National health reform and CT

The Patient Protection and Affordability Care Act, passed Congress and signed by the President in March 2010, offers CT exciting opportunities to expand health coverage, improve the quality of care and reduce costs. However, it also creates new responsibilities for our state.

National health reform in a nutshell:

- *Individual mandate* – Residents with incomes over the federal poverty level (FPL, $10,830 for an individual) will be required to have health care coverage, either through a public program, through an employer's plan or by direct purchase. Subsidies are available for people with incomes up to four times the FPL. Penalties range from $750 to $2,250 per family based on income and will be enforced by deduction from income tax refunds.
- *Employer mandate* – Employers with over 50 workers will be assessed a fine of $750 to $2,000 per worker not offered coverage.
- *Small business tax credits* – Provides refundable credits to some small businesses (fewer than 25 employees) with low income workers (average wages below $40,000/yr).
- *Medicaid* – Expands Medicaid coverage to all state citizens and legal immigrants below 133% of FPL ($14,404 for an individual) regardless of family circumstance. This is a significant change to Medicaid eligibility in CT which currently is limited to children, their parents, elderly and disabled residents. It is expected that CT's Medicaid will enroll between 114,000 and 155,000 new members in January 2014 due to this expansion. The largest share of this expansion is funded by the federal government, but CT's share of the costs is estimated at between $263 and $440 million.[i] National reform also increases Medicaid primary care provider rates to Medicare levels, with the federal government picking up the full cost for 2013 and 2014.
- *State insurance exchange* – National reform provides grants for states to develop an insurance marketplace to help consumers shop intelligently for good coverage. Coverage offered in the exchange will be affordable with caps on premiums and out of pocket costs.
- *Insurance reforms* – National reform prohibits denials of coverage for pre-existing conditions, sets standards for benefit packages to be offered in the exchange, limits lifetime and annual coverage maximums, and requires insurers to spend 80 or 85% of premiums on medical care and quality enhancements. Under national reform, insurers can no longer cancel policies just when policyholders get sick. Insurers cannot charge more based on sex or health status– pricing can only be based on age and geography, with limits on how much rates can vary.
- *Allows children to stay on their parents' coverage to age* 26 – Although CT was one of a handful of states with similar laws, passage of the federal act covers all employer coverage policies and exempts the benefits from taxes.
- *Comparative effectiveness research* – Currently new technologies, treatments and drugs are not tested for their effectiveness before being widely adopted. Many analysts believe this lack of information is one of the largest drivers of health care cost escalation. National reform devotes significant resources for research to determine which treatments are most effective for which patients.
- *Health care workforce* – National reform includes numerous programs to address looming shortages across health care fields.
- Closes the *Medicare* prescription drug donut hole by 2020. National reform also stabilizes Medicare's funding for an additional decade, in part by reducing overpayments to Medicare Advantage HMOs.

- *Taxes on high value health plans* – In 2018, national reform includes taxes on expensive health plans. The tax is intended to raise revenue and to hold down premium costs.
- *Nutrition labeling on menus* – To help consumers make healthier choices, chain restaurants will have to post nutritional information, including calories, for their food.

What does CT need to consider as national reform rolls out?[ii]

Because of our SustiNet planning process, CT is already moving ahead with health reform planning. However, many questions remain.

- How will DSS handle the influx of more than 100,000 new Medicaid enrollees? CT's HUSKY program has been troubled with administrative inefficiencies, HMO overpayments, low provider participation, lack of transparency, confusing client education/notices, poor outreach, and inadequate state oversight of contractors.
    - How will DSS offices be staffed up to handle the expanded workload?
    - How will the state find newly eligible members and how will current clients be notified of new eligibility options?
    - How will the state implement a premium assistance program for Medicaid eligible residents?
- How will the state implement aggressive new waste and fraud surveillance monitoring? Which agency will be responsible?
- How will CT implement an insurance exchange? The CT Insurance Dept. has not been a strong protector of consumers' rights even with our limited standards in current law. CID does not now consider the affordability of coverage as a parameter in regulating insurance rates. It is unclear if CID has the research or public input capacity to make sophisticated assessments of benefit packages and rates. Questions of the lack of political will at CID to protect consumers led to the creation of the separate Office of Health Care Advocate (formerly the Office of Managed Care Ombudsman).
    - How will the state monitor the health of private insurance plans?
    - How will the state monitor and enforce provisions prohibiting pre-existing condition exclusions and lifetime caps on care?
    - How will the state monitor plans for inappropriate behavior such as risk segmentation, creaming, inappropriate marketing practices, etc?
    - How will the state create a trusted source of information on insurance offerings for consumers? How will the state get the word out about the information? CID's current managed care plan report card is a helpful resource for consumers and payers, but very few know about it.
- How will CT's health care system interact with an individual mandate?
- How will the state's fragmented and dysfunctional health data systems be improved to meet new demands and standards?
- How will the state incorporate public input, advocate feedback, provider satisfaction, CMS supervision and legislative initiatives into policy to ensure effective monitoring, clear communications and common goals?
- How will the state build sufficient health policy capacity to track federal policy updates and to communicate with federal agencies to ensure compliance?
- Will health care planning be transparent with adequate public notice and opportunities for input? As an example, DSS' recent HUSKY application waiver was submitted to the General

Assembly and scheduled for public input on the last possible day without adequate opportunities for thoughtful policymaking. In fact, legislators and bureaucrats worked out back room deals to develop the waiver application in a process that pointedly excluded advocates. Not surprisingly, although it was not the intention of the legislators involved, the resulting waiver deal harmed consumers and significantly set back important initiatives such as PCCM.

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Sources:

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[ii] Questions for CT: How will we implement national Medicaid health reforms, CT Health Policy Project Issue Brief, January 2010.