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# *Idaho's Newly Eligible Medicaid Population: Demographic and Health Condition Information*

**Idaho Department of Health and Welfare**
**September 18, 2012**

# Executive Summary

The purpose of this report is to provide the Idaho Department of Health and Welfare (IDHW) with an analysis of its potential newly eligible population as well as a review of and recommendations for possible Medicaid benefit design options. These options are structured to meet the requirements for a Medicaid expansion as envisioned by the Patient Protection and Affordable Care Act (PPACA). The information and data provided in this report are meant to inform the Department of what its Medicaid environment may look like in an expansion scenario. The report is not meant to advocate a particular position, but rather to be used by Idaho as one point of evidence as it evaluates its decision to expand.

# Parameters of the Medicaid Expansion Provision

## Overview of the PPACA's Medicaid Expansion Provision

### *The PPACA's Medicaid Expansion Provision*

While the PPACA contains several Medicaid and CHIP-related provisions, the most significant change to Medicaid was the eligibility expansion. This provision required states to expand Medicaid eligibility to all adults, age 19–64, with income below 133% of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid.[1] This represents the single largest eligibility expansion since the Medicaid program was established in 1965.[2]

Currently Medicaid is provided to low-income children, parents, pregnant women, seniors, and persons with disabilities—and each group has different income eligibility criteria and standards. However, starting in 2014, most childless adults and parents with income below 133% FPL will qualify for coverage (this income level is roughly equivalent to $15,000 for an individual and $30,000 for a family of four). Eligibility for these "newly eligible" individuals will be based on Modified Adjusted Gross Income (MAGI), which differs from the categorical eligibility determinations of the traditional Medicaid program.

[1] Current Medicaid income disregards are replaced by a 5% income disregard, which makes the effective eligibility rate 138% FPL. In the current Medicaid program, a state determines the gross income and resources of the applicant, and then deducts certain items which may be disregarded (e.g., earned income, child care income, etc.). Under the expansion, most current income disregards are replaced by a single 5% income disregard.
[2] Medicaid and the State's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline, Congressional Research Service (August 19, 2010).

### *Funding*

New federal match rates will provide 100% federal funding for the care of the newly eligible Medicaid population for three years (2014–2016). After 2016, the funding will gradually be reduced to 90% by 2020 and is expected to hold at 90% thereafter. However, this funding is only available to the "newly eligible" or those who do not qualify for Medicaid under the traditional categories.

If a person applies for Medicaid after 2014, and is found to be eligible for the traditional programs, the state will only receive the regular match rate for the new enrollee.[3] Because Idaho's existing eligibility standards are relatively low, it can be expected many of those who apply for Medicaid under the expansion will qualify as "newly eligible."[4]

### *Benefit Package Requirements*

States are required to provide most people who become newly eligible for Medicaid with "benchmark" benefits. The benchmark package must: 1) meet existing rules set forth in the Deficit Reduction Act of 2005; 2) provide all "essential health benefits;" 3) be equal to one of the three available benchmark plans or be HHS Secretary-approved coverage; and 4) meet additional Medicaid requirements.

The Medicaid benchmark benefits must be equal to one of the three following benchmarks:[5]

1. The standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employee Health Benefits Plan (FEHBP)
2. Any state employee plan generally available in a state
3. The state HMO plan that has the largest commercial, non-Medicaid enrollment

States can also select a benefit package different from the ones listed above, as long as it is approved by the Secretary of Health and Human Services (HHS). HHS has indicated that a state's traditional Medicaid benefit package will be a Secretary-approved option.

## Supreme Court Ruling

In a 5–4 decision, the Supreme Court upheld the individual mandate, ruling that it "may reasonably be characterized as a tax." The Court also stipulated that the federal government is precluded from withdrawing existing Medicaid funds based on a state's refusal to comply with the expansion—effectively allowing states to choose whether to participate in the Medicaid expansion.

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[3] Idaho's FY2012 federal match rate was 70.2%, meaning the federal government pays up to 70% of medical costs and the state pays the remaining 30%.

[4] Idaho does not offer coverage to childless adults. Its income eligibility for jobless parents is roughly 21% FPL and the income eligibility for working parents is 39% FPL. Idaho also currently provides premium assistance to adults up to 185% FPL under a waiver; individuals must have income below the eligibility threshold and work for a qualified small employer in order to enroll in the program.

[5] Equal can also mean "equivalent in actuarial value."

Since the ruling, HHS and the Centers for Medicare & Medicaid Services (CMS) have provided some guidance to states, including:

1. The change in the Medicaid provision does not affect other aspects of the law, meaning the provisions relating to the Maintenance of Effort, Disproportionate Share Hospital Program funding reductions, and primary care provider reimbursement increases are not affected.[6]

2. Those who do not qualify for Medicaid or exchange subsidies (which are provided to persons with income between 100% and 400% FPL) will not be penalized for not purchasing insurance. It is unlikely HHS will extend the availability to subsidies to persons with income below 100% FPL.

