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

Prepared for the Idaho Department of Health and Welfare

The purpose of this report is to provide the Idaho Department of Health and Welfare 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. 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 and to provide the State with evidence as it evaluates its decision to expand.

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LEAVITT PARTNERS

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Introduction

Under the Patient Protection and Affordable Care Act (PPACA), states were required to expand Medicaid to adults, age 19–64, with income below 133% of the federal poverty level (FPL).[1] This provision represented the single largest eligibility expansion since the establishment of the Medicaid program in 1965. However, as part of the Supreme Court's decision on the constitutionality of the law, the Court ruled that, as written, the PPACA's Medicaid expansion provision violates the Constitution. In response, the Court stipulated that the federal government is precluded from withdrawing a state's existing Medicaid funds based on the state's refusal to comply with the expansion.

The Court's final ruling on the Medicaid provision effectively allows states to choose whether to participate in the Medicaid expansion. In order to determine whether to opt into the expansion, many states are now in the process of examining their existing Medicaid programs, budgets, and populations that will potentially become newly eligible for Medicaid.

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 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.

The report is divided into four sections. Section I provides an overview of the Medicaid expansion provision, including the parameters for funding and benefit design, as well as the effects of the Supreme Court ruling. Section II provides an analysis of the newly eligible population in Idaho. The analysis evaluates state and national data regarding the newly eligible low-income adult population as well as demographic and health condition information specific to the Idaho population. Section III provides an overview of other states' experiences with expanding Medicaid to adult populations. It includes the population's utilization patterns, the benefit package and delivery system used for the population, and the cost of providing care to the population. In Section IV, Leavitt Partners provides recommendations for benefit design options for the newly eligible population.

Section I: Parameters of the Medicaid Expansion Provision

Overview of the PPACA's Medicaid Expansion Provision

The Patient Protection and Affordable Care Act

The PPACA was signed into law by President Obama on March 23, 2010. The law contains numerous provisions that are designed to affect all aspects of health system reform, including requiring individuals to purchase insurance, reforming private insurance markets, promoting innovative ideas to contain

[1] Current Medicaid income disregards are replaced by a 5% income disregard, which makes the effective eligibility rate 138% FPL.

costs, improving the quality of health system performance, and expanding public programs. These provisions will take effect over several years—some having started in 2010.

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% FPL who are not otherwise eligible for Medicaid.

Medicaid is currently primarily provided to low-income children, parents, pregnant women, seniors, and persons with disabilities—and each group has different income eligibility criteria and standards. The expansion provision changes the Medicaid program by not only expanding eligibility to a new population (low-income childless adults), but also by raising the mandatory income eligibility level for other adult populations (jobless and working parents) to 133% FPL. This represents the single largest eligibility expansion since the Medicaid program was implemented in 1965.[2]

Eligibility for individuals who qualify for Medicaid under the expansion will be based on Modified Adjusted Gross Income (MAGI), which differs from the categorical eligibility determinations of the traditional Medicaid program. Persons with income below 133% FPL, who are not otherwise eligible for Medicaid, will qualify for the expansion program. This means that individuals with annual income up to $14,856 and a family of four with income up to $30,657 will potentially be eligible for Medicaid. The law also includes a 5% income disregard, making the effective income rate 138% FPL.[3]

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. States are responsible for covering the percent not paid by the federal government, as well as the associated administrative costs of providing coverage to the new population.

It is important to note, however, that the new federal match rates only apply to the "newly eligible" or those who do not qualify for Medicaid under the traditional Medicaid 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 (Idaho's FY2012 match rate was 70.2%, meaning the federal government pays 70% of medical costs and the state pays the remaining 30%).

With the implementation of exchanges, it is expected that awareness of public programs will increase and a significant portion of those enrolling in Medicaid with the expansion population may be those who are currently eligible, but not enrolled. This could place significant pressure on tight state budgets.

[2] Medicaid and the State's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline, Congressional Research Service (August 19, 2010).

[3] 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 5% income disregard.

However, 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 Secretary-approved coverage; and 4) meet additional Medicaid requirements.

Deficit Reduction Act of 2005:
The Deficit Reduction Act (DRA) gave states the option to provide select Medicaid groups an alternative benefit package. Prior to the Act, states were required to offer all federally-mandated services to all Medicaid enrollees (although states retained the discretion to offer optional benefits). All federally mandated traditional Medicaid benefits are listed in Figure 1. The PPACA added two new mandatory benefits (free-standing birth clinics and tobacco cessation services for pregnant woman) as well as new optional benefits to the Medicaid program (preventive services for adults, health homes for persons with chronic conditions, and the expansion of home and community-based services as an alternative to institutional care).

Figure 1

Federally Mandated Traditional Medicaid Benefits		
Inpatient hospital services	Federally qualified health center services	Nurse midwife services
Outpatient hospital services	Non-emergency transportation	Nurse practitioner services
Physician services	Home health services	Rural health clinic services
Early and Periodic Screening, Diagnostic, and Treatment services for individuals under 21	Laboratory and X-ray services	Tobacco cessation counseling and pharmacotherapy for pregnant women
Family planning services and supplies	Nursing facility services (for ages 21 and over)	Freestanding birth center services

The purpose of the DRA was to provide states with additional flexibility in setting their Medicaid benefit packages. As such, the alternative benefit package (i.e., benchmark or benchmark-equivalent coverage) allows states to provide certain Medicaid populations with benefits that differ from those offered in the

[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.

traditional Medicaid package. The benchmark benefit package may be provided to populations based on health status or geographic region. However, states do not have complete freedom in setting the benefit package. The Social Security Act (the Act),[5] which incorporates both DRA and PPACA provisions, specifies that the benefit package must be based on one of three commercial insurance products or be a package approved by the Secretary of Health and Human Services (HHS).[6]

Traditional Medicaid groups that cannot be mandatorily enrolled in benchmark coverage include:[7]

1. Pregnant women
2. Persons who are blind or disabled
3. The dual eligible
4. Terminally ill persons who are receiving hospice care
5. Individuals that qualify for long term/institutional care services based on medical condition
6. Persons who are medically frail, "have serious and complex medical conditions," "disabling mental disorders," and persons with "physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living"
7. Children in foster groups or who are receiving adoption assistance
8. Section 1931 parents
9. Women who qualify for Medicaid due to breast or cervical cancer
10. Individuals who qualify for medical assistance because a TB-infection
11. Individuals receiving only emergency services
12. Medically needy

As indicated above, many groups are exempt from benchmark coverage. Therefore, if a state decides to utilize this option for the newly eligible population, it will need to evaluate how to handle the churn that may occur, not only between Medicaid and the exchange, but between existing Medicaid eligibility categories as well.[8] States can allow benchmark-exempt individuals to enroll in the benchmark benefit package, but their enrollment must be voluntary and the individual must retain the option to enroll in traditional standard benefits at any time.

Essential Health Benefits:
Essential Health Benefits (EHB) are a baseline comprehensive package of items and services that all small group and individual health plans, offered both inside and outside the exchange, must provide starting in 2014. All 10 EHB categories must also be offered in the Medicaid benefit package. If the selected benchmark plan does not cover all of the required benefits, the state must supplement the benefits from other benchmark plans. The 10 EHB categories are listed in Figure 2; however, specific benefits and services to be offered within each of the categories have not been defined. That decision has been left to the states by allowing them to select their benchmark benefit packages.

[5] Social Security Act, Sections 1916 and 1937.
[6] Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser Family Foundation (August 2010).
[7] Ibid.
[8] CMS has 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 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.

Figure 2

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

Benchmark Benefits:
In addition to providing essential health benefits, the Medicaid benchmark benefits must be equal to one of the three following benchmarks:[9]

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 the state
3. The state HMO plan that has the largest commercial, non-Medicaid enrollment

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

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

[9] Equal can also mean "equivalent in actuarial value." States can reduce the actuarial value of coverage of the benchmark plan by 25% of what is covered in the comparison plan.

Figure 2).[10] 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.

Cost-Sharing:
The cost-sharing amounts states can charge the newly eligible Medicaid population depends on both the enrollees' income and the service being provided.[11] 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, however, the amount of cost-sharing allowed increases as the enrollee's income increases. Certain groups are exempt from any cost-sharing, regardless of income (pregnant women, certain children, and individuals with special needs), and certain services are exempt from cost-sharing as well (preventive care for children, emergency care, and family planning services). The Act allows for cost-sharing to be adjusted for medical inflation over time as well as for states to condition continuing Medicaid eligibility on the payment of premiums. Providers can also refuse care for failure to pay service-related cost-sharing.[12]

Historically, states that expanded coverage to additional adult populations through 1115 Waivers were able receive further flexibility on copayments and cost-sharing in order to achieve policy preferences and Budget Neutrality.[13] The amount of flexibility allowed to these states varies based on the objectives of the 1115 Waiver and is somewhat dependent on the goals of the current Administration.

[10] Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser Family Foundation (August 2010).
[11] Medicaid: A Primer, Congressional Research Service (July 15, 2010).
[12] Ibid.
[13] In order to receive approval for 1115 Waivers, states must show that the waiver is "budget neutral"—meaning federal Medicaid expenditures spent over the waiver period will be no greater than they would have been without the waiver.

Figure 3

Medicaid Premium and Cost-Sharing Limits for Adults			
	≤100% FPL	101% – 150% FPL	> 150% FPL
Premiums	Not allowed	Not allowed	Generally not allowed
Cost-Sharing (may include deductibles, copayments, or coinsurance)			
Most Services	Nominal	Up to 10% of the cost of the service or a nominal charge	Up to 20% of the cost of the service or a nominal charge
Prescription Drugs: • Preferred • Non-preferred	Nominal Nominal	Nominal Nominal	Nominal Up to 20% of the cost of the drug
Non-emergency use of emergency department	Nominal	Up to twice the nominal amount	No limit, but 5% family cap applies
Preventive Services	Nominal	Up to 10% of the cost of the service or a nominal charge	Up to 20% of the cost of the service or a nominal charge
Cap on total premiums, deductibles, and cost-sharing	5% of family income		
Service may be denied for non-payment of cost-sharing	No	Yes	Yes

Note: Some groups are exempt from the cost-sharing described in this table (e.g., most pregnant women, terminally ill individuals receiving hospice care, institutionalized spend-down individuals, breast and cervical cancer patients, and Indians receiving services from Indian providers). However, they can be charged for non-emergency use of an emergency department and for non-preferred prescription drug use.
SOURCE: Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser (Aug. 2010)

Supreme Court Ruling

On June 28th, the Supreme Court released its much-anticipated decision on the constitutionality of the health reform law. In a 5–4 decision, the Court upheld the individual mandate, ruling that, while it exceeds the powers delegated to Congress by the Commerce Clause and Necessary and Proper Clause (the constitutional provisions relied upon by the administration in its principal defense of the law), it "may reasonably be characterized as a tax."

In a relatively surprise move, the Court also ruled that the PPACA's Medicaid expansion provision violates the Constitution. Instead of striking the provision, however, the Court stipulated that the federal government is precluded from withdrawing a state's existing Medicaid funds based on the state's refusal to comply with the expansion. The Court's final ruling effectively allows states to choose whether to participate in the Medicaid expansion.

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.[14]

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 of subsidies to persons with income below 100% FPL.

3. Any IT-related funds states receive to expand their Medicaid systems or build an exchange will not have to be refunded if the state later decides not to opt into the expansion or implement an exchange.

4. There is no deadline for states having to notify HHS of plans to implement the Medicaid expansion. However, because state legislatures will need to authorize the new expansion program, as well as appropriate the use of federal funds, many states will be making their decisions during the upcoming 2013 legislative sessions. CMS has also indicated that states can opt out of the expansion at any time.

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. The most frequently asked questions include:

1. Will states have the option to expand Medicaid to a different level of poverty and receive full expansion funding? The way the law is written, the decision to expand is a binary one, but could HHS provide flexibility on this? If CMS does not have the legal authority to implement this change through a State Plan, could it be done using its 1115 Waiver authority? How would the budget neutrality requirement in 1115 Waivers be handled? What can possibly be changed through current statutory provisions through the legislative and appropriations process?

2. How flexible will HHS be in allowing states to expand their current Medicaid programs to 100% FPL or a level other than 133% FPL through 1115 Waivers (without officially opting into the expansion, but in an effort to close the gap between those who are eligible to receive subsidies and those who are currently eligible for Medicaid)? Will HHS try to move states into the full expansion by denying 1115 Waivers that expand current Medicaid programs up to 100% FPL?

In order to determine whether to opt into the expansion, many states are now in the process of examining their existing Medicaid programs, budgets, and populations that will potentially become newly eligible for Medicaid. While it is expected that HHS will provide as much state flexibility as possible in their guidance in order to incentivize states to opt into the expansion, states have a difficult decision to make. States will have to align the budgetary realities of their Medicaid program with their political culture in determining whether or not to expand their Medicaid programs.

[14] 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.

Section II: Idaho's Newly Eligible Population

Estimated Number of Newly Eligible

The Congressional Budget Office has estimated that roughly 16 million adults nationwide could gain insurance coverage under the Medicaid expansion provision. It is estimated that these newly eligible adults account for 37% of all of the currently uninsured in the nation.[15] Given their socioeconomic standing and because many were previously ineligible for care, it is expected the newly eligible population will have unique health care needs that will drive their utilization and costs of care.

Existing Estimates

Several groups have estimated the number of persons in Idaho who will be newly eligible for Medicaid under the expansion. The Kaiser Commission on Medicaid and the Uninsured estimates that there were roughly 133,600 uninsured persons in Idaho below 133% FPL in 2010.[16] However, this number includes children, and does not account for persons who are currently eligible for Medicaid but not enrolled.

A study conducted in May 2010 by the Kaiser Commission on Medicaid and the Uninsured estimates the total number of new Medicaid enrollees in Idaho, including those who are currently eligible but not enrolled, will range between 86,000–115,700 by 2019.[17] This study uses two scenarios to develop its estimates: 1) a standard participation scenario and 2) an enhanced outreach scenario. The standard scenario assumes a 57% participation rate among the newly eligible and lower participation across other groups. The enhanced scenario assumes a 75% participation rate among the newly eligible. Under the standard participation scenario, Idaho state spending would increase by $101 million between 2014 and 2019. Under the enhanced scenario, Idaho state spending would increase by $133 million.

A policy brief, produced by the Urban Institute Health Policy Center, estimates that the total number of individuals in Idaho who will be eligible for Medicaid in 2014 is 126,000.[18] The number of individuals newly eligible for Medicaid is 108,000, while the number of individuals currently eligible, but not enrolled is 18,000. Of the 108,000 who are "newly eligible," 79,000 have income less than 100% FPL.

Finally, Milliman recently completed a project for IDHW in which it estimated Medicaid enrollment in Idaho for calendar years 2014–2023. Using several assumptions in its analysis, Milliman estimates total new enrollees will range between 104,040–161,220 in 2014. These estimates include those who are currently eligible for Medicaid, but not enrolled.

Using the information above as reference points, Leavitt Partners created its own estimates of the newly eligible on a county-by-county basis. Because the purpose of this report is to provide recommendations

[15] Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty, Kaiser Family Foundation (April 2010).
[16] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 and 2011 Current Population Survey. Available from Kaiser Family Foundation's statehealthfacts.org.
[17] Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, Kaiser Commission on Medicaid and the Uninsured (May 2010).
[18] Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults would not Be Eligible for Medicaid?, The Urban Institute (July 5, 2012).

for a benchmark package for the newly eligible Medicaid population, Leavitt Partners' estimates isolate the newly eligible population and exclude those who are currently eligible but not enrolled.

Assumptions and Methodology

Using data from Census' Small Area Health Insurance Estimates, Leavitt Partners was able to obtain the number of uninsured persons, age 18–64, with income below 133% FPL in 2009. These estimates serve as the base of persons who are potentially eligible for Medicaid under the expansion. However, to obtain accurate estimates, it is necessary to exclude those who are currently eligible for Medicaid and any noncitizens that are counted in the uninsured population.[19]

To estimate the number of uninsured noncitizens in each county, Leavitt Partners used data from Census Bureau's 2009 American Community Survey that provided the number of non-U.S. citizens, age 18 years and older, by county. In 2009, the national uninsured rate for noncitizens was 46%. Applying this percent to the number of noncitizens per county provides estimates of the number of uninsured noncitizens who will be ineligible for full Medicaid coverage.

To estimate the number of persons who are currently eligible for Medicaid, Leavitt Partners assumes 11% to 12% of the uninsured population falls into this category. This assumption is consistent with the Kaiser study and the Urban Institute policy brief, which uses a model to simulate the number of currently eligible, but not enrolled individuals for each state. The model uses available information on eligibility guidelines, including income thresholds for family size, the extent of income disregards, etc.[20]

Extracting the number of currently eligible and noncitizens from the Small Area Health Insurance Estimates provides a base estimate of those who will be newly eligible for Medicaid in 2009. Leavitt Partners then applies separate growth rates for 2010–2012 and 2013–2014 to forecast the estimates for 2014.[21] To create final estimates, Leavitt Partners applies some of the same assumptions used in the Milliman report. Leavitt Partners assumes 85% of the currently uninsured population will enroll in Medicaid. This estimate is consistent with estimates from other studies. It also reflects the behaviors of the low-income population that will become eligible for Medicaid, as studies have found that the take-up rate for lower-income persons is fairly high.

To finalize the estimates, Leavitt Partners assumes 30% of those receiving coverage in the private marketplace will shift to the Medicaid program under an expansion scenario.[22] This percent includes

[19] Noncitizens can still receive some emergency services paid for by Medicaid. These services are limited to services provided in an emergency department setting. By expanding Medicaid, more noncitizens will become eligible for Medicaid emergency services; however, most services currently provided to noncitizens relate to pregnant women, such as labor and delivery.

[20] Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults would not Be Eligible for Medicaid?, The Urban Institute (July 5, 2012).

[21] Separate growth rates were used to account for recession years and post-recession years. Assuming the economy will experience a slight recovery in the next few years, a smaller growth rate was used for years 2013 and 2014.

[22] Based on experiences from other states and the attitude surrounding Medicaid in western states, Leavitt Partners does not believe many people will drop their employer-sponsored insurance to move to Medicaid. While some employers may drop coverage to allow employees to take advantage of premium subsidies available through

both individuals choosing to drop private insurance and employers choosing to drop employer-sponsored insurance. This estimate is consistent with the crowd-out estimates reported in other states and nationally, which range from 25% to 50%.[23]

Estimates of the Number of Newly Eligible in Idaho

Using the data, assumptions, and methodology described above, Leavitt Partners estimates there will be 97,066–111,525 persons newly eligible for Medicaid in 2014.[24] 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 rages from 106,872–123,824. Estimates of the newly eligible are provided in Figure 4 and Figure 5:

Figure 4

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.

the exchange, evidence from Massachusetts and other states found very few employers "dumped" employees. Therefore Leavitt Partners assumes a "crowd-out" rate of 40% for at least the first few years of the expansion.

[23] Evaluation of Wisconsin's BadgerCare Plus Health Care Coverage Program: Target Efficiency and the Displacement of Private Insurance: How Many New BadgerCare Enrollees Came from the Uninsured?, Population Health Institute, University of Wisconsin-Madison (December 2010).

[24] A range of estimates is provided, determined by the base data used (one set of county estimates is larger than the other). However, the assumptions and methodology used in generating the estimates is the same.

Figure 5

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 provision that would expand Medicaid eligibility to 133% FPL, 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.

Modified Adjusted Gross Income:
Starting in 2014, eligibility for the expansion population and other Medicaid groups will no longer be based on various categorical income determinations, but will be based on a standard income definition—Modified Adjusted Gross Income (MAGI). MAGI will be used to determine Medicaid and CHIP eligibility, premiums, and cost-sharing. Under the MAGI methodology, asset tests and most income disregards will no longer be used in determining an individual's eligibility. As a result, some income sources that most states currently count in Medicaid eligibility are not counted in the MAGI methodology. The excluded income sources consist of disability and survivor's Social Security benefits, VA benefits, workman's compensation, alimony and child support income, pretax contributions like some child care costs, retirement savings, and the employee portion of flexible spending accounts. Additionally, the deductions for self-employment income are treated differently.[25] A single income disregard of 5% FPL will be applied instead of using the current income disregards.

The expansion population's eligibility will be determined by MAGI, as will the eligibility of some of the existing traditional Medicaid groups.[26] Regardless of a state's decision to expand, income eligibility for children, pregnant women, and Section 1931 parents will be based on the MAGI determination starting in 2014. Groups that are exempt include: 1) groups for whom the Medicaid Agency is not required to make an income determination (e.g., the SSI population, foster care children, etc.); 2) the aged, blind, or disabled; 3) the elderly and individuals with long-term care needs; 4) the medically needy; and 5) some dually eligible (i.e., enrollees in a Medicare Savings Program).[27]

Elimination of Asset Tests:
If an individual qualifies for Medicaid based on the MAGI determination, they must be immediately enrolled in the Medicaid program.[28] States are prohibited from applying asset or resource tests on populations whose eligibility is based on MAGI.[29] Eliminating these tests will potentially increase the number of persons who are eligible for Medicaid under the current income thresholds, even though the thresholds have not changed.

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[25] Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014, Kaiser Commission on Medicaid and the Uninsured (June 2011).

[26] Certain newly eligible, such as those with disabilities or the medically frail, may be subject to different income counting rules. Official guidance from CMS on any exempt newly eligible has not yet been released.

[27] Medicaid and CHIP in 2014: A Seamless Path to Affordable Coverage, Seniors and Individuals with Disabilities in the New World of MAGI, Center for Medicaid and CHIP Services (April 26, 2012).

[28] States may pursue additional eligibility tests if the individual indicates on the application: 1) a potential for eligibility based on another basis; 2) submits an application designed for MAGI-excepted eligibility; 3) requests a MAGI-excepted determination; and/or 4) the Agency has information indicating such potential eligibility.

[29] Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline, Congressional Research Service (January 18, 2012).

Changes in the Definition of a Household:
By transitioning to the MAGI determination, family size will now be based on the number of personal exemptions an applicant claims on their tax return (i.e., the IRS tax household definition). Under this system, a household includes the taxpayer, his/her spouse, and any child or other person whom the applicant claims as a tax dependent.[30] The total income of a household will therefore equal the MAGI of all individuals in the tax filing unit. Under the current Medicaid system, states differ in their approach to determining household size and determining whose income to include when calculating eligibility.

Changes in the Application and Redetermination Process:
The PPACA establishes a 12-month renewal period for MAGI-based Medicaid enrollees. The Medicaid Agency is required to pre-populate and electronically verify as much of the renewal application as possible in order to minimize the burden on the applicant. Self-attestation for most eligibility criteria is encouraged, except for proof of citizenship or immigration status. Citizenship and immigration status must be verified through federal electronic verification data sources. Medicaid Agencies may not require applicants to submit information not needed for eligibility and paper documentation cannot be required if electronic information is available. Agencies may also not require individuals to complete an in-person interview as part of the application or redetermination process.

IDHW's eligibility administrators have expressed a concern that the revised procedural requirements will result in an increase in total caseloads. The new processes also lack active cooperation from the recipient, placing the burden largely on the states to determine Medicaid eligibility.

Coordination of Eligibility Determinations:
Under the PPACA, states are required to provide a standard application form, accessible through the exchange, for all state health subsidy programs starting in 2014.[31] Based on this application, the exchange will electronically assess whether the individual is eligible for Medicaid, CHIP, or premium subsidies. States may allow the exchange to make final Medicaid eligibility determinations (based on federal electronic verification data sources) or make an initial assessment of Medicaid eligibility and refer the applicant to the Medicaid agency. If the applicant is determined to be ineligible for Medicaid and/or CHIP, the state must ensure that the individual is screened for premium subsidy eligibility without having to submit another application.

While MAGI will also be used for determining the amount of premium subsidies a person is eligible for through the exchange, the income rules for the two programs do not perfectly align. Medicaid eligibility is based on current monthly income whereas eligibility for premium subsidies is based on annual income. Processes have been established to provide seamless transitions between the two systems; however, there may be persons who are income-eligible for both programs at the same time and persons who have income just above the Medicaid threshold and just below the premium subsidy threshold. Addressing both of these cases can create an administrative burden for states.

Effect on Idaho:
IDHW estimates that the Medicaid provisions outlined above 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

[30] Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014, Kaiser Commission on Medicaid and the Uninsured (June 2011).
[31] Starting 2014, states are required to establish a website that links Medicaid to the state's exchanges.

not enrolled, who may enroll in Medicaid in an expansion scenario). Based on the expected changes to the State's current eligibility system as well as taking into account enrollment in other state subsidy programs, IDHW estimates Medicaid enrollment could increase by 100,000–150,000 in an expansion scenario. Roughly 75% of this number is the newly eligible and the remaining 25% comprises the eligibility surge (15%) and the woodwork effect (10%; the currently eligible, but not enrolled).[32]

Idaho Demographic and Health Condition Information

The estimates presented above indicate the number of persons who will qualify for Medicaid in an expansion scenario. However, to create a benefit package that will adequately meet the needs of this population, it is important to understand the population's demographics and health conditions. To provide this information, 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 (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.[33] Census data providing health insurance coverage status by age show individuals, age 25–34, make up the largest share of uninsured adults.[34] However, as indicated by 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.

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 this 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

[32] The difference between this estimate and the ones provided by Leavitt Partners are due to different base estimates and slightly different methodology.
[33] U.S. Census Bureau, Small Area Health Estimates 2009.
[34] U.S. Census Bureau, American Community Survey 2008–2010 (3-year estimates).

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.**[35] 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 and detailed information 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.

Behavioral Risk Factor Surveillance System

Key Findings:

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.

Prevalence of Health Conditions and Risk Factors by Income:
Data from the 2010 Idaho Behavioral Risk Factor Surveillance System illustrate the health risks and behaviors specific to Idaho's population. While the survey is not directly intended to highlight the needs of the newly eligible Medicaid population, data points related to this population can be extrapolated using the survey's income breakout. Some key points inferred from this report include:

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

1. **Health insurance is highly correlated with income.** People earning less than $15K (or who have the lowest income in Idaho) are seven times more likely to not have health insurance than their counterparts earning more than $50K (median household income in Idaho in 2010 was $46,423). This group is also about three times more likely not to have dental insurance.

2. **The prevalence of chronic conditions is much higher among persons with lower income.** People earning less than $15K per year have an incidence of diabetes two times higher and an incidence of asthma nearly 1.5 times higher than their counterparts earning more than $50K. Obesity, which can lead to the development of chronic conditions, is also inversely correlated with income. People with income less than $15K per year are almost twice as likely to be obese than those with income over $50K.

3. **While smoking and drug abuse are higher among the low income population, these factors are more directly related to age.** People earning less than $15K per year are nearly four times more likely to smoke and 1.5 times more likely to abuse drugs than those earning $50K or more per year. However, the incidence of drug abuse is 33 times higher among persons age 18–24 and 17 times higher among persons age 25–34 than those over age 65 (people age 25–34 are three times more likely to smoke). Males also have a much higher rate of smoking and drug abuse than females. Heavy drinking is not strongly correlated with income or age.

4. **The rate of preventive cancer screenings is much lower among persons with lower income.** Women earning less than $15k per year are two times more likely not to have received a Pap test in the past three years and two times more likely not to have had a mammogram in the past two years compared to those earning above $50k. Men earning less than $15k are 1.5 times more likely to have not had a prostate exam in the past two years. Of adults age 50 and older, individuals earning less than $15k per year are also 1.5 times more likely not to have had a colorectal cancer screening than those earning more than $50k per year.[36]

Health Conditions and Risk Factors of the Newly Eligible:

The above points illustrate how income relates to health conditions and how those most likely to be newly eligible for Medicaid compare to Idaho's population with higher income. However, to get a better indication of how prevalent health conditions and risk factors are within the newly eligible population, a cross-sectional analysis of the data was conducted. Figure 6 shows the number of uninsured Idaho adults, age 18–64 with incomes below $25,000, with selected risk factors. While the income cutoff of $15,000 is used above to highlight the health disparities between those in the lowest income bracket and those earning close to Idaho's median household income, the cutoff of $25,000 is used in in this analysis because it provides a more accurate estimate of the "newly eligible."[37] These data provide rough estimates of how many of the newly eligible Medicaid population in Idaho will have existing health conditions, substance abuse issues, and which ones will have had previous access to care.

The data show the uninsured population with income below $25,000 has higher rates of chronic conditions and substance abuse issues than the general population (particularly obesity, illicit drug use, heavy drinking, and smoking). The exceptions are asthma, high cholesterol, and high blood pressure. The data also show the low-income, uninsured population has a much lower rate of accessing preventive cancer screenings than the general population. In terms of population estimates, the percentages and

[36] Idaho adults aged 50 and older who never had a sigmoidoscopy or colonoscopy.
[37] $25,000 is roughly equal to the gross yearly income for a family of three at 133% FPL.

numbers presented in Figure 6 indicate a significant portion of the newly eligible population will be obese, smoke, and have high cholesterol, all of which are indicators of more serious chronic conditions.

Figure 6

Prevalence of Select Risk Factors Among Uninsured Idaho Adults Age 18–64 with Incomes Below $25,000, 2010			
	Statewide	Low Income Uninsured	Population Estimate (Low Income Uninsured)[5]
Select Risk Factor			
Diabetes	**8.0%**	**8.9%**	9,800
Asthma	**8.8%**	**8.4%**	9,300
Obesity	**26.9%**	**38.2%**	39,900
Illicit Drug Use[1]	**4.3%**	**5.7%**	5,700
Heavy Drinking[2]	**4.0%**	**6.0%**	6,500
Current Smoker	**15.7%**	**28.2%**	31,300
High Cholesterol[3]	**37.3%**	**33.6%**	14,900
High Blood Pressure[3]	**25.9%**	**17.8%**	18,100
No Cancer Screening[4]			
No Colorectal Cancer Screening	**40.2%**	**77.8%**	15,700
No Breast Cancer Screening	**36.2%**	**61.1%**	12,000
No Cervical Cancer Screening	**23.8%**	**30.7%**	12,500
No Prostate Cancer Screening	**50.8%**	**84.6%**	13,000

[1] Illicit drug use includes using prescription drugs without a prescription and drugs used to get high or for curiosity within the past 12 months.
[2] Heavy drinking is defined as having >2 drinks/day for males or >1 drink/day for females.
[3] This question was not asked in the 2010 BRFSS so data come from the 2009 survey.
[4] 2006, 2008, and 2010 low income uninsured data were aggregated to derive reliable estimates.
[5] Population estimates vary due to sample size.

SOURCE: Idaho Behavioral Risk Factor Surveillance System (BRFSS), 2010.

Regional Variations:

The BRFSS also calculates results on a regional basis, providing data for each of the seven public health care districts in Idaho. The information provided in Figure 7 provides estimates of how many people within each district have health conditions and/or substance abuse issues—indicating which regions may have greater health problems that will need to be addressed in an expansion scenario. For example, District 3 and District 4 generally have the largest number of persons with selected risk factors. However, it should be noted that while some districts have a higher prevalence of certain health factors, none of the districts stand out as having more health concerns overall.

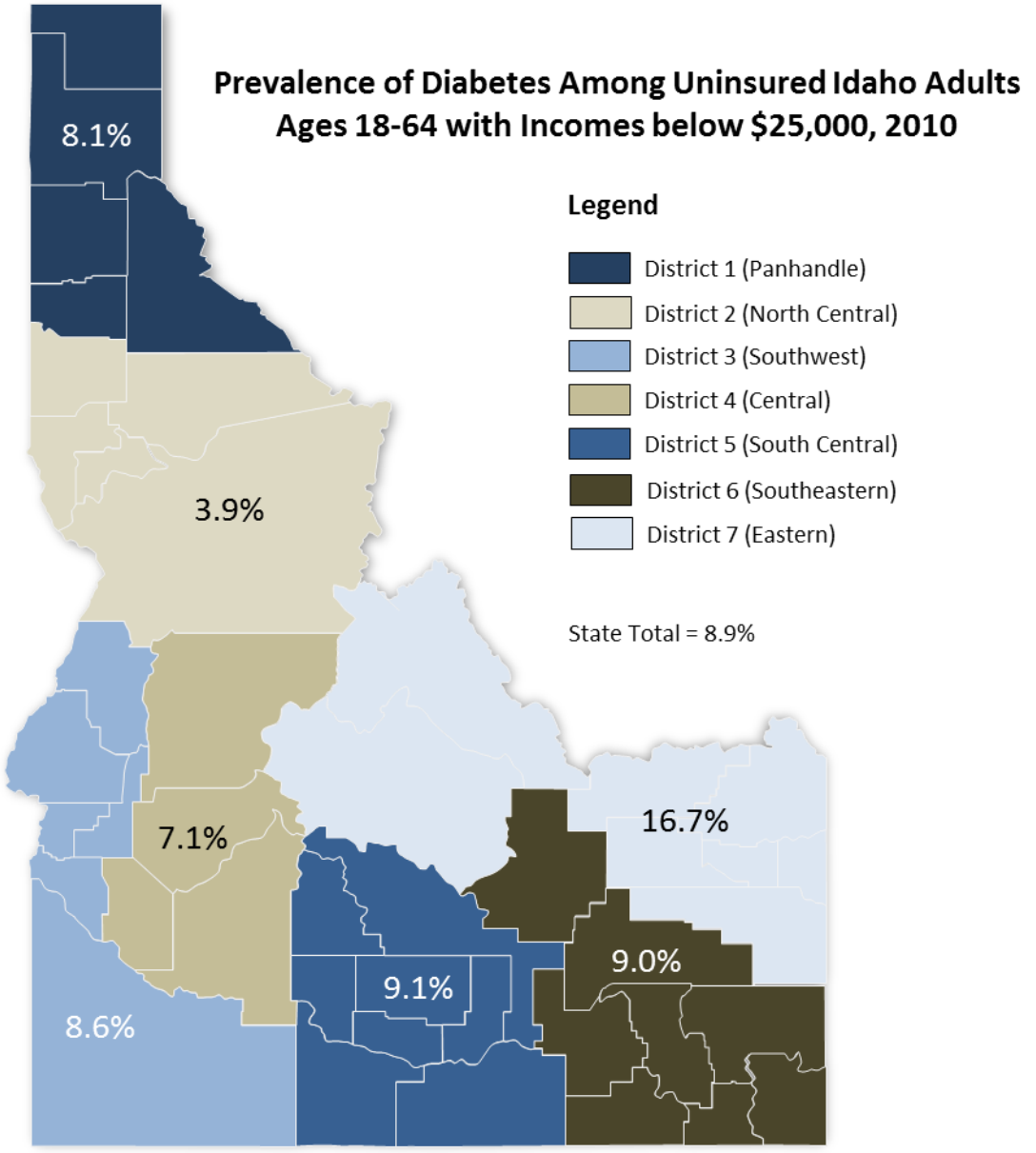
Figure 7

Prevalence of Select Risk Factors Among Uninsured Idaho Adults Age 18–64 with Incomes Below $25,000 by Health District, 2010								
	District 1		District 2		District 3		District 4	
Districts 1–4	%	Pop. Estimate[5]	%	Pop. Estimate	%	Pop. Estimate	%	Pop. Estimate
Select Risk Factor								
Diabetes	**8.1%**	1,400	**3.9%**	300	**8.6%**	2,100	**7.1%**	1,800
Asthma	**16.8%**	2,800	**8.3%**	500	**6.4%**	1,500	**11.1%**	2,900
Obesity	**29.6%**	4,900	**39.7%**	2,600	**34.2%**	7,600	**44.1%**	11,100
Illicit Drug Use[1]	**4.6%**	700	**15.5%**	900	**7.1%**	1,600	**6.0%**	1,400
Heavy Drinking[2]	**14.6%**	2,400	**2.5%**	200	**3.5%**	800	**4.1%**	1,000
Current Smoker	**38.5%**	6,400	**47.8%**	3,200	**29.3%**	7,000	**22.3%**	5,800
High Cholesterol[3]	*	*	*	*	*	*	*	*
High Blood Pressure[3]	**13.1%**	2,200	**19.1%**	2,000	**22.7%**	5,300	*	*
No Cancer Screening[4]								
No Colorectal Cancer Screening	**77.3%**	3,500	**87.1%**	1,300	**81.3%**	2,600	**67.9%**	3,500
No Breast Cancer Screening	**65.4%**	2,200	**71.2%**	1,000	**61.7%**	2,500	**60.4%**	2700
No Cervical Cancer Screening	**23.6%**	1,600	**27.3%**	800	**43.7%**	3,700	**32.5%**	2,600
No Prostate Cancer Screening	**86.8%**	2,600	*	*	*	*	*	*

	District 5		District 6		District 7	
Districts 5–7	%	Pop. Estimate	%	Pop. Estimate	%	Pop. Estimate
Select Risk Factor						
Diabetes	**9.1%**	1,400	**9.0%**	900	**16.7%**	2,000
Asthma	**2.3%**	300	**7.5%**	800	**3.5%**	400
Obesity	**35.9%**	4,700	**55.7%**	5,300	**32.1%**	3,700
Illicit Drug Use[1]	**0.5%**	100	**2.5%**	200	**7.6%**	800
Heavy Drinking[2]	**2.1%**	300	**15.2%**	1,600	**1.8%**	200
Current Smoker	**14.9%**	2,300	**37.6%**	3,900	**22.7%**	2,700
High Cholesterol[3]	*	*	*	*	*	*
High Blood Pressure[3]	**10.4%**	1,500	*	*	*	*
No Cancer Screening[4]						
No Colorectal Cancer Screening	**92.3%**	2,200	*	*	*	*
No Breast Cancer Screening	**43.0%**	1,100	**59.1%**	1,300	*	*
No Cervical Cancer Screening	**18.8%**	1,200	**31.1%**	1,000	**32.1%**	1,500
No Prostate Cancer Screening	*	*	*	*	*	*

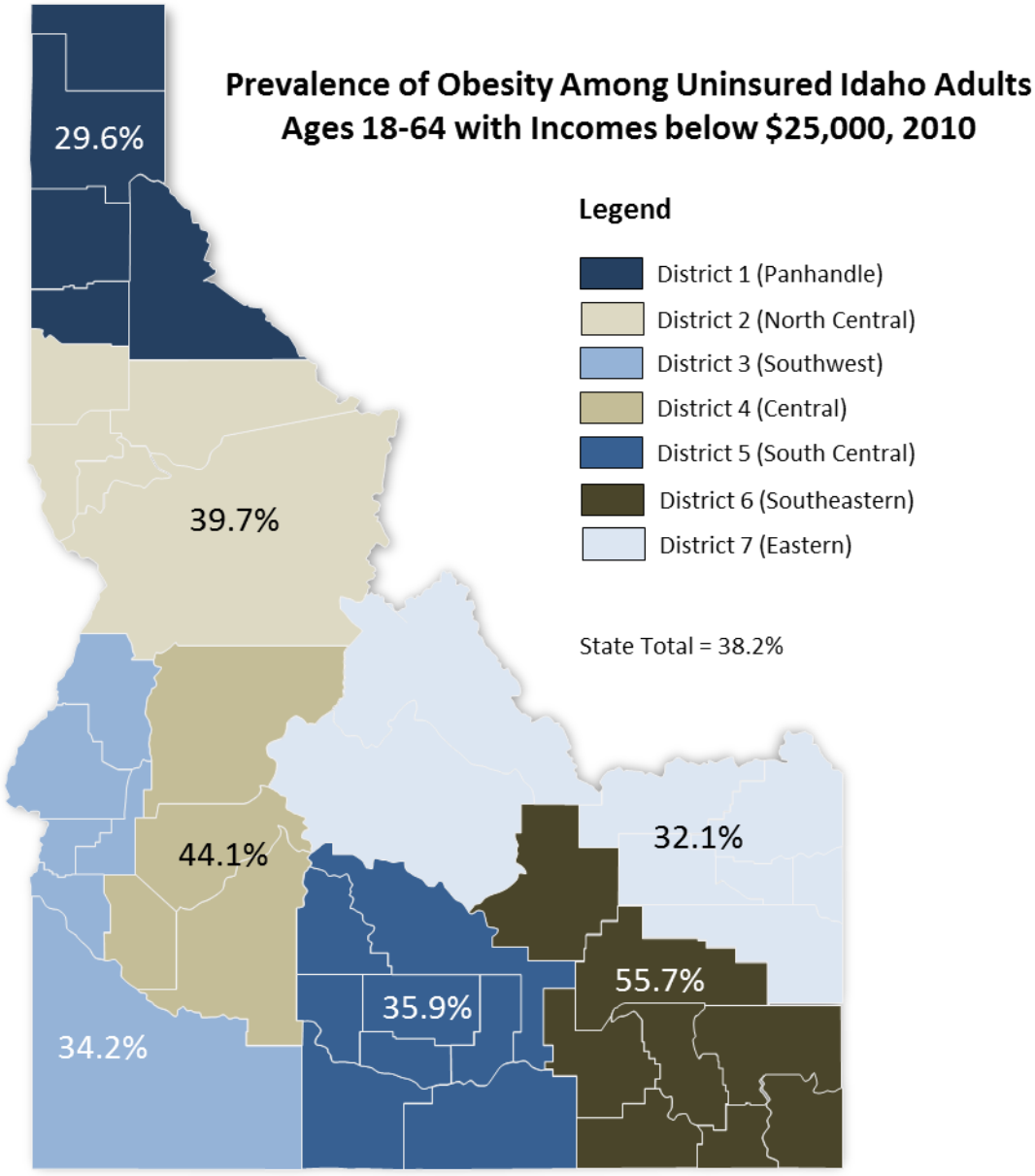
[1] Illicit drug use includes prescription drugs without a prescription and drugs used to get high or for curiosity within the past 12 months.
[2] Heavy drinking is defined as having >2 drinks/day for males or >1 drink/day for females.
[3] This question was not asked in the 2010 BRFSS so data come from the 2009 survey.
[4] 2006, 2008, and 2010 low income uninsured data were aggregated to derive reliable estimates.
[5] Population estimates vary due to sample size.
SOURCE: Idaho Behavioral Risk Factor Surveillance System (BRFSS), 2010.

