



The Future of Medicaid

Capitol Area Health Alliance
December 7, 2011

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Director, Medical Services Administration



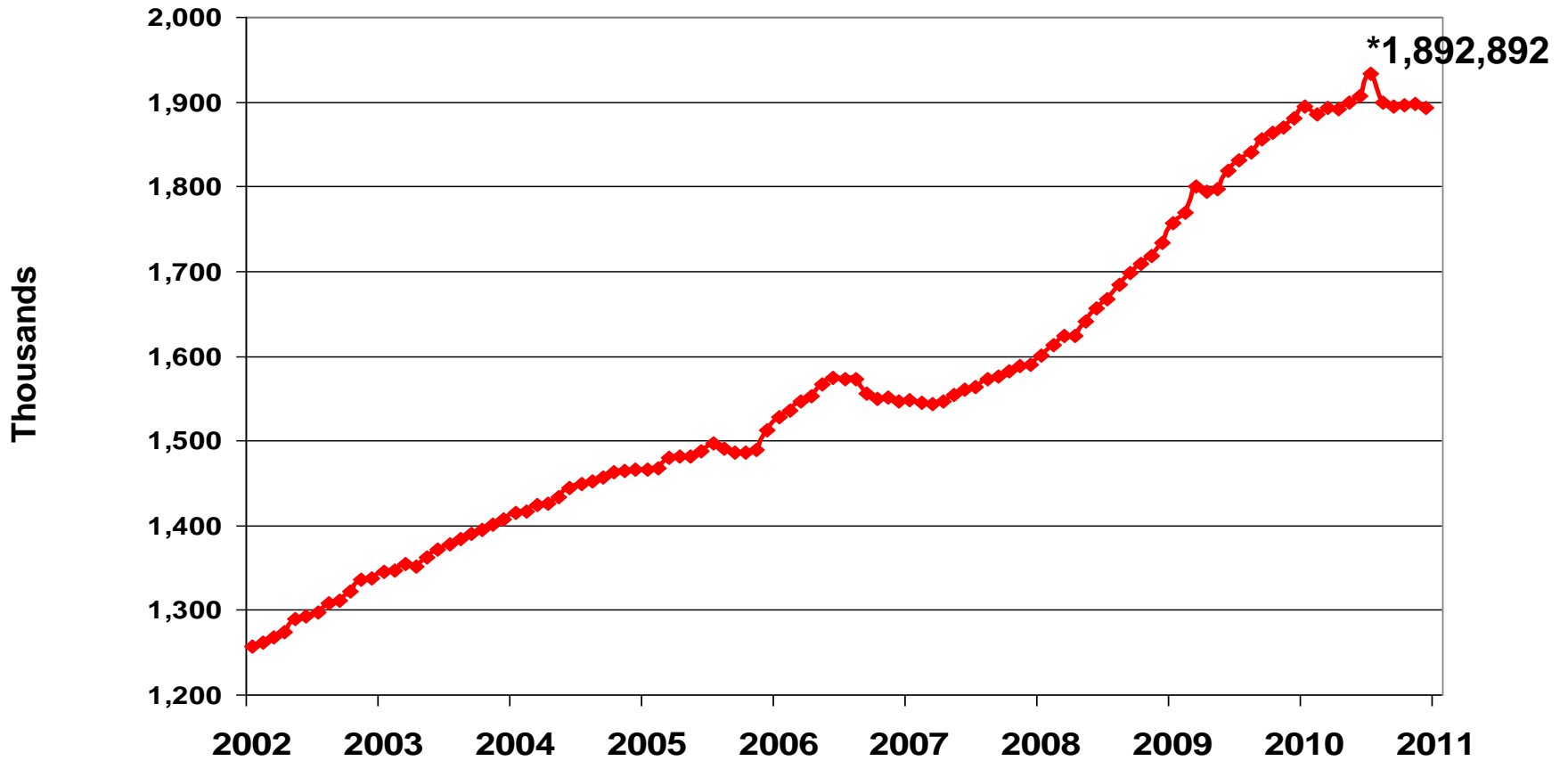
Topics

- Medicaid Yesterday
- Medicaid Today
- The ACA and the Future of Medicaid

Medicaid Yesterday

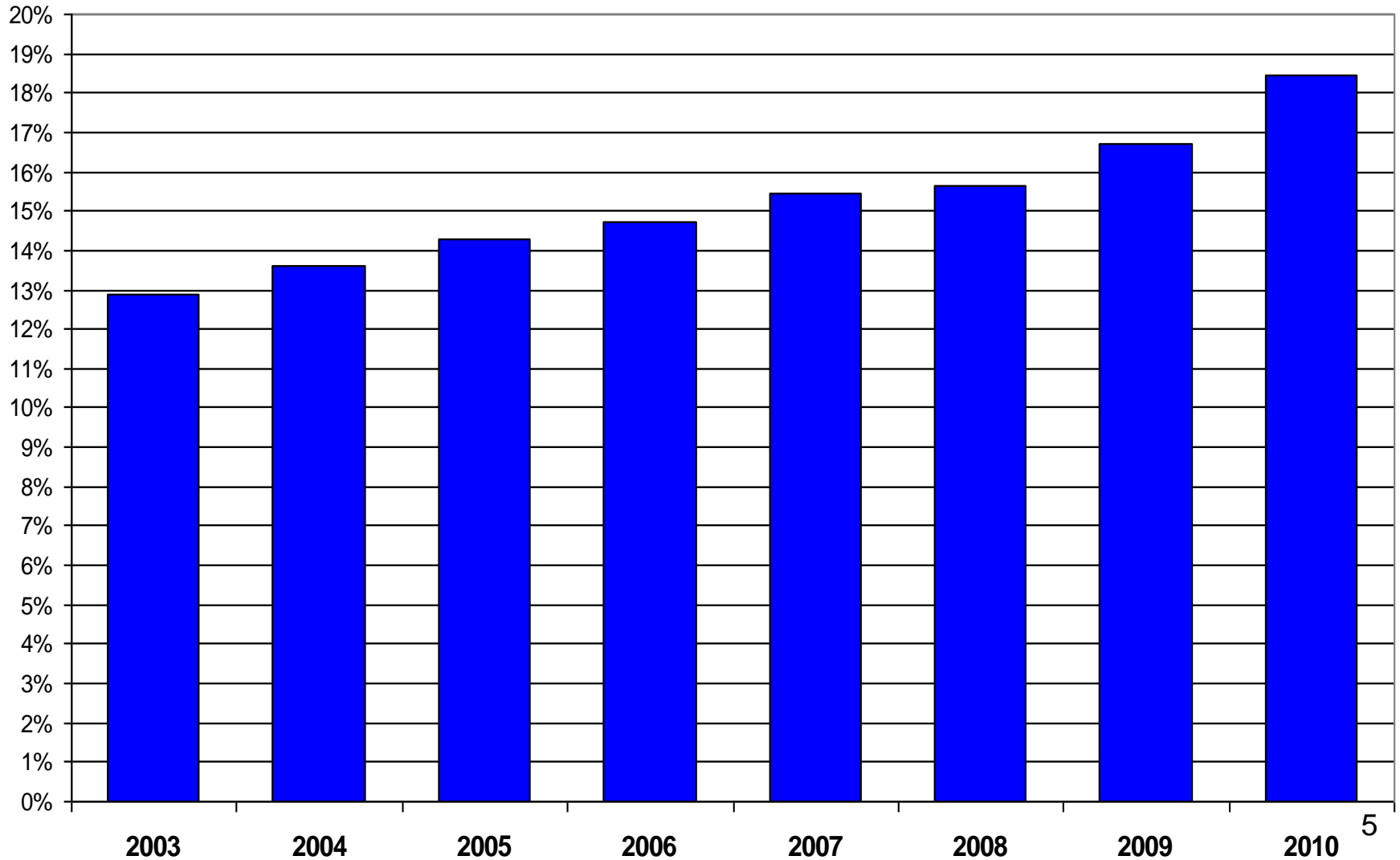
Providing Historical Context

Michigan Medicaid Caseload

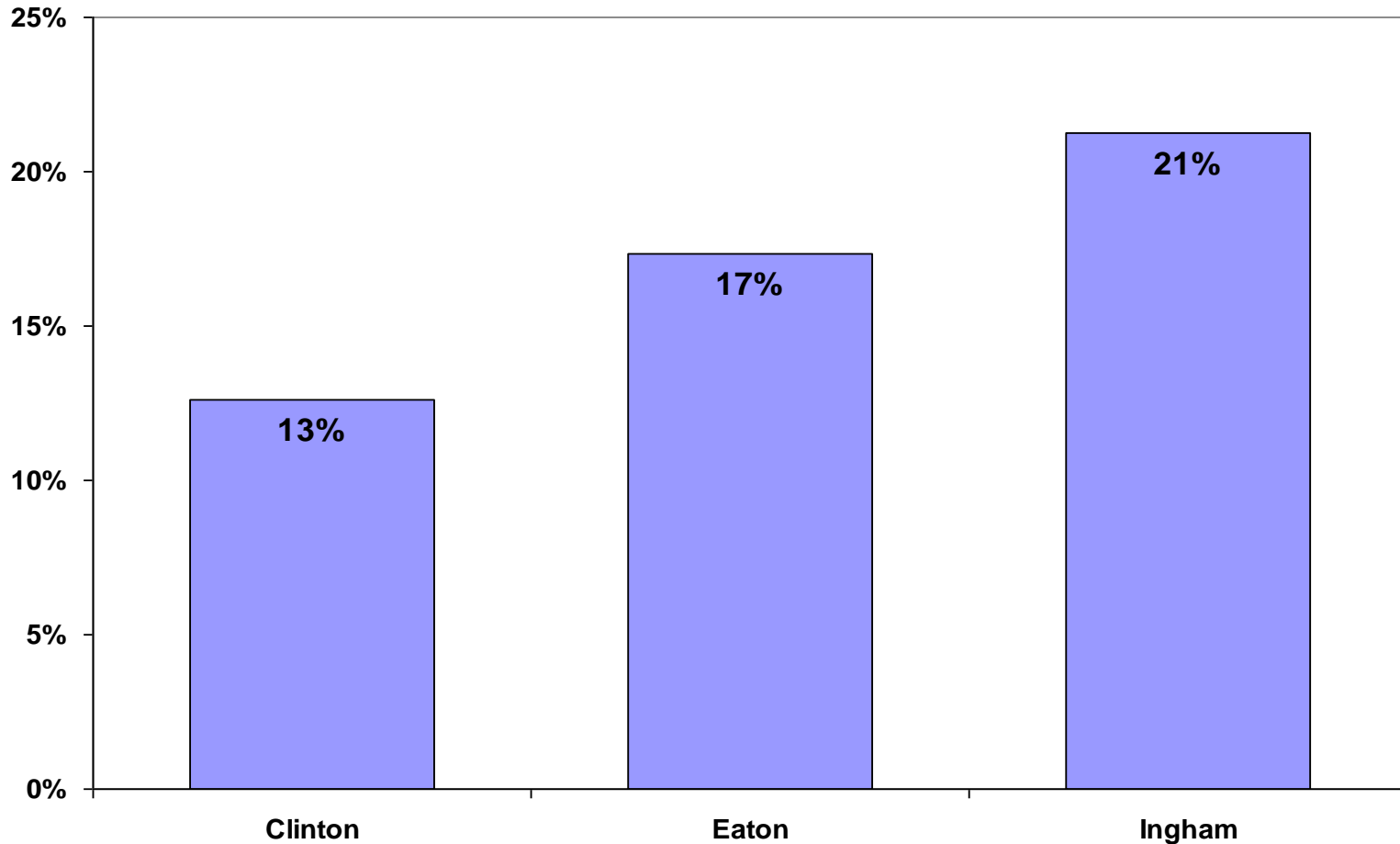


