MEDICAID: 
*Outlook* 
*Health Care Reform*
## Current Medicaid Landscape

<table>
<thead>
<tr>
<th>Segment</th>
<th>Lives</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicaid</td>
<td>53,600,803</td>
<td>100%</td>
</tr>
<tr>
<td>Fee-For-Service</td>
<td>27,524,801</td>
<td>51%</td>
</tr>
<tr>
<td>Managed Medicaid</td>
<td>26,076,002</td>
<td>49%</td>
</tr>
</tbody>
</table>

Source: Artia Solutions – October 2011
Medicaid Enrollment 2011

53 Million Enrollees

- Adults: 25%
- Children: 50%
- Aged & Disabled: 15%
- Dual Eligibles: 10%
State Budget Outlook

- State budgets are beginning to show signs of recovery
- Overall fiscal outlook for remainder of 2012 and into 2013: (Fall of 2011 Survey of State Fiscal Directors by NSCL)
  - 23 were “Cautiously Optimistic”
  - 20 were “Concerned”
  - 7 were “Positive”
State Budget Outlook

- Medicaid spending continues to be a concern
  - Enrollment Growth
  - Unachieved budgeted savings (MediCal provider rate cut)
  - No more AARA funding
  - Preparation for Medicaid expansion in 2014

- Prisons

- State Pension Plans
State Budget Outlook
2012–13 Budget Projections

- Pennsylvania – $750 million deficit
- Florida – $1.7 billion deficit
- California – $13 billion deficit
  - $3 billion gap in 2011–12
  - $10 billion expected operating shortfall for 2012–13

Drivers:
- Lower than predicted revenues
- Health care spending (Medicaid)
- Education
- Prisons

Source:
PA – State Budget Secretary Report
FL – Economic Demographic Research (EDR) of Florida
CA – Legislative Analysts Office 2012–2013 Fiscal Outlook
Medicaid Enrollees and Expenditures, FY 2008

**Enrollees**
- Total = 59.5 million

**Expenditures**
- Total = $317.7 billion

**Percentage Breakdown**
- Children: 49%
- Adults: 25%
- Elderly: 10%
- Disabled: 15%

**SOURCE:** KCMU/Urban Institute estimates based on data from FY 2008 MSIS and CMS Form-64, 2010.
Forces Impacting Medicaid Enrollment Over The Next 3 Years

- **Managed Medicaid Expansion**
  - 20 States currently have legislation that will either move lives from FFS to MCO or carve the pharmacy benefit back to MCO
  - Over 8 million lives impacted

- **Health Care Reform**
  - 16 million lives will be added to Medicaid enrollment in 2014 as a result of Medicaid Expansion
  - 24 million lives will receive subsidized healthcare via State Exchanges beginning in 2014
## Top 15 Medicaid States

<table>
<thead>
<tr>
<th>State</th>
<th>FFS Lives</th>
<th>Managed Plans</th>
<th>Total Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>3,701,814</td>
<td>3,255,750</td>
<td>6,957,564</td>
</tr>
<tr>
<td>New York</td>
<td>1,434,198</td>
<td>3,333,987</td>
<td>4,768,185</td>
</tr>
<tr>
<td>Texas</td>
<td>1,062,501</td>
<td>2,172,896</td>
<td>3,235,397</td>
</tr>
<tr>
<td>Illinois</td>
<td>2,794,126</td>
<td>195,874</td>
<td>2,990,000</td>
</tr>
<tr>
<td>Florida</td>
<td>1,774,619</td>
<td>1,128,264</td>
<td>2,902,883</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>984,633</td>
<td>1,234,759</td>
<td>2,219,392</td>
</tr>
<tr>
<td>Ohio</td>
<td>603,887</td>
<td>1,541,113</td>
<td>2,145,000</td>
</tr>
<tr>
<td>Michigan</td>
<td>715,927</td>
<td>1,223,264</td>
<td>1,939,191</td>
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<tr>
<td>Georgia</td>
<td>565,000</td>
<td>1,114,180</td>
<td>1,679,180</td>
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<tr>
<td>North Carolina</td>
<td>1,462,409</td>
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<td>1,462,409</td>
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<td>Arizona</td>
<td>149,946</td>
<td>1,194,227</td>
<td>1,344,173</td>
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<td>Massachusetts</td>
<td>847,230</td>
<td>409,086</td>
<td>1,256,316</td>
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<td>Tennessee</td>
<td>0</td>
<td>1,212,715</td>
<td>1,212,715</td>
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<td>Washington</td>
<td>563,334</td>
<td>631,191</td>
<td>1,194,525</td>
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<tr>
<td>Louisiana</td>
<td>1,175,149</td>
<td>0</td>
<td>1,175,149</td>
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</table>

