

SENATE OF VIRGINIA

# Senate Finance Committee

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## Medicaid Expansion: Policy Issues

November 15, 2012



SENATE FINANCE COMMITTEE

# Introduction

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- On June 28, 2012, the U.S. Supreme Court handed down what many expected to be the “last word” on federal health care reform.
- The Court upheld the constitutionality of all the major provisions of the Patient Protection and Affordable Care Act (ACA) with one exception.
  - It returned to states the decision whether or not to expand Medicaid eligibility up to 138 percent of poverty.
- Beyond Medicaid, the Commonwealth will also need to wrestle with policy questions surrounding what kind of health benefit exchange will be operated in Virginia.



# Overview

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- This presentation is designed to provide:
  - A high-level overview of the Affordable Care Act and possible implications for the Commonwealth;
  - A snapshot of Virginia’s health insurance market, including shedding light on the question “who are the Commonwealth’s uninsured?”; and
  - Some examples of the pros and cons of expanding Medicaid coverage or staying with the status quo.
- This presentation will focus almost entirely on the question of whether or not Virginia should expand Medicaid eligibility, since that is the major unanswered question from the Supreme Court’s ruling.
  - At some point, additional policy questions surrounding the health benefit exchange will also need to be discussed and decided upon by policymakers.



# The Affordable Care Act in a Nutshell

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- The ACA expands access to health care coverage and reforms the health insurance marketplace. The law:
  - Requires most U.S. citizens and legal residents to have health insurance;
  - Creates health benefit exchanges to help individuals and small businesses purchase health insurance;
  - Offers subsidies to low-income individuals with income between 138 and 400 percent of poverty to purchase insurance; and
  - Expands Medicaid (at state option) for all individuals with income under 138 percent of poverty.
- The ACA requires a larger pool of insured individuals to cover the cost of eliminating insurance underwriting (i.e., pre-existing conditions) while standardizing insurance benefits and pricing.



# Other Provisions of the ACA

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## Examples of ACA's Insurance Provisions Already in Place

Allows children to remain on their parents' policy up to age 26

Prohibits lifetime limits on coverage

Eliminates copayments for preventive care provided through Medicare

## Examples of ACA's Medicaid Provisions On the Horizon

Increases primary care reimbursement rates to 100 percent of Medicare in 2013 and 2014

Reduces disproportionate share hospital (DSH) payments by 50 percent by 2019

Imposes a new methodology -- the modified adjusted gross income (MAGI) standard -- to determine eligibility for Medicaid

## Examples of ACA's Financing Provisions

Imposes a tax on individuals without qualifying health care coverage (2014)

Limits the amount of contributions to flexible spending accounts to \$2,500 per year (2013)

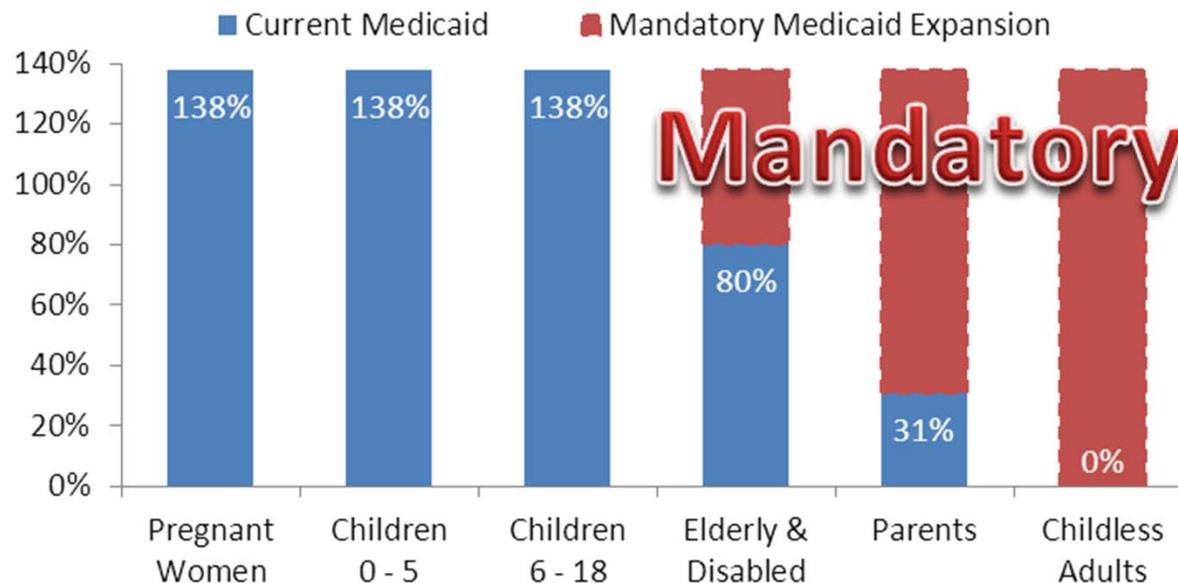
Increases the Medicare Part A (hospital insurance) tax rate from 1.45 to 2.35 percent on earnings over \$200,000 for individuals and \$250,000 for married couples filing jointly (2013)



# A Closer Look at Medicaid Before the Supreme Court's Decision

- Historically, states have established Medicaid income eligibility limits for certain mandatory populations such as pregnant women, children, the elderly and disabled, and some low-income parents.
  - The ACA required states to expand Medicaid up to 138 percent of poverty to standardize income eligibility levels across the country.

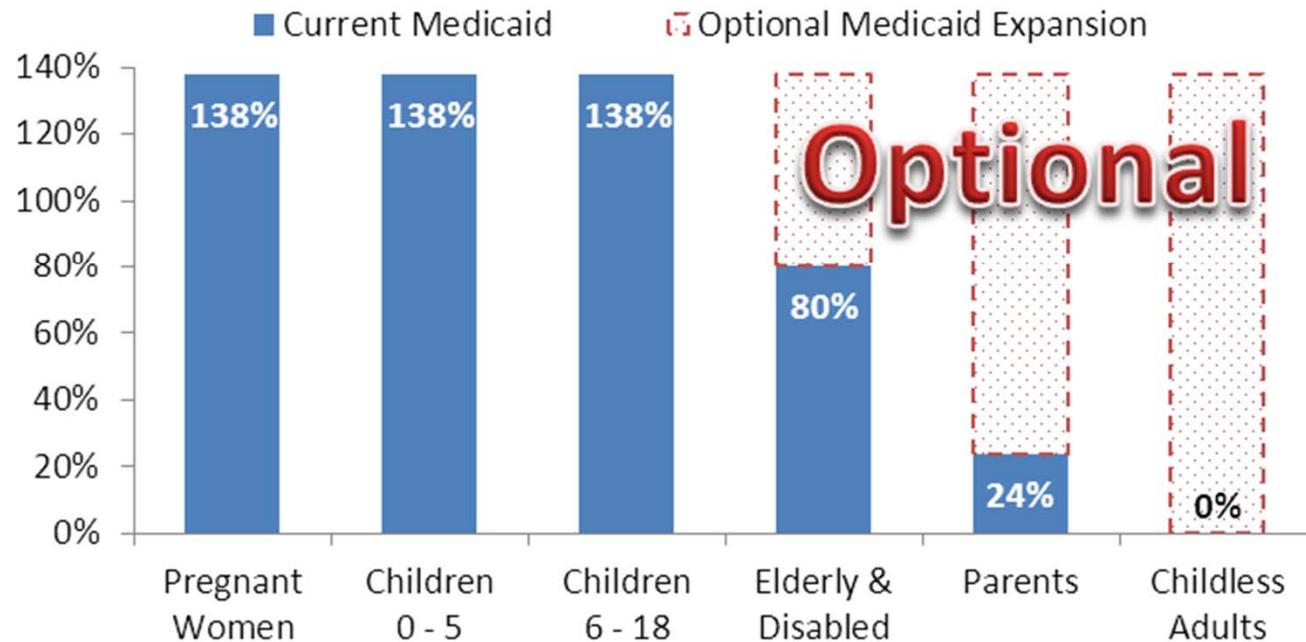
**ACA Eligibility Levels Prior to Supreme Court Decision**  
(As Percent of Poverty)



# Medicaid Expansion Question

- The Supreme Court's decision leaves it to state policymakers to decide whether or not to expand Medicaid's income eligibility levels – the Medicaid expansion is optional.

