

## Overview of Health Reform for Arkansans

*We may think of the health care system in our country as long-established and without major change. In reality, it is a system shaped over a relatively short period of time by substantial events. The 2010 Patient Protection and Affordable Care Act (the Act) is the latest milestone in the evolution of health care in the United States. The Act presents both challenges and opportunities. How will the health reform law affect health care and health insurance for Arkansans? Federal agencies responsible for implementing the law still have to determine how the law will be interpreted. Yet, Arkansas policymakers can prepare for an effective implementation by understanding the provisions of the law as it is currently written, how those provisions might alter current practices in Arkansas, and what choices Arkansas policymakers can make to help shape this changing system.*

### U.S. HEALTH CARE: AN EVOLVING SYSTEM

Current health reform may be better understood by taking a look at the evolution of our health care system and how it became what it is today.

Our modern health care system in the U.S. is largely a product of the last 100 years. During the early 20<sup>th</sup> century, the theory and treatment of disease became more scientifically informed, and advances in medical treatments resulted in the growth and expense of receiving care. In response, health insurance was offered as a way to lower costs for those needing health care by spreading the expenses across a large pool of contributing members. This began as a not-for-profit venture in the 1920s but was quickly taken up by for-profit companies.

During and after World War II, several key events occurred. In 1941, in an effort to avoid wage inflation due to labor demand, the federal government implemented a wage and price freeze. To remain competitive, employers responded by offering health insurance and other unrestricted benefits to their workers. Thus, the U.S. health care system became unlike that in any other developed nation—linked to employer-sponsored benefits. During the post-World War II era, employer-based health insurance became a standard component of most wage and benefit structures—offered by employers and expected by employees. Today, almost 88%<sup>1</sup> of those who are privately insured receive their coverage through their own employer benefits or those of a family member.

In the mid-1950s, many hospitals began to take advantage of low-interest loans made available through the Hill-Burton Act of Congress, which carried with them the commitment to treat all patients regardless of their ability to pay. Despite these changes, the rise of job-based

### HEALTH INSURANCE COVERAGE IN ARKANSAS

Thirteen years ago, only 21%<sup>2</sup> of children in Arkansas had health insurance. Now, all but 9%<sup>3</sup> are insured because of the State Children's Health Insurance Program (SCHIP) established in 1997 that has been shaped into the existing ARKids First program.

In Arkansas the majority of our children and adults 65 years of age and older have health insurance coverage. However, 505,000<sup>4</sup> Arkansans, most between the ages of 19 and 64, are without health insurance.

Of those in the 19-64 age group who do have coverage, the primary source is through their employer. However, the majority of Arkansas businesses are small (fewer than 50 employees), and less than 30%<sup>5</sup> of these small businesses currently provide health care benefits. New reforms will not require these employers to offer insurance to their employees.

insurance did not adequately support needed services for those outside the workforce, and continued growth in the complexity and costs of treatment increasingly placed health care outside of the reach of most people without employer sponsored insurance—particularly the elderly and the poor.

In 1965, after contentious debate, the federal government extended its responsibility from providing assistance to hospitals to actually providing financing for individual care. As additions to the Social Security Act, a federally run program entitled Medicare was established for the elderly, and a federal-state partnership entitled Medicaid was established for the poor. Initially opposed by the American Medical Association and other established health care provider groups, Medicare and Medicaid have become the primary source of financial support for the health of America's seniors, and with the 1997 expansion of the State Children's Health Insurance Program (CHIP), for many of America's children. Congress's addition of pharmaceutical coverage to the Medicare program in 2003 again demonstrated the continued evolution of our health care system and the growing responsibility for its financing. Today a large portion of health care coverage in the U.S. is publicly financed through these and other government-operated programs.

Growth of private sector employer-based coverage and public sector programs such as Medicare and Medicaid expanded access to health care for many previously uninsured Americans, but did little to contain steadily increasing costs. With the rise of modern medicine came the associated increased costs of providing care. New industries were developed to advance pharmaceutical treatments, enhance radiographic imaging, develop new medical devices and implants, and explore new and promising therapies. As these scientific breakthroughs continue to support increasingly complex therapeutic efforts, and the health care system continues to expand, an increasing proportion of the nation's wealth goes to pay for health care.

Attempts to control health care costs in the U.S. have included development of practice guidelines to both improve quality and standardize treatment, peer review of services provided to assure appropriate medical treatment, and various types of utilization review to eliminate or reduce unnecessary or avoidable utilization. In 1973, Congress authorized prepayment for medical services in an effort to explore alternatives to the traditional fee-for-service insurance model, which led to development of new managed-care models across the nation. Individual case management, disease management, and population-based strategies to improve health and avoid costly services continue to evolve.

