

Overview of the Affordable Care Act



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The Forum for America's Ideas



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States have been reforming

- 34 states had high-risk pools.
- 37 states had some requirement about covering young adult children on parental plans.
- Several states had premium assistance programs
- In 2009, 17 states had state tax credits for small employers to purchase health insurance.
- Many states expanded Medicaid beyond required levels
- Some states covered non-traditional populations (e.g., childless adults) through Medicaid waivers
- Massachusetts & Utah had insurance exchanges and Washington had enabling legislation to create one.



The Laws

- The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010.
- The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law on March 31, 2010 and amended some of the provisions of P.L. 111-148.
- The package is now referred to as..."The Affordable Care Act"



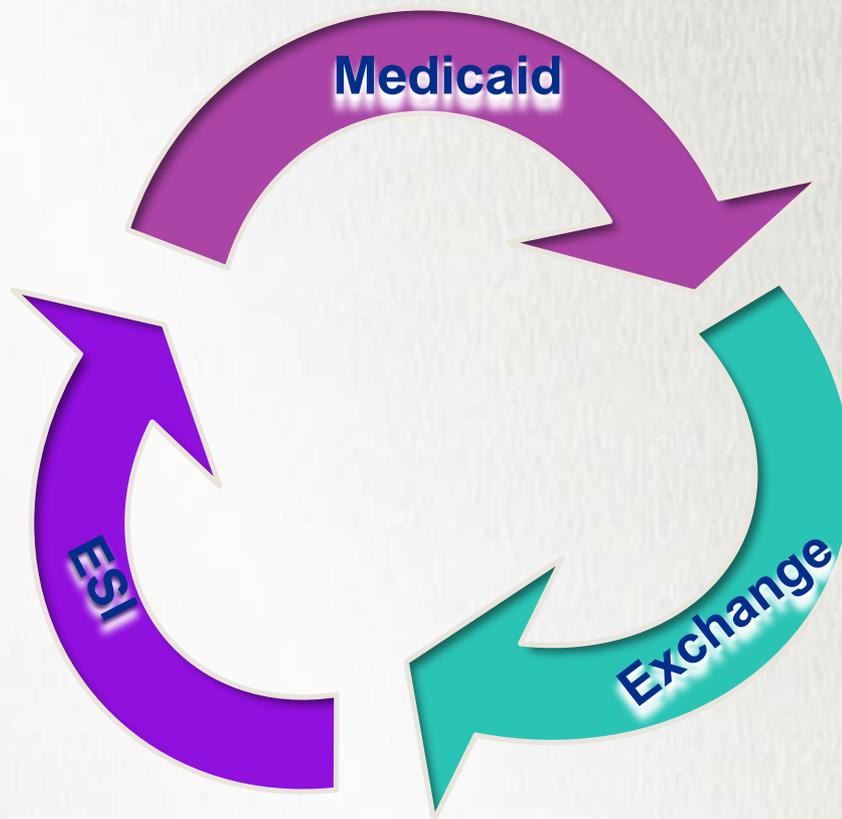
Access Key Provisions

- Maintains an employer-based system, with employer requirements
- Maintains private insurance market
- Requires most people to have insurance ("individual mandate")
- Creates temporary high-risk pools
- Requires creation of health insurance exchanges, with subsidies for many (up to 400% FPL)
- Expands Medicaid significantly (to 133% FPL)
- Requires plans to allow coverage for young adults on their parent's policy.
- Enacts health insurance reforms like no preexisting condition exclusions
- Establishes a long-term care program (CLASS) -- community living assistance



A system of coverage per CMS

- Creating a *system* of coverage across Medicaid/Exchange/ESI
- Make “No Wrong Door” a reality





Employer Responsibility

- Employers with >50 employees that don't offer affordable coverage will face penalties of up to \$2,000 per full-time worker/year beginning in 2014
- Small employers with <50 employees will be exempt from penalties
- Tax credits available for some small businesses that offer health benefits (more on this later)



Individual Responsibility (Mandate)

- Most people must have health insurance, beginning in 2014.
- Penalty for those who do not have coverage--greater of:
 - A flat fee \$95 in 2014; \$325 in 2015; and \$695 in 2016 OR the following percent of the excess household income above the threshold amount required to file a tax return--1% of income in 2014; 2% of income in 2015; 2.5% of income in 2016+
- Exceptions:
 - Financial hardship (if the cost exceeds 8% of income)
 - Religious objections
 - American Indians
 - People uninsured for less than 3 months
 - People with incomes below the tax filing threshold.



Insurance Reforms- Now (2010)

- Established temporary high risk pool
- Extends coverage for young people up to 26th year through parents' insurance
- Establishes a new, independent patient appeals process
- Prohibits plans from imposing pre-existing condition exclusions on children
- Prohibits plans from imposing lifetime limits on coverage
- Eliminates co-payments and deductibles for preventive care under new private plans
- Prohibits insurance discrimination based on salary
- States complete needs assessment for at-risk communities



Health Insurance Reforms - Later

- Prohibition on preexisting condition exclusions for everyone
- Guaranteed issue/Guaranteed renewal
- Premium rating rules
- Non-discrimination in benefits
- Mental health and substance abuse services parity
- Prohibits discrimination based on health status
- Prohibits annual and lifetime caps



State Grants - Rate Review

- Secretary Sebelius announced the availability of \$51 million in Health Insurance Premium Review Grants on June 7, 2010. These funds are the first round of grants available to states through a new \$250 million grant program to create and strengthen insurance rate review processes.
- All states and the District of Columbia are eligible for the first round of rate review grants.
- To receive a grant, a state must submit a plan for how it will use grant funds to develop or enhance its process of reviewing and approving, disapproving, or modifying health insurance premium requests.
- Montana received a \$1 million grant.



Medical Loss Ratio

- Large group plans that fail to have a medical loss ratio (MLR) of 85 percent and individual and small group plans that fail to have a MLR or 80% by January 1, 2011, will be required to provide rebates to plan participants.
- HHS is authorized to adjust these rates to avoid market destabilization.
- HHS is working closely with the National Association of Insurance Commissioners (NAIC) and other stakeholders to develop a plan.



CLASS Act

- Creates a new national insurance program, Community Living Assistance Supports and Services (CLASS), to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.
- Financed through *voluntary* payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to people with disabilities of any age.
- Could result in Medicaid savings.
- Controversial



Maternal & Child Health

- Maternal, Infant, and Early Childhood Home Visiting Programs
 - Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s).
 - Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.
 - Establishes competitive grants appropriated at \$100 million in 2010, \$250 million in 2011, \$350 million in 2012, \$400 million in 2013 & 2014
 - A maintenance of effort (MOE) applies and prohibits grants from supplanting existing funding for these services.
 - First grants were awarded on July 21, 2010 to 49 states, the District of Columbia, and five territories.



Other Provisions of Note

- Grants to Support School-Based Health Clinics
- Increased Community Health Center Funding
- National Health Service Corps Improvements
- Workforce Grants/Initiatives
- Public Health Initiatives
- Medicare Improvements for Rural Areas
- Medicare Rate Improvements/Medicare Rate Reductions
- Indian Health Service Reauthorization
- Menu labeling for chain restaurants
- Medical home demonstration project
- Data collection to improve disparities in health

Health Benefit/Insurance Exchanges



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What is an Exchange?

- It is a marketplace for health insurance.
- Provides a set of coverage options for individuals and small businesses with more transparency than currently exists today.
- It is a vehicle for administering the new federal tax credits for certain people that don't have coverage through their employer.
- It is an enrollment "facilitator" for public programs such as Medicaid and CHIP.