**ACA Eligibility Levels After the Supreme Court Decision**  
(As Percent of Poverty)



# What Does The Medicaid Expansion Mean for the General Assembly?

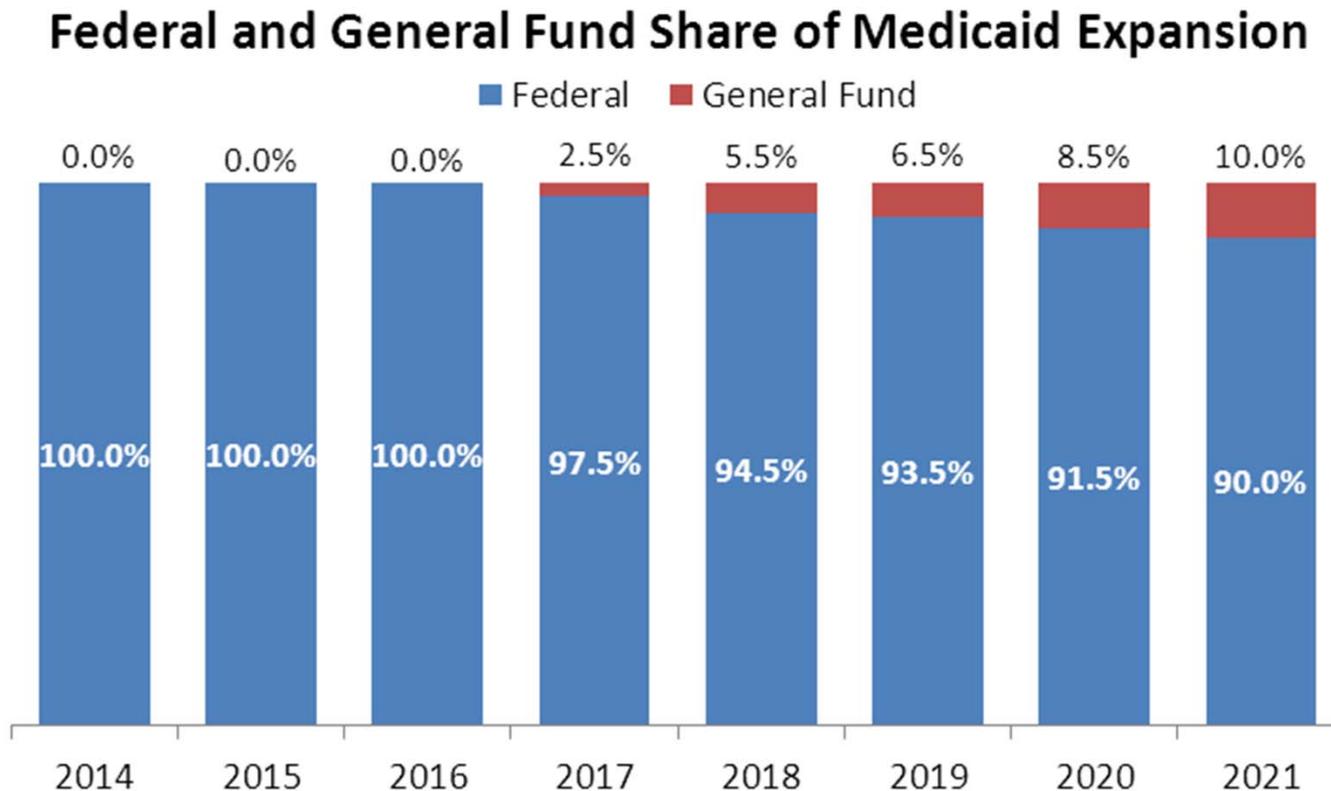
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- The General Assembly will need to consider a number of questions about the expansion of Medicaid:
  - How much will it cost?
    - What costs could be avoided if we expand coverage?
    - What is the cost of not expanding coverage?
  - Who will be covered?
    - What is the profile of potential Medicaid enrollees?
  - What additional resources might be needed to ensure the capacity of the system if coverage is expanded?
  - How will eligibility for Medicaid interact with the health benefit exchange?
- The complexity of the policy issues involved, itemization of costs and cost savings, and iteration of different expansion scenarios will require staff time and expertise to determine what decision is in the best interest of the Commonwealth.



# Other Medicaid Considerations

- The general fund cost of expanding Medicaid will be minimal in the first few years with the federal government paying 100 percent of the cost through December 31, 2016.



# What Does The Health Benefit Exchange Question Mean for the General Assembly?

- It is unlikely the state can operate its own exchange at this late hour.
- Virginia will likely need to default to the federally-facilitated exchange (FFE) or an FFE-partnership with the state conducting plan management and/or consumer assistance.
- The Commonwealth will need to decide whether and when to transition to a state-based exchange and what kind of oversight policymakers want over the health insurance market.

<b>Advantages of State-Based vs. Federally-facilitated Exchange</b>	
<b><u>State-based exchange</u></b>	<b><u>Federally-facilitated exchange (FFE)</u></b>
Ability to oversee VA health insurance market	Let the feds do initial work on implementation
Possibly better coordination of enrollees in public programs and exchange	State can takeover exchange function when it is prepared to do so
Understanding of local issues and plans	Feds can take the heat for any glitches
Unique quality and performance goals	Allows time for transition to new leadership



# Other Exchange Considerations

- Since August 2010, the Virginia Health Reform Initiative (VHRI) has done considerable spadework preparing for the implementation of the ACA.
  - The work of the VHRI will benefit legislators as myriad policy questions surrounding the exchange are discussed and debated.
- Like the Medicaid question, considerable time and attention will be required to determine the best way forward for the Commonwealth.

Deadlines Related to the Exchange	
November 16, 2012* (* Postponed until December 14, 2012)	States that choose to operate a state-based exchange must submit a letter from the Governor and blueprint to federal Department of HHS. No decision results in a federally-facilitated exchange.
January 1, 2013	Federal government approves (or conditionally approves) the state's exchange blueprint.
October 1, 2013	State begins open enrollment.
January 1, 2014	Exchange coverage goes into effect.



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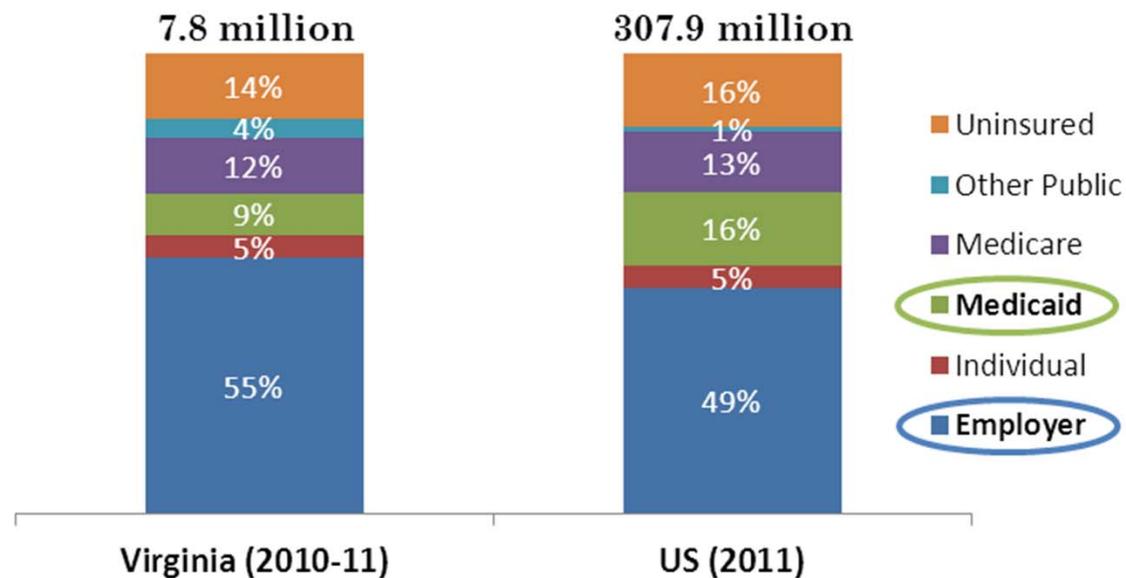
# What do we know about the uninsured in Virginia?



# Virginia Residents by Health Insurance Status

- More than one million Virginia residents report being uninsured, about 14 percent of the state's overall population.

Health Insurance Status of Virginia and U.S. Residents



- Compared to the U.S. average:
  - More Virginians receive health insurance through their employer; and
  - Fewer are covered by Medicaid.



# Why Are Virginians Uninsured?

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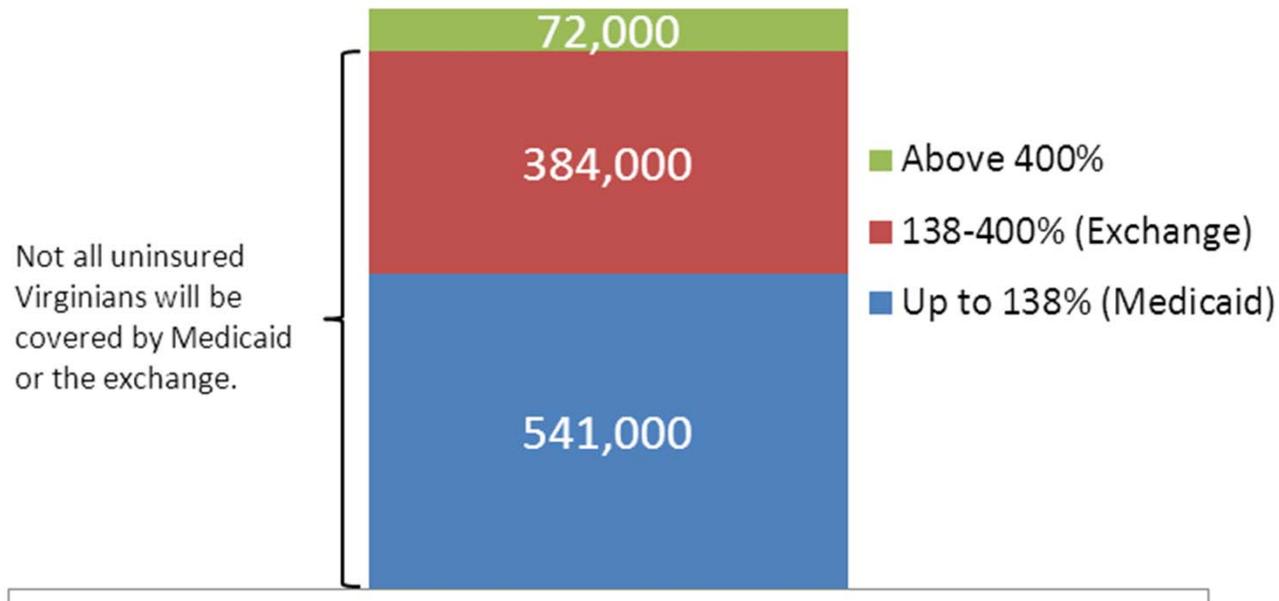
- Health insurance is expensive -- premiums for family coverage have nearly doubled from \$8,003 to \$15,745 since 2002.
  - The amount contributed by employees has also doubled since 2002, even for large firms with 200 or more employees.
- Many of the uninsured are not offered health insurance through their employer or cannot afford to pay the premiums if coverage is offered.
  - Employees in the agriculture and service sectors are less likely to have health insurance coverage.
- Publicly-financed health care is targeted to the elderly or disabled (i.e., Medicare) and pregnant women, children, the elderly and disabled, and low-income families (i.e., Medicaid).
  - Only parents with income up to 31 percent of poverty are eligible for Medicaid in Virginia (\$7,146 for a family of four).
- Others are uninsured because they are undocumented or choose to go without coverage.