One hundred years after the beginning of the modern health care system, the U.S. has some of the most advanced therapeutic options available anywhere in the world. However, quality has not improved proportionally to the increased costs associated with these advances. The U.S. spends almost twice what other developed nations spend, but the quality of care provided on most standardized scales falls far short of many other nations. In addition, the growing number of uninsured individuals (46 million<sup>6</sup> in the U.S. and 505,000<sup>7</sup> in Arkansas), combined with the uncertainty of those with health insurance being able to maintain it, has raised political pressure to change the health care system. The combination of increasing costs and a looming funding shortfall in Medicare as baby boomers become eligible has continued to force the health care system into the political spotlight.

As we enter the second decade of the 21<sup>st</sup> century, new changes are underway that will continue the evolution of our health care system. The Sustainable Growth Rate (SGR) reductions in the Balanced Budget Act of 1997 threaten Medicare's physician participation at the

same time that the availability of primary care physicians is shrinking. The American Recovery and Reinvestment Act of 2009 is stimulating the adoption of electronic health records and health information exchanges across the clinical spectrum. The Patient Protection and Affordable Care Act of 2010 represents the single largest set of changes to U.S. health care since the establishment of Medicare and Medicaid. The outcome of these changes will be shaped by and through the input of state policymakers, local health and health care providers, and, most importantly, consumers.

## **HEALTH CARE REFORM AND PRIVATE HEALTH INSURANCE**

In passing health care reform legislation, Congress recognized the key roles of employer-based and individual health insurance in providing coverage. Congress' stated intent in passage of the 2010 Patient Protection and Affordable Care Act was to retain much of the present marketplace while strengthening protections for consumers facing financial exposure or at risk of losing coverage. Mindful that health insurance and health care are regulated at multiple levels, the changes required in the Act are a combination of new federal requirements and state requirements for implementation and oversight.

The law gives states a great deal of flexibility in determining the structure of the private insurance market and the specific ways in which new requirements are carried out. With health reform, states play an important role in:

- Regulating the Insurance Market
- Health Insurance Exchanges for Individuals and Small Businesses
- Consumer Assistance

### **Regulating the Insurance Market**

Under existing federal statutes (e.g., the McCarran-Ferguson Act of 1945), states have traditionally been responsible for regulating much of the health insurance sold within their borders. The health reform law changes the nature of health insurance regulation but anticipates that the existing mechanisms within the state will continue to perform the regulatory functions under the new guidelines. Each state's insurance department will have new responsibilities for oversight and enforcement of new market standards. Therefore, it will be necessary for each state to perform a complete analysis to compare current state law with each new federal provision, identify a timeline for implementing each new provision, and, where necessary, identify new human and financial resources that will be necessary to carry out the changing level of health insurance regulation within the state. Figure 1 highlights some of the changes in insurance regulation and the effective dates of those provisions.

### **Health Insurance Exchanges for Individuals and Small Businesses**

The Act requires states to establish and directly manage or facilitate the development of new health care "exchanges" by 2014. The purpose of these new marketplaces is to provide individuals and small businesses with affordable health insurance purchase options and to assist them in complying with new coverage requirements.

Beginning in 2014, citizens will be responsible for ensuring that they are covered by health insurance. The intent of this requirement is to spread risk over an increased pool of covered people. Those people who have not obtained insurance through their employer and are not eligible for and enrolled in public programs will be expected to obtain their coverage through a health insurance exchange in 2014. States may elect to create an exchange directly, facilitate

the establishment of a separate non-profit exchange entity, or participate in a federally administered exchange. Exchanges will organize the market for individuals to purchase coverage, ensure that premiums comply with regulations, and administer federal subsidies for anyone whose income is less than or equal to 400% of the federal poverty level (FPL) who buys a plan through the exchange. FPL income requirements are adjusted annually; as a comparison, in 2010 the levels would be \$43,320 for individuals and \$88,200 for families of four. In 2014, 323,000<sup>8</sup> Arkansans are expected to qualify for these premium subsidies.

Businesses will also be required to share responsibility for offering health coverage to their employees. Under health care reform, employers with the equivalent of 50 or more full-time workers will be expected to offer health benefits starting in 2014. In Arkansas, 96.4%<sup>9</sup> of these 17,000<sup>10</sup> businesses already offer health insurance to their employees, leaving only 600 that do not already offer coverage.