Health Insurance Exchanges

- Every state must have Exchange(s) for individuals and small businesses (up to 100 employees), effective Jan. 1, 2014; May open to large employers effective January 1, 2017; or "alternative" program.
- Flexibility in determining if the state will create an exchange (feds will run it, if not), who will govern it, and how it will be structured.
- Exchange plans must cover at least 60% of service costs: varies based on bronze [60%], silver [70%], gold [80%] or platinum [90%]
- NAIC released model legislation and HHS released initial guidance



Health Insurance Exchanges

Requires the Secretary to:

- Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
- Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange's Internet portal.
- Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.



Health Insurance Exchanges

- State Planning and Implementation Grants
 - Requires the Secretary to award grants, available 3/23/2011 until 2015, to states for planning and establishment of American Health Benefit Exchanges.
 - 48 states received planning grants (\$1 million granted to Montana)
 - Implementation grants will be awarded Spring 2011
- States must declare intention to administer the exchange or to permit the federal fall-back by the end of 2012.



What will the exchange do:

At a minimum, an Exchange must:

- Provide “Essential Health Benefits” (e.g., maternity, newborn care & pediatric; mental health & substance abuse services)
- Implement procedures for certification, recertification, and decertification of health plans.
- Operate toll-free hotline.
- Maintain Internet website with standardized info.
- Assign a rating to each plan.
- Utilize standardized format for presenting options.
- Inform individuals of eligibility for Medicaid, CHIP or other applicable state or local public programs.

Source: Brian Webb, NAIC, presentation at NCSL's Fall Forum Dec. 2010.



What will the exchange do?(continued)

- Make available a calculator to determine the actual cost of coverage after subsidies.
- Grant a certification attesting that the individual is not subject to the coverage mandate because:
 - there is no affordable option available, or
 - the individual is exempt from the mandate
- Transfer to the Treasury a list of exempt individuals and employees eligible for tax credit.
- Provide to each employer the name of employees eligible for tax credit.
- Establish a Navigator program.

Source: Brian Webb, NAIC, presentation at NCSL's Fall Forum Dec. 2010.



Some Considerations for establishing an Exchange

- Should the state establish an exchange? Does it have the capacity to establish, operate and sustain an exchange? What are the pros and cons of allowing the federal government to set up the exchange?
- What legislation or regulations are needed to create, implement and administer the exchange?
- How will the exchange be governed and administered, by a government agency or a nonprofit organization?
- Who will pay for it?
- What data are needed to make policy decisions regarding the exchange, and who will collect it?



Some Considerations for establishing an Exchange (cont.)

- Will the exchange have additional functions beyond the "minimum?"
- How will the state make the exchange “interoperable” with the Medicaid program?
- What is the role of agents?
- What about state-mandated benefits?
 - States may mandate benefits not in the essential benefits package but would have to pay for those benefits outside the core package on behalf of individuals receiving premium subsidies.



Federal Tax Credits and Subsidies

- Tax credits for families with income between 133% poverty level (\$29,326 family of 4) and 400% (\$88,200 family of 4)
- Sliding scale: limit premium costs to between 2% of income for up to 133% of the FPL and 9.5% for those between 300-400% of FPL.
- Limit out-of-pocket spending for people with incomes between 100%-400% of FPL.



Who gets the tax credits or subsidies?

- Individual who:
- are citizens of the U.S.
- are not enrolled under an exchange plan as an employee or dependent
- have a MAGI of less than 400% of the FPL [\$43,000 for an individual or \$88,000 for a family of four],
- are not eligible for Medicaid,
- are not enrolled in an employer's qualified health benefit plan, a grandfathered plan (group or nongroup), Medicare, Medicaid, military or veterans' coverage or other coverage, and
- are not a full-time employee in a firm where the employer offers health insurance and makes the required contribution toward that coverage.



Small Business Tax Credit

- Businesses with less than 25 FTE (some businesses who employ more than 25 employees will qualify) and average annual wages less than \$50K per employee will qualify beginning with amounts paid after Dec 31, 2009.
- The maximum credit will be available to employers with 10 or fewer full-time equivalent employees and average annual wages of less than \$25,000.
- To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost.
- Businesses that receive state health care tax credits may also qualify for the federal tax credit. (Insure Montana provides a refundable state income tax credit to small employers.)
- Dental and vision care qualify for the credit as well.



Small Business Tax Credit cont.

2010 - 2013

- For 2010 through 2013, eligible employers will receive a small business credit for up to 35 percent of their contribution toward the employee's health insurance premium.
- Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution.

2014 and thereafter

- For 2014 and beyond, small employers who purchase coverage through the new Health Insurance Exchanges can receive a tax credit for two years of up to 50 percent of their contribution.
- Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.



Various Structure Options: Some Comparisons of MA and UT

Massachusetts

- Multiple employers can contribute
- Offers a choice of 6 plans in the exchange
- Governed by a board , who determines which plans are included in the exchange

Utah

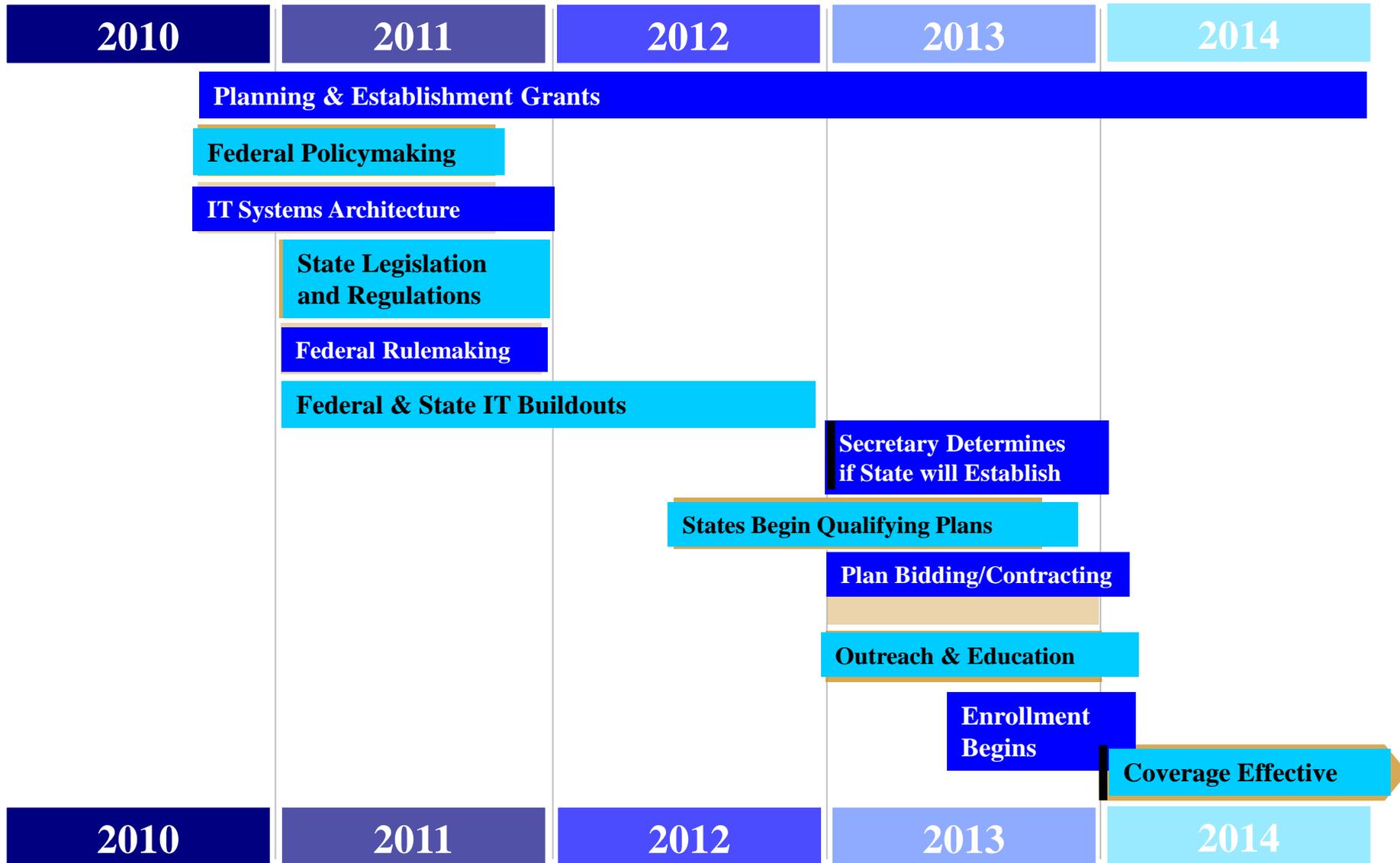
- Allows employees of small employers to compare, select, and enroll in commercial health insurance through an entirely online, internet-based process, large employers are included on a pilot basis
- 146 plans included in the exchange
- Administered and facilitated by the Office of Consumer Health Services.
- Allows employers to determine their contribution levels (a defined contribution arrangement)



