Federal Health Care Reform Implementation and Its Impact on Rhode Island

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I. Executive Summary & RIPEC Commentary

RIPEC prepared this report to inform policymakers and the public about provisions in the new health care law that affect state and local governments, as well as to describe some of the decisions Rhode Island will need to make in the coming years to implement health care reform in the state. The state's decisions may have a significant impact on the way health care is administered, delivered and paid for in Rhode Island and may affect the state's economy and competitiveness. With a number of key deadlines approaching, RIPEC encourages the incoming executive and legislative branch leadership to collaborate with key stakeholders to make informed decisions about the future of health care in Rhode Island.

The Patient Protection and Affordable Care Act (PPACA), which was signed into law in March 2010, includes many significant changes to the way health care financing and delivery are administered in the United States. PPACA included a number of changes to private health insurance, including new minimum standards for coverage. The measure also aims to reduce the number of uninsured Americans through a number of provisions – 1) the expansion of Medicaid to include individuals with incomes up to 133% of the Federal poverty level; 2) the creation of state health exchanges for individuals to purchase coverage, 3) an individual mandate requiring U.S. citizens and legal residents to maintain health care coverage; 4) employer penalties for large companies that do not provide adequate health care coverage for their workers; and 5) Federal subsidies to assist certain individuals and small business owners in obtaining coverage.

Key Provisions of the Patient Protection and Affordable Care Act (PPACA)

PPACA requires a number of changes to health insurance and group health plans. Plans will not be able to deny coverage to people with pre-existing conditions, are required to cover children until the age of 26 on their parents' policy, and cannot set annual or lifetime limits on essential health benefits (such as such as hospitalization, prescription drugs and other services). Many of these new mandates came into effect on September 23, 2010, with others being implemented in the coming years.

PPACA expands Medicaid eligibility to include non-elderly individuals with incomes up to 133 percent of the Federal poverty level (FPL), starting January 1, 2014. To encourage states to enroll this expanded population, the Federal government will pay a higher share of Medicaid costs for newly eligible people enrolled in Medicaid in 2014 or later. The Federal government will bear the full cost of newly eligible populations in the first three years, with the Federal share declining gradually through 2020. PPACA also increases Federal matching funds for the Children's Health Insurance Program (CHIP), which provides health care to low-income children.

PPACA authorizes states to establish American Health Benefit Exchanges – a marketplace for individuals to purchase health insurance from qualifying plans. The exchange is intended, at a minimum, to serve individuals and families with incomes between 133 percent and 400 percent of the Federal poverty level (FPL), who do not qualify for Medicaid or other Federal programs, and who do not have access to affordable employer-based health insurance. Exchanges must be administered by a state government or nonprofit entity and will be responsible for ensuring that

private health insurance plans offered within the exchange meet Federal standards. An exchange may operate in multiple states with the approval of the Secretary of Health and Human Services. If the state is not expected to have a functioning exchange by 2014, the U.S. Department of Health and Human Services may intervene and establish an exchange, either directly or by contracting with a nonprofit organization. States are also authorized to create a Small Business Health Options Program (SHOP) exchange to assist small businesses in enrolling their employees into health plans in the small group market.

Starting January 1, 2014, nearly all U.S. citizens and legal residents will be required to have health care coverage that meets minimum standards established by the Federal government. Those who do not maintain coverage may be subject to financial penalties, which would be paid when filing income taxes. Certain low-income individuals and families may be exempt from penalties and/or qualify for Federally subsidized care, either through enrollment in Medicaid or by obtaining premium credits in the health exchanges.

PPACA does not mandate that employers provide health care for their employees; instead, it subjects certain large employers (those with more than 50 full-time equivalent employees) to tax penalties if they do not offer health care coverage that meets minimum criteria. Large employers with more than 200 full-time employees will be required to enroll employees automatically into employer-sponsored health plans while providing sufficient notice and time for the employee to opt out.

PPACA makes a number of changes to Federal funding for health care programs, including increasing the Federal Medicaid match for newly eligible populations enrolling in Medicaid starting in 2014, as well as increasing the Federal match for the Children's Health Insurance Program (CHIP). Because health reform is expected to reduce the number of uninsured Americans, the Federal government will decrease payments to states under Medicare and Medicaid's Disproportionate Share Hospital (DSH) programs, which currently provide financial support to help cover the higher costs of treating low-income patients and the uninsured. PPACA also mandates other cuts in Federal health care funding, including reductions in some Medicare payments to providers (in expectation of efficiency improvements) and non-payment of treatment for health-care acquired conditions under Medicaid and Medicare, among others.

The Federal government will also provide premium support and cost-sharing subsidies to individuals and families with incomes between 133 percent and 400 percent FPL who purchase their health insurance through a state exchange. Federal support will be on a sliding scale, and the maximum individual contribution toward premiums will increase with income level.

The law also creates new tax incentives for small businesses and small nonprofit organizations to provide health care coverage. Benefits are limited to companies or organizations with 25 or fewer employees and where the average wage is less than $50,000.

In addition to those aspects described above, PPACA includes numerous other provisions intended to reduce the number of uninsured Americans and improve health care outcomes. Some other programs and provisions that may have policy and budgetary impacts at the state and local level in Rhode Island include:

- establishment of a temporary high-risk health insurance pool, which offers Federal assistance to states to provide health insurance to people who may otherwise not qualify because of a chronic illness;
- creation of the Early Retirement Reinsurance Program, which provides Federal assistance to employers to defray the costs of health insurance coverage for retirees over the age of 55 who do not yet qualify for Medicare;
- creation of the Community Living Assistance Services and Supports (CLASS) long-term care insurance program, which permits workers, on a voluntary basis, to have a portion of their paycheck deducted to pay for long-term care insurance through the Federal government; and
- grant funding for several new initiatives, including to improve consumer access to health insurance information, assist states in reviewing health insurance rate increases, and support states in planning and implementing the exchange system.

PPACA's Implementation in Rhode Island

According to Mathematica Policy Research, an estimated 140,000 Rhode Islanders under the age of 65 lacked health insurance in March of 2010, representing 16 percent of Rhode Island's non-elderly population – a percentage that has climbed in recent years. PPACA will reduce the number of uninsured Rhode Islanders, though the number of people gaining access to health insurance and the total costs of implementation will depend largely on policy decisions the state will make in the coming months and years. Implementation may also require the state to modify a number of existing programs intended to provide affordable health care to Rhode Island residents.

The transition period after the election provides a good opportunity for the newly elected Governor and other state elected officials to develop a health care strategy for the state and to consider how federal health care reform may be used to achieve policy objectives, including improving the state's fiscal health and economic competitiveness. Some of the main decisions that the state must make regarding PPACA implementation occur in the following areas:

<u>Medicaid Expansion</u>

States will be required to expand Medicaid eligibility to non-elderly adults whose incomes are at or below 133 percent FPL by the January 1, 2014, deadline. PPACA contains a maintenance of effort (MOE) provision preventing states from reducing their Medicaid and CHIP program eligibility in the coming years. If states are experiencing or projecting budget deficits, they may apply for a MOE waiver in order to reduce eligibility requirements for optional populations, though Rhode Island faces additional steps before reducing optional benefits and populations because of other existing MOE requirements, including under the state's Global Waiver agreement.

Key questions facing the state regarding Medicaid policy include:

- estimating the number of people expected to enroll under Medicaid expansion;
- deciding how to adapt existing programs to meet the health care needs of this new population;
- choosing whether to implement Medicaid expansion before the January 1, 2014, deadline;

- deciding whether to apply for a maintenance of effort (MOE) waiver if the state faces budget deficits;
- choosing which optional populations should be covered and which optional benefits should be provided; and
- determining how to proceed with the current Global Waiver and whether to incorporate its programs and objectives into Medicaid expansion.

Creation of State Health Exchanges

PPACA authorizes states to establish American Health Benefit Exchanges to serve individuals and families between 133 percent and 400 percent FPL, who do not qualify for Medicaid or other Federal programs, and who cannot get access to affordable health insurance. Exchanges must be established by January 1, 2014, though states must demonstrate to the U.S. Department of Health and Human Services (HHS) their readiness to implement exchanges by January 1, 2013.

Key questions facing the state include:

- choosing whether to establish a state-run exchange or to cede authority to the Federal government;
- deciding how the exchange should be developed, who should administer it and what services it should provide;
- considering how best to coordinate the health exchange with other existing health care programs (such as RIte Care and RIte Share) and employer-sponsored insurance;
- deciding what level of support to provide for small businesses through the Small Business Health Options Program (SHOP) Exchange;
- considering collaboration with other states in exchange design and administration; and
- choosing whether to include optional populations.

Changes to Health Insurance

PPACA requires a number of changes to health insurance and group health plans, which will affect existing health insurance plans with state and municipal employees. In most cases, existing state and local government plans meet many of the new requirements, such as a ban on capping certain benefits. Additionally, the state's Office of the Health Insurance Commissioner (OHIC) will be charged with overseeing health insurers' and group health plans' compliance with the new mandates and determining what constitutes reasonable premium increases on an annual basis.

Key questions facing the state and municipal governments include:

- ensuring that their own health insurance plans comply with new Federal mandates, including coverage of children under 26;
- choosing whether to maintain grandfathered status for any health insurance plans in existence before March 23, 2010;
- deciding whether to apply for the Early Retirement Reinsurance Program for reimbursement of retiree health insurance costs (applicable to municipal governments, as the state has already applied); and
- passing legislation to provide state enforcement of Federal health insurance mandates.

Administration and Oversight – Many of the PPACA's mandates and initiatives will require legislative approval, while their implementation and coordination with other programs will fall to a variety of state agencies. Further, reform efforts will impact health care providers, insurance companies, customers, and numerous other groups, suggesting the need for state collaboration with these groups for optimal results.

