



# **Preliminary Estimates of the Impact of Federal Health Reform on State Spending in Kansas**

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# Federal Health Reform: KHPA's Role

- **Health reforms address major, longstanding policy questions**
  - ...but accelerate demands on health care providers and spending
- **Key reforms are delegated to states to implement**
  - ...while other reforms are left to states altogether
- **KHPA's statutory role**
  - ...help implement the new laws
  - ...provide information to policymakers about the new laws
  - ...address key remaining policy issues



# Federal Health Reform: Two New Laws

- **Patient Protection and Affordable Care Act of 2010 (PPACA)**
  - Based on Senate health reform legislation
  - Passed March 23, 2010
- **Health Care and Education Affordability Reconciliation Act of 2010**
  - Added some elements of House reform proposals to the Senate version
  - Passed April 2, 2010



# Federal Reforms: Long Run Objectives

- **Adopt common definition of standard, or minimum, coverage**
  - Minimum coverage implies affordable cost-sharing
  - Includes prescription drugs and mental health parity
- **Extend group-like insurance coverage to everyone**
  - Eliminates differences in insurance premiums due to health risks and history
  - Private, portable, group-like coverage for individuals and small businesses
- **Get insurers to compete with each other rather than consumers**
  - New marketplace should facilitate price shopping and ease enrollment
  - Stabilize private insurance markets through required participation
- **Buy or subsidize minimum coverage to ensure affordability**
  - Greatly expand Medicaid to cover the lowest-income Americans
  - Public subsidies to help others buy private insurance



# Federal Reforms: Private Insurance

- **Changes to occur within 90 days:**
  - New, temporary re-insurance pool for early retirees
  - Create new high-risk pools for those with pre-existing conditions
- **Changes taking effect within six months**
  - Provide dependent coverage for children up to age 26 for all policies
  - Eliminate lifetime limits on dollar value of coverage
  - Prohibit insurers from retroactively dropping coverage except for fraud
  - Prohibit pre-existing condition exclusions for children
  - Up to a 35% subsidy for small employers (under 25) to provide insurance
- **Changes taking effect in 2014**
  - Guarantee d offers of insurance to all eligible consumers
  - Eliminate any premium differences based on health risks or gender and limit age-rating to a premium ratio of 3-1
  - Income –related subsidies for both premiums and cost-sharing
  - Create new insurance marketplace through “exchanges”



# Federal Reforms: Health Insurance Subsidies

- **Sliding scale premium subsidies based on income**
  - Under 150% FPL: Max. of 2-4% of income
  - 150-200% FPL: Max . of 4-6.3%
  - 200- 400% FPL: Max . of 6.3-9.5%
- **Cost-sharing protections based on income**
  - Under 150% FPL: Max. of 6% of covered costs
  - 150-200% FPL: Max. of 15%
  - 200-400% FPL: Max. of 27-30%
  - Separate income-related out-of-pocket caps
- **Insurance reforms, subsidies, and cost-sharing protections interact**
  - Some out-of-pocket costs shift into premiums
  - Raw premiums for young adults will go up
  - Young adults are most likely to qualify for subsidies and protections
- **Federal government bears limited risk for un-affordable premiums**



# Federal Reforms: Insurance Exchanges

- Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP), with option for state to allow federal government to establish the exchange
- Subsidies available only through the new exchanges
- Administered by governmental agency or non-profit
- Available to individuals and small businesses (up to 100 employees)
- States can allow larger businesses to buy coverage in SHOP in 2017
- States may form regional exchanges with other states or within the state
- Federal funding available to establish exchanges through 1/1/2015



# Federal Reforms: Medicaid Expansion

- Maintenance of effort for Medicaid eligibility: current Medicaid eligibility rules are set in stone until 2014
- Medicaid is expanded in 2014
- All non-disabled under 65, up to 138% FPL (includes childless adults)
- Feds cover 100% of cost for expansion group in 2014 through 2016
  - 2017: 95%
  - 2018: 94%
  - 2019: 93%
  - 2020 and thereafter: 90%
- Some state flexibility in covered benefits for newly-eligible; must meet minimum standards set by Federal government





