Federal Health Care Reform: Overview of Impacts on Medicaid

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Introduction

- The Patient Protection and Affordable Care Act (ACA, also known as "Health Care Reform") was signed into law March 23, 2010.
- The law is complex and will require a significant amount of time and effort to plan and implement over the next 3 years.
- There continues to be strong public policy debate on the law.
  - 28 states (including Iowa) have filed lawsuits challenging the constitutionality of the law, particularly the individual mandate to purchase insurance and the mandatory Medicaid expansion.
  - Strong efforts to repeal or change the law in Congress.

What does that mean for planning?

- The ACA is the law at this time -- we have the obligation to plan and be prepared for implementation.
- All states except for one have received planning grants and are working on implementation plans (including Iowa).
- Dynamic that on the one hand see pursuit of political and judicial remedies/changes to the law, but on the other hand, responsibly planning for implementation.
- Uncertainty makes planning more difficult. Plans have to be flexible.

Affordable Care Act (ACA)

- Key provisions take effect January 1, 2014.
- Creation of Health Benefits Exchange (HBE).
  - Exchange is a 'marketplace' to allow consumers to compare plan benefits and price, provide consumer assistance, facilitate plan enrollment.
- Medicaid expansion to 133% of the Federal Poverty Level. *
- Mandate for individuals to have insurance coverage, penalties for large employers who don't offer insurance.

* 133% FPL = $14,404 household of 1, $29,327 household of 4

Coverage Strategy in the ACA

- Employer-based coverage (large groups)
- Health Benefits Exchange for Individuals and Small Groups
  - Tax subsidies for 133% to 400% of Federal Poverty Level (FPL)
- Medicaid for all below 133% FPL
- CHIP for children through 2019
- Criticism has been that the law focuses on coverage/access and doesn't do enough to control health care costs

Focus areas for Implementation

I. **Health Insurance Benefits Exchange** including tax subsidies

II. **Medicaid Expansion** to 133% of FPL and development of Benchmark benefit plan

III. **Coordination of Enrollment:** Integration of Exchange and Medicaid Eligibility Delivery System

IV. **Information Technology:** Transforming the Medicaid Eligibility Delivery System

V. **Opportunities**: The ACA includes options, not mandatory, for States to improve or re-balance health care programs

I. Health Benefits Exchange

- Establish a State Exchange or allow the federal exchange?
  - If state, what do you want it to do? There are a range of options.
- Decision regarding governance:
  - Who, what & how? State agencies, public/private partnerships, 501c3, or a hybrid?
- Authorize the Powers and Duties
  - What are the role of navigators and call centers, how are exchanges shaped through plan ratings and market changes?
  - How is exchange integrated with Medicaid?
  - Funding and Staffing

II. Medicaid Expansion

- Medicaid expansion to 133% of Federal Poverty Level.
  - o January 1, 2014
  - o Expansion financed with 100% Federal funds in 2014-2016, phases down to 90% match
  - o Mandates a number of changes to streamline eligibility and will result in increased enrollment
- **Iowa Medicaid enrollment estimated to increase by 25%, or by 80,000-100,000 Iowans in 2014 under the ACA**

Medicaid Expansion: Benchmark Plan

- 'New eligibles' (those added under the expansion to 133% FPL) have at least a 'Benchmark' Benefit Plan.
  - Called 'benchmark' because it is a benefit package drawn from approved comparison plan.
- Benchmark plans typically would be less comprehensive than regular Medicaid. ACA makes some changes.
- States have some flexibility to design the plan, but now must include mental health, substance abuse, rehabilitation.
- What services will we cover, with what limits?
  - Mental Health benefits? Opportunity to leverage higher Medicaid match rate to save on services currently 100% state and county funded, and impact MH populations in prisons and jails

