The Hilltop Institute

analysis to advance the health of vulnerable populations

What Federal Health Care Reform Legislation Means to States

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Overview of Implications

- Medicaid-Related
- Exchanges
- Insurance-Related
- Information Technology
- Long-Term Services and Supports
- Workforce
- Preventive Services and Public Health

Medicaid: 1. Eligibility

- Substantial increase in enrollment (estimated 16 million)
  - Cover all adults below 133% of the federal poverty level (FPL)
  - Capacity-building in state Medicaid administrative infrastructure
  - Capacity-building in delivery system
  - Work “smarter” with technology

- Eligibility Maintenance of Effort (MOE) as of date of enactment (adult MOE until January 2014; children MOE until 2019)

Medicaid:
2. Financing and Payments

- Full federal financing for newly eligible 2014-2016, decreasing annually thereafter, until reaching rate of 90% federal funding for 2020 and beyond
- Increase Medicaid payments to primary care providers to equivalence with Medicare in 2013 and 2014; rate increase funded with 100% federal financing
- Prohibition on Medicaid payments for health care acquired conditions (such as illnesses acquired in the hospital)
- Extends drug rebate to Medicaid managed care plans

Medicaid:
3. Options and Demos

- Options:
  - Incentives for community-based long-term care
  - Attendant care for individuals with disabilities
  - Health homes for individuals with chronic conditions
  - Beneficiary wellness programs
- Demonstrations:
  - Bundled payments for episodes of care around hospitalization
  - Pediatric accountable care organizations

Exchanges

- States need to establish Exchanges for individuals and small groups (or default to HHS)
  - Create organization and governing body
  - Calculate subsidies (advanceable tax credits) to people between 133 and 400% of the FPL
  - Certify “qualified health plans” with “essential health benefits”
  - Certify exemptions to individual mandate
  - Outreach, education, and plan comparisons
  - Enrollment process and access to care
  - Navigator function

Exchanges continued

- Coordination with Medicaid and CHIP: Screening, eligibility, and enrollment process, including seamless transitions
- Exchanges must become financially self-sustaining by 2015
- Large groups (up to 100) can participate in 2014, and must participate no later than 2016

Insurance-Related

- Adopt adjusted community rating rules
- Adopt insurance reforms (eliminate annual and lifetime caps, prohibit rescission, provide guarantee issue and renewability; prohibit pre-existing condition barrier; enforce medical loss ratios; allow dependents up to age 26 to stay on parents' policies)
- State evaluation of mandated benefits:
  - State may opt to mandate benefits that exceed Essential Health Benefits
  - If so, state must pay margin increase in costs inside and outside the Exchange
- Phase-in of small business tax credits

Insurance-Related continued

- State option to merge individual and small group markets
- Consider whether and how to revise insurance code or tax code to adjust various assessments and fees on commercial insurance products
- State option to form health care choice compacts
- Establish new high-risk pool (until January 2014), or default to HHS

Insurance-Related continued

- Integrate into Exchange populations in existing state-subsidized insurance pools
- State option to create Basic Health Plan for low-income uninsured up to 200% of the FPL
- Create nonprofit member-run insurance companies in states
- Temporary reinsurance programs for early retirees
- High likelihood of new selection dynamics:
  - People select OPM plan inside Exchange, which may be less expensive because it is exempt from stricter state insurance codes
  - Insurers offer different products inside and outside the Exchange

Information Technology

- Create new eligibility system, with capacity to link to federal agencies (IRS, DHS, etc.)
- Resolve system issues in link between Exchange and commercial carriers (enrollment process, including premium collection)
- Consumer information
  - Website development
  - Grant opportunities to states for consumer assistance

Long-Term Services and Supports

- “Community Living Assistance Services and Support” (CLASS) Act
- Better alignment of Medicare and Medicaid for “dual eligibles,” who comprise vast majority of nursing facility residents
- Community First Choice Option to allow states to provide attendant supports and services to individuals with incomes up to 150% of the FPL institutional level of care
- Extension of “Money Follows the Person” program

Workforce

- Increased demand on health care services will require capacity in the delivery system, particularly for primary care services
  - National workforce policy development
  - Increasing supply of health care workers
  - Education and training of workforce
  - Strengthening primary care

Preventive Services and Public Health

- Coverage of preventive benefits in Essential Health Benefits package
- Creation of the National Prevention, Health Promotion, and Public Health Council
- Three-year grants to states to develop and provide incentives to prevent chronic diseases

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

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