Figure 7a



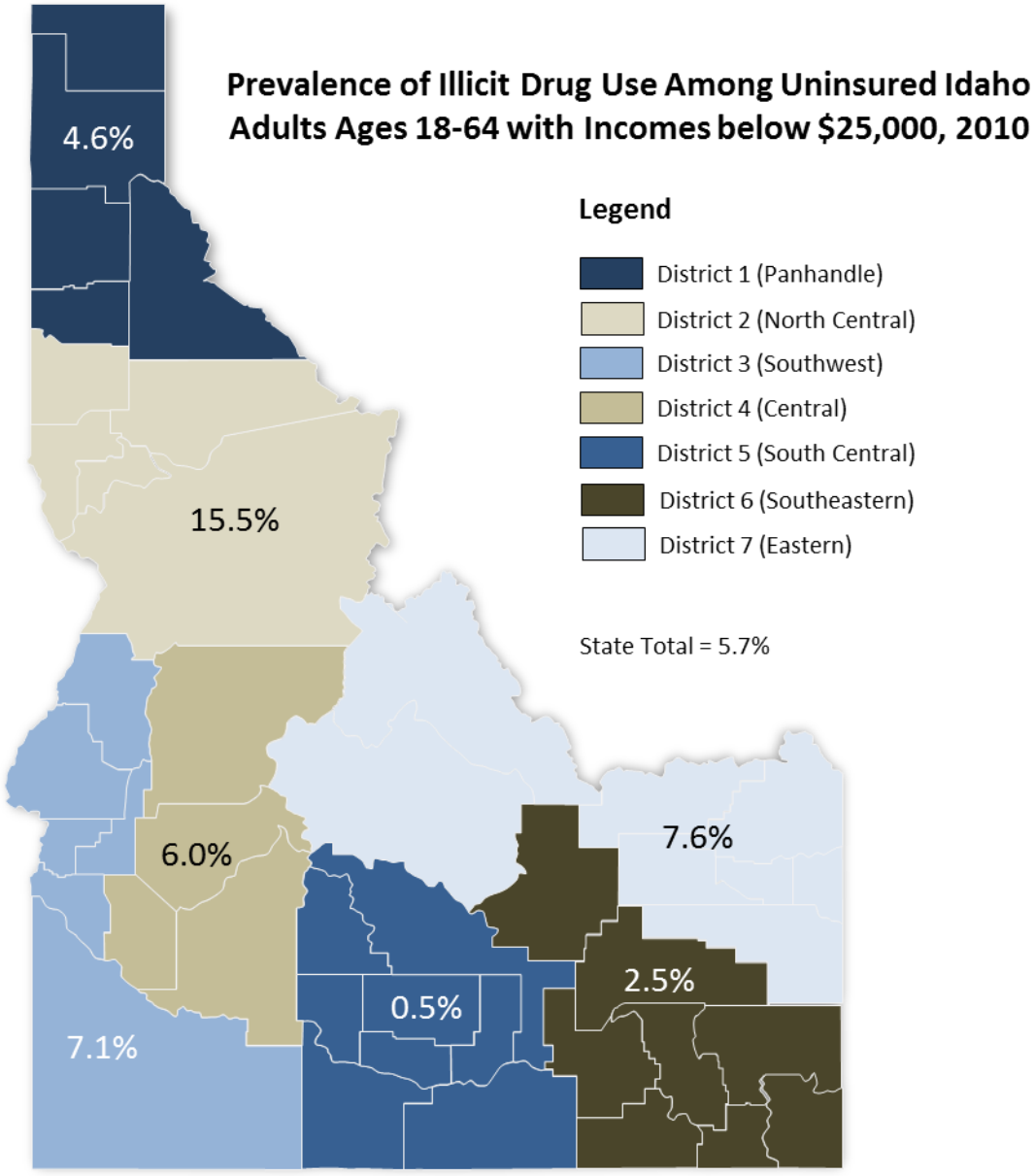
Data Source: Idaho Behavioral Risk Factor Surveillance System (BRFSS), 2010

Figure 7b



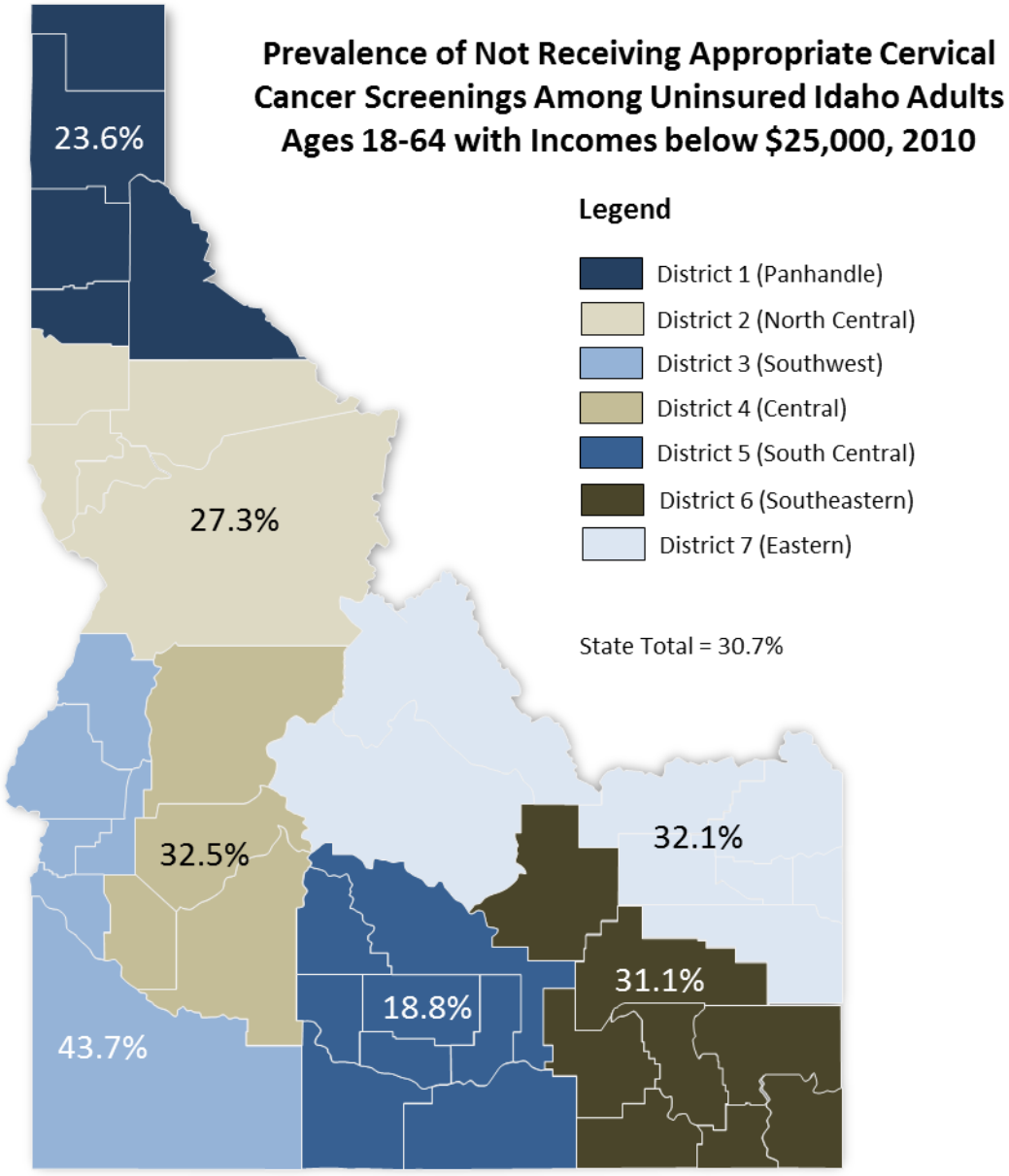
Data Source: Idaho Behavioral Risk Factor Surveillance System (BRFSS), 2010

Figure 7c



Data Source: Idaho Behavioral Risk Factor Surveillance System (BRFSS), 2010

Figure 7d



Data Source: Idaho Behavioral Risk Factor Surveillance System (BRFSS), 2010

Catastrophic Health Care Cost Program (Medically Indigent Services)

Key Findings:

1. It is estimated 6,000 program applicants will qualify for Medicaid in 2014.[38] 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.

Program Overview:
The Medically Indigent Services Program is a county-based program that helps the indigent pay for necessary medical services. The program is incident-based and persons apply on an "as needed" basis when faced with a catastrophic illness or injury. To receive assistance a person must be ineligible for Medicaid or other state assistance programs, not have access to health insurance that will adequately cover the medical services, as well as meet the necessary income/resource standards.[39]

County Commissioners approve an application for financial assistance if it is determined that necessary medical services have been, or will be provided to a medically indigent resident in accordance with Title 31 Chapter 35, Hospitals for Indigent Sick. If an applicant is accepted, the county pays up to $11,000 of

[38] Estimate by Medically Indigent Services administrators. [38] 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.

[39] The standard is defined as: "If an adult, together with his or her spouse, or whose parents or guardian if a minor, does not have income and other resources available to him from whatever source sufficient to pay for necessary medical services." *Idaho Statute, Title 31 Counties and County Law, Chapter 35 Hospitals for Indigent Sick.*

the participant's medical expenses in a 12-month period. Once this amount is exceeded, bills are paid by the state-run Catastrophic Health Care Cost Program (CAT), which receives funds from general appropriations as well as $5 for each seat belt fine collected. Participants are expected to reimburse both the county and the CAT program for all or a portion of their medical expenses. The counties and the CAT board have had limited success in seeking reimbursement from those who are able to make some payment.

Before an application is approved by the county, it is sent to IDHW to be reviewed for Medicaid eligibility. Of the 6,688 applications processed in FY2012, 634, or roughly 9% of the applicants were found to be eligible for Medicaid. It is estimated that when Medicaid expands to 133% FPL, close to 90% of applicants may qualify.[40] Based on FY2012 applications, this indicates that 6,019 applicants would qualify for Medicaid in 2014. In FY2011, 7,652 applications were received; indicating up to 6,900 individuals would be newly eligible.[41]

Demographic and Health Condition Information:
In terms of general demographics, data from the CAT program show males represent a higher rate of cases than females (2,409 vs. 2,175). In terms of individual diagnoses, women experience higher rates of cancer, respiratory, and digestive system issues than males.

Figure 8

Number of CAT Cases by Gender, FY2011		
	Male	Female
Accident Vehicle	83	35
Accident General	210	114
Coronary	259	149
Cancer	180	196
Respiratory	74	89
Mental Health	485	488
General	672	643
Chronic Disease	78	42
Neurology	28	16
Digestive System	330	377
Total	**2,409**	**2,173**

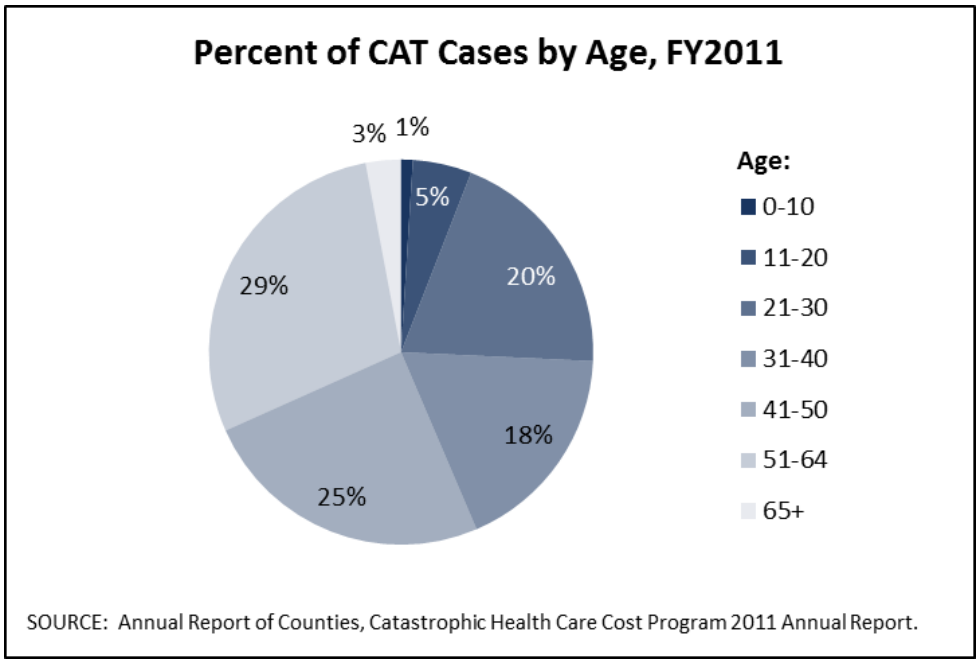
SOURCE: Annual Report of Counties, Catastrophic Health Care Cost Program 2011 Annual Report.

[40] Estimate by Medically Indigent Services administrators.
[41] 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.

Single person households account for the highest rate of cases (2,015), followed by two person households (1,435). The number of cases significantly decreases as household size increase to three, four, and five, most likely reflecting the higher incomes and insured rates of larger families.

Figure 9 illustrates the percent of cases by age group for the CAT program in FY2011. Persons age 51–64 account for the largest number of cases, totaling 1,356. This age group experiences cancer- and coronary-related diagnoses at a much higher rate than any other age group, the most common diagnoses being female-related cancers (such as breast or cervical) and chest pain. This age group also experiences a high rate of disease/infection- and orthopedic-related diagnoses.

Figure 9



SOURCE: Annual Report of Counties, Catastrophic Health Care Cost Program 2011 Annual Report.

Persons age 41–50 account for the second largest number of cases, totaling 1,149. This age group experiences a higher rate of chronic conditions than any other age group, the most common being alcoholism followed by diabetes. As with the 51–64 age group, the 41–50 age group experiences a high rate of disease/infection- and orthopedic-related diagnoses.

The number of cases for persons, age 31–40, in FY2011 was 820. In terms of general diagnostic codes, this age group does not experience a higher rate than other age groups. However, they do experience a high rate of mental health diagnoses, including bipolar disorder and depression. They are also the age group with the highest rate of schizophrenia diagnoses.

Persons age 21–30 account for the third largest number of cases, totaling 911.The diagnoses that are most prevalent in this age group include: 1) motor vehicle accidents; 2) general accidents (particularly alcohol and drug-related accidents and sports injuries); 3) mental health diagnoses (particularly depression, bipolar disorder, and suicide); 4) appendectomy; and 5) gallbladder-related disorders. As with the other age groups, this group experiences a high rate of disease/infection- and orthopedic-related diagnoses as well.

Figure 10

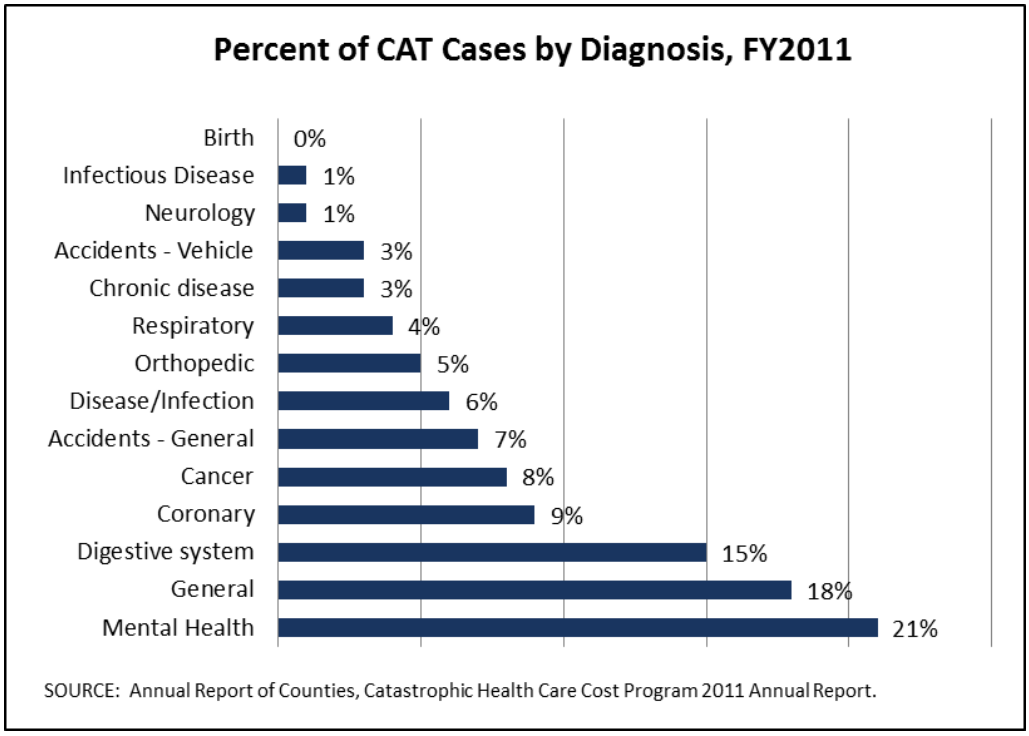
Prevalence of CAT Cases and Diagnoses by Age Group, FY2011		
Age Group	# of Cases	Diagnoses with Higher Prevalence in this Age Group than Other Age Groups
51–64	1,356	• Cancer • Coronary-related
41–50	1,149	• Chronic Conditions (most common are alcoholism & diabetes)
31–40	820	*Does not experience any diagnoses at a higher rate than other age groups; but does experience a high rate of mental health diagnoses, including bipolar disorder and depression.*
21–30	911	• Motor Vehicle Accidents • General Accidents (particularly alcohol- and drug-related accidents and sports injuries) • Mental Health Diagnoses (particularly depression, bipolar disorder, and suicide) • Appendectomy • Gallbladder-related disorders

SOURCE: Annual Report of Counties, Catastrophic Health Care Cost Program 2011 Annual Report.

Excluding general diagnoses, the most common diagnoses are mental health, digestive system, and coronary-related diagnoses. As indicated earlier, the most common mental health diagnoses are bipolar disorder and depression. Within the digestive system category, abdomen- and gallbladder-related diagnoses are the most common, while chest pain and myocardial infarction are the most common diagnoses within the coronary category.

The diagnosis categories with the smallest number of cases were birth, infectious disease, and neurology. Each of these categories had less than 100 cases.

Figure 11[42]

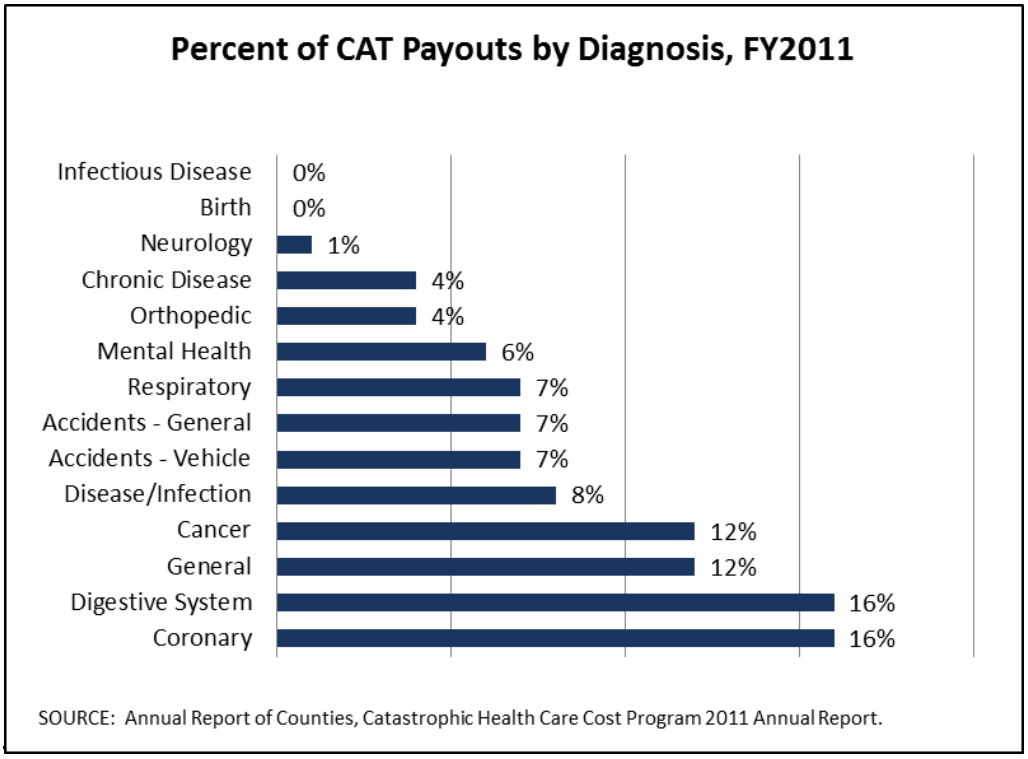


Costs:

Even though mental health, digestive system, and coronary-related diagnoses are the most common among this population, they are not the most expensive services. The most expensive diagnosis categories (general diagnoses excluded) by amount paid in FY2011 are coronary ($8.2M), digestive system ($8.1M), and cancer ($5.9M). The diagnosis categories with the smallest amount paid include birth-related services and infectious disease. However, the amount paid to these two categories is likely more of a reflection of the small number of diagnoses, rather than the cost of the service.

[42] "General" was the largest category in the data provided by the CAT program. However, to better understand specific diagnoses, "disease/infection" and "orthopedic," the two largest diagnoses in the "general" category, were removed from this category and placed in their own, separate categories.

Figure 12



In FY2009, a total of $44.5 million state and county dollars were spent on Medically Indigent Services (Figure 13). This amount increased during recession years to a total of $51.1 million in FY2011. County dollars accounted for close to 48% of the total, while state dollars accounted for 52%. In terms of provider payments, from July 1, 2010 to June 30, 2011, the CAT board approved the payment of 1,276 cases for a total of $34.9 million in provider payments. From July 1, 2011 to December 31, 2011, the board approved 654 new cases (in addition to ongoing cases) and paid a total of $11.9 million.

Figure 13

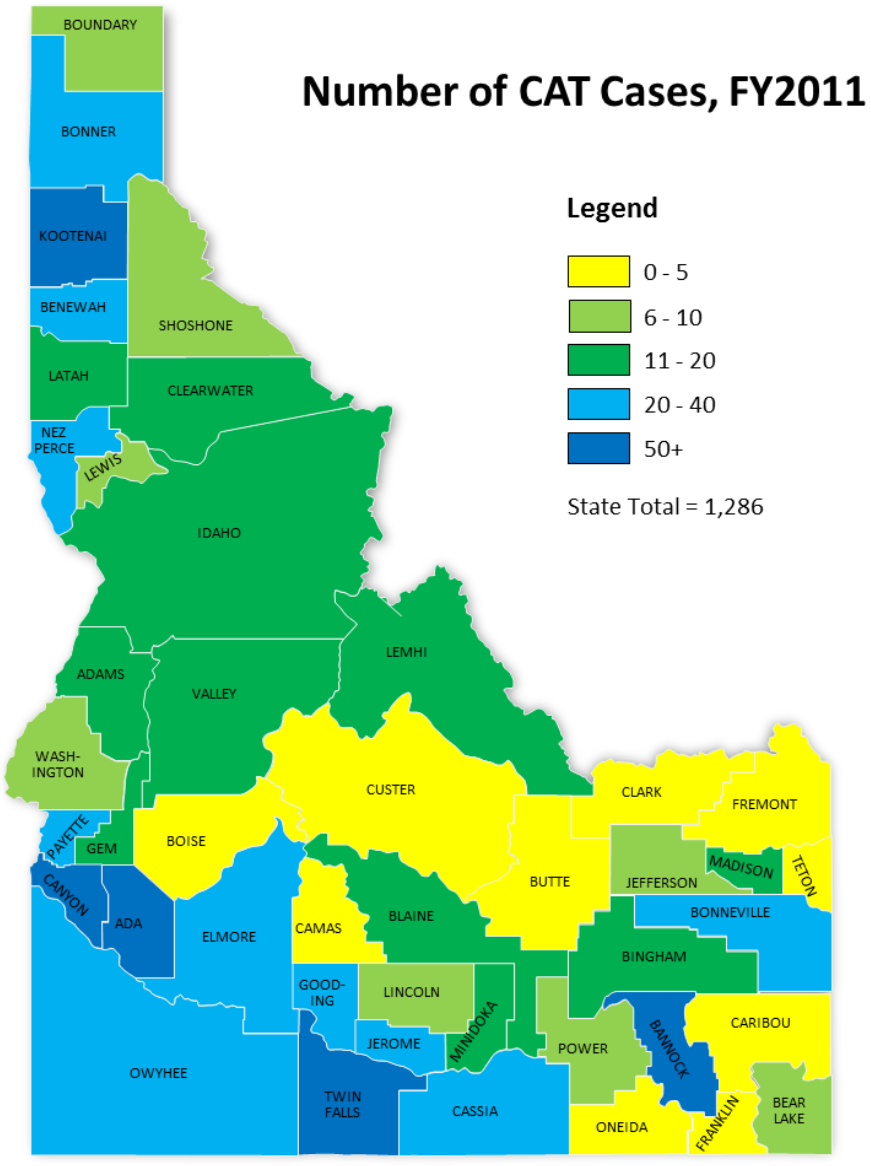
Total State and County Dollars Spent on Medically Indigent Services, FY2009 – FY2011

	2009	2010	2011
New Case Load	4,323	4,363	4,590
County Dollars	$18,920,000	$21,790,000	$24,509,947
CAT (State) Dollars	$25,596,529	$22,776,305	$26,605,616
Combined State & County Dollars	$44,516,529	$44,566,305	$51,115,564

SOURCE: Catastrophic Health Care Cost Program, Joint Finance & Appropriations Committee Presentation (January 16, 2012).

Regional Impact:
Data from the CAT program show that Ada County continually submits the largest number of cases for CAT approval and payment. Ada County submitted 403 cases in FY2011, and is expected to submit a similarly high number in FY2012. This is four times the amount of cases submitted by the county with the next highest number of cases (Kootenai, 142). However, this is not unexpected given Ada County has the largest population in Idaho as well as one of the poorest populations. In general, the counties which submit the largest number of cases for CAT approval and payment are the same counties that are expected to have the highest number of newly eligible (Figure 14). This supports the idea that the majority of the population currently participating in the CAT program will qualify for Medicaid under an expansion scenario.

Figure 14



Data Source: Annual Report of Counties, Catastrophic Health Care Cost Program 2011 Annual Report

Community Health Centers

Key Findings:

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.[43] It can be estimated that the state portion spent on CHCs was about $6.5 million in 2011.[44] These funds are used to treat the currently eligible population. CHCs would receive additional Medicaid funds to provide care for the newly eligible.

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.

Program Overview:
Thirteen Community Health Centers (CHCs) are located in Idaho. These centers are community-owned, nonprofit organizations that provide patient-centered primary health care services to individuals who lack access to other health care. Individuals served by these centers include low-income, uninsured, migrant, homeless, and rural patients. In addition to providing health care, many CHCs provide dental, behavioral health, pharmacy, and community outreach services. CHCs also offer services that make accessing health care easier, such as transportation, case management, health education, and culturally-sensitive care through the use of interpreter services.

Patients without insurance are charged on a sliding fee scale that is determined by income and family size. While the uninsured represent the largest group of patients served by CHCs, money collected through "self-pay" only accounts for 10% of total CHC revenue. It is estimated that Idaho's CHCs serve 12% of the State's Medicaid enrollees, but only account for 1% of Idaho's Medicaid expenditures.[45] The

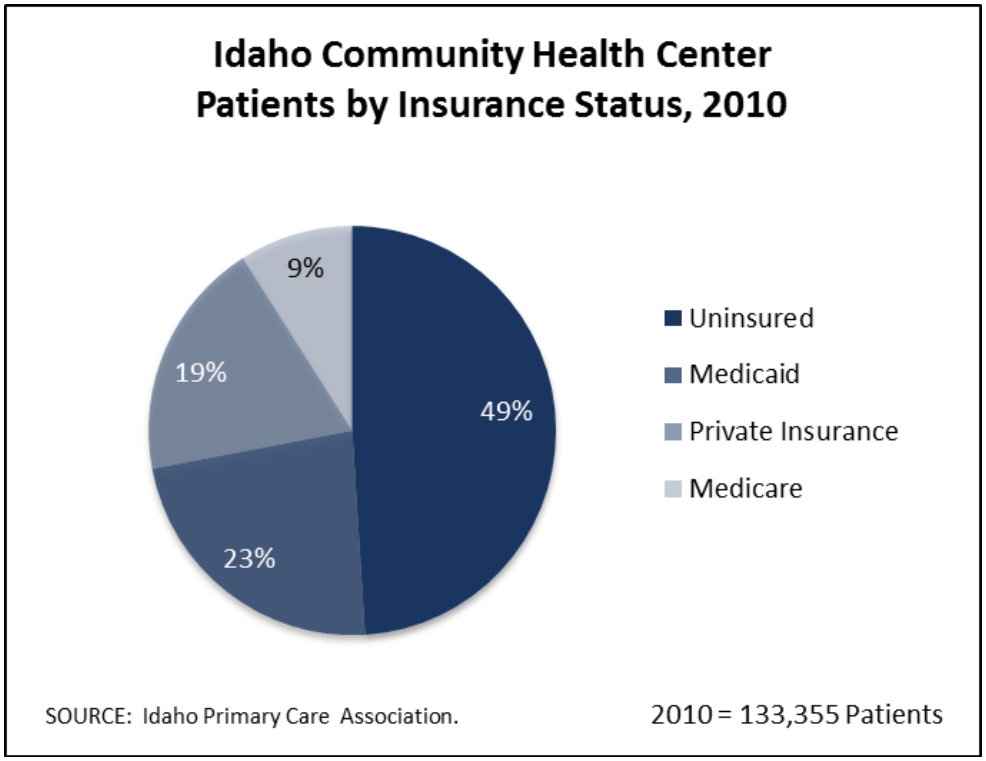
[43] Idaho Primary Care Association.
[44] Ibid.
[45] Ibid.

State pays CHCs for services provided to Medicaid patients through a prospective payment system (PPS) rate, which is a bundled payment for a comprehensive set of services including primary care, immunizations, chronic care management, etc.

Idaho's CHCs served 133,355 patients in 2010. Figure 15a, shows the percent of patients served by health insurance status. While Medicaid patients accounted for 23% of total patients in 2010, it is estimated that 35,042 or 26% of current patients will become eligible for Medicaid under an expansion scenario (Figure 16).[46] As a result, Medicaid will account for 50% of Idaho's total CHC patient population (slightly more than half of whom will be newly eligible). It is also estimated that 13,855 patients, or 10%, will become eligible for coverage through the insurance exchange.

If Idaho decides to opt into the Medicaid expansion, CHC's will begin receiving Medicaid payments for an increased portion of their existing population (as well as Medicaid payments for any newly eligible patients that seek care at CHCs). The additional payments should free up some of the federal grant funds CHCs currently receive to provide care to underserved populations (CHCs will continue to serve uninsured and underserved populations; however, they will represent a small portion of the overall patient profile). While it is not clear as to whether these grants will be reduced and/or eliminated in the later years of an expansion scenario, IDHW has an immediate opportunity to collaborate with CHCs to discuss how best these funds can be used to enhance the infrastructure needed for an expanded Medicaid population and to help with the State's delivery system reforms.

Figure 15a



[46] Analysis conducted by the Primary Care Association.

