Health Care Reform: Six Ways It Will Affect States

By Kate Tormey and Debra Miller

There are varying perspectives on the more than 2,500-page health care reform law, signed by President Obama in late March 2010, but most state policymakers can agree on one thing: A lot is going to change in the next four years.

The changes brought about by the health care reform law will have huge implications for state governments, even if not everyone sees the implications the same way. For instance, Maryland Gov. Martin O'Malley, who appeared at the bill signing ceremony, believes the bill could ultimately save his state $1 billion over the next decade. But in Virginia, Gov. Bob McDonnell's administration estimates the bill's Medicaid provisions alone could cost his state $1 billion over 12 years beginning in 2014.

Six main provisions will have great importance to state policymakers.

1. Law will overhaul Medicaid

Medicaid will be expanded in 2014 to cover all citizens and legal immigrants under age 65 who earn up to 133 percent of the federal poverty level—$14,404 for an individual and $29,327 for a family of four in 2009.

The new population to be covered in Medicaid will be largely made up of childless adults, who typically have not been eligible for the state-federal program. Less than half the states provide any health insurance for those people, and most of the programs are very limited in scope, whether they are Medicaid waiver programs or state-funded only programs. (See Table A for more details.)

An estimated 17 million adults—or 37 percent of the nation's uninsured population—could gain coverage through the mandated Medicaid expansion, according to the Kaiser Family Foundation, and the states will have some help paying for it. The federal government will cover 100 percent of the cost of insuring newly eligible people from 2014 through 2016, but the federal share drops to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond.

But there are other anticipated expenses with this expansion. State Medicaid administrators know that outreach efforts for the newly eligible populations will also bring into the program individuals who were previously eligible but didn't know it. States will receive only their traditional Medicaid match rates for those people—even though Congress intended to minimize states' new financial obligations. In addition, the increased administrative expenses of outreach and claims processing for a larger population will continue to be matched at regular rates. So for some states the federal promise of minimal state expenses due to new mandates may seem hollow.

For a number of states, income eligibility levels for adults with children have remained constant since the welfare reform mandates of 1988. In less wealthy Southern states, especially, eligibility has changed little—and parents, whether working or jobless, are not eligible if their income is more than one-third or one-half the federal poverty level. (See Table A for more details.)

But some states—such as Wisconsin, Minnesota, Maine and Massachusetts—already had expanded Medicaid coverage beyond existing federal requirements, and the health care bill recognizes those states by providing a separate package of Medicaid financial assistance. Current state matching levels will be reduced 50 percent in 2014, 60 percent in 2015, 70 percent in 2016, 80 percent in 2017 and 90 percent in 2018 when all states will reach the same matching formula for adults, except for pregnant women.

Until 2014, states must maintain their current eligibility levels for Medicaid using the current federal-state funding agreement. The so-called enhanced Medicaid matching rates provided in the American Recovery and Reinvestment Act are set to expire Dec. 31, 2010, with Congress expected to extend them only to June 30, 2011. States are exempt from this "maintenance of effort" requirement if they can prove that they are experiencing a budget deficit.

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. After that, states likely will be responsible for setting, and funding, their own reimbursement rates.

