CHRT

POLICY BRIEF

Policy Brief April 2011

Guide to State Requirements and Policy Choices in the Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (ACA) requires the establishment of significant new state-level structures by the year 2014. This document summarizes major requirements and policy choices for states between now and 2014[1], and describes other components of the ACA[2] that do not involve state implementation but have state budgetary impacts.

The two most significant ACA requirements for state implementation between now and 2014 are:

1. **To establish health insurance exchanges** for individuals and small businesses
2. **To expand Medicaid coverage** to cover all those up to 133 percent of the federal poverty level (138 percent with the five percent income disregard), regardless of categorical eligibility.

The ACA outlines major elements of implementation for health insurance exchanges and the Medicaid expansion but also gives states flexibility in many key areas. If states decline to implement some key initiatives, however, it does not mean implementation won't occur—rather, it means decisions will be made at the federal rather than state level.

The ACA also includes significant provisions relating to long term care *(noted in bold in table 4)*. These provisions include a new long term care insurance program as well as new opportunities within the Medicaid program to promote home and community-based services for long term care.

This document provides a list of actions, implementation dates, funding, and policy issues for:

- State requirements and policy choices in the ACA *(tables 1–4)*
- ACA provisions with potential budgetary impact but no state action required *(table 5)*

The final page of this paper provides a guide to acronyms used in this document and a list of useful websites by ACA topic.

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[1] This assessment was completed under the assumption that the ACA will be implemented based on the statute as it exists December 2010. If court challenges or the political process results in some substantive change to the ACA, revisions to this analysis would be required.

[2] Information technology is an important enabling element for many efforts to improve quality and transform the health care delivery system but most of the federal financial support for IT was committed through the ARRA, which is not described here.

[3] The ACA also includes many grant and demonstration project opportunities involving wellness programs, patient centered medical home demonstrations, expansion of federally qualified health centers, and Medicaid physician reimbursement enhancement. A list of these opportunities may be found in CHRT's June 2010 policy brief, **The Patient Protection and Affordable Care Act at the State and Local Level**, available on the **CHRT.org** website.

The Center for Healthcare Research & Transformation (CHRT) sponsors research and public information to promote evidence-based care delivery, improve population health, and expand access to care. Housed at the University of Michigan, CHRT is a nonprofit partnership between U-M and Blue Cross Blue Shield of Michigan to test the best ideas for improving the effectiveness and efficiency of the health care system.

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TABLE: 1
Health Insurance Exchanges — REQUIREMENTS

Requirement (Section Number)	Implementation Date	Funding & if appropriated	Policy Issues
Establish a process for the annual review of premium increases to determine whether increase is reasonable. (1003)	FY2010 through FY2014	$250 million appropriated over five year period. $46 million in premium review assistance grants awarded 8/16/10.	• **2011** Insurers requesting 10% or higher increase subject to review. • **2012** State-specific thresholds to be set. • States must make recommendations to their exchange regarding whether an insurer should be excluded based on unjustifiable premium increases. If state is unable to conduct review, HHS will do so.
Establish health insurance exchanges to provide specified health benefits coverage to individuals and small businesses. (1311)	1/1/14	$49 million in planning & implementation grants awarded 9/30/10. Exchange must be self sustaining by 1/1/15.	• States must notify HHS by 1/1/13 whether or not they intend to operate a state based exchange. (1321) • States may choose to establish a single exchange, jointly form regional exchanges, or form multiple subsidiary exchanges if each one serves a distinct geographic area. • Exchanges may contract with entities with experience and not associated with insurers or state Medicaid agency. • States may require additional benefits for essential benefits package (i.e., state mandated benefits) but the state must cover cost of subsidies.
Impose charges on health plans in the individual or small group markets with enrollees that have lower-than-average actuarial risks and make payments to plans with higher-than-average risks. (1343)	1/1/14		
Streamline enrollment procedures and establish secure, electronic transfer of information between Medicaid, CHIP and exchanges. (1413)	1/1/14	Not included in section, however part of the planning grant is to determine what needs to be modified or built.	• States may develop and use their own alternative streamlined forms if consistent with federal standards to be developed.
Contract with one or more reinsurance entities to replace the temporary high risk pool. (1341)	2014 through 2016	Funded through insurer contributions.	• Reinsurance entity must be non-profit. • States may have more than one reinsurance entity. • Two or more states may enter into agreements to create entities to administer reinsurance in those states.

