

An Overview of State Expansion Pathways

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Closing the Coverage Gap for Adults

NEW ADULT GROUP



- Childless adults with income below 138% FPL (\$16,105)
- Parents with incomes between 49-138% (\$5,718-\$16,105)
- 248,000 new adult enrollees



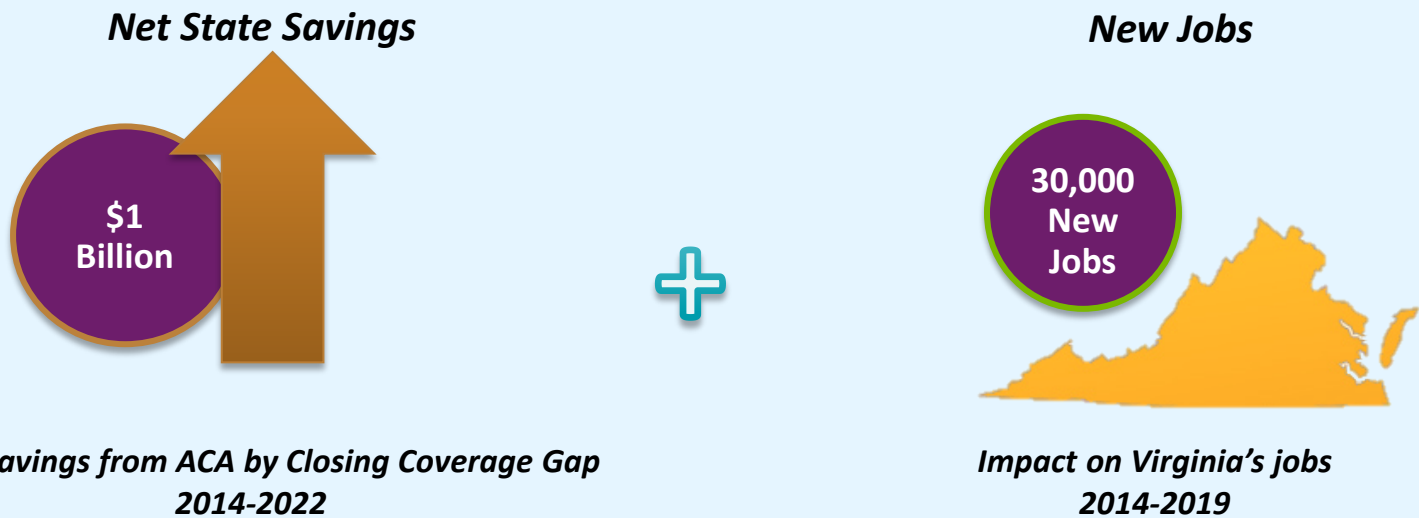
ALTERNATIVE BENEFIT PLAN

- 10 Essential Health Benefits
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 and 20 year olds
- Non-emergency medical transportation

ENHANCED FEDERAL MATCHING RATE NEWLY ELIGIBLE ADULTS UP TO 138% FPL

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

Benefits of Expansion Extend Beyond Increased Coverage



Without Expansion, Virginia Faces Greater Financial Risk

If Virginia does not expand:

- × Virginia would forgo, on average, \$1.9 billion in new federal funds annually between 2014-2022, according to Department of Medical Assistance Services estimates.
- × Virginia could face challenges recruiting **health professionals** as neighboring states expand.
- × A study by the **Commonwealth Fund** found that by 2022, \$2.8 billion in taxes paid by Virginians would be distributed to other states who do expand.
- × **Jackson Hewitt (Jan. 2014)** found that large employers in Virginia could see increased “shared responsibility” tax penalties under the ACA of up to \$64 million each year if Virginia does not expand.
- × **Moody's (Mar. 2013):** “States that opt out of Medicaid expansion will have to choose whether to compensate for the shortfalls with their own funds or leave hospitals to absorb the costs, which will increase rating pressure on the hospitals. States that choose to fund uncompensated care costs themselves could face budgetary strain.”
- × **Fitch Ratings (Oct. 2013):** Hospitals in states that will not expand Medicaid in 2014 will face "greater financial challenges and rating pressure" compared with hospitals in states that will expand Medicaid.

