

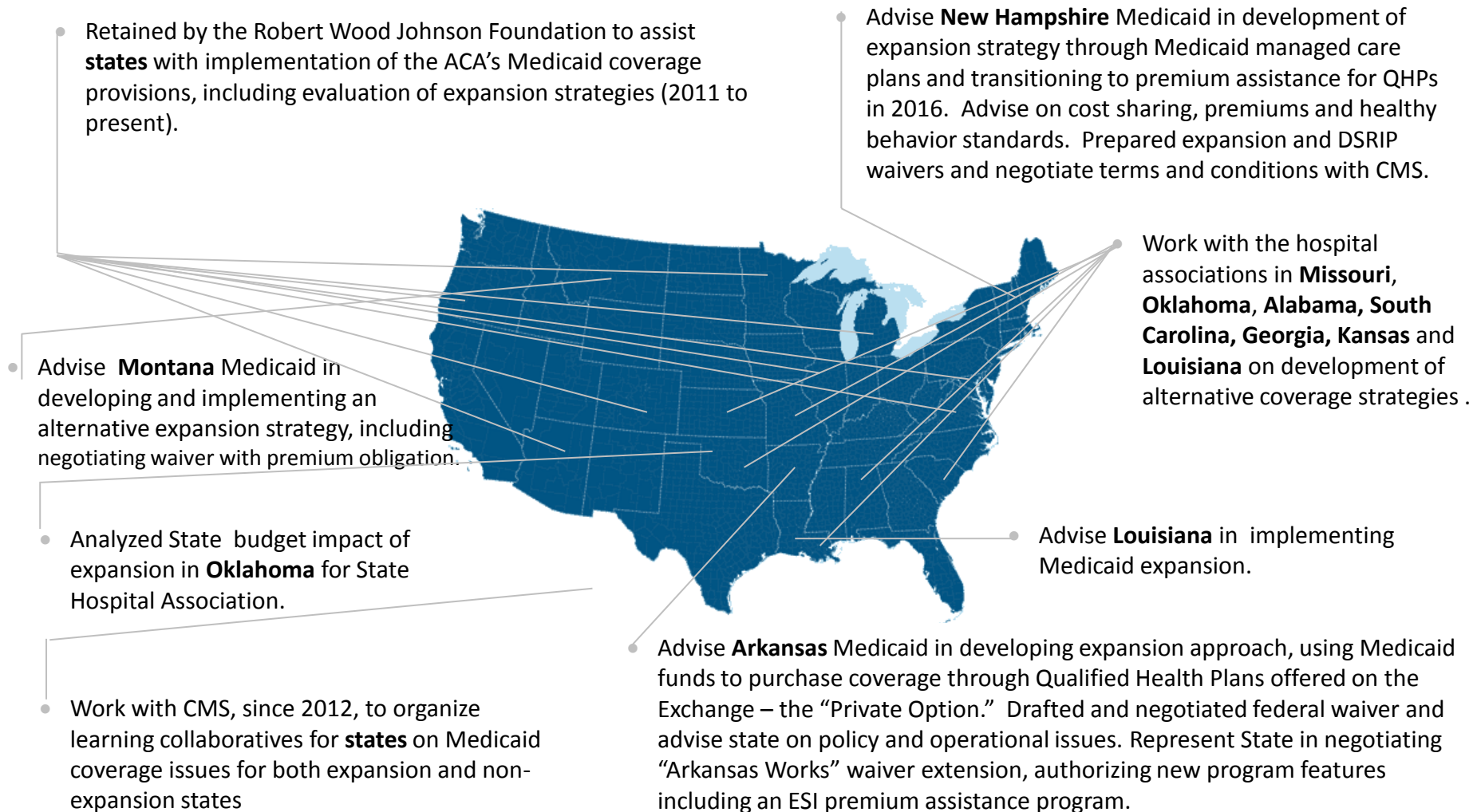
Medicaid and the Coverage Gap: Overview of Options and Economics

Prepared for the Idaho Legislative Task Force

August 29, 2016

Manatt's Medicaid Coverage Expertise

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Link to Oklahoma State Budget Impact Report:

<http://www.okoha.com/Images/OHADocs/Transforming%20Health%20Care/Estimated%20State%20Budget%20Impact%20of%20SoonerCare%20Expansion%20FINAL.PDF>

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Agenda

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- Coverage Options
- The Economics

Coverage Options

Medicaid Coverage Decisions Are In States' Hands

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31 States and D.C. Have Expanded Medicaid

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Medicaid expansion decisions as of August 2016. Arizona, Arkansas, New Hampshire, and Ohio have pending waivers to modify their existing expansions.

Why do States Pursue Alternative Coverage Models?

