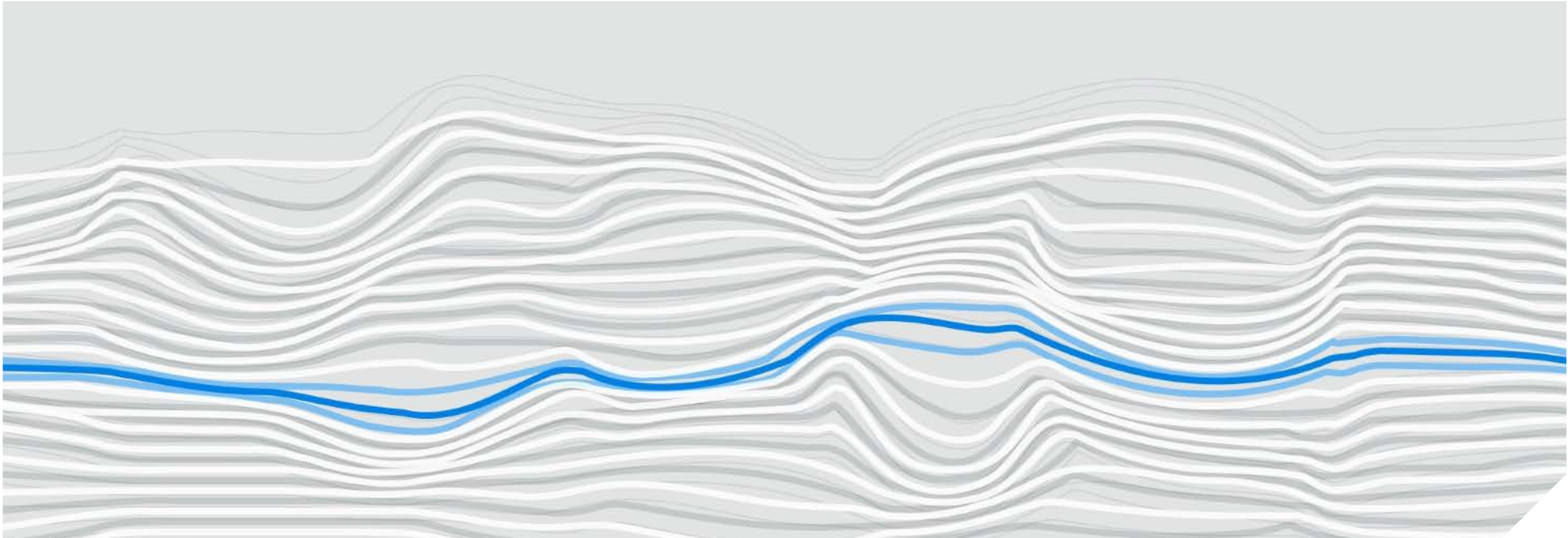


Medicaid Expansion

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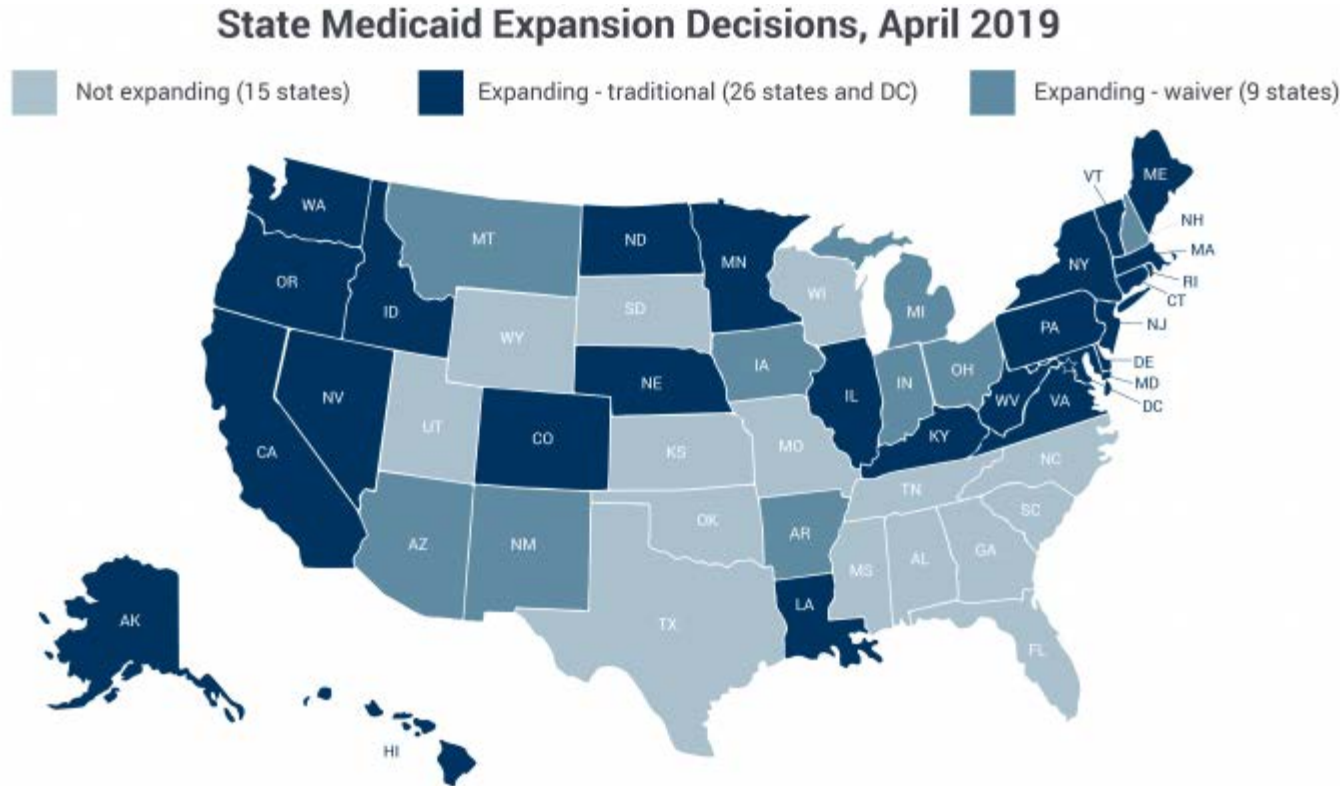
16 JULY 2019



Agenda

- 3 **Medicaid expansion decisions**
- 4 **State approaches for expansion**
- 5 **Participation and enrollment ramp-up**
- 6 **Initial cost, changes in service utilization, especially pharmacy**
- 8 **Changes in morbidity over time**
- 9 **Medically frail**
- 11 **Funding for the expansion**

