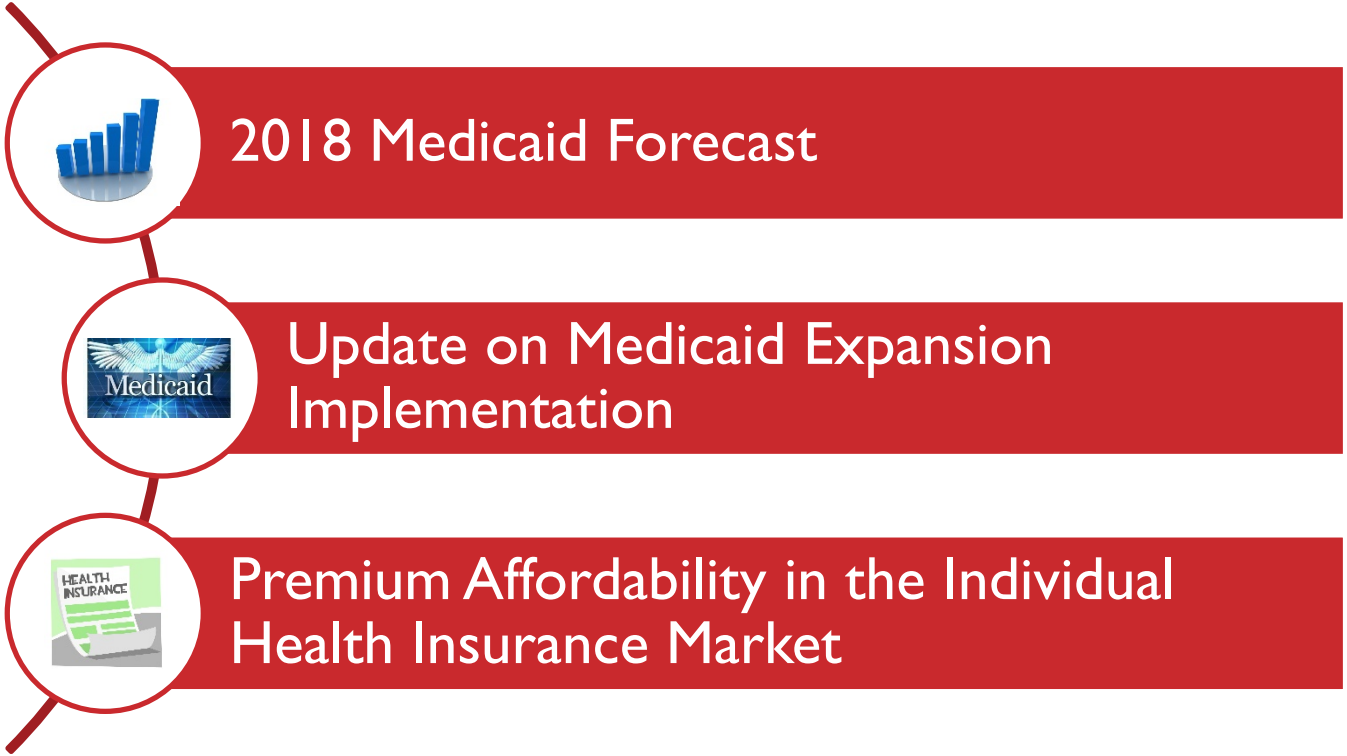
Major Budget Issues in Health and Human Resources for the 2019 Session

Annual Meeting

November 16, 2018

Presentation Overview



Medicaid Forecast

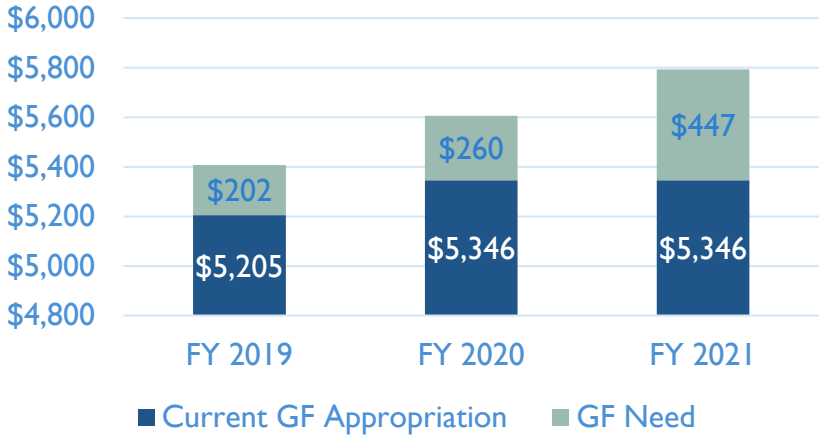
Trends and Funding Required for the 2019 Session

2018 Medicaid Forecast Reflects Higher Need Than Previously Projected in Last Year's Forecast

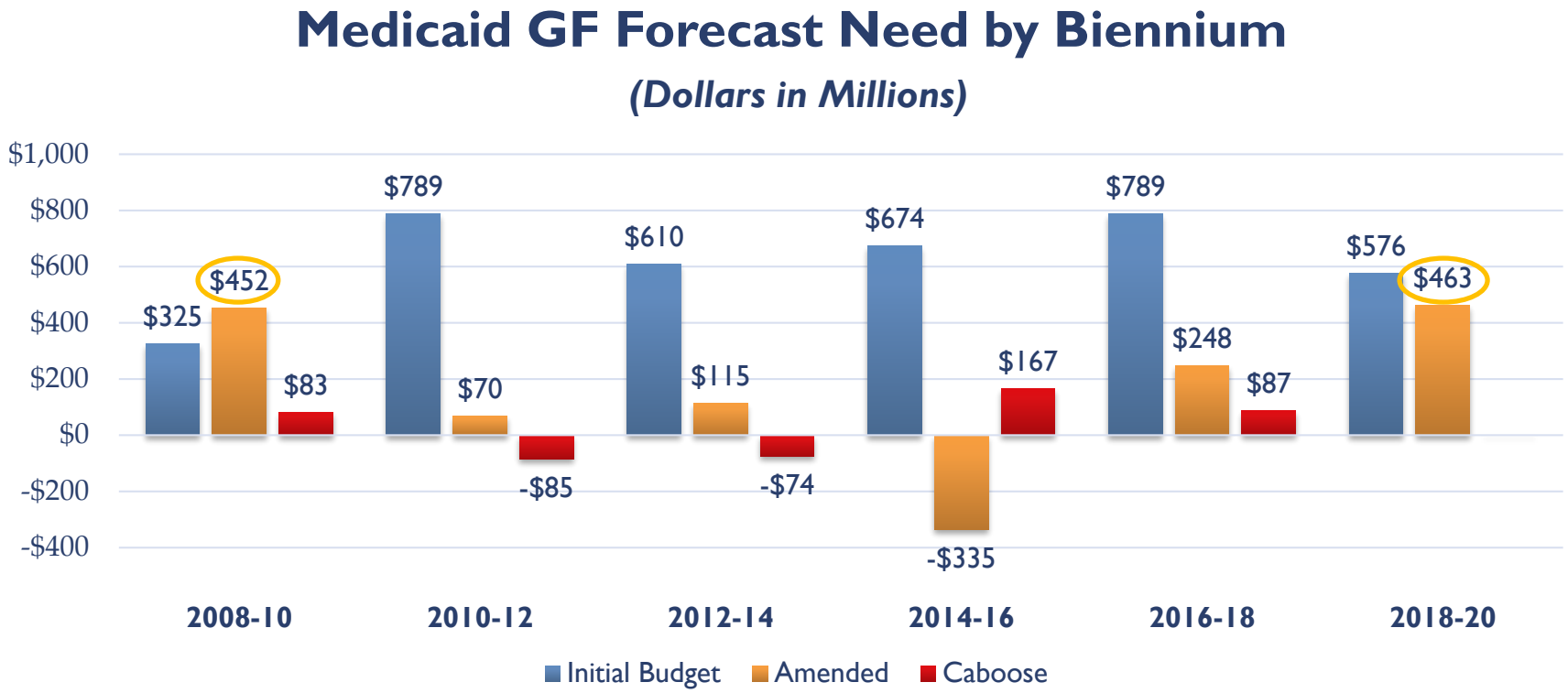
- New forecast requires additional funding of **$462.5 million GF for 2018 - 20 biennium.**
- Last year, the 2017 Forecast for the 2018-20 Biennium required **$576 million GF.**
- Forecast does incorporate Medicaid Expansion savings, which reduces the growth rate.
- Base Medicaid spending is projected to increase by:

Fiscal Year	2019	2020	2021
2018 Forecast	6.2%	2.6%	3.5%
2017 Forecast	2.5%	3.4%	N/A

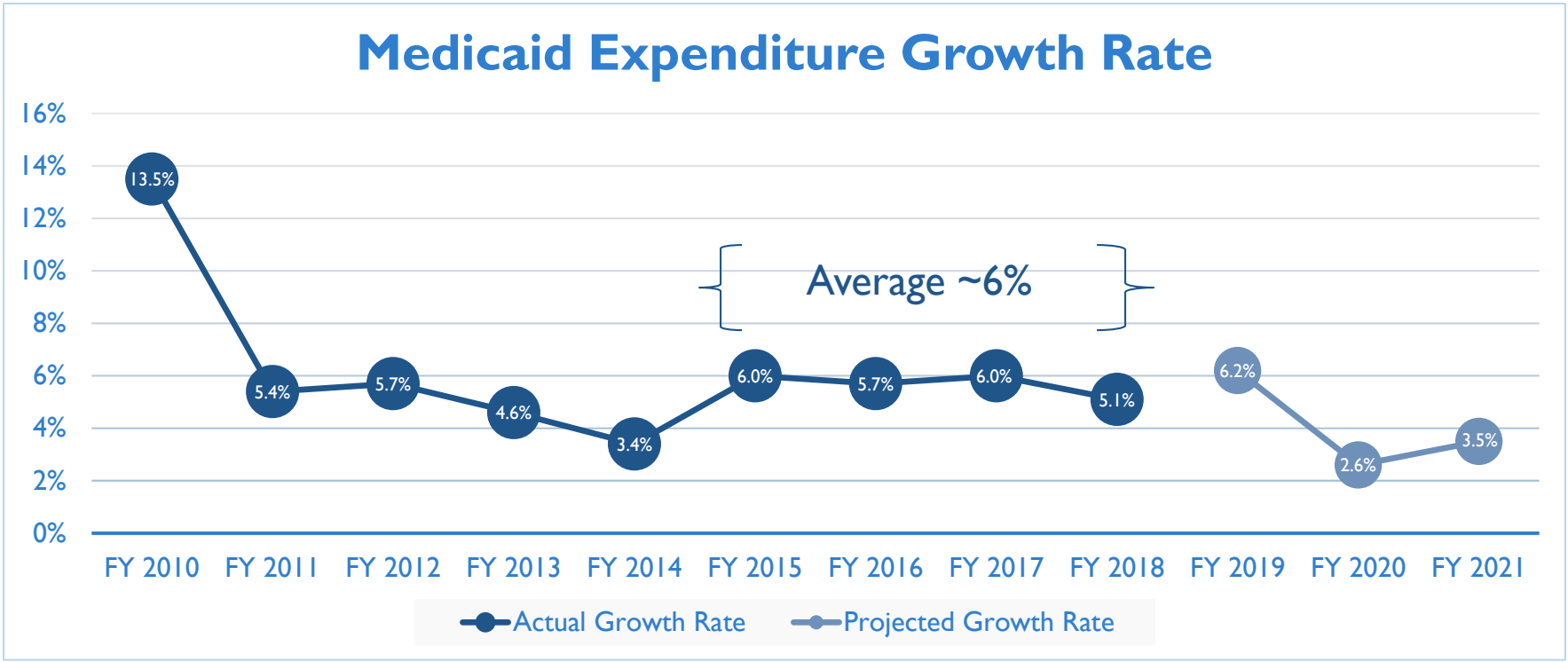
November 2018 Medicaid Forecast
(Dollars in Millions)



Last Increase in an Amended Year of this Magnitude was the 2008 -10 Biennium



Recent Medicaid Expenditure Growth has Averaged Closer to 6% - Projected Growth May Still be Too Low



Note: Expenditures in FY 2011, FY 2012, FY 2015 and FY 2016 have been adjusted to reflect payment shifts between fiscal years in order to better reflect realistic expenditure patterns in the program.

2018 Forecast Driven Largely by Managed Care Rates

Managed Care Rates:

- Managed care savings built into the rates for Commonwealth Coordinated Care (CCC) Plus were not fully realized.
- Medallion 4.0 managed care rates are slightly higher.

Hospital Fee-For-Service (FFS) Claims:

- A slower transition of the population from fee-for-service to the new CCC Plus managed care program results in higher FFS claims.

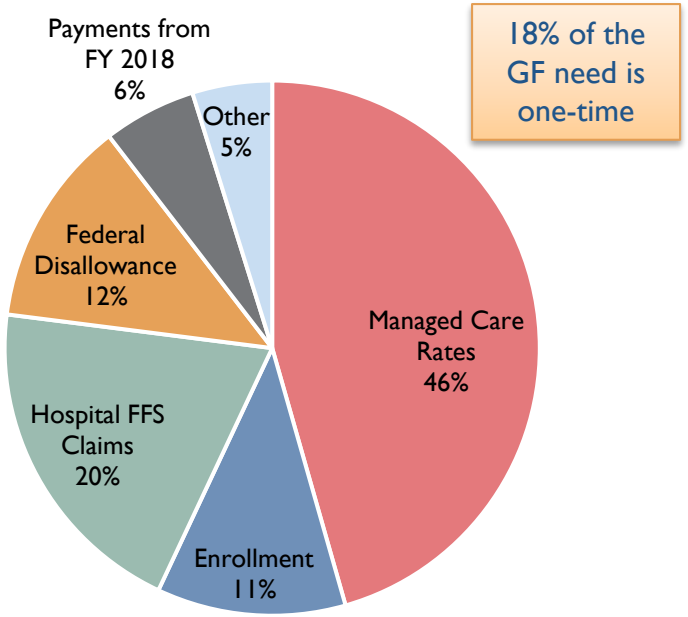
Enrollment:

- Children's enrollment higher than projected.