Figure 15b

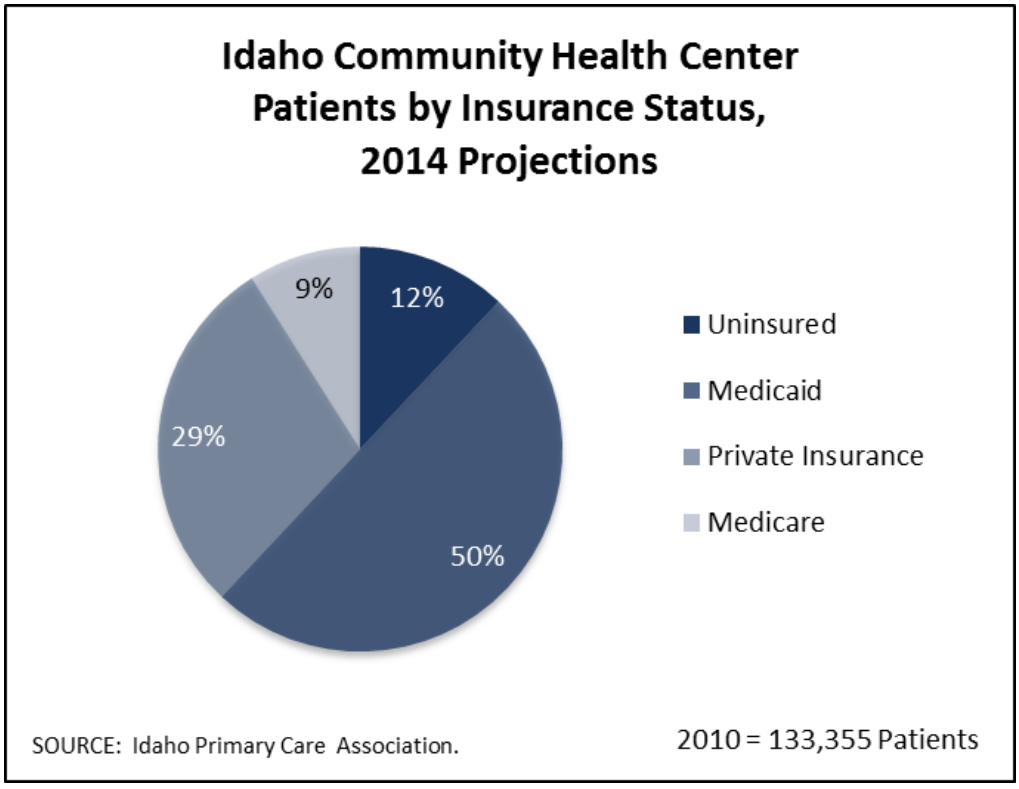
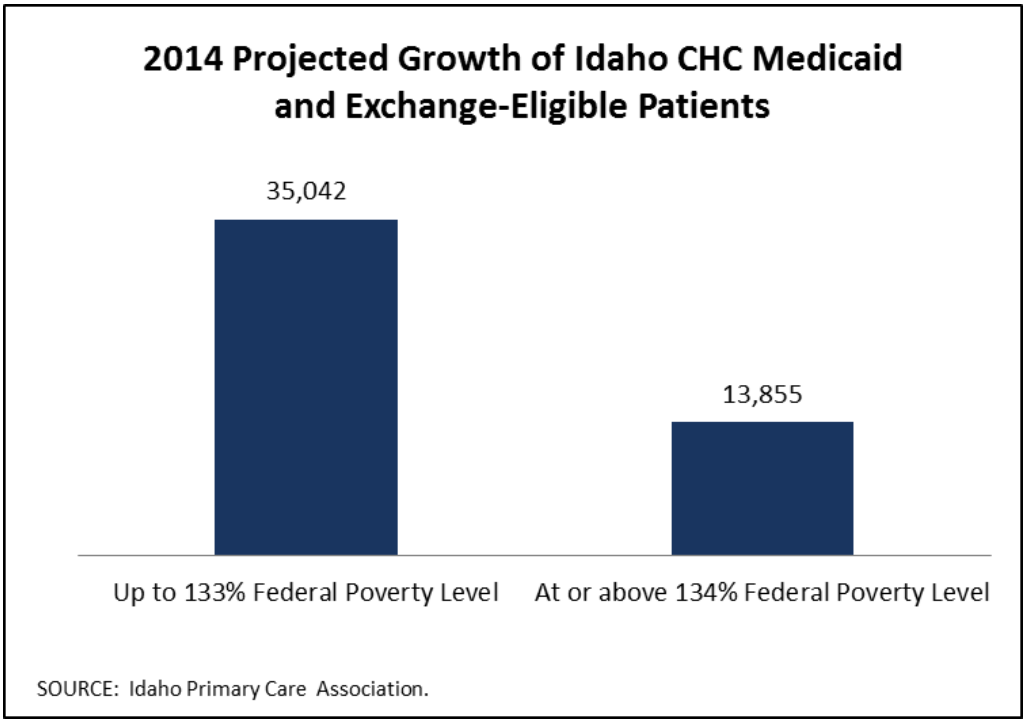


Figure 16



Demographic and Health Condition Information:
It is not possible to segregate the data provided by the Idaho Primary Care Association by income level or uninsured status, but given roughly 44% of all adult patients age 19–64 are expected to become newly eligible for Medicaid, the full data set can be used to extrapolate basic demographic and health condition information for this population.

Figure 17 shows that the largest segment of adult patients seeking care at Idaho 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. Young males also make up a larger segment of the patient population than their older counterparts, which could be a reflection of them seeking care for their young families.

Figure 17

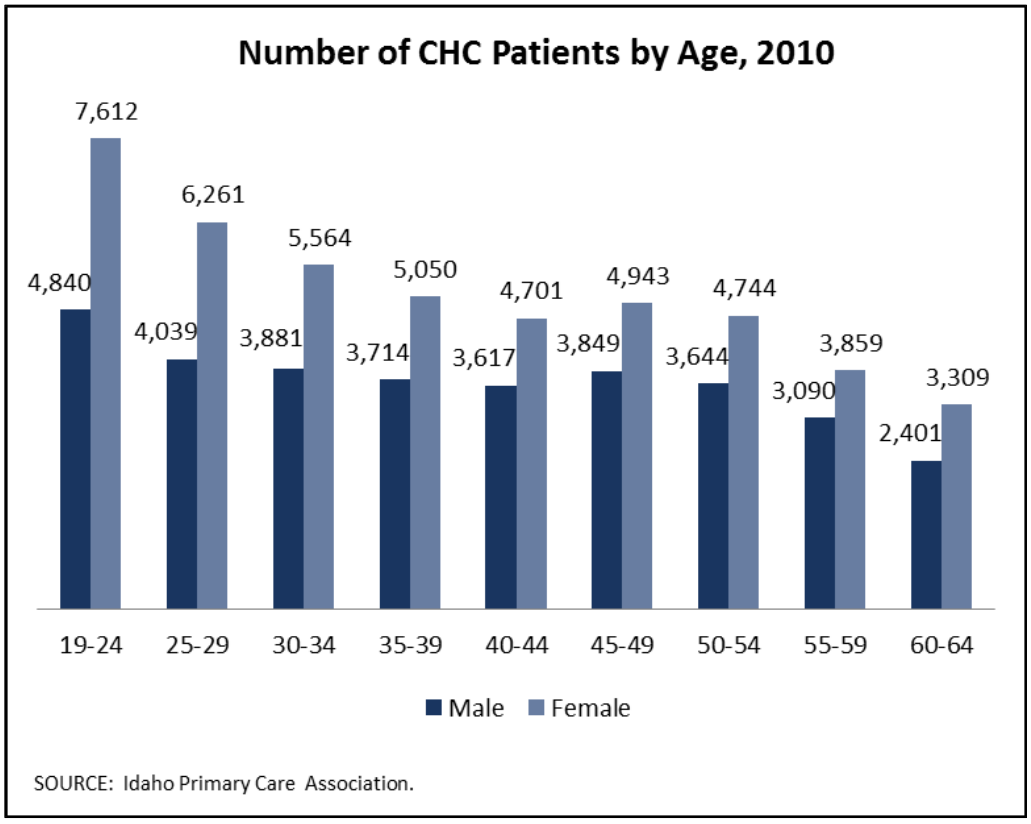
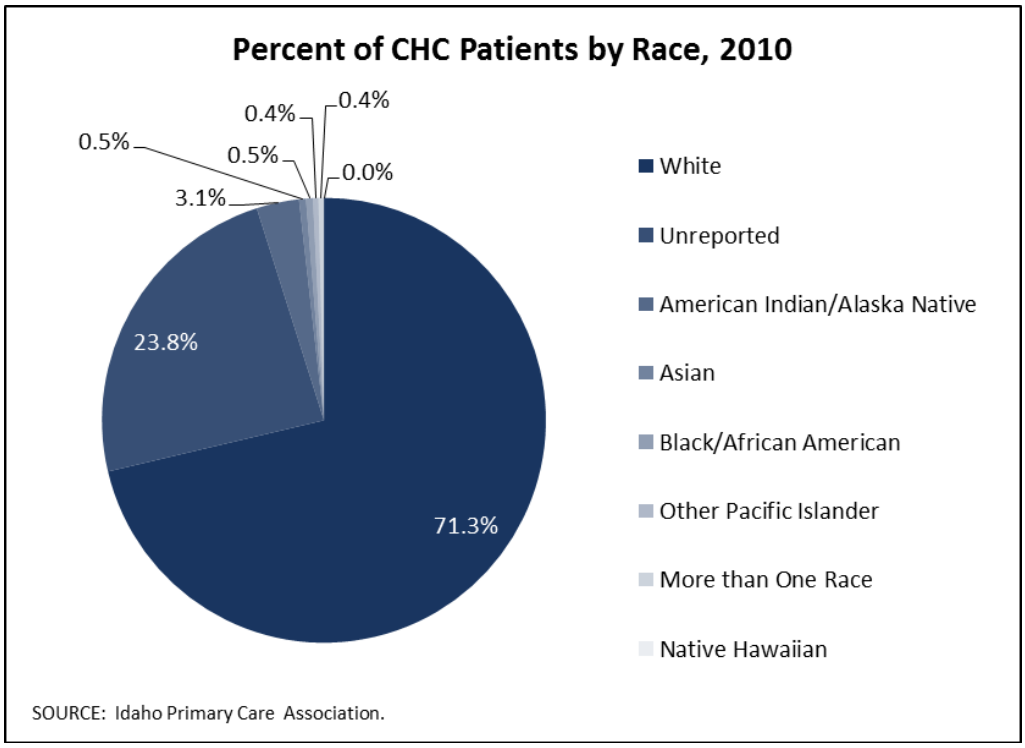


Figure 18 shows the distribution of CHC patients by race. Mirroring Idaho's general demographics, the majority of patients are white. However, in terms of ethnicity, roughly 30.7% of the patients identify as Hispanic/Latino, which is much larger than the segment represented in Idaho's general demographics. About 9.5% of the total patient population is migrant/seasonal workers, while 5.5% are homeless. Close to 20% of the total patient population is best served in a language other than English, indicating a need for interpreter services if the Medicaid program expands.

The demographics of the newly eligible Medicaid population are likely to mirror these general demographics, especially for the portion of the population that seek care at CHCs. However, because

noncitizens will not be eligible for Medicaid services, CHCs may see an overall decline in the proportion of noncitizens and migrant/seasonal workers it serves. The total number will not decline, but because CHCs will be serving a larger Medicaid population, the proportion may decline.

Figure 18



Close to 50% of the CHC patient population has income below 100% FPL. Given the current Medicaid income eligibility threshold for adults is fairly low in Idaho, it can be inferred the majority of the patients from Idaho's CHCs who transition to Medicaid will have very low income (between 20% and 100% FPL).

Figure 19 shows the number of patients with common primary diagnoses by diagnostic category.[47] The most common medical-related diagnoses 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 (other mental disorders excluded). These diagnoses are less serious and more easily treated that many of diagnoses present in the CAT program.

[47] Common diagnoses are defined as diagnoses with more than 100 visits.

Figure 19

Number of CHC Patients with Common Primary Diagnoses, 2010	
Diagnostic Category	Number of Patients
Selected Infectious and Parasitic Diseases	
Syphilis and Other Sexually Transmitted Diseases	90
Hepatitis C	226
Selected Diseases of the Respiratory System	
Asthma	1,991
Chronic Bronchitis and Emphysema	1,539
Selected Other Medical Conditions	
Abnormal Cervical Findings	286
Diabetes Mellitus	7,520
Heart Disease	1,637
Hypertension	9,118
Contact Dermatitis and Other Eczema	1,501
Overweight and Obesity	1,373
Selected Mental Health & Substance Abuse Conditions	
Alcohol-Related Disorders	537
Other Substance-Related Disorders (Excludes Tobacco Use)	465
Tobacco Use Disorders	601
Depression and Other Mood Disorders	9,203
Anxiety Disorders Including PTSD	3,837
Attention Deficit and Disruptive Behavior Disorders	1,182
Other Mental Disorders (Excludes Drug or Alcohol Dependence, Includes Mental Retardation)	4,497

SOURCE: Idaho Primary Care Association.

Figure 20 table shows the number of patients with common diagnostic tests, screenings, and preventive services by service category.[48] These are the tests, screenings, and preventive services that were most performed by Idaho CHCs in 2010. Most are common preventive services typically offered by primary care providers.

Figure 20

Number of Patients with Common Diagnostic Tests, Screenings, and Preventive Services, 2010	
Service Category	**Number of Patients**
HIV Tests	1,338
Mammogram	1,606
Pap Test	6,634
Immunizations	14,600
Seasonal Flu Vaccine	8,598
Contraceptive Management	3,701

SOURCE: Idaho Primary Care Association.

Costs:

Figure 21 shows the CHCs' total costs associated with providing medical care, clinical services, and other services-related to accessing health care to all CHC patients. Some of the enabling and other program-related services listed in the table may be indicative of support services that could be beneficial in a new Medicaid benchmark package, such as case management, interpreter services, and eligibility assistance. 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.[49]

As mentioned above, it is estimated Idaho's CHCs serve 12% of all Medicaid enrollees in Idaho. In 2011, total Idaho CHC Medicaid revenue was $21.6 million.[50] Considering the federal government covers roughly 70% of Idaho's Medicaid costs for medical care, it can be estimated that the state portion spent on CHCs was about $6.5 million.[51] These funds are used to treat the currently eligible population. CHCs would receive additional Medicaid funds to provide care for the newly eligible.

[48] Common services are defined as services with more than 1,000 visits.
[49] Idaho Primary Care Association.
[50] Ibid.
[51] The Department of Health and Welfare estimates total Medicaid expenditures on Federally Qualified Health Centers was $11.2 million in FY2011. This includes both state and federal funds.

Figure 21

CHC Financial Costs Associated with Medical Care and Other Services, 2010	
Financial Costs for Medical Care	**Accrued Cost**
Medical Staff	$21,397,883
Lab and X-ray	$1,978,174
Medical/Other Direct	$3,327,589
Total Medical Care Services	**$26,703,646**
Financial Costs for Other Clinical Services	
Dental	$8,447,404
Mental Health	$4,145,545
Substance Abuse	$172,699
Pharmacy not including pharmaceuticals	$1,269,806
Pharmaceuticals	$1,647,991
Other Professional	$29,789
Total Other Clinical Services	**$15,713,234**
Financial Costs of Enabling and Other Program-Related Services	
Case Management	$646,329
Transportation	$26,343
Outreach	$302,517
Patient and Community Education	$233,252
Eligibility Assistance	$354,860
Interpretation Services	$426,976
Other Enabling	$95,715
Total Enabling Services Costs	**$2,085,992**
Other Related Services	$0
Total Enabling and Other Services	**$2,085,992**
Overhead and Totals	
Facility	$4,376,237
Administration	$13,569,852
Total Overhead	**$17,946,089**
Total Accrued Costs	**$62,448,961**

SOURCE: Idaho Primary Care Association.

Regional Impact:
Figure 22 shows how individual Idaho CHCs rate in terms of patients accessing appropriate care for three specific chronic conditions. In general, Dirne Community Health Center in Coeur D'Alene has the highest rates of patients accessing appropriate care across the three health conditions. The Community Council of Idaho has the lowest rate—largely due to the low rate of female patients receiving Pap tests. However, it is important to note that the variation in patient outcomes is affected by many factors, including number of total patients, patient make-up, and geographical location (the patients' proximity to CHCs). Figure 23 shows the location of all Idaho CHCs.

Figure 22

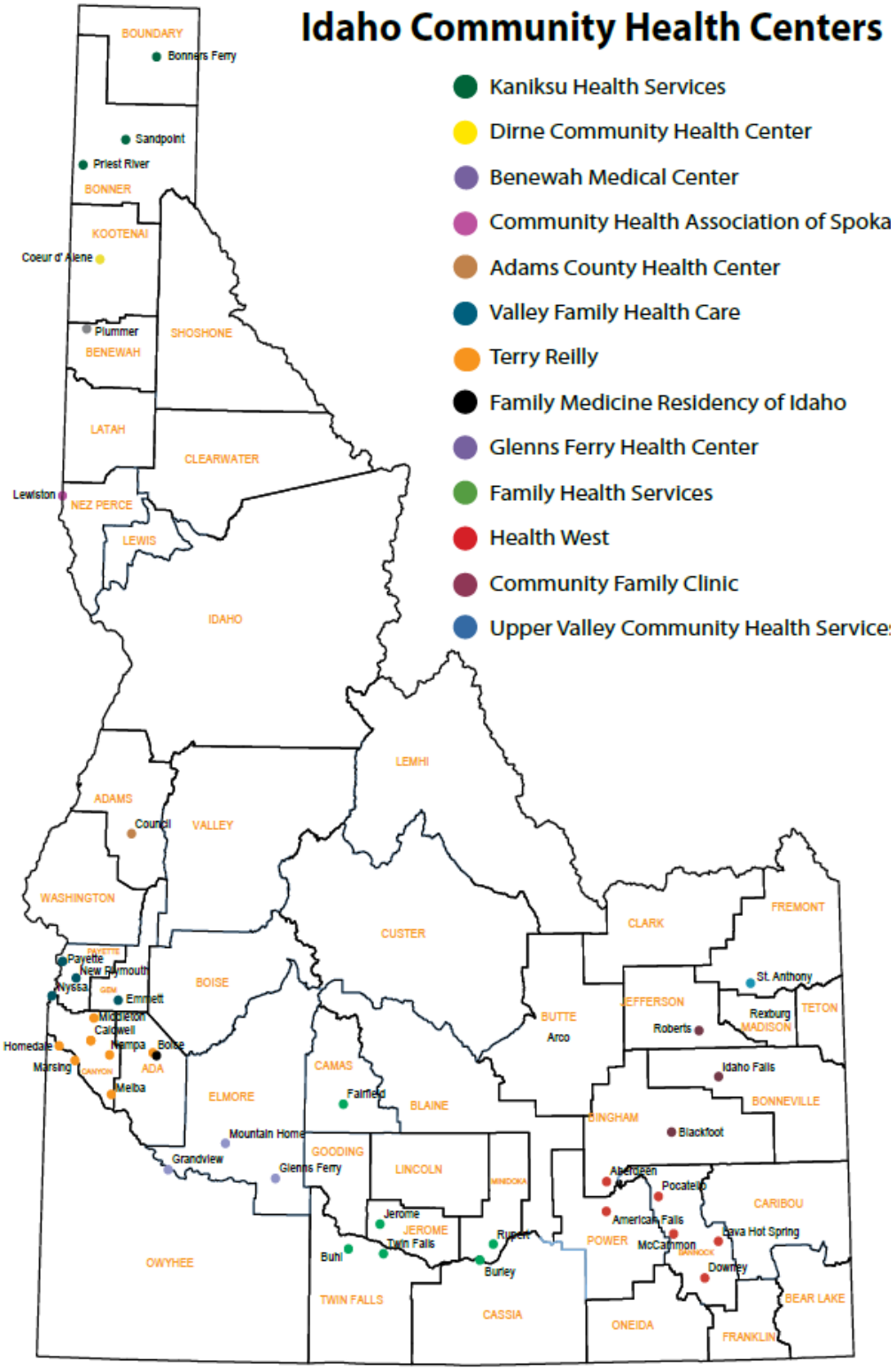
Number of CHC Patients Accessing Appropriate Care by Community Health Center, 2010

Center Name	City	Diabetes Control	Hyper-tension Control	Cervical Cancer Screenings
Terry Reilly Health Services	Nampa	62.9%	55.7%	44.6%
Health West, Inc.	Pocatello	87.1%	67.1%	57.1%
Community Council Of Idaho, Inc.	Caldwell	48.2%	53.9%	17.0%
Benewah Medical Center	Plummer	77.1%	61.4%	55.7%
Glenns Ferry Health Center, Inc.	Glenns Ferry	40.0%	50.1%	62.9%
Valley Family Health Care, Inc.	Payette	85.7%	62.9%	40.0%
Family Health Services Corporation	Twin Falls	80.0%	60.0%	51.4%
Upper Valley Community Health Services, Inc.	Saint Anthony	68.2%	70.9%	61.4%
Adams County Health Center, Inc.	Council	90.9%	50.0%	50.0%
Boundary Regional Community Health Center	Bonners Ferry	68.6%	61.4%	47.1%
Dirne Community Health Center, Inc.	Coeur D'Alene	98.6%	60.0%	48.6%

Note: Diabetes Control: The percent of adults, age 18–75, with diabetes who has their blood sugar under control, defined as an HbA1c fewer than 9%. Hypertension Control: The percent of adults, age 18–85 with hypertension, who has their blood pressure under control, defined as under 140/90. Cervical Cancer Screening: The percent of women, age 24–64, with at least one Pap test in the prior three years.

SOURCE: Interactive Chart: Quality Of Care At Community Health Centers, Kaiser Health News (April 17, 2012).

Figure 23


Idaho Community Health Centers
Kaniksu Health Services
Dirne Community Health Center
Benewah Medical Center
Community Health Association of Spoka
Adams County Health Center
Valley Family Health Care
Terry Reilly
Family Medicine Residency of Idaho
Glenns Ferry Health Center
Family Health Services
Health West
Community Family Clinic
Upper Valley Community Health Service
BOUNDARY
Bonners Ferry
Sandpoint
Priest River
BONNER
KOOTENAI
Coeur d' Alene
Plummer
BENEWAH
SHOSHONE
LATAH
CLEARWATER
Lewiston
NEZ PERCE
LEWIS
IDAHO
LEMHI
ADAMS
Council
VALLEY
WASHINGTON
CUSTER
CLARK
FREMONT
St. Anthony
JEFFERSON
TETON
Rexburg
MADISON
Roberts
BUTTE
Arco
Idaho Falls
BONNEVILLE
BINGHAM
Blackfoot
Payette
New Plymouth
Wyssa
Emmett
BOISE
Middleton
Caldwell
Homedale
Nampa
Boise
Marsing
ADA
Melba
ELMORE
CAMAS
Fairfield
BLAINE
Mountain Home
Grandview
Glenns Ferry
GOODING
LINCOLN
MINIDOKA
Abderdeen
Pocatello
CARIBOU
American Falls
Jerome
JEROME
Twin Falls
Buhl
Rupert
Burley
POWER
McCammon
Lava Hot Spring
Downey
OWYHEE
TWIN FALLS
CASSIA
ONEIDA
BEAR LAKE
FRANKLIN

Adult Mental Health Services Provided by the State

Key Findings:

1. It is estimated that roughly 4,300 program participants will be newly eligible for Medicaid.[52] 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.

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 participants are single person households, indicating the newly eligible population 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.

Program Overview:
Through the Division of Behavioral Health, IDHW provides state-funded and operated community-based mental health care services.[53] Services are provided through Regional Mental Health Centers (RMHC) located throughout the State. Each RMHC 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, short-term mental health intervention, etc.

[52] 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%.
[53] Idaho Department of Health and Welfare.

The total number of adults who are eligible for mental health services is established by the Department, which has the discretion to limit or prioritize mental health services, define eligibility criteria, or establish the number of persons eligible based on factors such as availability of funding, the degree of financial need, the degree of clinical need, etc.[54] Although the Department may set stricter requirements at any time, to be eligible for mental health services an applicant must meet three basic criteria: 1) be an adult; 2) be an Idaho resident; and 3) have a primary diagnosis of SPMI (unless the Department decides to waive this requirement).[55] Participants are generally uninsured individuals who pay for services based on a sliding fee scale that is determined by income, household size, and other factors. The program also treats some Medicaid enrollees. Currently those under 133% FPL are responsible for paying up to 20% of the cost-sharing responsibility.[56]

Data from Division of Behavioral Health show there were 4,509 non-pregnant individuals age 19–64 who received ongoing mental health services through the Adult Mental Health Services program in FY2011. As of May 24, 2012, there were 2,322 participants in the program. Based on data from the program, close to 96% of this population would qualify for Medicaid under the expansion (Figure 24). This indicates that as of FY2011, more than 4,300 participants from this program may be eligible for Medicaid in an expansion scenario.[57]

Figure 24

Number of Adult Mental Health Program Participants Qualifying for Medicaid by Household Size, 2012

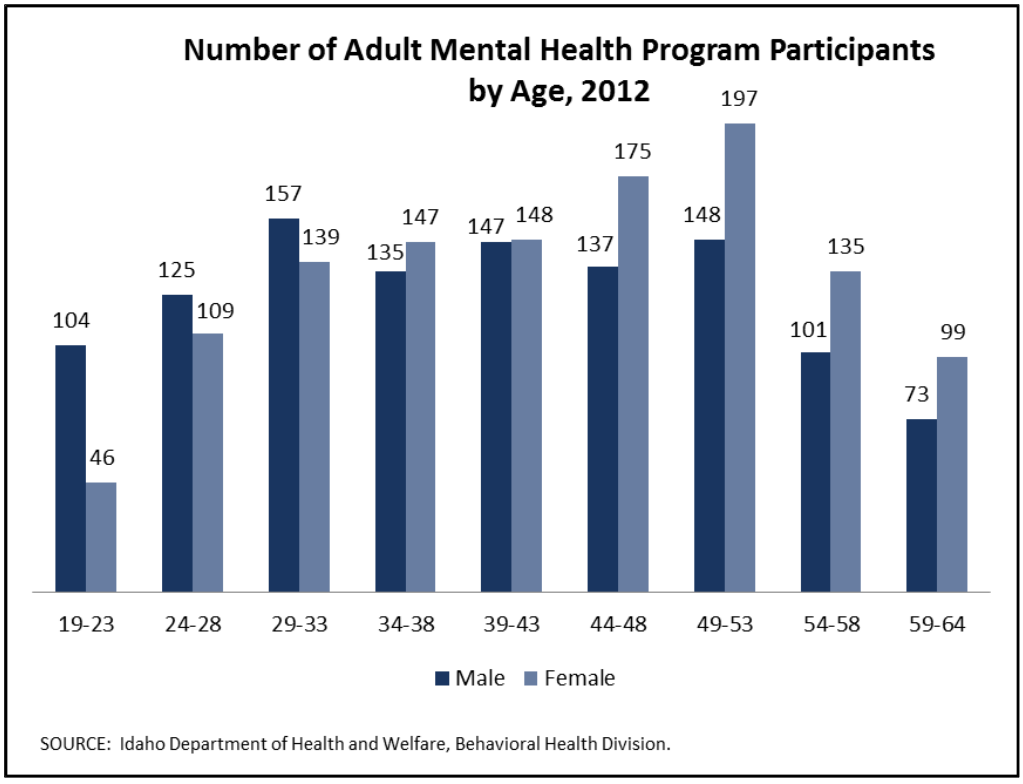
	Income < 133% FPL	Income > 133% FPL	Total
No Income	1,161	0	1,161
Single Person Households w/ Income	423	36	459
Two Person Households w/ Income	168	25	193
Three Person Households w/ Income	58	11	69
Four Person Households w/ Income	67	5	72
Five Person Households w/ Income	33	2	35
Six Person Households w/ Income	17	1	18
Seven Person Households w/ Income	8	0	8
Eight Person Households w/ Income	3	0	3
Total Number of Individuals	**1,938**	**80**	**2,018**

Note: Income determination is based on Client Reported Gross Annual Income.
SOURCE: Idaho Department of Health and Welfare, Behavioral Health Division.

[54] IDAPA 16, Title 07, Chapter 33: 16.07.33 – Adult Mental Health Services.
[55] An applicant who has epilepsy, an intellectual disability, dementia, a developmental disability, physical disability, or who is aged or impaired by chronic alcoholism or drug abuse, is not eligible for mental health services, unless, in addition to such conditions, he has a primary diagnosis of SPMI or is determined eligible under a waiver.
[56] IDAPA 16, Title 07, Chapter 01: 16.07.01 – Behavioral Health Sliding Fee Schedules.
[57] 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%.

Demographic and Health Condition Information:
The distribution of male and female participants (non-pregnant, age 19–64) is fairly uniform across the age groups, although there tends to be more young male participants than female participants and more older female participants than male participants (Figure 25). The age group with the largest number of total participants is age 49–53, a large portion of which are female participants. Close to 75% of all participants are single person households, indicating that the portion of this population moving to Medicaid in an expansion scenario will largely be childless adults.

Figure 25



The distribution of primary diagnoses is also fairly uniform across the age groups, with individuals between the ages of 49–53 having the largest number of primary diagnoses (Figure 26). Figure 27 shows the most common diagnoses by age. While the first and second most common diagnoses vary between the age groups, overall the most common diagnoses for the entire population include: 1) major depressive disorder, without psychotic features; 2) schizoaffective disorder; 3) schizophrenia, paranoid type; and 4) bipolar II disorder.

Figure 26

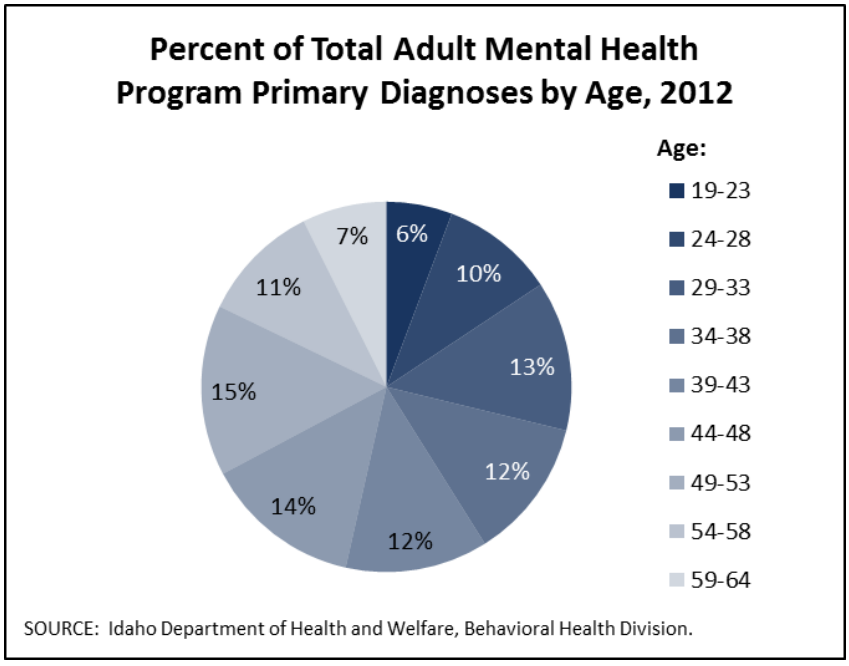


Figure 27

Most Common Adult Mental Health Program Diagnoses by Age, 2012		
Age	Most Common Primary Diagnosis	Second Most Common Primary Diagnosis
19–23	Major Depressive Disorder, Without Psychotic Features	Schizoaffective Disorder
24–28	Major Depressive Disorder, Without Psychotic Features	Bipolar II Disorder
29–33	Schizoaffective Disorder	Schizophrenia, Paranoid Type
34–38	Major Depressive Disorder, Without Psychotic Features	Schizophrenia, Paranoid Type
39–43	Major Depressive Disorder, Without Psychotic Features	Schizoaffective Disorder
44–48	Schizoaffective Disorder	Major Depressive Disorder, Without Psychotic Features
49–53	Schizoaffective Disorder	Major Depressive Disorder, Without Psychotic Features
54–58	Schizoaffective Disorder	Major Depressive Disorder, Without Psychotic Features
59–64	Schizoaffective Disorder	Major Depressive Disorder, Without Psychotic Features

SOURCE: Idaho Department of Health and Welfare, Behavioral Health Division.

The most common diagnoses for all non-pregnant adults age 19–64 are listed in Figure 28. The diagnoses listed represent the top 70% of total diagnoses. 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.

Figure 28

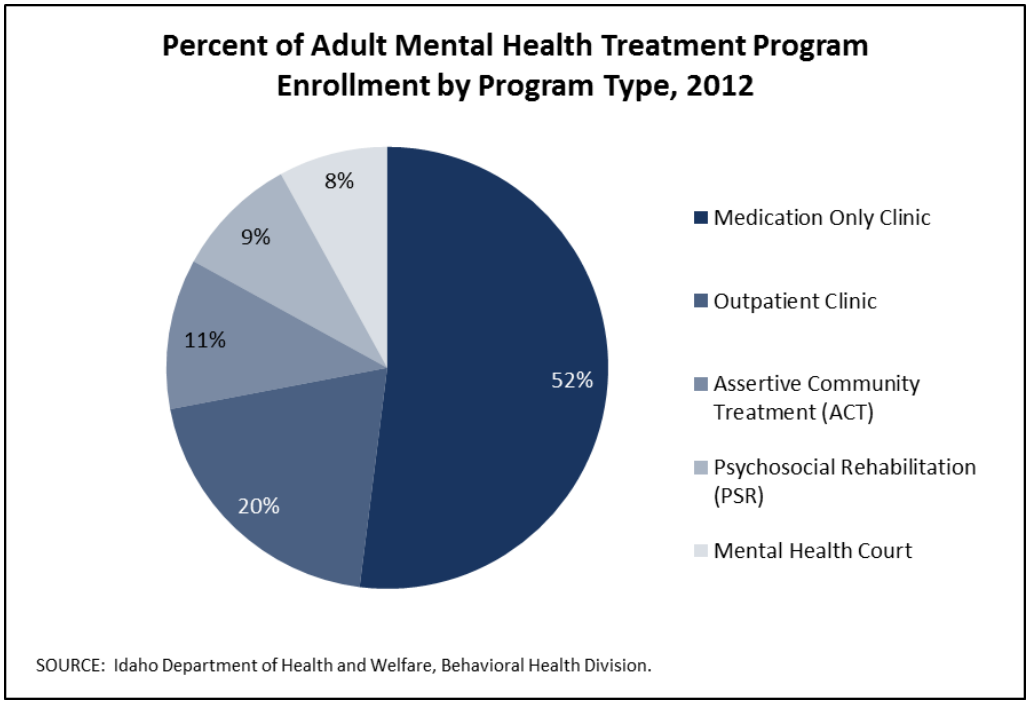
Most Common Diagnoses for Adult Mental Health Program Participants Age 19–64, 2012	
Primary Dx Description	**% of Totals**
Major Depressive Disorder, Recurrent, Severe Without Psychotic Features	13.6%
Schizoaffective Disorder	13.1%
Schizophrenia, Paranoid Type	9.5%
Bipolar II Disorder	7.3%
Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features	4.2%
Major Depressive Disorder, Recurrent, Severe With Psychotic Features	4.2%
Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features	3.7%
Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features	2.7%
Schizophrenia, Undifferentiated Type	2.6%
Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features	2.5%
Psychotic Disorders NOS	2.5%
Bipolar Disorder NOS	2.3%
Major Depressive Disorder, Recurrent, Moderate	2.3%

SOURCE: Idaho Department of Health and Welfare, Behavioral Health Division.

Most Adult Mental Health Services participants are enrolled in a treatment program, whether it is an outpatient clinic or a psychological rehabilitation program. These programs provide case management services and help monitor a participant's progress over time. Figure 29 shows the percent of total enrollment in treatment programs by program type. The most common treatment programs participants are enrolled in, both overall and for each age group, are medication-only clinics. Females have a slightly higher enrollment in treatment programs (1,115) than males (1,062).

Given close to 96% of program participants are expected to be newly eligible for Medicaid, it may be beneficial to include similar services and treatment programs in the Medicaid benchmark package. This will help ensure this population maintains some continuity of care.

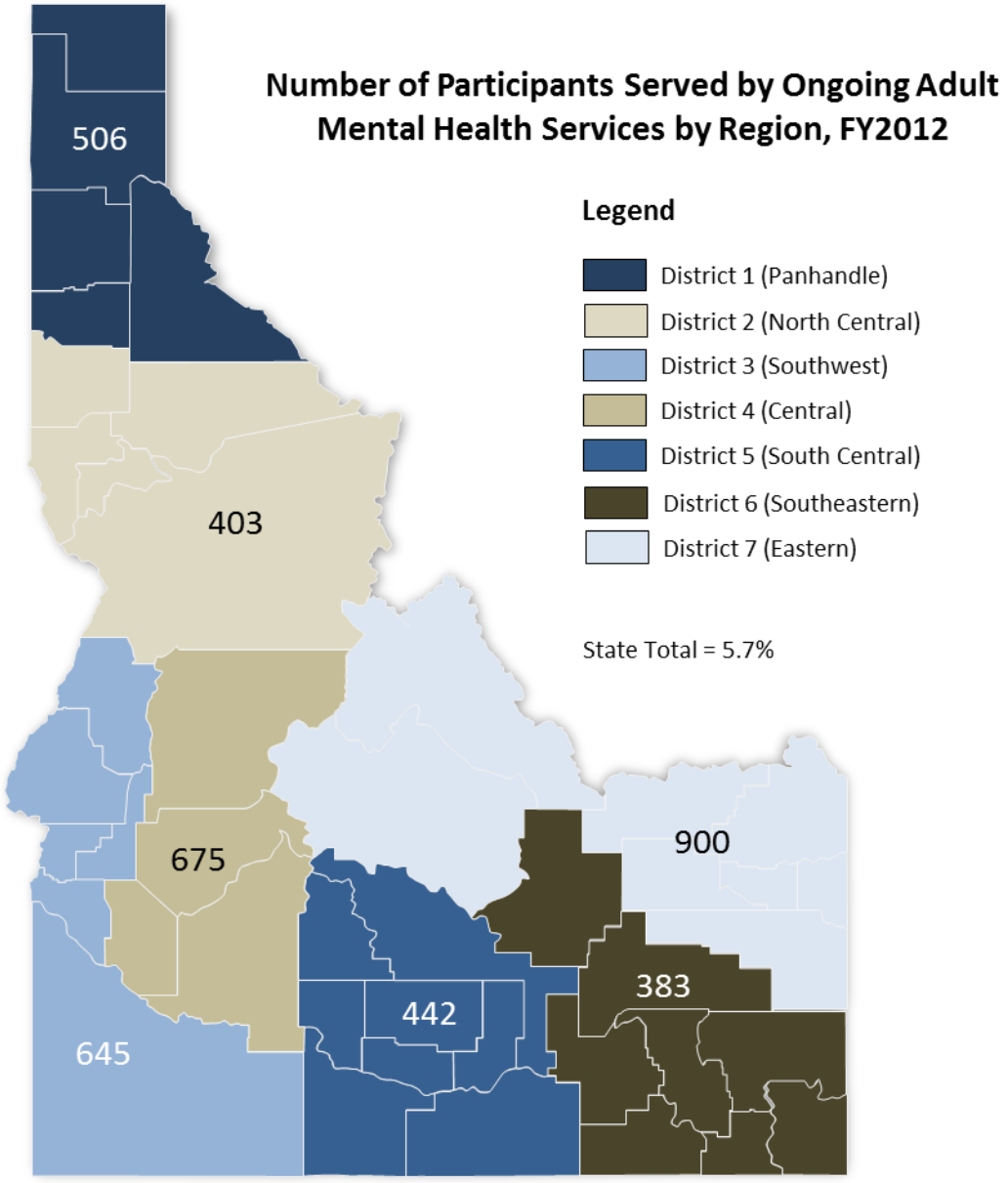
Figure 29



Costs:
The total amount of state dollars spent on Adult Mental Health Services in FY2011 was roughly $16.5 million. This cost includes both the cost spent on medical care and administrative services. Given close to 96% of this population will move into Medicaid in an expansion scenario, it is likely the Medicaid program could experience similar costs for providing mental health services in the first few years of operation. However, whereas Adult Mental Health Services is currently funded with state dollars, under an expansion scenario, the federal government will pay 90% or more of the medical care costs.