Businesses with more than 50 full-time employees that **do** offer coverage to their employees will be expected to share the cost for any full-time employee who forgoes his or her employer plan and receives a premium subsidy when purchasing insurance through an exchange. A business will pay a penalty of \$3,000 for each employee receiving a subsidy, with the total payment capped at the amount that would be assessed if the business did not offer insurance at all (\$2,000 for each full-time employee, with no assessment for the first 30 employees). If no employees receive a premium subsidy, the business does not pay anything.

Businesses with more than 50 full-time employees that **do not** offer any coverage to their employees will be subject to different penalties. If these businesses have at least one full-time employee who receives a premium subsidy through an exchange, they will be expected to pay a fee for every full-time employee, even if not all of those employees receive premium subsidies. The business will pay a penalty of \$2,000 for each full-time employee, but will not be assessed for the first 30 full-time employees. If no employees receive a premium subsidy, the business does not pay anything.

Almost all employers with 200 or more full-time employees will be required to automatically enroll their employees in their employer-offered plan. Those businesses with 100 or fewer employees will be able to purchase insurance through an employer exchange—the Small Business Health Options Program (SHOP)—beginning in 2014, and may continue to participate as they grow beyond 100 employees. Established by the state and managed either publicly or privately, the SHOP exchange is intended to expand options for small businesses and lower the challenges of offering health insurance. After 2017, states may allow employers with more than 100 employees to begin to participate in the exchange.

Importantly for small businesses, employers with the equivalent of fewer than 25 full-time employees and average wages under \$50,000 are eligible for tax credits of up to 35% of eligible premium costs (25% for tax-exempt) for tax years 2010 through 2013, and up to 50% (35% for tax-exempt) for two tax years beginning in 2014. In Arkansas, this represents approximately 41,000<sup>11</sup> small businesses. These small businesses are not subject to the coverage requirements of larger companies, but are eligible for these tax credits if they offer coverage and contribute at least half of their employees' premium costs.

**Figure 1: Selected Changes to Insurance Regulations in Arkansas**

Current Practice in Arkansas	New Regulation	Effective Date
Plans report premiums to the state and the United States Department of Health and Human Services (HHS).	Plans must report the share of the premium spent on medical care to the state and HHS, which must be publicly reported.	2010
Arkansas's high-risk insurance pool currently covers about 3,000 <sup>i</sup> lives.	Existing state high-risk pools may continue. The federal government will fund a second, temporary high-risk coverage pool that states may elect to administer or leave to the federal government. At least 61,000 <sup>ii</sup> Arkansans are estimated to be eligible for this new high-risk pool, and federal funding will supplement up to 2,500 <sup>iii</sup> enrollees.	July 2010—January 2014
Plans may impose annual or lifetime limits on	Health insurance companies may not impose lifetime limits and will	September 2010
Plans define in the contract the age at which dependent coverage will end.	Children can potentially remain covered on a parent's plan up to age 26. About 14,000 <sup>iv</sup> young adult Arkansans are expected to benefit immediately.	Open enrollment periods beginning September 2010; some insurers are offering earlier enrollment.
Health insurance companies may exclude from coverage altogether, or offer limited coverage to, individuals with pre-existing conditions.	Beginning immediately for children and in 2014 for adults, health insurance companies may not deny coverage to anyone based on a pre-existing condition (guaranteed issue).	Children (18 and under) - September 2010
Plans determine how much of the premium goes to administration and overhead and how much is spent on medical care.	Health plans will be required to offer rebates to enrollees if they pay out less than 85% (large group market) or 80% (small group market) of their premiums for direct medical care and quality measures.	January 2011
Premiums can be adjusted to reflect individual age and health status.	Premiums must be community-rated with small variations allowed for age, family composition, and smokers.	January 2014

<sup>i</sup> U.S. Government Accountability Office. "GAO-09-730R State High-Risk Health Insurance Pools: HRP Enrollment in 2008 and Estimate of the Potentially Eligible Population, 2005-2007 State." p.7, *U.S. Government Accountability Office*. n.p., 22 July 2009. Web. 30 June 2010. <<http://www.gao.gov/new.items/d09730r.pdf>>. (Staff Note: Number rounded to the nearest 1,000.)