*September 2011

Michigan's Medicaid Eligibility Percentage Per Capita

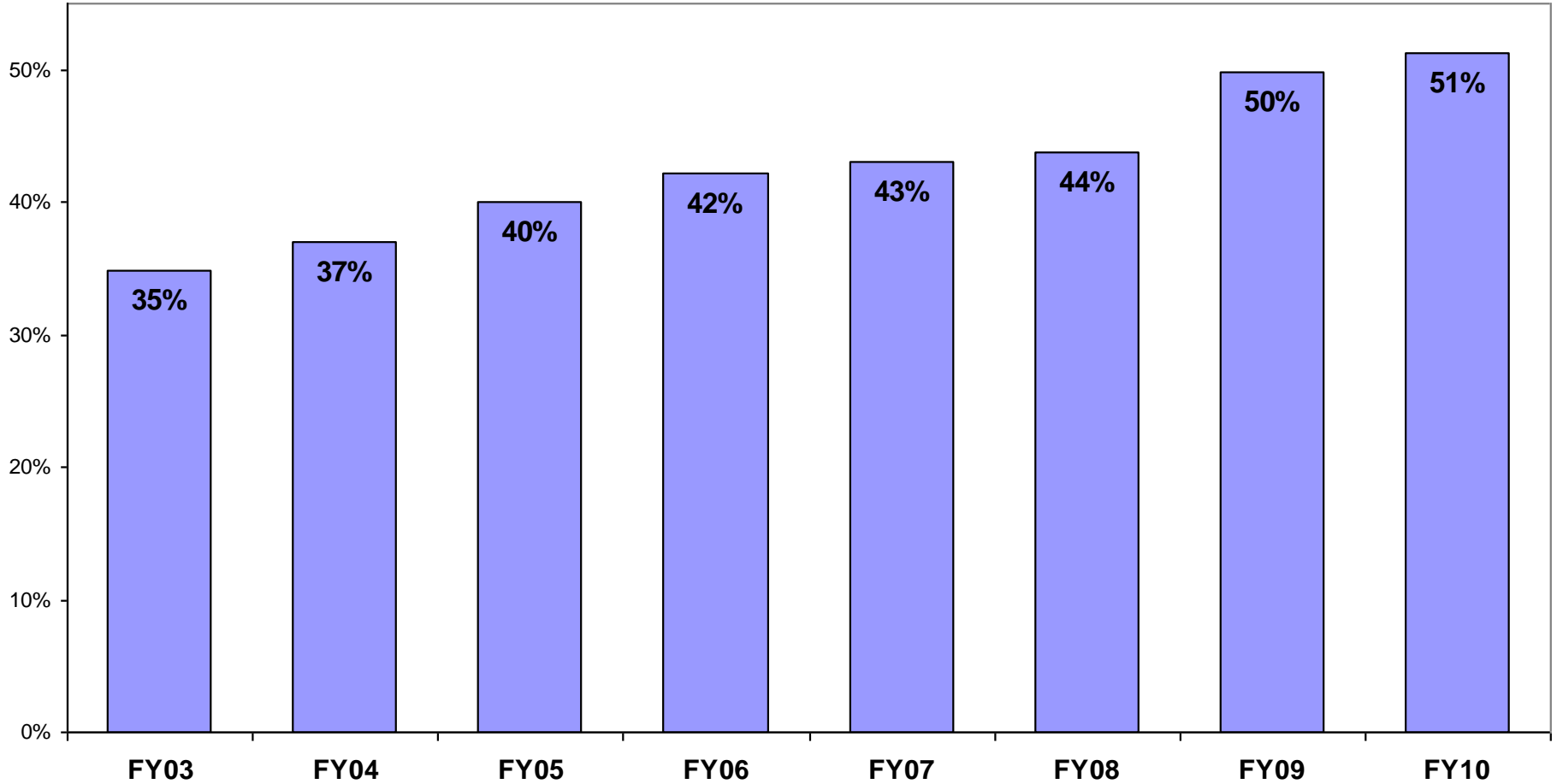


Census 2010 % of Population w Medicaid Coverage

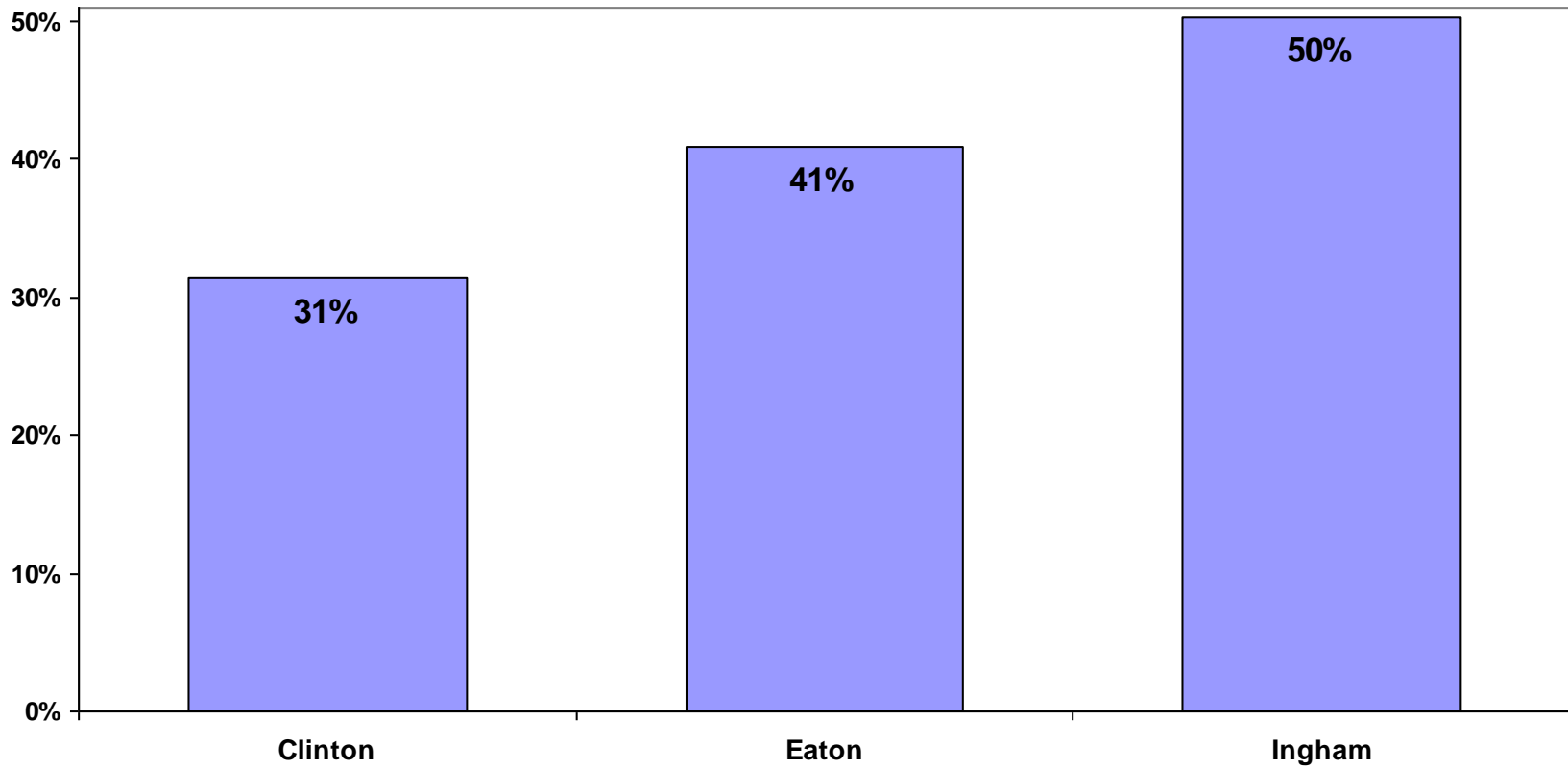


Includes ABW Enrollment

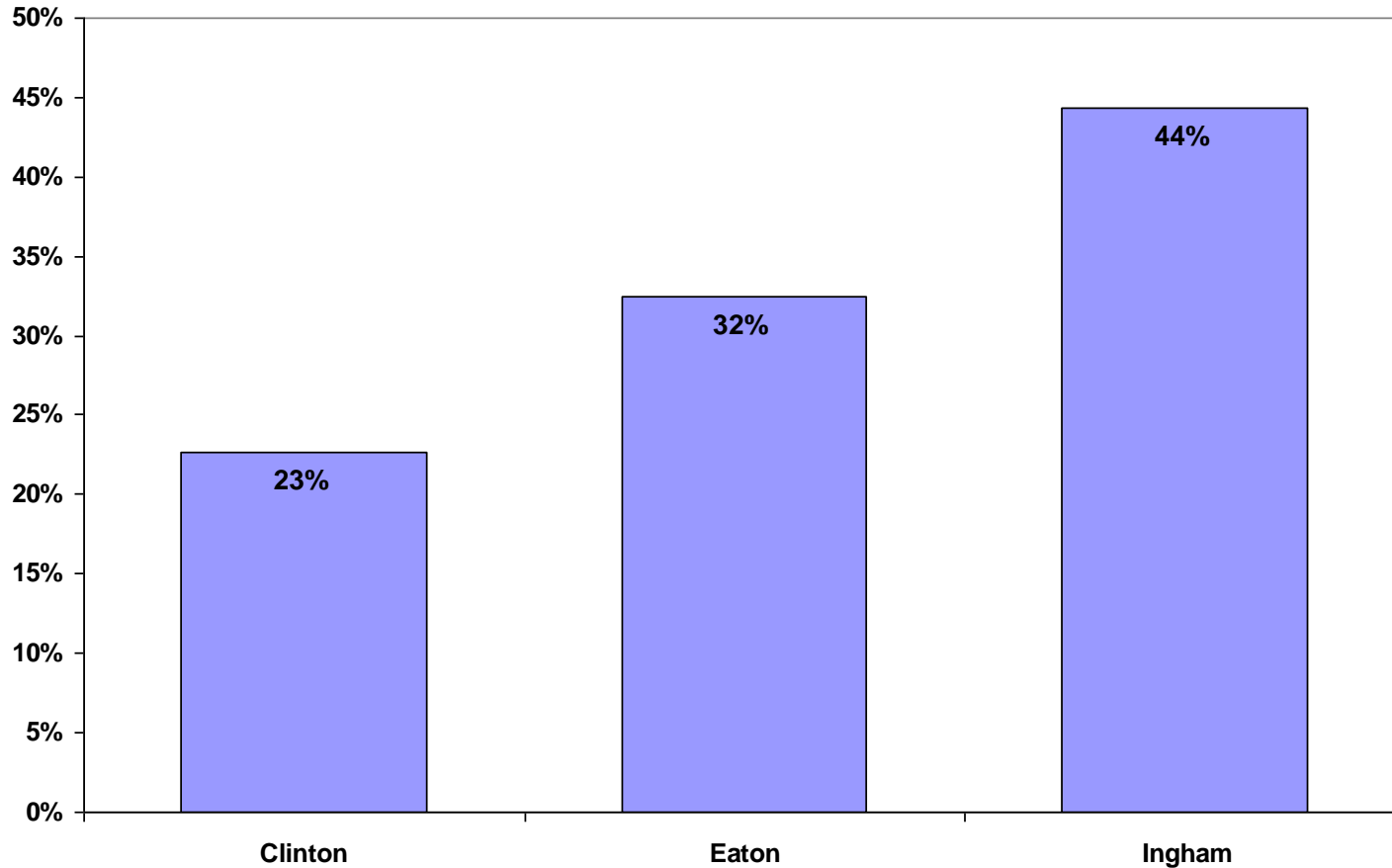
Michigan Medicaid Births as Percent of Total Michigan Births



FY 2010 Medicaid Births as Percent of All Vital Births

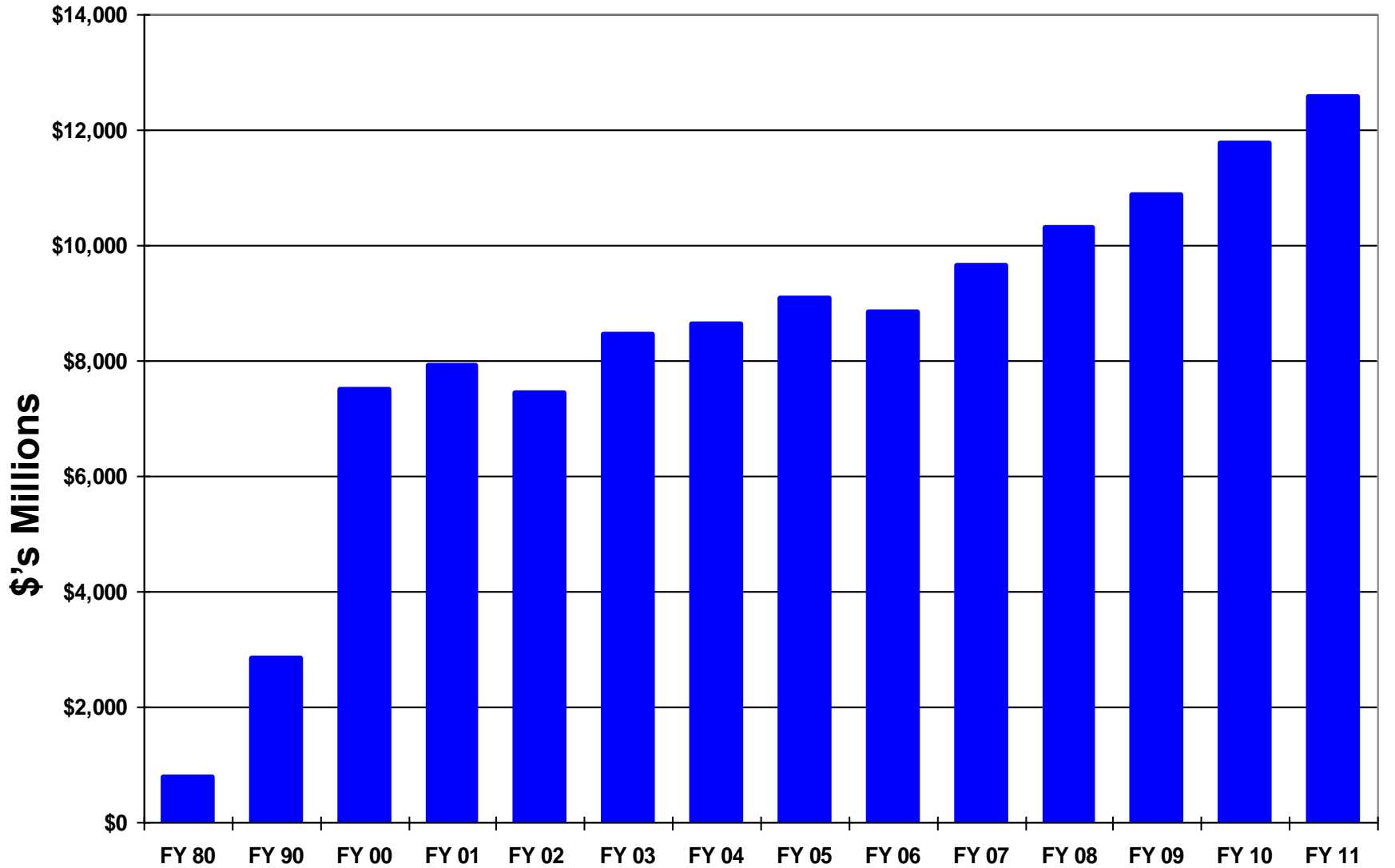


FY 2010 Medicaid as % of Population < 18