# Federal Reforms: Children's Health Insurance Program

- Require states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019
- Extend funding for CHIP through 2019
- Benefit package and cost-sharing rules continue as under current law
- In 2015, increase federal CHIP match rate by 23 percentage points
- Federal allotments for CHIP funding remain in place, limiting potential enrollment
- Eligible children who can't enroll due to limited funding will be eligible for tax credits in the state exchanges



# Federal Reforms: State Responsibilities

- Implement insurance reforms
- Choose whether to design, govern and implement health insurance exchanges
- Coordinate Medicaid and the new exchange(s)
  - ensure access to coverage
  - seamless transitions between different sources of coverage
- Select benefit package for Medicaid expansion group
- Set Medicaid payment rates and secure access to providers
- Determine Medicaid's new role in the health care system
- Determine response to numerous grant and demonstration projects opportunities
- Control growth in current and future costs



# Health Reform Estimates: Key Assumptions

- **State spending is best understood in a more comprehensive estimate**
  - Employer-sponsored coverage offsets Medicaid (for those also eligible for both)
  - Impact of coverage mandate affects Medicaid participation
  - Overall reduction in the number of uninsured could have an impact on ongoing spending for state programs designed for the uninsured
- **State fiscal impact is dependent on future state decisions**
  - Programs designed to secure access for the uninsured may need to be reviewed
  - Estimates examine state spending under a range of future policy choices, including potential increases in Medicaid provider payment rates
  - Estimates are needed to help policymakers with these difficult choices over the next three years
- **Results are consistent with national estimates by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS)**
  - 6% residual rate of un-insurance
  - Small net impact on employer-sponsored coverage
  - Small positive impact on total health spending