Medicaid expansion decisions by state



- Three of the Medicaid expansion decisions relate to Fall 2018 ballot measures (Idaho, Nebraska, Utah)
 - Utah is moving ahead with an 1115 waiver, some changes from initial ballot measure
- Wisconsin covers up to 100% FPL
- Active discussion in Kansas, Georgia, and many other non-expansion states

From MACPAC

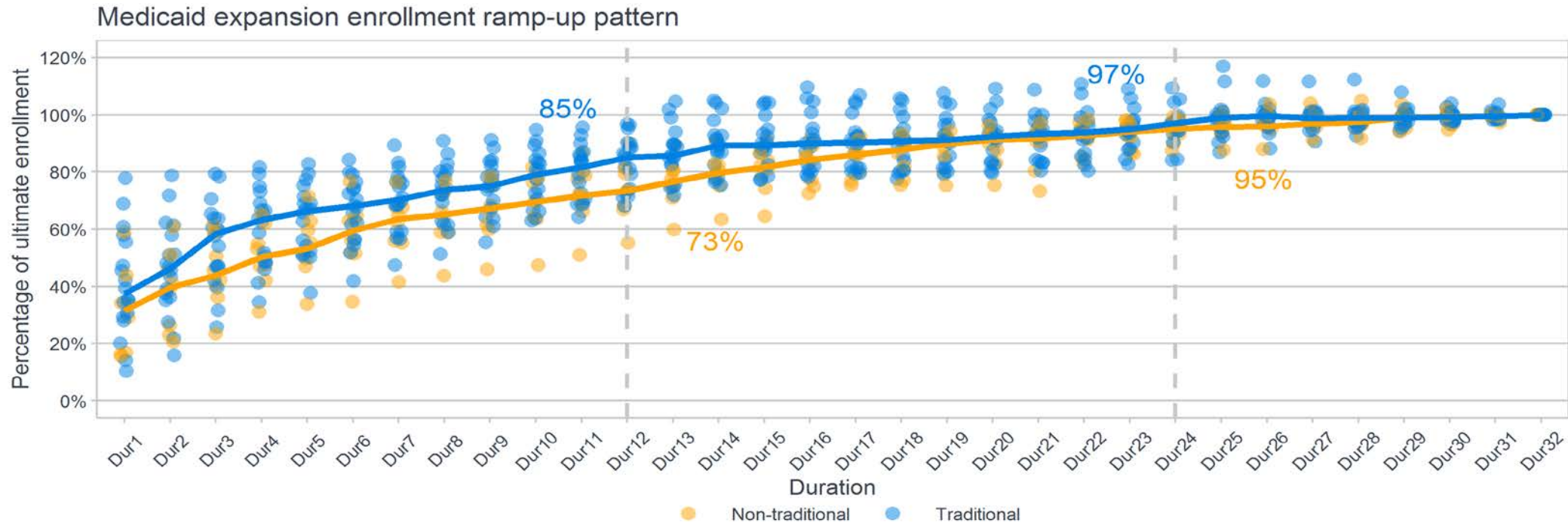
Source: <https://www.macpac.gov/subtopic/medicaid-expansion/>