Source: Artia Solutions – October 2011
In 2011, OH and NY are expected to see the most significant Managed Medicaid shift in Rx benefit

Projected Variation of Medicaid Enrollment Shift from FFS to MM in 2011-2013

- **More FFS Dominant**
  - Both access control and claim adjudication continue to reside in FFS
  - Access control remains in states but claim adjudication shifts to MCOs
  - Rx benefit management to be shifted from FFS to MCOs
  - Rx benefit management continue to reside in MCOs

- **More MCO Dominant**
  - More FFS Dominant
  - More MCO Dominant

<table>
<thead>
<tr>
<th>State</th>
<th># of Lives Shifting</th>
<th>% of FFS Shifting</th>
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</thead>
<tbody>
<tr>
<td>TX</td>
<td>(2.1M, 67%)</td>
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</tr>
<tr>
<td>LA</td>
<td>(800K, 68%)</td>
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<tr>
<td>IL</td>
<td>(1.4M, 50%)</td>
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<tr>
<td>NY</td>
<td>(No shift of lives)</td>
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<tr>
<td>OH</td>
<td>(No shift of lives)</td>
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</tr>
<tr>
<td>SC</td>
<td>(80K, 25%)</td>
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</tr>
<tr>
<td>NJ</td>
<td>(121K, 39%)</td>
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</tr>
<tr>
<td>KY</td>
<td>(460K, 82%)</td>
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</tr>
<tr>
<td>WV</td>
<td>(55K, 31%)</td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td>(200K, 28%)</td>
<td></td>
</tr>
<tr>
<td>FL</td>
<td>(1.5M, 85%)</td>
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</tr>
</tbody>
</table>

**Ownership of Pharmacy Benefit Management**

Expected Timeline of Shift
# California

<table>
<thead>
<tr>
<th>Lives</th>
<th>Current</th>
<th>Proposed</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6,957,564</td>
<td>6,957,564</td>
<td>0</td>
</tr>
<tr>
<td>FFS</td>
<td>3,701,814</td>
<td>3,341,814</td>
<td>-360,000</td>
</tr>
<tr>
<td>MM</td>
<td>3,255,750</td>
<td>3,615,750</td>
<td>+360,000</td>
</tr>
</tbody>
</table>

### Legislation/Notes:
- State to move 360 K lives to MCOs
- Begins 10/1/11
- Plans Manage Rx Benefit

### Top MCOs
- Over 50 MCOs registered in CA
- For a list of plans, see link below:
  [http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx](http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx)
## Florida

<table>
<thead>
<tr>
<th>Lives</th>
<th>Current</th>
<th>Proposed</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2,902,883</td>
<td>2,902,883</td>
<td>0</td>
</tr>
<tr>
<td>FFS</td>
<td>1,774,619</td>
<td>274,619</td>
<td>-1,500,000</td>
</tr>
<tr>
<td>MM</td>
<td>1,128,264</td>
<td>2,628,264</td>
<td>+1,500,000</td>
</tr>
</tbody>
</table>

### Legislation/Notes:
- Migration of 1.5 MM enrollees to MCOs to begin on 12/1/2013
- MCOs likely to control Rx Benefit
- Small FFS Lives will remain
- State will control FFS lives and retain Provider Synergies as Rebate Admin.