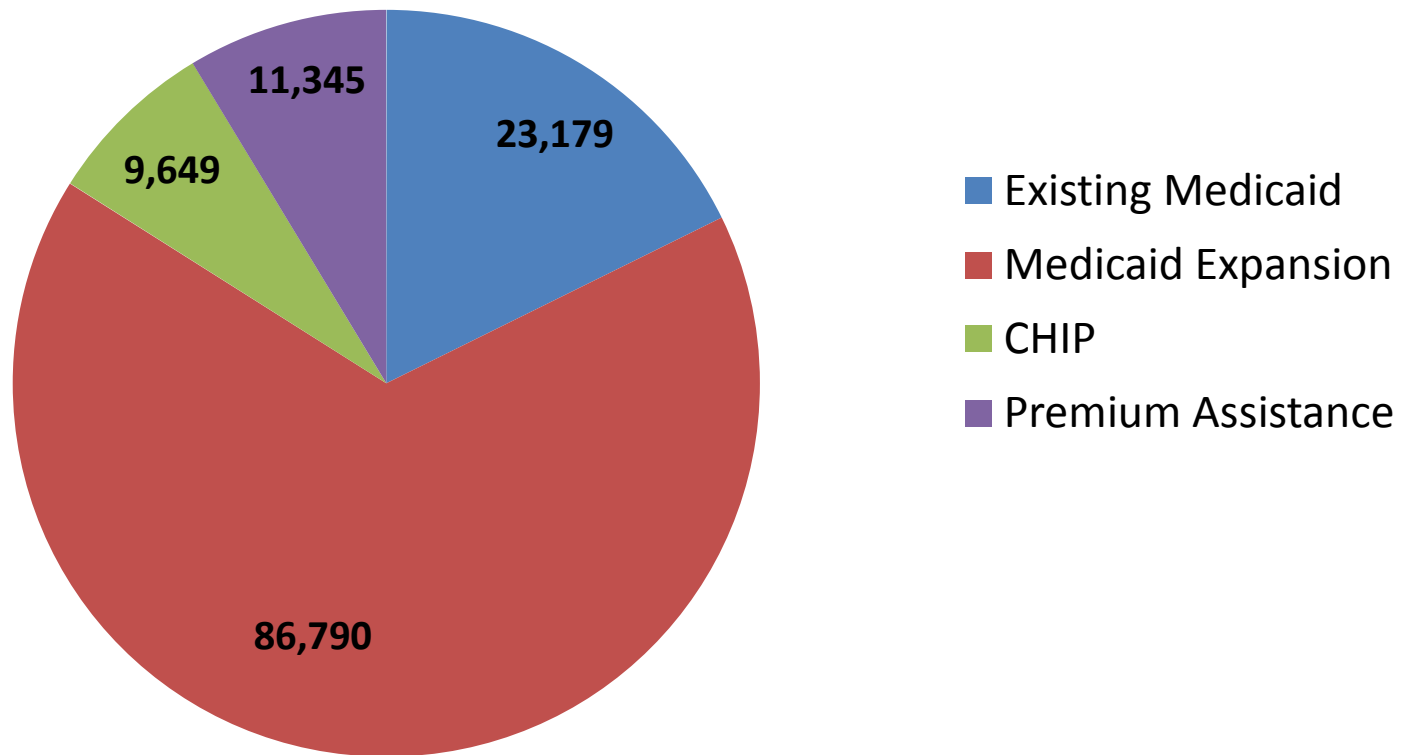


# Health Reform Estimates: Source and Process

- **Coverage and basic cost estimates produced by *schramm-raleigh Health Strategy* with funding from the United Methodist Health Ministry Fund**
  - Additional analysis of impact on state spending by KHPA
- **“Point” estimates**
  - Represent the most likely outcome of Federal reforms based on actuarial advice and national benchmarks
  - Assume the state takes no additional actions to expand coverage nor reduce spending (except to eliminate MediKan)
  - “Point” estimate corresponds to “Scenario 2” in the actuarial model
- **“Upper bound” estimates of coverage**
  - Assumes residual rate of un-insurance is 4% rather than 6%
  - Other potential costs, such as provider rate increases, are identified separately
  - Corresponds to “Scenario 4” in the actuarial model
- **Estimates include increased cost of program administration**
  - 5% of gross increase in spending; matched by the Federal government at 50%
- **Estimates expressed in constant dollars using 2011 as a base**



# Federal Reforms: Projected Growth of 131,000 in Kansas Medicaid and CHIP





# Federal Reforms: Impact of Enhanced Match Rates on Medicaid Costs in 2020

	<u>All Funds Spending</u> (\$ millions)	<u>Average</u> <u>State Share</u>	<u>State Spending</u> (\$ millions)
Baseline spending	1,541	40.2%	619
Spending with reform	<u>1,972</u>	<u>31.5%</u>	<u>621</u>
Change	+432	-8.7%	+2
Percent change	28.0%		0.3%

Notes: Reflects point estimate. Includes spending on medical care only. Excludes administrative costs and changes in DSH spending.



