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Hot Topics

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Health Reform Implementation

Outlook for county budgets not yet clear

By Charles Taylor
SENIOR STAFF WRITER

For Hillsborough County, Fla., the glass is either half empty or half full when it comes to implementing the Patient Protection and Affordable Care Act, the new national health care reform law. It depends not upon whom you ask but on several factors yet unknown.

"On one hand, after 2014 our expenditures are going to go down for the indigent population," said David P. Rogoff, Hillsborough County's director of family and aging services, "on the other hand based upon the Medicaid-match formula, we already know that expansion of Medicaid for our county will close to double the number of enrollees in Medicaid."

Since the county pays a share of Medicaid coverage, its outlay for the program will be more than before. Still, Rogoff expects the county to find itself in a better position than it's currently in.

Under the Patient Protection and Affordable Care Act (PPACA), all U.S. citizens and legal residents, with limited exceptions, will be required to have qualifying health insurance coverage by 2014 or pay a penalty. Coverage can be obtained through their employers, Medicare, Medicaid or purchased through state-based health insurance exchanges that the law requires to be created.

Counties will be affected in a number of ways — both as providers or administrators of health care for low-income residents and as employers who provide health benefits to their employees. In 28 states, counties are required to provide medical services to their low-income and chronically ill residents. Twenty-eight states require counties to pay a part of the non-federal shares of Medicaid costs for their resident.

To cover the poor, the PPACA allows states to expand their Medicaid programs to include childless adults who earn up to 133 percent of the federal poverty level, currently $14,400 per year for an individual. By early July, only Connecticut and the District of Columbia had applied for and received permission from the federal government to expand their Medicaid programs immediately, according to the Kaiser Family Foundation.

Hillsborough County currently spends $80 million to $90 million annually to cover indigent health care, which is paid from a sales-tax-funded trust.

"One way or the other, in 2016 when the thing is fully implemented, we're going to be paying less than 80 million per year, which is good for us," Rogoff said. "We would like to see as much covered as possible, but it's still less than 80 million that we're currently spending, so it potentially is a good thing."

Nick Macchione is director of San Diego County, Calif.'s Health and Human Services Agency, which operates a psychiatric hospital for indigent patients. He said it's impossible to know what the budgetary impact to the county will be under the health care reform law, calling any projections "extremely premature." So much, he said, depends on whether the state requires additional local cost sharing.

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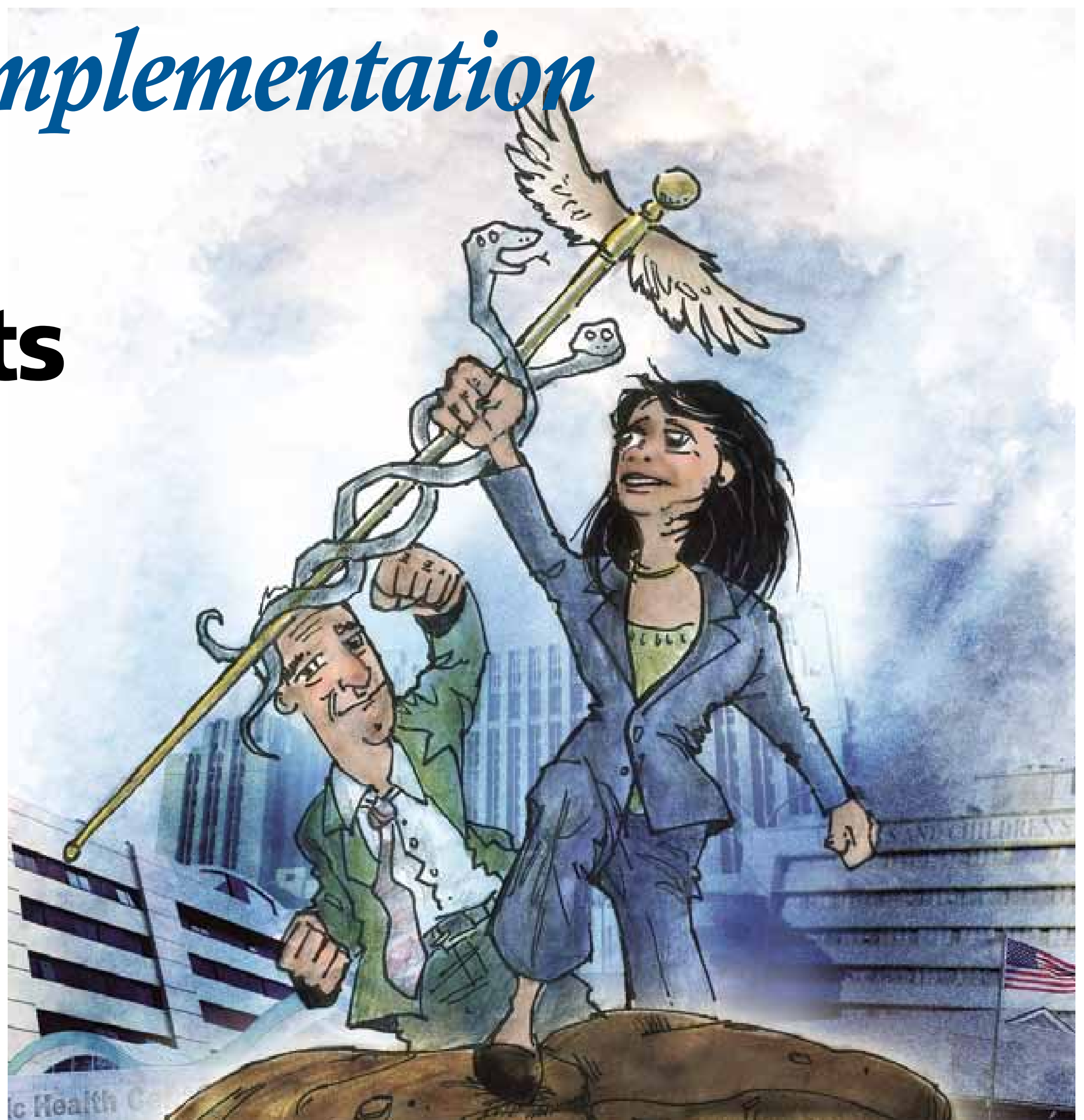

Health Reform Implementation FAQs

Q: How does the health reform law expand health insurance coverage for individuals and how will individuals be able to obtain coverage to meet the law's requirements?

