Implementing the Affordable Care Act in Kansas: Public and Private Health Insurance Coverage Expansions

American Public Human Service Association

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Overview

- About KHPA
- Brief description of Federal reforms
- Summary of expected changes in Kansas
- KHPA’s role in implementation of reforms
- Transforming eligibility, enrollment and outreach for health insurance

What is the Kansas Health Policy Authority?

- Established in 2005 to coordinate health and health care policy in Kansas.
- Single State Medicaid Agency
  - Directly administer medical programs
  - Pass-through federal funding for SRS, Aging, JJA
- Children's Health Insurance Program
- State Employee Health Plan
- State Employee Worker's Compensation
- Health Policy Analysis and Recommendations
- Primary Goals in 2010:
  - Manage Medicaid and other health care spending
  - Implement Federal health reforms

Public Insurance Programs in Kansas

- Medicaid: Free coverage for very-low income families, elderly and disabled
  - Federal government pays appr. 60%; state pays 40% (temporarily 70%/30% under ARRA)
  - Entitlement program: anyone eligible is entitled to benefits if they enroll
  - Pregnant women and infants up to 150% FPL
  - Children: 100% or 133% of FPL, depending on age
  - Elderly and Disabled: income limits vary, 100 – 200% FPL
  - Adult Parents and Caregivers: appx. 30% FPL
  - "Medically Needy" – Adults with incomes above threshold with large medical bills
  - Childless adults are not covered
- CHIP: Low-cost coverage for uninsured children in families that don't qualify for Medicaid
  - Income limit: 250% of 2008 FPL (appx. 241% current FPL)
  - Premiums: $20 - $75 per-family, per-month, depending on income
  - "HealthWave:" State contracts with MCO; pays flat, capitated rate for each beneficiary – also serves 125,000 Medicaid children and parents
  - Federal block grant funding: Feds pay 72% in Kansas, up to grant limit; state pays 28%

Federal Health Reform: Two New Laws

- **Patient Protection and Affordable Care Act of 2010 (ACA)**
  - Based on Senate health reform legislation
  - Passed March 23, 2010
- **Health Care and Education Affordability Reconciliation Act of 2010**
  - Added some elements of House reform proposals to the Senate version
  - Passed April 2, 2010

Federal Reforms: Presumed Objectives

- **Define health insurance coverage**
  - Minimum coverage includes standard benefits and implies affordable cost-sharing
  - Includes prescription drugs and mental health parity
- **Secure access to an offer of group-like insurance coverage for everyone**
  - Eliminates differences in insurance premiums due to the health risks of individuals or co-workers
  - Private, portable insurance for those buying as individuals and employees
- **Get insurers to compete with each other rather than consumers**
  - New exchanges should facilitate price shopping and ease enrollment
  - Stabilize private insurance markets through required participation
- **Buy or subsidize minimum coverage to ensure affordability**
  - Greatly expand Medicaid to cover the lowest-income Americans
  - Cost-sharing protections and Federal tax subsidies for premiums aid others

Federal Reforms: Health Insurance Subsidies

- **Sliding scale premium subsidies based on income**
  - Under 150% FPL: Max. of 2-4% of income
  - 150-200% FPL: Max . of 4-6.3%
  - 200- 400% FPL: Max . of 6.3-9.5%
- **Cost-sharing protections based on income**
  - Under 150% FPL: Max. of 6% of covered costs
  - 150-200% FPL: Max. of 15%
  - 200-400% FPL: Max. of 27-30%
  - Separate income-related out-of-pocket caps
- **Insurance reforms, subsidies, and cost-sharing protections interact**
  - Some out-of-pocket costs shift into premiums
  - Raw premiums for young adults will go up
  - Young adults are most likely to qualify for subsidies and protections
- **Federal government bears limited risk for un-affordable premiums**

Federal Reforms: Insurance Exchanges

- Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP), with option for state to allow federal government to establish the exchange
- Subsidies available only through the new exchanges
- Administered by governmental agency or non-profit
- Available to individuals and small businesses (up to 100 employees)
- States can allow larger businesses to buy coverage in SHOP in 2017
- States may form regional exchanges with other states or within the state
- Federal funding available to establish exchanges through 1/1/2015

Federal Reforms: Medicaid Expansion

- Maintenance of effort for Medicaid eligibility: current Medicaid eligibility rules are set in stone until 2014
- Medicaid is expanded in 2014
- All non-disabled under 65, up to 138% FPL (includes childless adults)
- Feds cover 100% of cost for expansion group in 2014 through 2016
  - 2017: 95%
  - 2018: 94%
  - 2019: 93%
  - 2020 and thereafter: 90%
- Some state flexibility in covered benefits for newly-eligible
  - Must meet minimum standards set by Federal government
  - Minimum standards include new benefits like "habilitation" and "rehabilitation"
  - The ACA-amended Medicaid statute allows states to provide up to the full Medicaid benefit package to the expansion population