Key questions facing the state government include:

- deciding what the strategic goals for health reform should be and which state administrative structure is most appropriate for PPACA implementation;
- coordinating current state-administered health care activities and planning for changes to Federal health care financing (e.g., new grant opportunities, Medicaid reimbursement rates, etc.);
- developing methods to integrate reform efforts with existing health care delivery and payment systems and assessing whether improvements can be made to reduce costs and improve competitiveness;
- assessing existing technology assets and personnel levels to establish whether they are sufficient to meet increased demand under new programs and making new investments, as necessary; and
- modifying existing state laws and procedures to comply with PPACA, including calculation of eligibility requirements and prevention and prosecution of waste, fraud and abuse.

RIPEC Commentary

Much of PPACA's implementation requires action at the state level, and Rhode Island should start planning now. By establishing a strategic vision of how health care in Rhode Island should be structured, administered and evaluated, policymakers can lay the groundwork for health care reform that best meets the needs of state residents. In previous reports, RIPEC has suggested the need for improvements to the efficiency and effectiveness of state-administered health care programs, and PPACA implementation provides Rhode Island with an opportunity to improve health outcomes, delivery and payment systems, and measurement and assessment metrics. Not only will early planning encourage smoother implementation and minimize disruption, but it may also afford the state a stronger position when applying for competitive Federal grants in the coming years.

Appropriate planning for health care reform is also important because the state's reform efforts may have far-reaching impacts on our economy. The health care and social service sector represented nearly 20% of all private employment in Rhode Island in 2009 and is projected to grow substantially over the next decade. The expected reduction in the number of uninsured Rhode Islanders under PPACA will increase demand for health care services and may require changes in the way health care is administered in the state. The state should therefore collaborate with health care service providers, insurers and business owners on reform efforts to minimize unintended consequences.

Based on discussions with numerous stakeholders, RIPEC has several observations and recommendations that policymakers may wish to consider when proceeding with health care reform implementation.

Medicaid Expansion

Rhode Island can choose whether to expand Medicaid eligibility before the January 1, 2014, deadline, as well as decide which optional populations should be covered and which optional benefits should be provided. Those decisions should be grounded in careful analysis of both their impact on the state budget and the health outcomes the state wishes to promote.

The expansion of Medicaid to include non-elderly individuals with incomes below 133 percent of the Federal poverty level (FPL) will add as many as 68,000 people to a system that has primarily focused on low-income children and their parents, the elderly and the disabled. To prepare for this transition, the state should begin assessing the demographics and health care usage of this population to understand their needs. Because this population may have different health care needs from those of existing Medicaid patients, the state may require new programs and initiatives to meet their needs, as well as updated metrics for measuring health care outcomes and assessing the efficacy of public programs.

Since not all people who qualify for Medicaid will necessarily enroll, the costs of insuring the expanded Medicaid population will depend on how many people ultimately participate – a variable influenced by the scope and effectiveness of Federal and state outreach to newly eligible populations. A report by the Kaiser Commission on Medicaid and the Uninsured assessed two scenarios based on different rates of Medicaid enrollment (57 percent under the "status quo scenario" and 75 percent under the "enhanced scenario") and found that the higher enrollment rate translated into nearly 18,000 more Medicaid enrollees. Kaiser's analysis suggests that Rhode Island's budget estimates for future Medicaid expenditures will be dependent on the effectiveness of enrollment outreach programs. Because Federal mandates will reduce states' ability to manage Medicaid expenditures through benefit or eligibility reductions, enrollment estimates will be a key factor in state budgeting. When preparing future budget projections in the Revenue and Caseload Estimating Conferences, the state may wish to consider preparing several scenarios using different enrollment rates and develop a range of feasible Medicaid enrollment numbers and spending estimates.

The state must also decide when to implement the expanded Medicaid program – either at the 2014 deadline or earlier. If Rhode Island's analysis forecasts substantial savings or other benefits by insuring this newly eligible population (through reduced uncompensated care costs, better health outcomes, etc.), the state may wish to consider implementing the Medicaid expansion before 2014.

If the state projects budget deficits, it may apply for a waiver from the maintenance of effort (MOE) requirement in PPACA that prevents any reduction in Medicaid eligibility or benefits. However, any changes to Medicaid eligibility or benefits before June 30, 2011, would endanger Federal stimulus funds under the American Recovery and Reinvestment Act (ARRA), and most changes after that date would still need approval from the Centers for Medicare & Medicaid Services (CMS) under the terms of the state's Global Waiver agreement. Finally, as several of the optional benefits currently offered under Medicaid are preventive in nature, rescinding them may lead to increased expenditures in other categories (e.g., restricting home- and community-based services could lead to more costly hospitalizations). When making eligibility and benefit

decisions, policymakers should be aware of these trade-offs and incorporate them into cost-benefit analyses.

Creation of Health Exchanges

If Rhode Island chooses to develop a health exchange, it must decide what the main goals of the exchange should be, which optional populations to include, and whether to integrate the exchange with other health care programs. The state must also select the appropriate administrative structure for the exchange – either state-run or administered by a nonprofit organization.

The exchange will need to be integrated with existing programs such as RIte Care and RIte Share, which currently serve populations that will be eligible for subsidies in the exchange. When reviewing the various options for these populations, the state should consider enrollees' out-of-pocket costs, state spending and third-party contributions (i.e., employer contributions under RIte Share) to gauge the impact of including various categories of enrollees in RIte Care/Share or the exchanges. The state should also consider the impact of various scenarios on health care outcomes for enrollees (e.g., examining the impact of having parents and children in different health care systems).

The state should also consider which services it should provide to small businesses through the Small Business Health Options Program (SHOP) Exchange and whether SHOP should be incorporated into the individual exchange. When making those decisions, the state should estimate the number of small businesses that would likely use the exchange as a vehicle for purchasing health insurance and assess their needs. Some small businesses may need only a one-stop shop for access to health insurance-related information, while others may want to purchase insurance through the exchange. By forecasting the likely usage and costs, as well as identifying any new or existing revenue sources that could support operational expenses, the state can make an informed decision about how to provide appropriate services to small business owners in a cost-effective manner.

In addition to small businesses, the exchange could eventually serve other populations such as state and municipal employees, individuals and families above 400 percent FPL, or larger businesses. As with small businesses, the state should consider the needs of each population and whether they can be met in a cost-effective fashion. A larger exchange serving optional populations may help the state achieve certain health care policy objectives, but it could be more complicated to manage and may not necessarily lead to lower insurance costs for consumers. Further, because expansion of exchanges to optional populations could alter the administration and cost structure of existing health insurance plans in the private market, policymakers should consider the entire health insurance market and assess potential positive and negative consequences of including various populations in an exchange.

Finally, PPACA also permits the operation of multi-state exchanges. Rhode Island may explore the possibility of working with other New England states to develop and maintain a multi-state exchange. Even if Rhode Island chooses to operate its own exchange, opportunity exists for collaboration with other states on exchange design (e.g., case management program development, shared staff, information technology, etc.), which may lower implementation costs.

Administration and Oversight

Rhode Island should decide what administrative structure is most appropriate to develop the strategic objectives of its health care reform efforts, decide how changes will be implemented, and determine how to measure success. To date in Rhode Island, implementation has occurred primarily in the form of ad hoc cooperation within the executive agencies. Lieutenant Governor Elizabeth Roberts created the HealthyRI Task Force, which convened numerous stakeholders to make non-binding recommendations.

Other states have taken a variety of approaches to implementation, including joint legislative committees, Cabinet-level executive agency working groups, and broader task forces with representatives from government, the health care industry and other stakeholders. These bodies also vary in their influence, ranging from advisory groups to those with implementation authority. Rhode Island may look to some of these models to ascertain which decision-making structure is most appropriate for the state's needs and how best to coordinate existing executive agencies to implement PPACA.

However the state decides to implement health care reform, RIPEC believes that policy decisions should be grounded in careful analysis of budget impact and health care outcomes. The state budget will be affected by a number of factors, including:

- the state share of the cost of Medicaid expansion, which will be affected by the timeline for implementation, the number of new enrollees, and the optional populations and benefits covered, among others;
- the impact of higher Federal matching rates for Medicaid and CHIP;
- the scheduled reduction in Medicare and Medicaid DSH payments;
- the ability to reduce retiree health care costs through the Early Retirement Reimbursement Program;
- the availability of additional Federal funds for specific initiatives (such as home- and community-based services);
- potential cost savings through reforms to payment or delivery systems; and
- a reduction in uncompensated care costs resulting from fewer uninsured persons in the state.

Policymakers should seek to understand how any new or modified programs would be used by the public and what health outcomes they would likely produce. It is important to note that the populations in Medicaid (incomes up to 133 percent FPL), those in the exchange (133 percent to 400 percent FPL) and others with employer-based or other insurance (greater than 400 percent FPL) will not remain static. As incomes rise and fall, people will move from one form of health coverage to another. Further, new requirements on private insurance plans, such as the bans on annual and lifetime limits, will permit some populations (e.g., children with special health care needs) to be covered by private market plans instead of participating in government-run programs. As a result, the state will need to decide how to structure enrollment procedures, plans and benefits to minimize disruption as people move among the various programs.

PPACA requires states to use Modified Adjusted Gross Income (MAGI) by 2014 as the sole determinant of eligibility for most populations in Medicaid and CHIP programs. Rhode Island

will need to adjust its eligibility evaluation process to comply with the new Federal rule. As part of that process, Rhode Island may wish to review the eligibility requirements for other state-run assistance programs to determine whether any changes should be made to harmonize enrollment systems to facilitate coordination across programs.

Implementation of PPACA at the state level has already begun, though the coming months will require significant involvement by the legislative and executive branches of government. (See Figure 1: Timeline for PPACA Implementation) The newly elected Governor and other state officials should use the transitional period to start developing an implementation strategy for health care reform. Given the scope of PPACA and its potential impact in Rhode Island, the state should begin engaging stakeholders as soon as possible to solicit feedback on the aforementioned issues. By carefully considering various implementation scenarios and their impact on budgets and health care outcomes, the state can promote informed decision-making and tailor implementation to the state's specific needs. The state can also review its existing health care payment and delivery systems, as well as personnel and information technology infrastructure capabilities, to see if any modifications or improvements are warranted to meet the demands of PPACA implementation.

