



CCRC
Actuaries, LLC

STATE OF WEST VIRGINIA



HEALTH INSURANCE MARKETPLACE

Medicaid Expansion Report

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Section I - Executive Summary

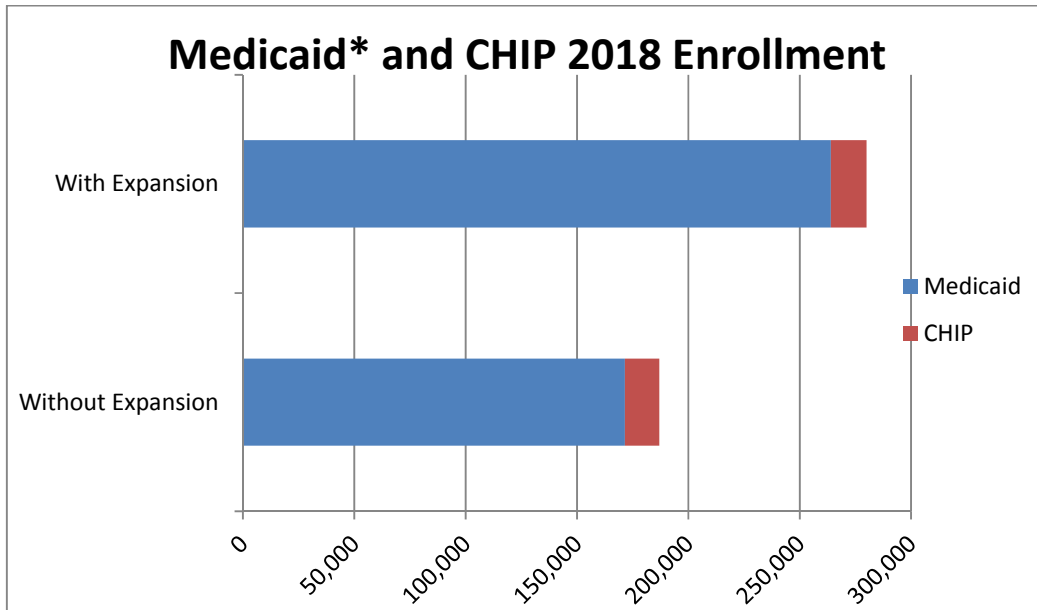
CCRC Actuaries, LLC (“CCRC Actuaries”) was engaged by The West Virginia Offices of the Insurance Commissioner (“WVOIC”) to perform various actuarial and economic analyses with regard to the West Virginia Health Marketplace (“The Marketplace”) as defined by the Affordable Care Act (“ACA”). The project team included CCRC Actuaries, Dr. Jonathan Gruber of Massachusetts Institute of Technology (“MIT”) who performed the economic analysis, and Mike Madalena who assisted in data management, manipulation and analysis.

The analysis in this report was performed to assist the WVOIC in determining the effect of the ACA on the public programs of Medicaid and the West Virginia Children’s Health Insurance Program (“WVCHIP”) and evaluate the projected population enrollment and financial impact of expanding Medicaid under the ACA. Estimates that include WVCHIP are based on the assumption that the program will be administered as it is now, without regard to further policy options available to WVCHIP under the ACA. The WVCHIP program and Medicaid program are administered separately in West Virginia. The Children’s Health Insurance Program Reauthorization Act (“CHIPRA”) funds WVCHIP through Federal Fiscal Year 2015, these projections assume that CHIPRA is extended.

The United States Supreme Court upheld most elements of the ACA in the summer of 2012. The recent Supreme Court decision has given states an uncertain amount of leeway in implementing the expansion of Medicaid under the ACA. As a result, it is important that states such as West Virginia understand the implications of the possible alternative policies they might pursue in this arena. At a minimum, this implies a comparison of (a) expanding Medicaid to 133% of the federal poverty level, as in the ACA; or (b) implementing no Medicaid expansion.

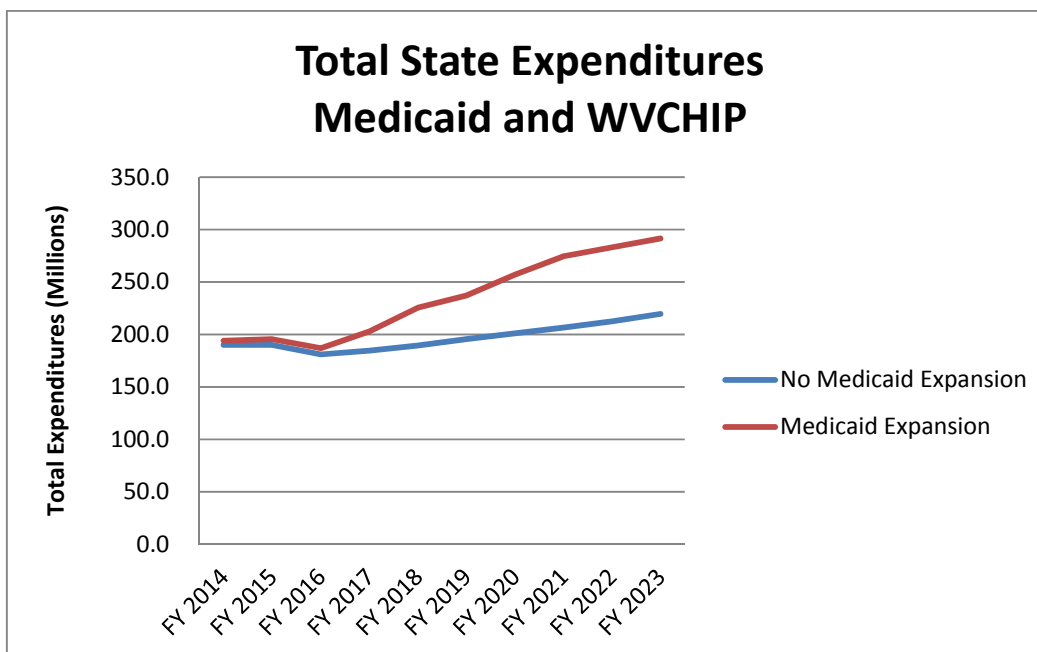
The project team utilized actuarial analyses and the Gruber Microsimulation Model (“GMSIM model”) to capture the implications of each of these options for West Virginia. GMSIM allows individuals to move across insurance types as Medicaid eligibility varies, so that when Medicaid eligibility is restricted or expanded we can assess how it impacts the distribution across private insurance and the uninsured. We have assessed the implications of these alternative policies for the State of West Virginia.

In total, 93,000 more West Virginia residents will be enrolled in Medicaid and the WVCHIP in 2018 if Medicaid is expanded under the ACA.



*Includes non-disabled individuals under age 65.

The annual cost of Medicaid and WVCHIP assuming the Medicaid expansion can be found in Table 4 on page 18. The annual cost of Medicaid and WVCHIP assuming no Medicaid expansion can be found in Table 8 on page 22. The federal government is picking up the majority of the cost of the expansion in the early years, resulting in a \$15.5 million dollar cost to the state for the combined Fiscal Years (“FY”) 2014 – 2016. After this period, the state share will increase with the expansion costing \$72.0 million by FY 2023. The combined state expenditures for FY 2017 – 2023 are projected to increase \$362.5 million. It is assumed that of those individuals who will ultimately participate in Medicaid through the expansion, 75% will participate in 2014 and 94% will participate in 2015.



Expanding Medicaid will result in decreased participation in the Marketplace. This decrease, in combination with the increased enrollment in Medicaid and WVCHIP, will result in a reduction in the projected uninsured by 45,000. In 2016, it is estimated there will be 121,000 uninsured in the State of West Virginia assuming no Medicaid expansion; as compared to only 76,000 uninsured assuming a Medicaid expansion. There is a corresponding reduction in The Marketplace participation to account for this difference.

