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MEMORANDUM

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TO: Interested Persons

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SUBJECT: Implementation of Federal Health Care Reform in Colorado

This memorandum provides an overview of key events at the state and federal levels in the implementation of the Patient Protection and Affordable Care Act (PPACA), commonly referred to as federal health care reform. Specifically, this memorandum outlines upcoming provisions of PPACA that are scheduled to take effect between 2012 and 2018. In particular, this memorandum focuses on provisions affecting public health care programs, private health insurance, and taxation.

Public Health Care Programs

Federal health care reform includes a number of provisions affecting client eligibility, federal funding to states, and payments to health care providers under public health care programs such as Medicaid and the State Children's Health Insurance Program. Changes to these programs are listed below.

Medicaid expansion. PPACA requires states to expand Medicaid in 2014 to all individuals with incomes below 133 percent of the Federal Poverty Level (FPL) who are under age 65 and not eligible for Medicare. However, following the recent Supreme Court ruling in June 2012, state participation in the Medicaid expansion is effectively optional. States that do not expand Medicaid risk losing only federal funding associated with the expansion, not their entire allotment of federal funding for existing Medicaid populations. For the initial years of the expansion (2014 to 2016), the federal government will fund 100 percent of the states' Medicaid expansion costs. This federal match is gradually reduced over time to 90 percent of costs in 2020 and beyond, with states paying the remainder of costs for expansion populations.

Medicaid eligibility in Colorado. With the implementation of House Bill 09-1293, Colorado has partially expanded Medicaid to some of the population targeted by PPACA. However, Colorado has not yet met the goal of covering all persons with incomes below133 percent of the FPL as set forth in PPACA. For example, Colorado has expanded Medicaid coverage to childless adults only for persons with incomes below 100 percent of FPL. Further, current funding limits eligibility for

this group to persons with incomes below 10 percent of FPL, up to an enrollment cap of 10,000 individuals. Coverage for adults with children is also below the 133 percent target of PPACA, as Colorado offers Medicaid coverage to parents with income up to 100 percent of the FPL.

Future Medicaid funding under PPACA. It is unclear if the state costs for the populations covered under Colorado's partial expansion of Medicaid will be eligible for the 100 percent federal match under PPACA, or if the current federal match of 50 percent will continue until the state implements the complete expansion under PPACA. Potentially, the Medicaid costs for serving adults without dependent children with incomes up to 100 percent of the FPL and parents with incomes between 61 and 100 percent of the FPL could be paid entirely with federal funds. The federal DHSS is expected to promulgate rules in the future that outline how states will be reimbursed for "newly eligible" populations when, and if, they expand their Medicaid programs to meet the PPACA goals.

Medicaid coverage of preventive services. Starting in 2013, states with Medicaid programs that cover certain preventative services and immunizations at no cost to clients will receive a 1 percent increase in federal matching payments. Eligible services covered by this provision are recommended by the U.S. Preventive Services Task Force. Colorado requires Medicaid clients to pay a co-pay for a number of these recommended services, and thus is not be eligible for the increased federal matching funds under current state law.

Medicaid payments for primary care. In 2013 and 2014, Medicaid payments for primary care services are increased to an amount equal to 100 percent of the Medicare payment rate in these years. This rate increase to providers is entirely financed with federal funds. In total, states are expected to receive more than $11 billion in federal funds for their Medicaid primary care systems.

Extension of the State Children's Health Insurance Program. Authorization and funding for the State Children's Health Insurance Program (SCHIP) is extended through 2015.

Federal match for State Children's Health Insurance Program. In 2015, the federal match to states for SCHIP is increased by 23 percentage points, up to a total of 100 percent. Colorado currently has a 65 percent federal match rate to operate its children's health insurance program, the Child Health Plan Plus (CHP+), which is expected to increase to 88 percent under this provision.

Disproportionate Share Hospital payments. Disproportionate Share Hospital (DSH) allotments under Medicaid and Medicare are distributed to providers who serve a large number of uninsured patients. As federal health reform is expected to reduce the number of persons without insurance, the total amount of Medicaid DSH payments provided to all states is reduced by:

- $0.5 billion in 2014;
- $0.6 billion in 2015;
- $0.6 billion in 2016;
- $1.8 billion in 2017;
- $5.0 billion in 2018;
- $5.6 billion in 2019; and
- $4.0 billion in 2020.

Colorado will have to determine how to implement the reduction in DSH payments. Additionally, Medicare DSH payments are initially reduced by 75 percent in 2014. Subsequent Medicare DSH payments may be increased based on the percentage of the population that is uninsured and the amount of uncompensated care provided.

Private Health Insurance

Provisions of federal health reform concerning private health insurance seek to expand access to coverage and increase the quality and cost-effectiveness of health plans. Key provisions discussed below include changes to the health insurance marketplace, new regulations affecting health plans, and mandates on individuals to obtain, and certain employers to offer, health insurance.

