Overhaul Rx

Lawmakers have plenty of work ahead to comply with the new federal health care law.

BY RACHEL BRAND

Concerned. Excited. Digging in.

As the spotlight on the overhaul of the health system shifts to the states, legislators are preparing for the largest transformation of health care in 30 years.

"We are overwhelmed, but so are the feds," says Representative Peggy Welch of Indiana. "We are all in this together, and we all want to be successful."

Even if your state's attorney general is arguing the new law is unconstitutional, she says, legislators need to move ahead.

Massachusetts Senator Richard Moore, whose state provided a model for health care change, offers this advice: "State lawmakers need to start planning now. It's going to take time for it all to roll out. We should begin to listen and find reliable sources of information."

Rachel Brand is a freelance writer in Denver who covers health care issues.

The $960 billion federal health law aims to expand coverage to 32 million more Americans. It relies on a combination of Medicaid expansions, subsidies, tax credits and mandates. The law also allocates money to improve quality and halts certain widely criticized insurance practices.

The biggest changes come in 2014 when Medicaid expands and states create exchanges or marketplaces for health insurance. But first there's much to do this year.

In recent months, legislators have been traveling to Washington to voice concerns and get clarification about state responsibilities. This summer, some states will convene councils, agencies and commissions to plan and coordinate implementation. In July, new state high-risk pools will open. By September, state regulators will enforce tighter insurance regulations.

"The new federal health care legislation has a whole lot of regulatory discretion," says Utah House Speaker Dave Clark. "In that void, it's going to be necessary for states to have their voices heard collectively in Washington. States have a tremendous opportunity to assert themselves."

In Colorado, for instance, the health system changes touch 10 state agencies. Policymakers—with no new money—have formed an implementation council.

"State officials need to figure out where they have talent and resources to do some of the planning," says Joan Henneberry, Colorado's executive director of the Department of Health Care Policy and Financing. "Since they haven't gotten any new federal funds, they should do a quick environmental scan to find people on state payroll who have a talent for this stuff.

REPRESENTATIVE
PEGGY WELCH
INDIANA

SENATOR
RICHARD MOORE
MASSACHUSETTS

HOUSE SPEAKER
DAVE CLARK
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MASSACHUSETTS SENATOR RICHARD MOORE

"Then you need to develop a coordinated response. It will be a disaster if you go about it willy-nilly."

Finally, the federal changes provide a laundry list of competitive grants and funding to help states set up consumer assistance offices, review insurers' rate hikes, support home nurse visits to high-risk pregnant women, and provide sex education and abstinence programs, among other things. Plus, the feds have directly allocated $11 billion to support community health centers.

"We have a responsibility as legislators to ask our governors' offices what they are doing to take some of this money off the table," says Indiana's Welch. "I will be really disappointed if any of the dollars scheduled to go to Indiana are left behind."

HIGH-RISK POOLS

Thirty-four states already run high-risk insurance pools. These pools provide coverage for people with pre-existing conditions who were either denied insurance coverage or could buy it only at sky-high prices.

Nationally, 201,000 people participate in the pools, which charge enrollees between 125 percent and 200 percent of the standard rate. The standard rate is what a healthy person would pay for insurance.

Some policies came with high deductibles, co-payments and lifetime coverage caps. While only a few states had frozen enrollment, most believed the policies' costs—as well as their limited benefits—stopped people from signing up.

The new federal law sets aside $5 billion to fund new, temporary high-risk programs that are more affordable and accessible. New enrollees will pay the standard rate, which is less than $5,950 a year for an individual and no more than $11,900 for a family.

As one of the most visible parts of the health system changes, high-risk pools will be in the spotlight.

"We're getting a lot more media attention," says Richard Popper, executive director of the Maryland Health Insurance Plan. "The program will be judged a success based on how quickly enrollment ramps up and how much of the $5 billion Congress authorized is expended."

The pools open in July and phase out by 2014 when health insurance exchanges kick in. For states without an existing high-risk pool, legislators and governors could quickly move to create one, but the short time frame makes that unlikely. Most will likely join a federal pool or open one in an existing state-run program.

The $5 billion will be allocated over 3½ years to states on a formula based on population, number of uninsured and cost of living. The current state programs cost an estimated $2 billion a year. That leaves high-risk program administrators fearful.

"How far $5 billion is going to go is a question that is on everybody's mind," says Amie Goldman, CEO of the High-Risk Sharing Plan of Wisconsin. "There are millions of people in this country who are uninsured, have pre-existing conditions, and have not been able to get coverage in the private market because of their conditions.

"There are lots of people who could benefit from this."

There also could be backlash from existing high-risk pool enrollees. Under a requirement that new enrollees be uninsured for at least six months, current high-risk enrollees can't switch to a new, less expensive plan. While existing enrollees could quit their plan, wait six months and re-enroll, most have serious medical conditions so that is not a viable option.

