HEALTH REFORM

May 15, 2017

Georgia Health Policy Center

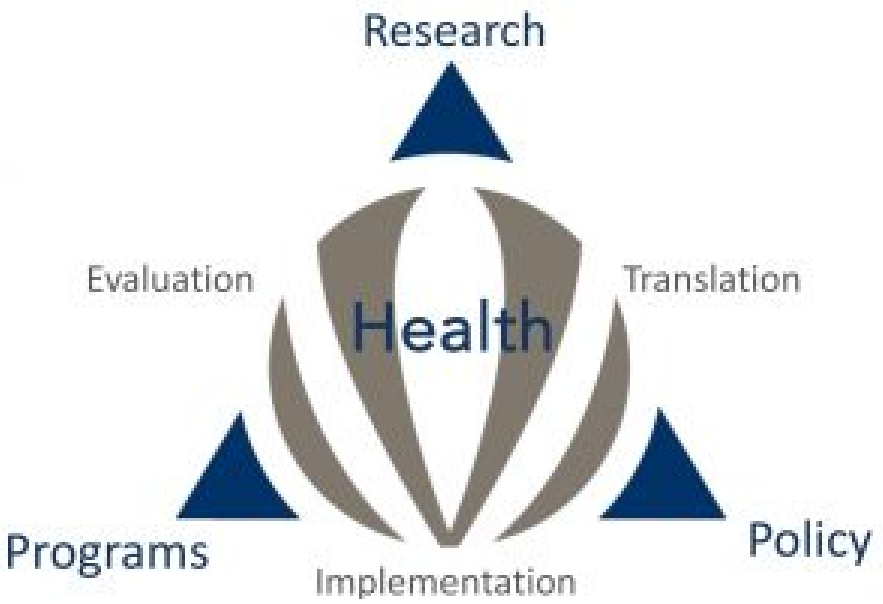
Melissa Haberlen, JD, MPH
Georgia Health Policy Center

Georgia Health Policy Center

Georgia State University J. Mack Robinson College of Business

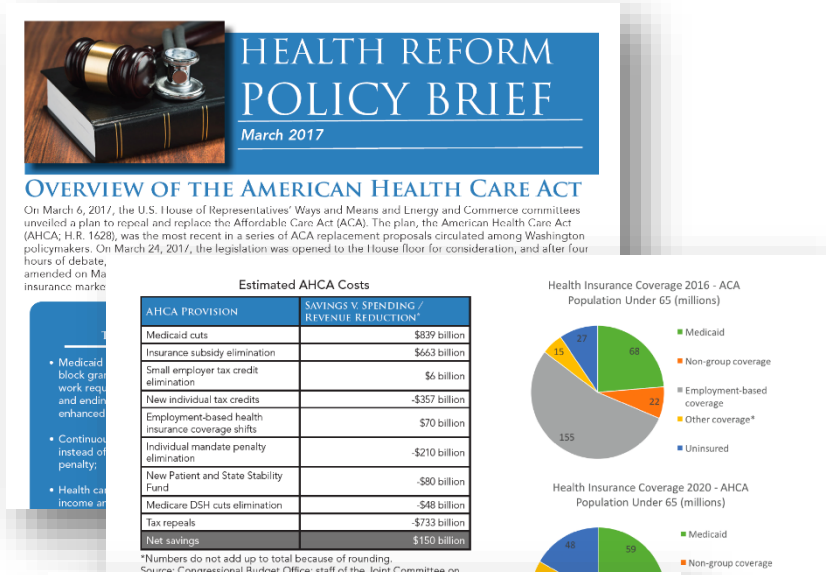
GHPC Overview

- Mission: Integrating research, policy, and programs to advance health and well-being.



Health Reform – 2017

1. Convened Interdisciplinary Work Group
   - Faculty / Staff from Andrew Young School of Policy Studies, Robinson College of Business, and GSU College of Law
   - Bi-weekly meetings
   - Live tracker
   - Data repository
2. Policy Brief Package, Resources, and Tools
   - AHCA overview, Market stabilization, Cost-sharing reduction subsidies, etc.
3. Presentations
4. State-Level Support
   - State agencies; Legislature



HEALTH REFORM POLICY BRIEF

March 2017

OVERVIEW OF THE AMERICAN HEALTH CARE ACT

On March 6, 2017, the U.S. House of Representatives' Ways and Means and Energy and Commerce committees unveiled a plan to repeal and replace the Affordable Care Act (ACA). The plan, the American Health Care Act (AHCA; H.R. 1628), was the most recent in a series of ACA replacement proposals circulated among Washington policymakers. On March 24, 2017, the legislation was opened to the House floor for consideration, and after four hours of debate,

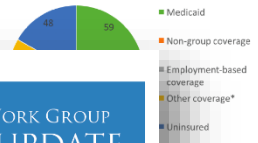
Estimated AHCA Costs

AHCA Provision	Savings v. Spending / Revenue Reduction*
Medicaid cuts	$839 billion
Insurance subsidy elimination	$663 billion
Small employer tax credit elimination	$6 billion
New individual tax credits	-$357 billion
Employment-based health insurance coverage shifts	$70 billion
Individual mandate penalty elimination	-$210 billion
New Patient and State Stability Fund	-$80 billion
Medicare DSH cuts elimination	-$48 billion
Tax repeals	-$733 billion
Net savings	$150 billion

*Numbers do not add up to total because of rounding.

Health Insurance Coverage 2016 - ACA
Population Under 65 (millions)

Health Insurance Coverage 2020 - AHCA
Population Under 65 (millions)



HEALTH CARE REFORM WORK GROUP
REGULATORY UPDATE

April 14, 2017

SUMMARY OF HHS MARKET STABILIZATION FINAL RULE

On April 13, 2017, the Department of Health and Human Services (HHS) issued a final rule[1], making several changes to regulations for the individual and small-group health insurance markets. The rule was created in response to the increasing number of insurers leaving the exchanges in certain states and counties, in large part due to their inability to attract and keep the healthy consumers necessary for a stable risk pool. As insurers leave markets, consumers have less choice for affordable health plans, destabilizing the risk pools even further.

The final rule seeks to stabilize risk pools for insurers in hopes of stemming their exit from the market, while increasing competition and, therefore, consumer choice and affordability. To accomplish these goals, the rule increases incentives for individuals to remain continuously enrolled, while decreasing the ability of individuals to enroll only after becoming sick. The final rule affects the regulations for individual and small-group markets located at 45 C.F.R. parts 147, 155, and 156 by:

- Shortening the open enrollment period for the 2018 plan year so that it runs from November 1, 2017 to December 15, 2017 (currently, the end date is

enrollment applicants, allowing the remaining half to verify eligibility by simply self-certifying that they were eligible. By requiring a higher level of verification, the rule seeks to make it more difficult for individuals to wait until they get sick before enrolling in health insurance.

- Allowing insurers to apply current premium payments to past-due premiums for coverage provided during the preceding 12 months by the same insurer.
- Increasing the minor variations allowed for determining actuarial value (AV) of the four "metal" levels of coverage (bronze, silver, gold, and platinum). Current regulations allow minor variation of AV (i.e., plans must be within two percentage points of 70%, 80%, or 90% to qualify as silver, gold, or platinum plans, respectively). The final rule slightly increases the variation allowed to give more flexibility to insurers in designing new plans and providing more options to keep cost sharing the same from year to year. The rule does not change the variation for silver plans with cost- sharing

GHPC Standards

HEALTH REFORM

May 15, 2017

HEALTH CARE COVERAGE IN GEORGIA

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Georgia Health Policy Center

Georgia State University J. MACK ROBINSON COLLEGE OF BUSINESS

Agenda

I. What are the numbers?

II. What are the trends?

III. Medicaid
- DSH and the Safety Net
- Waivers

WHAT ARE THE NUMBERS?

