MONTANA LEGISLATIVE BRANCH

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DATE: November 19, 2009

TO: Legislative Finance Committee

FROM: Lois Steinbeck
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RE: Federal Health Reform – HR 3962

INTRODUCTION

The Legislative Finance Committee (LFC) heard a presentation on federal health reform proposals from Joy Johnson Wilson, Health Policy Director/Federal Affairs Counsel of the National Conference of State Legislatures (NCSL) at its September meeting. This memorandum summarizes the most recent NCSL analysis of the federal action related to health reform.

STATUS OF FEDERAL LEGISLATION

The U.S. House of Representatives passed the Affordable Health Care for America Act of 2009 (HR 3962) by a narrow vote Saturday, November 7. The U.S. Senate referred two bills from committees. Senate leadership combined the two into a single bill, which was released November 19.

This summary focuses on the House bill. The LFC will receive an update on the Senate bill once legislative staff has an opportunity to review it.

HR 3962

There are several elements of HR 3962 that would impact Montana state expenditures and policies regarding health insurance. The highlights of the most significant changes are discussed, including impacts to Medicaid, the state employee health plan, and state oversight of compliance by political subdivisions of the state.

Medicaid

The House legislation makes several changes to Medicaid eligibility, federal match rates and covered services; Medicaid provider rates and rate methodologies; and computer system interfaces.

Eligibility, Federal Match Rate, Covered Services

The House bill:

- Raises eligibility to 150 percent of the federal poverty level (FPL)
  - Increases current Montana Medicaid eligibility from 133 percent of the FPL for children and from about 40 percent FPL for low-income parents
- Expands eligibility to all persons, including childless, nondisabled adults
  - Requires Montana to include a new eligibility group not currently served
- Eliminates consideration of assets for eligibility
  - Eliminates Montana asset limit of $3,000 for low-income parents
- Pegs the federal match rate for the newly eligible at 100 percent from 2013 to 2015 and 91 percent after 2015
- Establishes a permanent maintenance of effort as of June 16, 2009 that requires states to maintain eligibility levels in place as of that date
- Requires states to suspend, rather than terminate, Medicaid eligibility for juveniles under 18 when they become incarcerated so that Medicaid can pay for services when they are released
- Makes podiatry and optometrist services and nonemergency transportation mandatory covered services[1]
- Establishes new optional services – family planning, nurse home visitation, HIV infection[2]

Medicaid Rates and Reimbursement

The House bill:

- Requires states to raise Medicaid provider rates for primary care providers[3] to the Medicare rate and funds the rate increase at the same federal match rate as for the newly eligible
- Requires states to document methodologies used to develop Medicaid rates and processes followed for public review and comment on Medicaid rates and report both to the federal Department of Health and Human Services
- Requires the U.S. Secretary of Health and Human Services to review and approve state rate methodologies, with the assurance that payment levels are adequate
- Establishes sanctions to require states to come into compliance if the Secretary does not approve the methodologies
- Appropriates $6 billion for temporary supplemental payments for three years to skilled nursing homes that have a high number of Medicare and Medicaid clients
- Eliminates Medicaid reimbursement for hospital acquired conditions similar to changes already adopted in the Medicare program
- Appropriates funds for development of school based clinics and requires state Medicaid programs to reimburse eligible services

Interoperability with Insurance Exchanges

[1] Under current law these services are optional services, meaning that a state can chose to cover the service as part of its Medicaid plan.

[2] The HIV option expires when health exchanges are operational.

[3] Primary care providers include providers in addition to physicians.