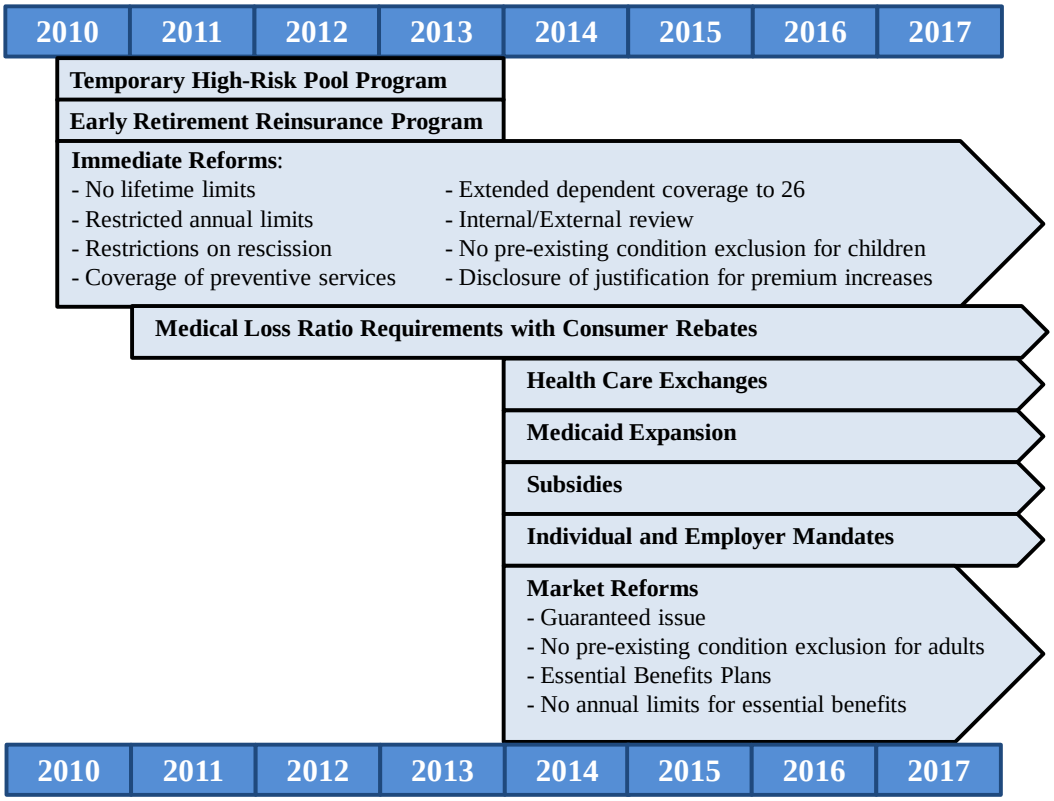
Potential Challenges to Implementation

Congress's goal when passing PPACA was to reduce the number of uninsured Americans while simultaneously reducing Federal expenditures on health care through cost containment and other efforts. The likelihood that those goals will be achieved will depend on how the law is implemented, whether any of the current provisions are amended in future legislation, and whether political or legal challenges result in partial or full repeal of the law.

The nonpartisan Congressional Budget Office (CBO) estimated that PPACA will increase the percentage of non-elderly adults with health insurance in the U.S. from 83 percent in 2010 to 94 percent by 2019. The CBO also projected it would lead to $124 billion less in Federal spending on health care between 2010 and 2019. However, the CBO noted that spending reduction projections were dependent on the success of cost containment measures. For example, under the new law, many Medicare provider payments would rise at a rate lower than the inflation rate, under the assumption that efficiency improvements to the health care system will materialize and lead to greater productivity. In Rhode Island, the ability to improve the cost-effectiveness of health care reform will depend on whether and how the state pursues changes to health care delivery and payment procedures. If the efficiencies projected under PPACA are not realized in Rhode Island, health care providers may be harmed by the lower provider payments expected in the coming years.

Another uncertainty in PPACA implementation is the prospect of political changes or legal challenges that could lead to a full or partial repeal of legislation. Future Congresses may rescind or alter aspects of the law (or not fund programs at authorized levels), and some state governments have objected to implementing PPACA. A lawsuit filed by Florida and nineteen other states has challenged the law on Constitutional grounds, and outgoing Rhode Island Governor Don Carcieri has expressed his support for the suit. Rhode Island policymakers should monitor developments in these areas when pursuing PPACA implementation.

Figure 1: Timeline for PPACA Implementation



Source: National Association of Insurance Commissioners

II. Overview of Patient Protection and Affordable Care Act (PPACA)

In March 2010, President Barack Obama signed into law two pieces of health care reform legislation: the Patient Protection and Affordable Care Act (PPACA; Public Law 111-148) and the Health Care and Education Reconciliation Act (HCERA; Public Law 111-152). The final version of PPACA included a number of changes to private health insurers and group health plans, including new minimum standards for coverage.[1] The measure also aims to reduce the number of uninsured Americans through a number of provisions – 1) the expansion of Medicaid to include certain childless adults; 2) the creation of state health exchanges for individuals to purchase coverage, 3) an individual mandate requiring U.S. citizens and legal residents to maintain health care coverage; 4) employer penalties for large companies that do not provide adequate health care coverage for their workers; and 5) Federal subsidies to assist certain individuals and small business owners in obtaining coverage.

Since the primary purpose of this report is to explain how PPACA will affect Rhode Island state and local governments, the summary information included below reflects only a subset of the many provisions set forth in law. (See Appendix A for additional resources about PPACA implementation.)

Changes to Existing Health Insurance Markets

PPACA requires a number of changes to health insurance and group health plans, with a goal of establishing minimum standards for health insurance coverage.

Key Health Insurance Market Changes in PPACA:

- establishes temporary high-risk insurance pools to provide coverage to individuals with pre-existing conditions
- prohibits insurers from setting annual or lifetime limits on coverage of "essential health benefits" (such as hospitalization, prescription drugs and other services, as defined by the Federal government)
- prevents insurers from rescinding coverage if a policyholder becomes injured or sick ("rescissions")
- creates an annual review process to define and identify "unreasonable" premium increases proposed by insurers
- requires coverage of preventive health services without cost-sharing
- permits parents to include dependent children younger than 26 on their insurance plan
- sets limits on administrative spending by health insurers
- requires insurers to provide coverage to those with pre-existing conditions
- requires insurers to establish a claims appeal process that meets minimum standards

[1] For simplification purposes, the use of "PPACA" in this report refers to the final version, as amended by HCERA.

The law's insurance eligibility and benefit requirements will apply to new individual and group insurance plans in the private market, including self-insured plans. Individual and group plans that existed before the date of health care reform enactment (March 23, 2010) are considered "grandfathered" and are exempt from many new requirements, though they must still meet the following criteria:[2]

- must not place limits on lifetime benefits or "essential health benefits" (applicable to plan years beginning September 23, 2010[3]);
- must not rescind coverage if insured becomes sick or injured (applicable to plan years beginning September 23, 2010);
- must extend coverage to dependent children under the age of 26 (applicable to plan years beginning September 23, 2010); and
- must not have waiting periods for coverage in excess of 90 days (applicable to plan years beginning January 1, 2014)

Additionally, grandfathered group plans must comply with the following:

- must not place annual limits on "essential health benefits" (applicable to plan years beginning September 23, 2010);
- cannot exclude coverage to dependent children under the age of 19 with pre-existing health conditions (applicable to plan years beginning September 23, 2010); and
- cannot exclude coverage on the basis of pre-existing health conditions (applicable to plan years beginning January 1, 2014).

To maintain their plans' grandfathered status, employers must not make major alterations to their health insurance coverage, including changes in insurance carrier, benefits or substantial increases in employee deductibles or copayments. Maintaining grandfathered status also entails administrative requirements such as reporting on any changes to the grandfathered plan, as well as informing existing and potential enrollees in the plan about how the grandfathered plan differs from the minimum PPACA requirements for new plans.[4]

Changes to Medicaid and Children's Health Insurance Program (CHIP)

Medicaid is the Federal health care program serving low-income populations that meet certain eligibility requirements. It is administered by the states and jointly funded by the Federal government and the states. The Federal component of Medicaid payments is known as the Federal Medical Assistance Percentage (FMAP), which is established annually by formula and which varies from state to state.

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[2] Fernandez, Bernadette. "Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)." 27 April 2010. Congressional Research Service. Web. Retrieved 23 August 2010 from: http://www.ncsl.org/documents/health/Grandfathered.pdf .

[3] A plan year begins at the time an employer's coverage is initiated or renewed with the health insurer; thus, the implementation of the mandates on grandfathered plans may occur after the date specified.

[4] For more information about employer requirements for grandfathering plans, see http://www.healthcare.gov/news/factsheets/keeping_the_health_plan_you_have_grandfathered.html.

Rhode Island currently receives a base FMAP of about 52.6 percent, though stimulus provisions in the American Recovery and Reinvestment Act (ARRA) have resulted in an enhanced FMAP of approximately 63.9 percent. The Enhanced FMAP under ARRA will be gradually phased out until July of 2011, when Rhode Island's FMAP returns to the scheduled base level of approximately 53.0 percent.[5] (See Table 1: Medicaid Federal Medical Assistance Percentage for Rhode Island, 2006-2011).

Table 1: Medicaid Federal Medical Assistance Percentage for Rhode Island, 2006-2011

Federal Fiscal Year	Base FMAP	FMAP under ARRA
2006	54.45 %	54.45 %
2007	52.36 %	52.36 %
2008	52.51 %	52.51 %
2009	52.59 %	63.89 %
2010	52.63 %	63.92 %
2011 Q1	52.97 %	64.22 %
2011 Q2	52.97 %	61.39 %
2011 Q3	52.97 %	59.51 %
2011 Q4	52.97 %	52.97 %
Combined 2011	52.97 %	59.52 %

Note: Federal Fiscal Year (FFY) begins October 1.