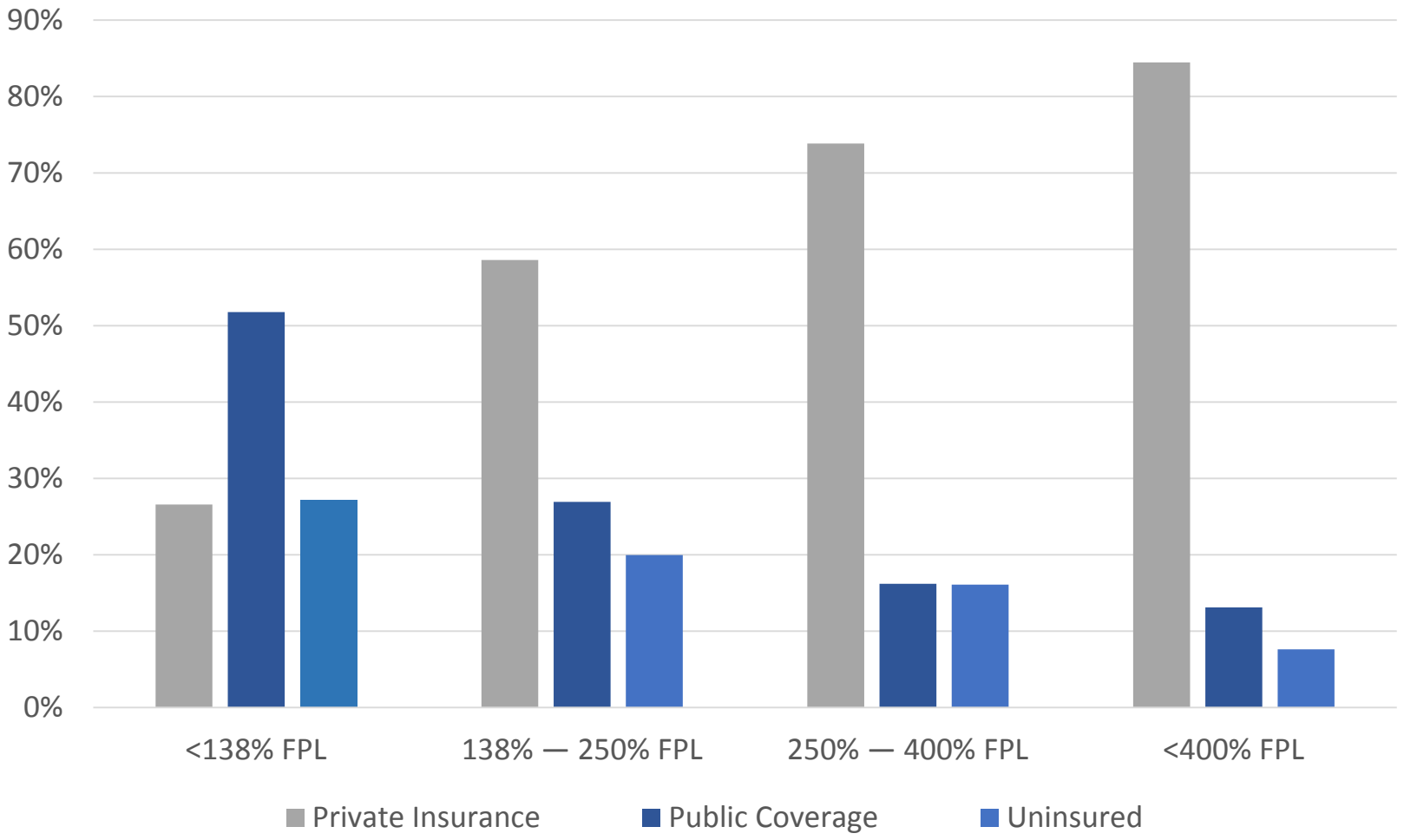
And what about Marketplace coverage?

Coverage in Georgia, 2015

Non – Elderly (<65)	Number (in Millions)	Percent of Non-Elderly
Total Population	8.81	100%
Privately Insured	5.52	63%
Employer Sponsored	4.66	53%
Non-Group Health	.91	10%
Public Coverage	2.44	28%
Uninsured	1.39	16%

Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2016

Coverage by Family Income



Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2015 & 2016

Coverage by Family Income

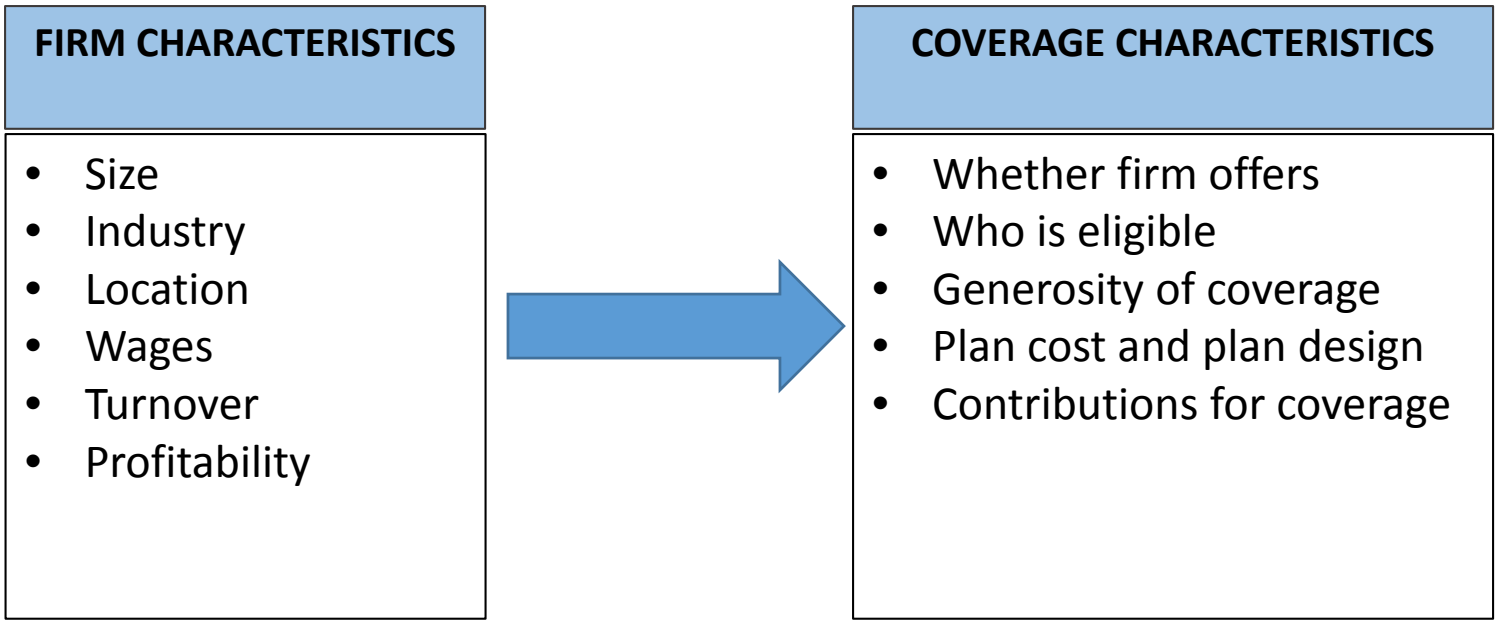
- 2.2 million Georgians (one quarter of the nonelderly population) live in families with incomes at or below 138% Federal Poverty Level (FPL; $33,500 for a family of 4).

- >600,000 of these report no insurance at any time during the year (2014/2015 average).

- Low income families experience significant income fluctuations.

Employer-Sponsored Insurance

- 85%-90% of individuals with private insurance have it through an employer-sponsored plan because of the tax subsidy and the risk pooling advantage.

