Health Reform Implementation in WA State

November 28, 2012
Nathan Johnson, Assistant Director, Health Care Policy
## Today’s Update

<table>
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<th>ACA Coverage Opportunities</th>
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<td>Policy Discussion</td>
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<td>Timeline of Key Tasks</td>
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</table>
### The Supreme Court Decision

A divided Supreme Court ruled that:

- **The Affordable Care Act (ACA) requirement for individuals to have insurance or pay a tax penalty is constitutional.**

- **States can choose not to expand Medicaid to cover all state residents under 133% FPL, without risking federal funding for their entire Medicaid program.**

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“**The Affordable Care Act’s requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.**”

— Chief Justice Roberts in Majority Opinion

“**In this case, the financial ‘inducement’ Congress has chosen is much more than ‘relatively mild encouragement’—it is a gun to the head.**”

— Chief Justice Roberts in Majority Opinion
The Decision’s Implications for Medicaid

States May Opt Out of Medicaid Expansion

The Balance of ACA Medicaid Provisions Stand

- Simplification of Eligibility
- Streamlining of Existing Programs
- Maintenance of Effort
- Drug Rebates in Medicaid Managed Care
- DSH Payment Reductions
- Delivery System Reform
- Primary Care Rate Increase
Today’s Washington State Landscape
Medicaid Coverage 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 and parents
  – 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 declines to 90% in 2020 and remains at 90% thereafter
Federal Basic Health Plan Option for individuals with incomes between 138% and 200% of the FPL will not be available in 2014.
The Exchange: A Doorway to Coverage

Think: Amazon.com or Expedia...
A simple way to shop for health insurance

1. Find out your eligibility for Qualified Health Plans
2. Find out your eligibility for Medicaid, CHIP, and Premium Tax Credits/Cost Sharing Reductions
3. Compare your plan options
4. Choose a plan and enroll!
The Exchange: One-Stop Shopping for Health Insurance

1. Apply for coverage
2. Select health plan
3. Enroll in health plan
4. Insured
Applying is Easy

Application Must Be

- Single and streamlined, for use enrolling into Medicaid, CHIP, premium tax credits/cost sharing reductions, and qualified health plans
- Accepted via: website, phone, mail, in-person, and other common electronic means
- Federally approved (if using state-specific form, rather than Federal model)
Premium Tax Credits/Cost Sharing Reductions

Individuals up to 400% of the FPL who are ineligible for Medicaid are eligible for premium tax credits and cost sharing reductions, determined by an individual’s income levels:

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Premium as Percent of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133% FPL</td>
<td>2% of income</td>
</tr>
<tr>
<td>133-150% FPL</td>
<td>3-4% of income</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>4-6.3% of income</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>6.3-8.05% of income</td>
</tr>
<tr>
<td>250-300% FPL</td>
<td>8.05-9.5% of income</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>9.5% of income</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Reduction in Out-of-Pocket Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150% FPL</td>
<td>94% of the actuarial value*</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>87% of the actuarial value</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>73% of the actuarial value</td>
</tr>
</tbody>
</table>

*Of the second lowest cost Silver plan
Qualified Health Plans

- Qualified Health Plans (QHPs) will be available to individuals and small employers in the Exchange.

- The Exchange will:
  - Set standards for QHPs
  - Certify participating plans, and
  - Rank plans from **bronze to platinum** to indicate what level of coverage the plan offers.

- QHPs must:
  - Provide “Essential Health Benefits” (EHBs)
  - Ensure sufficient choice of providers
  - Be accountable for performance on clinical quality measures and patient satisfaction
  - Implement a quality improvement strategy
  - Provide accurate and standardized consumer information
  - Be a private health insurance plan.

<table>
<thead>
<tr>
<th>Level</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60% of actuarial value of benefits</td>
</tr>
<tr>
<td>Silver</td>
<td>70% of actuarial value of benefits</td>
</tr>
<tr>
<td>Gold</td>
<td>80% of actuarial value of benefits</td>
</tr>
<tr>
<td>Platinum</td>
<td>90% of actuarial value of benefits</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>High-deductible plan for individuals up to age 30 or individuals exempted from the mandate to purchase coverage</td>
</tr>
<tr>
<td><strong>Private Market Reforms</strong></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Not Allowed</strong></td>
<td></td>
</tr>
<tr>
<td>• Elimination of annual/lifetime limits</td>
<td></td>
</tr>
<tr>
<td>• Elimination of pre-existing conditions exclusion</td>
<td></td>
</tr>
<tr>
<td>• Elimination of rescissions</td>
<td></td>
</tr>
<tr>
<td><strong>Allowed</strong></td>
<td></td>
</tr>
<tr>
<td>• Expansion of dependent coverage up to age 26</td>
<td></td>
</tr>
<tr>
<td>• Coverage of preventive health services with no cost-sharing</td>
<td></td>
</tr>
<tr>
<td>• Uniform explanation of coverage documents</td>
<td></td>
</tr>
<tr>
<td>• Reporting requirements regarding quality of care</td>
<td></td>
</tr>
<tr>
<td>• Process to review unreasonable rate increases by health plans</td>
<td></td>
</tr>
<tr>
<td>• New standards related to medical loss ratios and subsequent rebates to plan participants</td>
<td></td>
</tr>
</tbody>
</table>
Consumer Assistance Will Be Available

