HEATH CARE REFORM

Position Statement

NASW, Iowa Chapter supports the Patient Protection and 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 health care system for all.

Discussion

- *Private Health Insurance*

Health care in the U.S. is financed through a mix of privately funded health insurance and publicly funded health care programs. Employer-sponsored health insurance accounts for the largest share of privately funded health insurance. Nationwide, in 2007-2008, 57% of Americans received employer-sponsored health insurance while another 5% had self-funded health insurance; in Iowa, the rate was 65% for employer-sponsored insurance and 7% for self-funded insurance ("State health facts", n.d.).

While over half of employers offer health coverage to their employees, until the passage of the Affordable Care Act, there was no legal obligation to do so. Cost is a key factor in the availability of employer-sponsored group-based health insurance. From 2000-2009, premiums doubled in cost, from $2471 to $4824 for individual plans, and from $6438 to $13,375 for family plans (Kaiser Commission on Medicaid and the Uninsured, 2009). Employees with coverage saw their share of premium costs double as well, and most also experienced higher deductibles, larger co-payments, and more restrictive plans. Small businesses have been especially hard hit. They actually pay higher premiums for the same coverage, partly because they have fewer employees among which to distribute the costs, and partly because they have less bargaining power in the health care marketplace. During the past decade, many larger businesses have continued to offer health care coverage while the proportion of small businesses (< 100 employees) offering coverage has fallen (Cannon, 2010). Consequently, in a state such as Iowa, where more than 85% of the businesses are small enterprises with 20 or fewer workers, health care coverage has not been uniformly available to workers. In 2008, about 1/3 of Iowa's small businesses with fewer than 10 employees offered coverage, while 2/3 of those with 10-24 employees offered coverage, and 9/10 of those with 25 or more employees offered coverage (Cannon, 2010).

A small percentage of Americans rely on self-funded, non-group private health insurance. Such individuals may include part-time or newly hired workers who are ineligible for employer plans, self-employed persons, or individuals who cannot afford their share of employer-sponsored plans. For an individual with a poor health status, non-group plans can be more expensive and restrictive in terms of the available coverage. The federal tax system permits such taxpayers to deduct the cost of health insurance premiums if they are self-employed, or to deduct health costs that exceed 7.5% of the taxpayer's adjusted gross income (Kaiser Commission on Medicaid and the Uninsured, 2009). For example, a family in Iowa earning the median income of $61,663 ("Iowa quick facts", 2010) would be able to deduct those health expenses in excess of $4625. While the deduction is laudable, its value to the average family is likely to be limited.

- *Public Health Insurance*

Publicly funded health care programs principally include Medicare, which covers individuals age 65 and older, Medicaid, which serves low-income or medically needy Americans, and the Children's Health Insurance Program (CHIP), which covers uninsured low-income children. Among those under age 65, nationally, 19% were enrolled in public programs in 2008-2009, while in Iowa, 16% were enrolled ("State health facts", n.d.).

Medicare provides several types of coverage – hospital insurance (Part A), outpatient medical services (Part B) and prescription drug coverage (Part D). Because Medicare does not cover the full cost of services,

enrollees are required to pay premiums. Enrollees also have the option of receiving services through private health insurance or traditional Medicare network (Part C).

Medicaid is a *categorical* program that provides health and long-term care coverage to persons in certain eligibility categories -- pregnant women, low-income children and their parents. Medicaid benefits also are available to qualifying individuals with disabilities who have very low incomes, as well as elderly Americans who need long-term nursing care and have expended their personal incomes and assets. Nationally, Medicaid spending in FY 2008 was over $338B, while in Iowa, it was $2.8B ("State health facts", n.d.). Since Iowa ranks fourth in the nation in the percentage of persons over age 65, and second in the nation in the percentage of people age 85 and over (Iowa Insurance Division, 2007), it is perhaps not surprising to note that nearly half of the state's Medicaid spending in FY 2008 -- $1.29B -- was for long-term care.

