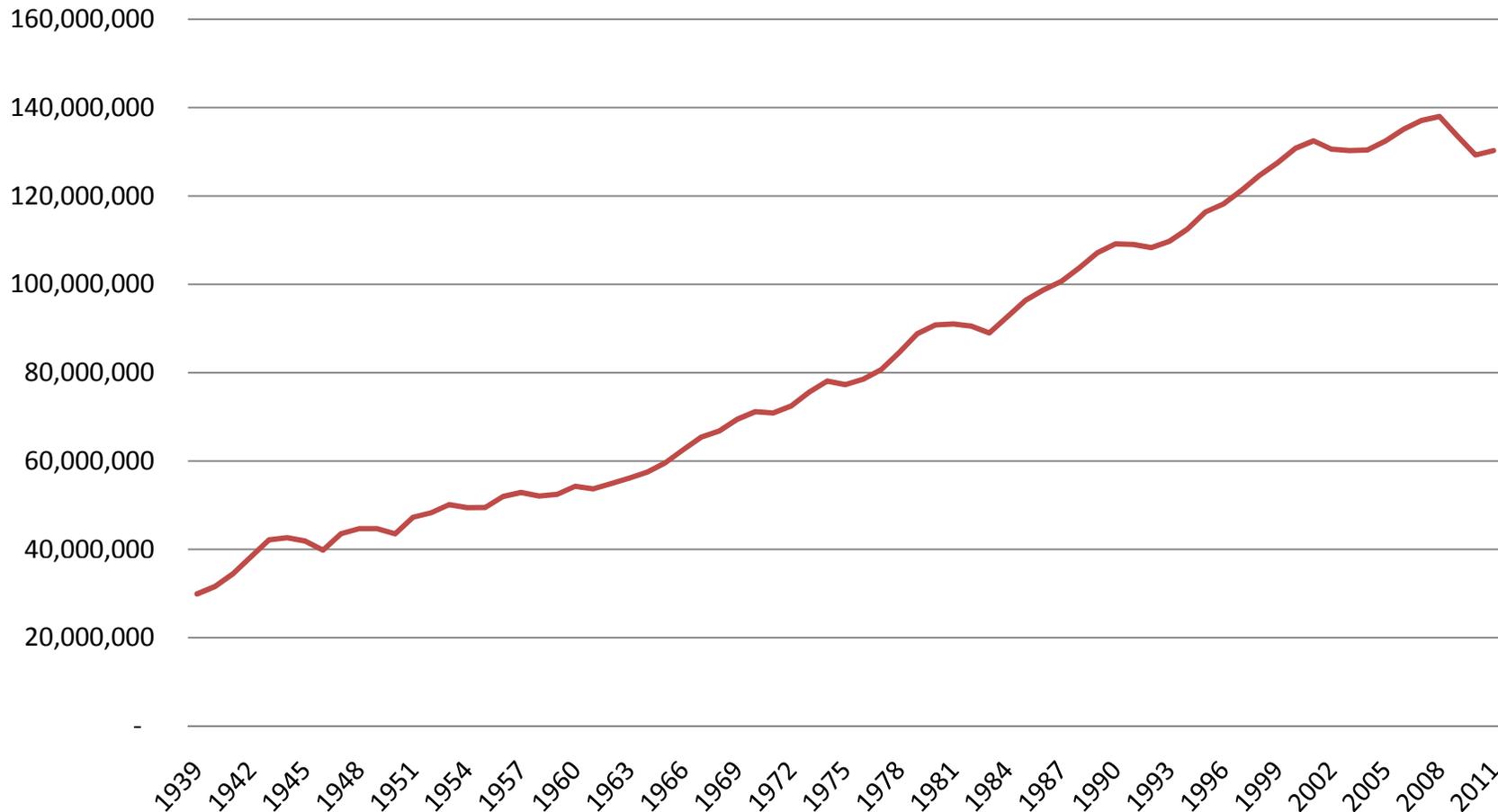
## US Real Gross Domestic Product





# Fundamental Shifts in the US Economy

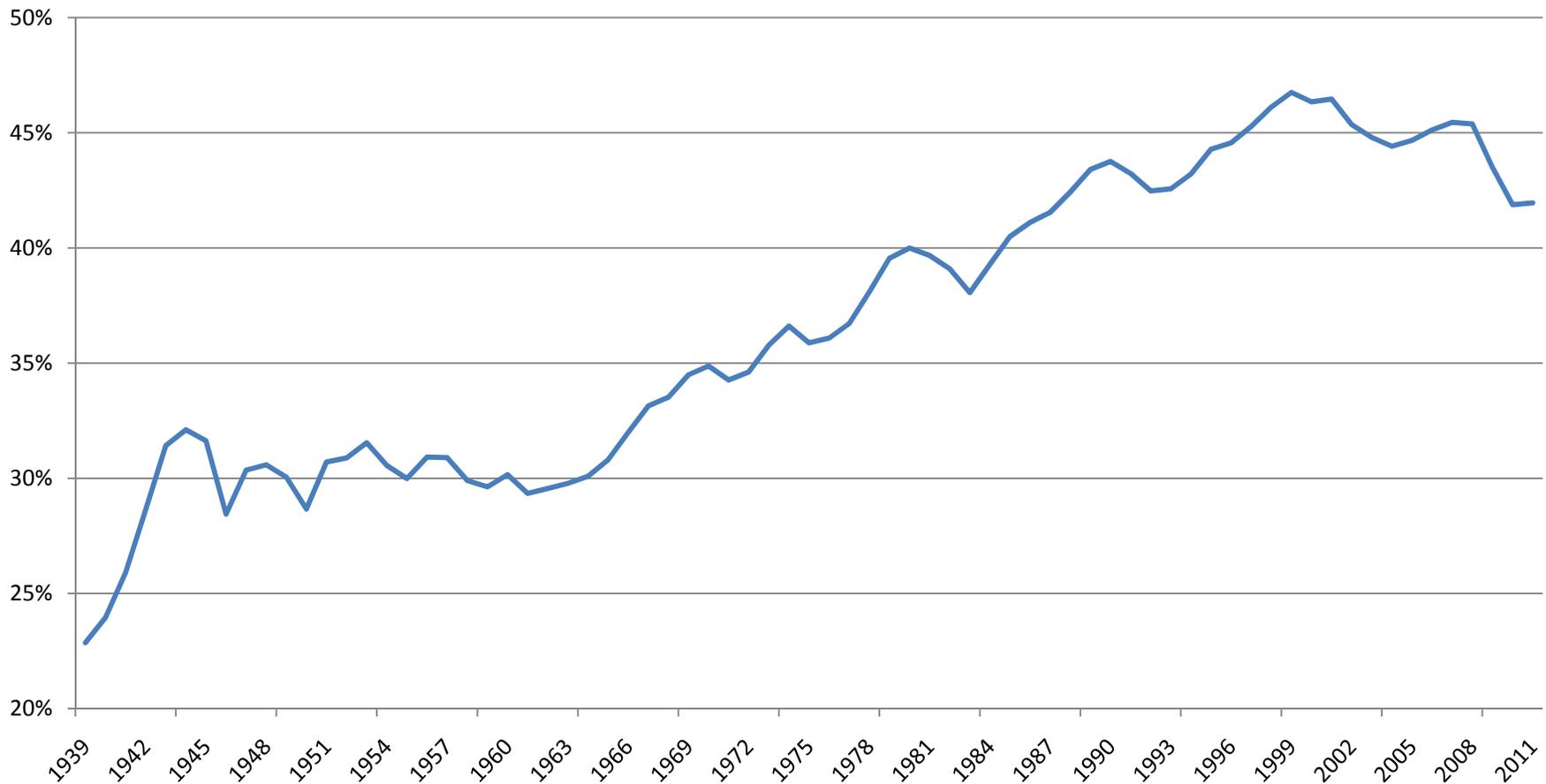
**Total US Non-Farm Employment Since 1939 (ref=January)**





# Fundamental Shifts in the US Economy

Percentage of US Population that is Employed (ref=January)





