

Medicaid Options Community Workgroup

Personal Wellness & Responsibility

Background

- Section 1332 of the Affordable Care Act (ACA)
 - Allows states to propose alternative ways of covering their population with the Secretary's approval
 - State proposals must provide equivalent coverage to the same populations with no added expense to the federal government

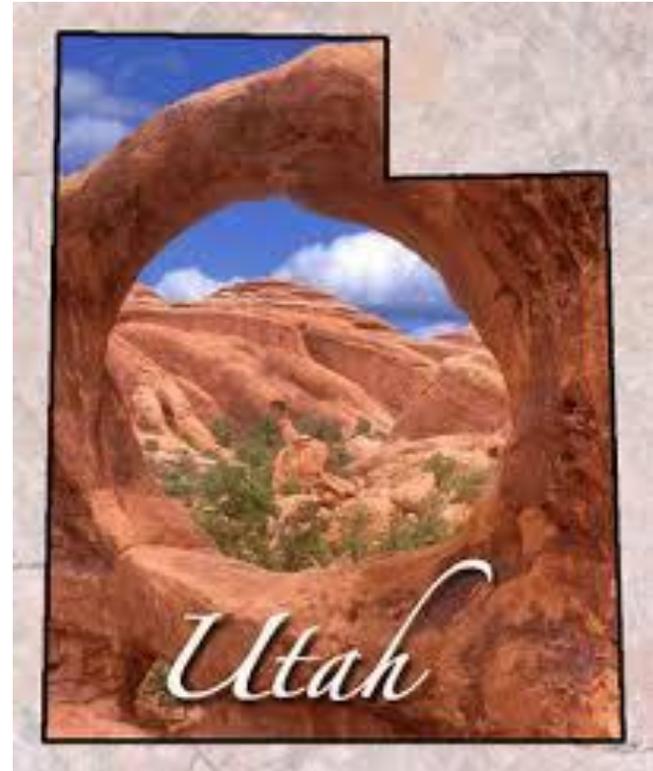
Opportunities

- CMS has approved consumer-driven, cost-sharing models of coverage for the uninsured in 6 states
- Indiana's unique patient engagement program has proven:
 - Low-income uninsured are:
 - grateful to have health insurance coverage
 - willing to contribute to their health insurance coverage
 - making efficient health care choices with appropriate incentives
 - Results in positive utilization and quality outcomes through a new model of patient engagement and value-based purchasing

Create a distinctively Utah approach to providing medical assistance for low-income individuals and families

Who Would Be Covered

- Coverage is for low-income families and individuals
 - Defined as below 100% or 138% Federal poverty level (FPL)
 - The choice of cut-off would affect the level of federal funding available.
- Increase access through some form of coverage and eliminate the coverage gaps that exist in current law



Principles

The Family is the Unit

- Treat families as a unit with interrelated needs and resources

Private Insurance Model

- Capitalize on the private sector's ability to create high-value solutions

Aligned Incentives

- Reintroduce incentives for families to seek better jobs and earn higher incomes; create a Bridge to Self Sufficiency

Patient Engagement

- Give patients a vested interest in seeking better value in the health care system