There is a common misconception that all low-income persons qualify for Medicaid. In fact, because Medicaid is restricted by specific eligibility categories, coverage is not available to single adults under age 65, childless couples, working families without employer coverage, or undocumented persons. A notable exception is the IowaCare program, created in 2005 and set to expire in 2013, which was designed to *partially* address this lack of medical coverage. Adults, aged 19-64, who previously received free, state- or county-funded services were enrolled in IowaCare, and required to pay a monthly premium, in exchange for limited Medicaid coverage at one of two medical institutions. In 2010, the IowaCare Medical Home pilot was created. Four *medical home* sites were designated around the state, and 25,000 enrollees were assigned to an identified medical home for their health care; additional medical homes were included later, so that all participants eventually had a designated medical home ("IowaCare", n.d.). Although the program was originally expected to cover 14,000 adults, by 2012, some 73,000 persons were enrolled (Hatch, 2012).

The Children's Health Insurance Program (CHIP) is a publicly funded program that extends health care coverage to children whose families earn too much to qualify for Medicaid. The majority of CHIP-eligible children live in families where the household income is below 200% of federal poverty guidelines and where there is at least one working adult (Kaiser Commission on Medicaid and the Uninsured, 2010). In Iowa, eligible families with incomes below 300% of poverty select a health plan and pay a monthly premium (up to $40) which allows a child under age 19 to receive medical, hospital, vision, mental health, and dental care (if elected) from a network provider. As a result of such programs, Iowa is one of six states in which the rate of uninsured children is less than 5% (Kaiser Commission on Medicaid and the Uninsured, 2010).

- *Uninsured Americans*

A large number of Americans do not have health care coverage of any kind, either because their employer does not provide it, they cannot afford it themselves, or they are among the working poor whose incomes are too high to allow them to qualify for publicly funded programs. An estimated 49,997,900 non-elderly Americans were uninsured in 2008-2009, including some 309,700 non-elderly Iowans ("State health facts", n.d.).

According to the Kaiser Commission on Medicaid and the Uninsured (2009, pp. 4-10), a number of facts characterize the lives of those who are uninsured: most are adults, particularly young adults who are more likely to have part-time jobs, low-wage jobs, and/or jobs without benefits; 4 out of 5 are working full or part time; 3 out of 5 have no post-secondary education and lack the skills needed for higher-wage occupations; 2 out of 3 are either poor (below 100% FPL) or near poor (100-199% FPL) by federal guidelines; 4 out of 5 are native-born or naturalized citizens; 3 out of 4 have gone without coverage for more than a year; 1 in 2 lack a regular *medical home* for needed care; most experience an erosion of care that over time leads to undiagnosed or silent health problems, lack of preventive care, avoidable hospitalizations, and premature death; many do not get follow up treatments or fill prescriptions because of expected costs; most pay 2-4 times greater costs than insured persons because they are charged the full cost of care rather than the discounted rates negotiated through group health plans; many are forced to pay costs at the time of service, either in cash, negotiated payments or credit card charges, or risk being turned away; and most have few savings or assets, leaving them unable to pay off large medical debts or putting them at risk of financial ruin.

While a seemingly "normal" fact of life, the lack of health care coverage experienced by some Americans ultimately has repercussions for all Americans. It creates a dynamic in which those who are forced to defer or go without primary and preventative care often later turn to expensive emergency care, leaving health care providers, hospitals, and clinics to absorb the *uncompensated* costs. The Kaiser Commission on Medicaid and the Uninsured (2009) estimated that in 2008, while uninsured Americans paid about one-third of their care costs directly, an estimated $57B in uncompensated costs remained. Much of this cost is funded by federal and state tax dollars, paid primarily to hospitals, which utilize the most expensive care and bear disproportionate costs. This results in cost shifting in which local community health centers are left with fewer dollars to assist with primary and preventative care costs for needy persons. Additionally, some of the unreimbursed costs are shifted to those covered by insurance, ultimately leaving fewer persons able to afford insurance. Families USA estimated that the *hidden health tax* on insured families in Iowa was $1,017 in 2008 (McAndrew, 2010). In the past decade (2000-2009), insurance premiums for Iowa families rose 3.2 times faster than median earnings, leaving more struggling to afford the cost of health care.

- *Health Care Reform and implementation*

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 are excluded) access to affordable, quality health care. Various states quickly issued a legal challenge to the Act, arguing that it imposed a health care mandate. However, in 2012, the U.S. Supreme Court ruled that the essential components of the Act were legal, thereby setting in motion its full implementation. The following is a discussion of the implementation process related to key provisions of the law, with attention to the impact in Iowa.