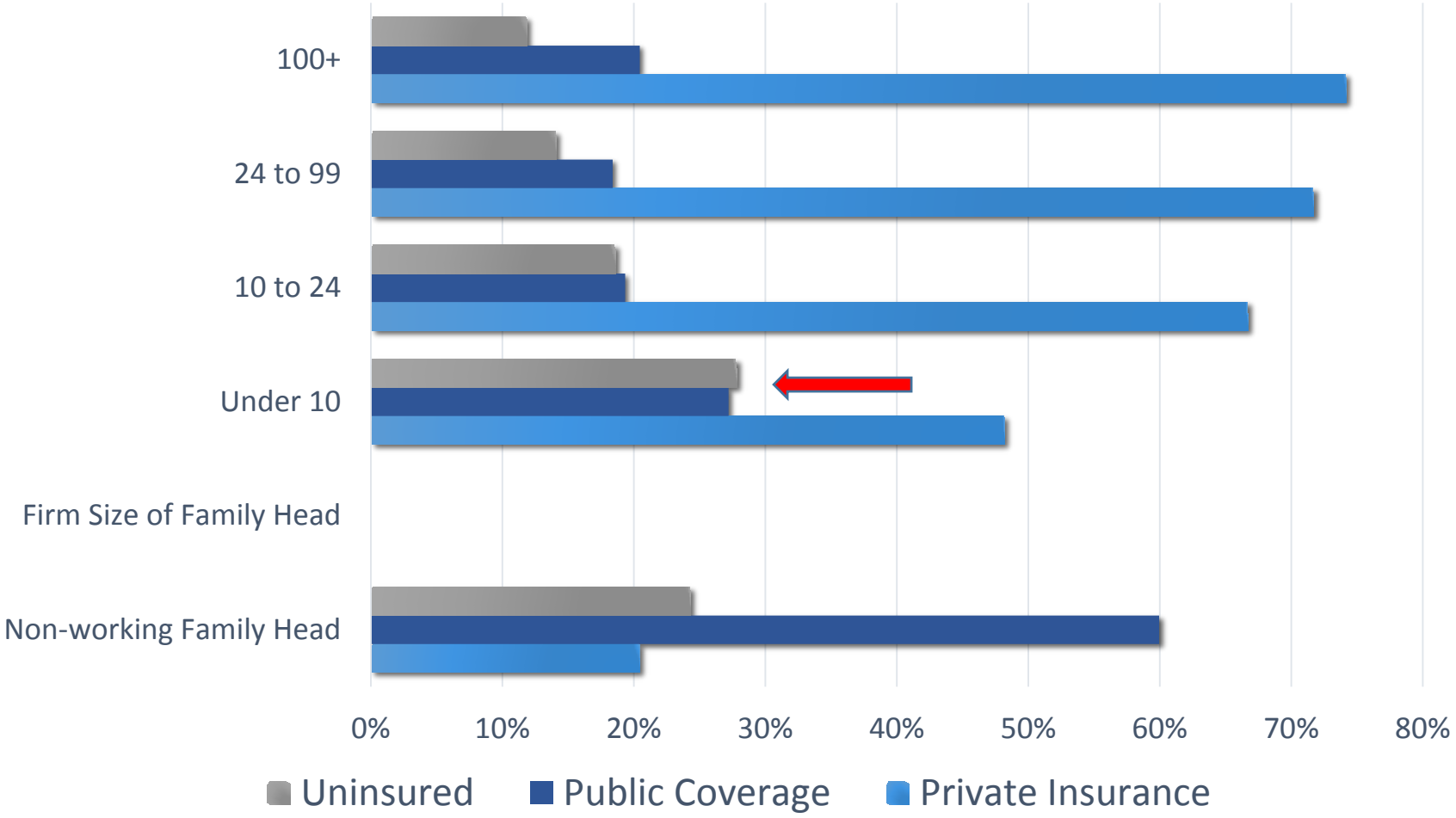


Georgia Workers by Firm Size of Family Head, 2014 – 15 Average

Firm Size of Family Head	Number (in millions)	Share of Nonelderly population
Non-working Family	1.02	12%
Firm Size		
Under 10	1.35	15%
10 to 24	1.00	11%
25 to 99	.59	7%
100 to 999	1.39	16%
Over 1000	3.36	39%

Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2015 & 2016

Coverage of Georgians by Firm Size of Family Head, 2014 – 15



Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2015 & 2016

Georgia vs. National Average: Firms Offering Insurance in 2015

	Georgia	USA
All Firms	39.9%	45.7%
Firms <10 Employees	14.5%	22.7%
Firms <50 Employees	19.9%	29.4%
Firms with 50 or more	98.7%	96%

Data source: Medical Expenditure Panel Survey – Insurance Component from 2015
https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2015/tiia2.pdf

Firm Size and Coverage

- Georgians whose family head works at a very small firm are more likely to be uninsured than those in families without a worker (28% versus 24%).

- About half of those purchasing individual coverage are in families headed by a worker from a small firm (<25 employee).

- Small firms less likely to offer – especially in Georgia. Uninsured in families headed by a large firm worker are most likely not eligible or not participating in their firms coverage.

Self-Funded Plans

- Using Current Population Survey, we estimate about 60% (2.8 million) Georgians are enrolled in a plan that is self-funded.
  - Consistent with national averages
- Not subject to state insurance regulations.
- Employee Benefits Research Institute finds that smaller firms (25-99) are increasingly likely to self-insure.

Rural Urban Coverage Differences, 2014 – 15 Average

	Urban	Rural
Share of all nonelderly residents in Georgia	78%	22%
Share by coverage categories		
Privately Insured	66%	52%
Group Health	56%	45%
Individual Coverage	10%	8%
Public Coverage	24%	34%
Uninsured	16%	19%

Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2015 & 2016

Survey of Georgia Small Employers, 2011

By Region		
	Total Firms	**Insurance Offered**
Total: Georgia	115,166	47%
Region		
Rural North	22,461	47%
Rural South	17,100	39%
Atlanta	59,441	50%
Other Metro Areas	16,163	47%

- In 2011, average wages in small firms in south rural Georgia were $1,000 per month lower than the state wide average.

Source: Georgia Health Policy Center http://ghpc.gsu.edu/files/2014/01/2011_Georgia_Employer_Survey.pdf

Georgia Marketplace Participation

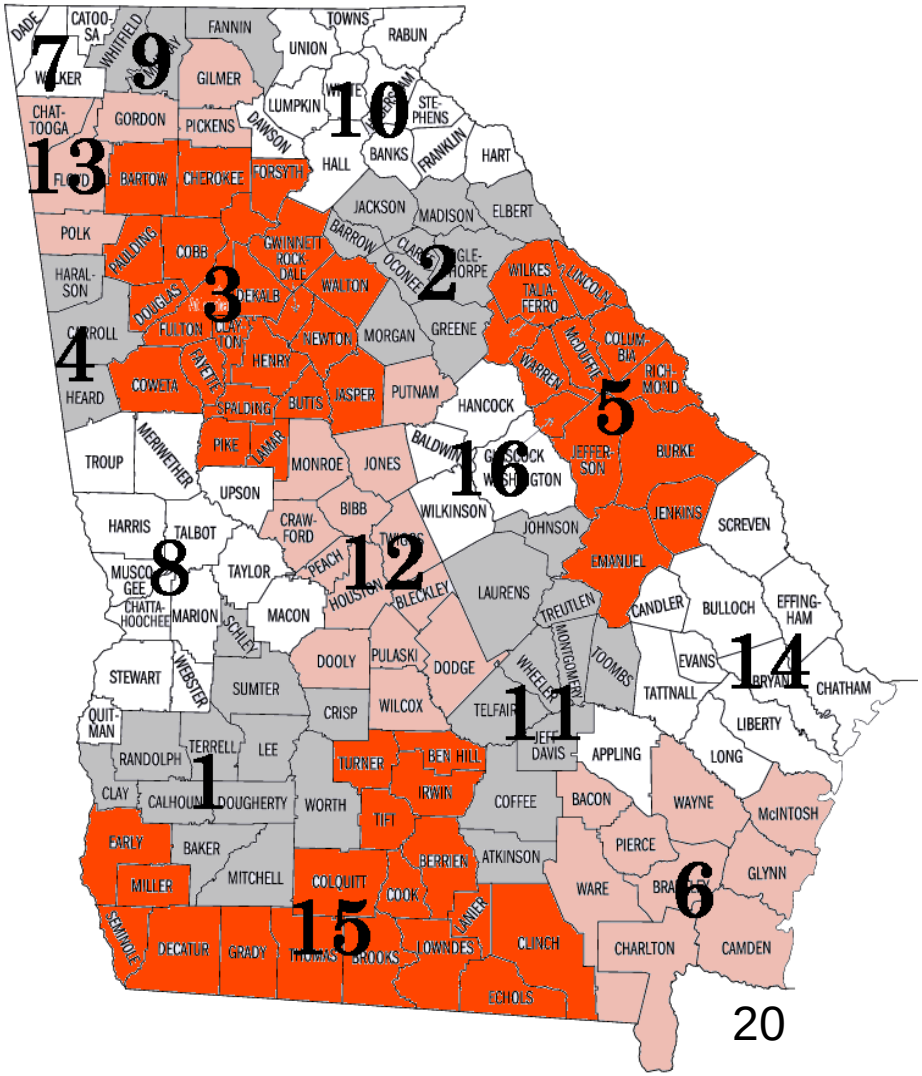
Year	2014	2015	2016	2017
Total Enrollment	**310,434**	**541,032**	**587,833**	**493,880**
Share with Advance Payment Tax Credits	**92%***	**89%**	**86%**	**87%**
Share with Cost-Sharing Reduction	**68%**	**67%**	**65%**	**69%**
Number of Issuers	**4**	**7**	**7**	**5**

*2014 share is for December. Attrition was likely higher among those not receiving a tax credit.

