

Medicaid Forecast and Impact of Health Care Reform

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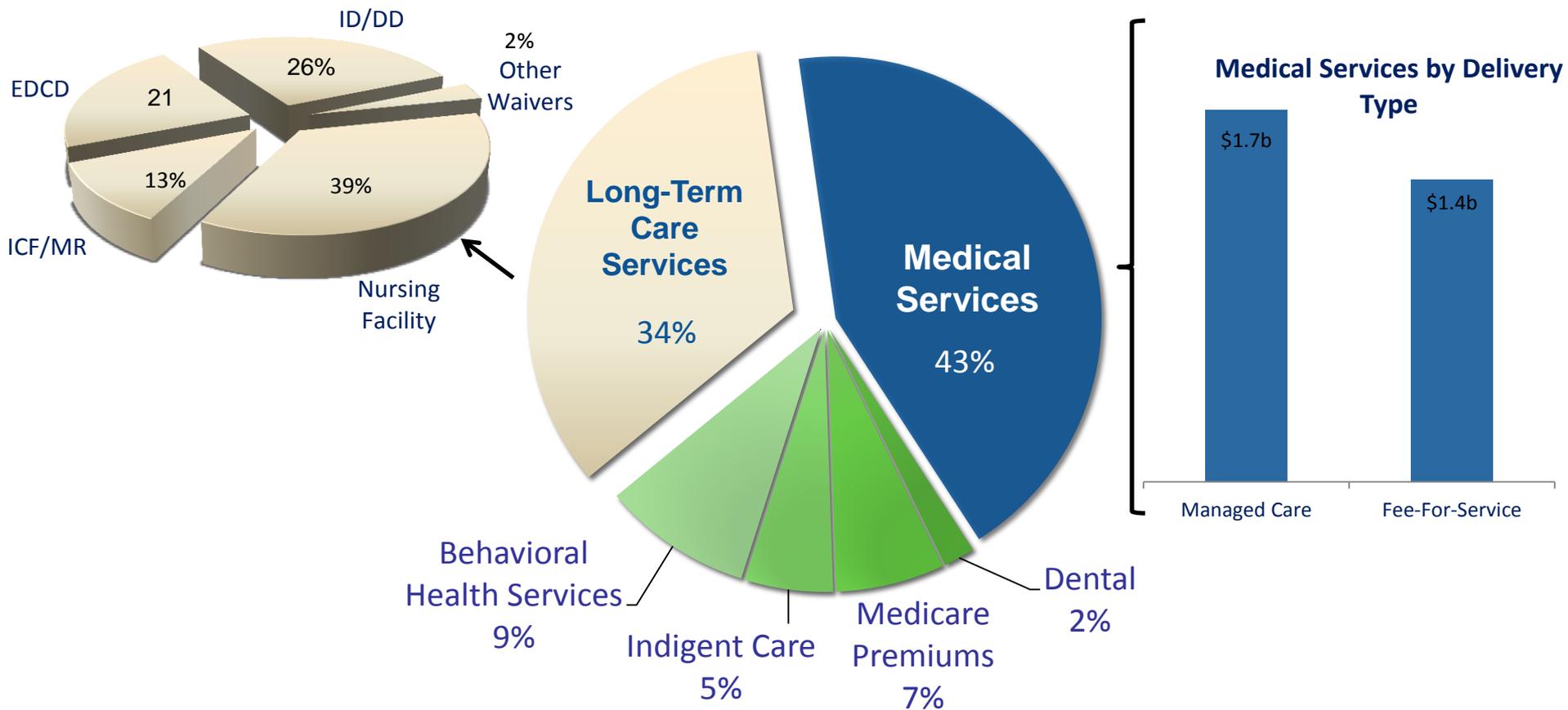
- Overview of the Virginia Medicaid Program
- Medicaid Forecast
- Impact of Health Care Reform on the Virginia Medicaid Program
- Medicaid Expansion Issues