States using nontraditional approaches have used 1115 Waivers to cover or make program changes for the Expansion population

State	Premium Assistance	Premium / Monthly Contributions	Copayments	Healthy Behaviors/ Health Risk Assessment	Work requirement/ Community Engagement
Arizona		✓	✓		✓
Arkansas	✓	✓	✓		
Indiana		✓	✓	✓	✓
Kentucky		✓	✓	✓	✓
Michigan		✓	✓	✓	✓
New Hampshire			✓	✓	✓
Ohio		✓	✓	✓	✓
Utah	✓		✓		✓

Enrollment ramp-up

Ramp-up to “ultimate”



Using the 27 states with at least 32 months experience through September 2017

- **Non-traditional (8):** Arizona, Arkansas, Indiana, Iowa, Michigan, New Hampshire, New Mexico, Ohio
- **Traditional (19):** California, Colorado, Connecticut, Delaware, DC, Hawaii, Illinois, Kentucky, Maryland, Minnesota, Nevada, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, Washington, West Virginia

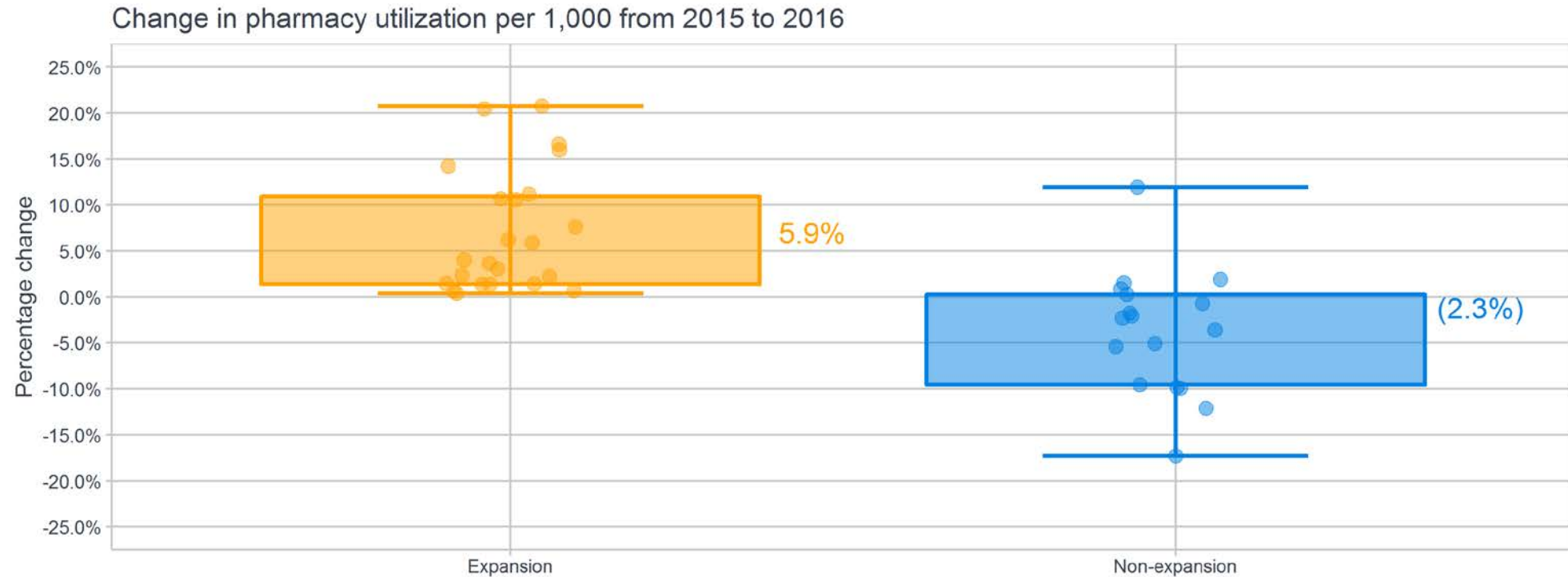
CMS Medicaid Budget and Expenditure System (MBES)