### Top MCOs
1. WellCare (HealthEase & StayWell)
2. UnitedHealthcare
3. Molina
4. Coventry/Buena Vista
5. Humana

Source: Artia Solutions – October 2011
### Illinois

<table>
<thead>
<tr>
<th>Lives</th>
<th>Current</th>
<th>Proposed</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2,990,000</td>
<td>2,990,000</td>
<td>0</td>
</tr>
<tr>
<td>FFS</td>
<td>2,794,126</td>
<td>1,394,126</td>
<td>-1,400,000</td>
</tr>
<tr>
<td>MM</td>
<td>195,874</td>
<td>1,595,874</td>
<td>+1,400,000</td>
</tr>
</tbody>
</table>

### Legislation/Notes:
- Migration to MCOs to begin on 7/1/12
- State to manage Rx Benefit
- State controls Rx Benefit & contracting

### Top MCOs
1. Harmony Health Plan
2. Family Health Network
3. Meridian Health Plan

Source: Artia Solutions – October 2011
### Louisiana

<table>
<thead>
<tr>
<th>Lives</th>
<th>Current</th>
<th>Proposed</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,175,149</td>
<td>1,175,149</td>
<td>0</td>
</tr>
<tr>
<td>FFS</td>
<td>1,175,149</td>
<td>375,149</td>
<td>-800,000</td>
</tr>
<tr>
<td>MM</td>
<td>0</td>
<td>800,000</td>
<td>+800,000</td>
</tr>
</tbody>
</table>

**Legislation/Notes:**

- Moving enrollees to MCOs starting 10/1/11.
- Aetna filed legal injunction filed to block migration
- State retains Rx Benefit control
- Part of Provider Synergies TOP$ Pool

**Top MCOs**

1. AMERIGROUP
2. Centene
3. AmeriHealth Mercy
4. UnitedHealthcare
5. Community Health Solutions

Source: Artia Solutions – October 2011
## Connecticut

<table>
<thead>
<tr>
<th>Lives</th>
<th>Current</th>
<th>Proposed</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>494,635</td>
<td>494,635</td>
<td>0</td>
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<tr>
<td>FFS</td>
<td>111,635</td>
<td>494,635</td>
<td>+383,000</td>
</tr>
<tr>
<td>MM</td>
<td>383,000</td>
<td>0</td>
<td>-383,000</td>
</tr>
</tbody>
</table>

### Legislation/Notes:
- After comprehensive audit and analysis, state has decided it can better manage Medicaid lives than MCO’s
- “Connecticut has a 15 year history with MCO’s and there has been a diminishing confidence in the value of what they can provide” Mark Schaefer, Medicaid Director
- Effective 1/1/12, 383,000 MCO’s lives will move back to FFS

### Top MCOs
1. Aetna
2. UnitedHealthcare
3. Community Health Network

Source: Artia Solutions – October 2011
Managed Medicaid

Advocacy Issues

- Much more restricted access to branded drugs than FFS
- No transparency in prior authorization requirements
- Total freedom in formulary management
- Practically no appeals process—no ombudsman
- Adverse selection
Health Care Reform
The U.S. Healthcare System
PRIOR TO HEALTHCARE REFORM LEGISLATION

MEDICARE
Operated by the Centers for Medicare & Medicaid Services, benefits set by Congress

PART A
The part of Medicare that pays hospital bills

PART B
The part of Medicare that pays physician bills

PART D
The part of Medicare that pays prescription drug benefits

MEDICARE ADVANTAGE
Private sector alternatives to Medicare

MEDICAID
Program for the poor and disabled, administered by states, jointly funded with federal government, frequently administered through private plans

S-CHEP
Program for low-income children and some families, jointly funded with federal government, frequently administered through private plans

MICHIGAN & SUPPLEMENTAL BENEFITS
Program that closes the Medicare gaps for the Medicare prescription drug benefit

INSURERS & LICENSING BOARDS
Responsibility for medical care, compliance with state regulations, coverage, and claims

PRIVATE INSURERS, BEARING RISK
Insurers that both administer benefits and pay for care with private practices, built up over time

PRIVATE INSURERS, ADMINISTRATION ONLY
Insurers that administer benefits for companies that self-insure

PHYSICIANS IN PRIVATE PRACTICE
Doctors who operate on their own as individual proprietors or in small groups

INDEPENDENT PRACTICE ASSOCIATIONS
Large networks of physicians that contract with insurers, sometimes through capitation

GROUP PRACTICES
Integrated, multi-specialty groups of physicians that coordinate and manage care

PRIVATE SAFETY NET HOSPITALS
Hospitals that provide large amounts of care to the poor and uninsured