3. There is no deadline for states having to notify HHS of plans to implement the Medicaid expansion and states can opt out of the expansion at any time without penalty.

While it is expected that HHS will release additional guidance to states in the upcoming months, many questions still surround the Medicaid expansion provision and what the ruling means for states.

# Idaho's Newly Eligible Population

## Estimated Number of Newly Eligible

Leavitt Partners estimates there will be 97,066–111,525 persons newly eligible for Medicaid in 2014. This reflects the adult population, age 18–64, and excludes those who are currently eligible, but not enrolled in Medicaid. The estimated total number of new Medicaid enrollees, including the currently eligible, but not enrolled is 106,872–123,824. Estimates of the newly eligible are provided in Figures 1–2 and the assumptions and methodology used to create these estimates are described in the full report.

Figure 1

| Estimated Number of Newly Eligible in Idaho, 2014 | | |
|---|---|---|
| | Low Estimate | High Estimate |
| Newly Eligible | 97,066 | 111,525 |
| Currently Eligible, but Not Enrolled | 9,806 | 12,299 |
| **Total** | **106,872** | **123,824** |

SOURCE: Leavitt Partners.

[6] Under the PPACA, HHS will reduce aggregate Medicaid DSH allotments between FY2014 and FY2020 to account for the decline in the number of uninsured. The amount expected to be reduced increases from $500 million in FY2014 to $5.6 billion in FY2019. In 2013 and 2014, states must increase primary care physician rates so they are equal to Medicare rates.

Figure 2

| Estimated Number of Newly Eligible by County, 2014 (Low Estimate) | | | |
|---|---|---|---|
| Ada County | 17,307 | Gem County | 1,132 |
| Adams County | 333 | Gooding County | 909 |
| Bannock County | 5,759 | Idaho County | 1,190 |
| Bear Lake County | 405 | Jefferson County | 1,595 |
| Benewah County | 632 | Jerome County | 1,386 |
| Bingham County | 2,804 | Kootenai County | 9,528 |
| Blaine County | 521 | Latah County | 3,085 |
| Boise County | 522 | Lemhi County | 660 |
| Bonner County | 3,020 | Lewis County | 248 |
| Bonneville County | 5,351 | Lincoln County | 320 |
| Boundary County | 919 | Madison County | 3,736 |
| Butte County | 207 | Minidoka County | 1,193 |
| Camas County | 69 | Nez Perce County | 2,088 |
| Canyon County | 14,618 | Oneida County | 302 |
| Caribou County | 347 | Owyhee County | 788 |
| Cassia County | 1,417 | Payette County | 1,720 |
| Clark County | 43 | Power County | 427 |
| Clearwater County | 558 | Shoshone County | 835 |
| Custer County | 333 | Teton County | 672 |
| Elmore County | 2,181 | Twin Falls County | 4,885 |
| Franklin County | 793 | Valley County | 582 |
| Fremont County | 996 | Washington County | 647 |
| **Idaho State** | | **97,066** | |

Note: Numbers may not sum to total due to rounding.
SOURCE: Leavitt Partners.

### *Optional versus Mandatory Expansion*

While the Supreme Court ruling allows states to opt out of the Medicaid expansion, other PPACA provisions will effectively expand Medicaid eligibility above current state levels, regardless of whether states choose to expand or not. These changes essentially create an optional and a mandatory Medicaid expansion. The mandatory expansion is based on several factors, including: 1) the use of Modified Adjusted Gross Income to determine income eligibility; 2) the elimination of asset tests; 3) changes in the definition of a household; 4) changes in the application and redetermination process; and 5) coordination of eligibility determinations.

IDHW estimates that these factors could increase Idaho's Medicaid enrollment by 5% to 10%, regardless of whether the State decides to expand or not (also known as "eligibility surge" this number does not take into account the newly eligible or the currently eligible, but not enrolled, who may enroll in Medicaid in an expansion scenario).

## Idaho Demographic and Health Condition Information

To provide demographic and health condition information specific to the newly eligible population, Leavitt Partners examined state-specific data from Idaho's Behavioral Risk Factor Surveillance System as well as four Idaho programs that currently provide health care services to persons who will likely be newly eligible for Medicaid—the Idaho Catastrophic Health Care Cost Program (CAT or Medically Indigent Services), the Idaho Primary Care Association (or Community Health Centers), Idaho Adult Mental Health Services provided by the State, and the Department of Corrections.

