HEATHCARE REFORM

Position Statement

NASW, Iowa Chapter supports the Affordable Care Act, and affirms its implementation in a manner that maximizes benefits for uninsured Iowans, makes strategic use of limited federal and state resources, and strengthens the healthcare system for all.

Background: Rationale for Health Care Reform

In 2010 Congress enacted, and President Obama signed into law, the *Patient Protection and Affordable Care Act, P.L.111-148*, designed to provide U.S. citizens and legal residents (undocumented persons were excluded) access to affordable, quality health care. The Affordable Care Act (ACA) was designed to be integrated with the existing private and public systems of healthcare coverage to address the needs of uninsured individuals and their families.

- *Private and Public Systems of Healthcare Coverage*

Most healthcare coverge in the U.S. is privately funded, with employer-sponsored insurance accounting for the largest share. Nationwide in 2013, 48% of workers had employer-sponsored health insurance while 6% had self-funded insurance; in Iowa, the rate was 54% for employer-sponsored insurance and 7% for self-funded insurance (Kaiser Family Foundation, 2014). Not surprisingly, small businesses with under 25 workers faced particular challenges in offering coverage since they paid higher premiums and had less marketplace bargaining power. In Iowa, where 85% of businesses are small, coverage has varied – 1/3 of firms with under 10 workers offered coverage compared to 2/3 of those with 10-24 workers (Cannon, 2010).

Publicly funded healthcare programs are intended to address the needs of persons within certain elibility categories. The key programs include Medicare, which covers those age 65 and older and those approved for Social Security disability insurance, Medicaid, which serves low-income and/or medically needy persons, and the Children's Health Insurance Program (CHIP), which covers uninsured low-income children. In 2013, nationwide, 16% participated in Medicaid and CHIP programs, while 15% participated in Medicare; in Iowa, 14% were covered by Medicaid and CHIP, while another 14% received Medicare (Kaiser Family Foundation, 2014).

- *Uninsured Americans and Unreimbursed Costs*

Prior to the ACA, gaps in the private and public sytems left many with no healthcare coverage, either because their employers did not provide it, they could not afford it themselves, or they did not qualify for publicly funded programs. An estimated 47 million non-elderly Americans were uninsured in 2012 (Kaiser Family Foundation, 2013), including some 254,275 non-elderly Iowans (Kaiser Family Foundation, n.d.). Among these, most were working adults, especially single adults, age 18-64 holding part-time or low-wage jobs, or jobs without benefits; not surprisingly, over half of such persons were poor or near poor. Over time, uninsured persons typically experience an erosion of care leading to undiagnosed problems, lack of treatment, avoidable hospitalizations, and premature death. Without the cost discounts provided by insurance, they typically bear the full cost of care, paying as much as double that of insured individuals. As such, they risk being turned away from health providers or incurring large medical debts that place them in financial jeopardy (Kaiser, Family Foundation, October 29, 2014).

Ultimately, the lack of healthcare coverage by some Americans has repercussions for everyone. Often, uninsured individuals who defer or go without healthcare later turn to expensive hospital-based emergency care, resulting in large *uncompensated* costs. The estimated cost of such uncompensated care was $84.9 billion in 2013 (Coughlin, Holohan, Caswell, & McGrath, 2014). Federal and state tax dollars funded $53.3 billion of this expense, paid primarily to hospitals which disproportionately bore these costs. As a result, tax dollars were diverted from local community health centers which provided less-costly, non-emergency services. Additionally, some unreimbursed costs were shifted to those with insurance, resulting in a *hidden*

health tax which, for insured Iowa families, was estimated to exceed $1000 per year (Families USA, 2010). Over time, these hidden costs make heathcare coverage less affordable for everyone.

Affordable Care Act: Key Provisions and Implementation

The ACA was designed to make healthcare coverage affordable and accessible for all. Key provisions (with implementation dates) are discussed below, with attention to the impact of the ACA in Iowa.

- *Insurance coverage for young adults (2010).*

The ACA extended dependent coverage to young adults, either single or married, allowing them to remain on their parents' health insurance until age 26. As a result, an estimated 20,000 young adults in Iowa have gained insurance coverage (U.S. Department of Health and Human Services [USDHHS], September 2014).

