

IN THE PUBLIC INTEREST

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AN SOA PROJECT ON COMMUNICATING THE FINANCIAL HEALTH OF PUBLIC PENSION PLANS

By Sandy Mackenzie

The financial position of many state and local pension plans has deteriorated over the past decade. Public plans typically hold 50 percent or more of their assets in equities; some of this deterioration reflects the effect of the 2008-2009 stock market collapse on the value of the assets of public plans. This decline has by now been reversed. Nonetheless, many state and local plans are still substantially underfunded. The data collected by the Public Fund Survey as of mid- to end-2013, is based on the estimates of state plans, which typically assume a discount rate of 7.5 to 8.0 percent. This survey finds that about one-in-five plans, including some of the country's largest, is estimated to have funding (asset to liability) ratios below 60 percent.^{1,2}

Because of the concerns of many stakeholders over the finances of public pension plans, the Society of Actuaries (SOA) Social Insurance and Public Finance Section (SI&PF) commissioned a research project in July 2012 titled, "Communicating the Financial Health of Public Pension Plans," hereafter referred to as the Project. The Project's premise was that the financial health of public pension plans was not being clearly communicated to key stakeholders. The Project's researcher was Sandy Mackenzie, the author of this article.

A great deal of information is available on public pension plans, but that information typically is not presented in a user-friendly way. Summary documents vary in quality and often do not give a clear and comprehensive picture of a plan's financial operations or basic structure. A noticeable improvement in communication could increase the chances of a successful resolution of the financial problems of underfunded plans and reduce the

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LETTER FROM THE EDITOR

By Jeffery M. Rykhus

The current issue of *In The Public Interest* is a short synopsis of what is going on in our section today, with some significant holes. We haven't recently published any articles on Social Security, other than Bruce Schobel's factual treatment of the annual changes to Social Security published in the Jan. 2014 issue, and his summary of the annual Social Security Trustee's Report. We certainly welcome more articles on Social Security. We also could benefit from more articles on public pensions. While our section covers some of the broadest areas of any section, it is difficult to publish something from Medicare, Medicaid, health care reform subsidies, public pensions, and Social Security in every single issue. We also would like to include more international articles to compare social insurance programs in other countries to those in the United States.


In this issue we include an article by Sandy Mckenzie describing the research report "An SOA Project on Communicating the Financial Health of Public Pension Plans." This SI&PF-sponsored research was released in 2014 and has been the subject of a fair amount of debate and discussion given the subject matter. We expect this will continue to be a topic that engenders actuarial debate and hope that the discussion results in better understanding of the issues and, ultimately, in better-informed public policy. Sven Sinclair addresses this debate in his "Vice Chairperson's Corner" and shares his philosophical and practical outlook on the way actuaries should address the controversies that arise in our profession. Sven also describes the current activities of the section and the recent successful webcast on Social Security retirement benefit calculation.

R. Dale Hall also takes a philosophical look at the staid topic of mortality patterns among the oldest old. He suggests a practical way that people can use recent mortality data to better prepare themselves to fund retirement, using the Life Preparancy Age in his article "Mortality Age Patterns: Trends, Projections, and Life Preparancy," in the Living To 100 Section. In "Let's Talk: Interview With an Actuary in the Public Interest," John Bertko describes his career working toward universal health care coverage and on being a technical consultant for recent major health care programs such as Medicare Part D and the Affordable Care Act.

Finally, since Medicaid continues to be a lynchpin in expanding health care coverage to all, we have included two articles regarding the subject, “Medicaid Expansion: A Comparison of Two States Under Section 1115 Demonstration Waivers,” by Christopher T. Pettit and Robert M. Damler, and “Medicaid And the ACA,” by Robert M. Damler and Marlene T. Howard, a reprint courtesy of the American Academy of Actuaries. Thanks to Mr. Damler for providing a double whammy for this issue of *In The Public Interest*.

Sincerely,

Jeffery M. Rykhus

Editor, *In The Public Interest* 



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VICE CHAIRPERSON'S CORNER

By Sven Sinclair



Sven Sinclair, FSA, MAAA, is an economist with the Social Security Administration. He can be contacted at sven.sinclair@ssa.gov.

Social insurance includes a variety of programs and draws on the expertise of actuaries from almost every traditional discipline. General insurance actuaries have been involved in workers' compensation insurance for at least a century. In the United States, Social Security has been providing retirement benefits for almost eight decades and disability benefits for close to six decades. Medicare, the biggest social insurance health care program, celebrates its first half century this year. Similar (and, in the case of health, more comprehensive) programs rely on actuaries' work in Canada as well.


Besides social insurance, our section is, by its name and mission, also concerned with public finance. Actuarial expertise is required for such disparate publicly financed programs as Medicaid and public-sector employees' pension plans. One of the most enjoyable aspects of being involved in the Social Insurance and Public Finance Section's work is the opportunity to collaborate with actuaries of very diverse professional backgrounds. What this also means is that, no matter what your practice area is, you can be a valuable contributor to the section, if you are interested in it.

This March, we held another well-attended webinar on Social Security; this time, the topic was how to calculate your Social Security retirement benefits. More than 700 attendees and their numerous questions testify to the broad interest in this topic—not surprising since it is personally relevant for almost every individual working in the United States. We are planning another Social Security webinar for later this year, covering the state of the Disability Insurance program, which has a trust fund that is getting close to depletion and, thus, requires urgent Congressional action.

Our Health Subcommittee has been very active, and some of its efforts will come to fruition during the Health Meeting in June, where we will co-sponsor, along with the Long Term Care Insurance Section, a panel discussion about the role of the public sector in the financing and provision of Long-Term Care Services and Support (LTCSS). We will also celebrate Medicare's 50th birthday with a continental breakfast and a lively discussion.

In the area of public employee pension plans, last year we sponsored sessions at the Health Meeting in San Francisco and at the Annual Meeting in Orlando. We also published the SOA research paper titled "Report on Communicating the Financial Health of Public Pension Plans," available at the SOA website. Public pensions have recently been a "hot" topic both in the sense of heightened media attention devoted to some severely underfunded plans and in the sense of controversy within the actuarial profession.

Controversy can be a good thing, leading to discussion, problem solving, and advances in methods and practices. However, it can also be an obstacle when there are more than abstract principles at stake, including, potentially, the reputations of individuals and organizations. When there is a controversy, it is important to have open communication in which all sides are heard—and listened to. The goal should be to work toward an understanding of several interrelated, but distinct, questions: What, ideally, should the actuarial methods look like in a perfect world? What are the real-world constraints and how should they modify the answer to the previous question? And, if that answer differs from current practices, how do we get from here to there?

In resolving controversies, we should take care to benefit both the public and the actuarial profession. And we should keep in mind that serving the public well is also the best deal for the actuarial profession in the long run. 

chances of a relapse.

The premise of the Project's report—available on the SOA's website at <http://www.soa.org/Files/Research/Projects/2014-pension-research-report.pdf>—is that there is a need for concise summary reviews of the financial health and prospects of state and municipal plans. These summary reviews would give stakeholders an overview that would allow them to arrive at informed opinions on the desirability of changes to the structure and the parameters (e.g., the accrual rate or rates and the contribution rate) of these plans. To illustrate how that might be done, the Project's mandate included the preparation of two sample reviews of two different state systems. This article describes and compares these reviews and the dashboards that accompany them. The reviews and dashboards are integral parts of the Project's report. The discussion of the reviews and dashboards is followed by a concluding section that addresses the Project's broader goals. The article is intended to give the flavor of the two reviews and dashboards and is not a substitute for reading and evaluating them directly. It is drawn largely from the report's introduction.³

THE PLAN REVIEWS

Each of the sample reviews covers a single state pension system. To conceal their identities, the pension systems have been renamed the Adams Public Employee Retirement System (PERS) and the Jackson PERS. Each review has an accompanying dashboard that presents key quantitative indicators and a summary of the structure of benefits and actuarial assumptions. The two state systems were chosen to illustrate how developments in plans in different financial circumstances can be treated in a summary review. The Adams PERS reported a funding ratio of 63 percent at end-2012, which was the last year for which comprehensive information on the plan was available. The Jackson PERS reported a funding ratio of 86 percent for the year ending in June 2012.

