

CHAPTER 6 BEST PRACTICES IN PROVIDING BETTER HEALTH INSURANCE

6.1 RURAL RESIDENTS

Appalachian counties rank high on health insurance coverage when compared to the U.S. However, having coverage does not assure protection from medical costs. Benefits vary from policy to policy and state to state. Moreover, insurers set prices and organize benefits packages on the basis of their expected payouts. This is described as their “medical loss ratio.” To price their policies competitively, insurers need a large group of healthy people who have low medical loss ratios. Low population and older ages in rural areas reduce the number of available healthy people. To serve rural residents, insurers must aggregate groups large enough to balance high with low users. Presently, all health insurance plans are state regulated; and insurance companies cannot market across state lines. To some extent, large companies and large membership organizations can aggregate rural areas within a state, thus attaining some purchasing leverage with insurance companies, but state boundary hurdles remain.

Professional groups, Farm Bureaus and Rural Electric Cooperatives have historically formed membership groups and brokered private health insurance plans. Tennessee Rural Health (TRH), a Farm Bureau membership organization, for example, covers 95 Tennessee counties and offers a variety of plans.⁶² Many large employers bypass insurance companies and self-insure, working across state lines to meet local requirements. Small companies cannot form good risk pools alone. For them, membership organizations, large insurer sponsored small group plans and state risk pools are common solutions. Individuals traditionally turn to membership groups and large insurer’s individual plans. Individual plans are age- and location-risk rated and may price out of the reach of many. Health reform will not change this. A report by United Health observes that rural adults and particularly those in the rural south are more likely than urban ones to have a range of chronic conditions. This makes their geographic risk higher and their healthcare more expensive.

The last option for small companies and individuals is state high-risk pools. These pools focus on persons who have pre-existing, often chronic conditions that make them ineligible for individual or group plans. Chronic disease tends to associate with pre-existing conditions that preclude qualification from private insurance programs. For these people, government programs, employment by a large company or access to risk pools are the only options. Many state-wide high risk pools require subsidies.⁶³ Even then, many rural and urban residents find them unaffordable. The difference between rural and urban levels of uninsurance is only two percent.⁶⁴ Federal health insurance programs provide uniform accessibility to rural and urban residents and a higher proportion of rural than urban residents are covered by CHIP, Medicare and/or Medicaid (31 compared to 25 percent).

⁶² TRH Health Coverage, <http://www.trh.com>. Accessed October 27, 2011.

⁶³ S. Khimm. Why are High-risk Pools Having So Much Trouble? Health Insurance Resource Center, Health Insurance Risk Pool News, 06/01/2011 http://www.washingtonpost.com/blogs/ezra-klein/post/why-are-high-risk-pools-having-so-much-trouble/2011/06/01/AGbBVZGH_blog.html. Accessed October 25, 2011.

⁶⁴ Modernizing Rural Health Care: Coverage, Quality and Innovation. Working Paper 6. July 2011. http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper6.pdf. Accessed October 25, 2011.

As noted in Chapter 4 of this report, health insurance coverage is not necessarily associated with good health outcomes. By contrast, a recent survey of literature and statistics by United Health Center for Health Reform & Modernization (United Health) and data from the Patient Centered Primary Care Collaborative consistently indicate that integrated healthcare delivery systems built around a primary care medical home, customer engagement and multidisciplinary teams that use independent practitioners to the full scope of their practices and not subject to older licensing constraints do produce good clinical outcomes and use fewer health resources in both urban and rural settings.

United Health reports that a majority of rural primary care doctors agree with this approach.⁶⁵ On the positive side, United Health authors note that a higher proportion of rural than urban primary care providers accept new Medicaid patients.

Three-quarters of rural residents live in the south and the west, and 60 percent of people living in rural counties live close to an urban area.⁶⁶ Nonetheless, data from a United Health/ Harris Interactive survey note that more than half of rural patients travel an average of 60 miles for specialty care. Primary access and health insurance coverage are not the only barriers to full care. What the insurer pays the provider is also important; and some private and government insurers have traditionally paid less than cost for services. Medicare is the benchmark payer, and tends to pay below cost in most markets. TRICARE, the program for military retirees and families pays significantly less than Medicare. Medicaid may pay as little as 55 percent of Medicare. However, Medicaid payments in rural areas are closer to Medicare payments, averaging 82 percent of Medicare.⁶⁷ As demonstrated by the HCC component of the HCCA, Medicare payments in the Appalachian Region are, for the most part, substantially lower than in the rest of the country.