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html

Insurance Regions in Georgia

- Metro-Atlanta has 60 percent of the Marketplace enrollees
  - 10 times more than the next largest market
  - Premiums in Atlanta have been relatively stable
- 4 rural markets had fewer than 10,000 enrollees each



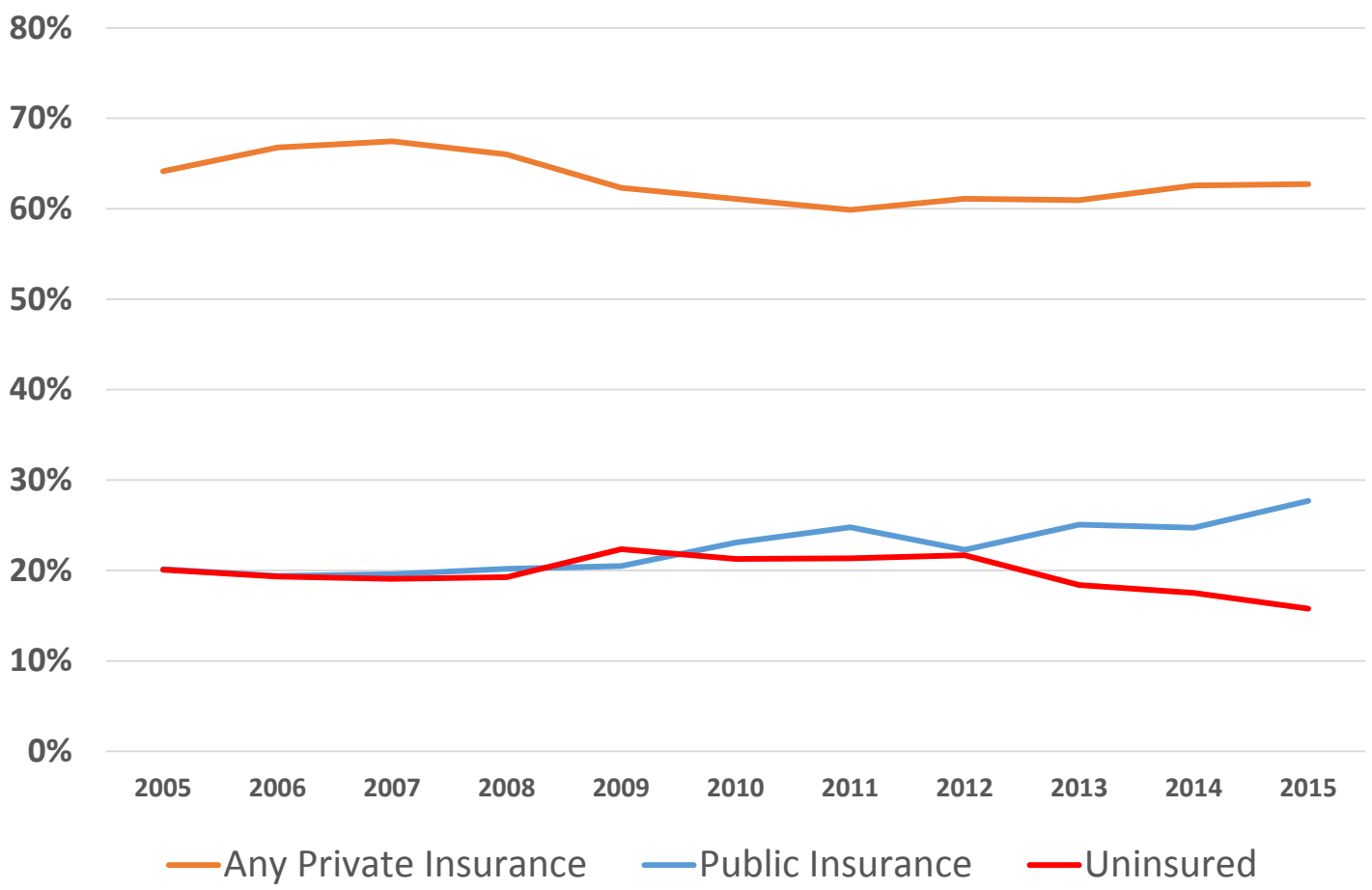
Cost of Single Coverage in Georgia, 2015

	Total Annual Premium	Contribution
Employer-sponsored Insurance		
Firms under 50 Employees	$6,016	$1,149
Firms with 50+ Employees	$5,418	$1,202
Market Place Coverage: Weighted Average Benchmark Silver Premium		
21 Year Old	$2,523	
40 Year Old	$3,224	
64 Year Old	$9,672	
Maximum Contribution at 400% FPL		$4,517

Source: Medical Expenditure Panel Survey – Insurance Component , Kaiser's Health Research and Education Trust, and tabulations from CMS Marketplace data
https://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html