Virginia Medicaid Program

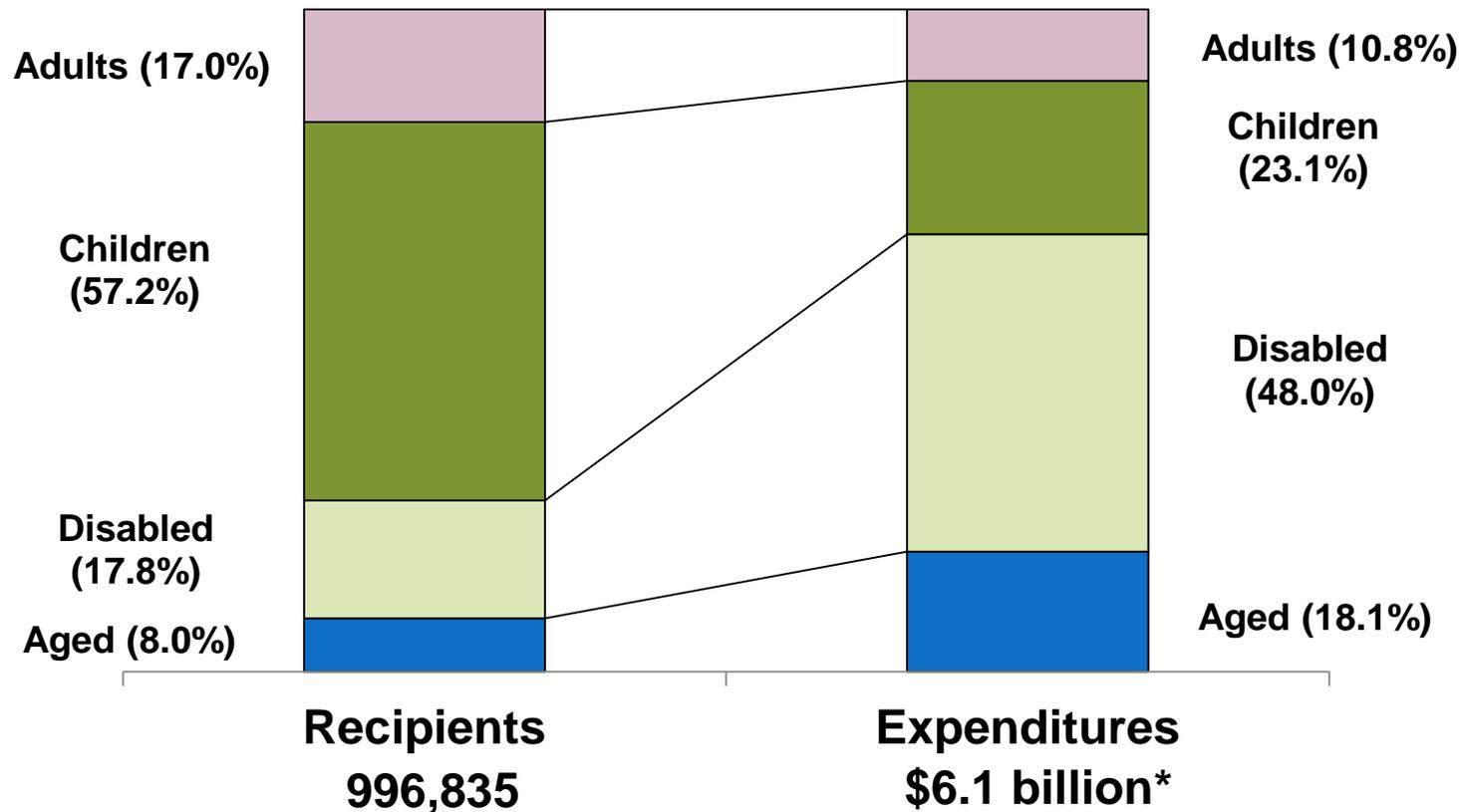
- Largest health care financing program for low-income persons in Virginia
 - Aged, blind or disabled
 - Children
 - Member of a family with children
 - Pregnant women
 - Certain Medicare beneficiaries
- In FY 2012, Medicaid provided payments on behalf of 996,835 recipients at a total program cost of \$7.0 billion
- Program costs are shared by the state and federal government
- Virginia's share is 50% in FY 2012 based on per capita income

Virginia Medicaid Expenditures by Service Type FY 2012

Long-Term Care Expenditures



Comparison of Recipient Groups as a Percent of All Recipients and Expenditures (FY 2012)



*Does not include approximately \$913.3 million in lump sum expenditures that cannot be attributable to individual recipients.

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Medicaid Forecast

- Official Medicaid forecast updated every November
 - Governor's introduced budget may include updated data elements
- 2011 Official Medicaid forecast projected spending for FY 2012 and the 2012-14 biennium
 - Forecast for FY 2012 was reduced by \$85.4 million GF
 - Forecast for 2012-14 introduced budget required an additional \$650.5 million GF
 - Included the inflationary adjustments for hospitals, nursing homes, others, removed in a separate policy action
 - Included the cost of rebasing nursing home rates, removed in a separate policy action
- 2012 Session technical adjustments to the forecast
 - Modified enrollment period for "woodwork" population from July 1, 2013 to January 1, 2014
 - "Woodwork" describes individuals who could be Medicaid eligible today, but are not enrolled. They are expected to enroll in 2014 due to the individual mandate provisions contained in the federal Patient Protection and Affordable Care Act (ACA)
 - Adjusted the federal match rate (FMAP) from 50% to 65% for children between 100 and 133 percent of the federal poverty level who are currently in the FAMIS program but would be moved into Medicaid under the ACA provisions