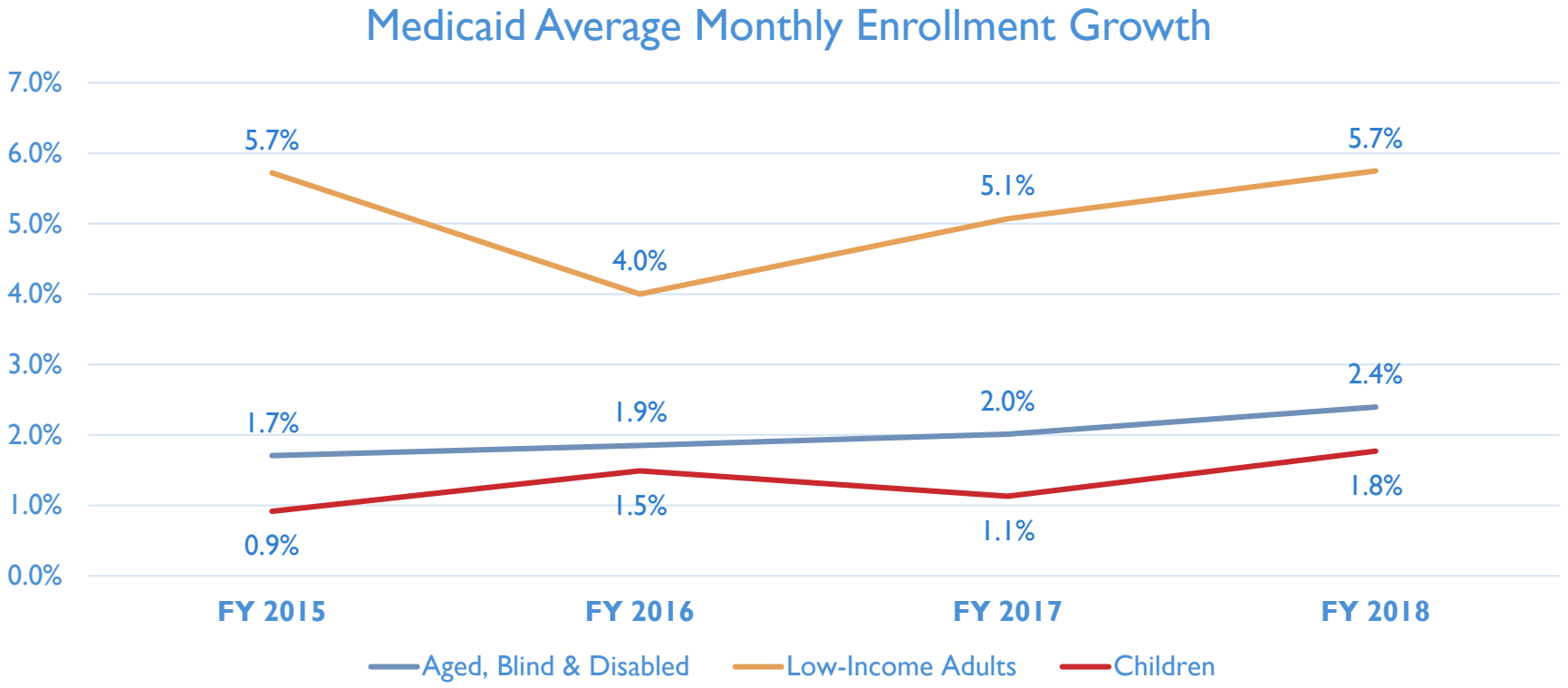
Piedmont and Catawba Hospital Disallowance:

- $58 million GF for FY 2019.

Sources of $462.5 million Medicaid GF Need



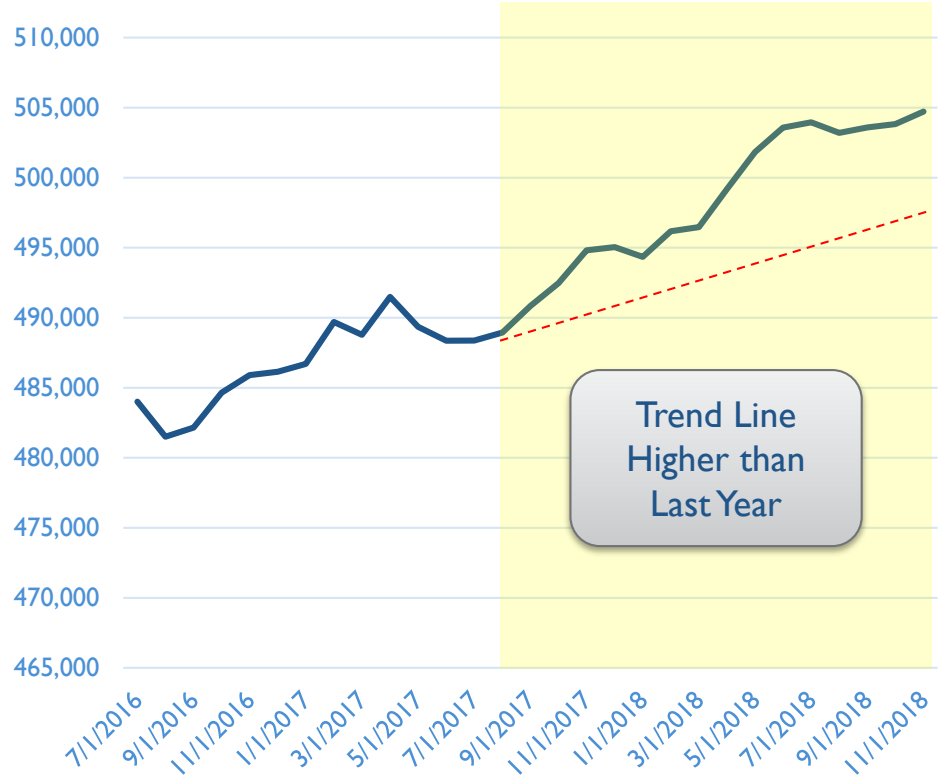
Recent Medicaid Enrollment Trends



Source: Department of Medical Assistance Services Monthly Enrollment Report.

Children's Enrollment Grew Faster Than Anticipated

- August 2017 – June 2018 experienced faster growth in enrollment for children.
- About ~1% growth was projected versus 1.8% actual in FY 2018.
- Federal reauthorization of the Children's Health Insurance Program may have increased attention and interest in coverage.
- Impact is $52.8 million in higher GF costs over the biennium.



Piedmont and Catawba Hospitals Disallowance

- U.S. Health and Human Services Inspector General Report in 2014 found the two hospitals were not properly certified as psychiatric hospitals for Medicaid.

Federal Disallowance = $58 million GF

Potential Liability = $117.4 million GF

- The Commonwealth disagrees but will have to pay the disallowance now as it moves further through the appeals process.
- Current disallowance is only for the 2006-2010 period, leaving a potential future liability of up to $117.4 million for the years since 2010.
- The Commonwealth will begin the official appeal in December.
- The State will also need to replace the Medicaid funding for Piedmont and Catawba hospitals with state funds for continued operation (net cost of $13 million).

