

THE AFFORDABLE CARE ACT: WHAT TO EXPECT OVER THE NEXT 10 MONTHS

Bagels & Briefing for Utah Legislators
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Presented by:

Office of Legislative Research and General Counsel
Office of the Legislative Fiscal Analyst



ACA's GOAL

- REDUCE THE NUMBER OF UNINSURED
- OTHER GOALS AS WELL, BUT THEY ARE SUBORDINATE
 - Increase preventive care
 - Explore use of new payment and delivery models
 - Etc.

HOW DECREASE THE NUMBER OF UNINSURED?

- INCREASE ENROLLMENT IN PRIVATE COVERAGE
- INCREASE ENROLLMENT IN MEDICAID

HOW INCREASE ENROLLMENT IN PRIVATE COVERAGE?

- INDIVIDUAL EXCHANGE
 - Individual (nongroup) plans
 - Federal premium and cost sharing subsidies
 - Screens all applicants for public coverage and enrolls in Medicaid, if eligible
 - Utah has refused to implement

- EMPLOYER EXCHANGE (*SMALL BUSINESS HEALTH OPTIONS PROGRAM OR SHOP*)
 - Group plans
 - 2014–15: ≤ 50 employees required (51-100 optional)
 - 2016: ≤ 100 employees required
 - 2017: 100+ employees optional
 - Not subsidized
 - Like *Avenue H*, Utah's existing exchange for employers/employees

HOW TO IMPLEMENT EXCHANGES?

- HHS ASKED STATES TO CHOOSE ONE OF THREE DOORS



HHS runs
both exchanges

State runs
both exchanges

HHS "partners"
with state to
run both exchanges

HOW TO IMPLEMENT EXCHANGES?

- UTAH CHOSE A FOURTH DOOR



HHS runs
both exchanges

State runs
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HHS "partners"
with state to
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HHS runs
individual exchange;
state runs
employer exchange

HOW TO IMPLEMENT EXCHANGES?

- UTAH'S FOURTH DOOR
 - HHS runs the individual exchange, administers federal premium subsidies, operates the navigators program, and administers penalties
 - Utah runs the employer exchange
 - *Avenue H* would satisfy employer exchange (SHOP) requirements
 - Utah has responsibility for:
 - Determining Medicaid eligibility (individual exchange applicants)
 - Plan management (qualified health plans)
 - Other MOU provisions

WILL HHS LET UTAH
GO THROUGH THE FOURTH DOOR?

- STATE NEGOTIATING WITH HHS
- STATE'S ROLE WILL DEPEND ON RESULT

STATE IMPLEMENTATION REQUIREMENTS BETWEEN NOW AND 2014

- EXCHANGES

- Complete "fourth door" negotiations
 - State's role will depend on results

- *Avenue H* modifications to be ACA compliant as a *SHOP* exchange
 - List new plans & rates
 - Categorize plans as bronze, silver, gold, or platinum
 - Modify current application and rate setting processes to reflect ACA
 - Allow employers to limit employees to metallic level
 - Add rate transparency and carrier quality information
 - Add carriers

STATE IMPLEMENTATION REQUIREMENTS BETWEEN NOW AND 2014

Marketplace Timeline

	FEB 2013	MAR 2013	APR 2013	MAY 2013	JUN 2013	JUL 2013	AUG 2013	SEP 2013	OCT 2013
Policy	<u>2/2013</u> Essential Health Benefits & Market Rules, Payment Notice		<u>3/2013</u> Medicaid FMAP Rule		<u>4/2013</u> Eligibility Rule (Marketplace & Medicaid/CHIP Appeals)				
Operations & IT	<u>2/2013</u> Income Definition Business Rules Finalized		<u>4/2013</u> Issuers Submit QHP Rating & Benefit Data for HHS Marketplace		<u>7/2013</u> Final QHP Evaluation Results Recd. & Data Finalized		<u>8/2013</u> QHP Plan Preview for HHS & Partner Marketplaces	<u>9/2013</u> IT Dev. & Integration Testing Complete	
Issuers & States	<u>2/2013</u> State Partnership Marketplace Blueprints Due		<u>3/2013</u> Secretary Final Decisions for Marketplaces		<u>7/2013</u> State Dept. of Insurance Approval of QHPs, State Partnership Review of QHPs Complete				
			<u>3/2013</u> Issuer QHP Plan Designs Complete						
Consumer Assistance			<u>4/2013</u> Single Streamlined Application Finalized			<u>6/2013</u> Web Re-Launch & Call Center Launch	<u>7/2013</u> Navigator Portal Available	<u>8/2013</u> Navigator/Agent/Broker Training Complete	<u>10/2013</u> ENROLLMENT BEGINS