Regional Impact:
Regional data from the Adult Mental Health Services program show most participants come from Region 7, Region 3, and Region 4. These regions correspond to the public health districts listed in the Behavioral Risk Factor Surveillance System section and support the finding that most of the newly eligible population is expected to come from District 3 and District 4. While more of the population from these Districts seem to have significant health issues, the fact that a portion has been utilizing the Adult Mental Health Services program should somewhat reduce their pent-up need for mental health care.

Figure 30



Data Source: Idaho Department of Health and Welfare, Behavioral Health Division

Corrections

Key Findings:

1. On average, about 2,000 individuals are released from correctional facilities each year.[58] 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; 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. 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.

Program Overview:
On average, about 2,000 individuals are released from correctional facilities each year.[59] Close to 95% of these individuals are adults age 19–64, so it is expected that majority will be newly eligible for Medicaid under the 2014 expansion. These persons are likely to have little-to-no income and existing mental and/or health conditions. While in a corrections facility, inmates have access to onsite procedures as well as both inpatient and outpatient care provided at off-site 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 in the Medicaid program if expanded.

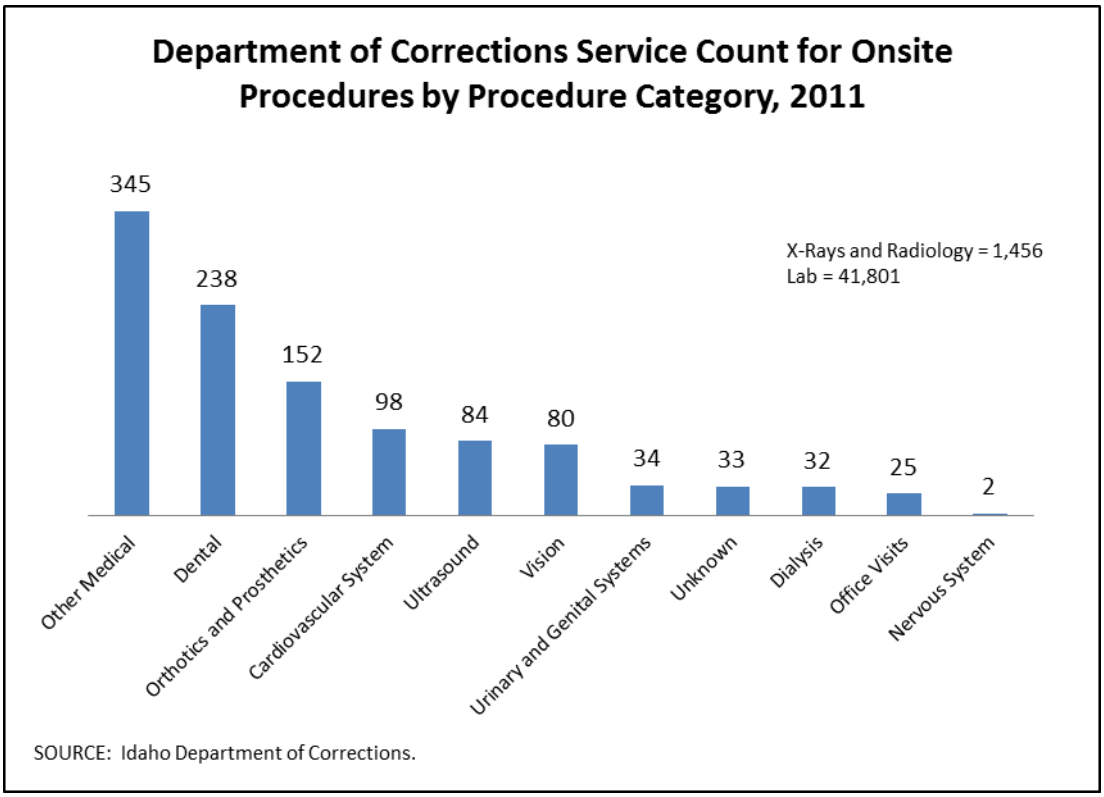
States may also choose to pay for inmates' off-site medical treatment through Medicaid. In 1997, HHS established a general rule allowing Medicaid-eligible inmates who receive treatment at hospitals or other outpatient clinics to have their bills paid for with Medicaid dollars. Persons on parole or under house arrest are also eligible. Under a Medicaid expansion scenario, the majority of inmates will be Medicaid-eligible; meaning part of the state's costs associated with providing these inmates with medical care will be offset with federal funds. To further integrate corrections with Idaho's Medicaid program, the Department of Corrections could become a participant in the State's Health Information Exchange (HIE). When newly eligible individuals are released from prison, their health records could be

[58] Idaho Department of Corrections.
[59] Ibid.

transferred to their designated Medicaid provider. This would provide IDHW with information on the individual's specific health needs and reduce duplication of any tests and procedures already completed in the correctional system.

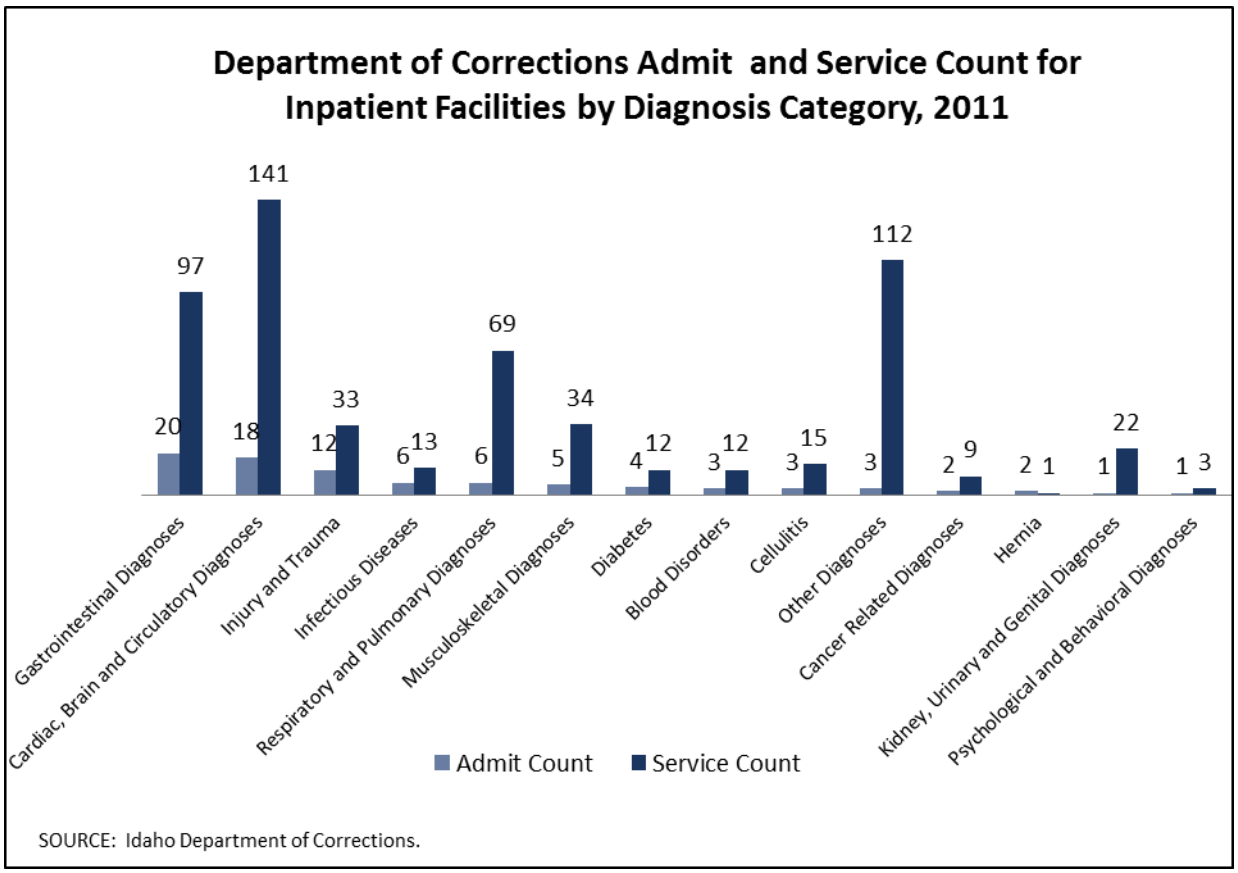
Demographic and Health Condition Information:
Isolating the adult population age 19–64, the Department of Corrections' data show the diagnosis categories for which inmates are most commonly treated. In terms of treatments provided on-site at corrections facilities, inmates most commonly receive: 1) labs; 2) X-rays and other radiology services; 3) dental services; 4) orthotics and prosthetics; and 5) cardiovascular system treatments. Office visits are low, indicating that preventive care treatments may be uncommon and that this population is treated on an "as-needed" basis.

Figure 31



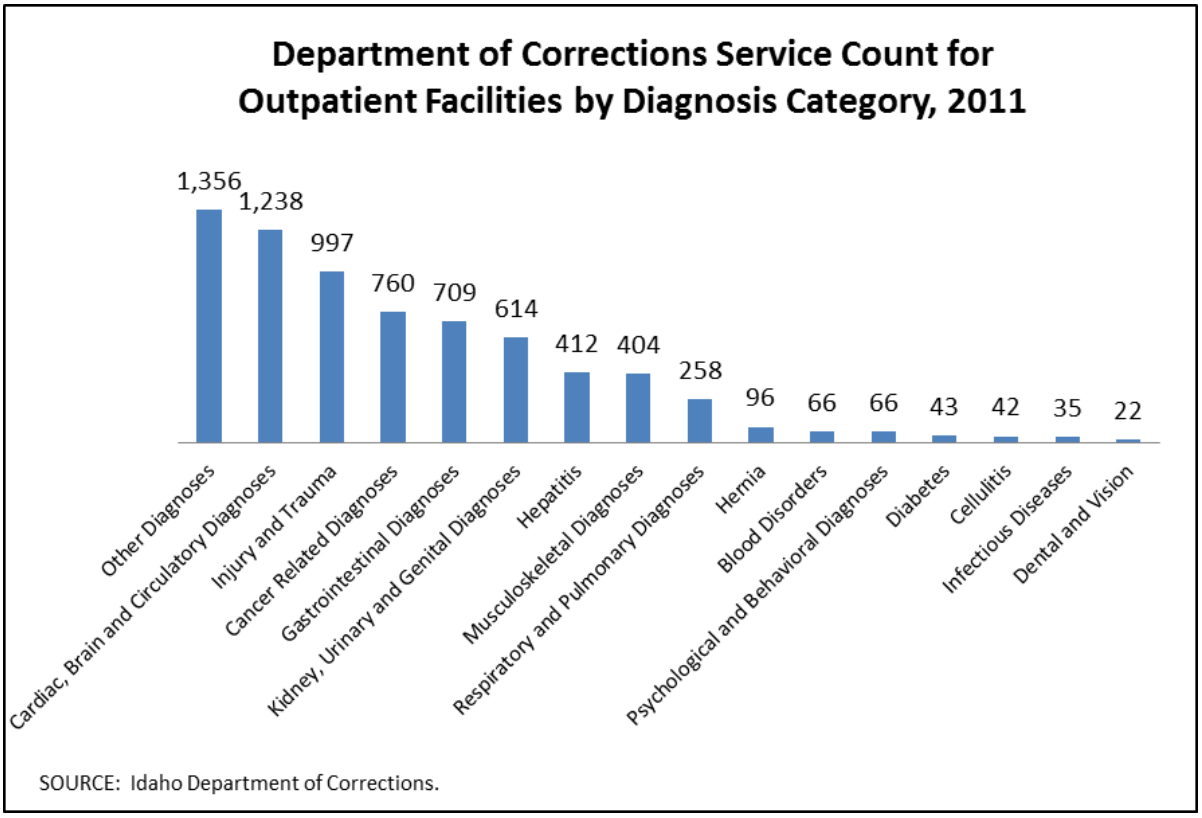
In terms of inpatient facilities, Figure 32 shows the diagnosis categories inmates are admitted for and the categories of services inmates receive while in an inpatient care setting. The data show that in 2011, inmates were most commonly admitted for: 1) gastrointestinal diagnoses; 2) cardiac, brain, and circulatory diagnoses; and 3) injury and trauma. Once admitted, inmates received treatment for a variety of additional services, indicating a need for care that was previously not addressed.

Figure 32



In terms of outpatient facilities, Figure 33 shows the diagnosis categories of services inmates receive while in outpatient care. Outside of "other diagnoses," the data show: 1) cardiac, brain, and circulatory diagnoses; 2) injury and trauma; 3) cancer-related diagnoses; and 4) gastrointestinal diagnoses are the most common services received by inmates at an outpatient facility. The most common procedures and tests received while in an outpatient care setting include x-rays and radiology, office visits, cardiovascular-related procedures, ambulance and transportation, and labs.

Figure 33



Costs:

Figure 34 shows the total cost amount spent on the top five diagnosis categories by facility type in 2011. Given the majority of this population is expected to move into Medicaid in an expansion scenario, it is likely the Medicaid program could have similar costs in the first few years of operation. The table also provides some indication of which services are most commonly used in each facility and which services are the most expensive to treat. Figure 35 shows the total amount spent by the Department of Corrections on medical care by facility type. The Department spent a total of $5.5 million of state dollars on medical care in 2011.

Figure 34

Top Five Diagnosis Categories by Cost by Facility Type, 2011		
Onsite Procedures	**Service Count**	**Cost Amount**
Lab	41,801	$463,399
Dental	238	$80,544
Other Medical	345	$42,941
Orthotics and Prosthetics	152	$37,964
Vision	80	$20,485
Inpatient Facilities (Admit)	**Admit Count**	**Cost Amount**
Cardiac, Brain and Circulatory Diagnoses	18	$323,204
Gastrointestinal Diagnoses	20	$240,573
Musculoskeletal Diagnoses	5	$146,040
Infectious Diseases	6	$139,525
Injury and Trauma	12	$133,503
Inpatient Facilities (Professional Services)	**Service Count**	**Cost Amount**
Musculoskeletal Diagnoses	34	$72,001
Cardiac, Brain and Circulatory Diagnoses	141	$36,935
Gastrointestinal Diagnoses	97	$34,964
Other Diagnoses	112	$18,682
Injury and Trauma	33	$12,829
Outpatient Facilities (Professional Services)	**Service Count**	**Cost Amount**
Injury and Trauma	997	$397,462
Cancer-Related Diagnoses	760	$354,334
Cardiac, Brain and Circulatory Diagnoses	1,238	$291,413
Kidney, Urinary and Genital Diagnoses	614	$253,646
Other Diagnoses	1,356	$252,816
Outpatient Facilities (Procedures)	**Service Count**	**Cost Amount**
Ambulance and Transportation	347	$95,304
Office Visits	623	$86,681
MRI	79	$76,818
Anesthesia	162	$70,222
Endoscopy	78	$64,296

SOURCE: Idaho Department of Corrections.

Figure 35

Total Amount Spent per Facility Type, 2011	
Facility Type	**Total Cost**
Onsite Procedures	$711,155
Inpatient Facilities (Admit)	$1,343,258
Inpatient Facilities (Professional Services)	$213,876
Outpatient Facilities (Professional Services)	$2,119,906
Outpatient Facilities (Procedures)	$1,087,195
Total	**$5,475,390**

SOURCE: Idaho Department of Corrections.

Other State Programs

While this report provides information on the four programs outlined above, it is important to note that there are other state- and grant-funded programs in Idaho that serve individuals who will potentially become newly eligible for Medicaid. For example, many of the childless adults who currently participate in the Ryan White HIV/AIDS program will likely become newly eligible. This program works with states and community organizations to provide HIV-related services to those who do not have sufficient health care coverage or financial resources.

Local health departments in Idaho have also established state or locally-funded programs and services, such as the Tuberculosis program (TB). In order to accurately estimate the health care needs of the newly eligible population and the costs of expanding the Medicaid program, IDHW should inventory and analyze what state, county, and local programs currently exist that provide services to a population that could become newly eligible for Medicaid. As more people become newly eligible, some of the services these programs provide may not be necessary, meaning Idaho could lose the federal grant dollars and/or leverage the program's state funds as part of its federal match.

How Idaho's Newly Eligible Compare to National Estimates

The data and information presented above provide a good indication of what the demographics and health care needs will be of the newly eligible population in Idaho. Several similar studies have been conducted at the national level, providing general information on the characteristics of the newly eligible population nationwide. Examining these data is helpful in determining whether Idaho's newly eligible population has the same general characteristics found at the national level and if any key differences may exist. While the data indicate that Idaho does seem to follow the same trends identified at the national level, some differences do exist—specifically around access to care.

Using national data sources to analyze the uninsured population below 133% FPL, several studies have found that general characteristics of the newly eligible population include:

Most are extremely poor. Close to half of all uninsured adults below 133% FPL at the national level have family income levels at or below 50% FPL. This is roughly $5,600 for a single person and $11,500 for a family of four.[60] Information from the four state programs presented above corroborate that this finding is true for Idaho as well, as many of those who will become newly eligible for Medicaid currently report as having little-to-no income. Additional data from the Census Bureau show that the distribution of the nonelderly uninsured in Idaho largely mirrors the national distribution (Figure 36).

It is generally reported that 2/3 of the newly eligible population will have income below 100% FPL and that the remaining 1/3 will have income between 100% and 133% FPL. The data presented in the Figure 36 show this ratio is true for Idaho as well, as close to 75% of the nonelderly uninsured population that is eligible for Medicaid have income below 100% FPL. The Urban Institute policy brief calculated a similar ratio in its estimates, with 73% of the newly eligible population having income below 100% FPL.[61]

Figure 36

Distribution of the Nonelderly Uninsured by FPL, 2009–2010

		ID #	ID %	US #	US %
Eligible for Medicaid	Under 100% FPL	99,500	38%	19,933,800	41%
	100–133% FPL	34,100	13%	6,396,300	13%
Eligible for Exchange Subsidies	134–250% FPL	82,500	32%	11,869,700	24%
	251–399% FPL	29,700	11%	6,235,200	13%
Not Eligible	400%+ FPL	NSD	NSD	4,676,900	10%
Total		**260,200**	**100%**	**49,111,900**	**100%**

Note: NSD = Not Sufficient Data.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 and 2011 Current Population Survey.

Most are childless adults. Adults without dependent children comprise close to 70% of the national newly eligible population; the remaining 30% are parents. Uninsured childless adults are also significantly more likely to be below 50% FPL than parents. Data from the Census Bureau show there are 81,800 uninsured nonelderly adults with dependent children and 134,900 uninsured nonelderly adults without dependent children in Idaho.[62] These numbers indicate childless adults account for 62% of Idaho's nonelderly uninsured adult population—and it is expected that this percent would increase as

[60] Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty, Kaiser Family Foundation (April 2010).
[61] Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults would not Be Eligible for Medicaid?, The Urban Institute (July 5, 2012).
[62] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 and 2011 Current Population Survey.

income thresholds are restricted. The data presented in Figure 37 also show that there are about 32,000 more adults in poverty without children than with children. 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.

Figure 37

Adults below 100% FPL by Family Structure, 2009–2010				
	ID #	ID %	US #	US %
Adults with Children	64,700	17%	10,898,800	17%
Adults with No Children	96,300	19%	24,911,400	20%
Total	**161,000**	**18%**	**35,810,200**	**19%**

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 and 2011 Current Population Survey.

Most are 25–54 years old. Of the childless adults who will be newly eligible for Medicaid at the national level, 53% are between 25 and 54 years old (34% are ages 19–25 and 13% are ages 55–64).[63] Of the parents, 81% of the population is between the ages of 25–54. In Idaho, persons age 40–64 account for roughly one-third of the nonelderly uninsured adult population with income below 133% FPL.[64] This indicates the majority of the newly eligible population in Idaho may be younger persons, below the age of 40. Census data providing health insurance coverage status by age show individuals, age 25–34, make up the largest share of uninsured adults in Idaho.[65] The number of males and females are fairly evenly distributed among the newly eligible.

Most have not had regular access to care. Census data show about 60% of the uninsured adults below 133% FPL at the national level have no usual source of care, such as a regular doctor's office, clinic, or health center. This makes it difficult for this population to access care when needed and results in sporadic access to preventive services. Other studies validate this finding; uninsured persons have been shown to have less contact with medical providers, less use of prescription drugs, fewer ambulatory visits, and fewer hospitalizations.[66] Other studies show nearly half of all uninsured, non-elderly individuals are likely to delay needed care due to cost.[67] While some studies have found these populations are on average healthier relative to adults who are currently enrolled in Medicaid[68] (a

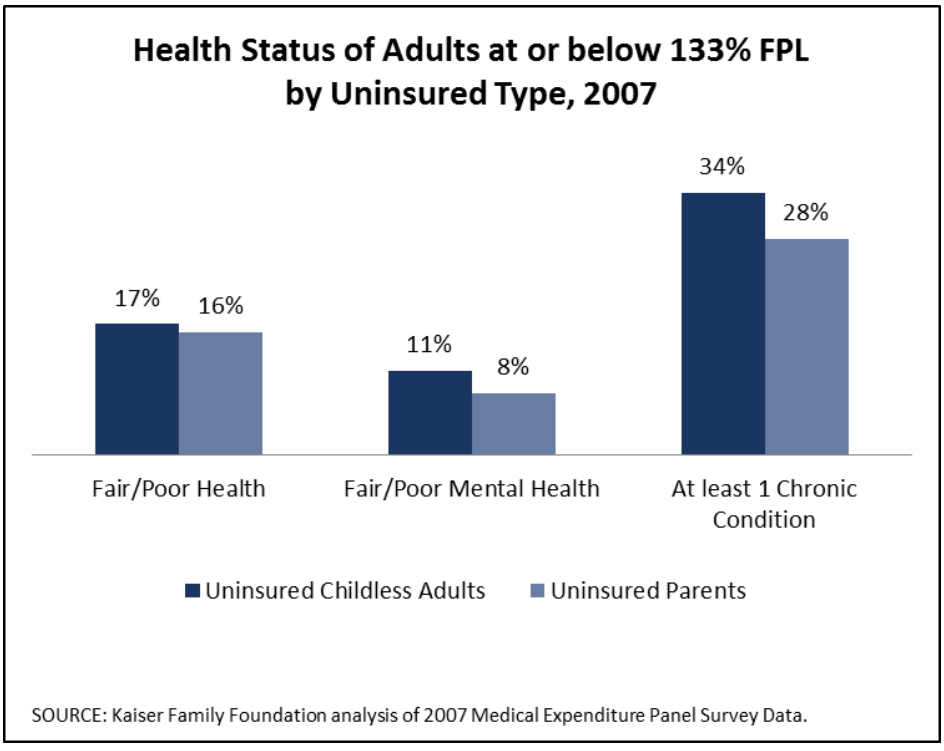
[63] Starting September 2010, some uninsured adults, age 19–25, may qualify to remain on their parent's private health insurance policies.
[64] U.S. Census Bureau, Small Area Health Estimates 2009.
[65] U.S. Census Bureau, American Community Survey 2008–2010 (3-year estimates).
[66] Pent-Up Demand for Health Care Services among the Newly Insured, State Health Access Data Assistance Center (August 2005).
[67] Ibid.
[68] The Health Status of New Medicaid Enrollees under Health Reform, Robert Wood Johnson Foundation (August 2010).

difference which may be due to the uninsured having higher rates of undiagnosed chronic conditions[69]), it can be expected that most newly eligible individuals have some pent-up need for care.

Information presented in the Idaho Demographic and Health Condition Information section indicates that about half of the newly eligible population is possibly receiving treatment from one of the four state programs examined in this report.[70] However, because some of the programs only treat specific diagnoses or incidents, it is expected that this population will have a pent-up need for health care for services that are not currently available to them. It is also unknown whether the portion of the newly eligible population that is not being served by these programs has had regular access to care, but in general it can be expected that a need for care will exist.

Many have significant health conditions. It is estimated that one in six of the newly eligible at the national level are in fair or poor health and one in three has a diagnosed chronic condition, such as hypertension or depression.[71] Among those with a chronic condition, more than 40% have not visited a doctor within the past year. Also, because uninsured persons do not have regular access to care and are more likely to delay seeking care, they are more prone to unnecessary progression of disease and illness. As a result, their illnesses tend to be more advanced and require higher levels of treatment.

Figure 38



[69] Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty, Kaiser Family Foundation (April 2010).

[70] Assuming there is no, or only minor duplication of populations between the programs. Because all data were de-identified, it is not known whether duplication exists between the programs. However, based on the data provided by the programs, it is expected very little, if any, duplication exists.

[71] Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences, Kaiser Commission on Medicaid and the Uninsured (July 2010).

Information from the four state programs presented above verify this finding and show that the newly eligible population in Idaho will likely suffer from both treatable chronic conditions such as diabetes and hypertension, as well as other serious chronic conditions, such as cancer, mental health disorders, and substance abuse.

Mental health issues are prevalent. Studies have estimated that between 35% and 60% of the newly eligible population at the national level will have mental health conditions and that at least one-third will have chemical dependence and/or substance abuse issues.[72] The prevalence of depression is estimated to be more than twice as high among the uninsured.[73] This is definitely true for the newly eligible population in Idaho. All four of the state programs examined identified mental health issues as one of the most common diagnoses for this population.

The majority are currently employed. Data from the Census Bureau show the majority of those who are uninsured and/or live below the poverty level in Idaho are employed. Figure 39 shows that of the uninsured families in Idaho in 2010, more than two-thirds had at least one full-time worker in the family. While this percent would likely decrease as income is restricted, it is expected that the percent of employed families would remain the majority. Figure 40 supports this theory; it shows that of the families living below the poverty line (100% FPL), the majority are employed (64%).

Figure 39

Distribution of the Nonelderly Uninsured by Family Work Status, 2010				
	At least 1 full time Worker	Part Time Workers	Non Workers	Total
Idaho	68%	16%	16%	100%
U.S. Average	61%	16%	24%	100%

Source: Kaiser State Health Facts; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 and 2011 Current Population Survey.

Figure 40

Persons Age 16 years and Over with Income Below 100% FPL by Employment Status, 2010				
	Employed	Unemployed	Not in Labor Force	Total
Idaho	64%	5%	32%	100%
U.S. Average	65%	5%	31%	100%

Source: U.S. Census Bureau, American Community Survey 2010.

[72] Medicaid Expansion Opportunities & Risks – Behavioral Care, Milliman Behavioral Health Advisor (October 2010).
[73] Medicaid Expansion: Consequences for the Pharmaceutical Market, Milliman Pharmaco-Actuarial Advisor (April 2010).

Section III: 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.

This section provides a general review of the utilization patterns and costs experienced by expansion states. It then provides detailed information on eight states that expanded their Medicaid programs to populations similar to what the newly eligible population will be under the PPACA. This section includes information on the population's utilization patterns, costs, benefit package, and delivery system. States included in the analysis were selected using the following criteria: 1) is there sufficient information available on the program to analyze its population and effectiveness; 2) how similar is the program to the Medicaid expansion under the PPACA; and 3) how similar is the state's demographics and political environment to Idaho's.

Key Findings:

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.[74]

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."[75]

   Figure 41 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.

[74] The Health Status of New Medicaid Enrollees under Health Reform, Robert Wood Johnson Foundation (August 2010).
[75] Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States, Center for Health Care Strategies, Inc. (August 2010).

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 41

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: Childless Adults: $7,361 (annual); $613 PMPM
Indiana	Healthy Indiana Plan	FY2014 (estimated) costs: Healthy Indiana Plan: $440
Maine	MaineCare for Childless Adults	FY2007–2008 costs: Childless Adults: $406
Oregon	Oregon Health Plan Standard	2010 costs: Adults and Couples: $679
Washington	Basic Health Plan Disability Lifeline	2009 costs: Basic Health Plan (BHP): $248 Disability Lifeline: $570
Wisconsin	BadgerCare Plus Health Insurance	2010 PMPM cost (45+ males): BadgerCare Plus Core Plan (childless adults): $224 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.

General Utilization Patterns and Costs of the Newly Eligible

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. While a review of the literature shows there are conflicting findings on whether pent-up demand exists among the uninsured, there is general agreement that increased health care utilization among the newly enrolled, previously uninsured population lasts only for a short time.[76] As the population receives

[76] Pent-Up Demand for Health Care Services among the Newly Insured, State Health Access Data Assistance Center (August 2005).

appropriate care and utilizes more preventive services, overall utilization and costs tend to decrease in the long run.

For example, studies of children in the Western Pennsylvania's Children's Health Insurance Program found that overall utilization rates were highest in the first four months of coverage and then decreased over time. The studies also found that children who had been uninsured for longer periods of time accounted for most of the increase in utilization observed in the first month of coverage.[77]

Another study found that adults newly enrolled in Oregon's Medicaid expansion program used health care services most intensively during their initial month of eligibility. Approximately 50% of new adult enrollees used some health services during their first month of eligibility. This utilization rate is significantly higher than the enrollees' average monthly utilization rate over the entire eligibility period.

However, findings of pent-up demand were more noticeable among the newly insured population who had been without coverage for extended periods of time and those with chronic conditions. For example, a study of newly insured persons in Minnesota showed nearly half of the population required and received treatments for chronic conditions after enrolling in a health plan. The cost of care for this population was 15% higher than the control group, largely due to the number of prescription drugs required to manage and treat previously untreated chronic conditions.

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 in the expansion program (due to adverse selection). Therefore, if the program has relatively low participation rates, the risk of adverse selection is much higher.[78] This results in a sicker, more costly population. However, if participation rates are high, the cost of treating the sicker population will be mitigated by the healthier population, which uses fewer services.

The cost of covering the newly eligible population will be less than traditional Medicaid, but higher than programs that currently offer services to parents of dependent children. A study conducted by the Robert Wood Johnson Foundation predicts that adults who enroll in Medicaid under reform are likely to be more expensive than those who remain uninsured (due to adverse selection), but less expensive than those currently enrolled in Medicaid.[79] This is largely due to the fact that current Medicaid programs treat disabled adults, whose costs of care are significantly higher than the population that will qualify for Medicaid under the expansion.

However, there will be variations in the costs of newly eligible population as well. State experiences suggest that childless adults (who do not qualify for Medicaid in most states) are likely to have higher costs and more complex care needs than adults with dependent children. States that have expanded their Medicaid and other state-funded programs to cover childless adults have found that a large portion of the enrollees have substantially higher costs and care needs than the parent population.[80] It is

[77] Pent-Up Demand for Health Care Services among the Newly Insured, State Health Access Data Assistance Center (August 2005).
[78] The Health Status of New Medicaid Enrollees under Health Reform, Robert Wood Johnson Foundation (August 2010).
[79] Ibid.
[80] Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States, Center for Health Care Strategies, Inc. (August 2010).

estimated that "if benefit packages were comparable—the costs for low-income childless adults would be approximately halfway between those of non-disabled and disabled adults."[81]

While the costs of treating a population with more complex care needs are higher, there are some associated benefits as well. For example, this population is likely to have lower churn rates and lengthier periods of enrollment.[82] This will allow the Medicaid program to ensure the enrollees are receiving appropriate, continuous care—potentially reducing the rate of avoidable hospitalizations and expensive emergency department visits.[83]

Meeting the newly eligible population's diverse health care needs will require a broad package of benefits. 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, states will need to provide a broad package of benefits. This package may include specialized treatments, disease management programs that address significant mental and physical health conditions, and the use of strategies to promote the use of primary and preventive care. Information on recommended Medicaid benefit packages is provided in Section IV.

Experiences from Expansion States

Arizona

Arizona is one of six states that cover childless adults below 100% FPL (AZ, DE, HI, MA, NY, VT). Arizona expanded its Medicaid program (Arizona Health Care Containment System) in 2001 through an 1115 Waiver to include childless adults and other groups with income below 100% FPL who are not otherwise eligible for Medicaid. As of June 1, 2011, enrollment for childless adults in the program was 225,000. However, in July 2011, Arizona froze the enrollment of childless adults in order to address state budget problems. CMS approved the enrollment cuts and it is estimated that roughly 100,000 childless adults would lose coverage in the first fiscal year.

Demographics and Utilization:
Arizona's adult Medicaid population consists of three groups: parents, childless adults, and adults with disabilities. In general, parents make up about half of the Medicaid population, while childless adults account for about a third, and the remaining 20% are adults with disabilities. Relative to the parent and adults with disability populations, childless adults tend to be older and are more likely to be male (half of the childless adults were between the ages of 45–64).

In terms of utilization patterns, Arizona found that childless adults are less likely to access the health system than parents. On average, 82% of childless adults go to the physician/hospital in a year vs. 96% of parents. This is true for inpatient and outpatient hospital visits, emergency department visits, physician visits, lab/x-ray use, and prescription drug use.

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[81] Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States, Center for Health Care Strategies, Inc. (August 2010). Sandra Hunt of PricewaterhouseCoopers, Oregon's Medicaid actuary and a consultant to Wisconsin on its BadgerCare Plus low-income childless adult program.
[82] Ibid.
[83] Pent-Up Demand for Health Care Services among the Newly Insured, State Health Access Data Assistance Center (August 2005).

However, of the childless adults that do access the health system, their average rates of utilization tend to be higher than parents (an average of 53 vs. 41 claims).[84] Childless adults more frequently visit inpatient and outpatient hospitals (and have longer lengths of stay), emergency departments, physician offices, and mental health providers—as well as use more lab/x-ray services and prescription drugs. Childless adults are also more likely to use emergency transportation services than parents.

In terms of specific diagnoses, mental illness is the most prevalent condition for childless adults. This population has a much higher utilization rate of mental health services than parents. A significant portion of the childless adults utilizing mental health services have dual diagnoses of mental illness and substance abuse. Rates of hypertension and diabetes are also high among childless adults and they are more likely than parents to have congestive heart failure and chronic obstructive pulmonary disease.

Benefit Package and Delivery System:
Unlike most expansion programs, Arizona offers childless adults the same benefit package that is available to other Medicaid enrollees. Services for adults typically include: 1) behavioral health (including both mental health and substance abuse treatment); 2) dialysis; 3) emergency care; 4) family planning; 5) hospital services; 6) immunizations; 7) lab and x-ray; 8) doctor visits; 9) podiatry services; 10) physical exams; 11) prescriptions; 12) specialist care; 13) surgery services; 14) medical transportation; and 15) annual well-women exams.

Cost-sharing is typically higher for this population than the traditional Medicaid populations. In general, childless adults pay $4 for generic prescriptions (or brand name prescriptions when there is no generic), $5 for doctor office visits, $10 for brand name prescriptions when there is a generic drug available, and $30 for the nonemergency use of an emergency department. Pharmacists and medical providers can also refuse services if copayments are not made.

Childless adults are enrolled in pre-paid, capitated health plans. Enrollees can choose which health plan to enroll in, depending on the managed care organizations' (MCO) service areas. Before the enrollment freeze in 2011, eligibility was renewed every 12 months.

Cost:
In 2010, the projected average annual cost per childless adult was $7,361. This is about halfway between currently enrolled Medicaid adults, age 45 and older, and adults with disabilities (the cost for Medicaid adults was $5,305; the cost for SSI/disabled adults was $9,428). Expenditures for injury, heart and circulation, and musculoskeletal systems tend to be the highest costs incurred by childless adults.

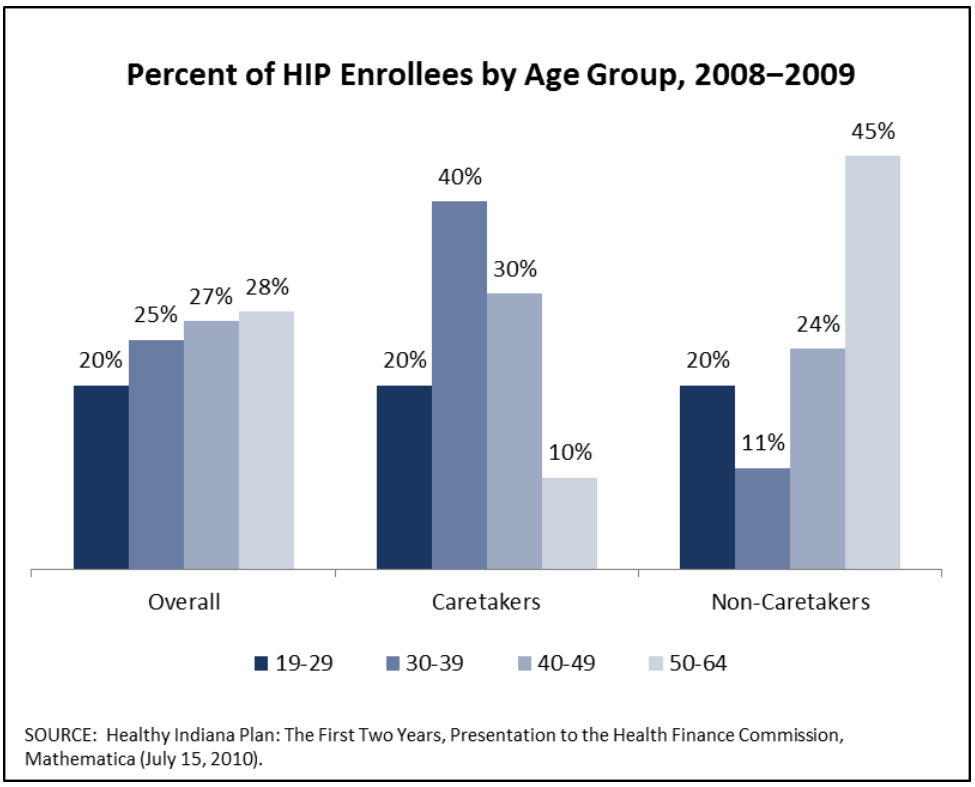
Indiana

In 2008, Indiana expanded its Medicaid program through an 1115 Waiver to two additional populations, custodial parents (caretakers) and childless adults (non-caretakers), with income below 200% FPL, who are not otherwise eligible for Medicaid. Adults must be uninsured for at least six months to be eligible to enroll in the Healthy Indiana Plan (HIP). Enrollment of childless adults is currently capped at 36,500. The original cap of 34,000 was reached in the first year. Enrollment is currently closed for childless adults, although it opens periodically to add members up to the cap.