Federal Reforms: State Responsibilities

- **Implement insurance reforms**
  - decide whether to accept the responsibility and opportunities that come with the establishment of an exchange
  - define what kind of competition they want inside the exchange
  - decide how to govern these new and potentially dominant health insurance markets
  - decide whether, and how, to use the buying power and regulatory influence they have been given in Federal legislation
- **Coordinate Medicaid and the new exchange(s)**
  - ensure access to coverage
  - seamless transitions between different sources of coverage
- **Determine Medicaid's new role in the health care system**
  - simplify eligibility and select benefit package for Medicaid expansion group
  - set Medicaid payment rates and secure access to providers
- **Respond to numerous grant and demonstration projects opportunities**
  - Addressing public health issues
  - Experimenting with new payment methods to better coordinate care

Health Reform Estimates: Key Assumptions

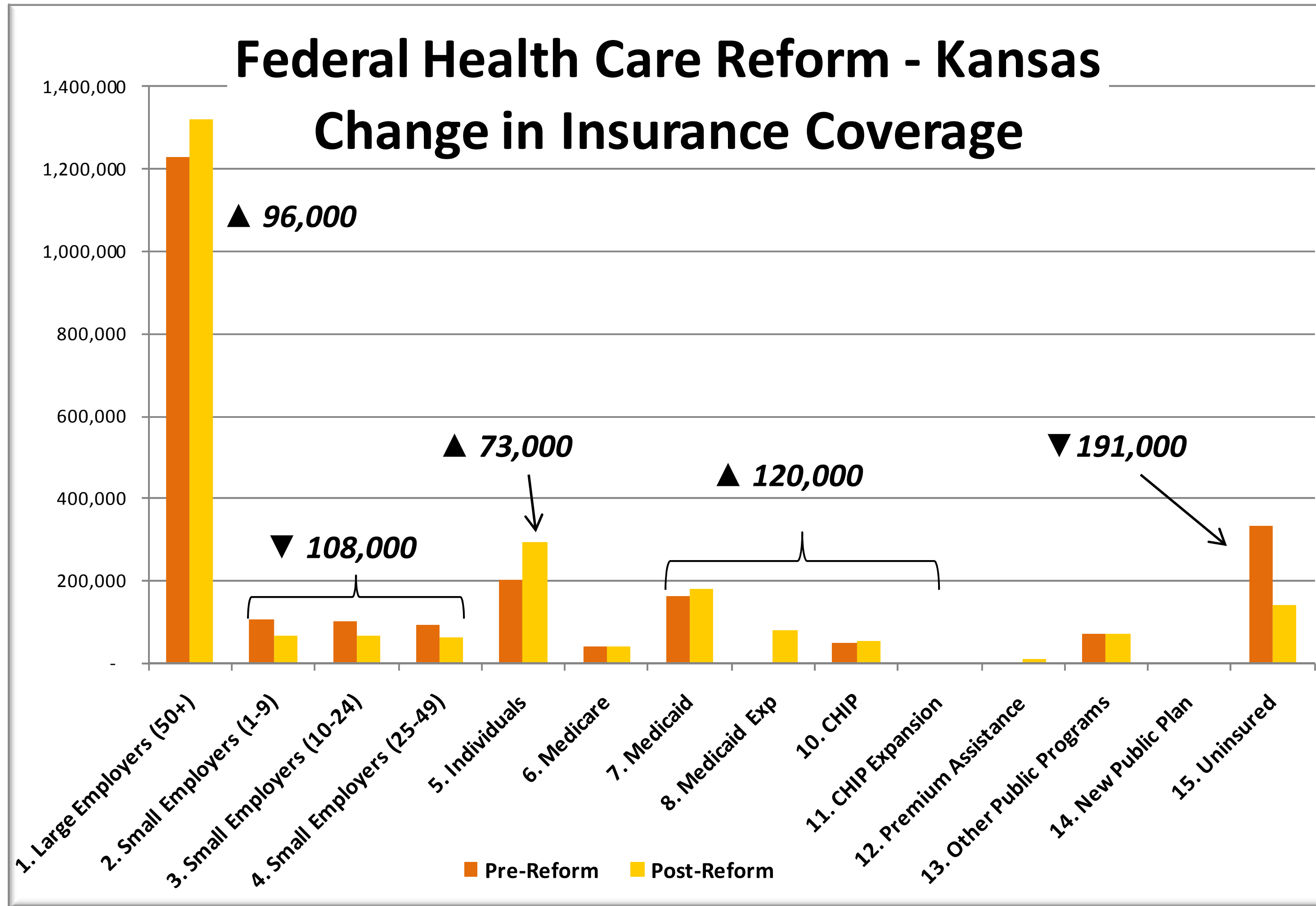
- **Purpose of the analysis is to inform Kansas decision makers**
  - Analysis is not designed to address the question of federal reform
  - Analysis does not include populations the Federal government has already assumed responsibility for (Medicare)
  - Analysis does not estimate impact on the Federal budget, nor Federal taxes
- **State spending is best understood in a more comprehensive estimate**
  - Employer-sponsored coverage offsets Medicaid (for those also eligible for both)
  - Impact of coverage mandate affects Medicaid participation
  - Overall reduction in the number of uninsured could have an impact on ongoing spending for state programs designed for the uninsured
- **State fiscal impact is dependent on future state decisions**
  - Programs designed to secure access for the uninsured may need to be reviewed
  - Estimates examine state spending under a range of future policy choices, including potential increases in Medicaid provider payment rates
  - Estimates are needed to help policymakers with these difficult choices over the next three years
- **Results are consistent with national estimates by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS)**
  - 6% residual rate of un-insurance
  - Small net impact on employer-sponsored coverage
  - Small positive impact on total health spending

