

Federal health reform: How will it impact states?

Debate in U.S. capital will shape health policy in Midwest

by Kathryn Tormey (ktormey@csg.org)



The U.S. Congress is currently considering several proposals that would overhaul the nation's health care system. While the bills differ in their methods of reform, they would all have a significant impact on state health policy.

The Midwestern Office of the Council of State Governments supports several groups of state officials, including the Midwestern Governors Association and the Midwestern Legislative Conference, an association of all legislators in the region's 11 states. The Canadian provinces of Manitoba, Ontario and Saskatchewan are affiliate members of the MLC.

As the health care reform debate heats up on Capitol Hill, Americans have many questions about a new national health care system, such as “How much will it cost?,” “Will I have to change my insurance plan?” and “Will I be able to keep my doctor?”

Policymakers, too, have questions — particularly about how federal reforms would affect their states' finances, which are already being stretched to the limit.

This year, overall U.S. spending on health care is expected to reach \$2.5 trillion, or 17.6 percent of the gross domestic product.

States have felt the pinch of the rising cost of health care, particularly due to mounting spending pressures in their Medicaid budgets.

In fiscal year 2007, Medicaid accounted for \$137 billion in state spending — about 21 percent of total state expenditures, according to the National Association of State Budget Officers. Over the next 10 years, total state Medicaid expenditures are estimated to more than double, to \$290 billion, according to the U.S. Centers for Medicare & Medicaid Services.

But costs aren't the only challenge faced in this nation's health care system.

Despite state efforts to increase insurance coverage, nearly 47 million people are uninsured in the United States. There are about 6.4 million uninsured people living in the Midwest, where states' uninsured rates range from a high of 13.2 percent in Illinois to a low of 8.5 percent in Minnesota.

Along with the uninsured, there is the problem of the nation's “underinsured.” About

half of Americans say they have put off medical care sometime in the last year because of concerns about the cost, according to the Kaiser Family Foundation.

Along with threatening access to care, rising health care costs also could have a devastating impact on an already struggling economy.

A National Coalition on Health Care report found, for example, that without any changes to the current system, 178,000 small-business jobs would be lost by 2018 as a result of health care costs.

But while it has become clear that the system is in need of improvement, how national reform will be achieved is still under debate.

As of early October, the U.S. Congress was considering several different proposals.

Inside, we highlight how these proposals could impact states. We do so by looking at components of two bills that were making their way through Congress as of early October: HR 3200, which has been approved by several House committees, and a bill being developed by the Senate Finance Committee — also known as the “Baucus bill,” named after its chief author, Sen. Max Baucus of Montana.

State policymakers are closely watching the debate to see how federal reforms will impact their budgets and health care systems.

If the federal government expands the reach of Medicaid, for example (which all the major congressional proposals do), states will be impacted. Likewise, the proposed new health insurance exchanges could affect state health policy and insurance regulations. ★

Eye on the bottom line

Federal proposals to expand Medicaid, revamp health insurance markets could have significant policy and budgetary implications for states

by Kathryn Tormey (ktormey@csg.org)

In the eyes of state officials, perhaps the most consequential element of the current federal proposals is a possible expansion of Medicaid, the health program that provides insurance for 58 million people and that is funded jointly by the states and the federal government.

In order to receive federal financial support for Medicaid, states are required to provide coverage for certain groups of low-income people, such as families with children, people with disabilities, the elderly, and pregnant women.

Beyond the federal government's broad eligibility criteria, though, states are given flexibility to shape their own programs. They determine who qualifies for the program (states set different income thresholds, for example), design their own benefit packages and set payment levels for providers.

This flexibility also allows states to expand coverage to additional groups of people — through waivers and state plan amendments (which are financed in part by the federal government) or through separate programs funded solely by the state. For example, although the federal government requires states to cover pregnant women who earn up to 133 percent of the federal poverty level, nine Midwestern states offer coverage to women with higher incomes (see table on back page).

But there are also certain low-income populations that many state Medicaid programs currently don't cover.

All of the proposals under serious consideration in the U.S. Congress would require states to expand Medicaid eligibility to *all* people with incomes below a certain income level. As of early October, the bills set this new threshold at either 133 percent or 150 percent of the federal poverty level.

States already cover most children in these income categories through Medicaid or the State Children's Health Insurance Program (another state-federal partnership).

But they don't necessarily cover the parents of these low-income children; under the proposed Medicaid expansions in the federal reform proposals, states would be required to cover all parents who meet the new income-eligibility threshold.

Another group that would be added to Medicaid rolls is low-income, non-disabled, childless adults, who have historically not received health insurance from Medicaid. More than half of the states don't cover these individuals at all, due in part to the fact that the federal government does not usually provide Medicaid matching funds to cover adults without dependents.