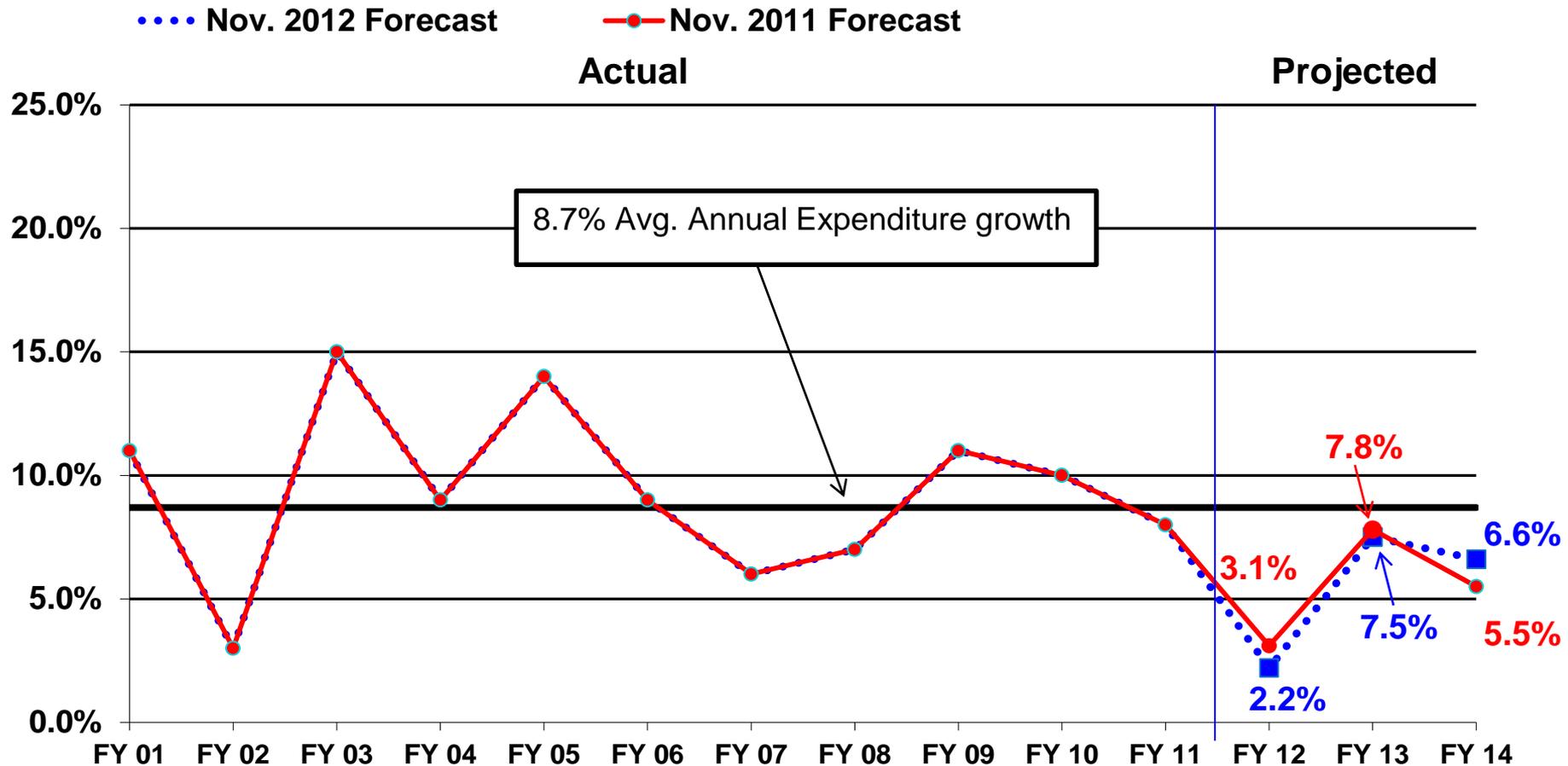
What Factors Have Changed to Affect the 2012-14 Medicaid Forecast?

- Factors increasing Medicaid costs
 - Fee for service medical expenditures are slightly higher than originally projected
 - May be a result of increased acuity for those left in the fee for service program compared to those enrolled in managed care
 - Growth in personal care and adult community-based mental health expenditures
 - \$10.5 million in GF in FY 2012 expenditures moved to FY 2013 due to billing delays by state ID/MH facilities
 - \$20 million in savings from managed behavioral health care will not be realized over the biennium due to legal challenge of vendor disqualification
 - \$28 million GF in quarterly payments to teaching hospitals were delayed from FY 2012 to FY 2013
 - \$16 million represents prior year cost settlements and enhanced DSH payments that were assumed to be delayed per Appropriation Act language adopted in 2009 Session
 - \$12 million in DSH payments couldn't be paid to teaching hospitals because of hitting the federal cap on these payments for FFY 2012
 - Hospital rebasing included in the FY 2014 forecast
 - Required by Medicaid regulations
 - Rebasing has become a policy choice in recent years

What Factors Have Changed to Affect the 2012-14 Medicaid Forecast?