PPACA expands Medicaid eligibility to include non-elderly individuals with incomes below 133 percent of the Federal poverty level (FPL), starting January 1, 2014. (See Appendix B for Federal poverty level figures for 2010.) To encourage states to enroll this expanded population, the Federal government will pay a higher share of Medicaid costs for newly eligible people enrolled in Medicaid in 2014 or later. The Federal government will bear the full cost in the first three years, with the Federal share declining gradually through 2020. (See Table 2: Federal Medical Assistance Percentage for Newly Eligible Medicaid Enrollees)

Table 2: Federal Medical Assistance Percentage for Newly Eligible Medicaid Enrollees

Year	Federal share (FMAP)
2014	100 %
2015	100 %
2016	100 %
2017	95 %
2018	94 %
2019	93 %
2020	90 %

[5] The state's Global Waiver agreement with the Centers for Medicare and Medicaid Services (CMS) sets cumulative Federal funding limits for most state Medicaid- and CHIP-related expenditures over five years. As a result, future changes to the state's base FMAP rate will have less of an impact on Federal funding to RI than in other states.

People with incomes up to 133 percent FPL will be eligible to enroll in Medicaid starting on January 1, 2014, though states may enroll this population earlier. If states expand eligibility before the 2014 deadline, they can expect to receive only their standard FMAP (Table 1) and not the higher PPACA FMAP levels (Table 2).

PPACA increases Federal matching funds for the Children's Health Insurance Program (CHIP), the Federal program that provides health insurance for low-income children and extends authorization for the program for two years, through 2015. Like Medicaid, CHIP is administered by the states and is jointly funded between the Federal and state governments. The Federal contribution for CHIP is higher than that of Medicaid and is known as the Enhanced Federal Medical Assistance Percentage (E-FMAP). In Federal Fiscal Year 2011, Rhode Island's E-FMAP is 67.1 percent.[6] Starting in Federal Fiscal Year 2014 (October 1, 2013), PPACA increases each state's E-FMAP for CHIP programs by 23 percentage points, up to a maximum of 100 percent. For Rhode Island, this would mean an E-FMAP of approximately 90 percent. In exchange, states must accept maintenance of effort requirements and agree not to reduce eligibility requirements or benefits to children under CHIP programs. PPACA also gives states the option of offering CHIP eligibility to children of state employees with access to health insurance where premiums and cost sharing exceed 5 percent of family income.

PPACA also standardizes states' eligibility standards for low-income health programs. Currently, states may use a variety of methods (e.g., assets tests) for calculating eligibility in programs funded by Medicaid and the Children's Health Insurance Program (CHIP). Starting in 2014, the new law will require eligibility for most populations to be assessed solely on the individual's or family's Modified Adjusted Gross Income (MAGI), as calculated and reported to the Internal Revenue Service for tax-filing purposes.

State Health Care Exchanges

PPACA authorizes states to establish American Health Benefit Exchanges – a marketplace for individuals to purchase health insurance from qualifying plans. The exchange is intended primarily to serve individuals and families with incomes between 133 percent and 400 percent of the Federal poverty level (FPL), who do not qualify for Medicaid or other Federal programs, and who do not have access to affordable employer-based health insurance.[7] These populations may be eligible for Federal premium subsidies and cost-sharing credits, but only if they purchase insurance through the exchanges. (See "Federal Funding Provisions – Subsidies, Tax Benefits and Penalties" section below for more information.)

Exchanges must be administered by a state government or nonprofit entity and will be responsible for ensuring that private health insurance plans offered within the exchange meet Federal standards. The exchange may not be run by an insurance company and will not provide

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[6] "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2010 through September 30, 2011." Federal Register 74. 27 November 2009. 62315-62317. Retrieved from http://aspe.hhs.gov/health/fmap11.htm

[7] Certain individuals who have access to employer-based health insurance may still qualify for premium support in the exchange if either 1) the employer-based plan requires an individual to contribute more than 9.5 percent of total household income to the self-only plan; or 2) the plan pays for less than 60 percent of covered health care expenses.

insurance coverage directly. The plans offered in the exchange will include state-approved private plans as well as multi-state qualified health plans, as approved by the Director of the U.S. Office of Personnel Management.

Any plan offered in the exchange must be a certified "qualified health plan" (QHP), which is required to provide essential health benefits while maintaining Federal limits on out-of-pocket expenses and deductibles. QHPs may be provided at four different levels: bronze, silver, gold and platinum, corresponding to the level of benefits provided.[8] Health insurers that wish to offer plans in the exchange must provide at least one silver and gold option to ensure a sufficient variety of options to consumers.

State exchanges must present information about the available plans in a standardized format, provide cost calculators and tools to allow basic comparison of plans, and determine applicants' eligibility for cost-sharing subsidies and premium credits, among other responsibilities. States must declare their intention to establish an exchange by January 1, 2013. If a state is not expected to have a functioning exchange by 2014, the U.S. Department of Health and Human Services may intervene and establish an exchange, either directly or by contracting with a nonprofit organization.

States are also authorized to create a Small Business Health Options Program (SHOP) exchange to assist small businesses in enrolling their employees into QHPs in the small group market. The SHOP exchange may be combined with the individual exchange into one entity.

States may choose to use the exchanges to reach populations beyond those groups specified in PPACA. An exchange may operate in multiple states with the approval of the Secretary of Health and Human Services. States may apply for Federal funding to establish the exchanges, but after 2015, exchanges are expected to be financially self-sufficient.

States will be afforded some flexibility in developing exchanges and Medicaid programs under PPACA. For example, states are permitted to establish a Basic Health Program to enroll populations between 133 percent and 200 percent of FPL in Medicaid instead of requiring that they be covered in the exchange. Under a Basic Health Program, states would not receive FMAP payments for such individuals; instead, states would receive 95 percent of the tax credits and cost-sharing support that the qualifying individuals would receive if they were enrolled in the exchange.

Individual Mandate

Starting January 1, 2014, nearly all U.S. citizens and legal residents will be required to have health care coverage that meets minimum standards established by the Federal government.[9]

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[8] Qualifying health plans are categorized into four levels depending on their actuarial value, or the average proportion of eligible medical costs covered by the insurance plan. Bronze plans must have an actuarial value of 60 percent (i.e., they pay for 60 percent of eligible medical costs), with silver plans at 70 percent, gold at 80 percent and platinum at 90 percent.

[9] Exemptions from the individual mandate may be provided to members of certain religious organizations and American Indians. Incarcerated persons and individuals not lawfully present in the United States are not covered under the legislation.

Eligible plans will include qualifying employer-sponsored coverage, individual plans purchased through health exchanges, Federal and/or state programs (Medicare, Medicaid, etc.) or grandfathered plans in existence before the date of enactment (March 23, 2010).

Those who do not maintain coverage may be subject to financial penalties equivalent to a percentage of income or a flat fee, whichever is lower. (See Table 3: Individual Penalties for Lack of Health Insurance Coverage.) The penalty must be paid when filing income tax returns.

Table 3: Individual Penalties for Lack of Health Insurance Coverage

Year	***Penalty is the lesser of :***		
2014	1.0 % of household income		$95 per individual
2015	2.0 % of household income		$325 per individual
2016	2.5 % of household income	***or***	$695 per individual
after 2016	2.5 % of household income		$695 per individual + annual inflation adjustment
• Per-person penalties are reduced by 50 percent for dependent children under the age of 18 • A family's total penalty may not exceed 300 percent of the individual flat fee • Total penalty cannot exceed the national average of the lowest-cost health care plan available in the state individual exchanges ("bronze option"), based on family size			

Certain low-income individuals and families may be exempt from penalties and/or qualify for subsidized care, either through enrollment in Medicaid or by obtaining premium credits in the health exchanges. Further, penalties will not be assessed on those without coverage for 90 days or less over the course of one year.

Employer Requirements

PPACA does not mandate that employers provide health care for their employees; instead, it subjects certain large employers to tax penalties if they do not offer health care coverage that meets minimum criteria. Under the law, large employers are defined as those with at least 50 full-time equivalent (FTE) employees.[10]

Starting in 2014, a large employer will incur a tax penalty if it has at least one full-time employee receiving a premium credit to purchase health care using one of the state exchanges. (An employee may receive a premium credit if his/her income qualifies for exchange coverage, and 1) his/her employer-based plan requires an individual to contribute more than 9.5 percent of total household income to the self-only plan; or 2) the plan has an actuarial value of less than 60 percent.) However, large employers that do not offer health insurance will not incur penalties if none of their employees qualify for premium credits (e.g., if their incomes are all higher than 400 percent FPL) or if their employees receive health care coverage from sources other than the exchange (e.g., for example, if they are eligible to enroll in expanded Medicaid).

[10] A full-time employee is defined as one working at least 30 hours per week, or 120 hours per month. The number of full-time equivalent (FTE) employees is calculated from the number of full-time employees, the number of part-time employees, and the hours worked by part-time employees. Full-time equivalent employees = number of full-time employees + (total number of hours worked by part-time employees/120). FTEs do not include seasonal full-time employees that work for fewer than 120 days of the year.

For employers that provide health insurance and pay a portion of their employees' premiums, PPACA creates a free choice voucher program. If an employee's income is less than 400 percent FPL and his/her personal contribution to employer-sponsored insurance is between 8 percent and 9.8 percent of household income, the employee would qualify for a free choice voucher to purchase insurance in the state exchange. The employer would pay the equivalent of the employer contribution to health insurance in the form of a voucher, though the employer would not incur the tax penalty associated with employees purchasing health insurance in the exchange.

Large employers with more than 200 full-time employees will be required to enroll employees automatically into employer-sponsored health care while providing sufficient notice and time for the employee to opt out. This provision may be implemented before 2014 at the discretion of the Secretary of Health and Human Services.

As noted above, small businesses would be able to offer employees health insurance through the SHOP exchange system, and some may qualify for Federal tax credits. (See "Federal Funding Provisions – Subsidies, Tax Benefits and Penalties" section.)

Federal Funding Provisions

PPACA makes a number of changes to Federal funding for health care programs, creates tax incentives and penalties to encourage access to affordable health care, and establishes new grant opportunities to help states modernize their health care systems and achieve specific outcomes.

