Health Reform: 6 Ways It Will Impact States

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From dramatically expanding the reach of Medicaid to creating new state-based health insurance exchanges, the federal health care legislation recently signed into law will have a far-reaching impact on states. This cover story of Stateline Midwest examines six ways that state-level health care and insurance policy will be affected.


In states across the region, and the nation, there are very different perspectives on the recently enacted health care law — and there is plenty of uncertainty about its impact.

But most legislators can agree on one thing: A lot is going to change in the next four years. And those changes will have huge implications for state government, which has been the nation’s laboratory for innovation and reform in health care.

CSG Midwest [6] conducted interviews with policy experts, legislators and state officials about the impact of health care reform on states. Below are details on six provisions that they considered most important to state policymakers.

1. State Medicaid rolls will swell

Medicaid will be expanded in 2014 to cover all citizens and legal immigrants under 65 years of age who earn up to 133 percent of the federal poverty level. This new population of Medicaid enrollees will be largely made up of childless adults, a group typically not eligible for the state-federal program.

About 17 million adults — or 37 percent of the nation’s uninsured population — could gain coverage through this expansion, according to the Kaiser Family Foundation [7]. But how will states, already struggling with rising health care expenditures, pay for this mandated expansion?

Between 2014 and 2016, the federal government will cover 100 percent of the cost of insuring these “newly eligibles.” The federal share then gradually drops until it reaches 90 percent in 2020.

For most states in the Midwest, the Medicaid changes will essentially involve expanding current programs to include the newly eligible populations. But some states (such as Wisconsin and Minnesota) already had expanded Medicaid coverage beyond existing federal requirements; the health care bill recognizes these “expansion states” by providing a separate package of financial
assistance.

Under another provision of the law, Medicaid reimbursements to primary-care providers will be increased to match Medicare rates in 2013 and 2014, an increase that will be fully funded by the federal government in those years. (As the current law stands, health care experts say, states will likely be responsible for setting their own reimbursement rates after 2014.)

This increase in rates is viewed as critical to having enough doctors to treat the millions of people who will be added to Medicaid rolls.

“When providers are better able to serve the patients, the patients are better off too,” says Minnesota Sen. Linda Berglin, a Democrat from Minneapolis.

Beyond questions of who will pay for the Medicaid expansion and how reimbursement rates will be set is the issue of health care policy. Will states be afforded the flexibility to innovate?

Berglin believes the federal legislation can complement and advance some of the health reforms already in place in Minnesota.

“One provision we are very excited about is that [for] states that create medical homes for their chronically ill patients, Medicaid will cover 90 percent of the cost of covering them within those medical homes,” she says.

That federal provision builds on 2008 legislation passed in Minnesota that allows providers to become certified medical homes in exchange for enhanced payments. Berglin says 73 percent of the state’s providers have become certified medical homes or are working to do so.

But in Indiana, some leaders worry that one of their state’s innovative programs could fall by the wayside.

The Healthy Indiana [8] program allows uninsured adults to purchase private insurance with state subsidies. The health plans also come with savings accounts that are used to pay for medical care.

It took policymakers several years to design a state-specific program that worked for Indiana, Sen. Patricia Miller says. Once the federal reform legislation was passed, though, Republican Gov. Mitch Daniels closed the program to new enrollees because of concerns it would be wiped out under the new federal law.

Robin Rudowitz, associate director at the Kaiser Commission on Medicaid and the Uninsured [9], says the fate of programs such as Healthy Indiana, which covers adults earning up to 200 percent of the federal poverty level, is unclear.

She says the key stumbling block may be that the federal government requires certain “benchmark” benefits for all enrollees. Premium-assistance programs such as Healthy Indiana might not currently fit those criteria, and its eligible members might have to be moved to Medicaid.

Rudowitz adds that the ability of states to submit waivers to alter their current Medicaid programs — or create new ones — depends on how the U.S. Centers for Medicare and Medicaid Services draft rules going forward.

In the meantime, Miller says, her state, and a handful of others, will continue to challenge the federal health bill.
“The federal government has well overstepped its powers under the Constitution and is infringing on the rights of states,” adds Miller, a Republican from Indianapolis.

2. States oversee new regulations

The new federal law also makes changes to the way private health insurance plans must be structured. States will be in charge of enforcing these new regulations, reviewing rates and the solvency of plans, and overseeing various other requirements.