Managed Care Rate Assumptions Were Too Low

	Last Year's Forecast		New Rate Assumptions				
	2019	2020	2019		2020		2021
CCC Plus Rates	2.4%	3.5%	5.4%	+3	4.8%	+1.3	4.3%
Medallion 4.0 Rates	NC*	3.8%	NC*		4.1%		4.2%

CCC Plus - The newer managed care program for long-term care services, which began August 2017.

Medallion 4.0 - The traditional managed care program to cover mostly children and low-income adults.

** NC means "No Change" as the rates for Medallion 4.0 are set on a fiscal year basis so the 2019 column reflects FY 2019 for which those rates are in place. CCC Plus rates are set by calendar year and therefore the 2019 rates are not final.*

How are Rates Set for Managed Care?

Two Separate Processes: Developing rate projections for budget development and setting the actuarial rates for the programs.

Only a few DMAS staff are involved in this process.

** Types of data include: eligibility files, fee-for-service claims, health plan encounters, health plan vendor payments, and health plan financial data.*

CCC Plus Rates Are Substantially Higher

Why are the rates so much higher?

- DMAS directed the actuary to assume aggressive savings when the program was launched in 2017.
- The savings offset the higher administrative costs for the program to maintain budget neutrality.
- Based on a federal "actuarially sound" standard to set rates, the savings assumptions were unrealistic and eventually would show up in future rates. This impact is reflected in the current Medicaid forecast.
- Savings in managed care long-term care programs typically take 3-5 years to occur based on experience in other states.

Current Medicaid Forecast May Not Adequately Fund All Needs

Two Major Areas of Uncertainty:

- Managed Care Rates
  - With limited experience in the CCC Plus program the rates for calendar year 2020 could end up being higher than projected if actual trends are higher.
- Woodwork Effect from Medicaid Expansion
  - Outreach efforts will likely result in individuals currently eligible but not enrolled to sign-up for the program.
    - These are traditional enrollees funded at a 50% state match.
    - The 2018 forecast only assumes 1,000 woodwork individuals over the biennium will enroll.
    - In a September 1, 2017 report to the General Assembly, the Department of Medical Assistance Services estimated 28,000 adults were eligible but not enrolled in Medicaid.
    - 2016 data* from the U.S. Census Bureau indicates as many as 42,000 children are uninsured with family income at 200 percent or less of the federal poverty level.

* *Source: Staff Analysis of Urban Institute Report, March 2018, for the Health Care Foundation. Based on 2016 American Community Survey data.*

Potential Medicaid Budget Needs

Potential Budget Need	Est. Fiscal Impact 2018-20 Biennium
Woodwork Enrollment Higher • 5,000 more adults enroll than projected • 10,000 more adults enroll than projected	 $35 million GF $70 million GF
Larger Managed Care Rate Increase for 2020 • Rate Increase for 2020 one percent higher	$12 million GF (FY 2020) (Only for six-months due to calendar year rate)

- In the 2019 Session, the General Assembly may need to consider reserving additional funding in FY 2020 to provide a buffer from these potential unbudgeted costs to limit any unexpected need in a caboose bill in the 2020 Session.

Options to Achieve Managed Care Budget Savings

- Lower the capitation rate increase for the CCC Plus program for 2019.
  - May increase fiscal pressure on the managed care plans, which is the original issue DMAS created when they launched the program with unrealistic assumptions.
  - Estimated savings of a one percent reduction in the 2019 increase ~$30 - 40 million GF.
- Provide no increase in the administrative cost component for the CCC Plus program.
  - May limit the ability of the managed care plans to improve care coordination for enrollees.
  - Savings of ~$13 million GF.
- Modify the profit margin caps.
  - Current limit is a maximum of 6.5% (100% of first 3%, then half of the amount up to 10%).
  - May result in limited impact in this biennium since the plans are likely experiencing little or no profit.

Options to Improve Integrity in Medicaid Forecasting / Rate Setting

- Add actuarial staff or contractor support at the Department of Planning and Budget or as part of JLARC's HHR Oversight function to provide a double-check on managed care rate assumptions.
- Create a Medicaid forecasting group to include executive branch and legislative staff that would meet on a regular basis to oversee the forecasting process.
- Create a separate, independent entity responsible for developing and setting rates for the managed care programs.

Prior Legislative Actions:

2016 Session - DMAS required to submit annual notice of actuarial assumptions for managed care.

2017 Session - DMAS required to report the fiscal impact of final managed care rates as compared to the budget.

Improving Medicaid Budget Oversight and Accountability

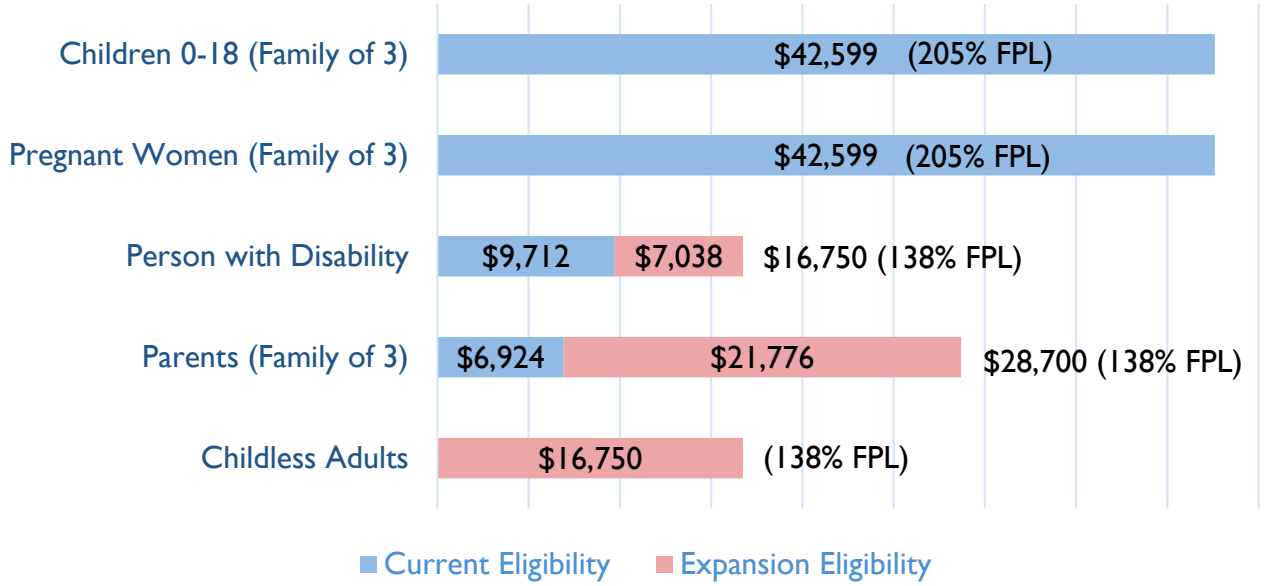
- 2018 Appropriation Act establishes a Medicaid state **spending target** starting with the 2020-22 biennium.
  - Joint Subcommittee for HHR Oversight will establish the target based on certain factors by September 15 each year.
  - Governor must abide by the spending target in his introduced budget each year, but shall provide notice and rationale if the target is exceeded.
- Other options the General Assembly could consider:
  - Modifying the language to require the Governor to adhere to the target in his proposed budget without exception.
  - Further, language could be added to provide the Governor authority to modify Medicaid program requirements during each fiscal year to lower Medicaid spending, as needed, in order to remain within the spending target.
  - For example, such authority would allow the Governor to suspend any planned provider rate increases or retract ones that took effect during the fiscal year.