Payment Rates

As noted above, starting in 2014, the Federal government will increase the Federal Medical Assistance Percentage (FMAP) for newly eligible persons in Medicaid. Between 2014 and 2016, the Federal government will pay 100 percent of qualifying health care costs of non-elderly individuals with incomes below 133 percent FPL that enroll in Medicaid. That percentage will decline gradually to 90 percent by 2020. States may choose to expand enrollment in Medicaid before 2014, but they can expect to receive only their base FMAP for the new population.

The Federal government will also increase the Enhanced FMAP (E-FMAP) for state CHIP programs. Starting in Federal Fiscal Year 2014 (October 1, 2013), each state's E-FMAP will increase by 23 percentage points, up to a maximum of 100 percent. For Rhode Island, this would translate to an E-FMAP of approximately 90 percent.

PPACA aims to promote certain health outcomes by providing increased Medicaid FMAP rates for specific populations and health care services. The Federal government will provide higher FMAP rates for primary care providers, preventive care and immunizations for adults in Medicaid, smoking cessation for pregnant women, patient-centered medical home programs for people with chronic illnesses, and home- and community-based services as an alternative to institutional care.

Because health reform is expected to reduce the number of uninsured Americans, the Federal government will decrease payments to states under Medicare and Medicaid's Disproportionate Share Hospital (DSH) programs, which currently provide financial support to states to help cover the higher costs of treating low-income patients and the uninsured. Total Medicare DSH

payments to states will be reduced 75 percent starting in Federal Fiscal Year 2015, though additional funding may be provided in subsequent years to address any ongoing occurrences of uncompensated care. Aggregate Medicaid DSH payments to states would be reduced by $500 million in 2014, $600 million in 2015, $600 million in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. However, not all states will be impacted equally; the law charges the Secretary of Health and Human Services to develop an allocation plan for Medicaid DSH reductions based on the number of uninsured in a state, historical DSH payments and other factors.

PPACA also mandates other cuts in Federal health care funding, including reductions in some Medicare payments to providers (in expectation of efficiency improvements) and non-payment of treatment for health-care acquired conditions (e.g., medical errors) under Medicaid, among others.

Subsidies, Tax Benefits and Penalties

The Federal government will provide premium support and cost-sharing subsidies to individuals and families with incomes between 133 percent and 400 percent FPL who purchase their health insurance through a state exchange. The Federal government will provide tax credits to help offset the cost of health insurance premiums. The specific tax benefit will be calculated to ensure that individuals do not pay above a specified percentage of their income on premiums (using the second least expensive silver plan offered in the exchange as a guideline for premium calculations). Federal support will be on a sliding scale, and the maximum individual contribution toward premiums will increase with income level. (See Table 4: Premium Support for Persons Below 400 Percent FPL Purchasing Health Insurance in an Exchange.)

Table 4: Premium Support for Persons Below 400 Percent FPL Purchasing Health Insurance in an Exchange

Income Level	Maximum individual contribution toward premium
up to 133 % FPL	2.0 % of income
133-150 % FPL	3.0 – 4.0 % of income
150-200 % FPL	4.0 - 6.3 % of income
200-250 % FPL	6.3 – 8.05 % of income
250-300 % FPL	8.05 – 9.5 % of income
300-400 % FPL	9.5 % of income

The Federal government will also provide cost-sharing subsidies to limit out-of-pocket expenses of individuals and families with incomes between 133 percent and 400 percent FPL who purchase insurance through an exchange. The cost-sharing subsidies will reduce out-of-pocket expenses (deductibles, copayments, etc.) such that the insurance plan covers a specified percentage of all health care expenses. As with premium credits, cost-sharing support will be on a sliding scale based on income.

As described above, PPACA creates new tax penalties on large businesses that do not provide affordable health care to their employees. The law also creates new tax incentives for small businesses and small nonprofit organizations to provide health care coverage. Benefits are limited to companies or organizations with 25 or fewer employees and where the average wage

is less than $50,000. (See Table 5: Premium Support for Small Businesses and Nonprofit Organizations.)

Table 5: Premium Support for Small Businesses and Nonprofit Organizations

Year	Maximum Small Business Tax Credit	Maximum Small Nonprofit Tax Credit
2010-2013	35% of employer contribution to health insurance premium	25% of employer contribution to health insurance premium
2014 and after	50% of employer contribution to health insurance premium	35% of employer contribution to health insurance premium
• The maximum tax credit is available to employers with 10 of fewer full-time equivalent (FTE) employees, and whose average taxable wage is $25,000. The credit is phased out as the number of FTEs increases from 10 to 25 and as the average wage rises to $50,000. • For nonprofits, the tax credit comes in the form of a reduction in the employer contribution to Medicare tax on employee wages. • Starting in 2014, small businesses may claim the tax credit only for two consecutive years.		

PPACA also establishes the Early Retirement Reinsurance Program, which provides Federal assistance to employers (including businesses, unions, state and local governments, and nonprofits) to defray the costs of health insurance coverage for retirees over the age of 55 who do not yet qualify for Medicare.[11] For employers approved through the application process, the Department of Health and Human Services will pay 80 percent of medical costs between $15,000 and $90,000. The program will run through January 1, 2014, when the exchanges and other programs will provide alternatives for early retirees.

Other PPACA Programs and Initiatives

In addition to those aspects described above, PPACA includes numerous other provisions intended to reduce the number of uninsured Americans and improve health care outcomes. Some other programs and provisions that may have policy and budgetary impacts at the state and local level in Rhode Island include:

- Establishment of a temporary high-risk health insurance pool – Offers Federal assistance to states to provide health insurance to people who may otherwise not qualify because of a chronic illness.
- Creation of the Community Living Assistance Services and Supports (CLASS) long-term care insurance program – Permits workers, on a voluntary basis, to have a portion of their paycheck deducted to pay for long-term care insurance provided by the Federal government. People contributing to CLASS would receive cash payments to pay for health and personal care needs if they became disabled or develop a chronic illness. Employers may deduct CLASS premiums from wages and also have the option of automatically enrolling workers. Premium contributions by employees are generally not tax deductible, and any employer contribution toward employees' CLASS premiums is not considered taxable income for the employee. (PPACA requires that CLASS be actuarially sound and supported entirely by premiums.)

[11] More information about the Early Retirement Reinsurance Program and the application process is available at http://www.errp.gov/.

- Gradual elimination of the "doughnut hole" under Medicare's prescription drug plan (Medicare Part D) – The current Medicare prescription drug benefit is capped (to the first $2,830 in total drug costs in 2010), requiring some seniors to pay the full cost of prescription drugs before catastrophic coverage takes effect (when total out-of-pocket drug costs reach $4,550). PPACA provides a $250 rebate to seniors affected by the doughnut hole in 2010, while offering drug discounts and incrementally greater government cost-sharing in subsequent years until the hole is closed in 2020.
- Authorization of Consumer-Oriented and Operated Plans (COOP) – Allows the creation of new, member-run nonprofit organizations that offer Qualified Health Plans (QHPs, described above).
- Establishment of the Patient Centered Outcomes Research Institute – a nonprofit organization charged with researching the effectiveness of different prevention, diagnosis and treatment techniques on specific patient populations. The Institute will be funded partly through assessments on health insurance policies and self-insured plans ($1 per insured individual starting in 2013, and $2 in 2014; the assessment will then rise with the medical inflation rate through 2019).
- Grant funding for several new initiatives, including to:
    - improve consumer access to health insurance information;
    - assist states in reviewing health insurance premium increases;
    - assist states in planning and implementing the exchange system;
    - enhance educational and workforce development opportunities for health professionals;
    - promote healthier lifestyles for Medicaid patients; and
    - support school-based health centers.

Implementation

Implementation of PPACA will take place over the course of the next decade, with most changes occurring on or before January 1, 2014, when the exchanges must be officially established. PPACA involves mandatory components, which will require legislative or executive action, as well as voluntary programs, such as grant programs to which the state agencies, employers or nonprofits may apply. Section IV of this report addresses some of the questions the state may consider when developing a strategy for health care reform implementation.

The state of Rhode Island has started to implement some provisions, such as the creation of the temporary high-risk insurance pool, which provides $13 million over three years and will provide insurance for between 500 and 1,000 uninsured Rhode Islanders.[12] The state has also applied for other funding opportunities, including a grant to help states with exchange design and the Early Retirement Reinsurance Program.

Appendix C contains a timeline for implementation for many provisions of health reform law, though specific deadlines for some programs and initiatives have yet to be established.

[12] At the state's request, Blue Cross Blue Shield of Rhode Island is the official administrator of the Pre-Existing Condition Insurance Plan of Rhode Island. More information is available at https://www.bcbsri.com/BCBSRIWeb/plansandservices/PECIPRI/index.jsp

III. The Uninsured and Health Care Safety Net Programs in Rhode Island

The nonpartisan Congressional Budget Office (CBO) estimated that PPACA will increase the percentage of non-elderly adults with health insurance in the U.S. from 83 percent in 2010 to 94 percent by 2019.[13] The law will reduce the number of uninsured Rhode Islanders, though the number of people gaining access to health insurance and the total costs of implementation will depend partly on policy decisions the state will make in the coming months and years. Implementation may also require the state to modify a number of existing programs intended to provide affordable health care to Rhode Island residents.

The Uninsured in Rhode Island

According to a recent study published by Mathematica Policy Research, an estimated 140,000 Rhode Islanders under the age of 65 lacked health insurance in March of 2010, representing 16 percent of Rhode Island's non-elderly population.[14] The study also estimated that a total of 187,000 Rhode Islanders, or 21 percent of the state's non-elderly population, would lack health insurance for some portion of 2010; this population includes 99,200 who are uninsured for part of the year, and 88,600 who are uninsured the entire year. According to the Mathematica study, about 64 percent of the uninsured are childless adults who are ineligible for Medicaid.

The report also found that the percentage of non-elderly Rhode Islanders without health insurance has climbed in recent years. Between 2001 and 2008, the percentage of non-elderly Rhode Islanders without health insurance rose from 9.0 percent to 11.8 percent, largely tracking increases in the state's unemployment rate.