[84] Pent-Up Demand for Health Care Services among the Newly Insured, State Health Access Data Assistance Center (August 2005).

Demographics and Utilization:
A July 2010 review of the HIP population shows caretakers make up approximately 60% of all enrollees in the HIP program. In general, caretakers tend to be young females; nearly 60% were age 20–40. This is considerably different from the non-caretaker population; close to 70% were 40 years or older (Figure 42). Most childless participants are female (58%), the only member of their family (68%), and have income below 100% FPL.

Figure 42



SOURCE: Healthy Indiana Plan: The First Two Years, Presentation to the Health Finance Commission, Mathematica (July 15, 2010).

In terms of utilization patterns, both the caretaker and non-caretaker HIP populations use more health care services than the typical commercial population with the same age/gender characteristics. A study conducted by Milliman, which examined inpatient hospital days, prescription drug use, office visits, physical exams, hospital inpatient visits, and emergency department visits, found caretakers have a higher utilization rate than the commercial population for all services, but particularly inpatient days and emergency department visits.[85] Non-caretakers had even higher utilization rates than the caretaker population. Compared to the commercial population, non-caretakers had nearly three times as many inpatient services per capita and prescription drug utilization was nearly 50% higher.

While the HIP population has higher rates of utilization, their pattern of utilization decreases over time. The Milliman study found that use of inpatient, outpatient, and physician services peaked in the second and third months of enrollment, but leveled off by the end of the first year. The one exception to this

[85] Experience under the Healthy Indiana Plan: The Short-Term Cost Challenges of Expanding Coverage to the Uninsured, Milliman (August 2009).

trend is utilization of pharmacy services which continued to increase over time. A study conducted in 2010 by Mathematica corroborates this evidence; it showed close to 91% of all HIP participants had a physician office visit during the first year of enrollment while nearly 60% obtained a preventive service.[86]

Both caretakers and non-caretakers suffer from high rates of chronic conditions, such as asthma, heart disease, depression/anxiety, diabetes, and seizure disorders. Both asthma and depression were twice as prevalent in the HIP population as the commercial population—and heart disease was most prevalent among non-caretakers. The Mathematica study also found that chronic conditions are common among the HIP population, but that most of the population suffers from low-cost chronic conditions.

Figure 43

Percent of HIP Members by Number of Chronic Conditions, 2008–2009				
		Number of Chronic Conditions		
Category	Number of Members	None	1 to 2	3 or more
Low, Medium, and High-Cost Chronic Conditions				
All HIP Members	61,784	21%	28%	51%
Caretakers	29,246	27%	31%	41%
Non-Caretakers	32,538	16%	24%	60%
Medium and High-Cost Conditions Only				
All HIP Members	61,784	82%	17%	1%
Caretakers	29,246	89%	11%	< 1%
Non-Caretakers	32,538	76%	22%	2%

Note: Condition categories based on the Chronic Illness and Disability Payment System (CDPS).
SOURCE: Mathematica analyses of HIP encounter records. From Healthy Indiana Plan: The First Two Years, Presentation to the Health Finance Commission, Mathematica (July 15, 2010).

Benefit Package and Delivery System:
In general, HIP enrollees have access to most services that are available in the State's traditional Medicaid program. Services typically include: 1) mental health care services; 2) inpatient hospital services; 3) prescription drug coverage; 4) emergency department services; 5) physician office services; 6) diagnostic services; 7) outpatient services, including therapy services; 8) comprehensive disease management; 9) home health services, including case management; 10) urgent care center services; 11) preventive care services; 12) family planning services; 13) hospice services; and 14) substance abuse

[86] Healthy Indiana Plan: The First Two Years, Presentation to the Health Finance Commission, Mathematica (July 15, 2010).

services. HIP does not cover dental, vision, chiropractic, or podiatry services (except for diabetics). It also does not cover hearing aids (except for 19–20 year olds), maternity services, and various other services. Figure 44 shows the services HIP covers and how these services compare to traditional Medicaid.[87]

Figure 44

Benefit Package for Members in the Hoosier Healthwise Program (Traditional Medicaid) and Healthy Indiana Plan, 2010			
Benefit	HHW	HIP	Notes on Benefit for HHW and HIP or Limits if Covered in the HIP
Inpatient Medical/Surgical	X	X	
Emergency department services	X	X	Self-referral Co-pay for services for HIP members when the service is determined to be non-emergent
Urgent care	X	X	
Outpatient hospital	X	X	
Outpatient Mental Health and Substance Abuse	X	X	Medicaid Rehabilitation Option (MRO) and Psychiatric Residential Treatment Facility (PRTF) services are not the responsibility of the MCOs; Psychiatry is a self-referred service
Primary care physician services	X	X	
Preventive care services	X	X	
Immunizations	X		Self-referral
EPSDT services	X	X	In HIP, lead screening only for members age 19 and 20
Specialist physician services	X	X	
Radiology and pathology	X	X	
Physical, occupational, and speech therapy	X	X	In HIP, 25-visit annual maximum for each type of therapy
Chiropractic services	X		Self-referral
Podiatry services	X		Self-referral
Eye care services	X		Self-referral; excludes surgical services
Prescription Drug	X	X	Brand name drugs are not covered where a generic substitute is available

[87] External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year Calendar 2009, Burns & Associates, Inc. (November 30, 2010).

Home health/Home IV therapy	X	X	Excludes custodial care but includes case management
Skilled Nursing Facility	X	X	
Ambulance	X	X	Emergency ambulance transportation only
Durable Medical Equipment	X	X	
Family Planning Services	X	X	Self-referral; excludes abortions, abortifacients
Hearing Aids	X	X	In HIP, ages 19 and 20 only
FQHC and Rural Health Center Services	X	X	In HIP, subject to the benefit coverage limits
Disease Management Services	X	X	
HIV/AIDS targeted case management	X		Limited to 60 hours quarter to Package A and Package B members only
Diabetes self-management	X		
Transportation	X		

Note: The Hoosier Healthwise program covers children, pregnant women, and low-income families.
SOURCE: External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year Calendar 2009, Burns & Associates, Inc. (November 30, 2010).

Cost-sharing in the HIP program is typically higher than traditional Medicaid. HIP coverage is subject to a $1,100 deductible and benefits are capped at $300,000 annually with a $1 million lifetime benefit cap. In an effort to promote preventive care, the State provides up to $500 in preventive services each year. Any services used beyond the $500 and services that are considered outside of preventive services are subject to deductibles.

Payments for the deductible can be drawn from an enrollees' Personal Wellness Responsibility (POWER) account, which operates similar to a basic HSA account. POWER accounts are funded through a combination of enrollee, state, and federal contributions. Enrollees' contribution amounts are scaled by household income and range from 0% to 5%, based on the enrollees' income. Enrollees are billed monthly for their contribution and failure to pay the required contribution during a 12-month period result in penalties or disenrollment.

Figure 45

POWER Account Contributions by HIP Members, 2010	
Annual Household Income	**Maximum Account Contribution**
All enrollees at or below 100% FPL	No more than 2% of income
All enrollees 100% –125% FPL	No more than 3% of income
All enrollees 125% – 150% FPL	No more than 4% of income
HIP Caretakers 150% – 200% FPL	No more than 4.5% of income
HIP Adults 150% – 200% FPL	No more than 5% of income

SOURCE: External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year Calendar 2009, Burns & Associates, Inc. (November 30, 2010).

Unused POWER account funds roll over year to year (assuming the enrollee has met all program requirements), providing incentives for members to obtain annual preventive care requirements first. Because POWER accounts are capped at $1,100, any funds that are rolled over effectively reduce the enrollee's account contribution amount in the following year. If an enrollee uses services in excess of the $1,100, the State covers the excess costs.

HIP participants are enrolled in one of three health plans: Anthem, MDWise (both pre-paid, capitated plans), or the Enhanced Service Plan (ESP), which is for enrollees with significant medical needs. A questionnaire administered as part of the application process identifies high-need, high-risk participants (i.e., participants with cancers, HIV/AIDS, hemophilia, aplastic anemia, or organ transplants). These participants are placed in the ESP plan, which is a state-run, fee-for-service program. ESP participants can access the same primary care providers as other HIP participants, but the State contracts with the high-risk pool to process ESP claims and provide information on chronic condition management and preventive care.[88] HIP enrollees are approved for 12-month periods. They may be refused renewal if HIP has reached maximum enrollment.

Cost:
Health care costs for HIP enrollees have been higher than expected. In 2009, the costs of the HIP program exceeded the tax revenue collected that year (the state share of funding is provided through an increase in the state tobacco tax as well as funds diverted from the federal disproportionate share hospital program). The unexpected costs resulted in increased payment rates for participating health plans and put a strain on state budgets.

[88] Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States, Center for Health Care Strategies, Inc. (August 2010).

Part of the unexpected cost is due to the rapid enrollment of the non-caretaker population. Studies show the costs of the non-caretaker population are substantially higher than the costs of the caretaker population. For example, inpatient hospital and prescription drug use for non-caretakers is almost twice as high as that of non-disabled adults. The State partially addressed the problem by carving out pharmacy from managed care. A 2011 study by Milliman estimates that in FY2014, the PMPM cost of providing care to HIP enrollees will be $440.[89]

While the program's costs have been higher than expected, steady enrollment and high retention rates indicate that many uninsured residents are willing to contribute to the cost of their health care. In the first two years of operation, only about 3% of HIP enrollees left the program because they failed to pay their monthly contributions.

Iowa

The IowaCare program was authorized by the Iowa legislature under a Medicaid expansion program and began operation on July 1, 2005. The program was created to help fill the loss of the State's indigent care program and Iowa now uses funds that would have been used for the indigent care as part of the match for federal funds. In October 2010, Iowa assigned 25,000 IowaCare members to a medical home at one of four designated clinics.[90] The medical homes provide routine care, preventive services, and disease management. The program covers adults, age 19–64, with income below 200% FPL who are not otherwise eligible for Medicaid.

Demographics and Utilization:
The majority of IowaCare enrollees are low-income, childless adults (in 2009, 88% of IowaCare members were childless adults and 83% had incomes below 100% FPL; the average monthly income for an IowaCare member was $850).[91] There are slightly more males than females enrolled in the program and while the distribution of enrollees is fairly evenly divided across the age groups, the highest percent of enrollees are in the 41–50 age bracket.[92]

[89] Healthy Indian Plan State Plan Amendment Financial Projection, Milliman (January 25, 2011).
[90] Evaluation of the IowaCare Program: Baseline Information for the Medical Home Expansion, Public Policy Center at the University of Iowa (October 2011).
[91] The Healthy Indiana Plan and Health Coverage of Childless Adults across the States, Indiana Legislative Services Agency (July 2011).
[92] Outcomes of the IowaCare Program For Year Ending September 30, 2010, Public Policy Center at the University of Iowa (August 2011).

Figure 46

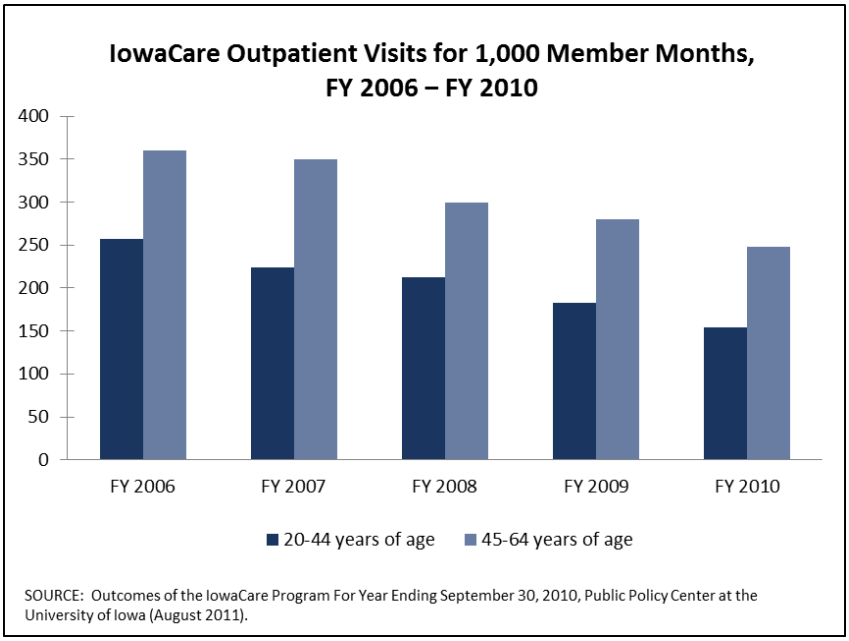
Demographics of People Enrolled in IowaCare for at Least One Month by State Fiscal Year, FY2006 – FY2010					
Demographic Characteristic	FY2006 Number Percent	FY2007 Number Percent	FY2008 Number Percent	FY2009 Number Percent	FY2010 Number Percent
Gender					
Female	12,365 51%	14,369 49%	16,424 50%	21,166 49%	27,009 48%
Male	11,911 49%	14,766 51%	16,693 50%	21,981 51%	28,746 52%
Age					
19–21 years	1,471 6%	1,540 5%	1,185 4%	1,713 4%	2,149 4%
22–30 years	5,167 21%	5,962 21%	6,897 21%	9,361 22%	12,559 23%
31–40 years	4,983 21%	5,680 20%	6,109 18%	8,158 19%	10,771 19%
41–50 years	7,334 30%	8,877 31%	9,499 29%	11,910 28%	14,751 27%
51–60 ears	4,357 18%	5,751 20%	7,502 23%	9,547 22%	12,356 22%
Over 60 years	964 4%	1,325 4%	1,919 6%	2,458 6%	3,168 6%

SOURCE: Outcomes of the IowaCare Program For Year Ending September 30, 2010, Public Policy Center at the University of Iowa (August 2011).

Similar to other states, the older population has a much higher utilization rate. Figure 47 shows the rate of outpatient visits for IowaCare enrollees, age 20–44 and 45–64. While the number of outpatient visits trended downward between FY2006 and FY2010 (likely an indication of an initial pent-up need for care), the older population maintained a higher utilization rate over time. The same trend exists for ambulatory surgeries and observation room stays. The older population also had a higher rate of inpatient discharges and longer lengths of stay at inpatient facilities.[93]

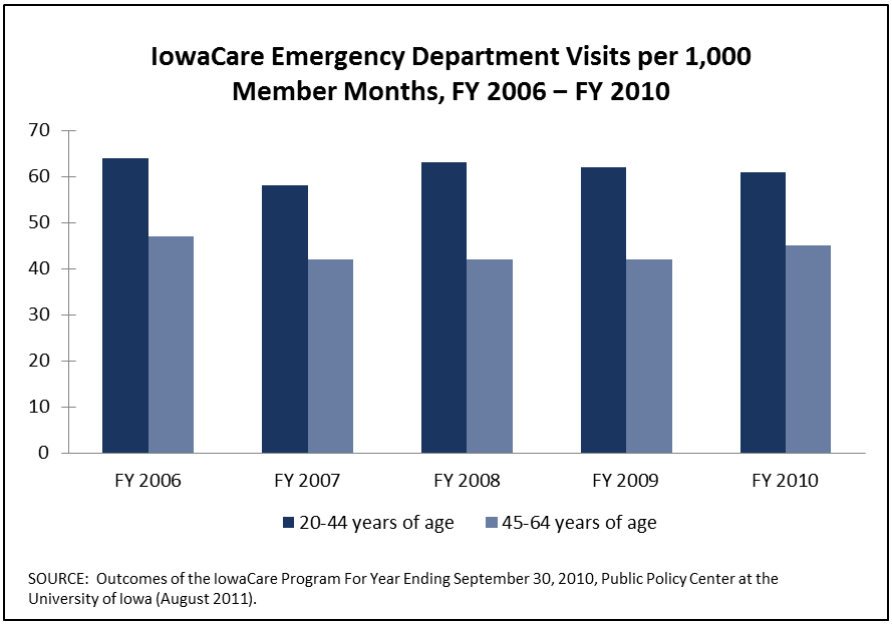
[93] Outcomes of the IowaCare Program For Year Ending September 30, 2010, Public Policy Center at the University of Iowa (August 2011).

Figure 47



The one exception to this trend is emergency department visits. As indicated in Figure 48, the IowaCare population age 20–44 had a higher rate of emergency department visits. The utilization rates remain steady over time, indicating a possible need to promote primary and preventive care. In general, about two-thirds of IowaCare enrollees reported having visited an emergency department in the previous six months. One in 10 enrollees had been to an emergency department four or more times during a 6-month period. However, because the younger population is more prone to injuries and accidents, the higher rate of emergency department visits may be an indication of age rather than access to care.

Figure 48



Studies of the IowaCare program also indicate that most enrollees have a pent-up need for care (two-thirds of enrollees had no health insurance for more than two years prior to enrollment) and a higher incidence of chronic conditions. The most frequently reported chronic physical and mental health conditions for the IowaCare population are listed in Figure 49.[94]

Figure 49

Most Commonly Reported Chronic Conditions of IowaCare Enrollees, 2011			
Chronic Health Conditions	**Percent**	**Chronic Mental Health Conditions**	**Percent**
Hypertension	36%	**Depression**	36%
Dental, tooth or mouth problems	35%	**Anxiety**	29%
Back or neck problems	31%	**Other mental health condition**	10%
Arthritis, bone or joint problems	30%	**Other emotional problem than depression or anxiety**	9%
Allergies or sinus problems	27%	**Attention problems**	9%
Recurrent indigestion or heartburn	20%	**A learning disability**	7%
Diabetes or Asthma	14%	**Drug or alcohol-related problem**	5%

SOURCE: Evaluation of the IowaCare Program: Baseline information for the Medical Home Expansion, Public Policy Center at the University of Iowa (October 2011).

Benefit Package and Delivery System:

The benefits offered in the IowaCare program are more limited than the benefits offered in the traditional Medicaid program. Services covered by the program typically include: 1) limited inpatient and outpatient hospital services; 2) physician services; and 3) basic dental services. Prescription drugs used for smoking cessation and those prescribed during and after a hospital stay or in the hospital outpatient clinic are also covered.[95] The two hospitals covered in the Iowa network also provide limited prescription drugs and durable medical equipment through charitable care.

In terms of physician services, one physical examination (and associated laboratory tests) may be provided annually by any Iowa Medicaid provider in the enrollees' area (although $3 copay applies). However, any additional services or follow-up care must be performed by an approved IowaCare provider. The IowaCare network is limited to the University UIHC in Iowa City and Broadlawns Hospital in Des Moines. Services provided by providers outside the IowaCare network are not covered.

[94] Evaluation of the IowaCare Program: Baseline information for the Medical Home Expansion, Public Policy Center at the University of Iowa (October 2011).

[95] IowaCare members that were formerly enrolled in the Indigent Care Program in FY2005 are eligible to continue to receive prescriptions that are normally covered by Medicaid.

The IowaCare program does not provide transportation, but limited transportation services are provided by UIHC. However, because getting to UIHC requires significant travel for many enrollees, it is important for enrollees to be able to access medical assistance by phone. "About half of all enrollees had called their personal doctor's office during regular business hours for help or advice in the previous six months. Over half (55%) usually or always got the help they needed when calling."[96]

IowaCare members with income above 150% FPL pay a monthly premium. Premiums are based on a sliding fee scale and range from $50 to $85.[97] After paying a premium for four consecutive months, a member may request a hardship waiver for the premium payment on a month-by-month basis. In addition to the copay charged for receiving an annual exam from a non-IowaCare Medicaid provider, copayments typically only apply to take-home medicines resulting from an inpatient stay. The facility issuing the medication decides the amount of the copay.

Cost:
No cost estimates were provided in the research available on the IowaCare program. However, given the older population has a higher utilization rate, it is likely those age 45–64 account for a considerable portion of the costs. Pursuant to both state law and the terms and conditions of the 1115 Waiver, enrollment in IowaCare may be limited or closed in order to guarantee that expenditures remain within the appropriated amount. As of January 2012, enrollment in the program had not been capped.

Maine

In 2002, Maine submitted and received approval for an 1115 Waiver to cover childless adults below 100% FPL.[98] In order to qualify for MaineCare, an applicant's assets may not exceed $2,000 for an individual and $3,000 for a couple, while savings may not exceed $8,000 for an individual or $12,000 for a couple. Total enrollment is capped at 20,000 enrollees. As of January 2012, enrollment in the program was closed. The 1115 Waiver authorizes the State to expand up to 125% FPL, but due to budget constraints, Maine limited the program to 100% FPL.

Demographics and Utilization:
The State estimated that up to 11,000 new childless adult members would enroll in MaineCare in the first year. However, by October 2003 close to 17,000 members had enrolled in the program and soon after enrollment in the program closed due to enrollment caps.[99] Part of this dramatic increase is due to the pent-up need for care of the childless adult population; however, it is more likely due to the extensive outreach work done by Maine's Department of Health and Human Services. For example, the Department automatically enrolled eligible individuals on other public program databases and worked with other state Departments to send information about the new program to their enrollees. "This resulted in approximately 5,000 individuals enrolling 'overnight,' according to state officials."[100]

[96] Evaluation of the IowaCare Program: Baseline information for the Medical Home Expansion, Public Policy Center at the University of Iowa (October 2011).
[97] Ibid.
[98] Childless adults age 19–20 are eligible up to 150% FPL.
[99] Childless Adult Coverage in Maine, Economic and Social Research Institute (August 2004).
[100] Ibid.

Childless adults in MaineCare tend to have a high prevalence of diabetes, depression, smoking, and substance abuse issues. Studies have found that while the expansion population used a variety of services, including inpatient, outpatient, physician, private non-medical institutions, and community support services, the most frequently utilized services were mental health and chemical dependency treatment. This is consistent with the conditions found in other uninsured childless adult populations.

Similar to the ratios found at the national level, the top 5% of childless adult enrollees in MaineCare accounted for 44% of total costs, while the top 10% accounted for 60% of total costs. Conversely, most of the enrollees account for only a small amount of total MaineCare expenditure (50% of enrollees had less than $892 in total paid claims and as a group accounted for only 3% of total expenditures).[101]

High cost enrollees (defined as those with more than $10,000 in total annual paid claims) were more likely than the overall waiver population to be enrolled for all 12 months (68% vs. 42%). This indicates that similar to Indiana, adults with significant medical needs are the first to enroll when coverage is expanded.[102] Mental health and substance abuse diagnoses are shown to account for four of the top 10, and nine of the top 20 most costly diagnoses (with substance abuse treatment being the highest in terms of number of encounters and dollars spent by the State).[103]

Other costly chronic conditions include high blood pressure, high cholesterol, diabetes, and heart disease. Pharmaceutical spending was also much higher than expected (similar to Indiana's experience). Data from a study completed by the University of Southern Maine found that approximately one-third of prescriptions filled were for psychiatric drugs, 14% were for pain medications, and 10% were gastro-intestinal medications. The study found smoking is an indication of high costs as well. 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 and that smoking cessation programs may be beneficial to the newly eligible population. This is especially true for Idaho, given a significant portion of its newly eligible population is expected to smoke.

Benefit Package and Delivery System:
Medicaid benefit package. Services typically include: 1) outpatient mental health (up to 16 visits per year with licensed practitioners, limit does not apply to emergency and crisis services); 2) alcohol/drug treatment; 3) chiropractic; 4) limited dental; 5) emergency department; 6) vision services (glasses excluded); 7) family planning; 8) hospital; 9) ambulatory clinic services and ambulatory surgical center services; 10) physicians and clinics; 11) advanced practice RN services; 12) pharmacy; and 13) transportation.

The cost-sharing requirements for childless adults are the same as the traditional Medicaid program. Examples of cost-sharing include: $1 to $3 for defined services, $2 for generic drugs, and $3 for brand-name drugs. The program does not assess premiums or deductibles on the expansion population.

MaineCare uses a primary care case management program for its childless adults. However, waivers are provided to enrollees whose health status or geographic location makes them better suited for a fee-for-service program. Since 2007, Maine has contracted a care management firm to serve chronically ill

[101] MaineCare for Childless Adults Waiver Year 7 Annual Report, October 1, 2008 – September 30, 2009, University of Southern Maine (February 2010).
[102] Ibid.
[103] Ibid.

enrollees, including those with those with multiple chronic conditions, high inpatient or emergency department use, care or service coordination needs, and/or multiple pharmacy issues.

Cost:
In FY2008, the average PMPM cost for childless adults was $406. This was more than the non-disabled parent population ($143) and less than disabled adult population ($1,003).[104] In FY2008, MaineCare provided services to 18,510 members at a total cost of $90.3 million. While the exact percent vary year to year, in general hospital inpatient and outpatient services account for 50% of total expenditures, prescription drugs account for 20%, and psychiatric, mental health, and substance abuse services make up between 9% and 10% of total expenditures each year.[105]

In terms of pharmaceuticals, Maine originally based its cost estimates on the costs for non-disabled MaineCare adults with dependent children. The cost for this population was approximately $470 per year. However, in 2009, the cost of providing pharmaceutical to childless adults was almost three times this amount, at $1,300 per year.[106]

Due to an increase in membership and a decrease in state revenue, MaineCare is projected to have a funding shortfall in FY2012, forcing the State to cut enrollees. Cuts could come as early as September and could include 15,000 parents with income between 100% and 133% FPL as well as 6,000 19–20 year olds with income up to 150% FPL. It is not known whether CMS will allow the cuts.[107]

New Mexico

New Mexico's State Coverage Insurance (SCI) Program is slightly different from the other expansion programs described in this section in the sense that the program targets adults working for small businesses with 50 or fewer employees. The program is available to individuals, age 19–64 years old, with income less than 200% FPL, and who work for a participating employer. Both employers and employees are responsible for paying a set premium each month; employees' premiums are scaled based on the enrollee's household income. Employees with household income below 100% FPL are typically not required to pay a premium; however, the amount of premium assistance is contingent on the availability of state funding.

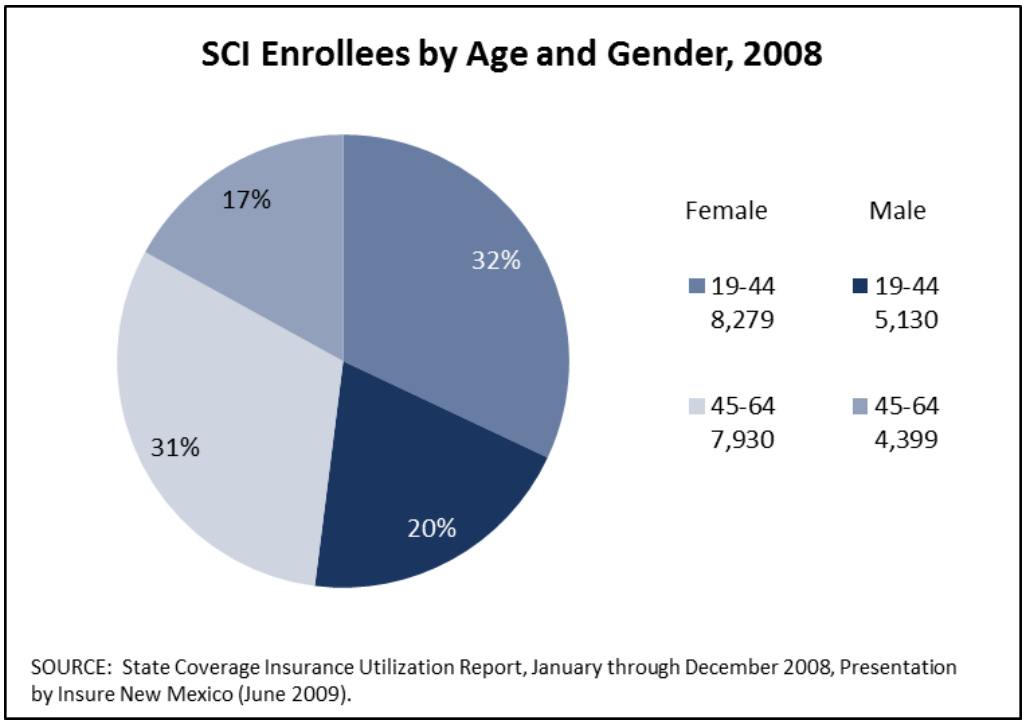
Individuals who do not work for participating employers are also eligible to participate in the program, but are responsible for paying both the employer and employee share of premium costs. In June 2009, it was estimated 30% to 40% of those enrolled in the program were not working due to unemployment, disability, retirement, or homemaker status.[108] As of March 2011, there were a total of 44,295 enrollees in the program (27,961 childless adults and 16,334 adults with dependent children). Enrollment in the

[104] Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States, Center for Health Care Strategies, Inc. (August 2010).
[105] MaineCare for Childless Adults Waiver Year 7 Annual Report, October 1, 2008 – September 30, 2009, University of Southern Maine (February 2010).
[106] Ibid.
[107] Maine's Efforts to Pare Medicaid May Put It on Collision Course with Administration, Kaiser Health News (July 12, 2012).
[108] Participation in the New Mexico State Coverage Insurance (SCI) Program: Lessons from Enrollees, State Health Access Data Assistance Center (November 2010).

program is currently closed and a waiting list has been established; as of March 2011 there were 30,000 individuals on the waiting list.

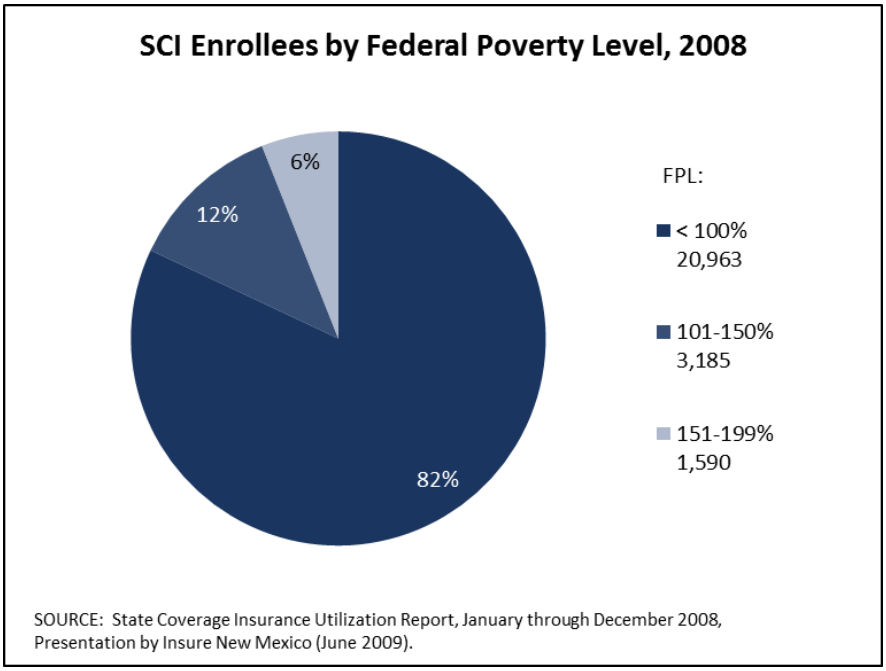
Demographics and Utilization:
The distribution of participants' gender and age in New Mexico's SCI Program is fairly evenly distributed, although participants tend to be slightly older (average age is 47 years old) and more likely to be female.[109] Even with generous income disregards under the SCI program (some working adults are eligible up to 400% FPL), studies have shown that more than half of total enrollees have income below 100% FPL.[110] Also, most of the employed enrollees did not have health insurance in the year prior to enrolling, indicating a possible pent-up need for care.

Figure 50a



[109] State Coverage Insurance Utilization Report, January through December 2008, Presentation by Insure New Mexico (June 2009).
[110] Participation in the New Mexico State Coverage Insurance (SCI) Program: Lessons from Enrollees, State Health Access Data Assistance Center (November 2010).

Figure 50b



A study that used claims data from 2008 to evaluate the SCI program found that most enrollees visited a primary care provider rather than a specialty care provider (72% of total visits compared to 26%). This provides some indication that those enrolled in the program are appropriately accessing primary and preventive care services. The same is true for emergency department visits, which has helped to control program costs (Figure 51).

Figure 51

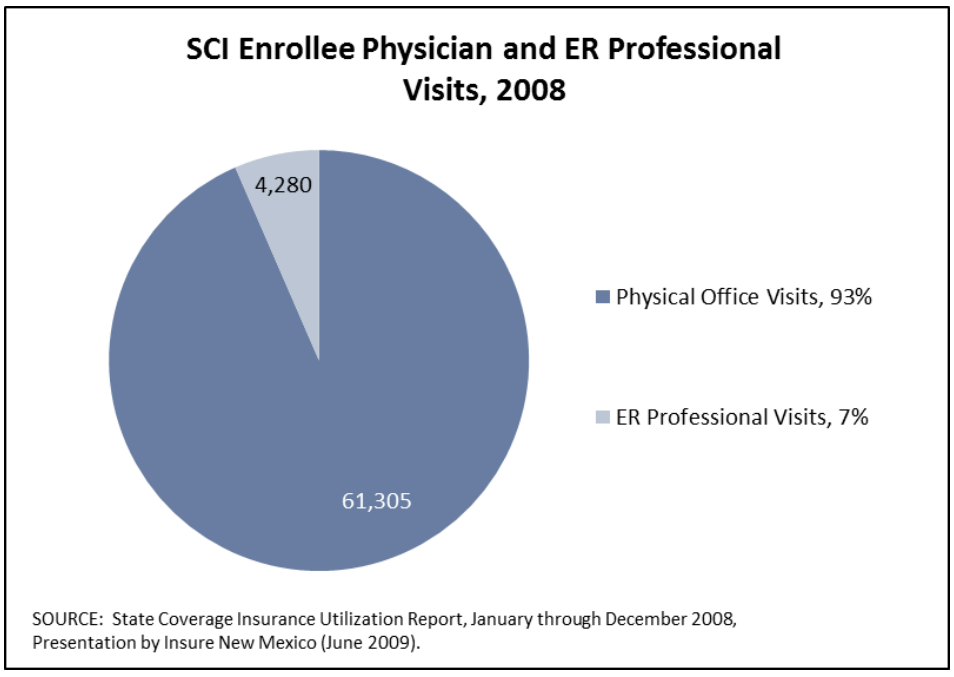
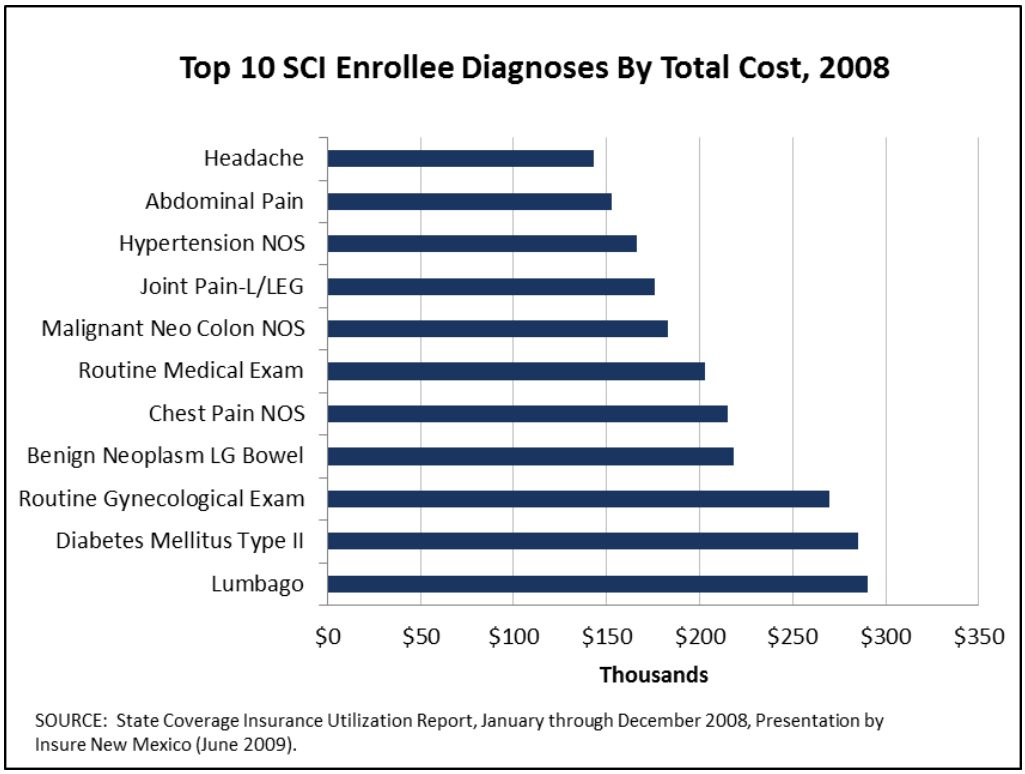


Figure 52, shows the professional routine care services most utilized by SCI program enrollees and their associated costs. As with other expansion populations, the SCI population seems to experience high rates of diabetes, heart disease, and hypertension. However, as indicated above, program enrollees are also accessing preventive care services, which reduce overall costs. Enrollees with over $100,000 in claims represented less than 1% of total program enrollees.[111]

Figure 52



Benefit Package and Delivery System:
Because the SCI program is a public/private partnership, the benefits package is less than what is offered in the traditional Medicaid program. Services typically include: 1) behavioral health services, including alcohol/drug treatment; 2) diabetes treatment, equipment, supplies, and management; 4) diagnostics; 5) emergency department; 6) home care; 7) inpatient hospital medical and surgical care; 8) maternity care; 9) medical supply and equipment; 10) outpatient surgical center; 11) pre/post natal care; 12) physicians and clinics; 13) physicals/preventive care; 14) prescriptions; and 15) rehabilitative therapies.