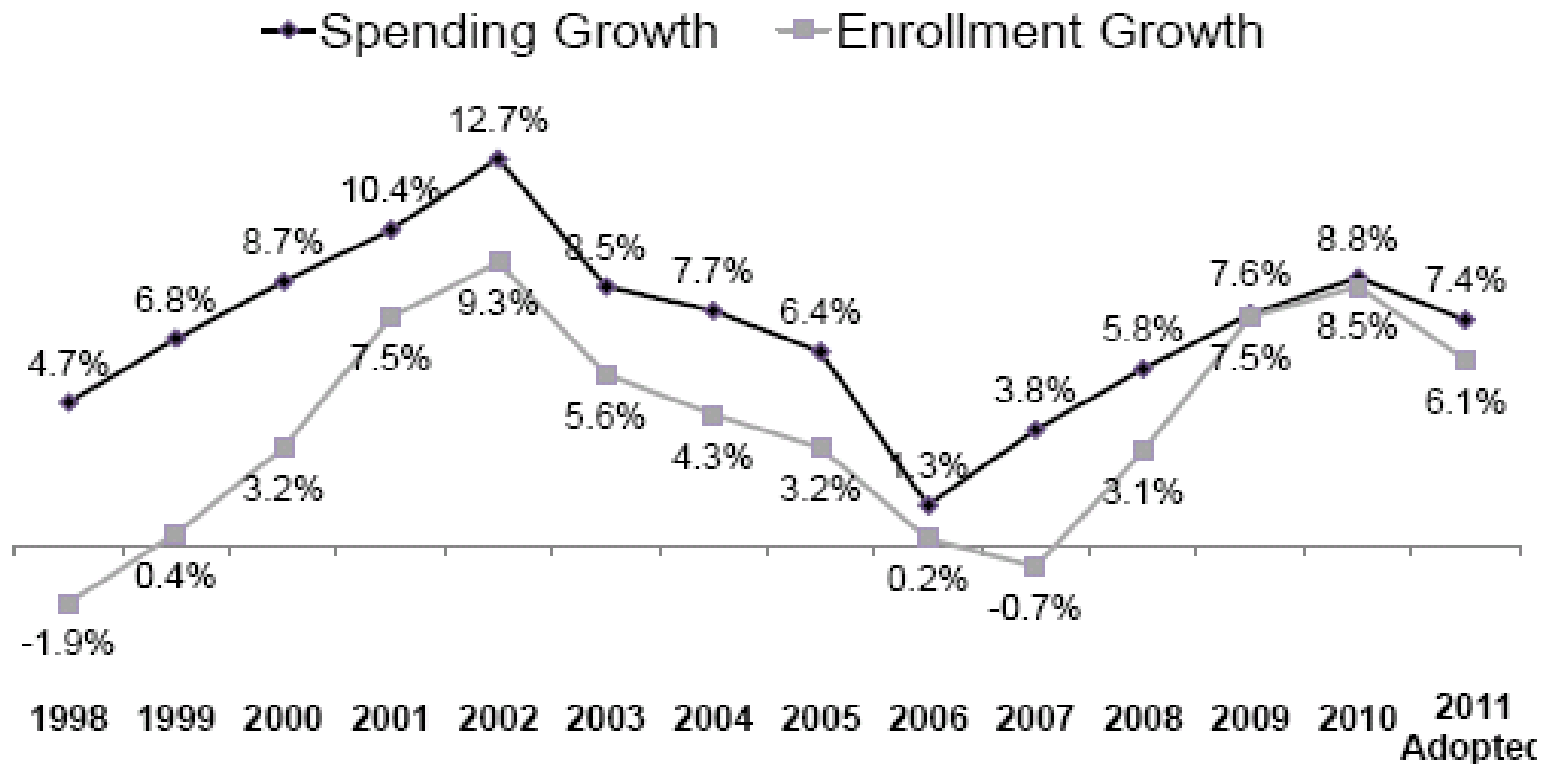


Includes ABW Enrollment

Total MI Medicaid Expenditures



Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2011



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: Enrollment Data for 1998-2009: *Medicaid Enrollment in 50 States*, KCMU.

Spending Data from KCMU Analysis of CMS Form 84 Data for Historic Medicaid Growth Rates. FY 2010 and FY 2011 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.