CHIP: Children's Health Insurance Plan **QHP:** Quality Health Plan
FMAP: Federal Medical Assistance Percentages (Matching funds for Medicaid and other State-administered programs)

Source: CCIIO The Center for Consumer Information & Insurance Oversight, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Accessed 3/4/13 at <http://cciio.cms.gov/resources/files/marketplace-timeline.pdf>

STATE IMPLEMENTATION REQUIREMENTS BETWEEN NOW AND 2014

- MEDICAID
 - Implement mandatory expansion
 - Enhance eRep to send/receive data to/from exchange
 - Develop MAGI methodology
 - Convert from proprietary code to open source code
 - Modify Medicaid Management Information System (MMIS)

- OPTIONAL EXPANSION
 - Department of Health study by PCG

STATE IMPLEMENTATION REQUIREMENTS

BETWEEN NOW AND 2014

- **OCTOBER 1, 2013**
 - Exchanges open and enrollment in commercial plans for coverage beginning 1/1/14 or later begins
- **JANUARY 1, 2014**
 - Exchange plan coverage begins
 - Federal premium and cost sharing subsidies begin
 - Individual penalties begin
 - Employer penalties begin
 - Etc.

STATE IMPLEMENTATION REQUIREMENTS

BEYOND 2014

- WHAT HAPPENS TO *AVENUE H* IF "FOURTH DOOR" IS CLOSED?
- HOW WILL THE STATE RESPOND IF THE ACA THREATENS THE VIABILITY OF THE INDIVIDUAL OR SMALL GROUP MARKETS?
- SHOULD THE STATE IMPLEMENT A BASIC HEALTH PROGRAM? (delayed one year)
- SHOULD THE STATE DEVELOP AN ACA WAIVER PROPOSAL? (2017 is earliest implementation date)

For additional information about the Affordable Care Act and Utah health reform, contact:

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FISCAL NOTE

H.B. 153

SHORT TITLE: Medicaid Amendments

SPONSOR: Chavez-Houck, R.

2013 GENERAL SESSION

STATE GOVERNMENT (UCA 36-12-13(2)(b))

Enacting this bill could increase total costs for Medicaid by an estimated \$245 million in FY 2014 and \$521 million in FY 2015. By FY 2021 the total cost increase could be around \$700 million. In fiscal years FY 2014 through FY 2016, federal funding will cover these cost increases and reduce the State's share of costs. By FY 2021 the bill's General Fund cost could be an estimated \$60 million.

The bill deposits the General Fund cost share decrease of \$4,549,200 in FY 2014 and \$13,024,700 in FY 2015 and FY 2016 into the Medicaid Growth Reduction and Budget Stabilization Account. The bill would also reduce the Education Fund's cost share by \$222,000 in FY 2014 and \$444,000 ongoing beginning in FY 2015. Finally, the bill would reduce the cost share born by restricted funds by \$1,219,600 in FY 2014 and \$2,439,100 ongoing beginning in FY 2015.

