

HEALTH REFORM

After passage of the Affordable Care Act,
the work—and the criticisms—persist.



NCSL tracks state actions on federal health reform closely. You can learn more about federal regulations, state legislation, Medicaid, insurance reform and more at www.ncsl.org/healthreform. Several NCSL health staff contributed to this package of stories related to the two-year anniversary of the Affordable Care Act.

TURNSTWO

Health reform passed by Congress in 2010 is probably the most controversial domestic legislation of the Obama administration to date.

As the Affordable Care Act marks its second anniversary this month, opponents continue to vilify its complex—and feared costly—provisions, while backers praise its groundbreaking attempt to extend health coverage to nearly all Americans.

The U.S. Supreme Court will hear arguments this month challenging the law's requirements that everyone carry insurance and that states expand their Medicaid programs. Rulings are expected by summer.

State lawmakers, meanwhile, have their hands full trying to comply with the law's various provisions. Legislatures considered more than 900 bills related to the act in 2011, and more than 200 have been introduced so far in 2012.

The cost of implementing federal health reform concerns state lawmakers who have had to deal with unprecedented budget shortfalls in the last four years. They are keenly aware of the millions of Americans who currently qualify for Medicaid but are not yet enrolled, and who will seek coverage once the individual mandate kicks in. Unlike the newly eligible, these millions will not qualify for the law's generous federal match.

The Supreme Court's pending action "casts a dark cloud over dozens of state legislatures, which will adjourn prior to the decisions on key provisions of the law," says Alabama Representative Greg Wren (R), co-chair of NCSL's Health Reform Implementation Task Force. "Clarity has been sought, yet the maze of lawsuits, elections, session schedules,



Representative
Greg Wren (R)
Alabama

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—Representative Greg Wren (R), Alabama

"The ACA has already brought us positive results, such as coverage for young adults and those with pre-existing conditions, health insurance tax credits for small business and relief for seniors reaching the coverage gap under Medicare Part D."

—Assemblyman Herb Conaway (D), New Jersey

and deep political divides cast dark clouds over all the implementation mandates."

Despite what some see as an unprecedented overreach by the federal government into health care, the law has made some changes that are less controversial—and in some quarters, welcome. It requires coverage for young adults up to age 26 and those with pre-existing conditions; offers health insurance tax credits for small businesses; and relief for seniors reaching the coverage gap under Medicare Part D. It also requires insurance plans to spend at least 80 percent of premiums on health services, and provides free preventive services and new coverage for thousands of children and adults previously denied. The federal government has distributed more than \$4 billion to states to help implement the complex law.

New Jersey Assemblyman Herb Conaway (D), a physician and the other co-chair of the NCSL task force, also points out that "Americans will no longer need to fear bankruptcy because of high medical costs."

As states deal with upcoming deadlines, including requirements to have insurance exchanges up and running and to expand Medicaid by Jan. 1, 2014, this year's legislative sessions have been busy with additional work and scrutiny.

"Meeting the ACA's mandatory deadlines for exchanges will continue to prove a daunting legislative endeavor," says Wren.



Assemblyman
Herb Conaway (D)
New Jersey

—Martha King

Health Reform by the Numbers

\$4 billion

Federal money given to states to implement the law, as of December 2011.

49.9 million

Americans uninsured, as of the 2010 census.

24.2 million

People who received Medicare preventive health screenings with no co-payment, including a wellness exam, in 2011.

20 million

Additional patients anticipated by community health centers by 2019.

16 million

Additional Americans who may qualify for Medicaid in 2014.

2.5 million

Young adults up to age 26 recently covered by parents' plans.

44,852

People with pre-existing health conditions newly insured through high-risk pools, as of Nov. 30, 2011.

28

State attorneys general or executives who have joined the suits now before the U.S. Supreme Court against certain provisions in the law.

28

States that have received federal funds to establish insurance exchanges, as of Jan. 15, 2012.

19

States that have passed legislation opposing parts of the act.

12

States that enacted legislation to create health exchanges.

Exchanges: Job No.1

Health insurance exchanges, often likened to travel websites such as Expedia or Travelocity but for insurance plans, are the most pressing piece of federal health reform state lawmakers will deal with this year.

These insurance marketplaces must be up and running by the start of 2014. By 2020, an estimated 24 million Americans will be using them to shop for health insurance.

Creating them is no easy task. They require complex technology systems, and must operate in concert with state Medicaid programs. In addition, exchanges must be able to help people determine whether or not they qualify for a federal subsidy to make insurance more affordable.