Medicaid is the primary coverage for institutional long term care; and spending on the 30 percent elderly Medicaid beneficiaries who also have Medicare coverage uses 77 percent of Medicare and Medicaid funds spent. This group of “dual eligibles” represents an opportunity and a challenge for the Appalachian Region, where a significant portion of the population is older, lower income and has chronic disease. Efforts to control costs and outcomes for this group are just emerging and represent significant opportunity for regional information sharing. Judy Feder argues that Medicare must take the lead because the federal share of spending exceeds the state share.⁶⁸ Others argue that the smaller state unit can innovate faster. Still others argue for privatized contracts with national managed care companies.

6.2 POTENTIAL FOR APPALACHIAN REGION

As noted in Chapter 3, poor health insurance coverage is concentrated in four states in the Appalachian Region. Most Appalachian counties in Mississippi, Georgia, North Carolina and eastern West Virginia, rank below the HIC 39th percentile. Please see Figure 15 of this report. These low coverage statistics reflect state Medicaid eligibility limits, absence of major employers, limited individual purchasing capacity, and other barriers not explored in this report.

⁶⁵ Ibid.

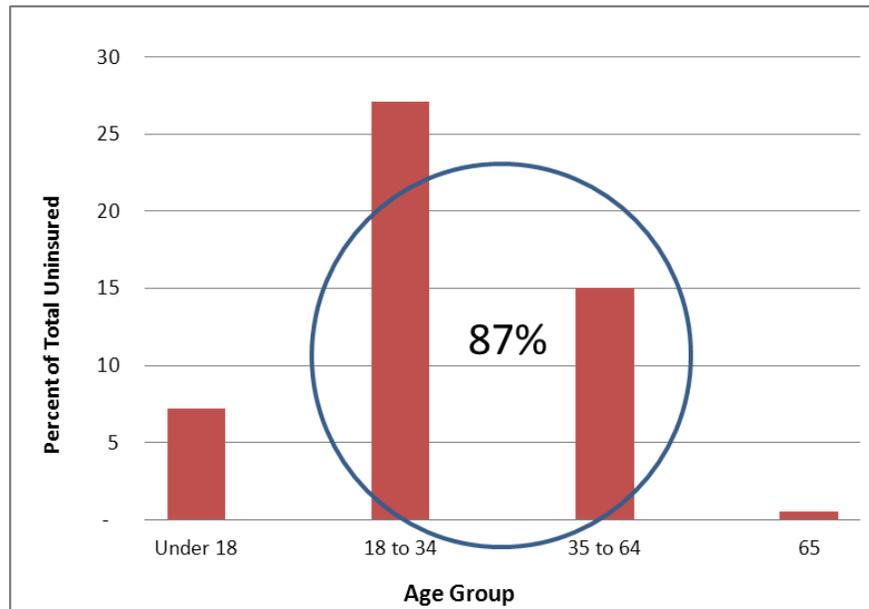
⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Feder, J. Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead. Georgetown University Urban Institute for Alliance for Health Reform Briefing. Washington, D.C., October 28, 2011.

Nationwide, and in the Appalachian Region, most of the people who have no health insurance are between the ages of 18 and 64. In 2009, they represented 87 percent of the uninsured, but only 63 percent of the total population of the Appalachian Region. About twice as many 18 to 34 year olds as 34 to 64 year olds were uninsured. Ineligible for public programs, this group depends on private health insurance. Individual plans, pools and insurance exchanges are the options available to them.⁶⁹

FIGURE 45 – APPALACHIAN REGION UNINSURED BY AGE GROUP, 2009



Source: American Community Survey Data Set 2009 prepared for the Appalachian Regional Commission 9/1/2011

Membership cooperatives have historically played a major role in health insurance improvement in the Appalachian Region. They face new challenges as health reform's health exchanges permit marketing across state lines. Strong ones may become a valuable resource. It is too early to tell.