State Experiences

- California passed legislation in 2010 creating the California Health Benefit Exchange
- Massachusetts and Utah have existing exchanges
 - Utah - free market exchange with an open door for insurance plans and currently no significant regulatory role.
 - MA - actively regulates and selects insurance plans that are offered, negotiates rates and requires reporting.
- Washington has an exchange for small businesses (1-50 FTE).
- New Jersey has a 2010 pending bill to establish an exchange. About 4 states (including Montana HB 124) have filed bills in 2011 to date.

Exchange Timeline





Montana specific activities:

- Montana Office of the Commissioner of Securities and Insurance held stakeholder meetings and has a 25-member advisory council on exchanges.
- Montana House Bill No. 124 would create an exchange and provides for governance and oversight. It proposes a quasi-governmental Exchange Authority Board that is attached to the Office of the Montana Commissioner of Securities and Insurance.
- Montana is one of five states that currently have filed bills to establish an exchange (as of January 7).

Medicaid Provisions in the Affordable Care Act



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Medicaid Has Always Been a Cornerstone for Reform

- States have continually relied on Medicaid to meet new demands and initiate reforms
 - Improving infant mortality rates
 - Providing coverage for those living with HIV/AIDS
 - Covering people with disabilities in the labor market, children with special needs, and providing community based LTC
 - Developing new care coordination models
 - Initiating Electronic Health Records (EHRs)
 - Significantly reducing uninsured rate among children



Medicaid Expansion

- Establishes a national minimum eligibility level at 133% of federal poverty level (FPL)
 - (In 2010: \$14,400 for individual; \$29,326 family of 3)
 - Estimates for Montana from the Urban Institute:*
 - 42,000 newly eligible individuals
 - 26,000 currently eligible but not enrolled
 - *"How Would States Be Affected by Health Reform?" Jan. 2010



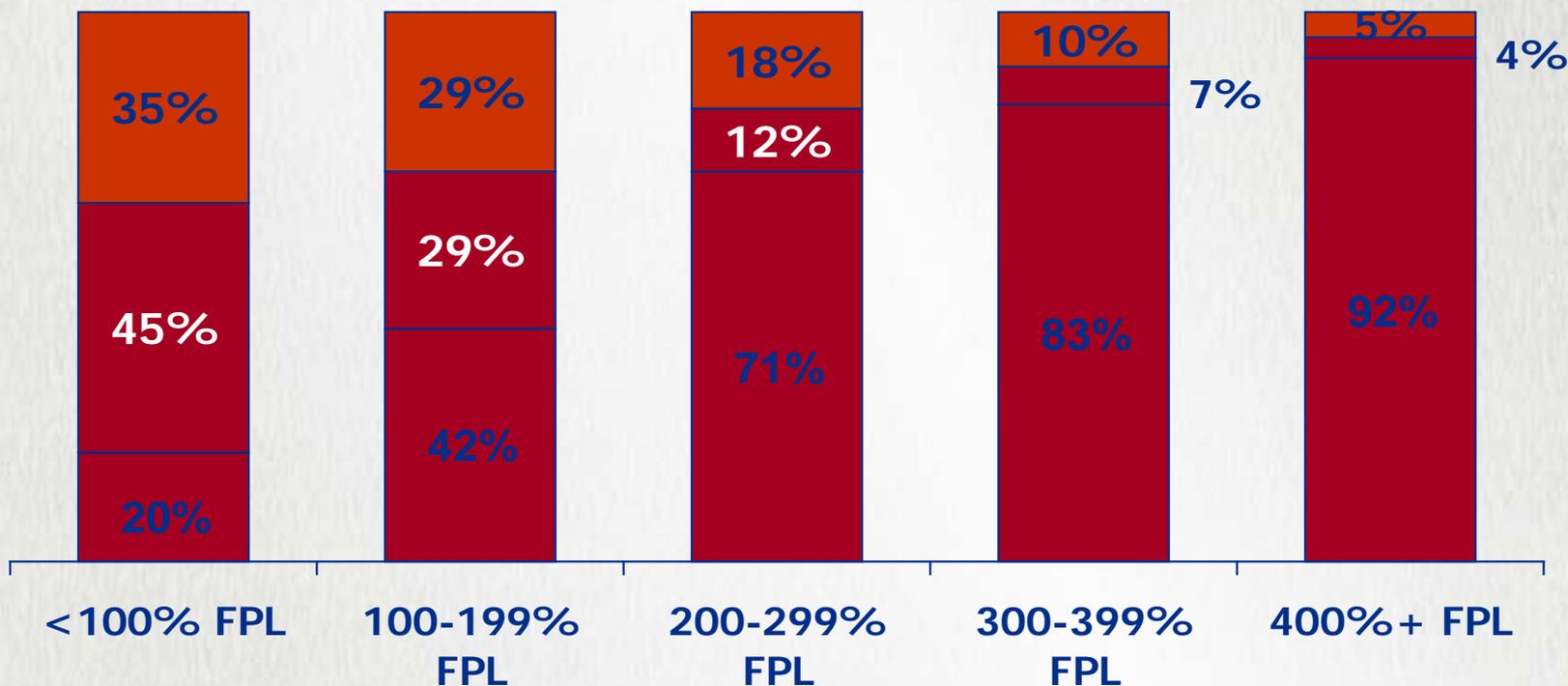
Medicaid Expansion

- Eligibility based on Modified Adjusted Gross Income or MAGI with no asset tests (Exempt: SSI, child welfare, SSDI, medically needy, Medicare Savings Programs)
- Adds new mandatory categories of Medicaid-eligibles:
(1) Single, childless adults who are not disabled; (2) Parents;
(3) Former Foster Care Children (aged-out of foster care)
- Option for states to begin expansion for certain non-elderly individuals with incomes up to 133% of FPL effective April 1, 2010. Coverage would be reimbursed at the state's regular Medicaid FMAP.
 - Connecticut and Washington, D.C.



Health Insurance Coverage of the Nonelderly by Poverty Level, 2008

■ Employer/Other Private ■ Medicaid/Other Public ■ Uninsured



SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2009 ASEC Supplement to the CPS.



