National Health Care Reform – Implications for Virginia

House Appropriations Committee Retreat

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- ☑ Genesis of Reform
- ☐ Health Insurance Affordability and Access to Health Care Coverage
- ☐ Financing Mechanisms
- ☐ Impact on Virginia's State Budget

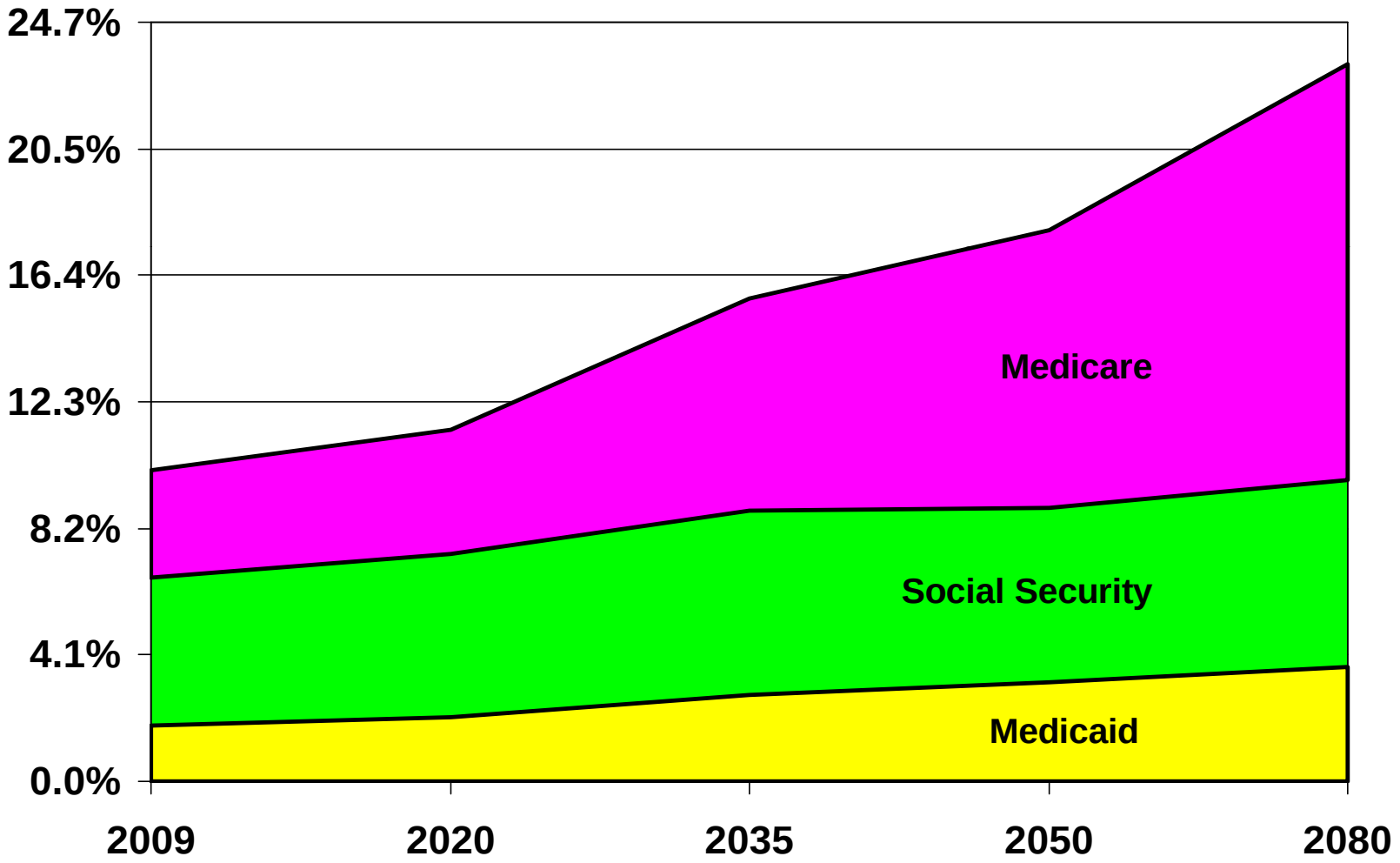
History of Health Care Reform

- Topic of discussion in national politics for almost a century
- 1960s and 1970s
  - Birth of Medicaid and Medicare in 1965
  - Spiraling health care costs becomes topic of national debates in late 1960s and early 1970s
  - 1973 federal government funds health maintenance organization (HMO) demonstration projects
  - Universal health insurance was 1976 Presidential campaign issue; recession overtakes issue
- 1990s
  - 1993 President Clinton proposed a national health care plan with universal coverage and managed competition in the health insurance market
  - Some stabilization of health care costs begin in 1990s, due in part to HMO expansions
  - 1997 State Children's Health Insurance Program (S-CHIP) was passed providing health care coverage to children in families with incomes up to 200% of the federal poverty level (FPL)

History of Health Care Reform

- 2000s
  - Early 2000s, again health care costs begin to spiral
  - Recession of early 2000s
    - Employers begin to pass on more health care costs to employees
    - May 2003, state Medicaid growth and budgetary pressures result in federal fiscal relief through a temporary 2.95% increase in the federal Medicaid match rate (FMAP)
  - Congressionally mandated annual reports of the Agency for Healthcare Research and Quality (AHRQ) on national health care quality and disparities indicate suboptimal health care and access with slow improvement over time
- 2009
  - President Obama's key legislative priority
  - Annual report of the Board of Trustees of the Social Security and Medicare programs has sounded alarms about program growth rates
    - 2009 update estimates Medicare insolvency by 2017 years and a cash deficit of $3.1 trillion over the next 10 years
  - Congressional Budget Office (CBO) short and long range projections indicate unsustainable growth rates in major entitlement programs -- Social Security, Medicare and Medicaid

