U.S. Supreme Court Decision Affordable Care Act: Option to Expand Medicaid

Scope of the legislative choices --

LFD
MONTANA LEGISLATIVE FISCAL DIVISION

Goals of the Presentation

- Update Legislative Finance Committee (LFC) on US Supreme Court decision
- Identify Medicaid program changes required by Patient Protection and Affordable Care Act – ACA
- Discuss legislative option to expand Medicaid
- Broadly identify impacts of opting to expand Medicaid versus not expanding
- Identify which information legislative staff will prepare for session consideration
- Discuss Legislative Council request for LFC to decide whether it would recommend contracting for additional information on the impacts of expanding or not expanding Medicaid
- Determine LFC recommendation/course of action

ACA and Medicaid Eligibility

- Supreme Court upheld the Affordable Care Act – ACA, except
  - A state may not be compelled to expand its Medicaid program or lose all federal Medicaid matching funds
  - Medicaid expansion now a state (legislative) option
- However, ACA does require some changes to the current Montana Medicaid program
  - Changes unrelated to Medicaid expansion
- Increased Medicaid enrollment due to ACA changes
  - Two primary reasons
  - Two different state match rates for services costs
  - Some impact to administrative cost

Changes to Current Program

- A number of persons who are currently eligible but not enrolled (woodwork effect)
  - State cost at regular Medicaid match rate for services 34% to 35% for 2015 biennium
- Persons who meet current income/financial eligibility but have excess resources/assets therefore new enrollees
  - ACA change – assets test cannot be used for eligibility for persons who are not disabled and between the ages of 19-64
  - No state cost initially – 100% federally funded 2014-2017; then state match increases up to10% by 2020
- Allocation of new enrollees and therefore state cost to be determined by algorithm (being developed)
  - Algorithm will allocate new enrollees between two groups; two match rates
- Some impact on administrative costs
  - May be partially offset by required Medicaid eligibility link with health insurance exchange

Changes to Current Program

- Loss of federal/state payment to partially offset cost of uncompensated hospital care
  - Medicaid disproportionate hospital payments (DSH) gradually reduced over a number of years
  - DSH payments – $17.6 million in FY 12 (includes $6.0 million state match)
  - Federal schedule of reductions not yet available
- State flexibility to alter current eligibility limited until January 1, 2014
  - About 34% federal poverty level for non-working households
  - About 56% federal poverty level for working households
  - Includes HMK eligibility
- Some state savings due to "refinance" of state and local government costs for health programs – eg Mental Health Services Plan, chemical dependency services
  - Analysis needed to determine whether cost reduction for a narrow health benefit would be greater than state Medicaid match required in future years
- Legislative staff will analyze executive estimate of ACA related costs for existing Medicaid program
  - Legislative staff will produce an independent estimate of such costs as necessary

Medicaid Expansion is Optional

- ACA creates new category of eligibility
  - Nondisabled persons age 16-64 - income up to 138% federal poverty level
  - Primarily childless adults and low-income parents
  - Income eligibility only; no assets considered

- Enhanced federal funds for Medicaid expansion
  - 2014 – 2016 – 100% federal match for Medicaid services
  - 2017 -2020 state match required and gradually increases to 10% for expansion population

- States can opt in and out; but 100% federal match available for a 3 year window – 2014 – 2016

- If Legislature opts to expand Medicaid, it will need to amend statute (53-6-131, MCA) and provide an appropriation
  - DPHHS will need to submit a Medicaid state plan amendment for federal approval

Cost of Medicaid Expansion

- The cost to expand depends on
  - Number of persons potentially eligible
  - Take up rate (percent of eligibles who enroll each year)
    - No public program has achieved 100% enrollment
    - Medicare enrollment is 96% of those eligible
  - Cost per eligible person
    - Medicaid bench mark plan – not identified
  - Associated administrative cost
- Several cost estimates have been prepared (next page)
- Expect cost estimates to change
  - Federal guidance still needed for many policies
  - Data will be refined over time

Comparison of Cost Estimates

Various Estimates of the Cost of Medicaid Expansion - 2014 - 2019								
	Enrollment		Per	Total Cost to		Federal Cost -		
			Enrollee	State - Millions		Millions		Date of
Publisher	Low	High	Cost*	Low	High	Low	High	Publication
Department of Public Health and Human Services*		84,088	$7,200		$163.4		$3,140.0	4/19/10
Kaiser Family Foundation/Urban Institute**	57,356	78,840	n/a	100.0	155.0	2,200.0	2,600.0	5/1/10
Bureau of Business and Economic Research***	47,000	55,000	9,937					8/20/12

*The cost per enrollee is the adult cost. The average cost per child is $3,180. Both costs are inflated through the study period.

**The total enrollment includes both persons who are currently eligible but not enrolled as well as those who are eligible because of Medicaid expansion.

***The total state and federal costs from 2014-2019 are not available. However, the 2020 annual estimate in millions is: low state - $101.9; high state - $118.9; low federal - $757.1; high federal - $909.9.