In 2014, all U.S. citizens and legal residents, with a few exceptions, will be required to have qualifying health insurance coverage or they will have to pay a tax penalty.

Individuals can obtain coverage through their employer, Medicare, Medicaid, other federal programs such as veterans' health care, or by purchasing coverage through state-based health insurance exchanges, which are essentially regulated insurance marketplaces.

Medicaid will be expanded in 2014 to include all non-Medicare eligible individuals under age 65 who have incomes up to 133 percent of the federal poverty level (FPL), including adults without children.

This year, individuals with pre-existing medical conditions who have not had health insurance coverage for the past six months will be able to apply for coverage through a temporary high-risk pool program funded by the federal government, called the Pre-existing Condition Insurance Plan (PCIP).

States have the option to run the high-risk pool program themselves, but in states that choose not to run the high-risk pool program, the U.S. Department of Health and Human Services will operate the temporary high-risk pool. The temporary high-risk pool program offers eligible individuals coverage until 2014, when insurers will not be permitted to deny coverage to any individual based on pre-existing health conditions, the state-based health insurance exchanges are established and Medicaid coverage is expanded.

Q: What are the state-based health insurance exchanges and how will they operate?

State-based health insurance exchanges are essentially

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Insurance overhaul affects county policies

By Charlie Ban
Staff Writer

Woodbury County, Iowa counts its low employee turnover as an asset, except when looking at its health insurance costs.

The county is self-insured, and as much as the long tenures of its 450 employees add to the wealth of experience and continuity in its workforce, caring for people throughout their careers can be fiscally brutal, especially when spouses and dependents are added to the mix.

A year ago, a surge in medical care claims had bled Woodbury County's insurance reserves down to less than $300,000, below the state-mandated minimum. New wellness programs and a drop in claims helped the county restock its reserves to $1.5 million, but it's only a matter of time before everyone starts aging together, again.

"Our employees stay for a long time, at least 10 to 25 years, so we have an older age group that requires more medical attention," said county Human Resources Director J.D. Pellersels. "We reached the 'aging' plateau a year or two ago that caused that spike in claims, and we're probably going to see up to a 20 percent increase in retirements over the next four years."

The cost of insuring those workers and retirees will increase with the passage of Patient Protection and Affordable Care Act (PPACA) because coverage will be expanded, but other benefits should offset the increases, primarily the early retiree reinsurance program.

The reinsurance program allows employers to receive reinsurance reimbursement for claims by retirees who are older than 55 but not eligible for Medicare. The reimbursement pays up to 80 percent of claims for medical costs between $15,000 and $90,000.

Woodbury County can now be reimbursed up to $75,000 per person, for each of the 12 retired employees currently eligible.

Ed Gilliland, Woodbury County's insurance consultant, said the reinvestment program is the high point in the health insurance overhaul for the county.

"Any public body in Iowa is going to have a certain number of early retirees on their plan, and most health conditions occur then, so early retirees are a high cost," he said. "When you have a plan like this, a reinvestment program can be a tremendous help."

Gilliland said the overall changes to the county's plan, and many public plans, required by the PPACA will be insignificant.

Employees will no longer be charged copayments for preventative health measures, and the limits on lifetime essential benefit maximums will be removed. Unmarried children of employees will be covered until the end of the year that they turn 26. The PPACA also prohibits insurers from rescinding coverage except in cases of fraud or denying coverage to children under the age of 19 with preexisting conditions.

"You'll see a little cost increase here and a little there," he said. "Nothing really offsets that from a savings perspective; that's why it's important to be proactive in adopting wellness programs and health screenings so people are active in managing their health."

San Mateo County, Calif. Benefits Program Manager Ray Guillen said the changes to his county's fully insured policy will be minimal for the county's approximately 5,500 insured employees.

"There will be very minor changes for most public agencies," he said. "We only had to make three or four adjustments."

San Mateo has just lowered its maximum age of covered children to 24, from 30, and now it will have to increase back to 26.

"We were counting on some of the savings from dropping that age limit," Guillen said. "We'll still save, just not as much."

Pima County, Ariz. Human Resources Director Gwyn Hatcher said most of the PPACA requirements were already satisfied by the county's full-insured policy, which covers more 7,000 employees, plus some spouses and dependants.

"Most of it was already done," she said. "The pre-existing condition limitations, the 90-day waiting period and lifetime maximums were already gone. All we have to do is increase the maximum age one year."

Gilliland said the PPACA requirement that might cause the most headache for counties would be having to report certain information to the U.S. Department of Health and Human Services.

"Everyone's a little nervous about making sure we have that information able to be delivered to the federal government in a timely manner," he said.

Insurance changes you need to know as a county employer

In June 2010, a temporary reinsurance program was established, the Early Retiree Reinsurance Program, and began accepting applications to reimburse employers for some costs associated with providing health insurance to non-Medicare eligible retirees over age 55, as well as their spouses and dependents.

The payments from the reinsurance program are intended to provide financial relief to employers for high-cost claims and to help them maintain health care coverage for early retirees, and the savings gained through the program can help employers lower their health care costs or offer employees reduced premiums. Self-funded plans can apply for reimbursement, and counties that provide coverage to early retirees and meet the other application criteria are eligible to apply.

The temporary program will end in 2014 or sooner if the $5 billion in available funds is exhausted. Applications are processed in the order they are received and are available at: *www.hhs.gov/ociio/regulations/index.html#eerp*.

Also in 2010, the law requires all individual and group health insurance plans that provide coverage to beneficiaries' dependent children to provide them coverage until they reach age 26.

This rule also applies to existing employer plans (plans in existence on March 23, 2010, which are considered grandfathered health plans) unless the adult child has another offer of employer-based coverage. However in 2014, this exception for grandfathered health plans will not apply, and young adults up to age 26 will be able to remain on their parent's employer-sponsored plan even if the young adult is eligible for coverage through their employer.