6.3 IMPACT OF HEALTH REFORM LEGISLATION

6.3.1 INSURANCE EXCHANGES

Health insurance exchanges are mandated by health reform, but some already exist. They sell direct to the consumer. Early reports indicate that their premium price will be critical to attract enrollment. Pennsylvania, a state that ranks high on the HIC index of health insurance coverage, posts insurance plan rates on a website⁷⁰, and supports a low cost state health insurance plan for people with pre-existing conditions. The Pennsylvania health risk exchange pool appears to have done the best job of making care affordable.

⁶⁹ Data from B27010. Types of Health Insurance Coverage By Age - Universe: Civilian Non-institutionalized Population Data Set: 2009 American Community Survey 1-Year Estimates, Survey: American Community Survey, Puerto Rico Community Survey Table compiled by ARC 9/1/2011.

⁷⁰ www.Pahealthinsurancecoverage.com.

Its low price has attracted a significant subscriber base. Monthly premiums for PA Fair Care are only \$283 and enrollment is strong.⁷¹ Unknown is whether the pool size and subsequent organization of delivery system response to management of care for this high-risk group can offset the higher cost of their care. A pilot North Carolina high-risk plan priced closer to market rates experienced slow enrollment.⁷²

Health reform's mandates for expanded Medicaid eligibility and health insurance exchanges will require creative cost management to keep costs under control. Newly eligible people, after 2014, will have incomes below 133 percent poverty, a group at high risk of poor health and related high healthcare costs.

6.3.2 INNOVATION OPPORTUNITIES

Health reform launched CMS Center for Medicare and Medicaid Innovations (CMMI) with \$10 billion in funding for the 10-years ending in 2021. Projects and programs are emerging in three- to five-year rapid cycle improvements intended to test and implement delivery system changes that will: improve health, reduce cost and improve customer satisfaction. First funding will begin in January 2012. ARC is uniquely positioned to facilitate an understanding of the region's needs and opportunities among the highly motivated staff at CMMI. Understanding regional variations is important to the work of CMMI, and they are continually soliciting new ideas in advance of releasing innovation cycles. Recent patterns indicate that each cycle will produce limited awards involving five to 40 participants nationwide. Cycle announcements generally precede letters of intent due by only 45 days. Hence, advance planning is critical to success.

Authorization for the CMMI permits CMS to use rapid cycle improvement approaches to bring success from pilots to mainstream quickly. This break-through program is led by Richard Gilfillan, MD. Prior to taking the position, Dr. Gilfillan was a member of the Danville, Pennsylvania leadership team at Geisinger Health System that piloted some of the early health reform programs.

One improvement project that will be funded in 2012, involves multi-year grants of \$1.0 million to \$30 million to "a broad set of innovation partners to identify and test new care delivery and payment models that originate in the field and that produce better care, better health, and reduced cost through improvement for identified target populations."

This project is ideally suited to the Appalachian Region; it requires state and healthcare provider participation and would put ARC and participating states front and center with some of the program's strategic goals. In announcing this initiative, CMS emphasized the project's potential to develop and sustain employment for extended practice providers and entry-level workers like community health workers. Although applications for that batch of innovation projects were due in January 2012, the nature of the CMMI projects and its focus on population health offers a good platform for ARC to encourage similar projects that could specifically benefit the Appalachian Region.

6.3.3 DELIVERY SYSTEM

Most health insurers, federal and private, are starting to design their coverage around integrated care delivery systems. In these, patient information is shared among providers who agree to common goals and common use of evidence based medicine. As these take hold, formal connections between healthcare specialty centers and remote communities should improve.

⁷¹ Bracken, D. State's uninsured about to get new options, News and Observer, Raleigh, NC June 30, 2010. http://www.portal.state.pa.us/portal/server.pt/community/health_insurance/9189/pa_fair_care/666211.

⁷² <http://www.newsobserver.com/2010/06/30/558114/health-options-about-to-expand.html#storylink=misearch>.

A few pilots aimed at controlling costs for people with chronic disease are underway and more are expected in 2012 as part of CMS Chronic Care Innovations.⁷³ In North Carolina, Blue Cross teamed with the University of North Carolina with plans to offer a clinic dedicated to subscribers who are high risk. Incentives for that program are still under development. Maryland Blue Cross is incentivizing primary care providers to become medical homes. Georgia Department of Community Health has organized quality programs to focus on rewarding outcomes, particularly in long term care.

