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***Virginia Medicaid
Department of Medical
Assistance Services***

**Medicaid Expansion Estimates
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**Sandra Hunt,
Principal, M.P.P.**

Agenda

Background

Our Role

Methodology, Key Considerations and Assumptions

Results

Additional Information

Background

PwC Experience with Virginia Medicaid and other states

- Consulting actuary to Virginia since 1997; more than 25 years experience with Medicaid Managed Care in 15 states including expansion programs in Oregon, Tennessee, Wisconsin, Kentucky, and others
- Rate-setting work in Virginia:
 - Medallion II and MCO Expansions
 - FAMIS and FAMIS MOMS, PACE, Commonwealth Coordinated Care Dual Demonstration
- Other consulting projects: Cost Effectiveness, presentations to VHRI Advisory Council
- Commercial and Medicare Experience
 - Exchange rate filings in 10+ states
 - Develop rates for Medicare Advantage plans, and review rates for CMS

Our Role

PwC Role in DMAS ACA Budget Estimates

- Initial per capita (PMPM) estimates prepared September 2012
- Updated estimates prepared December 2013, with initial discussions in September 2013
- Developed PMPM cost estimates of specific population cohorts:
 - Currently eligible for VA Medicaid, but not enrolled
- **“Woodwork” or “Welcome Mat” population**
 - New costs for currently enrolled population - income between 29% and 133% FPL:
 - > **Parents of children (Caretaker Adults)**
 - > **Disabled under 65 (ABD)**
 - Newly Eligible up to 133% FPL
 - > **Primarily Childless Adults**

Methodology and Assumptions

PwC Methodology, Key Consideration and Assumptions for PMPM Estimates

- All new Medicaid cohorts would be enrolled in Managed Care Organizations (MCOs)
- Base PMPM developed with health plan data used for Medallion II MCO rate-setting for CY 2014 contracts
- Updated estimates rely on new information
 - More recent experience from the Medallion II program
 - Experience of early Medicaid expansion programs

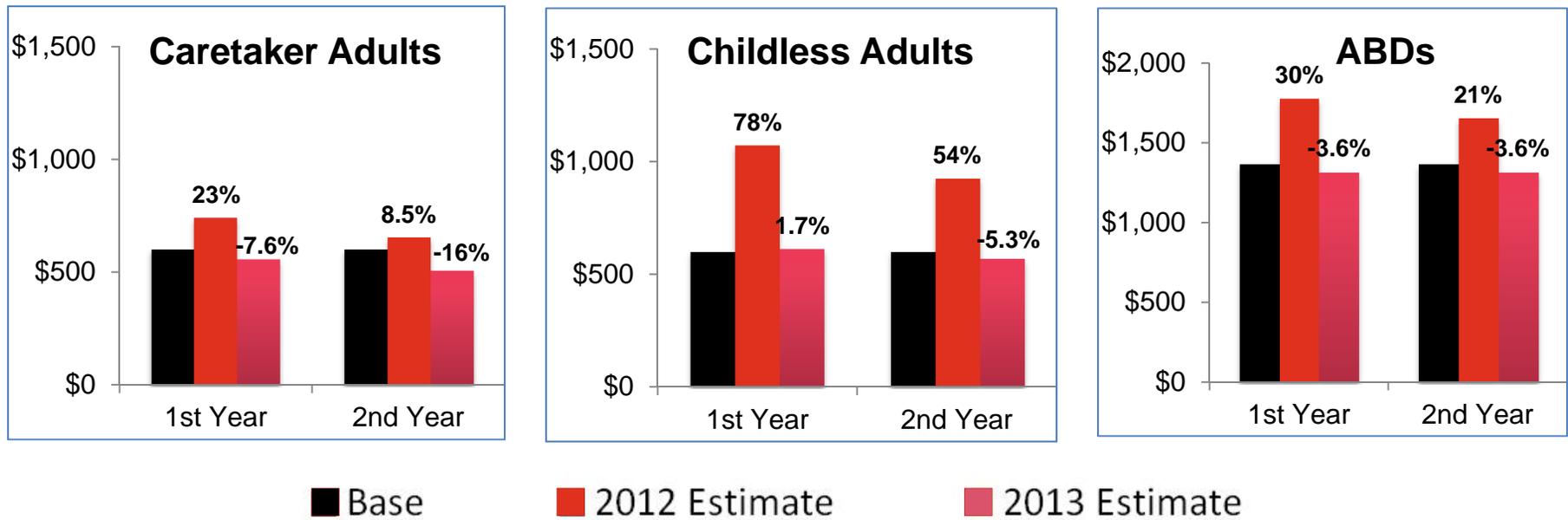
Methodology and Assumptions

PwC Methodology, Key Consideration and Assumptions for PMPM Estimates

- Demographic characteristics
 - Age/gender
 - Maternity status (all pregnant women fall into currently eligible categories)
- Covered services
 - Benchmark benefit plan
 - Mental Health and Substance Abuse
- Health status of the population
 - Pent up demand
 - Adverse risk
 - Enrollment timing and take up rate

Results

Summary of PMPM Estimates



Results

Primary Drivers for Change in Revised Estimates

2012 Estimate

- Estimates were initially conservative to protect against underestimate
- Little was known about likely cost of expansion populations, and expectation was for a high level of adverse selection
- Expansion populations were initially assumed to have more chronic conditions and costs most similar to current aged/disabled populations

2013 Estimate

- In-depth review of recent information from states having experience with expansion populations: Wisconsin, Oregon, California, and additional work in Arizona, Minnesota, New York, Washington
- Concluded that expansion populations are more likely to have costs in line with, or even lower, than currently covered low-income adults
- In depth analysis of Wisconsin BadgerCare + population, and Oregon Health Plan provided most relevant information

Additional Information

Takeaways from new analysis

- Early enrollees will be most costly, and their costs will taper off as need is met
- Broad enrollment will result in lower per capita costs; lack of premium requirement encourages a broader mix
- Current eligible but not enrolled have costs below current enrollees
- Higher income new eligibles in traditional categories are likely the same or slightly less expensive than current population
- Newly eligible childless adult costs are the most difficult to project and likely to initially be somewhat higher than parents with children, with higher Mental Health and Substance Abuse needs; physical health needs tend to be lower

Q&A

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