Medicaid Expansion

Implementation Update

Who Qualifies under Medicaid Expansion?

- Childless adults age 19 – 64, not Medicare eligible, with income up to 138% of the Federal Poverty Level (FPL).

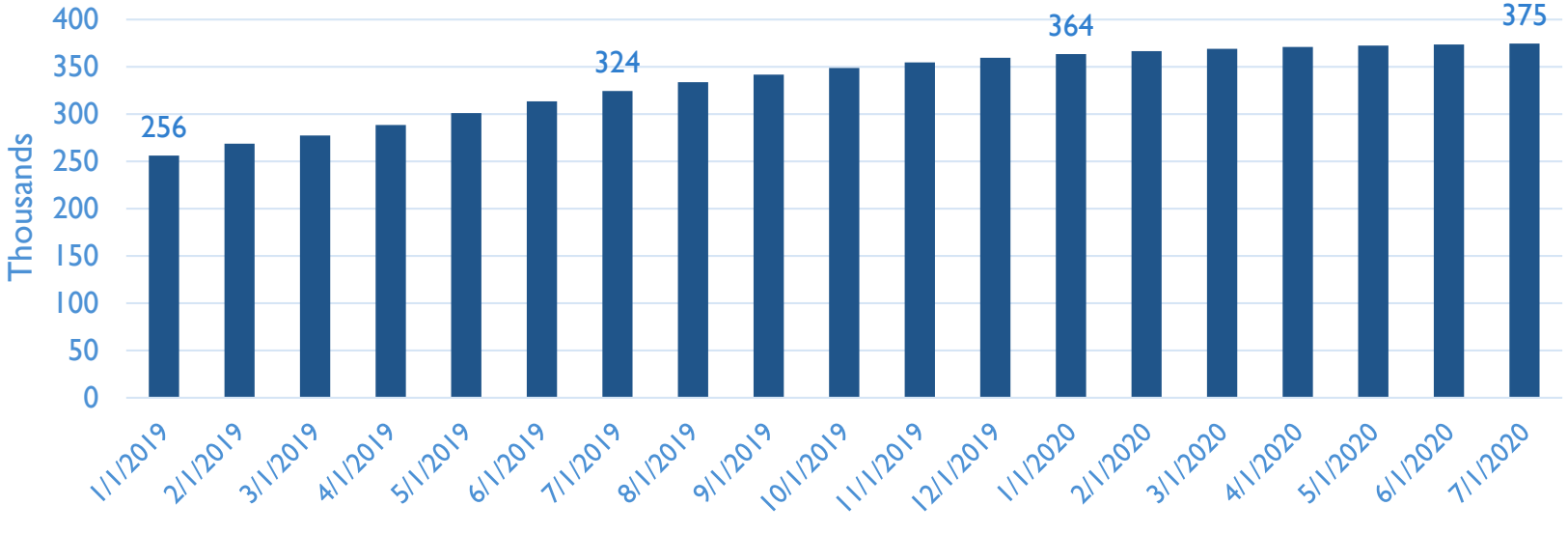


Note: The percent income may vary by locality for the parents group.

Medicaid Expansion Enrollment Projections

- Enrollment began November 1.

- The Departments of Medicaid Assistance Services and Social Services have implemented automatic enrollment for enrollees in the GAP waiver and family planning program. In addition, expedited enrollment has been implemented for SNAP enrollees and parents of low-income Medicaid children.

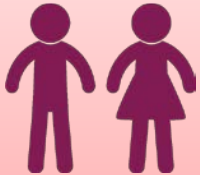


Medicaid Expansion Costs and Savings - Virginia

Item ($ in millions)	FY 2019 State Costs	FY 2020 State Costs	FY 2019 Federal	FY 2020 Federal
Coverage of Newly Eligible Adults	$70.5	$276.9	$936.8	$2,983.3
Administrative Costs (DMAS and DSS)	15.7	16.3	40.2	37.1
1115 Waiver Administrative Costs (DMAS)	1.7	3.2	1.7	7.2
1115 Waiver Administrative Costs (DSS)	-	2.2	-	**6.4**
Total Costs	**$87.9**	**$298.6**	**$978.7**	**$3,034.0**
Indigent Care Savings	($47.5)	($110.3)	($47.5)	($110.3)
State-funded Behavioral Health Services	(11.1)	(25.0)	-	-
Inpatient Hospital Costs of State Prisoners	(10.3)	(23.4)	-	-
Elimination / Substitution of State-funded Coverage for Newly Eligible	(32.4)	(111.0)	(33.8)	(116.4)
Total Savings	**($101.3)**	**($269.7)**	**($81.3)**	**($226.7)**

Hospital Provider Assessments: Overview

Coverage Assessment



Covers the full cost of expansion. Expected to be approximately 0.5% in FY19 and 1.4% in FY20.

Payment Rate Assessment

Covers the state cost of increasing hospital reimbursement rates to approximately average cost. Rate projected to be 1.2% in FY19 and 1.9% in FY20.

Two assessments with many of the same features

- Assessed on most private acute hospitals – excludes public, freestanding psychiatric, rehabilitation, children's, long-stay, long-term acute, and critical access hospitals.
- DMAS responsible for calculating and levying the assessment.
- Assessments are a percentage of net patient revenue.
- Total of the two assessments cannot exceed 6% of net patient revenue (Federal limit).

Medicaid Expansion and the Rate Enhancement Projected to Increase Net Revenue to Private Hospitals by $1.6 Billion

($ in millions)	FY 2019	FY 2020
Coverage Assessment	$87.9	$298.6
Rate Enhancement Assessment	194.6	420.4
Total Assessment Paid by Private Acute Hospitals	**$282.5**	**$719.0**
Revenue from Coverage Expansion	$236.9	$777.5
Revenue from Medicaid Rate Enhancement	463.6	1,138.0
Total Revenue to Private Acute Hospitals	**$700.5**	**$1,915.5**
Net Revenue Impact for Private Acute Hospitals	***$418.0***	***$1,196.5***

Source: *Staff analysis of Medicaid forecast and Department of Medical Assistance Services estimates.*
Note: *These estimates do not take into account any loss of commercial business that would result from individuals whose coverage shifts from the federal marketplace to Medicaid as a result of Medicaid Expansion.*