The tables below document the movements across different insurance types due to the ACA. The rows show the population divided by their insurance status in 2016 in the absence of the ACA, while the columns show the population divided by their insurance status with the ACA. This first table shows the case where there is a Medicaid expansion.

For example, in the top panel the “Total” column shows that absent the ACA there would be 910,000 individuals in employer sponsored insurance, and that there would be 246,000 uninsured. Likewise, the “Total” row shows that after the ACA (with expansion) there will be 910,000 individuals in employer sponsored insurance, and 77,000 uninsured

Medicaid Expansion for 2016

Before ACA Insurance Status	After ACA Implementation Insurance Status				Total
	ESI	Non-group	Public	Uninsured	
Employer Sponsored Insurance	871,000	18,000	17,000	4,000	910,000
Non-group	1,000	26,000	-	1,000	28,000
Public	1,000	-	182,000	-	183,000
Uninsured	34,000	63,000	78,000	71,000	246,000
Total	907,000	107,000	277,000	76,000	1,367,000

The individual cells show movements across particular insurance categories. So for example, 871,000 individuals start in ESI and remain in ESI. At the same time, 18,000 move to non-group insurance, 17,000 move to Medicaid, and 4,000 become uninsured (through firm dropping). Likewise, of the 246,000 individuals who start out as uninsured, 34,000 move to employer-sponsored insurance, 63,000 move to non-group insurance, and 78,000 move to public insurance, while 71,000 remain uninsured. The erosion of employer insurance is happening primarily in the smallest firms.

For the 76,000 individuals who remain uninsured, 42,000 are eligible for public insurance, 15,000 are eligible for Employer Sponsored Insurance, and 13,000 are eligible for subsidized non-group insurance. The rest, about 6,000, are eligible for non-subsidized non-group insurance.

No Medicaid Expansion for 2016

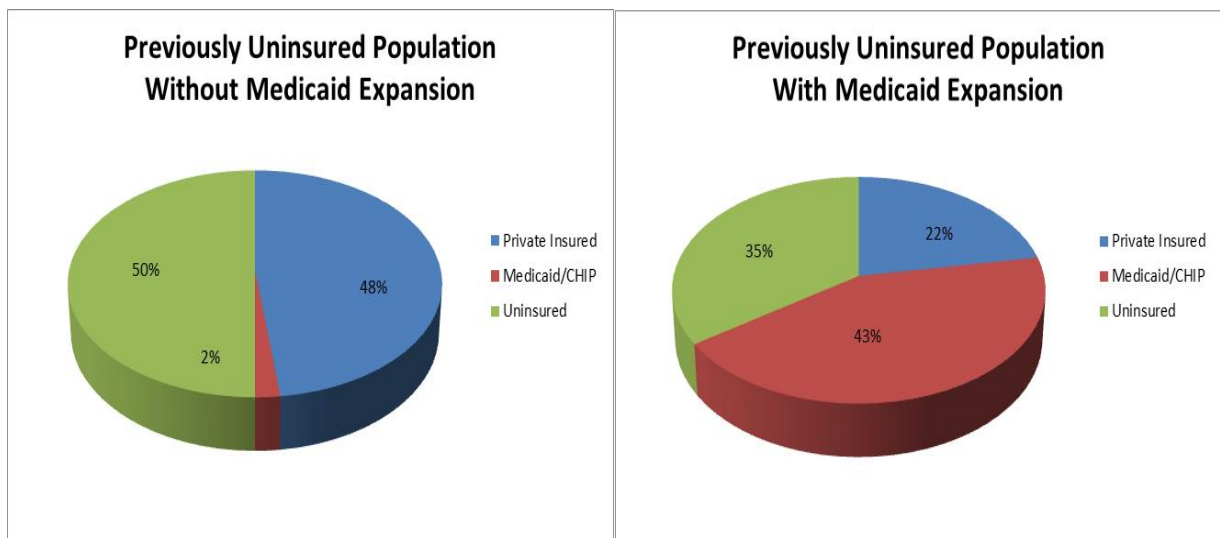
Before ACA Insurance Status	After ACA Implementation Insurance Status				Total
	ESI	Non-group	Public	Uninsured	
Employer Sponsored Insurance	874,000	29,000	2,000	5,000	910,000
Non-group	1,000	26,000	-	1,000	28,000
Public	1,000	-	182,000	-	183,000
Uninsured	42,000	86,000	3,000	115,000	246,000
Total	918,000	141,000	187,000	121,000	1,367,000

This table above shows the identical exercise without the Medicaid expansion. As we showed earlier, this leads to a much smaller number of publicly insured individuals, as well as a higher number of uninsured.

There is less employer erosion as more employees stay with their employer rather than moving to Medicaid. And there is larger movement to non-group insurance among the formerly uninsured from 100-133% of poverty as this is their only option.

The following chart depicts what happens to the 246,000 uninsured under each scenario.

Uninsured Migration - 2016



Expanding Medicaid will impact the premiums in the Marketplace. In 2016, premiums for the commercial individual Marketplace are projected to be 5% lower assuming Medicaid expansion versus no Medicaid expansion. Additionally, employers in West Virginia will pay approximately \$6 million less in penalties with an expansion of Medicaid.

Summary Comparison Population (non-elderly/non-dual) and Financial Impact of the Affordable Care Act on Medicaid Budget	No Medicaid Expansion	
	Population	State Dollars Only
	FY 2018	FY 2014-2023
	(in thousands)	(in millions)
Total State Expenditures - Medicaid	171.5	\$1,940.0
Total State Expenditures - WVCHIP	15.5	<u>30.0</u>
Total State Expenditures	187.0	\$1,970.0
Percentage Change to Baseline State - Medicaid		1.8%
Percentage Change to Baseline State - WVCHIP		-66.9%
Percentage Change to Baseline State		-1.3%

Summary Comparison Population(non-elderly/non-dual) and Financial Impact of the Affordable Care Act on Medicaid Budget	Medicaid Expansion	
	Population	State Dollars Only
	FY 2018	FY 2014-2023
	(in thousands)	(in millions)
Total State Expenditures - Medicaid	264.0	\$2,318.0
Total State Expenditures - WVCHIP	16.0	<u>30.0</u>
Total State Expenditures	280.0	\$2,348.0
Percentage Change to Baseline State - Medicaid		21.6%
Percentage Change to Baseline State - WVCHIP		-66.9%
Percentage Change to Baseline State		17.6%

As an alternative to expanding Medicaid, additional research is underway regarding the use of federal Medicaid dollars to buy private health insurance through the state exchange established under the ACA.

Section II - Summary Comparison - Medicaid Expansion

The projection of the effects of the Medicaid expansion is developed based on an assumed Baseline Projection. This projection assumes the ACA was not passed, and projects non-elderly/non-dual Medicaid and WVCHIP enrollment and costs from 2014 through 2020. The impact of the ACA is broken down into three eligibility populations which we have grouped into the following segments.