PRIVATE NON-SAFETY NET HOSPITALS
Hospitals that provide care mostly to the insured and relatively affluent

PUBLIC HOSPITALS
Hospitals owned and operated by the government

NURSING HOMES
Long-term care at homes and institutions

DEPARTMENT OF LABOR
Under (Am) known as OSHA, federal agency that regulates safety and health in the workplace

COMMUNITY CLINICS
Clinics, often funded by the government, that provide basic medical care to the poor and uninsured

STATE GOVERNMENTS
Finance state insurance programs and low-income providers, regulate insurance plans

INSTITUTE OF MEDICINE
Independent advisory board,作 assess health care systems and policies

AHRO
Agency for Healthcare Research and Quality—researches treatment effectiveness and real world costs

DRUGMAKERS
The pharmaceutical industry

DEVICE MAKERS
The companies that make implantable medical devices, etc.

EQUIPMENT MANUFACTURERS
The companies that make scanners, etc.

PHARMACISTS
Pharmaceutical Benefits Managers—intermediaries that buy drugs at a discount

PBM
Pharmacy Benefit Managers

LONG-TERM CARE INSURANCE
Insurance for long-term care not covered by regular insurance

FDA
Food and Drug Administration

INTERNAL REVENUE SERVICE
Tax collection agency for the federal government

INDEPENDENT PRACTICE ASSOCIATIONS
Large networks of physicians that contract with insurers, sometimes through capitation

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Tax collection agency for the federal government
Healthcare Reform Drivers

- **Rising healthcare costs**
  - U.S. spends ~ $7,000/person*
  - Premiums rising faster than wages
- **Inferior quality of care**
  - WHO ranked U.S. 37th worldwide
  - Adults get half of recommended care
- **Access**
  - 46 million uninsured**
- **Irrational payment incentives**
  - Rewards volume of care, not quality
- **Economic downturn**
  - Less profit/employment → less coverage
  - Greater sensitivity to costs

**Source: Kaiser Family Foundation Commission on Medicaid and the Uninsured: [http://www.kff.org/uninsured/profile.cfm](http://www.kff.org/uninsured/profile.cfm)
Among 284 million people under age 65

Uninsured Demographics

Total Uninsured: 54 M

Source: Kaiser Commission on the Uninsured, “KFF the Uninsured a Primer”, Supplemental Data Tables, December 2010
Health Care Reform by the Numbers

- Reduce Number of Uninsured by 32 M (from 54 M to 22 M)
  - Estimated to increase the percentage of insured from 83% to 94% in the U.S.
- 16 M new enrollees into Medicaid
- 24 M in to Exchanges
- (3 M) net reduction in employer based coverage
  - 7 M newly covered (mandate)
  - (9 M) would lose coverage from Firms eliminating coverage
  - (1–2 M) Obtain coverage from exchange
- (5 M) decline in individual non group coverage; most will move to exchanges

Source: Congressional Budget Office (CBO), Selected CBO Publications Related to Health Care Legislation, “Estimated effects of the insurance coverage provisions of the Reconciliation Proposal (PPACA) combined with H.R. 3590”, Table 4, December 2010
Health Care Reform Evolution from 2010-2017

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Small business tax credit</td>
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<tr>
<td>Early retiree reinsurance program</td>
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<td>Pre-existing condition insurance plan</td>
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<td>Young adults up to age 26 on parents’ insurance plan</td>
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<tr>
<td>• Prohibition against lifetime insurance caps and recissions</td>
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<tr>
<td>• Preventive service coverage without cost-sharing</td>
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<tr>
<td>States adopt exchange legislation</td>
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<td>Annual review of premium increases</td>
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<tr>
<td>Public reporting by insurers on share of premiums spent on medical costs</td>
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<tr>
<td>Insurers must spend at least 85% of premiums (large group) or 80% (small group/individual) on medical costs or provide rebates to enrollees</td>
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<td>Exchanges begin certifying qualified health plans</td>
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<td>HHS Certifies exchanges</td>
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<td>Exchange open enrollment begins</td>
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<td>Medicaid expansion</td>
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<tr>
<td>Insurance market reforms including no rating on health</td>
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<tr>
<td>Essential benefits standard</td>
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<td>Premium and cost-sharing credits for exchange plans</td>
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<td>Premium increases a criterion for carrier exchange participation</td>
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<tr>
<td>Individual requirement to have insurance</td>
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<tr>
<td>Employer shared responsibility payments</td>
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<tr>
<td>Option for state waiver to design alternative coverage programs</td>
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</tr>
</tbody>
</table>
# Impact to Top 15 States Enrollment is Significant