The costs of health care services received by the uninsured are borne by a number of sources. The Mathematica report estimated total health care costs for the uninsured in Rhode Island to be $246.1 million in 2010. (See Table 6: Estimated Costs and Distribution of Uncompensated Care in Rhode Island, 2010.) The uninsured pay $76 million of those costs through their own out-of-pocket expenditures, with the remaining $170 million covered by Federal, state and local government, the private sector and nonprofit entities. The Federal government's most significant contribution to uncompensated care comes from Medicare and Medicaid Disproportionate Share Hospital (DSH) payments, which help cover the higher costs of treating low-income patients and the uninsured. In Rhode Island, hospitals are required, as a condition of licensing, to provide charity care at no cost to patients with incomes up to 200 percent FPL, and at partial cost for those with incomes up to 300 percent FPL.

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[13] Elmendorf, Douglas W. Letter to The Honorable Nancy Pelosi. 20 Mar. 2010. Congressional Budget Office. Web. Retrieved from http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

[14] Chollet, Deborah, Jeffrey Ballou, Allison Barrett, and Thomas Bell. *Study of Rhode Island's Uninsured: Current Costs and Future Opportunities*. Washington, DC: Mathematica Policy Research, 11 March 2010. Retrieved from website of RI Office of Health Insurance Commissioner http://www.ohic.ri.gov/documents/Insurers/Reports/2010 percent20Uninsured percent20Study percent20Report/1_Mathematica percent20Final percent20Report.pdf

Table 6: Estimated Costs and Distribution of Uncompensated Care in Rhode Island, 2010

	Part-Year Uninsured				Full-Year Uninsured		All Uninsured	
	Insured Spending		Uninsured Spending		Uninsured Spending		Uninsured Spending	
	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
Total spending ($ millions)	$358.3	100.0%	$41.9	100.0%	$204.2	100.0%	$246.1	100.0%
Out-of-pocket	$64.1	17.9%	$15.0	35.8%	$61.0	29.9%	$76.0	30.9%
Spending net of out-of pocket	$294.2	82.1%	$26.9	64.2%	$143.1	70.1%	$170.0	69.1%
Private insurance	$115.5	32.2%	$0.0	0.0%	$0.0	0.0%	$0.0	0.0%
Medicaid	$134.6	37.6%	$0.0	0.0%	$0.0	0.0%	$0.0	0.0%
Other public (a)	$37.0	10.3%	$7.2	17.1%	$38.7	18.9%	$45.9	18.7%
Other private (b)	$7.0	2.0%	$5.3	12.7%	$47.9	23.5%	$53.2	21.6%
Uncompensated care	$0.0	0.0%	$14.4	34.5%	$56.6	27.7%	$71.0	28.9%

(a) Includes the Veterans Administration and workers compensation, as well as the AIDS Drug Assistance Program or other programs that pay for care, drugs, or medical equipment.

(b) Includes any type of private 3rd-party payer such as automobile insurance, accident, or home owners' insurance; employers; or other private sources other than health insurance.

Source: Mathematica Policy Research

Existing State Health Care Programs

Rhode Island administers a number of programs that help cover the cost of health insurance for specific low-income populations. Most programs are funded jointly by the Federal and state governments through Medicaid and the Children's Health Insurance Program (CHIP). Unlike many states that administer a separate program for children (funded through the Federal government), Rhode Island combines Medicaid and CHIP funding streams into one system. The Federal government sets mandatory minimum coverage requirements for programs funded through Medicaid and CHIP, though states may apply to provide additional services or reach broader populations.

Rhode Island's largest health care assistance program for low-income residents is RIte Care, the managed care program available to pregnant women, children under 19, and parents of children under 19 that meet income eligibility requirements. (See Table 7: Current Eligibility Criteria for RIte Care and RIte Share.) RIte Care participants receive health care coverage by enrolling in either UnitedHealthCare of New England or Neighborhood Health Plan of RI. (Blue Cross/Blue Shield of Rhode Island ended its participation with RIte Care in August 2010.) The state covers the full cost of premiums for those with incomes below 150 percent FPL, and enrollees with incomes at 150 percent FPL or higher contribute toward monthly premiums ($61 per month for 150-185 percent FPL, $77 per month for 185-200 percent FPL, and $92 per month for 200-250 percent FPL).

Table 7: Current Eligibility Criteria for RIte Care and RIte Share

Population	Current Eligibility in RI (Family income as a percent of FPL)
Children	250 %
Pregnant Women	250 %
Parents with children under 19	175 %
Adults without children	Not covered

RIte Share offers qualifying participants premium support payments to help recipients pay for their employee contribution toward employer-offered health insurance. The eligibility and cost-sharing requirements are the same as with RIte Care (see Table 7), but RIte Share is supported by

employer contributions. According to the RI Department of Human Services, 867 employers participated in RIte Share in State Fiscal Year 2009.

In addition to RIte Care and RIte Share, the state provides Medicaid-funded health care services to children under 19 with special health care needs, children in substitute (foster) care and adults who are elderly, blind or disabled. (See Table 8: Enrollment and Expenditures by Category, State Fiscal Year 2009.)

Table 8: Enrollment and Expenditures by Category, State Fiscal Year 2009

Program/Population	Enrollment	Expenditures	Average Cost Per Enrollee
RIte Care	106,158	$366,495,862	$3,452
RIte Share	8,493	$5,254,648	$619
Children w/Special Health Care Needs	6,479	$139,466,588	$21,526
Children in Substitute Care	2,289	$67,028,975	$29,283
Elderly, Blind and Disabled Adults	45,354	$1,052,465,631	$23,206
Total	**168,773**	**$1,630,711,704**	**$9,662**

Source: RI Department of Human Services

It is important to note that Medicaid caseload levels are not static. In May 2010, the state Revenue & Caseload Estimating Conference found that enrollment in RIte Care was 116,601 (an increase of 9.8 percent over SFY 2009 levels) and RIte Share was 11,258 (an increase of 32.6 percent), while the state covered 2,077 children in substitute care (a decrease of 9.2 percent) and 6,804 children with special health care needs (an increase of 5.0 percent). Enrollment of the elderly and adults with disabilities rose only slightly. The increase in most categories resulted largely from the economic downturn, and future enrollment may decline if the state's economy improves.

The Federal government gives states the flexibility to augment their Medicaid and CHIP programs by including optional populations and offering additional benefits. Optional covered populations in Rhode Island include low-income elderly adults and adults with disabilities, children older than five years old in families between 100 percent and 250 percent FPL, parents up to 175 percent FPL, children with special health care needs, and others. Optional services include preventive care, prescription drugs, dental services, and home- and community-based services (as an alternative to institutional care), among others.[15]

Since July 2009, Rhode Island has operated its Medicaid and CHIP programs under the terms of an agreement with the Centers for Medicare & Medicaid Services (CMS) known as the Global Waiver. The Global Waiver caps Federal funding on Medicaid and CHIP programs in exchange for greater state flexibility in program administration. Under the Global Waiver, the state may receive Federal funding for services not traditionally covered under Medicaid (known as "Costs Not Otherwise Matchable," or CNOMs), and any changes to benefits or covered populations

[15] A more complete description of optional populations and benefits is included in the "Rhode Island Annual Medicaid Expenditure Report – State Fiscal Year 2008" prepared by the Rhode Island Executive Office of Health and Human Services" available at http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Reports/RI_Medicaid_Expend2008_final.pdf.

must be approved by CMS. The terms of the Global Waiver expire on December 31, 2013, though the state can terminate the agreement earlier by alerting CMS and providing a phase-out plan. If the state wishes to extend the demonstration project, it must notify CMS at least twelve months before the expiration date.[16]

State and local governments also administer health insurance for their employees, and those policies may be affected by new mandates under PPACA. According to the Rhode Island Department of Administration, the state provides health insurance to 44,435 state employees, retirees, and their spouses and dependents, including those working at the University of Rhode Island, Rhode Island College and the Community College of Rhode Island. In State Fiscal Year 2010, the state spent $143.2 million in health care benefits for workers and $38.6 million for retiree health.

In State Fiscal Year 2010, municipal governments employed approximately 9,400 people and budgeted $167.9 million for medical and dental coverage for active employees and retirees.[17] School districts accounted for an additional $229.8 million in health and dental expenditures for 22,937 active employees and retirees in State Fiscal Year 2008 (the most recent year for which data were available).[18]

The state, municipal and school district plans differ in their benefits coverage, though most of these health insurance plans already meet many of the new mandates required under PPACA (e.g., no lifetime limit on benefits). However, nearly all of the plans must still implement the requirement that children under 26 be covered.

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[16] Complete terms of the Global Waiver are available at http://www.eohhs.ri.gov/documents/documents10/RI_1115_Demo_GW_12_09.pdf

[17] Rhode Island Department of Revenue. Division of Municipal Finance. *Municipal Budget Survey, FY2010*. 1 February 2010. http://www.muni-info.ri.gov/documents/finances/municipal percent20budget percent20info/2010 percent20Budget percent20Survey percent20for percent20web percent20updated percent202-1-10.pdf

[18] Rhode Island Department of Education. *Anticipated Expenditures for Health Benefits*. December 2007.

IV. State Implementation of PPACA

PPACA contains both mandatory provisions with which states must comply and optional programs that states may use to modify or modernize their health care systems. Even with many mandatory provisions, the states will have some flexibility in deciding how to tailor new programs to the needs of their residents.

Covered Populations and Benefits Prior to 2014

PPACA expands Medicaid eligibility to include non-elderly individuals with incomes below 133 percent of the Federal poverty level (FPL). The law also includes new mandatory benefits under Medicaid as well as optional services that states may provide. Rhode Island can choose whether it wants to expand Medicaid eligibility before the January 1, 2014, deadline, as well as decide which optional populations should be covered and which optional benefits should be provided.