A handful of states, however, have expanded coverage to this population by obtaining federal waivers and/or creating state-funded programs. Nineteen states — including **INDIANA**, **IOWA**, **MICHIGAN**, **MINNESOTA** and **WISCONSIN** — offer coverage to

childless adults, though in most states it is less comprehensive than that offered through Medicaid.

Minnesota's program is completely state-funded; the other three Midwestern states' programs are partially funded by the federal government through waivers, according to the Kaiser Family Foundation. The seven other states in the Midwest do not provide Medicaid coverage to low-income, non-disabled, childless adults. The federal proposals would require all states to do so.

Proponents of this Medicaid expansion say it would significantly reduce the nation's number of uninsured people. According to Kaiser, more than 20 percent of adults without dependents are uninsured, and 43 percent of adults living under 133 percent of the poverty level are uninsured.

The Congressional Budget Office estimates that if Medicaid eligibility were expanded to 133 percent of the federal poverty level, there would be roughly 11 million more Medicaid enrollees than is projected under current law.

But will states have to foot part of the bill for this expansion, either now or in the future?

This is a critical question for policymakers, particularly at a time when Medicaid budgets are already being pinched as a result of the economic downturn. States, then, have a keen interest in making sure that any final congressional bill adequately funds any Medicaid expansion.

Potential fiscal impact on Midwestern states

In exchange for expanding Medicaid coverage, states will receive some additional federal funding to support the expanded programs. But how much states will be expected to contribute to a Medicaid expansion — and for how long — remains a concern for policymakers.

For example, states currently set varying income thresholds for parents to qualify for Medicaid. But if federal law mandated coverage for everyone under 133 percent of poverty, Midwestern states would face a variety of changes to their programs.

Medicaid programs in eight Midwestern states currently cover parents — both working and unemployed — at income levels ranging from 20 percent to 90 percent of the federal poverty level (see table on back page).

Under the proposed federal reforms, these states would be required to increase eligibility for this population.

HR 3200, which had been approved by several House committees as of early October, would cover 100 percent of the states' cost to expand Medicaid through 2014. After that date, states would have to pay 10 percent of the cost to cover the newly eligible enrollees.

However, a preliminary analysis done by the CBO on the full impact of HR 3200 found that the bill would actually reduce state spending on Medicaid by \$10 billion between 2010 and 2019.

The Senate Finance Committee bill, as written in early October, would take a different approach. It would increase the states' federal medical assistance percentages (FMAPs), or the share of Medicaid that the federal government agrees to pay, for the newly eligible population. States could receive an FMAP increase of up to 37.3 percentage points to cover the expanded population.

As a result, under the bill, the federal government would cover anywhere from 77 to 95 percent of the cost of the Medicaid expansion, with the rates varying from state to state.

The CBO has estimated that the bill would result in a \$33 billion increase in state spending from 2010 to 2019.

Some state Medicaid programs already cover some or all of the populations that they would be required to insure under the federal proposals for health care reform. States will not receive additional federal funds for maintaining their current level of coverage. Instead, the federal money would be used to help in cases where states must expand eligibility in order to comply with the new federal requirements.

There also are states that have already expanded their Medicaid programs to cover populations above and beyond the income requirements proposed in the federal legislation.

For example, **ILLINOIS**, Minnesota and Wisconsin have expanded Medicaid to cover parents with incomes higher than 133 percent of the federal poverty level (at 185 percent, 200 percent and 275 percent, respectively).

A key question for these states is whether they will be required to maintain their more-generous eligibility levels, either permanently or for a set period of time, in order to receive an increase in federal Medicaid funding.

The Senate Finance bill (as written in early October) included such a "maintenance of effort" provision, but it would expire in 2013, when the Medicaid expansion to 133 percent of the federal poverty level would begin.

The bill would create a category called "expansion states," those that have already increased coverage above 100 percent of the federal poverty level for parents and childless adults, regardless of their employment status (Minnesota and Wisconsin would qualify).

These states would initially receive a smaller FMAP increase (27.3 percentage points), whereas other states would receive an increase of 37.3 percentage points to pay for the expansion (see table for current FMAPs).

Those rates would equalize over time, and would be 32.3 percentage points higher than current FMAPs by 2019.

"High-need" states — those with high unemployment rates and that are expected to see a large increase in enrollees after the Medicaid expansion takes effect — would receive 100 percent federal funding for five years. As of early October, Michigan, Nevada, Oregon and Rhode Island would qualify.

Under HR 3200, states would have to keep current eligibility levels under a permanent maintenance-of-effort provision. However, the bill also has a provision to provide some assistance to states that have already expanded coverage to people above

133 percent of the federal poverty level.

If state programs had originally expanded coverage through the use of federal waivers, the federal government would take on the full cost of coverage for Medicaid enrollees up to 133 percent of poverty. These states would then only share the costs of covering enrollees above 133 percent of the poverty level — under a traditional FMAP.