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Tailor Medicaid coverage to their State's healthcare landscape



Achieve a specific policy objective, including:

- Encourage personal responsibility
- Promote healthy behaviors and wellness
- Align Medicaid coverage with the Marketplace or employer-sponsored insurance



Increase support for coverage expansion in State

Features of Alternative Coverage Models

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Expansion Feature		State Examples
	Premiums	Indiana, Iowa, Michigan, Montana (requires a waiver)
	Cost Sharing	Indiana (waiver to test \$25 co-pay for repeated non-emergent use of ED; states may impose some cost sharing without a waiver)
	Health Savings-Like Accounts	Indiana, Michigan
	Healthy Behavior Incentives	Indiana, Iowa, Michigan
	Connecting to Work	Indiana, New Hampshire (referrals only; may <i>not</i> condition coverage on work/training requirement)
	Benefits & Coverage	Iowa, Indiana (waivers of non-emergency medical transportation)
	Premium Assistance for QHPs	Arkansas, New Hampshire (if mandatory, requires a waiver)
	Premium Assistance for Employer Sponsored Insurance (ESI)	Indiana, New Hampshire

Premiums



Federal Medicaid law bars premiums for individuals below 150% FPL without a waiver. CMS has granted waivers permitting states to charge expansion adults premiums up to 2% of household income.

State	Premiums by income level	Penalties for Non-Payment
Indiana	<ul style="list-style-type: none">• ≤5% FPL: minimum of \$1• >5% FPL: 2% of household income	<ul style="list-style-type: none">• <100% FPL: Premium payment not required. Those who pay premiums receive enhanced benefit package (addition of dental and vision)• >100% FPL: After 60-day grace period, disenrollment with six-month lock-out
Iowa	<ul style="list-style-type: none">• 50%-100% FPL: Up to \$5 per month• 100%-138% FPL: Up to \$10 per month	<ul style="list-style-type: none">• 50%-100% FPL: Payment not a condition of eligibility• 100%-138% FPL: May be disenrolled unless attest to hardship
Michigan	<ul style="list-style-type: none">• 100%-138% FPL: 2% of income	<ul style="list-style-type: none">• Non-payment results in debt that can be collected by managed care plan or State
Montana	<ul style="list-style-type: none">• 50%-138% FPL: 2% of income	<ul style="list-style-type: none">• Non-payment results in a debt to the State• 100%-138% FPL: After 90-day grace period, disenrollment. May re-enroll upon payment of premium owed or upon Department of Revenue quarterly debt assessment without repayment

Cost Sharing

- States may impose co-payments on most Medicaid-covered benefits without a waiver (some populations exempted)
- Authority to waive co-payment caps is limited

INDIANA

- Received a two year cost sharing waiver to test a \$25 co-pay for repeated non-emergent use of ED
- New adults with incomes <100% FPL who do not contribute to Indiana's HSA program are also subject to maximum permitted cost sharing for other services

Health Savings-Like Accounts (HSAs)

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- Some states are providing Health Savings-like Accounts (HSAs) for newly eligible beneficiaries.
- HSAs are not specifically addressed in federal law; contributions generally would be considered premiums.

INDIANA

- “POWER” accounts are jointly funded by beneficiary premiums and Medicaid funds
- Medicaid funds the difference between the beneficiary’s monthly premiums and the full \$2,500 POWER account value

MICHIGAN

- Enrollees with incomes > 100% FPL pay monthly premiums and co-pays into “MI Health Account” and do not pay co-pays at point of service*
- Enrollee participation in healthy behaviors can reduce premium and co-pay obligations

*Exceptions are certain high-cost services carved out of Medicaid MCO coverage and paid through FFS Medicaid.

Healthy Behavior Incentives

Some states are forgiving co-pays or premiums for beneficiaries who fulfill certain healthy behaviors. Depending on design, a waiver might be needed.

Examples of “healthy behaviors”:

- ☐ Completion of a health risk assessment
- ☐ Completion of a preventive annual health visit
- ☐ Participation in a disease management program

MICHIGAN

- Individuals >100 - 138% FPL who complete healthy behaviors:
 - Receive a 50% reduction in required contributions to Health Savings-like Accounts, and
 - Are eligible for reduced co-pays
- Individuals ≤100% FPL who complete healthy behaviors:
 - Receive a \$50 gift card, and
 - Are eligible for reduced co-pays

Premium Assistance for ESI and QHPs

Some states are using “premium assistance” to purchase employer sponsored insurance (ESI) or qualified health plans (QHPs) for Medicaid enrollees.