The sample reviews were prepared to give plan

management, plan sponsors and other interested parties a model of how the state of a plan's finances and its benefits and financing sources can be summarily described and analyzed. The main goal of the Project is for the sample reviews to inspire the managers of public plans to prepare their own reviews. The sample reviews are intended to serve as examples to those plan managers who would be called upon to write a review of their own plan.

The Project's researcher was by definition an outsider. As a result, the sample reviews the researcher prepared are limited in some respects. An outsider cannot commission simulations on the impact of changes in actuarial or economic assumptions, for example, even though these simulations may have been reported in the plan's Comprehensive Annual Financial Report (CAFR), actuarial studies or other documents. Without a simulation model of a plan, it is very difficult to gauge the impact of measures taken to improve the plan's finances. Nonetheless, the two reviews can still serve as an expository model for plan "insiders." When important information was not available, the researcher sometimes included analyses of financial developments based on his conjectures in order to give the review a more analytical treatment of the issues. These conjectures were intended to stand in for what would be more solidly based analyses by drafters from plan management.

SIMILARITIES AND DIFFERENCES BETWEEN THE REVIEWS

The two sample reviews were deliberately organized in a similar way, although they were not written using a template. The fact that they are narratives illustrated by tables and charts rather than simply a compilation of data might lead readers to overlook the substantial similarities in form between them. The organization by section of each review is almost identical, and each one begins with an introduction, which is followed by sections on benefit determination, contributions, investments, and funding. Each has a short conclusion. Both reviews emphasize

The Project's mandate included the preparation of two sample reviews of two different state systems.

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If a table like the table on Page 7 was featured in all reviews, comparisons of one review with others would be more informative.

the subjects of benefits and plan financing, offer explanations for recent financing trends, and generally avoid going into detail. The tables and boxes that illustrate the reviews' observations are also substantially similar. Finally, the two reviews are more or less equal in length at six to seven pages.

There are differences between the coverage and emphasis of the two sample reviews as well. Both plans made changes to their cost-of-living adjustments (COLAs), which the reviews describe. However, the treatments in the reviews of these changes differ because in the Jackson PERS current retirees were completely unaffected by the changes, which was not the case with the Adams PERS, where the annual adjustment to the pensions of current retirees was reduced. In addition, the recent changes to the COLA in the Adams PERS require a fuller explanation because of the way they differ in their respective impact on differing age groups.

The reviews' descriptions and analyses of the financial position of the two plans also differ. The analysis of developments in the funding ratio is more detailed in the case of the Adams PERS than in the case of the Jackson PERS, in part because, given the substantial decline in the ratio of the Adams PERS over the previous 12 years, the subject really deserves more attention, and in part because there is more information available for the Adams PERS than for the Jackson PERS. In particular, the review of the Adams PERS includes a brief discussion of a simulation analysis of the impact of changes to the discount rate on the funding ratio. That discussion is lacking in the review of the Jackson PERS because of the unavailability of necessary data.

The review of the Adams PERS notes that the reported funding ratio exceeded 100 percent in the early 2000s, and attributes its subsequent large decline to a combination of factors: large investment losses as a result of declining stock prices, the decision to reduce the discount rate by $\frac{1}{2}$ percentage point in two steps,⁴ shortfalls in employer contributions—not a major problem in the case of the Jackson PERS—and other influences. It illustrates its discussion with a table, reproduced below, with information drawn from a number of CAFRs, that provides a statistical analysis for the very large increase in the Unfunded Actuarial Accrued Liability (UAAL). That analysis illustrates the major role of a shortfall in income from investments over the past 12 years. If a table like the table on Page 7 was featured in all reviews, comparisons of one review with others would be more informative.



The reviews emphasize the measures that each plan has taken in recent years to improve its financial position.

Table: Adams PERS: Analysis of Changes in UAAL, 2000–2012

	2000-2004	2005-2007	2008-2012	2000-2012
Changes in UAAL	(13,612)	(229)	(9,668)	(23,509)
Age and service retirements	(1,931)	(150)	(117)	(2,198)
Investment income	(6,812)	1,605	(10,474)	(15,681)
Purchase of noncovered service	(1,457)	(73)	–	(1,530)
Actuarial assumption changes	(1,554)	1534	(4,164)	(4,183)
Contribution deficiency	(720)	(1,419)	(1,442)	(3,580)
Expected change in UAAL	114	(1,221)	(2,862)	(3,970)
Effect of changes in plan provisions	–	–	9,005	9,005
Other influences	(1,252)	(506)	388	(1,370)

Source (in millions): CAFRs for 2004, 2007, and 2012.

The Project report also suggests that a specific structural factor might have contributed to the current low funding ratio: the pensions paid by the Adams PERS start earlier and pay more for the same work history than those of the Jackson PERS. For example, an Adams PERS plan member with 30 years of service is entitled to a pension of 75 percent of final salary that starts at age 50. A member of the Jackson PERS regular class (which contains most Jackson PERS members) retiring at age 63 with 30 years of service would have a replacement ratio of 49 percent. However, the brief introduction of the Adams review points out that most Adams PERS members are not covered by Social Security, making a comparison of the benefit structure of the two plans difficult. In any event, the structure of benefits in the Adams PERS has not changed by enough to explain a large part of the decline in the plan’s funding ratio.

The reviews emphasize the measures that each plan has taken in recent years to improve its financial position. This was particularly important in the case of the Adams PERS given its low

funding ratio. There appears to have been less urgency in the case of the Jackson PERS, and the measures taken in 2011 were designed to take effect gradually. The change to the COLA of the Jackson PERS has little effect on members nearing retirement, but the adjustment for inflation declines with the number of years of service a member is from retirement and falls to zero for new members. The reform package spares retirees and older workers, which was not the case with the changes made to the COLA of the Adams PERS.

Both reviews also try to shed light on the behavior of the funding ratio by analyzing the behavior of plan assets and liabilities. The Adams PERS review notes that plan liabilities grew by 6.0 percent per year between 2002 and 2012. Their growth was boosted by the strong growth in the number of retirees and in the average monthly pension. The latter development partly reflects the generous COLAs that were in place through 2005. The growth in assets over this period was only 2.5 percent per year at an annual rate. A similar analysis of the behavior of assets and liabilities is found in the Jackson PERS review.

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It is also hoped that the information in the reviews and the dashboards (even if incomplete) would be sufficient to enable an overall picture of the general health of a public pension plan to emerge.

Had these sample reviews been prepared by plan management, they could have been part of the actuarial control cycle and might also have included projections of future performance and additional analysis of the reasons for any deviation in actual unfunded liabilities from their actuarial projections. Particularly useful would be a quantitative analysis of the impact of changes to the plan that both plans have recently implemented.

THE DASHBOARDS

In contrast with the narrative reviews, the dashboard asks for the same information from each plan. Most of the requested information is quantitative and is requested for both recent and past dates. The dashboard asks for qualitative information on benefits and actuarial assumptions and methods, since a purely quantitative description in these areas is not feasible.

The dashboards are composed of 11 panels: demographic indicators, investment policy, investment returns, funding indicators and ratios, plan maturity indicators, plan sensitivity indicators, sponsor indicators, and related indicators, in addition to the panels for actuarial methods and assumptions and benefits. Almost all of the information they display came from various CAFRs, mostly those for plan years 1997, 2002, 2007, and 2012, since the dashboard was designed to present information at five-year intervals.