State-based health insurance exchanges. States must indicate to the United States Department of Health and Human Services (DHHS) whether they will operate a state-based health insurance exchange and, if so, must submit the exchange application to DHHS by November 16, 2012. State health insurance exchanges must be operational by January 1, 2014. If a state has not taken action to establish an exchange, the federal government will set up the exchange for that state. Although states have discretion in establishing exchanges, federal law includes requirements that all exchanges must meet. Exchanges must:

- be administered by a governmental agency or a nonprofit entity;
- develop a process for certification of plans as qualified health plans; and
- offer health insurance plans to both individuals and small businesses.

The Colorado Health Benefit Exchange was created by Senate Bill 11-200, and the exchange submitted its establishment application to the federal DHHS in December 2011. The Colorado Health Benefit Exchange is scheduled to open for business in October 2013, with insurance coverage beginning January 1, 2014.

Flexible spending account limits. Beginning in 2013, the PPACA limits personal contributions to flexible spending accounts for medical expenses to $2,500 per year, which then increases annually by a cost-of-living adjustment. This limit does not apply to employer contributions.

Consumer operated and oriented health insurance plans. Federal health care reform includes the creation of the Consumer Operated and Oriented Plan (CO-OP) program within the DHHS to foster the creation of nonprofit, member-run health insurance companies. These CO-OP insurers are to be established by July 1, 2013, and may begin offering health plans beginning in January 2014. The CO-OP program offers low-interest loans to eligible nonprofit groups to help set up and maintain these plans. As of October 2012, the DHHS has awarded $1.8 billion in loans to 23 nonprofits in 23 states. In Colorado, the Colorado Health Insurance Cooperative, Inc. received a $69 million loan in July 2012 to establish a CO-OP.

Health insurance regulations. In 2014, the changes to the federal regulations for fully insured group and individual health insurance plans will:

- require the Secretary of the HHS to develop a single set of operating rules to process insurance transactions;
- prohibit plans from applying preexisting coverage limitations;
- specify that rates may only vary based on: (1) family size; (2) geographic area; (3) age; and (4) tobacco use.
- require health insurers to offer coverage to any individual or group that applies;
- require health insurers to renew coverage at the option of the plan sponsor or the covered individual;
- prohibit insurance carriers from placing annual limits on the dollar value of coverage;
- prohibit health plans from basing eligibility for coverage on: (1) health status; (2) medical condition; (3) claims experience; (4) receipt of medical care; (5) genetic information; (6) evidence of insurability; or (7) disability or other health status-related factor; and
- prohibit a plan from applying a waiting period for coverage longer than 90 days.

Individual requirement to have insurance. Beginning in 2014, federal health care reform requires U.S. citizens and legal residents to have qualifying health insurance coverage. Qualifying health coverage may include private insurance or public health insurance such as Medicaid. Individuals who do not maintain adequate coverage are subject to a federal tax penalty.

Health insurance cost-sharing subsidies. In 2014, people with incomes up to 250 percent of FPL are eligible for reduced cost-sharing (e.g., coverage with lower deductibles and co-payments) paid for by the federal government. These subsidies are not available for use with public insurance programs.

Employer responsibilities. In 2014, employers with more than 200 employees are required to automatically enroll new employees in a health care plan and provide information about how the employee can opt out of coverage. Employers must also provide information to employees about the exchange. Large employers (employers with 50 or more employees) that fail to offer full-time employees the opportunity to enroll in health care coverage or that have a waiting period of more than 60 days for the employee to enroll in coverage are subject to financial penalties. Large employers must also submit an annual report on the health insurance coverage provided to their full-time employees. Full-time employees are defined as those who work at least 30 hours per week.

Reinsurance program. States must establish reinsurance programs, starting in 2014. These state-based reinsurance programs will be funded through payments made by group health plans, and the program will provide payments to individual health insurers that cover high-risk individuals in the insurance market. States must coordinate with or eliminate any existing high-risk pool in the state in order to implement this provision. Currently, Colorado has two existing high-risk insurance pools: CoverColorado, established by the state legislature in 1991; and the federally established GettingUSCovered.

Insurance wellness programs. Beginning in 2014, employers may offer insurance premium incentives of up to 30 percent to employees for participating in wellness programs and meeting certain health-related standards. A ten-state pilot program has been created for participating states to provide similar incentives for persons participating in wellness programs who have health insurance in the individual market.

Health care choice compacts. In 2016, states are allowed to form health care choice compacts, which permit health insurers to sell policies in all states participating in the compact.