- Factors reducing Medicaid costs
 - Further changes in the enrollment rates for “woodwork” population
 - Reduction of \$19.2 million GF in the FY 2014 forecast
 - Assumes lower enrollment rate in the first six months of 2014
 - Assumes a lower per member per month cost based on assumptions that most of the woodwork population are children instead of adults
- Virginia Health Care Fund revenues will reduce the GF costs of the Medicaid program
 - Fund has a \$65 million balance from prior year pharmacy rebates
 - Projected to increase by \$65 million each year in the 2012-14 beinnium from additional prior year pharmacy rebates
 - Primarily due to rebates on behalf of managed care recipients required under the federal health care reform legislation
 - Will be reflected in updates to the Virginia Health Care Fund revenues, not included in Official Medicaid forecast

Annual % Change in Medicaid Expenditures



Note: Represents percentage change in all funds, state and federal, adjusted for payment timing changes, cash management, FMAP maximization.

Source: Preliminary DPB and DMAS consensus forecast

Preliminary Medicaid Forecast: GF Need

(GF \$ in millions)

Medicaid Forecast	FY 2013	FY 2014
Medicaid Expenditures Baseline Forecast	\$46.2	(\$13.6)
Rebasing of Hospital Operating Costs		\$22.0
Rebasing of Hospital DSH Costs		\$60.0
Offset from Virginia Health Care Fund Balance	(\$65.0)	
Estimated Additional Revenue in the Virginia Health Care Fund from Prior Year Pharmacy Rebates	(\$65.0)	(\$65.0)
Total Change in GF Need	(\$83.8)	\$3.4

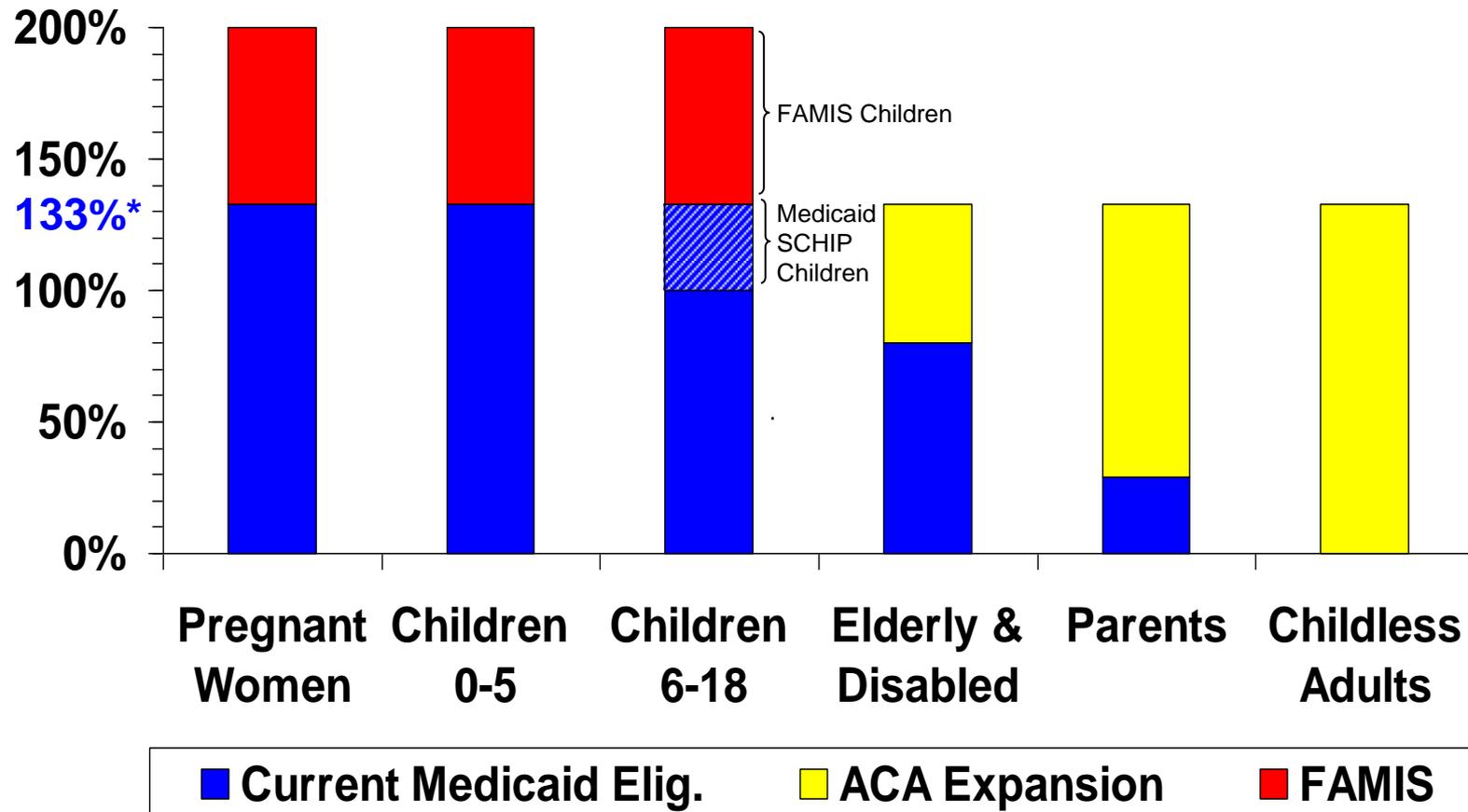
Note: Reflects preliminary Medicaid expenditure forecast which may be further refined in the Official forecast. Projected revenues for the Virginia Health Care Fund (VHCF) are preliminary and may change when finalized.