Most ACA health reform payment changes are scheduled to occur in 2014. Communities that fail to form integrated healthcare delivery systems before 2014 will get behind in the rapid cycle of healthcare delivery reform, and may lack the resources to ever catch up. Early reports from reform initiatives indicate that the massive change effort involved in health reform requires collective work, either by group association, health system membership or insurance/ practice cooperation. Lack of capital or tendency to accept relationships as they are may work against particularly the most remote communities. On the other hand, the Appalachian Region has demonstrated time and again that its independent inventiveness can, of necessity, design solutions faster than more cosmopolitan large centers.

Rural Health Clinics, which are in every Appalachian state, except Maryland,⁷⁴ have the organized approach and the improved primary care payment required to support coordinated care, but they still consist largely of two to four providers, and are not quite large enough to support the care coordinators and behavioral health specialists that are associated with outcome changes. As the originator of that legislation, ARC can help focus CMS attention on changes needed in Medicare and Medicaid to make the Rural Health Clinic form of primary care more accessible in the region. Today, once a location attains the Medically Underserved Area (MUA) benchmark level of primary health manpower, practices lose the opportunity to become designated as Rural Health Clinics. This was not the original intent of the legislation. In 2011, a committee formed to study the criteria for qualifying an area to have Rural Health Clinics was asked by one Governor to provide for “Exceptional Medically Underserved Areas.” This designation is defined in legislation and adding it to the eligibility qualifications would permit a practice to keep Rural Health Clinic status if its area loses its official designation as an MUA. See Appendix J.

An insightful United Health report⁷⁵ lists core strategies that will modernize rural delivery systems:

- Provide incentives to expand the availability of rural primary care physicians.
- Encourage greater teamwork in rural primary care, including making full use of the skills of advanced nurse practitioners and other health professionals.
- Increase clinical collaboration across rural regions and with urban providers.
- Support greater integration and coordination of rural care with health information technology.
- Use mobile infrastructure to bring care to rural areas.
- Adopt new approaches to improving consumer health and wellness, including new alliances with third sector/non-traditional partners.
- Improve payments for primary care physicians.

⁷³ CMS press release Health Care Reform Law Demonstration To Improve Care, Lower Costs For Seniors And People With Disabilities, Dec 20, 2011.

⁷⁴ CMS Listing of Certified Rural Health Clinics. July 2011.

⁷⁵ Modernizing Rural Health Care, op. cit.

Emergence of telemedicine for reaching remote areas will be constrained by the speed with which all remote regions have access to broadband coverage. The National Broadband Plan, released in 2010, recommends as a national broadband availability target that every household in America have access to affordable broadband service offering actual download (i.e., to the customer) speeds of at least 4 Mbps and actual upload (i.e., from the customer) speeds of at least 1 Mbps. It notes that 14 to 24 million still lack access.⁷⁶

The U.S. Food and Drug Administration (FDA) also plays a role in access to telemedicine. Before a tool can be used for healthcare purposes, it must be submitted to the FDA for approval. The time to market delays in FDA approval now represent barriers to widespread adoption and product development.

6.3.4 ESTIMATED CHANGES IN MEDICAID STATE SPENDING

ACA requires that, starting in 2013, states must pay primary care physicians Medicare rates for Medicaid beneficiaries. For the years 2013 and 2014, the federal government will pay the differential in full. After 2014, the burden will shift to the states. Thus, a good thing may come at high cost to states, if cost management associated with health reform does not occur.

Health reform is intended to create savings that will offset the costs. Kaiser Commission on Medicaid and the Uninsured notes that states have a major role on the implementation side of health reform, including Medicaid expansion, health insurance exchange design, private insurance regulation, and developing coordinated eligibility and enrollment processes.⁷⁷

Looking at five states including Maryland and New York, as examples, the Kaiser Report notes:

- The federal program will pay all costs associated with covering new Medicaid enrollees between 2014 and 2020, and phase down to 90 percent of the new eligibles' costs after that.
- Program design changes in Medicaid are intended to increase coordination of care for Medicare/Medicaid dual eligibles and reduce cost of their care. As noted earlier, this group is among the most expensive to serve.
- States can set up a health insurance exchange, or the federal government will do it for them.

As noted in Chapters 1 and 5, increases in Medicaid enrollment may put severe pressures on state Medicaid budgets, particularly after 2014. Though state costs for new eligibles will be offset by federal payments at first, the costs of expanded benefits for existing eligibles will be entirely born by states. States struggling with Medicaid budget deficits of \$100 million and more as a result of the current recession may not have funds to meet the health reform mandates.