<table>
<thead>
<tr>
<th>State</th>
<th>Baseline (Current) Medicaid Enrollment*</th>
<th>Total New Medicaid Enrollees*</th>
<th>Total Exchange Population 139–400% FPL**</th>
<th>Total All New Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>9.986</td>
<td>2.009</td>
<td>4.283</td>
<td>6.291</td>
</tr>
<tr>
<td>Texas</td>
<td>3.955</td>
<td>1.798</td>
<td>3.822</td>
<td>5.620</td>
</tr>
<tr>
<td>Florida</td>
<td>2.742</td>
<td>0.952</td>
<td>2.456</td>
<td>3.407</td>
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<tr>
<td>Ohio</td>
<td>2.089</td>
<td>0.667</td>
<td>0.699</td>
<td>1.366</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1.658</td>
<td>0.633</td>
<td>0.790</td>
<td>1.423</td>
</tr>
<tr>
<td>Illinois</td>
<td>2.449</td>
<td>0.631</td>
<td>0.952</td>
<td>1.583</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>2.219</td>
<td>0.482</td>
<td>0.664</td>
<td>1.146</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1.026</td>
<td>0.390</td>
<td>0.708</td>
<td>1.098</td>
</tr>
<tr>
<td>Kentucky</td>
<td>0.881</td>
<td>0.329</td>
<td>0.304</td>
<td>0.633</td>
</tr>
<tr>
<td>New York</td>
<td>5.137</td>
<td>0.306</td>
<td>2.025</td>
<td>2.331</td>
</tr>
<tr>
<td>Washington</td>
<td>1.176</td>
<td>0.296</td>
<td>0.447</td>
<td>0.743</td>
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<tr>
<td>Wisconsin</td>
<td>0.988</td>
<td>0.206</td>
<td>0.270</td>
<td>0.476</td>
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<tr>
<td>Connecticut</td>
<td>0.567</td>
<td>0.114</td>
<td>0.207</td>
<td>0.321</td>
</tr>
<tr>
<td>Arizona</td>
<td>1.364</td>
<td>0.105</td>
<td>1.019</td>
<td>1.125</td>
</tr>
<tr>
<td>Massachusetts**</td>
<td>1.465</td>
<td>0.030</td>
<td>0.234</td>
<td>0.264</td>
</tr>
<tr>
<td>Total</td>
<td>37.702</td>
<td>8.949</td>
<td>18.879</td>
<td>27.828</td>
</tr>
</tbody>
</table>

*Numbers Presented in Millions

*Source: Kaiser Commission on Medicaid and the Uninsured; Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults At or Below 133% FPL, Table 7

**Source: Artia Solutions – Projected Exchange Population by State; Applied state estimates of the uninsured below 400% FPL (Kaiser Commission on Medicaid and the Uninsured – The Uninsured A Primer – October 2010 Supplemental Data Tables, Table 22), less projected new Medicaid enrollees
# Health Care Reform by the numbers

**MEDICAID EXPANSION POPULATION CHARACTERISTICS BY AGE & ETHNICITY**

<table>
<thead>
<tr>
<th>Age</th>
<th>Medicaid Total Race / Ethnicity</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Asian/ S. Pacific</th>
<th>Indian / Alaska Native</th>
<th>Two or More Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–18</td>
<td>2.70</td>
<td>1.21</td>
<td>0.43</td>
<td>0.88</td>
<td>0.12</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>19–25</td>
<td>3.25</td>
<td>1.46</td>
<td>0.51</td>
<td>1.06</td>
<td>0.15</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>26–34</td>
<td>3.41</td>
<td>1.53</td>
<td>0.54</td>
<td>1.11</td>
<td>0.15</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>35–44</td>
<td>2.80</td>
<td>1.25</td>
<td>0.44</td>
<td>0.92</td>
<td>0.13</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>45–54</td>
<td>2.40</td>
<td>1.08</td>
<td>0.38</td>
<td>0.79</td>
<td>0.11</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>55–64</td>
<td>1.44</td>
<td>0.65</td>
<td>0.23</td>
<td>0.47</td>
<td>0.07</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Total</td>
<td>16.00</td>
<td>7.17</td>
<td>2.53</td>
<td>5.23</td>
<td>0.73</td>
<td>0.19</td>
<td>0.19</td>
</tr>
</tbody>
</table>