- *Insurance restrictions—consumer protections (2010)*

The ACA imposed several important restrictions on insurance companies. Insurers were prohibited from: 1) denying or dropping coverage of children or adults based on pre-existing conditions, 2) imposing lifetime limits on coverage, 3) charging higher rates for female beneficiaries, and 4) spending less than 80% of every premium dollar on services and benefits to enrollees (vs. overhead, salaries, marketing). According to USDHHS (September 2014), such provisions have benefited over 1.2 million non-elderly Iowans, including 167,995 children, who have pre-existing conditions. Additionally, they have equalized premium costs for some 433,000 female enrollees and have helped to reduce premium growth – requests by insurers to raise annual premiums by more than 10% have dropped markedly, from 75% to 14%.

- *Quality healthcare outcomes and provider incentives (2012)*

In an effort to link healthcare quality to affordability, the ACA incentived a system in which medical providers are rewarded for managing overall health. To achieve this, physicians were encouraged to form Accountable Care Organizations (ACOs), groups of providers organized to coordinate care needs, improve health outcomes, and limit expensive hospital admissions. Providers are reimbursed on a fee-for-service basis, but they assume responsibility for managing enrollees' health outcomes; when enrollees achieve certain designated healthy behavior/wellness benchmarks, providers are eligible for additional payments. Begining in January 2015, physicain payments will be tied to quality rather than volume of care – higher quality outcomes will be linked to higher payment levels. In addition, hospitals serving Medicare participants are offered financial incentives to achieve publicly reported quality outcomes related to heart, lung and surgical care, infectious disease reduction, and patient satisfaction (USDHHS, December 2014); efforts are focused on coordinating care for high-risk clients to reduce hospital re-admissions.

Linking provider reimbursements to care outcomes represents new thinking in terms of health management, shifting from medical intervention to overall health and wellness. To achieve such outcomes, ACOs will need to explore the social determinants of health and engage in case management-type activities – for example, treating a person's asthsma may involve modifying his/her living environment rather than prescribing medication. However, there are questions about the extent to which providers are prepared to engage in, and the reimbursement system is prepared to pay for, such activities. Additionally, applying the ACO model to traditional Medicare by tying reimbursement rates to hospital re-admissions raises other issues. Hospitals which do not meet the thresholds will face cuts in their reimbursement levels. While this may challenge providers to improve their outcomes, it may have a negative impact on small rural hospitals which disproportionately serve older, poorer and less healthly individuals. Providers may turn away those in more fragile health, or reduce the use of medically justified tests and procedures to avoid loss of funding.

- *Health insurance exchanges and qualified plans (2014).*

The ACA provided for the creation of online, insurance marketplaces, termed "exchanges." Loosely based on insurance pools, exchanges provide a single point of acces for both private and public (Medicaid, CHIP) healthcare insurance. Exchanges are intended to assist individuals and small businesses in selecting the best coverage by providing information about the costs and benefits of various qualified health plans, as well providing information about available subsidies, such as premium tax credits and costsharing reductions, and

Medicaid eligibility. In order to qualify for subsidies, consumers must purchase a plan on the exchange. To be included in the exchange, qualified plans must offer a set of essential benefits including emergency, hospital, maternal, and pediatric care; laboratory testing; mental health and prescription drug coverage; and rehabilitative, ambulatory and preventive services (Iowa Insurance Division, n.d.). Plans are designated as platinum, gold, silver or bronze, based on the premium and actuarial value or the percent of covered costs (e.g., 90% for platinum, 60% for bronze). States were given the option of developing their own state-run exchanges, partnering in a federal-state exchange, or accepting a federally-controlled exchange; federal funding assisted with initial start-up costs, but all exchanges are required to be self-supporting by January 2015 (Centers for Medicare & Medicaid Services, 2012).

Iowa elected to use the federal-state partnership model. Accordingly, the state utilizes the federal exchange but maintains control (through the Iowa Insurance Division) over the plans allowed into the exchange, the determination of Medicaid and CHIP elgibility, and the activities related to consumer assistance. However, unlike other states which developed their own consumer assistance activities, Iowa's consumer assistance is provided through federal navigators and certified application counselors employed by certified designated organizations. Additionally, no state funds have been provided for outreach and education. Instead, in 2014 the state utilized federal grant monies that were re-allocated to seven organizations to support such efforts. Release of these funds was delayed in both enrollment periods; for the 2014-2015 enrollment period, release of the funds is not expected until more than half-way through the enrollment period. Arguably, such factors contributed to Iowa being tied with South Dakota for last place in overall enrollments. During the first enrollment period outreach efforts engaged 190,000 Iowans, while just over 29,000 Iowans secured healthcare coverage through the exchange; among these, more than 7,800 were young adults, aged 18 to 34 (USDHHS, September 2014). Thus far, only 11% of eligible Iowans have enrolled (Bartolone, 2014).

