
# Self-Selection of Managed Care Organizations

## An Ohio Department of Medicaid Study

Submitted March 31, 2016

**The Ohio Department of Medicaid**
John R. Kasich, Governor  John B. McCarthy, Director

## Introduction

In partnership with the Centers for Medicare & Medicaid Services (CMS), the Ohio Department of Medicaid (ODM) conducted a self-study to determine the feasibility of delaying Medicaid eligibility and enrollment until an individual self-selects a specific managed care plan (MCP). Additional research was completed by Milliman, Inc. to analyze the financial impact of delaying an individual's Medicaid coverage until the individual self-selects a MCP in which to enroll. The self-study and financial analysis was completed to meet requirements under Section 327.330 of the State of Ohio's Fiscal Year 2016-2017 budget.

## Federal Law and Regulations

Federal laws and regulations prohibit a state process used to defer eligibility in the Medicaid program until a consumer chooses a MCP. The Social Security Act requires "a state plan for Medicaid assistance must provide that all individuals wishing to make application for Medicaid assistance under the plan shall have the opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." *42 U.S.C. 1396(a)(8)*. Providing medical assistance is not related to when the state makes the determination or when the consumer enrolls in a MCP, but is related to the individual being eligible at application. *See 42 U.S.C. 1396(a)(10)(A)(i)*. For example, federal law requires the provision of up to three months of retroactive Medicaid coverage during a period prior to a consumer submitting a Medicaid application. *See 42 U.S.C. 1396(a)(34)*. In addition to the mandate that states provide Medicaid coverage when the consumer is eligible, states also must provide coverage even before application submission when appropriate. *Id.*

Federal regulations are specific regarding requirements that the state must provide Medicaid services promptly and without delay. The Code of Federal Regulations provides direction to the Medicaid agency by requiring the agency to "furnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures." *42 CFR 435.903(a)*. The requirement is not only that the eligibility effective date is immediate; but also, if the consumer was eligible at the time and received Medicaid services, eligibility is effective up to three months prior to the month of application. *See 42 CFR 435.915. See also 42 CFR 435.911(c)(1) for promptly furnishing Medicaid to each individual … in a Modified Adjusted Gross Income based category*. The federal government clearly indicated its mandate to provide Medicaid services quickly and without deferment.

## State Law and Regulations

Ohio Medicaid implemented a presumptive eligibility option years ago. *See Ohio Rev. Code 5163.02, Ohio Rev. Code 5163.10 and Ohio Rev. Code 5163.101*. Presumptive eligibility allows receipt of services by a consumer as a result of an initial, simplified determination of eligibility based on the consumer's self-declared statements. The purpose of presumptive eligibility is to provide immediate access to care and services based on an initial, simplified determination of eligibility for Medicaid coverage for consumers. *See Ohio Adm. Code 5160:1-1-62*. Delaying Medicaid coverage until a consumer selects a MCP conflicts with the intent and purpose of presumptive eligibility, as immediate access to care and services is also delayed.

## Financial Analysis

Financial analysis was completed by Milliman, Inc. to analyze the financial impact of delaying an individual's coverage until the individual self-selects an MCP to enroll. *See Self-Select Analysis, Milliman, March 11, 2016. Attached.*

On average, Milliman, Inc. estimated that the self-select provision would reduce enrollment in the Ohio Medicaid managed care program and result in some significant initial savings in the program (see report attached). Overall, it estimated that the provision would reduce enrollment by potentially 192,000 beneficiaries (a 7.9% reduction to 2016 Medicaid managed care enrollment) and a cost savings of up to $327.3 million (2.9% reduction). It was stressed, however, that actual savings may be significantly different depending on a number of different factors, including future behaviors of ODM beneficiaries.

The approach may result in higher per enrollee costs for the remaining Medicaid population. *Id.* These consequences are likely due to the type of individuals who would still self-select a MCP, those who have current or on-going health issues, and individuals less likely to self-select, those who have little to no claims history. *Id.*

Milliman, Inc. also indicated that several additional factors may affect the increase in self-selection rates. First, ODM would likely educate consumers regarding a mandatory self-selection procedure in order to gain or maintain Medicaid coverage. *Id.* Second, the Affordable Care Act may have helped individuals become accustomed to maintain or gain health coverage by taking action, rather than allowing such coverage to lapse or terminate due to a failure to act. *Id.* These factors indicate that individuals may be more likely to self-select a MCP than historical evidence indicates. *Id.*