Plan management might choose to prepare a dashboard to complement a review of its plan, and could choose to supply either more or less information than the dashboard calls for. The dashboard's usefulness will not stand or fall on the absence of a few series. The indicators in each section have been chosen to provide a comprehensive picture of the plan's basic demographic and financial structure and financial position. Some of them are more important than others, and a plan's management might wish to provide alternative indicators. A detailed request for data like this one should ideally achieve a basic uni-



formity in the information that different plans will supply. The current version of the dashboard makes an ambitious data request, and it may well be that experience with it will result in a reduction in the amount of data requested, and perhaps some change in the relative importance of the different panels.

SIMILARITIES AND DIFFERENCES BETWEEN THE DASHBOARD DATA

By comparing the two sets of panels, it is clear that it was easier to find information for some panels than for others. Information on demographic indicators, plan maturity indicators, and the qualitative indicators on actuarial practices and benefits was relatively easy to come by. Information on funding was less easy to find, apart from such standard indicators as Actuarial Accrued Liability (AAL) and Actuarial Valuation of Assets (AVA), and the funding ratio derived therefrom. Of course, that published sources were not enough to fill in every cell in the dashboards' tables is not a sign that plan management could not compile the missing information.

Each of the dashboards has gaps in data that are not found in the other. Because there is no pub-


likely available CAFR for the Adams PERS for 1997, most of the time series data lack the observation for 1997. However, the results of a “what-if” scenario, specifically, the impact on UAAL of a change to the discount rate of 1½ percentage points was available for the Adams PERS but not for the Jackson PERS.

CONCLUDING OBSERVATIONS

It bears repeating that the sample reviews of the pension systems of state and local government employees of Adams and Jackson are not meant to be templates carved in granite. Despite the similar organization of the two reviews, their design is not intended to force the experience of different public plans into a straitjacket. Plan management could choose to emphasize some issues more and others less, to write at greater length, or to be even more concise. Ideally, these reviews will be short enough to encourage interested stakeholders to read them. Another goal would be for them to have an organization sufficiently similar to facilitate comparisons. It is also hoped that the information in the reviews and the dashboards (even if incomplete) would be sufficient to enable an overall picture of the general health of a public pension plan to emerge.

Although the Project’s basic goal was the preparation of summary reviews that could serve as examples to plan managements seriously considering preparing similar reviews of their own plans, the two sample plans this article has discussed are, in a sense, a work in progress. They are intended to stimulate a dialogue that will

make them more useful to both plan management and the broader community of stakeholders in public pension plans.

It could be that the review and dashboards that plan managements would like to prepare would be quite different from these prototypes. However, in the eyes of the author/researcher and the Project oversight group recruited to oversee this research effort, the Project will have been worthwhile to the extent that it leads to a better and broader understanding of the finances of public pension plans. The exact shape of a summary review of a pension system does not matter as much as its effectiveness in communicating the actual state of the plan’s finances. 



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ENDNOTES

- ¹ The Public Fund Survey (PFS) collected information as of mid- to end-2013 on 126 state and local plans, whose assets represent 85 percent of the total assets of these plans. Of the 126 plans, 28 had funding ratios below 60 percent. The website of the PFS is at publicfundsurvey.org.
- ² State plans typically assume a discount rate that reflects the expected return on their assets. Financial economists choose a discount rate that reflects the risk attached to a plan’s liabilities, which would be much lower. Novy-Marx and Rauh estimate that the total liabilities of state plans at the end of 2008 were \$5.2 trillion, compared with the liability derived from plan estimates of \$3 trillion. See “The Liabilities and Risks of State-Sponsored Pension Plans” in the *Journal of Economic Perspectives*, Volume 23, Number 4 Fall 2009.
- ³ The reviews and dashboards are not intended to be actuarial reports prepared by actuaries, but reports that plan management could prepare for various stakeholders. The reports and dashboards were not designed to comply with actuarial standards.
- ⁴ By way of comparison, Treasury 10-year bond rates declined from 6.66 percent at the beginning of 2000 to 1.97 percent at the beginning of 2012.

LIVING TO 100

MORTALITY AGE PATTERNS: TRENDS, PROJECTIONS AND LIFE PREPARANCY

By R. Dale Hall



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During the SOA's recent Living to 100 Symposium, one of the sessions that got me thinking much more deeply about the financing of public retirement plans was titled "Mortality Age Patterns: Trends and Projections." Individuals at the session presented research on the growing lifespans of retirees, increasing the challenges that public plans can face in determining appropriate funding levels. The presentations were followed by a terrific discussion on the papers by Johnny Li, and an even broader informal discussion from key audience members on the subject. All of the abstracts, papers, discussant comments and the informal discussion transcript are available at the SOA's online monograph at <https://www.soa.org/Library/Monographs/Life/Living-to-100/2014/2014-toc-listing.aspx>.

The key to these papers lies mainly in their focus on what mortality observations can be made—not just as people enter the early phases of retirement ages—but also at more extreme ages. In the past several decades, the right-hand tail of the "age at death" distribution has grown considerably denser. Compounding the two issues of a


volatile and declining interest rate environment, as well as economic uncertainty in public plan sponsor contributions, there is also a growing need to fund annuity payments for longer periods of time.

The SOA recently gave testimony at the Select Revenue Measures subcommittee of the U.S. House Ways and Means Committee on the evolution of our exposed RP-2014 mortality table, developed by the SOA's Retirement Plans Experience Committee. While the prime focus of the study is the mortality of individuals within privately-sponsored plans, previous generations of the study, such as RP-2000, have often been used as a starting point (often with factors applied, and additional details of the specific plan incorporated) for evaluating public plan liabilities. We should also note that the SOA is planning to begin its investigation on a public-plan specific mortality table in 2015, with the intention of, additionally, studying subgroups where mortality may differ within a plan—such as for teachers or public protection occupations. In the testimony, most of the focus was on the commonly-asked question: "What is the life expectancy increase in moving to the new table for a retiree who has lived to age 65?" In some respects, it's an appropriate question, and it certainly is the one that gets quoted most often. However, hidden in the details of the life expectancy calculation are some underlying concepts about what is actually happening at the more extreme ages.

As actuaries, we know that life expectancies are more a measure of the mean of a survival distribution. Lower mortality rates mean higher life expectancies. The "life expectancy at birth" or "life expectancy at age 65" calculation, however, can tell only portions of the story. What might be more important for retirees and plan sponsors to know is the age at which a specified (smaller) percentage of the retiree population is expected to survive—perhaps a percentage such as 5 percent or 10 percent. I've come to call this term the *Life Preparancy Age*, with the name as a reminder to retirees to prepare their retirement portfolios to be successful 90 percent or 95 percent of the time, instead of only 50 percent of the

time, as implied by life expectancy. We've seen through some initial calculations under the RP-2000 basis, compared to an RP-2014 basis, that while life expectancies for retirees may increase two to 2.5 years, Life Preparancy Ages can increase well beyond three or more years due to the material improvements in mortality for ages 80 and higher.

I'd encourage actuaries, plan sponsors and retirement advisers to look through our recently released monograph of the proceedings of Living to 100, as well as note some of the growing results from our exposed RP-2014 mortality tables and RPEC_2014 mortality model. As we con-

tinue our study on public plan mortality in the future, having a solid understanding of what's occurring in longevity research around the world will be of great benefit. 