Segment 1 – Woodwork Effect

Not everyone who is currently eligible for Medicaid coverage enrolls in the program. The GMSIM model projects new participation based on the uninsured economic status and the cost of coverage, as well as a myriad of social and economic factors. The impact of these individuals joining Medicaid and WVCHIP is commonly referred to as the Woodwork Effect. The following chart defines the four components of the Woodwork effect:

Group	Definition
Ex-ante Medicaid (Ex-Post Population - Ex-Ante)	Previously enrolled in Medicaid who leave due to the ACA
Ex-Ante WVCHIP	Previously enrolled in WVCHIP who leave due to the ACA
Medicaid - Newly Joining Old Eligibles	Previously unenrolled in Medicaid who join due to the ACA
WVCHIP - Newly Joining WVCHIP Old Eligibles	Previously unenrolled in WVCHIP who join due to the ACA

Most of the woodwork happens because of the mandate and other aspects of health reform. The expansion also creates a small woodwork effect. The woodwork population consists of those individuals who would have been previously eligible for public assistance through Medicaid or WVCHIP using current eligibility standards, who chose not to enroll in those programs, but who now enroll due to provisions of the ACA. We estimate that this population consists of only 6,000 persons. This number is projected to be very low because (a) current adult Medicaid eligibility standards are very restrictive, with income requirements established at an equivalent of 16% of the federal poverty level (approximately \$3,768 using 2013 FPL guidelines for a family of four) and must be tied to an eligible dependent child, and (b) the individual mandate does not apply to most of this population, since their incomes are below the tax filing threshold at which the mandate applies.

The ACA mandates that the State determine those individuals who would have been previously eligible for Medicaid and who now enroll for purposes of federal claiming. Expenditures incurred by the State for services provided through Medicaid for the woodwork population are not eligible for the enhanced federal match rate provided for an expansion population as defined in the ACA.

Segment 2 – ACA Mandates (not including optional adult expansion)

This segment includes the mandatory ACA changes. This includes the estimated impact of the Modified Adjusted Gross Income (“MAGI”) change, primary care fee increase, WVCHIP enhanced FMAP, foster children expansion to age 26 and increases to administrative costs.

Segment 3 – Optional Adult Medicaid Expansion

This segment illustrates the impact to the state should Medicaid eligibility expand to families with income below 133% of the Federal Poverty Level. This report does not include an assumption of West Virginia savings due to a reduction of uncompensated care costs. If coverage is expanded, the state can expect to see declines in uncompensated care costs due to spending on hospital care for people without insurance. Some studies have estimated the state will save \$20-30 million per year in uncompensated care costs.

In particular, “The Cost and Coverage implications of the ACA Medicaid Expansion: National and State-by-State Analysis” by the Urban Institute, published in November 2012, reports an estimated \$281 million in state and local non-Medicaid savings on uncompensated care for the period 2013-2022 for West Virginia.

In the following charts, the non-bolded lines include the total state impact for each sub-item of each segment. The bolded lines summarize the total impact for Medicaid and WVCHIP separately.

Population (non-elderly/non-dual) of the Affordable Care Act on Medicaid Budget	Medicaid Expansion	No Medicaid Expansion
	FY 2018	
	(in thousands)	
Baseline State Population - Medicaid	162.0	162.0
Baseline State Population - WVCHIP	21.0	21.0
Segment 1 Population: Medicaid	2.5	1.5
Segment 1 Population: WVCHIP	3.0	2.5
Segment 2 Population: ACA Mandates - Medicaid	8.0	8.0
Segment 2 Population: ACA Mandates - WVCHIP	-8.0	-8.0
Segment 3 Population: Medicaid	91.5	0
Total ACA Population Growth (Segments 1, 2 & 3) - Medicaid	102.0	9.5
Total ACA Population Growth (Segments 1, 2 & 3) - WVCHIP	-5.0	-5.5
Total ACA Population Growth (Segments 1, 2 & 3)	97.0	4.0
Total State Population - Medicaid	264.0	171.5
Total State Population - WVCHIP	16.0	15.5
Total State Population	280.0	187.0

Financial (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget State Dollars Only	Medicaid Expansion	No Medicaid Expansion
	FY 2014-2023 (in millions)	
Baseline State Expenditures - Medicaid	\$1,906.0	\$1,906.0
Baseline State Expenditures - WVCHIP	\$90.5	90.5
Additional ACA Spending - Additional State Cost for Each Medicaid Expansion Segment		
Segment 1 Costs: Medicaid	\$14.5	\$12.0
Segment 1 Costs: WVCHIP	10.5	8.5
Segment 2 Costs: ACA Mandates - Medicaid	22.0	22.0
Segment 2 Costs: ACA Mandates - WVCHIP	-71.0	-69.0
Segment 3 Costs: Medicaid	375.5	0.0
Total ACA Spending Growth (Segments 1, 2 & 3) - Medicaid	\$412.0	\$34.0
Total ACA Spending Growth (Segments 1, 2 & 3) - WVCHIP	-60.5	-60.5
Total ACA Spending Growth (Segments 1, 2 & 3)	\$351.5	-\$26.5
Total State Expenditures - Medicaid	\$2,318.0	\$1,940.0
Total State Expenditures - WVCHIP	30.0	30.0
Total State Expenditures	\$2,348.0	\$1,970.0
Percentage Change to Baseline State - Medicaid	21.6%	1.8%
Percentage Change to Baseline State - WVCHIP	-66.9%	-66.9%
Percentage Change to Baseline State	17.6%	-1.3%

Section III - Overview of the Gruber Microsimulation Model (GMSIM)

The results presented in this report are based on modeling performed using the microsimulation model described in this section. There are two major components to the Gruber Microsimulation Model (“GMSIM”): the “premod” which is the baseline dataset, and the GMSIM model itself which produces the simulation results.

The data base for the GMSIM application to West Virginia is the Current Population Survey (“CPS”). This is the largest nationally representative survey with information on health insurance coverage, health, income, and other demographic information. The CPS is designed to be representative at the state level. We pool the latest three years of the CPS in order to have a sufficiently large sample size for our analysis of West Virginia.

To improve the accuracy of our pre-reform estimations of the non-group and small group markets in West Virginia, we used data provided by Madalena Consulting (“MC”). MC provided us with data on annual claims, plan premium and actuarial value that is based on data submitted by West Virginia insurers. We first use this data to adjust our estimated distribution of “true cost” or annual expected health spending to match the distribution of claims paid by West Virginia insurers. Next, we match the distribution of insurance products in these markets. We begin by grouping together plans with similar actuarial value, which we then refer to as a “product”. Then we group the enrollees into sub-population cells determined by the enrollee’s age, sex, and claims cost. We find the distribution of “product” market share and average premium and actuarial value for each “product” in each age, sex, and claims population group. We then assign individuals from the CPS to products, matching the distribution of enrollment and premium spending that we observe in the MC data. At the end of this process, our estimation of the West Virginia non-group and small group markets reflects the actual West Virginia marketplace.

To model firm behavior, it is important to understand that firms make decisions based on the firm wide aggregate effects of a policy. To mimic this in GMSIM, we construct “synthetic firms” which are meant to reflect the demographics of actual firms. The core of this computation comes from the U.S. Bureau of Labor & Statistics (“BLS”) data providing the earnings distribution of co-workers for individuals of any given earnings level, for various firm sizes and regions of the country. Using these data, we randomly select individuals in the same firm size/region/health insurance offering cell as a given worker in the survey data in order to statistically replicate the earnings distribution that the BLS data would predict for that worker. These 99 workers then become the co-workers in a worker’s synthetic firm.

To project our “premod” forward for future year analysis we use a variety of income and health cost inflation rates, as well as population projections from the Census Bureau, and insurance growth rates from the Congressional Budget Office (“CBO”). We use CBO’s projections for GDP growth to inflate income measures. We use a flat 5.7% growth rate for commercial insurers to inflate health care costs following the CBO. For Medicaid claims, a 3% growth rate in health care costs was used after reviewing state experience. We grow the overall population based on Census Bureau projections of population growth by age and sex. We also adjust the relative size of insurance categories using growth rates supplied by CBO.