Governors Weigh In

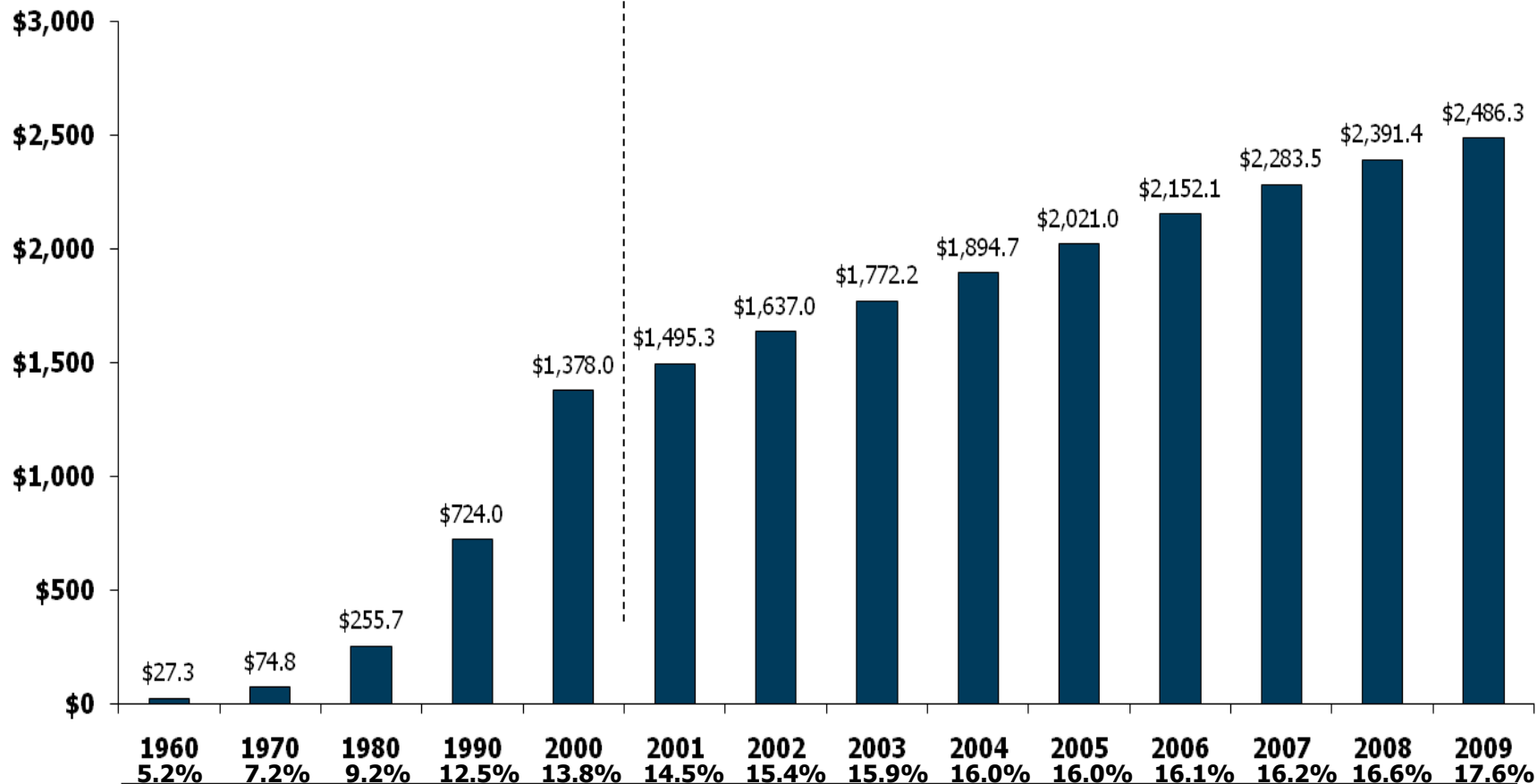
- "Medicaid is poised to wreak havoc on the state's budget for years to come," Gov. Gary Herbert (R-UT) told a House subcommittee in March, "threatening our ability to fund critical services, such as transportation and education."
- "Medicaid costs are getting out of control," said Gov. Rick Scott (R-FL), a former hospital executive who has proposed a dramatic privatization of the program in his state.

“One of Medicaid’s biggest problems is mission creep. . . In short, an ever expanding Medicaid program is devastating for the nation’s and the state’s finances, and by spreading itself so thin it fails to provide adequate care for those who need it.”

Sen. Orrin Hatch
June 15, 2011

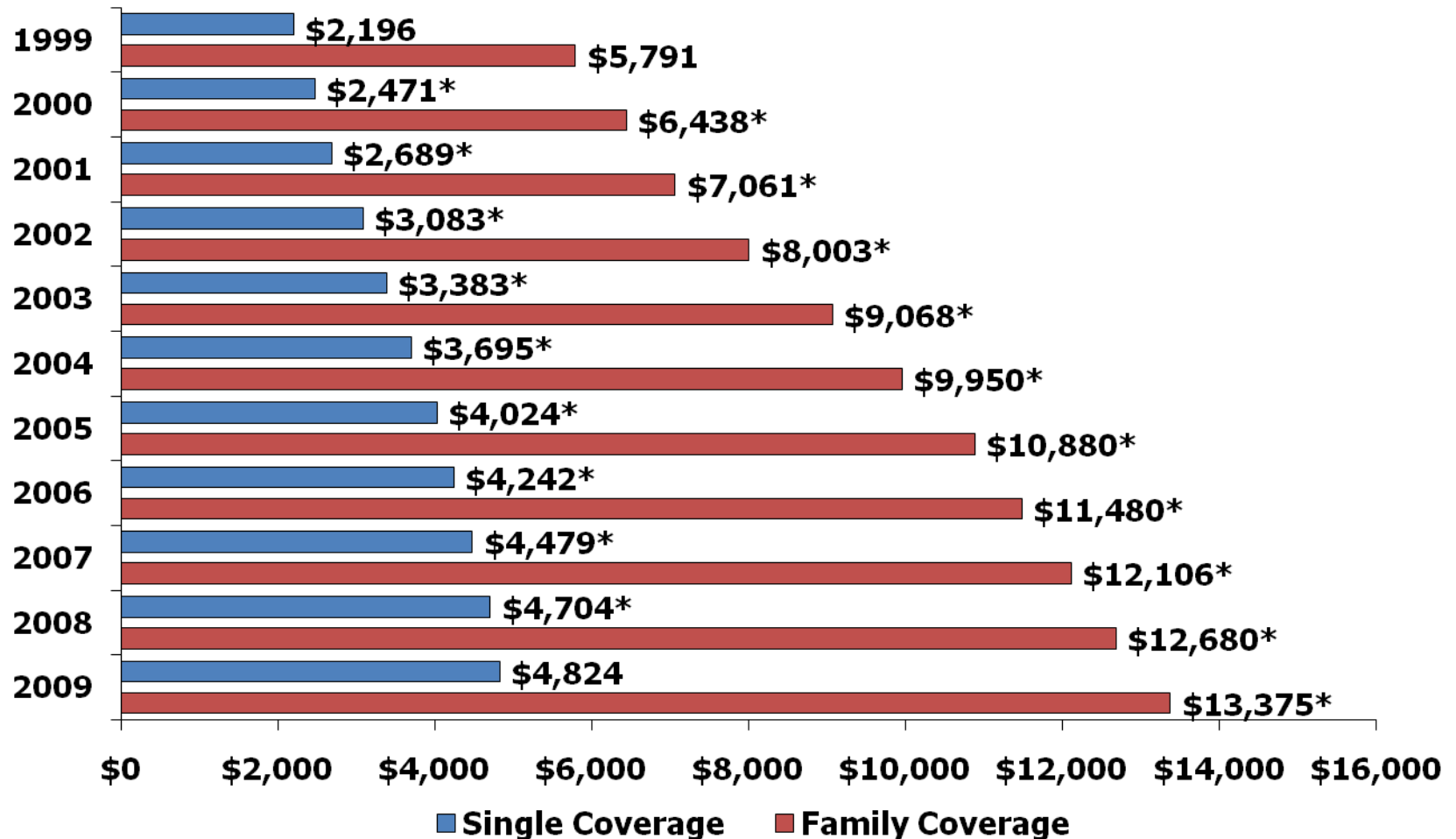
National Health Expenditures and Their Share of Gross Domestic Product, 1960-2009

Dollars in Billions:



NHE as a Share of GDP

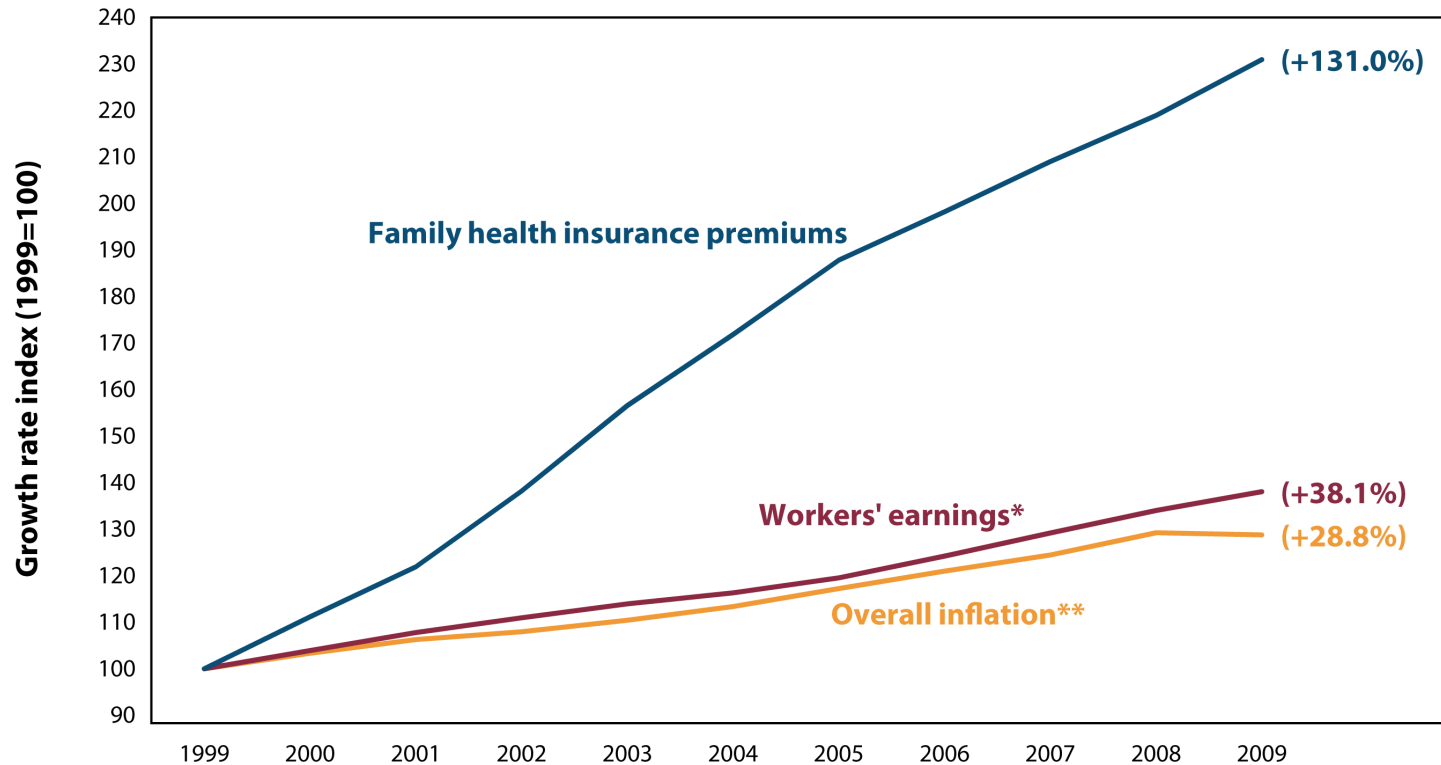
Average Annual Premiums for Single and Family Coverage, 1999-2009