<https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/enrollment-mbes/index.html>

Maturation of experience for new adults

Changes in service utilization

- Could see initial pent-up demand during first year
 - Dental, vision, pathology
 - May be much reduced echo during year 2 as enrollment ramp-up continues
- Pharmacy – gradual increase as new enrollees start maintenance medications



Maturation of experience for new adults

Another look at pharmacy utilization

- Internal Medicaid data
 - Low, medium, and high expenditure examples
- Duration-based analysis
- More direct approach
- PMPM ramp-up similar to earlier enrollment plot

CY 2015 PHARMACY CLAIMS PMPM BY DURATION

DURATION	RATE CELL 1	RATE CELL 2	RATE CELL 3
1	\$ 2.02	\$ 20.64	\$ 48.78
2	7.23	68.86	153.62
3	4.87	91.16	207.38
4	7.25	96.48	210.48
5	9.74	108.41	251.36
6	11.48	123.88	297.48
7	8.14	128.79	343.05
8	10.59	127.96	345.57
9	7.77	132.23	336.96
10	10.63	143.02	362.00
11	13.16	149.89	355.47

Maturation of experience for new adults

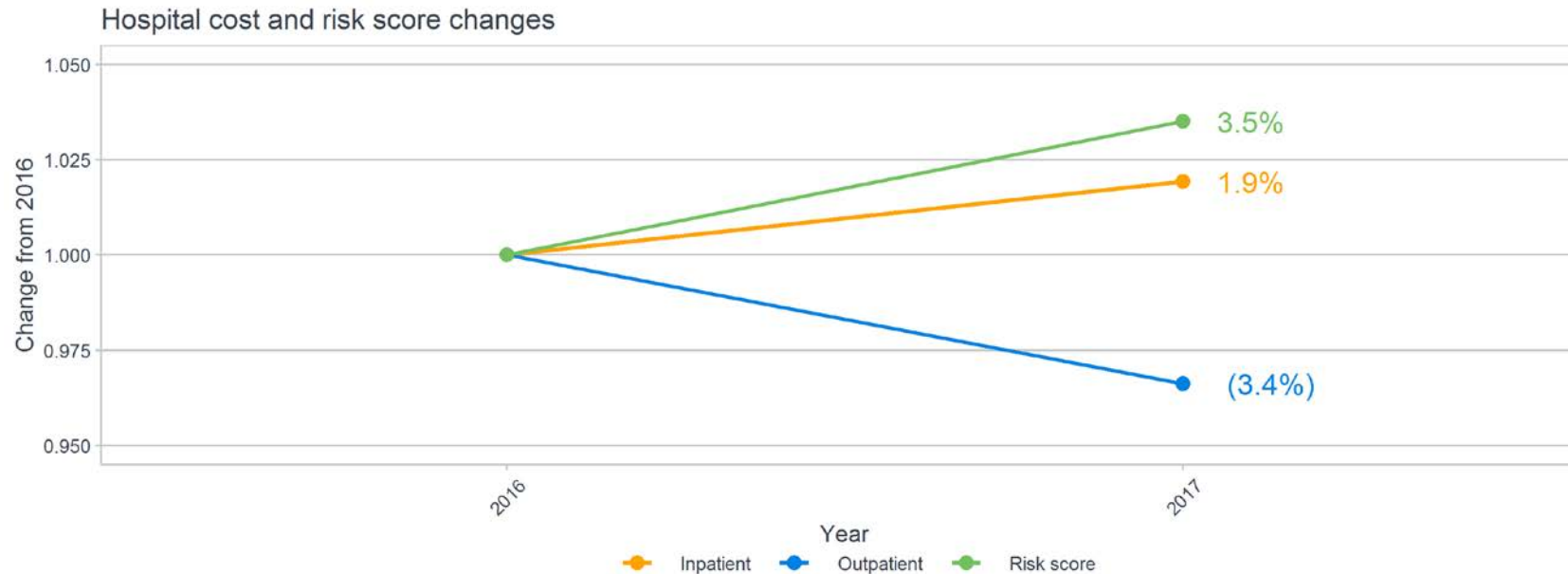
Morbidity changes

- **Risk score increases during initial years**

- May be significant, on the order of 5% per year
- Discovery of underlying chronic conditions
- Improved documentation of conditions
- Higher retention of older and higher morbidity enrollees

- **Cost and utilization increases**

- More modest than risk score increases
- Health plan management of chronic conditions
- Part of risk score increase due to documentation, not real cost