Based on the information provided from these programs, as well as some state-specific data from national sources, it is estimated that the newly eligible population in Idaho will:

1. **Consist of both a younger, relatively healthy population as well as an older population suffering from chronic conditions.** Persons age 40–64 account for roughly one-third of the low-income nonelderly uninsured adult population in Idaho.[7] Census data providing health insurance coverage status by age show individuals, age 25–34, make up the largest share of uninsured adults.[8] However, as indicated by the state program data, a significant portion of the population that is older tends to experience more costly chronic conditions.

2. **Suffer from both treatable chronic conditions such as diabetes and hypertension, as well as other serious chronic conditions such as cancer, coronary-related diagnoses (i.e., myocardial infarction), and gastrointestinal diagnoses.** About one-third of the newly eligible population is expected to be obese, smoke, and/or have high cholesterol, all of which are indicators of more serious chronic conditions.

3. **Have prevalent mental health issues.** All four of the state programs identified mental health issues as one of the most common diagnoses for this population. A considerable portion of the newly eligible population is expected to experience depression, anxiety disorders (including PTSD), bipolar disorders, schizoaffective disorders, schizophrenia, and alcoholism.

[7] U.S. Census Bureau, Small Area Health Estimates 2009.
[8] U.S. Census Bureau, American Community Survey 2008–2010 (3-year estimates).

4. **Have some pent-up need for care.** While about half of the population is possibly receiving treatment through the four state-run programs examined in the report, many of the programs only treat specific diagnoses or incidents. As such, it is expected that the newly eligible population will have a pent-up need for care for services that are not currently available to them. However, not all persons who enroll in Medicaid under the expansion will immediately seek services even if they have a pent-up need for care—some will continue to delay care due to an unperceived need, a lack of knowledge of how to access the system, etc.

5. **Consist of a large childless adult population.**[9] Most of the participants in the CAT and Adult Mental Health Services programs come from single person households. Data from the Census Bureau also indicate childless adults account for 62% of Idaho's nonelderly adult population—and it is expected that this percent will increase as income thresholds are restricted. Research has shown that childless adults tend to have higher utilization rates and are more expensive than the uninsured parent population—largely due to a greater pent-up need for care. They also tend to suffer from more chronic conditions and mental health/substance abuse issues.

6. **Have income below 100% FPL.** Information from the four state programs indicates that most of those who will become newly eligible for Medicaid have income below 100% FPL, with a sizeable portion reporting to have little-to-no income. Data from the Census Bureau show that close to 75% of the newly eligible population in Idaho has income below 100% FPL. Census data also show that roughly 64% of those individuals are employed.

Key findings from the four state programs, as well as Idaho's Behavioral Risk Factor Surveillance System, are outlined below. The summaries provide demographic and health condition information specific to the newly eligible population, as well as highlight possible benefits to include in a Medicaid benchmark benefit package.

Figure 3

| Estimated Number of Participants that will be Newly Eligible for Medicaid by State Program | |
|---|---|
| **State Program** | **Estimated Number of Participants[1]** |
| Idaho Catastrophic Health Care Cost Program (CAT or Medically Indigent Services) | 6,000 |
| Idaho Community Health Centers (CHC) | 35,000 |
| Idaho Adult Mental Health Services provided by the State | 4,300 |
| Corrections | 2,000 |
| **Total** | **47,300** |

[1] Estimates are based on the latest fiscal year for which data were provided. While there may be some overlap of participants between programs, it is expected that this number is minimal as each program targets a fairly distinct population. The number of participants presented for the CAT program is an overestimate as the estimate is based on cases and not individual participants. The number of participants in the Adult Mental Health Services program is also likely an overestimate as it may include some individuals who are currently enrolled in Medicaid.

[9] "Childless adult" is defined as having no dependent children.

## *Behavioral Risk Factor Surveillance System*

1. The prevalence of chronic conditions is higher among persons with lower income and the rate of preventive screenings is much lower.

2. The newly eligible population will have higher rates of chronic conditions and substance abuse issues than the general population. A significant portion of the newly eligible population is expected to be obese, smoke, and have high cholesterol, all of which are indicators of more serious chronic conditions.

3. Public Health Districts 3 and 4, which include Ada, Canyon, Boise, and Gem Counties among others, generally have the largest number of persons with selected risk factors. However, while some districts have a higher prevalence of certain health factors, none of the districts stand out as having more health concerns overall.

## *Catastrophic Health Care Cost Program (Medically Indigent Services)*

1. It is estimated 6,000 program applicants will qualify for Medicaid in 2014.[10] The counties which submit the largest number of cases for CAT approval and payment are generally the same counties that are expected to have the highest number of newly eligible, supporting the idea that the majority of the population both applying for and currently participating in the CAT program will qualify for Medicaid under an expansion scenario.

2. The population is primarily made up of single or two person households (likely childless adults) and is generally an older population (age 51–64).

