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SOUTHERN LEGISLATIVE CONFERENCE

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THE COUNCIL OF STATE GOVERNMENTS

HEALTHCARE REFORM: EXCHANGES AND THE EXPANSION OF MEDICAID

AN ISSUE ALERT FROM THE SLC

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Introduction

In the world of politics, there are few simple problems and fewer simple solutions. However, some problems are more complex than others, as well as their corresponding solutions. Whether or not to build a certain bridge may invoke varying arguments for or against the project, but when the decision is made, there are a limited number of options for how to move forward. Not so with healthcare in America. There may be some tenets most Americans can agree upon but, beyond that, the solutions become more complicated. For instance, most agree that every American needs access to healthcare, in some form or fashion, but how to accomplish that is where the water gets murky. More precisely, unlike building a bridge, each answer to the problem comes with its own set of positive and negative economic and public health consequences.

Part of the difficulty in arriving at a solution is the sheer scope of the problem. The United States pays more per capita in healthcare than any other country, spending a staggering $7,538 per person per year. Norway is a distant second, at $5,003 per person, according to statistics from the Kaiser Family Foundation. The nation's healthcare spending was estimated at $2.7 trillion last year and is slated to surpass $3 trillion in 2014, according to a report by Bloomberg News. And as the cost of delivering healthcare continues to rise, the number of uninsured continues to grow, premiums continue to escalate, benefits shrink, employees continue to lose insurance through their workplace, employers continue to struggle with the cost of offering sufficient coverage and many people avoid or prolong care due to cost.

Table 1 UNINSURED POPULATION BY STATE 2010

State	Number Uninsured	Percentage of Total Population
Alabama	744,100	16
Arkansas	540,300	19
Florida	3,924,800	21
Georgia	1,942,600	20
Kentucky	659,900	15
Louisiana	765,800	17
Mississippi	555,300	19
Missouri	853,300	14
North Carolina	1,620,300	18
Oklahoma	638,500	18
South Carolina	843,600	19
Tennessee	933,700	15
Texas	6,234,900	25
Virginia	1,039,300	13
West Virginia	245,800	14
Region	21,542,200	17
United States	49,903,900	16

Source: "Health Insurance Coverage of the Total Population, states (2009-2010), U.S. (2010)," Kaiser Family Foundation.

According to a report by the U.S. Census Bureau, approximately 157 million people under the age of 65 have coverage through employer-sponsored insurance, either as an employee or as a dependent of an employee, but that number continues to shrink. Part of the reason is that, from 1999 to 2009, health insurance premiums more than doubled in the United States, rising by more than $7,500 for the average family receiving insurance through their employer. Also, the number of small employers offering health insurance dropped from 65 percent to 59 percent during that same

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time. Regionally, the percentage of Southerners who are uninsured, 17.6 percent, is greater than the national average of about 16 percent, according to the Kaiser Family Foundation, and one Southern state, Texas, has the highest percentage, 25 percent, of uninsured persons on the country.

Changes established by the Patient Protection and Affordable Care Act (ACA), passed by Congress in March 2010, address many of the major problems associated with accessing healthcare in America. The ACA provides some protections to consumers, many of which already have been implemented. Beginning in 2011, most health insurance companies were required to spend at least 80 percent of premium dollars on healthcare and quality improvements, rather than overhead and administrative costs. Another rule already in effect allows parents to keep adult children under the age of 26 on their health insurance plans. In 2014, other major provisions kick in, including the requirement for all individuals to have insurance and for businesses with more than 50 employees to offer affordable coverage. Beginning in 2014, all individuals without insurance will pay a penalty of $695 or 2.5 percent of annual household income, whichever is greater. The penalty increases annually based on cost of living. Also, large firms will face fines between $2,000 and $3,000 per worker for not offering insurance or for offering plans that are deemed "unaffordable," those that cost workers more than 9.5 percent of their annual household income. A breakdown of the key features of the ACA can be found here at the U.S. Department of Health and Human Services (HHS).

However, like all complicated solutions, those sought by the ACA are not without repercussions. The most obvious negative consequence of implementing the ACA is cost, of grave concern to state budgets that already are financially strapped. The Congressional Budget Office (CBO) predicts that the insurance coverage provisions of the ACA will have a net cost of approximately $1.1 trillion over the 2012-2021 period. This includes gross additional costs of $1.5 trillion for Medicaid, the Children's Health Insurance Program, tax credits and other subsidies for purchasing health insurance through the newly established health exchanges, and tax credits for small employers. The CBO notes that the offset to these costs is about $0.4 trillion in receipts from penalty payments, a new excise tax on high premium insurance plans, and other budgetary effects, such as increases in tax revenues.