STATE BUDGET DETAIL TABLE

	FY 2013	FY 2014	FY 2015
Revenue:			
Federal Funds	\$0	\$246,749,400	\$523,972,800
Restricted Funds	\$0	\$4,549,200	\$13,024,700
Total Revenue	\$0	\$251,298,600	\$536,997,500
Expenditure:			
General Fund	\$0	\$4,549,200	\$13,024,700
General Fund	\$0	(\$13,024,700)	(\$13,024,700)
General Fund, One-Time	\$0	\$8,475,500	\$0
Education Fund	\$0	(\$444,000)	(\$444,000)
Education Fund, One-Time	\$0	\$222,000	\$0
Federal Funds	\$0	\$246,749,400	\$523,972,800
Restricted Funds	\$0	(\$1,219,600)	(\$2,439,100)
Total Expenditure	\$0	\$245,307,800	\$521,089,700
Net Impact, All Funds (Rev.-Exp.)	\$0	\$5,990,800	\$15,907,800
Net Impact, General/Education Funds	\$0	\$222,000	\$444,000

FISCAL NOTE

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LOCAL GOVERNMENTS (UCA 36-12-13(2)(c))

Local government mental health and substance abuse services will be replaced for 10,600 individuals with full Medicaid coverage at a higher federal match rate which generates General Fund savings of about \$2,000,000 one-time in FY 2014 and \$4,000,000 ongoing for FY 2015 and FY 2016. These savings then decline annually beginning in FY 2017 to about \$2,800,000 by FY 2021. County governments will also see savings for newly eligible inmates for Medicaid to cover some inpatient hospital medical costs.

DIRECT EXPENDITURES BY UTAH RESIDENTS AND BUSINESSES (UCA 36-12-13(2)(d))

Medicaid spending will increase by up to \$248.0 million for 131,500 individuals in FY 2014 and spending will increase to \$732.4 million for 160,100 people by FY 2021.

PERFORMANCE NOTE (JR 4-2-404): Required from Health by 3/4/2013

2/27/2013, 01:37 PM, Lead Analyst: Frandsen, R./Attorney: CJD

State of Utah, Office of the Legislative Fiscal Analyst



MEDICAID CONSENSUS FORECASTING

EXECUTIVE APPROPRIATIONS COMMITTEE
STAFF: RUSSELL FRANSEN & THOMAS YOUNG

ISSUE BRIEF

SUMMARY

The Medicaid consensus forecast team estimates surplus General Fund in FY 2013 of \$40.9 million and \$1.8 million in FY 2014. For the Children’s Health Insurance Program, consensus forecast estimates General Fund surplus in FY 2013 of \$3.8 million and a cost of \$1.5 million in FY 2014. The Legislature may want to include these estimates in the base budgets for FY 2013 and FY 2014. These estimates do not include any funding for state administration or any optional provider inflation. The 2011-2012 consensus process helped save the State from appropriating an additional General Fund of \$13 million for FY 2012 during the 2012 General Session for medical services in Medicaid.

DISCUSSION AND ANALYSIS

Below is a summary of the consensus General Fund mandatory cost estimates for FY 2013 & FY 2014:

Consensus General Fund Estimates (Surplus)/Cost	Medicaid		CHIP	
	FY 2013	FY 2014	FY 2013	FY 2014
Baseline Caseload	\$ (40.9)	\$ (21.2)	\$ (3.8)	\$ (0.8)
Federal Health Care Reform	\$ -	\$ 19.4	\$ -	\$ 2.3
Total in Millions	\$ (40.9)	\$ (1.8)	\$ (3.8)	\$ 1.5

Medicaid – What is Included in Consensus for Mandatory Costs?