# Federal Reforms: Impact on State Spending at Full Implementation in 2020

State options regarding direct spending for the safety net\*

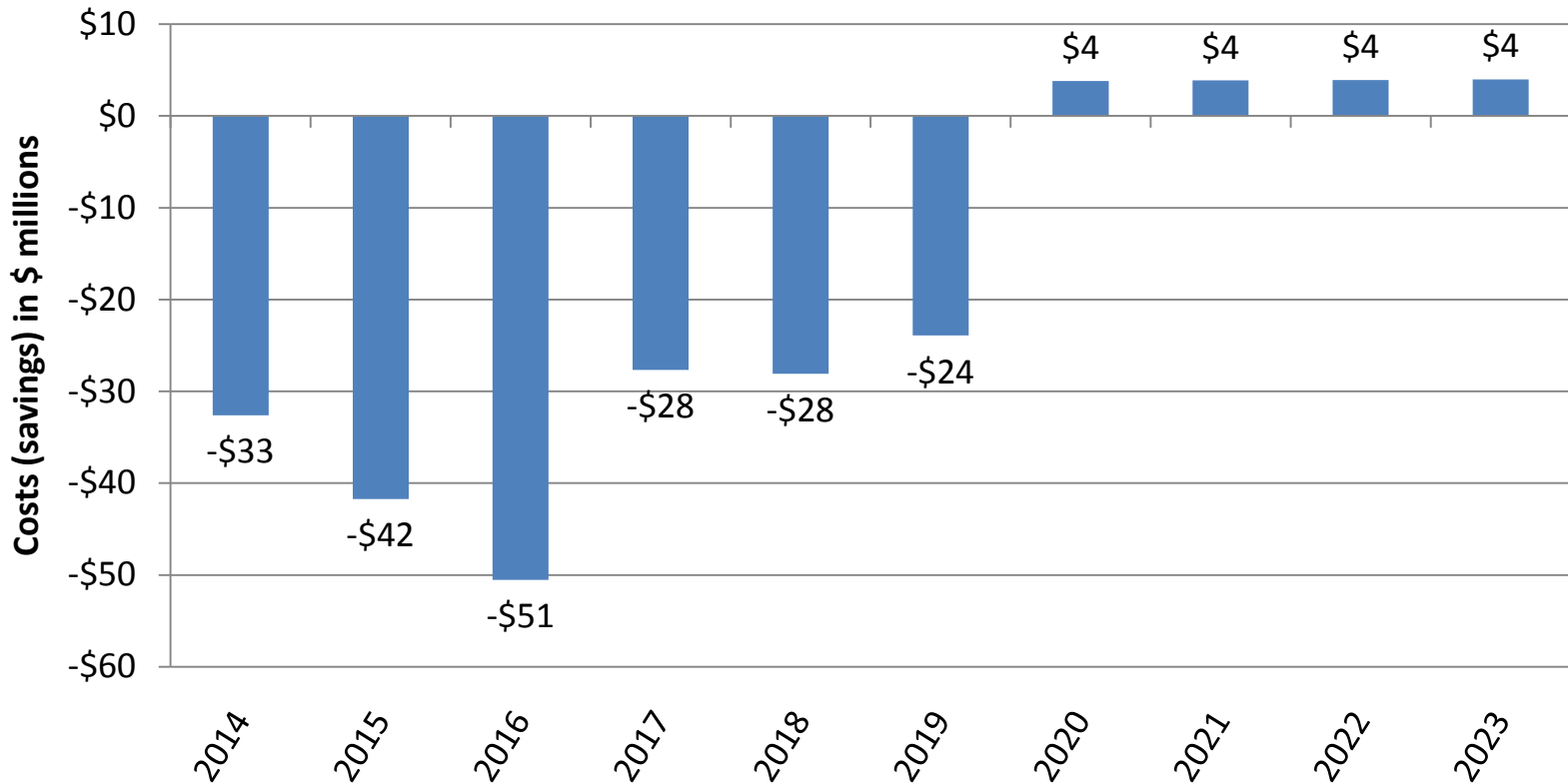
	Maintain all state spending on the safety net	Reduce state spending on the safety net by half	Eliminate state spending on the safety net
Point estimate plus 5% provider rate increase	\$35 M	\$12 M	-\$8 M
Upper bound estimate of coverage	\$7 M	-\$16 M	-\$35 M
Point estimate	\$4 M	-\$19 M	-\$39 M

Additional risk: +/- \$15 million variance in true cost of Medicaid benefit package. Impact subject to state choice and federal regulation over covered benefits.

\*Options are illustrative and do not reflect the opinions of KHPA staff, nor the KHPA Board. State spending totals for the uninsured through the safety net are preliminary (\$40-\$45 million annually) .