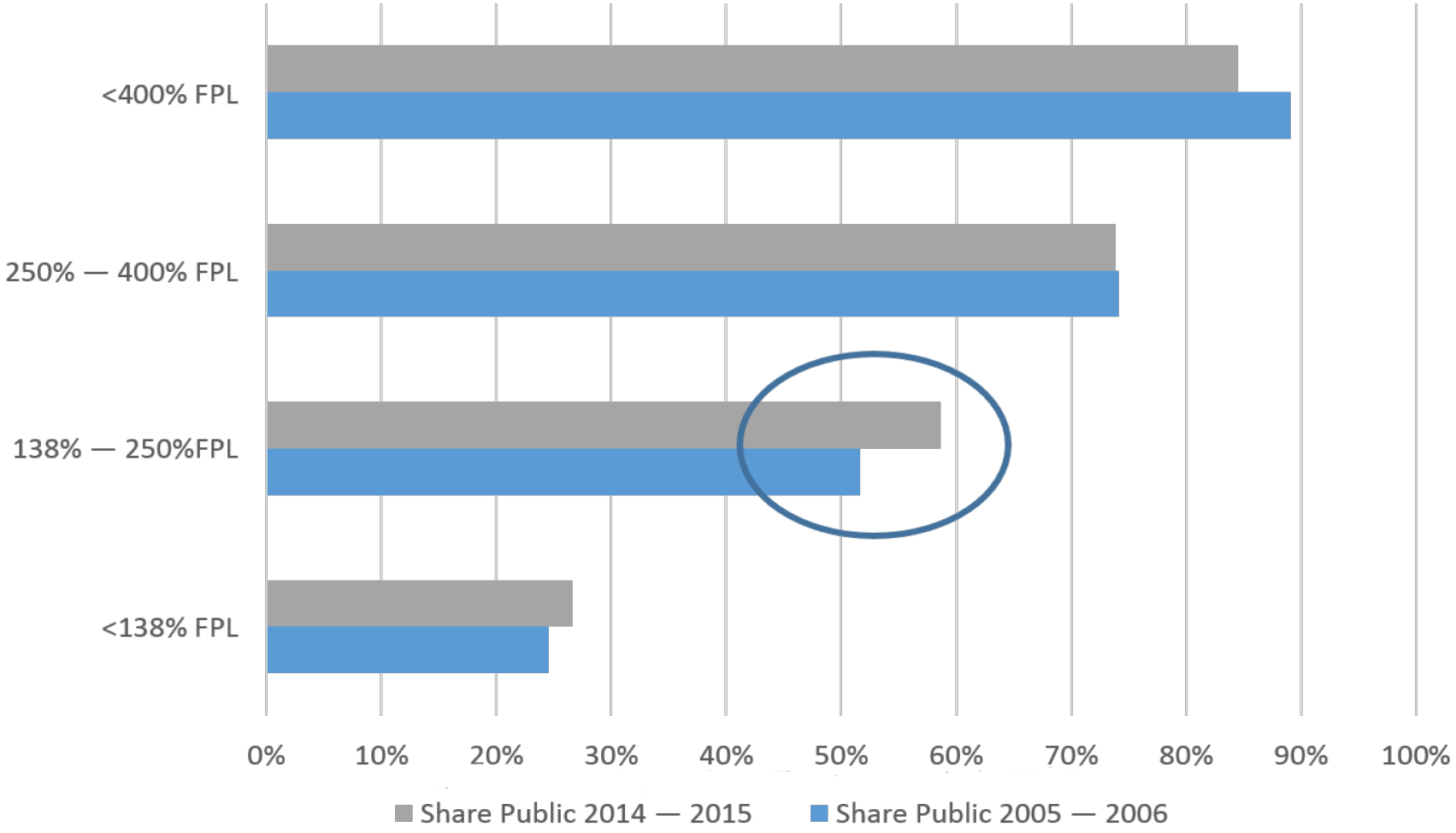
WHAT ARE THE TRENDS

Trends in Coverage: Nonelderly Georgians



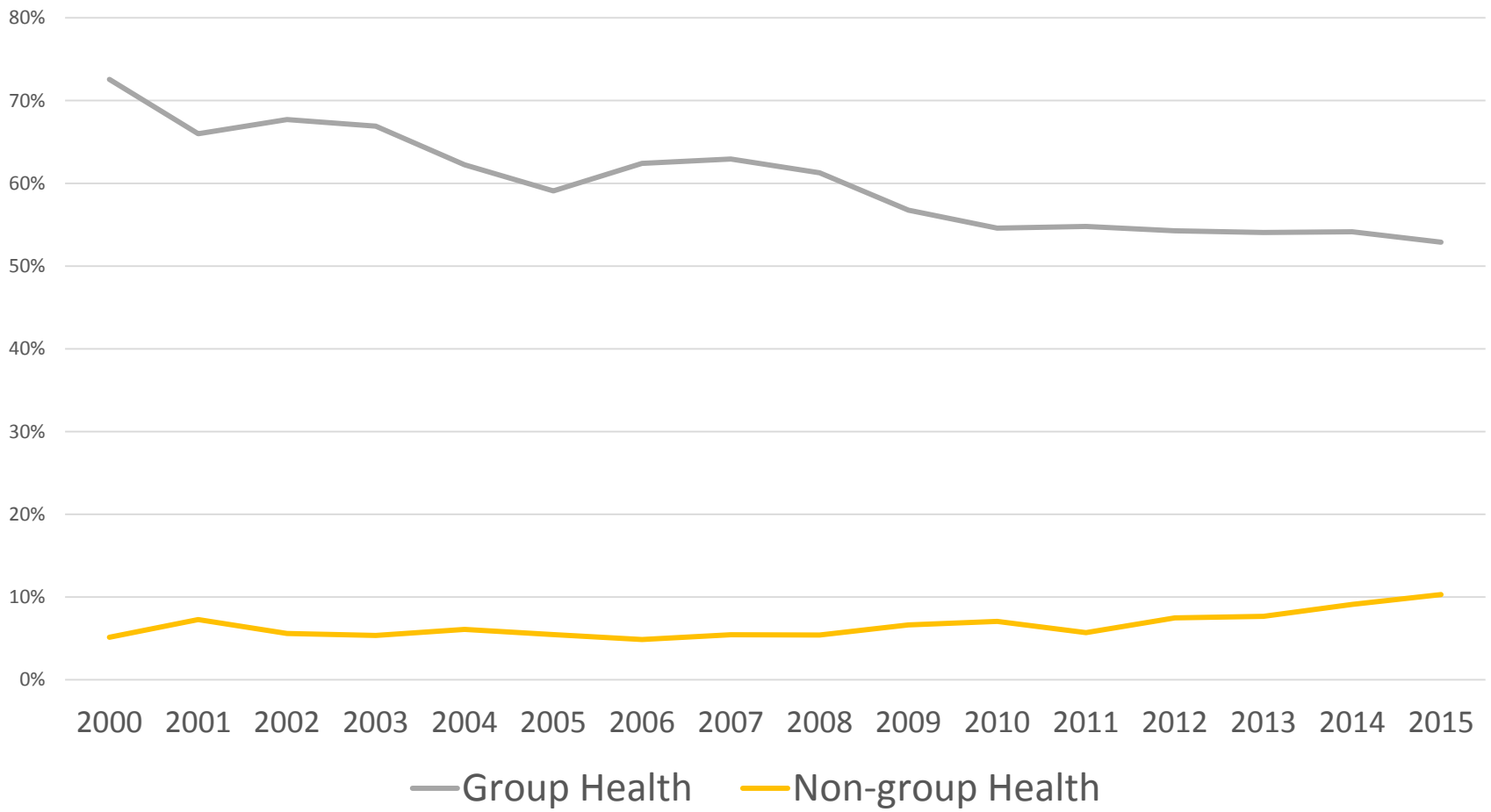
Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2000-2016

Trends in Private Coverage: Income Group



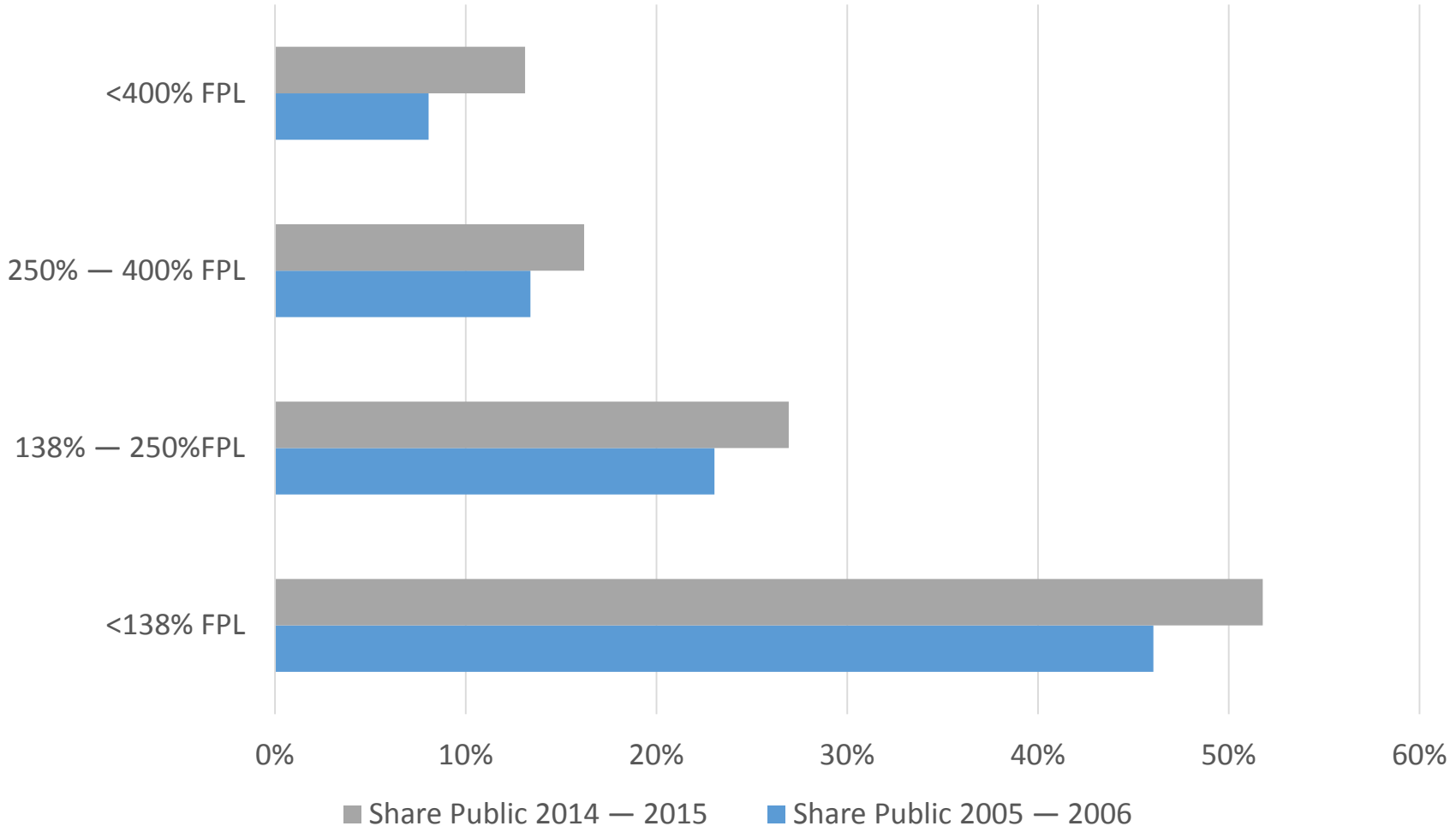
Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2004, 2005, 20015, 20016

Trends in Coverage: Growth of Non-Group Private



Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2000-2016

Trends in Public Coverage: Income Group



Data source: The Annual Social and Economic Supplement to the Current Population Survey: March 2004, 2005, 20015, 2016