* Estimate is statistically different from estimate for the previous year shown (p<.05). Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

Growth of health insurance premiums far outpaces workers' earnings and overall inflation

Growth rate index of family health insurance premiums, workers' earnings, and overall inflation, 1999-2009

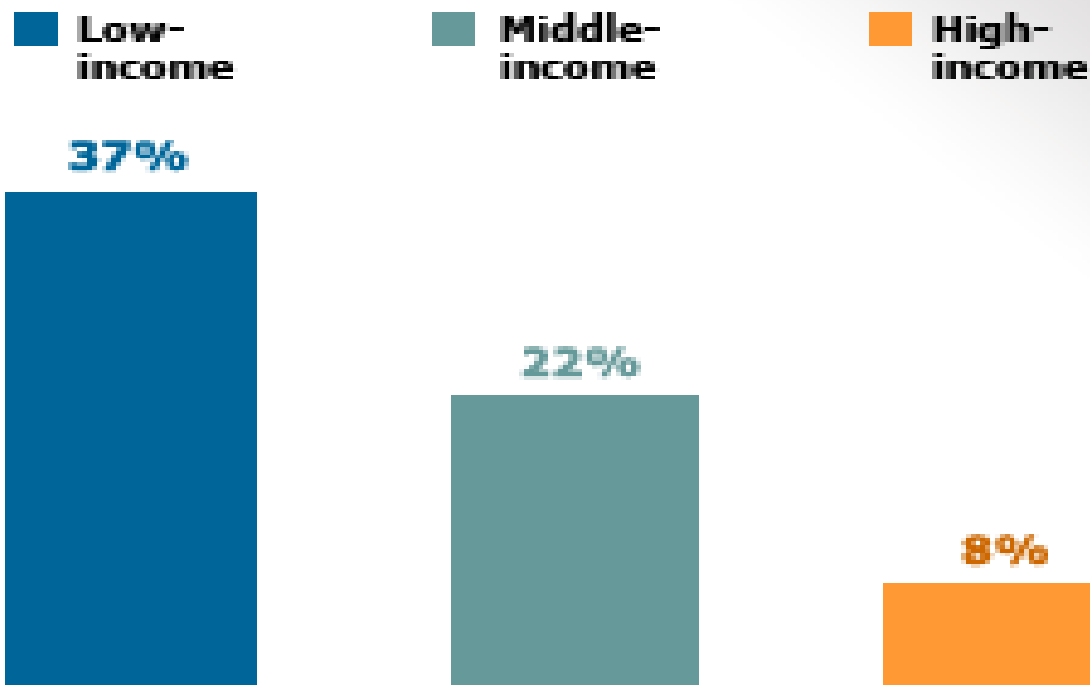


* Workers' earnings as measured by average hourly earnings for private sector production workers.

** Overall inflation as measured by the Consumer Price Index for All Urban Consumers (CPI-U).

Source: EPI analysis of Kaiser Family Foundation and Bureau of Labor Statistics data.

Health Care Costs Putting Financial Drain on Low and Middle Income Americans

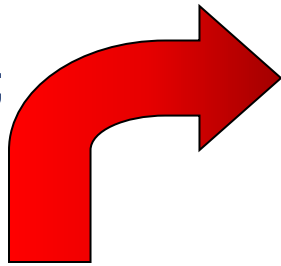


37% of low-income people and 22% of middle income people with private coverage spend more than 10% of their household income on health care, compared with 8% of high-income people.

The Medicaid Rate Cut 'Death Spiral'

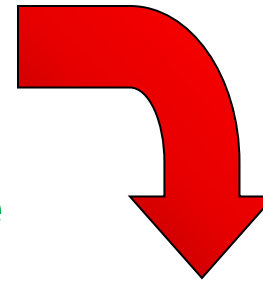
Cutting Medicaid rates impacts private coverage and spurs growth in Medicaid enrollment

Fewer MI workers can afford coverage; enroll in Medicaid



Growing number of Medicaid beneficiaries seek health care

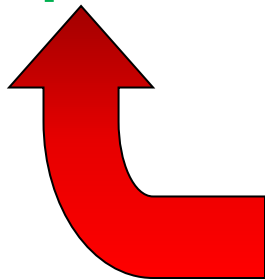
MI Medicaid reimburses providers at less than cost