To reach the ~1,000,000 uninsured Washington residents, the State will rely on:

**Navigators, Agents and Brokers:** will provide help to consumers and small businesses with enrolling into coverage on the Exchange; provide advice to consumers about their enrollment options and premium tax credits; and make referrals of complex cases to Consumer Assistance Programs

**Community-Based Organizations:** Continued partnership with existing community-based network

**Call Center:** Toll-Free Hotline operated by the Exchange to provide insurance application assistance
Uninsured Groups 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

- Report available at:
  [http://www.hca.wa.gov/hcr/resources.html](http://www.hca.wa.gov/hcr/resources.html)
Post Implementation of the ACA: Subsidized Coverage Landscape in Washington

1.16 million current enrollees

- 545,000 currently eligible but not enrolled**
- 494,000 newly eligible
- 532,000 eligible for subsidies

Note: Analysis forecast assumes full take up rate and the ACA was in effect in 2011. **Includes individuals who have access to other coverage (e.g., employer sponsored insurance). Sources: The ACA Medicaid Expansion in Washington, Health Policy Center, Urban Institute (May 2012); The ACA Basic Health Program in Washington State, Health Policy Center, Urban Institute (May 2012); Milliman Market Analysis; *and Washington Health Care Authority for Medicaid/CHIP enrollment.
Eligibility/Enrollment Projections

<table>
<thead>
<tr>
<th></th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Enrolled</td>
<td>1,095,254</td>
</tr>
<tr>
<td>Potential New Enrollees</td>
<td></td>
</tr>
<tr>
<td>Currently Eligible, Not Enrolled¹</td>
<td>544,921</td>
</tr>
<tr>
<td>Newly Eligible Under Reform</td>
<td>494,307</td>
</tr>
<tr>
<td>Projected New Enrollment²</td>
<td></td>
</tr>
<tr>
<td>Currently Eligible, Not Enrolled</td>
<td>77,913</td>
</tr>
<tr>
<td>Newly Eligible</td>
<td>250,308</td>
</tr>
</tbody>
</table>

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

~429,000 have private coverage and most will retain that coverage.

Welcome Mat
~11,000 uninsured adults
~18,500 uninsured children
~30,500 insured children
~18,000 insured adults
Health Status of Likely New Medicaid Enrollees

New Medicaid Enrollees Report Good Health Overall

<table>
<thead>
<tr>
<th>Eligibility of Projected New Enrollees</th>
<th>Currently Eligible, Not Enrolled</th>
<th>Newly Eligible</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>77,913</td>
<td>100.0%</td>
<td>250,308</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Status</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent - Good</td>
<td>58,726</td>
<td>75.4%</td>
<td>180,407</td>
<td>72.1%</td>
<td>239,133</td>
<td>72.9%</td>
</tr>
<tr>
<td>Fair - Poor</td>
<td>19,187</td>
<td>24.6%</td>
<td>69,901</td>
<td>27.9%</td>
<td>89,088</td>
<td>27.1%</td>
</tr>
</tbody>
</table>

Source: UI Analysis of Augmented WA State Database
Health of New Medicaid Enrollees

• Most new Medicaid enrollees report good health, regardless of eligibility pathway

• Newly eligible new Medicaid enrollees (~98% adult) report better health than current adult Medicaid enrollees
  – 28% of new Medicaid enrollees are in fair/poor health versus 40% of current adult Medicaid enrollees
### Age of Likely Nonelderly Medicaid Enrollees

Newly Eligible New Enrollees are Almost All Adults

<table>
<thead>
<tr>
<th>Age</th>
<th>Currently Eligible, Not Enrolled</th>
<th>Newly Eligible</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>77,913</td>
<td>100.0%</td>
<td>250,308</td>
</tr>
<tr>
<td>0 – 18 years</td>
<td>49,115</td>
<td>63.0%</td>
<td>5,512</td>
</tr>
<tr>
<td>19 - 24 years</td>
<td>2,400</td>
<td>3.1%</td>
<td>80,037</td>
</tr>
<tr>
<td>25 - 44 years</td>
<td>23,281</td>
<td>29.9%</td>
<td>75,553</td>
</tr>
<tr>
<td>45 - 64 years</td>
<td>3,117</td>
<td>4.0%</td>
<td>89,206</td>
</tr>
</tbody>
</table>