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What We Knew Last Session

- Effective January 1, 2014, the federal Personal Protection and Affordable Care Act (ACA) expands Medicaid coverage of adults to 138% of the Federal Poverty Level (FPL)
 - Represents 133% FPL plus a 5% income disregard
 - \$15,415 for an individual in 2012
 - \$31,809 for a family of four in 2012
 - ACA also modifies income calculation
- Expands coverage for groups currently covered in Medicaid
 - Low-income families with children:
 - Eligibility for these parents and other caretaker adults is currently limited to those with incomes about 29% FPL
 - Disabled adults not eligible for Medicare:
 - Eligibility is currently limited to those with incomes up to 80% FPL
 - Not in need of long-term care services
- Adds new coverage groups to Medicaid
 - Childless adults under the age of 65 who are currently not covered unless they meet some other coverage group (aged, blind, disabled, for example)
 - Former foster care “children” up to age 26 (regardless of income)

Medicaid Expansions Compared to Current Virginia Eligibility Levels*



*Does not include 5% income disregard allowed in determining financial eligibility for ACA Medicaid expansion population.

What We Knew Last Session

- Federal government would pay 100% of the cost of the newly eligible Medicaid recipients through 2016, declining each year thereafter to 90% by 2020 and beyond
 - 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020
- Requires states to maintain current income eligibility levels for children in Medicaid and the children's health insurance program (CHIP / FAMIS) until 2019
 - Increases the federal match rate for FAMIS by 23% beginning 2015-2019 from the current 65% to 87%
- Requires states who cover children between 100% and 133% FPL through FAMIS to enroll these children in Medicaid
 - State can continue to receive the federal CHIP/FAMIS match rate on this group – for Virginia the FMAP is 65%
- Requires states to maintain current income eligibility levels for adults until January 1, 2014

What Did the Budget Assume?

- “Woodwork” population
 - Subject to Current Medicaid FMAP rate – 50% for Virginia
 - Assumed 6 months of costs and an enrollment rate of about 80% (2012 Medicaid forecast reduces this enrollment rate)
- Newly eligible groups
 - Cost borne by federal government initially
 - FMAP rate of 100% for FY 2014 to FY 2016
 - Assumed 6 months of costs and an enrollment rate of almost 71%

FY 2014 Budget for Health Care Reform (\$ in millions)

Eligible Group	# Eligible	State GF	Federal NGF	All Funds
Medicaid “woodwork” effect	48,724	\$44.3	\$44.3	\$88.6
Newly Eligible (133% FPL)	299,764	\$0	\$1,099.7	\$1,099.7
DOC Inmate Hospital Savings	1,000	(\$15.2)	\$15.2	\$0

What Has Changed Since Last Session?

- Supreme Court of the United States (SCOTUS) June 2012 ruling addressed two major policy provisions of the law
 - Individual Mandate
 - Can Congress require individuals to purchase health insurance?
 - Ruling upheld the law citing Congressional authority to tax
 - Medicaid Expansion
 - Can the federal government require states to expand Medicaid under threat of withholding federal funds for existing Medicaid programs?
 - Ruling did not uphold this provision of the ACA citing that it was unduly coercive
- Medicaid expansion is now optional for states
 - State policy decision is required to elect whether or not to expand Medicaid under the ACA
 - States can opt out without jeopardizing federal funding for existing Medicaid programs

How Does the Supreme Court Ruling Impact Low-Income Individuals?