Establishment of Insurance Exchanges

On July 28, the U.S. Supreme Court ruled that most of the requirements laid out by the ACA were constitutional. Perhaps most importantly, Chief Justice John Roberts, writing the majority opinion, ruled that the penalty paid by someone who refuses to purchase insurance is considered a tax, at least in terms of how it is collected and, therefore, is a constitutional provision under the Commerce Clause. Many states' decisions to go forward with implementing exchanges have been contingent on whether or not the Supreme Court upheld that portion of the ACA, which they did. According to the ACA, states can either operate their own exchange or allow the federal government to do so. This second option would entail reorganization of a state's insurance industry. Consequently, most states have done what is necessary to keep this from happening.

The first formal federal inspection of states' implementation progress is scheduled for January 2013, and by 2014 states will be required to operate health insurance exchanges or have the federal government do it for them. Individuals and small businesses, which are not subject to penalties, will have access to these state- or federally-run health insurance marketplaces, which are designed to promote competition and allow purchasers to compare private health insurance options while providing them with more choices when negotiating plans. According to a report by HHS, middle-income families purchasing insurance through the exchange could save as much as $2,300 per year beginning in 2014, and small businesses could save up to an average of $350 per family policy by buying insurance through the exchange. Small businesses also will be eligible for tax credits that help offset the cost of providing insurance, covering 35 percent of their premiums. According to a note released by the U.S. Department of the Treasury at the end of 2011, approximately 309,000 small businesses already have received these tax credits, which amounted to about $435 million in credits last year. That number is expected to increase steadily through 2020. Also, individuals and families who do not qualify for Medicaid, and who have incomes of 400 percent of the poverty line, will be eligible for federally funded subsidies—on a sliding scale—to help them purchase private coverage through the new healthcare exchanges. While the law requires new regulations and taxes on health insurers, the individual mandate is estimated to guarantee them an additional $1 trillion in gross revenue over eight years, largely from new policyholders, according to estimates by Bloomberg Government.

The journal Health Affairs warns that more many individual health plans will not meet the ACA's requirements for "essential coverage," and the concern is that, although these individuals will not have to purchase new health insurance immediately, it is likely that they will eventually be required to purchase different, possibly more expensive, coverage to fulfill this requirement. Also, a report by Deloitte, a benefits consulting firm, warns that at least 10 percent of businesses

are likely to drop insurance over the next few years, leaving their employees to purchase insurance on their own or through an exchange—the latter of which would lead to higher implementation costs than anticipated. The Cato Institute, which has advised states to not establish exchanges, warns that the federal government does not have the funds to run exchanges even for half the states.

There also are exchange implementation concerns regarding information technology (IT). While the expansion of health IT, such as the implementation of electronic medical records, has helped health professionals better manage health information, thereby improving quality of care, technology may be an obstacle for healthcare reform. The concern is that current IT systems cannot handle the expansion of data sharing between thousands of computers and software systems required by the health exchanges. The Department of Health and Human Services currently is working on establishing a national "data hub," but there is speculation as to whether or not these systems will be operational in time for states to implement exchanges, according to a report by the Heartland Institute.

Medicaid Expansion

The Supreme Court upheld all provisions in the ACA except one: the provision that would allow the federal government to withdraw all of a state's Medicaid funding if they failed to comply with the expansion. The Supreme Court ruled that the federal government has the right to expand Medicaid, the joint federal-state program for low-income citizens that now covers about 60 million Americans. Medicaid, which began in 1965, currently costs approximately $370 billion annually to maintain and covers about 30 percent of all children, 70 percent of nursing home residents, 40 percent of all births, and approximately half of all people living under the federal poverty level, according to a report by the Kaiser Family Foundation. The Supreme Court ruled that the federal government could not threaten states with eliminating all Medicaid funding if they chose not to expand the program. Seven justices agreed that Congress exceeded its authority by forcing the all-or-nothing mandate on states. This provision already was being challenged by 26 states and the National Federation of Independent Business as unconstitutionally "coercive." The justices agreed and concluded that if a state chooses not to participate in the expansion of Medicaid, then the federal government can withdraw only funds specifically targeted to the expansion, and cannot take away existing funds. In other words, according to Chief Justice Roberts' majority opinion, the federal government can offer an expansion of Medicaid, but cannot penalize states for not participating in the expansion.

The ACA proposes to eliminate the traditional eligibility categories for Medicaid, such as children, pregnant women, elderly and disabled individuals, and offer coverage to anyone with an income at or below 133 percent of the federal poverty level, or approximately $31,000 for a family of four. According to HHS, the expansion could provide coverage for up to 17 million more low-income adults and children and would cost states nothing in the short term. One of the enticements offered by the federal government for participating in the expansion is that it would shift a significant portion of the costs borne by state and local governments for healthcare for uninsured persons to Medicaid. In other words, 100 percent of healthcare costs for newly covered individuals would be covered by the federal government, under Medicaid, through 2016. According to a report by the Urban Institute states and local governments pay $10.6 billion, or more than 18 percent, every year for the cost of caring for uninsured people, just under what Medicaid covers annually. The same dynamic can be applied to mental health services for the uninsured, almost half of which is covered by state and local governments, according to a report by the National Association of State Mental Health Program Directors Research Institute.