# 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?

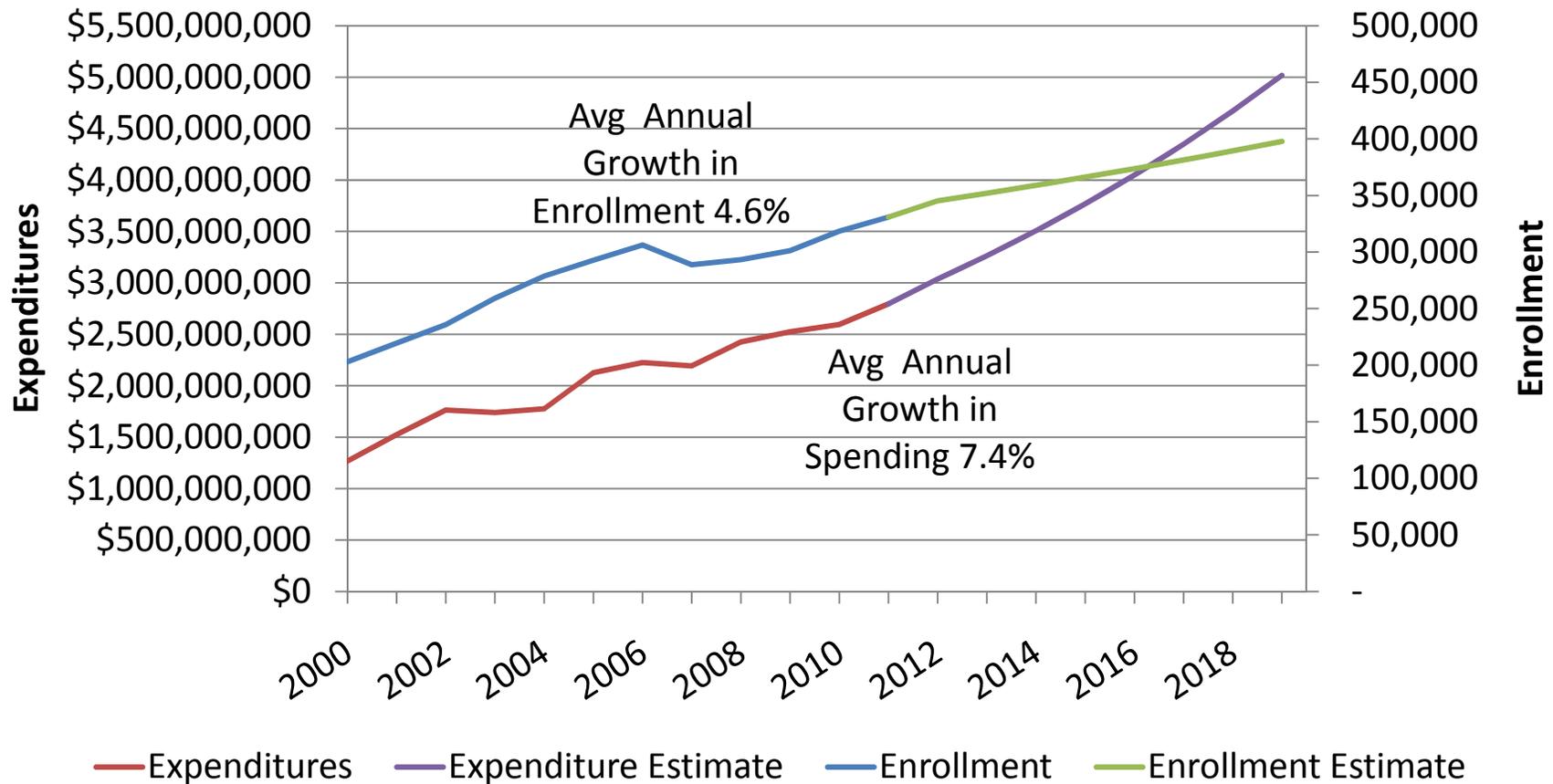


# The Medicaid Cost Crisis



