

Performance Evaluation Fact Sheet

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES IMPACT OF MEDICAID ELIGIBILITY EXPANSION AND HEALTHY MONTANA KIDS MONITORING

ISSUE STATEMENT

The legislature identified two areas of interest in SJ 26 related to Medicaid and Healthy Montana Kids (HMK), programs administered by the Department of Public Health and Human Services (DPHHS):

- Continued implementation of HMK
- Defining components and cost of Medicaid eligibility expansion due to the Patient Protection and Affordable Care Act of 2010 (ACA)

The goal of this issue is to enable the 2013 Legislature to obtain better information to establish 2015 biennium appropriations for:

- HMK
- Medicaid services

Continued implementation of HMK and expansion of Medicaid services due to ACA are combined in this issue because:

- HMK includes both Medicaid and Children's Health Insurance Program (CHIP) services costs;
- If there is excess state special revenue from the insurance premium tax allocated to pay the state match for HMK services, it can be used to offset the general fund used to pay the state match for Medicaid services; and
- The expansion of Medicaid eligibility authorized in ACA could indirectly cause enrollment to increase in HMK.

HISTORY AND PURPOSE OF PROGRAM OR ITEM

The HMK and Medicaid programs are designed to provide health care services to low income individuals including children, some parents, persons over 65, and disabled persons. The Medicaid program was initiated in 1965 (Title XIX of the federal Social Security Act). Funding for children's health services was expanded when the Children's Health Insurance Program (CHIP) was passed in 1997 (Title XXI of the Social Security Act). Both are funded supported by federal funds that require a state match:

- About 22% for CHIP in the 2013 biennium
- About 34% for Medicaid in the 2013 biennium

The HMK program was enacted by voter initiative in November 2008 (Initiative 155 – I-155). The initiative raised financial eligibility for CHIP services up to 250% of the federal poverty level (FPL) - \$55,875 for a family of four in 2011, and raised Medicaid eligibility for children up to 185% of FPL. The initiative also eliminated assets tests for Medicaid eligibility for children.¹ The initiative diverted a portion of insurance premium taxes to a state special

¹ Previous to the passage of the initiative, CHIP eligibility had been 175% of the federal poverty level. Medicaid eligibility for children had been 150% of the federal poverty level for children up to 1 year old, 133% of the federal poverty level for children up to 6 years old, and 100% of the federal poverty level for children up to 19. In addition, family assets could not exceed \$15,000 for a child to be eligible for Medicaid. The 2009 Legislature provided appropriations to fund CHIP eligibility up to 250% FPL and Medicaid eligibility up to 133% FPL.

revenue account to pay for increases in HMK enrollment above the number of children enrolled as of November 2, 2008 – 63,970. Enrollment as of August 2011 grew to 88,467, for a net increase of 24,497 children.

The legislature appropriated funds to provide services to children in families with incomes from 134% to 250% of FPL from federal CHIP grant funding and to provide services to children in families with incomes up to 133% of FPL from federal Medicaid matching funds. The legislature also reduced the amount of insurance premium tax flowing into the HMK state special revenue account from 33% (originally enacted through I - 155) to 16.67%. On July 1, 2013 the allocation will return to 33% of the insurance premium tax.

Funding for the State Match

The primary funding sources for the state share of HMK and Medicaid are:

- General fund
- HMK insurance premium tax state special revenue (discussed previously)
- Health and Medicaid initiatives state special revenue – tobacco tax increase enacted by citizen initiative
- Tobacco settlement funds – allocation enacted by citizen initiative

State Cost for Medicaid Eligibility Expansion

Unless there are substantive changes to ACA, Medicaid eligibility will expand beginning January 1, 2014. The three most notable changes are:

1. The income eligibility for persons who are not pregnant, disabled, or aged (over 65) will be established at 138%² of the federal poverty level – \$38,843 for a family of four in 2011;
2. Assets tests will be eliminated, for example the value and number of vehicles will not be considered; and
3. Childless adults under the age of 65 will be eligible for Medicaid.

In the first few years, the federal government will pay for the entire cost of newly eligible adults. However, states are still required to fund the state match (estimated to be 33.26% for Montana) for any increase in enrollment of adults and children who would have been eligible for Medicaid prior to the expansion. States will begin to pick up a share of the cost of the Medicaid expansion starting January 1, 2017, with the full state share rising to 10% in 2020 and beyond.³ Estimates of the Montana cost of the Medicaid expansion vary greatly.

Medicaid enrollment was 105,159 in August 2011, including 69,276 children and 35,883 adults.

MEASURES FOR DETERMINING EFFECTIVENESS

Outcome and Task

The outcome of this issue is to prepare information for the 2013 Legislature to consider as it establishes appropriations for Medicaid and HMK services costs and to provide real time information about continued implementation of HMK.

The tasks to be completed by LFD staff in support of this outcome are:

1. Provide historic and current enrollment for HMK and Medicaid at each LFC meeting beginning December 2011 based on monthly enrollment data published by DPHHS;
2. Estimate the number of persons that would be newly eligible for Medicaid and the cost of that expansion;
 - a. A draft estimate will be prepared for the March “Big Picture” report
 - b. A refined estimate will be prepared during the 2015 budget analysis in response to new federal information regarding:

² ACA establishes financial eligibility for Medicaid at 133% of the federal poverty level. Persons’ eligibility will be based on the adjusted gross income reported on their federal income tax form, with a few exceptions. There is a 5% income disregard in addition, raising the effective eligibility rate to 138% of the federal poverty level. Federal poverty rates are published annually and usually increase from 1% to 4%.

³ Recent federal spending reduction suggestions include moving to a blended federal Medicaid match rate for the Children’s Health Insurance Program and the ACA Medicaid expansion population and regular Medicaid population. It is possible that a blended rate could raise overall state cost shares for these programs compared to current match rates.

- i. Federal methodologies that allocate increased enrollment between those eligible due to federal eligibility changes and those who would have been eligible under the former state eligibility criteria (expected September 2012)
 - ii. Definition of essential health benefits that must be covered by Medicaid and group health policies offered on the health insurance exchange;
3. At the October 2012 LFC meeting, review assumptions for HMK appropriations compared to actual enrollment and costs in the base year; and
4. Define a methodology to estimate the HMK Medicaid cost component and better articulate its interaction with total Medicaid caseload and funding.

CURRENT STATUS

The LFC will initially review this work item and take action at its December 2011 meeting.

POTENTIAL OPTIONS OR DECISION POINTS

Potential options for LFC consideration for this meeting are:

1. Choose to discontinue study of this item;
2. Accept proposed measures for effectiveness; or
3. Add or modify proposed measures for effectiveness.