PPACA contains a maintenance of effort (MOE) provision preventing states from reducing their Medicaid and CHIP program eligibility in the coming years. The MOE provision took effect on the date of enactment (March 23, 2010) and lasts through 2013 for adults and 2019 for children. If states are experiencing or projecting budget deficits, they may apply for a MOE waiver in order to reduce eligibility requirements for optional populations.

Rhode Island's ability to apply for a MOE waiver based on financial hardship is affected by two other factors. First, the enhanced FMAP provided under the American Recovery and Reinvestment Act (ARRA) includes separate MOE requirements; any reduction in Medicaid or CHIP program eligibility before the expiration of ARRA's enhanced FMAP on June 30, 2011, could result in a loss of Federal matching dollars. Second, as part of its Global Waiver agreement, the state set participant eligibility and benefit requirements with which it must comply. Any changes to Medicaid eligibility before the Global Waiver's expiration on December 31, 2013, would require the approval of both the state legislature and the Administrator of the Centers for Medicare and Medicaid Services.

Expansion of Medicaid to 133 Percent of Federal Poverty Level

PPACA expands Medicaid eligibility to include non-elderly individuals with incomes below 133 percent of the Federal poverty level (FPL), which must begin by January 1, 2014, though states are permitted to do so earlier. According to preliminary estimates by the RI Department of Human Services, approximately 68,000 of the state's 140,000 uninsured would be newly eligible for Medicaid under the 133 percent FPL expansion. A reduction in the number of uninsured would lower uncompensated care costs for the Federal and state governments, as well as for hospitals and other health care providers.

Not all people who qualify for Medicaid will necessarily enroll. The costs of insuring the expanded Medicaid population will therefore depend on how many people ultimately participate – a variable influenced by the scope and effectiveness of Federal and state outreach to newly eligible populations. A report by the Kaiser Commission on Medicaid and the Uninsured estimates that, if the future rate of Medicaid enrollment approximates the current level (57 percent of those eligible actually enroll), Rhode Island can expect to have 41,185 new Medicaid

enrollees by 2019, 29,147 of whom would have been previously uninsured.[19] Under their "enhanced scenario," where government outreach efforts boost enrollment to 75 percent of those eligible, the state would have 58,841 new enrollees by 2019, 40,850 of whom had been previously uninsured. Though Kaiser's estimate of the total number of the uninsured in Rhode Island is lower than the estimate in the Mathematica, Kaiser's analysis suggests that Rhode Island's budget estimates for future Medicaid expenditures will be dependent on the effectiveness of outreach programs on enrollment.

The state must also decide when to implement the expanded Medicaid program – either at the 2014 deadline or earlier. Starting in 2014, the Federal government will cover most of the costs of insuring this population through an enhanced FMAP (see Table 2), though the state will share some of the new costs (5 percent starting in 2017 and climbing gradually to 10 percent in 2020). If states expand eligibility before 2014, they can expect to receive only their standard FMAP.

Policymakers will also need to consider the future of programs under the Global Waiver. Since the state needs to decide in 2012 whether to request CMS approval for renewal of the Global Waiver – more than a year before the deadline for implementation of Medicaid expansion – the state will need to decide whether to maintain existing programs under the conditions of the Global Waiver or seek to incorporate them into Medicaid expansion and other aspects of health care reform.

Creation of State Health Exchanges

If Rhode Island chooses to develop an American Health Benefit Exchange, it must decide what the main goals of the exchange should be, which populations to include, and whether to integrate the exchange with other health care insurance options. The state must also decide how to pay for administration of the exchange, as exchanges are expected to financially self-sufficient after 2015.

The exchange will also need to be integrated with existing programs such as RIte Care and RIte Share. After 2014, certain pregnant women, parents and children that currently qualify for RIte Care and RIte Share will be eligible for Federal subsidies in the exchange.[20] States also have the ability to offer a Basic Health Plan for non-elderly individuals between 133 percent and 200 percent FPL.

The state should also consider what level of support to provide small businesses through the Small Business Health Options Program (SHOP) Exchange, which could be incorporated into the individual exchange. In addition to small businesses, the exchange could serve other populations such as state and municipal employees, individuals and families above 400 percent FPL, or larger businesses. Finally, PPACA also permits the operation of multi-state exchanges.

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[19] Holahan, John and Irene Headen. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133 percent FPL." Kaiser (need full citation) 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

[20] These include children and pregnant women between 133 percent and 250 percent FPL and parents between 133 percent and 175 percent FPL.

Rhode Island may explore the possibility of working with other New England states to develop and maintain a multi-state exchange.

Mandatory Changes to Health Insurance

PPACA requires a number of changes to health insurance and group health plans, which will affect existing health insurance plans with state and municipal employees. In most cases, existing state and local government plans meet many of the new requirements, such as a ban on capping certain benefits. However, most existing plans will need to comply with the new requirement allowing employees to include children under the age of 26 on their policy, effective for all plan years beginning after September 23, 2010. State and local governments can choose whether to offer this new benefit now or at the date of their policy renewal (July 1, 2011, for most state and municipal policies). The new benefit is expected to raise state and local government health care costs by approximately 2 percent to 2.25 percent, which should be added to budget forecasts.

State and municipal governments can decide whether to maintain grandfathered status for any health plans in existence before March 23, 2010. As previously noted, maintaining grandfathered status also entails administrative requirements such as reporting on any changes to the grandfathered plan, as well as informing existing and potential enrollees in the plan about how the grandfathered plan differs from the minimum PPACA requirements for new plans.

State and municipal governments may also choose to apply to Early Retirement Reinsurance Program, which helps offset the costs of providing health insurance coverage to retirees over the age of 55 who do not yet qualify for Medicare. For employers approved through the application process, the U.S. Department of Health and Human Services will pay 80 percent of medical costs between $15,000 and $90,000, though funding for the program is authorized only up to $5 billion. The program will run through January 1, 2014, when the exchanges and other programs will provide alternatives for early retirees.

The State of Rhode Island has applied for reimbursement under the program, which, if approved, could result in savings of $810,000 in Fiscal Year 2010 and $9.9 million in Fiscal Year 2011. Municipal governments may wish to consult with their health insurance providers to determine whether any insurance costs could qualify for reimbursement under the program. Because municipalities may not be certain of exact retirement health costs, Blue Cross & Blue Shield of Rhode Island has developed an ERRP benefits estimator using actuarial data derived from the number of retired employees receiving health care benefits and the plan year period.[21] Municipalities that choose to apply for ERRP benefits can access an application and more information at the official program website (http://errp.gov/).

[21] More information about the Blue Cross & Blue Shield ERRP estimator is available at https://www.bcbsri.com/BCBSRIWeb/public/early_retiree_reinsurance_program.jsp.

Administration and Oversight

Another key question facing the state is deciding who will be in charge of implementing health care reform. Many of the new mandates and initiatives will require legislative approval, while their implementation and coordination with other programs will fall to a variety of state agencies, including the Executive Office of Health and Human Services, the Department of Administration, the Office of the Health Insurance Commissioner, and others. Further, reform efforts will impact health care providers, insurance companies, customers, and numerous other groups.

Other states have taken a variety of approaches to implementation, including joint legislative committees, Cabinet-level executive agency working groups, and broader task forces with representatives from government, the health care industry and other stakeholders.[22] These bodies also vary in their influence, ranging from advisory groups to those with implementation authority. To date in Rhode Island, implementation has occurred primarily in the form of ad hoc cooperation within the agencies. Lieutenant Governor Elizabeth Roberts created the HealthyRI Task Force, which convened a variety of stakeholders to make non-binding recommendations.[23]

PPACA includes new provisions that may require the state to review existing programs and procedures. The law requires states to use Modified Adjusted Gross Income (MAGI) by 2014 as the sole determinant of eligibility for most populations in Medicaid and CHIP programs, requiring changes to existing eligibility criteria and the application process. Further, as Medicaid expansion will add tens of thousands of people to state caseloads, the state may wish to review current technology assets and personnel to determine whether they are sufficient to meet requirements under reform.

Implementation of PPACA at the state level has already begun, though the coming months will require significant involvement by the legislative and executive branches of government. A list of key deadlines is included below, and a complete timeline is available in Appendix C.

[22] The National Conference of State Legislatures has been compiling a list of states' implementation efforts, available at http://www.ncsl.org/default.aspx?tabid=20231.

[23] The Healthy RI Task Force recommendations are available at http://www.ltgov.ri.gov/taskforce/Healthy percent20RI percent20Task percent20Force percent20Report percent2009.23.10.pdf .

PPACA Timeline with Key Dates for Implementation

2010

- States, with support from the Federal government, must establish a process for reviewing increases in health plan premiums and require plans to justify proposed increases; states are required to report on trends in premium increases (effective for 2010 plan years)

- Health plans must report medical loss ratios (the amount of revenue from premiums spent on medical services) (effective for 2010 plan years)

- States have the option of providing Medicaid coverage to childless adults with incomes up to 133% of the Federal poverty level (optional starting April 1; mandatory as of January 1, 2014)

- State and local governments may apply to the Early Retirement Reinsurance Program (applications accepted starting in June)

- States must establish a temporary high risk health insurance pool program with funding provided by the Federal government (June 23)

- States must update laws regulating insurance to include the following:
    - Prohibition on annual and lifetime limits on dollar value of coverage;
    - Prohibition on rescission of coverage by insurers;
    - Required coverage of preventive health services rated A or B by the U.S. Preventive Services Task Force without cost sharing;
    - Extension of adult dependent coverage to age 26 by group and individual plans;
    - Prohibition on the use of preexisting condition exclusions for children;
    - Prohibition on discrimination based on salary;
    - Plan incorporation of revised internal and external appeals process requirements; and
    - Assurances of plan and provider compliance with patient protections.