Regional Data: 2008-2009

| State | % uninsured | % <poverty* uninsured | % Firms that offer insurance |
|-----------|-------------|-----------------------|------------------------------|
| U.S. | 17% | 36% | 55% |
| ID | 15 | 36 | 45 |
| MT | 16 | 33 | 39.5 |
| NE | 12 | 32 | 45.4 |
| UT | 14 | 34 | 46.4 |
| WV | 15 | 42 | 40.5 |

Poverty Level In 2010: \$10,830 for individual; \$22,050 family of 4)

Sources: Kaiser Family Foundation, State Health Facts, from the Census Bureau Current

Population Survey



Enhanced FMAP for New Eligibles

Enhanced FMAP for Newly Eligible Enrollees 2014-2020

| Year | Federal Match |
|---------------------|---------------|
| 2014 | 100% |
| 2015 | 100% |
| 2016 | 100% |
| 2017 | 95% |
| 2018 | 94% |
| 2019 | 93% |
| 2020 and thereafter | 90% |

There are special provisions for "expansion states"





Medicaid Expansion Features

Temporary Maintenance of Effort/Eligibility

- Prohibits eligibility changes that are more restrictive than those in place on date of enactment (March 23, 2010)
- Expires in 2014 when the health care exchanges become effective

State Financial Hardship Exemption from Maintenance of Effort

- Governor must certify that state is in deficit or will be in deficit to qualify for the hardship exemption (12/31/2010). No state has applied to date



Other Medicaid Mandates/Changes

- Phase-in Medicare rates for primary care providers (100% federal match for increment above current rate) for 2013 and 2014 only
- Coverage of preventive services, no cost-sharing
- Reimbursement of Medicaid services provided by school-based health clinics
- Quality measures for adult beneficiaries
- Non-Payment for certain Health Care Acquired Conditions (mirrors Medicare provision)
- State use of National Correct Coding Initiative (NCCI) – 10/1/2010
- Background checks for direct patient access employees of long term care facilities and providers
- Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women (10/1/2010)



Other Medicaid Mandates/Changes (cont.)

- Incentives for Coverage of Preventive Services
 - Add 1 percentage point to regular FMAP
- Incentive Grants for the Prevention of Chronic Diseases (1/1/2011) to promote healthy lifestyles
- Medical Home – State Option
- Prescription drug provisions include changes to the prescription drug rebate program, the status of some formerly excludable drugs and the average manufacturers price.



Medicaid & Long-Term Care

- Community First Option (10/1/2011)
- Home & Community-Based Services
- Home & Community-Based Incentives (2011)
- Money Follows the Person Rebalancing Demonstration
- Treatment of Spousal Impoverishment in Home & Community-Based Programs (1/1/2014)
- Funding for Aging and Disability Resource Centers
- Waiver Authority for Dual-Eligible Demonstrations
- Establishes a Federal Coordinated Health Care Office within CMS (for dual-eligibles) – 3/1/2010



Some State Concerns

- Transformation left largely to the states
- Budget Issues
 - Underfunding of the underlying program
 - No coverage for undocumented immigrants
 - No statutory countercyclical trigger
 - Implications of reduction in federal assistance in the future
 - Long term care
- Budget Impacts
 - Newly eligible and others who will "come out of the woodwork"
 - Systems upgrades for eligibility & interoperability with the Exchanges
 - Staffing: State and local government
 - Workforce/Infrastructure
 - Provider reimbursement; Training & recruitment
- State flexibility



State Flexibility Under the ACA

Section 1332

- The Waiver for State Innovation provision allows states to waive out of some of the requirements of the ACA (beginning 2017)
 - Individual mandate
 - Employer penalty for failure to provide coverage
 - Standards for a basic health insurance policy
 - Establishment of a health insurance exchange; and
 - Design for how federal subsidies would have to reduce premiums and co-pays for people.
- How?
 - Pass a law to provide health insurance coverage to citizens.
 - The secretaries of HHS and Treasury review the state law to determine if the law meets the requirements for consideration of a state waiver.



Flexibility cont.

- Requirements -- the state law must ensure that:
 - Individuals receive insurance coverage that is at least as comprehensive as the ACA coverage;
 - Individuals receive insurance that is as affordable as it would otherwise be under federal law;
 - The state program covers as many people as would have been covered through the ACA; and
 - The state program does not increase the federal deficit (budget neutrality).
 - Note: States can collect all of the federal money (subsidies for premiums, subsidies for co-pays, and tax credits for small business) and use those dollars to finance coverage for individuals in the state according to the new state law.



Federal Legislation to Amend Sec. 1332 Waiver Provisions

- The Empowering States to Innovate Act (S. 3958), introduced on November 17, 2010, sponsored by Senators Wyden (D-OR) and Senator Scott Brown (R-MA)
 - Moves the effective date of the waiver from 2017 to 2014; and
 - Requires the HHS Secretary to start receiving state waiver applications within 6 months of passage of the Act.
- This legislation will have to be reintroduced in the 112th Congress.
- There are likely to be other bills introduced in the 112th Congress that will include provisions to provide more flexibility to state legislatures.



Reduction in DSH Payments

- Directs the HHS Secretary to reduce DSH payments to states by \$14.1 billion between FY 2014-FY 2020

| Fiscal Year | Reduction |
|-------------|---------------|
| 2014 | \$500 million |
| 2015 | \$600 million |
| 2016 | \$600 million |
| 2017 | \$1.8 billion |
| 2018 | \$5 billion |
| 2019 | \$5.6 billion |
| 2020 | \$4 billion |

Reductions will be made quarterly in equal installments





Reduction in DSH Payments

- Requires the Secretary to carry out the reductions using the "DSH Health Reform Methodology" that will impose the largest reductions on states that:
 - Have the lowest percentage of uninsured individuals (determined on the basis of: (1) data from the Bureau of the Census; (2) audited hospital reports; and (3) other information likely to yield accurate data) during the most recent year for which the data is available; or
 - Do not target their DSH payments to: (a) hospitals with high volumes of Medicaid inpatients; and (b) hospitals that have high levels of uncompensated care (excluding bad debt).



What Happens to CHIP?

- Extends the current CHIP authorization through 9/30/15.
- From FY 2016 to FY 2019, states will receive a 23% point increase in the CHIP match rate, capped at 100 percent.
- CHIP-eligible children, who cannot enroll in CHIP due to federal allotment caps, will be deemed ineligible and will then be eligible for tax credits in the exchange.
- Requires states to maintain current income eligibility levels for CHIP through September 30, 2019.
 - Prohibits states from implementing implement eligibility standards, methodologies, or procedures that were more restrictive than those in place on the date of enactment (March 23, 2010), with the exception of waiting lists for enrolling children in CHIP.
 - Conditions future Medicaid payments on compliance with the maintenance of effort provision.



CHIP & the Exchange

- CHIP and the Health Insurance Exchange
 - Provides that after FY 2015 states may enroll targeted low-income children in qualified health plans that have been certified by the Secretary.
 - Requires the Secretary to no later than April 1, 2015 to review in each state the benefits offered for children and the cost-sharing imposed by qualified health plans offered through a Health Insurance Exchange.
 - Requires the Secretary to certify (certification of comparability of pediatric coverage) plans that offer benefits for children and impose cost-sharing that the Secretary determines are at least comparable to the benefits and cost-sharing protections provided under the state CHIP.