<sup>ii</sup> U.S. Government Accountability Office. "GAO-09-730R State High-Risk Health Insurance Pools: HRP Enrollment in 2008 and Estimate of the Potentially Eligible Population, 2005-2007 State." p.7, *U.S. Government Accountability Office*. n.p., 22 July 2009. Web. 30 June 2010. <<http://www.gao.gov/new.items/d09730r.pdf>>. (Note: "GAO data collection instrument administered to all 34 HRPs operational in 2008 and analysis of data from the 2006 Medical Expenditure Panel Survey (MEPS) and U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. GAO estimated the potentially eligible population, including dependents, by (1) determining the percentage of uninsured individuals with at least one chronic condition using 2006 MEPS data, and (2) applying that percentage to Current Population Estimates (CPS) estimates of the 3-year average uninsured population in each of the 34 states with an HRP (2005-2007). The CPS estimates are subject to sampling error of plus or minus 1.3 percent at the 90 percent confidence level. The MEPS and CPS data used were the most current available at the time we performed our work.") (Staff Note: Number rounded to the nearest 1,000.)

<sup>iii</sup> Arkansas Comprehensive Health Insurance Pool. "Draft Application for Federal High Risk Pool Coverage." *Arkansas CHIP Draft Proposal to Administer the Temporary Federal High-Risk Pool in Arkansas*. July 1, 2010.

<sup>iv</sup> HealthReform.gov. "The Affordable Care Act: Immediate Benefits for Arkansas." *www.HealthReform.gov*. n.p., n.d. Web. 30 June 2010. <<http://www.healthreform.gov/reports/statehealthreform/arkansas.html>>. (Note: "U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2009; and 45 CFR Parts 144, 146, and 147. [http://www.hhs.gov/ocio/regulations/pr\\_a\\_omnibus\\_final.pdf](http://www.hhs.gov/ocio/regulations/pr_a_omnibus_final.pdf)") (Staff Note: Number rounded to the nearest 1,000.)

## Consumer Assistance

The law anticipates that states will either establish a new agency or task an existing office to provide health insurance-related consumer assistance to those purchasing coverage in the individual or small group exchanges. There are federal grants available to help states establish these offices, with funding available as early as 2010. The decision about when and how to implement this policy in Arkansas will fall to state policymakers.

## HEALTH CARE REFORM AND PUBLIC HEALTH INSURANCE

The new legislation introduces many changes to Medicaid, the primary public health insurance program in Arkansas. Health reform provisions for this program will be largely federally funded but will also require increased financial obligations for states. As in most states, Medicaid in Arkansas is the second largest budget item (following spending for education) representing 16.5% or \$3.7 billion of the state's budget. Last year, 750,000<sup>12</sup> people in Arkansas (about one-fourth of the population), including the majority of children, received Medicaid services (see Figure 2). Medicaid paid for the delivery of 63%<sup>13</sup> of all babies born in the state. In addition, Medicaid pays for a large portion of nursing home care provided to individuals in Arkansas.

Figure 3 shows percent distribution of Medicaid expenditures by enrollment group. In the last 10 years, primary payment for these services has come from the federal government, with Arkansas receiving slightly more than 3 federal dollars for every 1 state dollar appropriated by the Arkansas General Assembly.

The changes to public health insurance coverage outlined in the new law can be viewed in three categories:

- Expanded Eligibility
- New Benefits under Health Care Reform
- Changes in Public Health Insurance Financing

### CURRENT MEDICAID AND ARKIDS FIRST INCOME ELIGIBILITY IN ARKANSAS<sup>14</sup>

The Medicaid eligibility threshold for children (under 19) and pregnant women is at 200% of FPL (\$44,100 for a family of four).

Income eligibility for individuals who are aged, blind or disabled generally varies from 73% to 135% of FPL (\$7,900-\$14,400), except for those same individuals who qualify for nursing home care with 73% to 224% of FPL (\$7,900-\$24,250).

Arkansas's safety net benefits waiver program—ARHealthNetworks—provides certain health care benefits to adults who are self-employed or working for small businesses, with subsidies available to those with incomes at or below 200% of FPL (\$21,660 for an individual).

**Figure 2: Arkansas Population Served by Medicaid**

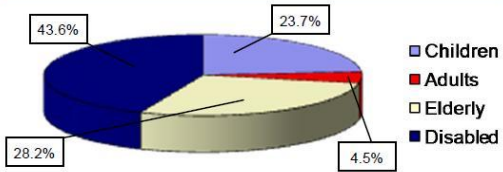
Arkansas Population (2009) <sup>i</sup>		Number of Arkansans Served by Medicaid <sup>ii</sup>	% of Age Group Served by Medicaid	Newly-Eligible Under Health Care Reform <sup>iii</sup>
All Ages	2,826,804	658,454	23%	251,000
Elderly (65 and older)	356,275	59,633	17%	
Adults (19-64)	1,726,118	189,598	11%	
Children (under 19)	744,410	409,223	55%	

<sup>i</sup> U.S. Census Bureau. "Current Population Survey, Annual Social and Economic Supplement, 2009, Arkansas: Age." *U.S. Census Bureau Current Population Survey (CPS) Table Creator For the Annual Social and Economic Supplement*. U.S. Census Bureau, 2009. Web. 7 July 2010. <[http://www.census.gov/hhes/www/cps/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cps/cps_table_creator.html)>.