- State covers cost of premiums for ESI or QHP plan
- State wraps missing benefits and cost-sharing above Medicaid limits
- Premium assistance must be cost effective for State

ARKANSAS

Premium Assistance for QHPs

- New adults enrolled in Marketplace QHPs
- State Insurance Department requires QHPs to offer at least one plan that meets State’s standard benefit design
- Beneficiaries may only select among lower cost QHPs
- Medicaid covers costs of premiums and deductibles
- Medically frail individuals excluded

Sustaining Expansion

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Savings from Expanded Coverage*



Provider and Health Plan Financing



Delivery System Reform



Sunset Provision

“A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.”

CMS Guidance, 12/10/2012

*Savings from new coverage are discussed in the companion presentation

Flexibility to Phase-in Implementation

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States decide when to implement new coverage



No deadline to implement



Federal matching rate is linked to calendar year and declines over time regardless of when a state implements



Many factors affect timing of implementation



Existing versus new delivery system



IT changes required to implement state's model



Waiver versus State Plan Amendment (SPA)

The Economics

The New Adult Group and Enhanced Federal Matching Rate 17

New Adult Group in Idaho (Ages 19-64)



- Childless adults with incomes below 138% FPL
- Parents with incomes from 35% FPL up to 138% FPL

35% FPL: \$7,056 per year for a family of 3
138% FPL: \$16,394 per year for a single adult; \$27,821 per year for a family of 3

YEAR	ENHANCED FEDERAL MATCHING RATE, NEWLY ELIGIBLE ADULTS UP TO 138% FPL*	
	State Share	Federal Share
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

Idaho's 2016 Standard Federal Matching Rate: **71 %**

*Newly Eligible enhanced federal matching rates are mandated in Section 1905(y)(1) of the Affordable Care Act

Early Results Across Expansion States

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Sharp Drops in Uninsured Rates

- National surveys show all states experiencing ACA-related drops in uninsured rate, but expansion states had a 37.7% decline, as compared to 9% in non-expansion states.

Stabilization of Rural Hospitals

- As of Sept. 2015, non-expansion states had nearly double the percent of rural hospitals at risk of closure as compared to expansion states.

Sharp Drops in Hospital Uncompensated Care Costs

- Hospital uncompensated care costs were an estimated \$7.4 billion (21%) less in 2014 than they would have been without ACA expansions.
- Ascension hospitals in expansion states saw 40% decrease in uncompensated care in 2014, compared to 6% decrease in non-expansion states.
- In Arkansas, \$1.1 billion reduction in hospital uncompensated care costs is expected between 2017-2021.

Economic Benefits to State Budgets

- Arkansas projects a net positive impact on the state budget of \$637 million from 2017 – 2021.
- Kentucky has had a \$300 million net positive impact on the State General Fund in two years and projects \$820 million in savings from 2014-2021.
- New Mexico's expansion expected to create \$316 million surplus for State's General Fund between 2014 – 2021.

Impact on State Budgets

1 State Costs

- Coverage for newly eligible adults
- Increased administration

2 State Savings

- Accessing enhanced federal matching funds for some previously enrolled Medicaid beneficiaries now eligible for the new adult group
- Replacing State General Funds that have historically supported programs and services for the uninsured with Medicaid funds

3 Revenue Gains

- As a result of expansion, revenue generated from plan and provider assessments increases

4 Redeployed State DSH Funds

- As federal Disproportionate Share Hospital (DSH) dollars decrease, state matching dollars are freed up and can be redeployed to cover new adults

Savings From Accessing Enhanced Federal Matching Funds

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Categories	
Medically Needy	State receives enhanced federal match when adults - who previously would have had to “spend down” to a state’s medically needy eligibility threshold - enroll in Medicaid through the new adult group.
Disabled	With expansion, some individuals who previously would have needed a disability determination to qualify for Medicaid may enroll in the new adult group based on income alone. This leads to fewer disability determinations (resulting in administrative savings in the short term), and fewer individuals in disability groups (long term savings).
Pregnant Women	Women enrolled in the new adult group who become pregnant remain in the new adult group; States continue to receive enhanced federal match. Note: no savings for women who are pregnant at the time of application or renewal.
Family Planning Programs	States often cover individuals not otherwise eligible for Medicaid in family planning programs. With expansion, States replace family planning match (90% for family planning services; regular match for other related services) with newly eligible match.
Breast & Cervical Cancer Treatment Program	States cover certain adults with breast or cervical cancer through Breast and Cervical Cancer Treatment Program at the CHIP match rate. With expansion, enrollees with incomes < 138% FPL qualify for coverage through the new adult group.
Waiver Programs	States that have used Medicaid waivers to cover adults prior to expansion (and received regular match), may be able to transition these individuals into the new adult group and thereby access enhanced match.