# Uninsured Virginians by Income Level

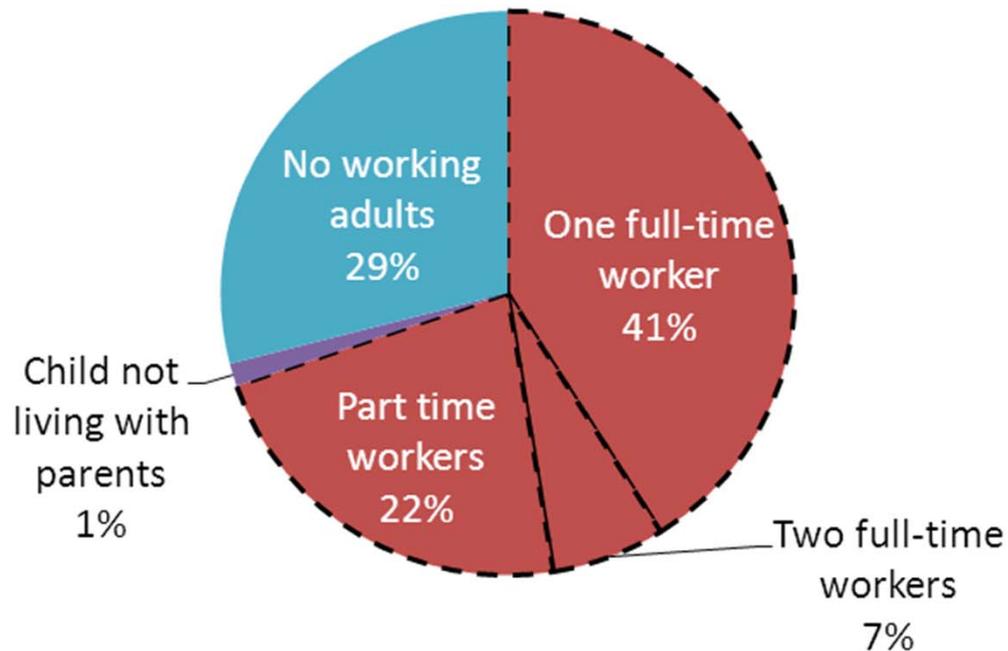
- More than half of non-elderly uninsured Virginians (54.3 percent) live in families with income up to 138 percent of poverty.
  - In 2012, 138 percent of poverty equates to \$15,415 for an individual and \$31,809 for a family of four.

**Non-Elderly Uninsured Virginians by Income**  
(As Percent of Poverty)



# Uninsured Virginians by Employment Status

Uninsured Virginians by Employment Status (2010)

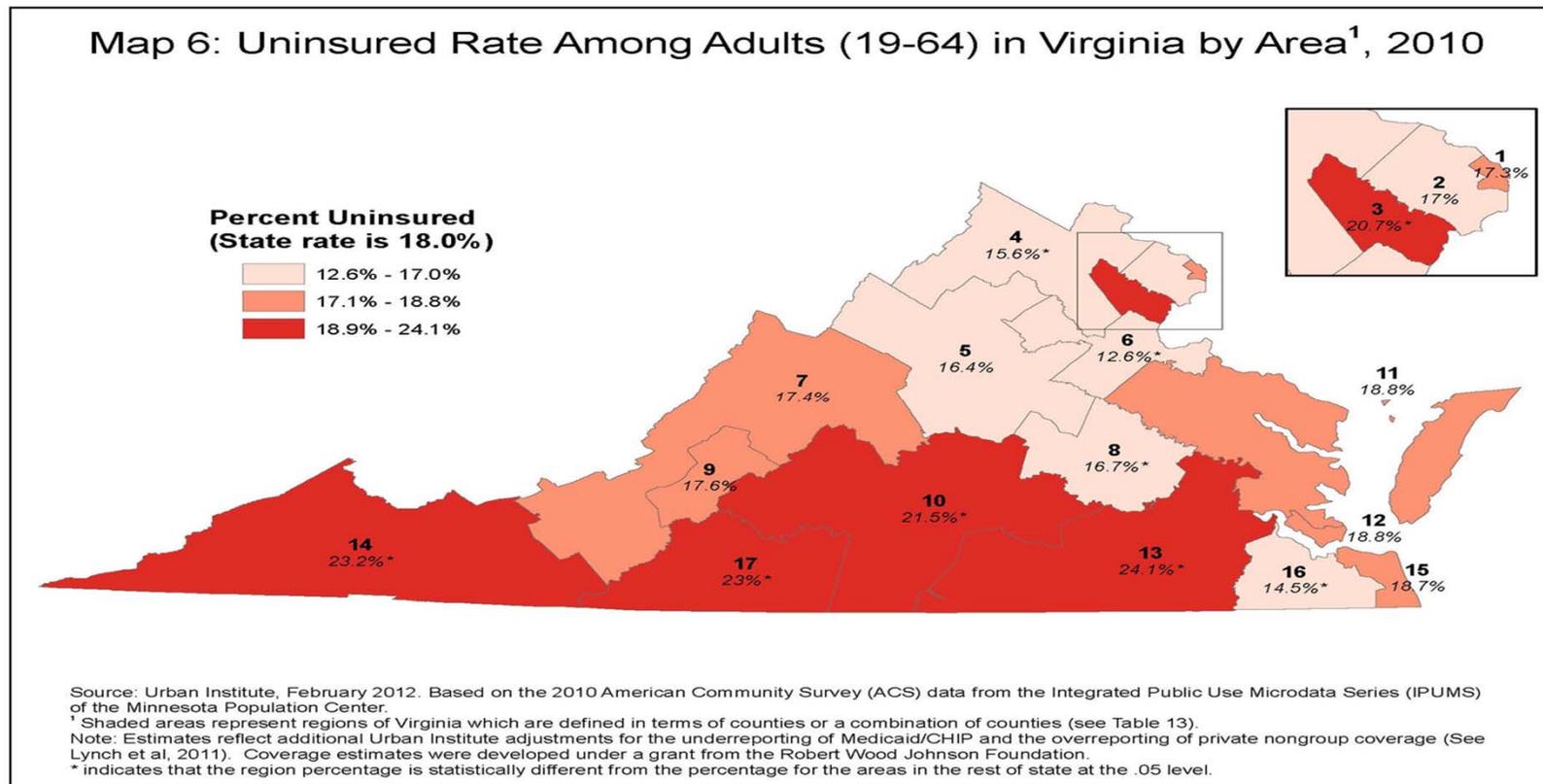


- 70 percent of the uninsured in Virginia live in families with at least one full-time or part-time worker.
- Only 37 percent of small businesses (under 50 employees) offer health insurance in Virginia.



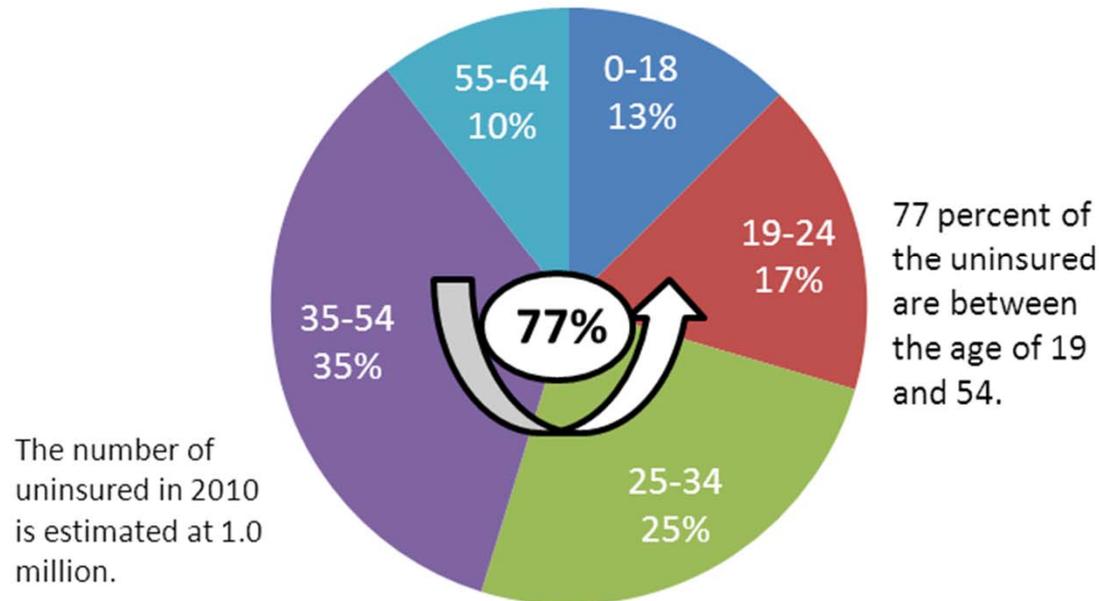
# Uninsured Virginians by Geographic Location

- A larger percentage of the population living in Southwest and Southside Virginia, as well as Prince William County, are uninsured.



# Uninsured Virginians by Age

Non-elderly Uninsured Virginians by Age (2010)



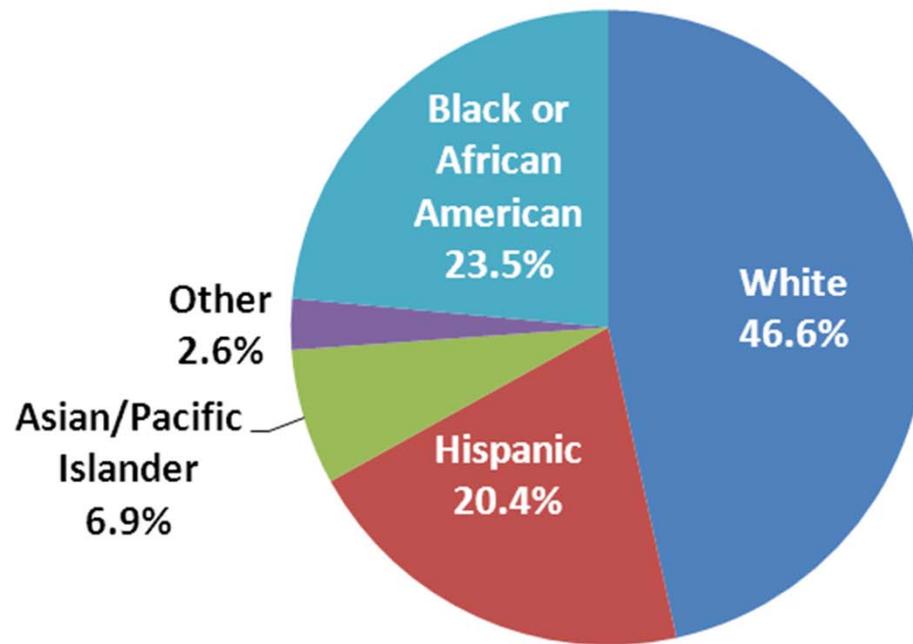
- Children make up a surprisingly large percent of the uninsured (13 percent) even after efforts to expand coverage through Medicaid and FAMIS.
  - 43,954 children are expected to enroll in Medicaid as a result of the “woodwork effect”.



# Uninsured Virginians by Race

- Fewer than one-half of the uninsured are white, non-Hispanic.
  - 23.5 percent are black or African American; and
  - 20.4 percent are Hispanic.

Non-elderly Uninsured Virginians by Race (2010)



# Uninsured Virginians and Veterans Status

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- The Urban Institute estimates that 1 in 10 of the nation's 12.5 million non-elderly veterans have no health insurance and do not use the Veterans' Administration (VA) for their health care needs.
  - In Virginia, it is estimated that 56,000 veterans and their family members are without insurance, accounting for 5.6 percent of the uninsured.
- Veterans may not utilize VA-funded health care services because of:
  - A complex prioritization system;
  - Increased demand for services and long waiting lists for primary care;
  - Proximity to VA facilities and outpatient services; and
  - Affordability.
- More states have identified veterans receiving Medicaid benefits.
  - Last session, funding was provided to transition veterans from Medicaid to more comprehensive federal benefits, including health care.
- Uninsured veterans and their families would likely be eligible for Medicaid if coverage is expanded.



# Uninsured Virginians and Health Status

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- It remains unclear what the health status of new Medicaid enrollees might look like if eligibility is expanded.
  - DMAS’ actuaries originally estimated a 15 percent higher average cost for most new enrollees.
  - However, analyses of national expenditure data suggest the overall health of the uninsured may be less costly than the current population of Medicaid recipients.
    - The uninsured reported fewer health problems and functional limitations compared to Medicaid recipients in the same income category.
- It is clear that the uninsured:
  - Receive less preventive care;
  - Are diagnosed at more advanced disease states; and
  - Receive less therapeutic care and have higher mortality rates once diagnosed.
- Further, 55 percent of uninsured adults in Virginia report having “unmet health needs” due to cost.



# Where Do the Uninsured Receive Health Care?

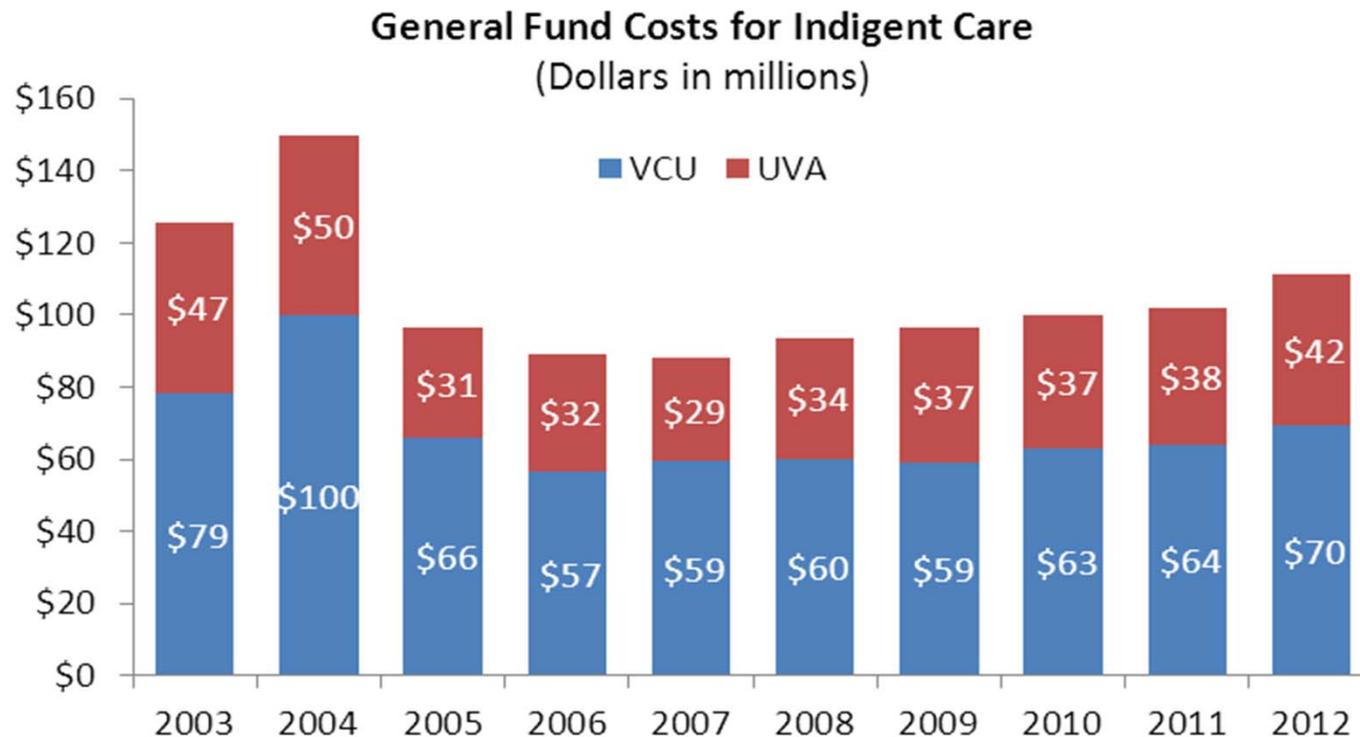
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- The uninsured receive health care in many different locations and settings.
  - Sixty percent of uninsured adults have no regular source of care when they get sick; the provision of care is fragmented.
- Many of the uninsured use hospital emergency rooms after delaying treatment for routine illnesses or chronic diseases.
- Others seek care at community health centers, free clinics or similar organizations.
  - These groups provided care to 226,000 uninsured Virginians in 2011, less than one-third of the 703,000 uninsured with income under 200 percent of poverty.
- Doctors may provide charity care to the uninsured in their offices.
- Many of the uninsured simply go without care.



# How Much Does It Cost To Serve the Uninsured?

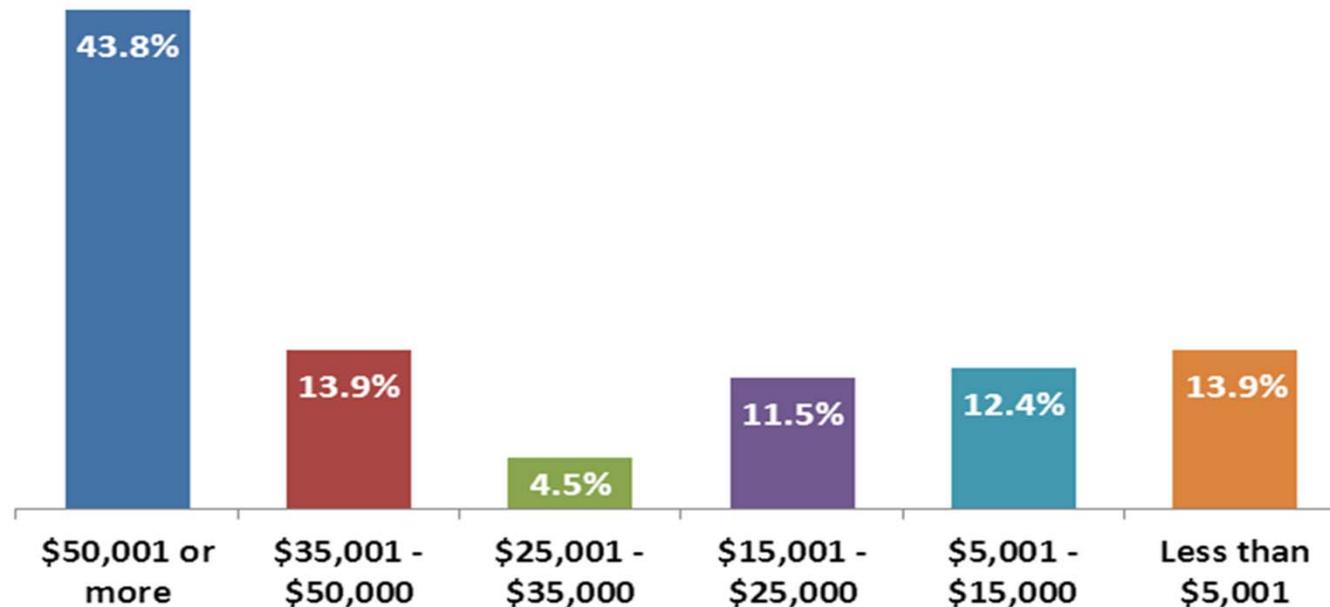
- Over a ten-year period Virginia spent over \$1.0 billion from the general fund subsidizing the cost of indigent care at the University of Virginia and Virginia Commonwealth University Health Systems, including \$112 million GF in the most recent fiscal year.