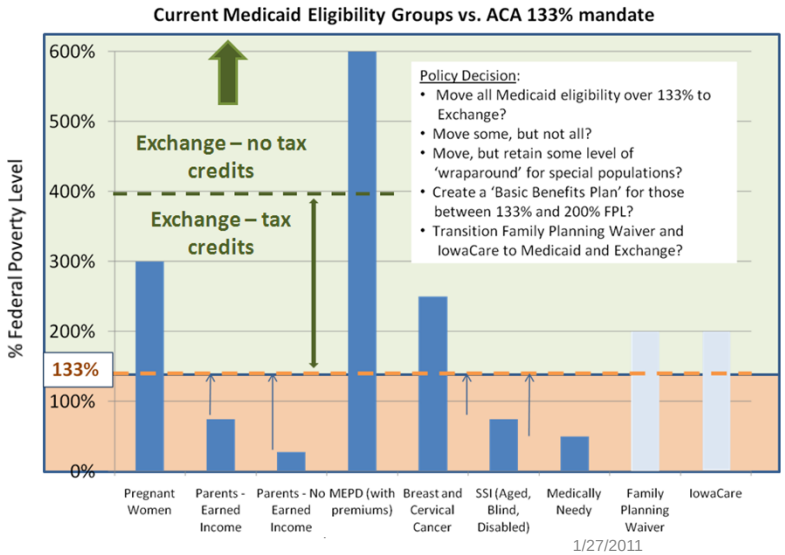
Medicaid Expansion: Eligibility changes

- Deliberate and significant changes in how Medicaid eligibility is done:
  - Clear separation from other public assistance programs
  - Elimination of coverage based on categories – all covered below 133% FPL
  - Fundamental changes in eligibility determination income standards and processes
    - Income tax standards – "Modified Adjusted Gross Income"
    - Electronic verification with IRS and other federal sources
    - No asset tests
- Maintenance of Effort: State prohibited from reducing or restricting eligibility until 2014 (with some exceptions)

Medicaid Expansion: Policy Decisions

- Current Medicaid coverage goes above 133% FPL for some groups
- Do we continue those groups?
  - o Enact option to create a Basic Health Plan between 133% FPL to 200% FPL?
  - o Move to the Exchange?
  - o Move some, not all?
  - o Wraparound?
- IowaCare planned phase-out

Medicaid Expansion: Policy Decisions



III. Coordination of Enrollment

- Eligibility functions:
  - Medicaid agency – Medicaid and CHIP eligibility
  - Exchange - Eligibility for tax credits that will subsidize purchase of insurance
- Eligibility Gateway: ACA requires integration of eligibility and enrollment between Medicaid and the Exchange
  - Common web-based application for Medicaid, CHIP, tax credits
  - Exchange must screen applicants for Medicaid and CHIP and Medicaid/CHIP must accept referral without further review
  - Medicaid must ensure referral to exchange for those found ineligible for Medicaid and CHIP
  - Many people will move back and forth between Medicaid and tax credits
  - Requirement for 'seamlessness' in moving among programs
- Need for high degree of coordination and collaboration in operational planning between Medicaid and Exchange

Coordination of Enrollment - Strategy

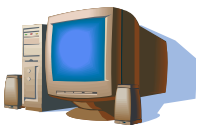
- Exchange may contract with Medicaid to determine eligibility for tax credit subsidies
- CMS encouraging states to plan for integrated strategy -- Exchange contract with Medicaid agency to perform eligibility for the tax credits, single process and system
- Need to address:
  - IT solutions for Medicaid/CHIP eligibility
  - IT solutions for tax credit eligibility
  - Must be "seamless"
  - Planning toward IT strategy that can support eligibility for both, contract with the Exchange

IV. Information Technology

- Fundamental changes in Medicaid eligibility standards.
- Large volume to enroll in short period of time.
- We believe there will be need for significant IT investment and re-engineering of the DHS Field operations on eligibility.