Medicaid Expansion Implementation Process

Dual-Track Process

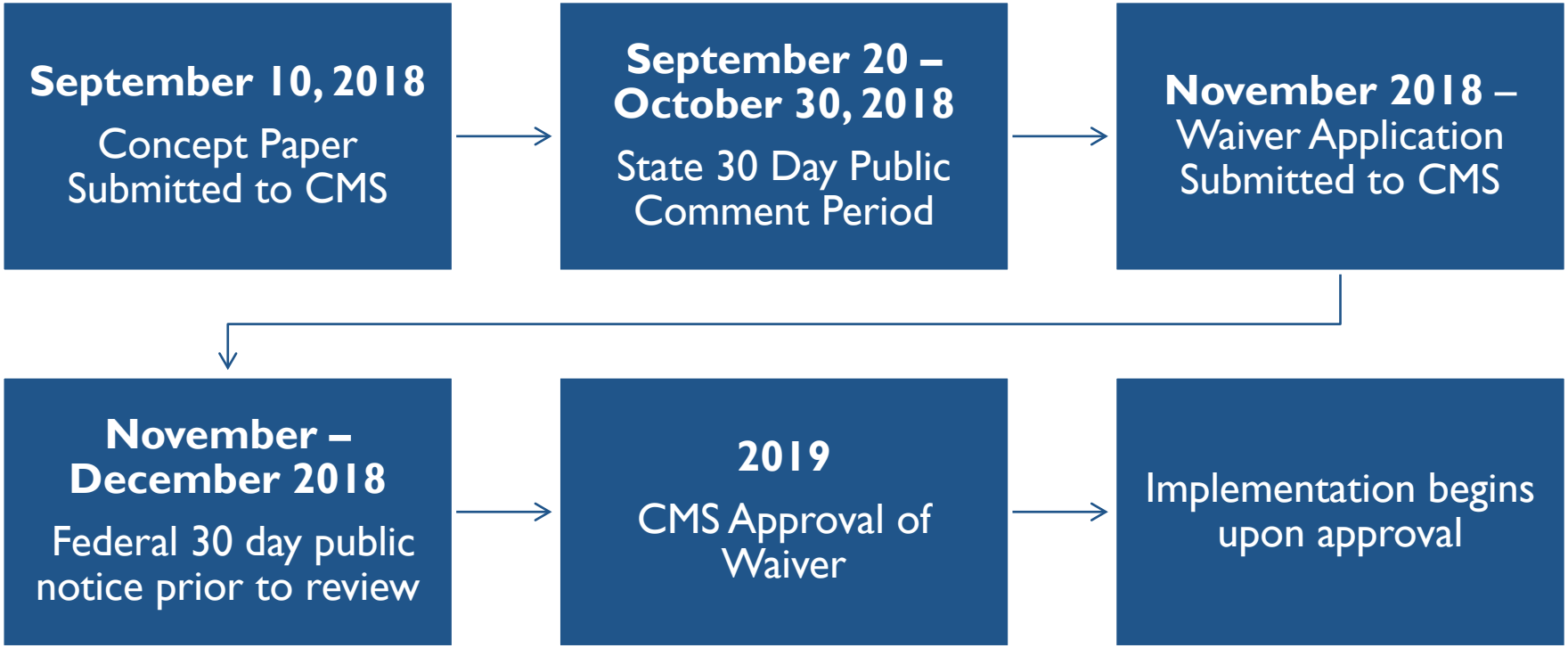
Amend State Plan for Coverage

- Provide traditional Medicaid coverage on January 1, 2019.
- Centers for Medicare and Medicaid Services has granted approval.

Apply for an 1115 Waiver

- Submit a waiver application 150 days after budget signed into law (November 4, 2018).
- Negotiation with CMS has no time limit.

Implementation Timeline for 1115 Waiver



Key Features of the Virginia "Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency" (COMPASS) Waiver

Work/Community Engagement (TEEOP)	• Requirement to participate in training, education, employment and other community engagement opportunities for 80 hours per month. • Applies to all "able-bodied adults" in the Medicaid program who are not exempt.
Health & Wellness Program	• Requirement for premiums and co-payments, health & wellness accounts and healthy behavior incentives. • Applies to Medicaid enrollees with incomes between 100-138% FPL, who are not exempt.
Housing & Employment Supports for High-Risk Enrollees	• A supportive housing and employment supports benefit for high-risk Medicaid enrollees.

Medicaid Expansion Implementation Issues

- **Provider Rates**
  - Consideration for funding an increase in physician rates / other providers to ensure access.
- **1115 Waiver Modifications**
  - Additional direction may be necessary to clarify exemptions, participating work activities, and other requirements of the 1115 waiver.
- **Hospital Provider Assessments**
  - Technical changes to modify timeline for setting assessment and process to forecast coverage costs.
- **Monitoring the Impact of Medicaid Expansion**
  - Developing metrics to ensure appropriate utilization of services (i.e. non-emergency use of the emergency room) and measures of health outcomes.
- **Ensuring State Savings from Expansion**
  - Department of Corrections: Consider providing authority for DOC to sign Medicaid applications on behalf of inmates.
  - Community Services Boards: Monitoring of enrollment of populations served to ensure budget savings is achieved.
- **Changing Role of Free Clinics**
  - Purpose and allocation of state funding may need to be modified to reflect smaller uninsured population, which could include boosting the dental safety net.

Individual Health Insurance Market

Affordability of Premiums

2018 Session Activity Related to Affordability in the Individual Market

- In response to premium rate increases for 2018 averaging 69%, the General Assembly passed several bills to increase options to promote affordable health insurance:

Bill	Purpose	Final Action
SB 672	Defined small employers to include self-employed persons.	Signed by Governor
SB 844	Allowed short-term limited duration insurance up to 364 days and allowed state-mandated benefits to be offered, but not required.	Vetoed
SB 934	Authorizes benefits consortium (associations) to offer health insurance plans to its members.	Vetoed
SB 935	Defined sponsoring associations for the purpose of purchasing health insurance in the small employer market.	Vetoed
SB 964	Expand access to catastrophic insurance to anyone in the individual insurance market through a Section 1332 Affordable Care Act waiver.	Vetoed

- General Assembly created the Virginia Market Stability Workgroup to evaluate trends and develop state options for stabilizing the market. Report is pending.

What is the Individual Health Insurance Market?

- Affordable Care Act created a federal exchange for individuals to purchase insurance. (Supplanted the existing market.)
- Premium Subsidies for individuals from 100 to 400% of the federal poverty level.
- No denial for pre-existing conditions, no life-time limits, minimum essential coverage and a medical loss ratio of 80%.
- Four levels of coverage (Bronze, Silver, Gold and Platinum) with different consumer cost-sharing.

There are 3 Different Health Insurance Markets

Large Group Market

- Employer sponsored health insurance covers most individuals
- Plans regulated under ERISA, not the ACA
- Typically self-insured