# Potential Growth in Kansas Medicaid

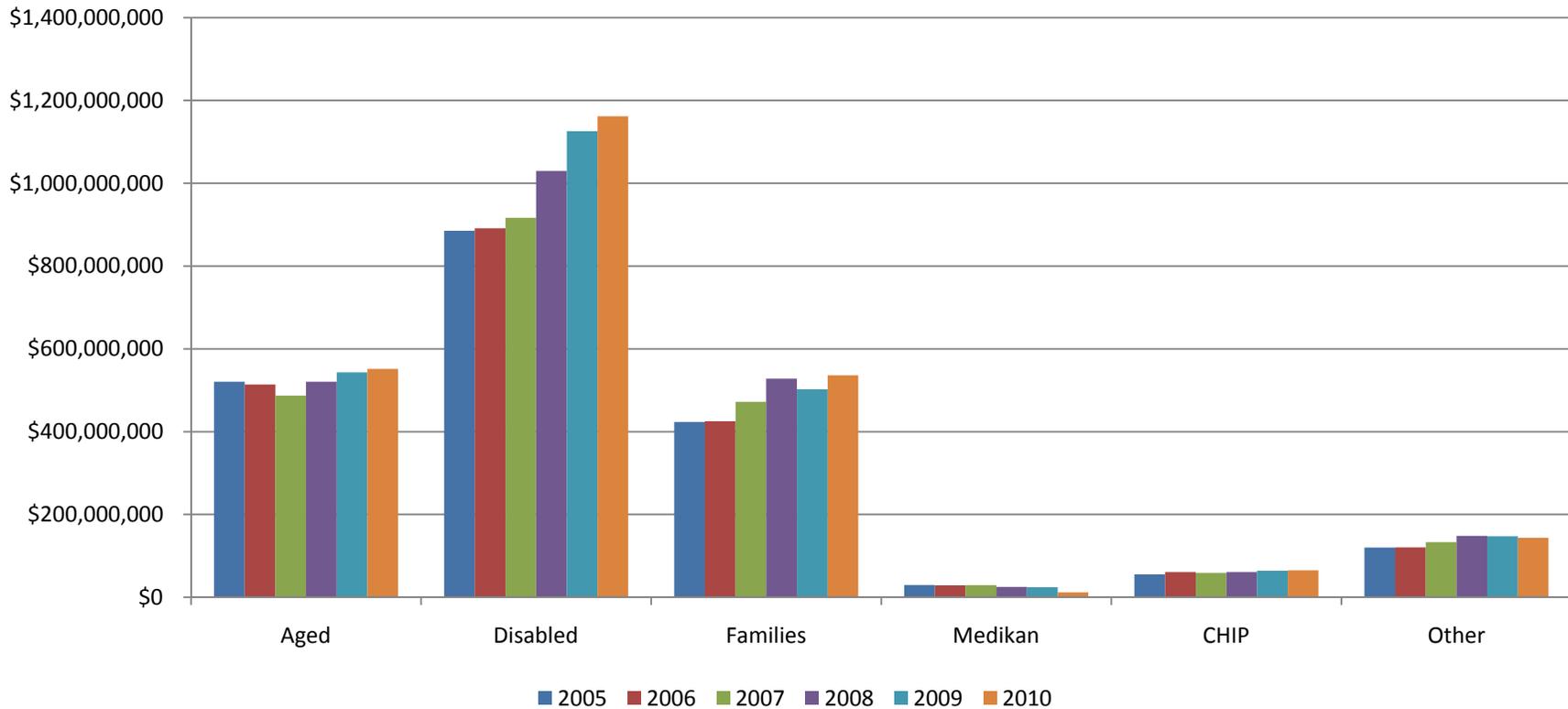
**Total Medicaid (without federal reforms)**