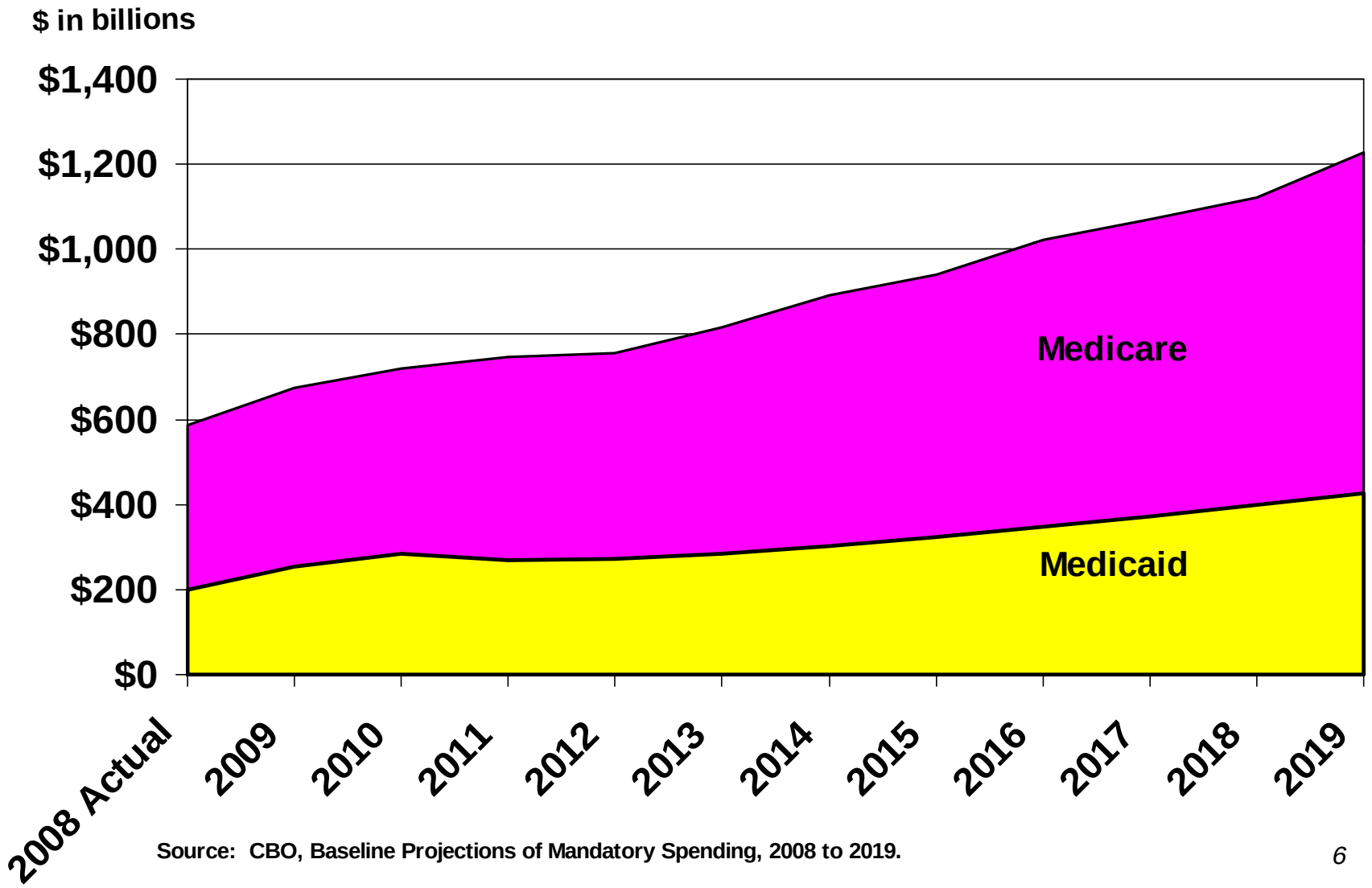
Projected Federal Spending as Percentage of GDP Under CBO's Long-Term Budget Scenario



Source: CBO Testimony, Statement of Douglas W. Elmendorf, Director, before the Committee on the Budget, U.S. Senate, "The Long-Term Budget Outlook," July 16, 2009.