"I'm sure some people will realize the rates could be different," says Maryland's Popper. "But in the health insurance marketplace, there is a lot of premium and payment inequity. … Until you get to 2014, the world really isn't reshaped."

INSURANCE MARKET REFORMS

By Sept. 23, all health plans—both employer-sponsored and private—must abide by new requirements that curb unpopular practices and expand coverage. State divisions of insurance will be on the front lines of enforcing these laws. The plan changes, however, go into effect at the start of the new "plan year," which is Jan. 1, 2011, for many insurance policies.

"Legislators are going to want to provide oversight and play a watchdog role on their divisions of insurance to make sure they are implementing the new law," says Jack Meyer, principal at Health Management Associates.

Policymakers also may want to examine existing statutes to see if changes are needed so that divisions of insurance can make the changes.

For instance, plans must cover children with pre-existing conditions and lift lifetime annual limits on coverage for everyone. These new rules are designed to help patients with expensive medical conditions.

What's more, the law requires that new insurance policies provide preventive services such as mammograms, physicals and immunizations with no deductibles or co-

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UTAH HOUSE SPEAKER DAVE CLARK, DISCUSSING INSURANCE EXCHANGES

STATES PUSH BACK

With divisions well-defined in Congress over the federal overhaul of health care, it is no surprise that some legislators are pressing for states to redefine or opt out of parts of the overall plan.

In the past 12 months, a flood of proposed "anti-reform" state plans and constitutional amendments have been filed in at least 39 states, gaining widespread attention and stirring debate about state powers and federal preemption. Almost all focused on opposing the requirement that everyone have health insurance, suggesting instead that residents be given a choice whether to have health insurance, with no state penalties for choosing not to.

Three states—Arizona, Florida and Oklahoma—will have constitutional amendments onthe 2010 ballot.

So far this year, three other states enacted laws that primarily focus inward:

◆ Utah's statute prohibits any state agency from making health system changes unless the Legislature approves.

◆ Virginia added a provision called "Health insurance coverage not required" that bars state penalties or fines for not complying with any federal requirement.

◆ Idaho requires residents "be free to choose or decline to choose any … health care services without penalty," while "no state official shall enforce" federal health mandates.

Virginia lawmakers were first to pass a law with five Democratic votes providing the critical majority. Senator Fred Quayle, a Republican who is the Senate sponsor, said the individual mandate is unprecedented. "I don't think in the entire history of this country there has ever been any act of Congress requiring a citizen to buy anything.''

Delegate Jennifer McClellan, a Democrat who opposed the bill, says, "If a state thinks the federal government is overstepping its authority, the state can't just say, 'I'm not going to do that.' "

Although 30 states had proposed constitutional amendments to block some reforms, states' own procedures proved a hurdle. Mississippi and Wyoming, for example, were unable to muster the super-majority votes needed to put health reform on the November ballot. By May 1, such bills had failed in 16 states and were pending in up to 15 others.

Largely separate from legislative actions, 18 state attorneys general announced a formal court challenge, claiming the federal health system changes violate the 10th Amendment of the U.S. Constitution. The outcome of these federal suits can't be predicted.

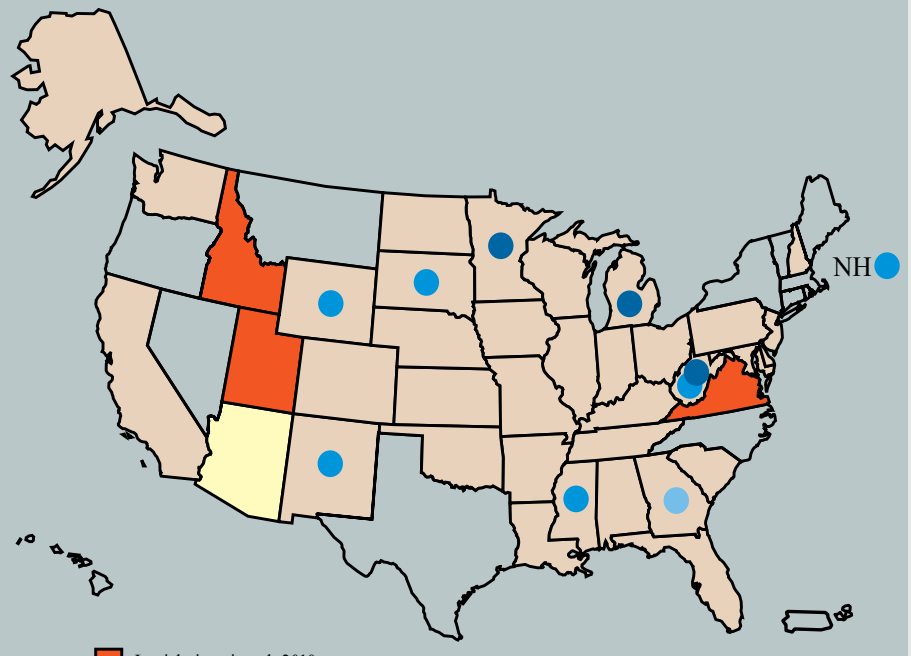
As state officials move quickly to implement the first requirements of the federal law, many now realize the new law favors state-federal partnerships and provides optional funding opportunities. For example, states can set up the consumer information offices, premium rate reviews, health insurance purchase exchanges and high-risk pools for those denied commercial coverage with federal management only as a fallback.