<sup>ii</sup> Arkansas Department of Human Services, Division of Medical Services, Decision Support System. Data retrieved on 6/30/2010 for point in time 12/31/2009. (Note: Total number served in a year may be different than number served at a single point in time.)

<sup>iii</sup> Holahan, John, and Linda Blumberg. "How Would States Be Affected by Health Reform?" p.9, *Timely Analysis of Immediate Health Policy Issues* (Jan. 2010): Web. 30 June 2010. <[http://www.urban.org/UploadedPDF/412015\\_affected\\_by\\_health\\_reform.pdf](http://www.urban.org/UploadedPDF/412015_affected_by_health_reform.pdf)>. (Note: "Source: Urban Institute Analysis of 2007-2008 Current Population Surveys.") (Staff Note: Number rounded to the nearest 1,000.)

**Figure 3: Percent Distribution of Medicaid Dollars by Enrollment Group<sup>i</sup>**



<sup>i</sup> The Kaiser Family Foundation. "Distribution of Medicaid Payments by Enrollment Group, FY2007." [www.StateHealthFacts.org](http://www.StateHealthFacts.org). The Kaiser Family Foundation, July 2010. Web. 16 July 2010. <<http://www.statehealthfacts.org/profileind.jsp?ind=858&cat=4&rgn=5>>. (Note: "Data Source: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) and CMS-64 reports from the Centers for Medicare and Medicaid Services (CMS), 2010.")

### Expanded Eligibility

Beginning in 2014, states will be required to extend health insurance through Medicaid coverage to most individuals aged 19-64 years with incomes at or below 133% of the federal poverty level (FPL), which in 2010 is \$14,400 for an individual. This eligibility will be in addition to those groups presently covered under Medicaid, including low-income and disabled children, their caretakers, pregnant women, disabled adults, and certain other vulnerable populations.

Approximately 251,000<sup>15</sup> legal residents of Arkansas will become newly eligible for public insurance based on the new income requirements. Although many of these newly eligible people may choose the benefits and zero cost of Medicaid, factors such as lack of awareness and negative connotations of public insurance may mean that some people choose a public subsidy to purchase health insurance in the private market, or will pay the penalty to remain uninsured.

The health reform law extends authorization and funding for Arkansas Medicaid through 2015 and requires states to maintain current income eligibility levels for children (now at 200% of FPL) until 2019. However, the law states that this requirement should not be construed as preventing a state from expanding eligibility standards during that time.

### New Benefits under Health Care Reform

Both current and newly eligible Medicare and Medicaid recipients will see new benefits as a result of health care reform. Some of these include:

- Expanded services and funding options for special populations, including maternal and child populations, and long-term and elder care through Medicaid;
- Covered participation in evidence-based prevention programs through Medicare;
- Option to participate in a national, voluntary long-term care insurance program;
- Extended Medicaid coverage of prescription drugs through benchmark benefits, rebates, and requirements to cover specific drugs; and
- Temporary provision of a \$250 rebate for those seniors who do not receive Medicare financial assistance for prescription drugs while in the Medicare Part D "donut hole."

### Changes in Public Health Insurance Financing

Congress recognized the additional burden health care reform places on state governments due to expansion of Medicaid. Among numerous modifications, for the 3-year period from 2014 to 2016, the federal government will reimburse states for the **full cost of coverage** (100% Federal Medical Assistance Percentage [FMAP]) for any individuals enrolled in Medicaid who became newly eligible as a result of the reform. This federal subsidy for new enrollees will fall to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. Enrollees newly eligible under reform will continue to be covered at 90% FMAP while others will be covered at original FMAP rates, which are currently set to be 71.37% for the 2011 fiscal year and projected to be 70.73%

for the 2012 fiscal year. Beginning in 2013, states that provide preventive services and immunizations at no out-of-pocket cost will receive an increase of 1% FMAP for these services.

Currently, states are required to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income and Medicaid patients. Federal DSH allotments to states will be reduced based on changes in state-specific uninsured rates over time. The law offers options for investing in other safety net providers such as community health centers, psychiatric hospitals, and rural hospitals.