## Conclusion

A delay in providing access and services to a consumer due to an administrative process of determining eligibility and requiring selection of a MCP violates the spirit and the letter of the laws and regulations surrounding the Medicaid program. *42 U.S.C. 1396(a)(8), 42 U.S.C. 1396(a)(10)(A)(i), 42 U.S.C. 1396(a)(34), 42 CFR 435.903(a), 42 CFR 435.915, 42 CFR 435.911(c)(1), Ohio Rev. Code 5163.02, Ohio Rev. Code 5163.10, Ohio Rev. Code 5163.101 and Ohio Adm. Code 5160:1-1-62.* The federal laws and regulations, as well as state laws and regulations, prohibit any delay in determining Medicaid eligibility until a MCP enrollment choice is made. *Id.* The financial analysis demonstrated that although a self-select provision may initially reduce enrollment in the Ohio Medicaid programs, it would result in higher per enrollee costs, self-selection would likely increase and the individuals enrolled would likely have current or ongoing health issues. It is reasonable to conclude that although there may be modest initial financial savings if Ohio delays an individual's Medicaid coverage until an individual self-selects a MCP, the results may not provide an actual savings.

Addendum

Milliman Client Report

# Self-Select Analysis

## Medicaid Managed Care Program

## Ohio Department of Medicaid

March 11, 2016

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# I. EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) was retained by the Ohio Department of Medicaid (ODM) to analyze the financial impact of delaying an individual's coverage under the Medicaid Managed Care (MMC) program until the individual self-selects a Managed Care Plan (MCP) to enroll (self-select provision). This analysis was completed to meet the requirements under Section 327.330 of Ohio's Fiscal Year 2016-17 budget. *An assessment of whether such a policy is permissible under federal law was outside the scope of our analysis.* Additionally, our analysis does not estimate any financial impact to entities other than ODM.

Figure 1 illustrates estimated savings and enrollment changes associated with ODM implementing the self-select provision for the MMC program. ***The values shown in Figure 1 should be presented as high level estimates for the self-select provision, as much uncertainty is associated with the outcomes of such a policy.*** On an aggregate basis, we estimate the self-select provision would reduce enrollment by 192,000 beneficiaries (a 7.9% reduction to estimated 2016 MMC enrollment), and a cost savings of $327.3 million (2.9% reduction). To the extent the self-select provision was implemented, actual savings may be significantly smaller or larger than the estimate provided in this report. Actual savings are dependent on the future behavior of ODM beneficiaries, which is certain to vary from the assumptions used in our analysis.

**Figure 1**
**Ohio Department of Medicaid**
**Estimated Savings from Implementation of Self-Select Provision**
**Values Based on CY 2016 Enrollment and Cost**

| Population | Enrollment (Average Monthly) | | | Annual Cost Per Enrollee | | | Aggregate ($ Millions) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Current Policy | Post Self-Select | % Change | Current Policy | Post Self-Select | % Change | Current Policy | Post Self-Select | % Change |
| CFC | 1,641,000 | 1,532,000 | (6.6%) | $ 3,219 | $ 3,368 | 4.6% | $ 5,283 | $ 5,160 | (2.3%) |
| ABD | 135,000 | 130,000 | (3.9%) | $ 15,597 | $ 16,013 | 2.7% | $ 2,106 | $ 2,082 | (1.1%) |
| Extension | 641,000 | 563,000 | (12.1%) | $ 6,345 | $ 6,903 | 8.8% | $ 4,067 | $ 3,886 | (4.4%) |
| **Composite** | **2,417,000** | **2,225,000** | **(7.9%)** | **$ 4,739** | **$ 5,001** | **5.5%** | **$ 11,455** | **$ 11,128** | **(2.9%)** |

Notes:
1. Values have been rounded.
2. Current Policy' values based on CY 2016 certification of MMC capitation rates.
3. For illustrative purposes, maternity costs have been included with the CFC population.

While the self-select provision is estimated to reduce enrollment in Ohio's Medicaid program, we believe it would result in higher per enrollee costs for the remaining population. We estimate the individuals least likely to enroll in the Medicaid program if MCP self-selection was required would generally be individuals with limited or no recent healthcare claims history. Individuals with known or on-going health issues would be more likely to self-select a MCP, even if a material number of these individuals are currently relying on the auto-enrollment or assignment process to be enrolled in Medicaid coverage. Therefore, estimated savings from the self-select provision do not directly correspond to the decrease in the number of individuals covered under the MMC program under this policy.

Additionally, it is realistic to expect that voluntary selection rates would increase from historical levels as consumers are educated on the need to actively select a health plan to maintain or gain Medicaid coverage. With Ohio implementing the Medicaid expansion, as well as available premium assistance in the individual insurance marketplace, consumers may be predisposed to maintaining health insurance coverage rather than allowing it to terminate or not begin for failing to self-select a MCP.