⁷⁶ Federal Communications Commission News Release July 20, 2010, Washington, DC. <http://www.fcc.gov/measuring-broadband-america> National Broadband Plan at 135 (recommending that the national broadband availability target also include "acceptable quality of service for the most common interactive applications").

⁷⁷ R.R. Bovbjerg, B.A. Ormond and V. Chen. State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts. Kaiser Commission on Medicaid and the Uninsured. February 2011.

There is no consensus on what health reform will cost individual states. One Kaiser report notes that incremental costs for states could range from a five-year \$164 million in West Virginia to \$1.1 billion in Pennsylvania. For all states together, estimates range from \$20 billion reported by the Congressional Budget Office to a savings of \$33 billion estimated by CMS. Variations reflect the difficulty estimating the size of the uninsured gap and how individuals will respond to the opportunities. CMS estimates presume a dramatic reduction in physician Medicare payments that will not occur. An automatic adjustment in a formula known as the Sustainable Growth Rate (SGR) would reduce physician payments 35 percent. However, Congress has reversed this formula every time it reaches double digits.

The United Health report forecasts that under health reform, rural areas could see coverage increase by eight million new Medicaid or health insurance exchange beneficiaries, of whom about five million will be newly insured. All but three Appalachian states, West Virginia, Pennsylvania and New York, will increase their Medicaid enrollment by 30 to 44.9 percent.⁷⁸

Whether rural primary care providers will have capacity or willingness to absorb the Medicaid increase is a matter of concern. In the Appalachian Region, United Health reports that Alabama, Georgia, Mississippi, northern West Virginia and North Carolina will have the substantial primary care challenges. The Kaiser Commission on Medicaid and the Uninsured added Kentucky to the primary care shortage list.⁷⁹ Without coverage, budgets may not increase as much.

States will retain their role in determining Medicaid payment amounts. Low payments will likely result in sustained patterns of healthcare provider access problems in areas with high concentrations of Medicaid beneficiaries.

As noted earlier, the big ACA impact will occur in 2014, when Medicaid eligibility must expand to cover non-elderly adults who have incomes up to 133 percent of the federal poverty level (FPL). The federal government will cover 100 percent of all costs for these newly eligible from 2014 through 2016. After that, the federal share will begin to shift to states. In 2017, the portion of newly eligible covered by the federal government will decrease to 95 percent and will gradually decrease to 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 onward. States will receive the same Medicaid matching rate (FMAP) for the classes of people eligible for Medicaid before healthcare reform.

Costs of state health insurance exchange pools are included in estimates of new Medicaid costs.

Several briefs have argued the state burden from healthcare reform will be minimal because the federal government will cover most of the Medicaid expansion costs. They argue that expansion of Medicaid services and coverage will also allow states to shift or eliminate health costs that will be newly covered under ACA. Table 26 describes a range of early estimates – ranked in ascending order of state Medicaid spending change due to health reform.

⁷⁸ Amednews.com. Interactive map, a major expansion, data from HRSA Area Resource File, 2008. <http://www.ama-assn.org/amednews/site/media/braceforit.htm>. Accessed October 27, 2011.

⁷⁹ Ibid.

TABLE 26 - SUMMARY OF MEDICAID EXPANSION EFFECT ON STATE BUDGETS

Study	% Change from Baseline (2014-2019)	New Medicaid Enrollees (2019)	Total State Spending (2014-2019)
Angeles and Broaddus	1.25%	N/A	\$20.0 billion
Holahan and Headen (standard)	1.4%	15.9 million	\$21.1 billion
Holahan and Headen (enhanced)	2.9%	22.8 million	\$43.2 billion
Milliman (Mississippi)**	10.4%	N/A	N/A
Milliman (Nebraska)**	10.7%	N/A	N/A
Milliman (Indiana)**	15.4%	N/A	N/A

* Baseline assumes no passage of healthcare reform

** Milliman estimates are for individual states only

Angeles and Broaddus from the Center on Budget and Policy Priorities have addressed the question of federal and state costs for Medicaid as health reform rolls out. These authors project that the federal government will shift most of the cost burden away from states. From 2014 through 2019, the first five years of healthcare reform, states will see a 1.25 percent increase in Medicaid spending as a result of ACA.⁸⁰ Taking the CBO baseline estimates from March 2010, Angeles and Broaddus estimate that the additional \$20 billion in Medicaid expansion cost from 2014 through 2019 is a small percentage of the projected \$1.6 trillion that states will already spend on existing Medicaid expenditures. The increased cost from healthcare reform over the pre-reform spending represents a 1.25 percent increase through 2019.