Numbers presented in Millions

Source: Calculations based on CBO estimate of Medicaid Expansion applied to Characteristics of Nonelderly Uninsured under 400% FPL (The Uninsured, A Primer, Supplemental Data Tables, December 2010 Kaiser Family Foundation)
### Health Care Reform By The Numbers

**HEALTH CARE EXCHANGE POPULATION CHARACTERISTICS**

**AGE & ETHNICITY**

**Numbers presented in Millions**

Source: Calculations based on CBO estimate of Medicaid Expansion applied to Characteristics of Nonelderly Uninsured under 400% FPL ([The Uninsured: A Primer, Supplemental Data Tables, December 2010 Kaiser Family Foundation](#))

<table>
<thead>
<tr>
<th>Age</th>
<th>Health Exchange Total Race / Ethnicity</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Asian/S. Pacific</th>
<th>Indian / Alaska Native</th>
<th>Two or More Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–18</td>
<td>4.90</td>
<td>2.20</td>
<td>0.77</td>
<td>1.60</td>
<td>0.22</td>
<td>0.05</td>
<td>0.05</td>
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<tr>
<td>19–25</td>
<td>5.89</td>
<td>2.64</td>
<td>0.93</td>
<td>1.93</td>
<td>0.27</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td>26–34</td>
<td>6.12</td>
<td>2.77</td>
<td>0.98</td>
<td>2.02</td>
<td>0.28</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td>35–44</td>
<td>5.08</td>
<td>2.27</td>
<td>0.80</td>
<td>1.66</td>
<td>0.23</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>45–54</td>
<td>4.35</td>
<td>1.95</td>
<td>0.69</td>
<td>1.42</td>
<td>0.20</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>55–64</td>
<td>2.61</td>
<td>1.17</td>
<td>0.41</td>
<td>0.85</td>
<td>0.12</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>Total</td>
<td>29.00</td>
<td>12.99</td>
<td>4.58</td>
<td>9.48</td>
<td>1.31</td>
<td>0.32</td>
<td>0.32</td>
</tr>
</tbody>
</table>
The New System

DIAGRAM OF NEW HEALTHCARE SYSTEM
Impact on Medicaid:

- **Medicaid will be a HEALTH INSURANCE OPTION**
  - No longer a safety net system
- Enrollment in standard benefit expansion (0–133% FPL) increases from 36 million to 52 million
- Enrollment resulting from expansion and participation as a subsidy option in an Exchange has the potential to be from 52 to 76 million
- State Medicaid programs collectively becomes the nation’s largest insurance option, covering 25% of the total population

*FPL = Federal Poverty Limit, 133% of FPL = 133% of poverty is $29,726
Health Exchange Overview
Goals
What exchanges hope to accomplish

- Offer competition and choice
- Drive down costs by creating competition between insurance companies
- Allow the same purchasing power as larger firms and will give consumers a choice of plans
Health Benefit Exchanges will Expand Coverage Beyond Historical Medicaid FFS

- Definition: A conduit for government subsidized health care for individuals ranging from 0–400% of poverty level

- 4 Functions – Establish single integrated process
  1. Determine Consumer Eligibility
  2. Facilitate Enrollment Into Coverage
  3. Health Plan Enrollment
  4. Benefit Package Design
# Health Benefit Exchanges have Essential Benefit Provisions

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Essential Benefits</th>
<th>Minimum Benchmark</th>
<th>Standard Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lab and x-ray</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Inpatient &amp; Outpatient Hospital</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pediatric Services incl. oral and vision</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rehabilitative and habilitative</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>EPSDT</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Non-emergency Transportation</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Essential Community Providers</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Services</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Home Health Services</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Source: Robert Wood Johnson Foundation
States Progress on Exchange Legislation
AS OF DECEMBER 2011

Massachusetts and Utah passed laws prior to the enactment of the Affordable Care Act in March 2010

Source: National Conference of State Legislatures, Federal Health Reform: State Legislative Tracking Database.
Starting in 2014, individuals and small businesses will...