Shorter Term Projected Federal Spending on the Medicare and Medicaid Programs

2008 - 2019

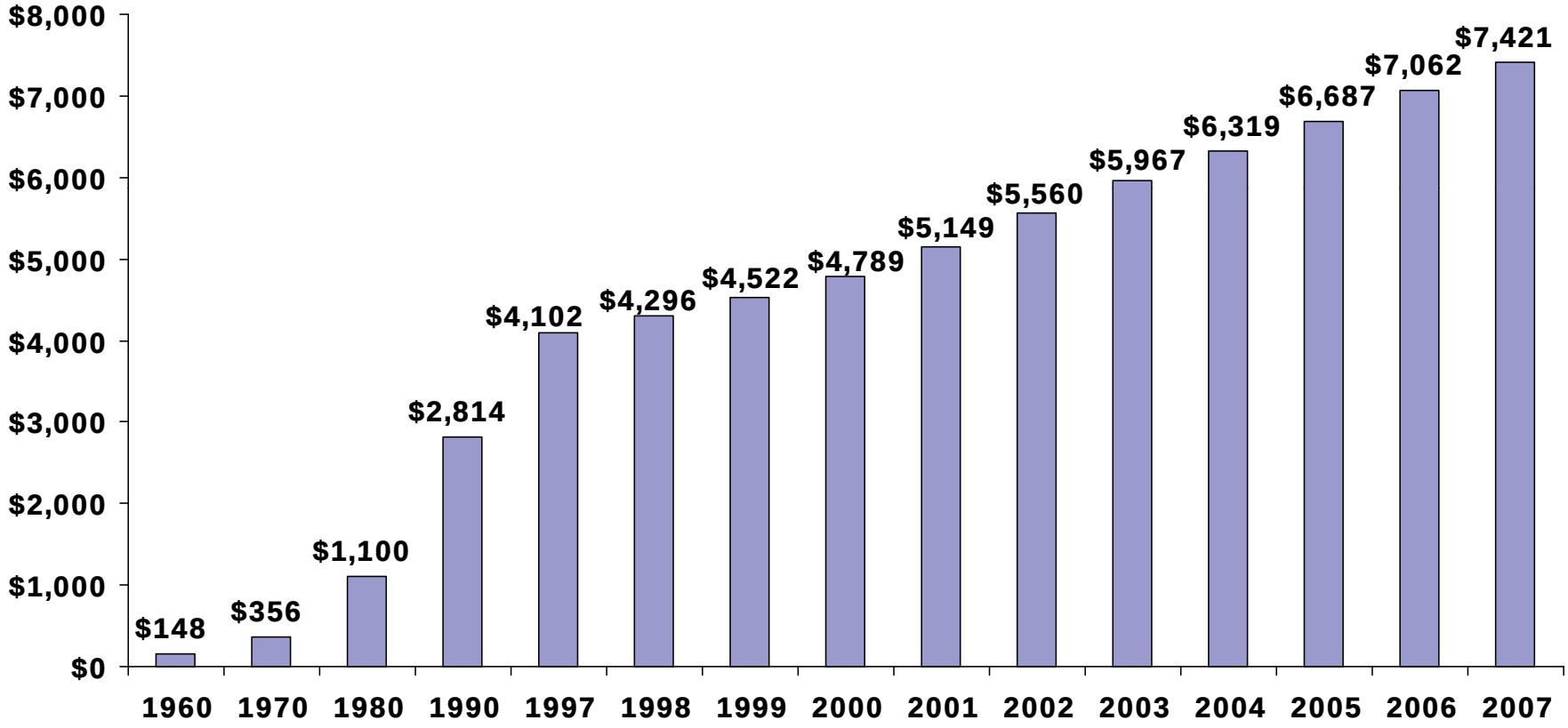


Source: CBO, Baseline Projections of Mandatory Spending, 2008 to 2019.

Other Issues Leading to Current Reform Efforts

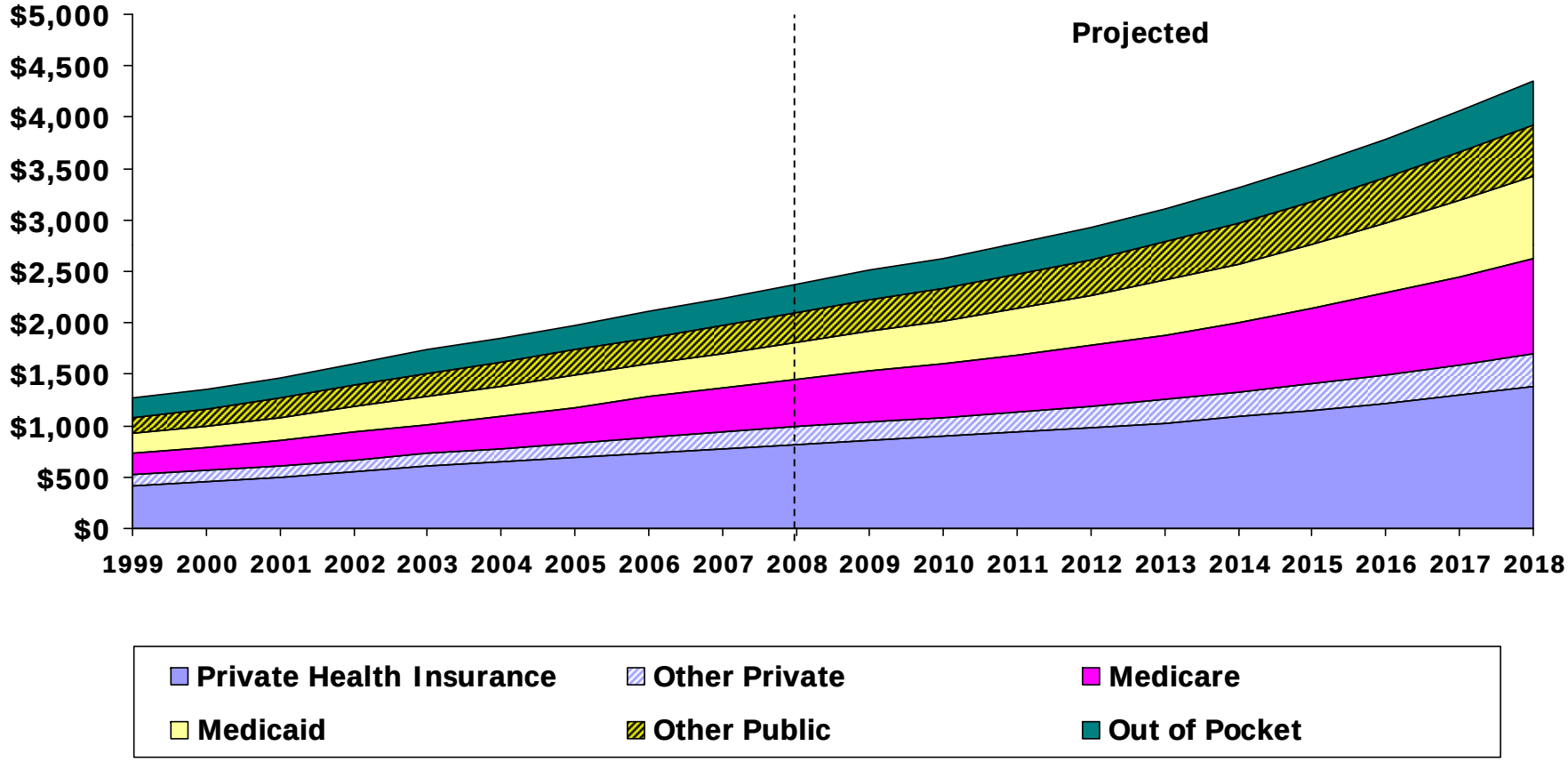
- Continued rise in health care costs
  - National health expenditures per capita have nearly doubled in the past 10 years
    - Health care spending has grown at an average annual rate of 9.6 percent since 1970, outstripping other measures of economic growth
  - Growing costs are also an issue for private third party payers
    - Private health insurance is the largest source of health spending
    - Health insurance premium increases outpace inflation and growth in workers' earnings
    - Belief that cost shifting of public programs on private payers results in higher health care costs for private payers
- Concern about the impact of growing uninsured population on economy and health care costs

National Health Expenditures (NHE) per Capita,1960-2007



Source: Kaiser Family Foundation, Health Care Costs A Primer, March 2009.