ENDNOTE

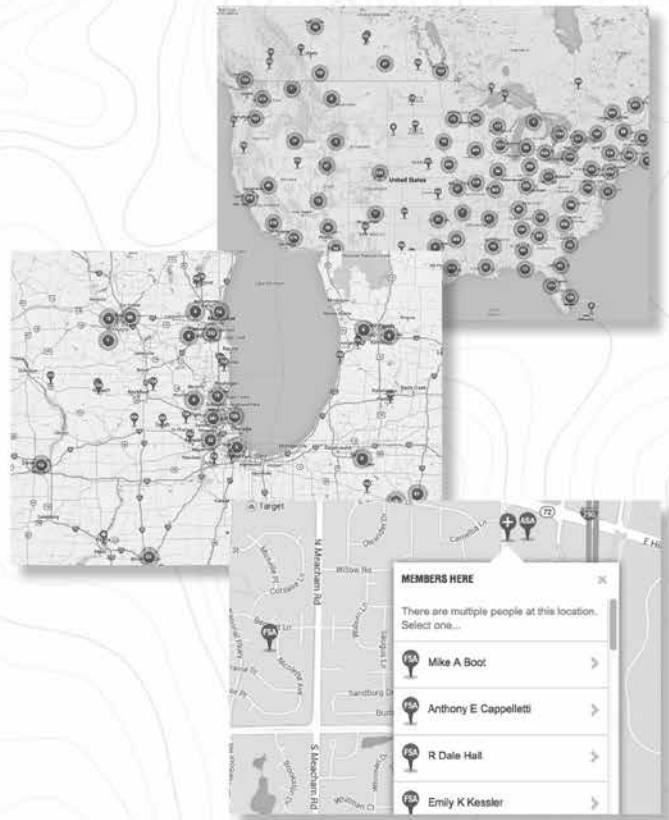
¹ The session covered three papers on the topic: "Coherent Projections of Age, Period and Cohort Dependent Mortality Improvements" by Matthias Börger and Marie-Christine Aleksic; "Measurement of Mortality among Centenarians in Canada" by Nadine Ouellette and Robert Bourbeau; and "Mortality Trajectories at Extreme Old Ages: A Comparative Study of Different Data Sources on U.S. Old-Age Mortality" by Natalia S. Gavrilova and Leonid A. Gavrilov.

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LET'S TALK

INTERVIEW WITH AN ACTUARY IN THE PUBLIC INTEREST

Questions by the editor. Responses by John Bertko



John Bertko, FSA, MAAA, is retired. He can be contacted at john.bertko@gmail.com.

WHAT ARE YOU DOING TODAY?

After nearly three years working in Washington, D.C., as the senior actuary at the Center for Consumer Information and Insurance Oversight (CCIIO), I “retired” and then joined Covered California (Covered CA) in early Feb., 2014, as the chief actuary (as an independent consultant). Since Covered CA uses an active purchaser model, there is a lot to do in working with the 10 Covered CA contracted plans. In addition to helping with decisions on 2015 standard benefits (one of the major decisions), we engaged in scrutiny of proposed 2015 rates to prepare for negotiations, with the help of the Covered CA actuarial consultant in Milliman’s San Diego office.

As one part of the preparation for these negotiations, we contracted with a researcher at UC-San Francisco and our sister agency, the Department of Health Care Services research unit, to prepare a preliminary risk adjustment assessment of Covered CA enrollees. These results, which were shared with the plans during negotiations, should be published soon and were of great use in helping the plans understand their position in the state’s individual market and the relative importance of risk adjustment on 2015 premiums.

ARE THERE ANY BROAD GOALS THAT UNDERLIE YOUR ACTIVITIES?

I’m an optimist and suggest that the work we are all doing (including both my colleagues at Covered CA and at CCIIO, on the federal level) is helping in bringing insurance coverage to millions of Californians (and to citizens of other states). At the same time, we at Covered CA have used the leverage of our relative success to keep premium increases to a minimum. Future goals are to make continued progress towards offering affordable insurance and to bring change and accountability to California’s health care system.

While the direction of health care trend and new technology can seem relentlessly upward, my goal is to make incremental progress in holding down costs and getting better value for money

spent. Sometimes it is hard to measure success against “what would have happened without the Affordable Care Act (ACA),” but our recent efforts have been a good start.

CAN YOU DESCRIBE YOUR STYLE?

There are several ways to describe style—professionally, personally, as a manager, and in other dimensions. Professionally, I think it is best to always question the methods and assumptions one uses. New data becomes available or new methods are created. But, on top of everything, I believe it is crucial to make empirically-based decisions—to use data to support one’s decisions, instead of only using theories. While building models is part of our profession, those models must be validated constantly.

Personally, I like to think that I try to treat everyone I meet in my job with respect. Everyone has a viewpoint and can make a contribution. It is only when someone confuses opinions with facts that I sometimes consider them “not thoughtful.” Plus, actuaries must be thorough—use all the facts, not just the ones which support a particular theory or an opinion.

HAVE YOU SERVED ON ANY GOVERNMENT ADVISORY COMMITTEES?

I have had lots of “actuarial fun” serving on various committees. The longest service was my six years as a Medicare Payment Advisory Commission (MedPAC) Commissioner, dealing with the wide range of Medicare reimbursement and policy issues. Another interesting advisory group was working on the Congressional Budget Office’s health care advisors panel. On this one, I was the only actuary in a roomful of top U.S. health care economists—lots to learn from them, while my contribution was a dash of “real world” experience. Finally, I served on two of the recent Medicare Trustees Technical Advisory Panels. The first was shortly after the Medicare Modernization Act (MMA) was passed and was used to help the Centers for Medicare & Medic-

aid Services (CMS) and the U.S. Department of Health & Human Services (DHHS) evaluate the Medicare Part D benefit's effect. The second was similar—a long and involved debate following enactment of the Affordable Care Act (ACA)—and involved helping the Medicare Trustees understand and project the effects of the ACA on Medicare.

WHAT IS YOUR EDUCATIONAL BACKGROUND?

Having been an undergraduate way back in the last century, I received a degree in mathematics, with an emphasis on probability and statistics from Case Western Reserve University. Then, courtesy of the draft lottery, I found myself teaching at the U.S. Naval Nuclear Power School for almost four years. It did wonders for deepening my understanding of differential equations and nuclear physics.

My real education came as a result of working with a lot of smart people—as a consultant at one of the big accounting firms. There were lots of smart CPAs, MBAs and PhDs assembled on health care consulting teams, and you can't help but learn from actual projects (e.g., Mergers and Acquisitions [M&A] assignments, assessments of provider contracts, financial modeling, etc.) from colleagues who do a lot of this work. Finally, after being a consultant for 20 years, I became a chief actuary and found out how good my own advice was (luckily, most of it seems to have been sound).

WHAT IS YOUR PROFESSIONAL BACKGROUND?

Coming out of the Navy at the advanced age of 26 to start my actuarial career, I was serious about catching up with my cohort of young actuaries-in-training. With a modest jump-start of passing two exams in my last year in the Navy (while teaching some parts of those exams), I managed to finish within five years, taking my last fellowship exam two weeks before my first daughter was born (pew!). After several years of practice, I became a member of the Academy of Actuaries and did enough pension work as a



consultant to qualify as an enrolled actuary (a designation which lapsed two decades ago, due to my becoming obsessed with health care problems and challenges).

WHAT HAS BEEN IMPORTANT IN HELPING YOU FOCUS ON THE PUBLIC INTEREST?

I think I had always been interested in public policy topics, after taking both policy and economics classes in college. In my first consulting job, the firm focused on serving private sector clients, and the managing partner grudgingly let me take on a few projects for state and local governments. When he found out we could grow this practice successfully, I was “off and running.”

Most public or government health care projects were challenging: our team worked on the Prioritized Care project for Oregon's Medicaid system (sometimes called “rationing” Medicaid care), on re-organizing the WA State Health Care Authority, on developing a purchasing co-op for the Health Insurance Plan of California (HIPC,)

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Always think about explaining what you did today to your spouse or children. Was it useful to society in some way? Are you proud of your overall effort?

and many other similar projects. These had the advantage of generally wading into “new territory” by using or extending actuarial tools, data and methods. Plus, they were intellectual “fun.”