# Recent Growth in Spending by Population

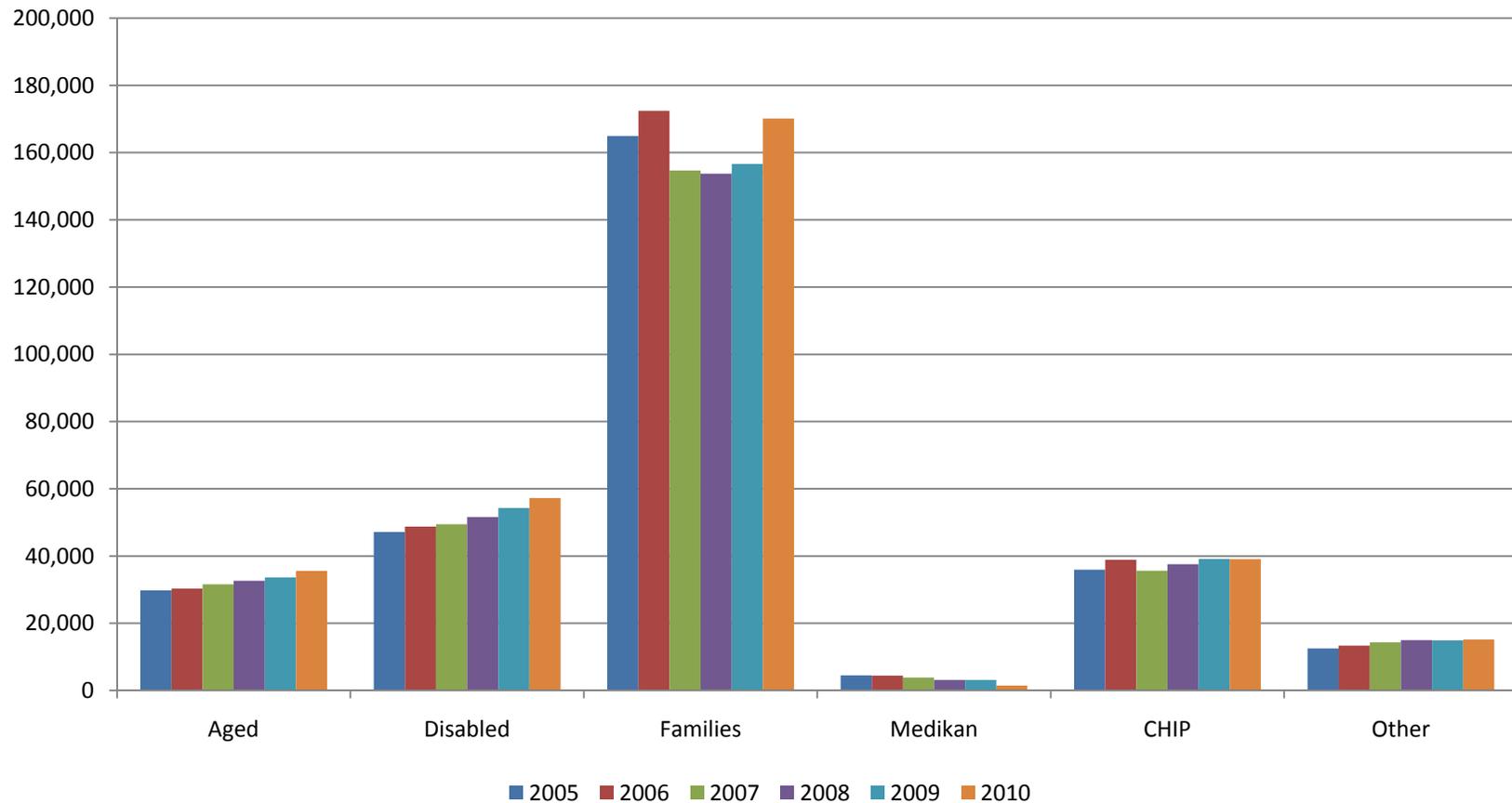
Population Expenditures 2005-2010





# Recent Growth in Enrollment

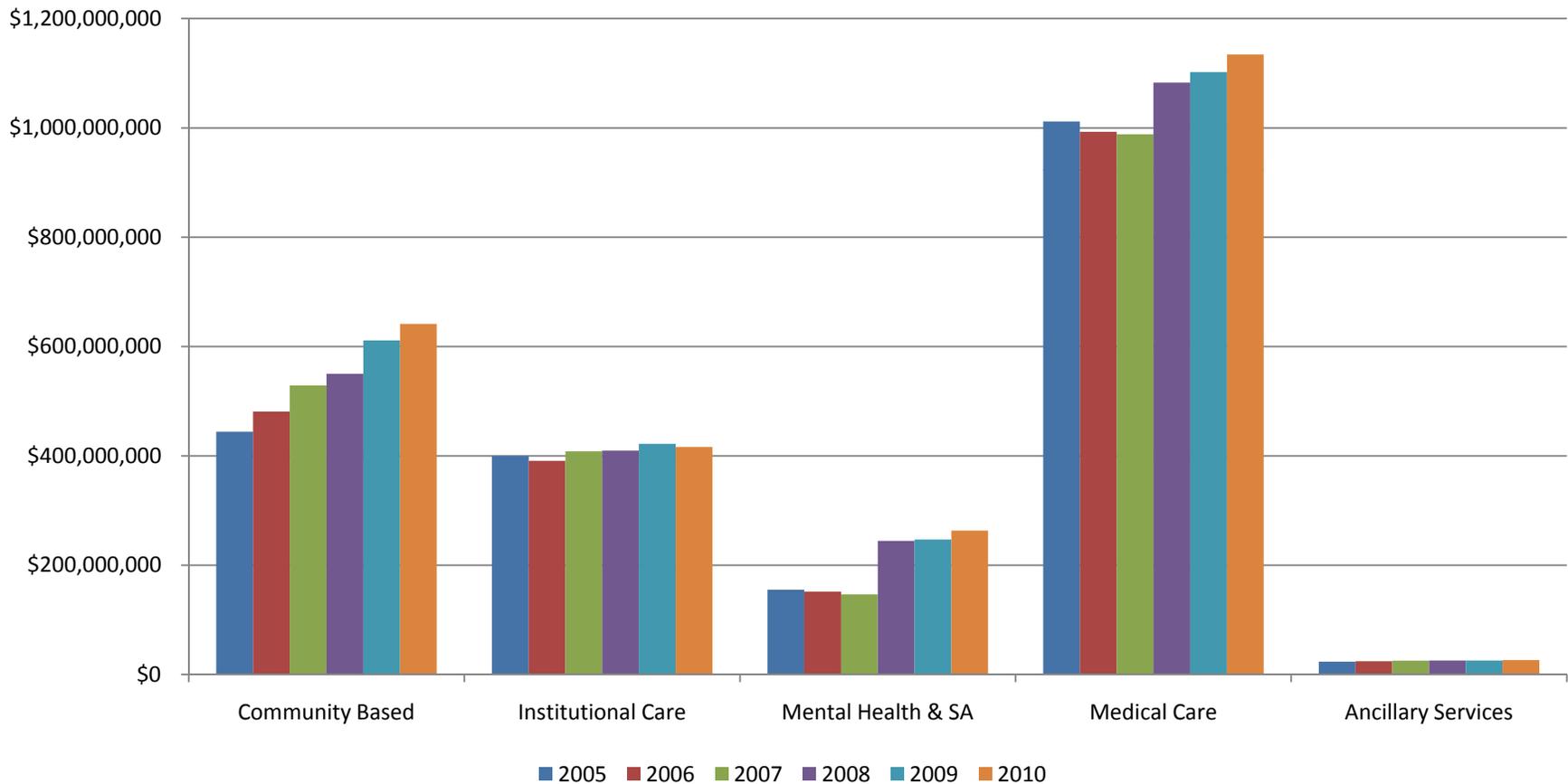
## Population Enrollment 2005-2010





# Recent Growth in Spending by Type of Service

Service Expenditures 2005-2010