TABLE: 2
Health Insurance Exchanges — POLICY CHOICES

Policy Choice (Section Number)	Implementation Date	Funding & if appropriated	Policy Issues
States may establish, expand or support offices of health insurance consumer assistance or ombudsman programs to assist and educate consumers and collect consumer problem related data. (1002)	FY2010	$30 million appropriated for FY 2010 and authorized as needed for subsequent fiscal years. $30 million in grants awarded 10/19/10.	• Funding is for states or exchanges operating in states.
States may opt out of abortion coverage in qualified health plans offered through exchanges. (1303)	1/1/14		• If plan covers abortion services, may not use funds from subsidies provided through the exchange. Must collect a separate payment from enrollees for the actuarial value of the service. • State insurance commissioner is required to ensure plans comply with segregation of funds.
Until 1/1/16, states may choose to define the small group market as 1-50 employees; the Act defines the small group market as 1-100 employees. (1304)	1/1/14 – 1/1/16		
Two or more states may develop interstate compacts, under which one or more qualified health plans for individuals can be offered in each "compacting" state. (1333)	1/1/16 (standards available by 1/1/13)		• Issuers would be subject to specified laws in purchaser's home state. • Plans must be licensed in each state where they offer coverage or submit to state's jurisdiction. • States may require multi-state plans to offer additional benefits but must pay for the additional cost.

States may apply for five-year waivers to the exchange requirements. (1332)	Plan years beginning 1/1/17		• States may apply for waivers of the following requirements:
			  • Qualified health benefits plans
			  • Health insurance exchanges
			  • Reduced cost sharing in QHPs
			  • Premium subsidies
			  • Employer mandate
			  • Individual mandate
			• Coverage must be equivalent to coverage offered in exchange, cover at least as many residents, and not increase the federal deficit.

TABLE: 3
Medicaid Coverage — REQUIREMENTS

Requirement (Section Number)	Implementation Date	Funding & if appropriated	Policy Issues
Payment is prohibited for health care-acquired conditions. (2702)	7/1/11		• Regulations for state plans must conform to Medicare regulations. Adjustments in regulations permitted, related to differences in populations..
Medicaid "benchmark" coverage expanded to all who are at or below 133% of FPL. (2001)	1/1/14	**2014 – 2016**: 100% federal funding for the expanded population. **2017 – 2020**: federal share phases down to 90%.	• States may expand Medicaid coverage prior to 2014. Also have option to provide Medicaid coverage to those above 133% FPL but not before starting with most needy. • Must maintain same level of benefits and eligibility (maintenance of effort, or "MOE") through 2013 for adults; MOE through 9/30/19 for children covered under CHIP or Medicaid. MOE not required 1/1/11 – 1/1/14 for adults above 133% FPL if state budget deficit. • For most Medicaid enrollees, income would be based on modified adjusted gross income without a resource or assets test. • Determine approach for benchmark coverage, which must be equivalent to essential benefits package.
Medicaid eligibility to be determined using modified adjusted gross income (2002). Applies 5% income disregard (added by 1004 of the Reconciliation Act).	1/1/14		• Income eligibility is effectively 138% FPL (instead of 133%) when applying 5% income disregard. • Income disregards and asset tests generally no longer apply, with some exceptions, i.e., individuals eligible for long term care or for Medicaid through another program.
Premium assistance and wrap-around benefits to be offered to Medicaid beneficiaries who are offered employer-sponsored insurance, if it is cost effective to do so. (2003)	1/1/14		
Enrollment procedures to be streamlined; secure electronic transfer of information to be established between Medicaid, CHIP and the exchanges. (1413)	1/1/14	Not included in section, but built into the exchange implementation.	• States may develop and use their own alternative streamlined forms if consistent with federal standards to be developed.
Requires coverage of certain drugs. (2502)	1/1/14		• Medicaid may no longer exclude coverage of smoking cessation and specified anti-anxiety drugs.
CHIP match rate increases 23 percentage points (up to 100% of funding). CHIP eligible children not enrolled due to limits in allotted spaces must be covered by exchange and eligible for tax credits. (2101)	FY2016 to FY 2019		• Income eligibility based on modified adjusted gross income. • Children excluded due to elimination of income disregards must still be covered. • Extends reauthorization of CHIP through 9/30/15 (as amended by 10203).

