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State Implications of Health Reform in Georgia

How will the health reform law affect health care and health insurance for Georgians? Federal agencies responsible for implementing the law still have to determine how the law will be interpreted. Yet, Georgia policymakers can prepare for an effective implementation by understanding the provisions of the law as it is currently written, how those provisions might alter current practices in Georgia, and what choices Georgia policymakers can make to shape the system. This brief is the second in a series on health reform. Upcoming communications will include: Community Implications and the Provider Impact.

PUBLIC HEALTH INSURANCE

The health reform law introduces many changes to the two major state health insurance programs: Medicaid and the Children's Health Insurance Program (CHIP/Georgia's PeachCare for Kids). By 2019, as many as 16 million more people may be covered under these programs nationwide.* Health reform provisions for these public insurance programs will likely require increased financial obligations for states. In 2008, states allocated roughly 17% of their general fund budgets to the Medicaid program, making it the second largest program in most state budgets (following spending for elementary and secondary education).

The changes to public health insurance coverage outlined in the law can be viewed in two main categories:

- Expanded eligibility, and
- Changes to payment mechanisms.

• EXPANDED ELIGIBILITY

Beginning in 2014, states will be required to extend Medicaid coverage beyond traditionally covered groups/eligibility categories (such as qualified children, their caretakers, pregnant women, the disabled, and certain other vulnerable populations) to most individuals under the age of 65 who are at or below 133% of the federal poverty level (FPL). As of April 2010, states can voluntarily expand early but would do so without a federal match. There has been some variation among states in setting income limits for different eligibility categories. Therefore, the reform law will impact states differently.

Figure 1 shows the change in eligibility for selected population groups in Georgia that could be impacted. Currently, adults with children qualify for family Medicaid coverage if they are at or below 29% FPL, equivalent to an annual income of $4,272 for a family of two**. The new income limit of 133% FPL would represent an annual income of $19,380 for such a family. Childless adults, previously ineligible for public coverage based on income alone, will also be eligible for Medicaid if their family income is less than 133% FPL. For children, the reform law may represent a change in their source of public coverage. For example, children in Georgia with family income between 100 and 133% FPL who are currently eligible for PeachCare for Kids will be newly eligible for Medicaid coverage.

Based on 2008 numbers and assuming full implementation of health reform, approximately 700,000 Georgians may become newly eligible for public insurance. Of those, some may choose a public subsidy to purchase health insurance in the private market.

** Estimated by the Congressional Budget Office, March 20, 2010.*
*** Based on 2009 income limits.*

FIGURE 1: ELIGIBILITY CHANGES IN PUBLIC INSURANCE FOR SELECTED POPULATION GROUPS IN GEORGIA

SELECTED POPULATIONS***	CURRENT ELIGIBILITY	NEW ELIGIBILITY+
CHILDREN 6-18 YEARS-OLD LIVING IN FAMILIES 100-133% FPL	PEACHCARE FOR KIDS WITH A PREMIUM	MEDICAID WITH NO PREMIUM
ADULTS WITH CHILDREN	MEDICAID AVAILABLE FOR THOSE AT OR BELOW 29% FPL *($4,272/year for a family of two)*	MEDICAID AVAILABLE FOR THOSE AT OR BELOW 133% FPL *($19,380/year for a family of two)*
ADULTS WITH NO CHILDREN	NONE	MEDICAID AVAILABLE FOR THOSE AT OR BELOW 133% FPL *($14,412/year for a single adult)*

= APPROXIMATELY 700,000 NEWLY ELIGIBLE FOR PUBLIC INSURANCE IN GEORGIA++

****No changes in eligibility for the aged, blind, and disabled or other vulnerable populations.*
+After full implementation of health reform.
++ Based on 2008 estimates.

The health reform law also extends authorization and funding for CHIP (PeachCare for Kids in Georgia) through 2015 and requires states to maintain current income eligibility levels for children until 2019. The current annual income limit for PeachCare for Kids is 235% FPL, or $34,240 per year for a family of two. The reform law also states that this requirement should not be construed as preventing a state from applying *less* restrictive eligibility standards during that time. In other words, the law allows states to expand CHIP eligibility standards. Children eligible for PeachCare for Kids coverage who cannot enroll because of allotment caps must be covered through the state's insurance exchange.

- **CHANGES TO PAYMENT MECHANISMS**
  Between 2014 and 2016, the federal government will reimburse states for the full cost of coverage [100% Federal Medical Assistance Percentage (FMAP)] for any individuals newly eligible for Medicaid as a result of the reform. This federal subsidy will fall to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. The law requires income eligibility to be based on modified adjusted gross income without an asset test or resource test [though existing income accounting rules remain in place for the elderly and groups eligible through another category, such as foster care or the Supplemental Security Income (SSI) program].