While working first as a consultant and then as the chief actuary for a company with a large Medicare Advantage business, I had the privilege of being asked by Congressional staff about the technical details of “getting change right” for what eventually became Medicare Part D in the MMA. Later, after I retired, I continued to be asked about complex technical and industry questions for health insurance reform. Since I firmly believe that we, as a country, need to provide health care for all of our citizens, it has been rewarding to be able to help as an advisor.

WHAT ARE YOU MOST PROUD OF?

While debate continues about the current status and the future of the ACA, I think our combined efforts (at both the state and federal level) have brought health insurance to millions of Americans and actually saved peoples’ lives. All of the health care system fits together in an intricate puzzle, and we need to solve all parts of the puzzle simultaneously. It does not all have to be perfect (“don’t let the perfect be the enemy of the good”), but we have made a lot of progress in the last four years, since enactment of the ACA.

WHAT ARE SOME WAYS YOU HAVE BEEN ABLE TO STAND UP FOR THE PUBLIC INTEREST?


Over the last five years, I think there was a lot of “misinformation” that was the result of speculation. Pundits screamed in the press that “life on

Earth as we know it is ending.” I did my part to dispel rumors, to provide useful and relevant data and to challenge some of the people who were making outrageous statements.

That said, there is plenty of room for improvement, both in the ACA provisions and in implementation. However, we need to have a more civil and productive atmosphere in which to make those course corrections possible.

DO YOU HAVE ANY THOUGHTS TO SHARE WITH CURRENT AND FUTURE ACTUARIES WORKING IN PROFESSIONAL ROLES HAVING A DIRECT IMPACT ON THE PUBLIC?

I like to think that most, if not all, health actuaries have a direct or indirect impact on the public. Since nearly all of our work (with the possible exception of the most technical aspects) has an effect on the public, those whom I call our “neighbors,” we need to balance the need for the success (financial or otherwise) of our employer or clients with the effect of our decisions on these neighbors. One of the things that actuaries (as well as other scientists or “techies”) need to do is to explain things better to the public. Always think about explaining what you did today to your spouse or children. Was it useful to society in some way? Are you proud of your overall effort? Is someone better off after you finished today’s (or this year’s) tasks?

I’ll leave everyone with that challenge from the 1960s: “If you are not part of the solution, you’re part of the problem.” Just pick your problem to address! 

MEDICAID EXPANSION: A COMPARISON OF TWO STATES UNDER SECTION 1115 DEMONSTRATION WAIVERS

By Christopher T. Pettit and Robert M. Damler

The Patient Protection and Affordable Care Act (ACA) provided states with the ability to expand coverage for low-income individuals who were historically not eligible to receive benefits under the Medicaid program. The expansion allows full Medicaid benefits coverage for parents and childless adults under the age of 65 with income levels up to 133 percent (138 percent with 5 percent income disregard under Modified Adjusted Gross Income conversion) of the federal poverty level (FPL). While initially a mandated portion of the ACA, Medicaid expansion became a state option by a June 2012 U.S. Supreme Court ruling. As of the writing of this article, 29 states and the District of Columbia have opted to expand Medicaid benefits to childless adults under the ACA provisions.¹ For states that elected to expand Medicaid coverage, the federal government will fully fund Medicaid coverage for newly eligible individuals in those states through 2016. In 2017, the federal government's Medicaid funding rate for the newly eligible beneficiaries drops to 95 percent, and then to 90 percent in 2020 and beyond. Although there is no immediate required state match for medical expenses (administrative expenses are not 100 percent federally matched), each state must consider the financial impact of maintaining the Medicaid expansion population beyond 2020, when the state share of the funding responsibility will rise to 10 percent of total cost.

The Medicaid program is operated on a state-by-state basis and displays significant variation in its operation and structure across the country. Given that the ACA does not specify the structure of expansion programs, it is no surprise that designs vary from state to state. This article provides a comparison of two Medicaid expansion programs: the Healthy Michigan Plan and the Healthy Indiana Plan (HIP) 2.0. Both Michigan and Indiana opted to use a Section 1115 demonstration waiver to implement their respective programs.

SECTION 1115 DEMONSTRATION WAIVERS

Section 1115 of the Social Security Act gives the secretary of the U.S. Department of Health and Human Services (DHHS) authority to approve experimental, pilot or demonstration projects that promote the objectives of Medicaid and the

Children's Health Insurance Program (CHIP). One of the identified purposes of the demonstration waiver authority is to demonstrate and evaluate whether using an innovative service delivery system will improve care, increase efficiency and reduce costs.² Both the Healthy Michigan Plan and the HIP 2.0 attempt to meet these goals by using benefit designs that encourage personal responsibility and engage participants in making health care decisions based on cost and quality.

OVERVIEW OF PROGRAMS

While each of the programs was implemented to provide coverage to parents and childless adults up to 133 percent FPL under an 1115 waiver, the programs were implemented with different characteristics. The following provides an overview of each program and a comparison of a few of these characteristics.

HEALTHY MICHIGAN PLAN

On Sept. 16, 2013, Governor Rick Snyder signed the Medicaid expansion bill into law for the State of Michigan, thereby creating the Healthy Michigan Plan. The plan was implemented by amending a previously approved Section 1115 demonstration waiver—Adult Benefit Waiver. The prior demonstration waiver offered a limited benefit package to childless adults with income up to 35 percent FPL. The new Healthy Michigan Plan focuses on increasing access to quality health care while encouraging members to adopt healthy behaviors. The plan was expected to provide health coverage to nearly 500,000 Michiganders (a number that was exceeded within the first 12 months of open enrollment). Though no specific analysis has been performed, the rapid increase in enrollment may have helped to mitigate some of the pent-up demand.

HEALTHY INDIANA PLAN: HIP 2.0

The first HIP (1.0) was passed by legislation in 2007. Enrollment began on Jan. 1, 2008. This initial program was approved by the Centers for Medicare and Medicaid Services (CMS) under a Section 1115 waiver authority and provided health care benefits for parents and childless adults up to 200 percent FPL. HIP 2.0 built upon HIP 1.0 and was the result of negotiations between the State



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of Indiana and CMS to use the HIP structure to provide services to parents and childless adults up to 133 percent FPL. It is anticipated that HIP 2.0 will serve more than 450,000 Hoosiers. Similar to HIP 1.0, HIP 2.0 was implemented under a Section 1115 waiver authority. Similar to the Healthy Michigan Plan, HIP 2.0 focuses on increasing access to quality health care while encouraging members to adopt healthy behaviors and promoting personal responsibility.

COMPARISON OF KEY PROGRAM CHARACTERISTICS

The table in Figure 1 provides a high-level summary of the key characteristics associated with each of the programs.

The remainder of the article describes the components of the expansion program characteristics listed in Figure 1 in more detail.

General Benefit Design HEALTHY MICHIGAN PLAN

Although technically established as an Alternative Benefit Plan (ABP), the list of covered services under the Healthy Michigan Plan is identical to the current state plan. As an ABP, the Healthy Michigan Plan covers federal essential health benefits along with other State Plan services and benefits. The Healthy Michigan Plan provides consistent benefits to all enrollees, with the only variation being the level of required cost sharing. Two different types of member cost sharing are required: a contribution equal to 2 percent of income along with copayments for members above 100 percent FPL and copayments only for members below 100 percent FPL. For members who agree to participate in certain healthy behavior activities, the member cost sharing can be reduced. Claims are paid on a first dollar basis at the point of service with member contributions and copayments paid to a member's MI Health Account on a six-month time lag. A \$1,000 deductible is applied to the benefit coverage with a member's contributions applied to medical service payment at the price point of \$1,000 minus that member's required annual contribution. For example, contributions for a member required to contribute \$200 annually would only pay for services above \$800 and up to \$1,000.