- *Insurance coverage for young adults:* Beginning in 2010, the Affordable Care Act (ACA) extended dependent coverage, allowing young adults, either single or married, to remain on their parents' health insurance until age 26. Data from the U.S Department of Health and Human Services [USDHHS] (October 2012) showed that as of December 2011, some 20,000 young adults in Iowa had gained insurance coverage as a result.

- *Insurance industry restrictions—pre-existing conditions, lifetime limits and the 80/20 rule*: The ACA imposed several important restrictions on insurance companies. One provision restricted insurance companies from denying or dropping coverage for either children or adults based on pre-existing conditions. As a result, the federal government reported that some 326 Iowans previously denied coverage had secured it under a specialized pre-existing condition plan (USDHHS, October 2012). A second provision in the law banned insurers from imposing lifetime limits on coverage, a particular concern for those with chronic illnesses who might otherwise have had to forgo care once the benefit ceiling had been reached. Over 1M Iowa residents have benefited from this provision (USDHHS, October 2012). A third provision, known as the *80/20 rule*, requires health insurers to spend 80% of premium dollars on services and benefits to enrollees, rather than on administrative overhead, executive salaries, or marketing. If they fail to comply, companies must provide consumers, whether individual or group policyholders, with a rebate or premium reduction. For 2012, the government estimated that nationally the 80/20 rule had resulted in over $1B in rebates or lower premiums. In Iowa, some 28,000 privately insured persons received over $1M in rebates (USDHHS, October 2012).

- *Tax credits for small businesses*: The ACA created tax credits to assist small businesses, with fewer than 25 employees and annual wages under $50,000, in providing employee health care coverage. To be eligible for the tax credit, employers must contribute at least 50% of the total premium costs. Analysis by Families USA and Small Business Majority ("Good business sense", 2012) suggested that nationally, 3.2M small businesses were eligible for the tax credit, at an average value of $800 per employee. In Iowa, an estimated 41,000 businesses qualified for the tax credit.

- *Senior drug coverage*: Provisions in the Act were designed to address the skyrocketing cost of prescription drugs for seniors, specifically, the Medicare Part D "donut hole" coverage gap; by 2020, that gap is to be closed entirely. In 2007, more than 8M seniors hit the drug coverage gap (Iowa Insurance Division, 2010), leaving many unable to afford much-needed medicines or having to forgo other necessities. The ACA provides a $250 "donut hole" cost reimbursement, as well as a 50% discount on name-brand and generic drugs. Consequently, Iowa's seniors have saved nearly $54M, an average of $600 per person (USDHHS, October 2012).

- *Home-and-community based services*: The Act expanded Home-and-Community-Based Services (HCBS) through Medicaid. Under this provision, Medicaid-eligible seniors may receive home-care services, allowing them to remain at home rather than prematurely going to nursing homes. The result is a better quality of life for Iowa's elderly and significant cost saving for the state. Toward this end, Iowa established a Community First Choice Option, through which Medicaid programs can offer 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 (National Council for Community Behavioral Healthcare, n.d.).

- *Health insurance exchanges*: To expand health care access for all, the Act provides for the creation of new online, insurance marketplaces, termed "insurance exchanges", which states must implement by January 2014. Exchanges are loosely based on pools, and 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 regarding available subsidies and Medicaid eligibility. To be included in the exchange, qualified plans must offer a set of essential benefits, including emergency, hospital, maternal care, laboratory, mental health, prescription drug, rehabilitative, ambulatory and preventive services (Iowa Insurance Division, n.d.). States may create a state-run exchange, join in a federal-state exchange, or accept a federally-controlled exchange. Federal funding has been provided to assist states in the start-up costs, but all exchanges are required to be self-supporting by January 2015 (Centers for Medicare & Medicaid Services [CMMS], 2012). Governor Brandstad, who has strongly opposed the ACA, reluctantly notified CMMS officials in November 2012 that Iowa would move forward in creating its own exchange ("Branstad", 2012). However, given the late start, it may be difficult for the state to meet the October 2013 deadline for establishing a fully functional exchange. If so, the state may be forced to accept a one-size federal exchange, rather that something tailored to the needs of Iowans.