“Exchanges dominated meetings throughout 2011, yet the vast majority of state legislatures must deal with the federal establishment mandates this year,” says Alabama Representative Greg Wren (R).

“Legislatures continue to wrangle through the policies and politics of exchanges, and constitutional uncertainties loom at every step along the way,” he says.

Massachusetts and Utah created insurance exchanges even before federal health reform. As of Jan. 1, 10 additional states have passed legislation to create their own, and many others are still planning or studying options. Louisiana officials chose to let the federal government run their exchange, and a few other states may follow suit.

“The ACA gives states some flexibility to craft the insurance exchanges in ways that make sense to them,” says Colorado Senator Betty Boyd (D), who chairs the Senate Health and Human Services Committee and co-chairs NCSL’s Health Committee. “We wanted to make sure we retained control, for example, over whether to have a state agency run it or establish an independent nonprofit entity.”



Senator
Betty Boyd (D)
Colorado

Four territories and every state but Alaska received federal money (although Florida,

Louisiana and New Hampshire returned theirs) to use in planning an exchange. At least 28 states and the District of Columbia have received additional federal funding to move beyond initial planning. The ACA also allows for a state-federal partnership and for multi-state partnerships to establish exchanges.

Some lawmakers in Wyoming would prefer to combine their efforts with other small states to increase the size of their insurance pool and share the costs of the technology.

“We oppose the ACA, but don’t want the federal government to run our exchange, so we are moving forward with planning,” says Wyoming Representative Elaine Harvey (R), who chairs the House Health Committee. “Wyoming was already on track to propose partnerships with other states related to health insurance compacts, but the ACA diverted everyone’s attention.”



Representative
Elaine Harvey (R)
Wyoming

—Martha Salazar

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—Colorado Senator
Betty Boyd (D), Colorado

Big Changes for Insurers

A casual observer might be excused for thinking the Affordable Care Act has more to do with reforming insurance than with health care. Indeed, during its first two years, the act’s most visible features have been aimed at the commercial insurance market.

Many states are currently implementing more than a dozen major new requirements. Most of these provisions are based on long-standing practices in the states, which for decades have led efforts to regulate health insurance, affecting who and what is covered, how much it costs, and how consumers will navigate the often complicated systems.

The new pace of change has been daunting, and the effects far-reaching. One of the first changes noticed by the public occurred in July 2010 with the launch of the Pre-Existing Condition Insurance Plan for people denied insurance because of their serious health condition or chronic disease. Twenty-seven states chose to run these high-risk pools, while the others and the District of Columbia opted to have the federal government handle it.

Another high-profile provision requires insurers to offer the option for young adults through age 25 to stay on their parents’ plans. Since September 2010, 2.5 million young adults have done so.

The most frequently used new benefit is Medicare preventive screenings with no co-pay, including an annual wellness exam, which about 24.2 million people took advantage of in 2011.

Other key provisions affecting insurance providers include:

◆ **Drug coverage.** After Medicare patients spend more than \$2,810 a year on medications, they now receive a 50 percent discount on most of their drugs. In 2011, this saved 3.6 million people at least \$2.1 billion. This shrinks the Medicare Part D coverage gap, the so-called donut hole, each year and eliminates it by 2020.

◆ **Rate review.** All states must now review or approve insurance rate increases greater than 10 percent, a practice about 20 states had already pioneered.

◆ **Required spending.** Insurance companies, starting in 2011 must spend at least 80 percent of premium revenues directly on medical care and quality improvement. If they don’t, they are required to return the extra money. Starting in 2012, insurance companies may be required to return up to \$1.4 billion to the purchasers of several million policies, according to the U.S. Department of Health and Human Services. Six states have received waivers that exempt certain insurance companies from this so-called medical loss requirement.

◆ **Limits on coverage.** In 2011, insurance plans were not allowed to limit annual coverage of essential benefits to less than \$750,000. The limits increase to \$1.25 million this year, \$2 million next year, and are prohibited altogether starting in 2014. An optional waiver allows some existing partial coverage plans to retain their limits.

◆ **Consumer rights.** The federal law now requires independent appeals of denied payments for services or treatments. Forty states already required appeals, but only for some state regulated policies. This change covers about 100 million more people. —Richard Cauchi

Sharp Divisions Persist Over Law's Future

Changing the nation's health system has become a lightning rod for partisan disagreement, although state legislatures have seen far less paralysis and, at times, more thoughtful debate than has Congress.