Table A: Income Eligibility Level as a Percent of Federal Poverty Level

State or other jurisdiction	Medicaid/CHIP Expansion			CHIP	Medicaid			Childless Adults	
	Infants (0–1)	Children (1–5)	Children (6–19)	Separate state program	Pregnant women	Jobless parents	Working parents	Comparable to Medicaid	More limited benefit package
Alabama	133%	133%	100%	300%	133%	11%	24%	NA	NA
Alaska	175%	175%	175%	NA	175%	77%	81%	NA	NA
Arizona	140%	133%	100%	200%	150%	106%	106%	100%	NA
Arkansas	200%	200%	200%	NA	200%	13%	17%	NA	200% (a)(c)
California	200%	133%	100%	250%	200%	100%	106%	NA	NA
Colorado	133%	133%	100%	205%	200%	60%	66%	NA	NA
Connecticut	185%	185%	185%	300%	250%	185%	191%	NA	300% (c)
Delaware	200%	133%	100%	200%	200%	100%	121%	100%	NA
Florida	200%	133%	100%	200%	185%	20%	53%	NA	NA
Georgia	200%	133%	100%	235%	200%	28%	50%	NA	NA
Hawaii	300%	300%	300%	NA	185%	100%	100%	100% (b)	NA
Idaho	133%	133%	133%	185%	133%	21%	27%	NA	185% (a)
Illinois	200%	133%	133%	200%	200%	185%	185%	NA	NA
Indiana	200%	150%	150%	250%	200%	19%	25%	NA	200% (b)
Iowa	300%	133%	133%	300%	300%	28%	83%	NA	200%
Kansas	150%	133%	100%	241%	150%	26%	32%	NA	NA
Kentucky	185%	150%	150%	200%	185%	36%	62%	NA	NA
Louisiana	200%	200%	200%	250%	200%	11%	25%	NA	NA
Maine	200%	150%	150%	200%	200%	200%	206%	NA	100% (b) 300% (c)
Maryland	300%	300%	300%	NA	250%	116%	116%	NA	116%
Massachusetts	200%	150%	150%	300%	200%	133%	133%	133%	300%
Michigan	185%	150%	150%	200%	185%	37%	64%	NA	35%
Minnesota	280%	275%	275%	NA	275%	215%	215%	NA	200% (c)
Mississippi	185%	133%	100%	200%	185%	24%	44%	NA	NA
Missouri	185%	150%	150%	300%	185%	19%	25%	NA	NA
Montana	133%	133%	133%	250%	150%	32%	56%	NA	NA
Nebraska	200%	200%	200%	NA	185%	47%	58%	NA	NA
Nevada	133%	133%	100%	200%	185%	25%	88%	NA	NA
New Hampshire	300%	185%	185%	300%	185%	39%	49%	NA	NA
New Jersey	200%	133%	133%	350%	200%	200%	200%	NA	NA
New Mexico	235%	235%	235%	NA	235%	29%	67%	NA	200%
New York	200%	133%	100%	400%	200%	150%	150%	100%	NA
North Carolina	200%	200%	100%	200%	185%	36%	49%	NA	NA
North Dakota	133%	133%	100%	160%	133%	34%	59%	NA	NA
Ohio	200%	200%	200%	NA	200%	90%	90%	NA	NA
Oklahoma	185%	185%	185%	NA	185%	31%	47%	NA	200% (a)
Oregon	133%	133%	100%	300%	185%	32%	40%	NA	100% (b) 185% (b)(c)
Pennsylvania	185%	133%	100%	300%	185%	26%	34%	NA	200% (b)(c)
Rhode Island	250%	250%	250%	NA	250%	175%	181%	NA	NA
South Carolina	185%	150%	150%	200%	185%	48%	89%	NA	NA
South Dakota	140%	140%	140%	200%	133%	52%	52%	NA	NA
Tennessee	185%	133%	100%	250%	250%	70%	129%	NA	$55,000/yr. (a)(c)
Texas	185%	133%	100%	200%	185%	12%	26%	NA	NA
Utah	133%	133%	100%	200%	133%	38%	44%	NA	150%
Vermont	300%	300%	300%	300%	200%	185%	191%	150%	300%
Virginia	133%	133%	133%	200%	200%	23%	29%	NA	NA
Washington	200%	200%	200%	300%	185%	37%	74%	NA	200% (b)(c)
West Virginia	150%	133%	100%	250%	150%	17%	33%	NA	NA
Wisconsin	300%	300%	300%	NA	300%	200%	200%	NA	200%
Wyoming	133%	133%	100%	200%	133%	39%	52%	NA	NA
Dist. of Columbia	300%	300%	300%	NA	300%	200%	207%	NA	200%

Source: Kaiser Commission on Medicaid and the Uninsured, April 2009 and December 2009.

Note: Some states do not have a separate CHIP program.

Key:
NA — Not applicable
(a) Employment requirement.
(b) Enrollment closed.
(c) State funded only program.

Figure A: Selected Provisions of Federal Health Care Reform Legislation Effective in 2010

Effective immediately:

Provide 2010 tax credits to offset health insurance premium costs for small businesses with fewer than 25 employees and average wages under $50,000. Eligible businesses must contribute at least 50 percent of employees' premium.

Medicare beneficiaries who reach the "doughnut hole" will receive $250 rebates for prescription drug costs.

