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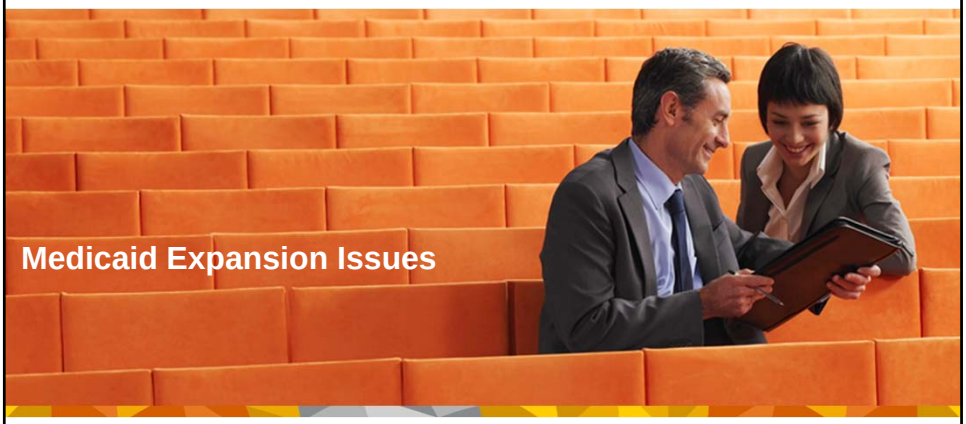


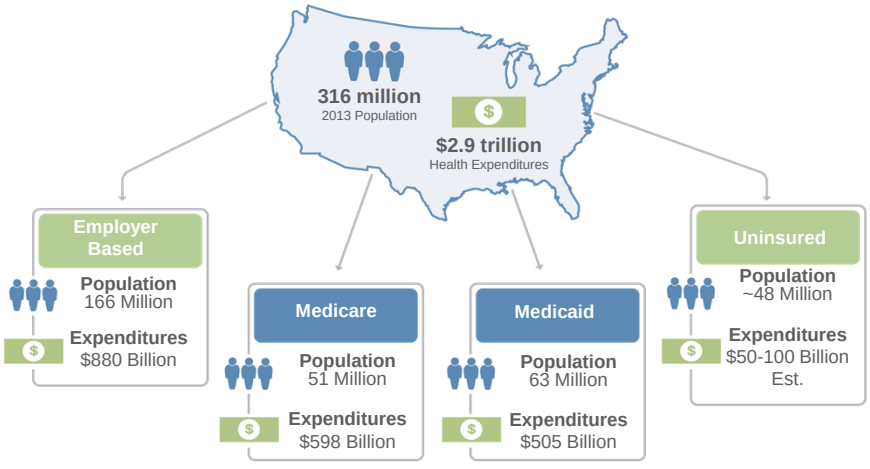
Medicaid Expansion Issues

Presented By:

Michael Rasmussen
Randall Brock

Shifting Marketplace

1 in 3 Americans in Government-Sponsored Health Care



Medicaid's Vital Roles

Assistance to Medicare Beneficiaries. Over 9 million seniors and people with disabilities who are also Medicare beneficiaries

Health Insurance Coverage. 62 million low-income Americans are covered by Medicaid

Long-Term Care Assistance. Per capita spending for elderly was $13,149 and those with disabilities $15,840 in 2009

MEDICAID

Support for Health Care System and the Safety Net. Between 2007 and 2011, total Medicaid enrollment grew by an average 5.6%

State Capacity for Health Coverage. Second largest item in state general fund budgets and single largest source of federal grant support to states

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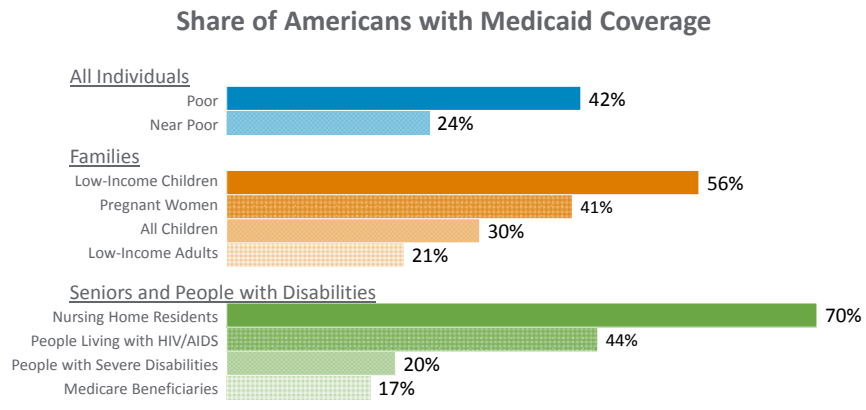
Medicaid's Role With Select Populations