HIP 2.0

HIP 2.0 offers a variety of different benefit packages. State plan benefits are provided to members previously eligible under Indiana's Medicaid eligibility rules, primarily parents below approximately 18 percent FPL. Members not previously eligible are offered an alternative benefit plan. Newly eligible members below 100 percent FPL have a choice between the Basic plan and the Plus plan. Plus plan members make monthly

Figure 1: Key Program Characteristics

Program Characteristic	Healthy Michigan Plan	Healthy Indiana Plan 2.0
General benefit design		
Covered Services	Essential health benefits plus additional state plan services for all enrollees	State plan benefits for the medically frail and Section 1931 caretakers Alternative Benefit Plan
Benefit Options	All enrollees subject to same benefit design	(1) Basic plan: copayments, available to members who are under 100 percent FPL only (2) Plus plan: POWER account contributions, emergency room copayment, and dental and vision benefits (3) HIP Link: Employer sponsored plan coordination
Medically Frail Requirement	No	Yes
Member features		
Account Name	MI Health account	POWER account
Contributions	2 percent of household income for members above 100 percent FPL	2 percent of family income for Plus plan benefits, with a minimum contribution of \$1 per month
Annual Value of HealthCare Account	\$1,000	\$2,500
Healthy Behavior Incentives	(1) No copays for preventive services or services associated with chronic conditions (2) Reduced contributions or other incentives if participating in healthy behavior activities	If member meets preventive service requirement: (1) Additional carry-over in Plus or (2) Discount on future Plus enrollment if in Basic
Health Risk Assessment	Limited HRA at time of enrollment with detailed completion by PCP	Screening within 90 days, detailed HRA for members with special health care needs
Penalties for Failure to Make Contributions	Loss of ability to reduce costs through healthy behaviors	Loss of coverage for six months if above 100 percent FPL, convert to Basic plan for those under 100 percent FPL
Additional program information		
Waiver Governance	Section 1115	Section 1115
Effective Date	April 1, 2014	Feb. 1, 2015
Capitation Rate Development	First dollar with consideration of contributions and copayments	Reflects \$2,500 deductible and applicable copayments
Low Income Family Parent Eligibility	Prior eligible population (i.e., those under 37.5 percent FPL) retain standard Medicaid program	Converted from Hoosier Healthwise Medicaid plan to HIP 2.0 plan
Provider Reimbursement	Traditional Medicaid	Medicare or Medicaid +30 percent for non-Medicare services

contributions to the Personal Wellness and Responsibility (POWER) account (described below), and in return have no required copayments, and receive additional benefits of dental and vision. Basic plan members do not make contributions to the POWER account, but copayments are required for many services. Plus plan members who do not make contributions as required are automatically switched to the Basic plan. Newly eligible members between 100 percent FPL and 133 percent FPL may only enroll in the Plus plan. Individuals identified as medically frail receive benefits through an ABP that is the State Plan. A third plan option, HIP Link, is available to individuals who have access to qualified employer sponsored insurance (ESI). HIP 2.0 benefits have an annual deductible of \$2,500 per person under the Basic and Plus plans, which is funded by the POWER account. Preventive benefits are not subject to the deductible. The POWER account under HIP Link is valued at \$4,000.

Member Features

HEALTHY MICHIGAN PLAN

Health care account

The MI Health Account is used to collect member contributions and copayments. The account is intended to increase member awareness of their use of health care services. Following the initial six months, members receive quarterly updates on the amount of money in the account and the services provided. Member contributions that are not used to pay down services remain in a member's MI Health Account and can be repaid as a voucher for purchasing health insurance when a member leaves the Healthy Michigan Plan.

Member contributions

Members below 100 percent FPL are only required to submit copayments. A contribution equal to 2 percent of income is levied on those above 100 percent FPL, but total member cost-sharing cannot be more than 5 percent of annual household income. No alternative benefit design is offered under the Healthy Michigan Plan. Therefore, members do not have an option of selecting a different cost-sharing structure. Members who do not make required contributions are not removed from the program, but lose the abil-

ity to reduce their cost-sharing through healthy behaviors.

Health risk assessment

At the time of enrollment, members are asked to complete a health risk assessment (HRA) form, which identifies the current health of enrollees as they enter the program. Incentives have been put in place by the state to encourage health plans to submit the forms. Additionally, health plans provide incentives to providers and participants to help facilitate a higher completion rate. One specific requirement in the Healthy Michigan Plan is for members to schedule an appointment with a primary care physician within 60 days of selecting a health plan. Most members in the Healthy Michigan Plan are to be enrolled with one of the participating health plans, and therefore most will be subject to this rule. It is at the time of the appointment with their selected primary care physician that members can select a healthy behavior activity to manage, to allow for potential reduction of cost sharing requirements. Annual appointments with a physician and an updated HRA are also requested by the program.

HIP 2.0

Healthcare account

The POWER account resembles a health savings account (HSA). The POWER account funds the plan's annual deductible, providing first dollar coverage of up to \$2,500 per year. If the member enrolls in the Plus plan benefit design, funding is shared by the Medicaid program and the member; otherwise the POWER account is fully funded by the Medicaid program. To encourage judicious use of health services, the member portion of unused POWER account funds may roll over and offset contribution amounts for future years. Any Medicaid funds remaining in the POWER account are returned to the Medicaid program at the end of each year or when a member leaves the program.

Member contributions

If a member is enrolled in the Plus benefit plan option, the member is required to make monthly contributions to the POWER account. Household POWER account contributions are generally 2

To encourage judicious use of health services, the member portion of unused POWER account funds may roll over and offset contribution amounts for future years.

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percent of annual family income. However, all HIP Plus members are required to make a minimum contribution of at least \$1 per month.

In addition to the two managed care options of HIP Plus and HIP Basic, HIP 2.0 members with access to ESI are offered a third option: HIP Link. This option has a POWER account with total funding of \$4,000. The POWER account is funded by the state Medicaid program. The larger POWER account balance under HIP Link is intended to be used to pay for the employee share of monthly employer insurance premiums as well as out-of-pocket medical expenses such as deductibles, copays, and coinsurance.

Health risk assessment


The application for HIP 2.0 allows applicants to self-identify as medically frail if they have qualifying conditions. These conditions include various high-cost medical and mental health conditions. Additionally, a member will qualify as medically frail if the member has a limitation of several activities of daily living (ADLs).

All HIP 2.0 members are enrolled in a managed care plan. The managed care plans are required to

complete a health screening on all new members within 90 days of enrollment. This information may also be used to identify a member as medically frail, if the person had not self-identified any of the issues during the application process.

Members identified as having special health care needs, either from the application or the screening, receive a detailed HRA, conducted by a health care professional.

SUMMARY OF COMPARISON

The ACA provided states with the option to expand Medicaid, but did not provide a specific framework in which to establish these new programs. The potential for program variety can begin to be understood by looking at the two programs studied in this article. Although both of these Medicaid expansion programs operate under Section 1115 waivers, there are significant differences in the way each is managed. The HIP originated in 2008 and has been altered through CMS negotiations and approval of the waiver in Jan. 2015. During the design phase of the Healthy Michigan Plan, several components of the original HIP program were considered and modified to result in the program that was established. As Medicaid expansion evolves, it will be interesting to see how states manage and change their programs, or even how states yet to expand Medicaid may consider future expansion design and new program implementation. 