- *Medicaid expansion*: A central component of the ACA is the expansion of Medicaid coverage to all persons with incomes up to 133% FPL – 138% after the 5% income disregard is included. For Iowa, the expansion would mean that an estimated 123,000 low-income and elderly individuals would receive coverage, including and additonal 73,000 individuals currently covered under the IowaCare program. The expansion is to be phased in over an eight-year period, with the federal share of the cost for new enrollees being 100% initially (2014-2016), and declining to 90% by 2020. Cost is a key concern with the expansion. Several reports, including one from the Iowa Department of Human Services, suggest that the state will reap a net savings in healthcare spending. Financial analysis by the Kaiser Foundation estimated that Iowa would spend approximately $30M less per year (as cited in Leys, November 2012), while the Child and Family Policy Center (Bruner, 2012) concluded that Iowa will save $282.6M over the eight years.

  There are three key issues for Iowa policymakers to consider regarding the expansion (Hatch, 2012). First, if Iowa does not expand Medicaid, the 73,000 persons currently covered under the IowaCare program will lose coverage at the end of 2013; under the Medicaid expansion, most would be covered. Second, as part of its cost reductions, the ACA will lower Medicaid reimbursements to hospitals; this will represent a projected loss of $220M, at the same time that Iowa hospitals can expect higher uncompensated costs related to the care of uncovered persons. Third, because Medicaid coverage includes a mental health component, both state and county budgets would be

positively affected by the expansion, as most mental health costs will be absorbed under Medicaid. In sum, the Medicaid expansion would be a windfall for Iowa, providing coverage for 123,000 new enrollees plus an additional 73,000 current IowaCare recipients, with 90-100% of the cost being absorbed by the federal government.

- *Mandatory health care coverage*: By 2014, all U.S. citizens and legal residents will be required to have health care coverage or face a penalty for non-participation ($695-2085, not to exceed 2.5% of income). In later years of the phase-in, subsidies are to be offered to middle class families ($30,000 - $88,000) to make coverage affordable (USDHHS, n.d.). According to Sen. Harkin's policy advisor, the federal government is expected to enforce this provision through employer verification and IRS tax returns (personal communication, N. Booth, October 15, 2012). One concern is how to monitor compliance of those who do not file tax returns.

  Additionally, by 2014 all businesses with 50 or more employees will be required to offer health insurance for those working 30 or more hours per week. There is a concern that some employers may try to circumvent this requirement by preemptively reducing the size of their workforce, or shifting more employees to part-time work (below 30 hours).

- *Coverage for low-income children*: Provisions in the ACA are intended to maintain and strengthen the state Children's Health Insurance Program (CHIP), also known as HAWK-I (Healthy and Well Kids in Iowa). In 2011, over 75,000 children in Iowa received health care coverage under CHIP ("Iowa: CHIP", 2011). Beginning in fiscal year 2016, all states, including Iowa, will receive a 23 percent increase in the portion of CHIP coverage that the federal government pays; meanwhile, if a state exhausts its federal CHIP allotment, by 2014 tax credits will be available to enroll CHIP-eligible children in comparable coverage through the new insurance exchanges (Families USA, 2010).

- *Support for Community Health Centers*: A key component of the ACA, especially for a rural state such as Iowa, was the expanded funding for community-based health centers. Nearly $40M has been received by the state, for both primary and preventative care, supporting services to an estimated 180,000 Iowans (USDHHS, October 2012).

- *Preventive care and wellness*: The ACA emphasizes on 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 could result in $5.60 in savings (as cited in USDHHS, February 2012). Toward this end, more than $10 million in 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.

- *Workforce development*: 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).

Recommendations

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

- Citizens, educators, health care professionals, social workers, and advocates should be directly involved in framing the policy discussions and implementation strategies related to health care reform in Iowa.
- Policymakers should immediately move forward with the development of a state-run insurance exchange, one that maximizes state autonomy and flexibility, gives careful consideration to the range of benefits and costs associated with various health plans, and provides citizens with comprehensive information needed to make informed choices.
- As part of a strategic decision to save costs and maximize care for the most vulnerable Iowans, state legislators and the Governor should vigorously support the expansion of Medicaid, rather than resort to the more limited IowaCare program.
- The state should work with the federal government to monitor compliance with the employer-mandated coverage, and assess its affect on the workforce patterns and health care access.
- The state should continue to strengthen the Community First Choice Option by offering services to beneficiaries who otherwise would require more costly levels of care.
- 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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