## **IMPROVING HEALTH CARE QUALITY**

With the goal of improving health care quality, states will be given the opportunity to build upon current quality improvement efforts in the private sector and existing strategies within their Medicaid programs, as well as inform the public about the performance of hospitals, nursing homes, and physicians through quality reporting on standardized Internet web sites. State Medicaid programs will also have opportunities to test models for improving the delivery, quality, and payment of services.

Specifically, states have options to consider related to the following:

- Health Information Technology (HIT) Capacity and Infrastructure
- Health Care Workforce
- Coordination within Systems of Care

### **Health Information Technology (HIT) Capacity and Infrastructure**

The health reform law imposes new electronic data reporting and oversight requirements on states related to public coverage programs. States will be required to implement technology initiatives already in use by the Medicare program, such as a national correct coding initiative, and a recovery audit contract for their Medicaid programs. The former is intended to reduce inappropriate hospital expenditures for health care-acquired conditions and requires sophisticated data reporting for fee-for-service Medicaid programs. The latter is one initiative to enhance Medicaid program integrity through systematic audits of provider billing practices. Additional financial support will be available to states to improve their capacity to combat waste, fraud, and abuse, much of it through electronic reporting and monitoring.

Technology grants will be available to states to facilitate enrollment in federal and state health programs through the utilization of compatible information systems and new security standards. States are encouraged to simplify enrollment applications and to coordinate state health insurance exchanges with CHIP (ARKids First) via state-run websites. Support to states is also available for improved data collection on health disparities and public health surveillance to inform state health planning.

Arkansas is already taking advantage of funding provided through federal dollars made available by the congressional passage of the [Health Information Technology for Economic and Clinical Health \(HITECH\) Act](#) included in the [American Recovery and Reinvestment Act of 2009](#). Planning is underway to establish a statewide electronic Health Information Exchange (HIE) that will provide a mechanism through which individuals, health care providers and health organizations can share health-related information. Goals of the HIE include facilitating the delivery of quality care, the cost-effective use of health resources and strengthening the delivery of health care throughout Arkansas, leading to improved patient care, individual health decisions and public health outcomes.

The Arkansas Office of Health Information Technology was created in May of 2010 to oversee development of the HIE, and the Arkansas Department of Human Services' Division of Medical Services is continuing to refine the development of their Medicaid Management Information System (MMIS) to improve their system and accommodate new federal requirements with the intent to contain costs and improve quality of care. Emerging federal regulations continue to include strong guidance regarding collaboration among HIT-related initiatives. Arkansas Medicaid and the Office of HIT will continue to work together closely under this guidance from the U.S. Department of Health and Human Services and other agencies.

For more information on HIT activities in Arkansas visit, [www.recovery.arkansas.gov/hie](http://www.recovery.arkansas.gov/hie).

### **Health Care Workforce**

Nearly half of Arkansas's population lives in rural areas, and all but two counties<sup>16</sup> in Arkansas are designated as partially or fully medically underserved areas. To ensure an adequate and effective health care workforce to manage existing and newly insured individuals, additional health professionals will be required throughout the state at various levels of service.

Several possibilities for attracting and retaining some additional health care workers are available to states. The law offers financing for increases in loan amounts to nursing students, loan repayment and forgiveness programs for public health and pediatric providers, and certification programs for personal or home care aides. Demonstration grants will be available for a range of health care professionals including long-term care workers, dentistry practitioners, alternative dental providers, mental health workers, and family nurse practitioners. Furthermore, funding is available for demonstration projects to develop academic curricula that integrate quality improvement and patient safety into the clinical education of health professionals and also for the creation of primary care extension programs to educate primary care providers about preventive medicine, health promotion, and chronic disease management.

Despite these programs, there will likely continue to be an insufficient number of practitioners to serve the needs of Arkansans unless there is consideration and implementation of additional mechanisms to incentivize health care professionals to work and stay in Arkansas.

### **Coordination within Systems of Care**

Opportunities exist to improve coordination, quality, and efficiency of health care services through new programs, payment reform, and funding to support collaboration among teams of health care professionals including doctors, nurses, pharmacists, and others. New offices within the Centers for Medicare and Medicaid Services will be added to better coordinate care across the Medicare and Medicaid programs, specifically for dual-eligible beneficiaries. The Community Living Assistance Services and Supports (CLASS) Act, the opt-out program for long-term care insurance, will impact current state options for home and community-based services through Medicaid.