ENDNOTES

- ¹ <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (as of May 18, 2015)
- ² <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html>



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MEDICAID AND THE ACA

By Robert M. Damler and Marlene T. Howard

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The Affordable Care Act (ACA) has had a significant effect on the way consumers, payers, and providers operate in the health care market. For Medicaid programs in particular, the ACA implemented changes that affected eligibility, funding, and policy related to the Medicaid program. While 28 states are moving forward with the implementation of Medicaid eligibility expansion for individuals between the ages of 18 and 64 and below 138 percent of the federal poverty level (FPL),¹ many other aspects of the 2010 legislation provide additional opportunities for eligibility and benefit changes that would interest key stakeholders and warrant consideration in actuarial budget forecasts.

One of the additional items relates to Section 1915(i) of the Social Security Act (SSA), which addresses the inclusion of home and community-based services (HCBS) in the state plan. State plan services refer to the scope of benefits that are covered by the Medicaid program and are agreed upon by the state and federal government agencies. While Section 1915(i) predated the enactment of the ACA, the ACA legislation provided some modifications to Section 1915(i) that increased its visibility in the HCBS landscape. The modifications have prompted a number of states to apply for the inclusion of HCBS in their respective state plans through the 1915(i) provision.²

The 1915(i) state plan option is viewed as a flexible solution to meeting the HCBS needs of individuals who do not qualify for the more restrictive eligibility criteria under a 1915(c) waiver program. Prior to deciding to implement a 1915(i) state plan option, there are several important implications that must be considered. This article discusses several features and considerations of the 1915(i) state plan option. We will also consider a unique example of a state that overcame Medicaid eligibility challenges by implementing a program using the 1915(i) state plan option.

OVERVIEW OF HOME AND COMMUNITY-BASED SERVICES

“Home and community-based services” refers to a set of benefits that are designed to assist in-

dividuals with alternatives to institutional care. The individuals require assistance with activities of daily living (ADLs) and may receive therapies to manage and treat chronic conditions. The required intensity of services will vary depending on the degree of an individual’s disability. In the Medicaid program, this service array has traditionally been provided under parameters set forth in Section 1915(c) of the SSA, which requires that an individual satisfy state-established institutional level of care criteria in order to become eligible for the HCBS waiver services. As a result, the majority of historical Medicaid experience for HCBS reflects the cost profile of a longterm care or nursing home population (i.e., those who meet the state-established institutional level of care criteria).

The 1915(i) state plan option offers an alternative method of providing HCBS through the Medicaid program. Recently, many states have been exploring this option and are interested in understanding the fiscal impact of 1915(i) implementation. When using historical experience to project expenditures for a 1915(i) state plan option, actuaries and states need to consider the varying risk profile of the targeted population, particularly for services that may already be provided under a 1915(c) waiver. The cost of services as part of a waiver may not be fully comparable to the cost for a population targeted for the 1915(i) state plan option, given the eligibility requirements that may vary between the 1915(c) waivers and the 1915(i) state plan option.

The table in Figure 1 (pg. 21) provides a comparison of the key policy issues between 1915(c) waivers and the 1915(i) state plan option. The sections that follow provide additional detail and describe the evolution of the 1915(i) state plan option, from its roots in the Deficit Reduction Act to modification under the ACA.

THE DEFICIT REDUCTION ACT AND 1915(I)

Section 1915(i) of the SSA was established under Section 6086 of the Deficit Reduction Act of 2005 (DRA), which discussed “Expanded Access

to Home and Community-Based Services for the Elderly and Disabled.” Effective Jan. 1, 2007, this version of Section 1915(i) afforded states the flexibility to add certain home and community-based services to the Medicaid state plan.³ Prior to the DRA, these services had to be included as part of a 1915(c) waiver program and could only be offered to individuals who met institutional level of care criteria.

In order for individuals to be eligible for benefits under the 1915(i) state plan option, the Medicaid program had to establish needs-based criteria,

which were required to be less stringent than those defined for institutional level of care. The more relaxed needs-based eligibility definition could result in escalating program costs. As a result, states were given the option to limit the number of people receiving the service package and establish waiting lists, to recognize budget constraints that could be present with implementing the 1915(i) state plan option.

Other significant aspects of the 1915(i) state plan option as presented in the DRA include the following:

The 1915(i) state plan option is viewed as a flexible solution to meeting the HCBS needs of individuals who do not qualify for the more restrictive eligibility criteria under a 1915(c) waiver program.

Figure 1: High-Level Comparison of 1915(c) Waivers and 1915(i) State Plan Option

	1915(c) Waivers	1915(i) State Plan Option (after ACA revisions)
Service array	Home and community-based services outlined under Section 1915(c)(4)(b) of the SSA. Examples: Case management, homemaker, respite care.	Same requirements as 1915(c). Service offerings are not limited to the services provided through established 1915(c) waivers, provided they are within the parameters outlined in Section 1915(c)(4)(b) of the SSA.
Income eligibility	300 percent of Supplemental Security Income Federal Benefit Rate.	150 percent of FPL.*
Medically needy eligibility requirements	State-established institutional level of care.	Needs-based criteria that are less stringent than 1915(c) requirements**. Example: Assistance with two activities of daily living.
Target populations (waiver of comparability requirements)	Permitted.	Permitted.
Statewide application	Permitted to be waived.	Not permitted to be waived.
Enrollment limits	Permitted.	Not permitted.
Demonstration of cost neutrality	Required.	Not required.

Source: *The income threshold for 1915(i) may vary, as explained later in this article.
 **Needs-based criteria will vary with the income threshold for 1915(i).

If states choose to define target populations, CMS will provide approval for an initial five-year period, and the 1915(i) application will need to be renewed at the end of the period for subsequent five-year approval periods.

- States did not have to demonstrate cost neutrality compared with institutional expenditures for the eligible population: This is primarily because there would be no comparable institutional cost for individuals who do not have to meet institutional level of care criteria for 1915(i) eligibility.
- Income eligibility threshold at 150 percent of FPL: In addition to meeting the needs-based criteria with a less restrictive definition than institutional level of care, an individual's income must be no higher than 150 percent of the federal poverty level to be eligible for the 1915(i) service package.
- Comparability requirement had to be met: Any Medicaid-covered individual who met the medical necessity criteria could utilize the HCBS package offered under 1915(i) (comparability requirement).
- Statewide application requirement was waived: States were permitted to limit the geographic scope of the 1915(i) state plan option. Under the ACA, states are no longer permitted to waive the statewide application requirement for services provided through the 1915(i) state plan option.

ACA AND NEW CONSIDERATIONS

Section 2402 of the ACA focused on "Removing Barriers to HCBS" and applied some important revisions to Section 1915(i). The Centers for Medicare and Medicaid Services (CMS) subsequently issued a final rule on Jan. 16, 2014, that provided clarification and additional information related to the revised Section 1915(i).

One of the most significant modifications to Section 1915(i) was the addition of Section 1915(i) (7), which allowed states to define target populations for the delivery of the HCBS benefit package. This section waives the comparability requirement established in the DRA version of Section 1915(i). The CMS final rule proposed that the parameters for the target populations be defined by "diagnosis, disability, Medicaid eligibility groups, and/or age."

The waiver of the comparability requirement allowed states to do the following:

- Define multiple target populations for 1915(i) and tailor multiple HCBS packages that could be individually allocated to each population; and
- Vary the amount, duration, and scope of a single 1915(i) service between various target populations.

If states choose to define target populations, CMS will provide approval for an initial five-year period, and the 1915(i) application will need to be renewed at the end of the period for subsequent five-year approval periods. States are required to use needs-based criteria in defining the target population, and are not permitted to require that an individual be assigned to a specific Medicaid eligibility group. For example, a state cannot require enrollment in a 1915(c) waiver in order to be eligible for the services outlined in the 1915(i) state plan option.