Additionally, in 2011 a new voluntary, self-funded insurance program for opt-out long-term care insurance, the Community Living Assistance Services and Supports (CLASS) Act, will be available, and employers that choose to participate will be required to implement automatic payroll deductions unless employees opt out of the program. The law also contains new reporting requirements for employers, such as the requirement to report the cost of health insurance coverage on W-2 forms in 2012.

HR Directors and the Health Reform Law Survey Highlights

In mid-June, NACo conducted a survey on how counties are preparing for the changes to employer-sponsored health plans that are mandated through the health reform law, the Patient Protection and Affordable Care Act (PPACA). The survey was sent to 677 county human resource directors. The 129 distinct county responses received were from counties in 35 states.

The majority of county human resource departments that responded to the survey are in some way preparing for the changes required by the health reform law — 43 percent are undertaking some degree of planning; 26 percent are in the initial planning stages.

62 percent of counties are either planning to apply for reimbursement or considering applying for reimbursement through the Early Retiree Reinsurance Program.

58 percent of counties expect the expansion of dependent coverage to young adults up to age 26 will likely result in considerable changes and cost increases to the health plans they offer.

Many counties — 46 percent — are still in the process of determining how they will respond to any increased costs that may be associated with implementing the changes that the health reform law requires, such as whether they will increase beneficiary cost-sharing or increase premiums.

Other significant concerns related to implementing the health reform law:

- additional reporting requirements contained in the law, such as the requirement to report the cost of health insurance coverage on W-2 forms in 2012 — 80 percent
- changes that occur in 2014, such as the employer free-rider penalty and others — 63 percent
- how the excise tax in 2018 on high cost health plans may affect plan offerings — 56 percent
- potential costs associated with seeking legal or other counsel to ensure compliance with the law — 55 percent, and
- potential effects on administrative processes — 52 percent.

States challenge new law's constitutionality

By Timothy Stoltzfus Jost, J.D.
Washington and Lee University

Timothy Stoltzfus Jost, J.D.

On March 23, 2010, President Obama signed into law the landmark Patient Protection and Affordable Care Act (PPACA). That same day, 13 state attorneys general, led by Florida's Bill McCollum, filed a lawsuit challenging the constitutionality of the law. Virginia's attorney general filed a separate challenge. Currently 20 state attorneys general are part of the Florida suit, joined by the National Association of Independent Businesses and two private individuals.

The primary claim of both the Florida and Virginia lawsuits is that PPACA's individual mandate is unconstitutional. As of 2014, PPACA will require all American citizens and legal residents to purchase health insurance or pay a penalty if they:

- do not have health insurance through their employment or through a public program
- have a household income above the income tax filing limit (currently $18,700 for a couple)
- can find an "affordable" basic insurance policy (one costing no more than 8 percent of their household income), and
- do not have a religious objection to insurance.

Uninsured Americans with incomes of less than 400 percent of the poverty level will receive a tax credit to help pay for the insurance.

Both lawsuits claim that the authority granted Congress by Article I of the Constitution, does not include the power to require individuals to purchase a product in a private market against their will. They contend that although Congress can regulate economic activity, it cannot compel individuals to engage in economic transactions who refuse to do so.

Article I of the Constitution grants Congress the power to regulate commerce among the several states. Since the New Deal, the Supreme Court has interpreted this authority expansively to allow Congress to regulate virtually any economic activity. Recent Supreme Court decisions, for example, have upheld the power of Congress to prohibit the cultivation of six marijuana plants for personal medicinal use and to criminalize partial-birth abortions. In two cases decided a decade ago, however, the Court held that the Commerce Power is not unlimited and that Congress cannot regulate activity that is not economic.

PPACA includes extensive congressional findings explaining how the individual mandate affects commerce. Congress found, for example, that the mandate is necessary to keep individuals from refusing to purchase affordable insurance and then once they require expensive medical care shifting the costs of their care to others. If individuals can simply wait until injury or illness strikes before purchasing insurance — which must be available regardless of health status or pre-existing condition — the temptation to game the system may be overwhelming absent a mandate.

Additionally, the Supreme Court has for decades upheld the power of Congress to tax behavior that it wishes to discourage. Taxing the refusal of individuals to purchase insurance, as the statute does, is arguably a proper exercise of the taxation power.

Virginia filed a separate case because it has enacted a state law prohibiting the individual mandate from being imposed on Virginians. If the mandate is found constitutional, however, the Virginia case falls as well. The Constitution's Supremacy Clause precludes states from nullifying federal law.

The Florida case further asserts that the exchange and enforcement provisions of the reform law are an unconstitutional attempt to "commandeer" state government. The Constitution generally prohibits the federal government from "commandeering" state officials to enforce federal law. But PPACA simply invites the states to implement the law. If a state declines, the federal government will implement the program in the state. This will reduce the regulatory power of the state, but not commandeer it.

The Florida lawsuit also claims that the legislation's Medicaid expansions fundamentally alter the Medicaid program and impose an unsustainable financial burden on the states.

PPACA extends Medicaid to all Americans with incomes up to 133 percent of the poverty level. The Medicaid expansions will be fully funded by the federal government for the first three years, but the state share will then gradually increase to 10 percent by 2020.

States will likely face additional Medicaid costs under PPACA. But the Supreme Court has long recognized extensive congressional power to impose conditions on spending programs, and a state can always withdraw from the Medicaid program if it finds it too burdensome.

It is unlikely that the federal courts will address the key issues raised by the state challenges. Under long-standing Supreme Court precedent, a state lacks standing to challenge the constitutionality of a federal law that does not actually injure the state. Moreover, PPACA does not go into effect for four years, and a challenge to it is presently premature. These cases are likely to be dismissed on jurisdictional grounds.

The mandate issue may reappear after 2014, however, when the IRS actually assesses the penalty against an individual who refuses to buy insurance or pay the penalty and the tax assessment is appealed. But by then, the law will be implemented, and the litigation may not have the political impact that it has today.

(Jost holds the Robert L. Willett Family Professorship of Law at Washington and Lee University School of Law.)

Issues remain unresolved in health reform Implementation

While the exact impact of implementing the health reform law remains unclear for counties, the following list highlights some of the key implementation issues which reflect core health reform principles that were endorsed by NACo members.