Multiple demonstration programs will be funded to create payment models that support efforts to tie Medicaid payment reform to quality improvements. These may include:

- Bundled payments for integrated care
- Fixed payment model for safety net hospitals
- Accountable care organizations that provide incentives to providers
- Regionalized, comprehensive, accountable emergency care and trauma systems
- Incentives for home-based primary care teams

## IMPROVING HEALTH

Health and well-being will be promoted through insurance coverage requirements and financial support of evidence-based prevention and wellness programs in states and communities. Health plans must improve health outcomes, prevent hospital readmissions, improve patient safety, and promote wellness and health through reporting requirements or reimbursement structures. The health reform law introduces new benefits under Medicaid and CHIP (ARKids First) such as preventive services for adults, medical homes for persons with chronic conditions, and expansion of home and community-based services as an alternative to institutional care through the state plan rather than through waivers. In 2010, all new individual and group plans will be required to cover preventive health care services at no out-of-pocket cost, including all recommendations of the U.S. Preventive Services Task Force. In 2011, Medicare will also begin to cover these preventive services with no out-of-pocket cost to all beneficiaries.

Reform also encourages wellness and disease prevention through demonstration projects, pilot programs, and grants. Opportunities are available for states to implement programs focused on childhood obesity, early childhood home visitation, education related to reproductive health, oral health promotion, and community-based health programs to reduce chronic disease in older adults. In addition, grants are available for small businesses that start wellness programs for employees.

## UNCERTAINTIES & CONCERNS

As with all new programs, the implementation decisions at federal, state, and local levels will be the major factor in determining the success or failure of this Act. Several factors remain uncertain and are worth noting to identify opportunities to optimize success and avoid pitfalls.

- The Patient Protection and Affordable Care Act does not address the Sustainable Growth Rate (SGR) reductions required of Medicare as called for in the Balanced Budget Act of 1997— failure to resolve these scheduled decreases in physician payments threatens to reduce participation by providers in the Medicare system.
- Elimination of some financial barriers through both public and private sector expansions within the Act will not immediately resolve the critical shortage of primary care providers across the nation.
- It is unclear what the impact of the individual and employer mandates and their respective exchanges will be. Will critical levels of participation be reached to achieve the goals of health care reform, or will non-participation due to insufficient penalties undermine coverage goals?
- The Congressional Budget Office (CBO) estimates there will be increased costs associated with the increased coverage under health care reform, and also estimates that those costs will be more than offset in the long run by savings and collected assessments. However, costs may rise during initial implementation due to a number of factors. Because the Act does not address how to manage these short-term increases, consideration must be given to minimizing fiscal impact in the near future while meeting the goal of expanding affordable coverage and realizing long-term savings.
- Because eligibility for coverage under a specific provision of health reform may not translate into full participation, thought must be given to properly aligning incentives to promote participation by both individuals and businesses.

## CONCLUSION

States play a critical role in the implementation of health care reform. Arkansas policymakers in the legislative branch and administrative agencies will have the chance to design key processes and systems to best meet the needs of Arkansans. Furthermore, some of the funding sources will require the state to strategically match Arkansas's needs to various provisions in the law.

This overview only touches on some of the most prominent aspects of what is currently known about the law in an effort to inform state policymakers of the leverage points available to impact the health and health care of Arkansas citizens. Additional and more detailed analyses of specific provisions of reform will be forthcoming, including cost and savings estimates and impacts on specific populations.

Note: Information shared in this overview is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules, it will be further interpreted. Details may change during this process.

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### Endnotes

<sup>1</sup> U.S. Census Bureau. "Current Population Survey, Annual Social and Economic Supplement, 2009, United States: Health Insurance: Private Insurance in 2008: Employment-Based Insurance in 2008." *U.S. Census Bureau Current Population Survey (CPS) Table Creator For the Annual Social and Economic Supplement*. U.S. Census Bureau, 2009. Web. 16 July 2010. <[http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)>.

<sup>2</sup> Arkansas Advocates for Children and Families. "Who We Are: Story." *www.ARAdvocates.org*. Arkansas Advocates for Children and Families, July 2010. Web. 7 July 2010. <<http://www.aradvocates.org/story/>>.

<sup>3</sup> Arkansas Advocates for Children and Families. "Who We Are: Story." *www.ARAdvocates.org*. Arkansas Advocates for Children and Families, July 2010. Web. 7 July 2010. <<http://www.aradvocates.org/story/>>.

<sup>4</sup> U.S. Census Bureau. "Current Population Survey, Annual Social and Economic Supplement, 2009, Arkansas: Health Insurance Coverage in 2008: Uninsured." *U.S. Census Bureau Current Population Survey (CPS) Table Creator For the Annual Social and Economic Supplement*. U.S. Census Bureau, 2009. Web. 7 July 2010. <[http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)>. (Staff Note: Number rounded to the nearest 1,000.)