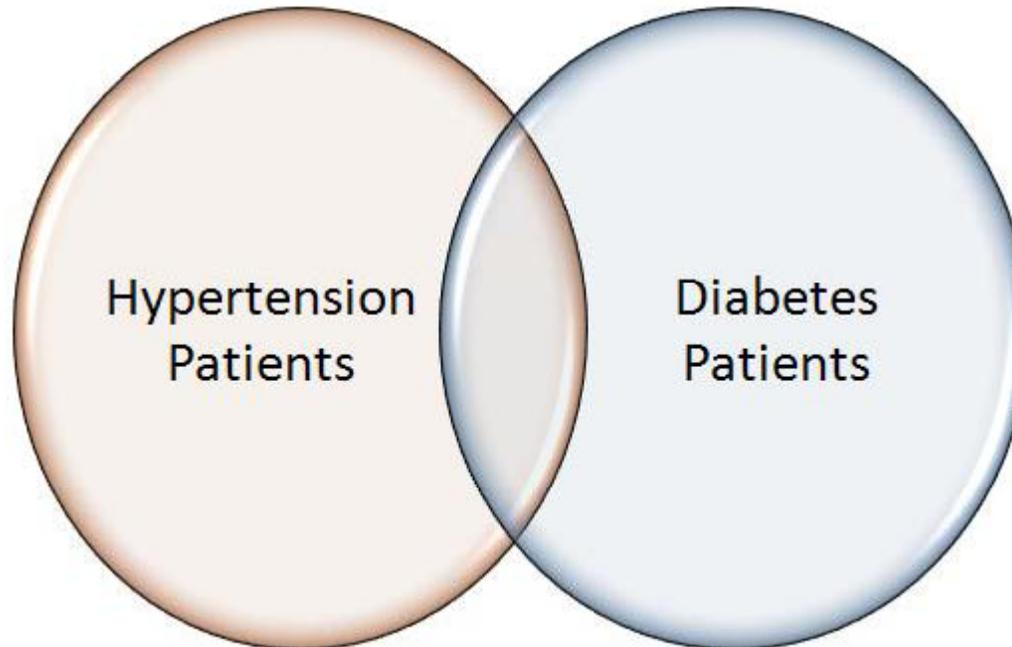


# Diagnosing the Medicaid Cost Crisis

- Long-run trends in Medicaid spending are driven by widespread increases in enrollment and increases in 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
- What is driving spending among the disabled?