Taxation

Tax provisions in federal health care reform serve a range of purposes. Some tax provisions aim to assist persons with low incomes and small businesses in purchasing health insurance. Other provisions include taxes and fees to offset the costs of expanding coverage, as well as to encourage persons to carry health insurance. According to estimates from the Congressional Budget Office, the net impact of these changes will raise $813 billion in federal revenue between 2012 and 2021.[1] The tax provisions of PPACA are all implemented at the federal level and do not require any state administration.

Health insurance premium tax credits. Starting in 2014, eligible individuals may receive refundable insurance premium tax credits to assist in paying the cost of health insurance purchased through a state-based health insurance exchange. These premium tax credits are available to families with incomes between 100 percent and 400 percent of the FPL.

Small employer health insurance tax credit. Beginning in 2014, small businesses and nonprofit organizations with 25 or fewer employees that pay average annual wages of less than $50,000 may receive a sliding-scale tax credit if the employer contributes at least 50 percent of the total premium costs of purchasing health insurance for employees. Alternatively, the credit may also be received if the employer contribution toward employee health coverage is equal to at least 50 percent of the premium for a benchmark health plan. In 2014 and 2015, small businesses meeting these requirements are eligible for a tax credit of up to 50 percent of the employer's contribution toward the employee's health insurance premium. Nonprofit organizations meeting these requirements are eligible for tax credits of up to 35 percent of the employer's contribution.

Medicare payroll tax increase. Medicare taxes increase 0.9 percent for individuals making more than $200,000 and for married couples filing jointly making more than $250,000 in 2013. The law also imposes a 3.8 percent Medicare tax on unearned income for higher-income earners.

Itemized deductions for medical expenses. Starting in 2013, the threshold for itemizing the deduction for medical expenses increases from 7.5 to 10.0 percent of adjusted gross income (AGI). Persons age 65 and older can claim the deduction for expenses above 7.5 percent of AGI through 2017.

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[1] Congressional Budget Office, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010,* Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011.

Employer retiree coverage deduction. In 2013, the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments is eliminated.

Medical device excise tax. Beginning in 2013, an excise tax of 2.3 percent is imposed on the sale of taxable medical devices.

Federal tax on high-value insurance. Beginning in 2018, a federal excise tax is assessed on high-value, employer-sponsored health plans with aggregate costs that exceed $10,200 for individuals and $27,500 for families.

Other health-related taxes. In 2014, various federal taxes are imposed on health-related items, including:

- a fee on companies that manufacture branded prescription drugs;
- an annual fee on health insurance companies based on the number of policies written combined with third-party administration fees; and
- an excise tax on indoor tanning services.

Implementation Timeline

Table 1 shows the key provisions of federal health reform by date.

Table 1
Key Provisions of Federal Health Reform by Date

Public Health Care Programs	Private Health Insurance	Taxation
2013		
• State Children's Health Insurance Program is extended from 2013 through 2015. • Federal matching funds increase for states offering preventive services under Medicaid at no cost to clients. • Medicaid payments for primary care increase to the Medicare rate.	• Personal contributions to flexible spending accounts are limited to $2,500 per year. • Nonprofit organizations may form member-run health insurance cooperatives under the Consumer Operated and Oriented Plan program (CO-OP plans) and seek federal loans.	• Medicare payroll tax increases for persons with incomes above $200,000 per year ($250,000 for couples), and a Medicare tax is imposed on unearned income for high-income earners. • Itemized deductions for medical expenses are limited. • Employer retiree coverage deduction for Medicare Part D retiree drug subsidy is eliminated. • Excise tax is imposed on taxable medical devices.

Table 1 (Cont.)
Key Provisions of Federal Health Reform by Date

Public Health Care Programs	Private Health Insurance	Taxation
2014		
• 2014 is the target date for states to expand Medicaid to most persons with incomes below 133 percent of the FPL. • Phase out of Disproportionate Share Hospital payments begins.	• State-based health insurance exchanges begin operation on January 1, 2014. • Consumer operated and oriented program (CO-OP) health plans may take effect. • Health insurers are required to sell policies to all applicants. • Health insurance coverage cannot be denied because of preexisting conditions. • Factors on which premiums may be based are limited. • Individual requirement to have insurance takes effect. • Health insurance premium and cost-sharing subsidies are available to persons with low-incomes. • Large employers are required to offer health insurance and meet other requirements. • State reinsurance programs must be established to offset health insurers' costs of covering high-risk individuals. • Employers may established health insurance wellness programs to offer incentives to participating employees.	• Health insurance premium tax credits are available to help persons purchase health insurance through state-based health exchanges. • Small employer health insurance tax credit is expanded and applies to health insurance bought through state-based health exchanges. • Various federal taxes and fees are imposed on manufacturers of branded prescription drugs, health insurance companies, and indoor tanning services.
2015		
• Federal match for State Children's Health Insurance Program is increased.		
2016		
	• Health care choice compacts may be established.	
2018		
		• Federal tax on high-value health insurance plans is imposed.