According to the CBO, from 2014 to 2022, the federal government would bear an average 93 percent of the costs of the Medicaid expansion, or $931 billion, providing federal funds remain available, and states would contribute an additional $73 billion. This is calculated by including the 100 percent coverage provided by the federal government for the first three years, tapering to 90 percent in 2020 and thereafter. The amount the federal government would transfer to states could total $20 billion over the first 10 years of expansion, from 2014 to 2020, according to the CBO.

Cost is perhaps the main concern for states, especially since all SLC states are required constitutionally to balance their budgets. Despite financial enticement by the federal government, an expansion could begin costing tens of millions of extra dollars beginning in 2017, depending on how quickly each state's Medicaid enrollment expands. Even though the percentages are quite small relative to what the federal government will be covering, the sum that states will have to allocate is quite large. This may prove daunting, particularly as states still are recovering from the economic downturn. For states that currently offer a lower eligibility rate, the jump to 133 percent would be much greater, the effects of which could be abruptly felt in 2017, when the federal government begins to phase out the percentage which it covers.

Table 2 FEDERAL AND STATE SHARE OF MEDICAID SPENDING, FY2010

State	Percent Federal Spending	Percent State Spending
Alabama	76.6	23.4
Arkansas	80.9	19.1
Florida	67.4	32.6
Georgia	74.4	25.6
Kentucky	79.8	20.2
Louisiana	79.9	20.1
Mississippi	84.4	15.6
Missouri	73.5	26.5
North Carolina	74.6	25.4
Oklahoma	76.4	23.6
South Carolina	78.8	21.2
Tennessee	75.2	24.8
Texas	70.2	29.8
Virginia	61.2	38.8
West Virginia	82.8	17.2
Region	70.4	29.6
U.S.	67.7	32.3

Source: "Federal and State Share of Medicaid Spending, FY2010," Kaiser Family Foundation.

Actual enrollment in the Medicaid program by eligible citizens is another concern. Currently, the program covers fewer than half of all individuals with incomes under the poverty level, according to a report by the Kaiser Family Foundation. However, the individual mandate, which requires all uninsured Americans to acquire health insurance, may help shrink the number of those who are eligible but fail to enroll, since these individuals would fear paying a penalty for inaction. Another concern is the prospect of increasing "crowd out" rates, or the number of people who currently have insurance but, as a result of becoming eligible for Medicaid, cancel their existing coverage in order to enroll in Medicaid. Perhaps one of the primary concerns for state lawmakers contemplating the expansion is that there are not enough primary care doctors to treat Medicaid patients. A provision in the ACA that will increase pay to primary care doctors to Medicare levels in 2013 and 2014, an average reimbursement increase of about 34 percent, may help ensure there are enough physicians to treat Medicaid patients. However, critics are concerned that this will not suffice, insisting that expanding coverage will be meaningless if individuals are unable to access primary care physicians.

Table 3 MEDICAID EXPANSION TO 133 PERCENT OF FPL, ENROLLMENT AND SPENDING CHANGE, 2014 - 2019

State	Percentage Change in Enrollment	Percent Increase State Spending
Alabama	36.9	3.6
Arkansas	27.9	4.7
Florida	34.7	1.9
Georgia	40.4	2.7
Kentucky	37.3	3.5
Louisiana	32.4	1.7
Mississippi	41.2	4.8
Missouri	29.8	1.7
North Carolina	38.2	2.6
Oklahoma	51.2	4.0
South Carolina	38.4	3.6
Tennessee	20.9	2.5
Texas	45.4	3.0
Virginia	41.8	1.8
West Virginia	29.5	2.4
Region	36.4	3.0
U.S.	27.4	1.4

Source: "Medicaid Expansion to 133% of Federal Poverty Level (FPL): Estimated Increase in Enrollment and Spending Relative to Baseline by 2019," Kaiser Family Foundation.

Conclusion

Deciding whether or not to expand Medicaid, implement a health insurance exchange or allow the federal government to do so, and preparing to implement other changes brought by the ACA, likely will be the top public health priority for states in the upcoming year. While states will play a huge role on what the implementation of the ACA looks like—the health insurance exchange being the best example—the Supreme Court in its decision began to narrow the scope of what state lawmakers will have to face in the months to come. Unless the ACA is overturned by Congress, the majority of the changes it will bring about have been settled. However, like all healthcare issues, these are complicated decisions, ones that yield various positive and negative consequences. Each state must decide what public health decision is best for its budget, businesses and individual citizens.

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