To begin the policy simulation process, we first consider firm reactions to policy changes. We do this because 90% of private health insurance is provided by employers, giving them great influence in insurance markets. To model firm behavior, we assume that the firm’s decision-making reflects the aggregation of worker characteristics and preferences. To model these preferences we compute

“pseudo-takeups”, which are the firm’s prediction of worker reactions to policy changes. We then average these reactions across the firm. There are three ways that we allow firms to react to policy changes and their predictions of worker behavior: change in employer sponsored insurance (“ESI”) offering, change in the premium contribution split, and change in the spending on the total ESI premium. We also consider the size of the firm, as small firm behavior is more sensitive to policy changes. We assume that total worker compensation remains constant, so firm increases in ESI spending are offset with wage reductions and decreases in spending are offset with increases in wages.

We model changes in ESI offering by considering the incentives to offer insurance provided by the policy. We consider each policy component separately and compute an “offer pressure” that reflects the influence of the policy component on the firm’s decision to offer or not offer insurance. Therefore, policies that provide viable alternatives to ESI coverage reduce the likelihood that the firm offers ESI. For example, the introduction of individual Exchanges or expansion of Medicaid would reduce the likelihood that a firm offers insurance. Additionally, policies that subsidize alternative sources of insurance reduce the likelihood that a firm will offer insurance. Subsidies or penalties for not offering insurance raise the probability of offering insurance. If there is a mandate policy, it will result in a positive offer pressure. Since individuals will be required to take up a form of insurance if they are uninsured and many will prefer ESI over other insurance types, this will reduce the likelihood that the firm drops coverage. The decision to offer insurance is the most direct method by which firms react to policy changes.

We utilize a similar framework to firm offering when considering contribution shift and spending decisions. In this process, we consider each policy component’s impact of the contribution decision and spending decision, and then aggregate the individual components to get the final contribution and spending change. The contribution and spending decisions are more subtle methods for firms to influence worker behavior. Policies that provide or subsidize alternative forms of insurance will cause firms to reduce their contribution to the ESI premium and reduce spending on the premium. This works as an indirect influence on workers to move to these alternatives. Conversely, when ESI is subsidized or firms are penalized for not providing coverage, firms will increase their contribution or spend more on the policy. All of these reactions will increase with the size of the subsidy or penalty. When firms change the total spending on the ESI premium, half of the spending increase goes to purchasing a higher actuarial value product, and half goes to buying unobservably better coverage (i.e. purchasing from a more reliable or higher reputation insurer).

After determining the firm response, we move on to estimate the reactions of individuals to the policy changes. When considering individual reactions, we use a hierarchy of insurance desirability. ESI is most desirable, followed by individual Exchanges, then traditional non-group insurance, and last is public health insurance. To decide between the insurance options we use “takeup” equations to determine the probability that an individual will move to a certain insurance type. Generally speaking, these equations are of the form:

$$\text{Takeup} = (\text{Constant} + \text{Elasticity} \times \% \text{ Price Change} \times \text{Income Effect}) \times \text{Income Adjustment}$$

The constant is a term that reflects the individual’s health and the desirability of the insurance option. The elasticity determines the responsiveness of individuals to price changes. These are determined, to the greatest extent possible, by a survey of the health economics literature. The price change measures the change in price from the pre-reform state to the post-reform state, and is adjusted for changes in the actuarial value of the plan. The income effect measures the level of the price change relative to income. This is important because price changes have diminishing returns to movement.

That is to say that as the price change becomes large in dollar terms its impact on movement gets progressively weaker. The income effect also picks up the assumption that price changes are less important as income rises. Finally, the income adjustment reflects the assumption that takeup of insurance will fall as the final cost of insurance rises relative to income. After we compute the takeup probabilities for all the possible insurance movements, we apply any regulatory apparatus. For example, individuals with an ESI offer may be barred from moving to the individual Exchange. After making the regulatory changes, we adjust the probabilities for overlap such that the sum of the movement probabilities and the probability of remaining on the pre-reform insurance category equals 100%.

By this point we have predicted the probability of the individual making all possible insurance choices. We now relax the assumption that each individual observation can only be on one insurance type. We use the movement probabilities as the share of the individual's weight that is moved to the relevant insurance category. For example, an observation might have a total weight of 1,000 and in the pre-reform state is uninsured. Pre-reform, we say this observation represents 1,000 uninsured individuals. Now in the post-reform world, we have concluded there is a 50% probability that this observation will continue to be uninsured, and a 50% probability that this observation will be covered by public health insurance. We now say that this observation represents 500 uninsured individuals and 500 individuals covered by public health insurance.

At this point we have computed what we call the voluntary movement: the movement that occurs as a result of individual and firm decisions. The next step is to apply any additional regulatory apparatus that affects movement such as an individual responsibility requirement or an auto-enrollment process. To make these adjustments, we move a portion of the observation's post-reform uninsured weight to a pre-determined insurance destination. The insurance destination represents the most likely source of insurance coverage for the person. The portion of the post-reform uninsured weight that is shifted depends on the insurance destination, and is calibrated to produce results in line with CBO estimates. We also have the capability to restrict the movement of undocumented immigrants. Utilizing data provided by Dr. Jeffery Passel of the Pew Hispanic Center, we are able to identify likely undocumented immigrants in the data, and to adjust or restrict their movement.

After considering the regulatory apparatus, we have finished the movement section of the model. To conclude the modeling process we finalize cost changes for individuals, firms, and governments. The first step in this process is to reset premiums in any Exchanges that have been created. Exchanges will charge premiums that reflect the underlying risk of the overall pool, instead of the individual as in traditional non-group markets. To model the premiums that will be charged in the new Exchanges we collaborate with CCRC to determine the effect of ACA regulations and Exchange population characteristics on premiums. This is an iterative process where we complete a model run and then CCRC provides premium effects, which we feed back into the model until the premiums and populations stabilize. For the initial run, we estimate Exchange premiums by using the existing non-group and half of the existing uninsured population (selected randomly). In the subsequent iterations, we use data from CCRC to predict an Exchange premium that is either higher or lower than the pre-reform premium based on the regulatory impacts of the ACA and the underlying cost of the Exchange population.

Section IV - Methodology and Key Assumptions

We projected both enrollment and healthcare expenditures for the existing Medicaid population and the expansion population. West Virginia provided existing Medicaid budget, claims and eligibility figures. The ACA Medicaid expansion involves the currently insured as well as uninsured adults and children. Consideration was given to individuals who are not enrolled in Medicaid but are eligible (the “woodwork effect” population).

West Virginia’s existing Medicaid income eligibility standards:

Eligibility Category	Maximum Income Level as a Percent of Poverty	Require an Asset Test
Child or adult with a disability; receiving SSI	\$710/month/individual \$1,066/month/couple	Yes
Child under 12 months	150%	No
Child 12 months to under 6 years	133%	No
Child 6 years to under 19 years	100%	No
Pregnant Women	150%	No
HIV Positive-Pharmacy Benefit	400%	No
Breast or Cervical Cancer Benefit	200%	No
Parent	16%	Yes

The optional Medicaid expansion included in the ACA will increase any standard below 133% of FPL up to 133% of FPL. The Adults income is expressed as a percentage of FPL but is not applied in that manner under the new ACA regulations (see Modified Adjusted Gross Income below.) To assist states in funding the Medicaid expansion, the ACA reflects the following Federal Medical Assistance Percentages (“FMAP”) for the expansion populations:

- 100% FMAP in Calendar Year 2014, 2015 and 2016
- 95% FMAP in Calendar Year 2017
- 94% FMAP in Calendar Year 2018
- 93% FMAP in Calendar Year 2019
- 90% FMAP in Calendar Year 2020+

Throughout this analysis, Medicaid’s medical trend is assumed to be 3% per year. It is assumed that of those individuals who will ultimately participate in Medicaid through the expansion, 75% will participate in 2014 and 94% will participate in 2015.

