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Optional Medicaid Expansion



The ACA expands Medicaid to adults aged 19–64 with incomes at or below 138% FPL



States will receive 100% FMAP rates for the newly eligible population from 2014 through 2016

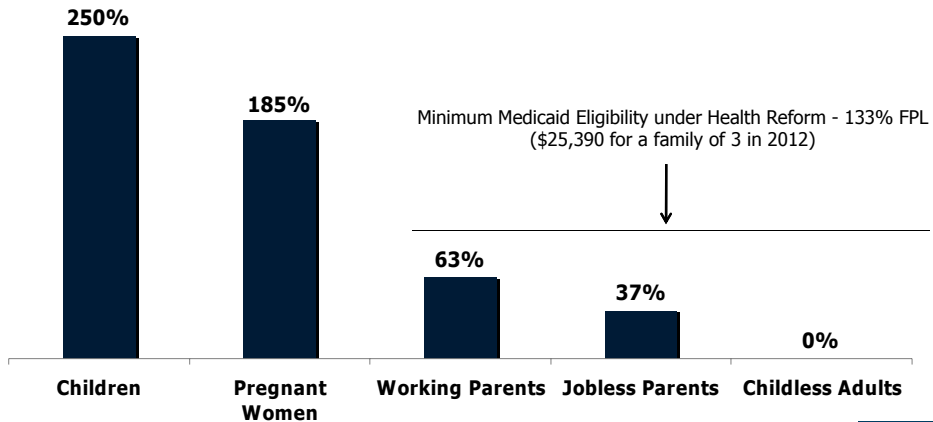
Declines and stays at 90 % FPL

FMAP rates decline gradually, reaching 90 percent in 2020.



Supreme Court did not change the Medicaid provision, but effectively allows states to opt out.

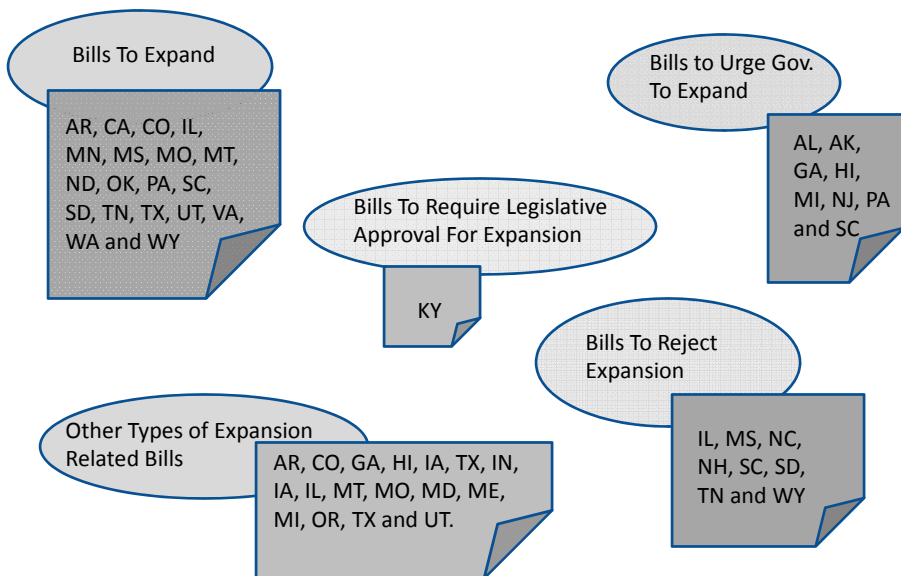
Median Medicaid/CHIP Eligibility Thresholds, January 2012



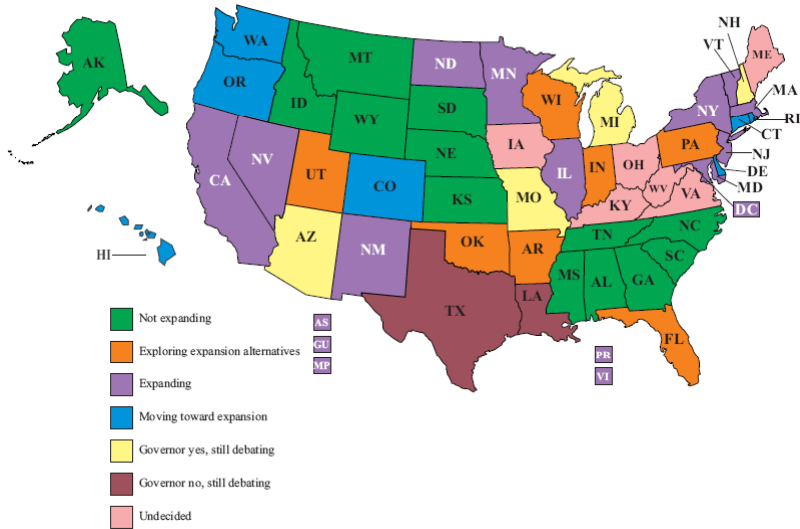
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.