Enrollment Issues Related to the Expansion of Medicaid

- The health reform law's requirement to expand Medicaid in 2014 raises a number of issues about how specifically these enrollment processes will function and interact with the state-based health insurance exchanges.
- The Department of Health and Human Services' Office of the National Coordinator for Health IT (ONC) has organized an enrollment workgroup to provide guidance on developing standards to facilitate enrollment in federal and state health and human services programs.
- In states where county human services agencies determine whether families are eligible for Medicaid, counties will likely continue to serve significant roles in developing processes to enroll individuals in the appropriate program, but their specific level of involvement is still unknown.
- Also, in the first few years the federal government will cover the costs of care provided to individuals who are newly eligible for Medicaid, but the associated administrative costs will be shared at the current rates by the states, and by counties where applicable.

Issues Related to Health Insurance Exchanges

- States have a range of options regarding the exchanges — in states that elect not to create an exchange the federal government will operate them, and in states that do opt to run the exchanges, they can structure them in a range of ways. According to the National Academy for State Health Policy, the choices a state makes in terms of structuring the exchange will affect the integration of the exchange into overall implementation efforts, including Medicaid and S-CHIP expansion.
- The health reform law allows jail inmates in custody pending disposition of charges to maintain eligibility for private insurance plans available through the exchange, so as state and federal regulators develop relevant rules counties will need to be engaged to take maximum advantage of the potential savings for a portion of their jail population.

Medicaid Provider Rates and Access to Care

- To help support access to care for individuals newly eligible for Medicaid in 2014, the health reform law contains an increase in Medicaid provider reimbursement rates for primary care providers in 2013 and 2014, raising them to Medicare levels. However, whether these increased provider reimbursement rates will be sufficient and what will occur after 2014 regarding the rates remains in question.
- States will continue to exercise

See ISSUES page 5

New law provides funding for local public health activities

In addition to the health reform law establishing a National Prevention, Health Promotion and Public Health Council that will be charged with developing a national prevention and health promotion strategy, there are sources of potential funding for local public health activities.

Prevention and Public Health Fund

The health reform law creates a Prevention and Public Health Fund to expand and support public health prevention and wellness programs and other public health activities.

In FY10, there is $500 million in funding available, with gradual funding increases each year to reach $2 billion in FY15 and totaling to $15 billion in mandatory funding over 10 years.

In mid-June, the first $250 million allocation of the fund for FY10 was dedicated to efforts to strengthen the primary care workforce, and the second $250 million FY10 allocation was directed toward initiatives that support prevention and enhance public health infrastructure.

Community Transformation Grants

The health reform law authorizes the creation of competitive grants to support efforts that reduce chronic disease, address health disparities and build the evidence base for prevention programs.

State and local government agencies (including local health departments), community-based organizations and Indian tribes are eligible to apply for the Community Transformation Grants; rural and frontier areas are targeted for 20 percent of the grants.

Funding for these grants is authorized but not appropriated; funding will come from the Prevention and Public Health Fund or through regular annual congressional appropriations.

Community Health Center Funding

The health reform law contains an $11 billion increase in funding for community health centers over five years.

This funding would provide an opportunity for counties that want to explore opening or expanding primary health care services in underserved areas.

Public Health Workforce Training

The law creates a loan repayment program for individuals receiving public health training; $195 million for FY10 is authorized but not yet appropriated. Funding — as yet determined — will also be available FY11–FY15.

See **FUNDING** *page 7*

California programs could become models for 'bridge to Medicare'

CHALLENGES *from page 1*

Counties across the country — large and small, and with varying local health care infrastructures — are faced with uncertain costs because it's unclear whether the law, as it evolves, will live up to federal expectations. However, this much is clear: between now and 2014, a series of changes will be rolled out that incrementally provide health insurance to some 32 million Americans, mostly low income, who currently lack coverage.

That is, unless the nearly two dozen states who are challenging the law prevail. The first of those lawsuits to reach oral arguments, *Commonwealth of Virginia v. Sebelius*, hinges on that state's contention that Congress exceeded its constitutional authority in requiring that most Americans purchase insurance (See *States challenge new law's constitutionality*, page 3).

Courtesy of San Diego County, Calif.

Public health facilities like the county-operated San Diego County Psychiatric Hospital address indigent residents' mental health needs.

Legal Challenges to Reform Law

"We're saying you can't draft someone into activity so you can regulate him," E. Duncan Getchell Jr., Virginia's solicitor general, said during a July 1 U.S. District Court hearing on the suit, *The New York Times* reported.

"I don't think that there's much of a chance that the law will be invalidated," said Tarrant County, Texas Commissioner Roy Brooks, who chairs NACo's Health Reform Subcommittee. His state is among those challenging the law. "It is in fact now the law of the land, and we all will be governed by it whether our governor likes it or not."

So, states and their localities are proceeding with implementation of the law — or planning for it — lest they be caught flat-footed.

In California, the state was already in the midst of re-negotiating its Medicaid Section 1115 Demonstration Waiver that funds hospitals and indigent care, which expires in August. "They're starting to design it as sort of a bridge to health care reform," said Farrah McDaid Ting, a senior legislative analyst with the California State Association of Counties. States have used waivers to create new health care delivery systems, expand Medicaid to non-eligible populations and provide services not normally covered by Medicaid — just as the PPACA requires.

"The CMS (Center for Medicare and Medicaid Services) is talking about how it could be a model for other states of how they bridge to health care reform," she said.

Macchione said, "Our goal is to build a bridge to 2014 that is as seamless as possible. However, we currently lack details about the state's plans for implementation."

Counties as Employers

Counties as employers have already begun implementing some of the law's provisions. In June, the U.S. Department of Health and Human Services established a reinsurance program to reimburse employers, including counties, for up to 80 percent of the cost of providing health insurance to early retirees between the ages of 55 and 64. And by Sept. 23, insurance plans that cover a beneficiary's dependent child must offer coverage until the child's 26th birthday.

Ed Gilliland, Woodbury County, Iowa's insurance consultant calls the former provision "a tremendous help" in reducing counties' liability — which in some cases is underfunded — to provide health insurance to retirees (see *How insurance overhaul affects county policies*, page 2).