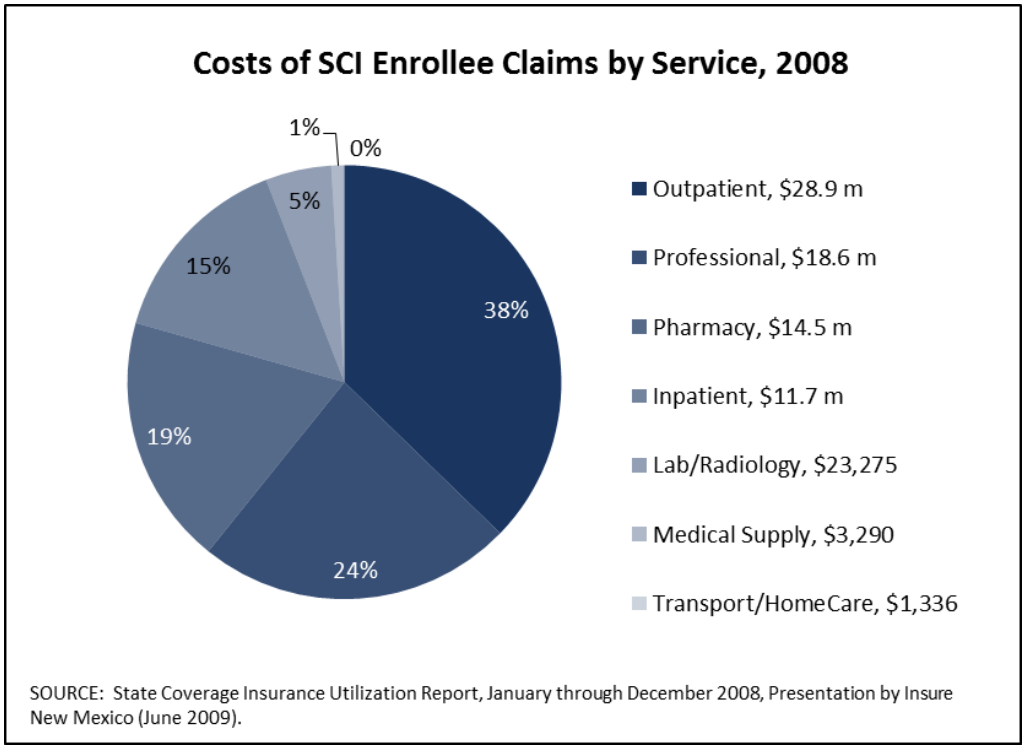
The program includes nominal copayments which are scaled by income. Individuals with household earnings less than 100% FPL typically pay no premiums or copays. Those earning 101% to 150% FPL pay $5 copays, while individuals earning 151% to 200% FPL pay $7 copays. The program also has a $100,000 annual claims benefit maximum. Enrollees who reach this maximum benefit level can choose to transfer to the State's high-risk insurance pool.

[111] State Coverage Insurance Utilization Report, January through December 2008, Presentation by Insure New Mexico (June 2009).

In terms of the delivery system, New Mexico's Human Services Department contracts with three health plans to offer the standardized benefit package. Brokers, certified by the State, are used to inform employers about the SCI program. Brokers' commissions are paid by the health plan carrier and are typically lower than commissions for commercial products.[112]

Cost:
No per member cost estimates were provided in the research available on the New Mexico's SCI program; however, because the program has a $100,000 annual claims benefit maximum and enrollment can be capped, costs are likely kept relatively low. For example, 2008 claims data show that 92.7% of SCI claims are under $10,000. Figure 53 shows the cost of claims by service. As with other expansion programs, pharmacy benefits represent a significant portion of program costs**.** In 2007, it was estimated expenditures for children and adults together accounted for just 45% of New Mexico's Medicaid payments. The elderly and the disabled together accounted for the remaining 55%.[113]

Figure 53



SOURCE: State Coverage Insurance Utilization Report, January through December 2008, Presentation by Insure New Mexico (June 2009).

Oregon

The Oregon Health Plan 2 (OHP 2) 1115 Waiver was approved in 2002, allowing Oregon to provide a health insurance subsidy program to low-income, uninsured residents. Uninsured adults age 19–64 with

[112] Small Business Participation in the New Mexico State Coverage Insurance Program: Evaluation Results, The Hilltop Institute (January 2010).
[113] Medicaid: An Integral Part of New Mexico's Economy, New Mexico Voices for Children (Updated September 2010).

incomes below 100% FPL are eligible to enroll in the OHP Standard plan, which provides limited coverage. Enrollment in the OHP Standard plan is currently closed; however, when new slots become available, individuals on a reservation list are selected through a random lottery draw. While the State's goal is to have an average monthly enrollment of 60,000 individuals, total enrollment in the OHP Standard plan was 72,961 as of April 2011.[114] It is estimated there are currently 260,000 individuals on the reservation list for the OHP Standard plan.[115]

Demographics and Utilization:
The OHP standard plan offers services to both adults with dependent children and childless adults. Studies of the program found that childless adults enrolled in the program had lower income, with 75% of enrollees earning $6,000 or less per year (compared to 46% of adults with children).[116] Childless adults also reported having poorer physical and mental health, as well as higher rates of disabilities. Over 30% of childless adults reported having a disability that prevented them from working, compared to 11% of adults with children.

Similar to results from other states, childless adults had higher rates of utilization across all categories of service. They had twice as many inpatient admissions and emergency department visits than adults with children and three times as many mental health and substance abuse-related visits. Childless adults were also more likely to use a higher rate of services in the first month of enrollment, indicating a pent-up need for care.

Other studies of the OHP Standard plan found the program to be successful in reducing both the number of uninsured and the negative health effects often associated with the low-income population. Those who enrolled in the program were more likely to describe their health as being "good" and were less likely to have an unpaid medical bill. While having access to insurance increased the utilization of outpatient and inpatient services and prescription drugs (and subsequently overall health care expenditures), it also increased the use of recommended preventive care screenings and primary care provider visits. It did not increase the utilization of emergency department visits.[117]

Benefit Package and Delivery System:
Benefits offered in the OHP Standard plan are more limited than the benefits offered in the traditional Medicaid program. Services typically offered in the OHP Standard plan include: 1) limited hospital benefits (restricted to emergent and urgent conditions); 2) physician services; 3) emergency transportation by ambulance; 4) prescription drugs; 5) lab and x-ray services; 6) some medical equipment and supplies; 7) outpatient chemical dependency services; 8) outpatient mental health; 9) emergency dental; and 10) hospice. Occasionally the plan may provide access to limited dental and vision services, but because all OHP benefit packages are based on Oregon's Prioritized List of Health Services, optional benefits are the first to be cut or limited in tight fiscal years.

Cost-sharing in the OHP Standard plan is typically higher than in the traditional Medicaid program and is scaled by income. OHP Standard plan enrollees may pay monthly premiums of $9 to $20, depending on

[114] OHP Standard Monthly Report, Oregon Health Authority (June 1, 2011).
[115] Ibid.
[116] Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States, Center for Health Care Strategies, Inc. (August 2010).
[117] The Oregon Health Insurance Experiment: Evidence from the First Year, NBER Working Paper # 17190 (July 2011).

their household income. Typically, those with income at or below 100% FPL do not pay premiums. Additional copayments may also apply. For example, if vision exams are provided, some enrollees may be subject to a $3 per visit per day copayment.

Most adults in the OHP Standard plan are enrolled in pre-paid, capitated health plans. Enrollees can choose which health plan to enroll in, depending on the MCOs' service areas. Close to 80% of Standard plan enrollees receive medical services through managed care programs, 90% receive dental care, and all enrollees receive mental health services through managed care providers.[118]

Cost:
The cost of care for childless adults is almost twice as high as the cost of care for parents in Oregon's OHP Standard plan. In 2010, the average PMPM cost was $679 for childless adults and $329 for adults with dependent children. A study conducted in 2008 estimated that the average annual Medicaid expenditures for an individual on the OHP Standard plan were about $3,000 between 2001–2004.[119]

Washington

The Basic Health program in Washington State was established in 1987 to provide coverage to adults with income below 200% FPL. The State also established the General Assistance-Unemployable (GA-U) program (Disability Lifeline) in 2004, which provided cash and medical assistance to childless adults below 38% FPL who cannot work. The Disability Lifeline program was discontinued in October 2011 and absorbed into three new cash assistance programs.[120] Enrollment in the Basic Health program closed in 2009, although a waiting list has been established. As of December 2010, total enrollment in the Basic Health Plan was 56,394 and the number of persons on the waitlist was 136,571. Washington converted its Basic Health program to waiver coverage in 2011 (the Transitional Bridge Demonstration provides the State with federal match dollars for three years as it transitions the Basic Health and other state-funded programs to the PPACA Medicaid expansion program).

Demographics and Utilization:
Similar to Indiana's program, enrollees in the Basic Health Plan tend to be female and have income below 100% FPL.[121] Most enrollees were uninsured for three years prior to enrolling in the program. A study conducted in 2006 found that roughly one-third of program enrollees had been enrolled for less than a year, 38% had been enrolled between two and five years, and the remaining 30% had been enrolled for more than five years. This indicates that while there is some churn among program participants, a significant number have conditions that require consistent treatment over time.

A telephone survey conducted of enrollees found that 68% of respondents indicated that they had a chronic health condition. Of the specific conditions that were identified, low back pain was most

[118] Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States, Center for Health Care Strategies, Inc. (August 2010).
[119] The Oregon Health Insurance Experiment: Evidence from the First Year, NBER Working Paper # 17190 (July 2011).
[120] Programs include: 1) cash assistance to the aged, blind, and disabled; 2) cash assistance to pregnant women; and 3) non-cash housing and other assistance provided through grants to homeless and housing providers.
[121] The Healthy Indiana Plan and Health Coverage of Childless Adults across the States, Indiana Legislative Services Agency (July 2011).

frequently listed. Hypertension, arthritis, and depression were also identified as common chronic conditions. Interestingly, however, close to two-thirds of respondents rated their health as "good" or "very good," which may be a reflection of the population receiving appropriate care.

While the Disability Lifeline program has been discontinued, it is interesting to examine the utilization patterns of its enrollees who were predominantly extremely low-income, childless adults. A study of the Disability Lifeline program shows that the population comprises slightly more males than females and that the mean age is 40 years old. The majority of the population experiences co-occurring, complex medical conditions, including chronic physical conditions, mental illness, and substance abuse. Data from FY2004 show 69% of the population experienced chronic physical conditions, 36% experienced mental illness, and 32% had substance abuse issues. More than 13% of the population experienced all three conditions.[122] The population's most common physical diagnoses, mental health diagnoses, and most used prescription drugs are presented in Figure 54.[123]

Figure 54

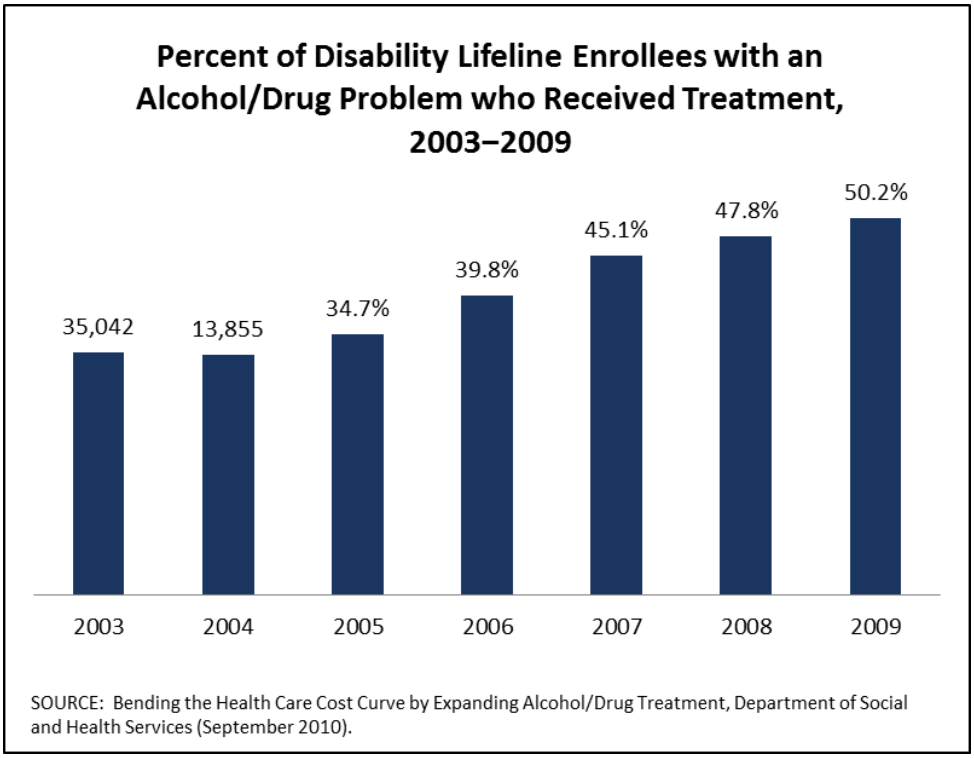
Common Disability Lifeline Enrollee Diagnoses, FY2003	
Mental Health Diagnoses	**Percent**
Depression	71%
Anxiety	48%
Thoughts of Death or Suicide	45%
Physical Health Diagnoses	**Percent**
Musculoskeletal	31%
Cardiovascular	27%
Pulmonary	21%
Prescription Drug Use	**Percent**
Depression	44%
Pain	42%
Minor Infections	36%

Note: Chronic obstructive pulmonary disease (COPD).
SOURCE: Disability Lifeline and the Mental Health Integration Program (MHIP), Presentation to Senate Health & Long Term Care Committee by Community Health Plan of Washington (January 12, 2011).

[122] Low-Income Health Care Programs in Washington, Presentation for Health and Human Services Appropriations Committee by Community Health Plan of Washington (February 1, 2011).
[123] Disability Lifeline and the Mental Health Integration Program (MHIP), Presentation to Senate Health & Long Term Care Committee by Community Health Plan of Washington (January 12, 2011).

While the Disability Lifeline population had serious and significant medical issues, there is evidence that providing the population with appropriate services resulted in effective treatment. For example, in the first 21 months after mental health benefits were added in two pilot counties, enrollees who received the services were shown to have: 1) reduced inpatient medical admissions; 2) a smaller increase in inpatient psychiatric costs; 3) a decrease in the number of arrests; and 4) a smaller increase in the proportion of clients living in homeless shelters or outdoors.[124] Figure 55 shows the proportion of Disability Lifeline enrollees with an alcohol/drug problem who received treatment between 2003–2009.[125] While overall costs of the Disability Lifeline were not impacted by the addition of mental health benefits, similar interventions show an overall cost savings in 2–4 years.

Figure 55



SOURCE: Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment, Department of Social and Health Services (September 2010).

Benefit Package and Delivery System:

The Basic Health Plan provides comprehensive services, but has a benefit package that is more limited than traditional Medicaid. The benefits offered in the plan typically include: 1) physician visits; 2) hospital care; 3) emergency care; and 4) prescription drugs. The plan does not provide dental coverage. The program has a $250 annual deductible and $1,500 out-of-pocket maximum per person per year limit that applies to certain services. Once an enrollee meets the annual deductible, the health plan applies an 80/20 coinsurance rate to certain benefits, such as hospital, mental health, chemical dependency, and chiropractic services.

[124] Low-Income Health Care Programs in Washington, Presentation for Health and Human Services Appropriations Committee by Community Health Plan of Washington (February 1, 2011).

[125] Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment, Department of Social and Health Services (September 2010).

Examples of copayment amounts include: 1) office visits, $15; 2) emergency department visits, $100; and 3) prescription drugs, $10. Enrollees are also assessed a monthly premium that is based on age, family income, the number of people in the family, the health plan selected, and location. The Disability Lifeline program also offers a benefit package that is less than traditional Medicaid. The program provides medically necessary benefits, including substance abuse and mental health treatment.

Basic Health Plan enrollees receive services through pre-paid, capitated health plans. Enrollees can choose which health plan to enroll in, depending on MCOs' service areas. Disability Lifeline participants were enrolled in the Community Health Plan of Washington, which is a local managed care organization. Any services provided to Disability Lifeline participants must be medically necessary and ordered by the primary care provider. The program's Mental Health Integration Program (MHIP) offered participants stepped care provided through a collaborative care team. The first step of the program focused on Health Center-based primary care/mental health services, care coordination, and wraparound services. The second step of the program offered community mental health center services.

Cost:
The average PMPM cost in 2009 for the Basic Health Plan was $248. Despite a more limited benefit package, the average PMPM in the Disability Lifeline program was $570. This is largely due to the fact that enrollees in the Disability Lifeline program suffer from more serious chronic conditions and mental health issues. However, the PMPM costs for alcohol and drug treatment in the Disability Lifeline program were much less than expected.

Wisconsin

Wisconsin's BadgerCare Plus Plans offer services to adults with income below 200% FPL. The BadgerCare Plus Standard Plan provides services to parents, while the BadgerCare Plus Core Plan provides a more limited benefit package to childless adults. The State also offered a state-funded BadgerCare Plus Basic Plan which provided temporary, unsubsidized health insurance to adults on the BadgerCare Plus Core Plan waiting list. Enrollment closed in the BadgerCare Plus Core Plan in 2010 and the BadgerCare Plus Basic Plan in 2011. In order to reduce program costs, Wisconsin also received approval from CMS to increase premiums for enrollees with income above 133% FPL. Premiums will range from 3% to 9.5% of income, and adults who fail to make their monthly premium payment without a valid excuse will be dropped from the program for one year. Adults with income above 133% FPL will also no longer be eligible for the programs if their employer provides insurance and their share of the premium is less than 9.5% of their family income.[126]

Demographics and Utilization:
When the Core Plan was implemented in 2009, 12,000 low-income, uninsured childless adults were automatically enrolled from the State's General Assistance Medical Program (GAMP). Enrollment was opened statewide on July 2009 and quickly surpassed state projections, indicating a pent-up need for care. By October 9, 2009, enrollment in the program was closed. Total enrollment reached a high of 65,000, but since the cap was imposed, total enrollment has gradually declined. As of May 2011 there were a roughly 36,000 individuals enrolled in the program.

[126] Feds OK Walker Plans to Cut Medicaid Costs, Milwaukee Wisconsin Journal Sentinel (April 27, 2012).

A 2011 analysis of the Basic Plan (the waiting list for the Core Plan) found that the majority of enrollees are white (84.8%), female (53.1%), and between 50 and 64 years of age (52.4%).[127] Close to 100% of enrollees have never been insured, most have no household income (41.9%), and the majority are unemployed (73.7%). The analysis also found that close to 80% of all enrollees received some form of services and that the services most frequently used included professional, pharmacy, and outpatient services.

A 2011 study by the Population Health Institute at the University of Wisconsin found that the incidence of chronic conditions is fairly high among Core Plan enrollees, particularly among those who were transitioned from the GAMP program. Figure 53 shows the prevalence of chronic conditions among this population. High blood pressure, depression, and diabetes were the most common chronic conditions experienced.[128] In terms of emergency department visits, the top five diagnoses for this population include: 1) unspecified chest pain; 2) lumbago (back pain); 3) abdominal pain; 4) headache; and 5) nondependent alcohol abuse.

Figure 56

Incidence of Chronic Conditions among Former GAMP and Other BadgerCare Plus Core Plan Enrollees, 2009	
	Percent
High Blood Pressure	32.7%
Depression	22.4%
Diabetes	18.7%
Heart Problems	15.8%
Asthma	12.2%
COPD	10.5%
Cancer	4.8%
Stroke	3.0%
Emphysema	1.3%

SOURCE: Evaluation of Wisconsin's BadgerCare Plus Core Plan for Adults without Dependent Children: How Does Coverage of Childless Adults Affect their Utilization?, Population Health Institute, University of Wisconsin-Madison (December 2011).

[127] The Healthy Indiana Plan and Health Coverage of Childless Adults across the States, Indiana Legislative Services Agency (July 2011).

[128] Evaluation of Wisconsin's BadgerCare Plus Core Plan for Adults without Dependent Children: How Does Coverage of Childless Adults Affect their Utilization?, Population Health Institute, University of Wisconsin-Madison (December 2011).

The study by the Population Health Institute also examined what effect obtaining coverage had on the overall utilization rates of childless adults. To determine the effect, the study examined the utilization rates of the former GAMP population, which previously received care through a general relief program. Results from the study show that the when enrolled in the Core Plan, the former GAMP population experienced a 39% increase in total emergency department visits.[129] Most of the visits were non-emergent visits, emergent visits that could have been treated in a primary care setting, and visits that would have been avoidable had the person had access to good primary care. Most visits were related to mental health, drug, and alcohol treatment. Interestingly, the increase in visits was fairly evenly distributed between males and females and among age groups, although emergency department visits increased most for individuals age 55 and older. The fact that emergency department visits increased upon enrollment in the program indicates that this population was not aware of how and when to access primary and preventive care for mental health and substance abuse issues.

In terms of hospitalizations, enrollment in the Core Plan resulted in a 29% decrease in the monthly hospitalization rate of former GAMP members. This decrease is consistent with decline in the Agency for Healthcare Research and Quality's (AHRQ) Preventive Quality Indices, indicating that by being enrolled in the program, individuals were receiving adequate primary care. For example, the monthly admission rate for short-term complications related to diabetes declined 32% and the rate for long-term complications related to diabetes declined 58%. Admissions for hypertension declined 66%, while admissions for dehydration declined 81%.[130]

In terms of outpatient visits, enrollment in the Core Plan resulted in a 65% increase in the total number of visits per month. The majority of this increase was due to an increase in the number of visits to specialists, while only 16% was attributed to an increase in primary care visits.[131] Enrollees visited outpatient settings to receive therapeutic care and episodic care. There was no increase in the use of preventive care. So while expanding coverage seems to reduce hospitalization, unless it is coupled with a focus on primary and preventive care, utilization of emergency departments and outpatient facilities may dramatically increase.

An analysis of Wisconsin's BadgerCare Plus programs examines the take up rates of each population in the program.[132] The analysis found the take up rate for parents/caretakers to be fairly high, close to 50% for the entire population. However, the take up rate for lower-income persons (those with income below 150% FPL) were much higher at 73%.[133] This is most likely due to the fact that persons at higher incomes have more access to insurance and better health, and are therefore less likely to need insurance. The take up rate for rural areas was also high; however, part of this may be due to a smaller uninsured population from which to calculate the take up rate. The analysis also found that the churn rate for the adult population was also relatively small, only 10.8%.[134] However, when broken out by income, the churn rate for those with income between 150% and 200% FPL was higher, close to 50%.

[129] Evaluation of Wisconsin's BadgerCare Plus Core Plan for Adults without Dependent Children: How Does Coverage of Childless Adults Affect their Utilization?, Population Health Institute, University of Wisconsin-Madison (December 2011).
[130] Ibid.
[131] Ibid.
[132] The take up rate is measured as the ratio in the change in enrollment to the number of uninsured.
[133] Evaluation of Wisconsin's BadgerCare Plus Health Care Coverage Program: Enrollment, Take-Up, Exit, and Churning: Has BadgerCare Plus Improved Access to and Continuity of Coverage?, Population Health Institute, University of Wisconsin-Madison (December 2010).
[134] The churn rate is defined as the percent of those who exit that re-enter within six months.

Figure 57

Take-Up Rates of BadgerCare Plus and Core Plan Enrollees, 2007–2009						
	All	<150% FPL	150–200% FPL	200% FPL+	Urban	Rural
Total Change in Enrollment/Population	6%	25%	19%	0%	5%	9%
Change in Enrollment from Uninsured/Estimated Size of Uninsured Population	49%	73%	65%	4%	39%	75%

SOURCE: Evaluation of Wisconsin's BadgerCare Plus Health Care Coverage Program: Enrollment, Take-Up, Exit, and Churning: Has BadgerCare Plus Improved Access to and Continuity of Coverage?, Population Health Institute, University of Wisconsin-Madison (December 2010).

In Wisconsin, persons below 150% FPL who are covered under Medicaid are permitted to enroll in the BadgerCare Plus program, regardless of whether they have existing coverage or access to other insurance. Medicaid is treated as a payer of last resort.[135] An analysis of Wisconsin's BadgerCare Plus programs found that only 11.8% of adults who had private coverage at the time of enrollment later dropped their insurance.[136] This is significantly lower than the crowd-out estimates reported in other states and nationally, which range from 25% to 50%. The analysis also showed that the rate of dropping private insurance decreased as household income declined.

Figure 58

Percent of Newly Enrolled BadgerCare Plus Members who Maintained or Dropped Private Coverage at or Near Enrollment, 2008–2009			
	Had Private Coverage at the Time of Enrollment	Maintained Private Coverage	Dropped Private Coverage
All	23.3%	12.4%	10.9%
Adults	22.7%	10.9%	11.8%
Children	23.8%	13.6%	10.2%

SOURCE: Evaluation of Wisconsin's BadgerCare Plus Health Care Coverage Program: Target Efficiency and the Displacement of Private Insurance: How Many New BadgerCare Enrollees Came from the Uninsured?, Population Health Institute, University of Wisconsin-Madison (December 2010).

[135] Evaluation of Wisconsin's BadgerCare Plus Health Care Coverage Program: Target Efficiency and the Displacement of Private Insurance: How Many New BadgerCare Enrollees Came from the Uninsured?, Population Health Institute, University of Wisconsin-Madison (December 2010).

[136] The study is not able to determine the reason for dropped coverage; whether it was at the enrollees' discretion or whether firms discontinued insurance due to the economic environment or because of the availability of BadgerCare Plus.

Benefit Package and Delivery System:
The Standard Plan benefit package is a broad Medicaid benefit package; while the benefits offered in the Core Plan are more limited (Basic Plan benefits are even further limited and have higher premiums and cost-sharing requirements). Services offered in the Core Plan typically include: 1) physician services; 2) diagnostic services, including lab and radiology; 3) inpatient and outpatient hospital services; 4) emergency outpatient services, including emergency dental and ambulance transportation services; 5) outpatient drugs per the Medicaid Pharmacy Benefit plan; 6) physical, occupational, and speech therapy (limited to 20 visits annually per discipline); 7) durable medical equipment limited to $2,500; and 8) disposable medical supplies. The plan does not include inpatient stays in a mental health institution or in the psychiatric ward of a hospital. Emergency-only dental services are covered and routine vision services are excluded.

Cost-sharing in the Core Plan is higher than the Standard Plan. Standard Plan copayments typically range from $0.50 to $3, while copayments in the Core Plan range from $0.50 to $15. Within the Core Plan, service-specific copayments are scaled by income levels. For example the copayment for emergency department visits is $3 for enrollees with income less than 100% FPL and $60 for enrollees with income between 100% and 200% FPL.

Total copayments are annually capped at $300 for enrollees with income below 100% FPL and $500 for enrollees with income between 100% and 200% FPL. Services requiring copayments include: 1) chiropractic; 2) doctor visits; 3) hospital visits; 4) emergency department visits; 5) ambulance; 6) emergency dental; 7) prescription drugs; 8) durable medical equipment, medical supplies, dialysis; 9) podiatry; 10) home health; 11) hospice; 12) psychiatrist visits; and 13) physician services for substance abuse. Enrollees are also required to pay an annual nonrefundable application fee of $60 for a tier 1 HMO and $75 for a tier 2 HMO.

Core Plan enrollees receive services through pre-paid, capitated health plans. Enrollees can choose which health plan to enroll in, depending on the MCOs' service areas and the results of their health needs assessment. A health needs assessment form is completed by every BadgerCare Plus enrollee as part of the application process. This assessment allows the State to analyze the applicant's health care needs and match them to appropriate managed care plans. The program also requires enrollees to receive a physical examination during their first year of participation.

Cost:
In 2010, the estimated PMPM cost for childless adult males, age 45 and older, enrolled in the Core Plan was $224. Interestingly, this is slightly lower than the estimated PMPM cost for parents of the same age and gender enrolled in the Standard Plan ($262). The PMPM rate for the SSI disabled Medicaid population in the 45 and over age group was $1,435, while the PMPM rate for the GAMP would have been $412.

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Section IV: Benefit Design Options

Benchmark Benefit Package Requirements

As mentioned in Section I, 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.[137]

Deficit Reduction Act of 2005

The Deficit Reduction Act (DRA) gives states the option to provide select Medicaid groups an alternative benefit package. Prior to the Act, states were required to offer all federally-mandated services to all Medicaid enrollees (although states retained the discretion to offer optional benefits). Elimination of the comparability requirements and the establishment of an alternative benefit package (i.e., benchmark or benchmark-equivalent coverage) through the DRA allow states to provide certain Medicaid populations with benefits that differ from those offered in the traditional Medicaid package.

Multiple Benchmark Benefit Packages:
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. However, states do not have complete freedom in setting the benefit package. The Social Security Act (the Act) specifies that the benefit package must be based on one of three commercial insurance products or be approved by the HHS Secretary.[138]

[137] HB260 (2011) directed the Idaho Department of Health and Welfare to transition away from a fee-for-service environment by incorporating managed care tools "to foster improved accountability and health outcomes."
[138] Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser Family Foundation (August 2010).

Benchmark Benefit Options:
The Medicaid benchmark benefits must be equal to one of the three following benchmarks:[139]

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 the state
3. The state HMO plan that has the largest commercial, non-Medicaid enrollment

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

Exempt Groups:
Several Medicaid groups are excluded from being mandatorily enrolled in benchmark coverage. These groups include:[140]

1. Pregnant women
2. Persons who are blind or disabled
3. The dual eligible
4. Terminally ill persons who are receiving hospice care
5. Individuals that qualify for long term/institutional care services based on medical condition
6. Persons who are medically frail, "have serious and complex medical conditions," "disabling mental disorders," and persons with "physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living"
7. Children in foster groups or who are receiving adoption assistance
8. Section 1931 parents
9. Women who qualify for Medicaid due to of breast or cervical cancer
10. Individuals who qualify for medical assistance because a TB-infection
11. Individuals receiving only emergency services
12. Medically needy

States can allow benchmark-exempt individuals to enroll in the benchmark benefit package, but their enrollment must be voluntary and the individual must retain the option to enroll in traditional standard benefits at any time.

Some Newly Eligible in Idaho May Not Qualify for Benchmark Coverage:
The exemption rule implies that certain groups of individuals who are considered "newly eligible" (because they don't qualify for Medicaid under the state's existing Medicaid eligibility rules) may not be eligible for benchmark coverage at all. For example, a portion of the newly eligible population in Idaho will be coming from the Adult Mental Health Services program, which provides services for the SPMI population. This population could be considered "medically frail" under the definition provided in the Act (i.e., have "disabling mental disorders," and/or "physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living").

[139] Equal can also mean "equivalent in actuarial value." States can reduce the actuarial value of coverage of some services in the benchmark plan by 25% of what is covered in the comparison plan.
[140] Code of Federal Regulations, Title 42 Public Health, parts 430–781 (October 1, 2011).

As such, this population would need to retain the option to enroll in Idaho's Standard Medicaid Plan, even though they are considered newly eligible and the State receives the increased federal match for them. Determining who among the newly eligible is possibly exempt from benchmark coverage could create an administrative burden for IDHW, unless there is a system in place that can make this determination early on and track it over time.

Churn Between Existing Medicaid Categories:
Because so many groups are exempt from benchmark coverage, a state that decides to utilize this option for the newly eligible population will need to evaluate how to handle the churn that may occur between existing Medicaid eligibility categories. For example, if a newly eligible enrollee becomes pregnant, she may no longer be eligible for mandatory enrollment in benchmark coverage and may have to be moved to traditional Medicaid coverage for pregnant women. Declines in income and health status could also affect a person's eligibility status.

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 expected to frequently transition between being eligible for Medicaid and for premium subsidies offered through a state's health insurance exchange. A study published in Health Affairs estimated that within six months, 35% of all adults with income below 200% FPL will experience churn between Medicaid and the exchange, and within a year, 50% of adults will experience such churn.[141] 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.[142]

Because premium credits will be tied to the second lowest-cost silver plan in each state, it makes sense to base the newly eligible benefit package on this plan. However, because Medicaid has higher cost-sharing requirements, additional benefit requirements, and because the benchmark options for the exchange differ from the ones for the newly eligible population, 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.[143]

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[141] Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges, Health Affairs 30, No. 2 (2011).

[142] 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 (70% for silver and 80% for gold), which is based on a benchmark plan selected by the state.

[143] 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.

Another reason why it may be beneficial to base the newly eligible benefit plan on the silver plan, or certify health plans to serve both Medicaid and exchange enrollees, is because under the PPACA, states will be required to provide a standard application form, accessible through the exchange, for all state health subsidy programs.[144] As mentioned in Section II, the exchange will electronically assess whether the individual is eligible for Medicaid, CHIP, or premium subsidies. States may allow the exchange to make final Medicaid eligibility determinations (based on federal electronic verification data sources) or make an initial assessment of Medicaid eligibility and refer the applicant to the Medicaid agency. If the applicant is determined to be ineligible for Medicaid and/or CHIP, the state must ensure that the individual is screened for premium subsidy eligibility without having to submit another application.

Benefit Design:
Before the establishment of the PPACA, it was required that benchmark benefit packages offer certain basic benefits, including:[145]

1. Inpatient and outpatient hospital services
2. Physician services
3. Lab/x-ray
4. Well-child care including immunization
5. Other appropriate preventive services designated by the Secretary

The PPACA slightly modified the benchmark benefit package by mandating that it include family planning services and supplies, prescription drugs, and mental health services in addition to meeting the other Essential Health Benefit requirements (discussed in the next section).[146]

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.[147] 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, however, the amount of cost-sharing allowed increases as the enrollee's income increases.

Certain groups are exempt from any cost-sharing, regardless of income (pregnant women, certain children, and individuals with special needs), and certain services are exempt from cost-sharing as well (preventive care for children, emergency care, and family planning services). The Act allows for cost-sharing to be adjusted for medical inflation over time as well as for states to condition continuing Medicaid eligibility on the payment of premiums. Providers can also refuse care for failure to pay service-related cost-sharing.[148]

[144] Starting 2014, states are required to establish a website that links Medicaid to the state exchanges.
[145] Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline, Congressional Research Service (August 19, 2010).
[146] Ibid.
[147] Medicaid: A Primer, Congressional Research Service (July 15, 2010).
[148] Ibid.

Figure 59

Medicaid Premium and Cost-Sharing Limits for Adults			
	≤100% FPL	101% – 150% FPL	> 150% FPL
Premiums	Not allowed	Not allowed	Generally not allowed
Cost-Sharing (may include deductibles, copayments, or coinsurance)			
Most Services	Nominal	Up to 10% of the cost of the service or a nominal charge	Up to 20% of the cost of the service or a nominal charge
Prescription Drugs: • Preferred • Non-preferred	Nominal Nominal	Nominal Nominal	Nominal Up to 20% of the cost of the drug
Non-emergency use of emergency department	Nominal	Up to twice the nominal amount	No limit, but 5% family cap applies
Preventive Services	Nominal	Up to 10% of the cost of the service or a nominal charge	Up to 20% of the cost of the service or a nominal charge
Cap on total premiums, deductibles, and cost-sharing charges for all family members	5% of family income		
Service may be denied for non-payment of cost-sharing	No	Yes	Yes

Note: Some groups are exempt from premium and cost-sharing limits described in this table. These groups include pregnant women (those above 150% FPL can be charged minimal premiums), terminally ill individuals receiving hospice care, institutionalized spend-down individuals, breast and cervical cancer patients, and Indians who receive services from Indian health care providers. However, these groups can be charged cost-sharing for non-emergency use of an emergency department and for non-preferred prescription drug use.

SOURCE: Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser (Aug. 2010)

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 60).[149] States may also add additional benefits to the benchmark plans. The benefit package must comply with Medicaid managed care requirements, and the state must allow for public input on the benefit package before filing a proposal with HHS.[150]

[149] Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, Kaiser Family Foundation (August 2010).
[150] Ibid.

Essential Health Benefits

Essential Health Benefits (EHB) are a baseline comprehensive package of items and services that all small group and individual health plans, offered both inside and outside the exchange, must provide starting in 2014. All 10 EHB categories must also be offered in the Medicaid benefit package. If the selected benchmark plan does not cover all of the required benefits, the state must supplement the benefits. The 10 EHB categories are listed in Figure 60; however, specific benefits and services to be offered within each of the categories have not been defined. That decision has been left to the states by allowing them to select their benchmark benefit packages.