Source: UI Analysis of Augmented WA State Database
Age of New Medicaid Enrollees

• Newly eligible new Medicaid enrollees are almost exclusively adults
  – Unsurprising given current generosity of children’s Medicaid/CHIP coverage
• New outreach under health reform will encourage currently eligible yet not enrolled children to take up Medicaid
  – 63% of currently eligible new Medicaid enrollees are 18 or under
Post-Reform Medicaid Enrollment of Nonelderly Adults
With Large Growth in Enrollment, Average Costs Decline

Reform: 633K Enrollees, Avg. Cost $7,293
(Baseline: 359K Enrollees, Avg. Cost $7,906)
Policy Discussion
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
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?
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.
### ACA Opportunity to Streamline Programs

#### 2014 Coverage Continuum through Insurance Affordability Programs

<table>
<thead>
<tr>
<th>Medicaid Standard</th>
<th>Medicaid Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP</td>
<td>CHIP</td>
</tr>
<tr>
<td>Family Planning Extension</td>
<td>QHP with Subsidy</td>
</tr>
<tr>
<td>Take Charge Family Planning</td>
<td>QHP without Subsidy</td>
</tr>
<tr>
<td>Psych. Indigent Inpatient Program</td>
<td></td>
</tr>
<tr>
<td>Breast &amp; Cervical Cancer Treatment</td>
<td></td>
</tr>
<tr>
<td>ADATSA</td>
<td></td>
</tr>
<tr>
<td>Basic Health Program</td>
<td></td>
</tr>
<tr>
<td>Medical Care Services Program</td>
<td></td>
</tr>
<tr>
<td>Presumptive SSI (aka DL-X)</td>
<td></td>
</tr>
</tbody>
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Streamlining considerations – numbers affected, access/continuity of coverage through IAP continuum, administrative complexity, transition timing.
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

- Standard BCBS PPO plan under FEHBP
- Largest non-Medicaid commercial HMO in the state
- Any generally available state employee plan
- Any other coverage that HHS Secretary determines to be appropriate for the targeted population

Benchmark Reference Plan = EHB Reference Plan

If Benchmark reference plan is FEHBP, HMO or state’s employee plan, that plan is the EHB reference plan

If Benchmark coverage is implemented under Sec.-approved option, state must designate an EHB reference plan

Designate EHB Reference Plan
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
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
New Research on Primary Care Access

• Results from a recent survey of primary care physicians in WA state show that:
  – About 90 percent of primary care physicians provide care for some patients covered by Medicaid.
  – Close to 80% of primary care physicians are accepting new patients
    • Only 30% of this group are not including Medicaid covered clients in their expansion plans
    • Just over 20% reported that all their new patients could be Medicaid covered.

• Reports available include:
  – Characteristics and distribution of current primary care physicians
  – Availability of Primary Care Physicians to Serve the Medicaid Expansion
    • http://www.ofm.wa.gov/researchbriefs/2012/brief065.pdf
  – Primary care physician availability in non-urban areas (available upon request)
Timeline of Key Tasks
Timeline of Key Tasks: Much Work to be Done

**June-Nov. 2012:** System Detail Design for MAGI Medicaid eligibility/enrollment

**May-Oct 2013:**
- Benchmark Benefit Design
- Optional Programs Transition

**Sep 2013:** CMS Systems Certification

**Oct 1 2013:** Go Live.
- Open enrollment begins.
- Medicaid applications accepted

**Jan 1 2014:** Medicaid coverage for newly eligible adults begins

**2012**

- **Aug-Dec, 2012:** Medicaid operational stakeholdering
  - Application Forms
  - Renewals Process
  - Quality Assurance
  - Client Letters

- **Nov 2012:** Fiscal modeling/Official Caseload Forecast Council projections

**2013**

- **Jan-April 2013:**
  - Legislative Session
  - WAC revisions
  - Initiate marketing & outreach campaign for Medicaid.
  - Complete System Development and Unit Testing by Feb 2013.
  - Primary Care provider rate increases go into effect Jan 1, 2013 through Dec 31, 2014.

- **Aug 2013:** Complete System Performance and Operational Readiness Testing

**2014**

- **Dec 31, 2014:** Conversion to MAGI Medicaid complete for all eligible enrollees
More Information

• Webinars & presentations around the state
  – See upcoming schedule & past events at:
    http://www.hca.wa.gov/hcr/me/stakeholdering.html
  – Register for November 30th webinar (1-3pm) on Medicaid Expansion with Manatt Health Solutions by visiting the following link:
    https://www2.gotomeeting.com/register/149630354

• 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:
    medicaidexpansion2014@hca.wa.gov