3. The population experiences a high rate of chronic conditions, including: 1) cancer; 2) coronary-related diagnoses (i.e., chest pain and myocardial infarction); 3) digestive system diagnoses (i.e., abdomen- and gallbladder-related disorders); 4) alcoholism; 5) diabetes; and 6) metal health diagnoses (the most prevalent being bipolar disorder and depression).

4. In FY2011, a total of $51.1 million state and county dollars were spent on Medically Indigent Services; county dollars accounted for 48% of the total, while state dollars accounted for 52%. Under a Medicaid expansion, this population would have better access to preventive care, potentially reducing catastrophic illness or injury and in turn reducing overall health care costs.

5. Because this population experiences a variety of serious physical and mental illnesses, it will benefit from services that help control and reduce the negative effects of these chronic conditions. Both primary and specialty care will need to be provided to adequately address this population's needs. The population may also benefit from care coordination and disease management programs.

[10] Estimate by Medically Indigent Services administrators. It is important to note that applicants represent cases, and not individuals. Each application is associated with a new case, but not necessarily to a new participant as that participant could have more than one case in a "CAT" year and more than one case in an "Applicant" year. For the purpose of this assessment, it is assumed that cases represent individuals; however, this likely results in an overestimate of the number of individuals that will be newly eligible for Medicaid.

## *Community Health Centers*

1. It is estimated 35,000 CHC patients will become newly eligible for Medicaid in 2014. After the expansion, Medicaid patients will represent 50% of Idaho's total current CHC patient population (slightly more than half of whom will be newly eligible). The majority of the population is expected to have income below 100% FPL.

2. The largest segment of adult patients seeking care at CHCs is young females, age 19–40. It is likely this segment of the population is mostly made up of women who are seeking care for their children in addition to receiving care for themselves.

3. The most common medical-related diagnoses of CHC patients include hypertension and diabetes. In terms of mental health-related diagnoses, the most common diagnoses are depression and other mood disorders, anxiety disorders (including PTSD), and attention deficit and disruptive behavior disorders. These diagnoses are less serious and more easily treated than many diagnoses present in the CAT program.

4. In 2010, total costs incurred by Idaho CHCs were $62.5 million. The Idaho Primary Care Association estimates the average cost per patient in 2010 was $588.[11] It can be estimated that the state portion spent on CHCs was about $6.5 million in 2011.[12] These funds are used to treat the currently eligible population. CHCs would receive additional Medicaid funds for the newly eligible, providing IDHW with an immediate opportunity to collaborate with CHCs to discuss how best these increased funds can be used to enhance the infrastructure needed for an expanded Medicaid population and to help with the State's delivery system reforms.

5. CHCs provide patient-centered, primary health care services as well as support services that could be beneficial to include in a new Medicaid benchmark package. Such support services include case management, eligibility assistance, and patient and community health education. Close to 20% of the total CHC patient population is best served in a language other than English, indicating a need for interpreter services if the Medicaid program expands.

## *Adult Mental Health Services Provided by the State*

1. It is estimated that roughly 4,300 program participants will be newly eligible for Medicaid.[13] Unlike the CHC population (which typically receives primary care services) and the CAT population (which receives treatment for both chronic physical and mental health issues), the Adult Mental Health Services population receives treatment for serious and persistent mental illnesses (SPMI), signifying a strong need for mental health services in the newly eligible Medicaid benefit package.

[11] Idaho Primary Care Association.
[12] Ibid.
[13] This is likely an overestimate as it may include some individuals who are currently enrolled in Medicaid. The Division of Behavioral Health is not able to isolate those currently enrolled in the Medicaid program, but estimate it could range upward of 20%.

2. The distribution of male and female participants is fairly uniform across the age groups, although the younger participants tend to be represented by more males than females, and the older participants are represented by more females than males. Close to 75% of all participants are single person households, indicating that the newly eligible population from this program will largely be childless adults.

3. The most common diagnoses for males include: 1) schizoaffective disorder; 2) schizophrenia, paranoid type; and 3) major depressive disorder, without psychotic features. The most common diagnoses for females include: 1) major depressive disorder, without psychotic features; 2) schizoaffective disorder; and 3) bipolar II disorder.

4. The total amount of state dollars spent on Adult Mental Health Services in FY2011 was $16.5 million. This cost includes both the cost spent on medical care and administrative services (some of this amount also includes Medicaid funds). Most participants come from Regions 3, 4, and 7, which correspond to the same populous health districts identified in the Behavioral Risk Factor section. While a greater number of persons in these districts have significant health issues, the fact that they have been receiving mental health services should somewhat reduce their pent-up need for mental health care. Under a Medicaid expansion scenario, this population would also have access to physical health care, resulting in better coordinated, continuous care—potentially reducing long-term illnesses and costs.