# A Picture of Chronic Conditions Among Disabled Recipients

## Hypertension and Diabetes Patients





# Chronic Conditions Among Disabled Recipients

SSI Disabled Hypertension Patients Expenditure by Episodes of Care

Episode of Care	FY 07 Expenditure	FY 08 Expenditure	FY 09 Expenditure
*Mental Health	\$ 19,470,626.53	\$ 10,545,687.92	\$ 6,858,631.14
Diabetes	\$ 8,933,706.96	\$ 10,459,032.98	\$ 9,670,361.45
Mental Hlth - Schizophrenia	\$ 10,451,819.31	\$ 6,997,382.24	\$ 6,858,631.14
Hypertension, Essential	\$ 8,277,959.76	\$ 7,269,614.69	\$ 7,160,513.93
Pneumonia, Bacterial	\$ 4,505,617.72	\$ 5,807,120.88	\$ 6,002,822.42
Coronary Artery Disease	\$ 5,208,510.50	\$ 5,407,204.51	\$ 5,417,332.81
Condition Rel to Tx - Med/Surg	\$ 4,547,452.49	\$ 3,898,230.61	\$ 3,579,839.59
Renal Function Failure	\$ 3,572,006.44	\$ 3,804,726.71	\$ 3,977,878.37
Osteoarthritis	\$ 3,379,792.86	\$ 3,822,380.31	\$ 3,690,618.09
Infec/Inflam - Skin/Subcu Tiss		\$ 5,681,519.28	\$ 4,869,995.61
Mental Hlth - Depression	\$ 3,552,531.06	\$ 3,548,305.68	
Mental Hlth - Bipolar Disorder	\$ 5,466,276.16		
Cerebrovascular Disease			\$ 3,699,274.31
<b>Total Expenditure</b>	<b>\$ 57,895,673.26</b>	<b>\$ 56,695,517.89</b>	<b>\$ 54,927,267.72</b>
			
Total SSI Population Expenditure	\$ 286,412,407.71	\$ 306,144,449.37	\$ 321,739,482.70
Hypertension Patients Percentage of SSI Total Expenditure	20.2%	18.5%	17.1%



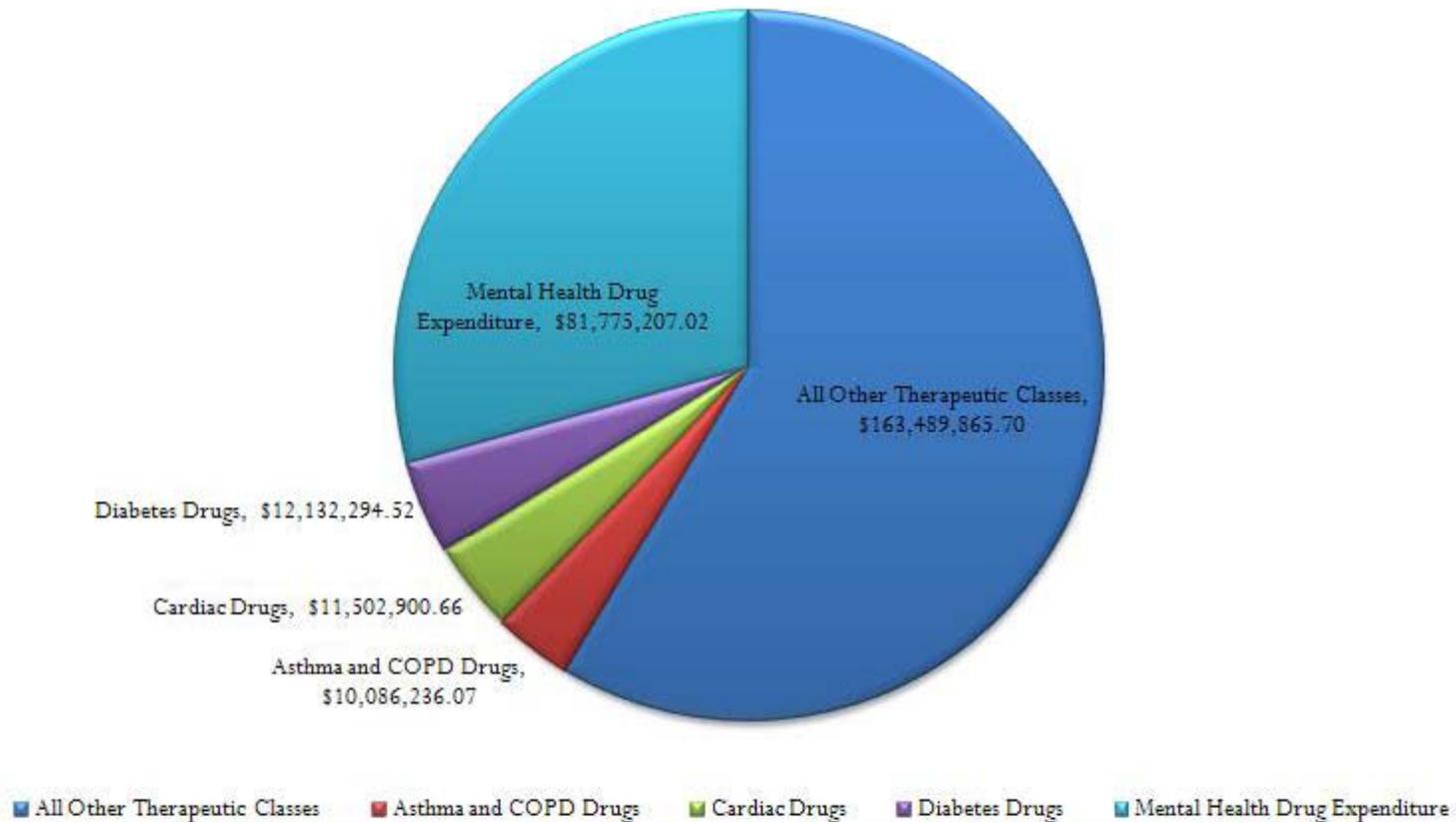
# Chronic Conditions Among Disabled Recipients

