

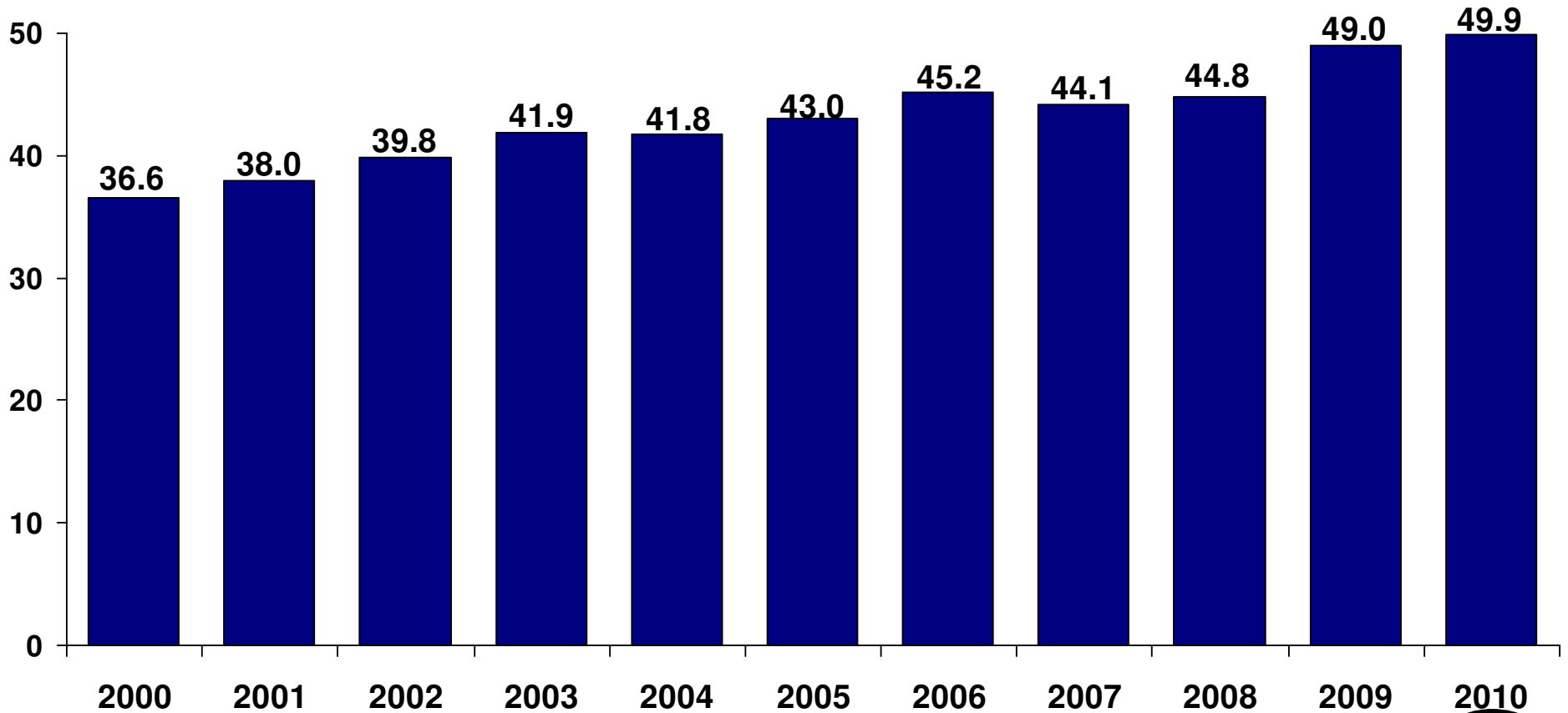
Implementing the Affordable Care Act: Integrating Medicaid and the State Insurance Exchanges

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**Women in Government: Health Reform Task Force
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13 Million More People Uninsured Over Last Decade

Millions of uninsured

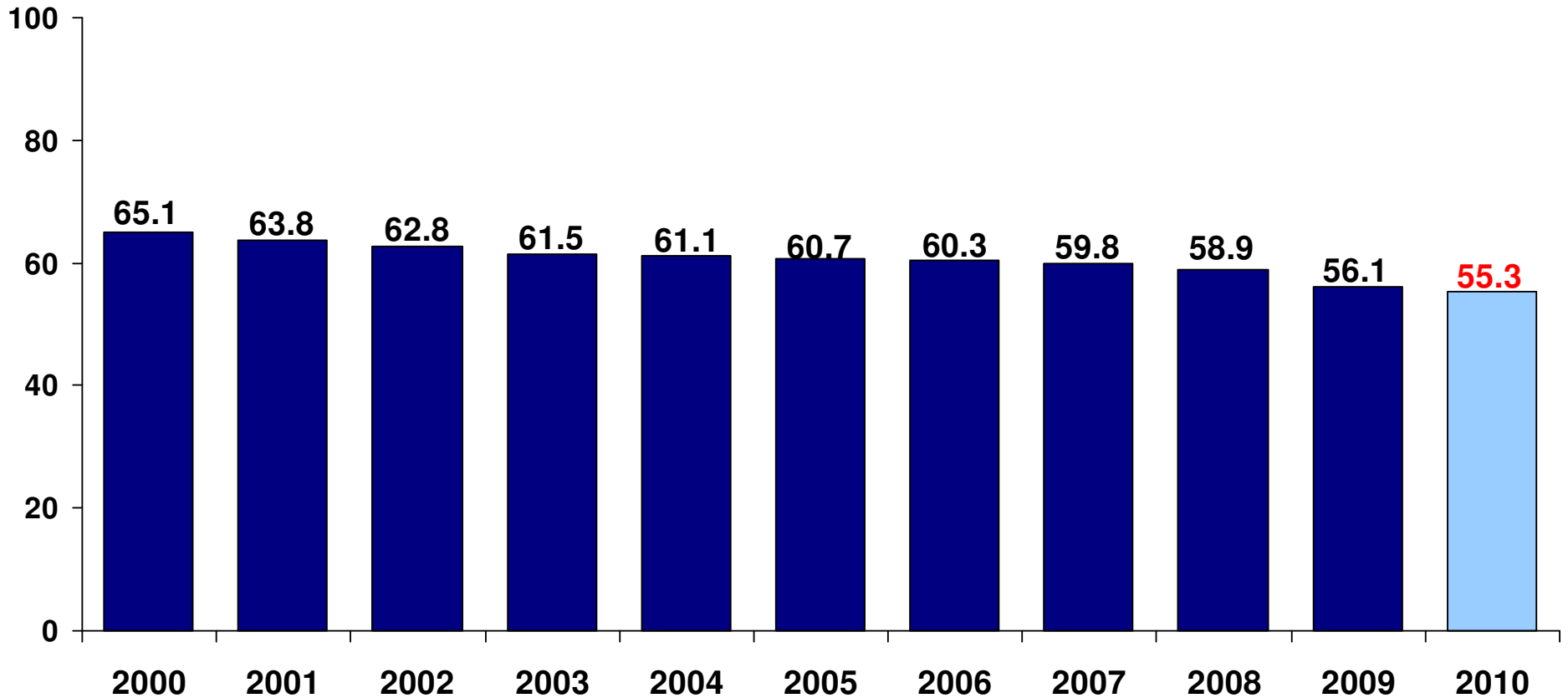


Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. United States Census Bureau, September 2011.



The Percent of People with Employment Based Insurance Continued to Decline in 2010

Percent of population covered by employment based insurance



Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. United States Census Bureau, September 2011.