Figure 60

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 disorder 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. If the state decides to use Secretary-approved coverage as its benchmark plan, it must designate an EHB reference plan. Unlike state exchanges, there is no default EHB benchmark reference plan for Medicaid and there is no substitution of benefits allowed within or across the 10 EHB categories.[151] The state Medicaid Agency is responsible for including all 10 EHB categories in its Medicaid benchmark plan and identifying that plan as part of it Medicaid State Plan changes.[152]

[151] Final rules on the Essential Health Benefit had not been released at the time this report was finalized.
[152] Frequently Asked Questions on Essential Health Benefits Bulletin, Centers for Medicare & Medicaid Services (February 17, 2012).

Pharmacy:
Similar to Medicare Part D, CMS intends to allow states to choose the specific drugs that are covered within the categories and classes of pharmacy benefits offered in the exchange's essential health benefit benchmark plan. For example, if the benchmark plan offers a drug in a certain category or class, the state's benefit design must offer at least one drug in that same category or class; however, the specific drugs on the formulary may vary.[153] It is not clear whether the same standard will apply to the Medicaid benchmark plan as future guidance is yet to be released. However, it is assumed that a state will be able to maintain its current preferred drug list when setting the benchmark plan, as long as the list complies with other Medicaid statutory requirements and the coverage has an aggregate actuarial value equivalent to the benchmark.[154]

Mental Health Parity and Addiction Equity Act:
The PPACA extends federal Mental Health Parity and Addiction Equity Act (MHP) requirements to benchmark plans. Previously, the MHP only applied to Medicaid managed care plans; however, under the PPACA, all benchmark plans must offer mental health and substance abuse benefits in parity with medical and surgical benefits, regardless of whether it is delivered through a Medicaid managed care system. Parity must be achieved with respect to both financial requirements (e.g., deductibles, copays, and coinsurance) as well as treatment limitations. Because all benchmark plans must cover EPSDT for persons under 21, they should already meet MHP requirements for children.[155]

Because mental health and substance abuse disorder services are one of the 10 required EHB categories, all benchmark plans must offer some services within this category—and, as specified by the MHP, the services must be offered in parity with medical and surgical benefits. While mental health and substance abuse services are currently covered in Idaho's standard and benchmark plans, both the amount of services and the associated costs could dramatically increase in order to meet the MHP requirements. As such, IDHW may consider establishing appropriate limits on medical services and/or establishing aggregate limits on both physical and mental health services in order to contain costs. However, this would need to be done within the statutory requirements of the Medicaid program, which may not offer much flexibility.

The issue of cost may be somewhat mitigated by essentially establishing two benchmark packages for the newly eligible population: 1) a low-cost healthy adult benchmark package, which includes limited physical and mental health services, and does not include long-term care services; and 2) a higher-cost medically frail benefit package, which fully aligns with Idaho's Enhanced Benchmark. This would allow Idaho to limit the effects of the MHP requirements by targeting necessary services to a specific population.

[153] Essential Health Benefits Bulletin, Centers for Consumer Information and Insurance Oversight (December 16, 2011).
[154] Under PPACA Section 2501, "states may now choose whether to include prescription drugs in managed care contracts or carve drugs out separately without losing the rebates paid by manufacturers"—meaning drug manufacturers are now required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid managed care organization.
[155] Frequently Asked Questions on Essential Health Benefits Bulletin, Centers for Medicare & Medicaid Services (February 17, 2012).

Uncertainties:
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.

While the 10 EHB categories are finalized, the specific benefits and services to be offered within each of the categories have not been defined. As mentioned above, that decision has been left to the states by allowing them to select their benchmark benefit packages. However, it is difficult to determine whether certain services fit in the 10 categories when there is not a well-established definition. For example, ambulatory care is a broad term that could be interpreted to include anything from outpatient physician and clinical services to a short-term institutional stay that lasts less than 24 hours. Massachusetts defines ambulatory care as all outpatient services, regardless of setting, including outpatient visits, day surgery, and related anesthesia. However, without a more refined national definition, it is difficult to know whether one of the benchmark options offer adequate ambulatory care services.

The second category that is not well defined is habilitative services. While Medicaid defines habilitation services as "services designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings,"[156] there is generally not an accepted definition of habilitative services and health plans typically do not identify it as a distinct service. As such, CCIIO is seeking comment on the definition and is considering two options for benchmark plans that do not include coverage of habilitative services:

1. "Habilitative services would be offered at parity with rehabilitative services—a plan covering services such as PT [physical therapy], OT [occupational therapy], and ST [speech therapy] for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation; or

2. As a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habilitative services in the future."[157]

Because the specific benefits under habilitative services have not been defined, it is difficult to evaluate how well the services offered by the different benchmark options meet this requirement. However, it is expected that, as with mental health, both the amount of services and the associated costs could dramatically increase. As such, IDHW may consider establishing appropriate limits or prior authorization requirements in order to contain costs. Establishing two benchmark packages for the newly eligible population would also allow IDHW to target habilitative services to the populations with the highest risk and greatest need. Some habilitative services are already offered in Idaho's Enhanced Benchmark plan, which may be sufficient to fulfill the EHB requirement.

The last uncertainty relates to whether CMS intends to require that benchmark plans include categories that are not applicable to the newly eligible population. For example, maternity and newborn services as

[156] 42 U.S.C. § 1396n(c)(5)(A)
[157] Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (December 16, 2011).

well as pediatric services, including oral and vision care, are required to be included in all Medicaid benchmark plans for the newly eligible population. No further guidance has been given on whether CMS intends to exclude these services from the newly eligible benefit package, allow states to substitute across coverage categories, or expects the addition of other services of equivalent value.[158]

Benchmark Plan Comparison

Having an understanding of the demographics and health conditions of the newly eligible population, as well as the benefit options that are available to them, allows IDHW to evaluate and ultimately select a benchmark benefit package for the population. The remainder of this paper provides IDHW with possible criteria and methodology to use when selecting a benchmark benefit design as well as outlines Leavitt Partners recommendation for a benchmark benefit package.

Criteria and Methodology

Criteria:
When selecting a benchmark package for the newly eligible, there are several criteria that should be considered throughout the selection process. These criteria were developed by Leavitt Partners and are based on both Leavitt Partners' experience working the Medicaid environment as well as criteria developed by other medical groups and policy institutions such as the Institute of Medicine.

1. **Meet the population's basic needs.** The first criteria in establishing a benchmark benefit is that it meet the basic needs of the population. Because Idaho's newly eligible population will consist of young, healthy parents, childless adults with a pent-up need for care, as well as an older population with serious chronic conditions, meeting the newly eligible's diverse health care needs will require a broad package of benefits. To best address these needs, it may be helpful to establish multiple benchmark packages targeting specific populations.

2. **Maintain continuity of coverage.** Because the population receiving the benchmark benefit will be churning between both the exchange and traditional Medicaid, it is important to select a benchmark benefit that conforms as closely as possible to one or both of these plans. Selecting a plan that is comparable in coverage to Idaho's exchange EHB reference plan will reduce churn among the higher-income population that will be transitioning between Medicaid and private insurance. Selecting a plan that is comparable in coverage to Idaho's Standard Plan and/or Benchmark plans will create alignment across Medicaid categories and administrative ease in tracking those who transition between the benchmark and traditional Medicaid plans.

3. **Adhere to known evidence-based guidelines.** When selecting a benchmark benefit, it is important to evaluate how well the benefits offered in the plan adhere to evidence-based guidelines. While there are both benefits and limitations to using these guidelines, in general, it has been shown that following such guidelines can improve quality of care, improve health outcomes, and improve the quality of clinical decisions. Adhering to evidence-based guidelines can also help IDHW prioritize benefits and use scientific evidence to back up coverage decisions.

[158] Depending on income disregards there may be some overlap between the different Medicaid programs, which could warrant the need for some of these services to be included in the benchmark benefit package.

4. **Optimize value and provide performance improvements.** Establishing a benchmark benefit package that optimizes health care value for enrollees is critical to the long-term success of the Medicaid program. To maintain this value it is also important to consider how performance improvements can be implemented and measured within the benefit design.

5. **Maintain cost effectiveness.** Selecting a benchmark benefit that promotes cost effectiveness is also critical to the long-term success of the Medicaid program. Selecting a benefit package with services and programs that have proven to be cost-effective will better enable Idaho to provide value to enrollees while maintaining low costs.

6. **Adhere to statutory requirements.** The benchmark benefit must adhere to all statutory requirements set by the State, the PPACA, the DRA, and other federal regulations.

Methodology:
Leavitt Partners methodology for evaluating the benchmark benefit options is outlined below. As Leavitt Partners evaluated the different options, it took into consideration the criteria described above.

1. Identify and review all possible benchmark benefit options, including Idaho's Basic Benchmark, Enhanced Benchmark, and Standard Medicaid Plans. Determine which plans present the best options and should be evaluated on a more detailed level.

2. Compare benefits, services, and limitations across all potential benchmark benefit options.

3. Identify meaningful differences in coverage between the benchmark benefit options and the Medicaid Basic Benchmark.

4. Determine how well each benchmark benefit option meets the EHB requirements. Determine whether plans cover all 10 mandated services and whether there are categories that will need to be supplemented.

5. Determine which plan best meets the criteria outlined above and/or whether multiple benchmark options are appropriate. Determine if additional services should be added and make a final benchmark benefit design recommendation.

Plan Comparison Results

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. The results of this comparison are summarized below. 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. This plan was chosen for comparison purposes for several reasons, including:

1. The currently enrolled Medicaid adult population will likely have medical needs similar to a significant portion of the newly eligible.

2. The plan has already received approval from the HHS Secretary.

3. IDHW administrators expressed a desire for a relatively scaled-down package. It could also be problematic to provide a benefit package that is richer than the one provided to a similar population that has lower income and asset-test limits.

4. The disabled and frail populations within the newly eligible population will continue to have access to a broader benefit package.

State HMO:
The comparison of the benefit benchmark options led to several general observations. First, the Blue Cross of Idaho (BCI) HMO Blue plan covers most of the EHB categories in some form, with the exception of pediatric dental; however, there is a prevailing theme of limits to care either through use of high copayments, annual benefit caps, and/or out-of-network exclusions. Generally speaking, this plan includes a number of broad exclusions that cut across several of the EHB categories and may reduce a person's ability to access care. However, it is important to note that the summary of benefits provided at the time this report was finalized details the financial burden, limits, and exclusions in the plan, but is relatively thin on describing the actual covered services.[159]

State Employee Plan:
The Blue Cross Traditional Plan for Idaho State Employees provides most of the benefit categories required by the EHB, except for pediatric dental. It does not specifically mention laboratory services, but that does not necessarily mean the services are excluded. This plan lines up well with Idaho's Medicaid plan in terms of offered benefits and services; however, there are several categories where the State Employees Plan coverage is more detailed or robust, including: 1) skilled nursing facilities; 2) home hospice; 3) TMJ; 4) transplants; and 5) therapies.

Standard Blue Cross/Blue Shield under the FEHBP:
Like the State Employee Plan, the FEHBP plan (standard Blue Cross/Blue Shield preferred provider option) provides comprehensive benefits, covering all of the required EHB categories. The plan's limitations also seem to generally align with the Basic Benchmark Plan. Where the plan limits differ, the limitations appear to exclude services that would be accessed by people with disabilities or the medically frail, both of whom are exempt from Medicaid benchmark coverage. Such limitations include limits on home health care, organ and tissue transplants, hospice, and inpatient skilled nursing facilities.

Secretary Approved Coverage (Idaho's Basic Benchmark Plan):
The Idaho Basic Benchmark Plan incorporates almost all of the EHB categories and other benefits required under the PPACA, including EPSTD. It also includes coverage that will meet most of the specific needs of Idaho's newly eligible population, including coverage for chronic conditions such as diabetes, hypertension, and asthma. In addition, the plan offers programs, such as disease management, smoking cessation, and weight loss, that directly address many of the newly eligibles' health risks.

Other required services the Basic Benchmark Plan offers that are not explicitly addressed in other plans include non-emergency transportation, interpreter services, and essential community providers. The non-Medicaid plans may pay for some of these services, but, if covered, are not likely to be to the same extent or with the same focus as the Basic Benchmark Plan. Additionally, there will be significant differences in the cost-sharing structure between the Basic Benchmark Plan and the commercial benchmark plans. Because the PPACA retains the current Medicaid restrictions on cost-sharing for the

[159] A detailed benefit summary was not available at the time this report was finalized.

newly eligible, cost-sharing for those under 100% FPL will be limited to nominal amounts. For individuals between 100% and 133% FPL, cost-sharing is limited to nominal amounts for some services like pharmacy, prohibited for some services like emergency services and family planning, and limited to 10% of the cost for most other services.

These amounts are well below those found in many of the other benchmark plans. For example, the State Employee Plan has a maximum out of pocket for an individual of $4,300 and $8,600 for a family. The $4,300 is over 25% for a single newly eligible person. The State Employee Plan's copayment for prescription drugs ranges between $10 and $50, depending on the nature of the drug (brand, generic, and formulary designations). Even the $10 copayment is over twice the amount allowed for the newly eligible. These differences point to some basic structural differences between the benchmark benefit options and the plan that will ultimately need to be constructed for the newly eligible group. In the Basic Benchmark Plan it appears as though those under 100% FPL are exempt from copayments and those above 100% FPL pay copayments on selective services at $3.65 as long as it does not exceed 10% of cost and other restrictions.

Like some of the other benchmark options, the Basic Benchmark Plan also includes services that are either not required under PPACA provisions or are required, but not likely to be utilized by the newly eligible population. For example, maternity and newborn coverage, pediatric, and child wellness services are covered. As mentioned above, it is not clear how HHS will eventually handle this issue, but Leavitt Partners believes that this provides an opportunity to include other services better tailored to the target population while still keeping the basic package at a lower price than the current benchmark plan.

One service that does not appear to be adequately covered under any of the plans is habilitation services. However, the plans do include physical, occupational, and speech therapy which is likely to be the basis for habilitation services. As mentioned above, CCIIO suggested consideration of two options if a benchmark plan does not include habilitation services. One is to offer habilitation services similar in scope, amount, and duration to rehabilitation services. The second is to propose a service definition of coverage to HHS for evaluation and approval. Another issue CCIIO is currently evaluating is whether the scope of habilitation services should include maintenance of function. Leavitt Partners recommends IDHW wait for further guidance before including "maintenance of function" services in the benchmark benefit package. Including such services could be very expensive and difficult to limit at a later time. If maintenance of function services must be included, Leavitt Partners recommends IDHW control the use of such services with limits and prior approval processes.

Recommendation

Final Recommendation: The Basic Benchmark Plan has the framework needed to meet the essential health needs of the majority of the target population and is aligned with the direction outlined by IDHW. 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 is Secretary-approved coverage, which increases the likelihood of it being approved as an appropriate

package for the newly eligible population. 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 as a foundation for the newly eligible benefit package has several additional advantages. First, is administrative ease; IDHW's staff is familiar with the plan—they understand the scope of coverage and the 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 already is an existing path to a more comprehensive plan for any newly eligible who may qualify as disabled or medically frail. These individuals are transferred to Idaho'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. As mentioned above, establishing two benchmark packages for the newly eligible population, a low-cost healthy adult benchmark package and a higher-cost medically frail benefit package, may help mitigate the frequency of churn for both higher-income, healthy adults and lower-income, high-risk enrollees.

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, 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.

Even though there is no deadline for states having to notify HHS of plans to implement the Medicaid expansion, Leavitt Partners recommends Idaho opt into the expansion as close to the 2014 start date as possible. This will provide the State with three years of 100% federal funding to evaluate the effectiveness of the Basic Benchmark Plan. During this period, IDHW can evaluate the utilization patterns of the newly eligible and determine whether the benefit package should be scaled down or whether additional services should be added to better meet this population's health care needs.

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. 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.

The 100% federal funding from 2014–2016 provides a good opportunity for IDHW to test the cost effectiveness of providing these services, particularly the cost effectiveness of implementing an expanded, coordinated approach to mental health disease management. If there is no local evidence of

the health and cost effectiveness after the three years, IDHW can return to a more scaled back model based on the lack of positive outcomes or choose to opt out of the expansion without penalty.

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. Interpreter services have been found to improve the access of health care by individuals with limited English proficiency. Research shows that individuals who use interpreter services have 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.[160]

While providing interpreter services has shown to increase overall costs, the costs are generally moderate and reasonable. Additional costs for language services are relatively small compared with gaps in health care access and medical spending among persons with limited English proficiency.[161] Further, an increase in the use of preventive and primary care is associated with a decrease in later costly health complications.[162] A map included in the Appendix shows the number of persons not proficient in English, indicating areas were interpreter services may be most needed.

Telehealth:
In the Basic Benchmark Plan it appears as though telehealth is limited to psychiatric services, specifically: 1) diagnostic assessments; 2) pharmacological management; and 3) psychotherapy with evaluation and management services 20 to 30 minutes in duration.[163] 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, hypertension, and mental health issues such as PTSD and depression. Telehealth is also an effective peer-to-peer educational tool for primary care physicians. In addition to using telehealth for diabetes education and training in Idaho, it could be expanded to cover training for other chronic conditions such as hypertension and asthma.

Telehealth is also very promising in terms of medical expenditure savings. The ability to link a patient and his or her primary care physician to a remote specialist by video can eliminate the need for a separate follow up consultation with the patient, reducing the overall number of in-person visits. This leads to large savings by eliminating redundant appointments, tests, and medical transportation costs.[164] Telehealth is also expected to decrease medical expenditures by reducing transfers from one hospital emergency department to another, from correctional facilities to physicians' offices and emergency departments, and from nursing homes to emergency departments and physicians' offices.[165]

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

[160] Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services, American Journal of Public Health (May 2004).
[161] Pay Now or Pay Later: Providing Interpreter services in Health Care, Health Affairs (2005).
[162] Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services, American Journal of Public Health (May 2004).
[163] Idaho Administrative Code, Department of Health & Welfare.
[164] The Telehealth Promise: Better Health Care and Cost Savings for the 21st Century, University of Texas Medical Branch (May 2008).
[165] Ibid.

providers. Maps included in the Appendix show the number of primary care providers per county as well as the number of persons per square mile—indicating areas where telehealth may be most beneficial. It is also estimated that 82% of Idaho's population are internet users, increasing the effectiveness of telehealth in the State. That said, establishing a telehealth system can be expensive, so Leavitt Partners recommends IDHW leverage both the existing infrastructure as well as examine the long-term financial sustainability of providing such a system. To possibly save costs, IDHW could establish multiple benchmark packages based on geographic region. This way, telehealth could be provided more extensively in rural areas that have a higher need. However, monitoring multiple benchmark packages could create an administrative burden for IDHW and actually increase costs over time.

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. A study conducted in Massachusetts found that providing a tobacco cessation medication benefit preceded a significant decrease in hospitalization claims caused by heart attack and coronary atherosclerosis. The implication from this study is that eliminating financial barriers for low-income smokers to obtain smoking cessation medication could lead to cost reductions from overall decreases in the use of hospital services.[166] A subsequent study estimated that the cost per program participant for smoking cessation treatments was less than the inpatient savings per participant in an amount of $1.00 to $3.12.[167] It was also found that smoking cessation programs that include behavioral counseling in addition to medications decreased smoking rates by 10%.[168] Further, the Smoking Prevalence, Savings, and Treatment (SmokingPaST) Framework, a tool designed to calculate the impact of investments in tobacco treatment programs on health and medical cost savings, shows that state and federal governments, as well as employers, can achieve significant declines in smoking rates and significant savings in medical costs through tobacco treatment and prevention programs.[169]

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 and type of services provided. In Maine's expansion program, mental health and substance abuse diagnoses accounted for four of the top 10, and nine of the top 20 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

[166] A Longitudinal Study of Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Hospitalizations for Cardiovascular Disease, PLOS Medicine (December 2010).
[167] The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts, PLOS Medicine (January 2012).
[168] Medicaid Coverage for Tobacco Dependence treatments in Massachusetts and Associated Decreases in Smoking Prevalence, PLoS One (March 2010).
[169] The SmokingPaST Framework: Illustrating the Impact of Quit Attempts, Quit Methods, and New Smokers on Smoking Prevalence, Years of Life Saved, Medical Costs Saved, Programming Costs, cost Effectiveness, and Return on Investment, American Journal of Health Promotion (September 2011).

appropriate services results in effective treatment. For example, in Washington's Disability Lifeline program, the first 21 months after mental health benefits were added in two pilot counties, enrollees who received the services were shown to have: 1) reduced inpatient medical admissions; 2) a smaller increase in inpatient psychiatric costs; 3) a decrease in the number of arrests; and 4) a smaller increase in the proportion of clients living in homeless shelters or outdoors. The majority of the population in this program experiences co-occurring, complex conditions, including chronic physical conditions, mental illness, and substance abuse.

In terms of mental health, research has shown that behavioral ailment is often highly correlated with physical ailment and that providing access to coordinated physical and mental health services can reduce costs. For example, data show that Medicaid beneficiaries in New York who have a SPMI diagnosis are about 25% more likely to have three or more chronic conditions than those without an SPMI diagnosis.[170] As mentioned above, Washington's Disability Lifeline Program, which coordinates physical health, mental health, chemical dependency, and long-term care services under a full risk capitation model, found that in the first two years of the program enrollees experienced lower rates of psychiatric inpatient hospitalization, an increase in outpatient mental health utilization, improved fill rates of mental health prescriptions, and decreased state hospital days.[171] Further, Bellevue Hospital Center in New York City has experienced changes in the service patterns among their patients and corresponding reductions in Medicaid charges by addressing undiagnosed or untreated mental illness.[172]

In terms of substance abuse, research has shown that providing substance abuse treatment for Medicaid beneficiaries may also reduce health care expenditures. Though adding substance abuse treatment will initially increase spending, Medicaid costs may decrease in the long run. One study of Washington's Disability Lifeline program found substance abuse treatment to be associated with PMPM expenditure savings upwards of $160.[173] Another study showed that the estimated savings from substance abuse treatment equaled about 35% of the annual Medicaid expenses incurred by clients with substance abuse problems.[174]

As mentioned in the Mental Health Parity section, establishing two benchmark packages for the newly eligible population, a low-cost healthy adult benchmark package and a higher-cost medically frail benefit package, would allow IDHW to target mental health and substance abuse programs to the populations with the highest-risk and greatest need. Establishing a sub-acute model with pre-authorization requirements for "stepped care" has also proven to be an effective way to provide appropriate services while simultaneously reducing inpatient hospital stays and controlling costs.[175] In this situation the payment follows the patient, ensuring they receive the necessary treatments and services.

[170] Providing Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery of Services, Medicaid Institute at United Hospital Fund (2009).
[171] Ibid.
[172] Rethinking Service Delivery for High-Cost Medicaid Patients, Medicaid Institute at United Hospital Fund (March 2009).
[173] Evaluation of an Innovative Medicaid Health Policy Initiative to Expand Substance Abuse Treatment in Washington State, Medical Care Research and Review (2012).
[174] The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State, The Milbank Quarterly (2006).
[175] 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.

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 beneficial to increase both the scale and 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.

In terms of disease management programs, results from some studies show that savings can be achieved, while other studies found that these programs cannot predict savings. Most of the research indicates that the cost-savings from the use of disease management programs is indistinct.[176,177,178] Whether a program produces savings or not seems be determined, in part, by the specificity of the diseases and the populations included in the program. Interventions used to manage congestive heart failure, multiple conditions among the elderly, and high-risk pregnancy seem to be the most promising for savings.[179] Despite these mixed results, however, disease management programs do seem to generally improve care quality and patient satisfaction.[180]

Studies on care coordination produce similar results—care coordination has been found to have the potential to yield some, but not considerable program savings.[181,182] Data on the evaluation of the Medicare Coordinated Care Demonstration from the first two years showed that there was a small, but statistically insignificant reduction in costs across all programs that included care coordination. There were favorable effects on the quality of preventive care, the number of preventable hospitalizations, and a person's well-being—as well as an increase in the percent of beneficiaries reporting they received health education. However, there were few effects on beneficiaries' overall satisfaction with care, no clear effects on adherence or self-care, and no reduction in program expenditures.[183] That said, programs that provide substantial in-person contact targeting moderate to severe individuals have shown to be cost-neutral and to improve some aspects of care.[184]

In terms of delivery systems, care coordination programs operating within a managed care or medical home environment have shown to be more successful than those operating within a fee-for-service

[176] Effects of Care Coordination on Hospitalization, Quality of Care and Health Care Expenditures among Medicare Beneficiaries, JAMA (2009).
[177] Evidence for the Effect of Disease Management: is $1 Billion a Year a Good Investment?, American Journal of Managed Care (December 2007).
[178] Report to Congress on the Evaluation of Medicare Disease Management Programs, Mathematica (February 2008).
[179] Chronic Disease Management: Evidence of Predictable Savings, Health Management Associates (November 2008).
[180] Ibid.
[181] The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years, Mathematica (2007).
[182] Effects of Care Coordination on Hospitalization, Quality of Care and Health Care Expenditures among Medicare Beneficiaries, JAMA (2009).
[183] The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years, Mathematica (2007).
[184] Effects of Care Coordination on Hospitalization, Quality of Care and Health Care Expenditures among Medicare Beneficiaries, JAMA (2009).

environment. This is because the success of care coordination programs, in large part, depends on provider participation and existence of a team-focused model.

Leavitt Partners advises IDHW to be cautious when establishing such programs and to focus on programs that target specific conditions and populations that benefit most from care coordination. As mentioned above, disease management programs targeting congestive heart failure and multiple conditions seem to be the most cost effective. Also, programs that provide substantial in-person contact targeting moderate to severe individuals have proven to be at least cost neutral.

Based on the newly eligible population's needs, as well as evidence presented in the mental health and substance abuse section, 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 to establish in Idaho. 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.

Establishing two benchmark packages for the newly eligible population would also allow IDHW to target disease management and care coordination programs to the populations with the highest risk and greatest need. If Idaho opts into the expansion, IDHW should consider using any funds that become available from the existing Substance Abuse and Mental Health Block Grants to develop the infrastructure and wrap-around services necessary for such programs.

Additional Areas of Consideration:
In addition to expanding the scale and scope of the programs listed above, there are other areas IDHW should consider when building a benchmark plan for the newly eligible. Based on the experience from other expansion states, IDHW should consider establishing programs and/or policies that:

1. **Promote primary care and reduce emergency department visits**. Evidence from both Iowa and Wisconsin showed that the rate of emergency department visits actually increased when the expansion population was enrolled in Medicaid. In Wisconsin, most of the visits were non-emergent visits, emergent visits that could have been treated in a primary care setting, and visits that would have been avoidable had the person had access to primary care.

   To avoid a similar situation, IDHW should considering establishing programs, policies, and/or delivery systems that promote the use of primary and preventive care. Possible strategies include: 1) medical home or HMO models, where the primary care provider becomes the gateway to more urgent/specialty care; 2) nurse hotlines that can provide individuals with assistance and direction when a primary care provider is not available; and 3) the use of telehealth to expand the reach of primary care and specialty providers. IDHW should collaborate with CHCs to use some of the increased funding it will receive under an expansion scenario (either the additional Medicaid payments or its existing federal grants) to develop the necessary infrastructure for such programs and/or systems.

   That said, it is important to note that, in some cases, use of emergency departments is appropriate. IDHW should not establish policies that may discourage the appropriate use of emergency departments. Contrary to the popular belief that most Medicaid emergency

department visits are for routine care, a new study from the Center for Studying Health System Change showed that 75% of visits were categorized as emergent, urgent, or semi-urgent.[185]

2. **Reduce pharmaceutical costs.** The pharmaceutical costs associated with the expansion population in Indiana, Maine, and New Mexico was higher than expected and increased over time. A large portion of these costs are due to mental health pharmaceuticals, which tend to be one of the more expensive drugs provided to Medicaid enrollees, heavily used by the expansion population, and heavily prescribed by providers. In Indiana, the use of inpatient, outpatient, and physician services peaked in the second and third months of enrollment, but leveled off by the end of the first year. The one exception to this trend was utilization of pharmacy services which continued to increase.

   There is not one clear strategy to reducing pharmaceutical costs. Some of the increase is simply due to pent-up need for care and the need to treat co-occurring, complex conditions. Possible strategies to reduce costs include: 1) establishing preferred drug lists or cost-sharing policies that promote the use of generic drugs; 2) establishing medication management programs (either through medical home or managed care models) that promote adherence; 3) establishing restrictions on or pre-authorizations for the use of certain medications; and 4) carving-in or carving-out pharmacy from managed care, depending on what program is currently being used and the associated costs.

   The current theory is that carving-in pharmacy is the most cost-effective strategy, especially with the change in the PPACA that allows Medicaid MCOs to receive manufacturer rebates.[186] It is important to note, however, that carving pharmacy into managed care or a coordinated care system may actually increase pharmaceutical costs as individuals access appropriate medication, even though overall health care utilization should decrease over time.

   The best approach to reducing or managing pharmaceutical costs is to accurately predict what the increase in these costs will be under an expansion scenario. Part of this is determining what pharmaceuticals have the highest cost and the highest utilization rate. Knowing the demographic and health condition information of the newly eligible is helpful in predicting what these costs will be.

3. **Use health needs assessments.** Both Wisconsin and Indiana included health needs assessments as part of the expansion populations' application process. The purpose of these assessments was to identify high-need, high-risk participants (i.e., participants with cancers, HIV/AIDS, hemophilia, aplastic anemia, or organ transplants) and place them in the appropriate program or managed care plan. Given IDHW will need to identify which of the newly eligible may not qualify for benchmark coverage (due to disabilities or being medically frail), this may be a valuable tool. However, there is little evidence on the cost-effectiveness of implementing such programs, other than it may alleviate administrative burden in the long run.

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[185] Dispelling Myths about Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms, Center for Studying Health System Change, Research Brief No. 23 (July 2012)

[186] Under PPACA Section 2501, "states may now choose whether to include prescription drugs in managed care contracts or carve drugs out separately without losing the rebates paid by manufacturers"—meaning drug manufacturers are now required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a MCO.

Next Steps

The purpose of this report is to provide an analysis of Idaho's 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 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 and to provide the State with evidence as it evaluates its decision to expand. Governor Otter has convened a Medicaid workgroup to continue to study this issue, and it is expected this group will use this report as part of its overall analysis

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 (i.e., maintaining status quo). Both direct and indirect costs should be considered in the analysis, including any foregone grant money that is currently used for programs that treat newly-eligible like populations.

2. Evaluate what alternative opportunities exist under the current Medicaid State Plan and what could be achieved through State Plan amendments or 1115 Waivers. While it is not clear what flexibility the current Administration will provide to states around the expansion, states should be aware of all of their options. For example, a state may consider expanding their current Medicaid program up to 100% FPL, establishing a targeted medically needy program, and/or establishing a state-run Pre-Existing Insurance Plan or expanding the State's High Risk Pool.

3. Determine what other considerations and externalities should be taken into account when deciding whether or not to expand. Examples include: 1) provider capacity; 2) compatibility with proposals for new delivery systems (i.e., Idaho's medical home initiative); 3) pharmacy costs related to the newly eligible and possible cost containment mechanisms; 4) the impact on the private insurance market; 5) the implementation of other PPACA Medicaid provisions; and 6) the economic advantages and disadvantages of expanding.

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, many states are waiting for the November election before formally declaring a decision as to whether or not they will expand. Because it is almost certain the Administration will not release detailed guidance before the election, and because there is no deadline for states having to notify HHS of plans to expand, Leavitt Partners recommends that Idaho wait to declare a formal decision until more guidance is released after the November election.

For example, if President Obama is reelected, Leavitt Partners believes the Administration will do everything in its power to incentivize states to opt in to the full Medicaid expansion, offering program flexibility as needed. Under this scenario, most states will ultimately choose to expand their Medicaid programs, although some Republican states will be slow to move.

Alternatively, if Republicans take both the White House and Congress, Leavitt Partners believes the Administration and Congress will effectively repeal the Medicaid expansion provision through state waivers or reduce the amount of federal funding made available to states. Under this scenario, the expansion will no longer be an attractive option for most states.

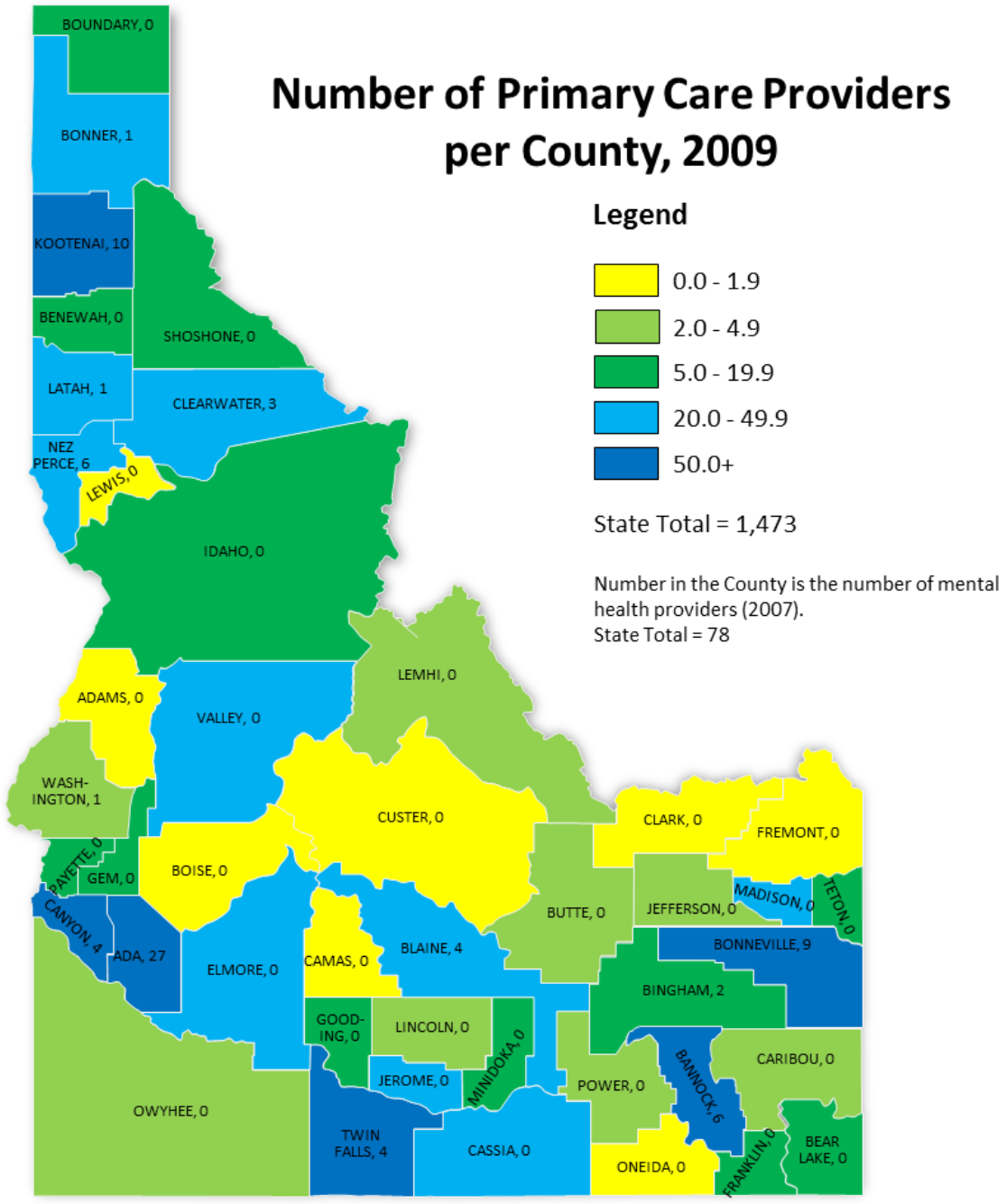
Given these possible scenarios, and the related uncertainties, it seems most advantageous for states to wait until more guidance is released after the November election before formally declaring a decision to expand. That said, because implementation deadlines are tight, Leavitt Partners believes that 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. This includes preparing for negotiations with CMS, implementing new delivery systems, and planning for any necessary RFPs.