MEDICAID

Eligibility in Georgia

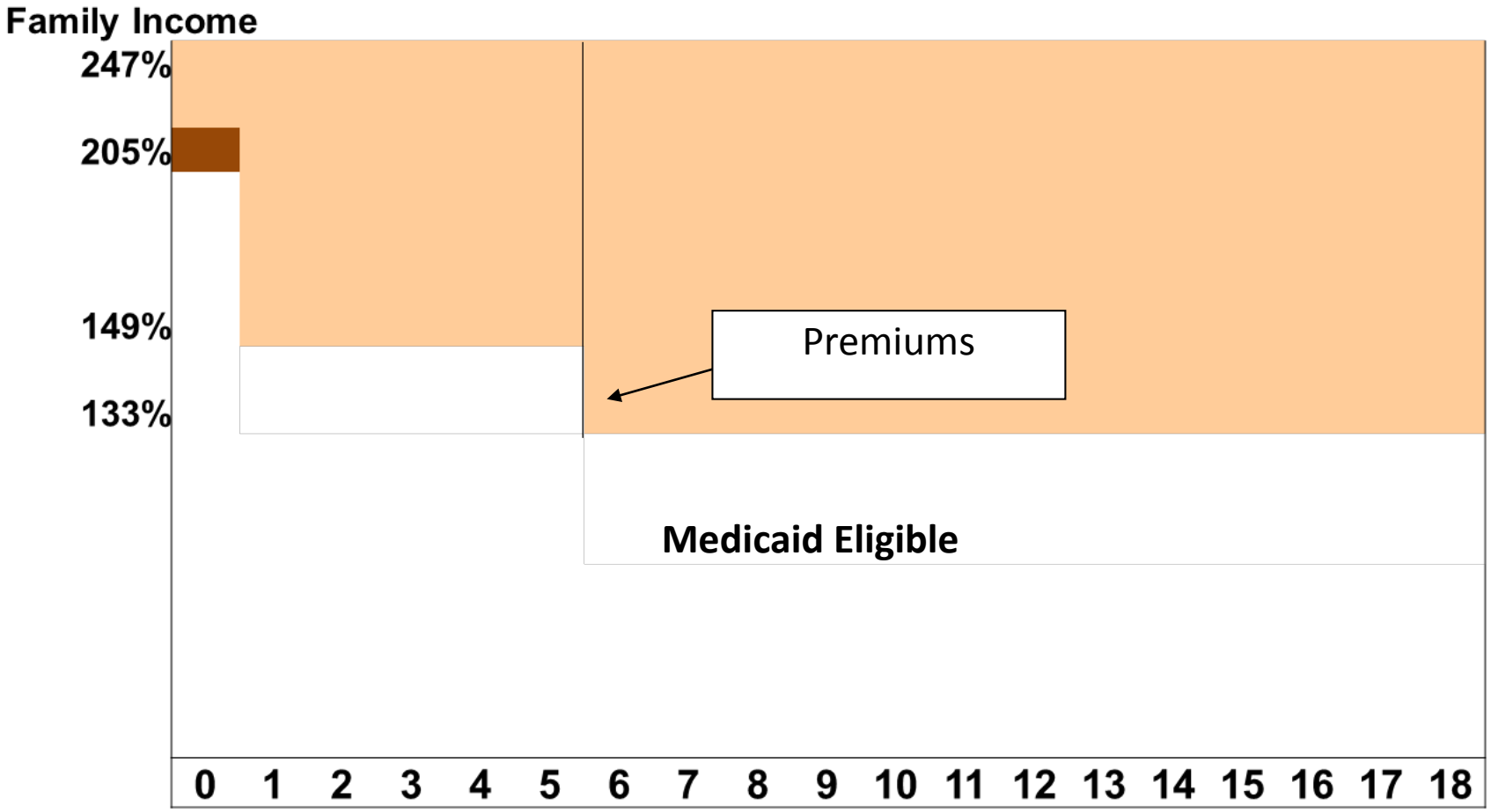
Category	Eligibility Requirement
Supplemental Security Income (automatic) and aged/blind/disabled	Annual income at or below 74% FPL ($8,924 single person)
Nursing-home-eligible and aged/blind/disabled	Annual income at or below $25,560 (single person)
Pregnant women and their infants	Family income below 225% FPL (~$46,000 family of 3)
Children in low-income households	Income limit varies according to child's age
Low-income parents	Family income below 37% FPL (~$7,550 family of 3)

Medicaid/CHIP Enrollment, 2016

	Unique Individuals (children may be in both totals)	Average Monthly
Total: Medicaid/CHIP	~2,570,000	1,990,548
Medicaid	2,388,522	1,862,573
CHIP	185,778	127,975

Source: Georgia Department of Community Health, 2016 Annual Report, http://dch.georgia.gov/sites/dch.georgia.gov/files/2016AnnualReport.pdf, accessed March 22, 2017

PeachCare for Kids®



Data source: Kaiser Family Foundation, Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017, http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017-Table-1, accessed May 11, 2017.

Medicaid/CHIP Spending in Georgia

- Total in 2016: $9.3 Billion
- Georgia spends less per capita and a smaller share of the State's budget than average

2014 Comparison	GEORGIA	USA
Medicaid % of state budget	22%	24%
Medicaid spending per capita	$1,008	$1,554

Source: 2016 Georgia Department of Community Health, 2016 Annual Report, http://dch.georgia.gov/sites/dch.georgia.gov/files/2016AnnualReport.pdf, accessed March 22, 2017
Data source: 2014 data UKCPR, U.S. Census Bureau, CMS-64 reports