# Uncompensated Care Provided by Hospitals and Physicians

- Virginia hospitals report providing \$515.3 million in charity care to low-income Virginians who were either uninsured or underinsured in 2010 -- care for which they received no compensation.
- Almost 44 percent of Virginia physicians report providing more than \$50,000 in uncompensated care annually.

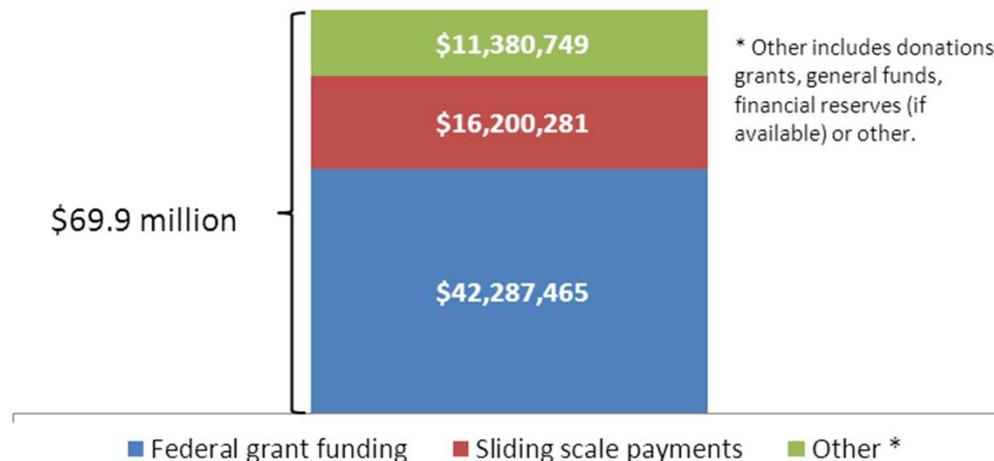
Estimate of Uncompensated Care by Virginia Physicians



# Cost of the Uninsured to the Health Safety Net

- Community health centers, free clinics and other organizations delivered \$102 million in care to the uninsured in 2011, not including \$187 million in pro bono services and products.
  - Community health centers subsidized the cost of providing health care services to 108,328 uninsured Virginians in 2011.
  - 70 percent of the uninsured seen by community health centers are expected to be eligible for Medicaid if coverage is expanded.

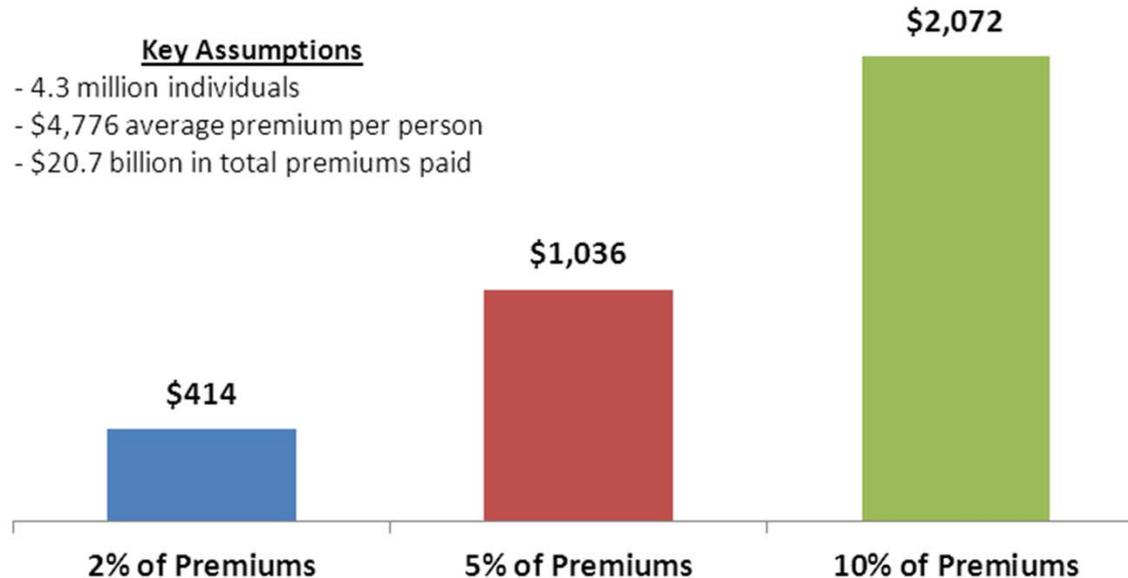
Cost of Serving Uninsured at Community Health Centers  
(FY 2011)



# The Cost of the Uninsured to Commercial Payers

- The cost of providing health care to the uninsured is reflected in the price paid by those who have health insurance.
  - This “hidden tax” is said to vary from as little as 1 to 2 percent of average monthly premiums to as much as 10 percent, depending on a state’s health insurance market.

The Cost of the Uninsured to Commercial Insurers in Virginia  
(Dollars in millions)



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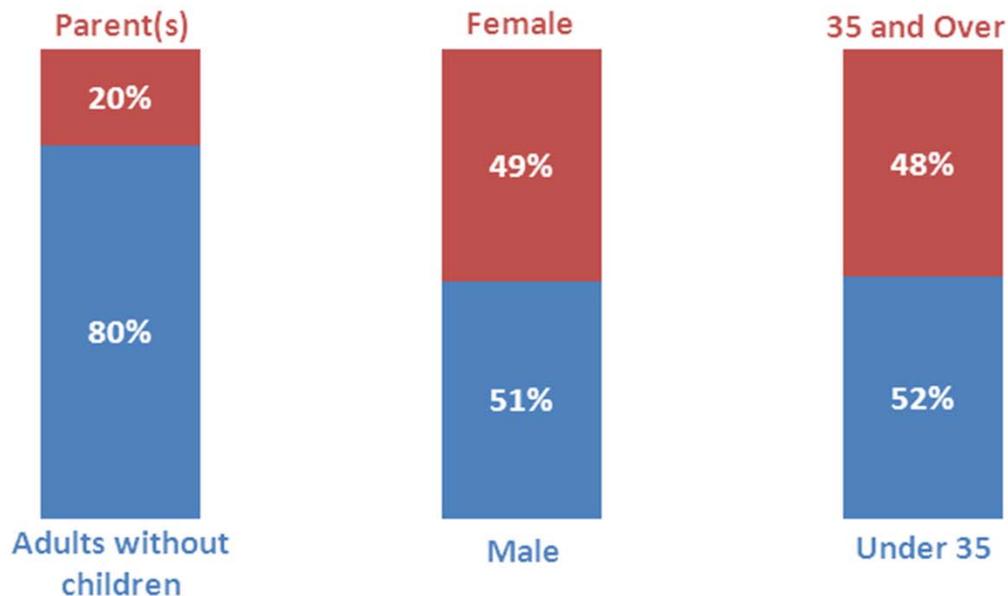
# **What are the implications of expanding or not expanding Medicaid coverage?**



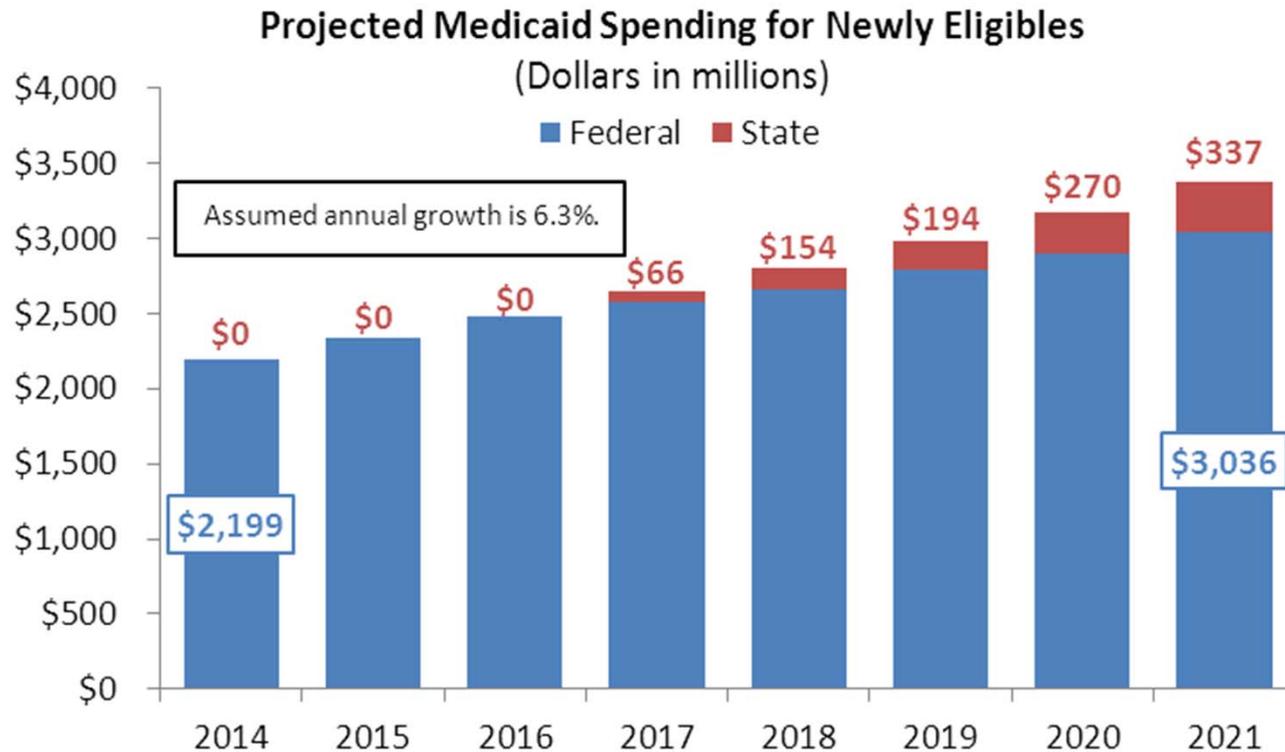
# Who would enroll in Medicaid if eligibility were expanded?