The House bill adds new administrative and management requirements. It:

- Establishes a national health insurance exchange where uninsured persons and small employers may compare policies and purchase health insurance
- Requires the insurance exchange and Medicaid program to be interoperable so that both entities can determine eligibility for the other
- Appropriates funds to help finance system changes[4]

Other Changes to Medicaid and Children's Health Insurance Program (CHIP)

The House bill has other significant changes. It:

- Sunsets CHIP at the end of 2013
- Extends the enhanced federal Medicaid match rate adopted under the American Recovery and Reinvestment Act of 2009 (ARRA) for an additional 6 months (through June 2011)
    - Would lower general fund Medicaid and foster care appropriations by another $26 million in the last half of FY 2011
- Eliminates Medicaid cost sharing on preventive services
- Requires states to develop quality measures for adult Medicaid beneficiaries
    - Mirrors the current requirement for states to develop and track quality measures for children's Medicaid services
- Institutes a background check, including an FBI fingerprint back ground check, for direct care staff with some funding for state implementation

State Government Employee Health Plans

States are treated like large employers with ERISA[5] plans. States (as large employers) are required to:

- Cover employees or face penalties
- Come into compliance with insurance provisions within five years
- Pay at least 72.5 percent of the cost of health coverage for employees and 65.0 percent of the cost for family coverage
- Ensure that political subdivisions are also in compliance with federal health insurance requirements with the penalty of eliminating federal public health funding for a state with subdivisions that are out of compliance
- Administer pay roll deductions for community living assistance and support services (CLASS) if an employee become disabled[6]

Other Changes

The House bill includes other changes that:

- Limit flexible spending accounts to $2,500 and alter types of qualified reimbursements[7]

[4] It is not clear that the federal appropriation is sufficient. Medicaid eligibility determination can be complex.

[5] ERISA stands for the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829, enacted September 2, 1974). ERISA establishes minimum standards for pension plans in private industry and provides for rules on the federal income tax effects of transactions associated with employee benefit plans.

[6] Employees are automatically enrolled unless they opt out

[7] One of the more significant changes is to exclude over-the-counter drugs as a qualified expense.

- Provide $5 billion to help states absorb persons with pre existing conditions into high risk pools until insurance exchanges are operational and authorizes the Secretary to work with states that don't have high risk pools to implement an alternative
- Allow states to "buy in" or pay the incremental premium to insurance exchanges to maintain state insurance mandates that are in addition to the required essential benefit package[8]
- Establish an essential benefit package

Cost Impact to Montana not Defined

At this time, there is insufficient detail and data to develop meaningful estimates of the potential cost to Montana of federal health reform proposals. For instance, one example is that the essential services coverage that would be required for the Medicaid expansion population is not clearly defined.

Another example that could significantly impact Montana, but that is vaguely defined, is the requirement that states comply with insurance provisions of the act and also assure that political subdivisions comply with the insurance provisions. As the law is written, failure to do so would result in a state losing its federal public health funding.[9] NCSL staff has expressed concern about this requirement because it appears to apply to counties, local governments, and such entities as water and sewer districts.[10]

Federal Legislation Uncertainty and the LFC

So where does the uncertainty of federal health reform legislation leave the LFC? The committee could consider the following options:

1) Draft a letter to the Montana Congressional delegation expressing concern about potential cost increases or workload impacts of items that most concern LFC members about HR 3962.

2) Request that staff continue to monitor federal legislation and provide updated summaries via e-mail as the Senate bill progresses.
   a. Depending on federal actions, the LFC could opt to hold a conference call to discuss action

3) Request that the LFC receive an update at the next regularly scheduled meeting without interim notifications

[8] It is not clear how the buy in would work and whether states would be required to pay the cost differential for all insurance policies.

[9] The wording of the specific section in HR 3962 is: "Subtitle E—Miscellaneous - SEC. 2585. STATES FAILING TO ADHERE TO CERTAIN EMPLOYMENT OBLIGATIONS.
A State is eligible for Federal funds under the provisions of the Public Health Service Act (42 U.S.C. 201 et 9 seq.) only if the State—
(1) agrees to be subject in its capacity as an employer to each obligation under division A of this Act and the amendments made by such division applicable to persons in their capacity as an employer; and
1 (2) assures that all political subdivisions in the State will do the same."

[10] Joy Johnson Wilson, Health Policy Director/Federal Affairs Counsel of the National Conference of State Legislatures, National Telephone Conference Call, Friday, November 13, 2009.