## SSI Disabled Diabetes Patients Expenditure by Episodes of Care

Episode of Care	FY 07 Expenditure	FY 08 Expenditure	FY 09 Expenditure
*Mental Health	\$ 14,461,090.60	\$ 10,650,256.31	\$ 4,917,227.58
Diabetes	\$ 15,758,609.36	\$ 18,078,677.22	\$ 17,599,448.54
Mental Hlth - Schizophrenia	\$ 7,910,255.11	\$ 5,147,486.72	\$ 4,917,227.58
Infec/ Inflam - Skin/ Subcu Tiss	\$ 4,089,968.31	\$ 5,703,397.89	\$ 4,364,837.17
Pneumonia, Bacterial	\$ 4,106,881.89	\$ 4,293,006.98	\$ 4,156,101.39
Coronary Artery Disease	\$ 4,127,257.39	\$ 3,752,721.62	\$ 4,138,178.87
Hypertension, Essential	\$ 3,678,536.60	\$ 2,828,879.71	\$ 3,185,540.33
Condition Rel to Tx - Med/ Surg	\$ 3,115,907.88	\$ 2,990,364.12	\$ 3,353,517.37
Renal Function Failure	\$ 2,652,392.87	\$ 2,422,917.42	\$ 2,474,299.74
Mental Hlth - Bipolar Disorder	\$ 3,776,999.09	\$ 2,688,455.65	
Mental Hlth - Depression	\$ 2,773,836.40	\$ 2,814,313.94	
Chronic Obstruc Pulm Dis(COPD)			\$ 2,157,424.34
Osteoarthritis			\$ 2,050,514.94
<b>Total Expenditure</b>	<b>\$ 51,990,644.90</b>	<b>\$ 50,720,221.27</b>	<b>\$ 48,397,090.27</b>
			
<b>Total SSI Population Expenditure</b>	<b>\$ 286,412,407.71</b>	<b>\$ 306,144,449.37</b>	<b>\$ 321,739,482.70</b>
<b>Diabetes Patients Percentage of SSI Total Expenditure</b>	<b>18.2%</b>	<b>16.6%</b>	<b>15.0%</b>

# Chronic Conditions Among Disabled Recipients

Prescription Expenditures by Therapeutic Class:  
SSI Disabled, All Ages FY 07-09





# Explaining Cost Growth Among Disabled Recipients

- Growth is comprised of spending across multiple chronic conditions
- Spending is concentrated across conditions that extend far beyond the proximate disability
- Medicaid spending is concentrated across service types, funding streams, and state agencies
- Much remains to be learned about the underlying causes of growth in spending
- Kansas' ongoing efforts to implement a medical home, coordinating care in a holistic fashion, appear to be steps in the right direction



# 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

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