  The federal government will also provide a 23 percentage point increase in the subsidy rate for state CHIP programs, up to a cap of a 100% subsidy starting in 2015. The health reform law extends and increases funding for Medicaid and CHIP enrollment and renewal activities from $100 million through 2013 to $140 million through 2015.

PRIVATE HEALTH INSURANCE

The law gives states a great deal of flexibility in determining the structure of the private insurance market in Georgia. With health reform, states play an important role in:

- Implementing new insurance market regulations,
- Helping consumers navigate the individual and small group markets through consumer assistance offices,
- Managing directly or facilitating the development of a new infrastructure called an "exchange" for selling insurance in the individual market, and
- Managing or facilitating an exchange for small businesses within the state.

These activities, together with other changes that the state can either take on or leave to the federal government, will affect the private health insurance market in significant ways.

- **REGULATING THE INSURANCE MARKET**
  States have traditionally been responsible for regulating all insurance sold within their borders. The health reform law changes the nature of health insurance regulation but anticipates that the existing mechanisms within the state will continue to perform the regulatory functions under the new guidelines. Therefore, it will be necessary for each state to perform a complete analysis to compare current state law with each new federal provision, identify a time line for implementing each new provision, and, where necessary, identify new resources that will be necessary to carry out a different level of health insurance regulation within the state. Figure 2 (next page) highlights some of the changes in insurance regulation and the dates for those changes.

- **CONSUMER ASSISTANCE**
  The law anticipates that states will establish a new or task an existing office to provide health insurance related consumer assistance to those purchasing coverage in the individual or small group markets. There are federal grants available to help states establish this office, and the funding is available as early as 2010. The decision about when and how to implement this policy in Georgia will fall to state policymakers.

- **EXCHANGES FOR INDIVIDUALS AND SMALL BUSINESSES**
  States will play a critical role in establishing a structure to manage the market for individual and small business health insurance. By 2014, citizens who are not eligible for public programs but do not obtain coverage through their employer will be expected to obtain their coverage through a Health Insurance Exchange. States will either create such an exchange directly or facilitate the establishment of a separate non-profit entity to develop and run it. The exchange will organize the market for individuals to purchase coverage, ensure that premiums meet regulations, and administer federal tax credits for individuals who have incomes at or below four times the federal poverty level.

  A similar entity called a Small business Health Options Program (SHOP) will be the vehicle for organizing the insurance market for small businesses (less than 100 employees). The SHOP could, like the individual exchange, be directly run by the state or be established by a separate non-profit entity at the discretion of the state. Alternatively, the state can also combine them to form a single exchange.

IMPROVING HEALTH CARE QUALITY

To improve health care quality, states will be given the opportunity to build upon current quality improvement strategies within their Medicaid/CHIP programs, as well as inform the public about the performance of hospitals, nursing homes, and physicians through quality reporting on standardized Internet websites. State Medicaid and CHIP programs will also have opportunities to test models for improving the delivery, quality, and payment of services. Specifically, states have options to consider related to the following:

- Health Information Technology (HIT) capacity and infrastructure,
- Health care workforce, and
- Coordination of the delivery system.

- **INFORMATION TECHNOLOGY AND INFRASTRUCTURE**
  The health reform law imposes new data reporting and oversight requirements on states related to public coverage programs. States will be required to implement initiatives

FIGURE 2: SELECTED CHANGES TO INSURANCE REGULATIONS IN GEORGIA

Current Practice in Georgia	New Regulation	Effective Date
Health insurance companies may exclude from coverage altogether, or offer limited coverage to, individuals with pre-existing conditions.	Health insurance companies may not deny coverage to anyone based on a pre-existing condition (guaranteed issue).	Children (18 and under) – September 2010 Adults – January 2014
Plans may impose annual or lifetime limits on coverage.	Health insurance companies may not impose lifetime limits and will have tight restrictions on annual limits.	September 2010
High risk individuals in Georgia can be denied coverage and have no options to obtain insurance. There is enabling legislation on the books, but a high risk pool has never been funded in Georgia.	A temporary national high risk pool for individuals will be implemented in any state without such a plan.	July 2010 – January 2014
Plans report premiums to the state.	Plans must report the share of the premium spent on medical care to the state. Premiums must be reviewed. State must report on trends in premiums and approve premium increases.	2010 2010
Plans determine how much of the premium goes to administration and overhead and how much is spent on medical care.	Plans in the individual and small group market must spend at least 80% of all premiums on medical care and plans in the large group market must spend at least 85%.	January 2011
Plans define in the contract the age at which dependent coverage will end.	Unmarried dependents up to age 26 can potentially remain covered under a parent's plan.	Open enrollment periods beginning September 2010
Premiums can be adjusted to reflect individual age and health status.	Premiums must be community-rated with small variations allowed for age, family composition, and smokers.	January 2014