<sup>5</sup> Agency for Healthcare Research and Quality. "Insurance Component State and Metro Area Tables: Table II.A.2 (2008) Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2008." *AHRQ 2008 Medical Expenditure Panel Survey-Insurance Component*. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. n.d. Web. 30 June 2010. <[http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2008/tia2.pdf](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tia2.pdf)>. (Note: "Definitions and descriptions of the methods used for this survey can be found in the Technical Appendix.")

<sup>6</sup> U.S. Census Bureau. "Current Population Survey, Annual Social and Economic Supplement, 2009, United States: Health Insurance Coverage in 2008: Uninsured." *U.S. Census Bureau Current Population Survey (CPS) Table Creator For the Annual Social and Economic Supplement*. U.S. Census Bureau, 2009. Web. 7 July 2010. <[http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)>. (Staff Note: Number rounded to the nearest 1,000,000.)

<sup>7</sup> U.S. Census Bureau. "Current Population Survey, Annual Social and Economic Supplement, 2009, Arkansas: Health Insurance Coverage in 2008: Uninsured." *U.S. Census Bureau Current Population Survey (CPS) Table Creator For the Annual Social and Economic Supplement*. U.S. Census Bureau, 2009. Web. 7 July 2010. <[http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)>. (Staff Note: Number rounded to the nearest 1,000.)

<sup>8</sup> The Democratic Policy Committee. "Special Report: The Benefits of Health Reform In Arkansas." *Democratic Policy Committee*. n.p., 22 June 2010. Web. 30 June 2010. <[http://dpc.senate.gov/docs/sr-111-2-41\\_states/ar.pdf](http://dpc.senate.gov/docs/sr-111-2-41_states/ar.pdf)>. (Note: "HealthReform.gov, accessed 6/15/10; Senate Finance Committee")

<sup>9</sup> Agency for Healthcare Research and Quality. "Insurance Component State and Metro Area Tables: Table II.A.2 (2008) Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2008." *AHRQ 2008 Medical Expenditure Panel Survey-Insurance Component*. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. n.d. Web. 30 June 2010.

<[http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2008/tia2.pdf](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tia2.pdf)>. (Note: "Definitions and descriptions of the methods used for this survey can be found in the Technical Appendix.")

<sup>10</sup> Agency for Healthcare Research and Quality. "Insurance Component State and Metro Area Tables: Table II.A.1 (2008) Number of private-sector establishments by firm size and State: United States, 2008." *AHRQ 2008 Medical Expenditure Panel Survey-Insurance Component*. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. n.d. Web. 30 June 2010. <[http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2008/tia1.pdf](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tia1.pdf)>. (Note: "Definitions and descriptions used for this survey can be found in the Technical Appendix. Totals may not sum exactly because of rounding.") (Staff Note: Number rounded to the nearest 1,000.)

<sup>11</sup> Agency for Healthcare Research and Quality. "Insurance Component State and Metro Area Tables: Table II.A.1 (2008) Number of private-sector establishments by firm size and State: United States, 2008." *AHRQ 2008 Medical Expenditure Panel Survey-Insurance Component*. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. n.d. Web. 30 June 2010. <[http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2008/tia1.pdf](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tia1.pdf)>. (Note: "Definitions and descriptions used for this survey can be found in the Technical Appendix. Totals may not sum exactly because of rounding.") (Staff Note: Number rounded to the nearest 1,000.)

<sup>12</sup> Arkansas Department of Human Services, Division of Medical Services. "Arkansas Medicaid Program Overview, State Fiscal Year 2009: State Fiscal Year 2009 in Review." p.7, *Arkansas Medicaid*. Arkansas Department of Human Services, 2009. Web. 30 June 2010. <<https://www.medicaid.state.ar.us/Download/general/MOB-SFY09.pdf>>.

<sup>13</sup> Arkansas Department of Human Services, Division of Medical Services. "Arkansas Medicaid Program Overview, State Fiscal Year 2009: State Fiscal Year 2009 in Review." p.7, *Arkansas Medicaid*. Arkansas Department of Human Services, 2009. Web. 30 June 2010. <<https://www.medicaid.state.ar.us/Download/general/MOB-SFY09.pdf>>.

<sup>14</sup> U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. "2010 Poverty Guidelines." *www.CMS.gov*. Centers for Medicare & Medicaid Services, 22 Jan. 2010. Web. 16 July 2010. <<https://www.cms.gov/MedicaidEligibility/Downloads/POV10Combo.pdf>>.

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