Cost sharing for designated "proven" preventive services is eliminated in Medicare and private plans.

States have the option to provide Medicaid coverage to parents and childless adults up to 133% poverty at current Medicaid matching rates.

HHS secretary and states will establish a process for review of excessive premium increases.

90 days after passage:

Establish a national high-risk pool for people with preexisting conditions; $5 billion appropriated.

Six months after passage:

Young adults under age 26 may stay on parents' plan.

Prohibits excluding coverage of children for preexisting conditions in the individual market.

Prohibits rescinding coverage once a person is enrolled in a plan.

Prohibits lifetime benefit caps and unreasonable annual limits.

Prohibits cost-sharing for preventive services.

Other 2010 provisions:

Require tobacco cessation coverage for pregnant women under Medicaid free of cost-sharing, effective October 1.

Expand community health centers and National Health Service Corps to provide increased access to care. $11 billion over 5 years beginning in 2010.

Effective July 1, 2010, 10 percent tax on amounts paid for indoor tanning services.

Sources: HR 3590, Patient Protection and Affordable Care Act; and HR 4872, Health Care and Education Reconciliation Act of 2010.

The increase in rates is viewed as critical to having enough doctors to treat the millions of people who will be added to Medicaid rolls. Increasing reimbursement levels will not only keep current Medicaid providers from leaving the system, but also might entice more providers to join it.

Work force shortages will also be exacerbated by provisions of the law to provide insurance to previously uninsured Americans. The bill attempts to address this problem through expanding scholarships and loans for primary care practitioners, increasing the number of graduate medical education training positions and supporting the development of primary care models such as medical homes and team management of chronic disease. In 2010, a multi-stakeholder Workforce Advisory Committee will be appointed to develop a national work force strategy.

In Minnesota, lawmakers like Sen. Linda Berglin are eager to see how the federal legislation will complement and advance what the state has done already.

"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 said.

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

Some state leaders worry their state's innovative programs could fall by the wayside because of the health care law. For instance, the Healthy Indiana 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.

Once the federal reform legislation was passed, however, Indiana Gov. Mitch Daniels closed the program to new enrollees because of concerns it would be wiped out under the new health regulations.

2. States to 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 impos-

Table B: High-Risk Insurance Pools

State	Year began	Enrollees 2007	Maximum lifetime benefits	Waiting period	Sources of funding	Cap as percentage of average comparable plan
Alabama (a)	1998	2,455	NA	NA	Premiums	200%
Alaska	1993	488	$1,000,000	6-month	Health plans	150%
Arkansas	1996	2,976	$1,000,000	6-month	Health plans	150%
California	1991	14,020	$750,000	3-month	Cigarette/tobacco surtax	137.5%
Colorado	1991	7,200	$1,000,000	6-month	Health plans/Unclaimed property	125%
Connecticut	1976	2,599	$1,000,000	12-month	Health plans	150%
Florida (b)	1989	347			Health plans	250%
Idaho (c)	2001	1,411	$1,000,000	12-month	Health plans	150%
Illinois	1989	16,410	$1,000,000	6-month	Health plans/State funds	150%
Indiana	1982	6,900	None	3-month	Health plans/State funds	150%
Iowa	1987	2,676	$3,000,000	6-month	Health plans	150%
Kansas	1993	1,886	$1,000,000	3-month	Health plans	125%
Kentucky	2001	4,158	Unlimited	12-month	Health plans/tobacco tax	175%
Louisiana	1992	1,139	$500,000	6-month	Mandated service charge/ assessments/state funds	200%
Maryland	2003	12,468	$2,000,000	6-months	tax assessments on hospitals	200%
Minnesota	1976	28,859	$5,000,000	6-month	Health plans/state funds	125%
Mississippi	1992	3,660	$500,000	6-month	Health plans/stop-loss and re-insurance carriers	175%
Missouri	1991	2,915	$1,000,000	6-month	Health plans/HMOs	150%
Montana	1987	3,101	$1,000,000	12-month	Health plans	150%
Nebraska	1986	5,058	$1,000,000	6-month	tax on health/accident premiums	135%
New Hampshire	2002	1,011	$2,000,000	9-month	health plans	150%
New Mexico	1988	4,757	None	6-month	Health plans	140%
North Carolina	2009		$1,000,000	12-month	State Funds	200%
North Dakota	1982	1,541	$1,000,000	6-month	Health plans	135%
Oklahoma	1996	2,027	$1,000,000	12-month	Health plans	150%
Oregon	1990	18,656	$2,000,000	6-month	Health plans	125%
South Carolina	1990	2,377	Determined by Board	6-month	Health plans/HMOs	200%
South Dakota (a)	2003	686	$1,000,000	NA	Health plans/stop-loss and re-insurance carriers/state funds	150%
Tennessee	1987	2,458	$1,000,000	3-month	State Funds/Health plans	200%
Texas	1998	27,733	$1,500,000	12-month	Health plans	200%
Utah	1991	3,516	$1,000,000	6-month	Dedicated state funds	150%
Washington	1988	3,447	$1,000,000	6-month	Health plans	150%
West Virginia	2005	497	$1,000,000	6-month	Assessments on hospitals	150%
Wisconsin	1981	17,126	$1,000,000	6-month	Health plans	200%
Wyoming	1991	622	$750,000	12-month	Health plans/HMOs/tax credits	200%

