Health care spending is 18 percent of the national economy so it is no wonder that big health issues face the states in 2014. The all-consuming question for states is how to contain costs. The Affordable Care Act kicks in full force in 2014 and states that haven't already decided to expand Medicaid eligibility may take up the question. The health marketplaces, while slow to start in October, were making more headway as 2014 began. Nearly 4 million (3.9) individuals had been deemed Medicaid or CHIP eligible and another 2.1 million selected private health insurance policies through the federal or state marketplaces by the end of December 2013. States will look at systems and delivery methods, including mental health, aging and professional scope of practice issues.

Medicaid: Two Big Questions for States

Two questions face Medicaid programs in the states. The first, whether to expand eligibility to 138 percent of the federal poverty level, has been answered in the affirmative by 25 states and the District of Columbia.
In the other states, the question is likely to be revisited as states feel the lure of federal funding to cover all the cost of expansion for three calendar years beginning Jan. 1, 2014. As covered by CSG magazine Capitol Ideas [3], New Hampshire and Virginia have concluded Medicaid studies that recommend expansion. Pennsylvania and Indiana that are currently in negotiations with HHS Secretary Sebelius on state-specific plans for expansion. Other states to watch include Tennessee, Missouri and Utah that are likely to revisit expansion in 2014.

Additional pressure may come on behalf of uninsured individuals who seek insurance through health insurance exchanges but learn they are not eligible for federal tax subsidies to make premiums affordable if their incomes are below 100 percent of the federal poverty level. The Affordable Care Act as drafted required Medicaid expansion, so subsidies were limited to those above Medicaid levels.

The Kaiser Family Foundation [4] estimates that nearly five million low-income uninsured Americans currently fall into this coverage gap. CSG [5] calculated that states’ decisions to decline federal funds to increase the income eligibility for Medicaid leaves a high of 1 in 20 of all Louisiana residents (or 5.26 percent) and a low of 1 in 70 Pennsylvania residents (or 1.42 percent) in the health insurance coverage gap.

The second question for states is how to reform their Medicaid programs to achieve better health care
outcomes at reduced costs. Some states, such as Virginia, Texas and Wyoming, have opted for reform before expanding eligibility. Other states, such as Oregon, Minnesota and Arkansas, are engaged in multi-pronged system redesign at the same time they are expanding Medicaid eligibility. Medicaid spending growth, whether related to increased enrollment or increased per capita costs, continues to absorb almost all of states’ annual revenue growth, crowding out other state priorities.

Even states not expanding Medicaid are likely to see some increase in enrollment due to national media attention to required health insurance coverage and Medicaid eligibility expansion. Kaiser Health News reported [6] that South Carolina officials predict a 16 percent jump in enrollment by the end of June, 2015, three times that of a typical year. Overall, the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured in a recent study [7] predicts a 5 percent growth in Medicaid enrollment next year.

Health Insurance Exchanges: How Will They Work?

The minority of states that decided to run state-based exchanges—only 14 states and the District of Columbia—encountered fewer problems and enrolled more uninsured people in Medicaid and private insurance plans in the early months of open enrollment than the error-prone federal exchange. Fixes to the federal and state marketplaces and public awareness of the mandate to have health insurance coverage lead to an upsurge of activity in December. On December 31, 2013, federal officials reported [8] 2.1 million Americans had selected a private insurance policy through the marketplaces. The target for enrollment by the end of March when the penalty takes hold is 7 million.


States, including the seven that early on indicated a partnership with the federal government, still can move to a state-based exchange.

While insurance premiums in the exchanges initially came in below estimates, insurance providers in 2014 will have more information to use in setting premiums for the 2015 plan year. Who and how many enroll by the close of open enrollment in March 2014, as well as early data on health care spending by the newly insured will be critical in setting the second round of premiums.

Mental Health: Building An Adequate System of Care
Lawmakers and their constituents are still reeling from the violence in Newtown, Conn., just one year ago. While a number of legislatures grappled with gun issues—and to a lesser extent school safety and mental health services—immediately after the deaths at Sandy Hook Elementary School, the adequacy of state mental health systems remains a huge question.

State mental health budgets were gutted following the 2008 recession. According to the National Association of State Mental Health Program Directors, reductions totaled $4.35 billion between 2009 and 2012. At least thirty-six states increased funding for mental health services during 2013, according to a recent report by the National Alliance on Mental Illness [10]. Yet six states posted decreases mental health budgets in 2013, including North Carolina where a $20 million cut was modified after public outcry, Alaska which added a 3.4 percent reduction to a 32 percent general fund cut from 2009 to 2012, and Wyoming as part of an 8 percent across the board cut to the Department of Health.

In December, 2013, Vice President Biden announced that the federal government was adding $100 million [11] in new funding for mental health services. However, advocates and providers will continue to push for parity between behavioral health and physical health in insurance policy coverage, Medicaid and state systems development and funding. In states that expand Medicaid eligibility, mental health services will be available to new populations, including persons released from correctional facilities who are more likely than the general population to suffer from mental illness.

Several states have adopted certification and funding for mental health first aid. Mental health first aid is a public education program that can help individuals across the community to understand mental illness, support timely intervention and save lives. For instance, in Texas since 2005, every new law enforcement officer is required to take a 16-hour training course.

**Health Workforce Adequacy: More Primary Care Needed**

States will continue to grapple with the shortage of health care providers. Many experts are predicting that additional pressures will be placed on primary care providers as more Americans have health care coverage due to the health insurance marketplaces and expanded Medicaid eligibility provided through the Affordable Care Act. Once primarily a problem in rural areas and underserved urban neighborhoods, the issue will be exacerbated even as policy analysts look to primary care and patient-centered health homes as levers to improve health outcomes and lower health costs.

State policymakers will be engaged in debates around scope of practice, increased professional training through new medical schools and residencies, and efficiency measures, such as telemedicine, electronic health records and networks.

Policymakers also will be asked to look at the consolidation of health care, as mega-hospitals emerge and hospitals buy formerly independent provider practices. Whether competition holds down health care costs may move from a theoretical debate to a practical concern.

**Baby Boomers Entering Senior Years: Care Giving Challenges**

The oldest baby boomers hit the official retirement age of 67 in 2013. The chart below from Bill McBride of Calculated Risk shows the change in the distribution of the American population by age from 1900 to forecasts for 2060. Watch the baby boomers move through the charts from births in 1945 on. Go here [12] to learn more about the inactive graph below.
Evidence suggests this generation has done less to plan and save for retirement than previous seniors. According to one survey, 60 percent have lost value in their investments due to the economic retrenchment. About 4 in 10 say they are delaying retirement.

Clearly, there will be more people over 65, both absolutely and proportionately, and they are likely to live longer, whether in good health or not. The implications are myriad. States will face increased pressure for community-based residential services in lieu of nursing homes. Many older Americans will need financial assistance on top of federal Medicare. Even as deaths decrease due to other diseases, increasing numbers of older seniors with Alzheimer’s disease and other dementias will need extra assistance and care. The larger number of cognitively impaired seniors will complicate the movement to self-directed medical care.
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