Health Promotion and Disease Prevention

While expanding health insurance coverage, the PPACA also focuses on prevention, an area where counties play a key role through public hospitals and health departments. New federal aid is expected to improve public health and ease the burden on county safety-net providers.

The law provides $15 billion over 10 years for disease prevention, wellness and public health through the Prevention and Public Health Fund, which can be used for such activities as prevention research and health screenings (See *New law provides funding for local public health activities*, above).

Carol Moehrle, president of the National Association of County and City Health Officers (NACCHO), said cooperation between elected county officials, health departments and other county agencies "will be essential to compete for new federal investments" and to leverage them to promote health and disease prevention (See *NACo affiliates weigh in on health reform*, page 5).

Tarrant County's Brooks has advocated for years for a closer relationship between preventative health care and those who provide hospital and specialized care. "I see only good things coming from the health reform act in that particular area, because it encourages a closer collaboration between those two systems," he said.

NACo's Ongoing Role

As health reform implementation progresses, Brooks said NACo will remain engaged and vigilant, and seek out opportunities to influence the roll-out.

"Our constant message is that people from America's counties, county representatives, NACo members must be on the advisory panels, the committees that are set up during the implementation process and charged with the responsibility of writing the rules and regs for this implementation," he said. … "[Counties] are the ones that actually 'do' health care in America, and for us not to be at those various tables is unacceptable and would be shortsighted."

NACo health care affiliates weigh in on health reform implementation

County News asked NACo affiliates in the health care arena to identify their key issues in the implementation of heath care reform, how they plan to work with their county leaders, and how county leaders can support their efforts in implementing reform measures.

Following are their responses.

National Association of County Human Services Administrators (NACHSA)

In many states, county human services agencies determine whether families are eligible for Medicaid. The new health reform law will expand Medicaid to single, low-income individuals. This expansion is a cornerstone of the new law, with an estimated 16 million individuals entering the program in 2014.

NACHSA members are beginning the work with their county boards to ensure a smooth transition administratively to ensure that newly eligible individuals are covered.

The transition, however, won't be simple or easy.

Each state Medicaid program has numerous options, eligibility levels and interactions with other public insurance such as the Child Health Insurance Program. The expansion will add new eligibility layers for county workers and beneficiaries to navigate.

Depending on their income, some newly eligible individuals will be on the cusp of being eligible for subsidies in other plans offered via the health insurance exchanges. Human services officials will need to work with their elected officials to identify eligible residents and simplify the steps to getting them enrolled in the right program.

The new law envisions that many individuals will use the Internet to enroll in health insurance options, including Medicaid. Given the resources and time required to design and launch automated systems, and the unique health needs or personal barriers many human services customers face, counties will continue to offer multiple ways to enroll, including in person, by phone or by mail. Linking and building upon existing systems will be critical to the success of the new law.

In the short term, the federal government will pay 100 percent of the costs of care provided to newly eligible Medicaid individuals. The costs of administering the new law, however, will be shared equally with the states, and in some states, counties.

Working to ensure that county residents receive coverage during a time of unprecedented county budget stress will require the close and innovative collaboration between elected county officials and county human services professionals.

National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)

The Affordable Care Act marks an important beginning for equity in public and private health care for people with mental illnesses, substance use disorders or developmental disabilities. The real work of bringing this groundbreaking law to communities around the country is at hand. Time is of the essence, as are renewed and new collaborations, including important linkages with other state and local government entities and policy leaders, such as NACo's membership.

NACBHDD's members in counties across the nation have developed a plan focused on how the act's implementation can best help millions with behavioral disorders, the majority of whom are served by public sector programs.

According to Leon Evans, immediate past board president of NACBHDD, the plan centers on three key areas: 1) Medicaid changes that provide insurance coverage for community-based care; 2) provision of wraparound services for people with the most serious mental and substance use disorders; and 3) the growth of county-wide facilities that integrate behavioral health and medical health that bring body and brain together to achieve prevention, intervention and recovery.

Achieving these ends will require the development of close working partnerships across county and state government, and also with organizations and groups with whom counties have not worked in the past, from federally qualified health centers, private sector health organizations and accountable care organizations. An accountable care organization is a network of health care providers that band together to provide the full continuum of health care services for patients.

The historical approach of behavioral health to "go it alone" is at an end as, at last, body and brain are brought back together through health reform.

As Ron Manderscheid, executive director of NACBHDD observed, "It has taken more than 60 years for the changes emblematic of the ACA to be realized. That is why we must waste no more time to make that change real for the people we serve. We must act now; we must act with one voice.

"To do otherwise would be to fail the people we have striven so long and so hard to serve: individual of all ages with mental illnesses, substance use disorders or developmental disabilities."

National Association of County Health Facility Administrators (NACHFA)

County long-term care facilities provide the safety net for the most vulnerable citizens in need of nursing home care. The Affordable Care Act has positive provisions with no targeted reductions in skilled nursing facility market basket for FY10–11, extension of the exceptions process for the Medicare Part B therapy cap until December 2010, elimination of Medicare Part D cost-sharing, the CLASS Act and a Government Accountability Office study on the Five Star Quality Rating System.

Other aspects promote greater transparency in ownership, ethics and compliance programs, quality assurance and performance incentives, improvement to the nursing home-comparison website, and tracking and reporting changes for greater staffing accountability. Potential negative provisions include a productivity adjustment to the skilled nursing facility formula used to calculate nursing home reimbursement that will begin in FY 2012 estimated to total $16.6 billion over 10 years.

Like NACo, we believe that access to quality care is critical. High-quality care is inextricably linked to adequate funding, a well-trained, dedicated and stable health professional and paraprofessional workforce, and the direct oversight by local governing boards.

County-owned nursing homes help reduce local health care costs by providing independent and assisted-living options, adult day care services, respite care, outpatient and inpatient rehabilitation, and so much more. All of these services seek to encourage flexibility in care setting and individual choice.

As skilled care facilities, we continue to meet the needs of high-acuity, post-acute care residents. Finally, the CLASS Act (Community Living Assistance Services and Supports Act) puts us one step closer to affordable long-term care insurance.