ACA Mandates that are not included in the optional Medicaid expansion will have a significant impact on Medicaid. The financial impacts of these changes are provided in Segment 2 and include:

- **Modified Adjusted Gross Income** - MAGI is the new methodology for calculation of income for certain Medicaid programs (see below) which closely mirrors how the IRS determines adjusted gross income for tax purposes. MAGI will replace multiple income disregards with one 5% income disregard for all programs and will remove asset/resource limits. Household composition will now mirror federal tax filing rules in most situations.

This simplified income calculation will be used to determine Medicaid eligibility and also by the Exchange to determine Premium Tax Subsidy Credits for those who do not qualify for Medicaid.

Groups that must use MAGI include pregnant women, children, adult caretaker/relatives and the newly eligible adult population.

- **Primary Care Fee increase to 100% of Medicare Reimbursement** - In 2013 and 2014, Medicaid fees for the ACA primary care services cannot be less than Medicare fees. The effective date of the provision is January 1, 2013. States can make the higher Medicaid payments as add-ons to their existing rates, or as lump-sum payments. The federal government will fund the full cost of the fee increase, up to the difference between Medicaid fees as of July 1, 2009 and Medicare fees in 2013 and 2014. The estimated federal costs are \$11.9 billion. States with current fees below their 2009 fees have to fund their regular share of that difference; the 100% federal match applies only to increases over July 1, 2009 rates. By the same token, states whose current fees exceed their 2009 fees will realize savings, estimated to total \$545 million. We have assumed that West Virginia will not continue the enhanced reimbursement schedule beyond 2014 unless the federal government extends the funding of this benefit.
- **Enhanced FMAP for WVCHIP** – The West Virginia WVCHIP expenditures are generally reimbursed at the enhanced FMAP (E-FMAP). This is calculated by reducing the state share under the regular FMAP by 30%. For West Virginia Fiscal Year 2012, FMAP for Medicaid was 72.62 and E-FMAP was 80.83. For this projection, we have assumed an E-FMAP of 80% for FY 2014 and FY 2015, increasing to 95% for FY 2016, and increasing to 100% for later years. In addition, we have assumed that current State funding of WVCHIP eligibles will transfer to Medicaid as these individuals move to Medicaid.
- **Expansion of Foster Care** – ACA establishes eligibility for children who have aged-out of the foster care system and had previously received Medicaid while in foster care until they turn 26.
- **Administrative Costs** – The higher enrollment in Medicaid associated with the expansion will result in additional administrative expenses. Individual administrative expenses associated with the expansion were developed by the Department of Health and Human Resources. Some administrative expenses which will be incurred to implement mandated ACA elements unrelated to the Medicaid expansion have not been estimated, and are not included in either projection. The exclusion of these expenses does not alter the conclusions of this report, as these expenses will be incurred under both scenarios.

The additional administrative costs were estimated based on the increases to Medicaid contracts impacted by the increase in enrollment such as MMIS and TPL activities, as well as estimates to perform outreach and enrollment activities, and staffing for county offices.

Expanding managed care will result in administrative cost savings. The Medicaid contract component of the administrative cost was developed based on assumptions that the expansion population would be enrolled and receive services using a Fee-for-Service model. The estimated administrative costs if these individuals receive services under a capitated model would reduce the Medicaid contract costs by an estimated amount of \$1.5 million per year beginning in Fiscal Years 2016 – 2020. The estimated reductions in Fiscal Years 2014 and 2015 range from \$275K - \$600K.

As an expansion of Medicaid managed care has not been analyzed in this report, the cost savings have not been included in this projection.

Table 1 - Medicaid Expansion - Detailed Population Movements
Population (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget
(Population in Thousands)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Segment 1 Population Change - Medicaid	0.5	1.5	2.0	2.5	2.5	2.5	2.5	2.5	2.5	2.5
Segment 1 Population Change - WVCHIP	1.0	2.0	3.0	3.0	3.0	3.0	3.0	3.5	3.5	3.5
Ex-ante Medicaid (Ex-Post Population - Ex-Ante)	0.0	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5
Ex-Ante WVCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid - Newly Joining Old Eligibles	0.5	2.0	2.5	3.0	3.0	3.0	3.0	3.0	3.0	3.0
WVCHIP - Newly Joining WVCHIP Old Eligibles	1.0	2.0	3.0	3.0	3.0	3.0	3.0	3.5	3.5	3.5
Segment 2 Population - Medicaid	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Segment 2 Population - WVCHIP	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0
Changes to MAGI	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid Leavers - Joining WVCHIP	2.5	2.5	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
WVCHIP Leavers - Joining Medicaid	10.5	10.5	11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0
Primary care fee increase	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
WVCHIP enhanced FMAP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Foster children expansion to age 26	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase to Administrative Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Segment 3 Population Change - Medicaid	63.0	78.5	88.5	90.0	91.5	90.5	93.0	94.5	94.5	95.0

Table 2 - Medicaid Expansion - Summary Population
Population (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget
(Population in Thousands)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Baseline Medicaid	177.0	172.0	162.0	162.0	162.0	162.0	162.0	162.0	162.0	162.5
Baseline WVCHIP	23.0	22.0	21.0	21.0	21.0	21.0	21.0	21.0	21.0	21.5
Segment 1 Population Change - Medicaid	0.5	1.5	2.0	2.5	2.5	2.5	2.5	2.5	2.5	2.5
Segment 1 Population Change - WVCHIP	1.0	2.0	3.0	3.0	3.0	3.0	3.0	3.5	3.5	3.5
Segment 2 Population - Medicaid	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Segment 2 Population - WVCHIP	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0
Segment 3 Population Change - Medicaid	63.0	78.5	88.5	90.0	91.5	90.5	93.0	94.5	94.5	95.0
Total Population Change - Medicaid	71.5	88.0	98.5	100.5	102.0	101.0	103.5	105.0	105.0	105.5
Total Population Change - WVCHIP	-7.0	-6.0	-5.0	-5.0	-5.0	-5.0	-5.0	-4.5	-4.5	-4.5
Total Population - Medicaid	248.5	260.0	260.5	262.5	264.0	263.0	265.5	267.0	267.0	268.0
Total Population - WVCHIP	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.5	16.5	17.0

Table 3 - Medicaid Expansion - Detailed Cost Changes
Financial (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget
State Dollars Only (Values in Millions)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
Segment 1 Costs: Medicaid	0.5	1.0	1.0	1.5	1.5	1.5	1.5	2.0	2.0	2.0	14.5
Segment 1 Costs: WVCHIP	0.0	0.5	1.5	1.0	1.0	1.0	1.0	1.5	1.5	1.5	10.5
Ex-ante Medicaid	0.0	-0.5	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-8.5
Ex-Ante WVCHIP	0.0	0.0	1.0	1.0	1.0	1.0	1.0	1.5	1.5	1.5	9.5
Medicaid - Newly Joining Old Eligibles	0.5	1.5	2.0	2.5	2.5	2.5	2.5	3.0	3.0	3.0	22.5
WVCHIP - Newly Joining WVCHIP Old Eligibles	0.0	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.5
Segment 2 Costs: ACA Mandates - Medicaid	4.0	4.0	3.0	1.5	1.5	1.5	1.5	1.5	1.5	2.0	22.0
Segment 2 Costs: ACA Mandates - WVCHIP	-3.5	-3.5	-7.0	-7.5	-7.5	-8.0	-8.0	-8.5	-8.5	-9.0	-71.0
Changes to MAGI	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid Leavers - Joining WVCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
WVCHIP Leavers - Joining Medicaid	0.5	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.5	9.5
Primary care fee increase	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
WVCHIP enhanced FMAP	0.0	0.0	-5.0	-7.0	-7.0	-7.5	-7.5	-8.0	-8.0	-8.5	-58.5
Foster children expansion to age 26	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Segment 3 Costs: Medicaid	4.0	5.5	5.5	18.5	35.5	42.0	56.0	67.5	69.5	71.5	375.5
Medicaid Cost of Care	0.0	0.0	0.0	13.0	30.0	36.5	50.5	62.0	64.0	66.0	322.0
Increase to Administrative Costs	4.0	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	53.5