- Have access to insurance choices similar to Members of Congress
- Compare health plans, get answers to questions, and secure health insurance
- Have the ability to access information regarding eligibility for advance payments of premium tax credits and cost sharing reductions or health programs
- Become eligible for a tax credit for coverage purchased for employees through the Exchange

State Exchanges Proposed Rules

<table>
<thead>
<tr>
<th>Date:</th>
<th>July 11, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rules:</td>
<td>requirements for implementing insurance exchanges, and the second regulation outlines HHS’ approach to the risk adjustment and reinsurance provisions that will be applied in exchanges.</td>
</tr>
<tr>
<td>Comment Deadline:</td>
<td>The initial comment period was set to close on September 28, 2011 however due to stakeholder feedback, the date was extended to October 31, 2011.</td>
</tr>
</tbody>
</table>
Areas Addressed by Exchange Rule
STANDARDS FOR FOUR ACTIVITIES PROPOSED

The proposal offers a framework to assist States in setting up Affordable Insurance Exchanges and gives States significant flexibility to build an Exchange that works for them.

Standards for four key activities are proposed:

<table>
<thead>
<tr>
<th>ONE</th>
<th>TWO</th>
<th>THREE</th>
<th>FOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>States that elect to establish and operate an Exchange</td>
<td>Health insurance plans to participate in an Exchange</td>
<td>Enrollment in health plans through Exchanges</td>
<td>Employers who opt to participate in the Small Business Health Options Program (SHOP)</td>
</tr>
</tbody>
</table>
Establishing Exchanges
Exchange Functions

Exchanges will perform a variety of functions such as:

- Certify health plans as Qualified Health Plans (QHPs) to be offered in the Exchange
- Operate a website to facilitate comparisons among qualified health plans for consumers
- Operate a toll-free hotline for consumer support, provide grant funding to entities for consumer assistance, called “Navigators”, and conduct outreach and education to consumers regarding Exchanges
- Facilitate enrollment of consumers in Exchange-qualified health plans

The Details /

- Exchange plans must be approved by HHS by January 1, 2013
- The proposed rule allows for conditional approval if the State is advanced in its preparation but cannot demonstrate complete readiness by the January 1, 2013 date
- The proposed rule also allows States that are not ready for 2014 to apply to operate the Exchange for 2015 or any subsequent year
HHS established state requirements as broadly as legally possible under the statutory language permitting a variety of exchange structures ranging from highly-regulated models to free market approaches.

“States have substantial flexibility in determining how to perform these functions and the regulation affords states considerable flexibility to implement exchanges as they see fit.”
Governance Board
- Governing bodies may be housed within government agencies or as freestanding non-profit entities (or a combination of both)
- At least half of the board must represent consumer interests (insurers, brokers, and agents may not make up a majority of representation in any state)
- The exchange must regularly consult with key stakeholders—including plans, providers, and employers

Open Enrollment
- Exchanges must have fixed, annual open enrollment periods with special enrollment periods for particular circumstances
- Initial open enrollment period will run from October 1, 2013 through February 28, 2014
  - In subsequent years, annual enrollment periods will run from October 15 through December 7 of each year
- Special enrollment periods will be granted for a variety of circumstances, including changes in dependent status or loss of minimum essential health coverage.
- Special enrollment periods permitting benefit tier changes will be granted for individuals who have a change in eligibility for premium or cost-sharing subsidies
Plan Bidding
- States have discretion conduct bidding according to 3 models:
- An active purchaser approach, competitive bidding approach (like in Medicaid managed care), or an “any-willing health plan” approach when considering contracting strategies.

SHOP Exchange
- The SHOP exchanges for small businesses may operate independently from the individual exchange or may be merged
- States must permit employee choice, whereby employers select a benefit tier and employees may choose any plan within that tier.
- Employers may elect to limit employees to just a single plan or permit employees to select plans from multiple benefit tiers.
- SHOP exchanges will permit rolling enrollment throughout the year.

