

The logo for the Washington State Health Care Authority. It features the text "Washington State Health Care Authority" in a dark blue, sans-serif font. The word "Authority" is significantly larger than the other words. A thick, dark red swoosh underline starts under the 'A' in "Authority", arches over the top of the word, and ends under the 'y'.

2014 Medicaid Expansion Update

Joint Legislative Select Committee on Health Reform Implementation
October 17, 2012

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Today's Update

The Affordable Care Act Coverage Options

Estimates of New Medicaid Enrollees

2013 Legislative Session Discussion

Timeline of Key Tasks

The ACA Coverage Options

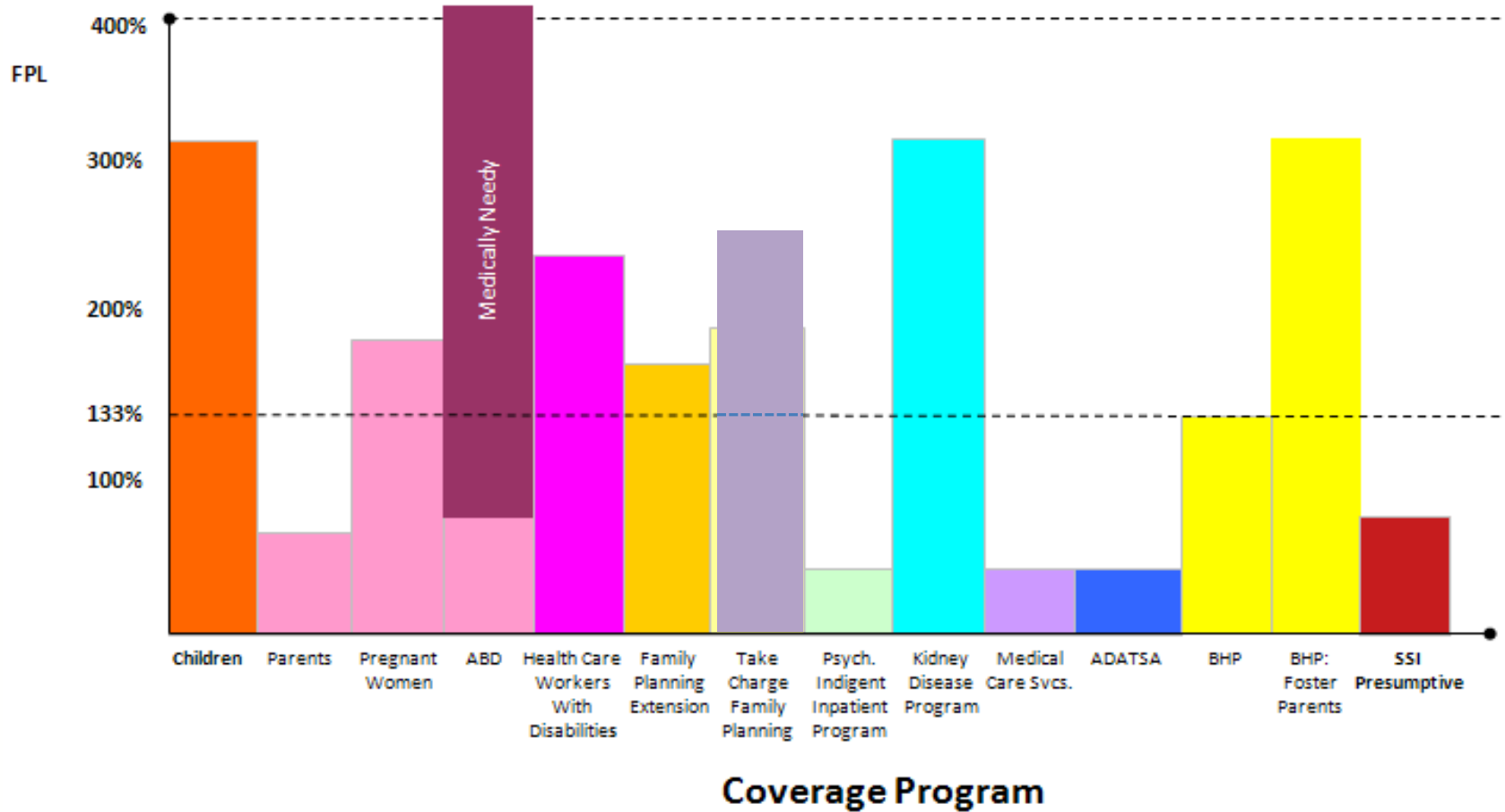
Today's Medicaid Covers...