State Employee Plans & States Opposing or Opting Out



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ACA and State Employee Health Plans

- State Employee Health Plans have some special status in relation to federal ACA law.
- State benefit plans can choose to stay the same, "grandfathered" for 2011+, or choose to switch.
- HHS will not be focusing on "nonfederal governmental plans" for compliance.
- State plans still are exempt from federal ERISA law.
- State plans may choose to conform, to be consistent with general population.
 - Preventive services, ombudsman, external appeals, quality of care



Grandfathered Plans:

What they are

- Existing health group or plan with agreement to make only few, limited changes in benefits. Covers old + new employees
- "Non-grandfathered" - any newly designed or substantially changed plan.

The Effect on States (Jan. 2011)

- HHS "does not intend to use its resources to enforce the requirements of HIPAA or the Affordable Care Act with respect to nonfederal governmental retiree-only plans or with respect to excepted benefits provided by nonfederal governmental plans."
- States may continue to apply state law requirements except if they prevent applying ACA requirements.
- States have "significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law."

-Source: CRS, January 2011 (see handout)



Some ACA Provisions intended to apply to all plans, including grandfathered & self-insured...

- No lifetime limits on health policies (includes dependent family members). (2010)
- Prohibitions on rescissions. (2010)
- Extension of dependent coverage until age 26 (who are not eligible for employer sponsored coverage)(2010).
- Uniform explanation of coverage documents and standardized definitions. (2011)
- Prohibition of preexisting condition exclusion or other discrimination based on health status. (2014)
- Prohibition on excessive waiting periods. (2014)



Self-Insured Employer Plans Have Some Exceptions or Exemptions

- Employers that self-insure (like Montana) are not treated the same as insurers.
- No limits on out-of-pocket or cost-sharing, no medical loss ratios or rate review, etc.
- In 2017 public employee plans can join an Exchange



Consumer-level changes

Montana



- Flexible Spending Account - Over The Counter pharmaceuticals restricted - In 2011 require a signed doctor's approval (a prescription)
- Adult dependents up to 26 already enrolled in state employee plan
- Tobacco cessation: MT already waives the co-payments and/or co-insurance for in-network



PPACA and union bargained plans

For collective-bargained (CBA) health plans

1. If ratified by March 23, 2010, bargained terms may remain valid through end of contract.
2. For self-insured, the federal "grandfathered" rules apply.



States Opposing or Opting Out of Certain Reforms

- 40 states had 115+ proposals in 2009-2010 to bar state government involvement in individual or employer insurance mandates.
- Most bills intended to formalize in state law a "freedom to choose or not to buy health insurance"
- Most do not discuss federal constitutionality
- widely discussed and covered by media



Common purpose and intent in state legislation considered or enacted in 2010

Within the jurisdiction of state government, there will be no implementation or enforcement of mandates (federal or state) that would require:

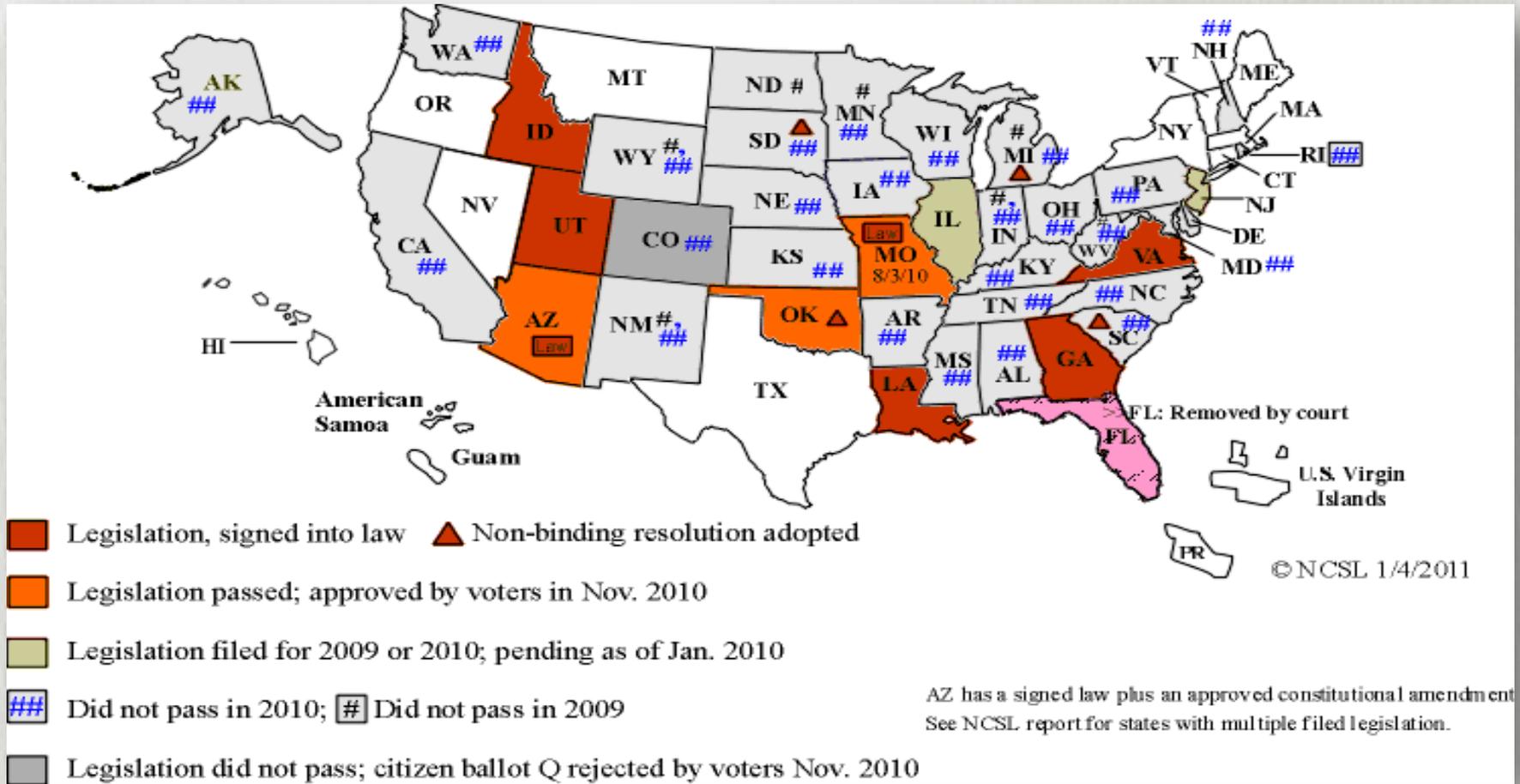
- purchase of insurance by individuals,
- or contribution to premiums by employers,
- or imposing fines or penalties for those who fail to do so.

This language generally:

- Is binding on state agencies for 2014 provisions.
- Does not block federal law provisions.



2009-2010 "Challenge" Measures in 40 states



8 laws. 2 constitutional*; Failed in 29

* AZ, OK have state constitutional amendments, passed in 2010





Challenges in Federal Courts Initiated by states

Overview: The role of court suits and federal health law.

- Virginia's federal district court ruled December 13, 2010 that the individual mandate to purchase insurance is unconstitutional.
 - Richmond, Va. Judge Henry Hudson wrote that the law's central requirement that most Americans obtain health insurance exceeds the regulatory authority granted to Congress under the Commerce Clause of the Constitution. The ruling does not by itself enjoin or halt any part of the federal law, pending rulings by higher courts.
- Florida: Federal District ruled two of six counts, the individual mandate and the Medicaid expansion can go to trial. 20 state AGs joined together. Judge Roger Vinson heard motions for summary judgment December 16, 2010.