# II. METHODOLOGY

To perform our analysis of the estimated impact of the self-select provision, we reviewed the percentage of MMC beneficiaries currently self-selecting a MCP, as well as the percentage of members who had no paid claims expense during a 12 month period.

The distribution of new enrollment in an MCP by enrollment type was summarized for calendar year (CY) 2014. Members were assigned new enrollment status under three circumstances.

1. New enrollment was assigned if the prior month's enrollment was fee for service (FFS). This included those members who left a managed care program and returned to FFS, but ultimately re-enrolled in managed care (86% of new enrollment).
2. New enrollment was assigned if a member enrolled for the first time in a managed care program with no prior FFS enrollment. Those who lost eligibility for a month or more and returned to the managed care program were included under this logic (6% of new enrollment).
3. Members were assigned new enrollment if there was a change in MCP as this often resulted in a change of enrollment type (8% of new enrollment).

Following assignment of new enrollment status, members were classified by 'Start Reason Code' and assigned an enrollment type based on the value of the code. Members enrolled prior to CY 2014 were not assigned new enrollment and were excluded from our analysis. Figure 2 indicates that a relatively low percentage of members currently voluntarily select a MCP. However, we believe voluntary enrollment rates would increase significantly to the extent the self-select provision was implemented.

**Figure 2**
**Ohio Department of Medicaid**
**Summary of Initial Managed Care Enrollment (Calendar Year 2014)**
**Voluntary vs. Assignment Selection**

| Population | New Initial MCP Enrollment Months | Percent Voluntary | Percent ARE (Autoenrollment) | Percent ASG (Assignment) | Percent Other |
|---|---|---|---|---|---|
| CFC | 475,302 | 34.8% | 16.6% | 48.4% | 0.2% |
| ABD <21 | 11,359 | 29.4% | 17.9% | 52.3% | 0.5% |
| ABD 21+ | 30,445 | 40.9% | 22.0% | 36.3% | 0.8% |
| Extension | 433,025 | 48.9% | 2.3% | 48.8% | 0.0% |

Based on information provided to us from ODM, we assumed that the codes which indicate an assignment/auto-enrollment occurred are:

- ARE – Auto Enrollment
- ASG – Assignment Enrollment
- DUA – Medicaid Only Passive Enrollment

Additionally, we assumed that the codes which indicate that a selection was made by the member are:

- COP – Change of Plan for Medicaid Only Recipient
- MEO – Medicaid Only Voluntary Enrollment
- OAE – Opt-Out after MyCare Enrollment
- OOH – Opt-out of Medicare Identified Through Hotline – MyCare Ohio
- OOI – Opt-in to the Medicare Portion of MyCare
- VOL – Voluntary Enrollment

MMC beneficiary claims experience from CY 2014 was summarized for members with 10 or more months of MMC eligibility during the calendar year. Figure 3 illustrates the percentage of MMC beneficiaries by population that did not have any paid claims expense during CY 2014. In the event the self-select provision is implemented, we believe these individuals are most likely to fail to select a MCP and therefore would be excluded from Medicaid coverage.

| Figure 3<br>Ohio Department of Medicaid<br>Summary of MMC Beneficiaries without Claims Expense (CY 2014)<br>Members with 10 or Greater MMC Eligibility Months | |
|---|---|
| **Population** | **Percentage of Beneficiaries without Claims Expense** |
| CFC | 8.9% |
| ABD | 5.2% |
| Extension | 16.2% |
| Total | 9.2% |

For purposes of estimating the impact of the self-select provision, we have assumed that 50% of beneficiaries without claims expense would fail to select a MCP. For example, in the CFC population, 8.9% of beneficiaries did not have paid claims expenses during 2014. We assumed that 50% of these beneficiaries (or approximately 4.45% of total beneficiaries) will fail to select a MCP.

In addition to assuming 50% of beneficiaries without claims expense would not select a MCP, we also assumed a portion of the residual individuals (representing one-third of the total beneficiaries failing to select a MCP) would not actively select a MCP. We have assumed this additional group of individuals would have costs equivalent to the average costs in the MMC program for the respective population. We assumed that for capitation rates to maintain actuarial soundness, MMC rates would be adjusted appropriately to reflect the change in the underlying morbidity of the population.

# III. LIMITATIONS

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide a financial impact estimate of ODM implementing a requirement that beneficiaries self-select a MCP for entry into the Medicaid Care Program (MMC). The data and information presented may not be appropriate for any other purpose.

The information contained in this letter, including the enclosures, has been prepared for ODM and their consultants and advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODM by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the assumptions contained in this report.

In performing this analysis, we relied on data and information provided by ODM and participating Medicaid managed care plans. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The services provided by Milliman to ODM were performed under the signed contract agreement between Milliman and ODM dated June 11, 2015.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.