- Children – 300% FPL;
- Pregnant women – 185% FPL;
- Families (parent & caretaker relatives) – ~40% FPL;
- Aged, blind, disabled adults - ~75% FPL

- Childless adults *may* be served in optional programs (e.g., Basic Health, Medical Care Services, ADATSA etc.)

- Today, Washington's Medicaid/CHIP programs cover ~1.16 million lives

Today's Washington State Landscape



Medicaid Expansion in 2014

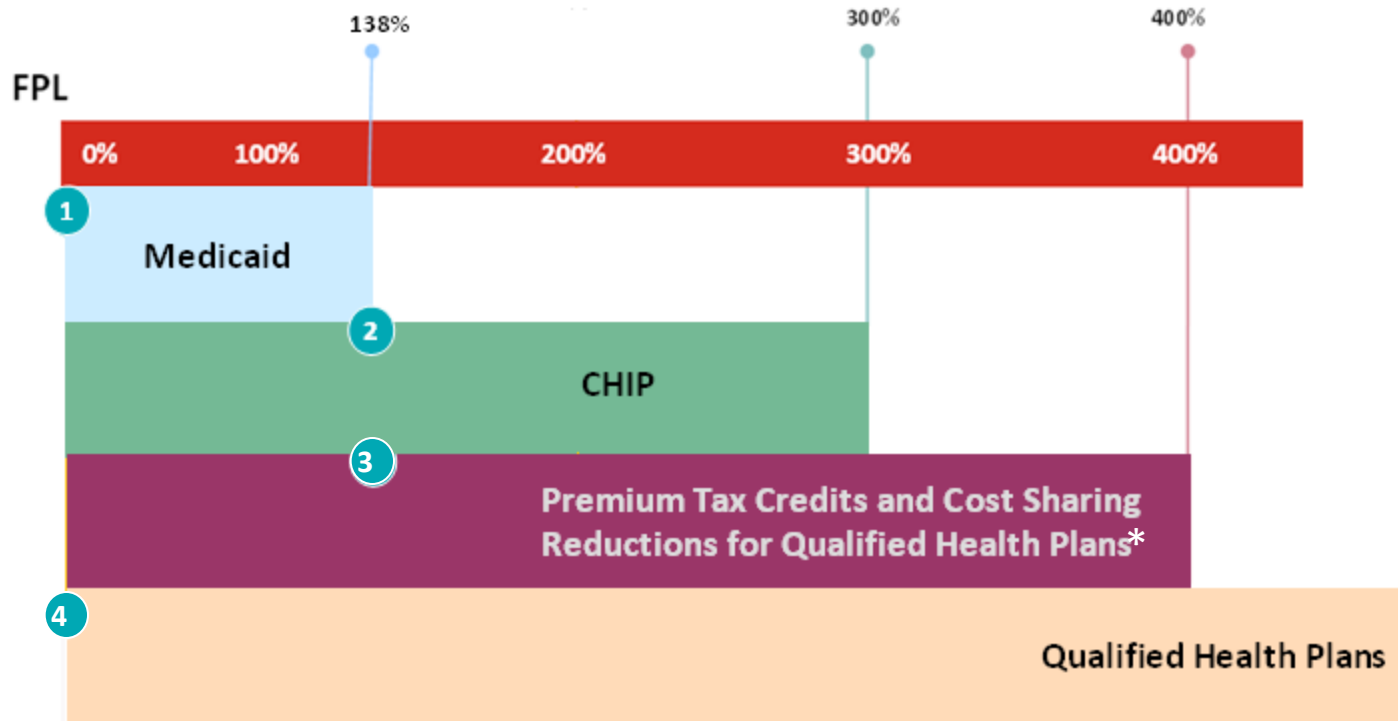
- Option to expand Medicaid to 138% of the FPL for adults under age 65 not receiving Medicare* - based on Modified Adjusted Gross Income (MAGI)
 - **MAGI** defines eligibility for children, pregnant women, parents & newly eligible adults
 - **Non-MAGI** (classic) Medicaid eligibility still applies to aged, blind, disabled, SSI, & foster children – ACA doesn't impact these groups
- In Washington, Medicaid expansion would offer new comprehensive coverage to:
 - **Childless adults** with incomes below 138% of the FPL
 - **Parents** with incomes between ~40% and 138% of the FPL

* The ACA's "133% of the FPL" = 138% of the FPL because of a 5% across-the-board income disregard

Enhanced Federal Funding for Newly Eligible Adults

- Newly eligible parents and childless adults include those who are:
 - under 65 years old
 - not pregnant
 - not entitled to Medicare
 - not in an existing Medicaid category (e.g. children, pregnant women, aged, blind and disabled)
- Enhanced federal funding for costs of newly eligible adults:
 - 100% federal funding from 2014-2016
 - Enhanced federal match gradually declines to 90% in 2020 and remains at 90% thereafter

2014 ACA Continuum of “Insurance Affordability Programs”



* Federal Basic Health Plan Option for individuals with incomes between 138% and 200% of the FPL will not be available in 2014.

Federal Basic Health Plan Option

- ACA Section 1331 – allowed subsidized insurance affordability program (IAP) for individuals with income up to 200% of FPL & not Medicaid eligible
- WA submitted proposal to CMS (June 18, 2012) requesting technical assistance to resolve critical design issues
- Follow-up request made August 21, 2012
- Resources redeployed because CMS guidance not provided and not likely

Uninsured Groups Will Remain

- Undocumented immigrants
- Individuals exempt from the mandate who choose to not be insured (e.g., because coverage not affordable)
- Individuals subject to the mandate who do not enroll (and are therefore subject to the penalty)
- Individuals who are eligible for Medicaid but do not enroll

Initial Estimates of Medicaid Expansion

Initial Enrollment Modeling

- Washington contracted with Urban Institute to model estimates of potential enrollment impact
...as if the Affordable Care Act were fully implemented in 2011
- Analysis includes:
 - Characteristics of new Medicaid enrollees
(e.g., age, health status, geographic location)
 - Projected eligibility counts
 - Projected enrollment & ramp-up
- Reports available at:
<http://www.hca.wa.gov/hcr/resources.html>

Eligibility/Enrollment Projections

	N
Currently Enrolled	1,095,254
Potential New Enrollees	1,039,228
Currently Eligible, Not Enrolled ¹	544,921
Newly Eligible Under Reform	494,307
Projected New Enrollment²	328,221
Currently Eligible, Not Enrolled	77,913
Newly Eligible	250,308

Most will retain their private ESI coverage

Welcome Mat
 ~29,000 uninsured adults
 ~49,000 children

New Eligibles
 Includes transfers from Transitional Bridge waiver programs

Source: UI Analysis of Augmented WA State Database

1. This estimate may be an overstatement. Our data represent a single point in time; crowd-out provisions and other aspects of eligibility that require knowledge of an applicant's history could not be modeled.
2. We simulate the Medicaid expansion as if fully implemented in 2011

Fiscal Impact Model By Nov 2012

- Workgroup (executive/legislative staff) building consensus FY14-21 models of ACA cost impact for 2013-15 budget proposals
 - Jul 2013 - Dec 2013 based on current programs
 - Post Jan 2014 based on ACA options

Caseload:

- Urban Institute ramp-up population estimates inform official Caseload Forecast Council impacts

Costs:

- Urban Institute per capita estimates inform HCA per capita forecast

2013 Legislative Discussion

Key Questions

- **Budget** – what are the short and long-term implications of full/partial/no Medicaid expansion?
- **Opportunities for streamlining** – how can current processes and programs be effectively streamlined?
- **Benefit design for new adults** – what are the parameters for the Benchmark benefit package?
- **Whole family coverage/churn** – what options best support families whose circumstances change?

ACA Requirements Regardless of Medicaid Expansion

- Conversion to MAGI eligibility determination methodology
- Most of “welcome mat” impact will occur due to general outreach, individual mandate, and “no wrong door” interface
 - *~65,000 (of 78,000) currently eligible not enrolled*
- Reduced disproportionate share hospital funding (DSH)
- Enhanced federal funding for Children’s Health Insurance program (CHIP) if reauthorized after September 2015
 - 23 percentage point increase to 88% from 2015-2019
- Primary care physicians paid at Medicare rates in 2013-2014
 - Federal government pays for additional costs in these years

Key Considerations

- Governor directed agencies to proceed with Medicaid expansion; spending authority will require further Legislative/Executive action
- Federal guidance still needed in critical areas
 - Methodology for streamlined federal funding (FMAP)
 - Medicaid Benchmark benefit design including mental health and substance abuse parity
 - Conversion to MAGI eligibility determination Oct 2013 for children, parents and pregnant women
 - Post eligibility review specifics
 - Final rules for 2013-14 primary care physician rate increase (expected Nov 2012)
 - Too late to support Federal Basic Health Option in 2014
 - Continued financing for Take Charge waiver (2014); CHIP reauthorization (2015); Transitional Medical Assistance (2014)
- Phased systems development to maximize success

Medicaid Expansion Goals

- Optimize opportunities to streamline administrative processes
- Leverage new federal financing opportunities to ensure the Medicaid expansion is sustainable
- Maximize use of technology to create consumer-friendly application/enrollment/renewal experience
- Maximize continuity of coverage & care as individuals move between subsidized coverage options
- Reform the Washington way --- comply with, or seek waiver from, specific ACA requirements related to coverage and eligibility, as needs are identified

Fiscal Implications of Expanding Medicaid

- **The cost of covering newly eligible adults with the benchmark package of benefits, considering:**
 - Number of newly eligible who enroll -- no means-tested program ever achieves 100% take-up
 - Per member per year costs of newly eligible -- newly eligibles tend to be lower-risk
 - Fully federally funded from 2014-2016, with federal funding decreasing to 90% of costs in 2020+
- **The potential State savings from current Medicaid and state/locally-funded services, and additional State revenues, including:**
 - Current Medicaid populations move to new adult group with enhanced federal match
 - Costs of State-funded programs for the uninsured (e.g. mental health/substance abuse programs) will go down as population gains Medicaid coverage
 - State revenue increases from provider/insurer assessments & general business taxes on new Medicaid revenue
- **The broader economic value of additional health care dollars to the health care system and the State economy**
 - Reduced number of uninsured (increased access to care, fewer medical bankruptcies)
 - Increased revenue for providers
 - Increased employment in the health care sector

Costs of Not Expanding Medicaid

Consumers

Individuals whose incomes are too high for Medicaid but too low for Premium Tax Credits (less than 100% of the FPL) will have no coverage options and NO tax subsidies for purchasing health insurance

Providers

Hospitals will face not only the continued costs of providing uncompensated care, but also a reduction in federal disproportionate share hospital (DSH) funding

Employers

Employers will face new coverage obligations for individuals with incomes between 100% and 138% of the FPL; additionally, large employers will face a penalty if full-time employees in this income bracket obtain a premium tax credit through the Exchange

Exchange

Interfacing between State Medicaid programs and the Exchange will become very complex administratively, with many “hand-offs” and eligibility determinations conducted against a patchwork of existing state Medicaid categories with variable income levels

Multiple Simplification Opportunities

- **New Income Counting Rules**

- Change from a complicated net income test to modified adjusted gross income (MAGI)
- Alignment across subsidy programs: Medicaid, CHIP and premium tax credits/cost sharing reductions

- **One Health Insurance Application Process**

- Simple process for everyone, regardless of income or eligibility for Medicaid, CHIP or premium tax credits/cost sharing reductions (or non-subsidized coverage in the Exchange)

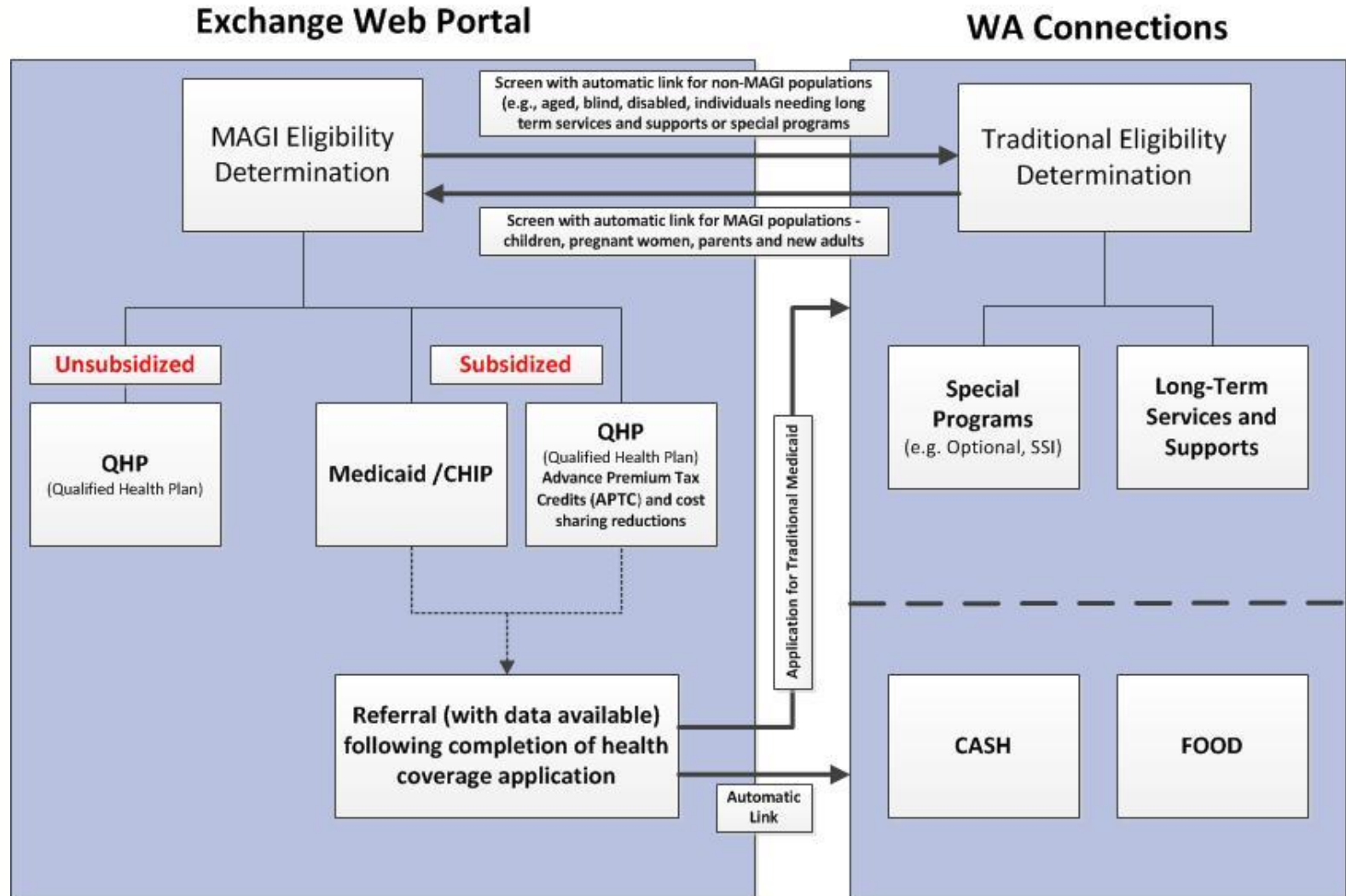
- **Simplified and Web-Based Enrollment Pathway**

- Eliminates paper-driven process (paper available for those who need it)
- Verification of applicants' attestation of eligibility using electronic data sources
- Real or near real time eligibility

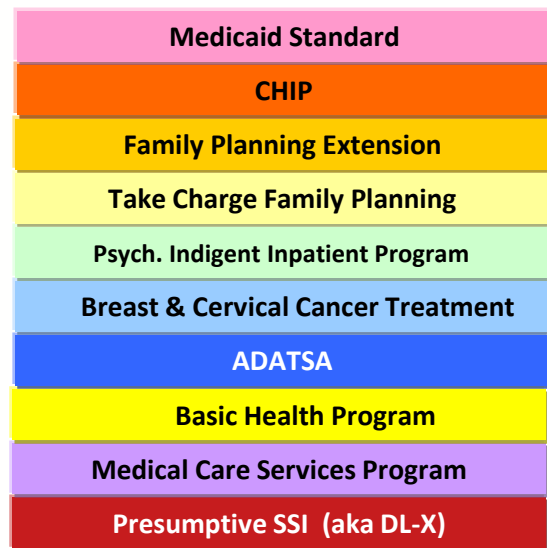
- **Administrative Renewal to Keep Individuals Covered and Reduce Churning**

- Exchange/Medicaid agency verifies eligibility up-front and sends notice
- Coverage is automatically renewed for another 12 months if all information remains correct

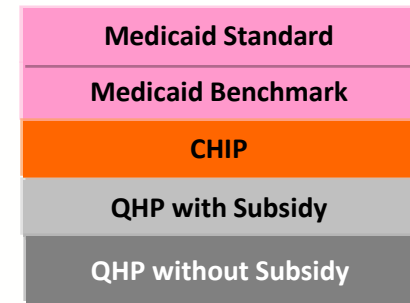
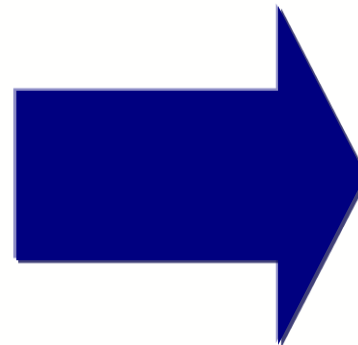
“No Wrong Door” Interface



Opportunity to Streamline Programs



2014 Coverage Continuum through Insurance Affordability Programs



Streamlining considerations – numbers affected, access/continuity of coverage through IAP continuum, administrative complexity, transition timing

Streamlining “Strawman”

- No change in current program
 - Health Care for Workers with Disabilities (supports return to work)
 - Medically Needy (*many will likely convert to new adult group at 100% FMAP*)
- Transfer enrollees to MAGI Medicaid/Exchange, eliminate current program and refinance state investment with federal dollars
 - Transitional Bridge waiver (Basic Health, Medical Care Services, ADATSA) required to end 12/31/13
 - Presumptive SSI (aka DL-X)
 - Breast & Cervical Cancer Treatment Program
- Assessment continues for link to cash/housing assistance and AEM impact

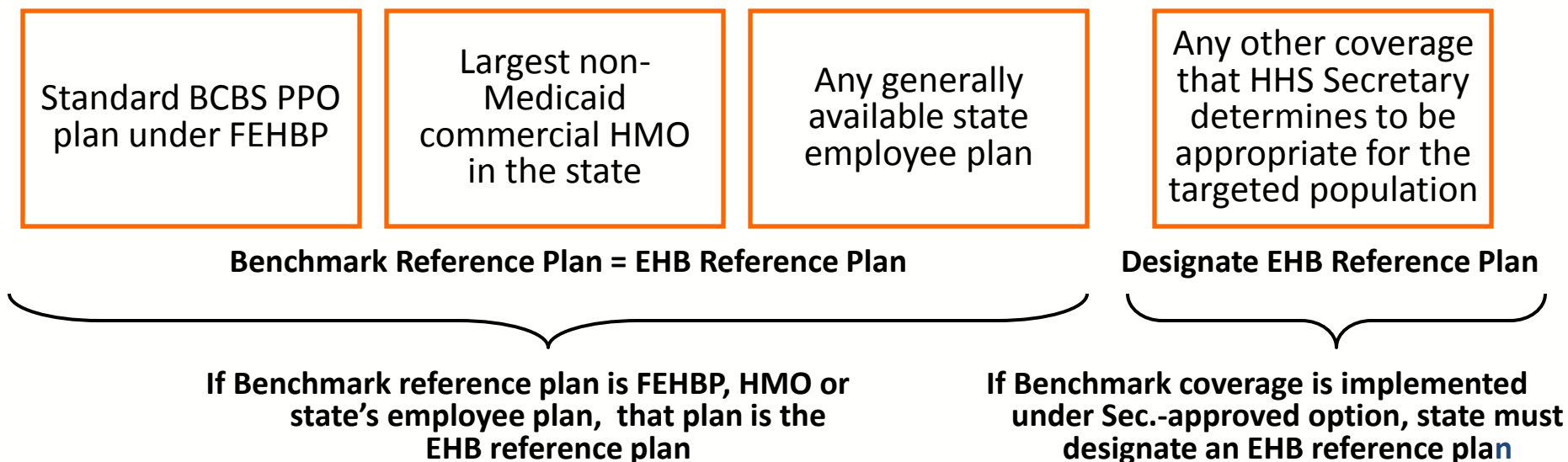
New Adult Group Receives Benchmark Coverage