Long-term care facility administrators will work closely with county officials, keeping them informed of all phases and effects of the progressive implementation of this legislation on current

See **AFFILIATES** *page 7*

Congress must still approve some public health funding

ISSUES *from page 3*

considerable authority over the scope and structure of Medicaid programs and services, so counties that participate in the delivery, administration or financing of Medicaid programs and services will need to remain focused and engaged with their state governments to protect their interests

Funding for Local Public Health Activities

While the health reform law contains a dedicated stream of funding for public health through the Prevention and Public Health Fund as well as a number of grants that local health departments are eligible to apply for, the availability of funding for many of the grants will depend on decisions made through the congressional appropriations process.

Continued Significant Role of Health Care Safety-net Services

• Although the health reform law expands coverage, there still will be uninsured individuals, and county safety-net services will continue to play very important roles as care providers for individuals both with and without coverage.

• Additionally, while the law requires states to target reductions to Medicaid disproportionate share hospital (DSH) payments, it will be important to monitor these efforts to ensure that Medicaid DSH cuts are as well-designed as possible.

NACo answers the who, what, when of health care reform

FAQs *from page 1*

regulated insurance marketplaces where individuals without employer-sponsored health insurance can purchase coverage or small businesses can obtain coverage for their employees.

Beginning in 2014, the exchanges for individuals will be called the American Health Benefit Exchanges and the Small Business Health Options Program, or SHOP. Exchanges will be for small businesses with up to 100 employees to purchase coverage for their employees. States can decide to create a single exchange that serves both individuals and small businesses, or offer coverage options through separate entities, and like the temporary high-risk pool program, the federal government will operate the exchange in states that elect not to run the program.

There will be premium tax credits for individuals and families with incomes between 133 percent and 400 percent FPL based on a sliding income scale to help them purchase coverage through the exchanges, as well as cost-sharing subsidies for individuals and families with incomes of 100 percent to 400 percent FPL based on a sliding income scale to help pay for high out-of-pocket medical costs.

Initially the exchanges will primarily serve individuals purchasing coverage on their own and small employers, although in 2017 states will have the option to allow larger employers to participate.

Q: How will the Medicaid expansion be financed?

When Medicaid is expanded in 2014, the expansion will be fully federally financed from 2014 to 2016, with progressively less federal financing each year until 2020 when the federal medical assistance percentage (FMAP) will cover 90 percent of the costs of covering the newly eligible.

States were given the option to implement the expansion as soon as April 1, 2010; however, states that choose to do so will not receive the higher FMAP rate until Jan. 1, 2014. Also, the law stipulates that states cannot require counties to contribute a greater percentage of the non-federal share of Medicaid than they contributed in 2009; however, this does not apply to the normal administrative FMAP.

Q: Does the health reform law contain provisions that change health insurance coverage rules?

Yes. In the first year after Sept. 23, 2010, all health insurance plans will be forbidden to:

- rescind coverage, except in cases of fraud or abuse
- restrict coverage for children under age 19 based on health conditions (in 2014, this provision will apply to all individuals), and
- implement lifetime caps on benefits.

Q: How does the health reform law affect Medicaid disproportionate share hospital (DSH) payments?

The health reform law does implement DSH reductions. From 2014 to 2019, the law contains a total of $14.1 billion in Medicaid DSH cuts, and the law requires states to target cuts to ensure DSH funds go to areas where they are most needed.

Q: Does the law contain any CMS changes or additional funding to help increase access to providers in underserved areas?

Yes. The National Health Service Corps, which provides scholarships and loan repayments for medical professionals who serve for a specified number of years in a Health Professional Shortage Area, is permanently reauthorized through the law, and funding for the program is enhanced to help bring an estimated 15,000 primary care providers to areas where there is a shortage of health care providers.

Also, the law provides scholarships and loans for training programs, authorizes funding for teaching health centers that expand or establish new primary care residency programs and in 2010, the National Healthcare Workforce Commission will be created to develop a national health care workforce strategy.

There will also be temporary increases in Medicaid provider payment rates — in 2013 and 2014, Medicaid payments for primary care services will be increased to match Medicare payment levels, and this temporary increase will be fully federally financed.

Q: Does the health reform law contain initiatives that are designed to improve Medicare, Medicaid and the Children's Health Insurance Program (CHIP)?

Yes. The health reform law authorizes the creation of a Center for Medicare and Medicaid Innovation. This unit within the Centers for Medicare and Medicaid Services (CMS) will be responsible for coordinating pilot and demonstration projects for payment and service delivery models to improve the efficiency and quality of Medicare, Medicaid and Children's Health Insurance Program (CHIP).

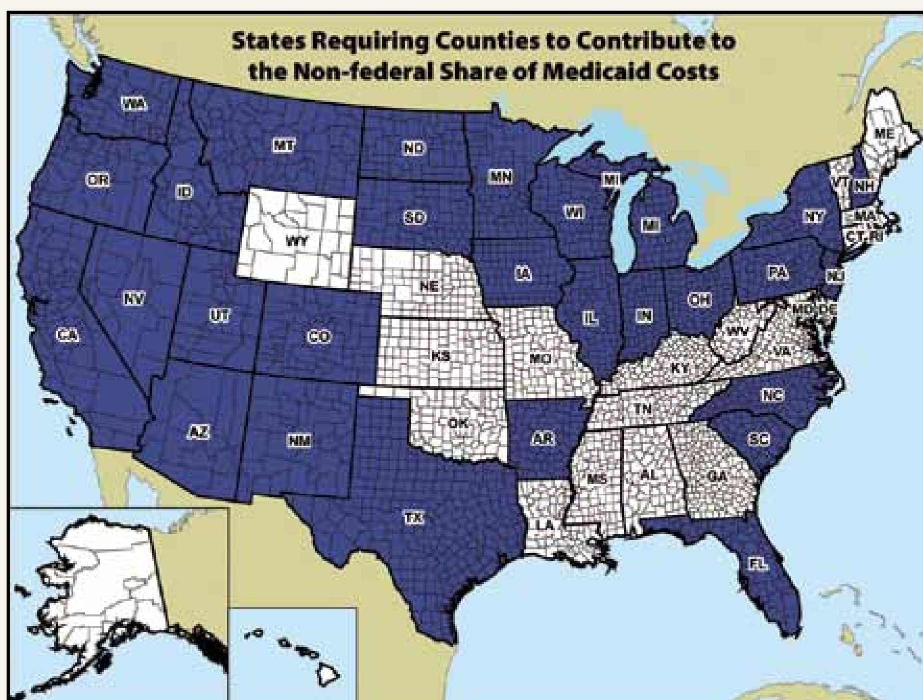
Also, for individuals who are eligible for both Medicare and Medicaid (often referred to as "dual eligibles"), the law creates the Federal Coordinated Health Care Office within the CMS. This office will be charged with improving care coordination for dually eligible individuals to increase their access to quality health care. There will also be new Medicaid demonstration projects designed to improve care coordination and payment methods, and the law also extends the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016.