The Medicaid forecast team (Legislative Fiscal Analyst, Governor’s Office of Planning and Budget, and the Department of Health) forecast a reduction in mandatory costs of \$40.9 million in FY 2013 and \$1.8 million in FY 2014. This forecast includes the following components: baseline caseload costs and impacts from federal health care reform. Each of these items has a more detailed discussion here below:

1. **Baseline caseload** includes the following additional costs/savings (all items are for FY 2014 unless specifically noted otherwise):
 - a. Baseline change in caseloads and cost per member per month – estimated increase of 5,900 or 2% clients in FY 2013 and 3,000 or 1% in FY 2014. A utilization increase of 3% in FY 2013. Caseload and per member per month changes represent the majority of all cost estimates.
 - b. Forced provider inflation of \$6.8 million – this includes cost increases over which the state has no control due to federal regulation or has opted not to exercise more state control over cost increases. About 95% of the increases come from the following four areas (listed in order of size): accountable care organization contracts, pharmacy drug reimbursement, Clawback payments to the federal government, and Medicare buy-in program. This is the first year that forced provider inflation was included in consensus forecasting. The consensus cost estimate is \$0.5 million less General Fund than the agency’s original estimate due to a caseload cost forecast that came in below FY 2013 appropriated levels.
 - c. Federal medical assistance percentage favorable change of 0.2% for a savings of about \$2.7 million.
 - d. Preferred Drug List additional projected savings of \$1.4 million.
 - e. A 2% State-funded increase in physician rates now to be paid by the federal government for a savings of \$0.8 million.

- f. Additional \$2.5 million in FY 2013 for funding of costs for the run out associated with change to accountable care organizations in January 2013
2. **Costs to Medicaid from federal health care reform** – The consensus group estimates \$19.4 million in General Fund costs to Medicaid for FY 2014. The following is a list of the areas with potential costs to the state in Medicaid from federal health care reform:
- a. Currently eligible but not enrolled individuals signing up for Medicaid – with changes to how some people apply for health insurance, this will likely increase the number of individuals who sign up for Medicaid. For example, all individuals who apply for tax credits to help pay for health insurance must first be determined ineligible for Medicaid.
 - b. Income determination to be based on modified adjusted gross income – this may result in less people denied services and less incomplete applications for Medicaid.
 - c. Asset Test Elimination for adults and pregnant clients.
 - d. Medicaid must cover youth for whom foster care was discontinued at age 18 or older until they are age 26. Utah currently covers up to age 21. The Department of Human Services estimates that we have about 1,900 Utah foster care graduates under age 26. The Department of Workforce Services estimates about 400 of those are currently served by Medicaid.
 - e. Children must be eligible to receive hospice services, which Utah Medicaid does not currently cover.

Why Did FY 2012 Have \$27.4 Million in Unspent General Fund in Medicaid?

Medicaid ended FY 2012 with \$27.4 million in unspent General Fund. The unexpected unspent balance was \$19.1 million or 5% as \$4.5 million was part of HB 272 (Menlove) *Pilot Program for Autism Spectrum Disorders Services* from the 2012 General Session and the federal government charged the state \$3.8 million less than originally planned. The \$19.1 million or 5% unexpected surplus is 1.4% due to caseload and 3.6% due to per member per month (PMPM) cost estimates. The consensus forecast estimated an average monthly client enrollment of 294,003 in FY 2012. FY 2012 saw 290,046 average monthly client enrollment. Below is how the difference compared by subcategory:

Subcategory	FY12 Actual		FY12 Consensus		Actual - Consensus	
	PMPM	Clients	PMPM	Clients	PMPM	Clients
Adult	\$ 75	25,974	\$ 107	26,004	\$ (32)	-30
Aged	\$ 695	11,385	\$ 268	11,536	\$ 426	-151
Blind/Disabled	\$ 230	31,963	\$ 315	32,013	\$ (84)	-50
Child	\$ 47	120,626	\$ 59	123,688	\$ (12)	-3,062
Molina	\$ 53	59,553	\$ 67	60,320	\$ (14)	-767
Primary Care Network	\$ 26	14,564	\$ 33	14,003	\$ (7)	561
Pregnant	\$ 383	4,176	\$ 506	4,178	\$ (123)	-2
Qualified Medicare Beneficiaries	\$ 71	21,804	\$ 84	22,262	\$ (13)	-458
Average Monthly Clients		290,046		294,003		-3,957

The 2012 General Session was the first year for consensus forecasting for Medicaid and Children’s Health Insurance Program and saved the State \$13 million General Fund in FY 2012 when compared to the original building block request for Medicaid.