While the ACA allowed the comparability requirement under 1915(i) to be waived, it eliminated the enrollment limit and waiting list provisions of the original 1915(i). Consequently, states need to be vigilant in their definitions of needs-based criteria and/or target populations, in order to manage the cost of the 1915(i) program as a component of state Medicaid budgets.

The ACA also expanded eligibility for the 1915(i) state plan option to individuals with incomes up to 300 percent of the Supplemental Security Income Federal Benefit Rate. If states choose to use this income eligibility definition for a 1915(i) service package, individuals must meet an institutional level of care as well as the needs-based criteria defined by the state. If states maintain the income eligibility threshold of 150 percent of FPL as established by the DRA, individuals do not have to meet an institutional level of care.

The waiver of the comparability requirement and the expanded income eligibility definition result in the following options in the design of a 1915(i)

service package for a population that meets an institutional level of care:

- **Offer home and community-based services that are not currently covered under the 1915(c) waiver:** In this scenario, the 1915(i) state plan option reduces the administrative burden required to amend the current waiver and demonstrate cost neutrality in order to provide additional HCBS. It is important to note, however, that because 1915(i) eligibility is determined by needs-based criteria and cannot be restricted to waiver enrollees, any individual who qualifies for this 1915(i) plan design can utilize these services without enrolling in an HCBS waiver.
- **Design 1915(i) service packages that mirror one or more of the current 1915(c) benefit packages:** This benefit design would allow a state to extend the scope of the HCBS to individuals who are eligible for the 1915(c) waiver but are unable to enroll because of enrollment limits presented by the waiver. An approved 1915(i) application of this type would allow states to offer the waiver service package to additional eligible individuals without having to amend the current waiver to increase enrollment slots, and would resolve any waiver waitlist issues. This strategy can also lead to a smooth phase-out of the current 1915(c) waivers if the state elects not to renew the 1915(c) waiver at the end of the demonstration period.

A final key component of the ACA as it relates to Section 1915(i) was the allowance for states to introduce an optional medically needy eligibility group that could qualify for full Medicaid coverage upon meeting the needs-based criteria for 1915(i) services. Using the 1915(i) state plan option as a vehicle for comprehensive Medicaid coverage can assist states in targeting certain groups that would not otherwise be eligible for Medicaid benefits.

The following example highlights the method one state used in applying this provision to ensure continued Medicaid coverage to one such specialized group.

INDIANA MEDICAID: 1915(I) FOR BEHAVIORAL AND PRIMARY HEALTH CARE COORDINATION

On June 1, 2014, the state of Indiana converted from Section 209(b) status to Section 1634 status. (In summary, a state operating under Section 209(b) status establishes state-specific eligibility criteria for Medicaid disability status rather than accepting the Supplemental Security Income (SSI) disability determination. Under Section 1634 status, Medicaid eligibility determinations for disabled individuals would be based on SSI eligibility determinations.)

The Office of Medicaid Policy and Planning (OMPP) raised the income eligibility limit to 100 percent of FPL for disabled individuals. This change enabled many beneficiaries affected by the transition to maintain full Medicaid coverage. Individuals with incomes exceeding this threshold would generally be eligible to purchase insurance through the exchange marketplace and

Using the 1915(i) state plan option as a vehicle for comprehensive Medicaid coverage can assist states in targeting certain groups that would not otherwise be eligible for Medicaid benefits.



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The goal of the 1915(i) service was to provide a pathway to full Medicaid coverage and the specific mental health services that would be required by the eligible individuals.

to receive premium subsidies. Unfortunately, a number of individuals were at risk of losing Medicaid coverage who were classified with serious mental illness, not meeting institutional levels of care, and with income levels exceeding 100 percent of FPL. Prior to the Section 1634 transition, these individuals qualified for a set of mental health services through the Medicaid Rehabilitation Option. With the conversion to Section 1634 status in the state, it was uncertain whether third-party reimbursement would be available to these individuals for the level of mental health services needed to function safely in the community.⁴

To allow for continuation of Medicaid coverage for this population, therefore, OMPP applied for a behavioral and primary health care coordination (BPHC) service under the 1915(i) state plan option, which is a care management benefit targeted to adults age 19 or older with a qualifying mental health condition and income up to 300 percent of FPL.

The goal of the 1915(i) service was to provide a pathway to full Medicaid coverage and the specific mental health services that would be required by the eligible individuals. This result was achieved through the optional eligibility group provisions and the income disregards for medically needy individuals outlined in Section 1902 of the SSA.⁵ Due to the 1915(i) program changes under the ACA, Indiana was able to maintain access to critical mental health services for more than 4,500 individuals.

SUMMARY

In the period between the January 2007 effective date of 1915(i) as set forth by the DRA and the revisions introduced by the ACA in 2010, only five states had incorporated HCBS into their state plans. By August 2014, 12 states were participating in the 1915(i) state plan option and four more states were planning to participate in federal fiscal year 2014. The growing popularity of the 1915(i) state plan option can be attributed to its flexibility, which allows states to do the following:


- Provide a vehicle for full Medicaid coverage to medically needy individuals who would not otherwise qualify for Medicaid;
- Add HCBS and/or expand coverage of individuals who meet institutional levels of care without having to amend current 1915(c) waivers; and
- Meet the HCBS needs of Medicaid enrollees who have a degree of physical and intellectual disability that does not qualify them for institutional levels of care.

A key consideration in the implementation of a 1915(i) service package is that the delivery of HCBS through the state plan may assist in managing eligible individuals' chronic conditions, and may lead to savings by delaying or avoiding more costly care in a hospital or other institutional setting. As a result, both the program cost and potential offsets in other service categories should be presented in discussions of the financial implications of providing the 1915(i) state plan option.

USEFUL RESOURCES

The following resources were instrumental in the writing of this article, and are also very good references for additional information related to the 1915(i) state plan option:

- Centers for Medicare and Medicaid Services (January 16, 2014). "Medicaid Program; State Plan Home and Community- Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule." Federal Register. See <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>.
- U.S. Government Accountability Office Report to Congressional Requesters (June 2012). "Medicaid: States' Plans to Pursue New and Revised Options for Home- and Community-Based Services." See <http://www.gao.gov/assets/600/591560.pdf>.

- Letter from Centers for Medicare and Medicaid Services to State Medicaid Directors (August 6, 2010). “Re: Improving Access to Home and Community-Based Services.” See <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10015.pdf>.
- Letter from Center for Medicaid and State Operations to State Medicaid Directors (April 4, 2008). “Guidance on Implementation of Section 6086 of Deficit Reduction Act of 2005.” See <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD040408.pdf>.
- O’Keeffe, J., Saucier, P., et al. (October 29, 2010). “Understanding Medicaid Home and Community Services: A Primer, 2010 Edition.” See <http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm>. 

ENDNOTES

- ¹ Kaiser Family Foundation (August 28, 2014). Status of State Action of the Medicaid Expansion Decision. State Health Facts. Retrieved October 27, 2014, from <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.
- ² According to the Kaiser Family Foundation, 12 states were participating in the 1915(i) state plan option and four more states were planning to participate in fiscal year 2014, as of August 2014. See <http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/>.
- ³ In an April 4, 2008, letter from CMS to state Medicaid directors, the service offerings were limited to any or all of the following: “case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. In addition, the following services may be provided for individuals with chronic mental illness: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).”
- ⁴ Indiana Family and Social Services Administration. Behavioral and Primary Healthcare Coordination (BPHC) 1915(i) Home and Community Based Service (HCBS). Retrieved October 27, 2014, from http://www.in.gov/fssa/files/BPHC_Overview_Presentation_for_Providers.pdf.
- ⁵ More information related to the BPHC program is available on the Indiana Medicaid website at <http://www.in.gov/fssa/ddrs/4862.htm>.

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