Currently, the insurance exchange in Iowa offers consumers very limited choices. There is only one insurer on the Iowa exchange, Coventry Health Care of Iowa. A second insurer, CoOpportunity, was taken over in December 2014 by the Iowa Insurance Division due to funding concerns, so no new plans are being sold by that insurer. As of yet, Iowa's largest insurer, Wellmark Blue Cross and Blue Shield, which controls over 80% of the insurance market share, has chosen to not participate in the exchange (Anderson, 2014; Bartolone, 2014). The State of Maryland, which uses a state based exchange, passed legislation requiring that carriers with a certain level of market share must offer qualified health plans on the Marketplace. This type of legislation would be helpful to provide Iowans with access to more products on the exchange. However, since Iowa uses the federal exchange, implementation of similar legislation could prove challenging.

- *Mandatory health care coverage – individuals and businesses (2014).*

Under the ACA, all individual citizens and legal residents are required to have health care coverage or face a penalty for non-participation. In 2014, penalties will be the greater of $95 per adult or 1% of household income. Penalties will increase to $2065 per household or 2.5% of income by 2016. To help make coverage affordable, cost-sharing reductions (e.g., copayments, deductibles, co-insurance) and premium tax credits will be available to those with incomes between 138-400% of the federal poverty level (FPL). The federal government is expected to enforce this provision through employer verification and IRS tax returns, though it is not clear how compliance will be monitored for those who do not file tax returns.

Additionally, the ACA obligates all businesses with 50 or more workers to offer health insurance to full-time equivalent (FTE) employees working 30 or more hours per week. There was some concern that employers might cut workers or shift them to part-time status (below 30 hours) to preemptively avoid this mandate. The employer health insurance requirement impacts 2.2% of businesses in Iowa (U.S. Census Bureau, 2012). If a business fails to offer insurance, and an employee subsequently purchases it through the exchange and qualifies for a subsidy, the business faces a penalty of $2000 per FTE (minus a 30-employee disregard). If a business offers coverage but it is not affordable (e.g., the least-cost plan exceeds 9.5% of the employee's income), the firm faces a $3,000 penalty for each employee who subsequently receives a subsidy.

The Small Business Health Options Program (SHOP), an insurance exchange for small businesses, was created to assist firms with 50 or fewer employees in providing coverage. Small businesses may utilize the SHOP marketplace to provide employer-sponsored health insurance, or offer employees a stipend that allows them to purchase their own individual/family insurance. Full phase-in of this provision has been delayed until 2015 for businesses with 100 or more employees, and until 2016 for businesses with 50-99 employees. Preliminary analysis by the Government Accounability Office (GAO) (2014) showed that in 2014 SHOP enrollment was below expectations in five states that were reviewed; factors such as delays in implementating the online enrollment, premium price competition from non-SHOP insurers (e.g., SHOP premiums were not the lowest) and the provision allowing business to renew non-qualifying pre-SHOP plans until 2016 seemingly contributed to the low enrollment and could impact future use of the SHOP exchange.

- *Tax credits for small businesses (2010)*

The ACA created tax credits to assist small businesses – those with fewer than 25 employees and annual wages under $50,000 – in providing employee health care coverage. For 2014 and subsequent tax years, eligible employers are required to contribute at least 50% of workers' premiums for a qualified health plan available through the SHOP exchange. In return, employers can receive up to 50% (previously 35%) of their contribution in tax savings. An estimated 3.2 million small businesses across the nation, including 41,000 in Iowa, were expected to qualify for the tax credit (Families USA, 2012). However, recent analysis by the GAO (2014) suggested that the size and administrative complexity of the tax credit may be limiting its use.

- *Medicaid expansion (2014)*

A central component of the ACA was the expansion of Medicaid coverage to all persons with incomes up to 133% FPL (138% after the 5% income disregard is included). For states choosing the expansion, the federal government is committed to absorbing 100% of costs from 2014-2016, and 90% of costs thereafter.

Iowa chose a hybrid, two-tiered approach to Medicaid expansion known as the Iowa Health and Wellness Plan (IHAWP) (Iowa Department of Human Services,2013; Vermeer, n.d.). The first level, the *Iowa Wellness Plan*, covers those aged 19-64 with incomes 0-100% FPL (including medically frail persons with incomes 0-138% FPL); the plan, administered by Medicaid, provides enrollees with services and care coordination through an integrated health home, an ACO. The second level, the *Marketplace Choice Plan*, covers those aged 19-64 with incomes 101-138% of FPL; the Marketplace Choice plan provides participants with comprehensive services purchased from commercial insurers through the exchange. Enrollees in both plans pay no co-payments (except for emergency room care), and their monthly premiums (not to exceed 5% of income) are reduced or waived if they attain certain healthy behavior/wellness benchmarks. Providers are eligible for additional payments when 50% of enrollees achieve the designated healthy behavior/wellness benchmarks. According to the Iowa Department of Human Services (IDHS) (November 2014), more than 113,000 Iowans were enrolled in the IHAWP plan in 2014.