Program Framework

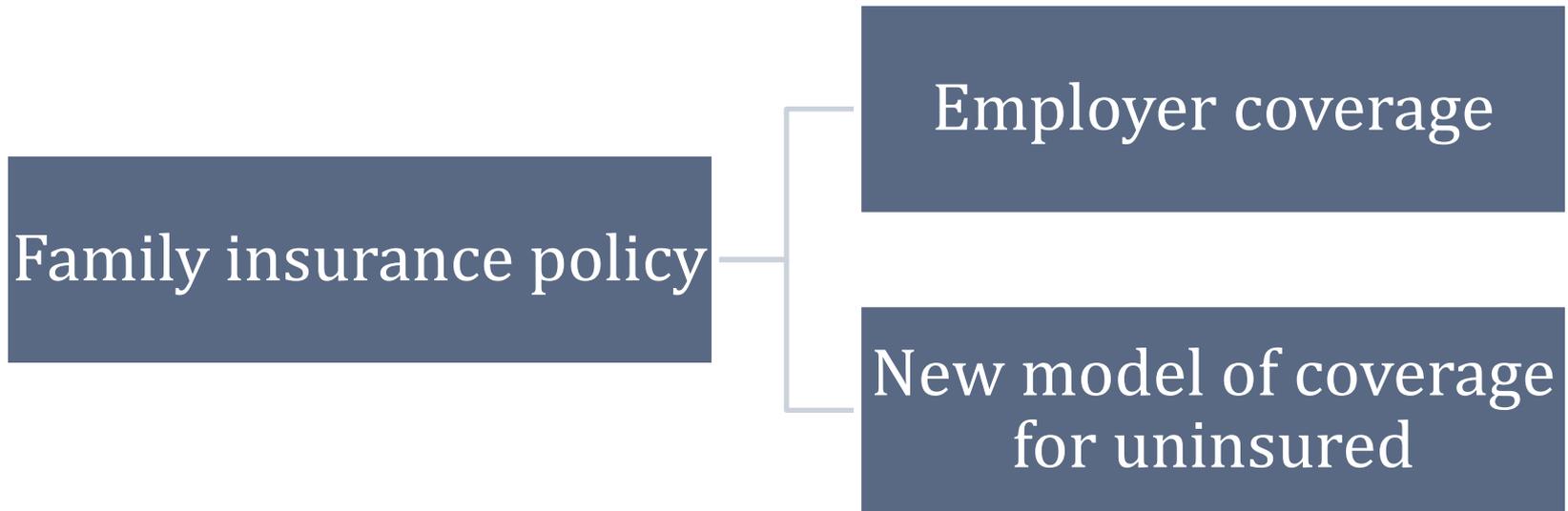
Premium Assistance

Support the purchase of family-based private coverage for low-income families and individuals where available