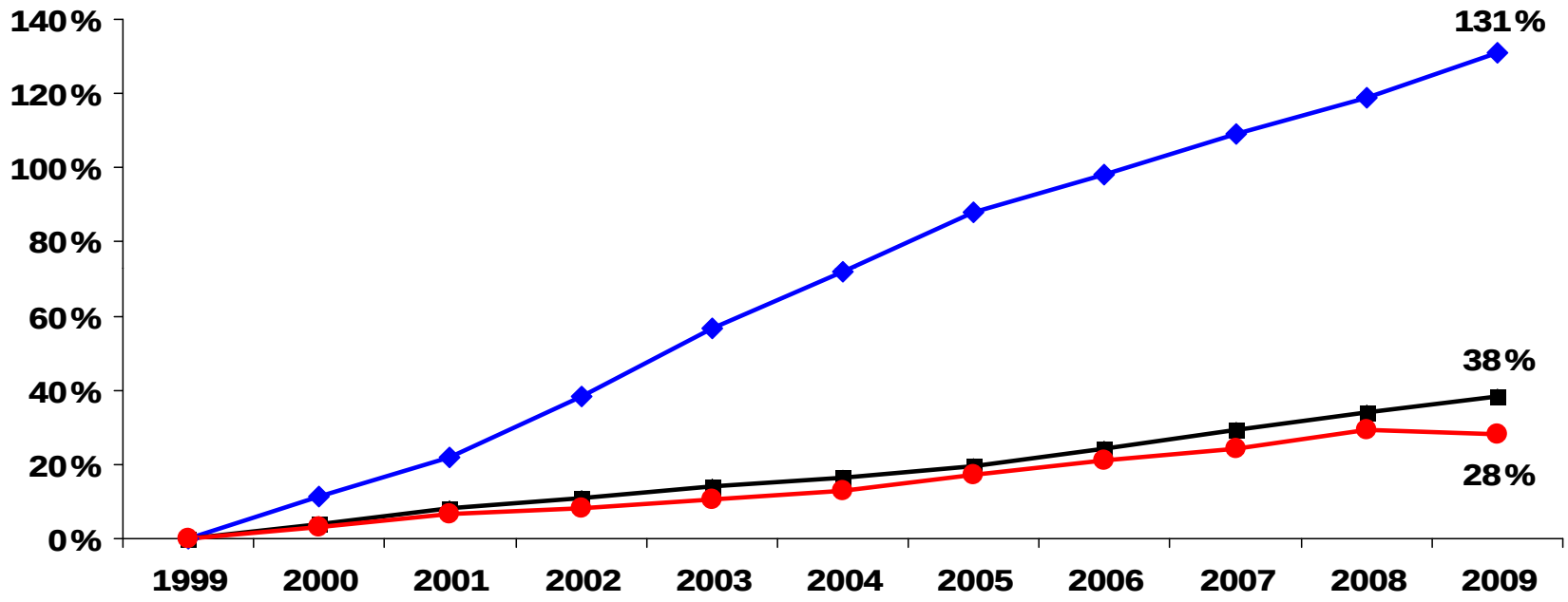
Relative Contributions to NHE By Source of Funds, 1999 to 2018 (in billions)



Note: First projected year is 2008

Source: Kaiser Family Foundation, Health Care Costs A Primer, March 2009.

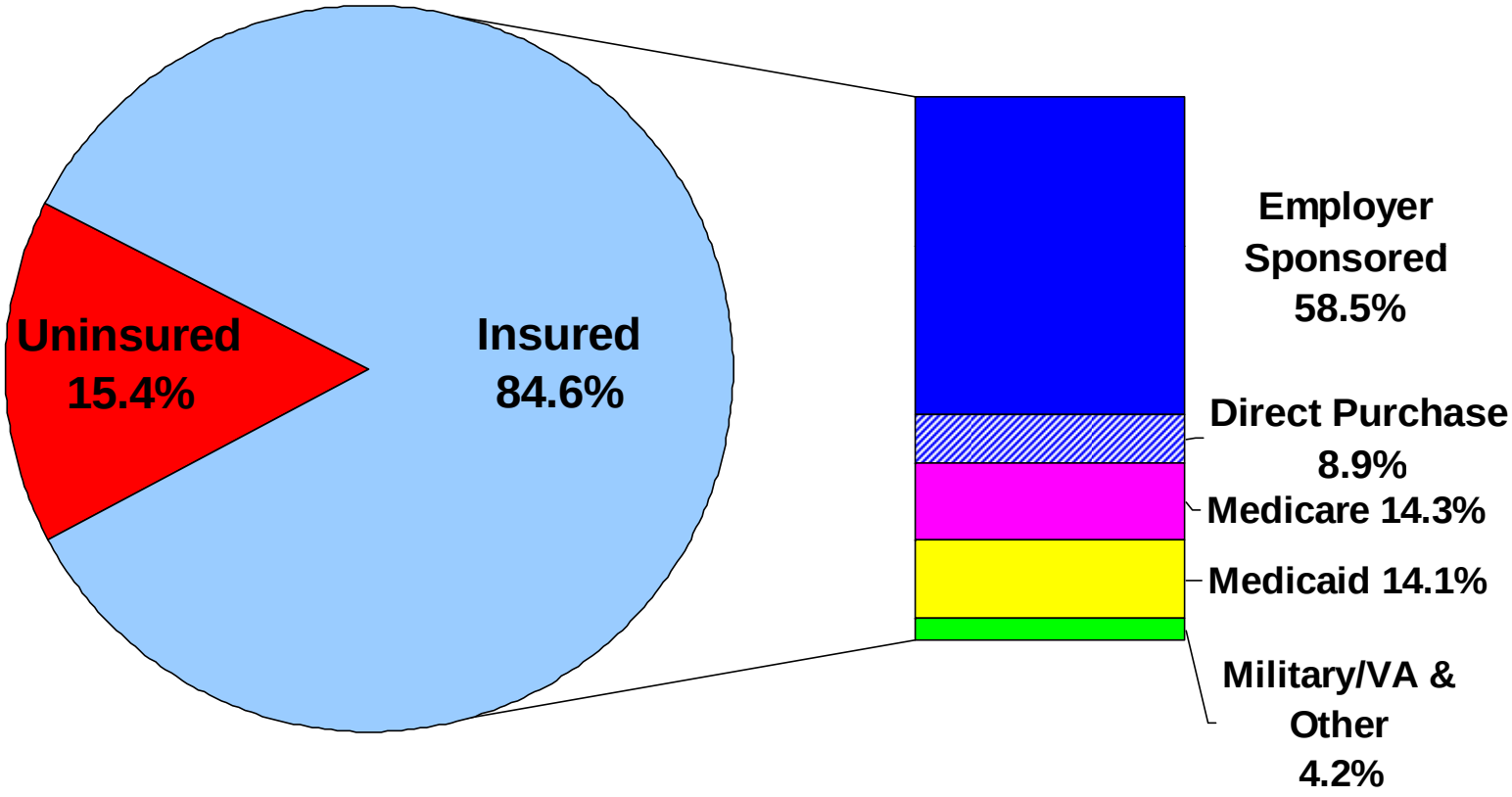
Cumulative Changes in Health Insurance Premiums, Inflation, and Workers' Earnings, 1999-2009