Network Adequacy
- The regulation stipulates that all qualified health plans must have a network that ensures sufficient choice of providers for enrollees, including safety-net providers.
Qualified Health Plans
Qualified Health Plans
ONLY QHPs CAN PARTICIPATE IN EXCHANGES

Health plans offered through the Exchange must be certified as Qualified Health Plans (QHPs). Exchanges have flexibility in many domains:

Health Plan Choices

- Exchanges are allowed to work with local health insurers on structuring qualified health plan choices that are in the best interest of their enrollees.
- Exchanges flexibility on accreditation deadlines, allowing new and innovative health plans to sell through the Exchange as they gain accreditation.

Standards for Health Plans:

- Exchanges may set the standards to ensure that consumers have a choice of health care providers within each qualified health plan.
- Marketing standards would be set by States and Exchanges in the proposed rule allowing health plans to align their Exchange marketing with other commercial practices in a State.

Stabilizing Premiums:

- ACA established three risk-mitigation programs to offset market uncertainty and risk selection to maintain the viability of Exchanges: temporary reinsurance and risk corridor programs, and a permanent risk adjustment program.
- The proposed rule on premium stabilization offers States options in designing and administering these programs.
Enrollment
**Continuity in Eligibility & Enrollment**

<table>
<thead>
<tr>
<th>Function</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application enters exchange</td>
<td>Data sharing for the purposes of determining eligibility for additional benefits.</td>
</tr>
<tr>
<td>Data collected to support application (i.e., citizenship, residency, income)</td>
<td>Social Services</td>
</tr>
<tr>
<td>System screens based on data and determines subsidy level</td>
<td>Health Benefit Exchange</td>
</tr>
<tr>
<td>Consumer is notified of his/her subsidy level</td>
<td>Health Benefit Exchange</td>
</tr>
<tr>
<td>Based on subsidy level, consumer is directed towards a selection of plans</td>
<td>Health Benefit Exchange</td>
</tr>
</tbody>
</table>

- **if Medicaid/CHIP, consumer is further directed**
  - Medicaid / CHIP Fee for Service
  - Medicaid Managed Care PCCM
  - CHIP Managed Care

- **Consumer chooses plan**
- **Consumer is notified that selection has been received**

- **Selected health plan receives enrollment data**
  - Notice to Consumer
  - Notice to Consumer
  - Notice and Data Transmission To Health Plan

- **Consumer is enrolled and coverage is activated**
### Subsidized Health Insurance Under the Affordable Care Act

<table>
<thead>
<tr>
<th>Federal poverty level</th>
<th>Income for a family of four</th>
<th>Premium tax credit cap as a share of income</th>
<th>Average cost-sharing as share of medical costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;133%</td>
<td>&lt;$29,726</td>
<td>Medicaid</td>
<td>Medicaid</td>
</tr>
<tr>
<td>133%–149%</td>
<td>$29,726–$33,525</td>
<td>3.0%–4.0%</td>
<td>6%</td>
</tr>
<tr>
<td>150%–199%</td>
<td>$33,525–$44,700</td>
<td>4.0%–6.3%</td>
<td>13%</td>
</tr>
<tr>
<td>200%–249%</td>
<td>$44,700–$55,875</td>
<td>6.3%–8.05%</td>
<td>27%</td>
</tr>
<tr>
<td>250%–299%</td>
<td>$55,875–$67,050</td>
<td>8.05%–9.5%</td>
<td>30%</td>
</tr>
<tr>
<td>300%–399%</td>
<td>$67,050–$89,400</td>
<td>9.5%</td>
<td>30%</td>
</tr>
<tr>
<td>&gt;400%</td>
<td>≥$89,400</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

### Four levels of cost-sharing

1. **1st tier** (Bronze) actuarial value: 60%
2. **2nd tier** (Silver) actuarial value: 70%
3. **3rd tier** (Gold) actuarial value: 80%
4. **4th tier** (Platinum) actuarial value: 90%

### Annual OOP limits (individual/family)

- 100%–200% FPL: 1/3 HSA limit, $1,983/$3,967
- 200%–300% FPL: 1/2 HSA limit, $2,975/$5,950
- 300%–400% FPL: 2/3 HSA limit, $3,967/$7,933

### Note

- FPL: Federal Poverty Level; OOP: out-of-pocket costs; Actuarial values are average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan.