Medicaid Expansion and Federal Basic Health Program Option

Joint Select Committee on Health Care Oversight
November 18, 2014

Nathan Johnson, Director
Division of Policy Planning and Performance
Health Care Authority
Overview of Today’s Topics

- Washington’s Medicaid expansion - update
- What’s next for Medicaid?
- Federal Basic Health Program Option - overview
Washington’s Medicaid Expansion
Foundation of Insurance Affordability

- **Apple Health** (Adult Medicaid)
- **Apple Health** (Pregnancy Medicaid)
- **Apple Health for Kids** (Medicaid/CHIP)

<table>
<thead>
<tr>
<th>% Federal Poverty Level</th>
<th>*138%</th>
<th>**193%</th>
<th>**312%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>100%</td>
<td>200%</td>
<td>300%</td>
<td>400%</td>
</tr>
</tbody>
</table>

**Premium Tax Credits & Cost-Sharing Reductions for Qualified Health Plans**

- Qualified Health Plans

* The ACA’s “133% of the FPL” is effectively 138% of the FPL because of a 5% across-the-board income disregard
** Based on a conversion of previous program eligibility standards converted to new MAGI income standards
No Wrong Door to Coverage

http://www.wahealthplanfinder.org/
Growth has been among expansion adults
“Welcome Mat” in Line with Projections*

* The “welcome mat” includes adults and children who would have been eligible for Medicaid based on standards before the ACA implementation, but they never enrolled at that time. It specifically reflects caseload growth resulting from ACA implementation that is beyond historical growth averages. For further details on the welcome mat impact see June Caseload Forecast Council update June 18, 2014.
Adults Now Make Up 54% of Medicaid Enrollment

Children 46%

Expansion Adults * 28%

Other Adults 26%

* Expansion adults make up over half of all Medicaid adults
Static 4-year Trend for Children Interrupted

Apple Health for Kids
Monthly Enrollment and Rate of Growth (Jan '09 - Jun '14)

HealthPlanFinder begins
Chronology of Progress: Medicaid Expansion Reached January 2014 Goal

Total New Adult Clients = 121,164*

Percent of Overall Target Met Statewide = 99.5%
As of January 2, 2014

*94 additional clients do not map to Washington counties.

Enrollment of Expansion Adults Surpassed Jan 2018 Target

Target for January 1, 2018 = 252,576

Percent of 2018 Target Met Statewide = 174%

Between October 1, 2013 and September 11, 2014

Recent New Adults Relatively Older Than Earlier New Adult Enrollees

MAY 2014
- Up to age 25: 43%
- Age 26-34: 23%
- Age 35-64: 34%

OCTOBER 2014
- Up to age 25: 20%
- Age 26-34: 51%
- Age 35-64: 29%
Distribution of Apple Health New Adults Enrollment by Race/Ethnicity Has Remained Consistent (October 2014)

* The Hispanic category includes all enrollees who indicated they are of Hispanic origin regardless of their race.
Why has Medicaid enrollment been so successful?

Outreach, marketing, education & collaboration

- Healthplanfinder online portal
- Community-based volunteers & partners
- Community-based specialists in every county (~50)
- Specialized HCA regional representatives
- Resources
  - Training modules
  - Enrollment process descriptions
  - Customer support referral guides
  - General webinars & training
  - Outreach toolkit
  - Guide to Apple Health coverage

Website: [http://www.hca.wa.gov/hcr/me/Pages/training_education.aspx](http://www.hca.wa.gov/hcr/me/Pages/training_education.aspx)

Outreach, marketing, education & collaboration

1. Why has Medicaid enrollment been so successful?

   - Healthplanfinder online portal
   - Community-based volunteers & partners
   - Community-based specialists in every county (~50)
   - Specialized HCA regional representatives

   **Resources**
   - Training modules
   - Enrollment process descriptions
   - Customer support referral guides
   - General webinars & training
   - Outreach toolkit
   - Guide to Apple Health coverage

   Website: [http://www.hca.wa.gov/hcr/me/Pages/training_education.aspx](http://www.hca.wa.gov/hcr/me/Pages/training_education.aspx)
What’s next for Medicaid?
Upcoming Changes

2015

- Administrative simplifications
  - Auto-enrollment into health coverage for individuals enrolled in ABD Cash/HEN and TANF cash programs
  - Hospital presumptive eligibility training (beginning this month) – safety-net to ensure access to care
  - IRS reporting for individuals covered by “Minimum essential coverage” - required with 2016 filing for tax year 2015

- Individual choice of managed care plan

2016

- Regional purchasing
- “Early adopter” regional service areas - managed care plans contract for full physical and behavioral health risk
- “Other” regional service areas
  - Managed care plans contract for physical health for all and mental health for individuals who do not meet access-to-care standards
  - Behavioral health organizations provide substance use disorder services for all and mental health for individuals who do meet access-to-care standards
RSA Designations
Health Care Spending – the Need for Reform

National Health Expenditures - 1965 to 2022

1 "The effects of changes to systems of health care financing resulting from the ACA will not be fully reflected in health care spending data for several years."

Total Health Care Expenditures (public, private, out-of-pocket)

Data from 2012 forward are projected by the CMS Office of the Actuary

Medicare

Medicaid

Washington State Health Care Authority
Medicaid’s Reform Requires Aligned Strategies

Phased Staging of Integrated Purchasing through Managed Care

- SIM (CMMI) Round 2, other grants, State funds, philanthropic and local support
- Revised federal authority - potential opportunities for waivers or SPAs

Evolution toward value-based payment that supports delivery system transformation

State, Community (ACH) and delivery system infrastructure
Business enterprise development, capacity building, and ongoing support.

E2SSB 6312: By January 1, 2020, the community behavioral health program must be fully integrated in a managed care health system that provides mental health services, chemical dependency services, and medical care services to Medicaid clients

Payment reform and investments to support increased accountability for health outcomes

e.g., Flexibility to derive savings and re-invest in implementing delivery system transformation
Federal Basic Health Plan Option - review
Federal Basic Health Program Option

* The ACA’s “133% of the FPL” is effectively 138% of the FPL because of a 5% across-the-board income disregard
** Based on a conversion of previous program eligibility standards converted to new MAGI income standards
FBHPO Overview

- States may use federal funding to subsidize coverage for individuals with incomes 138-200% of the federal poverty level (FPL) who would otherwise be eligible to purchase coverage through the HBE. States can use the FBHPO to reduce premiums and cost sharing for eligible consumers. Depending on design, the FBHPO may also help consumers maintain continuity across plans and providers as their income fluctuates above and below Medicaid levels.

- **Competitive Contracting**: The state must use a competitive process to procure contracts for two or more standard health plans (with limited exceptions) offered by licensed HMOs, licensed health insurers, networks of providers, and/or non-licensed HMOs participating in Medicaid/CHIP.

- **Comparable, or Better, Costs and Benefits**: Enrollees must receive at least the same benefits and pay no more in premiums & cost sharing than they would in an HBE qualified health plan (QHP).

- **Financing Formula**: The federal government pays the state 95% of the value of the premium tax credits and cost sharing reductions it would have provided to eligible individuals enrolled in the applicable second lowest cost silver HBE plan.

- **Administration**: States must set up a Trust Fund to receive federal funding and identify trustees to authorize withdrawals.

- **Blueprint**: States are required to prepare an operational readiness Blueprint for CMS certification and approval to implement. States may also receive “Interim Certification” from CMS.
FBHPO Advantages and Disadvantages

**Potential Advantages**

- Premiums and cost sharing are lower for enrollees than in QHPs
- May result in more individuals securing coverage and complying with the individual mandate
- Smoother transitions as incomes fluctuate at 138% FPL
- More affordable coverage vehicle for lawfully present immigrants who are not eligible for Medicaid because they have not been in the country for five years

**Potential Disadvantages**

- Federal funding may not cover cost of plans; State has financial exposure
- Design, development, start-up and ongoing administrative costs not federally funded
- New transition point is created at 200% FPL
- Affordability cliff at 200% FPL (depending on subsidies of premium tax credits/cost sharing reductions)
- Exchange volume will decline; individuals with income below 200% FPL will be enrolled in the FBHPO and not a QHP
- In order to reduce consumer costs, providers could be paid at a lower rate than what they would be paid in a QHP
- Does not address whole family coverage issues

Prior analysis available at: [http://www.hca.wa.gov/hcr/me/Pages/policies.aspx#federal](http://www.hca.wa.gov/hcr/me/Pages/policies.aspx#federal)
Implementation Timeline Overview

- Assumes legislature provides policy and fiscal expenditure authority
- March 2014 - CMS released final guidance for state & federal administration of FBHPO
- October 2014 - CMS released proposed federal funding rules & data sources to determine federal FBHPO payments for 2016 (final rules due Feb 2015)

<table>
<thead>
<tr>
<th>Spring Year 1</th>
<th>Summer Year 1</th>
<th>Winter Year 1</th>
<th>Spring Year 2</th>
<th>Summer Year 2</th>
<th>Fall Year 2</th>
<th>Nov Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington State legislative direction &amp; expenditure authority</td>
<td>Complete econometric modeling and policy design</td>
<td>Design system and plan for implementation</td>
<td>Submit interim CMS Blueprint &amp; Notify QHPs</td>
<td>Develop and test systems changes</td>
<td>Commence FBHPO Plan Selection</td>
<td>Submit final Blueprint for full certification</td>
<td>Submit data to CMS</td>
</tr>
</tbody>
</table>
Contacts for More Information

- MaryAnne Lindeblad, Medicaid Director
  maryanne.lindeblad@hca.wa.gov  l  360-725-1863

- Nathan Johnson, Policy, Planning & Performance Director
  nathan.johnson@hca.wa.gov  l  360-725-1880