Note: Due to a change in methods, the cumulative changes in the average family premium are somewhat different from those reported in previous versions of the Kaiser/HRET Survey of Employer-Sponsored Health Benefits. See the Survey Design and Methods Section for more information, available at http://www.kff.org/insurance/7936/index.cfm.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2009; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2009 (April to April).

U.S. Health Care Coverage, 2008



Source: U.S. Census, "A Preliminary Evaluation of Health Insurance Coverage in the 2008 American Community Survey," September 22, 2009.

Federal Health Care Reform: Caveats

- Presentation today provides very high level overview
  - Many provisions will not be covered today
- Bills are a moving target
- Analyses are incomplete
  - Cost of many provisions not known or difficult to determine
  - To date, most analyses focus primarily on the impact on the federal level (deficit, spending, savings, number of people impacted, etc.)
  - Limited industry analyses available in public forum
- Analysis of impacts on state governments
  - Not comprehensive or detailed
  - Probably understate the financial impact on states
  - Provide some preliminary ballpark estimates

Federal Health Care Reform Legislation

- Three main authorizing Committee proposals to reform health care
- House: Affordable Health Care for America Act (H.R. 3962)
- Senate Finance Committee: America's Healthy Future Act (S. 1796)
- Senate Health, Education, Labor and Pensions (HELP) Committee: Affordable Health Choices Act (S. 1679)

Stated Goals of Reform Bills

- Affordability
  - Health insurance market reforms
  - Health insurance pooling mechanisms for the small business and individual market
  - Health insurance subsidies
    - Small businesses
    - Low-income citizens
- Access to coverage
  - Individual mandates
  - Employer mandates
  - Medicaid expansion for certain low-income citizens
- Contain costs and enhance quality
  - Medicare and Medicaid program reforms
- Public health and workforce development

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Health Insurance Market Reform

- Affordability is often measured by the ability of individuals to pay private health insurance premiums, copayments, and deductibles
- Health insurance market reforms targeted at small and individual (non-group) market reforms, but large group plans also affected
  - Coverage would be standardized, denying coverage or varying the premium on the basis of medical history would be prohibited, and insurers would have to accept all applicants
  - Rates could vary with age, but only by a prescribed ratio that is less than the expected age-related variation in claims
  - Certain percentage of premium dollars must be spent on medical care
- Insurance pooling mechanisms
  - Bills create national or state operated health insurance exchanges or gateways through which small businesses and certain individuals may purchase insurance
- Premium subsidies to small businesses to provide health insurance to their employees
  - Early implementation targets businesses with 50 or fewer employees
  - Subsidies in form of tax credits
- Premium subsidies to low-income individuals to purchase health insurance through exchanges or gateways
  - Individual or family income up to 400% of the federal poverty level (FPL) -- 100% FPL is $18,310 for a family of 3 in 2009
  - Subsidies on a sliding scale

Access Issues

- Access is typically defined by the ability to obtain needed health care in a timely manner
- Bills largely define access in terms of access to health insurance for all through a combination of insurance subsidies as mentioned earlier, mandates on health insurance coverage, and Medicaid expansions
- Employer mandates “play or pay”
  - Must contribute to employee premium costs at a certain level or
  - Must pay fee or payroll percentage for employee’s coverage purchased through the exchange or gateway
  - Must auto-enroll employees in plans unless employee opts out
  - Exemptions apply to small businesses
- Individual mandates
  - Must have “acceptable” or “qualifying” coverage or
  - Must pay penalty
  - Exemptions for financial hardship, religious objections, Native Americans

Medicaid Expansion

- Currently Medicaid eligibility is determined by income and resource limits that vary among selected low-income groups
  - Income is measured as a percentage of the federal poverty level (currently $18,310 for a family of 3)
- Health care reform legislation increases in Medicaid eligibility for children, parents, childless adults who are not disabled, and non-institutionalized aged and disabled individuals
  - House and Senate HELP expand eligibility to 150% of federal poverty level (FPL)
  - Senate Finance bill expands eligibility to 133% FPL and allows individuals with income above 100% FPL to enroll in health plans through the exchange
  - No resource test
- Additional eligibility requirements
  - Maintenance of effort (MOE) for children in Medicaid
  - Coverage of newborns up to 2 months who are uninsured
  - Mandates certain level of coverage and certain benefits for new groups
- Increase the federal medical assistance percentage (FMAP) for newly eligible groups
  - House FMAP is 100% in 2013 and 2014; 91% for years 2015-2019
  - Senate Finance FMAP increases by 37.3% beginning in 2014, declining by 1% each year through 2019
    - States that have already expanded Medicaid receive FMAP increase of 27.3%, increasing by 1% each year through 2019
    - 1% increase in FMAP for certain preventive services
    - Provides 0.15% increase in Medicaid FMAP for existing enrollees effective 2014
- FMAP increase provided in the federal stimulus legislation (ARRA) is extended in House bill for 6 months from January through June, 2011

Children's Health Insurance Program

- House bill repeals Children's Health Insurance Program (CHIP)
  - Eligible children in families with incomes from 100%-150% FPL transitioned to Medicaid
  - Children in families with incomes above 150% FPL covered through exchange beginning in 2014
  - MOE on eligibility for children in CHIP and Medicaid, based on June 16, 2009 levels
- Senate Finance bill maintains CHIP until 2019
  - Benefits and cost sharing continue as is
  - Effective 2014, states receive 23% increase in CHIP federal match rate, capped at 100%
  - CHIP-eligible kids not able to enroll due to enrollment caps are eligible for tax credits in Exchange