    (effective for plan years starting after September 23, 2010)

- States have the option, through a Medicaid state plan amendment, of providing home and community-based services to certain individuals and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan (October 1)

2011

- Health plans must meet minimum medical loss ratio limits (the amount of revenue from premiums spent on medical services) – at least 85 percent in the large group market and 80 percent in the individual and small group markets; plans that do not meet minimum ratios must provide rebates to consumers (January 1)

- Federal government ends payments for Medicaid services related to health care-acquired conditions (January 1)

- States may qualify for higher Federal Medicaid matching payments for establishment of health home programs, as well as for promoting home- and community-based services (October 1)

2012

- Federal government implements new waste, fraud and abuse prevention efforts for providers and suppliers participating in Medicare, Medicaid and CHIP (January 1)

- Federal government establishes the Community Living Assistance Services and Supports (CLASS) program, a national voluntary long-term care insurance program; employees pay premiums through payroll deduction (target implementation, October 1)

PPACA Timeline with Key Dates for Implementation

2013

- States must notify the U.S. Department of Health and Human Services (HHS) whether they intend to establish an American Health Benefits Exchange (January 1)

- States may qualify for a one percentage point increase in Federal Medicaid matching funds if they offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations (January 1)

- Federal government increases Federal Medicaid matching payments for primary care services provided by primary care doctors to 100 percent Federal funding (January 1, 2013 through December 31, 2014)

- Federal government creates the Consumer Operated and Oriented Plan (CO-OP) program to authorize and provide funding for the creation of nonprofit, member-run health insurance companies to offer qualified health plans in all 50 states (target date to establish CO-OPs is July 1)

2014

- States must expand Medicaid to all non-elderly individuals with incomes up to 133% of the Federal poverty level (FPL); Federal government will increase Medicaid matching funds for the newly eligible (January 1)

- Individuals are required to have health coverage or face a tax penalty, with some exceptions granted for low-income and other populations (January 1)

- States (or the Federal government in their absence) must establish American Health Benefits Exchanges to create a marketplace for insurance for individuals and small employers; Federal government will provide premium support and cost-sharing subsidies to individuals with incomes between 133 and 400 percent of the Federal poverty level (January 1)

- States must update laws regulating insurance to include the following:
    - Prohibition on the use of preexisting condition exclusions for any applicant;
    - Limit waiting periods for coverage to no more than 90 days; and
    - Elimination of all annual limits.

  (effective for plan years starting January 1)

- Employers with more than 50 employees must provide affordable health care coverage to employees or face penalties mandate; employers with more than 200 employees must automatically enroll employees in employer-sponsored insurance with an opportunity to opt out of coverage (January 1)

- Federal government will reduce Medicaid and Medicare payments to states under the Disproportionate Share Hospital Program (October 1)

Sources: Kaiser Family Foundation, Implementation Timeline (http://healthreform.kff.org/timeline.aspx), *National Conference of State Legislatures, State Legislators' Checklist for Health Reform Implementation* (http://www.ncsl.org/default.aspx?tabid=20652) *HealthCare.gov*

For additional provisions included in PPACA, please see Appendix C

Appendix A: Other Resources for Information about PPACA

Text of Patient Protection and Affordable Care Act (PPACA; Public Law 111-148)
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ148.111.pdf

Text of Health Care and Education Reconciliation Act (HCERA; Public Law 111-152)
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ152.111.pdf

Understanding the New Law (Healthcare.gov)
http://www.healthcare.gov/law/introduction/index.html

Health Care Reform Source (prepared by Kaiser Family Foundation)
http://healthreform.kff.org/

State Legislators' Check List for Health Reform Implementation FY 2010 (prepared by National Council of State Legislatures)
http://www.ncsl.org/documents/health/2010CLHlthRef.pdf

Appendix B: Federal Poverty Level (FPL) for Individuals and Families in the 48 Contiguous States and District of Columbia, 2010

	Percent of Federal Poverty Level			
Persons in Family	100%	133%	250%	400%
1	$10,830	$14,404	$27,075	$43,320
2	$14,570	$19,378	$36,425	$58,280
3	$18,310	$24,352	$45,775	$73,240
4	$22,050	$29,327	$55,125	$88,200
5	$25,790	$34,301	$64,475	$103,160
6	$29,530	$39,275	$73,825	$118,120
7	$33,270	$44,249	$83,175	$133,080
8	$37,010	$49,223	$92,525	$148,040

For families with more than 8 persons, add $3,740 for each additional person to 100 percent FPL, $4,974 to 133 percent, $9,350 to 250 percent, and $14,960 to 400 percent.

Note that these figures apply for 2010. The Federal Poverty Level will be adjusted annually in future years to account for any changes in the cost of living.

Source: U.S. Department of Health and Human Services, "HHS Poverty Guidelines for the Remainder of 2010" http://aspe.hhs.gov/poverty/10poverty.shtml

Appendix C: Health Reform Implementation Timeline

Source: Kaiser Family Foundation (http://www.kff.org/healthreform/8060.cfm)

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85 percent for plans in the large group market and 80 percent for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases.

Medicare

- Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.
- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units.

- Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.

Medicaid

- Create a state option to cover childless adults though a Medicaid state plan amendment.
- Create a state option to provide Medicaid coverage for family planning services up to the highest level of eligibility for pregnant women to certain low-income individuals through a Medicaid state plan amendment.
- Create a new option for states to provide Children's Health Insurance Program (CHIP) coverage to children of state employees eligible for health benefits if certain conditions are met.
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 percent (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1 percent); increase the Medicaid rebate for non-innovator, multiple source drugs to 13 percent of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

Prescription Drugs

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

Quality Improvement

- Support comparative effectiveness research by establishing a nonprofit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.

Tax Changes

- Impose additional requirements on nonprofit hospitals. Impose a tax of $50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers.
- Impose a tax of 10 percent on the amount paid for indoor tanning services.

- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011

Long-term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventive services based on recommendations of the U.S. Preventive Services Task Force.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50 percent discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in Federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10 percent Medicare bonus payment to primary care physicians, and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Restructure payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates.
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

- Prohibit Federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90 percent FMAP for two years for health home related services including care management, care coordination and health promotion.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced Federal matching payments to increase non-institutionally based long-term care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Quality Improvement

- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.
- Establish a new trauma center program to strengthen emergency department and trauma center capacity.
- Improve access to care by increasing funding by $11 billion for community health centers and by $1.5 billion for the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

Workforce

- Establish Teaching Health Centers to provide payments for primary care residency programs in community-based ambulatory patient care centers.

Tax Changes

- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account or health flexible spending account and from being reimbursed on a tax-free basis through a health savings account or Archer medical savings account.
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20 percent of the disbursed amount.
- Impose new annual fees on the pharmaceutical manufacturing sector.

2012

Medicare

- Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care.
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.

- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
- Reduce annual market basket updates for home health agencies, skilled nursing facilities, hospices, and other Medicare providers.
- Create the Medicare Independence at Home demonstration program.
- Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Provide bonus payments to high-quality Medicare Advantage plans.
- Reduce rebates for Medicare Advantage plans.

Medicaid

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective Fiscal Years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Quality Improvement

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013

Insurance Reforms

- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)

Prevention/Wellness

- Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the Federal medical assistance percentage (FMAP) for these services.

Medicare

- Begin phasing-in Federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25 percent in 2020, in addition to the 50 percent manufacturer brand-name discount).
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100 percent Federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5 percent of adjusted gross income to 10 percent of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9 percent (from 1.45 percent to 2.35 percent) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8 percent assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3 percent on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment.Â Employers with 50 or more employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment.Â Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer.Â Employees may opt out of coverage.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or nonprofit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400 percent FPL to the following levels:
    - 100-200 percent FPL: one-third of the HSA limits ($1,983/individual and $3,967/family in 2010);
    - 200-300 percent FPL: one-half of the HSA limits ($2,975/individual and $5,950/family in 2010);
    - 300-400 percent FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family in 2010).
- Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60 percent of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a nonprofit entity and at least one plan must not provide coverage for abortions beyond those permitted by Federal law.
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200 percent FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- Allow states the option of merging the individual and small group markets.
- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- Require qualified health plans to meet new operating standards and reporting requirements.

Premium Subsidies

- Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400 percent FPL to purchase insurance through the Exchanges.

Medicare

- Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019).
- Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate.
- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75 percent and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. Require Medicare Advantage plans to have medical loss ratios no lower than 85 percent.

Medicaid

- Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133 percent FPL based on modified adjusted gross income (MAGI) and provide enhanced Federal matching for new eligibles.
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments.
- Increase spending caps for the territories.

Prevention/Wellness

- Permit employers to offer employees rewards of up to 30 percent, increasing to 50 percent if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Tax Changes

- Impose fees on the health insurance sector.

2015 and later

Insurance Reforms

- Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016)

Medicare

- Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1 percent. (Effective Fiscal Year 2015)

Tax Changes

- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. (Effective January 1, 2018)

Appendix D: Glossary of Acronyms

ARRA	American Recovery and Reinvestment Act
CBO	Congressional Budget Office (U.S.)
CHIP	Children's Health Insurance Program
CLASS	Community Living Assistance Services and Supports – Federally administered long-term care insurance
CMS	Centers for Medicare and Medicaid Services (U.S.)
CNOM	Costs Not Otherwise Matchable – Medical services available to RI populations under the Global Waiver that would not normally be covered under Medicaid
COOP	Consumer-Oriented and Operated Plans
DHS	Department of Human Services (R.I.)
DSH	Disproportionate Share Hospital
E-FMAP	Enhanced Federal Medical Assistance Percentage – Federal matching payment to states under CHIP
EOHHS	Executive Office of Health and Human Service (R.I.)
ERRP	Early Retirement Reinsurance Program
FFY	Federal Fiscal Year (October 1 – September 30)
FMAP	Federal Medical Assistance Percentage – Federal matching payment to states under Medicaid
FPL	Federal Poverty Level (see Appendix B for 2010 figures)
FTE	Full-time equivalent (employees)
FY	Fiscal Year
HCERA	Health Care and Education Reconciliation Act
HHS	Department of Health and Human Services (U.S.)
MAGI	Modified Adjusted Gross Income
MOE	Maintenance of effort – Federal requirement that States not restrict Medicaid eligibility or benefits
OHIC	Office of the Health Insurance Commissioner (R.I.)
OPM	Office of Personnel Management (U.S.)
PPACA	Patient Protection and Affordable Care Act
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
SFY	State Fiscal Year (July 1 – June 30)