Source: Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, "Top 5 Things to Know About Medicaid" (February 2011)

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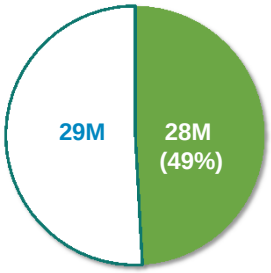
Medicaid Managed Care Remains Underpenetrated

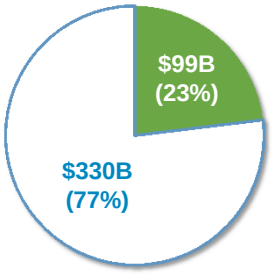
57 Million Medicaid Beneficiaries 2011

Programs
- FFS
- PACE
- PAHP
- PCCM
- PIHP



$429 Billion in Medicaid Expenditures 2011

Available Populations
- Frail Seniors (Duals)
- ABD / LTSS
- People with Disabilities
- Severe Mental Illness
- Intellectual & Developmental Disabilities



Unmanaged

Comprehensive Managed Care

High cost, high needs population makes up the "whitespace"

Sources: Medicaid Managed Care Enrollment Report Summary Statistics as of July 1, 2011, "Total Annual Medicaid Population Distribution by Year: Managed Care v. Other" and "Total Annual Medicaid Population Distribution by Year: Managed Care v. Other;" National Healthcare Expenditure Projections 2011-2012, Table 17. Commercial and Medicaid only enrollment reflects duplicated figures.

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Rate Process

- Every state works differently. *Generally:*
  - The State will have their actuary create the premium rates, which are usually community rated, often with risk adjustment
    - State will rely on data submitted from the MCOs to the State for this purpose
  - The State and their actuary will conduct rate meetings annually to explain the methodology and results
  - MCOs' actuaries will make arguments for the State's actuary to consider (usually in person meeting at the State)
    - Our goal is to ***influence*** the State and their actuary to consider our position
    - The choice is to accept or reject the rates. If we reject, we are out of a state, so this is an unlikely choice
  - State politics can play a big role in the rate setting process

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Capitation Rate Development (Overview of Basics)

Point estimates or rate ranges are developed for each rate cell as follows:

Base Claims (normally combined MCO data)

+ Program/Policy Changes (Benefits/Populations, etc.)
+ Claims Cost Trend to Contract Period (2-3 years)
- Managed Care Adjustments (if any)
= Projected Claims
+ MCO Assumed Administration Load
+ MCO Assumed Underwriting Profit/Risk/Contingency Load
+ MCO Premium Tax Load (if any)
= Capitation Rates by Category of Aid, Age/Gender/Region

Additional Financial Provisions

1. Rates can be retroactively changed up to 2 years later
2. Risk Adjustment
3. Minimum medical loss ratios/ Risk corridors/ Profit caps
4. Performance incentives/withholds – up to 5%
5. Provider pass-throughs and supplemental payments
6. Maternity supplemental payments or other event based payments
7. States can require reinsurance or risk pools

Major Impacts from Health Care Reform

1. Pharmacy Rebates
2. Increase to PCP Payments to 100% of Medicare
3. Health Insurer Fee
4. Medicaid Expansion
5. Dual Demonstration

Pharmacy Rebates

- Previous Regulation: Medicaid Drug Rebate Program (under OBRA'90)
  - Drug Manufacturers were required to give "best price" to State Fee For Service programs, which resulted in large rebates (Brand 15-23%, Generic 11%)
  - Did not apply to Managed Care programs
  - Resulted in some states carving out Pharmacy benefits from managed care to take advantage of higher rebates
- Drug Rebate Equalization Act (effective 2010)
  - Requires same rebates for Managed Care Programs as FFS, but States have to submit the claims
  - Some states are now carving Pharmacy back in as a result
- Impact to Managed Care Organizations:
  - Reduced supplemental rebates we were getting from Drug Manufacturers
  - Had to convince States to not expect same level of rebates when setting premium rates