# Federal Reforms: Net Impact on State Spending 2014-2023

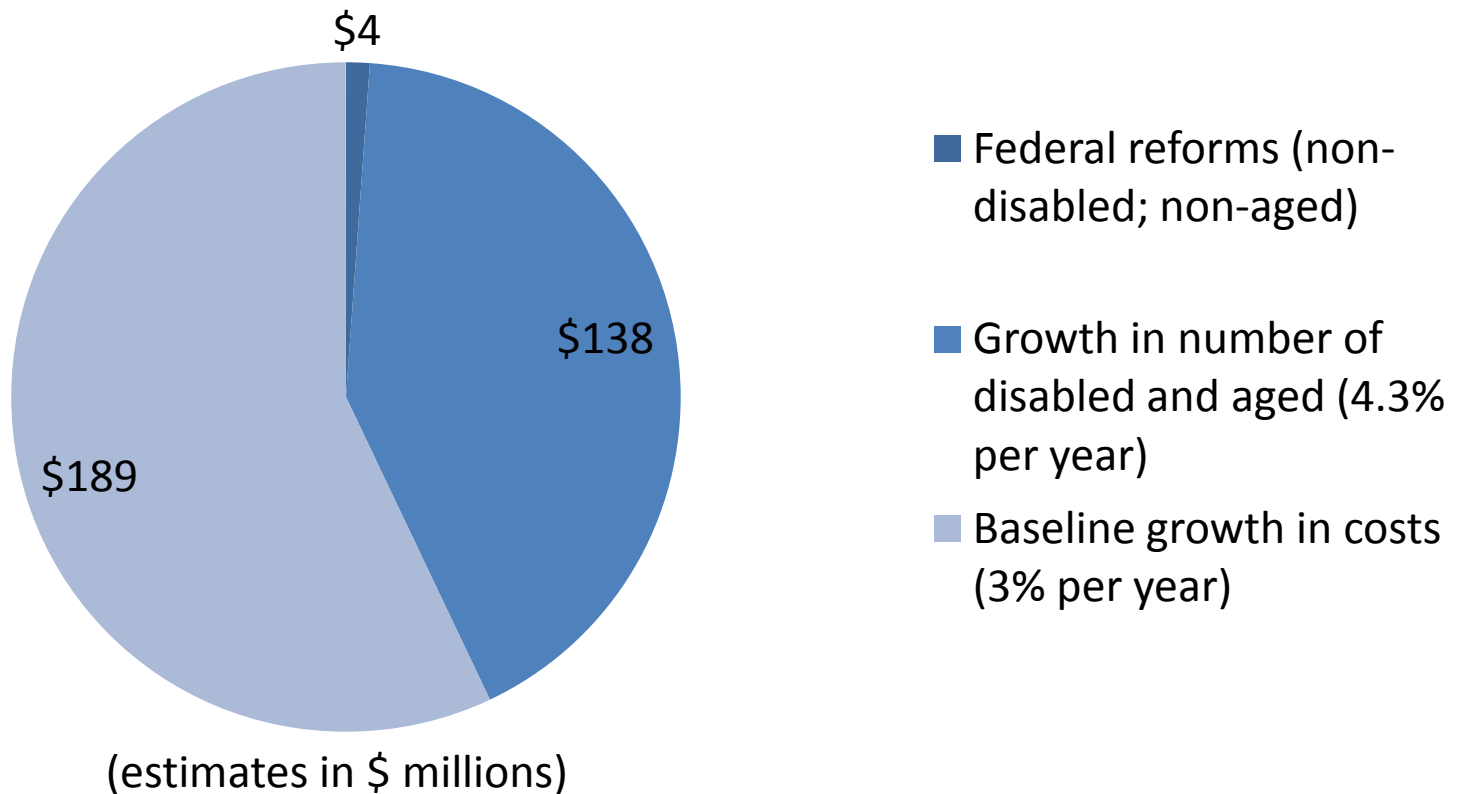


Note: Reflects point estimates. Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.





