

***Virginia Medicaid  
Department of Medical  
Assistance Services***

**Covering the Uninsured PMPM  
Estimates  
January 29, 2014**

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# ***Agenda***

Background

Our Role

Methodology, Key Considerations and Assumptions

Results

Additional Information

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# **Background**

## ***PwC Experience with Virginia Medicaid and other states***

- Consulting actuary to Virginia since 1997; more than 25 years experience with Medicaid Managed Care in 15 states including programs in Oregon, Tennessee, Wisconsin, Kentucky, and others
- Rate-setting work in Virginia:
  - Medallion II and Medicaid Managed Care roll out across the state
  - FAMIS and FAMIS MOMS, PACE, Commonwealth Coordinated Care Dual Demonstration
- Other consulting projects: Cost Effectiveness, presentations to VHRI Advisory Council
- Commercial and Medicare Experience
  - Exchange rate filings in 10+ states
  - Develop rates for Medicare Advantage plans, and review rates for CMS

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# ***Our Role***

## ***PwC Role in DMAS ACA Budget Estimates***

- Initial per capita (PMPM) estimates prepared September 2012
- Updated estimates prepared December 2013, with initial discussions in September 2013
- Developed PMPM cost estimates of specific population cohorts:
  - Currently eligible for VA Medicaid, but not enrolled
    - > **“Woodwork” or “Welcome Mat” population**
  - New costs for currently enrolled population - income between 29% and 133% FPL:
    - > **Parents of children (Caretaker Adults)**
    - > **Disabled under 65 (ABD)**
  - Newly Eligible up to 133% FPL
    - > **Primarily Childless Adults**

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## ***Methodology and Assumptions***

### ***PwC Methodology, Key Consideration and Assumptions for PMPM Estimates***

- All new Medicaid cohorts would be enrolled in Managed Care Organizations (MCOs)
- Base PMPM developed with health plan data used for Medallion II MCO rate-setting for CY 2014 contracts
- Updated estimates rely on new information
  - More recent experience from the Medallion II program
  - Experience of early Medicaid program extensions to uninsured populations

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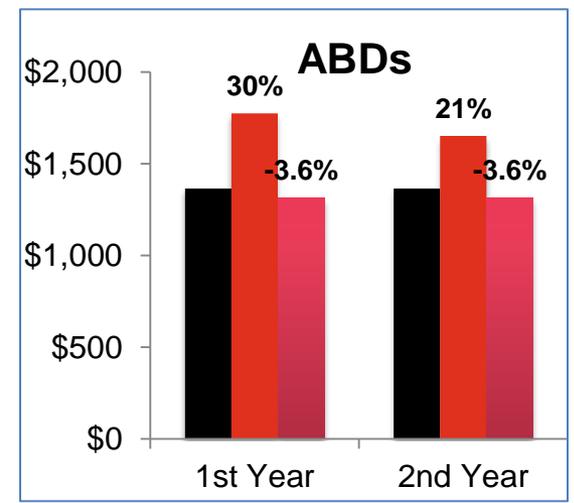
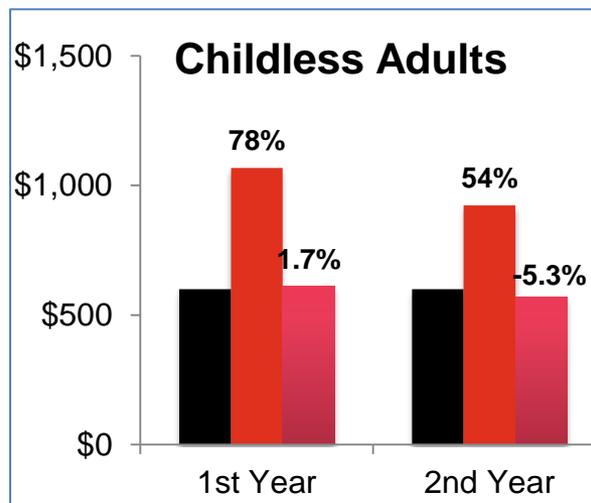
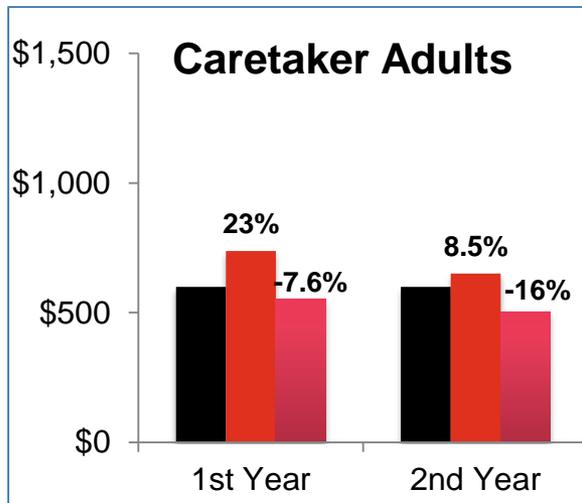
# ***Methodology and Assumptions***

## ***PwC Methodology, Key Consideration and Assumptions for PMPM Estimates***

- Demographic characteristics
  - Age/gender
  - Maternity status (all pregnant women fall into currently eligible categories)
- Covered services
  - Benchmark benefit plan
  - Mental Health and Substance Abuse
- Health status of the population
  - Pent up demand
  - Adverse risk
  - Enrollment timing and take up rate

# Results

## Summary of PMPM Estimates



■ Base

■ 2012 Estimate

■ 2013 Estimate

# **Results**

## ***Primary Drivers for Change in Revised Estimates***

### **2012 Estimate**

- Estimates were initially developed to ensure budget was not too low
- Little was known about likely cost of new populations, and expectation was for a very high level of adverse selection
- New enrollees were initially assumed to have more chronic conditions and costs most similar to current aged/disabled populations

### **2013 Estimate**

- In-depth review of recent information from states having experience with previously uninsured populations: Wisconsin, Oregon, California, and additional work in Arizona, Minnesota, New York, Washington
- Concluded that new enrollees are more likely to have costs in line with, or even lower, than currently covered low-income adults
- In depth analysis of Wisconsin BadgerCare + population, and Oregon Health Plan provided most relevant information

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## ***Additional Information***

### ***Takeaways from new analysis***

- Early enrollees will be most costly, and their costs will taper off as need is met
- Broad enrollment will result in lower per capita costs; lack of premium requirement encourages a broader mix
- Current eligible but not enrolled have costs below current enrollees
- Higher income new eligibles in traditional categories are likely the same or slightly less expensive than current population
- Newly eligible childless adult costs are the most difficult to project and likely to initially be somewhat higher than parents with children, with higher Mental Health and Substance Abuse needs; physical health needs tend to be lower

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# Q&A

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