TABLE: 4
Medicaid Coverage — POLICY CHOICES

Policy Choice (Section Number)	Implementation Date	Funding & if appropriated	Policy Issues
Extends and increases funding via CHIPRA for grants to states to improve outreach and enrollment in CHIP. (2101 as amended by 10203)	FY 2009 - FY 2015	$140 million appropriated for FY 2009 through 2015 (increased from $100 million and extended 2 years beyond FY 2013).	• States must not decrease state spending in previous fiscal year (maintenance of effort).
Allows states the option to provide CHIP coverage to children of some state employees eligible for health benefits. (2101 as amended by 10203)	3/23/2010		
Allows states the option to cover family planning services, supplies, and related medical diagnostic/treatment services for individuals who meet the income eligibility criteria for pregnant women (under the state's Medicaid or CHIP program) but are not pregnant. (2303)	March 23, 2010		• States may also waive asset test when determining eligibility
Long Term Care: Establishes the voluntary long term care insurance program titled CLASS (Community Living Assistance Services and Support) Independence Benefit Program. (Title VIII)	1/1/11	Self-funded	
Long Term Care: Expands Aging and Disability Resource Centers' initiatives to streamline access to long term care supports and services. (2405)	FY 2010 through FY 2014	$10 million appropriated for each fiscal year. $9.9 million in grants awarded 9/27/10.	
Long Term Care: Removes barriers to providing home and community-based services. (2402)	10/1/10		• Option to provide home care services through a state plan amendment rather than waiver. • Permits states to extend full Medicaid benefits to individuals receiving HCBS whose income does not exceed 300% of the supplemental security benefit. • Elect for 5 years and renewable for additional 5 years. • May phase in enrollment and may target subpopulations. Must be statewide.
Long Term Care: Establishes optional Medicaid benefit, i.e., the Community First Choice Program, that provides community based support services to Medicaid beneficiaries under 150% FPL or if greater, requiring institutional (e.g., nursing home) level of care. (2401)	10/1/11	6% federal medical assistance percentage (FMAP) increase for home and community based services (HCBS).	• States must maintain same level of expenditures for certain programs for individuals with disabilities or elderly individuals. • Option to include additional services such as transition costs from nursing home to community/home setting.

TABLE: 4
Medicaid Coverage — POLICY CHOICES *(continued)*

Policy Choice (Section Number)	Implementation Date	Funding & if appropriated	Policy Issues
Long Term Care: Creates state balancing incentives program option for states that undertake structural reforms, i.e., create a single point of entry for home and community based services (HCBS), offer case management, and use standardized assessment instruments to shift beneficiaries from nursing homes into HCBS. (10202)	10/1/11 – 9/30/15	5% FMAP increase for HCBS in states with less than 25% of LTC spent on HCBS. 2% increase if 25-50% spent on HCBS.	
Long Term Care: Extends funding authority for Medicaid Money Follows the Person demonstration. Includes a transition program to assist Medicaid beneficiaries in nursing homes move to the community, and a rebalancing program that allows more long term care expenditures to flow to community services and supports. (2403)	FY 2012 through 2016	$2.25 billion appropriated over five years. $9.9 million in grants awarded 9/27/10.	• Same program but with reduced length of stay requirement to 90 days from six months.
Allows states to expand Medicaid coverage of diagnostic, preventive, screening and rehabilitation services to include services highly rated by U.S. Preventive Task Force and eliminate cost sharing requirement for these services. (4106)	1/1/13	1% FMAP increase for states that eliminate cost sharing for preventive services and vaccines for adults.	
Allows states to establish optional basic health programs providing essential benefits for low income individuals (134 – 200% FPL) and legal immigrants above 133% FPL who are not eligible for Medicaid, as an alternative to the exchange. (1331)	1/1/14	State receives 95% of the tax credits and cost sharing reductions that would be provided to individual in standard health plan.	• Multiple plans preferable. • Regional compact with other states may be negotiated. • Must have equivalent coverage. • Premiums may not exceed what individual would pay in exchange. • Cost sharing may not exceed platinum plan in exchange for individuals under 150% FPL and gold plan for all others.