# Federal Reforms: Sources of Growth in Medicaid Spending 2011 vs. 2020



Note: Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.



# Federal Reforms: Summary of Potential Impact

- **Reduction in the number of uninsured**
  - Currently appr. 335,000 uninsured, or 14% of non-aged population
  - Expected reduction of 191,000 to about 6% of the non-aged population
- **Growth in Kansas Medicaid**
  - Expected growth of approximately 131,000 new participants
  - Some beneficiaries will shift to – or be jointly enrolled in -- employer coverage
  - Costs of CHIP program are nearly “federalized” at 95%
  - Overall Federal match rate grows from 60% to over 68% (average for medical care only)
- **Impact on state spending**
  - Some high-cost beneficiaries with intermittent coverage shifted to private insurance or migrate to the enhanced-match Medicaid expansion
  - Higher federal payments for expansion group (90% in 2020+) and CHIP (95%)
  - Long run impact on state spending is relatively small and depends on state choices
  - Substantial savings to the state during transition years (2014-2019) when the Federal government funds between 93% and 100% of the Medicaid expansion



# Federal Reform: Some Implications

- **Expanded role for Medicaid in funding the safety net**
  - Medicaid will become the major payer for some providers
  - Approach to payment and cost control will be more important
- **Reduced turnover among Medicaid beneficiaries**
  - Higher, uniform income threshold will increase continuity
  - Larger, more stable Medicaid population increases financial returns to the state for investments in prevention and care management
- **States will need to re-evaluate programs designed for the uninsured**
  - The state helps mitigate uncompensated care through Medicaid disproportionate share hospital (DSH) payments, direct state subsidies to health care and mental health clinics, special Medicaid reimbursements to clinics and critical access hospitals, etc.
  - Health reform will bring at least \$150 million in new health spending in the state
  - Many of the remaining uninsured will be eligible for subsidized coverage
  - Cultural expectations for coverage and individual responsibility may change
  - Key questions:
    - ❖ How much of current state spending on the safety net is devoted to the uninsured?
    - ❖ How much uncompensated care will remain?
    - ❖ What is the state's ongoing responsibility for those costs?



# Federal Reforms: What They Do Not Do

- **Change individual *health behaviors***
  - Directly confront the true cost drivers in health care: smoking, over-eating, inactivity
    - Reforms address responsibilities of the payers and providers, but not individuals
    - There are significant new public health grant opportunities
  - Make sure individuals face the right incentives as consumers of health care
    - Personal responsibility. Without the barrier of affordability, we will have to find other ways to keep health care utilization in check, e.g., affordable and enforceable co-payments or other financial incentives.
    - Transparency in price and quality of health care. Where possible, consumers need to have appropriate financial incentives to be prudent purchasers, and this requires appropriate information about what they are buying.
- **Reduce *health care prices* for consumers**
  - Expand the number of providers to create more price competition?
  - Fill in “missing” provider markets with changes in training and/or licensing?
  - Enact malpractice reforms?
- **Reduce *public spending* on health care**
  - Public spending on health care is unsustainable at the present rate of growth
  - In Kansas, increases in public spending will be driven by existing programs, not reform
  - Will requires changes in the delivery of care: technology and coordination are likely keys
  - Federal reform created new opportunities, but leaves concrete steps to states



# Next Steps for KHPA

- **Detailed review of new federal laws**
- **Work closely with other state agencies**
- **Closely monitor and work with Federal agencies**
- **Coordinate information system changes**
  - New enrollment system and outreach process (“KATCH” grant from HRSA)
  - New insurance exchanges
  - Other assistance programs serving similar populations
- **Work with health care stakeholders to develop cost-control options for policymakers**

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for a thriving Kansas*



<http://www.khpa.ks.gov/>