Overview of State Expansion Strategies

States are Using Different Pathways to Cover New Adults

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Medicaid Managed Care. States with robust Medicaid Managed Care programs are using these private plans to expand coverage



Premium Assistance for Private Insurance. Some states are pursuing a “private option” for expansion by purchasing QHP or ESI coverage for Medicaid-eligible enrollees



Benefits. States are seeking to align benefits to the commercial market and to waive the provision of certain traditional Medicaid benefits (e.g. NEMT)



Premiums and Cost-Sharing. States are increasingly looking to require co-payments and premiums, seeking federal waivers where necessary



Healthy Behavior Incentives. States are seeking to encourage healthy behaviors by forgiving co-pays and/or premiums for meeting certain health standards



State Protections. States are including sunset provisions or reauthorization requirements in expansion legislation, and in some cases are investing savings from expansion to cover the non-federal share of expansion costs in out-years

Premium Assistance for QHPs



Medicaid



QHP Coverage



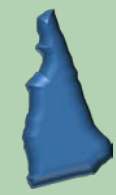
- Purchases QHP coverage for Medicaid eligible new adults
- Covers cost of premiums
- Wraps missing benefits and excessive cost-sharing



Arkansas is purchasing coverage for all childless adults and parents 17-133% FPL through QHPs in the Marketplace.

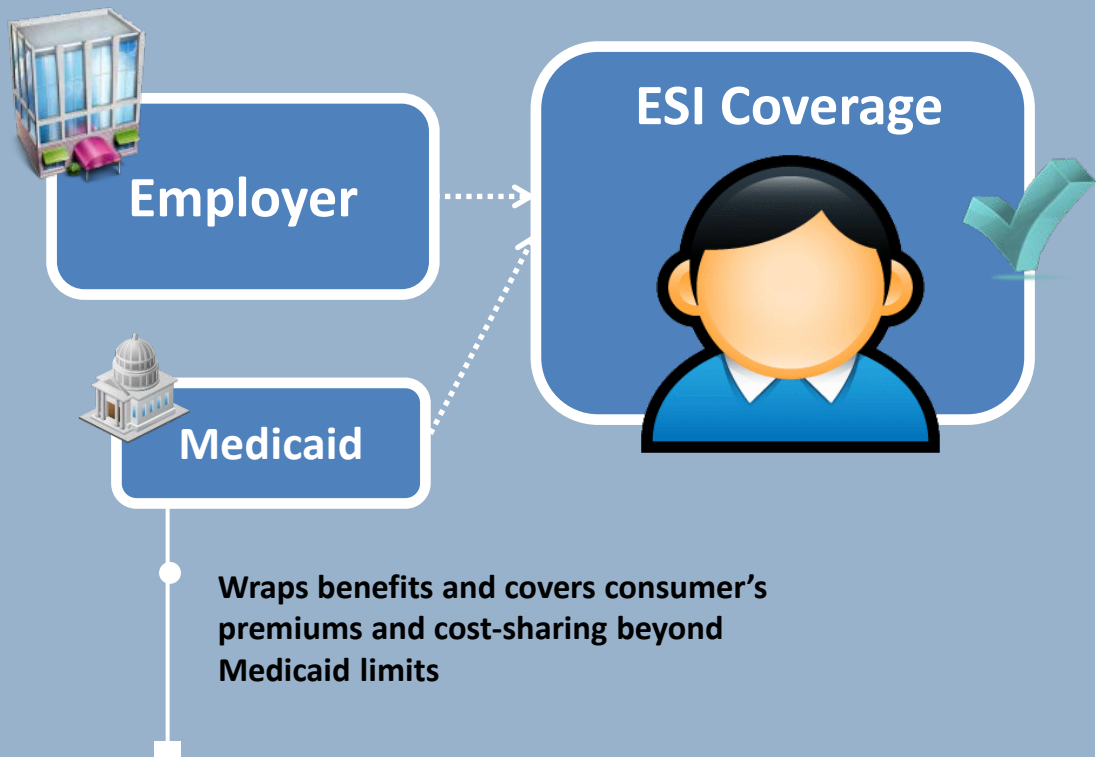


Iowa is purchasing coverage for newly eligible adults 100-133% FPL through QHPs in the Marketplace.