TABLE: 5

ACA Provisions with Potential Budgetary Impact (No State Action Required)

Provision (Section Number)	Implementation Date	Policy Issues
Increases prescription drug rebates. (2501)	1/1/10	
Establishes the Federal Coordinated Health Care Office to coordinate services for dual eligibles. (2602)	3/1/10	
Ensures that federal activities and surveys collect a wider range of data in order to better measure and address health care disparities. (4302)	3/23/12	• Authorizes funding as necessary for FY2010 through 2014.
Requires primary care physicians to be paid Medicare rates for primary care services to Medicaid beneficiaries. (1202 in HCERA)	Effective in 2013 and 2014	• 100% federally funded for state's additional costs.
Reduces Medicaid disproportionate share hospital (DSH) payments to states. (2551)	FY2014	• Gradually reduced through FY2020; will take into account state uninsured rates
Requires report on federally promulgated quality and health measures for Medicaid covered adults. Standardized reporting by 1/1/13 and annual reporting thereafter. (2701)	1/1/13	• $60 million appropriated FY 2010 – 2014. • Grants and contracts for development, testing and validation of innovative evidence based measures.

Guide to Acronyms Used in this Document

ACA	Patient Protection and Affordable Care Act
ARRA	American Recovery and Reinvestment Act
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
DSH	Disproportionate Share Hospital
FMAP	Federal Medical Assistance Percentages
FPL	Federal Poverty Level
HCBS	Home and Community Based Services
HCERA	Health Care and Education Reconciliation Act
HHS	Department of Health and Human Services
MOE	Maintenance of Effort
PCPs	Primary Care Physicians
QHP	Qualified Health Plan

Helpful Web-based Resources

Health Insurance Exchange

1) Health Insurance Exchanges and the Affordable Care Act: Eight Difficult issues
http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx

2) Implementing Health Insurance Exchanges: A Guide to State Activities and Choices
http://www.familiesusa.org/assets/pdfs/health-reform/Guide-to-Exchanges.pdf

3) Health Insurance Exchanges: Key Issues for State Implementation
http://www.rwjf.org/files/research/70388.pdf

Medicaid Expansion

1) Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and States
http://www.kff.org/healthreform/8072.cfm

2) Medicaid Coverage and Spending in Health Reform: National and State-By-State Results for Adults at or Below 133% FPL
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

3) Medicaid Benefit Expansion
http://www.healthreformgps.org/resources/medicaid-benefit-changes/

Enrollment

1) Building Enrollment Systems That Meet the Expectations of the Affordable Care Act
http://www.kff.org/healthreform/upload/8108.pdf

2) Enrollment Policy Provisions in the Patient Protection and Affordability Act
http://www.familiesusa.org/assets/pdfs/health-reform/Enrollment-Policy-Provisions.pdf

Long Term Care

1) Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services
http://www.nashp.org/sites/default/files/LTSS_SCAN-FINAL-9-29-10.PDF

2) Helping People With Long Term Health Care Needs – Improving Access to Home and Community Based Services in Medicaid
http://www.familiesusa.org/assets/pdfs/health-reform/help-with-long-term-health-needs.pdf

3) Medicaid Long Term Services and Supports: Key Changes in the Health Reform Law
http://www.kff.org/healthreform/upload/8079.pdf

4) The Community Living Assistance and Supports Services (CLASS) Act
http://www.kff.org/healthreform/upload/7996.pdf

5) Health Reform and Community Living Assistance Services and Supports(CLASS)
http://healthreformgps.org/resources/health-reform-and-community-living-assistance-services-and-supports-class/

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