Q: What other provisions in the health reform law may be of interest to county officials?

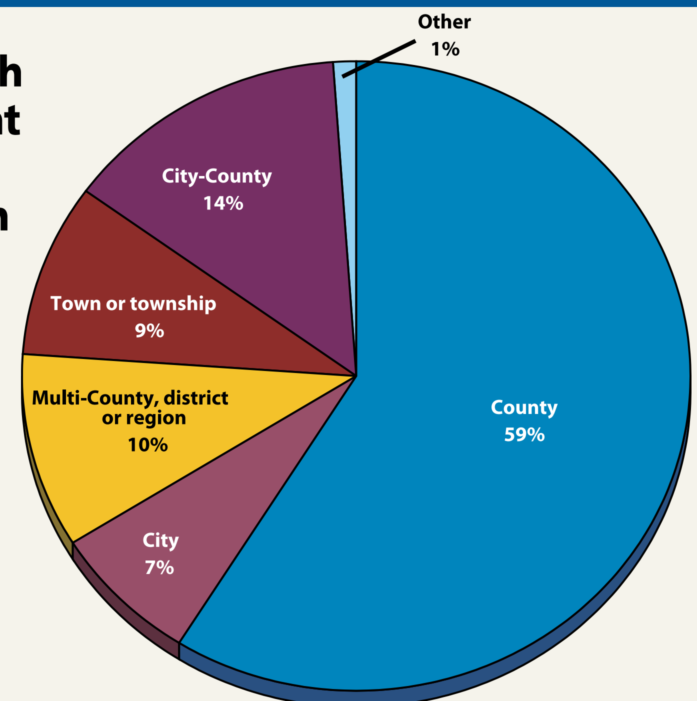
In 2010, there are additional requirements for nonprofit hospitals to provide a minimum level of charity care to justify their tax exemptions, as well as conduct and implement a community health needs assessment in coordination with public health experts and community leaders. These new requirements will be enforced through a $50,000 annual fee for noncompliance, and county officials can help play a role in these efforts to hold nonprofit hospitals accountable to ensure the safety net burden is shared.

Also, in 2011 the law requires chain restaurants and food sold from vending machines to provide information about each item's nutritional content. Regulations regarding these requirements are expected in 2011 and will further outline the role that county officials may serve in implementing this provision of the law.

Some Health Care Stats on Counties



Local Health Department Type of Jurisdiction



Source: National Association of City and County Health Officials National Profile of Local Health Departments, 2005

Collaboration needed to compete for new federal dollars

AFFILIATES *from page 5*

and future county nursing home residents. Collaboration will seek to maximize the benefits of health reform and overcome more negative provisions at the local level.

National Association of County & City Health Officials (NACCHO)

The Affordable Care Act includes an unprecedented emphasis on prevention and public health. Areas of particular interest to local health officials and their county elected officials are:

- expanded coverage for preventive services in private health insurance, Medicare and Medicaid, based on scientific evidence
- a National Prevention Strategy that will define the nation's most pressing health issues and recommend the most effective and achievable approaches for improving the nation's health
- a mandatory $15 billion federal investment over 10 years in prevention, wellness and public health through a Prevention and Public Health Fund for a variety of existing and new programs
- uniform federal menu labeling requirements for chain restaurants with regulations on implementation issued by FDA in March 2011
- $11 billion over five years in new funding for community health centers, for which eligible counties can apply alone or in partnership with nonprofit federally qualified health centers

Despite financial challenges in nearly every county, key priorities for county elected officials include:

- recognizing that health and high quality of life are paramount public safety issues essential for a prosperous and competitive community
- strong representation and advocacy with federal elected officials to maintain and expand funding and policies over time to keep local health department infrastructure competitive with high quality staff, necessary technology and training
- promote health by making use of the unique legal authorities and policy-making functions of counties, such as ordinances limiting tobacco use, land use decisions that encourage physical activity, such as installing sidewalks and bike paths, and provision of healthy foods in school cafeterias, and
- recognizing that the act will not insure everyone, and county officials will still need to ensure a local safety net of which their local health department is a part.

NACCHO President Carol Moehrle said, "Collaboration between county elected officials, health departments, and other county agencies will be essential to compete for new federal investments and leverage them successfully to create conditions in counties where the healthiest choice — to exercise, to practice good nutrition, to avoid tobacco use — can also become the easiest choice for everyone."

(For more information on the affiliates mentioned in this report, go to NACo's website — www.naco.org — and select About NACo ▶ Affiliates and State Associations.)

Grants available for disease surveillance, health promotion and diabetes prevention

FUNDING *from page 4*

The law also establishes allied health recruitment and retention programs and mid-career training programs for public health professionals; $60 million is authorized but not appropriated for FY10 for both programs, as well as necessary sums for FY11 through FY15 for training for mid-career public and allied health professionals.

Epidemiology-Laboratory Capacity Grants

The law establishes the Epidemiology and Laboratory Capacity Grant Program to award grants to eligible entities — such as state, local and tribal health departments — for efforts to improve surveillance for and response to infectious diseases and other conditions of public health importance.

Currently, $190 million has been authorized but not yet appropriated.

Healthy Aging, Living Well; Evaluation of Community-based Prevention; and Wellness

Competitive grants to state, local and tribal health departments to carry out five-year pilot programs to provide public health community interventions, screenings and when necessary, clinical referrals for individuals 55–64 years old.