Health Reform Estimates: Source and Process

- **Coverage and basic cost estimates produced by *schramm-raleigh Health Strategy* with funding from the United Methodist Health Ministry Fund**
  - Additional analysis of impact on state spending by KHPA
- **"Point" estimates**
  - Represent the most likely outcome of Federal reforms based on actuarial advice and national benchmarks
  - Assume the state takes no additional actions to expand coverage nor reduce spending (except to eliminate MediKan)
  - "Point" estimate corresponds to "Scenario 2" in the actuarial model
- **"Upper bound" estimates of coverage**
  - Assumes residual rate of un-insurance is 4% rather than 6%
  - Other potential costs, such as provider rate increases, are identified separately
  - Corresponds to "Scenario 4" in the actuarial model
- **Estimates include increased cost of program administration**
  - 5% of gross increase in spending; matched by the Federal government at 50%
- **Estimates expressed in constant dollars using 2011 as a base**
- **Limitations**
  - Estimates reflect impact on under-65 population only
  - Estimates do not reflect reductions in Medicare payments included as funding sources in health reform legislation
  - Do not replicate other analyses of the impact on Federal taxpayers

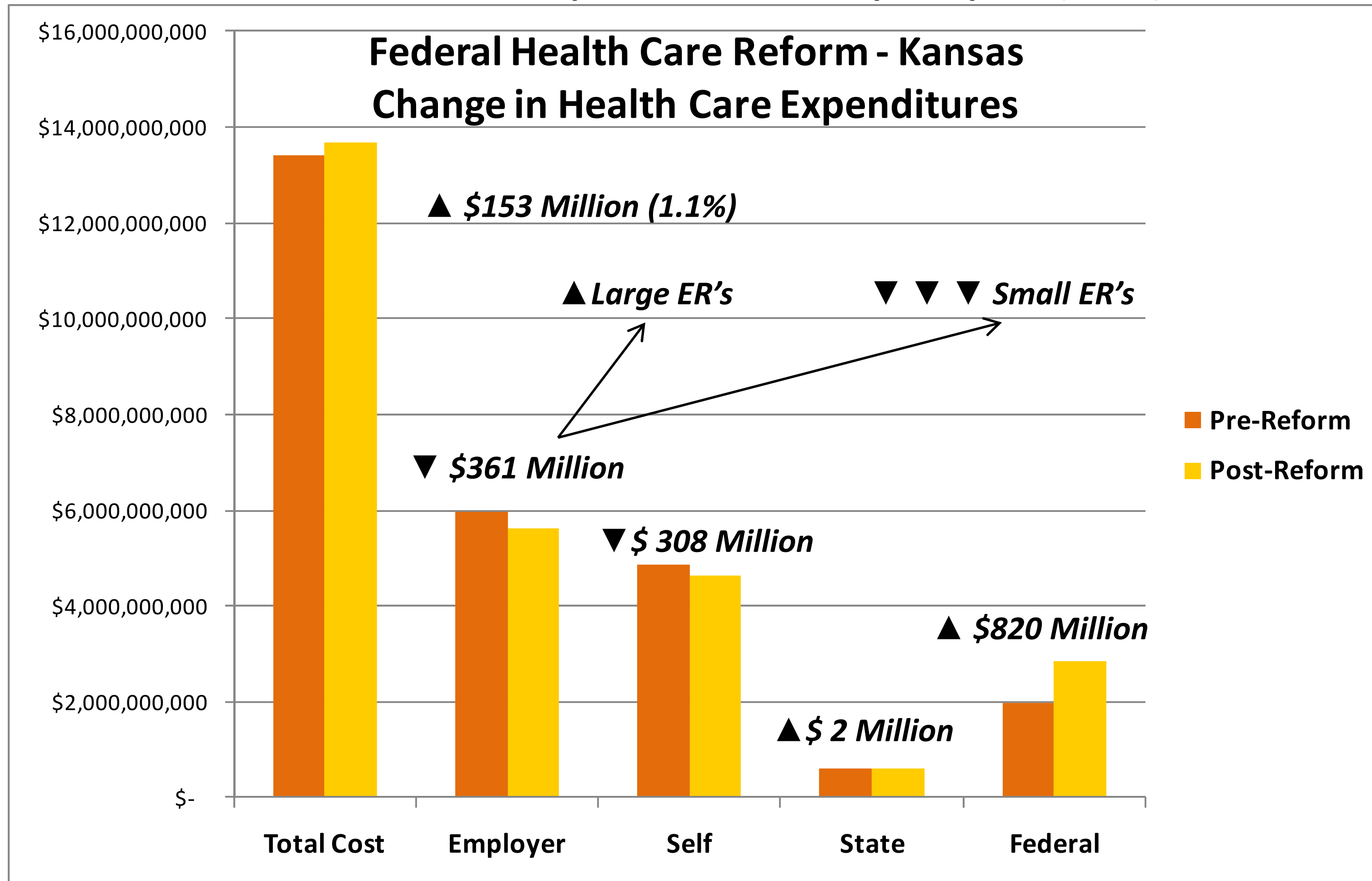
Kansas – Pre-FHCR vs. Post-FHCR

Distribution of Insurance Coverage by Payor (Sc2)