- The profile of Medicaid recipients will look different if eligibility is expanded.
  - DMAS estimates that 305,000 individuals would be eligible for Medicaid if coverage were expanded to families with income up to 138 percent of poverty.

## Who Are The Newly Medicaid Eligible?



# How much will it cost to expand Medicaid? (Revised)

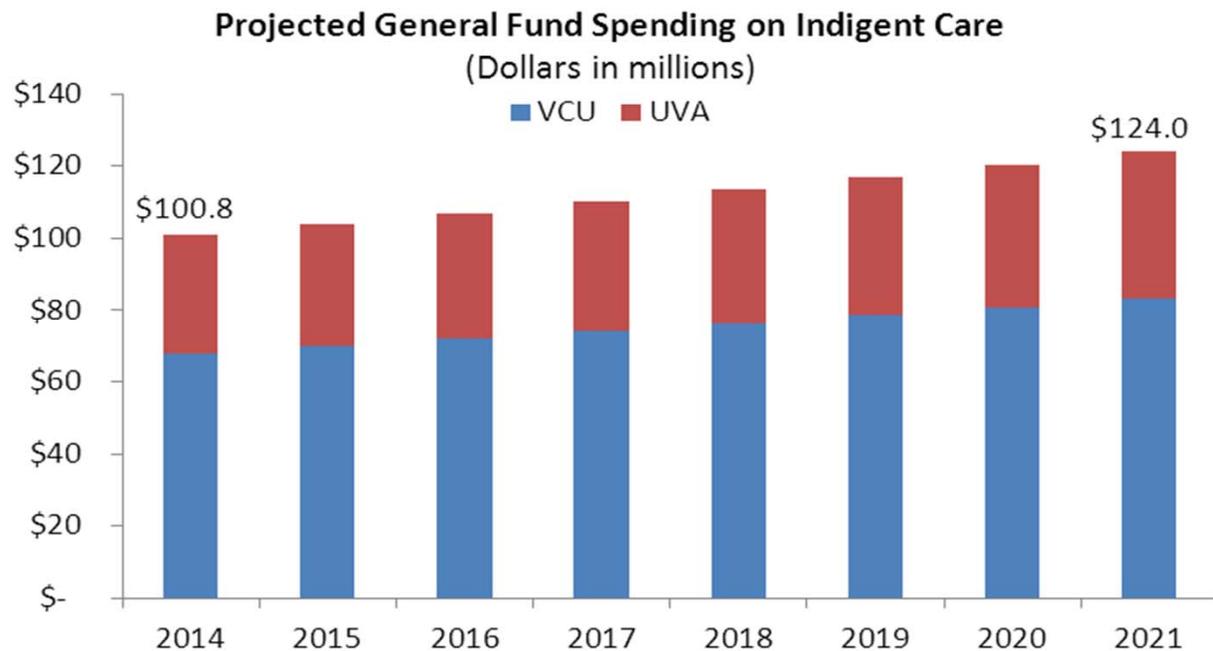


- The cost to the Commonwealth of the Medicaid expansion would likely be \$220 million beginning in the 2016-18 biennial budget not including administrative costs.



# Are There Potential Cost Savings from Expanding Medicaid?

- Expanding Medicaid will significantly reduce the need for indigent care subsidies that otherwise will exceed \$100 million GF annually.



- While the state's teaching hospitals will argue for continued support, annual general fund savings could range from 50 to 80 percent of current spending on indigent care.



# Potential Impact on General Fund Revenues?

- The infusion of more than \$2.2 billion each year from federal Medicaid funds should have a positive impact on health care employment in addition to general fund revenues.

<b>Medicaid Expansion and Employment Impact</b>				
	<b>New Federal Spending (*) (Dollars in millions)</b>	<b>New Federal Spending on Personnel (60%)** (Dollars in millions)</b>	<b>Entry Level Compensation for Health Care Jobs (***)</b>	<b>Possible Employment Impact</b>
<b>FY 2014</b>	\$ 2,199	\$1,320	\$44,368	29,743
<b>FY 2015</b>	2,338	1,403	45,699	30,696
<b>FY 2016</b>	2,485	1,491	47,070	31,680
<b>FY 2017</b>	2,576	1,545	48,482	31,877
<b>FY 2018</b>	2,654	1,592	49,936	31,886
<b>FY 2019</b>	2,792	1,677	51,434	32,560
<b>FY 2020</b>	2,904	1,742	52,977	32,884
<b>FY 2021</b>	3,036	1,822	54,567	33,381

\* Impact in FY 2014 is annualized.  
 \*\* VCU Health System estimate.  
 \*\*\* Bureau of Labor Statistics. Assumes 3% annual salary increase.



# Other Possible GF Impacts?

If the Commonwealth expands Medicaid eligibility...	Annual savings
...general fund revenues from income and sales tax should rise as more than \$2.2 billion in new federal funding each year is spent on health care services.	Unknown (positive)
...insurance premiums should rise more slowly, reducing the “hidden tax” borne by other commercial payers, including the state employees health plan.	\$17 million (2%) to \$42 million (5%)
...the cost of providing care to individuals with behavioral health needs who are currently ineligible for the program will be shifted to Medicaid if eligibility is expanded, resulting in general fund savings.	\$12 million+
...22,071 individuals currently served by community services boards could receive access to more comprehensive health care services in a timely manner improving overall health care and reducing emergency room visits.	Unknown (positive)
...individuals enrolled in Medicaid’s Family Planning Waiver and Breast and Cervical Cancer program can be shifted to the Medicaid expansion program at higher federal match rates.	Unknown (positive)
...the Department of Corrections (DOC) <b>may</b> be able to shift the cost of providing outpatient health care services to Medicaid, resulting in general fund savings.	Unknown



# What are some advantages of expanding coverage?

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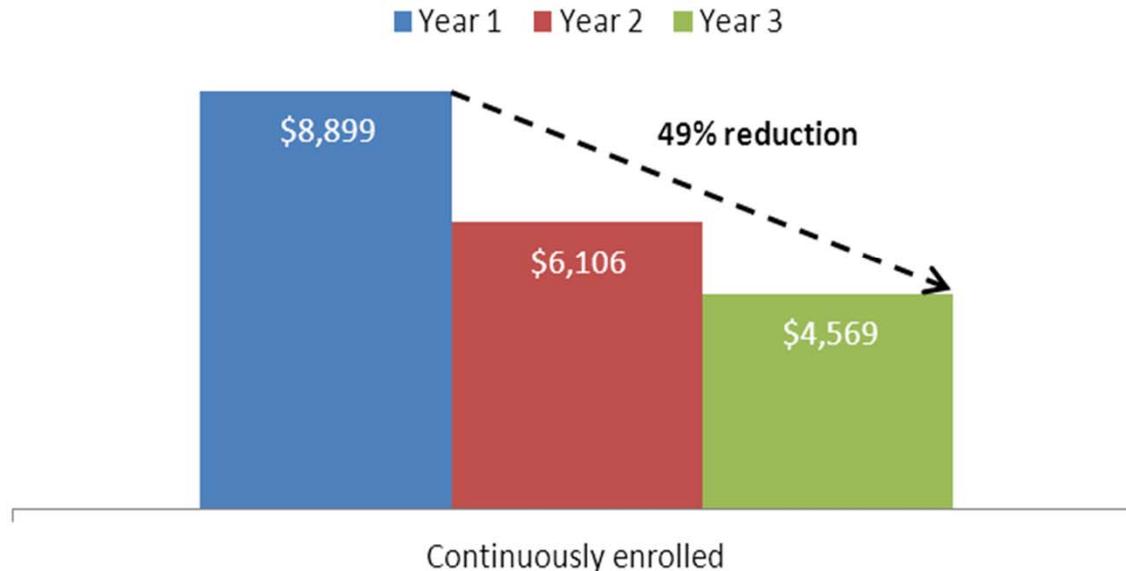
- Any pent-up demand for health care services among new enrollees will be paid entirely by the federal government from January 1, 2014 through December 31, 2016.
- Hospitals will be able to reduce the volume of uncompensated care they deliver as Medicaid funds are used for payment.
  - Rural hospitals that receive very little public funding for indigent patients will begin receiving reimbursements from Medicaid.
- Uninsured Virginians will not “wait-out” routine illnesses until their condition worsens and show up in the emergency room for more intensive interventions and more expensive care.
  - 30 percent of the uninsured postpone seeking care due to cost; and
  - 26 percent went without care due to cost.
- Improved access to care, better health outcomes and reduced mortality may result from the Medicaid expansion, according to a recent study in the *New England Journal of Medicine*.