Additional Federal Court challenges

- Michigan: In the first decision among more than 20 cases filed against the new law, a federal district judge in Detroit, Michigan dismissed a case and ruled in favor of the federal reform law; that decision has been appealed .
- Virginia, a second, private party suit by Liberty University was rejected in another federal district court on November 30; the judge's 54 page ruling upheld the federal law .
- 15+ other cases

Disclaimer: These actions by executive branch officials and private parties are provided for information only. They are legally separate from state lawmaking but may affect state deliberations.



Additional Resources

- State Employee Health Benefits
<http://www.ncsl.org/default.aspx?tabid=14345>
- State Legislation and Actions Challenging Certain Health Reforms
<http://www.ncsl.org/default.aspx?tabid=18906>
- Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis - Congressional Research Service
<http://www.ncsl.org/documents/health/Constitutionality.pdf>

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State Actions to Implement Health Reform



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**State policymaker considerations
and actions so far...
January 2011**

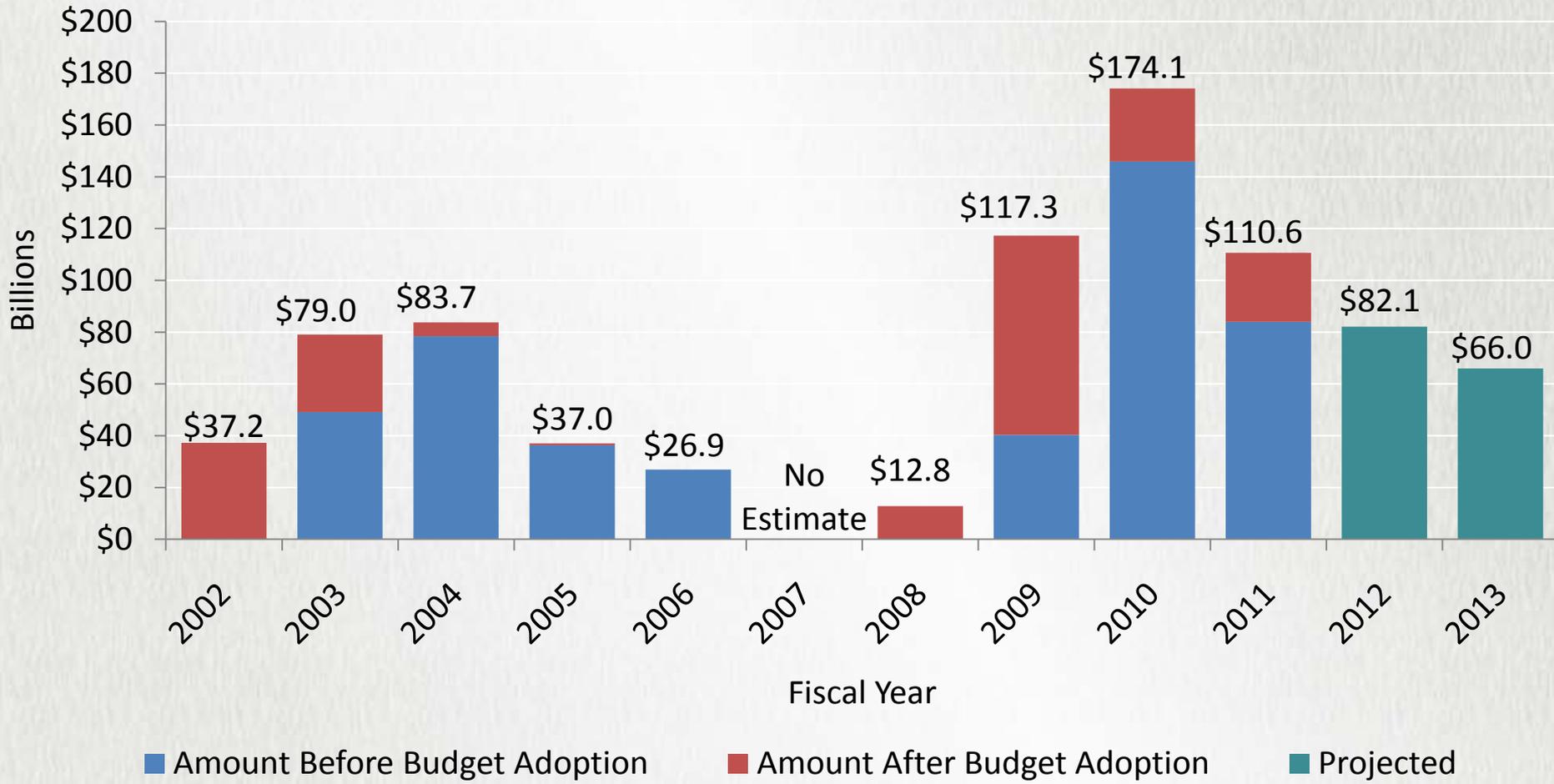


Some Challenges

- State budget issues
- Election turn-over & steep learning curve
- Coordination between executive & legislative branches
- Political resistance & legal challenges
- Planning for effective public outreach to partners and the public
- System upgrades for Medicaid/Exchange interoperability
- Health care workforce shortages
- State budget issues



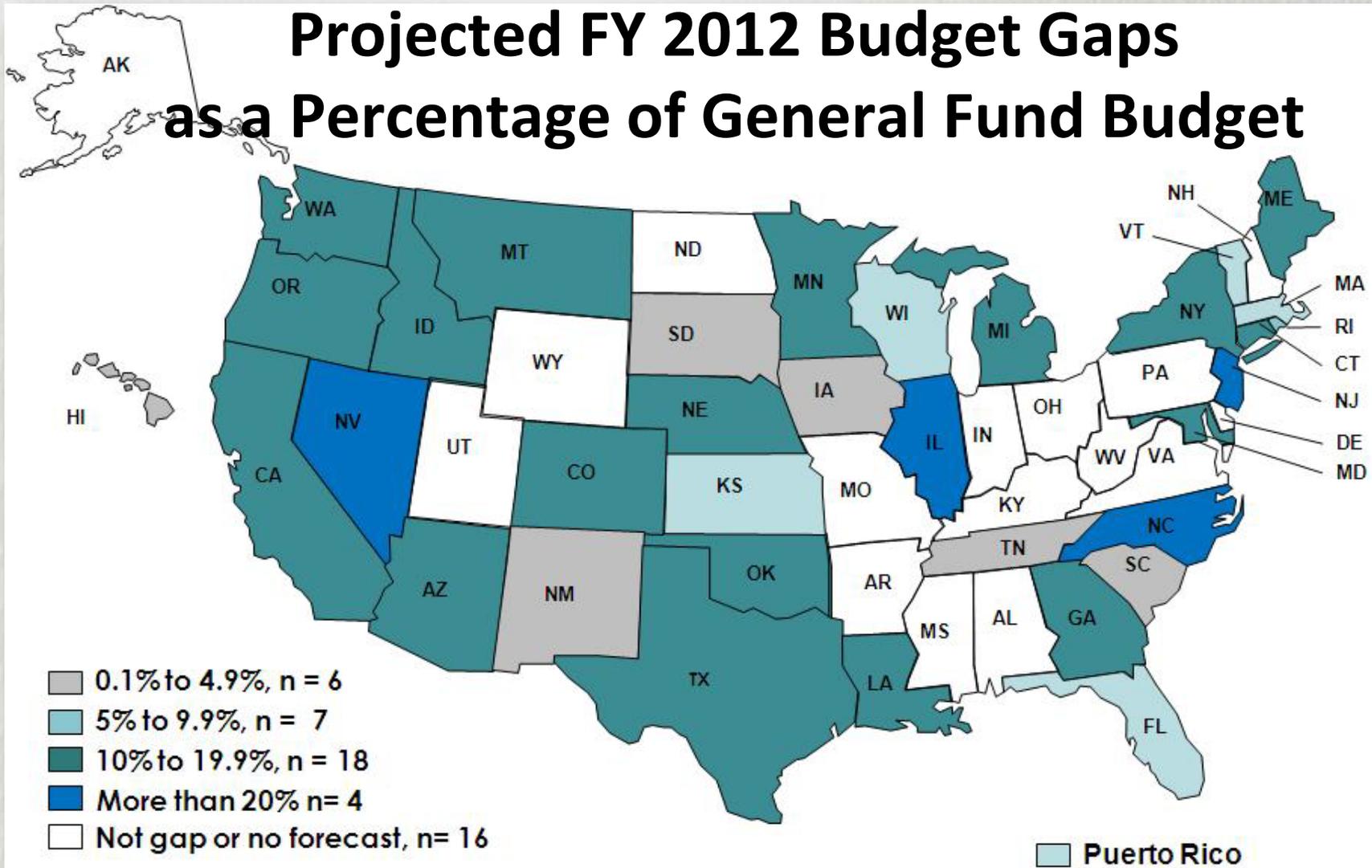
State Budget Gaps FY 2002-FY 2013 (projected)