- ACA authorizes federal provision of health insurance premium tax credits and/or subsidies for individuals with incomes between 100% and 400% FPL
 - Would apply to health insurance purchased from a qualified health plan through a health insurance exchange
 - If states do not expand Medicaid to 133% FPL, individuals between 100-133% FPL could get receive tax credits and subsidies to help with purchasing health insurance through the exchange
- If states choose not to expand Medicaid to 133% FPL and do not otherwise cover individuals up to 100% FPL, these individuals will have neither Medicaid coverage, nor be eligible for federal tax credits and/or subsidies for health insurance purchased through an exchange
 - Population would likely be eligible for an affordability exemption and penalty would be waived
 - Unclear whether states will be allowed to partially expand Medicaid to cover this population and receive the enhanced federal match rate
 - Virginia does not currently cover adults up to 100% FPL

What Provisions of the ACA Remain In Effect?

- Virginia received \$89.7 million in federal DSH funding in FY 2012
- ACA reduces DSH payments to hospitals beginning in 2014
 - DSH reductions are based on set amounts contained in the ACA and amount to 5% each year from 2014-2016, 16% in 2017, 45% in 2018 and 51% in 2019
 - U.S. Secretary of Health and Human Services required to target reductions:
 - Largest reductions to states with the lowest percentages of uninsured and
 - States that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients and uncompensated care (not including bad debt)
- Other Medicaid eligibility provisions continue
 - Maintenance of effort requirements for eligibility for children and adults remain in effect
 - No changes through 2019 for children in Medicaid and FAMIS
 - No changes for adults until January 1, 2014
 - Modifications to income calculation for determining eligibility continue
 - Requires IT systems changes, eligibility process changes

Other ACA Provisions Remain In Effect

- Provisions to increase primary care rates continue
 - Federal law requires state Medicaid programs to increase payments for primary care services up to the Medicare reimbursement level
 - Virginia Medicaid currently reimburses primary care services at 85% of the Medicare level (on average)
 - 100% federal reimbursement in effect 2 years (CY 2013 and CY 2014)
 - 100% FMAP rate ceases after this period
 - States have option to continue at regular FMAP rate
 - Estimated cost to increase rate:
 - \$35.2 million NGF in FY 2013
 - \$73.3 million NGF in FY 2014
- Information Technology / Medicaid modernization requirements still in place
 - Redesign of eligibility process (automation, process changes, connectivity to a health insurance exchange)
 - Medicaid electronic health records incentive program
 - Provider screening program, federal recovery audit program