Medicaid Caseload Cost Estimate (General Fund)	FY 2012	Higher/(Lower) Than Building Block
Building Block from Health	\$ 48	\$ -
October 2011 Consensus	\$ 44	\$ (4)
February 2012 Consensus	\$ 35	\$ (13)

Will FY 2013 Be Closer Than the 5% Error Rate from FY 2012?

There are several reasons to be hopeful that the consensus cost estimate for FY 2013 will be closer than the 5% error rate from FY 2012. These reasons include more clients in capitated care and a broader base for estimating per member per month costs. Effective January 2013, the number of Medicaid clients served by a capitated care contract will triple (from 20% to about 60% of all clients). This means that the per member per month cost per client will be a known factor as it will be a contracted monthly rate. If the consensus group correctly estimates client enrollment, then total cost would be 100% accurate. For the 40% of clients that will not be served by a capitated care contract, the consensus group will use 12 months of actual expenditures to forecast future costs. Previously in February 2012, the consensus group used the most recent seven months to estimate future costs. This broader base to forecast expenditures should better account for seasonal variations in spending.

Children’s Health Insurance Program (CHIP) – What is Included in Consensus?

The consensus team estimates a General Fund surplus of \$3.8 million in FY 2013 and a cost of \$1.5 million in FY 2014. The consensus for CHIP includes the following components:

1. **Baseline costs** – assumes a change in enrollment and a change in the cost per member per month. The consensus team estimates a 1.1% or 430 decrease in enrollment and a 1.2% increase in per member per month costs for FY 2013. For FY 2014 these same changes are increases of 1.4% or 510 and 4% respectively.
2. **Costs from federal health care reform** - the following is a list of the areas with costs to the state in the Children’s Health Insurance Program:
 - Shift of about 66% or 25,460 of CHIP children onto Medicaid due to the elimination of the asset test for children ages 6 to 18. These children newly shifted onto Medicaid will cost the state \$1.8 million more General Fund in FY 2014 due to Medicaid’s richer benefit package.
 - 2,850 currently eligible but not enrolled individuals signing up for CHIP at a cost of \$0.5 million General Fund.

Why Consensus Forecasting for Medicaid?

When arriving at final point estimates for tax revenue projections, economists from the Legislative Fiscal Analysts Office, the Governor’s Office of Planning and Budget, and the State Tax Commission compare numbers and attempt to reach a consensus. The details of each projection are examined and critiqued against the other offices’ numbers. By comparing competing forecasts, all involved parties attempt to flush out any errors or left out factors. These same reasons apply to Medicaid. From June 2000 to June 2012, Utah Medicaid grew from 121,300 clients to 252,600 clients, an increase of 108%. Over the same period, the percentage of the State’s population on Medicaid grew from 5.4% to 8.8%.

Officially, Medicaid is an "optional" program, one that a state can elect to offer. However, if a state offers the program, it must abide by strict federal regulations. As Utah has, to this point, chose to offer Medicaid, it has established an entitlement program for qualified individuals. That is, anyone who meets specific eligibility

criteria is "entitled" to Medicaid services. An accurate forecast is essential to adequately funding that entitlement.

Additional Resources

- *Medicaid Consensus Forecasting* Issue Brief from the 2011 Interim <http://le.utah.gov/interim/2011/pdf/00002030.pdf>
- Kaiser Summary of Federal Health Care Reform <http://le.utah.gov/interim/2012/pdf/00002141.pdf>

RECOMMENDATIONS

In some years the Legislature has opted to address Medicaid costs in the base budget. The Legislature may want to consider this option with the estimates contained in this brief. If so there are estimated General Fund surpluses in Medicaid of \$40.9 million in FY 2013 and \$1.8 million in FY 2014. These estimates do not include any funding for state administration or any optional provider inflation.