The Medicaid Benchmark must:

- Cover all 10 essential health benefits (EHBs)
 - Ambulatory Services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health and substance use disorder services, including behavioral health treatment
 - Prescription drugs
 - Rehabilitative and habilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care
- Meet mental health and substance abuse parity
- Cover non-emergency medical transportation
- Cover Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EHBs and Medicaid Benchmark Coverage

- State must identify an EHB reference plan for its Medicaid Benchmark
- If EHB reference plan does not cover all required EHBs, state must supplement



Benchmark Options

- Align Benchmark to Standard Medicaid benefits
 - Add Benchmark benefits to Standard
 - Add Standard benefits to Benchmark
- Offer different Medicaid benefit packages to different eligibility groups
 - Benchmark to new adult group
 - Medicaid Standard to children, pregnant women, low-income parents and aged / blind /disabled (ABD) individuals
- Offer two Benchmark benefit packages to new adult group
 - Healthy adult benefit package
 - Does not include long term care services
 - Medically Frail benefit package
 - Fully aligns with Medicaid Standard and includes long term care services
 - Includes long term care services but doesn't fully align to Medicaid Standard
 - Note, if Benchmark exemptions apply to new adult group, then State will be required to offer Standard benefits (with LTC services) to medically frail adults

Open Questions for Benchmark Design

- **IMD Services:**
 - Medicaid does not cover services provided to beneficiaries between the ages of 21 and 65 who are patients of Institutions for Mental Diseases (IMD).
 - If WA's EHB reference plan includes IMD services, must those services be included in Benchmark and will the state receive FMAP for covering them?
- **Home and Community-Based Waiver Services:**
 - May states include waiver services in Benchmark (they aren't specifically identified as mandatory/optional Medicaid services)?
- **EHB Reference Plan:**
 - If the EHB reference plan covers Medicaid optional services that the State does not cover in Standard, must Medicaid Benchmark cover these services?
 - If the EHB reference plan covers state mandates that otherwise do not apply to Medicaid, may or must Medicaid Benchmark cover these state mandates?
- **How will mental health parity be implemented in Benchmark?**
- **Federal guidance expected this year**