Within hours of the president's signature, 14 states had filed federal court challenges to the new law. By January 2011, 28 state attorneys general or governors were pursuing repeal efforts.

Legislators stepped into the arena as well. There are now 19 state laws, including three constitutional amendments, opposing certain provisions. Typically, they ban state government involvement in requirements to purchase health insurance. Similar legislation failed in 27 states.

These high-visibility opposition or "opt-out" moves reflect the strong partisan divide on the new federal law, critically labeled "Obamacare" by opponents in press releases and floor debates.

The change Arizona lawmakers approved in their constitution—"no law or rule shall compel any person or employer to participate in any health care system"—became a model for bills proposed in more than 40 states.

"The majority in Arizona's Legislature has little faith that the federal health reform law will benefit our citizens' health or lower health care costs," says Senator Nancy Barto (R), the lead sponsor. "Instead, we expect to advance health reforms that lower the high cost of care and allow more insurance options whether or not the Supreme Court upholds the federal law."

New Jersey Assemblyman Herb Conway (D) supports the law but is not surprised by the opposition to it. "Reform often comes in

fits and starts," he says. "A reform of this scale and magnitude will not proceed without challenges and difficulties."

For 2012, all eyes are on the U.S. Supreme Court, which has scheduled an unusual three-day oral argument for March 26-28. Constitutional experts predict a ruling by June. Supreme Court justices will deliberate over the key legal question of whether a federal law can require almost everyone to purchase or otherwise obtain health insurance and if that mandate can be removed from the rest of the act. The justices also will decide if Congress can require states to expand Medicaid coverage and withhold all funding from states that don't comply. Lawmakers who back the law are speaking out as well. The Working Group of State Legislators for Health Reform filed a "friend of the court" brief on behalf of 518 members from 50 states with the Supreme Court, defending the constitutionality of the new law.

"As legislators, we are on the front lines to implement this law," says Washington Senator Karen Keiser (D), a leader of the effort. "With legislators from all 50 states signing the brief, it's evident there is nationwide support for reform, even in states that are challenging the law. Those of us in state legislatures must act with confidence, knowing our implementation efforts will not be delayed or derailed by groundless constitutional challenges. We simply cannot wait any longer to take action on this bill; there is no time to lose."

—Richard Cauchi

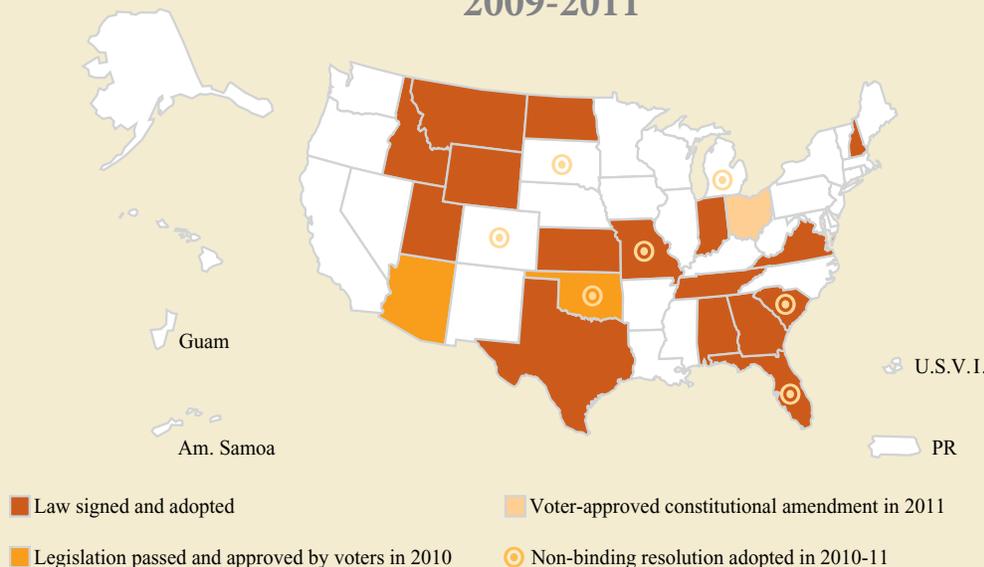


Senator
Nancy Barto (R)
Arizona



Senator
Karen Keiser (D)
Washington

State Actions Opposing Elements of Federal Health Reform 2009-2011



Transforming Medicaid

The nation's Medicaid program, which covers about 50 million people, faces a significant overhaul under the Affordable Care Act. The \$400-billion-a-year, joint state-federal program will be expanded in 2014 to cover all Americans under age 65 with family incomes at or below 133 percent of federal poverty guidelines—\$14,856 for an individual and \$30,657 for a family of four in 2012.