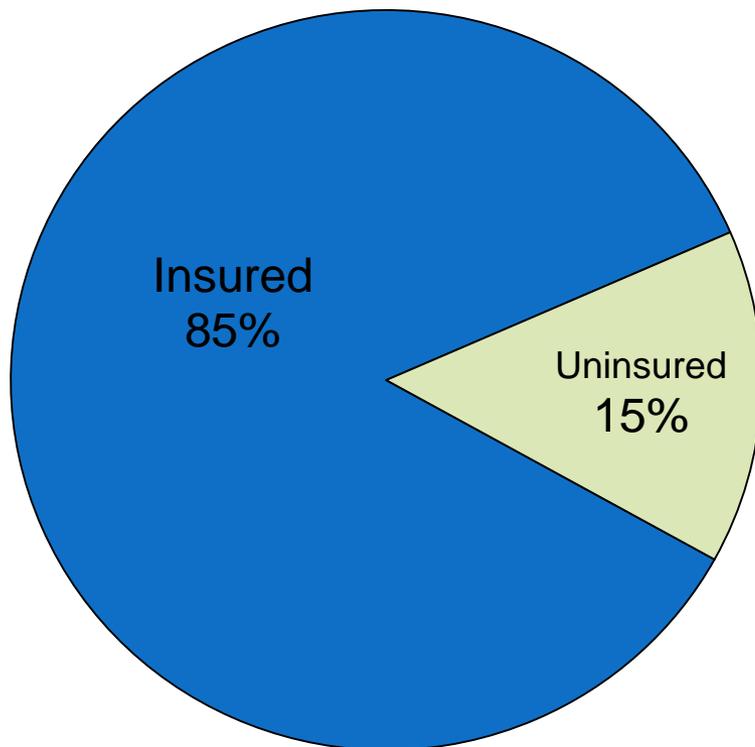
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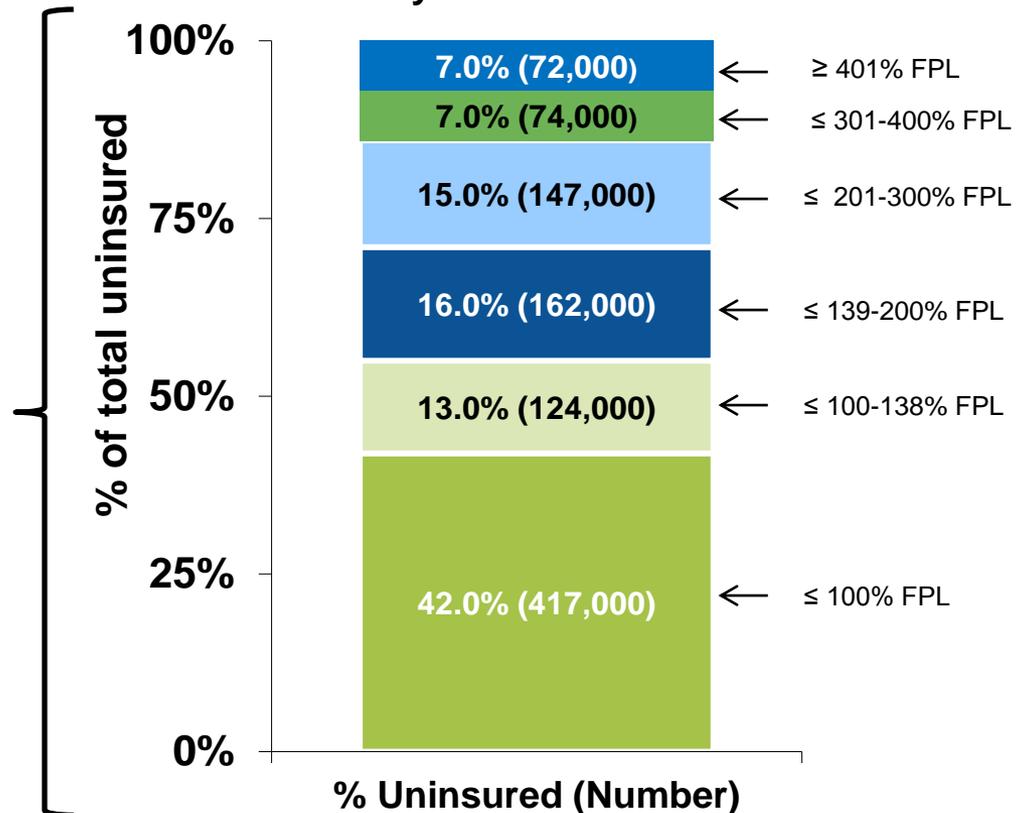
- How does expansion impacted the numbers of uninsured Virginians?
- What is the cost of expanding Medicaid?
- What other costs and savings could the state accrue by expanding Medicaid?
- What happens if the state chooses not to expand Medicaid?

Profile of Nonelderly Virginians by Insurance Status and Income Levels

Total Nonelderly Population in Virginia



Uninsured Nonelderly Population (≈1.0 million)
By Income Level



Source: Urban Institute, February 2012. Based on the 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). Estimates reflect additional Urban Institute adjustments for the underreporting of Medicaid/CHIP and the overreporting of private nongroup coverage (See Lynch et al, 2011). Coverage estimates were developed under a grant from the Robert Wood Johnson Foundation. Numbers may not total to 1,004,000 due to rounding and a small group of non-institutionalized individuals in group quarters are not included in income estimates due to difficulties associated with assigning an appropriate income to them.

Affordable Care Act

How Many Would Be Covered?

- 541,000 uninsured individuals with incomes \leq 138% FPL would be eligible for Medicaid expansion
 - ACA covers up to 133% FPL plus a 5% income disregard
 - Not all eligible for coverage (e.g., undocumented aliens)
 - Includes “woodwork” population
 - **400,000** potentially would enroll through Medicaid expansion based on a Virginia Health Reform Initiative (VHRI) consultant report
- 383,000 uninsured individuals with incomes between 139% and 400% FPL could purchase health insurance through an exchange
 - Not all eligible for coverage (e.g., undocumented aliens)
 - Some would opt for an affordability exemption
 - **100,000** potentially would obtain health insurance through a Health Insurance Exchange according a VHRI consultant report
- Together about one-half of the uninsured would have some type of health care coverage
 - About half would remain uninsured due to alien status, affordability exemption, or because they choose not to avail themselves of coverage (either by purchasing insurance or enrolling in Medicaid)

What Is the Cost to Expand Medicaid?