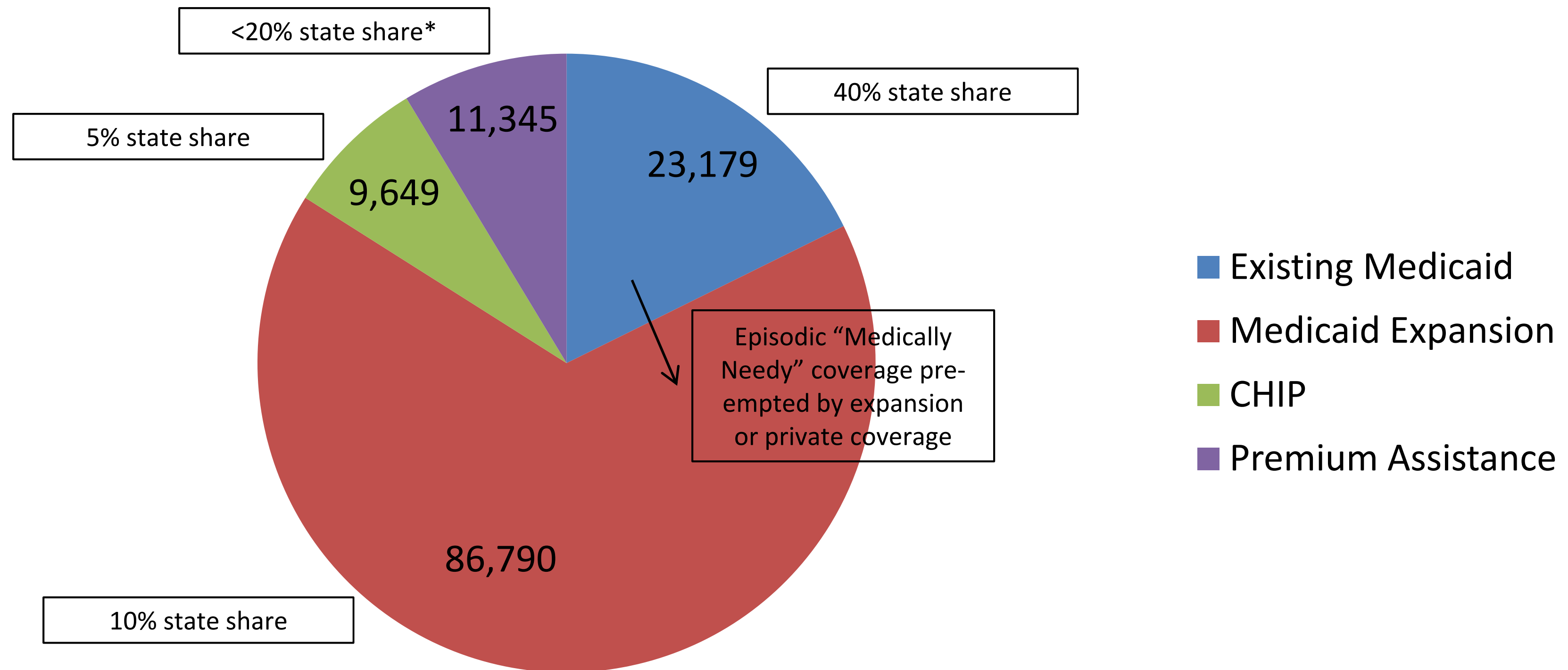


Kansas – Pre-FHCR vs. Post-FHCR

Health Care Expenditures by Payor (Sc2)



Federal Reforms: Sources of Growth in Medicaid and CHIP Coverage



*Employer provides primary coverage and pays most costs.

Federal Reforms: Impact on State Spending at Full Implementation in 2020

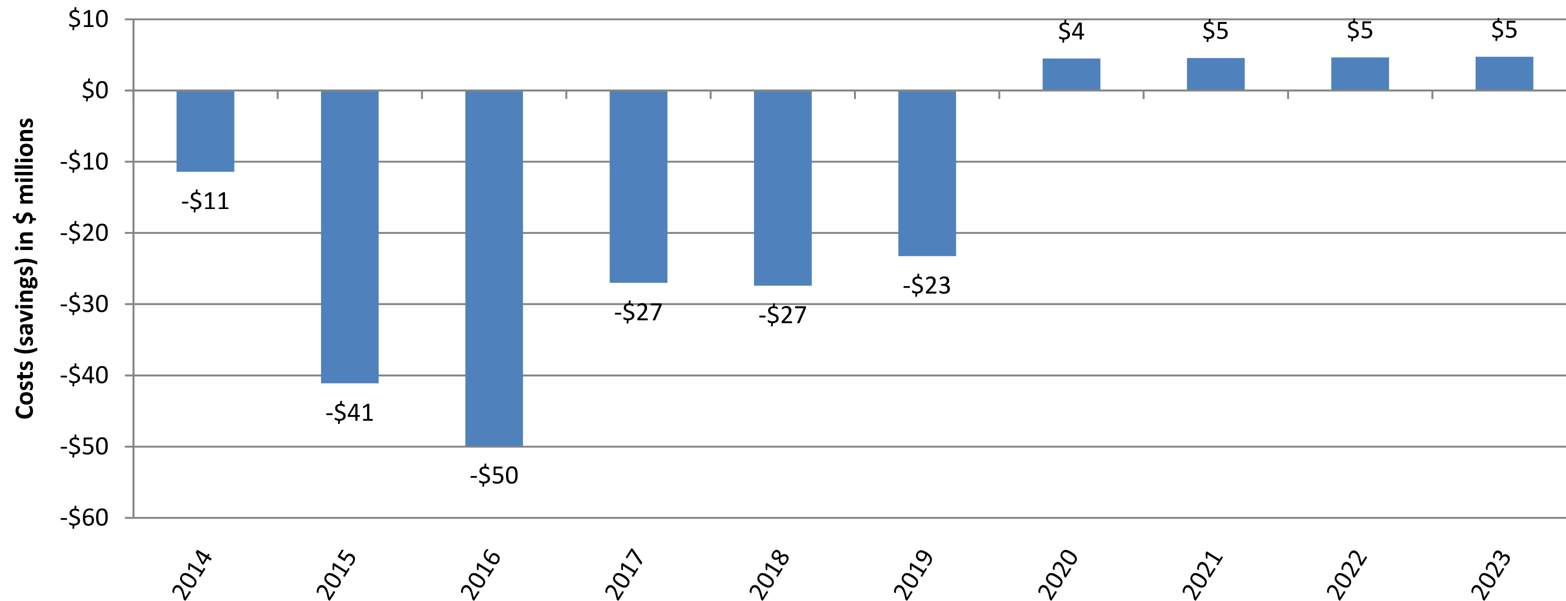
State options regarding direct spending for the safety net*

	Maintain all state spending on the safety net	Reduce state spending on the safety net by half	Eliminate state spending on the safety net
Point estimate plus 5% provider rate increase	$35 M	$12 M	-$8 M
Upper bound estimate of coverage	$7 M	-$16 M	-$35 M
Point estimate	$4 M	-$19 M	-$39 M

Additional risk: +/- $15 million variance in true cost of Medicaid benefit package. Impact subject to state choice and federal regulation over covered benefits.