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Financing Mechanisms

- Reform is financed through tax increases and spending reductions in the Medicare and Medicaid programs
- Taxes or surcharges
  - Additional tax on high income taxpayers ($500,000 single / $1 million married filing jointly)
  - Excise taxes on
    - High cost health plans and fully insured plans
    - Branded prescription drugs
    - Medical devices
    - Durable medical equipment
  - Taxes individuals without qualifying health coverage

Financing Mechanisms

- Other tax code changes
  - Eliminates employer deduction for retiree expenses related to Medicare Part D subsidy
  - Eliminates nontaxable reimbursements of over-the-counter drugs from health savings accounts (HSAs) and flexible spending accounts (FSAs)
  - Increases penalty for non-health related distributions from HSAs from 10% to 20%
  - Reduces the pre-tax contributions to FSAs, capping contributions at $2,500
    - Currently, FSA contributions capped at $5,000 for State employees
    - 11,503 employees had contributions in FY 2009
  - Raises the 7.5% AGI floor on the medical expense deduction to 10% for people under age 65

Medicare and Medicaid Reform

- Payment reductions for Medicare Advantage plans and most providers, except primary care physicians
  - Reduces payments for preventable hospital readmissions in Medicare
  - Prohibits federal Medicaid payments to states for services related to health care acquired conditions
- Reduces Hospital Disproportionate Share payments under Medicare and Medicaid
- Payment changes for the Medicare Part D prescription drug program
  - Requires Secretary of Health and Human Services to negotiate drug prices with pharmacy manufacturers for Medicare Part D plans
  - Requires drug rebates for individuals that are dually eligible for Medicaid and Medicare in Part D plan
  - Reduces Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple
- Increases Medicaid drug rebate percentage and extends to drug rebates to Medicaid managed care plans

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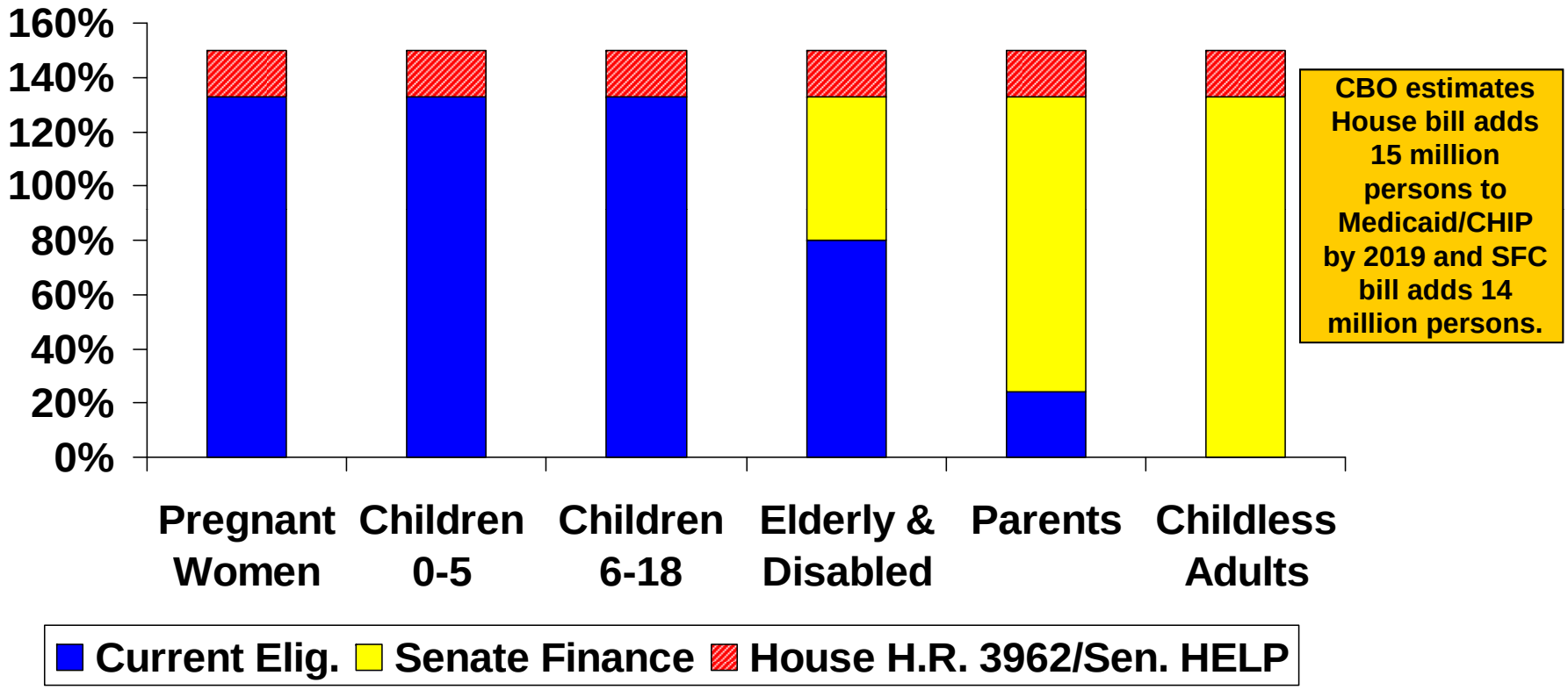
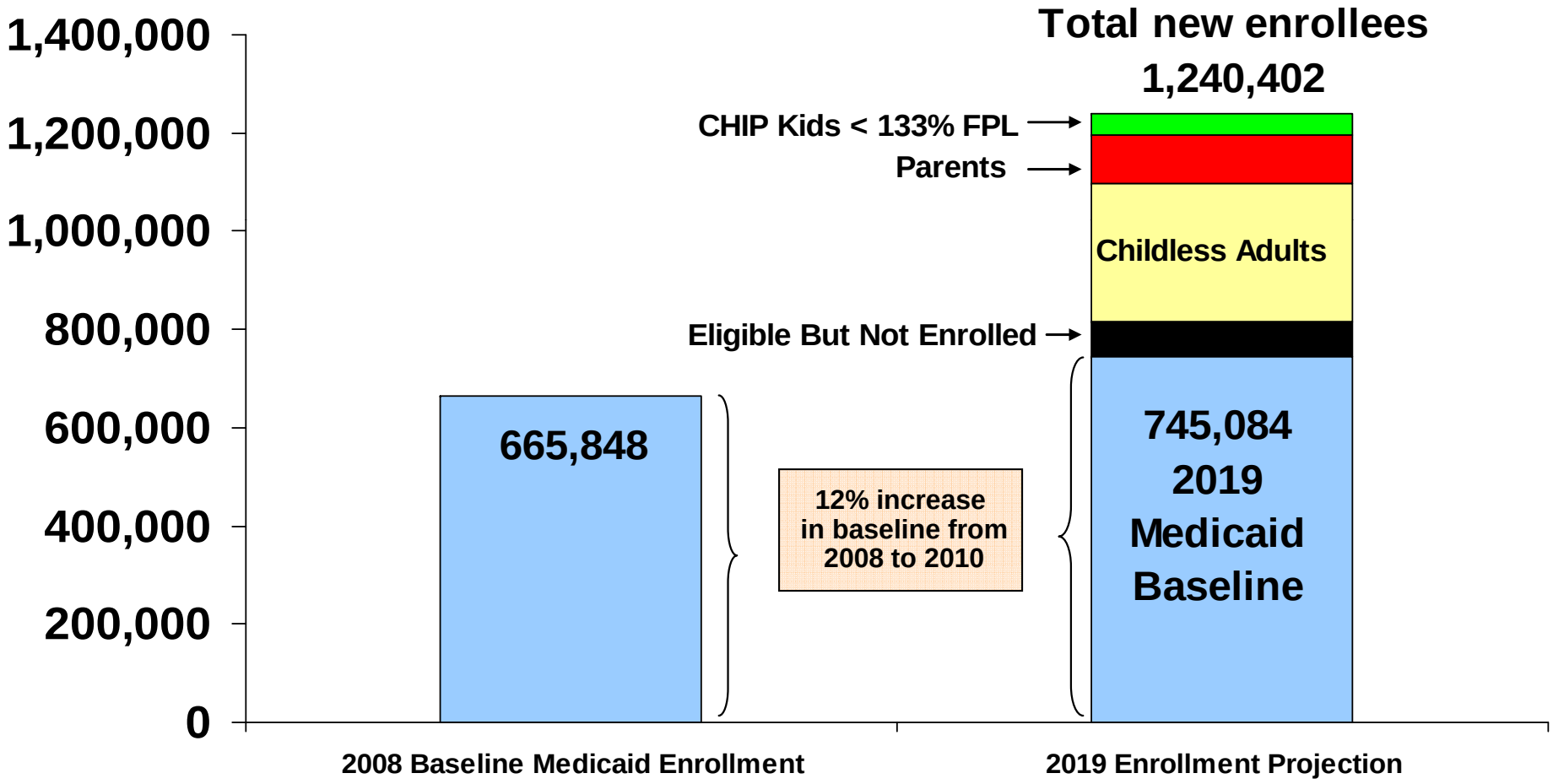
Medicaid Expansions Compared to Current Virginia Eligibility Levels