Source: NCSL survey of state legislative fiscal offices, various years.



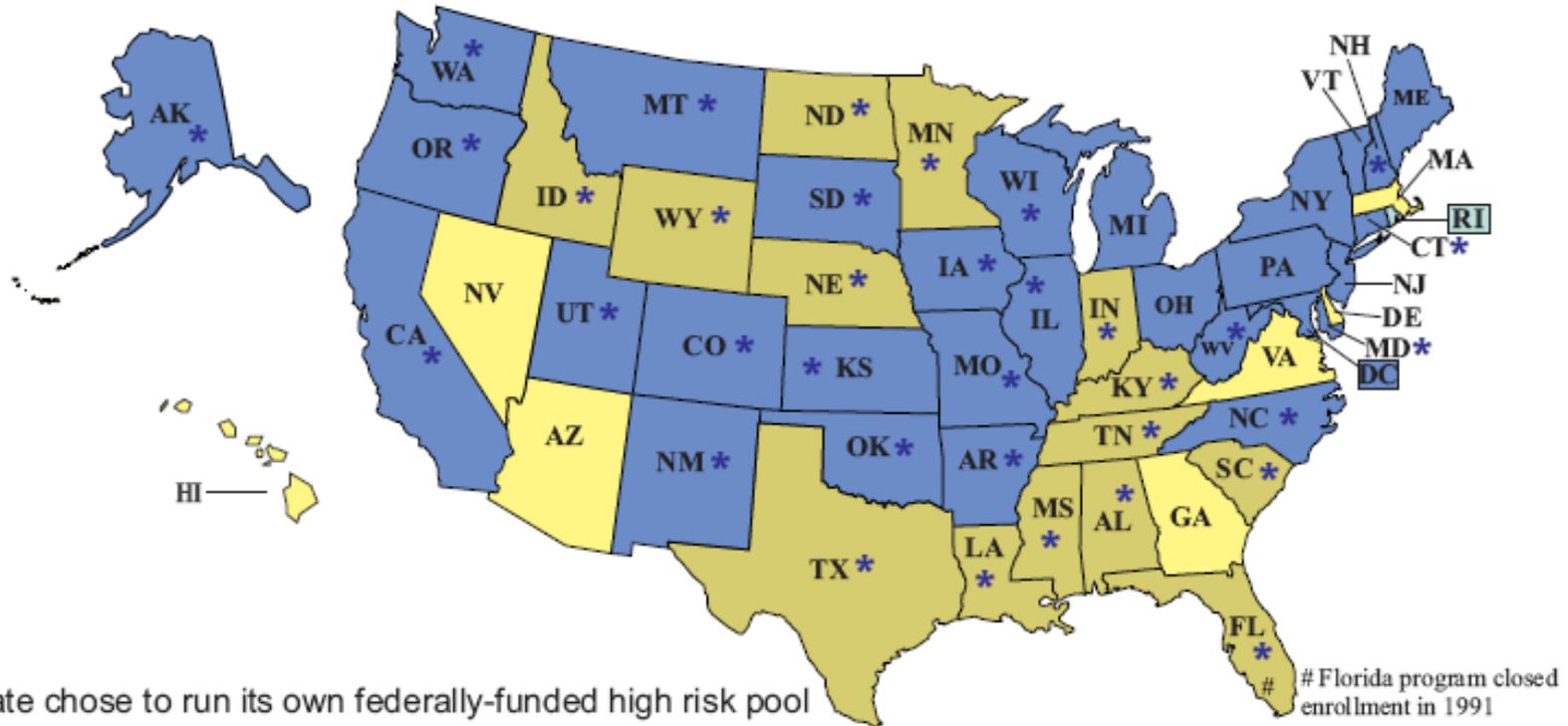
Projected FY 2012 Budget Gaps as a Percentage of General Fund Budget



Source: NCSL survey of state legislative fiscal offices, November 2010.



High Risk Pools: State Implementation, Federal Roles



- State chose to run its own federally-funded high risk pool
- State chose HIPAA insurance carrier to run federal pool
- State chose to have HHS run federally-funded high risk pool (July 2010-Dec. 2013)
- Current state pool; HHS to run federal pool
- * State currently runs its own state high risk pool, 2009-2010

Florida program closed enrollment in 1991

Source: NCSLreport at www.ncsl.org/?tabid=14329, NASCHIP and HHS.
Updated 7/2/2010- Announced intentions may be subject to change.





States Addressing "how's" and "who's"

- Creating Task Forces or Appointing officials to:
- Study details of the Affordable Care Act
- Examine how federal health reform will affect existing state programs
- Develop a plan for state implementation of health reform
- Determine lead agencies for implementing components of the new law
- Collect data to make informed outcomes



Implementation "Entities"

- Task forces, special committees, commissions, boards, etc.
- 33 states have at least one federal health reform implementation entity.
- 26 states are required to submit a report as part of the duties outlined in their official creation or as part of the committee charge.
- 12 states have a web link to information regarding the entities progress or to a completed report.



Implementation "Entities"

| Created by the Legislature | | Created by the Executive Branch | |
|----------------------------|--------------|---------------------------------|--------------|
| Alaska | New Hersey | California | Ohio |
| Delaware | New Mexico | Colorado | Pennsylvania |
| District of Columbia | New York | Connecticut | Vermont |
| Illinois | North Dakota | Illinois | Virginia |
| Iowa | Ohio | Maine | Washington |
| Minnesota | Oregon | Maryland | Wisconsin |





Reports/Recommendations

- Many task forces/commissions included reports and/or recommendations to the Legislature on how to implement federal health reform
- States creating health reform websites
- Holding community forums
- Considering ways to involve stakeholders
- Thinking both broadly and into specific provisions such as exchanges



Legislative Action

- Amending existing bills to include federal health reform
- Committee/Boards created as broad entities
- -Or- Committee/Boards are more specific to particular provisions:
 - high-risk pools, exchanges, insurance
- California is first state to create a state-based exchange as outlined by the Affordable Care Act
- What's ahead for 2011? (exchanges, system upgrades)



2010 Legislative Action

- Amending existing bills to include federal health reform
 - Insurance reforms
- Created committee/Boards created as broad entities that provide reports and/or recommendations:
 - 33 states currently have at least one implementation entity.
 - 16 of those implementation entities are required to submit recommendations/report studies of health reform in the state
- -Or- Committee/Boards are more specific to particular provisions:
 - High-risk pools, exchanges, insurance
- Creating State-Based Health Benefit Exchanges
 - California is first state to create a state-based exchange as outlined by the Affordable Care Act
 - New Jersey and Pennsylvania also introduced legislation to create an exchange



What's Ahead for 2011?