*Options are illustrative and do not reflect the opinions of KHPA staff, nor the KHPA Board. State spending totals for the uninsured through the safety net are preliminary ($40-$45 million annually) .

Federal Reforms: Net Impact on State Spending 2014-2023



Note: Reflects point estimates. Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.

Federal Reforms: Summary of Potential Impact

- **Reduction in the number of uninsured**
  - Currently appr. 335,000 uninsured, or 14% of non-aged population
  - Expected reduction of 191,000 to about 6% of the non-aged population
- **Growth in Kansas Medicaid**
  - Expected growth of approximately 131,000 new participants
  - Some beneficiaries will shift to – or be jointly enrolled in -- employer coverage
  - Costs of CHIP program are nearly “federalized” at 95%
  - Overall Federal Medicaid match rate grows from 60% to over 68% (average for medical care only)
- **Impact on state spending**
  - Some high-cost beneficiaries with intermittent coverage shifted to private insurance or migrate to the enhanced-match Medicaid expansion
  - Higher federal payments for expansion group (90% in 2020+) and CHIP (95%)
  - Long run impact on state spending is relatively small and depends on state choices
  - Substantial savings to the state during transition years (2014-2019) when the Federal government funds between 93% and 100% of the Medicaid expansion

Next Steps for KHPA

- **Detailed review of new federal laws**
  - Create options for Medicaid benefit packages
  - Create options for simplifying Medicaid eligibility
- **Work closely with other state agencies and stakeholders**
- **Closely monitor and work with Federal agencies**
- **Coordinate information system changes**

State Health Reform Grant

- State Health Access Program (SHAP) Grant from Health Resources and Services Administration (HRSA)
  - Final grant in a series of HRSA/SHAP grants
  - Kansas previously had 2 SHAP grants
  - Grant is to provide support for starting up programs that extend coverage to the uninsured population
  - SHAP grants will demonstrate, proof-test, and de-bug key elements of federal reform
- KHPA's project to cover the uninsured
  - Awarded approximately $40 million over 5 years (2009-2014)
  - Includes funds to build IS base for modern approach to outreach
  - Significant funding for outreach and enrollment
  - Expanding coverage to young adults

Coordinating health & health care for a thriving Kansas

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KANSAS HEALTH POLICY AUTHORITY