Bills would create new insurance regulations

As of early October, all bills being seriously considered in Congress included a mandate that individuals purchase health insurance. Under the proposals, low- and moderate-income individuals would be offered subsidies to help pay for the insurance. The bills also would require employers to help provide coverage for their workers or pay a penalty (with exceptions for certain small businesses).

Each of the major federal bills also would create health insurance exchanges, which would help consumers and small businesses shop for coverage. The proposals, however, set out varying roles and requirements for states.

Under both the House and Senate proposals being considered in early October, states would be required to enforce new federal insurance-market regulations. These new requirements may be more stringent than what most states currently impose.

All new health insurance policies would have to meet certain criteria, including "guaranteed issue" (prohibiting insurers from denying coverage based on a person's health status), modified community rating (prohibiting insurers from charging people more based on their health status), and minimum coverage standards. Currently, only six states (none in the Midwest) have laws requiring guaranteed issue for all insurance products.

The exchanges would offer plans in several categories, based on the level of benefits offered. The exchanges would be required to maintain Web sites and customer service hot lines.

Under the Senate Finance Committee bill, the exchanges would be state-based. States would have to adopt new insurance regulations in the individual and small-group markets and in the exchanges. States could, however, impose more-stringent regulations on the insurance policies sold within their borders.

As of early October, the Senate Finance bill specified that states would be provided with funding to launch the exchanges, but details were not included.

The House bill proposes a much smaller role for the states. It would create a national health connector that would allow people throughout the country to choose from the same health plans. The connector would virtually eliminate state-based individual insurance markets, but states would be responsible for implementing reforms of the small-group insurance market.

Another idea being considered by Congress is to authorize states to create regional health exchanges. These systems would allow states to pool the costs of administering the exchanges and give them more bargaining power with insurance companies. The ability for states to create regional health exchanges was included in the Senate Health, Education, Labor and Pensions Committee bill being considered in early October. ★

Medicaid eligibility levels (as a percentage of poverty level) and federal matching rates in Midwestern states

State	Pregnant women	Jobless parents	Working parents	Infants	Children ages 1-5	Children ages 6-19	SCHIP ¹	FMAP ²
Illinois	200%	185%	185%	200%	133%	133%	200%	50.0%
Indiana	200%	20%	26%	200%	150%	150%	250%	62.7%
Iowa	200%	29%	86%	200%	133%	133%	200%	61.7%
Kansas	150%	27%	34%	150%	133%	100%	200%	59.4%
Michigan	185%	39%	66%	185%	150%	150%	200%	58.1%
Minnesota	275%	275%	275%	280%	275%	275%	**	50.0%
Nebraska	185%	46%	58%	185%	185%	185%	**	58.0%
North Dakota	133%	45%	62%	133%	133%	100%	150%	63.8%
Ohio	200%	90%	90%	200%	200%	200%	**	60.8%
South Dakota	133%	54%	54%	140%	140%	140%	200%	60.0%
Wisconsin	300%	200%	200%	300%	300%	300%	**	57.6%
<i>Federal minimum</i>	133%	*	*	133%	133%	100%	N/A	50%

¹ Through the State Children's Health Insurance Program (SCHIP), a federal-state partnership, states can offer coverage to children in families whose incomes are too high to qualify them for Medicaid.

² The Federal Medical Assistance Percentage (FMAP) is the matching rate for federal funding of Medicaid. These figures are for FY 2008 and do not reflect increases granted under the American Recovery and Reinvestment Act.

* The federal minimum for parents is set by reference to each state's 1996 welfare eligibility level, which is below the poverty level in every state and below 50 percent of poverty in many states.

** State does not have a separate SCHIP program.

Source: The Kaiser Family Foundation

SOURCE GUIDE

For more information on health care reform, please visit the following Web sites:

Alliance for Health Reform
www.allhealth.org

Congressional Budget Office
www.cbo.gov

The Council of State Governments: State News
www.csg.org/pubs/statenews/index.aspx

The Kaiser Family Foundation
<http://healthreform.kff.org>

National Coalition on Health Care
www.nchc.org

National Health Policy Forum
www.nhpf.org/hpessentials.cfm#healthreform

U.S. Department of Health & Human Services:
 Health Care Reform
www.healthreform.gov

RETURN SERVICE REQUESTED

NON-PROFIT ORG.
 U.S. POSTAGE PAID
 FREEPORT, IL
 PERMIT NO. 210



Firstline
 Midwest

October 2009
 The Council of State Governments
 Midwestern Office
 701 E. 22nd Street, Suite 110
 Lombard, IL 60148-5651
 Phone: 630/925-1922
 Fax: 630/925-1930
 E-mail: csgm@csg.org
www.csgmidwest.org