Sources: Kaiser Commission for Medicaid and the Uninsured and National Association of State Comprehensive Health Insurance Plans.

Key:

NA — Not applicable

(a) The high-risk pools in Alabama and South Dakota are for portability purposes only.

(b) Closed to new enrollees since 1991.

(c) Under Idaho's program, all carriers who offer individual health insurance must also offer the Idaho Individual High-Risk Reinsurance Pool plans, as well as notify persons applying for individual coverage of these high-risk pool plans. Some analyses include Idaho in the number of states with high-risk pools and some do not.

ing lifetime dollar limits on benefits and cannot rescind coverage except in cases of fraud. Individuals up to age 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 people for any reason—including pre-existing conditions. They will not be able to impose annual benefit limits or charge people more based on their health status or gender. Rates will vary only based on age (limited to a 3-to-1 ratio), geographic area, family composition and tobacco use (limited to a 1.5-to-1 ratio).

State insurance commissioners will continue to have important oversight, but some rules will be set at the federal level. It remains unclear, however, exactly how the state-federal regulatory relationship will work. State officials are waiting for further guidance from the federal government.

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

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

3. State exchanges to 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 incomes are too high to qualify for the public health insurance program. To fill this coverage gap, state-based health exchanges will be created. States will also be allowed to form multi-state exchanges to take advantage of administrative efficiencies.

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, such as guaranteed issue and renewal.

States will be allowed to extend exchange coverage to employers with more than 100 employees beginning in 2017.

Perhaps the most similar model of an insurance exchange was established in Massachusetts when that state moved to universal health care insurance. Utah also has a more limited insurance exchange.

The Congressional Budget Office estimates about 24 million people will purchase insurance through the exchanges by 2019.

People whose incomes are between 133 percent and 400 percent of the federal poverty level will be eligible for subsidies. Premium credits will be offered on a sliding scale and will ensure that premium contributions do not exceed a certain percentage of income. In order to receive the subsidies, individuals must purchase insurance through the exchanges.

The new law lays out standards for the plans offered by the exchanges. Four benefit categories of plans, plus a catastrophic plan, will be offered through the exchanges. State governments may administer these exchanges or set up a nonprofit association to do so.

The state exchanges will provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements and premium taxes. They shall also define rating areas. These duties may overlap with state insurance departments and require new role definitions.

Beginning in 2016, states also will have the authority to create interstate health care compacts. Under these arrangements, insurers can sell policies in any state that belongs to the compact. Coverage under compacts must be at least as comprehensive and affordable as coverage provided through the state exchanges.

4. States can create new public plans

Many states insure some individuals with income levels above 133 percent of the poverty level—particularly children and pregnant women. (See Table A for more details.) These people are insured through Medicaid or another public health insurance program. Once the federal health law takes full effect, states can keep those people in the Medicaid program under the state's current federal matching rate or have this population of low-income families seek insurance through the exchanges.