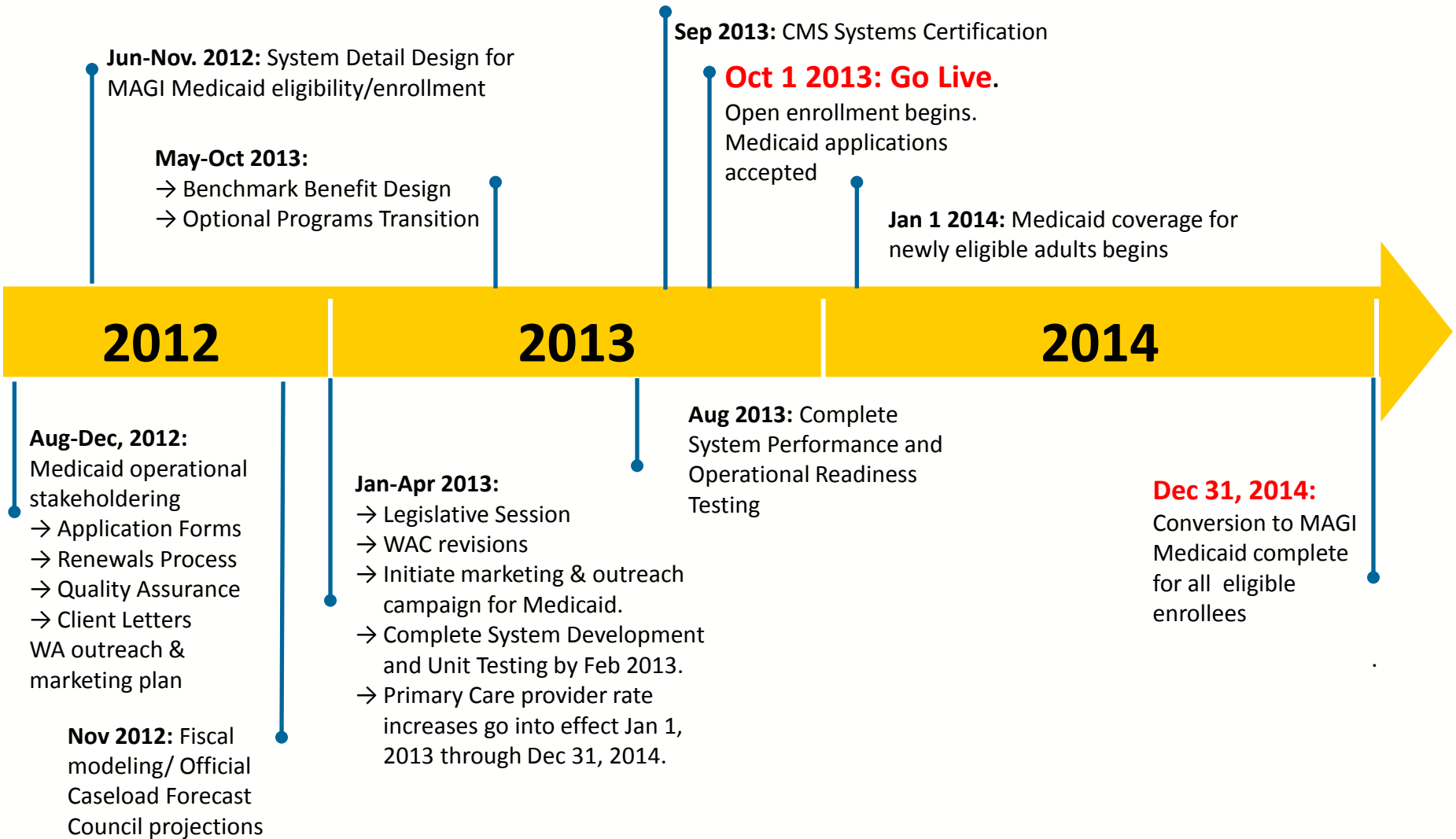
Whole Family Coverage/Churn Options

- Changes in circumstances cause churn across coverage (e.g., income, family or employment status, pregnancy, child birth)
- Differing eligibility levels potentially split families across different managed care plans and provider networks (e.g., children/pregnant mother in Medicaid, father in Exchange)

The Challenge = rationalizing and simplifying family coverage options

Timeline of Key Tasks

Timeline of Key Tasks: Much Work to be Done



Stakeholdering Opportunities

- Webinars & presentations around the state
 - See upcoming schedule & past events at:
<http://www.hca.wa.gov/hcr/me/stakeholdering.html>
- Listserv notification
 - To automatically receive information and stakeholdering notices subscribe at:
<http://listserv.wa.gov/cgi-bin/wa?SUBED1=HCA-STAKEHOLDERS&A=1>
- Main HCA web-site: <http://www.hca.wa.gov/>
 - For information about the Medicaid expansion:
<http://www.hca.wa.gov/hcr/me>
 - To contact us on the Medicaid expansion:
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