New Hampshire will purchase coverage for all newly eligible adults (without access to ESI) through QHPs in the Marketplace beginning in 2016. A “bridge” option will provide coverage beginning in 2014 through existing Medicaid MCOs.

Premium Assistance for Employer Sponsored Insurance



Iowa requires Medicaid-eligible individuals with access to ESI to take up that coverage, with Medicaid covering premiums and cost sharing above Medicaid levels and providing any benefits not covered by the employer's plan.



New Hampshire will require Medicaid-eligible individuals and their family members who have access to ESI to take up that coverage, with Medicaid covering premiums and cost sharing above Medicaid levels and providing any benefits not covered by the employer's plan.

Benefit, Network and Coverage Requirements

States are aligning the Alternative Benefit Plan with QHP standards



CMS has only waived non-emergency medical transportation for expansion adults

CMS has been asked but declined to waive:



Free access to family planning services and providers



Inclusion of Federally Qualified Health Centers (FQHCs) in network



Retroactive coverage

Personal Responsibility Strategies

CO-PAYMENTS

- Implement maximum allowable co-payments (see appendix for federal limits)
- Must be voluntary < 100% FPL
- May impose higher co-payments (up to \$8) for non-emergency use of the ER and for non-preferred drugs
- Inpatient hospital co-payments may be as much as \$75 for those < 100% FPL and 10% of the cost of the hospital stay for those > 100% FPL

PREMIUMS

- Premiums of up to 2% of income may be imposed under a waiver for those 100-138% FPL. This level of premiums is consistent with premiums for individuals with the same income in the Exchange.
- Virginia could request a waiver for higher premium levels, but CMS is unlikely to approve such a request

WELLNESS INCENTIVES

- Requires evidentiary base
- Requires protocols to track
- May be linked to reductions in cost sharing or premiums

WORK INCENTIVES

- Enrollees with vocational assessment receive additional, targeted benefits
- Assessment may not be a condition of eligibility (CMS has never approved a Medicaid work requirement)

Smooths cost sharing between Medicaid MCOs and QHPs
(see appendix)

Premiums & Cost-Sharing: State Examples



ARKANSAS:

No premiums

Cost-sharing for a range of services for individuals 100-133% FPL; in 2015 cost sharing will apply to individuals > 50% FPL



IOWA:

Beginning in 2015, premiums up to 2% of income for those 100-133% FPL

Cost-sharing limited to non-emergency use of the ER for individuals 100-133% FPL



MICHIGAN:

Premiums up to 2% of income for those 100-133% FPL

Cost-sharing for range of services for individuals 0-133% FPL

Healthy Behavior Incentives: State Examples

States are seeking to incent healthy behaviors by forgiving co-pays and/or premiums for meeting certain health standards



IOWA:

Premiums waived in second and future years for completion of health risk assessment and wellness exam during previous year

State must submit protocol with basis of healthy behavior standards and process for tracking for prior approval by CMS



MICHIGAN:

Healthy behavior may reduce cost-sharing obligations; unclear if may reduce premiums

State must submit protocol with basis of healthy behavior standards and process for tracking for prior approval by CMS



NEW HAMPSHIRE:

“To the greatest extent practicable the waiver shall incorporate measures to promote continuity of health insurance coverage and personal responsibility, including but not limited to: ... mandatory wellness programs.”

State developing approach

Strategies to Ensure Sustainable Financing for Coverage

ESTABLISH TRUST FUND

- Savings from coverage expansion would be set aside in a trust fund to cover the state share in future years

INCLUDE SUNSET PROVISION

- Expansion would be terminated within 120 days should the Federal match rate drop below Affordable Care Act levels.

“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

IDENTIFY SAVINGS/REVENUE

The State could realize savings from:

- Transitioning current Medicaid populations to the new adult group, including populations in limited benefit Medicaid programs, pregnant women, inmates receiving inpatient care and some disabled individuals
- Reducing state-funded programs for the uninsured or underinsured, including mental health and substance abuse programs, the state high risk pool and public health programs

The State could see increased revenues from:

- Health care services or insurance, including provider taxes, sales taxes and business taxes

Trust Funds: State Examples

States are setting up trust funds to invest savings from expansion to cover the non-federal share of expansion costs in out-years, when the federal match rate declines or to hold and expend federal funds



NEW HAMPSHIRE:

Established a trust fund to hold and expend federal dollars for the new Medicaid population. The trust fund will be administered by the Health & Human Services Commissioner, who will submit an annual report to the Governor and general assembly.



MICHIGAN:

Established a trust fund, in which state savings realized in the first year of expansion are to be deposited in the Fund to offset state risk related to expansion in future years.



Sunset Provisions: State Examples

States are including sunset provisions and/or reauthorization requirements in expansion legislation



ARKANSAS:

Financing for the expansion must be re-authorized each year, and should the federal match rate drop below the promised levels, the program would terminate after 120 days.



NEW HAMPSHIRE:

Expansion program terminates (and must be reauthorized) on December 31, 2016, unless federal match drops below 100% before that time, which would cause immediate termination.



IOWA:

If the federal match drops below promised levels, DHS may implement an alternative coverage plan (with statutory approval). If match drops below 90%, hospital reimbursement will be reduced by the same percentage in the following fiscal year (up to 5%)



Thank You!

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Appendix

Statute and Guidance on Cost Sharing and Premiums

Maximum Allowable Medicaid Premiums and Cost-Sharing:

	< 100% FPL ¹	100% - 150% FPL	≥ 150% FPL
Aggregate cost-sharing cap	5% household income	5% household income	5% household income
Premiums	Not allowed	Not allowed	Permitted, subject to aggregate cap

Maximum Service-Related Co-pays/Co-Insurance:

Outpatient Services	\$4	10% of the cost state pays	20% of the cost state pays
Non-emergency ER	\$8	\$8	No limit
Prescription drugs ²	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: 20% of cost state pays
Inpatient Services	\$75 per stay	10% of the total cost state pays for the entire stay	20% of the total cost state pays for the entire stay

(1) Cost sharing may **not** be mandatory for individuals with household incomes < 100% FPL. Providers may not deny services for failure to receive beneficiary copayments.

(2) If non-preferred drugs are medically necessary, preferred drug cost sharing applies.

Coverage Transitions: Premiums and Cost Sharing in VA

Maximum Premiums and Service Related Co-Payments/Co-Insurance		
	Medicaid Eligible Individual ¹	QHP Eligible Individual Enrolled in Silver Level Plan with a \$200 Deductible ²
	(100-138% FPL)	(150% FPL)
Premiums	\$27/month \$324/year ³	\$57/month \$684/year ⁴
Maximum Co-Payments and Co-Insurance		
Primary care	\$5 ⁵	\$15
Specialist visit	\$8-\$9 ⁶	15% Co-insurance after deductible
Non-emergency ER	\$8	Not a covered service
Rx Drugs ⁷	Preferred: \$4 Non-Preferred: \$8	Generic: \$10 Preferred: \$30 Non-Preferred: 15% Co-insurance after deductible Specialty: 15% Co-insurance after deductible

¹ Medicaid cost-sharing based on Social Security Act § 1916A and treatment rates provided by Virginia Department of Medical Assistance Services.

² Silver Level Plan cost sharing based on Anthem Blue Cross/Blue Shield Health Keepers Direct Access (cbau).

³ Monthly premiums are based on following calculation: 2 percent of income for Medicaid eligible individual with an income below 138% of the FPL. Note that to impose premiums on Medicaid eligible individuals requires a federal waiver.

⁴ Monthly premiums are based on following calculation: 4 percent of income for an individual with an income at 150% of the FPL as required by IRS regulations. See 26 CFR §1.36B-3.

⁵ Based on 10 percent of the treatment rate for Code 99213—the most frequently used outpatient/non-facility “sick visit” service for adults.

⁶ Based on 10 percent of the treatment rates for Codes 99385 and 99395—adults receiving outpatient/non-facility services. Weighted average for outpatient procedures is \$40 based on information provided by Virginia Department of Medical Assistance Services.

⁷ Social Security Act § 1916A establishes the Medicaid pharmacy limits for Preferred and Non-Preferred drugs.