Source: DMAS Presentation to Senate Finance Committee, October 22, 2009; The Henry J. Kaiser Family Foundation, Summary of Reform Proposals, updated November 3, 2009; NASMD, Sept. 16, 2009 Summary

Estimated Impact on Virginia's Medicaid Program to Expand to 133% of FPL



Source: The Lewin Group Analysis of S.1796 impact on states for the National Governors Association, October 6, 2009..

Projected Impact on State Medicaid and CHIP Spending Under Senate Finance Bill (S. 1796)

($ in millions)

Medicaid Expansion to 133% FPL	2014	2015	2016	2017	2018	2019
Newly eligible adults	$75.6	$197.1	$252.1	$288.9	$329.5	$374.4
Previously eligible and newly enrolled	$22.4	$54.0	$64.4	$69.1	$74.1	$79.4
CHIP children below 133% FPL moved to Medicaid	$11.2	$12.0	$12.9	$13.8	$14.7	$15.7
Estimated Total Impact	**$109.2**	**$263.1**	**$329.4**	**$371.8**	**$418.3**	**$469.5**
FMAP for Newly Eligible	87.3%	86.3%	85.3%	84.3%	83.3%	82.3%

Note: Estimates reflect only Medicaid expansion provisions in the bill. Does not include any offset for potential savings from other provisions contained in the bill such as, prescription drug cost savings.
Source: The Lewin Group Analysis of S.1796 impact on states for the National Governors Association, October 6, 2009.

Preliminary Cost Estimates for Virginia May Be Low

- Assumes baseline growth of Medicaid of 12% from 2008 to 2019
  - Historical growth over past 12 years was 24% with several years of contracted growth due to the impact of welfare reform on Medicaid eligibility
- Estimate assumes that only 60% of those eligible will enroll, despite mandate to be covered
  - Centers for Medicare and Medicaid Services (CMS) Chief Actuary predicts a "woodworking" effect will take place
    - More enrollments of persons previously eligible as a result of publicity, enrollment assistance through the health insurance exchange and reduced stigma associated with federal assistance for health care
- Does not account for impact of additional program requirements beyond eligibility expansions
  - CMS estimates an impact of $78 billion on federal expenditures from the years 2010-2019
- May not accurately reflect health care cost increases per enrollee over time

Other Medicaid Impacts on Virginia

- Requirements related to Medicaid payments
  - Assurance of Medicaid payment adequacy
  - Medicaid payments for primary care must equal Medicare payment levels by 2012
    - Virginia currently reimburses about 84.7% of Medicare for primary care
  - Prohibits federal reimbursement to states for services for health care acquired conditions
  - Reduces Medicaid DSH payments
    - Greatest impact state teaching hospitals
  - Higher FMAP rates generally will not apply to those currently eligible for Medicaid but not enrolled, even though there is an expectation that this population will grow
- Requirements to cover certain services
  - Prescriptions drugs (currently optional service)
  - Prevention services without cost sharing
  - Tobacco cessation products
  - Adult day health care services
  - Non-emergency transportation to medically necessary services
- Includes state options to extend coverage for services and certain individuals

Other State Impacts

- States employee health care plans required to comply with employer coverage and participation requirements in House bill or risk losing federal public health funding
  - States must assure that all political subdivisions also comply
- State spending for employee benefits
  - Estimated to increase to cover cost of covering workers who do not now have coverage or pay the penalty for uninsured workers
  - House bill prohibits post-retirement reductions in retiree health benefits
  - Additional reporting on health care coverage and participation requirements
- State administered exchanges could receive start-up funds, but must become self-sustaining
- State savings could be achieved through reducing state funds for safety net programs serving the uninsured
  - Indigent care funding at state teaching hospitals totals $109.5 million GF in FY 2010
  - FY 2010 funding for safety net health care programs totals $12.0 million GF
- Impact of tax code changes on Virginia taxpayers?
- Impact of the cost of administering insurance reforms?