- New estimates currently under development but not yet available
- 2010 estimate by DMAS included a range of 271,047 to 425,930 individuals potentially eligible for Medicaid expansion

Adjusted Annual Estimated GF Cost of Medicaid Expansion (GF \$ in millions)									
Medicaid Expansion to 133% FPL	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Woodwork impact	\$55.5	\$116.3	\$121.8	\$127.6	\$133.8	\$140.1	\$146.8	\$153.9	\$161.2
Newly eligible groups	\$0	\$0	\$0	\$64.0	\$147.8	\$183.0	\$250.9	\$309.6	\$324.6
SCHIP/FAMIS match rate savings	\$0	\$0	(\$23.4)	(\$40.6)	(\$42.6)	(\$43.9)	\$8.2	\$26.8	\$27.6
DSH Reductions	(\$2.8)	(\$4.3)	(\$4.5)	(\$11.2)	(\$31.5)	(\$40.9)	(\$33.0)	(\$7.5)	\$0
Pharmacy Rebates	(\$29.2)	(\$31.0)	(\$33.0)	(\$35.1)	(\$37.4)	(\$39.8)	(\$42.4)	(\$45.3)	(\$48.3)
Estimated GF Impact	\$23.5	\$81.0	\$60.9	\$104.7	\$170.1	\$198.5	\$330.5	\$437.5	\$465.1
SFY Adjusted FMAP for Newly Eligible	100%	100%	100%	97.5%	94.5%	93.5%	91.5%	90%	90%

Note: This table adjusts a 2010 DMAS estimate by averaging the lower and upper bound GF costs for each fiscal year and estimating the proportion of costs attributable to woodwork and newly eligible persons. Annual savings reflect assumptions by DMAS in 2010. FMAP percentages are adjusted to the state's fiscal year.

What Other State Costs Could Accrue?

- Medicaid managed care rates will increase due to premium tax provisions on insurers contained in the ACA
 - Medicaid is required by the federal government to set actuarially sound MCO rates
 - Insurance premium taxes are likely to increase Medicaid MCO rates by an estimated 1.9%
 - Could cost more than \$25.0 million GF annually by 2015 and will increase with managed care enrollment growth
- State must choose whether to extend physician rate increases 2016 and beyond
 - Federal reimbursement of 100% occurs for 2 years only
 - Likely to cost is at least \$37 million GF annually after 100% federal FMAP expires
- Likely to be additional administrative costs that have not been factored in the 2010 cost estimates

What Other State Savings Could Accrue?

- Additional pharmacy rebates could accrue as enrollment increases
- GF costs for Safety net programs for indigent persons may be reduced
 - Individuals between 100% and 200% FPL may purchase health insurance through an exchange and receive tax credits and cost sharing subsidies
 - Currently served by state teaching hospitals, free clinics, community health centers and other safety net providers
 - Difficult to predict how many would be eligible for an affordability exemption
- Reduction in GF costs for existing Medicaid/FAMIS programs
 - Savings could amount to about \$9 million GF annually
 - Populations could be shifted into new eligibility category increasing federal FMAP and reducing GF amounts
 - FAMIS Moms to 133% FPL
 - Women participating in Virginia's breast and cervical cancer screening and treatment program (Every Woman's Life Program)
- Reduction in GF costs for community behavioral health services
 - About one-third of the clients could be Medicaid eligible under expansion
 - Savings could amount to at least \$33 million GF annually
- DOC inmate hospitalization savings could amount to at least \$15.5 million GF annually

What Happens If Virginia Chooses Not to Expand Medicaid?

- It is likely that individuals with incomes between current Medicaid eligibility levels up to 100% FPL will continue to be uninsured
 - ACA does not authorize the provision of health insurance premium tax credits and cost sharing subsidies to individuals with incomes less than 100% FPL
 - These individuals could receive an affordability exemption from the individual mandate
- Individuals between 100% and 400% FPL will be eligible for premium tax credits and lower out-of-pocket liability if they choose to purchase insurance from a qualified health plan through a health insurance exchange
 - Also individuals between 100% and 250% FPL are eligible for cost sharing subsidies

What Happens If Virginia Chooses Not to Expand Medicaid?

- Virginia may experience budgetary offsets even if it chooses not to expand Medicaid
 - Pharmacy rebates
 - FAMIS match rate changes through 2019
 - Some indigent care savings in state funded safety net programs if individuals between 100%-200% FPL purchase health insurance
- Savings will be offset by some budgetary impacts
 - Medicaid costs for covering the “woodwork” population
 - Medicaid costs for coverage to former foster care kids under age 26
 - Insurance premium tax on Medicaid MCO rates
 - Loss of DSH payments

Final Thoughts – Uncertainty Ahead

- How will health care reform play out in the face of potential actions to address the federal budget deficit?
- Will the President and Congress will make modifications to the ACA to allow states to expand Medicaid at levels less than currently specified in the law and receive enhanced federal funds?
- Will states and the federal government be able to fully implement the ACA on January 1, 2014?
- What are the broader economic impacts in Virginia associated with ACA provisions?
- The ongoing annual cost to the state to expand Medicaid when fully implemented could be more than \$400 million GF
 - Revised estimates should be available for consideration soon
- Policy decisions in the near term and future will be needed to determine funding for:
 - Health safety net (e.g., DSH payments)
 - Physician rate increases provided for in the ACA