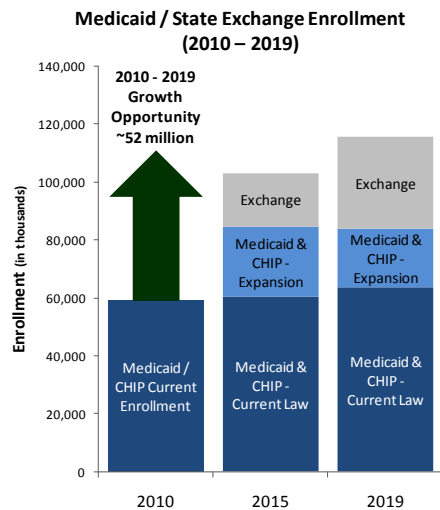




The Patient Protection and Affordable Care Act (PPACA) includes several broad-reaching provisions that will rapidly expand coverage to the low income population, as well as alter the delivery model. The legislation will expand Medicaid eligibility and create government subsidized insurance Exchanges resulting in an enrollment **increase of 52 million by 2019**.¹ The demographics of the low income population will place an increased emphasis on the key competencies required to serve the Medicaid and Government Subsidy markets.

With PPACA reducing employer coverage by 1 million by 2019, commercial health plans will likely turn to the Exchange to offset this decline and grow membership.¹ Meanwhile, the Exchange will present an opportunity for plans with Medicaid experience to expand their service offering beyond traditional Medicaid products. The Exchange market will be a strategic growth opportunity for those plans that have proven capabilities for serving the low income population. Additionally, plans that can manage the greater utilization of health care services by these newly covered individuals will have a strategic advantage.



Summary of Key Provisions

Given the current financial hurdles facing states, the impact of coverage expansion will further complicate state budget issues. Recent estimates project that the state share of Medicaid expenditures (from the newly eligibles) will exceed \$24 billion.² The low income population will be a key growth area for health plans as programs are expanded and states look to managed care to control costs. While traditional Medicaid and CHIP will still remain the primary coverage method, the legislation establishes alternative methods to serve the low income population. The following table summarizes the key legislative provisions:

Provision	Summary
Coverage Expansion	<ul style="list-style-type: none"> Effective January 2014, state Medicaid / CHIP programs will be federally mandated to provide coverage to all non-elderly adults and children with incomes up to 133 percent of the Federal Poverty Level (FPL).
Basic Health Program	<ul style="list-style-type: none"> Effective January 2014, states will be able to negotiate with health plans to provide coverage to those not eligible for Medicaid with income between 134 and 200 percent of the FPL. Program will be funded through a combination of federal premium and cost-sharing subsidies.
State-based Health Exchanges	<ul style="list-style-type: none"> Effective January 2014, individuals and families without health coverage who are not eligible for public programs (and <400 FPL) will be able to purchase insurance through state-based Exchanges.
New Programs	<ul style="list-style-type: none"> Effective January 2011, provides states with a new Medicaid state plan option to permit Medicaid enrollees with multiple chronic conditions to designate a provider as a health home. Effective October 2010, provides states with new option to offer home and community-based services through a Medicaid state plan.
Medicaid Rebate Changes	<ul style="list-style-type: none"> Medicaid managed care pharmacy programs are now eligible to receive drug rebate. Prescription drug rebates were previously restricted to Medicaid fee-for-service (FFS) programs. 100% of rebates between 15.1% and 23.1% are remitted to Federal Government not the State.

Overall Impact

Below are some macro level examples of the impact health care reform will have on the Medicaid and Government Subsidy markets:

- As a result of significant enrollment growth, **more states will likely move toward managed care.** While finalizing the 2010-11 budget, Florida discussed a major reform proposal that would have shifted nearly all Medicaid enrollees into managed care plans. This proposal will be reexamined in the 2011-12 budget cycle.
- **States will shift beneficiaries over 133% FPL to the Exchange** due to federal subsidies. CMS' Office of the Actuary estimates that 79 percent of the estimated 25 million exchange enrollees will receive Federal premium subsidies. In Wisconsin, officials have stated that by 2014, they will likely shift BadgerCare members with higher incomes (>133% FPL) into the Exchange.
- **Medicaid plans will have opportunity to enter the subsidized Exchange market.** For example, Centene's 2008 acquisition of the Celtic Group provided a product to compete in the Massachusetts Health Connector. CeltiCare is the lowest-cost health plan option for low income working adults (<300% FPL) enrolled in the Commonwealth Care program.
- Increased enrollment will put **added pressure on access to care** for low income populations. Currently only 40% of physicians accept all new Medicaid patients and 28% accept no new Medicaid patients.³ As highlighted by the Office of the Actuary, this could lead to price increases, cost-shifting, and/or changes in provider willingness to treat patients with low-reimbursement health coverage.¹
- **Newly eligible adults are likely to have a pent-up demand** for health care services and will have a higher risk profile. Of the additional 34 million people gaining coverage by 2019, 18 million will receive coverage from Medicaid due to the expansion of eligibility to 133 percent of FPL.¹ Effectively managing the costs of this population will present challenges for plans, especially those with limited Medicaid experience.
- **Contraction of the small group market** could increase enrollment in the Exchange and Medicaid beyond current projections. Smaller employers with low average salaries will likely terminate their existing coverage, which would allow their employees to qualify for subsidized coverage through the Exchanges.¹

HealthScape Insight:

Commercial plans will compete with Medicaid plans in the subsidized Exchange market

Additionally, other states have begun to respond budget pressures and health care reform:

- In the state of Washington, officials have suggested enrolling the newly eligible into its existing program, Basic Health Plan, which will receive federal subsidies.
- Hawaii moved its Aged, Blind, and Disabled (ABD) population into mandatory managed care plans in 2009. Ohio also mandates that the ABD population enrolls with managed care plans. Finally, Illinois recently held an RFP to enroll an estimated 38,000 ABD beneficiaries into managed care.