Note: Information shared in this brief is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules, it will be further interpreted. Details may change during this process.

programs. States will be required to implement initiatives already in use by the Medicare program, such as a national correct coding initiative and a recovery audit contract for their Medicaid programs. The former reduces inappropriate hospital expenditures for health care-acquired conditions and requires sophisticated data reporting for fee-for-service Medicaid programs. The latter is one initiative to enhance Medicaid program integrity through systematic audits of provider billing practices. Additional financial support will be available to states to improve their capacity to combat waste, fraud, and abuse.

Technology grants will be awarded to states to facilitate enrollment in federal and state health programs through the utilization of compatible information systems and new security standards. States are encouraged to simplify enrollment applications and to coordinate state health insurance exchanges with CHIP via state-run websites. Support to states is also available for improved data collection on health disparities and public health surveillance to inform state health planning.

- **HEALTH CARE WORKFORCE ISSUES**

To ensure an effective delivery system to manage newly covered individuals, several possibilities for attracting and retaining an effective health care workforce are available to states. The law offers increases in loan amounts to nursing students, loan repayment and forgiveness programs for public health and pediatric providers, and certification programs for personal or home care aides. The law also reallocates unused hospital residency slots (mostly primary care and general surgery) to states in the lowest quartile of medical resident-to-population ratio (such as Georgia). Demonstration grants will be available for a range of health care professionals including: long-term care workers, dentistry including alternative dental providers, mental health workers, and family nurse practitioners.

Furthermore, funding is available for demonstration projects to develop academic curricula that integrate quality improvement and patient safety into the clinical education of health professionals and create primary care extension programs to educate primary care providers about preventive medicine, health promotion, and chronic disease management.

- **COORDINATION WITHIN SYSTEMS OF CARE**

Opportunities exist to improve coordination, quality, and efficiency of health care services through new programs, payment reform, and funding to support collaboration among teams of health care professionals including doctors, nurses, pharmacists, and others. New offices within the Centers for Medicare and Medicaid Services will be added to better coordinate care across the Medicare and Medicaid/CHIP programs, specifically for dual-eligible beneficiaries. States may also consider how the CLASS Act, the opt-out program for long-term care insurance, might impact current state options for home and community-based services through Medicaid.

Multiple demonstration programs will support state efforts to tie quality improvement to Medicaid payment reform:

- Bundled payments for integrated care,
- Fixed payment model for safety net hospitals,
- Accountable care organizations that provide incentives to providers,
- Regionalized, comprehensive, accountable emergency care and trauma systems, and
- Incentives for home-based primary care teams.

States may also wish to monitor the impact of the health reform law on safety net providers. Under Medicaid, states are required to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income and Medicaid patients. Federal DSH allotments to states will be reduced based on changes in state-specific uninsurance rates over time. The law also offers options for investing in other safety net providers such as community health centers, psychiatric hospitals, and rural hospitals.

IMPROVING HEALTH

Health and well-being will be promoted through insurance coverage requirements and support of evidence-based programs in states and communities. Health plans must include reporting requirements or reimbursement structures that improve health outcomes, prevent hospital readmissions, improve patient safety, and promote wellness and health. The health reform law introduces new optional benefits under Medicaid and CHIP such as preventive services for adults, medical homes for persons with chronic conditions, and expansion of home and community-based services as an alternative to institutional care through the state plan rather than waivers.

Reform also encourages health prevention through demonstrations, pilot programs, and grants. Opportunities are available for states to implement programs focused on childhood obesity, early childhood home visitation, education related to reproductive health, oral health promotion, and community-based health programs to reduce chronic disease in older adults.

CONCLUSION

States are key partners in the implementation of health reform. Georgia policymakers in the legislative branch and administrative agencies will have the chance to design key processes and systems to best meet the needs of Georgians. Furthermore, some of the funding sources will require the state to strategically match Georgia's needs to various provisions in the law. This brief only touches on some of the most prominent aspects of what is currently known about the law in an effort to inform state policymakers of the leverage points available to impact the health and health care of Georgia citizens.