New Model of Coverage: Patient Engagement

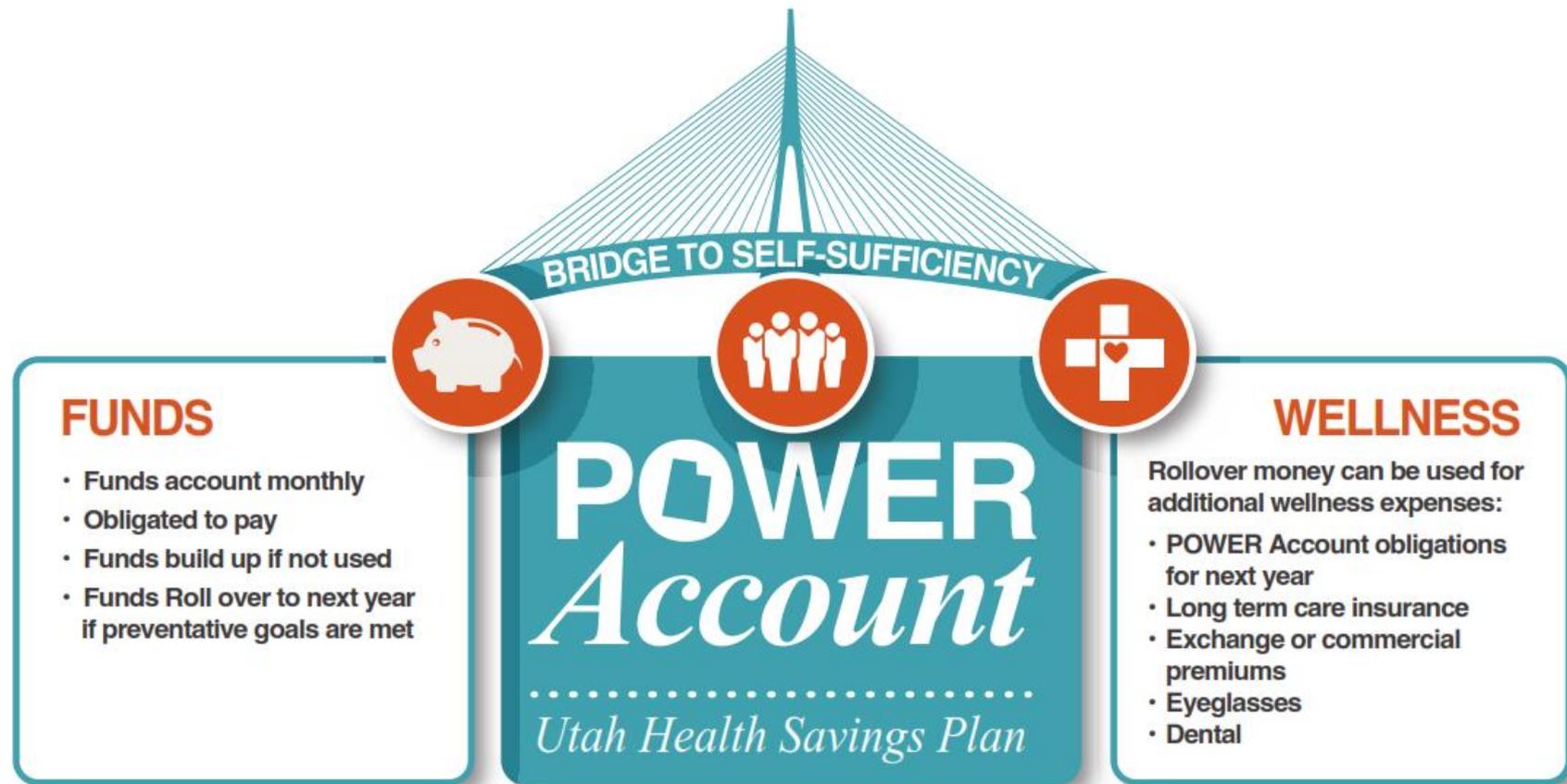
Create account where both member and public contributions combine to align incentives for cost-sensitive coverage to low-income families and individuals

Family Insurance Policy Options



The family is the unit

New Model of Coverage for Uninsured



Personal, Ownership, Wellness, Equity, Responsibility

The Proof is in the Numbers: Results from the Healthy Indiana Plan

Appropriate Utilization

- 14.8% decline in non-emergent ER use (2012)
- 25% increase in physician office visits (2012)
- 72% of members indicated they had not made a trip to the ER in the past six months (2013)
- 84.5% of enrollees had a routine check-up within the last year (2013 survey)
- 67% said since enrolling in HIP they are more likely to seek treatment when needed

Personal Responsibility

- Over 90% continue to make their required POWER account contributions on-time during enrollment in the program
- 92% of enrollees submitted all required materials for redetermination (2013)
- 82% who are not currently required to contribute to their POWER Account indicated that they would be willing to pay \$5 per month for HIP coverage and 75% indicated they would be willing to pay \$10 per month.
- Only 3% of members left HIP because they failed to pay their monthly contributions

Satisfaction*

- 96% of members surveyed were either somewhat or very satisfied with their overall experience with HIP
- 98% of members surveyed would reenroll in HIP

Challenges

- Major change to current program
- Need to carefully evaluate potential effect on program costs
- Program may or may not fit with CMS goals and objectives
- May not be appropriate for all low-income populations (disabled, institutionalized, dual-eligibles, etc.)

Cost and Source of Payment

Under Section 1332, the state can propose an alternate model for covering its citizens as long as it doesn't increase the federal deficit



State request for federal appropriation, equivalent to what the federal government would pay if Utah fully implemented ACA's requirements



Without fully implemented ACA requirements, likely need for additional state appropriations to fully fund the program



Levels of funds depend critically on program specifics, but plausible that current level of state funding could be adequate for the near term

Subgroup Participants

- Michael Hales, Utah Department of Health
- State Representative Ronda Menlove
- Greg Poulsen, Intermountain Healthcare
- Chad Westover, Molina Healthcare