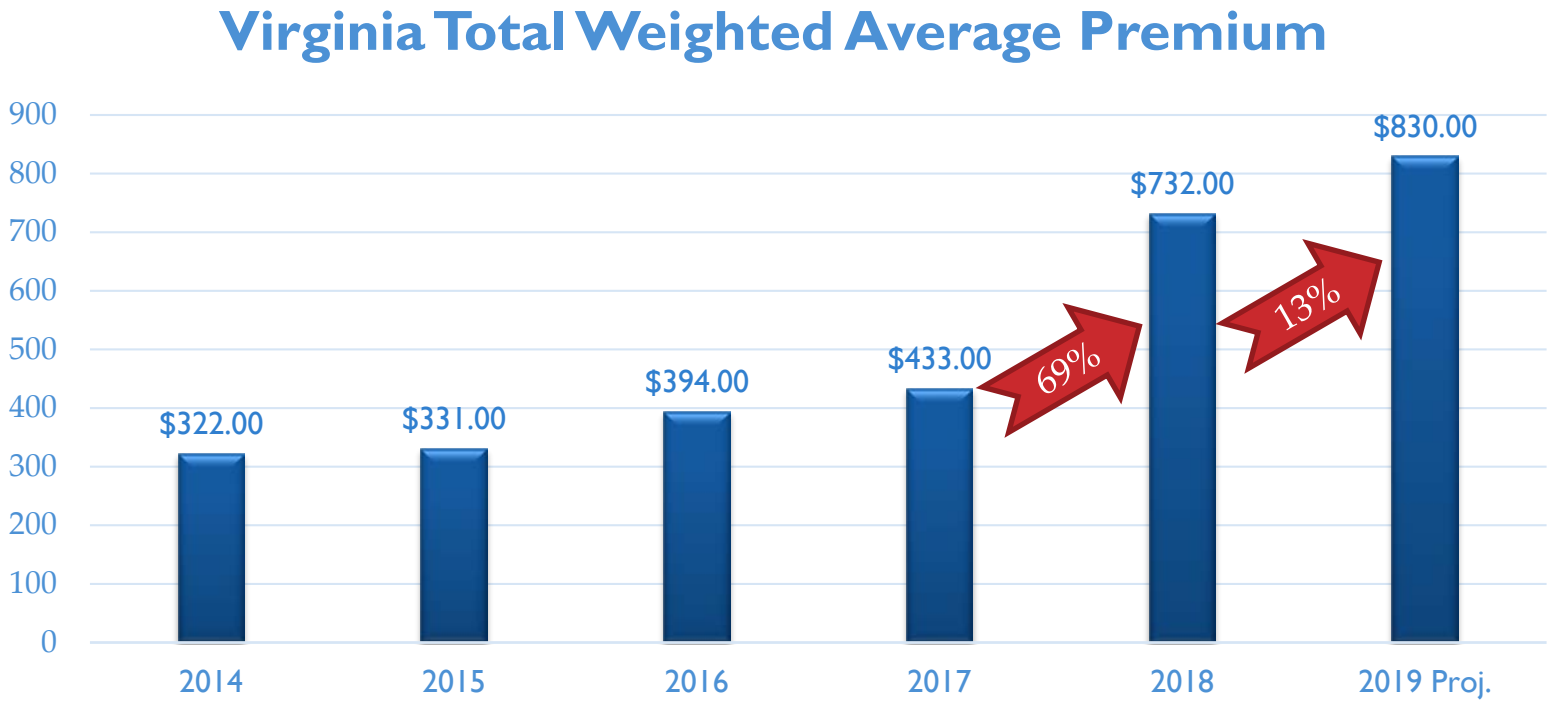
Small Group Market

- Small employers up to 50 employees
- Must meet all ACA requirements

Individual Market

- Individuals purchase insurance directly
- Must meet ACA requirements
- Sold through federal or state-based exchange

Premiums in the Individual Market Have Risen Dramatically Since 2017

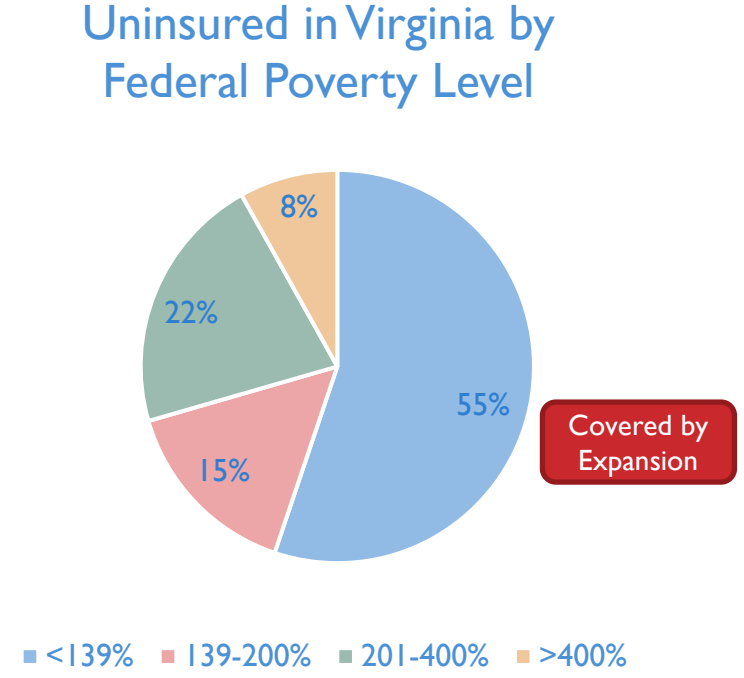


Source: Bureau of Insurance, State Corporation Commission.

Who is Impacted by Higher Premiums?

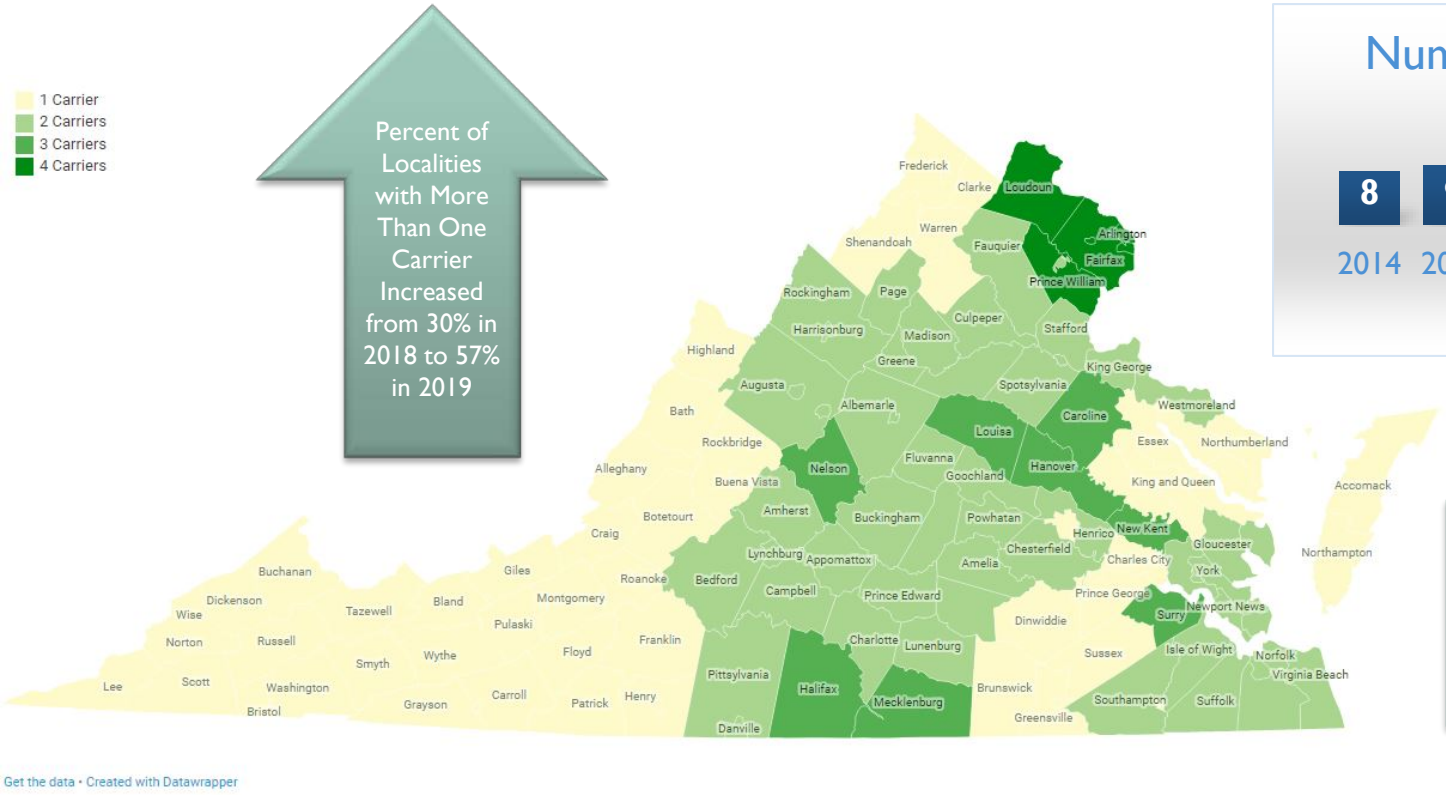
- Individuals (96,000) purchasing insurance with incomes above 400% of the federal poverty level.
- The number of uninsured above 400% is estimated at 69,000.
- Individuals receiving federal subsidies are protected from premium increases because of the federal subsidy.