—Richard Cauchi, NCSL

SENATOR
FRED QUAYLE
VIRGINIA

DELEGATE
JENNIFER MCCLELLAN
VIRGINIA

LEGISLATION OPPOSING FEDERAL HEALTH REFORM



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REPRESENTATIVE
MARK SMITH
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RON RAMSEY
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payments for patients. "New" is the operative word. If people stay on their existing health plan, the requirement doesn't stick. The exception is Medicare patients, who, starting next year, will be entitled to one free annual check up and screenings.

The new requirement is "a potentially huge expansion of preventive services" that might raise the cost of health insurance to employers and states, said Kansas Insurance Commissioner Sandy Praeger.

"You could argue that good preventive services can save money in the long term," Praeger says, "but it takes time."

YOUNG ADULT COVERAGE

Also by Sept. 23, health insurers must allow parents to keep their children on their health plans up until age 26. Many view this as an easy way to expand coverage, because young adults make up 13 million, or nearly 30 percent, of the nation's 47 million uninsured.

Before health reform, 38 states required "dependent" coverage, but age cutoffs varied. Plus, large self-insured employers were governed by federal law, creating a loophole.

"Now, the blanket covers a larger number of people," says Iowa Representative Mark Smith. While young adults need catastrophic coverage—in the case of accident or illness—having broader insurance coverage earlier will allow for intervention when problems begin.

"For instance, this is the age where a lot of mental health and substance abuse disorders show up," says Smith, who is also a substance abuse counselor. "The earlier we can intervene, the more likely we can have positive results."

As of April, five large insurers had agreed to adhere to the federal law in advance of the September deadline, allowing new college graduates to keep coverage over the summer.

The six states that already require insurance coverage beyond age 26 can continue to do so. Those rules, however, would only apply only to state-regulated insurance coverage.

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>
> TENNESSEE SENATE PRESIDENT RON RAMSEY

PREPARING FOR EXCHANGES

Although the federal law does not require states to have insurance exchanges set up until 2013, "if you haven't already started working on one, you're late," says Utah's Clark.

They're aimed at the individual and small group health insurance market, where competition has been scarce and price hikes enormous. Theoretically, exchanges will allow purchasers to band together and get group rates. Their rules are intended to bring transparency and competition to the market.

Already set up in Utah and Massachusetts, exchanges are an online information broker—like Expedia or Travelocity—for health plans.

They will vet and inspect plans, making sure they offer key benefits, have sufficient providers and meet other quality criteria. State insurance regulators will rate plans and can ask insurers to justify rate hikes.

Clark recommends state lawmakers look around the country at other exchanges and prepare model legislation for next session.

Exchanges can take many forms: nonprofit, government run, state-level or regional. While waiting for further federal guidance, some state officials are holding planning meetings to explore structures and governance.

"We think it's important to have that conversation now," says Colorado's Henneberry. "So that next year, we can apply for a planning grant from the federal government."

MEDICAID EXPANSION

Perhaps most controversial, the new law by 2014 expands Medicaid, the state-federal health care program for the poor, to cover people earning up to 133 percent of the poverty level, or about $29,300 for a family of four in 2009.

Medicaid costs are split between the states and the federal government, with Washington picking up 50 percent to 83 percent of the costs, depending on a state's per capita income. The federal government, however, will pick up 100 percent of the cost of this expansion for the first three years and then support declines to 90 percent by 2020.

Some governors and legislators protest that the state costs of expansion are an unfunded mandate. Further, the federal government has not offered to increase the percentage that it covers of administrative costs.

"It will be a huge unfunded mandate on the states," says Senate President Ron Ramsey of Tennessee. "We estimate health care reform will cost our state $1.2 billion over the next three years. It will break states at a time when we can least afford it."

Health and Human Services Secretary Kathleen Sebelius, however, sees it a little differently. "I would argue those new costs are balanced by new benefits to states," she says.

Indiana's Welch points out there is still ample time for state lawmakers to advocate for changes in the regulations that will help states afford the changes. "The point is, it's 2014. We need to be sharing our concerns with Washington to see what the final costs will be."

For states that already have begun coverage expansions, the 2014 program will build on their infrastructure. "States should not abandon or put on hold their current health care reform efforts," says Meyer of Health Management Associates. "They have been leaders in expanding coverage to groups left out due to our ancient and unfair Medicaid rules."

For others, a planning session may be in order. At a recent conference, a federal administrator repeated a common slogan: "2014 is now."

CHECK OUT more on how states are affected by the federal health care overhaul and NCSL's detailed tracking report of bills and resolutions in the states in response to the changes at www.ncsl.org.