Table 4 - Medicaid Expansion - Summary Cost
Financial (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget
State Dollars Only (Values in Millions)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
Baseline State Expenditures - Medicaid	181.0	180.0	174.5	179.5	184.5	190.0	195.5	201.0	207.0	213.0	1,906.0
Baseline State Expenditures - WVCHIP	8.0	8.0	8.5	8.5	9.0	9.0	9.5	9.5	10.0	10.5	90.5
Segment 1 Costs: Medicaid	0.5	1.0	1.0	1.5	1.5	1.5	1.5	2.0	2.0	2.0	14.5
Segment 1 Costs: WVCHIP	0.0	0.5	1.5	1.0	1.0	1.0	1.0	1.5	1.5	1.5	10.5
Segment 2 Costs: ACA Mandates - Medicaid	4.0	4.0	3.0	1.5	1.5	1.5	1.5	1.5	1.5	2.0	22.0
Segment 2 Costs: ACA Mandates - WVCHIP	-3.5	-3.5	-7.0	-7.5	-7.5	-8.0	-8.0	-8.5	-8.5	-9.0	-71.0
Segment 3 Costs: Medicaid	4.0	5.5	5.5	18.5	35.5	42.0	56.0	67.5	69.5	71.5	375.5
Total ACA Spending Growth (Segments 1, 2 & 3) - Medicaid	8.5	10.5	9.5	21.5	38.5	45.0	59.0	71.0	73.0	75.5	412.0
Total ACA Spending Growth (Segments 1, 2 & 3) - WVCHIP	-3.5	-3.0	-5.5	-6.5	-6.5	-7.0	-7.0	-7.0	-7.0	-7.5	-60.5
Total ACA Spending Growth (Segments 1, 2 & 3)	5.0	7.5	4.0	15.0	32.0	38.0	52.0	64.0	66.0	68.0	351.5
Total State Expenditures - Medicaid	189.5	190.5	184.0	201.0	223.0	235.0	254.5	272.0	280.0	288.5	2,318.0
Total State Expenditures - WVCHIP	4.5	5.0	3.0	2.0	2.5	2.0	2.5	2.5	3.0	3.0	30.0
Total State Expenditures	194.0	195.5	187.0	203.0	225.5	237.0	257.0	274.5	283.0	291.5	2,348.0
Percentage Change to Baseline State - Medicaid	4.7%	5.8%	5.4%	12.0%	20.9%	23.7%	30.2%	35.3%	35.3%	35.4%	21.6%
Percentage Change to Baseline State - WVCHIP	-43.8%	-37.5%	-64.7%	-76.5%	-72.2%	-77.8%	-73.7%	-73.7%	-70.0%	-71.4%	-66.9%
Percentage Change to Baseline State	2.6%	4.0%	2.2%	8.0%	16.5%	19.1%	25.4%	30.4%	30.4%	30.4%	17.6%
Federal Medicaid Expenditures	820.5	914.5	958.5	963.5	973.0	980.0	1,003.0	1,019.5	1,041.0	1,067.0	9,740.5
Federal WVCHIP Expenditures	18.0	20.0	24.0	26.5	27.5	29.5	30.5	32.5	34.0	36.0	278.5
Total Medicaid Expenditures	1,010.0	1,105.0	1,142.5	1,164.5	1,196.0	1,215.0	1,257.5	1,291.5	1,321.0	1,355.5	12,058.5
Total WVCHIP Expenditures	22.5	25.0	27.0	28.5	30.0	31.5	33.0	35.0	37.0	39.0	308.5

Table 5 - No Medicaid Expansion - Detailed Population Movements
Population (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget
(Population in Thousands)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Segment 1 Population Change - Medicaid	0.5	1.0	1.5	1.5	1.5	1.5	2.0	2.0	2.0	2.0
Segment 1 Population Change - WVCHIP	1.0	1.5	2.5	2.5	2.5	2.5	3.0	3.0	3.0	3.0
Ex-ante Medicaid (Ex-Post Population - Ex-Ante)	0.0	-0.5	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0
Ex-Ante WVCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid - Newly Joining Old Eligibles	0.5	1.5	2.5	2.5	2.5	2.5	3.0	3.0	3.0	3.0
WVCHIP - Newly Joining WVCHIP Old Eligibles	1.0	1.5	2.5	2.5	2.5	2.5	3.0	3.0	3.0	3.0
Segment 2 Population - Medicaid	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Segment 2 Population - WVCHIP	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0
Changes to MAGI	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid Leavers - Joining WVCHIP	2.5	2.5	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
WVCHIP Leavers - Joining Medicaid	10.5	10.5	11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0
Primary care fee increase	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
WVCHIP enhanced FMAP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Foster children expansion to age 26	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase to Administrative Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Segment 3 Population Change - Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Table 6 - No Medicaid Expansion - Summary Population
Population (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget
(Population in Thousands)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Baseline Medicaid	177.0	172.0	162.0	162.0	162.0	162.0	162.0	162.0	162.0	162.5
Baseline WVCHIP	23.0	22.0	21.0	21.0	21.0	21.0	21.0	21.0	21.0	21.5
Segment 1 Population Change - Medicaid	0.5	1.0	1.5	1.5	1.5	1.5	2.0	2.0	2.0	2.0
Segment 1 Population Change - WVCHIP	1.0	1.5	2.5	2.5	2.5	2.5	3.0	3.0	3.0	3.0
Segment 2 Population - Medicaid	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Segment 2 Population - WVCHIP	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0	-8.0
Segment 3 Population Change - Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Population Change - Medicaid	8.5	9.0	9.5	9.5	9.5	9.5	10.0	10.0	10.0	10.0
Total Population Change - WVCHIP	-7.0	-6.5	-5.5	-5.5	-5.5	-5.5	-5.0	-5.0	-5.0	-5.0
Total Population - Medicaid	185.5	181.0	171.5	171.5	171.5	171.5	172.0	172.0	172.0	172.5
Total Population - WVCHIP	16.0	15.5	15.5	15.5	15.5	15.5	16.0	16.0	16.0	16.5