Will Legislation Reform Health Care?

- Biggest issue remains, will reforms bend the cost curve and slow health care expenditures?
  - Criticisms have emerged that the legislation does not fully address the drivers of health care costs
    - How health care decisions are made (doctors, patients)
    - How market share drives costs and quality
    - Individual choices and responsibility
  - The Chief Actuary for the Centers for Medicare and Medicaid Actuary issued a report dated November 13, 2009 that states

    "…we estimate that most of the provisions of H.R. 3962 that were designed, in part, to reduce the rate of growth in health care costs would have a relatively small savings impact."
- Unclear how the insurance market reforms will ensure affordability
  - Insurance industry analysis looked at four provisions in SFC bill (S. 1796) related to insurance market reforms, weak coverage requirements, tax on high cost health plans, cost shifting from Medicare cuts and health sector taxes
  - Findings from analysis indicated that private health insurance coverage will increase
    - 49% increase for the individual (non-group) market
    - 28% increase for small employers (50 or fewer employees)
    - 11% increase for large employers
    - 9% increase for self-insured employers
  - Analysis criticized for not accounting for impact of new subsidies on the net insurance cost to households and other provisions which could potentially lower costs over the long term

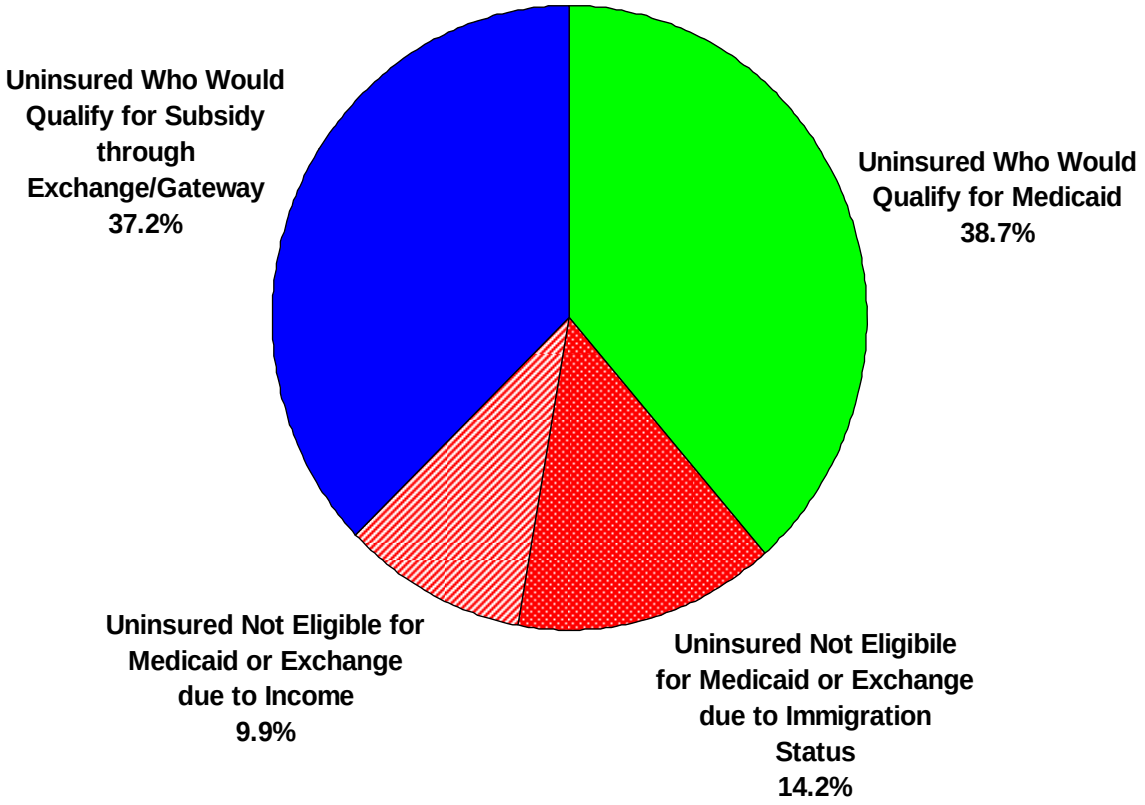
Will Legislation Reform Health Care?

- Medicare and Medicaid payment changes do not address the impact of cost shifting on private payers
  - Payments to most providers in Medicare will be reduced
  - Medicaid payments historically lower than Medicare and private payers
  - Some experts refute cost shifting as a major contributor to health system costs
  - One study indicates that 15% of the amount spent by commercial payers on hospital and physician payments is attributable to cost shifts by the Medicare and Medicaid programs
- Reforms focused on increasing value and quality of delivered health care focus primarily on the Medicare program, but may have broader application, though impact is unclear
- Payment reforms such as payments per episode, sharing of cost savings with accountable care organizations, and establishing medical homes hold promise, but impacts are still unclear as many are on a pilot basis

How Does Health Care Reform Affect Uninsured Numbers?

- CBO estimates 94% to 96% of population will be covered by 2019
- Estimates on the number of uninsured who will not be covered by either Medicaid or Exchange/ Gateway vary from 24% to 40% by 2019

Coverage of Uninsured Nonelderly Under Health Care Reform



Source: Urban Institute, "How Will the Uninsured Be Affected by Health Reform," Non-elderly Uninsured, Timely Analysis of Immediate Health Policy Issues, August 2009.