Employers sponsor fewer and less affordable plans

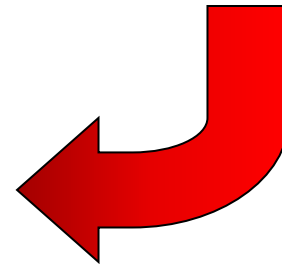
Undercompensated Care

Health care costs increase for employers and employees



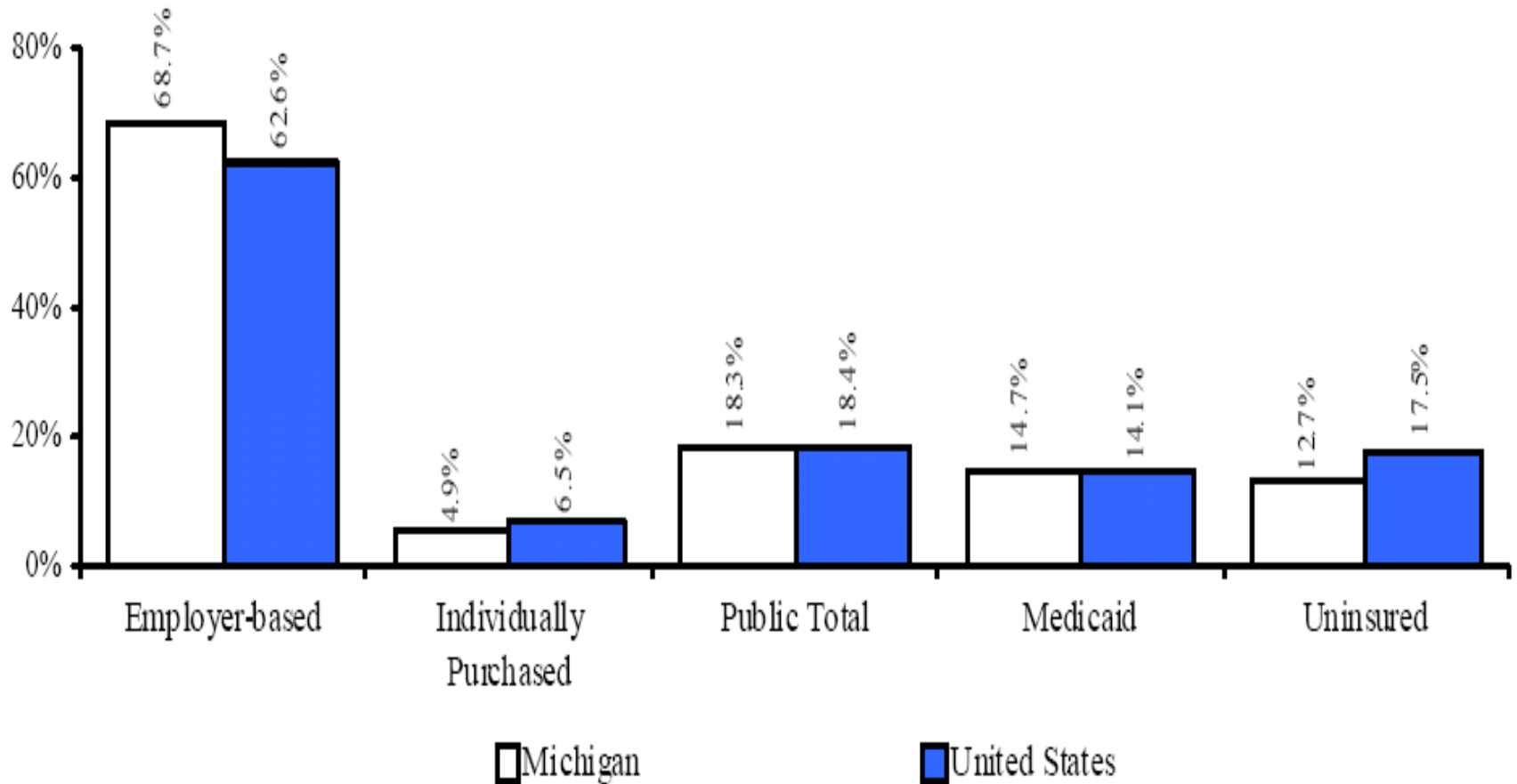
Higher private health plan premiums

Health care providers charge more to higher-reimbursing payers



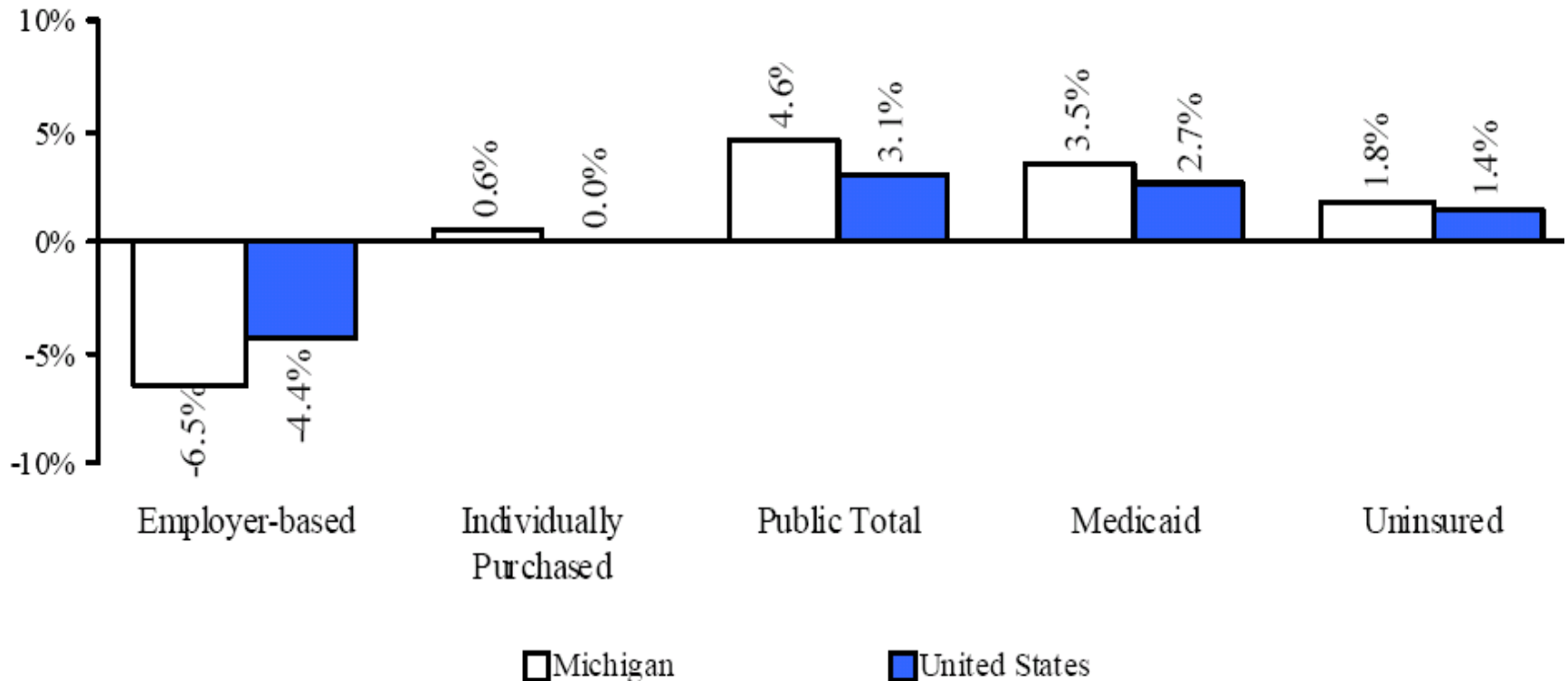
Health Insurance Coverage and the Uninsured

Non-elderly, 2006-2008

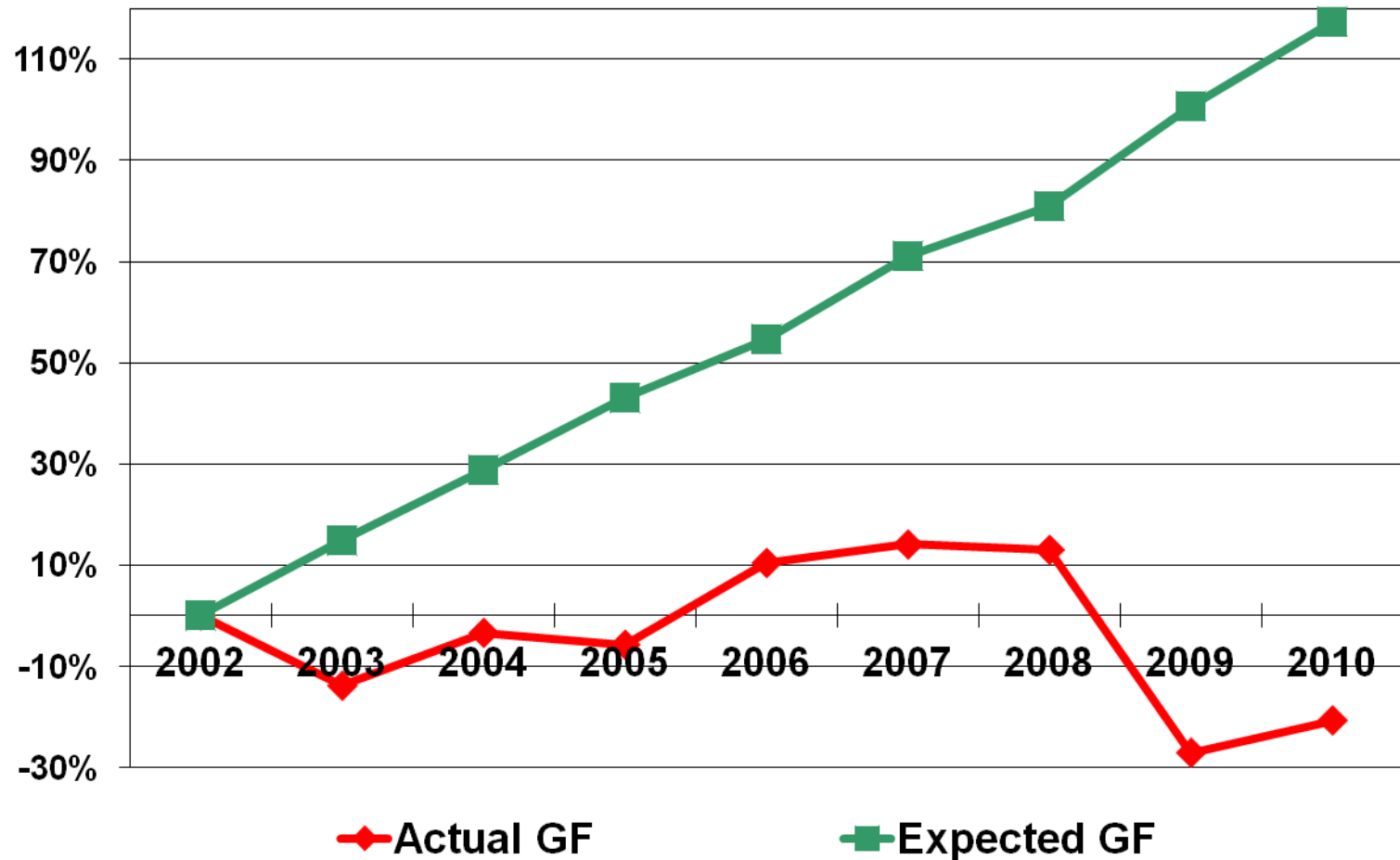


Change in Health Insurance Coverage and Uninsured

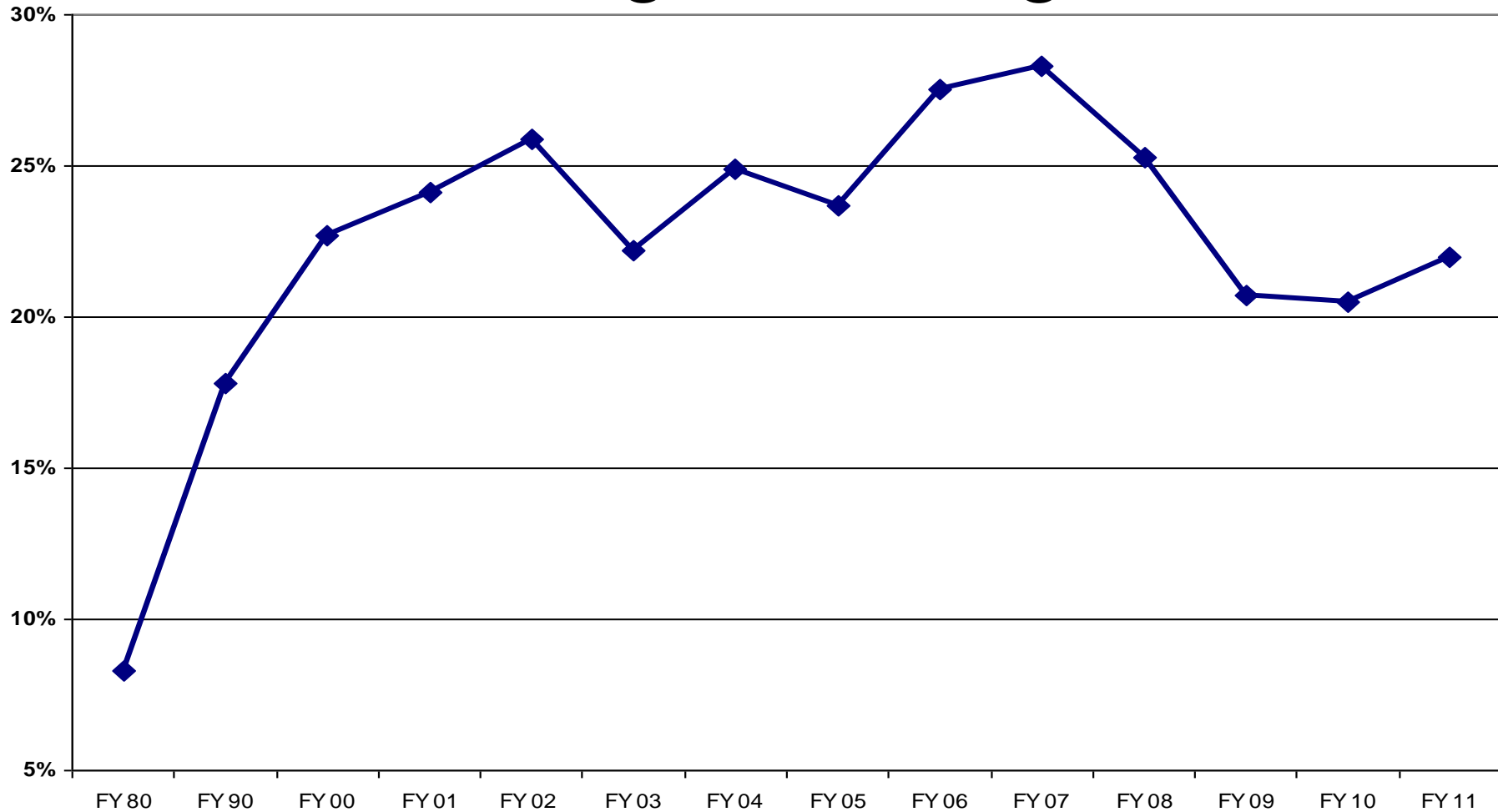
Non-elderly, 2000-2002 to 2006-2008



Michigan Medicaid GF Expenditures Actual vs Expected



Medicaid GF Expenditures as part of Michigan's Budget



Florida Center for Fiscal and Economic Policy

“Significant increases in Medicaid enrollment (and therefore Medicaid spending) and reductions in state revenue are simultaneous consequences of the same recession. In short, Medicaid was able to meet the additional need while simultaneously reducing the financial burden to the state.”