Reasons for differences in estimates

Source of data – census versus survey affects assumptions about number eligible

- Kaiser estimate includes "wood work" and expansion

Take up rates – % newly eligible who enroll by year

- Will be affected by outreach campaign, availability of exchange and ease of use

Cost per enrollee

- Will depend on benchmark plan selected for Medicaid enrollees

Whether state savings on other programs were included

Fiscal year versus calendar year

Timing – older versus more recent

Worth repeating – expect estimates to change as assumptions/data are refined

Other Impacts of Medicaid Expansion

- Impacts of opting to expand Medicaid or to retain status quo were identified through a literature review of national and state specific studies and analyses
- Direct and indirect economic impacts of increased federal Medicaid funds
- Impact on state tax revenues
- Reduction in the level of uncompensated care and reducing cost shift to other payors
  - Increased Medicaid enrollment expected to offset loss of DSH and some of the remaining uncompensated care

Other Impacts of Medicaid Expansion

- Crowd out effect – some persons with private health coverage will be eligible for Medicaid
- Inflationary cost pressures to compete for limited number of medical professionals
- Medical service capacity to serve persons who may have untreated medical needs and pent up demand for services
  - Significantly affected by age of new enrollee
- Improved health status and life expectancy for previously uninsured individuals
- New business location decisions (anecdotal)

Impacts of Not Expanding Medicaid

- Doughnut hole in coverage
  - Persons with incomes less than 100% of the federal poverty level but above Montana Medicaid standards receive no assistance to purchase insurance
  - Persons with household incomes from 100% to 138% of the federal poverty level are eligible for premium assistance and cost sharing limits when insurance purchased through exchange
  - Associated policy question asked by states: can Medicaid be expanded to 100% of the federal poverty level and still receive 100% federal match
  - Persons under 100% federal poverty level will be exempt from insurance mandate
- Direct and indirect economic impact less than that of full Medicaid expansion
  - Some new federal revenue
  - Persons with household incomes above 100% of the federal poverty level but below 400% are eligible for premium assistance and cost sharing limits when insurance purchased through exchange

Impacts of Not Expanding Medicaid

- Some offset to the cost of uncompensated care to due premium assistance, but offset is less than full Medicaid expansion
  - Premium assistance available to households with incomes from 100% to 400% of the federal poverty level
  - Doughnut hole in insurance coverage – level of cost shift to private sector and uninsured
- As income rises for persons in doughnut hole, they could participate in exchange and receive subsidies
  - Improved access to care, but would enter exchange with worse health status, pent up demand
  - National actuarial study notes increased cost for exchange policies due to lack of health insurance and poorer health status
- Enhanced market for private health insurance due to premium assistance for persons with household incomes from 100% FPL to 138% FPL who would otherwise be eligible for Medicaid expansion
- Continues Medicaid churn – when household income changes people move in and out of Medicaid and access to health services

Decision to Request Information Beyond HB 2 Appropriation Data

- What legislative staff plans to provide for the legislative session
  - The 2015 biennium appropriation needed for
    - Medicaid program changes that will occur due to ACA
    - Medicaid expansion subject to legislative authorization
  - An estimate of direct state and federal costs through 2020 to fund the Medicaid expansion
  - Too little time for legislative staff to provide a more comprehensive analysis of direct and indirect impacts related to the decision to expand Medicaid
- The Legislative Council discussed whether legislators need information about the decision to expand Medicaid beyond the scope of planned staff analysis
- The Council requested that the LFC review what other types of information legislators may wish to consider relative to a Medicaid expansion, whether to contract for an analysis, and what the contract should entail
- The Office of the State Auditor may be able to expand a current contract with the Bureau of Business and Economic Research at the University of Montana to include analysis of most of the impacts noted previously

Contract Constraints

- Time is short – session is 3 months away
- Pros/cons of two types of contracts
  - Actuarial contract
    - Can be sole source (statutory)
    - Must be well defined
    - Requires data sources to be in certain formats and "clean"
    - Can be let for any dollar amount, but probably more expensive than other types of contract/analysis
    - Could be difficult to complete within time constraints
  - Limited solicitation contracts between $5,001 – $25,000
    - Does not require an RFP, but would require a bid/evaluation process
    - Can limit bidders – must contact at least 3
    - Must have a rationale for selecting bidders
    - Must use vendors on Department of Administration contract list if practical
    - Can be problematic to garner bids from out of state entities since contracts require that Montana courts have jurisdiction for any disputes and contract amount is small
  - Normal request for proposal (RFP) procedure is not considered in this presentation due to time constraints to prepare and publish a request for bids, evaluate the bids, and complete the contract

Options

- Wait to see if the State Auditor includes expanded analysis of the Medicaid expansion in its current contract
  - If so, appoint a subcommittee to review contract results (due November 2012) and report to full LFC for action
  - If the LFC desires additional research after reviewing the report consider the following approach
  - If not, consider whether to contract (see next step)

- Contract for additional analysis
  - Use limited scope contract or series of limited scope contracts
  - Select items to include in contract(s)
  - Prioritize items if study appears to be too comprehensive to complete analysis within contract limit of $25,000
  - Define the due date for contract deliverables
    - At what point during session will legislators need this information
    - Plan at least 1 month to write the contract requirements, evaluate responses, and draft and sign the contract
    - Plan at least 1 month to do the contract work