There are several systemic issues regarding the IHAWP program. First, there are limited number of providers – the existing Medicaid network and one commercial insurer, Coventry Health – to serve the greatly expanded IHAWP population. A second insurer recently withdrew, in part because those enrolling (many former IowaCare recipients) tended to have chronic medical problems that required very costly care (Leys, 2014). This raises a concern about the capacity of the system to meet beneficiary needs and costs for the long term. Second, the healthy behaviors benchmarks for the second and subsequent years have yet to be identified. For the first year participants were required to complete health screenings and risk assessments. While the state has issued an RFP to develop and implement healthy behavior protocols for subsequent years, currently nothing exists. Third, as noted earlier, the shift from simple medical care to overall health management raises important questions about providers' readiness to engage in, and the state's willingness to pay for, such health management activities.

- *Coverage for low-income children (2014)*

Provisions in the ACA are intended to maintain the state-based CHIP. In Iowa, CHIP has three components: 1) a Medicaid expansion component covering children aged 6-18 whose families earn 122-167% FPL;

services are provided through the state's Medicaid provider network; 2) the Healthy and Well Kids in Iowa (*hawk-i*) component covering children 0-19 whose families earn less than 302% FPL; services are provided through a commercial health insurer with premiums paid by the state; and 3) a dental-only component (implemented in 2010) covering *hawk-i* eligible children whose families have health insurance. Provisions in the ACA require states to maintain their current CHIP programs through September 2019. Data from the IDHS (September 2014) showed that in 2014 nearly 60,000 children were being served – 18,390 in the Medicaid expansion program, 38,200 in the *hawk-i* program, and 3,290 in the dental-only program. Over the next two years, the Department projects that it will be serving an additional 5,400 children in the three program areas.

CHIP is authorized under title XXI of the Social Security Act, and is funded (with matching state funds) under a separate appropriation until September 2015. Current appropriations (federal and state) will not be sufficient to meet Iowa's projected enrollment increases through SFY 2015 (IDHS, September 2014). The Legislative Services Agency (2014) estimates that there will be a $68 million funding shortfall in the Medicaid budget for FY 2015. If CHIP is re-authorized in 2015 under provisions of the ACA, states are projected to receive a 23 percent increase in the federal share of CHIP funding. The funding re-authorization issue raises the question of whether CHIP will remain a separate program or whether it will be absorbed into the federal ACA.

- *Drug coverage for seniors (2011)*

Provisions in the ACA were designed to address the skyrocketing cost of prescription drugs for seniors, specifically, the Medicare Part D "donut hole" coverage gap; coverage will increase each year until 2020, when the gap is to be closed entirely. In 2007, more than 8 million seniors hit the drug coverage gap (Iowa Insurance Division, n.d.), leaving many unable to afford much-needed medicines or having to forgo other necessities. In 2013, "donut hole" reimbursements and discounts on name-brand and generic drugs provided 43,339 Iowans over $37 million in savings, at an average of $809 per person (USDHHS, September 2014).

- *Home-and-community based services (2011)*

The Act expanded Home-and-Community-Based Services (HCBS) through Medicaid, offering community-based attendant services and support to beneficiaries who would otherwise require the level of care offered in a hospital, intermediate- or long term-care facility ("Summary", 2013). Under the *Community First Choice Option*, Medicaid-eligible seniors may receive home-care services, allowing them to remain in their homes rather than prematurely going to nursing homes. Only eight states are currently participating in the plan; Iowa is not among them (Kaiser Family Foundation, October 2014). As a state in which over 13% of the population is age 65 or older (U.S. Census Bureau, 2014), Iowa could improve quality of life for its seniors while benefiting from significant cost savings if it participated in the *Community First Choice Option.*

- *Preventive care and wellness (2010)*

The ACA emphasizes cost-containment and best-practice strategies that focus on prevention and wellness to capture long range healthcare savings. A report by Trust for American's Health noted that for every $1~~$~~ spent on prevention can result in $5.60 in savings (as cited in USDHHS, February 2012). Toward this end, the federal grants have been awarded to Iowa to support prevention efforts related to obesity, heart disease, alcohol and tobacco cessation, and HIV prevention, among others. Additionally, new healthcare plans are required to cover prevention and wellness benefits, such as mammograms and colonoscopies, at no charge, by exempting these benefits from deductibles and other cost-sharing requirements.

- *Support for Community Health Centers (2010)*

A key component of the ACA, especially for a rural state such as Iowa, was the expanded funding for community-based health centers. In Iowa there are 14 heath centers, with 91 different site operations, that provide both primary and preventative care to nearly 180,000 Iowans, including nearly 40,000 Latinos and nearly 23,000 African Americans (USDHHS, September 2014).

- *Workforce development (2010)*

Provisions in the Act, including student loans and training programs, were designed to strengthen the nation's healthcare workforce for the decades ahead. A variety of such programs are underway in Iowa, including educational loan reimbursement for healthcare professionals who practice in shortage areas, training of personal care workers, and funding for expanded home-visiting programs for at-risk families and children (USDHHS, October 2012).

Discussion

By most accounts, the ACA has reduced the number of uninsured persons in the U.S. Reports suggest that the numbers have fallen particularly as as result of the coverage extended to young adults, and the expansion of Medicaid (McGill, 2014), yet some changes might be due to a "churning" effect. For example, many new Medicaid enrollees previously were covered under the IowaCare program (which ended in December 2013), so the increase in Medicaid enrollment numbers does not mean an equivalent reduction in the number of uninsured Iowans. Similarly, in the commercial market, some employers or individuals may have dropped more expensive coverage and purchased insurance on the exchange without a net change in the number of uninsured persons. The data regarding this churning effect remains unclear. Additionally, many of those who have secured coverage have been individuals who had pre-existing conditions, significant health concerns or very limited financial resources. Covering such individuals was clearly the goal of the ACA, but the longer-term financial stability of the program is dependent on the participation of younger individuals, those in the 18-34 age group who have fewer health costs and whose participation is necessary as a counterbalance to those with high health costs. In Iowa, 26% of those enrolled were in this younger age group (Anderson, 2014). Overall, there is an urgent need to attract those in this younger age group to ensure the long-term financial viability of the ACA.

Recommendations

NASW-Iowa chapter supports the following recommendations, designed to support strategic implementation of the Affordable Care Act.

- The state should work with the federal government to develop strategies for funding health management activies under ACOs, and adopt a "team approach" in which healthcare and social service providers collaborate in managing the social determinants of care. States such as Oregon and Minnesota have developed best practice approaches that could serve as models for Iowa.
- State policymakers should collect data to assess the impact of outcome-based hospital reimbursements to small rural hospitals that serve high numbers of Medicare recipients; the state needs to assess whether such hospitals are able to achieve a balance between providing quality care to frail elders while themselves remaining financially viable.
- State policymakers should appropriate funds and develop state-run procedures to support consumer enrollment, outreach and education to maximize enrollment on the insurance exchange. Younger enrollees, age 18-34, especially should be targeted.
- The state should explore legislation requiring carriers in Iowa with a certain level of market share to offer qualified health plans on the exchange.
- The state should work with the federal government to monitor compliance with the individual- and employer-mandated coverage, and assess its affect on the workforce patterns and healthcare access.
- The state should monitor the costs of, and expand the number of providers in IHAWP to ensure that the program is able to meet beneficiary needs and provide quality healthcare for the long term.
- State legislators will need to provide a supplemental appropriation for SFY15 and expand funding for SFY16 and beyond to address the expected shortfall in funding for the CHIP/*hawk-i* programs. As required by the ACA, the state should continue its current coverage of children whose families earn less than 300% FPL.
- The state should participate in the *Community First Choice Option* as a way to offer home-care services to beneficiaries who otherwise would require more costly services in intermediate- or long-term care facilities.

- The state should continue opportunities to strengthen its health care workforce, including increasing the number of physicians, nurses, psychiatrists, psychologists, social workers, and other health and mental health care providers. Support should be directed to evidence-based education and training programs, and focused on the delivery of culturally and linguistically competent care in both primary and preventative health care fields. Financial aid should be targeted toward those who make a commitment to work in underserved areas and/or with underserved populations.
- The state should continue to emphasize population-based health outcomes that bridge personal and public health concerns. Such strategies, already underway in some settings, emphasize environmentally-based health issues, public safety, alcohol and tobacco cessation, personal health and wellness, and quality of life and longevity issues.

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