John Holahan and Irene Headen conducted an analysis for the Kaiser Commission on Medicaid and the Uninsured. This study used a Medicaid participation model to create state-by-state results of the spending impact of Medicaid expansion. Using different multiple participation scenarios, the authors argue that “the federal government will pay a high portion of new Medicaid costs in all states and the increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted.”⁸¹ See details in Appendices F and G.

The standard participation scenario assumes newly eligible Medicaid enrollment is at the same rate as current Medicaid enrollment and minimal enrollment for currently eligible participants. Under the standard participation scenario, federal spending for Medicaid expansion, which does not include CHIP, will total \$443.5 billion for the federal government and \$21.1 billion for state governments through 2019.⁸² This is slightly higher than the CBO estimate of \$20 billion, which includes both Medicaid and CHIP expansion costs.

In the model, enrollment in Medicaid will expand by 15.9 million by 2019 and will lead to a reduction of 11.2 million uninsured individuals. Enrollment was expected to increase 27.4 percent from a baseline model with no reform legislation passed.

⁸⁰ January Angeles and Matthew Broaddus. “Federal Government Will Pick up Nearly All Costs of Health Reform’s Medicaid Expansion”. Center on Budget and Policy Priorities. Revised June 18, 2010. <http://www.cbpp.org/files/4-20-10health2.pdf>. Accessed January 3, 2011.

⁸¹ John Holahan and Irene Headen. “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL”. The Kaiser Commission on Medicaid and the Uninsured. May 2010. <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>. Accessed January 3, 2011.

⁸² Ibid. p. 23.

Because of federal match increases, state spending is projected to increase only 1.4 percent. In comparison, federal spending will increase 22.1 percent above the baseline model. A state-by-state breakout of the changes in Medicaid expansion enrollment and spending is seen in Appendix F for the standard scenario.

Under the enhanced participation scenario, the model uses a higher Medicaid participation level which would increase Medicaid enrollment and correspondingly it assumes a lower level of uninsured population. Enrollment in Medicaid would expand by 22.8 million by 2019 and would lead to a reduction of 17.5 million uninsured individuals. Under the enhanced scenario, 5.3 million would have had other health coverage before the passage of health reform.⁸³ Enrollment was expected to increase 39.3 percent from a baseline model with no reform legislation passed. Under this scenario, state spending is projected to increase 2.9 percent. Federal spending will increase 26.5 percent above the baseline model.⁸⁴ A state-by-state breakout of the changes in Medicaid expansion enrollment and spending is seen in Appendix G for the enhanced scenario.

Holahan and Headen argue that the increased enrollment for states will far exceed the new state costs. However, the authors caution the magnitude of enrollment and costs will vary by state and by existing Medicaid coverage. States that currently have fewer Medicaid benefits and high uninsured rates will see the largest increases in federal spending.⁸⁵

A different approach to cost estimates on an individual state basis have been created by Milliman, a consulting firm with a long history of involvement in healthcare actuarial estimates. Milliman's estimates of the state impact of healthcare reform are higher than other reports that have been released.

The states of Indiana, Mississippi, and Nebraska have commissioned individual reports estimating the additional Medicaid state costs from healthcare reform.⁸⁶ With a full participation scenario, the analysis assumes a full 100 percent participation rate at the beginning of Medicaid expansion in 2014. Under this scenario, the increase in Medicaid expansion costs from 2014 through 2019 would be 15.4, 10.4, and 10.7 percent for the states of Indiana, Mississippi, and Nebraska, respectively.

When compared to the Kaiser analysis at the enhanced scenario, which does not include CHIP and is at a lower participation rate, Milliman has increased Medicaid state costs for Indiana, Mississippi, and Nebraska at 4.8, 6.4, and 2.2 percent, respectively.