5. Each Regional Mental Health Center provides a variety of services designed for the SPMI population, which includes crisis screening and intervention, mental health screening, psychiatric clinical services, case management, individual and group therapy, medication clinics, etc. Given close to 96% of program participants are expected to be newly eligible, it may be beneficial to include similar services in the Medicaid benchmark package.

## *Corrections*

1. On average, about 2,000 individuals are released from correctional facilities each year.[14] Close to 95% of these individuals are adults age 19–64, so it is expected that the majority of this population will be newly eligible for Medicaid.

2. Inmates have access to onsite procedures as well as both inpatient and outpatient care provided at medical facilities, so their pent-up need for care may not be as great as other populations. However, because they have been receiving care, it is more likely they will have been diagnosed with chronic conditions that will require ongoing treatment under the Medicaid program.

3. In terms of onsite procedures, routine office visits are low—indicating that preventive care treatments may be uncommon and that this population is treated on an "as-needed" basis.

4. In terms of inpatient and outpatient facilities, inmates are typically admitted for a variety of diagnoses, including: 1) gastrointestinal; 2) cardiac, brain, and circulatory; 3) cancer-related;

[14] Idaho Department of Corrections.

and 4) injury and trauma. However, once admitted, inmates often receive treatment for a variety of additional services, indicating a need for care that was previously not addressed.

5. The total amount of state dollars the Department of Corrections spent on medical care in 2011 was $5.5 million.[15] This population has access to a variety of services while in correctional facilities; however, because office visits are infrequent, this population may benefit from programs and services that promote the use of primary care physicians and reduce long-term costs associated with untreated chronic conditions.

# State Experiences with Expanded Populations

As states make the decision whether or not to expand their Medicaid programs, it is helpful to understand what the newly eligible population's expected utilization patterns will be in addition to understanding its demographic and health condition information. While some utilization experience can be inferred from the Idaho-specific data presented above, examining the experience of other states that have already expanded their Medicaid programs to childless adults and parents can provide insight to the expected utilization patterns and possible costs of this population.

## Utilization Patterns and Costs of the Newly Eligible: Experiences from Expansion States

1. The utilization patterns and associated costs of the newly eligible population will in large part depend on how long the population has been uninsured and how many have serious chronic conditions. As such, childless adults are likely to have higher utilization rates than parents because they tend to have been uninsured longer, are older and have higher rates of disabilities, have a higher pent-up need for care, and have more chronic conditions and mental health/substance abuse issues.

2. The overall health of the newly eligible population will, in part, depend on the level of participation in the Medicaid program. Studies of the newly insured suggest that persons with more serious health problems will likely be the first to enroll. Therefore, if the program has relatively low participation rates, the risk of adverse selection is much higher.[16]

3. The cost of covering the newly eligible population will be less than traditional Medicaid (largely due to the high costs of the aged, blind and disabled populations), but higher than programs that currently offer services to adults with dependent children. "If benefit packages were comparable—the costs for low-income childless adults would be approximately halfway between those of non-disabled and disabled adults."[17]

[15] States may also choose to pay for inmates' off-site medical treatment through Medicaid.
[16] The Health Status of New Medicaid Enrollees under Health Reform, Robert Wood Johnson Foundation (August 2010).
[17] Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States, Center for Health Care Strategies, Inc. (August 2010).

Figure 4 shows the estimated per member per month (PMPM) costs associated with state Medicaid programs that have expanded coverage to childless adults and parents with income up to 100% FPL or more. In most cases the estimated PMPM costs range from $400 to $600, depending on the scope of benefits offered as well as the program's cost-sharing requirements. Only Arizona offered the expanded population full Medicaid coverage, indicating the estimated PMPM costs of expanding coverage to the newly eligible in Idaho may be closer to $600.

Figure 4

| State Expansion Programs and Estimated PMPM Costs, 2008–2014 | | |
|---|---|---|
| **State** | **Program Name** | **PMPM Costs** |
| Arizona | Arizona Health Care Containment System (Proposition 204) | CY2010 projected costs:<br>Childless Adults: $7,361 (annual); $613 PMPM |
| Indiana | Healthy Indiana Plan | FY2014 (estimated) costs:<br>Healthy Indiana Plan: $440 |
| Maine | MaineCare for Childless Adults | FY2007–2008 costs:<br>Childless Adults: $406 |
| Oregon | Oregon Health Plan Standard | 2010 costs:<br>Adults and Couples: $679 |
| Washington | Basic Health Plan<br>Disability Lifeline | 2009 costs:<br>Basic Health Plan (BHP): $248<br>Disability Lifeline: $570 |
| Wisconsin | BadgerCare Plus Health Insurance | 2010 PMPM cost (45+ males):<br>BadgerCare Plus Core Plan (childless adults): $224<br>BadgerCare Plus Standard (parents): $262 |

4. Pharmaceutical costs are generally higher than expected. Because the newly eligible population will likely suffer from more chronic conditions and mental health/substance abuse issues, its use of pharmaceuticals is much higher than the commercial population or currently eligible Medicaid parent populations. While the use of inpatient, outpatient, and physician services has shown to level off over time, the utilization of pharmacy services increases. Other frequently used services include mental health services and substance abuse treatment centers.