Medically frail

Rationale and identification

- States must formalize medically frail identification whenever the ABP differs from the Medicaid state plan (e.g., Arkansas, Indiana, Iowa, New Hampshire, New Mexico, North Dakota, Pennsylvania)
- Medically frail individuals
 - Must be given the option to choose Medicaid state plan benefits
 - May be exempt from participation in certain programs such as marketplace premium assistance or community engagement

Identification – Assessment Tool Uses

Claims and encounters, including prescription drugs

Medical records and physician assessment

Self-identified conditions, or application questionnaire

Medically Frail



Serious and complex medical condition



Mental disorder



Substance abuse disorder



ADL impairment



Disability determination

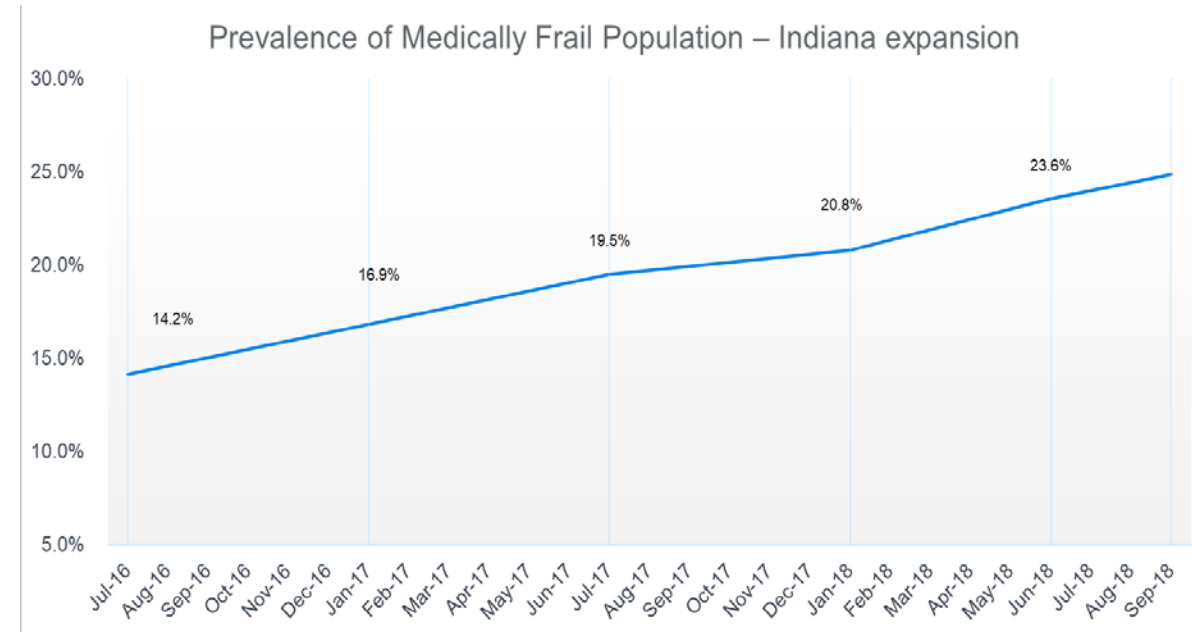


Supplemental Security Income

Medically frail

Prevalence and cost considerations

- Having separate medically frail capitation rates allows for built-in morbidity adjustments
- Medically frail prevalence may increase over time
 - Morbidity increases
 - Better identification processes
 - Improved documentation



- The cost for medically frail individuals is approximately three times that of non-medically frail

EXAMPLE CAPITATION EXPENSE IMPACT

	ENROLLMENT			CAPITATION RATE		
	MEDICALLY			MEDICALLY		
	NON-FRAIL	FRAIL	COMPOSITE	NON-FRAIL	FRAIL	COMPOSITE
PROJECTED	85	15	100	\$ 300.00	\$ 900.00	\$ 390.00
ACTUAL	75	25	100	\$ 300.00	\$ 900.00	\$ 450.00

INCREASE 15%

Financing Medicaid expansion

10% state share starting in 2020



Dedicated tax revenue (10)

- New or increased alcohol or tobacco taxes
- Provider taxes
- Health plan taxes



Savings from other programs

- Substance use disorder and mental health programs
- Incarcerated (hospital)
- Pregnant women
- Medically needy and waiver



State fiscal benefits

- Healthier workforce
- Less pressure on safety net and rural hospitals
- Federal revenue stimulus – Michigan study
 - 30,000 new jobs
 - \$150 million annual state revenue

Sources:

<https://www.governing.com/topics/health-human-services/gov-medicaid-expansion-funding-states.html>
<https://www.nejm.org/doi/full/10.1056/NEJMp1613981>



Thank you

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