Medicaid Today

Michigan Medicaid – Big Program

- \$12 billion appropriation in FY11
- Covers 19% of the state population
- Covers nearly 40% of all children in MI
- General Fund spending 21.8% of total

FY12 Budget

No Major Medicaid Reductions

- Preserves eligibility, coverage of optional services without rate reductions
- Recognizes vital role of Medicaid providing health coverage to vulnerable citizens
- Endorses MI Medicaid as a good investment
- Affirms MI Medicaid's commitment to managed care

Affirmation ≠ Status Quo

- FY12 Budget adopts many initiatives to push forward (plenty of work to do):
 - Claims tax substitution for HMO use tax
 - CSHCS converted to managed care
 - MIPCT
 - Integrated care for dual eligibles
 - Funding for EHR adoption

The Affordable Care Act and Future of Medicaid

Governor Snyder's Principles for Reinventing Michigan's Health Care

- Give all Michigan residents access to quality, affordable health care.
- Focus on prevention, wellness and personal responsibility; and
- Change the system to reduce costs.

Governor Snyder's Special Message to the Legislature on Health and Wellness

“Improving access to health care also will lead to improved wellness and costs savings. For too many individuals and small businesses, cost has put health care coverage out of reach. The Health Insurance Exchange, mandated by federal health care reform legislation, is an attempt to change that. The Affordable Care Act requires states to establish a health insurance exchange by 2014. Snyder said Michigan must be prudent in planning to meet federal requirements. If Michigan doesn't create its own exchange, the federal government will impose one.

In an effort to create a system uniquely designed to meet the needs of Michiganders, Snyder will ask lawmakers to pass legislation creating the MI Health Marketplace before Thanksgiving. The Michigan-based online health insurance exchange will emphasize free-market principles and provide a competitive marketplace for consumers through the use of technology.”

Sept 14, 2011

Healthcare Reform Implementation to Date

**Medicaid and
CHIP
Maintenance
of Effort**

**Established
High Risk Pool**

**Insurance
Market Reforms**

**Medical Loss
Ratio**

**Temporary
Re-Insurance
Program**

**\$1 million Rate
Review Grant**

Health Care Reform Planning Timeline

ACA PROVISION	2011			2012				2013				2014
	Apr-Jun 2011	Jul-Sep 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	Jul-Sep 2013	Oct-Dec 2013	Jan 2014
Initial Planning Phase Stakeholder Process Leadership Review Legislation/Policy Implementation												
§1311: Establishment of Health Benefits Exchange (mandatory)	→	→	→	→	→	→	→	→	→	→	→	GO LIVE
§2001: Medicaid Expansion to 133% FPL (mandatory)	→	→	→	→	→	→	→	→	→	→	→	GO LIVE
§1331: Basic Health Plan (optional)	→	→	→	→	→	→	→	→	→	→	→	GO LIVE
§2602: State Demonstrations to integrate care for dual eligible individuals (optional)	→	→	→	→	→	GO LIVE	→	→	→	→	→	→
§4106: 1% FMAP increase for evidence-based prevention services with no cost-sharing (optional)	→	→	→	→	→	→	→	GO LIVE	→	→	→	→
Various Insurance Market Reforms (mandatory)	→	→	→	→	→	GO LIVE	→	→	→	→	→	→
§1202: Medicaid rate increase for primary care physicians up to Medicare rate (2 years only)	→	→	→	→	→	→	→	GO LIVE	→	→	→	→
§2703: State option to provide health homes to Medicaid enrollees with chronic conditions (work in progress)	→	→	→	→	→	→	→	→	→	→	→	→
§3502: Patient Centered Medical Homes	→	→	→	→	→	→	→	→	→	→	→	→
												○○○○○ Stakeholder Steering Committee meetings

Health Insurance Exchanges: Background

- New health insurance market where individuals and small businesses can go to learn about available options and to purchase coverage.
- A more organized and competitive market for health insurance that offers: A choice of health plans, common rules in terms of offering and pricing insurance and, provides consumers with information to better understand their health insurance options
- Each Health Plan on the exchange must 4 coverage options:
 - Bronze 60% actuarial equivalent
 - Silver 70%
 - Gold 80%
 - Platinum 90%
- Bronze package would cost and cover the least and the platinum would cost and cover the most.
- Policies must cover essential services such as doctor visits, hospitalization, prescription drugs, maternity and diagnostic services.

Tax Impacts for Individuals and Small Business

- Starting in 2014, refundable and advanceable tax credits will be available to assist individuals in purchasing coverage and reduce health care cost sharing for individuals and families with incomes from 133% to 400% of the federal poverty level (i.e. \$29,327-\$88,200 for a family of four).
 - Level of subsidy is tied to the second lowest cost Silver plan in the exchange and is on a sliding scale.
- Tax credits available to small employers providing health coverage to employees
 - Employers with no more than 25 employees
 - Average annual wages of less than \$50,000
 - Phase I (2010-2013): tax credit up to 35% of employer cost
 - Phase II (2014-): tax credit up to 50% of employer cost, if purchased through Exchange (for 2 years)
- To receive the tax credit, you must purchase coverage through the Exchange.

Functions and Options of the Exchange

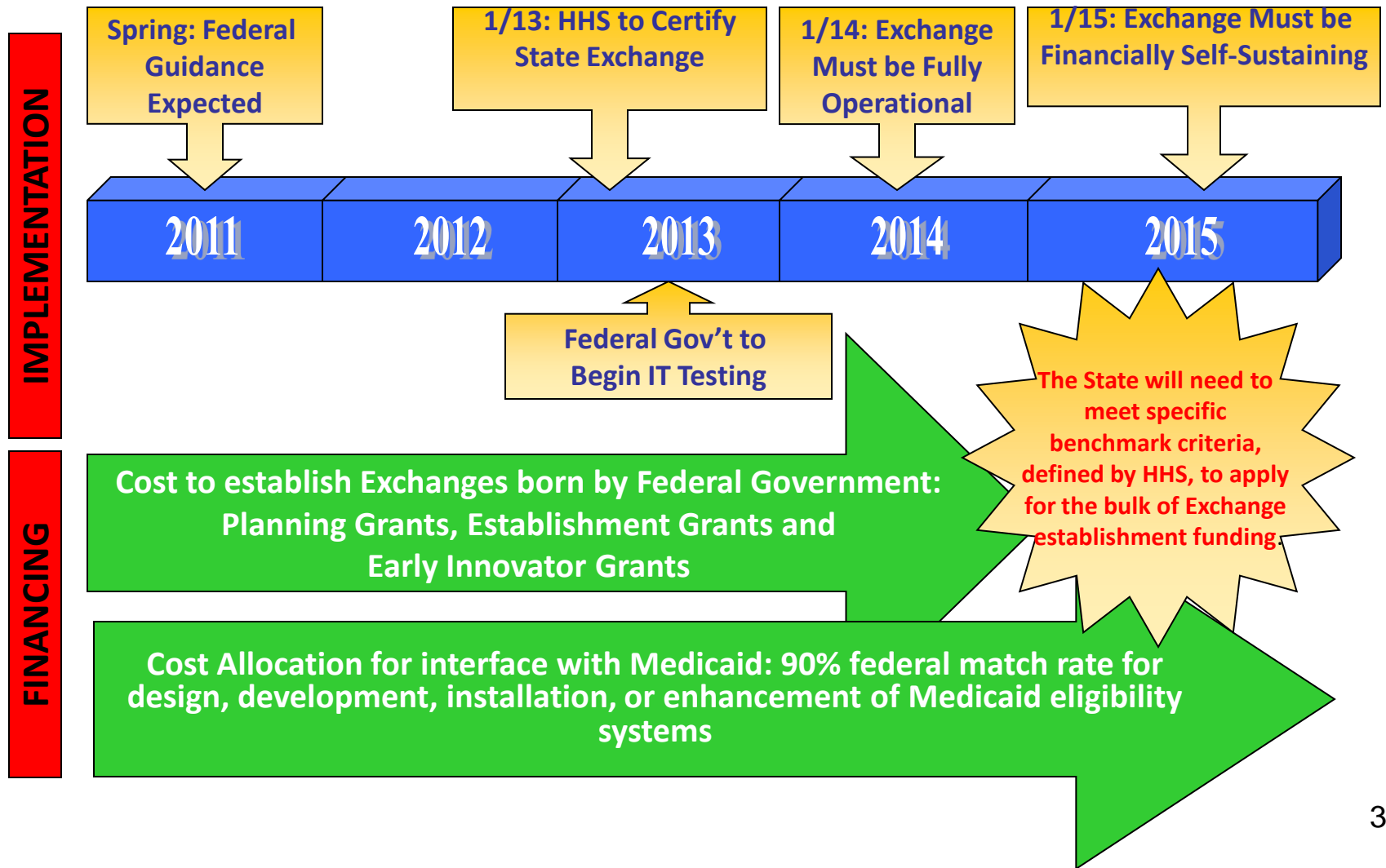
Mandatory Functions

- Certify and rate qualified health plans
- Operate hotline and Web site
- Standardize presentation of coverage options
- Inform individuals of Medicaid, CHIP eligibility and enroll them into these programs
- Help calculate plan costs
- Determine exemptions from individual mandate

Structural Options

- States can:
 - Independently operate the Exchange
 - Operate Exchange regionally with other states
 - Defer to the federal government for operation of the Exchange
- Exchange can be structured to be:
 - Established within existing or newly established state agency
 - Quasi-public authority
 - New non-profit entity







