Health Reform: Executive Summary
Presented to the KHPA Board, May 18, 2010

Executive Summary

In March 2010, Congress enacted the Patient Protection and Affordable Care Act, commonly known as federal health reform. The goal of the legislation is to achieve near-universal coverage of health care in the United States by extending group-like insurance to all adults, subsidizing the cost of health insurance premiums and stabilizing health insurance markets by requiring broader participation.

Although health reform was enacted through federal legislation, much of the responsibility for implementing its provisions has been delegated to states. In the months leading up to the bill's passage, and in the weeks since it was signed into law, there has been considerable debate over the impact it may have on state governments, consumers, employers and the uninsured. While these questions have been addressed on a broad, national scale, there has been little state-specific analysis, due in part to the wide variation among states in terms of their current insurance markets and health care programs.

The purpose of this report is to present an initial and preliminary estimate the impact federal health reform will have in Kansas. This analysis will likely prompt a more in-depth look at specific aspects of reform, and KHPA looks forward to feedback from policymakers, stakeholders and others that will help us to refine the estimates and help prepare the state for key choices that need to be made over the next three and a half years.

Key Elements of Federal Reform:

Although the legislation consists of thousands of pages, with scores of new initiatives and programs, there are five key elements that bear directly on the goals of expanding coverage and lowering the cost of health insurance. These provisions will take effect in 2014, when health reform is fully implemented. They include:

- **Expanding Medicaid Eligibility to 138% of the Federal Poverty Level:** Established in 1965, Medicaid is a joint federal-state program that provides health coverage to the poor. In March 2010, Medicaid covered more than 283,000 individuals. Eligibility in Kansas is limited to the elderly, people with disabilities, children, pregnant women and very-low income parents. It is not available to childless adults. Income limits vary according to a person's age and health status. For non-elderly, non-disabled parents and caregivers, the income threshold is about 31% of poverty. Beginning in 2014, states will be required to make Medicaid available to all adults, regardless of family status, up to 138% of the poverty level. The federal government will pay 100% of the cost of the newly eligible Medicaid enrollees through 2017, and then gradually reduce the federal share to 90% by 2020. Meanwhile, a "maintenance of effort" provision requires states to continue paying at the regular match rate (roughly 60% federal/40% state) for coverage of those who would otherwise qualify under existing income guidelines.

- **Increased Federal Funding for the Children's Health Insurance Program (CHIP):** CHIP was established in 1997 to provide low-cost health insurance to uninsured children whose families earn too much to qualify for Medicaid but who either cannot afford, or don't have access to private insurance. In March 2010, there were 40,290 Kansas children enrolled in CHIP.

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Like Medicaid, it is jointly funded by the state and federal governments. Federal funding is provided through an annual block grant. Enrollment may be limited by the availability of funds. Currently, federal funds pay approximately 72 percent of the cost of CHIP, with state funds making up the other 28 percent. Beginning in 2014, the federal government will pay 95 percent of the cost, leaving the state responsible for only 5 percent.

- **State-Based Insurance Exchanges:** Beginning in 2014, states (if they choose to) or the Federal government are responsible for establishing and operating web-based insurance "exchanges" that offer group-rate private health insurance to individuals and small employers (100 or fewer employees). Subsidies will be available to individuals on a sliding scale, depending on income, and tax credits will be available for employers who purchase through the exchanges. Policies that are offered through the exchanges must meet federal standards for premiums, benefits and cost-sharing. States have the option of forming partnerships to operate regional exchanges, or to form multiple exchanges for different regions within a state.

- **Employer Mandates and Penalties:** Beginning in 2014, all employers with more than 50 employees will be required to offer group coverage to their workers. Employees in firms that do not offer coverage, and employees with job-based coverage that is deemed unaffordable, will have the option of purchasing insurance through the exchanges. Employers will be assessed a tax penalty for each worker who qualifies for federal subsidies to buy through an exchange.

- **Individual Mandate:** Beginning in 2014, all U.S. citizens will be required to carry health insurance or pay a tax penalty for failing to carry insurance.

Methodology

To assess the impact these changes will have on the Kansas insurance market (including state government spending) the Kansas Health Policy Authority contracted with an independent actuarial firm, schrammraleigh Health Strategy.. The actuary relied on a Health Reform model it had developed to review the impact of the emerging health reform debates on states that it customized to Kansas as well as on key assumptions developed by the Congressional Budget Office and the Centers for Medicare and Medicaid Services. Our assumptions include current costs of health care by payor, the demand for health coverage, and the ultimate number of people covered. Those assumptions, combined with the final health reform legislation, drive the overall impact of reform on health insurance coverage, participation in different coverage options, and shifts in the number of people covered by public and private insurance programs. Using today's dollars and assuming full implementation in 2020, this model helps Kansas policymakers understand the implication of, and plan for, the potential shift in population, coverage, and costs associated with health reform.

Summary of Findings:

With the individual mandate, Medicaid's low cost, and the requirements in the health reform bills to streamline the application, outreach and enrollment process – improvements which are already underway at KHPA using Federal grant funds – it is assumed that nearly all individuals (98%) who will qualify for Medicaid will participate. At the same time, many individuals currently enrolled in Medicaid, including certain working individuals with high-cost health conditions, will be shifted into the private market or will migrate into the higher-match Medicaid expansion. Large employers will see increased participation in their group plans, especially among younger workers, resulting in a lower average cost per-person, but slightly higher total costs to the employer. Many small employers, on the other hand, are likely to discontinue their group policies and redirect their workers to buy coverage through the exchanges.