Changing Needs in Medicaid Eligibility and Outreach

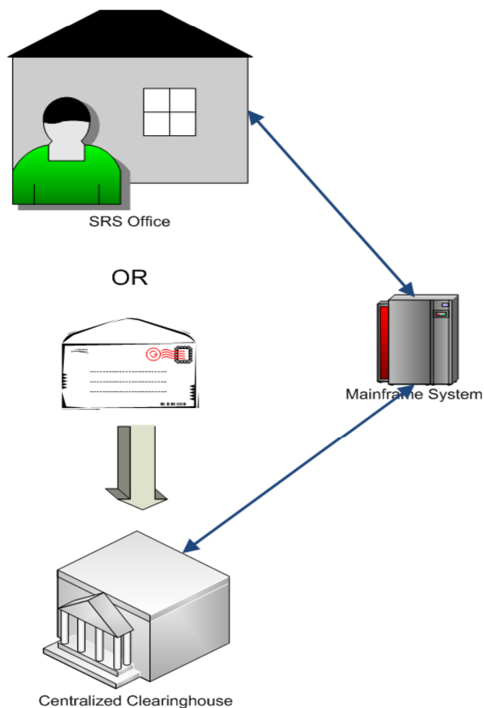


Figure 1

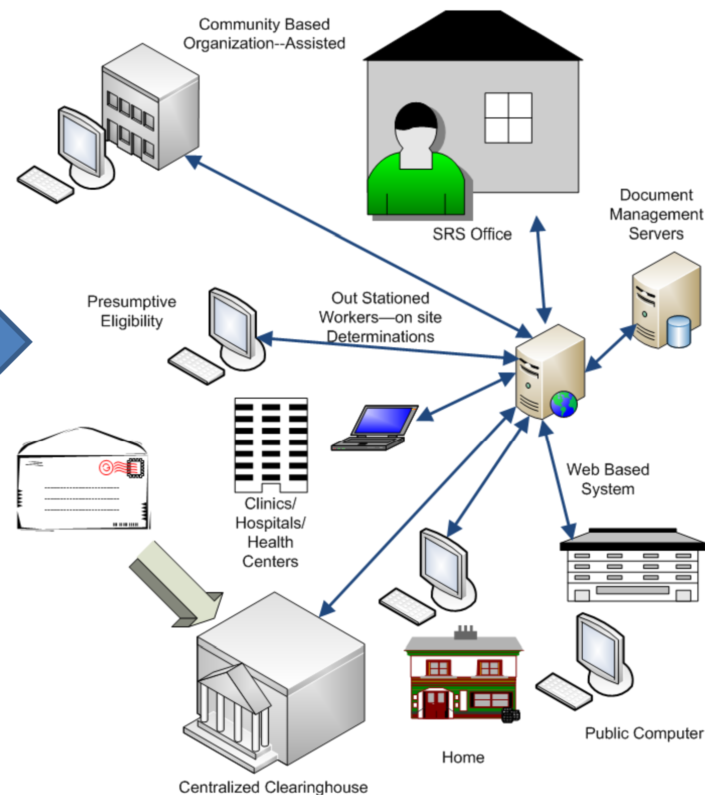


Figure 2

New Outreach Model for Medicaid and CHIP

- Dramatic shift to direct electronic and facilitated, community-based enrollment
- Four tiers in Kansas' project:
  - 12 eligibility workers outstationed primarily in safety net clinics around the state. Will provide staffing, training and equipment
  - Increase presumptive eligibility sites (PE)
  - Leverage community partners with application assistance
  - Place "kiosks" in locations around states to apply with computer access, document imaging, easy-to-use portal

Integrated Eligibility System for Health Insurance Coverage

Grant objectives

- Create full “vertically integrated” eligibility system for Medicaid and CHIP
- Create online application for Medicaid/CHIP and presumptive eligibility screening tool for community partners
- Enable full electronic adjudication to reduce error and increase the number and speed of determinations

Additional benefits and design criteria

- Provide a base for seamless eligibility determinations between health insurance products including subsidies for participants in insurance exchanges under the ACA
- Provide platform that can be used as a building block for the future Medicaid Management Information System (MMIS) – appr. 2015
- Work together with human service agency (SRS) to create a common, flexible platform to build – in stages – an integrated process for administering and coordinating means-tested programs, e.g., cash assistance & food stamps

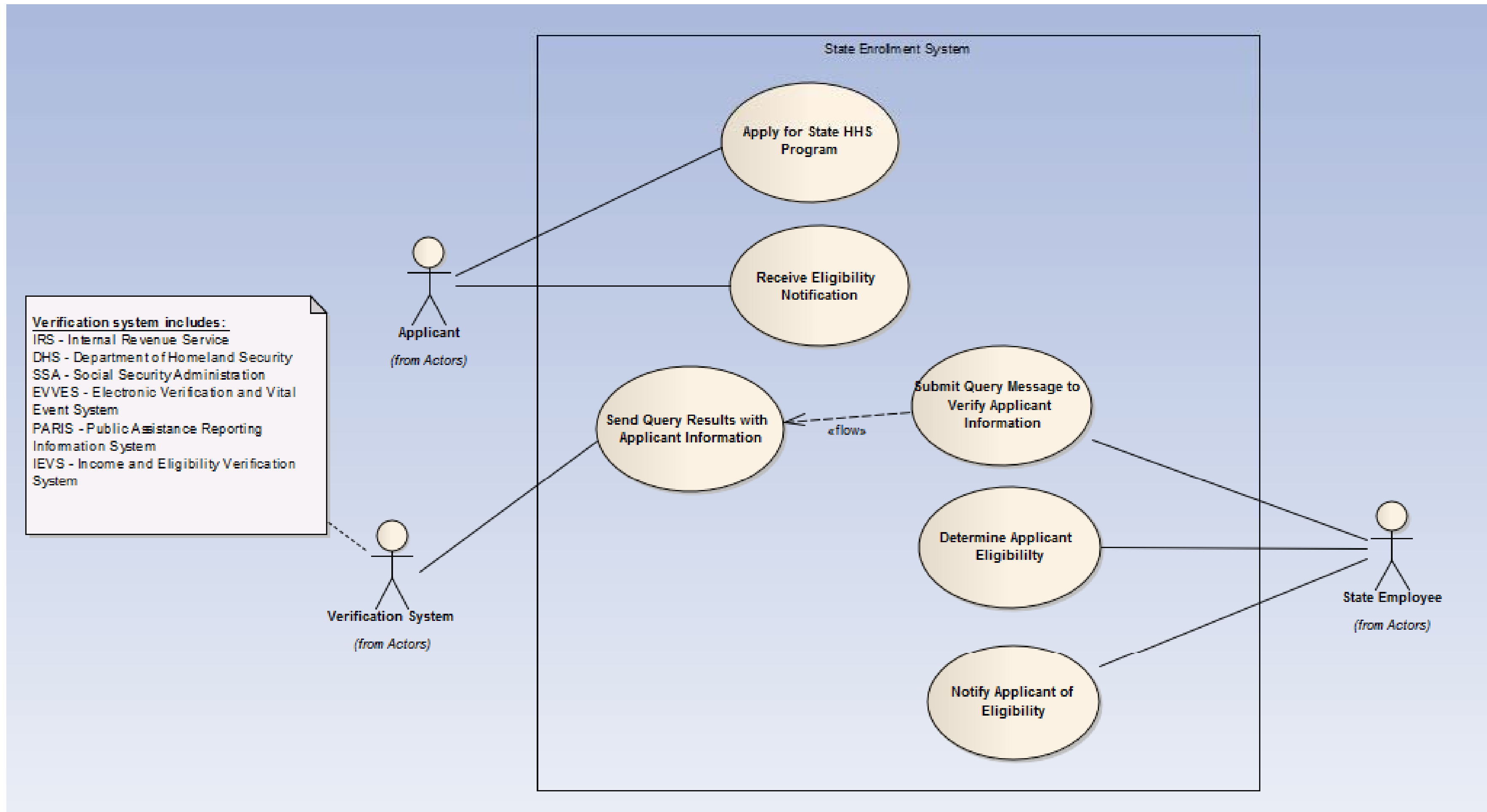
ACA Requirements for Coordination of Enrollment

- Sections 1413 and 2201 of the ACA include requirements to ensure integration of eligibility and enrollment between Medicaid and the exchange
  - States must make available a common web-based application for Medicaid, CHIP, and the subsidies and cost-sharing protections available in the exchange.
  - State exchanges must screen applicants for Medicaid and CHIP eligibility, and state Medicaid and CHIP programs must accept these referrals and enroll these individuals in the appropriate program without further review of eligibility.
  - State Medicaid programs must ensure that ineligible applicants are screened for eligibility for subsidies in state exchanges, and that those found eligible are enrolled in a plan through the exchange.
- States may choose to contract with their state Medicaid agency to determine eligibility for premium subsidies and cost-sharing protections within the exchange
- Given the potential duplication of effort and the financial disputes that could arise from two competing eligibility processes, I expect most states will take this option

ACA Requirements for Notification and Verification Standards and Protocols

- § 1561. HIT Enrollment, Standards and Protocols. Not later than 180 days after the enactment, the Secretary, in consultation with the HIT Policy and Standards Committees, shall develop interoperable and secure standards and protocols that facilitate enrollment in Federal and State health and human services programs through methods that include providing individuals and authorized 3rd parties notification of eligibility and verification of eligibility.

Applicant Enrollment Data Verification – CIM Business Scenario



Source: National Health Information Network, prepared for August 24, 2010 meeting of the Office of National Coordinator Enrollment Workgroup

Key Principles for Kansas in a State Health Insurance Enrollment Solution

- Function. The state needs an on-line real-time system to support eligibility determinations for 33% larger Medicaid population and another Medicaid-sized exchange population receiving approximately $600 million in income-based premium subsidies.
- Scale. Systems, human resources, and business processes must support concentrated enrollment of the expanded population in an annual "open enrollment period" beginning sometime between July and October 2013
- Integration. The state needs a single, integrated eligibility process for health insurance provided through Medicaid and the exchange, and needs to maintain or improve integration with eligibility for human service programs
  - Should also be built to serve as the eligibility subsystem of the MMIS
  - Potential to be modified to serve as the master patient index for an statewide health information exchange
- Timing. The new system must meet firm deadlines included in the ACA.
- Alignment. The procurement must meet the purposes of the HRSA SHAP grants to cover the uninsured and to be the leading edge of reform.

Other Considerations for States

- Planning for state-initiated replacement or upgrades may be time-consuming
  - Design, procurement and operational control will need to accommodate at least two separate agencies and multiple stages, i.e., Medicaid and the exchange(s)
  - It may be quite some time before exchanges are created -- and some may by quasi-private
- It is too late for your state to initiate a new eligibility system for both Medicaid and the exchange. Alternatives:
  - build a vertically integrated health insurance eligibility system for the exchange and income-based Medicaid groups
  - add a vertically integrated component to your existing system to implement reforms
  - ask the Federal govt. to build and/or procure a vertically integrated system
  - partner with other states?
- Are there efficiencies in using or upgrading the Medicaid business platform (MMIS) to also support interfaces with exchange operations, or to directly perform functions such as plan selection and enrollment, premium payment, cost allocation, federal reporting etc.?
- If integration of health insurance and human service enrollment systems and processes occurs in stages, what is the impact on operational costs during the transition period?
- Will applicants for private insurance in the exchange be presented with options to apply for the full range of state assistance programs?

http://www.khpa.ks.gov/