John Holahan and Stan Dorn argue that although states will spend slightly more of their own budgets on Medicaid through 2019 as a result of healthcare reform, there are potential areas for state savings. Citing CBO estimates, the authors say increases in Medicaid coverage will come from newly eligible and not from currently eligible individuals. Costs from newly eligible individuals would be mostly covered by the federal government and states most affected by reform are those that already have high number of currently eligible individuals as a result of high income eligibility levels. These states include New York, Massachusetts, and California.⁸⁷

⁸³ Ibid. p. 30.

⁸⁴ Ibid. p. 21.

⁸⁵ Holahan and Headen. p. 7.

⁸⁶ Robert Damler. "Letter to Anne Murphy, Secretary of the Indiana Family and Social Services Administration, on the Patient Protection and Affordable Care Act With House Reconciliation – Financial Analysis". Milliman, Inc. May 6, 2010; John Meerschaert. "Financial Impact Review of the Patient Protection and Affordable Care Act as Amended by H.R. 4782, The Reconciliation Act of 2010 on the Mississippi Medicaid Budget". Milliman, Inc. October 1, 2010; and Robert Damler, "Letter to Vivianne Chaumont, Director of the Nebraska Division of Medicaid and Long-Term Care, Department of Health and Human Services, on the Patient Protection and Affordable Care Act with House Reconciliation – Financial Analysis". Milliman, Inc. August 10, 2010.

⁸⁷ John Holahan and Stan Dorn. "What Is the Impact of the Patient Protection and Affordable Care Act (ACA) on the States?" Timely Analysis of Immediate Health Policy Issues, June 2010. <http://www.urban.org/UploadedPDF/412117-impact-patient-protection.pdf>.

The authors believe that ACA can provide savings for states in six areas that can vary from one state to another. First, states can reduce spending on their own existing, state-related health funding for the poor because federal Medicaid spending will replace those state services. A projected \$70 to \$80 billion in savings from 2014 through 2019 can be shifted from state to federal Medicaid services.⁸⁸ Second, significant savings could come from moving Medicaid patients above 133 percent of FPL out of Medicaid and into health insurance exchanges. Patients who are in the exchanges would qualify for a federal tax credit without state matching funds. Third, the authors believe states have smaller financial burdens on CHIP if Congress ends funding for the program in 2015 and young patients move from CHIP to expanded Medicaid coverage. Fourth, savings can be generated through greater integration and funding of dual eligibles. Fifth, states may reduce coverage for their employees and retirees. ACA provided an allowance of \$5 billion for its role in reducing chronic care costs through subsidized reinsurance for early retirees. Sixth, states that are currently providing coverage for patients whose income is between 133 and 200 percent of FPL can move the patients into the “basic health program” option. This option allows states to “convert ACA’s tax credits to funding for contracts with health plans serving adults in this income range.”⁸⁹

In addition to savings, Holahan and Dorn say ACA will increase effective federal matching rates in states that did not have broader eligibilities. States that might see greater matching rates would typically be in the south and the west.

ACA eliminates a major hospital funding program for low-income persons, the Disproportionate Share Program (DSH). CBO estimates that Medicaid DSH payments will fall as a result of the increasing number of insured patients. The CBO estimates a decrease in DSH payments of \$0.5 billion in 2014, \$0.6 billion in 2015, \$0.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019 and \$4 billion in 2020.⁹⁰ Hospital providers in urban areas will be most affected by this change.

There is no doubt that implementation of all the provisions of ACA will change the mix of state, local and federal payments for Medicaid at the state level. Further, estimates of the extent of these changes in state and local expenditures for Medicaid are highly dependent on a number of assumptions about the uptake rates of various kinds of public and private insurance as exemplified by the significant contrast between the estimates made by Milliman and those made by the Kaiser Commission. All of these estimates are related in turn to the actual design and implementation of the insurance exchanges, the pace at which these new structures are put in place, and the array of choices available to participants.

As important as these sector-specific factors may be, their impact may be dwarfed by variation in overall performance of the U.S. economy, particularly national and local unemployment levels, which may likely affect the burden on state and local governments, particularly as economic stimulus funds disappear. As described in Figure 6, private spending will continue to be the largest single source of healthcare revenue, thus a major determinant of access.

⁸⁸ Ibid. p. 2.

⁸⁹ Ibid. p. 2.

⁹⁰ Ibid. p. 3.