Table 7 - No Medicaid Expansion - Detailed Cost Changes
Financial (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget
State Dollars Only (Values in Millions)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
Segment 1 Costs: Medicaid	0.5	1.0	1.0	1.0	1.0	1.5	1.5	1.5	1.5	1.5	12.0
Segment 1 Costs: WVCHIP	0.0	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	8.5
Ex-ante Medicaid	0.0	-0.5	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-8.0
Ex-Ante WVCHIP	0.0	0.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	8.0
Medicaid - Newly Joining Old Eligibles	0.5	1.5	2.0	2.0	2.0	2.5	2.5	2.5	2.5	2.5	20.5
WVCHIP - Newly Joining WVCHIP Old Eligibles	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
Segment 2 Costs: ACA Mandates - Medicaid	4.0	4.0	3.0	1.5	1.5	1.5	1.5	1.5	1.5	2.0	22.0
Segment 2 Costs: ACA Mandates - WVCHIP	-3.5	-3.5	-7.0	-7.0	-7.5	-7.5	-8.0	-8.0	-8.5	-8.5	-69.0
Changes to MAGI	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid Leavers - Joining WVCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
WVCHIP Leavers - Joining Medicaid	0.5	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.5	9.5
Primary care fee increase	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
WVCHIP enhanced FMAP	0.0	0.0	-5.0	-6.5	-7.0	-7.0	-7.5	-7.5	-8.0	-8.0	-56.5
Foster children expansion to age 26	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Segment 3 Costs: Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid Cost of Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase to Administrative Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Table 8 - No Medicaid Expansion - Summary Cost
Financial (non-elderly/non-dual) Impact of the Affordable Care Act on Medicaid Budget
State Dollars Only (Values in Millions)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
Baseline State Expenditures - Medicaid	181.0	180.0	174.5	179.5	184.5	190.0	195.5	201.0	207.0	213.0	1,906.0
Baseline State Expenditures - WVCHIP	8.0	8.0	8.5	8.5	9.0	9.0	9.5	9.5	10.0	10.5	90.5
Segment 1 Costs: Medicaid	0.5	1.0	1.0	1.0	1.0	1.5	1.5	1.5	1.5	1.5	12.0
Segment 1 Costs: WVCHIP	0.0	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	8.5
Segment 2 Costs: ACA Mandates - Medicaid	4.0	4.0	3.0	1.5	1.5	1.5	1.5	1.5	1.5	2.0	22.0
Segment 2 Costs: ACA Mandates - WVCHIP	-3.5	-3.5	-7.0	-7.0	-7.5	-7.5	-8.0	-8.0	-8.5	-8.5	-69.0
Segment 3 Costs: Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total ACA Spending Growth (Segments 1, 2 & 3) - Medicaid	4.5	5.0	4.0	2.5	2.5	3.0	3.0	3.0	3.0	3.5	34.0
Total ACA Spending Growth (Segments 1, 2 & 3) - WVCHIP	-3.5	-3.0	-6.0	-6.0	-6.5	-6.5	-7.0	-7.0	-7.5	-7.5	-60.5
Total ACA Spending Growth (Segments 1, 2 & 3)	1.0	2.0	-2.0	-3.5	-4.0	-3.5	-4.0	-4.0	-4.5	-4.0	-26.5
Total State Expenditures - Medicaid	185.5	185.0	178.5	182.0	187.0	193.0	198.5	204.0	210.0	216.5	1,940.0
Total State Expenditures - WVCHIP	4.5	5.0	2.5	2.5	2.5	2.5	2.5	2.5	2.5	3.0	30.0
Total State Expenditures	190.0	190.0	181.0	184.5	189.5	195.5	201.0	206.5	212.5	219.5	1,970.0
Percentage Change to Baseline State - Medicaid	2.5%	2.8%	2.3%	1.4%	1.4%	1.6%	1.5%	1.5%	1.4%	1.6%	1.8%
Percentage Change to Baseline State - WVCHIP	-43.8%	-37.5%	-70.6%	-70.6%	-72.2%	-72.2%	-73.7%	-73.7%	-75.0%	-71.4%	-66.9%
Percentage Change to Baseline State	0.5%	1.1%	-1.1%	-1.9%	-2.1%	-1.8%	-2.0%	-1.9%	-2.1%	-1.8%	-1.3%
Federal Medicaid Expenditures	478.0	474.0	446.0	441.0	443.0	446.5	450.0	452.0	456.0	461.0	4,547.5
Federal WVCHIP Expenditures	18.0	20.0	24.5	26.0	27.5	29.0	30.5	32.5	34.5	36.0	278.5
Total Medicaid Expenditures	663.5	659.0	624.5	623.0	630.0	639.5	648.5	656.0	666.0	677.5	6,487.5
Total WVCHIP Expenditures	22.5	25.0	27.0	28.5	30.0	31.5	33.0	35.0	37.0	39.0	308.5

Section V - Description of Baseline Medicaid Data

This section describes the processes and parameters that were used in developing the baseline cost assumptions for the Medicaid expansion analysis.

Populations included in the analysis are non-disabled and non-Medicare adults and children enrolled in the West Virginia Medicaid population and all children enrolled in the standalone West Virginia Children's Health Insurance Program

The data were developed in November 2012 for an incurred analysis period of State Fiscal Year 2011 (FY2011). Eligibility and claims reflected retroactivity and transactions applied through October 2012. Given the completeness of the eligibility and claims data, adjustments for incurred but not reported ("IBNR") and other additional retroactivity were not applied.

The following sections describe the approach utilized in developing the analysis for each of the study populations.

Medicaid Child and Adult Population

Data Sources

The key data sources in the analysis are:

- HMO enrollment spans. Key data elements are member ID, enrolled plan (HMO), eligibility start date and eligibility end date.
- PAAS enrollment spans. Key data elements are member ID, eligibility start date, and eligibility end date.
- Medicaid enrollment spans. Key data elements are member ID, eligibility start date, eligibility end date, and rate code.
- Medicaid demographics. Key data elements are member ID, date of birth, gender, and county code.
- Medicare enrollment. Key data elements are member ID and Medicare effective date.
- Non-Pharmacy claims data. Key data elements are member ID, date of service, primary diagnosis, procedure code, form indicator, and amount paid. This dataset includes medical, dental, and behavioral health claims.
- Pharmacy claims data. Key data elements are member ID, dispense date, NDC code, and amount paid.

Each of the above datasets are provided by Molina Healthcare and are received on a monthly basis. These are the datasets utilized for the purposes of managed care rate setting and population of the encounter data warehouse maintained under a separate contract with West Virginia Bureau for Medical Services ("BMS").

In addition to the above datasets, the following information was used to augment and corroborate the build process:

- Managed care capitation rates for FY2011 (Key data elements are county code, benefit type, rate cell, capitation, and delivery payments).
- Capitation, ADPAY, and fee for service summary reports provided by Molina Healthcare for FY2011.

Methodology

The projection model utilizes per capita expenditures as inputs. To accommodate that goal, the unit of observation is the member, regardless if the member incurred claim expenses or not. To construct such a record, the following steps were executed:

- Select eligibility spans from the Medicaid eligibility span records that indicated enrollment at any point between 01-Jul-2010 and 30-Jun-2011.
- Edit the above records:
 - Delete any record that indicated Medicare eligibility during the eligibility span. This test was implemented by comparing the span record for the member to Medicare spans.
 - Delete any record that indicated SSI. The rate codes considered SSI are: ('AMSS','BMSS','DMSS','AMPG','BMPG','DMPG').
- Enhance the remaining eligibility spans:
 - Merge HMO attributes from HMO span records (plan, plan type, effective date of coverage, ending date of coverage).
 - Merge PAAS attributes from PAAS span records (PCPID, effective date of coverage, ending date of coverage).
 - Merge demographic attributes (DOB, gender, county of residence).
 - Set the rate cell based on age (at the end of the eligibility span) and gender.
 - Decode the benefit type from plan type and rate code.
 - Decode / set the HMO capitation from county code, benefit type, and rate code for HMO spans.
- Select claim records from the incurral period of 01-Jul-2010 and 30-Jun-2011.
- Enhance the claim records to types:
 - Medical – form indicator = ('I','M','O','V') and primary diagnosis not between 290.xx and 319.xx
 - Behavioral Health (“BH”) - form indicator = ('I','M','O','V') and primary diagnosis between 290.xx and 319.xx
 - Dental – form indicator = ('D')
 - Prescription drugs – all claims on prescription drug extract from Molina Healthcare.
- Merge the enhanced claims with the enhanced eligibility span records to create a summary of enrollment and cost for that eligibility span. The merge is based on matching member ID and comparing the incurral date on the claim to the effective and ending dates of coverage for each eligibility span.
- Calculate capitations paid (if an HMO span)
- Enrollment, claims, and capitations are assigned to the following variables on the member level summary records:
 - Member months
 - Medical
 - Behavioral Health (BH)
 - Dental
 - Prescription Drugs (RX)
 - Capitations and Kicker Payments (While capitations are calculated, kicker payments are allocated to women in appropriate rate cells based on enrollment and kicker payments reported by Molina Healthcare.

Adjustments and Assumptions

No adjustments are applied to the resulting dataset for benefits. All results reflect the benefit package and health insurance coverage in effect during FY2011.