Health Insurance Exchanges: Key Dates and Funding Opportunities



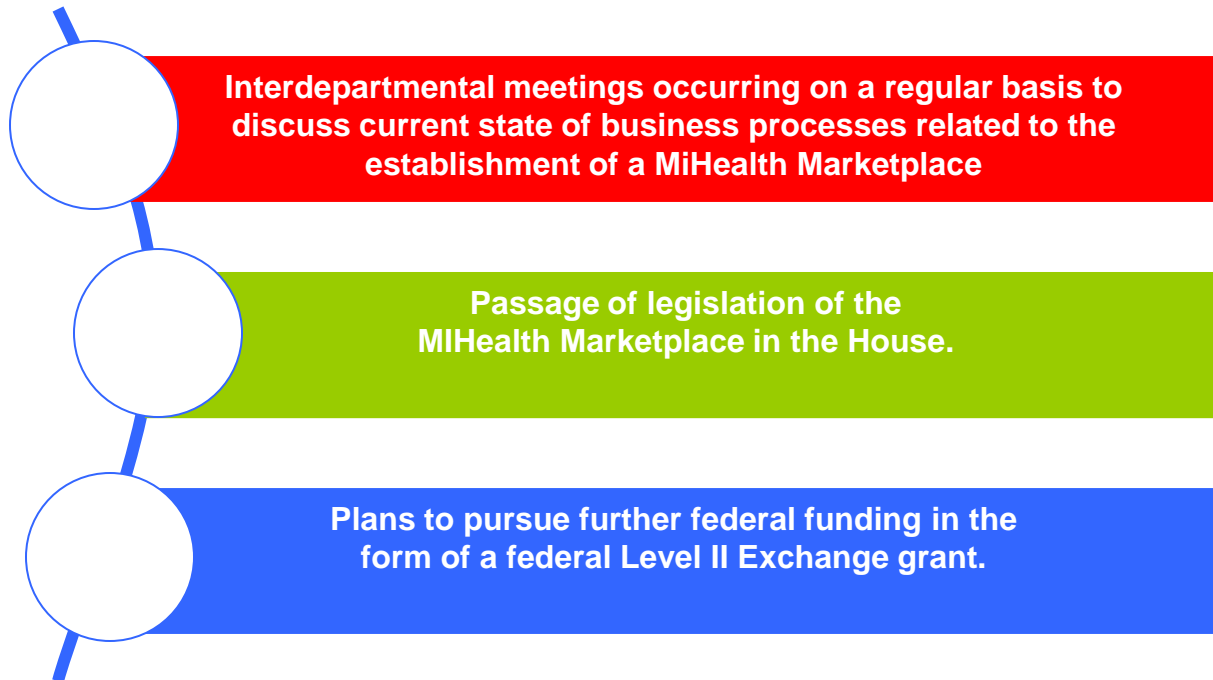
Exchange Planning and Establishment Grants

- Michigan received nearly \$1 million in a Planning Grant from HHS in September 2010 to begin planning for an Exchange in Michigan
 - Planning activities included: Stakeholder workgroup meetings, background research on Michigan's insurance landscape, and an IT gap analysis
- Michigan recently received a federal Level 1 Exchange grant of \$9,849,305.
 - Level 1 activities will include: additional analysis on the impacts of the Exchange and the Affordable Care Act in Michigan, including additional insurance market analysis; acquire contractual services to assist the State and the Exchange with legal matters, technology planning, education and outreach, financing and policy issues; and, support the State of Michigan as it works toward establishment of this new entity.

Health Insurance Exchange: Progress to Date

-  Five Stakeholder Workgroups were convened between February and April to discuss policy issues and make recommendations
-  Workgroups made over 50 consensus-based recommendations
-  Stakeholder recommendations compiled into a report for distribution to the Steering Committee, Legislature, others
-  A Steering Committee of leadership from 9 state agencies reviewed the stakeholder findings and made final recommendations to the Governor
-  Governor Snyder addressed the Legislature regarding the implementation of the MIHealth Marketplace
-  The Senate passed SB 693 creating the MIHealth Marketplace.

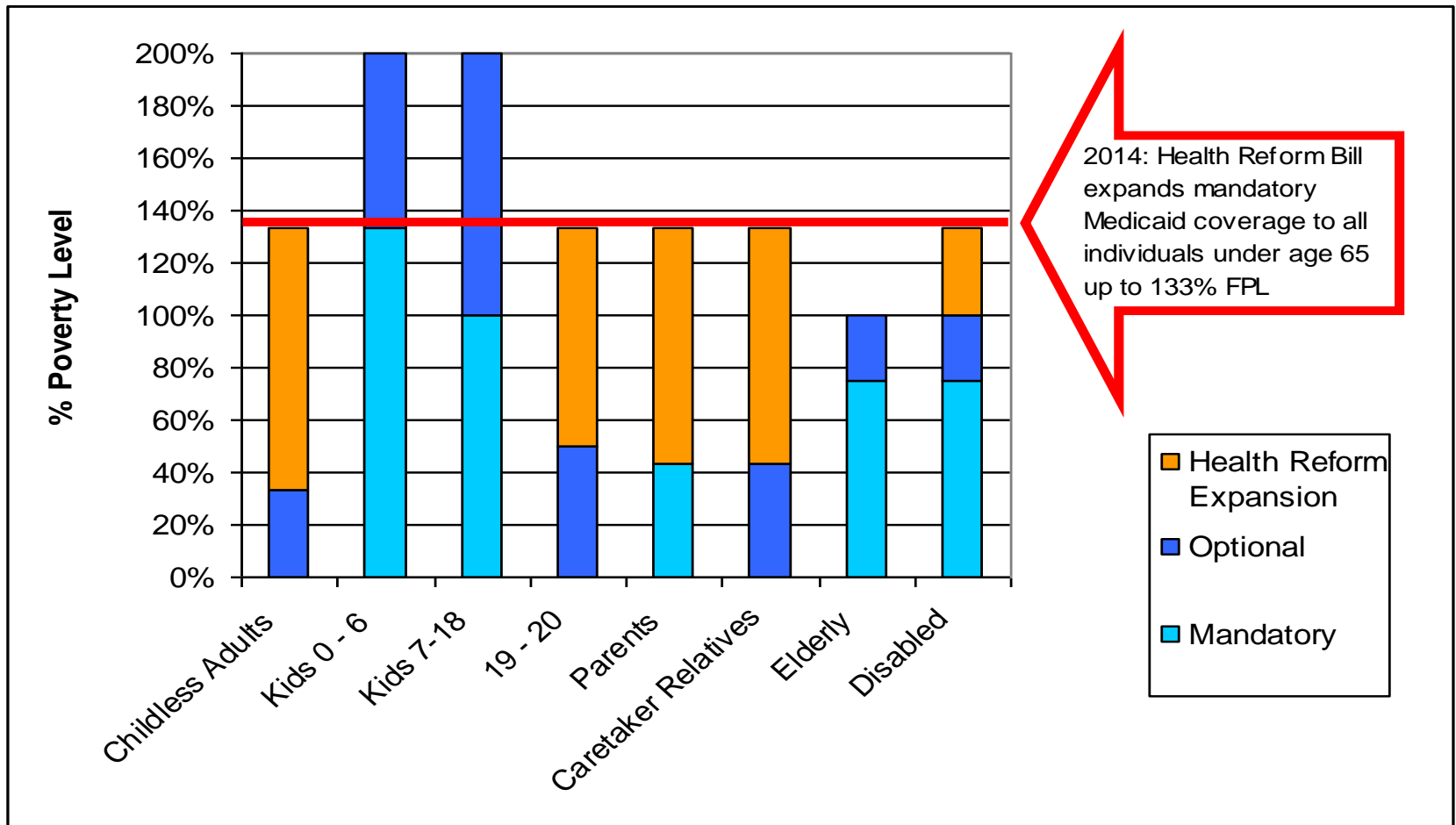
Health Insurance Exchange: Next Steps



ACA Changes to Medicaid

- Starting in 2014, expands Medicaid to everyone up to 133% FPL (\$29,327 for a family of 4).
 - Medicaid currently covers 1.9 million Michigan residents today.
 - Initial Estimated Enrollment Impacts: 450,000 - 500,000 new uninsured individuals will enroll in Medicaid (expansion+ woodwork effect).
- For CY13 and 14, increases Medicaid primary care rates to Medicare levels at 100% federal cost
- Enrollment simplification including IT redesign and coordination with the MIHealth Marketplace
- Many different cost effectiveness initiatives/demonstrations

Medicaid: Current and Expanded Eligibility



Proposed Rules: Enhanced FMAP Determinations

Per the ACA, starting in 2014, states will receive an enhanced FMAP for “newly eligible” beneficiaries. The matching rate starts at 100%, and decreases down to 90% in 2020 and beyond.

The proposed rule suggests allowing states the opportunity to choose among three methodologies to determine the newly eligible individuals whose expenditures would be eligible for these increased federal funds.

Year	Newly-Eligible Parents & Childless Adults (up to 133% FPL)
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 on	90%

Medicaid Expansion: Next Steps

- Proposed federal rules released August 12, 2011.
 - The rules address additional guidance on a simplified process for determining whether individuals are eligible for coverage through Exchanges, for premium tax credits to assist in the purchase of private insurance, or for other programs such as Medicaid or the Children's Health Insurance Program (CHIP).
- Michigan provided CMS with comments regarding the proposed rules
- Proposed rules are subject to revision based upon input received during the comment period.

Proposed Rules: Eligibility and MAGI

- The modified adjusted gross income (MAGI), as defined by the Internal Revenue Code, will be the new source of financial eligibility for most Medicaid groups.
- The CMS proposed rule proposes that state's utilize MAGI methods for counting household income, thereby eliminating the various income exclusions and disregards states currently use.
- Medicaid eligibility remains based on monthly income at the time of application.
- Proposed 12-month renewal period for MAGI-based Medicaid beneficiaries

Proposed Rules: Eligibility Simplification

- The proposed rules collapse existing Medicaid categories into three broad groups:
 - Parents
 - Pregnant Women
 - Children under age 19
- States would have the flexibility to set income eligibility standards for these groups, subject to federal rules.

System Reforms and Demonstration Projects

- State Demonstration to Integrate Care for Dual Eligible Individuals
 - DCH awarded nearly \$1 million in planning funding from CMS to develop Integrated Care over the next year
 - Key Objectives
 - Fully integrate Medicare and Medicaid program rules and funding with shared savings
 - Implement organized and coordinated service delivery systems across all service domains
 - Stakeholder process - summer of 2011

ACA Demonstration and Planning Grant Opportunities

- Money Follows the Person
- Health Homes – chronically ill enrollees
- Global payment system for some hospitals
- Pediatric ACOs
- Emergency psych demo project
- CHIP obesity demo
- Exchange planning grants
- Develop/upgrade MA eligibility systems

“Medicaid should be transformed within the context of 100% insurance coverage as a national objective. Leaving 43 million Americans uncovered is immoral, it is unjust, and over the long run it is more expensive.”

“A Vision for a 21st Century Medicaid Solution”

Newt Gingrich, The Center for Health Transformation

QUESTIONS