Increase to PCP payments to 100% of Medicare

- Medicaid payments for primary care providers are required to be 100% of the Medicare fee schedule for 2013 and 2014
  - Applies to FFS and managed care
  - States will receive 100% federal financing for the increased payment rates (for 2013 and 2014 only)
  - Providers eligible: family medicine, general internal medicine and pediatric medicine
  - Services eligible: E&M CPT codes and specific immunization CPT codes

Increase to PCP payments to 100% of Medicare

- Implementation Nightmare:
  - CMS provided guidance to States that they can use a variation of 3 models:
    - Model 1: Increase premium rates, no reconciliation *(5 states)*
    - Model 2: Increase premium rates, with true-up *(3 states)*
    - Model 3: Lump sum payment based on repricing of encounters/claims *(11 states)*
  - Variations by State
    - Each State chooses what method they will use and what they require for monitoring/tracking
    - Requires identification and attestation of affected providers – States may do this and send us a list, or we need to find and identify providers
    - WLP had to determine best way to pay the increase to the providers and track increase systematically
    - Effective date of 1/1/13 but requirements for all states were not sent until recently

PCP Increases in Southeastern States

Impact of Increasing PCP Fees to 100% of Medicare Allowable

State	PCP Fee Increase Estimates
Alabama	28.2%
Florida	81.8%
Georgia	16.3%
Louisiana	11.1%
Mississippi	19.0%
South Carolina	16.3%
Tennessee	na
Average	28.8%

Health Insurer Fee

- Medicaid product getting assigned same HIF as other products
  - But Federal government is picking up 60-70% of the tab; State picking up the rest
- Two Issues to attempt to get covered in Premium Rates:
  - Health Insurer Fee of about 1.5%
  - Lost Tax deductibility worth about 1%

Challenges to MCOs:

- CMS has not provided guidance on how to build into the premium rates
- States unwilling to commit without CMS guidance
- Ability to accrue the revenue surrounding the HIF may not line up with when the costs will be accrued (1/1/14)

Options State's are considering for HIF

- **Method 1 - Pay the Fee as a Pass-Through to the MCOs Outside of Capitation**
  - Since the Fee amount varies by MCO and is not known until invoices are released in August of the fee year, states could include in the contract with the MCOs an agreement to make a pass-through payment in September of each year that is equivalent to the MCO's Fee amount impact (including any tax considerations) for that state's Medicaid program.
- **Method 2 - Include an Estimate of the Fee in the Capitation Rates then True-Up Once the Actual Amount is Known**
  - A variation of the pass-through outside of capitation method above is to pre-pay the Fee during the year and true-up the payment once the actual amount is known. An estimated amount (potentially developed with input from the MCO) of the Fee as a percentage of the capitation rates can be included in the capitation rates. Then when the invoice is released in August of the fee year, the state can make a true-up pass-through payment to the MCO that is equivalent to the Fee amount impact (including any tax considerations) for the MCO related to that state's Medicaid program minus the amount already paid in the capitation rates.
- **Method 3 – Include an Estimate of the Fee in the Capitation Rates Without True-Up**
  - An estimate of the Fee amount impact (including any tax considerations) as a percentage of the capitation rates can be included in the capitation rates with no true-up.

Expansion of Medicaid Eligibility

- Eligibility for Medicaid was planned to expand to a new national benchmark of 133 % of FPL
- Equal to less than $30,000 for a family of 4 in 2011
- Extends coverage to:
  - Children 6-18
  - Children up to age 26 if they were in foster care at age 18
  - Parents, whose children are already covered
  - Childless Adults
- Includes new 5 percent income disregard, raising eligibility to 138 % of FPL
- Supreme Court Decision determined that States could not be required to expand Medicaid eligibility

Financing of Medicaid Expansion

- Health reform provides federal financing for those newly eligible for Medicaid coverage:

Year	Federal Medical Assistance Percentage (FMAP)
2014 to 2016	100 percent
2017	95 percent
2018	94 percent
2019	93 percent
2020 and After	90 percent

- States that expanded eligibility prior to 2014 will receive a phased-in FMAP increase for currently eligible, non-pregnant, childless adults

Eligibility Standards in Southeastern States

State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014[1]
(For MAGI Groups, based on state decisions as of October 24, 2013)