Appendix

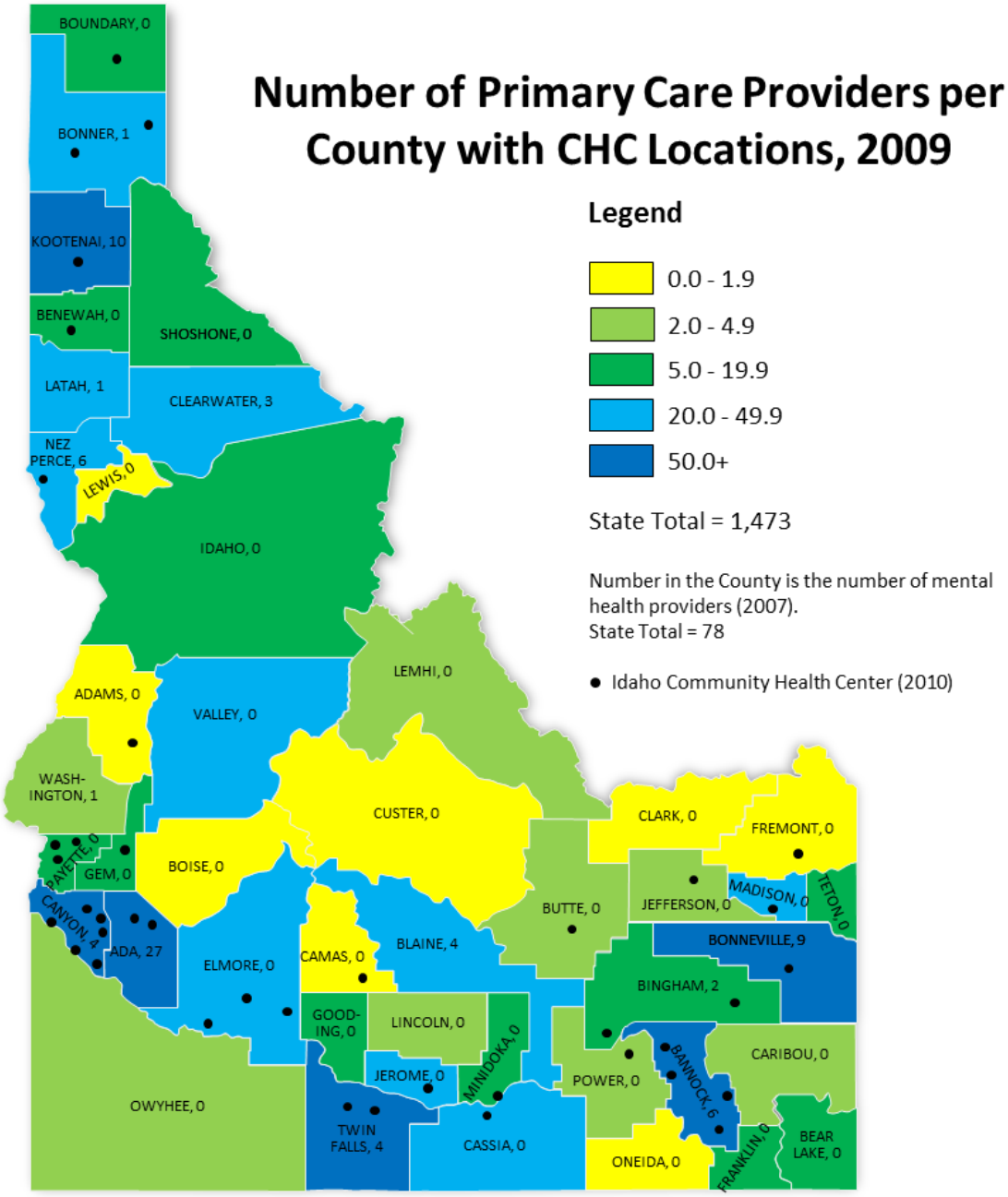
Provider Maps

Figure A-1



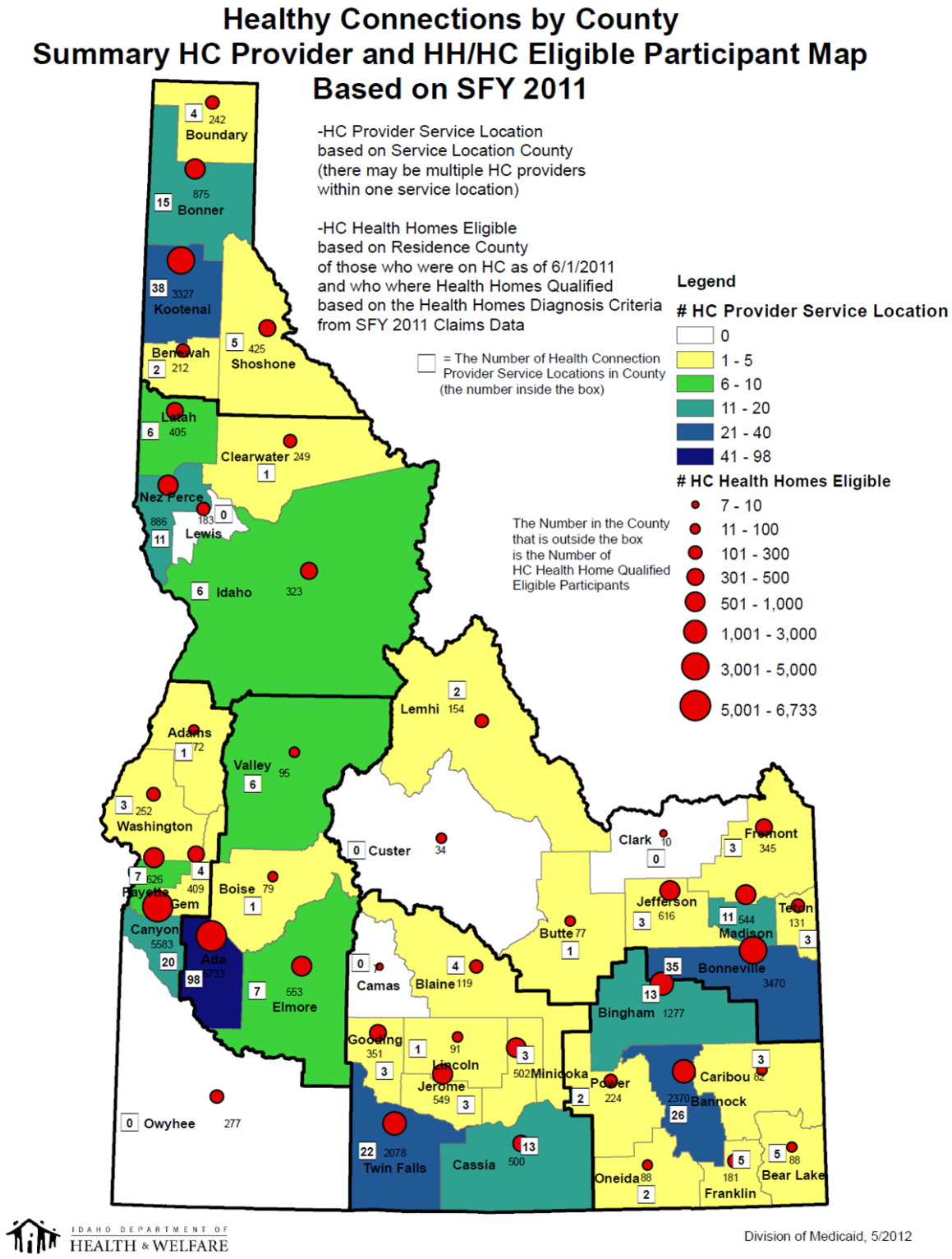
Data Source: Health Resources and Services, 2012 County Health Rankings

Figure A-2



Data Source: Health Resources and Services, 2012 County Health Rankings

Figure A-3


Healthy Connections by County
Summary HC Provider and HH/HC Eligible Participant Map
Based on SFY 2011
-HC Provider Service Location based on Service Location County (there may be multiple HC providers within one service location)
-HC Health Homes Eligible based on Residence County of those who were on HC as of 6/1/2011 and who where Health Homes Qualified based on the Health Homes Diagnosis Criteria from SFY 2011 Claims Data
= The Number of Health Connection Provider Service Locations in County (the number inside the box)
The Number in the County that is outside the box is the Number of HC Health Home Qualified Eligible Participants
Legend
HC Provider Service Location
0
1 - 5
6 - 10
11 - 20
21 - 40
41 - 98
HC Health Homes Eligible
7 - 10
11 - 100
101 - 300
301 - 500
501 - 1,000
1,001 - 3,000
3,001 - 5,000
5,001 - 6,733
Boundary 4 242
Bonner 15 875
Kootenai 38 3327
Benewah 2 212
Shoshone 5 425
Latah 6 405
Clearwater 1 249
Nez Perce 11 886
Lewis 0 183
Idaho 6 323
Adams 1 72
Washington 3 252
Payette 7 626
Gem 4 409
Boise 1 79
Canyon 20 5583
Ada 98 6733
Elmore 7 553
Owyhee 0 277
Valley 6 95
Lemhi 2 154
Custer 0 34
Camas 0 34
Blaine 4 119
Gooding 1 351
Lincoln 3 91
Jerome 3 549
Twin Falls 22 2078
Minidoka 3 502
Cassia 13 500
Clark 0 10
Fremont 3 345
Jefferson 3 616
Madison 11 544
Teton 3 131
Butte 1 77
Bonneville 35 3470
Bingham 13 1277
Power 2 224
Caribou 3 62
Bannock 26 2370
Oneida 2 88
Franklin 5 181
Bear Lake 5 88
IDAHO DEPARTMENT OF HEALTH & WELFARE
Division of Medicaid, 5/2012

Uninsured Rates

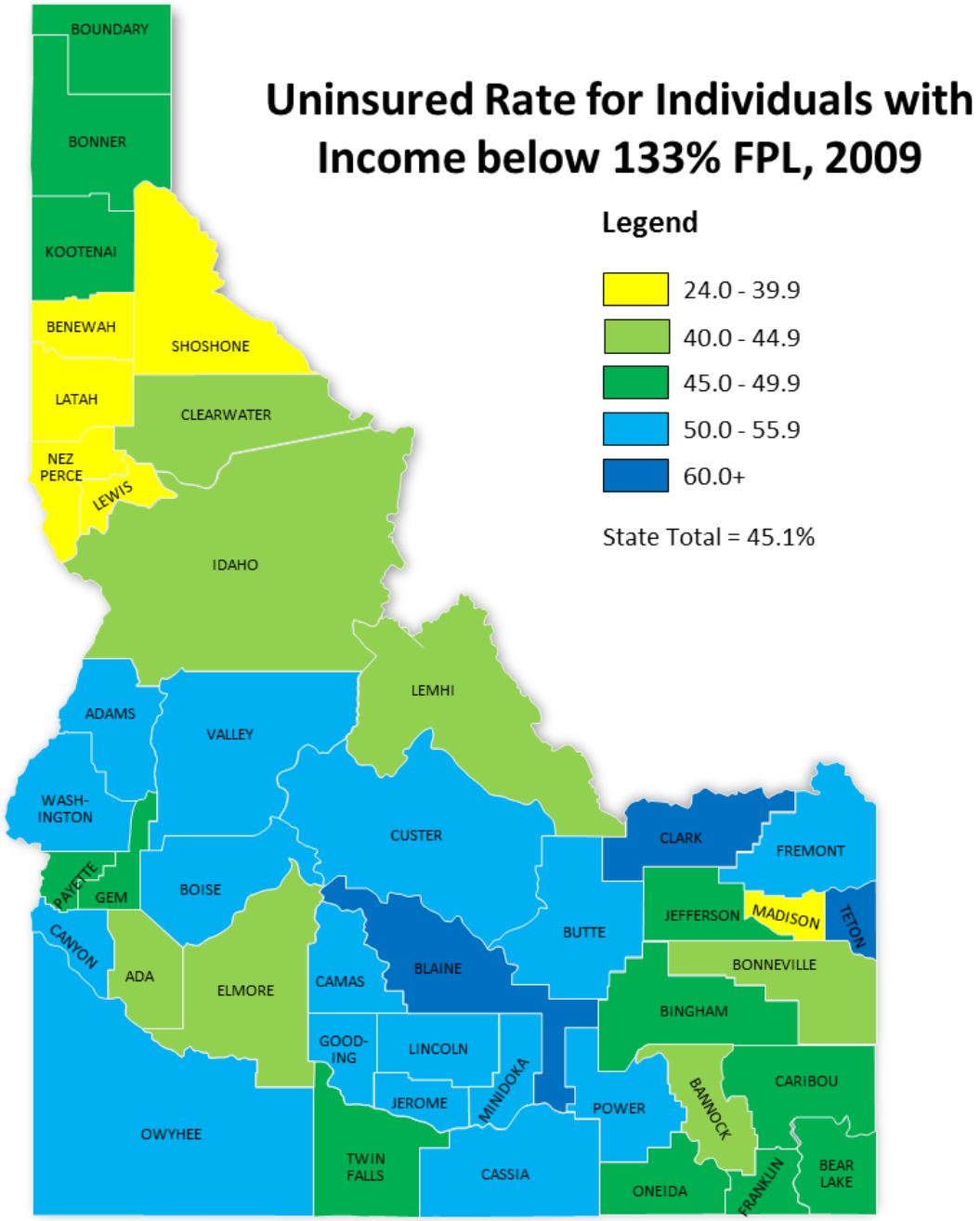
Figure A-4

Uninsured Rates by Income and County, 2009			
	Uninsured Rate for population, age 18–64, with income below 133% FPL	Uninsured Rate for entire population, age 18–64	Uninsured Rate for population, age 40–64, with income below 133% FPL
Ada County	43.2%	18.2%	31.2%
Adams County	54.0%	29.5%	50.9%
Bannock County	41.0%	20.9%	27.2%
Bear Lake County	46.2%	23.1%	43.2%
Benewah County	39.4%	23.7%	48.0%
Bingham County	46.5%	27.4%	33.7%
Blaine County	58.8%	22.2%	32.8%
Boise County	51.2%	22.8%	47.5%
Bonner County	45.0%	23.5%	44.8%
Bonneville County	41.5%	20.8%	31.9%
Boundary County	47.3%	27.0%	46.0%
Butte County	50.4%	26.3%	47.6%
Camas County	53.9%	24.1%	39.1%
Canyon County	50.6%	30.2%	30.2%
Caribou County	46.9%	21.0%	39.5%
Cassia County	50.4%	29.4%	36.9%
Clark County	58.1%	34.7%	37.8%
Clearwater County	44.5%	23.9%	47.0%
Custer County	51.5%	24.8%	46.7%
Elmore County	43.0%	23.9%	25.4%
Franklin County	45.2%	24.5%	37.8%
Fremont County	52.9%	31.7%	34.7%

Uninsured Rates by Income and County, 2009			
	Uninsured Rate for population, age 18–64, with income below 133% FPL	Uninsured Rate for entire population, age 18–64	Uninsured Rate for population, age 40–64, with income below 133% FPL
Gem County	47.7%	26.3%	42.8%
Gooding County	54.3%	32.0%	36.8%
Idaho County	42.1%	24.7%	46.7%
Jefferson County	48.1%	25.9%	34.1%
Jerome County	53.5%	31.5%	32.3%
Kootenai County	48.8%	22.6%	35.0%
Latah County	38.5%	19.9%	18.8%
Lemhi County	44.6%	24.5%	54.6%
Lewis County	35.9%	22.2%	53.0%
Lincoln County	53.8%	31.1%	41.8%
Madison County	24.0%	17.7%	15.5%
Minidoka County	50.5%	28.6%	35.9%
Nez Perce County	38.4%	18.7%	34.0%
Oneida County	45.2%	23.3%	43.5%
Owyhee County	54.7%	35.9%	40.3%
Payette County	47.0%	26.6%	37.5%
Power County	50.3%	29.5%	39.7%
Shoshone County	38.9%	21.5%	45.7%
Teton County	61.3%	30.9%	29.6%
Twin Falls County	48.0%	26.3%	33.1%
Valley County	52.5%	24.6%	44.0%
Washington County	50.7%	29.4%	43.4%
Idaho State	45.1%	23.1%	33.0%

SOURCE: U.S. Census Bureau, Small Area Health Insurance Estimates (2009).

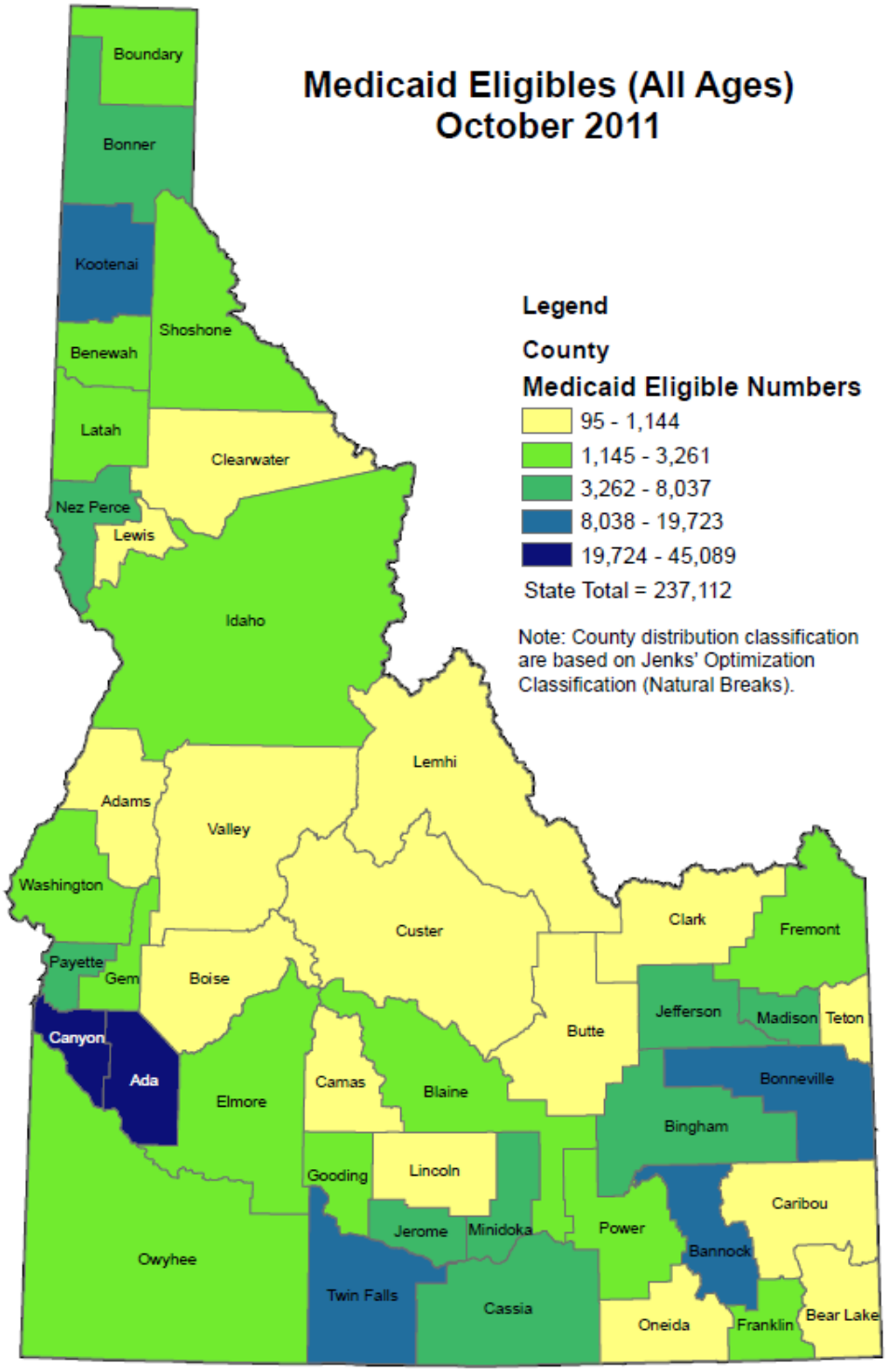
Figure A-5



Data Source: U.S. Census Bureau

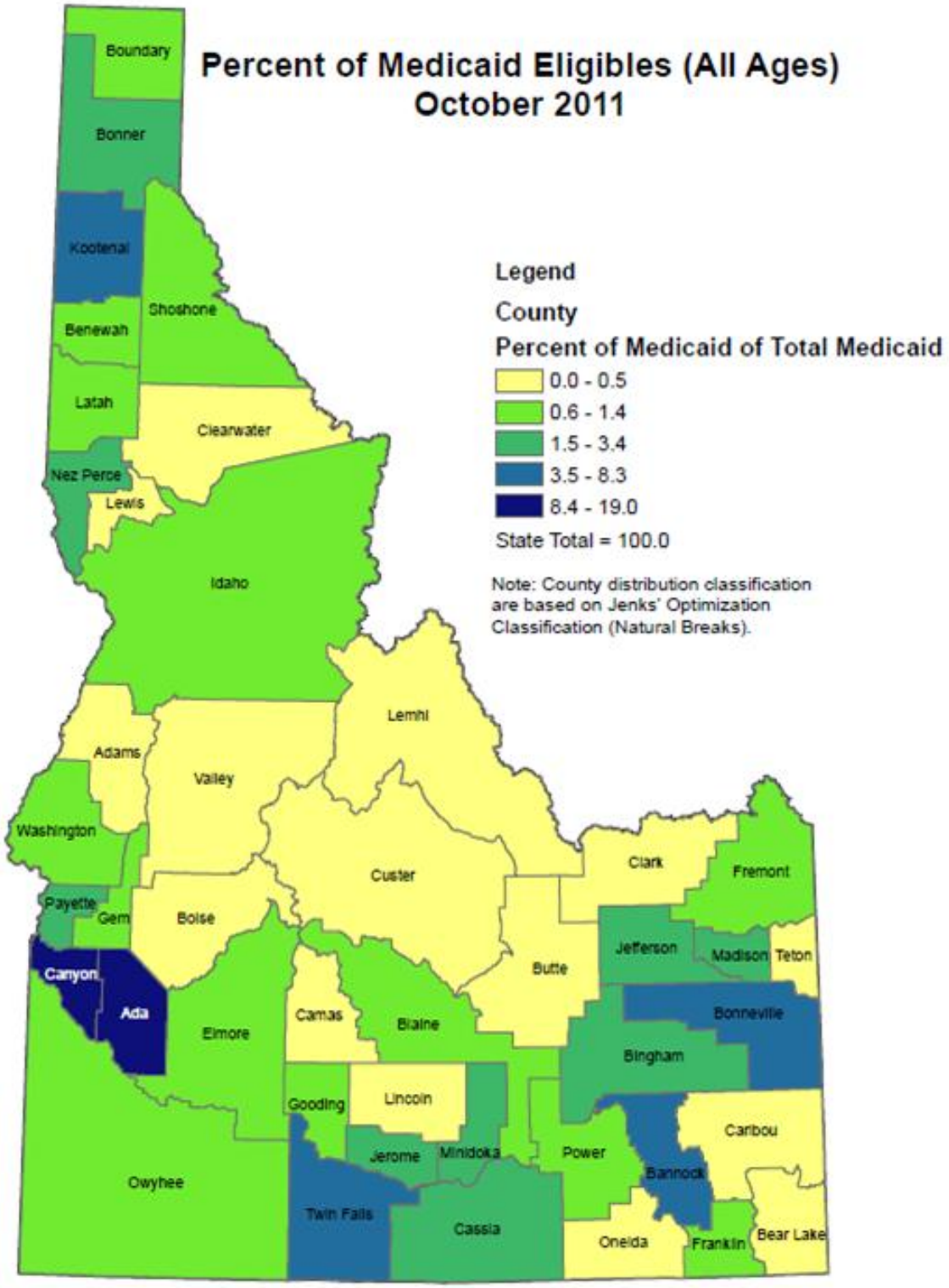
Medicaid Information

Figure A-6



Data Source: Idaho Department of Health and Welfare, Division of Medicaid

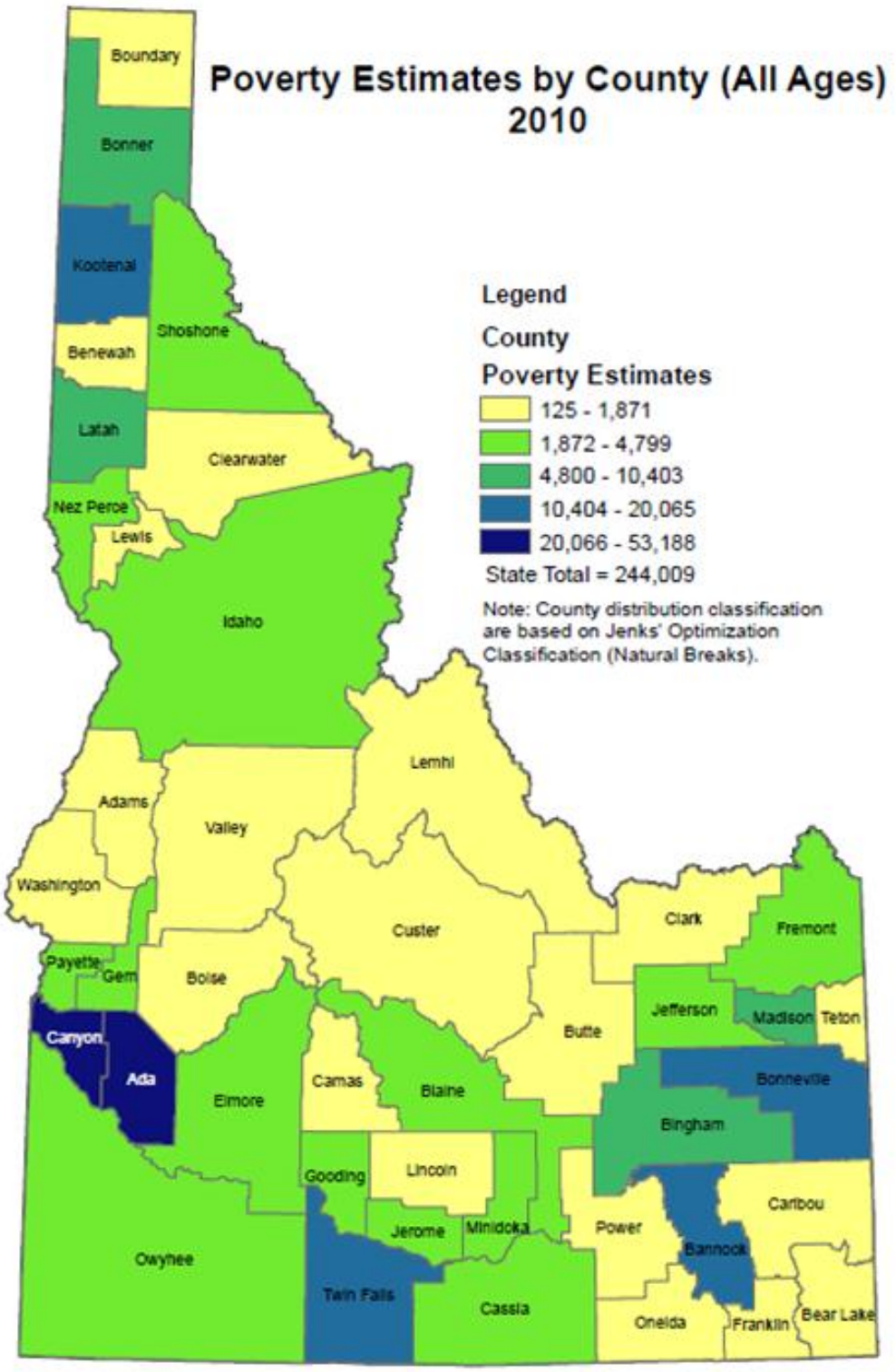
Figure A-7



Data Source: Idaho Department of Health and Welfare, Division of Medicaid

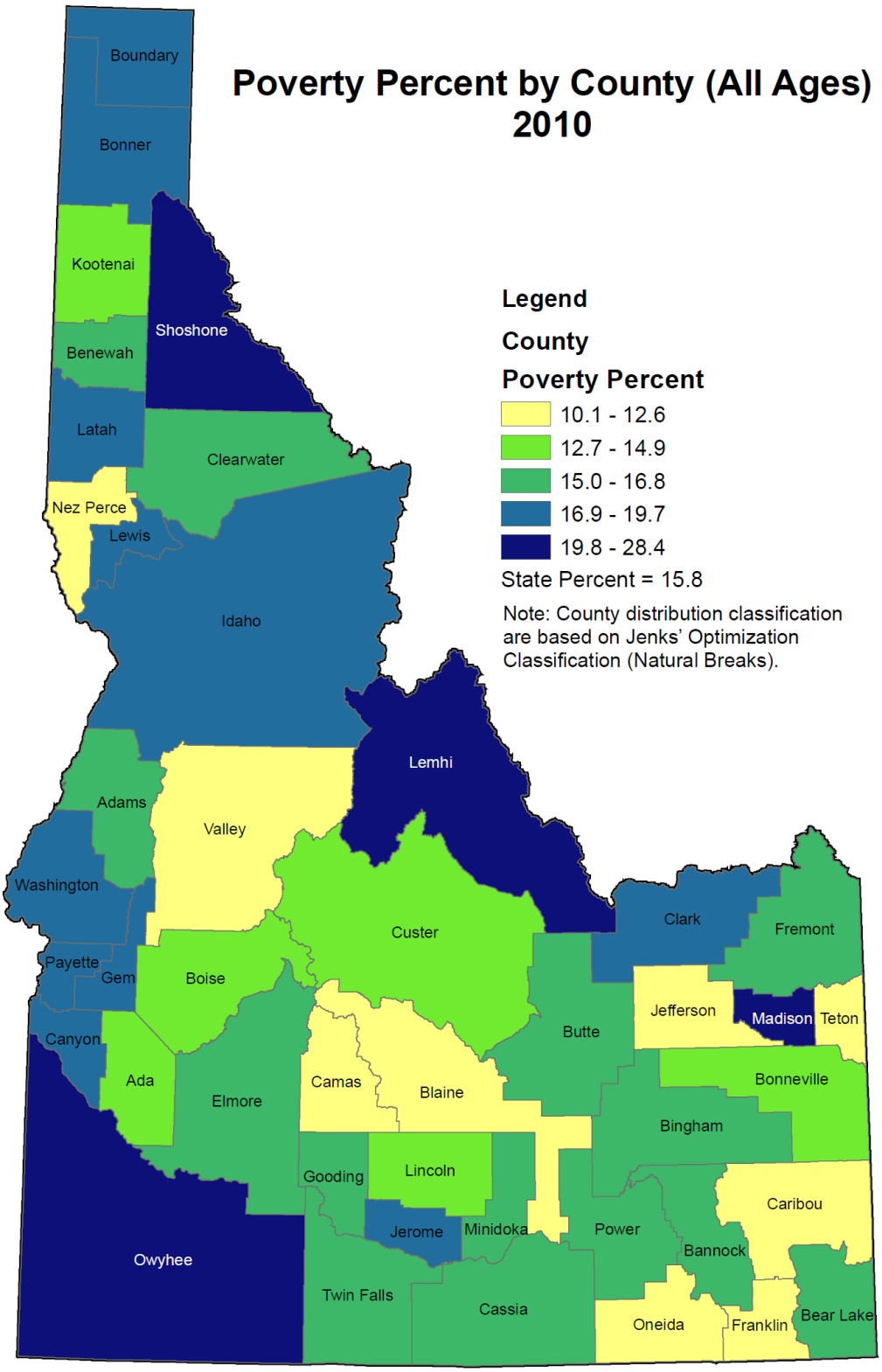
State Demographic Information

Figure A-8



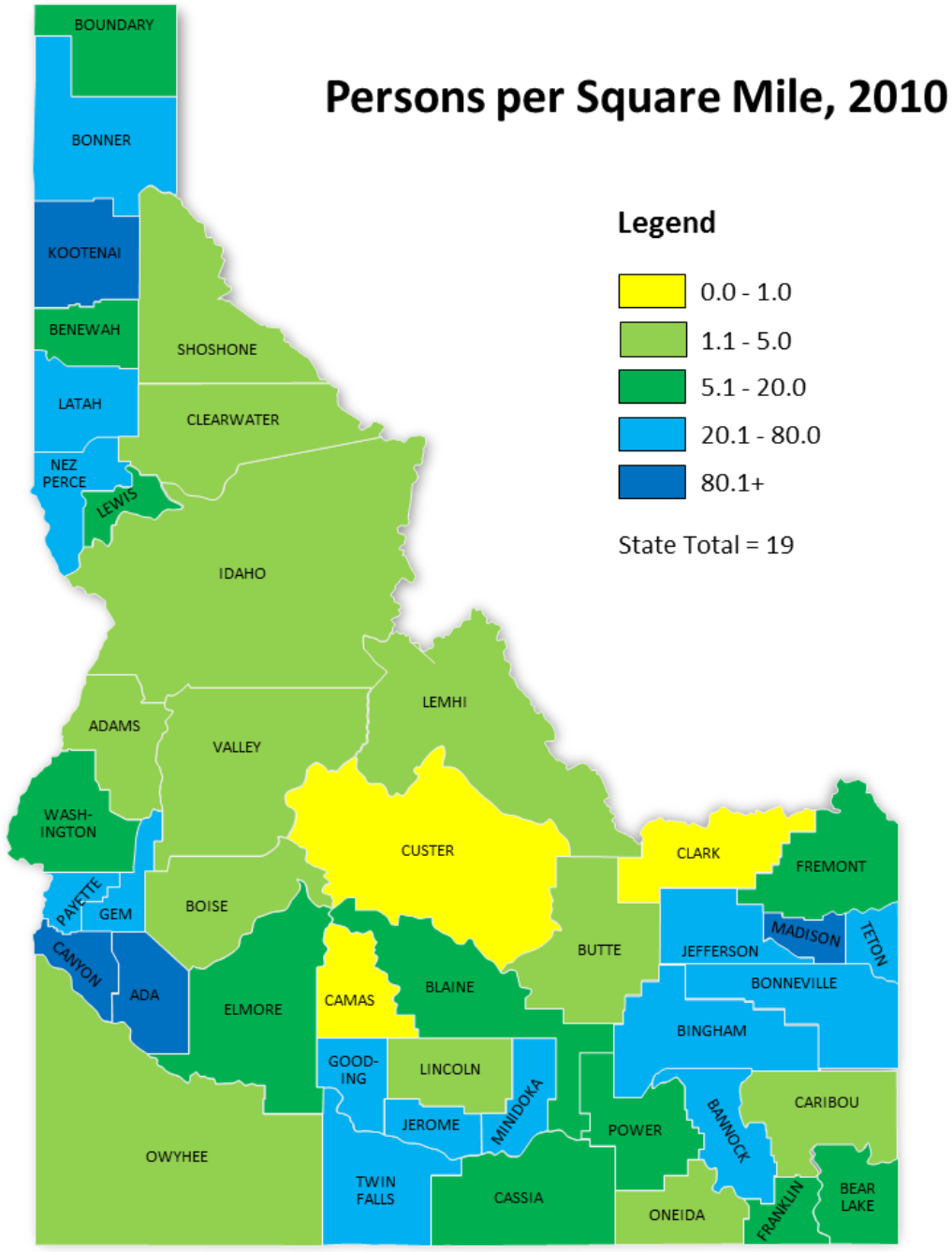
Data Source: Idaho Department of Health and Welfare, Division of Medicaid

Figure A-9



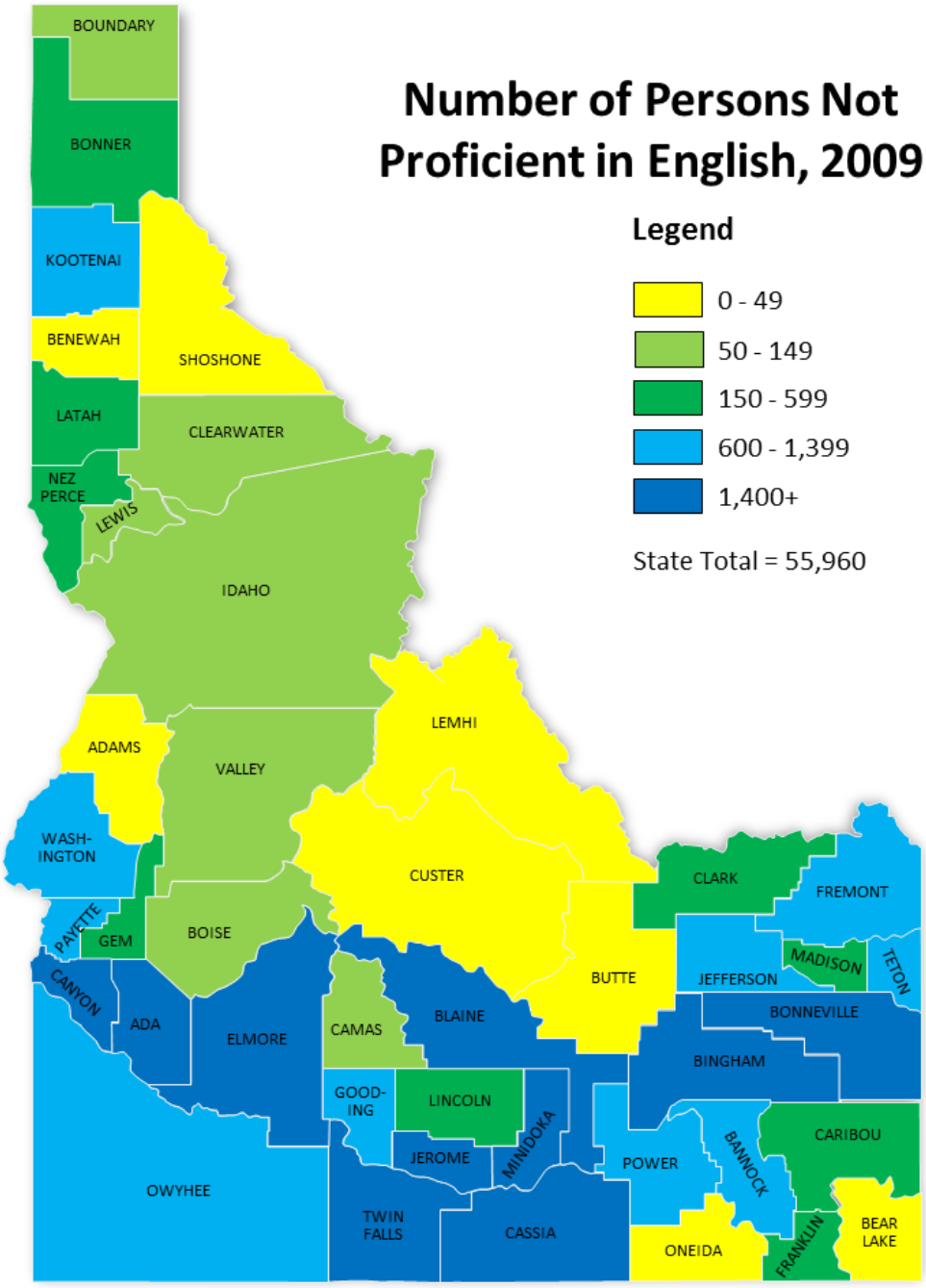
Data Source: Idaho Department of Health and Welfare, Division of Medicaid

Figure A-10



Data Source: U.S. Census Bureau

Figure A-11



Data Source: U.S. Census Bureau