Household Size	400% of Federal Poverty Level
1	$48,560
2	$83,120
3	$100,400



Sources: Centers for Medicare and Medicaid data files, the 2016 American Community Survey and the Bureau of Insurance, State Corporation Commission.

2019 Individual Market Carrier Coverage Has Improved Over 2018



Number of Carriers

2014	2015	2016	2017	2018	2019 (proj)
8	9	11	11	7	8

* Enrollment in 2015 declined from 495,000 to 425,000 in 2017.

Virginia Individual Market Outlook for 2019

- Federal actions that could impact the market:
  - Individual mandate penalty set at $0.
  - Short-term policies and association health plans.
  - Recent proposed federal regulations on health reimbursement accounts and greater flexibility for Section 1332 waivers.
- Medicaid Expansion should have a downward impact.
- Smaller premium increase than 2018 - 13.4% weighted average premium.
- New carrier (Virginia Premier) brings total to 8 carriers.
- Fewer localities with only one carrier.

Main Option Used by States to Reduce Individual Market Premiums: Reinsurance Program

- States can request a Section 1332 Waiver to use federal savings from implementing a Reinsurance Program in the individual marketplace.
  - A reinsurance program pays a portion of high-cost claims to limit the financial exposure of the insurance companies and thereby reduce premiums.
  - Similar programs in other states have reduced premiums by up to 20%. Seven states have been approved to fund reinsurance programs.
  - Will require state funds to fully fund the program (could use insurance assessment to fund the state share).
  - Must consider impact of other actions impacting the individual market to ensure desired premium reduction is achieved.

Premium Reduction	Annual State Costs*
5%	$41 million
10%	$81 million

* SCC Bureau of Insurance estimate.

Other State Options that Could Reduce Premiums

- Access to Non-ACA Health Insurance or ACA Catastrophic Plans
  - Alternative products (i.e. short-term insurance) can provide cheaper alternatives, but typically provide less coverage.
  - Catastrophic plans meet ACA coverage requirements and also allow three primary care visits before the deductible.
  - May reduce the number of individuals participating in the federal marketplace.
- Medicaid Buy-In Alternative or Limiting Provider Rates to Medicaid
  - Medicaid is a lower-cost product or alternatively Medicaid rates can lower the cost of the insurance product.
- Expand Insurer Participation
  - Require participation of insurers in the individual market to insure competition statewide.
- Provide an Individual Premium Tax Credit
  - In lieu of a reinsurance program, provide direct assistance to individuals above 400 percent of the federal poverty level.
  - May have limited effect since the financial assistance is after the fact through a tax refund and may not be sufficient to make the premiums affordable.
  - Unlike a reinsurance program, federal funding through a waiver is not available to fund this type of assistance.

Appendix

Medicaid Expansion Waiver: Work & Community Engagement

Participation Requirements

- Must participate in a qualifying work or community engagement activity, beginning with 20 hours per month and gradually escalating to 80 hours per month.
- Anyone not meeting the requirement for any three months within a 12-month period will have their coverage suspended until either the end of the year or after demonstrating compliance with the requirement for one month.

Activities

- **Employment**
- **Job skills training or job search activities/readiness**
- **Participation in a workforce program**
- **Education**
- **Training and apprenticeships**
- **Community or public services**
- **Caregiving services**
- **Other activities**

Medicaid Expansion Waiver: Work & Community Engagement

Exemptions

Standard Exemptions

- ✓ Pregnant and 6-months postpartum
- ✓ Children under age 19 and former foster care children under age 26
- ✓ Students in post-secondary education
- ✓ Medically frail individuals or seriously mentally ill
- ✓ Individuals who meet the work requirements of TANF and/or SNAP
- ✓ Individuals age 65 and older
- ✓ Individuals who have blindness or a disability
- ✓ Primary Caregivers
- ✓ Victims of domestic violence

Hardship/Good Cause Exemptions:

- ✓ Individuals who experience a hospitalization or serious illness or who live with an immediate family member who experiences a hospitalization or serious illness
- ✓ Temporary incapacitation
- ✓ Birth or death of a household member
- ✓ Severe inclement weather
- ✓ Family emergency
- ✓ Change in family living circumstances (e.g., separation, divorce)
- ✓ Individuals living in geographic areas with high unemployment rates or lack of workforce programs

Medicaid Expansion Waiver: Premiums & Wellness Accounts

- Medicaid enrollees with incomes from 100-138% of the FPL will be required to pay monthly premiums for Medicaid.
- Premium payments will go into Health and Wellness Accounts (HWAs).
- People who make the required premium payments and do at least one healthy behavior will be able to receive a Health Rewards gift card to pay for health-related services (e.g., eyeglasses or vitamins).
- People who make the required number of premium payments but do not do a healthy behavior will not be able to get a Health Reward. But, their HWA money will roll over to the next year, and they will have another chance to earn a Health Reward.
- People who do not pay their premiums for three months will have their Medicaid coverage suspended until making one premium payment.

INCOME	ANNUAL INCOME RANGE (Single Household)	MONTHLY PREMIUM
100-125% FPL	$12,140 - $15,175	$5 per month
126-138% FPL	$15,296 - $16,753	$10 per month

Federal Actions Impacting the Individual Health Insurance Marketplace

Recent Federal Actions	• Expand use of employer Health Reimbursement Agreements to purchase insurance in individual market. • Additional flexibility to meet Section 1332 waiver requirements.
Short-Term Insurance	• Designed for coverage gaps, exempt from ACA. • Medical underwriting, limits on coverage, typically excludes maternity, prescription drugs and mental health. • Premiums substantially lower than individual marketplace.
Association Health Plans	• Large group policy subject to ERISA (Not ACA). • Allows small employers to participate in large group policies.
Individual Mandate	• Congress reduced penalty to $0.