- Creating bills to:
 - Establish exchanges
 - 2011 HB 124 establishing the Montana health insurance exchange authority.
- Present alternatives to health reform
- Challenge certain components of federal law
- Change Insurance Regulations and Medicaid
- Upgrade Health Information Technology
- Designate who will apply for federal funds
- Address prevention and wellness



Health Reform Implementation Timeline



2010

- Small business tax credits
- Pre-existing condition insurance plan
- Rate review
- No cost-sharing for preventive services
- Dependent coverage expanded to age 26
- No lifetime caps on benefits

2011-2013

- Increased payments for primary care
- Reduced payments for Medicare providers and health plans
- No cost-sharing for preventive services in Medicare and Medicaid
- New delivery models in Medicare and Medicaid
- Changes to taxes and health industry fees

2014

- Medicaid expanded
- Health Insurance Exchanges operating
- Insurance carriers prohibited from denying coverage or charging more for pre-existing conditions
- Individual mandate takes effect
- Employer requirements
- Premium subsidies

2016

- Option for multi-state compacts

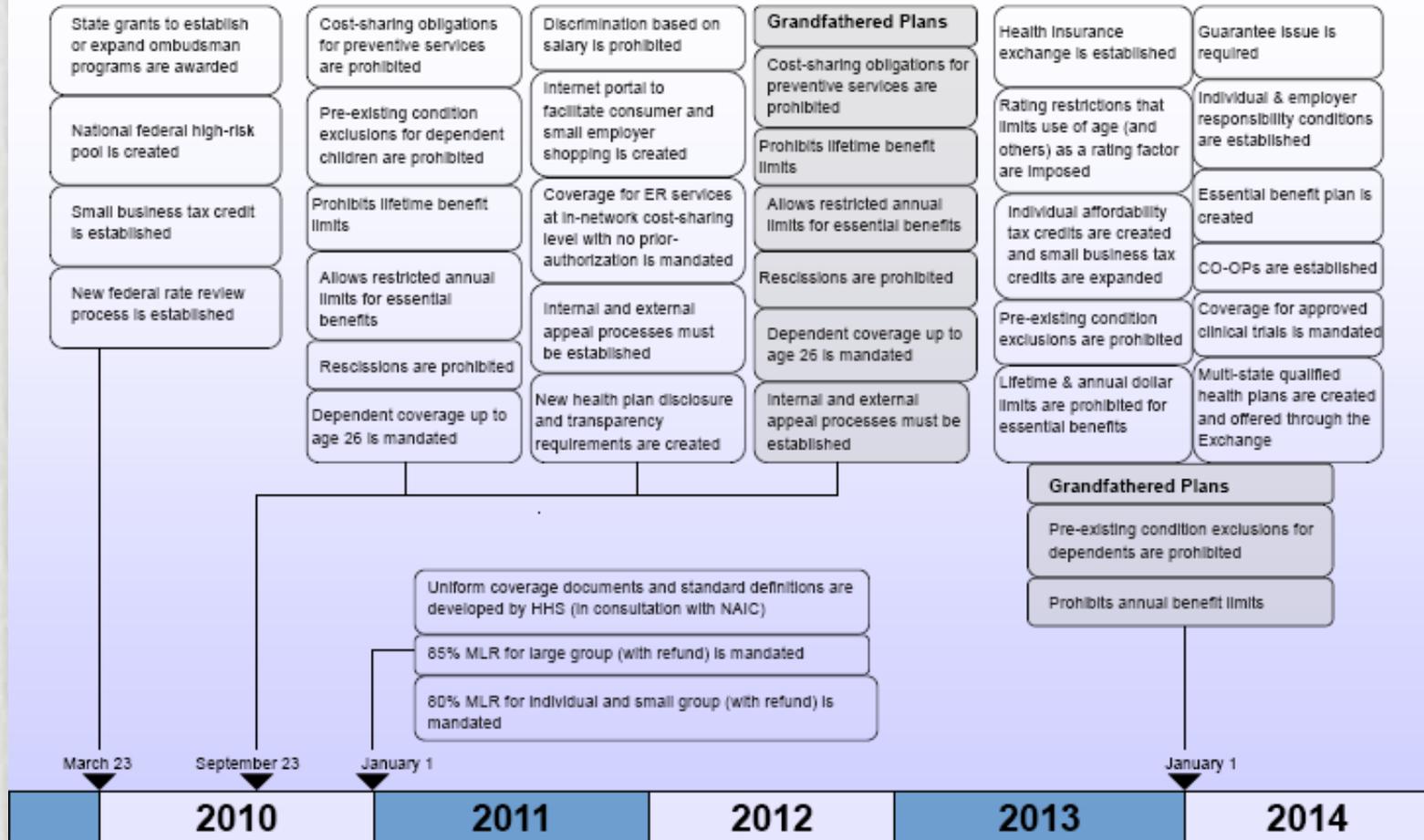
2018

- Excise tax on high-cost health plans

For a detailed 2011 timeline checklist, go to NCSL's webpage at http://www.ncsl.org/documents/health/State_Legislators_Checkdec20.pdf



Health Insurance Reform Timeline 2010-2014



Montana Commissioner of Securities and Insurance Monica J. Lindeen
www.csi.mt.gov

406-444-2040
1-800-332-6148





Given the timeline, state legislatures may be working on the following for 2011:

- American Health Benefit Exchanges
- Fraud, Waste, and Abuse
- Insurance Reforms
- Long-Term Care Coverage
- Medicare/Medicaid Reforms
- Quality of Care

- For 2011 State Legislature Checklist see handout or:
<http://www.ncsl.org/?tabid=20652>



Federal Grant Opportunities Available through ACA

- Health insurance consumer information
- Premium review
- Plan & establish Insurance Exchanges
- School-based health centers/clinics
- Childhood Home Visiting Grants
- Demos for health workforce needs
- Option for "health homes" for chronic care
- Medicaid incentives for healthy lifestyle
- Screening for environmental health problems
- Assistance for Pregnant & parenting teens



Federal grants and funding in MT

- **Montana - \$6.3 million**
 - **Examples**
 - **Demonstration Project/Workforce Needs 2.7 million**
 - **Therapeutic Discovery Project Program Tax Credits & Grants \$1,296,971**
 - **Public Health Fund & Prevention Workforce Grants \$1,110,003**
 - **Premium review grant \$1 million**
 - **Exchange Planning Grant \$1 million**
 - **Primary Care Residency Expansion Program \$960,000**
 - **Home Visitation \$663,933**
 - **State health professional grant \$346,840**
 - **And others.**



NCSL Resources on Health Reform

- Federal Health Reform Main Page
<http://www.ncsl.org/healthreform>
- State Actions to Implement Reform
<http://www.ncsl.org/?tabid=20231>
- State Reports and Research
<http://www.ncsl.org/?TabId=21448>
- State Actions to Implement Health Benefit Exchanges
<http://www.ncsl.org/?TabId=21388>
- States Challenging Health Reform
<http://www.ncsl.org/?TabId=18906>



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