The following table summarizes the results by rate cell.

Medicaid – FY 2011 Data

Age Sex	ADULTS AND CHILDREN								PMPM
	Member Months	Members	Medical	Behavior Health	Dental	Prescription Drugs	Capitations and Kick	Total	
00 - Under Age 1	134,304	11,192	534,157	391,159	5,912	1,374,298	49,032,968	51,338,494	382
01 - Age 1	122,689	10,224	720,884	1,771,456	77,083	2,633,194	15,041,183	20,243,801	165
02 - Age 2 to 14	1,216,668	101,389	7,796,287	31,689,247	28,694,800	40,488,185	84,701,926	193,370,445	159
03 - F / Age 15 to 19	152,944	12,745	1,391,383	4,417,588	6,082,805	6,901,241	30,008,346	48,801,364	319
04 - M / Age 15 to 19	134,077	11,173	918,009	4,700,455	4,449,366	5,965,959	9,764,940	25,798,729	192
05 - F / Age 20 to 29	141,923	11,827	2,266,548	2,509,686	638,675	8,158,919	65,074,105	78,647,934	554
06 - M / Age 20 to 29	16,474	1,373	119,334	307,879	43,063	912,420	2,715,139	4,097,834	249
07 - F / Age 30 to 39	89,591	7,466	1,329,443	2,447,259	42,857	11,795,649	29,806,241	45,421,449	507
08 - M / Age 30 to 39	20,932	1,744	164,771	481,145	11,922	2,116,651	4,937,114	7,711,604	368
09 - 40+	49,619	4,135	2,601,698	946,321	32,302	9,182,099	14,746,169	27,508,590	554
Overall	2,079,221	173,268	17,842,516	49,662,196	40,078,786	89,528,615	305,828,131	502,940,243	242

WVCHIP Population

Data Sources

The key data sources in the analysis are:

- Enrollment spans. Key data elements are member ID, date of birth, gender, county, eligibility start date and eligibility end date.
- Non-Pharmacy claims data. Key data elements are member ID, date of service, primary diagnosis, procedure code, HealthSmart application, and amount paid. This dataset includes medical, dental, and behavioral health claims.
- Pharmacy claims data. Key data elements are member ID, dispense date, NDC code, and amount paid.

Each of the above datasets are provided by HealthSmart, Express Scripts (ESI), and the State of West Virginia and are received on a monthly basis. These are the datasets utilized for the population of the claim data warehouse maintained under a separate contract with West Virginia WVCHIP.

In addition to the above datasets, the following information was used to augment and corroborate the build process:

- Monthly summary reports prepared by HealthSmart, for FY2011.
- WVCHIP annual reports.

Methodology

The projection model utilizes per capita expenditures as inputs. To accommodate that goal, the unit of observation is the member, regardless if the member incurred claim expenses or not. To construct such a record, the following steps were executed:

- Select eligibility spans from the WVCHIP eligibility span records that indicated enrollment at any point between 01-Jul-2010 and 30-Jun-2011.
- Enhance the remaining eligibility spans:
 - Set the rate cell based on age (at the end of the eligibility span) and gender. Ultimately, WVCHIP enrollment was expressed as one age / sex cell (Children)
- Select claim records from the incurral period of 01-Jul-2010 and 30-Jun-2011.
- Enhance the claim records to types:
 - Medical – HealthSmart claims application = ‘MEDICAL’ and primary diagnosis not between 290.xx and 319.xx
 - Behavioral Health (“BH”) – HealthSmart application = ‘MEDICAL’ and primary diagnosis between 290.xx and 319.xx
 - Dental - HealthSmart application = ‘DENTAL’
 - Prescription drugs – all claims on prescription drug extract from ESI
- Merge the enhanced claims with the enhanced eligibility span records to create a summary of enrollment and cost for that eligibility span. The merge is based on matching member id and comparing the incurral date on the claim to the effective and ending dates of coverage for each eligibility span.
- Enrollment, claims, and capitations are assigned to the following variables on the member level summary records:
 - Member months
 - Medical

- Behavioral Health (BH)
- Dental
- Prescription Drugs (RX)
- Capitations and Kicker payments are not applicable (all claim costs are reimbursed on a fee-for-service basis).

Adjustments and Assumptions

No adjustments are applied to the resulting dataset for benefits. All results reflect the benefit package and health insurance coverage in effect during FY2011.

The following table summarizes the results by rate cell.

WVCHIP – FY 2011 Data

CHILDREN								
Member Months	Members	Medical	Behavior Health	Dental	Prescription Drugs	Capitations and Kick	Total	PMPM
295,637	24,636	29,285,544	3,309,429	6,113,767	9,324,472	-	48,033,212	162

Exhibit
State Division of Medicaid
Financial Impact of the Affordable Care Act on State Medicaid Budget
Medicaid Expansion - (Values in Millions)

Affordable Care Act Changes:		FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Totals
Medicaid Total (State and Federal)		631.0	620.5	591.5	598.0	604.5	612.5	620.5	627.5	636.5	645.0	6,187.5
Baseline	FMAP	71.3%	71.0%	70.5%	70.0%	69.5%	69.0%	68.5%	68.0%	67.5%	67.0%	69.2%
	Federal Funds	450.0	440.5	417.0	418.5	420.0	422.5	425.0	426.5	429.5	432.0	4,281.5
	State Funds	181.0	180.0	174.5	179.5	184.5	190.0	195.5	201.0	207.0	213.0	1,906.0
Medicaid Total (State and Federal)		32.5	38.5	33.0	25.5	26.0	27.0	28.0	29.0	30.0	33.0	302.5
Segments 1 & 2	FMAP	86.2%	87.0%	87.9%	88.2%	88.5%	88.9%	89.3%	87.9%	88.3%	87.9%	87.9%
	Federal Funds	28.0	33.5	29.0	22.5	23.0	24.0	25.0	25.5	26.5	29.0	266.0
	State Funds	4.5	5.0	4.0	3.0	3.0	3.0	3.0	3.5	3.5	4.0	36.5
Medicaid Total (State and Federal)		336.0	429.5	502.0	525.0	549.5	559.5	593.0	618.5	638.0	661.0	5,412.0
Segment 3 - Cost of Care	FMAP	100.0%	100.0%	100.0%	97.5%	94.5%	93.5%	91.5%	90.0%	90.0%	90.0%	96.0%
	Federal Funds	336.0	429.5	502.0	512.0	519.5	523.0	542.5	556.5	574.0	595.0	5,090.0
	State Funds	0.0	0.0	0.0	13.0	30.0	36.5	50.5	62.0	64.0	66.0	322.0
Medicaid Total (State and Federal)		10.5	16.5	16.0	16.0	16.0	16.0	16.0	16.5	16.5	16.5	156.5
Segment 3 - Administrative	FMAP	61.9%	66.7%	65.6%	65.6%	65.6%	65.6%	65.6%	66.7%	66.7%	66.7%	65.8%
	Federal Funds	6.5	11.0	10.5	10.5	10.5	10.5	10.5	11.0	11.0	11.0	103.0
	State Funds	4.0	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	53.5
Medicaid Total (State and Federal)		1,010.0	1,105.0	1,142.5	1,164.5	1,196.0	1,215.0	1,257.5	1,291.5	1,321.0	1,355.5	12,058.5
Total Spending	FMAP	81.2%	82.8%	83.9%	82.7%	81.4%	80.7%	79.8%	78.9%	78.8%	78.7%	80.8%
with Medicaid Expansion	Federal Funds	820.5	914.5	958.5	963.5	973.0	980.0	1,003.0	1,019.5	1,041.0	1,067.0	9,740.5
	State Funds	189.5	190.5	184.0	201.0	223.0	235.0	254.5	272.0	280.0	288.5	2,318.0