Nearly Three of Five Adults Who Lost a Job with Health Benefits in the Past Two Years Became Uninsured

Percent of adults ages 19–64 who lost their job with employer-based benefits*

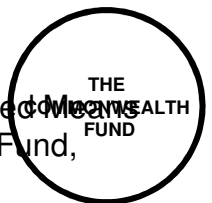
	Total [^]	<200% FPL	200% FPL or more	White	Black or Hispanic
Respondent lost job in past 2 years	18% 33 million	28% 20 million	11% 10 million	15% 18 million	25% 13 million
Respondent had insurance through job that was lost	46% 15 million	36% 7 million	69% 7 million	53% 10 million	41% 5 million
What happened when you lost your employer-based health insurance?					
Became uninsured	57	70	42	49	73
Went on spouse's insurance or found insurance through other source	25	22	29	27	21
Continued job-based coverage through COBRA	14	8	21	19	5

Note: FPL refers to Federal Poverty Level.

* Job lost in the past two years.

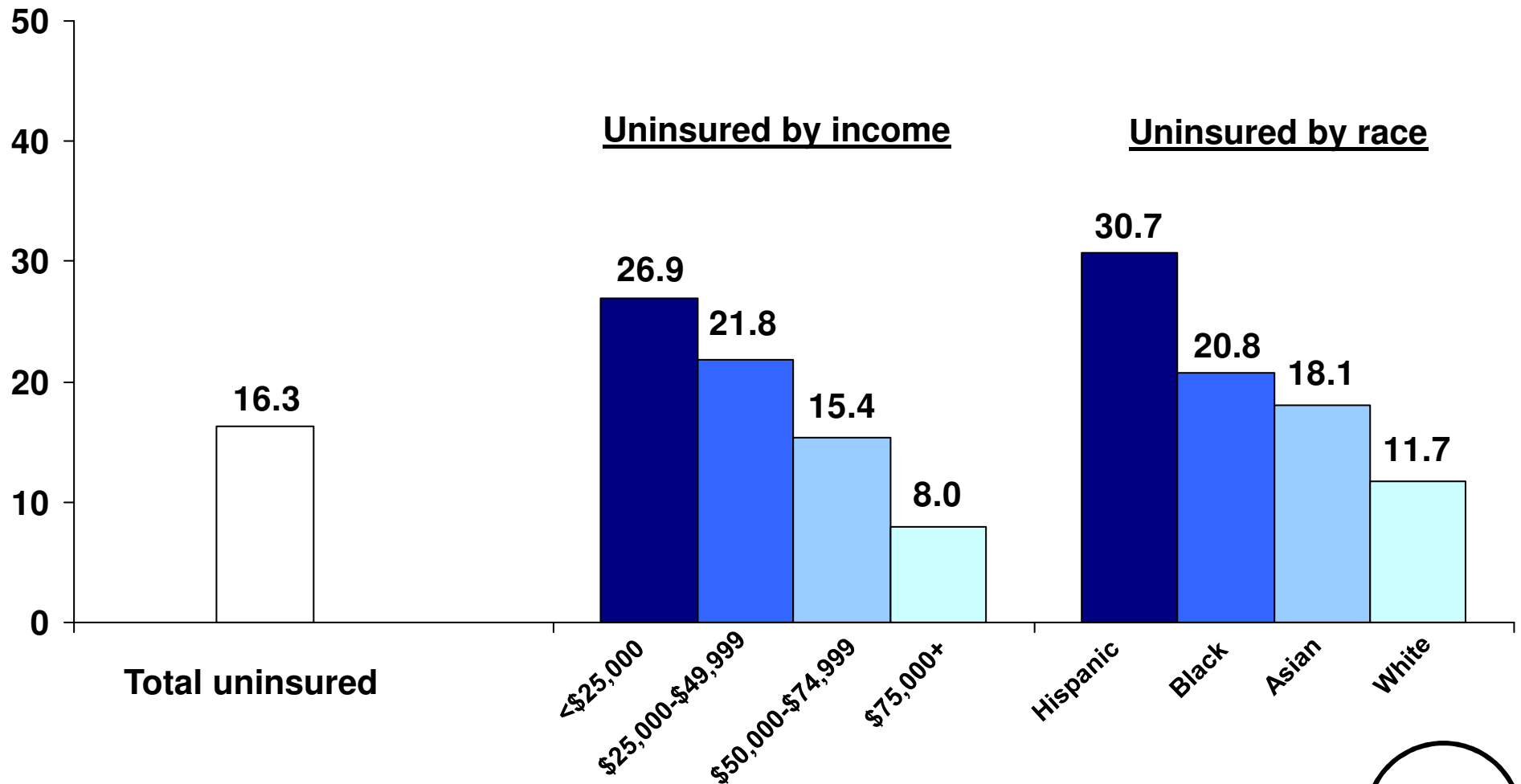
[^] Includes respondents who did not state their income level.

Source: M. M. Doty, S. R. Collins, R. Robertson, and T. Garber, Realizing Health Reform's Potential—When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help, The Commonwealth Fund, August 2011.



People with Low Incomes and Minorities Have Highest Uninsured Rates,⁵ 2010

Percent of population uninsured, by income and race

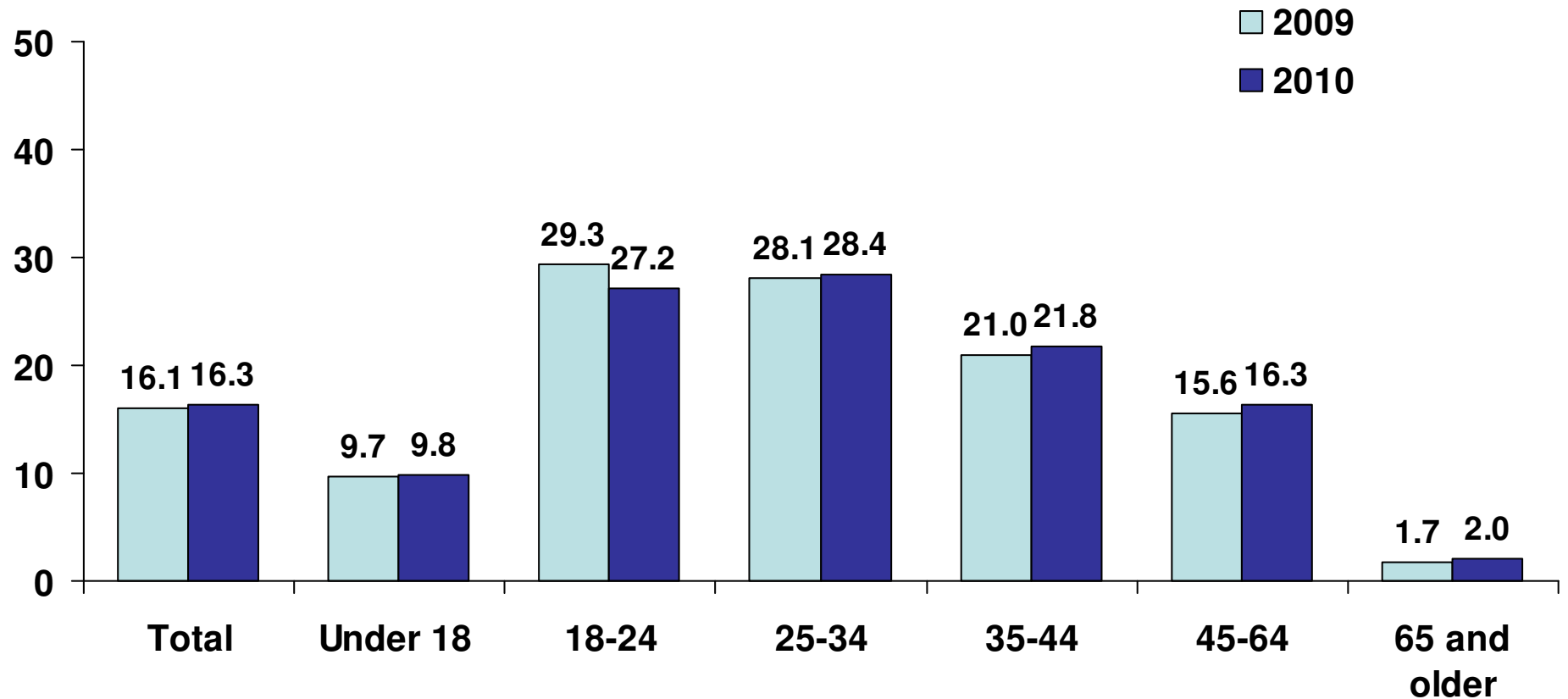


Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. United States Census Bureau, September 2011.



Young Adults Saw a Decrease in the Percent Uninsured in 2010

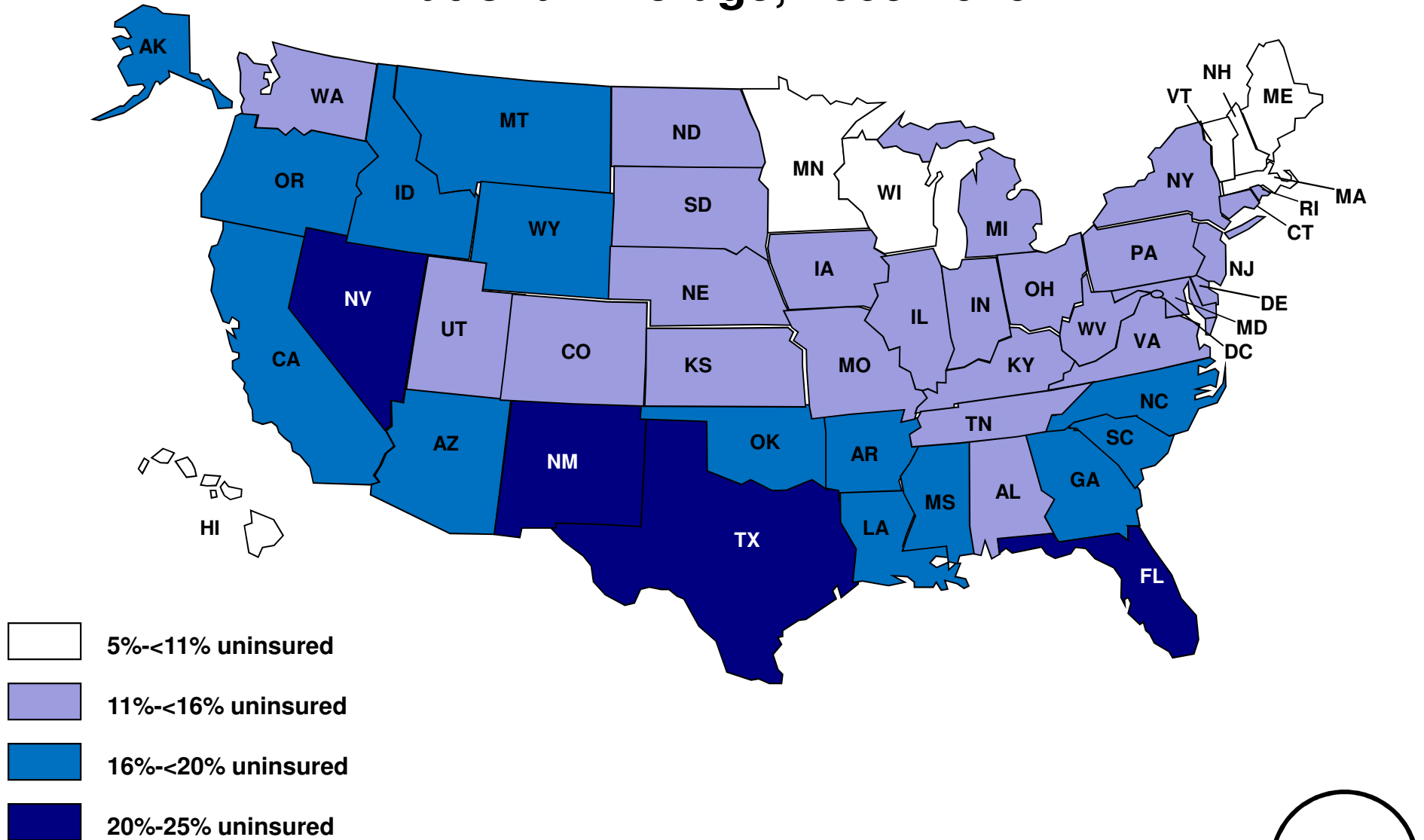
Percent of individuals who are uninsured, by age group



Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. United States Census Bureau, September 2011.



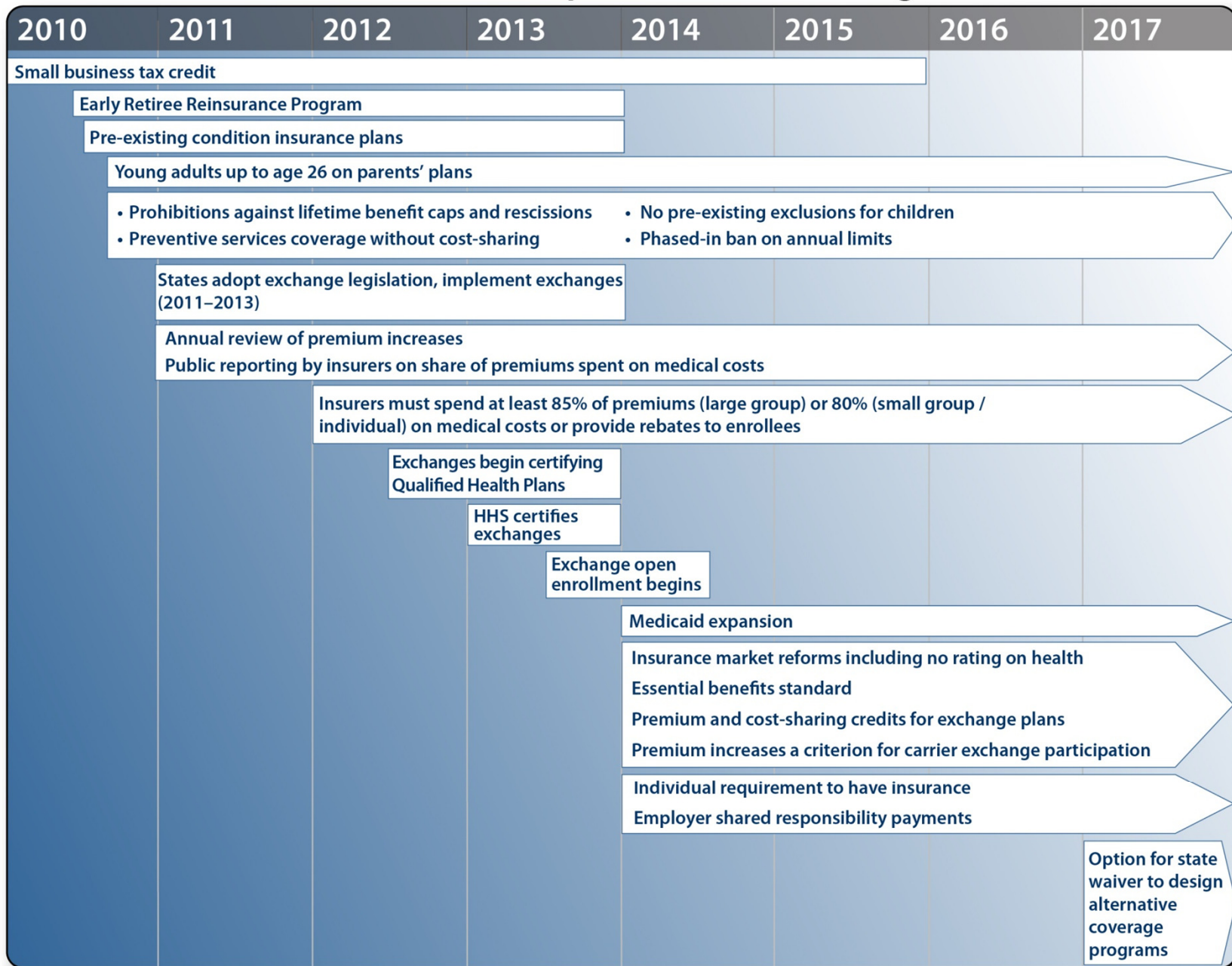
Eighteen States have Higher Rates of Uninsured than the National Average, 2009-2010



Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. United States Census Bureau, September 2011, percentages are two year averages 2009-2010; national average is 16.2% over the two-year period.



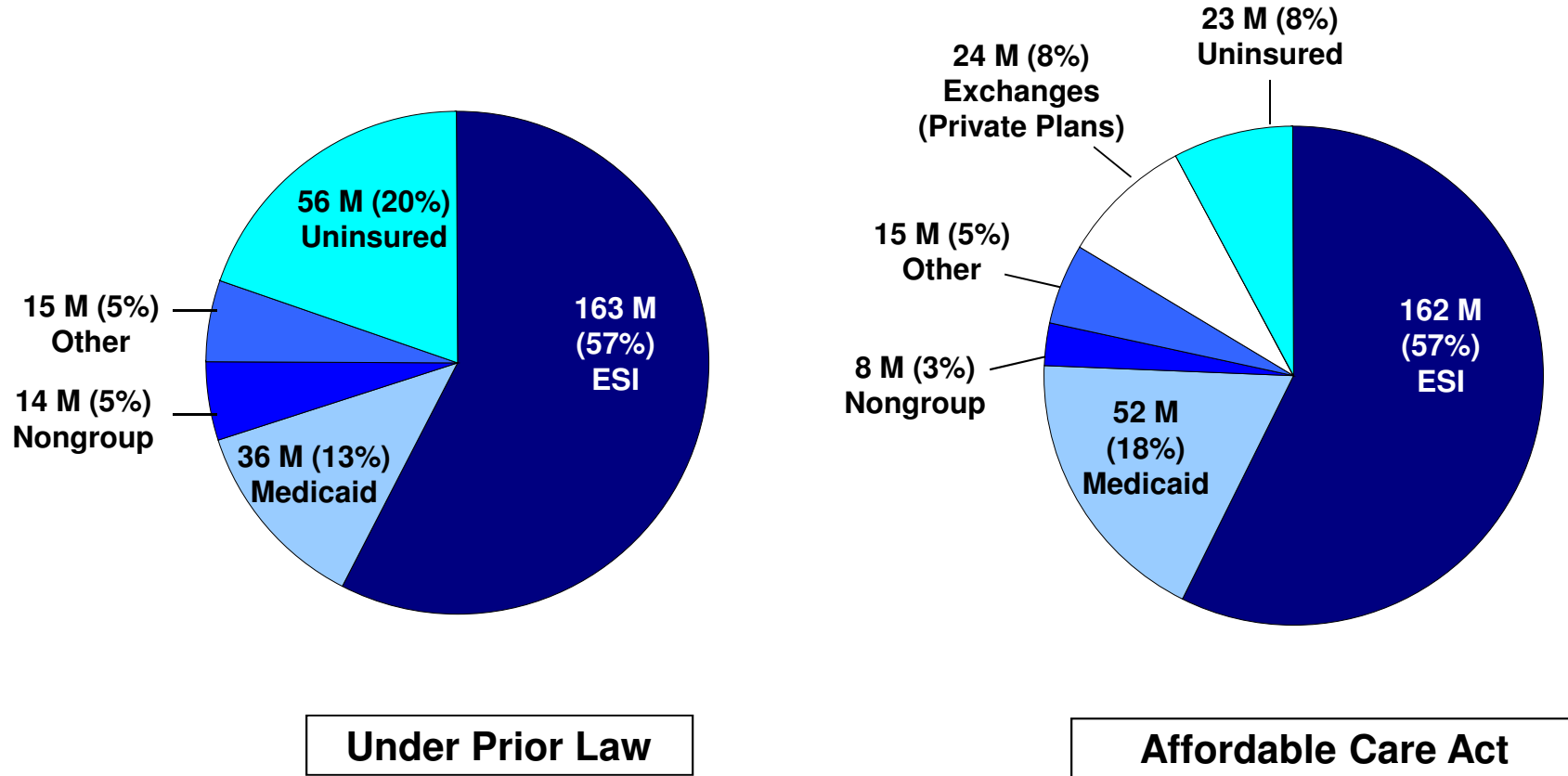
Timeline for Health Reform Implementation: Coverage Provisions



Source: National Association of Insurance Commissioners; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), <http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx>.



Source of Insurance Coverage Pre-Reform and Under Affordable Care Act, 2020

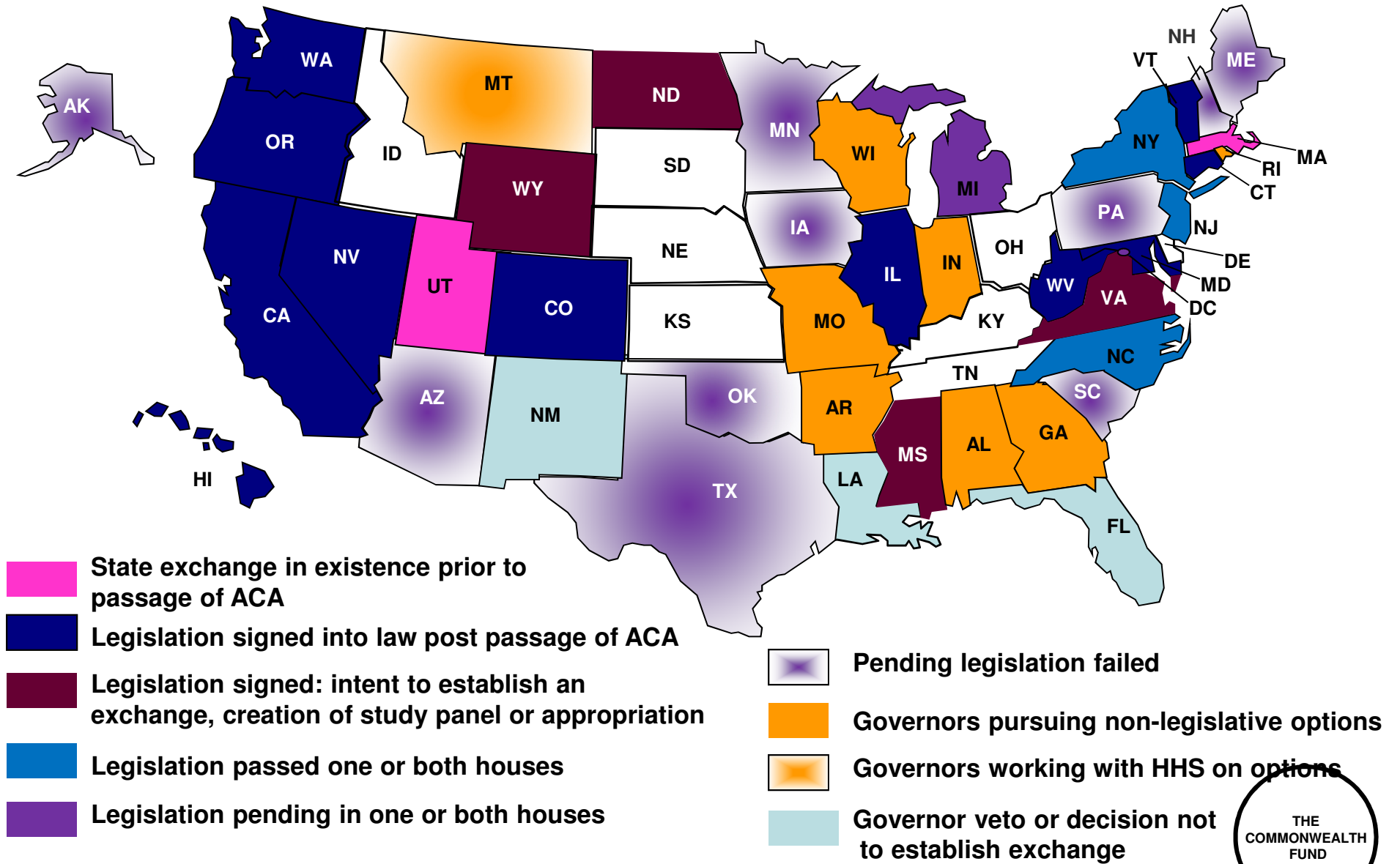


Among 284 million people under age 65

* Employees whose employers provide coverage through the exchange are shown as covered by their employers. Note: ESI is employer-sponsored insurance; "Other" includes Medicare.
 Source: Testimony Statement of Douglas W. Elmendorf, Director, before the Subcommittee on Health Committee on Energy and Commerce U.S. House of Representatives, CBO's Analysis of the Major Health Care Legislation Enacted in March 2010, March 30, 2011.
<http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>



Status of State Legislation to Establish Exchanges, As of October 2011



Source: National Conference of State Legislatures, Federal Health Reform: State Legislative Tracking Database.
<http://www.ncsl.org/default.aspx?TabId=22122>; Politico.com; Commonwealth Fund Analysis.



Insurance Affordability Programs Offered Through Exchanges¹¹

- **Medicaid for individuals with incomes under 133 percent of poverty**
- **CHIP for children with incomes over 133 percent of poverty to state ceiling**
- **Basic Health Program for individuals between 133% and 200% FPL (at state option)**
- **Premium tax credits and cost-sharing tax credits for qualified health plans (QHPs) for individuals with incomes to 400% FPL**



Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

FPL	Income	Premium contribution as a share of income	Out of Pocket limits	Actuarial value: Silver plan
<133%	S: <\$14,484 F: <\$29,726	2% (or Medicaid)	S: \$1,983 F: \$3,967	94%
133%- 149%	S: \$16,335 F: \$33,525	3.0%–4.0%		94%
150%–199%	S: \$21,780 F: \$44,700	4.0%–6.3%		87%
200%–249%	S: \$27,225 F: \$55,875	6.3%–8.05%	S: \$2,975 F: \$5,950	73%
250%–299%	S: \$32,670 F: \$67,050	8.05%–9.5%		70%
300%–399%	S: \$43,560 F: \$89,400	9.5%	S: \$3,967 F: \$7,933	70%
≥400%	S: ≥\$43,560 F: ≥\$89,400	—	S: \$5,950 F: \$11,900	—

Four levels of cost-sharing: 1st tier (Bronze) actuarial value: 60%
 2nd tier (Silver) actuarial value: 70%
 3rd tier (Gold) actuarial value: 80%
 4th tier (Platinum) actuarial value: 90%

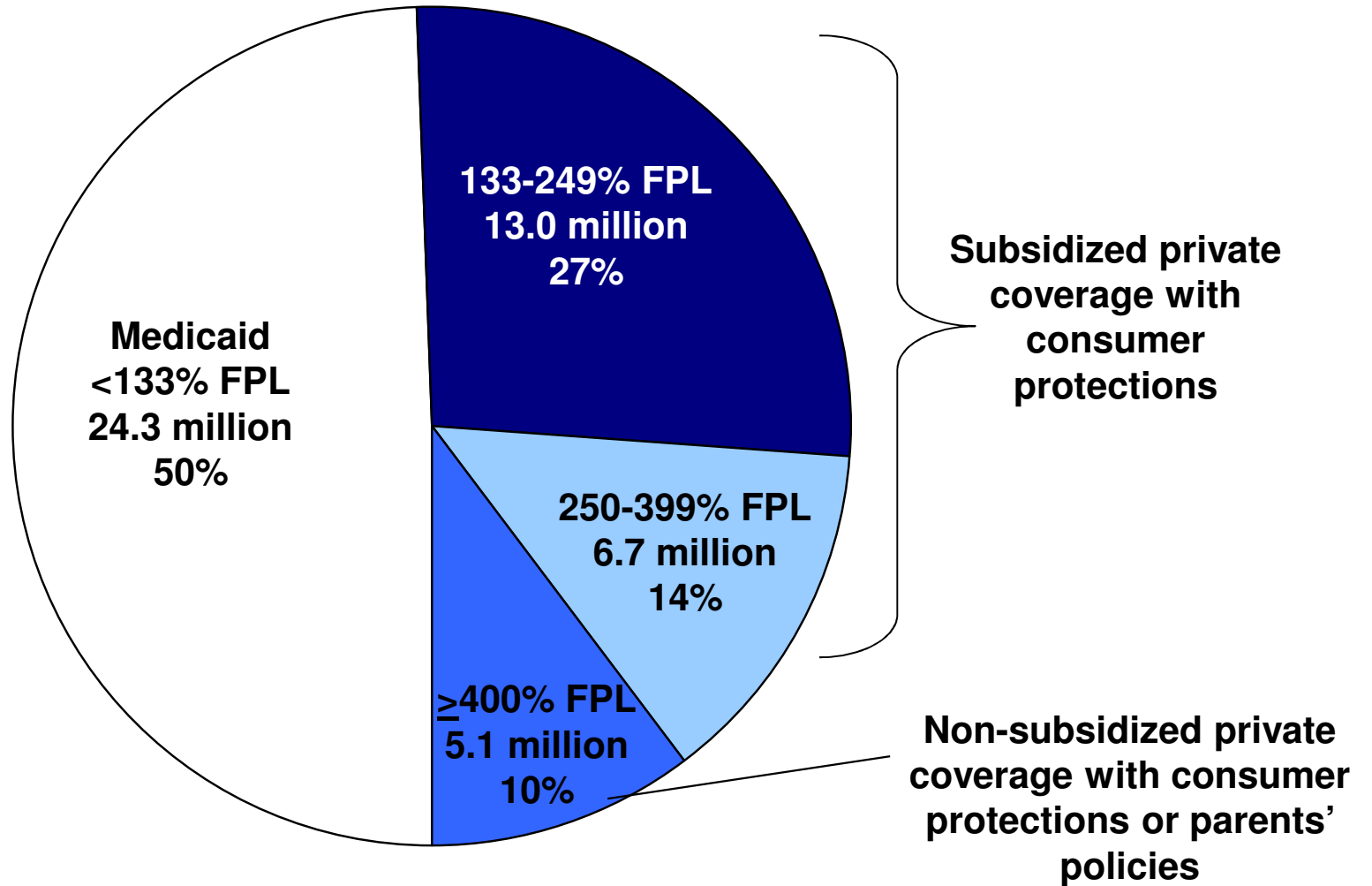
Catastrophic policy with essential benefits package available to young adults and people who cannot find plan premium ≤8% of income

Note: FPL refers to Federal Poverty Level. Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan.

Source: Federal poverty levels are for 2011; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), <http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx>.



Distribution of Uninsured Non-elderly Individuals in 2010, by Income Level and Provisions of the Affordable Care Act



49.1 million uninsured individuals, ages 0-64

Note: FPL refers to Federal Poverty Level

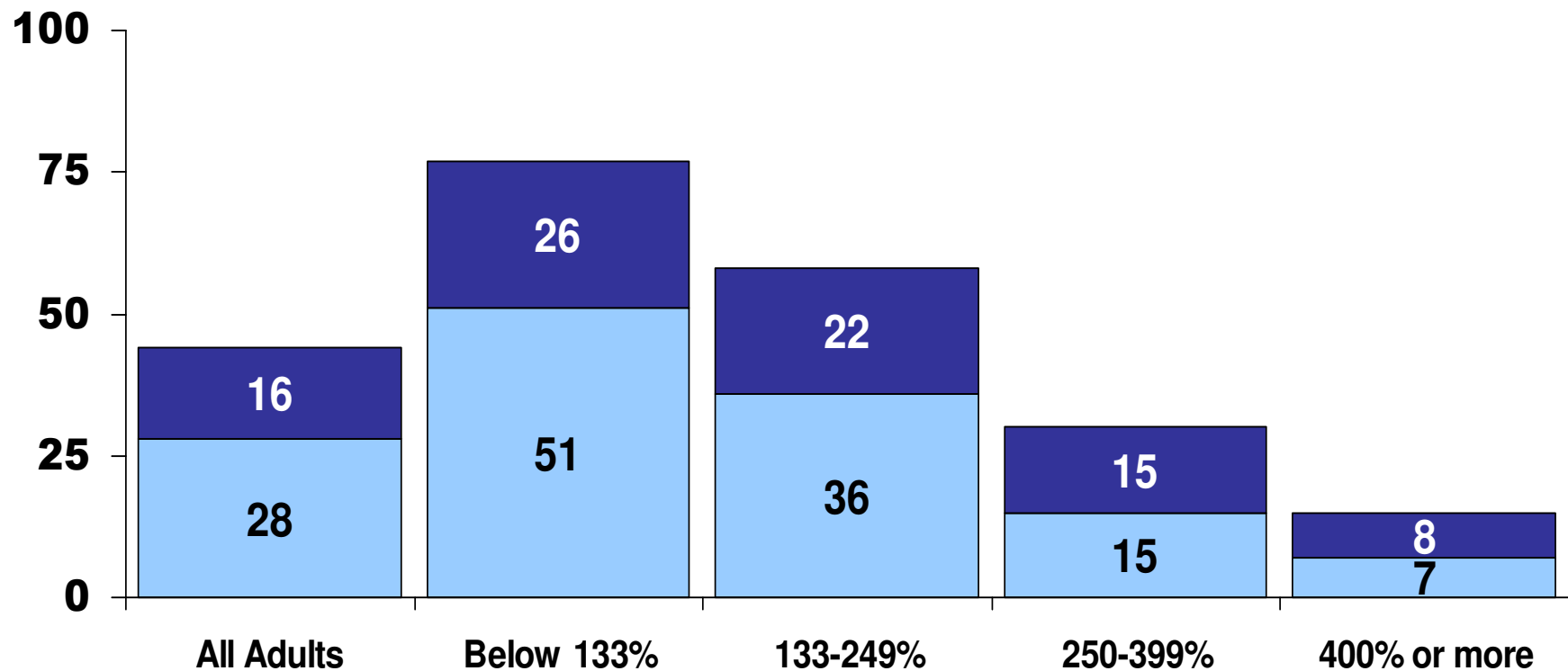
Source: Analysis of the March 2011 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund;



Underinsured and Uninsured Adults, By Poverty Group 2010

Percent of adults (ages 19–64) who are uninsured or underinsured

■ Uninsured during year ■ Underinsured



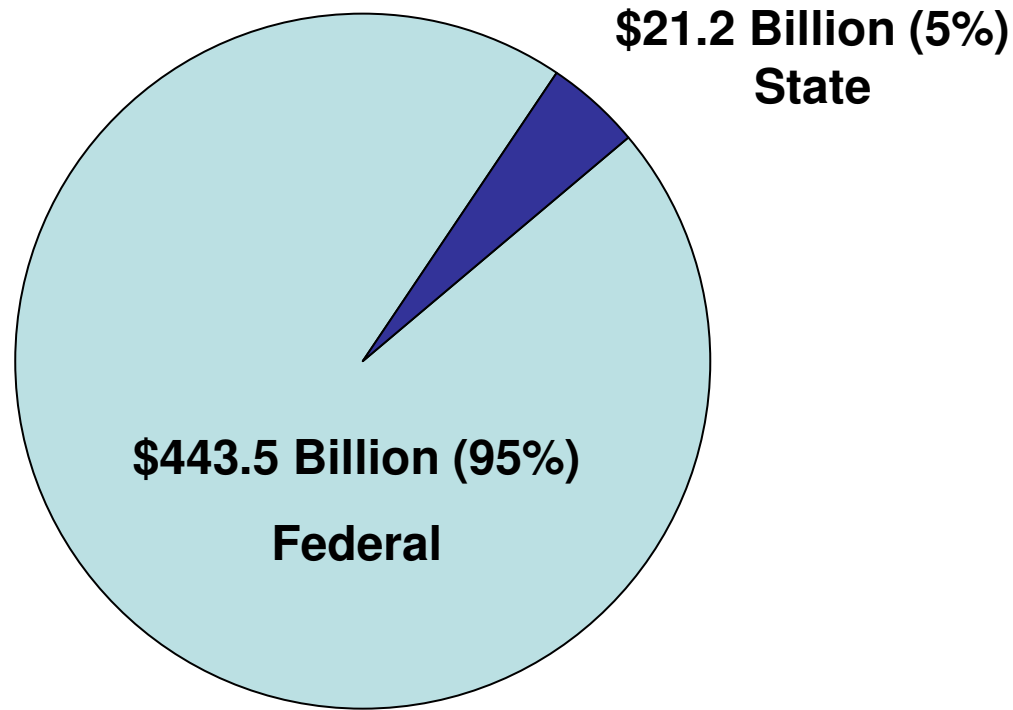
Source: C. Schoen, M. Doty, R. Robertson, S. Collins, Affordable Care Act Reforms Could Reduce the Number Underinsured by 70 percent. *Health Affairs* Sept, 2008. Data: 2003 and 2010 Commonwealth Fund Biennial Health Insurance Surveys

Medicaid Expansion

- **Income eligibility for Medicaid is expanded to adults to 133 percent of poverty, or \$29,726 for a family of four, \$14,484 for an individual**
- **Those newly eligible would receive “benchmark” benefit package that states can currently provide to some populations as an alternative to mandatory benefits under traditional Medicaid. Benchmark coverage must include the new essential health benefits package to be determined by HHS**
- **Provides federal Medicaid matching payments for newly eligible enrollees in all states except "expansion states" that have already expanded Medicaid to both parents and non-pregnant childless adults to 100 percent of poverty before December 1, 2009:**
 - **100 percent in 2014, 2015, and 2016;**
 - **95 percent in 2017;**
 - **94 percent in 2018;**
 - **93 percent in 2019;**
 - **90 percent thereafter.**
- **Expansion states will receive additional federal financial assistance that will phase-in over 2014-2019 according to a formula such that in 2019 and later, expansion states will receive the same level of federal matching for this population as other states.**



Changes in Spending from Medicaid Expansion Under the Affordable Care Act, 2014-2019

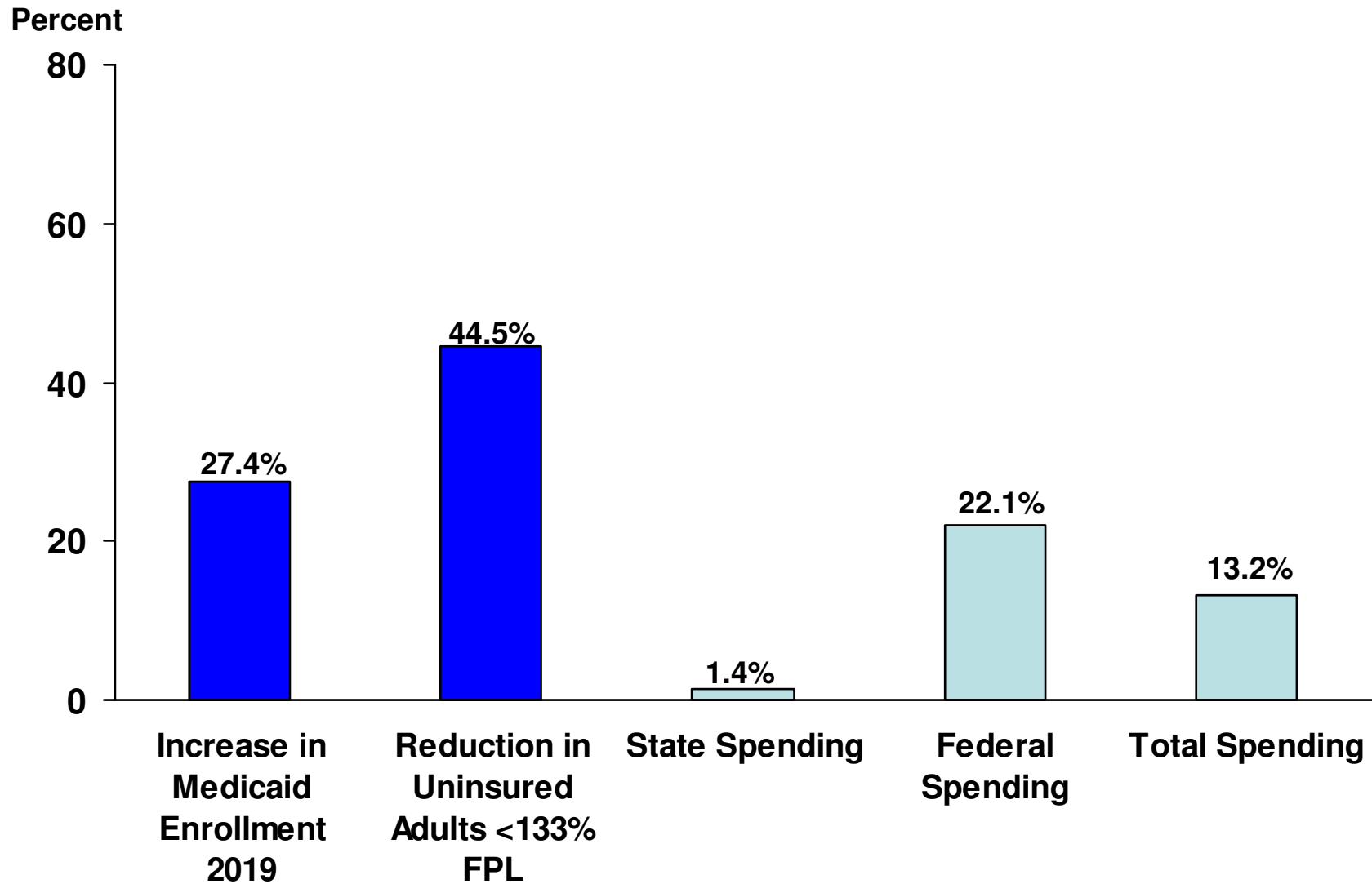


Total Change in Medicaid Spending
\$464.7 Billion

Source: J Holahan, I Headen. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. May 2010. Kaiser Family Foundation. *Projections based a 57% participation rate among newly eligible uninsured and lower rates across other coverage groups. Scenario assumes moderate levels of participation similar to current experience among those newly eligible and little additional participation among currently eligible individuals.



Estimated Change in Medicaid Enrollment, Uninsured Adults <133% FPL¹⁷ and Spending Over 2014-2019 as a Result of ACA Medicaid Expansion*



*Projections based on a 57% participation rate among newly eligible uninsured and lower rates across other coverage groups. Scenario assumes moderate levels of participation similar to current experience among those newly eligible and little additional participation among currently eligible individuals.

Source: J. Holahan, I. Headen, Medicaid Coverage and Spending in Health Reform. Kaiser Family Foundation. May 2010.



Medicaid Eligibility

- **Law creates new adult Medicaid eligibility category up to 133% FPL**
- **Children eligible at higher income categories in Medicaid and CHIP depending on standards in state**
- **Simplifies eligibility determinations by relying on MAGI for children and non-disabled adults; income disregards are replaced with a 5% across the board adjustment effectively increasing eligibility standard to 138%FPL**
- **Collapses current eligibility categories into four primary groups: children, pregnant women, parents, and the new adult group. Pregnant women: 6 current categories are collapsed into one.**
- **States may enroll people in new simple categories without first screening for other eligibility categories (e.g. disability)**
- **New federal funding for Medicaid adult expansion**
 - **Flexibility for states: rather than require states to track who was eligible before and after expansion, allows use of “proxy” rules for who is newly eligible, statistical sampling, or empirically based estimates of the share of spending associated with newly eligible enrollees.**

Source: DHHS, Proposed rule, Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010, August 12, 2011; T. Jost, Implementing Health Reform: Medicaid and Exchange Eligibility Determinations, Health Affairs Blog, August 13, 2011, <http://healthaffairs/blog>.

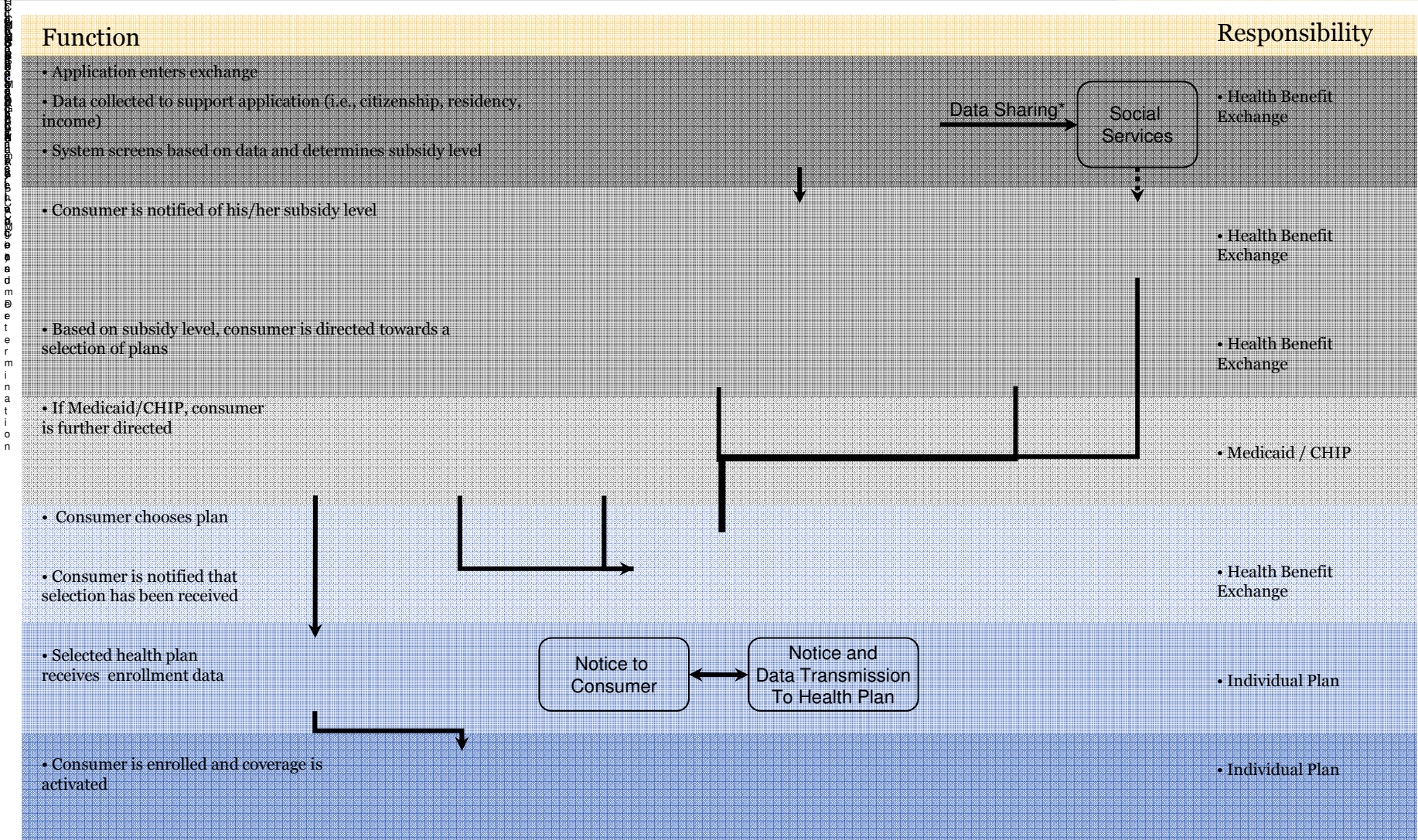


State Exchanges: Central Role in Eligibility Determinations

- **New proposed HHS rule interprets ACA as providing for “establishment of a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for insurance affordability programs and receive a determination of eligibility through any such program.”**
- **One application for all insurance affordability programs**
- **ACA requires simplification of Medicaid and CHIP eligibility policy and rules by using MAGI as basis for determining income eligibility**
- **Two differences in eligibility for Medicaid/CHIP vs. premium tax credits:**
 - **Medicaid/CHIP based on current income; tax credits on annual income**
 - **Premium tax credits paid in advance with reconciliation against tax return in year tax credit is applicable**
- **Exchanges determine eligibility for exchange participation and premium tax credits, based on federally supplied information; applicants can opt to bypass tax credit eligibility or request a smaller advance tax credit**
- **The law does not permit Medicaid programs to make coverage determinations for exchanges but the exchanges can contract with Medicaid for this purpose**
- **For exchanges to make Medicaid eligibility determinations, they must be public entities or have Medicaid workers on site.**

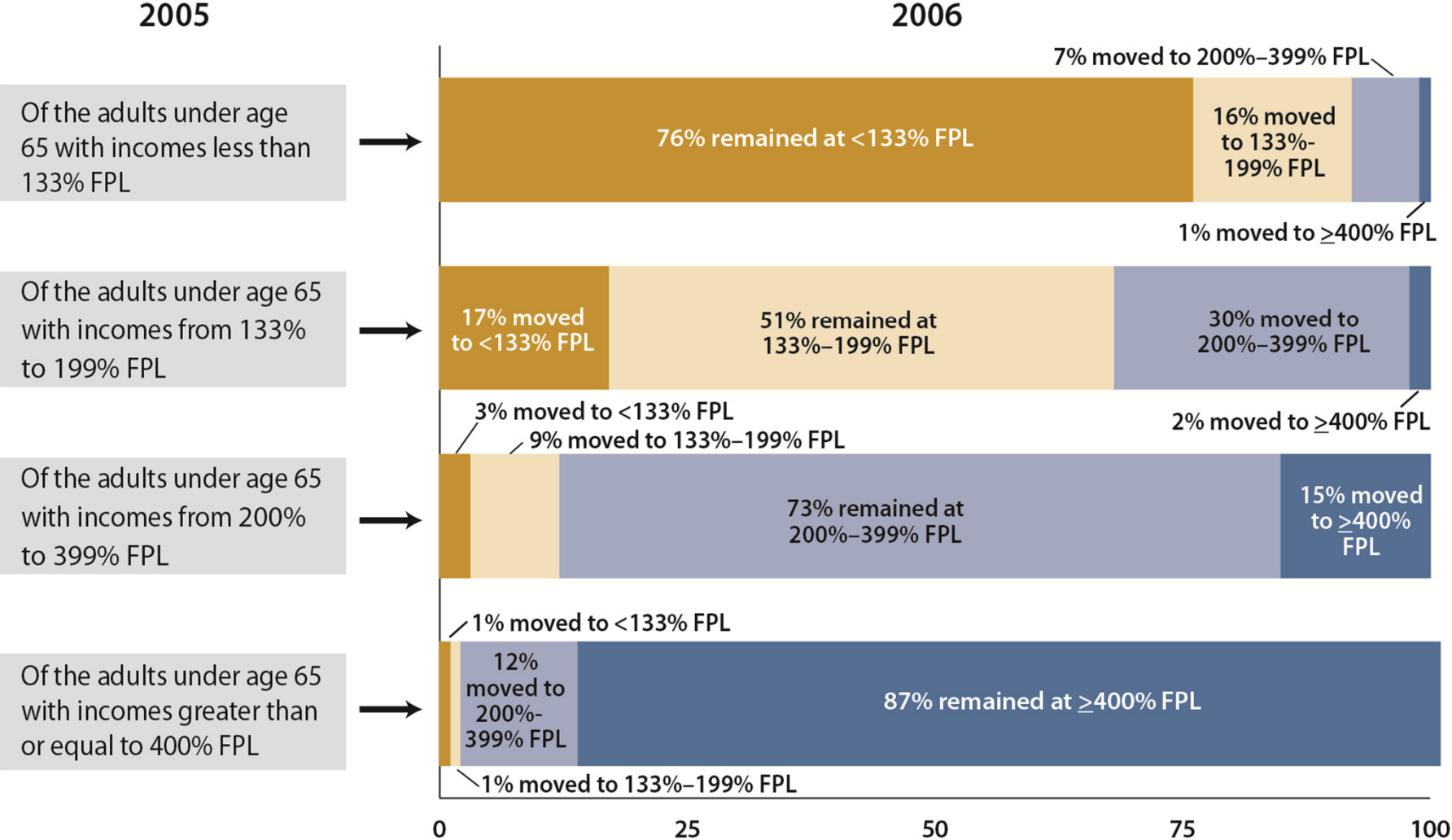


Continuity in Eligibility & Enrollment



* Data sharing for the purposes of determining eligibility for additional benefits.

Changes in Family Income, U.S. Population Under Age 65, 2005 to 2006²¹



Note: FPL = Federal poverty level.

Source: P.F. Short, K. Swartz, N. Uberoi et al., *Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change*, The Commonwealth Fund, May 2011.

Key State Implementation Issues: Basic Health Program (BHP) Option

- **Eligibility for BHP: people with incomes between 133% and 200% of FPL who would otherwise be eligible for premium tax credits through exchange**
- **Lawful immigrants with incomes < 133% of FPL who are not eligible for Medicaid**
- **States receive 95% of federal premium tax credits and cost-sharing credits**
- **Benefit plan must meet essential benefit package requirements**
- **Premiums paid by enrollees cannot exceed what they would have paid through exchange; cost-sharing requirements cannot exceed those for platinum plan for <150% of FPL or gold plan for all other enrollees**
- **State will create a competitive contracting process for health plans including negotiating premiums with plans and other plan designs such as incentives for care coordination**
- **Participating plans must maintain a medical loss ratio (percent of premium spent on medical care) of 85%**
- **BHP eligible individuals in states will not be eligible for tax credits in exchanges**



Key State Implementation Issues: Integrating Medicaid and Exchanges

- **Enrollment into Medicaid and CHIP in exchange vs. separate process:**
 - **Placing Medicaid and CHIP enrollment in exchange would lower administrative costs and improve continuity of coverage**
 - **Integration facilitates outreach and education, aids comparison shopping, especially in states with Medicaid/CHIP managed care plans**
 - **Eases transition between plans when income changes**
 - **Consider year long coverage periods for Medicaid/CHIP and sync with QHP open enrollment periods.**
- **Broad access to the same health plans and/or provider networks through Medicaid, the individual exchanges, small business (SHOP) exchanges**
 - **States might consider whether some or all qualified health plans in exchange should be required to offer full range of subsidized products**
 - **States might consider aligning QHP requirements with Medicaid managed care plans**
 - **California Health Benefit Exchange allows Medicaid managed care plans to participate in exchange**
 - **Merge individual /SHOP exchanges to smooth coverage transitions**
 - **Consider single risk adjustment program across all coverage options**

Key State Implementation Issues: Integrating Medicaid and Exchanges

- **States will need to consider where Medicaid fits in the administration of state exchanges**
 - **Integration of Medicaid and exchanges has potential to lower Medicaid costs through economies of scale across multiple payers in eligibility and enrollment systems, consumer outreach and education, health plan oversight, and administrative infrastructure**
 - **States might consider how best to use the expertise of Medicaid and insurance departments; which of the current functions of each agency should be consolidated in exchange**
 - **Consolidating Medicaid functions in the exchange would allow federal matching dollars to be available to help finance exchange functions**



Acknowledgements and Resources



Tracy Garber

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for timely analyses of health care reform
issues and emerging federal regulations
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