Savings From Replacing General Funds with Medicaid Funds

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Categories	
Mental/ Behavioral Health	State and local funding supports mental health and substance abuse treatment for uninsured individuals. With expansion, previously uninsured individuals are now eligible for Medicaid in the new adult group; states receive Medicaid funding.
Inmates	Medicaid covers inpatient costs of prisoners who would otherwise be eligible for Medicaid. With expansion, most prisoners will be Medicaid eligible, resulting in savings to state corrections budgets related to inpatient care. Medicaid expansion also permits states to provide Medicaid coverage immediately upon release.
Public Health	State and local funding supports health services for uninsured individuals (e.g. tobacco cessation programs, immunizations). With expansion, previously uninsured individuals are eligible for Medicaid in the new adult group; states receive Medicaid funding.
Other State Programs Targeted to Uninsured	Where states fund other programs that provide healthcare services to the uninsured, with expansion, previously uninsured individuals are now eligible for Medicaid in the new adult group; states receive Medicaid funding.

Sources:

Deborah Bachrach, Patricia Boozang, Avi Herring and Dori Glanz Reyneri. States Expanding Medicaid See Significant Budget Savings and Revenue Gains. RWJF, State Health Reform Assistance Network. March 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

Burs, Marguerite and Dague, Laura. The Effect of Expanding Medicaid Eligibility on Supplementary Security Income Program Participation (March 22, 2016). Available at SSRN: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2753784

Potential Savings for Counties

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Law Enforcement



**Homelessness
Services**



**Hospital
Uncompensated Care**



**Mental Health &
Substance Abuse Services**

Data Emerging on Broader Economic Impacts

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Economic Growth
State GDP



Indirect Tax Revenues
Income, Sales, Use Taxes



Earnings
Health Care Workers,
Average Household



Employment
Health Care Workers,
Indirect Workers

Colorado Health Foundation Report: <http://www.coloradohealth.org/WorkArea/DownloadAsset.aspx?id=8222>

University of New Mexico Report: http://bber.unm.edu/media/publications/Medicaid_Expansion_Final2116R.pdf

National Bureau of Economic Research Report on Job Impacts: <http://www.nber.org/papers/w22540>

Emerging Data on Access and Outcome Improvements

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Studies of Expansion States

- ✓ **Increased use of preventive care and regular care for chronic conditions**
- ✓ **Increased medication adherence and access to medications**
- ✓ **Increased access to diabetes screenings and regular care for chronic conditions**
- ✓ **Reduced emergency department visits**
- ✓ **Reduced mortality***

Early Michigan Experience

- Percentage of Primary Care Providers (PCPs) accepting new Medicaid patients rose from 49% to 55%
- Median wait times for new appointments were <2 weeks
- Healthy Michigan enrollees participated in health risk assessments more than twice as often as enrollees of typical commercial plan
- More than half of expansion enrollees had visited PCP as of Feb. 2015

*Evidence is from pre-ACA expansions of Medicaid

Sources: State of Michigan, "Healthy Michigan Plan—Risk Assessment Report" (July 2015); State Health Reform Assistance Network. "Medicaid Expansion: Just the Facts". RWJ State Health Reform Assistance Network. April 2016. Statenetwork.org/wp-content/uploads/2016/03/State-Network-GMMB-Manatt-Medicaid-Expansion-Just-the-Facts-April-2016.pdf; Sommers, Benjamin et. al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, JAMA, Aug. 2016 <http://archinte.jamanetwork.com/article.aspx?articleid=2542420>

Understanding and Refining Enrollment Projections

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Why has actual enrollment exceeded projections in many states?

- **Variation in survey-based estimates of the eligible population**
 - For example, Census Bureau tables typically use a family definition of income, rather than a health insurance unit definition that better reflects how income is counted for Medicaid eligibility purposes
- **Lack of clarity on best assumptions for uninsured take-up and crowd out**
 - Estimates for pre-ACA expansions varied substantially
- **Delayed renewals may have played a role in keeping enrollment artificially high**
 - 36 states received waivers from CMS for this purpose and in many cases the date of completion extended well into 2015

Understanding and Refining Enrollment Projections

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What is the evidence to date regarding the “woodwork” or “welcome-mat” effect?

- There has been a woodwork effect as a result of the ACA, but on average it appears similar between expansion and non-expansion states since January 2014
- In four states that expanded after January 2014, none have shown a substantial increase in previously eligible enrollment and two have shown a decrease

What is a reasonable expectation of take-up for the new adult group?

- In a majority of expansion states, enrollment increases are consistent with the high end of take-up seen under pre-ACA Medicaid expansions
- May be useful to focus on experience in recent expansion states
- Policies regarding transition of existing populations (e.g., SNAP) play an important role

Thank You!

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