Grantees must design a strategy to improve the health status of this population and include an evaluation component in their activities.

Funding for these grants is authorized but not appropriated.

Grants to Promote Positive Health Behaviors and Outcomes

Competitive grants will be offered through the Centers for Disease Control and Prevention to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

Eligible entities include public or nonprofit private entities, including states' or counties' public health departments, free health clinics, hospitals, or federally qualified health centers.

Funding for these grants is authorized but not appropriated.

National Diabetes Prevention Program

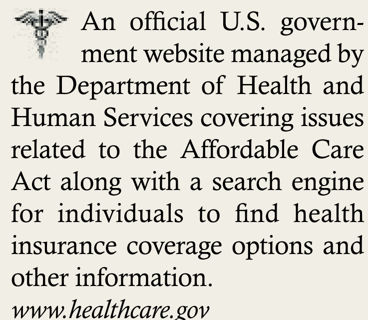
National Diabetes Prevention Program targeted for adults at high risk for the disease to be established through the Centers for Disease Control and Prevention.

Eligible entities include state and local health departments, tribal organizations, national networks of community-based nonprofits focused on health and wellbeing, and academic institutions.

The program is authorized from FY10 to FY14, but funding is not appropriated.

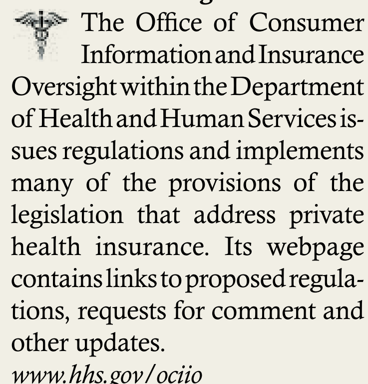
Health Reform Implementation Resource List

U.S. Government Resources



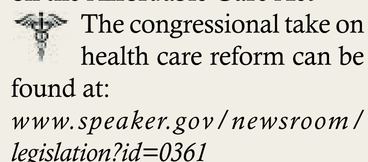
An official U.S. government website managed by the Department of Health and Human Services covering issues related to the Affordable Care Act along with a search engine for individuals to find health insurance coverage options and other information.
www.healthcare.gov

Department of Health and Human Services' Office of Consumer Information and Insurance Oversight



The Office of Consumer Information and Insurance Oversight within the Department of Health and Human Services issues regulations and implements many of the provisions of the legislation that address private health insurance. Its webpage contains links to proposed regulations, requests for comment and other updates.
www.hhs.gov/ociio

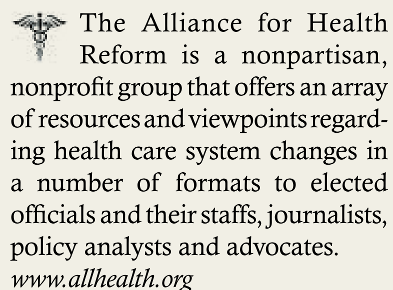
U.S. House of Representatives and U.S. Senate Information on the Affordable Care Act



The congressional take on health care reform can be found at:
www.speaker.gov/newsroom/legislation?id=0361
http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm

Other Resources

Alliance for Health Reform

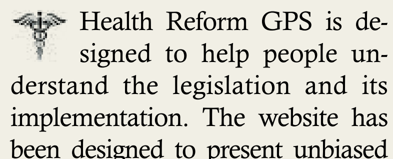


The Alliance for Health Reform is a nonpartisan, nonprofit group that offers an array of resources and viewpoints regarding health care system changes in a number of formats to elected officials and their staffs, journalists, policy analysts and advocates.
www.allhealth.org

The Commonwealth Fund

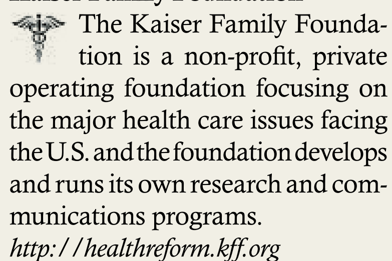
The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable. The fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy.
www.commonwealthfund.org/Health-Reform.aspx

Health Reform GPS



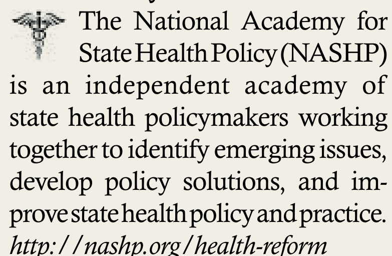
Health Reform GPS is designed to help people understand the legislation and its implementation. The website has been designed to present unbiased information about the health reform legislation while also setting forth implementation issues that may arise from a full range of stakeholder views on any particular topic. It is sponsored by the Robert Wood Johnson Foundation and the Hirsh Health Law and Policy Program of the George Washington University School of Public Health and Health Services.
www.healthreformgps.org/

Kaiser Family Foundation



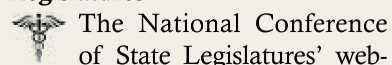
The Kaiser Family Foundation is a non-profit, private operating foundation focusing on the major health care issues facing the U.S. and the foundation develops and runs its own research and communications programs.
http://healthreform.kff.org

National Academy for State Health Policy



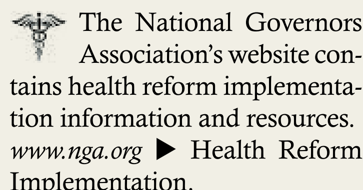
The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.
http://nashp.org/health-reform

National Conference of State Legislatures



The National Conference of State Legislatures' website contains health reform implementation information and resources.
www.ncsl.org ▶ Health Reform.

National Governors Association



The National Governors Association's website contains health reform implementation information and resources.
www.nga.org ▶ Health Reform Implementation.

NACo Affiliates

National Association of County & City Health Officials (NACCHO)
www.naccho.org/advocacy/health-reform.cfm

National Association of County Human Services Administrators (NACHSA)
www.nachsa.org

National Association of County Behavioral Health & Developmental Disability Directors (NACBHDD)
www.nacbhdd.org

National Association of Local Boards of Health (NALBOH)
www.nalboh.org