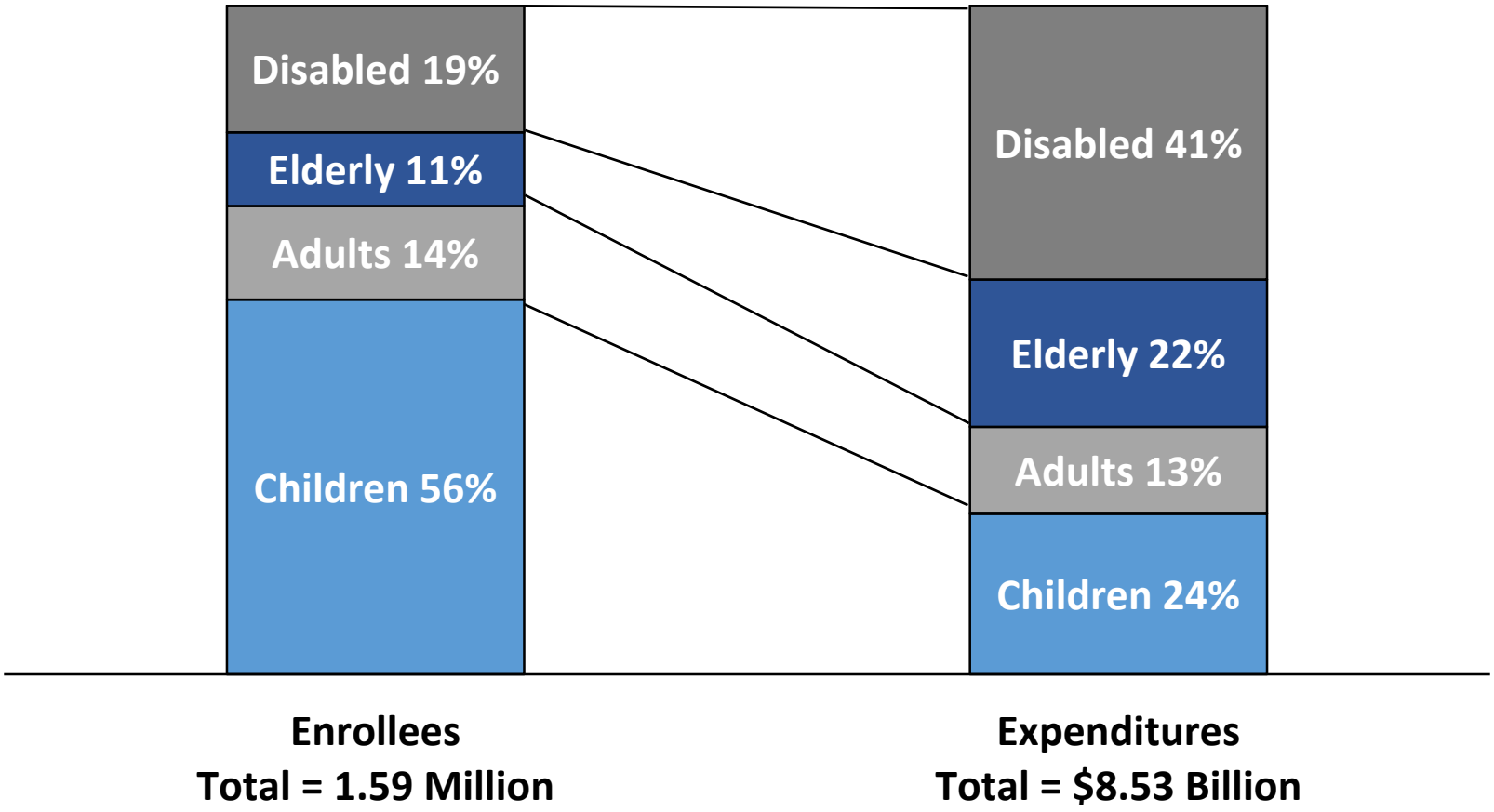
Medicaid Spending – State Comparison

Table 3. State Comparisons 2000-2014

	Overall Growth in Expenditures	Enrollee Growth	Growth in Per Enrollee Expenditures	Per Enrollee Exp. 2000	Rank in 2000	Per Enrollee Exp. 2014	Rank in 2014	Change in Rank
Alabama	48%	60%	-7%	$6,813	8	$6,315	12	-4
Arkansas	135%	134%	0%	$6,402	12	$6,406	11	1
Florida	96%	101%	-2%	$6,404	11	$6,274	13	-2
Georgia	66%	89%	-13%	$6,514	10	$5,695	15	-5
Kentucky	91%	82%	5%	$7,295	7	$7,646	3	4
Louisiana	58%	75%	-10%	$8,071	3	$7,268	4	-1
Mississippi	83%	48%	24%	$5,748	14	$7,100	6	8
Missouri	70%	22%	39%	$7,953	5	$11,049	1	4
North Carolina	70%	101%	-16%	$8,463	1	$7,124	5	-4
Oklahoma	112%	105%	3%	$6,237	13	$6,442	10	3
South Carolina	53%	76%	-13%	$6,699	9	$5,819	14	-5
Tennessee	42%	2%	39%	$4,955	15	$6,880	8	7
Texas	120%	160%	-15%	$8,373	2	$7,088	7	-5
Virginia	112%	100%	6%	$8,069	4	$8,552	2	2
West Virginia	82%	101%	-9%	$7,457	6	$6,754	9	-3

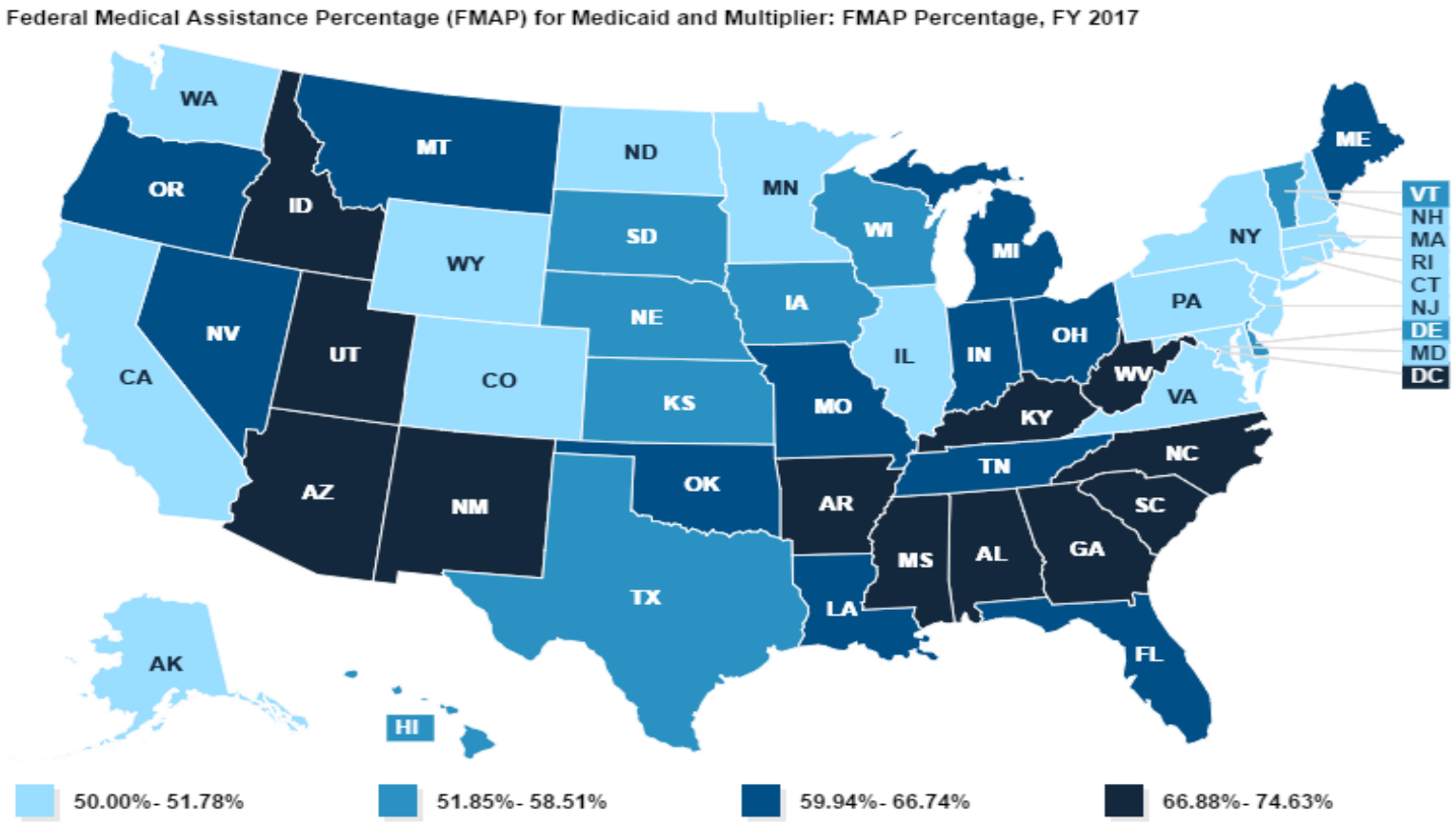
Sources: CMS-64 reports for spending, Kaiser Family Foundation for enrollment. Notes: Enrollment numbers are from counts of enrollments from December of each year. Table uses national GDP price deflator to adjust for inflation using 2015 as the base year. Arkansas expanded Medicaid effective January 1, 2014, so that is not showing up in these data yet.

GA Medicaid Spending Is Mostly for the Elderly, Disabled, FY 2013



Source: MACStats: Medicaid and CHIP Data Book, December 2016. https://www.macpac.gov/wp-content/uploads/2016/12/MACStats_DataBook_Dec2016.pdf

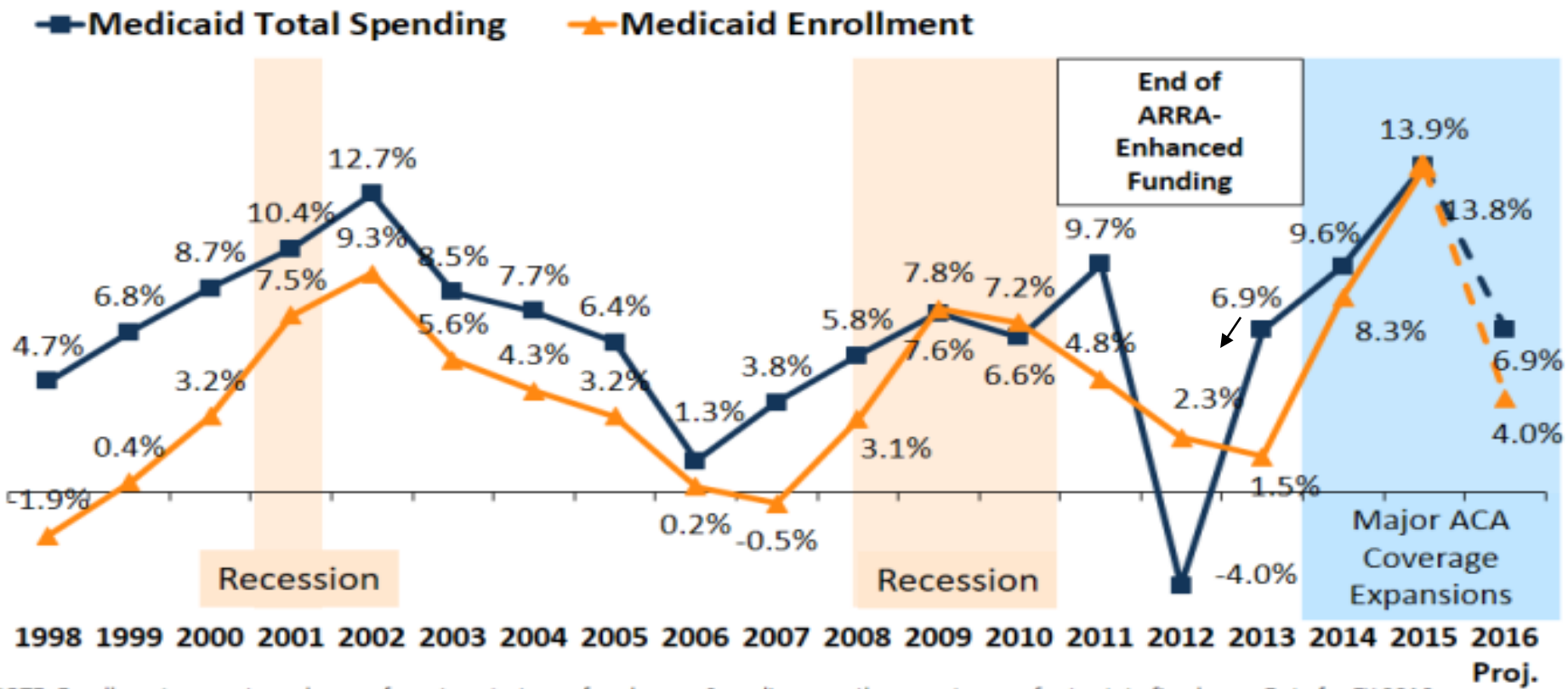
Federal and State Governments Share Medicaid Costs