State	Children				Pregnant Women		Adults		
	Medicaid Ages 0-1[2]	Medicaid Ages 1-5[2]	Medicaid Ages 6-18[2]	Separate CHIP[3]	Medicaid	CHIP	Parents[4]	Other Adults	Medicaid Expansion
Alabama	141%	141%	141%	312%	141%	N/A	13%	0%	N
Florida	206%	140%	133%	210% (1-18)	191%	N/A	31%	0%6	N
Georgia	205%	149%	133%	247%	220%	N/A	36%	0%	N
Louisiana	212%	212%	212%	250%	209%	N/A	19%	9	N
Mississippi	194%	143%	133%	209%	194%	N/A	24%	0%	N
South Carolina	208%	208%	208%	N/A	194%	N/A	62%	0%	N
Tennessee	195%	142%	133%	250%	195%	N/A	106%	0%	N
Washington	207%	207%	207%	300%	193%	N/A	133%	133%	Y

1 For these eligibility groups, an individual's income, computed based on the new Modified Adjusted Gross Income (MAGI)-based income rules and adjusted by a 5% disregard, is compared to the income standards identified in this table to determine if they are income eligible for Medicaid or CHIP. Other eligibility criteria also apply.
2 These eligibility standards include CHIP-funded Medicaid expansions.
3 Children in separate CHIP programs are typically charged premiums. This table does not include notations of states that have elected to provide CHIP coverage from conception to birth
4 In states that use dollar amounts rather than percentages of the federal poverty level (FPL) for 2013 to determine eligibility for parents, we converted those amounts to a percent of the FPL.

Projected Medicaid Enrollment Post-ACA SE States

Kaiser Commission of Medicaid and the Uninsured

Projected Medicaid Enrollment Projections: No ACA, ACA without Expansion and ACA with Expansion in 1,000s

State	No ACA Baseline	Post ACA: State Does Not Expand	Post ACA: State Expands	Post ACA: Incremental Impact of Expansion
Alabama	809	58	371	313
Florida	2,466	357	1,633	1,276
Georgia	1,524	157	855	698
Louisiana	993	58	456	398
Mississippi	669	57	288	231
South Carolina	813	56	368	312
Tennessee	1,319	76	438	362
Total	8,593	819	4,409	3,590

State Medicaid/CHIP and Marketplace Interactions (As of October 1, 2013)

State Medicaid/CHIP and Marketplace Interactions (As of October 1, 2013)

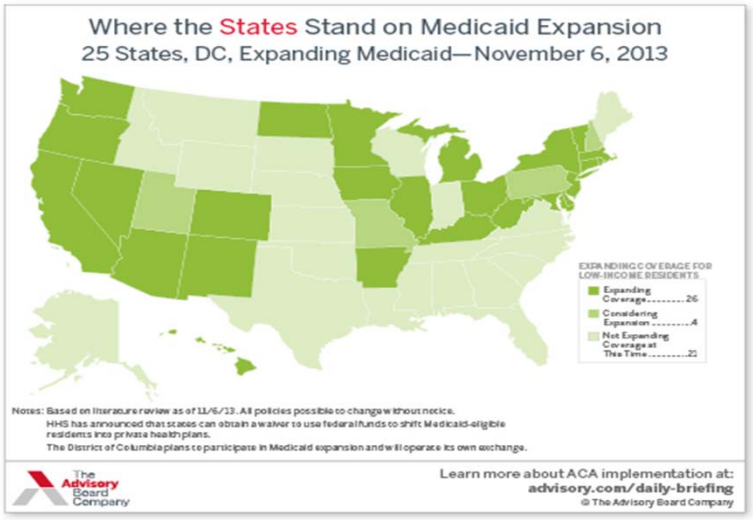
State	Marketplace Model: SBM/Partnership/FFM	FFM Assessment vs. Determination
Alabama	FFM	Determination state
Florida	FFM	Assessment state
Georgia	FFM	Assessment state
Louisiana	FFM	Determination state*
Mississippi	FFM	Assessment state
South Carolina	FFM	Assessment state
Tennessee	FFM	Determination state*

* State has elected to permit the FFM to make Medicaid/CHIP eligibility determinations temporarily as a mitigation strategy.