# New Enrollees Will Receive Better Care

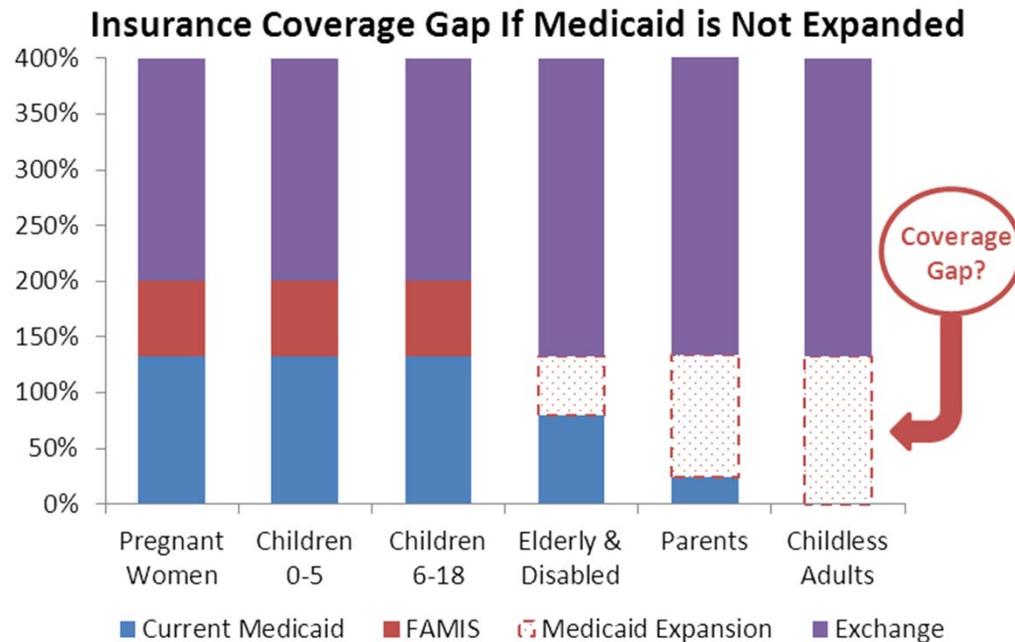
- Most of the newly Medicaid-eligible will be enrolled in managed care, a more efficient and effective way to care for the uninsured.
  - VCU’s Coordinated Care Program, a community-based primary care model for the uninsured, recently documented significant cost savings in the journal *Health Affairs* for the program’s enrollees, primarily due to fewer emergency room visits and inpatient stays.

**Average Cost Per Year for VCC Enrollees**



# Expanding Medicaid Will Avoid Equity Issues

- Many uninsured elderly and disabled adults as well as low-income parents and childless adults with income below 100 percent will be left without access to care if Medicaid is not expanded.
  - At the same time, uninsured Virginians with higher income -- between 100 and 400 percent of poverty -- will be eligible for premium subsidies through the health benefit exchange.



# What Is The Downside of Expanding Coverage?

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- Local government staff will have to manage higher caseloads that should be offset by recent investments (\$88 million) in health information technology infrastructure that are designed to streamline and expedite the eligibility process.
  - Over the past four years, local governments successfully weathered historic increases in food stamps rolls despite general fund budget reductions.
- Even with most of the cost of expanding Medicaid being borne by the federal government, the Commonwealth will need to pay 10 percent toward the cost of care by 2021.
  - Questions remain whether the federal government can ensure its financial commitment to Medicaid or the expansion with looming budget cuts.



# Other Consequences of Expanding Medicaid?

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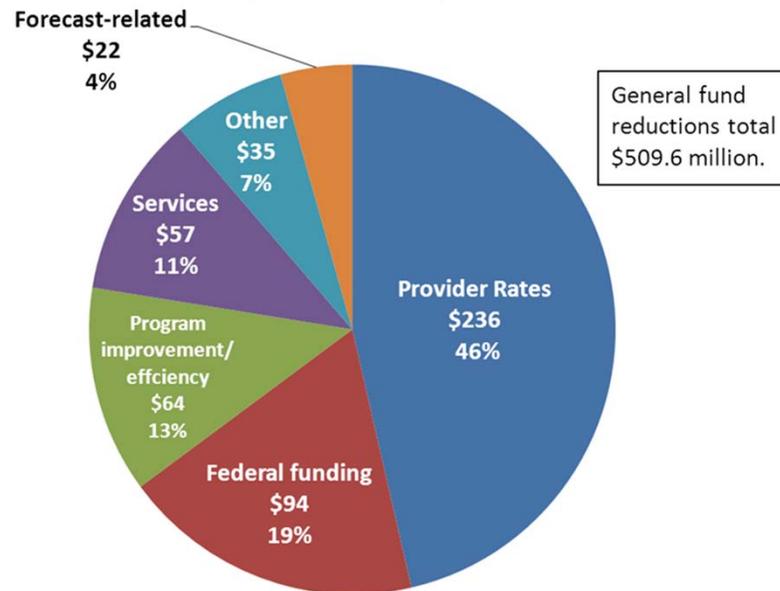
- Expanding Medicaid will place additional demands on the health care workforce.
  - While current delivery models are changing to accommodate the demand for health care, more attention will need to be devoted to primary care service delivery.
- The Commonwealth will be signing on to a new federal entitlement with uncertain fiscal implications if it chooses to expand Medicaid eligibility.



# Provider Rates Have Not Recovered from Budget Cuts

## 2010-12 Medicaid Budget Reductions

(Dollars in millions)



- The rates paid to attract and retain quality Medicaid providers remain low and have fallen during the recent recession.
  - While the ACA boosts primary care rates to Medicare levels in 2013 and 2014, attention will need to be paid to the adequacy of Virginia’s Medicaid rates to ensure the capacity exists to serve eligible enrollees.



# Is there a cost of not expanding Medicaid?

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- The Commonwealth will likely continue to subsidize the cost of providing indigent care at VCU and UVA Health Systems by more than \$100 million GF each year.
  - The reduction of disproportionate share hospital (DSH) payments will put pressure on the General Assembly to backfill the loss of federal funding.
- State funds will pay 100 percent of the cost of caring for 22,000 low-income Virginians with behavioral health needs through CSBs.
- Employers will face upward pressure in premiums as costs are shifted to the insured.
- Federal funds earmarked for the expansion of health care coverage to low-income Virginians will be shifted to other states or go unspent.



# Is There Another Way?

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- The Commonwealth may have another option.
- Virginia could opt in temporarily then opt out if concerns arise about the federal government's commitment to the Medicaid expansion.
- Federal officials may be amenable to state requests for flexibility to achieve expanded access to health insurance.
- What would that flexibility look like?
  - The provision of a Medicaid benefit that more closely resembles commercial insurance;
    - Trim certain services from the traditional Medicaid benefit package?
  - Income eligibility levels that are less than 138% of poverty;
    - Will the federal government let states expand Medicaid eligibility up to 100% of poverty?
  - Additional cost-sharing arrangements for the newly insured.
    - Will cost-sharing discourage enrollees from seeking care/be enforceable?
- Finding a “third way” will take time and effort.



# Conclusion

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- The Supreme Court affirmed the constitutionality of the ACA but deferred to states whether **or not** to expand Medicaid.
- There will be a cost of expanding Medicaid, but most of the cost will be paid by the federal government, whose share will decline from 100 percent in the first three years to 90 percent of cost in 2021.
- Currently, the cost of caring for the uninsured falls on public and private payors.
- Potential cost savings need to be thoroughly explored.
- Other advantages and disadvantages of expanding Medicaid also exist.
- The 2013 General Assembly will need to devote time, attention and energy to explore the best way for the Commonwealth to proceed with regard to the Medicaid expansion and health benefit exchange.



# Appendix I – Medicaid Review

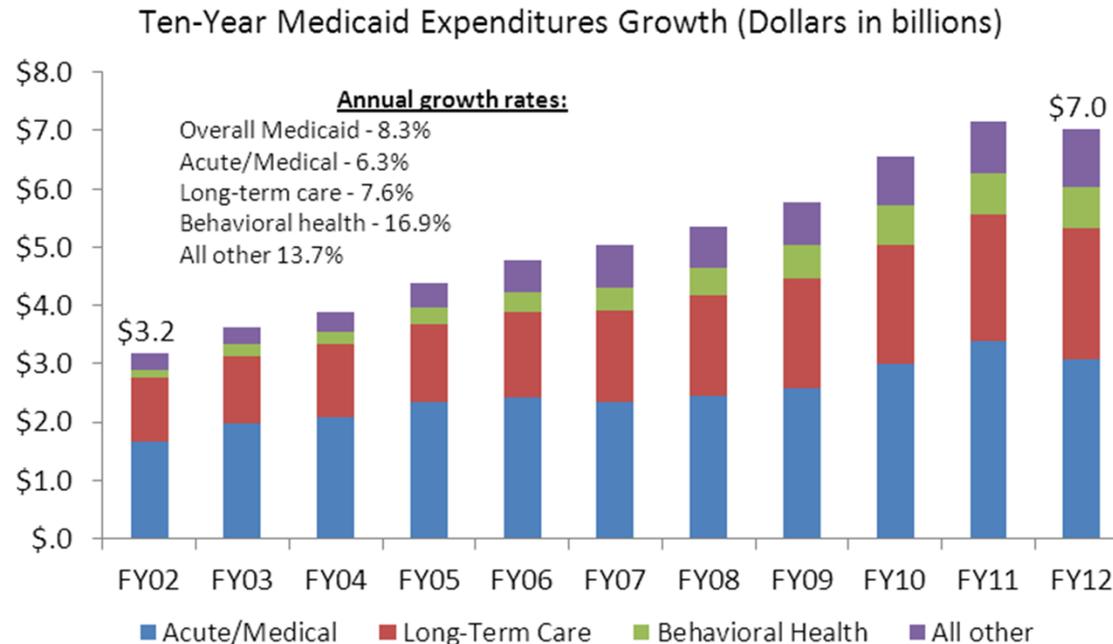
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**How much do we spend on Medicaid, how much has it grown, and what explains the growth?**



# How much was spent on Medicaid in FY 2012?

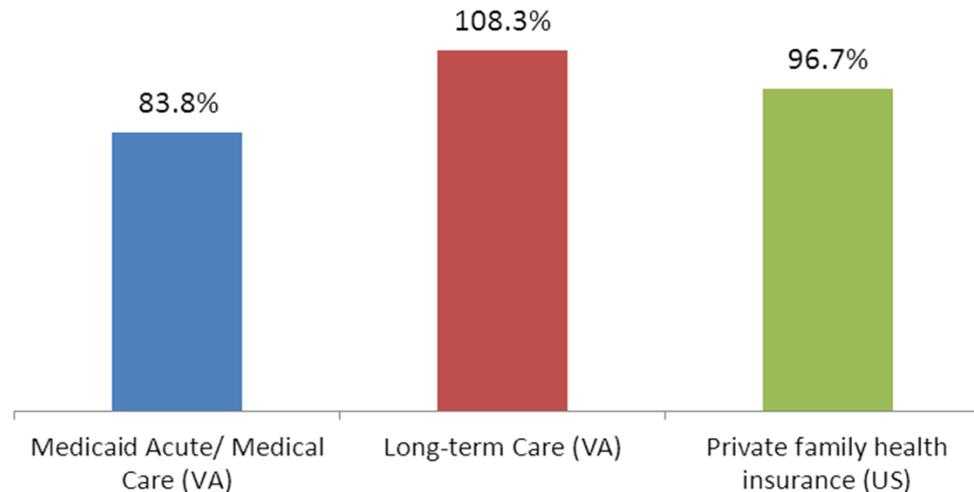
- Spending on Medicaid’s health and long-term care services more than doubled during the past ten years.
  - Under current law, Medicaid provides care for the aged, blind, and disabled, pregnant women, children and low-income adults.
- Spending grew much faster for long-term care services as opposed to acute/medical services.