5. Because the newly eligible population will consist of young, healthy parents, childless adults with a pent-up need for care, and an older population with serious chronic conditions, meeting the newly eligible's diverse health care needs will require a broad package of benefits.

# Benefit Design Options

## Benchmark Benefit Package Requirements

As mentioned above, the PPACA requires states to provide most people who become newly eligible for Medicaid with "benchmark" benefits. The benchmark package must: 1) meet existing rules set forth in the Deficit Reduction Act of 2005; 2) provide all "essential health benefits;" 3) be equal to one of the three available benchmark plans or be Secretary-approved coverage; and 4) meet additional Medicaid requirements. In this section, Leavitt Partners provides recommendations for benefit design options for the newly eligible population. Leavitt Partners assumes that this benefit design will be used in the new Medicaid delivery systems developed by the State, as directed by the Idaho Legislature.

### *Deficit Reduction Act of 2005*

The Deficit Reduction Act (DRA) gives states the option to provide select Medicaid groups an alternative benefit package. Multiple benchmark benefit packages may be provided to different populations based on health status or geographic region. For example, states can offer a comprehensive benchmark plan to high-risk populations while offering a more limited benchmark plan to relatively healthy populations.

**Churn Between Existing Medicaid Categories:**
Because many traditional Medicaid groups are excluded from receiving benchmark coverage, a state that utilizes a benchmark benefit for the newly eligible will need to evaluate how to handle the churn that may occur between the newly eligible and the existing Medicaid eligibility categories. The exemption rule also implies that certain groups of individuals who are considered "newly eligible" may not be eligible for benchmark coverage at all. As such, this population would need to retain the option to enroll in Idaho's Standard Medicaid Plan.

Having a benchmark plan that aligns with the benefit plan offered to pregnant women and Section 1931 parents may help reduce some of the administrative burden caused by the potential churn between the newly eligible and the existing Medicaid eligibility categories. CMS has also stated that, between renewal periods, states do not need to track or require the reporting of any life changes that may impact the eligibility status of an enrollee. This further reduces, but does not eliminate the administrative burden caused by potential churn. It is expected that states will still need to provide enrollees with notices of program information and benefit options, and must respond to any information they receive that impacts an enrollees' eligibility.

**Churn Between Medicaid and the Exchange:**
Medicaid-eligible individuals with income near the upper end of the income threshold (133% FPL) are also expected to frequently transition between being eligible for Medicaid and for premium subsidies offered through a state's health insurance exchange. Some possible ways to help minimize the impact of this churn is to certify health plans to serve both Medicaid and exchange enrollees or to use one of the exchange's metallic coverage levels (bronze, silver, gold, and platinum) as the basis for the newly eligible benefit plan.[18]

[18] Issuers participating in the exchange must offer at least one silver and one gold plan in the exchange. These plans are based on a specified share of the full actuarial value of the exchange's essential health benefits, which is based on a benchmark plan selected by the state.

Because premium credits will be tied to the second lowest-cost silver plan in each state, it may make most sense to base the newly eligible benefit plan on this silver plan. However, because Medicaid has additional benefit and higher cost-sharing requirements, the Medicaid newly eligible benefit plan may have an actuarial value that is significantly higher than most silver plans offered on the exchange. How well the two plans intersect will depend on which plan Idaho's Insurance Department selects as its essential health benefit and whether it can be enhanced to meet Medicaid requirements.[19]

**Cost-Sharing:**
While the amount, duration, and scope of limits in the benchmark benefit packages can be applied to the Medicaid population, the cost-sharing requirements cannot. The cost-sharing amounts states can charge the newly eligible Medicaid population depends on both the enrollees' income and the service being provided.[20] For adults below 100% FPL, states cannot charge more than a nominal amount for most services and cannot charge a premium or copay for emergency services or family planning services. Above 100% FPL, the amount of cost-sharing allowed increases as the enrollee's income increases.

**Additional Medicaid Requirements:**
The benchmark plan established for the newly eligible population must meet other Medicaid requirements, such as the requirement to cover non-emergency transportation services, family planning services and supplies, EPSDT for persons under age 21 covered under the state plan, and care provided by rural health clinics and federally qualified health centers (benefits required under Section 1937; see Figure 5).[21] The benefit package must also comply with Medicaid managed care requirements, and the state must allow for public input on the benefit package before filing a proposal with HHS.