Currently, the program covers low-income children, pregnant women, the elderly, people with disabilities, and adults with dependent children, but largely excludes childless adults. They will make up a large percentage of the newly eligible population—estimated to total about 16 million—in 2014. Additionally, a change in how eligibility will be calculated, called “modified adjusted gross income,” will effectively raise the eligibility level to 138 percent of the poverty level for most applicants. Another provision, the maintenance-of-effort requirement, forces each state to maintain the same Medicaid eligibility level that was in place on March 23, 2010.

These changes, however, will add strain to Medicaid budgets that, for the last several years, have been feeling the compound effect of decreases in state revenues and increases in enrollments—13.6 percent hike in enrollment between 2007 and 2009, and 7.2 percent between 2009 and 2010. These increased enrollments, coupled with the ACA-required expansions in 2014, will swell the cost of Medicaid, making it more important than ever for states to improve the program's effectiveness and efficiency.

In 2011, 47 states implemented at least one new policy to control Medicaid costs—such as reducing benefits and provider reimbursement rates—and 50 states plan to do so this year, according to the Kaiser Family Foundation. States are also experimenting with more long-term reforms, such as attaching provider payments to patients' health results, creating medical homes or streamlining services for those eligible for both Medicaid and Medicare.

Some policymakers see the Medicaid changes in federal health reform as an opportunity for states to improve the health care system and expand coverage to more people. New Jersey Assemblyman Herb Conaway (D) thinks the law will help states stabilize the financial health of hospitals and safety-net providers, which are currently required to provide some services without compensation. He acknowledges the fiscal challenges the expansion poses for states, but says, “As a physician, I think we need to ensure access to health insurance to hard-working people and their families.”

Many lawmakers want flexibility from the federal government to make changes in the rules for Medicaid, including those for eligibility.

“State legislatures allocate massive amounts of state funds to Medicaid,” says Alabama Representative Greg Wren (R). “We must be included in forming benefit, reimbursement, eligibility and enrollment policy. We can no longer be sent the invoice while being excluded from the discussion.”

—Melissa Hansen

States Decide Essential Benefits

States have long required insurance companies to offer certain benefits. More than 1,500 state laws mandate coverage, although they apply to different types of insurance. Idaho, for example, has only seven mandated services, Iowa has 20, while Florida has 40 and Maryland 55. By 2014, policies sold through exchanges, and most new plans sold to individuals and small employers, will have to cover the minimum or “essential” benefits approved by the federal government.

The federal law calls for states to pay consumers' costs for any state-mandated benefits not deemed essential by the new law and under rules to be issued by the U.S. Department of Health and Human Services (HHS).

Most observers expected a national, one-size-fits-all definition of essential benefits.

But last December, the HHS proposed giving states unexpected flexibility in deciding which of several existing insurance plans—small group plans, state and federal employee health plans, HMOs—to use as a benchmark for required coverage in their own states.

Under the proposed new rules, state officials will be able to choose among several plans that already cover their state-mandated benefits and have one such plan designated the HHS-approved standard. Essential benefits will then vary among states but states won't have to pay extra for consumers to purchase services required under state mandated benefits. The standards will apply to policies bought through exchanges as well as those sold outside of exchanges. The proposed rules may help states avoid incurring some new costs.

Although the increased flexibility is widely popular among many legislators, contentious issues remain. Lawmakers may be asked to reconcile differences among comprehensive coverage packages, or select a benefit package with fewer services at reduced premiums. Discussions of what is fair, what is affordable and what is medically necessary will likely keep this issue high on state legislative agendas.

—Richard Cauchi

What Insurers Must Cover

- ◆ Ambulance services.
- ◆ Emergency services.
- ◆ Hospitalization.
- ◆ Maternity and newborn care.
- ◆ Mental health and substance abuse services.
- ◆ Prescription drugs.
- ◆ Rehabilitative and self-help services and devices.
- ◆ Laboratory tests.
- ◆ Preventive wellness services and chronic disease management.
- ◆ Pediatric services, including dental and vision care.
- ◆ Other services determined by state mandates in state-selected benchmark plans.