Medicaid Expansion, Bills So Far



Medicaid Expansion Activity



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Premium Assistance

Exists for current Medicaid beneficiaries (mostly employer-based)

Must be cost effective and provide wrap-around services

HHS will consider approving a *limited* number of premium assistance demonstrations for the ACA expansion pop.



Premium Assistance: History

- Section 1906 Health Insurance Premium Payment (HIPP) Programs
- Section 1905(a) Premium Payment Option (Individual market)
- CHIP Family Coverage Option
- 1115 Waiver Authority
- New CHIPRA Premium Assistance Options in Medicaid and CHIP



State Experience

- 29 states operate Section 1906 HIPP programs.
- 16 states have 1115 waiver programs
- 6 states operate 1905(a) programs
- 5 states adopted the new Medicaid premium assistance from CHIPRA.
- 1 state adopted the new CHIP option from CHIPRA.



Overview of Existing Programs

- Small relative to total enrollment.
- Estimated spending on premium assistance program enrollees is 1% of total Medicaid spending.
- Relatively little experience with purchasing individual market coverage.
- Limited access to ESI among low-income individuals covered by Medicaid and CHIP.



Cost effectiveness to date

- States must establish that the cost of covering an individual through premium assistance is the same or less than covering the individual in the direct Medicaid or CHIP programs.
- A robust employer contribution and targeting high cost enrollees (pregnant women and children with disabilities) are often features of a cost effective program.
- The higher the income eligibility level, the more likely premium assistance is to be cost effective because a greater number of beneficiaries will have access to ESI.



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ACA Influence on Premium Assistance

- ACA Medicaid expansion and the creation of the exchange has increased interest in premium assistance.
- Potential to reduce churning between Medicaid and exchange.



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Premium Assistance Guidance for States

Will require 1115
demonstration
waiver

Must provide
choice: at least 2
QHPs

Wrap around
benefits

Only for the new
Medicaid adult
group

Encourage states
to target adults
110 to 133 % FPL

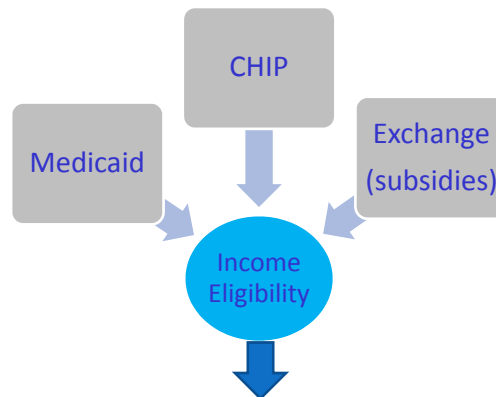
Will consider new
factors for cost
effectiveness



Arkansas SB 1020/Act 1497

- Health Care Independence Act of 2013
- Private insurance option for “low-risk” adults.
- Medicaid will pay premiums and supplemental cost sharing subsidies to the QHP in the Exchange for Medicaid eligible individuals.
- Dept of Human Services will create plan and seek necessary waivers from CMS.
- Provision to test a pilot program for health savings accounts or medical savings accounts during 2015.
- Other states interested in premium assistance: Ohio, Florida, Utah, Pennsylvania and others

Medicaid and Exchange Churning



Family income or job status changes
will change coverage plans.



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NCSL Resources

Health Reform home page:

<http://www.ncsl.org/?TabID=160>

State legislation database:

<http://www.ncsl.org/?TabId=22122>

Health Reform State Action newsletter:

<http://www.ncsl.org/default.aspx?TabId=22281>

Health Reform two-page briefs:

<http://www.ncsl.org/default.aspx?tabid=19023>

Cost Containment Briefs:

<http://www.ncsl.org/default.aspx?tabid=19200>



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Questions?

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