## *Essential Health Benefits*

Essential Health Benefits (EHB) are a baseline comprehensive package of 10 items and services that all small group and individual health plans must provide starting in 2014. All 10 EHB categories must be included in the Medicaid benefit package. If the selected benchmark plan does not cover all of the required benefits, the state must supplement the benefits.

[19] Because Idaho's Insurance Department has not yet selected an essential health benefits benchmark plan for its exchange, it cannot yet be determined how closely the silver plan aligns with Medicaid requirements.
[20] Medicaid: A Primer, Congressional Research Service (July 15, 2010).
[21] Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser Family Foundation (August 2010).

Figure 5

| Essential Health Benefit Categories | |
|---|---|
| Ambulatory patient services | Prescription Drugs |
| Emergency services | Rehabilitative and habilitative services and devices |
| Hospitalization | Laboratory services |
| Maternity and newborn care | Preventive and wellness services and chronic disease management |
| Mental health and substance abuse services | Pediatric services, including oral and vision care |
| **Benefits Required Under Section 1937** | |
| Early and Periodic Screening and Diagnostic Treatment (EPSDT) | Non-Emergency Transportation |
| Federally Qualified Health Centers & Rural Health Clinics | Family Planning Services |

Whichever benchmark option a state selects for its newly eligible population will also serve as its EHB benchmark reference plan. The PPACA also extends federal Mental Health Parity and Addiction Equity Act (MHP) requirements to benchmark plans, meaning all benchmark plans must offer mental health and substance abuse benefits in parity with medical and surgical benefits. Parity must be achieved with respect to both financial requirements as well as treatment limitations. While mental health and substance abuse services are currently covered in Idaho's Medicaid plans, both the amount of services and the associated costs could dramatically increase in order to meet the MHP requirements.

Because the final rules on the Essential Health Benefit had not been released at the time this report was finalized, there are some existing uncertainties associated with what services actually fall within the 10 categories and whether the Center for Consumer Information and Insurance Oversight (CCIIO) and/or CMS intend to require that benchmark plans include categories that are not applicable to the newly eligible population.

## Benchmark Plan Comparison

To create a sense of the best foundation on which to construct a recommended benefit package for Idaho, Leavitt Partners constructed a comparison of the different benchmark benefit options. To approximate a plan with the potential to be a Secretary-approved plan, Leavitt Partners utilized Idaho Medicaid's Basic Benchmark Plan for Children and Working Age Adults. Leavitt Partners methodology and criteria for evaluating the benchmark benefit options are outlined in the full report.

## *Recommendation*

**Final Recommendation: The Basic Benchmark Plan has the framework needed to meet the essential health needs of the majority of the target population. In addition, there already is an existing path to a more comprehensive plan (the Enhanced Benchmark plan) for any newly eligible who may qualify as disabled or medically frail. This benefit design can be used in the new delivery systems developed by the State, including in medical home and risk-based managed care models.**

After comparing the different benchmark benefit options, Leavitt Partners believes that the Idaho Basic Benchmark is the best foundation on which to build the plan for the newly eligible population. First, it already is Secretary-approved coverage. Second, the Idaho Basic Benchmark Plan includes benefits required under the PPACA as well as most of the EHB categories. Third, it includes services and programs that will meet most of the specific needs of Idaho's newly eligible population. For example, it provides disease management, smoking cessation, and weight reduction programs, which will directly address the newly eligible's high prevalence of chronic conditions, tobacco use, and obesity.

Beyond being a good match for the needs of the population, utilizing the existing plan has several additional advantages. First, is administrative ease; IDHW's staff already understand the scope of coverage and limits that apply. Using this plan would allow IDHW to maintain many of its current administrative processes, which would simplify its transition to an expansion scenario. Second, there is an existing path to a more comprehensive plan for any newly eligible who may be disabled or medically frail (these individuals are transferred to the State's Enhanced Benchmark plan). Finally, because there will likely be significant movement between the currently eligible adult population and the newly eligible population, having benefit packages that are similar in scope and design will provide continuity across programs and mitigate the challenges typically associated with churn.

This benefit design is meant to be used in the new delivery systems developed by the State, as directed by the Idaho Legislature in HB 260. These delivery systems include the use of medical home models and contracting with managed care organizations to administer benefits and manage the population's care. As indicated in Section III of the full report, most states that have already expanded Medicaid to an adult population use a pre-paid, capitated health plan delivery system. This is consistent with Idaho's move toward a more public/private delivery system approach.

## *Additional Services*

While the Basic Benchmark provides a solid framework on which to build the benefit plan for Idaho's newly eligible population, there are other services that are not covered in the benchmark plan that may be beneficial to add based on the health needs of the target population. Following is a list of additional services Leavitt Partners has identified that could potentially strengthen the newly eligible benefit package (more detail on each service is provided in the full report). Some of these services are already offered in the Basic Benchmark Plan, but could be expanded, while other services are not currently covered and would need to be added to the plan.