Operational Challenge: Transforming the Eligibility Process

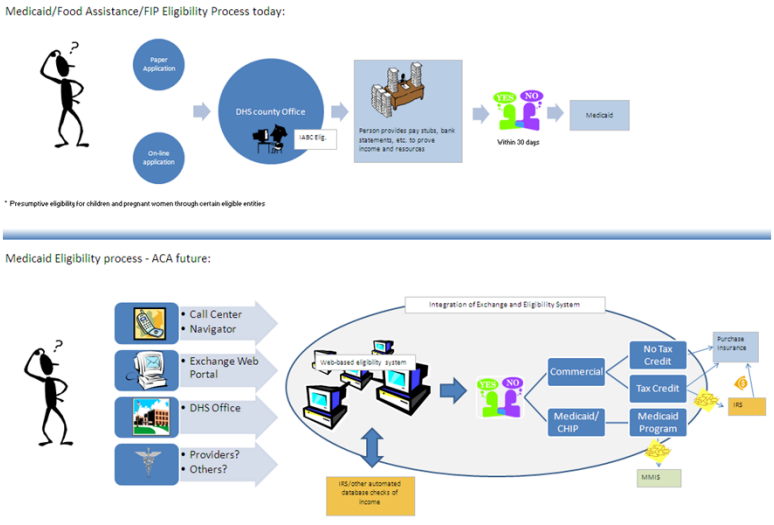
- Current mainframe eligibility system is 30 year old system that has major deficiencies.
- System, both process and IT, are burdened by:
  - Paper applications
  - Labor-intensive reviews and work flow
  - Off-system calculations and "work-arounds"
  - Very inflexible, expensive to maintain and operate



Operational Challenge: Transforming the Eligibility Process

- ACA requires:
  - Web-based functionality
  - Integration with Health Benefits Exchange and tax credit eligibility
  - New income standards and eligibility processes
  - Enrollment of large numbers of Iowans in short period of time
  - Need for IT to more fully support the process, to offset need for significant numbers of staff to handle increased volume
- At this time, we do not believe current system can be modified to meet requirements
- Possible funding sources for IT investment -- Newly announced 90% federal match for Medicaid eligibility IT

Operational Challenge: Transforming the Eligibility Process



Operational Challenge: Time

- Building eligibility systems is very complex and takes a lot of time – 3 years is not a lot of time
- Need for collaboration with Exchange – when that is established
- DHS has started planning:
  - Analysis of IT system options to meet ACA requirements
  - Cost Benefit Analysis
  - Goal to complete by end of February
- Provide options, budget estimates for the Governor and Legislature for FY 12 budget consideration – Initial estimate $30M total ($3M state funds)
- Request for Information from vendors planned for February/March 2011

V. Opportunities

- ACA has a number of new options for Medicaid
  - Health Homes (aka Medical Homes)
  - Incentives to increase use of home and community based services in long-term care
  - Incentives for preventative care
  - Grant opportunities
  - Enhanced Medicaid financing in the expansion might provide opportunities for other reforms, such as mental health system

Iowa's Planning Efforts

- Health Coverage Commission recommendations
- Exchange Planning Grant – $1M award for 1 year to develop implementation plan, 100% federal funds
  - Interagency planning group (DPH, Insurance Commissioner, DHS)
  - DHS share going toward Eligibility IT planning and analysis
- Exchange Implementation Grants – recently became available. Finances full cost of Exchange start-up, 100% federal funds
  - Does not cover operations. States must determine how Exchange costs will be financed post-implementation
- 90% match for Medicaid eligibility IT development/ system build costs, 75% match for IT operations and maintenance
- Federal guidance allows cost allocation among Exchange and Medicaid based on federal cost allocation rules

Challenges/Pressures

- Time
- Administrative resources
- Uncertainty
- Unknowns – need federal guidance
- Sheer number of things to try to get done in time of shrinking state resources
- Even with enhanced federal match, financing for state match needed

Questions?