Impact on Coverage: The U.S. Census Bureau estimates there are currently about 335,000 uninsured individuals in Kansas, or about 12 percent of the state's population. As a result of federal health reform, that number is expected to be reduced by about 190,000 (57%), leaving a residual uninsured population of about 143,000 individuals, which represents 5% of the state population and 6% of those under the age of 65. This residual uninsured group includes many young adults who will find the tax penalties for non-compliance are still less than the cost of coverage. It will also include many non-U.S. citizens who are ineligible to participate.

Medicaid accounts for most of the increase in coverage. An estimated 87,000 people will gain coverage through the expansion in eligibility. In addition, another 33,000 people who are currently eligible for Medicaid and CHIP but who don't participate will be induced to do so because of the individual mandate. This is sometimes called a "woodwork effect." Altogether, growth in Medicaid accounts for 57% of the reduction in the number of uninsured Kansans.

Large Employers (50 or more employees) are expected to add about 96,000 individuals to their group policies, due almost entirely to the employer mandate. That accounts for half of the increase in insurance coverage.

It is expected that many *small employers* (fewer than 50 employees) will discontinue offering group coverage, choosing instead to redirect those consumers (approximately 108,000) into the subsidized exchange market.

The *state-based exchange* will extend coverage to many non-elderly individuals who are currently uninsured because they can't access employer-sponsored group coverage, can't afford to buy coverage through the individual market and don't qualify for Medicaid. Overall, it is expected that the number of Kansans with individual health insurance policies will grow by more than 73,000 individuals, and that most (if not all) of these individuals will be covered in an insurance exchange.

Impact on Spending: For purposes of this analysis, all spending estimates are measured in constant 2011 dollars. With that measurement, total health care spending in Kansas from all payers (state and federal government; employers; and individuals) is expected to grow by about $150 million (1.1%) after full implementation of reform, from $13.418 billion to $13.571 post-reform. The most significant impact of reform on spending will be major shifts in the source of payment.

Federal Spending is projected to increase more than 30% ($800 million) per year due mainly to income-based subsidies provided in the exchanges and to increased federal spending on Medicaid and CHIP.

State government spending is likely to remain relatively flat, depending on policy options the state chooses to adopt. The net fiscal impact on State General Fund spending could range from -$39 million to +35 million per year. Among the choices the state will need to make is whether to increase reimbursement rates to providers in the expanded Medicaid program, and how much (and whether) to continue funding state programs that offer care to the uninsured and reimburse providers for uncompensated care. Sources of savings include higher federal matching rates for Medicaid and CHIP; the shifting of high-cost, high-risk populations from public insurance to private insurance or to the higher-match Medicaid expansion; and increased federal drug rebates. Additional costs include a substantial increase in the Medicaid population and administrative expenses related to that expansion.

Employer costs are projected to fall overall, but large employers would spend slightly more due to the employer mandate while small employers are likely to spend significantly less due to the shift from employer-sponsored coverage to individual coverage in the exchange markets.

Spending by individual consumers will account for a smaller percentage of total health care spending, but the impact on any given individual will depend on that person's circumstances. Young adults are likely to see an increase in premiums compared to what they pay now due to new limits on age- and risk-based premium differentials, but many will also qualify for income-related subsidies and cost-sharing limits. Most consumers who buy insurance through the individual or small-group markets are likely to see savings from the availability of federal subsidies for buying insurance through the exchange. The average per-person cost of insurance through large groups is likely to decrease because of broader participation due to individual and employer mandates. Additional factors that will result in savings for some individuals include:

(a) Prohibiting insurance companies from denying coverage or charging higher premiums based on pre-existing conditions
(b) Prohibiting gender-based premium differentials
(c) Limiting age-based premium differentials to a 3:1 ratio
(d) Limits on cost-sharing (deductibles and coinsurance) for private insurance offered through state-based exchanges

Conclusions

For most of the past century, U.S. policymakers and the general public have struggled with issues concerning access and affordability of health care coverage. That long-running debate has been punctuated by significant events such as the enactment of Medicare and Medicaid in 1965, as well as decisions *not* to enact other national health insurance proposals that were offered at various times from the 1940s through the 1990s. Throughout those debates, one central (and often divisive) question has been how big of a role the federal and state governments should play in the insurance market and how much of the market should be left to the private sector.

Passage of the Patient Protection and Affordable Care Act of 2010 marks another significant milestone in this ongoing process. The debate over the appropriate level of involvement between the public and private sectors is certain to continue for many years to come. Meanwhile, the immediate challenge confronting stakeholders in the health care system is to implement the new policies and address mounting concerns about public spending.

Federal reform calls for profound changes in the role of public insurance programs such as Medicaid and CHIP. Originally designed as a kind of safety-net, or even "welfare" service for those who otherwise had no access to health coverage, under federal reform they will soon become the largest single source of mandatory health coverage, and the largest single payer for health care services in the

United States. This fundamental change in the role of public insurance programs places enormous responsibility on states to coordinate their health plans with those offered in the private sector, and to more actively manage both the cost and quality of public health care services.