SOURCE: Kaiser Family Foundation's State Health Facts.

Exhibit 1.1

Economic conditions and policy changes drive growth in Medicaid enrollment and total spending.



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages refer to state fiscal year. Data for FY 2016 are projections based on enacted budgets (except for PA and IL).

SOURCE: Historic Medicaid enrollment growth rates are as reported in *Medicaid Enrollment June 2013 Data Snapshot*, KCMU, January 2014. Historic Medicaid spending growth rates are derived from KCMU Analysis of CMS Form 64 Data. FY 2014-2016 data are derived from the KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.

Disproportionate Share Hospital (DSH) Payments

- Supplemental payments from Medicaid, based on the percent of their patients who are
  - Low-income Medicare
  - Medicaid
  - Indigent
- State control over DSH policies, including method of distribution
  - Georgia ranks 9th in DSH payments nationwide

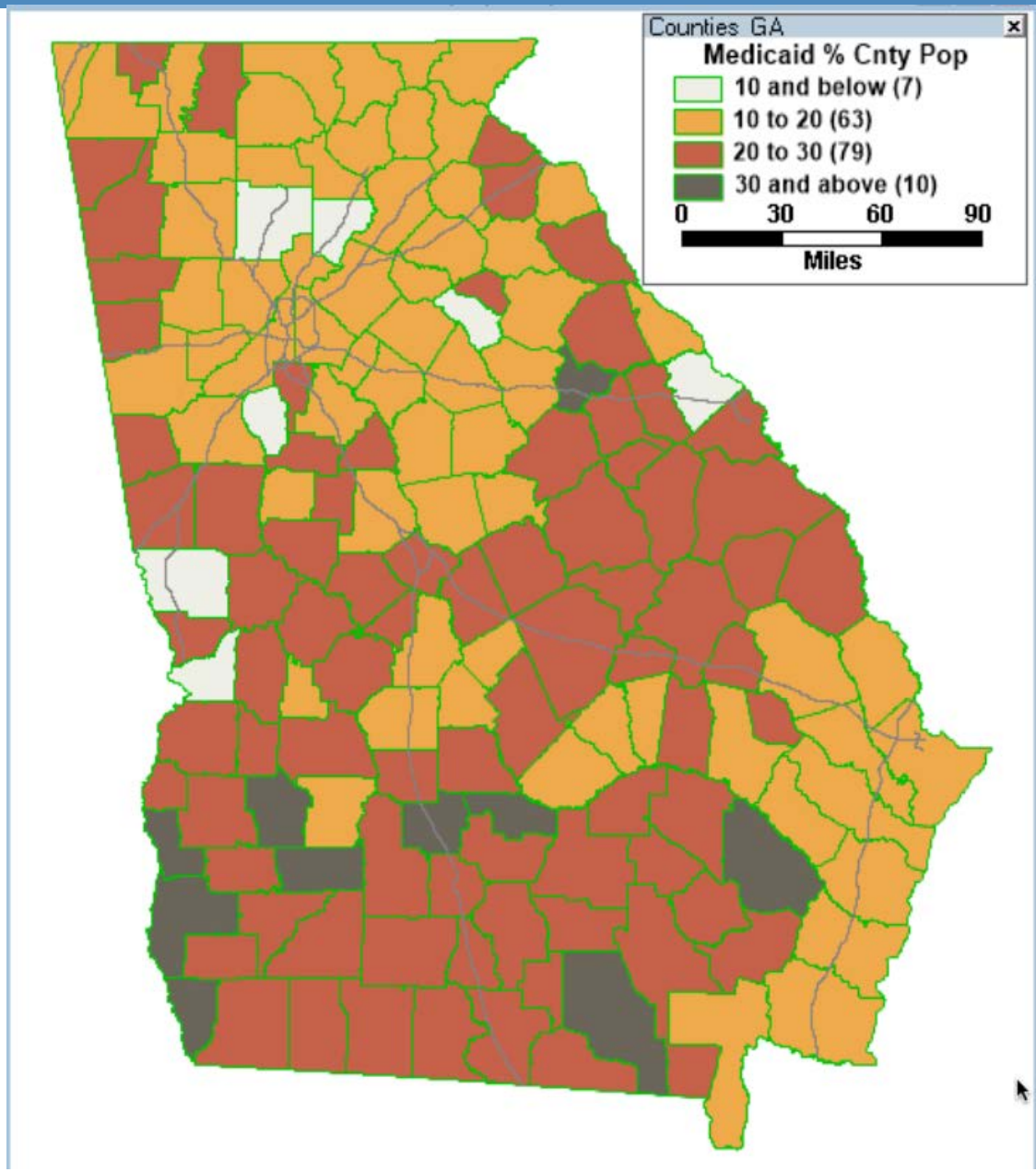
Why Are DSH Payments Important?

- Total Federal DSH allotments in FY 2017: 12 Billion
  - Georgia DSH allotment (federal dollars) ~ 295 million
  - Total DSH payments to GA hospitals about 435 million
    - 20% of total hospital payments

Fiscal Year	Federal Reduction in Billions	Estimated: Proportional GA Reduction in Millions
2018	-$2	-$52
2019	-$3	-$78
2020	-$4	-$104
2021	-$5	-$130
2022	-$6	-$157
2023	-$7	-$183
2024	-$8	-$209

Source: https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/ for federal reductions

Medicaid as a Share of the County's Population



Source: GSU Center for State and Local Finance

The Impact on Providers

- Negative operating margins
  - 40% of all hospitals
  - 60% of rural hospitals
- 7 Rural hospital closures since 2013
- Negative economic impact on the local community

Georgia Safety Net Hospitals

- About one-third of Georgia hospitals meet two of the following five conditions:
  - Children's or teaching hospital
  - Designated trauma center
  - Medicaid and PeachCare admissions ≥20% of all admissions
  - Uncompensated charges:
    - Indigent patients ≥ 6% gross revenue
    - Indigent and charity patients ≥ 10% of gross revenue
- Challenged by Medicare Value Based Purchasing structure
- Will be adversely affected by planned DSH cuts

Waivers

- Allow states to test new or existing ways to deliver and pay for health care services in Medicaid/CHIP.
  - Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.
  - Section 1115 Research & Demonstration Projects provide program flexibility to test new or existing approaches to financing and delivery.
    - Can be comprehensive or narrow

Medicaid Waivers – Section 1332

- HHS Secretary can allow flexibility in program administration & waive certain regulatory provisions
- State innovation & must be comprehensive
- Secretary Price has encouraged state innovation and waiver applications
  - 1332 waiver letter (March 13, 2017) specifically includes language about high risk pools
  - Medicaid / 1115 waiver letter (March 14, 2017)

APPENDICES

Sources of Information about Coverage

	Current Population Survey	American Community Survey	State-specific Surveys
Coverage questions	Past Calendar Year	Point in time – now	Point in time
Advantages	Most detailed information about families, employment, and income	Large sample size by state	State specific questions
	Consistent questions over time	Most current information	Can link to policy needs
Disadvantages	Recall required	Limited trending	Expensive
	Sample size	Less detail	Ad Hoc administration