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. But under

Figure B: Timeline for Implementation of Selected Provisions of Federal Health Care Reform Legislation, 2011 and Beyond

2011	*2012*	*2013*	*2014*
Medicare beneficiaries will receive a free annual wellness visit. 50% discounts on brand name drugs for Medicare beneficiaries in "doughnut hole." Provide a 10% bonus Medicare payment for primary care physicians for five years beginning in 2011. Establish national voluntary insurance program through payroll deduction to purchase community living assistance services and supports (CLASS program). State grants to test alternatives to civil tort lawsuits; $50 million in funds; report due to Congress 2016.	Release of Medicare claims data to measure performance of providers and suppliers but that protects patient privacy. Establish programs to demonstrate new payment approaches to increase quality and decrease costs. Begin demonstration program for pediatric providers to organize as Accountable Care Organizations (ACO) and share savings generated.	Limit contributions to tax-free flexible spending accounts to $2,500. Regulations issued for compacts to allow purchase of qualified health care plans across state lines. Medicare tax increase of 0.9% for individuals with adjusted gross income over $200,000 and couples over $250,000. New Medicare tax on investment income for same persons. Threshold to deduct medical expenses raised from 7.5% to 10%; delayed until 2017 for those 65 and over.	Prohibits any annual cap on benefits. Guaranteed issue of insurance in group and individual market. Waiting periods for coverage limited to 90 days. States establish insurance exchanges for individuals and small businesses with 50–100 employees. Premium subsidies will be available for persons between 133% and 400% of poverty purchasing insurance through an exchange. States will be required to expand Medicaid eligibility to all non-elderly adults and children with income below 133% of poverty. Individual mandate: Individuals will be required to have insurance or pay a penalty. Penalty is greater of $95 or 1% of taxable income in 2014 up to $695 or 2.5% of taxable income, not to exceed national average bronze plan premium. Insurers will pay an annual fee, according to market share. Yield $8–14 billion per year, 2014 to 2019.

2015	*2016*	*2017*	*2018*	*2019–2020*
Reduce Medicare payments to hospitals in top 25th percentile of rates of hospital-acquired infections.	Under interstate compacts, allow purchase of qualified health care plans across state lines.	States have the option to open insurance exchange to businesses with more 100 employees.	Excise tax on high-cost employer provided insurance plan goes into effect. 40% on plans with premiums in excess of $10,200 for individuals and $27,500 for family coverage.	Medicare "doughnut hole" completely phased out.

Source: HR 3590, Patient Protection and Affordable Care Act; and HR 4872, Health Care and Education Reconciliation Act of 2010.

the exchange, benefits might be less and 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 could receive 95 percent of the federal funds that those individuals would otherwise have received in subsidies to buy insurance in the state-based exchanges. This money could then be used to contract with a private plan and create a state program.

5. Improving access to information

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

Under the federal law, states will be required to provide a single online access point for individuals seeking information on different insurance options. This online access point must, for example, allow individuals to determine whether they are eligible for Medicaid or for a subsidy through the state-based exchange.

This is one administrative task for states; another will be handling what will likely be a sudden influx of new Medicaid applications.

6. High-risk pools play short-term role

Within 90 days of enactment of the health care bill, the federal government will set up a temporary high-risk pool—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; only children with pre-existing conditions are required to be covered in 2010, just six months after passage.)

Premium subsidies will be available through the new federal high-risk pool.

The legislation provides $5 billion for the pool until 2014. After 2014, the pools will not be necessary when insurance companies are prohibited from using pre-existing conditions to exclude persons from coverage.

Details about how the pool will be structured had not been released as of late March.

But some policy experts believe the federal government will contract with states' current high-risk pools. According to the National Association of State Comprehensive Health Insurance Plans, 35 states have high-risk pools. (See Table B for more details.)

Since the first high-risk pool was established in 1975, at least 1 million Americans have been insured through this mechanism. Enrollment figures for 2007, however, place the annualized numbers of people in state high-risk pools at about 210,000. Enrollment ranged from fewer than 350 in Florida to nearly 29,000 in Minnesota.

Conclusion

In the coming years, states will face a myriad of new challenges in the health care arena. The increased coverage promised by the new federal law will both provide and require new resources. Federal-state relationships will be tested. Whether the cost curve of rising health care costs can be bent for states' residents as well as states' budgets will be tested. Improving the quality of health care—and health—is another desired outcome to be measured over time.

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