

Idaho's Newly Eligible Medicaid Population: *Benefit Package Requirements and Recommendation*

September 27, 2012

Estimates of the Newly Eligible

	Low Estimate	High Estimate
Newly Eligible	97,066	111,525
Currently Eligible	9,806	12,299
Total	106,872	123,824

Estimates of the Newly Eligible

Estimated Number of Newly Eligible by County, 2014							
Ada County	17,307	Butte County	207	Gem County	1,132	Minidoka County	1,193
Adams County	333	Camas County	69	Gooding County	909	Nez Perce County	2,088
Bannock County	5,759	Canyon County	14,618	Idaho County	1,190	Oneida County	302
Bear Lake County	405	Caribou County	347	Jefferson County	1,595	Owyhee County	788
Benewah County	632	Cassia County	1,417	Jerome County	1,386	Payette County	1,720
Bingham County	2,804	Clark County	43	Kootenai County	9,528	Power County	427
Blaine County	521	Clearwater County	558	Latah County	3,085	Shoshone County	835
Boise County	522	Custer County	333	Lemhi County	660	Teton County	672
Bonner County	3,020	Elmore County	2,181	Lewis County	248	Twin Falls County	4,885
Bonneville County	5,351	Franklin County	793	Lincoln County	320	Valley County	582
Boundary County	919	Fremont County	996	Madison County	3,736	Washington County	647
Idaho State: 97,066							

Note: Numbers may not sum to total due to rounding.

State Programs

Estimated Number of Participants that will be Newly Eligible for Medicaid by State Program	
State Program	Estimated Number of Participants
Idaho Catastrophic Health Care Cost Program (CAT or Medically Indigent Services)	6,000
Idaho Community Health Centers (CHC)	35,000
Idaho Adult Mental Health Services	4,300
Corrections	2,000

The Newly Eligible Population in Idaho

1. Consist of both a younger, relatively healthy population as well as an older population with chronic conditions
2. Suffer from both treatable chronic conditions as well as other serious chronic conditions
3. Have prevalent mental health issues
4. Have some pent-up need for care
5. Consist of a large childless adult population
6. Have income below 100% FPL (many of whom are employed)

State Experiences with Expanded Populations

- Utilization patterns and associated costs will depend on how long the population has been uninsured and how many have serious chronic conditions
- Overall health will depend on the level of participation in the Medicaid program
- Cost of covering the newly eligible population will be less than traditional Medicaid
- Pharmaceutical costs are generally higher than expected
- It will be necessary to consider the newly eligible's diverse health care needs when designing a benefit package

Benchmark Benefit Package Requirements

1. Meet rules set forth in the Deficit Reduction Act of 2005
2. Be equal to one of the three available benchmark plans or be HHS Secretary-approved coverage
3. Meet additional Medicaid requirements
4. Provide all Essential Health Benefits

Deficit Reduction Act of 2005

- Multiple benchmark benefit packages
- Exempt groups (cannot be mandatorily enrolled)
- Cost-Sharing:
 - For adults below 100% FPL, states cannot charge more than a nominal amount
 - Above 100% FPL, the amount of cost-sharing allowed increases as the enrollee's income increases
 - Certain groups are exempt: pregnant women, certain children, and individuals with special needs
 - Certain services are exempt: preventive care for children, emergency care, and family planning services

Benchmark Benefit Options

- The standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employee Health Benefits Plan (FEHBP)
- Any state employee plan generally available in the state
- The state HMO plan that has the largest commercial, non-Medicaid enrollment
- Secretary approved coverage (e.g., the state's traditional Medicaid benefit package)

Additional Medicaid Requirements

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

Essential Health Benefits

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

Benchmark Plan Comparison Criteria

1. Meet the population's basic needs
2. Maintain continuity of coverage
3. Adhere to known evidence-based guidelines
4. Optimize value and provide performance improvements
5. Maintain cost effectiveness
6. Adhere to statutory requirements

Benchmark Plan Comparison

- State HMO (BlueCross of Idaho HMO Blue Plan)
- State Employee Plan (BlueCross Traditional Plan for Idaho State Employees)
- Standard BlueCross BlueShield under the FEHBP
- Secretary Approved Coverage (Idaho's Basic Benchmark Plan)

Recommendation: Idaho's Basic Benchmark

- Has the framework needed to meet the essential health needs of the majority of the target population
- Includes benefits required under the DRA and PPACA
- Allows for administrative ease
- There already is an existing path to a more comprehensive plan (the Enhanced Benchmark plan) for those qualifying as disabled or medically frail
- Can be used in new delivery systems developed by the State, including in medical home and risk-based managed care models



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