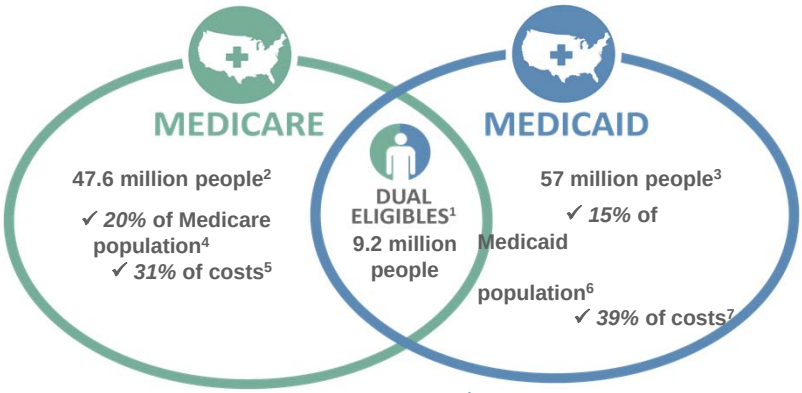
Costs of Newly Insured Low Income Individuals

- **Health Status, Risk Factors, and Medical Conditions Among Persons Enrolled in Medicaid vs. Uninsured Low-Income Adults Potentially Eligible for Medicaid Under the Affordable Care Act** *JAMA.* 2013;309(24):2579-2586. doi:10.1001/jama.2013.7106.
- Compared with those already enrolled in Medicaid, uninsured adults were less likely to be obese and sedentary and less likely to report a physical, mental, or emotional limitation.
- They also were less likely to have several chronic conditions. For example, 30.1% (95% CI, 26.8%-33.4%) of uninsured adults had hypertension, hypercholesterolemia, or diabetes compared with 38.6% (95% CI, 32.0%-45.3%) of those enrolled in Medicaid (P = .02).
- However, if they had these conditions, uninsured adults were less likely to be aware of them and less likely to have them controlled. For example, 80.1% (95% CI, 75.2%-85.1%) of the uninsured adults with at least 1 of these 3 conditions had at least 1 uncontrolled condition, compared with 63.4% (95% CI, 53.7%-73.1%) of adults enrolled in Medicaid.

Current Expansion Plans from The Advisory Board



Dual Eligibles & Dual Demonstration

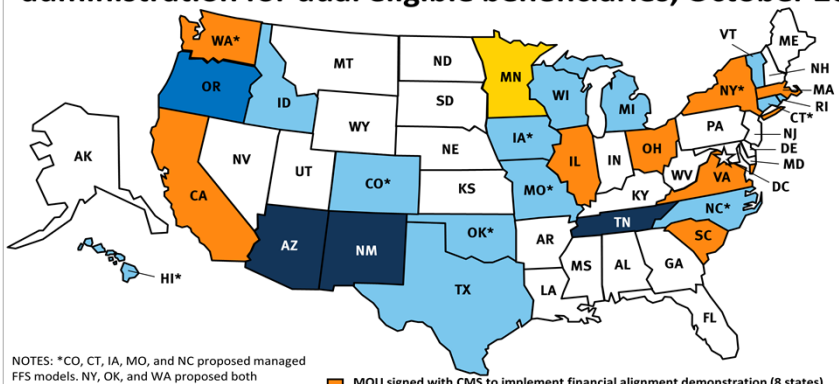


1. Medicaid and CHIP Payment and Access Commission, "Report to the Congress on Medicaid and CHIP" (March 2013), chapter 3, 47, data as of July 1, 2011, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf. 2. Kaiser State Health Fast Facts, "Total Medicare Beneficiaries, 2011," data as of July 1, 2011, http://www.statehealthfacts.org/comparemaptable.jsp?yr=200&typ=1&ind=290&cat=6&sub=74 . 3. Report to the Congress on Medicaid and CHIP, Ibid. 4. Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role for Dual Eligibles" (April 2012), http://www.kff.org/medicaid/upload/7846-03.pdf. 5. Ibid. 6. Ibid. 7. Ibid.

Dual Eligibles

- Pricing is more complicated than any product alone:
  - Medicare portion of the rate developed by CMS
  - Medicaid portion of the rate developed by State
  - County savings targets developed by outside consultant to CMS and increase each year from 1-5%
  - No specific load for admin
  - Need to make sure underwriting includes the totality of the business expenses and where there may be administrative savings by combining services

State demonstration proposals to align financing and/or administration for dual eligible beneficiaries, October 2013



NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; NY withdrew its managed FFS proposal. All other states proposed capitated models.
SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html, and state websites.

- MOU signed with CMS to implement financial alignment demonstration (8 states)
- MOU signed with CMS to implement administrative alignment demonstration (1 state)
- Proposal pending with CMS (13 states plus NY's DD proposal and WA's capitated proposal)
- Proposal submitted, will not pursue financial alignment but may pursue other administrative or programmatic alignment (1 state)
- Proposal withdrawn (3 states)
- Not participating in demonstration (24 states and DC)

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