# How has spending grown since FY 2002?

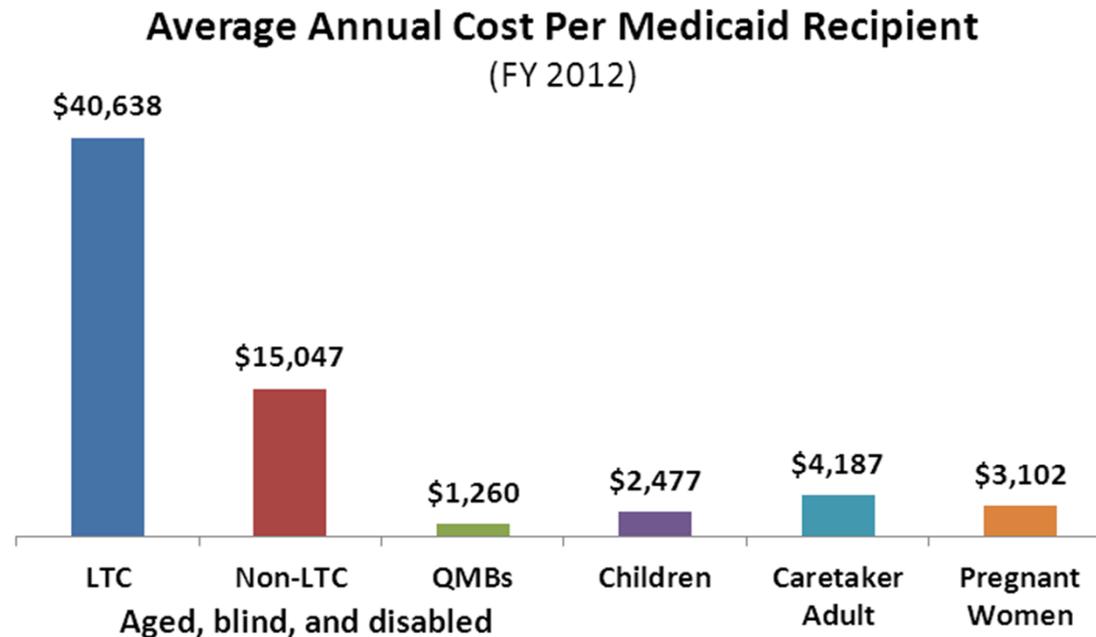
- Factors contributing to rising spending in Medicaid include:
  - Enrollment growth;
  - Overall trends in health care costs; and
  - Home and community-based waiver services and community-based behavioral health services.
- Policy choices and underlying cost growth contributed to significant growth in Medicaid long-term care services.

Comparison of Ten-Year Growth Rates Since 2002



# Why Has Medicaid LTC Spending Grown?

- Medicaid services for the aged, blind, and disabled, specifically long-term care (LTC) services, are ten times as high as health care costs for low-income Medicaid recipients.

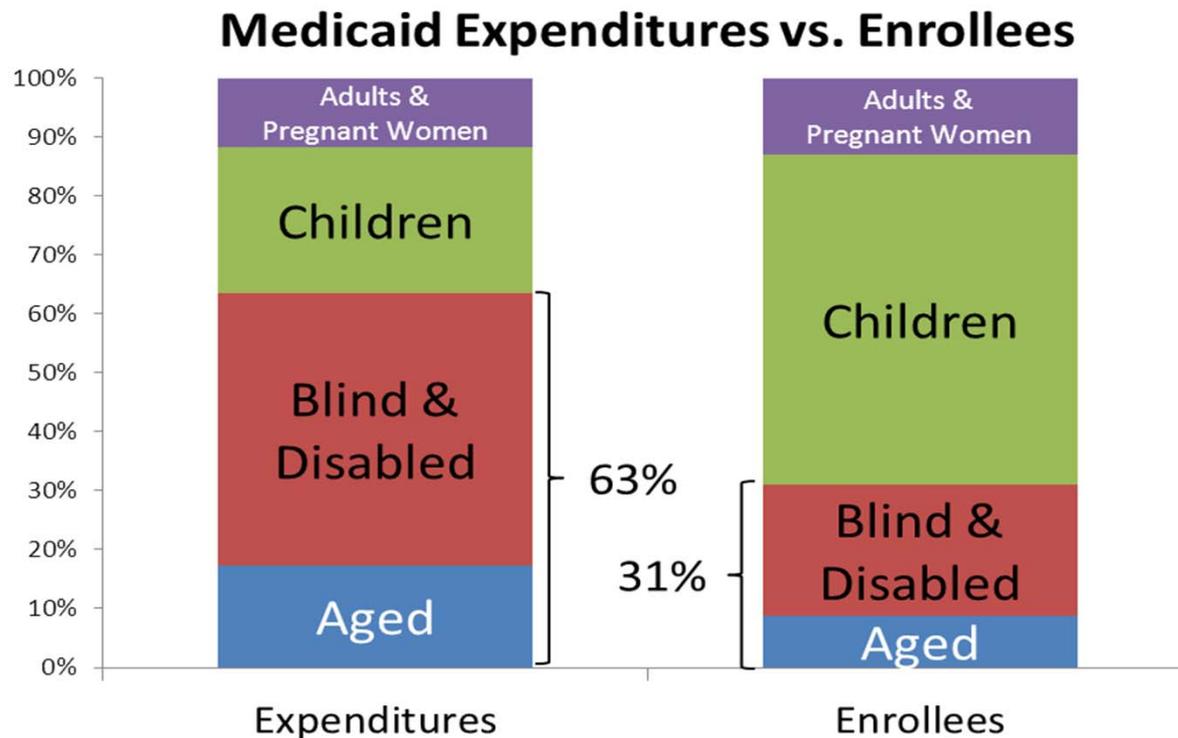


- Since FY 2008, the General Assembly has added 2,000 new intellectual disability (ID) waiver slots.



# Most Medicaid resources are consumed by a few recipients

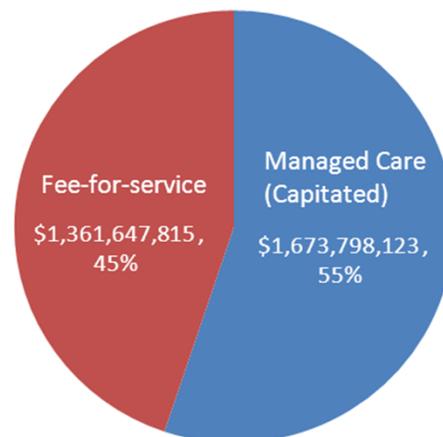
- While the aged, blind and disabled make up 63 percent of spending, they represent only 31 percent of Medicaid enrollees.
- National data suggest that 50 percent of Medicaid spending is made on behalf of 5 percent of Medicaid recipients.



# What has been done to control rising Medicaid costs?

- Dramatic growth in behavioral health services resulted in multiple program changes including:
  - Reduction in provider rates and additional audits;
  - Limitations on services; and
  - Independent eligibility process.
- The expansion of managed care principles or care coordination services continues to hold promise for traditional and non-traditional Medicaid populations with proper attention and oversight.

2012 Medicaid Payments for Acute/Medical Services



# Future Medicaid Challenges?

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- Recession-driven enrollment growth which has contributed to rising spending on health care services will abate as the economy improves.
  - Medicaid spending on LTC will be ongoing.
- Stagnant reimbursement rates will need to be addressed to retain and attract providers.
- The Department of Justice settlement agreement will require the addition of almost 5,000 new ID, developmental disability (DD) and other waiver slots.
  - The current rates and benefit packages for waiver recipients may be inadequate to address the needs of individuals in the community.
- While Medicaid is exempt from federal legislation calling for sequestration reductions, serious efforts to reform entitlement programs will likely involve this program.



# Appendix II: Mandatory Services

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## Mandatory Medicaid Services

Inpatient, outpatient and emergency hospital

Physician and nurse midwife

Federal qualified health centers/rural health clinic

Laboratory and x-ray

Transportation

Family planning and supplies

Nursing facility

Home health (e.g., nurse, aide)

Early and Periodic Screening, Diagnosis, and Treatment program for children (EPSDT)



# Appendix III: Optional Services

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## Optional Medicaid Services in Virginia

Certified pediatric nurse and family nurse practitioner

Routine dental care for persons under age 21

Prescription drugs

Rehabilitative Services (i.e., PT, OT, and SLP)

Home health (e.g., PT, OT, and SLP)

Hospice

Mental health services

Substance abuse services

Intermediate care facilities for persons with DD/ID and related conditions