Note: Federal rules require coverage for a range of women's preventive health services in new policies as of Aug. 1, 2012.

Prevention: More Than an Ounce

“As an ER physician, I see many patients who have problems that, with preventive care, would not land them in the ER. As an elected official, I see the huge cost preventable illness causes taxpayers.”

—Representative Doug Cox (R), Oklahoma

One aim of federal health reform is to shift the health system’s focus from treating sickness to keeping people healthy. The goal is to “move from a culture of sick care to a culture of prevention,” says U.S. Surgeon General Regina Benjamin. By doing so, states may reap both immediate and long-term savings.

Addressing many root causes of chronic diseases—poor diet, physical inactivity and smoking, for example—may lessen their huge burden on government budgets. Treating chronic diseases accounts for 75 percent of all health spending in the country.

“As an ER physician, I see many patients who have problems that, with preventive care, would not land them in the ER,” says Oklahoma Representative Doug Cox (R), chair of the House Appropriations and Budget Subcommittee on Public Health and Social Services. “As an elected official, I see the huge cost preventable illness causes taxpayers.”



Representative
Doug Cox (R)
Oklahoma

Several provisions of the federal health care law support preventive efforts. The National Prevention Strategy designed by the U.S. Department of Health and Human Services aims at increasing the number of Americans who are healthy at every stage of life by creating community environments that help people make healthy choices and ensuring access to preventive care. Another effort, the Childhood Obesity Demonstration Project, promotes healthy eating and physical activity to combat childhood obesity. The project will target low-income children enrolled in the Children’s Health Insurance Program, who generally have a high rate of obesity, with a program that combines preventive care doctor visits with changes at schools, day care, community food stores and parks.

Congress appropriated \$1 billion for 2012 for public health programs under the Prevention and Public Health Fund. Sixty-one state, tribal and community chronic disease prevention and health promotion projects received grants from the fund in 2011.

The law also requires:

- ◆ All new health insurance plans to cover routine immunizations, evidence-based screenings and counseling, and specific additional preventive services for children, youth and women with no out-of-pocket costs to patients.
- ◆ Businesses to provide reasonable time and a private place other than a bathroom for mothers to express breast milk, with some exceptions for small employers.
- ◆ Money for new school-based health centers and to operate existing ones.
- ◆ Nutritional labeling on restaurant menus and vending machines, once final federal rules become effective.

In addition, states can seek grants to offer Medicaid beneficiaries financial incentives for losing weight, lowering cholesterol, improving blood pressure and quitting smoking.

—Amy Winterfeld

Help Wanted: Doctors and Nurses

The Affordable Care Act will allow about 32 million more Americans to have health coverage by 2019, according to the Obama administration. Who will treat them?

Even before federal health reform, experts were predicting that, by 2025, the country would face a shortage of as many as 45,000 primary care providers—physicians, nurses, physician’s assistants, nurse practitioners and others. With that in mind, the law included provisions to strengthen the current primary care workforce and increase the number of providers in the future. The law:

- ◆ Increases payments for primary care services under Medicaid and Medicare.
- ◆ Provides grants to expand nursing education and training.
- ◆ Provided the money for clinics run by nurse practitioners.
- ◆ Provides financial incentives to physician’s assistants to work in primary care.
- ◆ Creates new payment models that provide financial incentives to primary care providers.
- ◆ Adds medical residency slots to train 500 more primary care physicians by 2015.
- ◆ Increases funding to community health centers by \$11 billion (although \$604 million was cut in 2011) over five years to expand primary care services.

Building on the more than \$200 million for health care workforce projects included in the 2009 stimulus act, the Affordable Care Act focuses on getting more doctors into needy communities, mainly small rural towns and big city centers. Along with the federal stimulus law, funding from the ACA has helped triple the number of doctors, nurses and other health care professionals serving these communities through the National Health Service Corps in the last three years.

State lawmakers have been addressing workforce shortages for years with loan repayment funding; programs to create a pipeline for health professionals, such as K-12 outreach initiatives; and efforts to improve health workforce retention, such as regulating mandatory overtime and addressing staff ratio requirements. Finding solutions to this very tricky problem can be difficult, however. By leveraging federal funding with state resources, soliciting participation from everyone involved, and working with medical schools, lawmakers can explore solutions and continue to play an important role in ensuring an adequate number of health providers for their states.

—Laura Tobler



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