1. **Interpreter Services:** While the Basic Benchmark Plan currently covers interpreter services, the services may need to be enhanced to better meet the newly eligibles needs. Idaho's CHCs indicated a need for interpreter services for the newly eligible population and such services are likely a significant need in other provider settings as well. Research shows that individuals who

use interpreter services experience significant increases in the receipt of preventive services, primary care physician visits, and prescription drugs, which may result in better health and lower costs over time.[22]

2. **Telehealth:** In the Basic Benchmark Plan it appears as though telehealth is limited to psychiatric services. With advances in the use of this technology, there is increasing evidence that telehealth can be an effective tool for the treatment and monitoring of chronic conditions such as diabetes, congestive heart failure, and hypertension. Telehealth may also be used to help alleviate provider capacity issues that may occur in an expansion scenario—particularly in Idaho's rural areas where there is a shortage of both medical and mental health providers.

3. **Smoking Cessation Programs:** The Basic Benchmark Plan currently provides a smoking cessation program for pregnant women and IDHW plans to expand these services to all Medicaid enrollees in 2014. Considering a large portion of the newly eligible population is expected to smoke, it may be necessary to expand the services and/or scale of this program. Maine found that within its expansion population, medical claims that include a nondependent tobacco use disorder consistently rank as one of the most costly conditions—indicating smoking is an underlying factor for more serious chronic conditions. Research has also shown that smoking cessation medication benefits are correlated with significant benefits to health.

4. **Mental Health and Substance Abuse Programs:** The Basic Benchmark Plan currently provides mental health services, but given that mental health conditions and substance abuse issues will be prevalent among Idaho's newly eligible population, it may be necessary to expand the scale of services provided. In Maine's expansion program, mental health and substance abuse diagnoses accounted for four of the top 10 most costly diagnoses (with substance abuse treatment being the highest in terms of number of encounters and dollars spent by the State).

   However, studies do show that providing this population with appropriate services results in effective and cost-saving treatment. Establishing a sub-acute model with pre-authorization requirements for "stepped care" has proven to be an effective way to provide appropriate services while simultaneously reducing inpatient hospital stays and controlling costs.[23]

5. **Disease Management/Care Coordination Programs:** The Basic Benchmark Plan currently provides disease management programs for diabetes, hypertension, and asthma, and under the proposed medical home model, IDHW plans to establish disease management programs focused on diabetes, asthma, and mental health conditions. Given this is a required EHB category and that a significant portion of Idaho's newly eligible population is expected to suffer from chronic conditions, it may be necessary to increase the scope of the plan's current programs. However, it is important to note that the evidence on the cost effectiveness of these programs is mixed. As such, Leavitt Partners advises IDHW to focus on programs that target specific conditions and populations that benefit most from care coordination.

[22] Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services, American Journal of Public Health (May 2004).

[23] In stepped care, patients initially receive the lowest appropriate level of care. If the patient's response to this level is not sufficient, the frequency and intensity of treatment can be "stepped up" to the next level of care.

Based on the newly eligible population's needs, programs that focus on coordinating a high-risk individual's co-occurring, complex physical and mental health conditions may be both beneficial and cost effective. Establishing two benchmark packages for the newly eligible population would allow IDHW to target disease management and care coordination programs to the populations with the highest risk and greatest need. In terms of the State's plan to carve out behavioral health through a risk-based system, IDHW may consider giving higher scores to contractors that propose innovative ways for integrating mental and physical health, and incentivize medical providers to work closely with mental health providers.

## Next Steps

In terms of next steps, Leavitt Partners recommends the State complete the following 3-step process.

1. Evaluate the costs associated with both expanding the State's Medicaid program and choosing to opt out of the expansion.

2. Evaluate what alternative opportunities exist under the current Medicaid State Plan and what could be achieved through State Plan amendments or 1115 Waivers.

3. Determine what other considerations and externalities should be taken into account when deciding whether or not to expand.

IDHW and the Medicaid workgroup have begun parts of this evaluation and are expected to complete the process within the next several months. Given the lack of guidance from CMS since the Supreme Court ruling, Leavitt Partners recommends that Idaho wait to declare a formal decision as to whether or not it will expand until more guidance is released after the November election.

That said, because implementation deadlines are tight, Leavitt Partners believes that Idaho should use the time before the election to continue evaluating its options and deciding how to design the program under an expansion scenario.

If Idaho decides to expand, Leavitt Partners recommends expanding in 2014, which will give the State three years of full federal funding to evaluate overall costs and utilization patterns of the newly eligible. Based on this evaluation, Idaho can make appropriate changes to the program or opt out of the expansion entirely after 2016. To take advantage of this opportunity, IDHW will need to be prepared to act quickly once more guidance is released after the election, and can therefore not wait to begin some early implementation activities.