For example, beginning later this year, existing insurance plans will be prohibited from imposing lifetime dollar limits on benefits and cannot rescind coverage except in cases of fraud. Individuals up to the age of 26 will be permitted to stay on their parents’ health plans, unless they have access to employer-based coverage.

Beginning in 2014, when all individuals must have health insurance or face a financial penalty (with some exceptions), private insurance plans will be prohibited from denying coverage to individuals. They also will not be able to impose annual benefit limits or charge people more based on their health status or gender.

“The bill is very clear that state insurance commissioners will continue to have important oversight; however, some of the rules that will be enforced will be set at the federal level, so there will be a new responsibility [on the part of the states],” Wisconsin Medicaid director Jason Helgerson says.

In addition, the federal legislation directs states to report on trends in insurance premiums and to identify plans with unjustified increases.

3. State exchanges fill coverage gaps

While the Medicaid expansion will help cover roughly one-third of uninsured Americans, there will still be people without access to employer-sponsored plans whose income levels disqualify them from the public health insurance program. To fill this coverage gap, state-based health exchanges will be created.

The exchanges will virtually replace the nation’s individual and small-group health insurance markets.

For the small-group market, state-based exchanges will be set up to serve small businesses with up to 100 employees. Meanwhile, individuals will use the exchanges to choose from a variety of health plans that meet criteria set by the federal government.

The Congressional Budget Office estimates [10] that about 24 million people will have purchased insurance through the exchanges by 2019. People with incomes up to 400 percent of the federal poverty level will be eligible for subsidies.

State governments may administer these exchanges themselves or set up a nonprofit association to do so. Beginning in 2015, they also will have the authority to create interstate health care compacts. Under these arrangements, insurers will be able to sell policies in any state that belongs to the compact.

Implementation of these state-based exchanges is sure to raise new policy issues. Berglin points out that Minnesota currently covers pregnant women up to 275 percent of the federal poverty level. Some of these women will now be seeking coverage on Minnesota’s health exchange. Should these women maintain their current level of benefits?
For example, Berglin says, dental care is extremely important for pregnant women. Recognizing this, the state might want to finance that coverage as a “wrap-around” benefit for low-income women receiving coverage through Minnesota’s health insurance exchange.

4. States can create new public plans

Most Midwestern states currently insure some individuals with income levels above 133 percent of the poverty level — particularly children and pregnant women. These people currently are insured through Medicaid or other public programs.

States will have several options on how to cover these individuals: Keep them in the Medicaid program or have this low-income population seek insurance through the exchanges.

Helgerson points out that states will have to weigh their options carefully. In Wisconsin, for example, this population currently receives comprehensive insurance through the state’s BadgerCare Plus program.

“When they move to the exchange, [they] could be worse off,” Helgerson says. “The benefits might be less, the cost sharing and premiums higher.”

The federal health bill does provide a third option for states: Create a “basic health plan” for people between 133 percent and 200 percent of the federal poverty level. Under this provision, states can receive 95 percent of the federal funds that those individuals would otherwise have received in federal insurance subsidies. With that money, states could instead contract with a private insurer to provide coverage for this population.

5. States face administrative challenges

In the next few years, Rudowitz says, states will need to figure out how to meet a requirement in the federal legislation geared toward administrative simplicity.

The law requires states to provide a single online access point for individuals seeking information on their insurance options. For example, this online access point must allow individuals to determine whether they are eligible for Medicaid or for a subsidy through the state-based exchange. Another administrative task for states will be handling the heavy influx of new Medicaid applications.

States must also create a consumer-assistance program to help people in the individual and small-group markets navigate the new system.

6. States’ high-risk pools may play role

Within 90 days of enactment of the health care bill, the federal government will set up a temporary high-risk pool. This pool will be an option for people with a pre-existing medical condition who have been uninsured for at least six months. (The law requiring insurers to cover people with pre-existing conditions does not take effect until 2014.)

Premium subsidies for the new federal high-risk pool will be available. The federal legislation provides $5 billion for the pool until 2014, but details about how the pool will be structured had not been released as of late March. Some policy experts expect the federal government to contract with states’ current high-risk pools. According to the National Association of State Comprehensive Health Insurance Plans, 35 states (all but Michigan and Ohio in the Midwest) have pools.
Helgerson says Wisconsin’s pool has about 17,000 people, the third-largest total in the nation.

“Our hope is that [with] the subsidies, we can further lower premiums and make our high-risk pool more accessible,” he says. “We know there are some people out there who could benefit.”
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