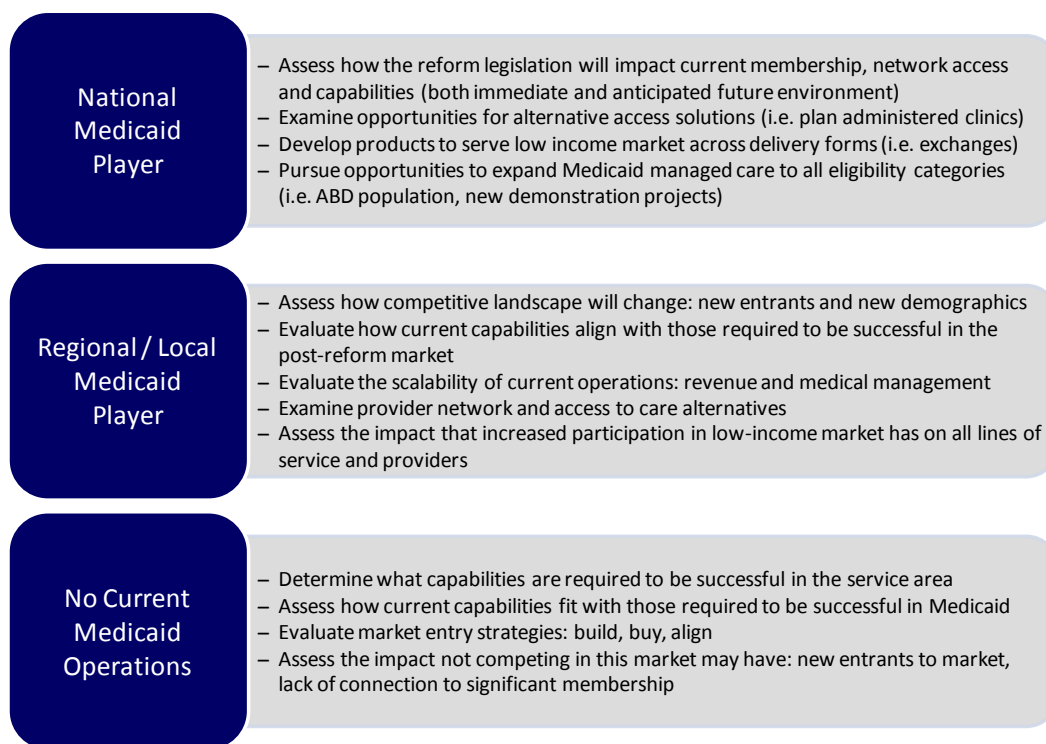
Medicaid & Government Subsidy Market Demographics

As health plans assess how these macro level trends affect their organization, it is important that they understand the demographics of the Medicaid and Government Subsidy markets. Health plans commercial competencies are vastly different from the capabilities required to be successful in Medicaid. The Medicaid population is characterized as transitory, less healthy and less educated. They also have limited access to transportation, unmet basic needs, show a higher rate of at risk pregnancies and lack financial incentives to reduce medical costs. The most challenging characteristic is the short

duration members are actually enrolled with Medicaid managed care plans. Furthermore, even within the Medicaid eligibility categories there is a hierarchy of complexity, as the ABD population accounts for over 70% of Medicaid expenditures. All of these factors require a health plan to adopt unique Medicaid focused strategies for managing the health care needs of this population.

Medicaid & Government Subsidy Market Considerations

Medicaid is likely to emerge from reform as the second largest health coverage option behind commercial insurance. Both commercial health plans and Medicaid managed care organizations will compete for market share in the Exchange. With limited growth potential in the commercial business segment and a declining small group market, the cost of not participating in the Medicaid and Government Subsidy markets is significant. While the specific capabilities that are inherent to serving Medicaid eligibles will remain the same, understanding the demographic differences and successfully managing the risk profile of the newly eligibles will determine the winners and losers. Below is an overview of some of the important considerations that plans will be evaluating across the Medicaid and Government Subsidy markets:



The shifting competitive landscape will present many opportunities and risks; a clearly defined strategy and implementation plan will allow plans to successfully compete in this environment. HealthScape has significant experience applying our strategic execution framework to government programs. We have assisted our clients enter and compete in government programs including: Medicare, Medicaid, TriCare and FEP. We invite you to contact us if you have any questions or would like to discuss further.

John Steele jsteele@healthscapeadvisors.com or 312.256.8611
 Arjun Aggarwal aggarwal@healthscapeadvisors.com or 312.256.8613
 Casey Bartolucci cbartolucci@healthscapeadvisors.com or 312.256.8623

1 Office of the Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010.
 2 UnitedHealth, "Coverage for Consumers, Savings for States: Options for Modernizing Medicaid," April 2010.
 3 Center for Studying Health System Change, "Data Bulletin No. 35: Results from HSC Research," September 2009.