Article from

The ACA@5

August 2015
Issue 1

Medicaid and the ACA

By Rebecca Owen

The Patient Protection and Affordable Care Act (ACA) changed Medicaid in ways that made front-page news, but there were also more subtle effects that, while unheralded, made a difference to all people involved in the program. Medicaid actuaries found themselves not in a niche practice, but front and center as the membership grew rapidly. Here are some brief highlights—more information on the specifics of the legislation as it pertains to Medicaid is available at *Medicaid.gov*.

THE BIG DEAL—MEDICAID EXPANSION

The original version of the bill expanded coverage to people whose income was at or below 138 percent of the federal poverty level. As with all complicated programs, this statement glosses over other eligibility nuances, but this summarizes the largest change. This expansion meant that many adults who were not previously able to qualify for Medicaid would be eligible for coverage. States that expanded Medicaid would receive federal matching funds that started out at 100 percent in 2014 and declined gradually to 90 percent by 2020.

On June 28, 2012, the U.S. Supreme Court issued a decision that while the individual mandate could be upheld, each state would decide whether or not to expand Medicaid. Immediately after the ruling some states made decisions to expand and some did not. For other states it was not an easy decision, with legislative bodies and governors frequently at odds. Several states used alternative methods of expanding, creating plans that required some sort of cost share or premium. As of the writing of this article, 29 states, including the District of Columbia, have chosen to expand; 16 states have not. After three years, the expansion question is still being discussed in six states.

One of the consequences of states not expanding Medicaid was that childless adults whose income fell below 100 percent of poverty remained ineligible for coverage, and because the original bill envisaged that these people would be in Medicaid, there was no provision for financial assistance for them from ACA exchange plans.

Using expanded income criteria for Medicaid eligibility means that there will be a need to interface between the exchanges and Medicaid that is more seamless than ever before. The bill earmarked federal funds to streamline the enrollment process for members. Many members applied for exchange coverage only to discover they were eligible for Medicaid, and there were some creative solutions implemented to help beneficiaries end up with the best coverage, including things like a chat box, message or phone call when a person appeared to be a potential Medicaid beneficiary.

One interesting challenge arises with the incarcerated population. Many qualified for coverage by income standards, but were, at the time, the responsibility of the criminal justice system. Some agencies were quick

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to enroll this population—and the challenges of providing continuity of care for prisoners arrived at a time when care managers were stretched thin starting programs for existing members. This is not a population whose risk is well understood, so actuaries found it challenging to estimate costs.

Most of the states that expanded Medicaid began enrollment on Jan. 1, 2014, although some states availed themselves of an option to expand early to specific populations. The response was emphatic and startling. Members poured in, swamping member service lines and often creating long wait times for primary care and mental health services. Of the millions of people who obtained coverage due to the ACA, approximately 65 percent were Medicaid eligible. Some of these members were newly eligible because of the change in coverage rules, but others—the woodwork population— would have been previously eligible for Medicaid. Some states reached target enrollments years ahead of schedule, and this onrush was challenging for anyone trying to estimate financials associated with Medicaid.

MORE THAN EXPANSION

The ACA created the concept of a benchmark or a benchmark equivalent benefit for Medicaid expansion beneficiaries. While this did not eliminate large differences between state coverages, it tried to create a coherent connection between the exchange plans and Medicaid plans.

The ACA addressed a number of core elements of Medicaid programs in less visible ways. Quality of care is a focal point for the discussion of how the health system transforms and in particular how quality and performance measures for adults are developed and used. There was a temporary increase in payments to primary care physicians. Health Homes, particularly for chronic and expensive patients, are encouraged through enhanced funding. Community-based long-term care services and supports (LTSS) are a formidable component of Medicaid care, and the ACA facilitated the delivery of these services through better tools and funding improvements.

Understanding metrics on enrollment, cost and utilization, quality metrics, and population profiles has not been a seamless process. The ACA provides federal funding for better eligibility systems—in no small part due to the need for good coordination with the exchanges. Also this beefed up investigations and consequences for providers who engage in fraudulent behavior, as is evident in the increase in reports of investigations and convictions.

Portions of the ACA focused on specific populations, in particular on members who are Medicare-Medicaid enrollees. The ACA created a new office to work on ways to improve the coordination of care between the two payers, including better connections between service types that have typically not been connected, such as LTSS and acute care or behavioral health. Aligning care for these beneficiaries is important for actuaries to consider, not just because coordinated care is more efficient, but because it is much better for the beneficiaries.

THE ACTUARIAL ROLE

While the specifics in the bill can be summarized into a neat list, the way the ACA transformed the lives of those who work in the Medicaid space is less quantifiable. Certainly the expansion of Medicaid, particularly with the increased emphasis on managed Medicaid, meant there were many more opportunities for health actuaries to work on Medicaid projects. Since many of the programs and the covered populations were new, it was not an easy task to estimate how and to what extent members would use services. The increased emphasis on coordination of care, especially the expectations of successful management of care included in rate estimates, required actuaries to have a much clearer idea of the sorts of programs that successfully reduced costs—and the size of these reductions. Demonstration projects, such as those focused on dual integration, brought together work groups from other disciplines. This was a great way to learn more than could be taught from mere data extracts. ■

Rebecca Owen is the health research actuary at the Society of Actuaries in Schaumburg, Illinois. She can be reached at *rowen@soa.org.*