

Medicaid Expansion Summary

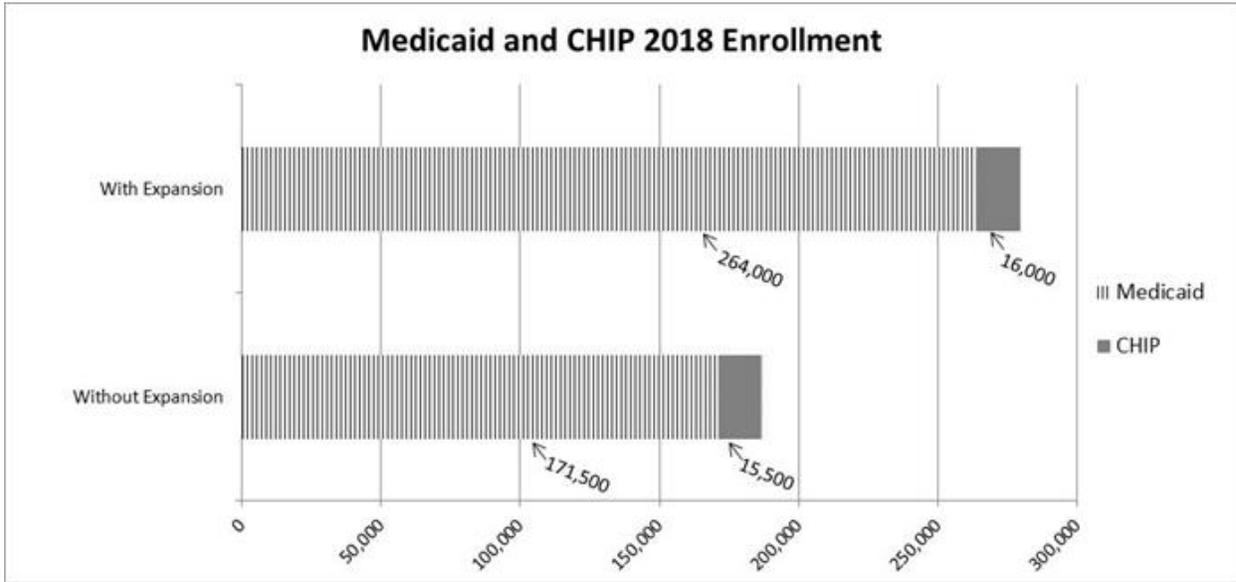
CCRC Actuaries, LLC (“CCRC Actuaries”) was engaged by The West Virginia Offices of the Insurance Commissioner (“WVOIC”) to perform various actuarial and economic analyses with regard to the West Virginia Health Marketplace (“The Marketplace”) as defined by the Affordable Care Act (“ACA”). The project 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.

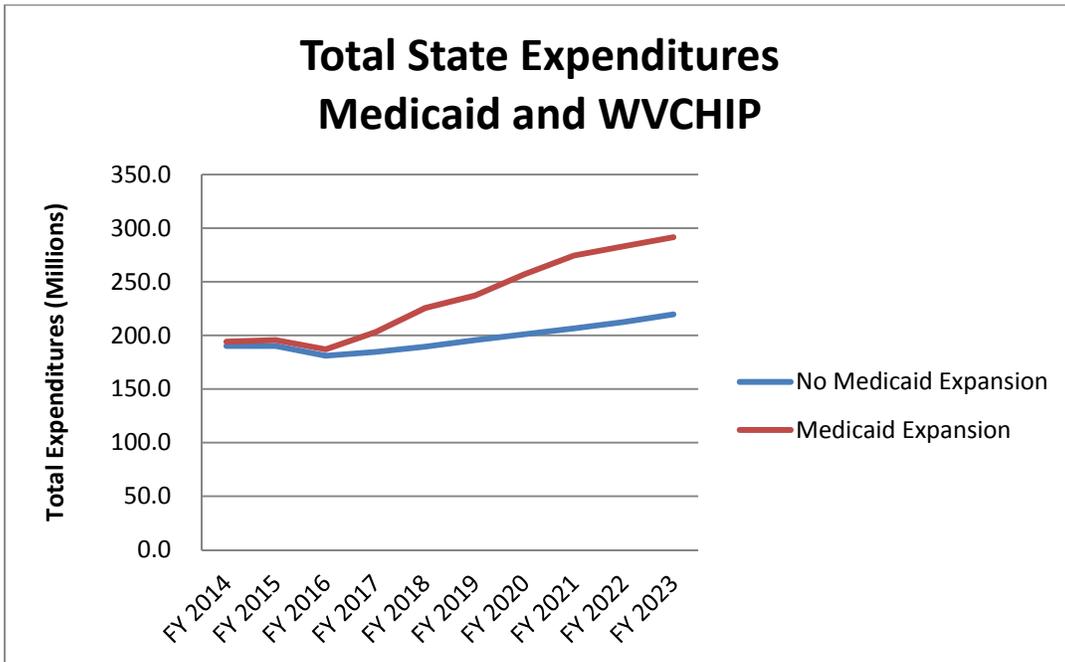
The project team utilized actuarial analyses and the Gruber Microsimulation Model (“GMSIM model”) to capture the implications of each of these options for West Virginia. GMSIM allows individuals to move across insurance types as Medicaid eligibility varies, so that when Medicaid eligibility is restricted 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

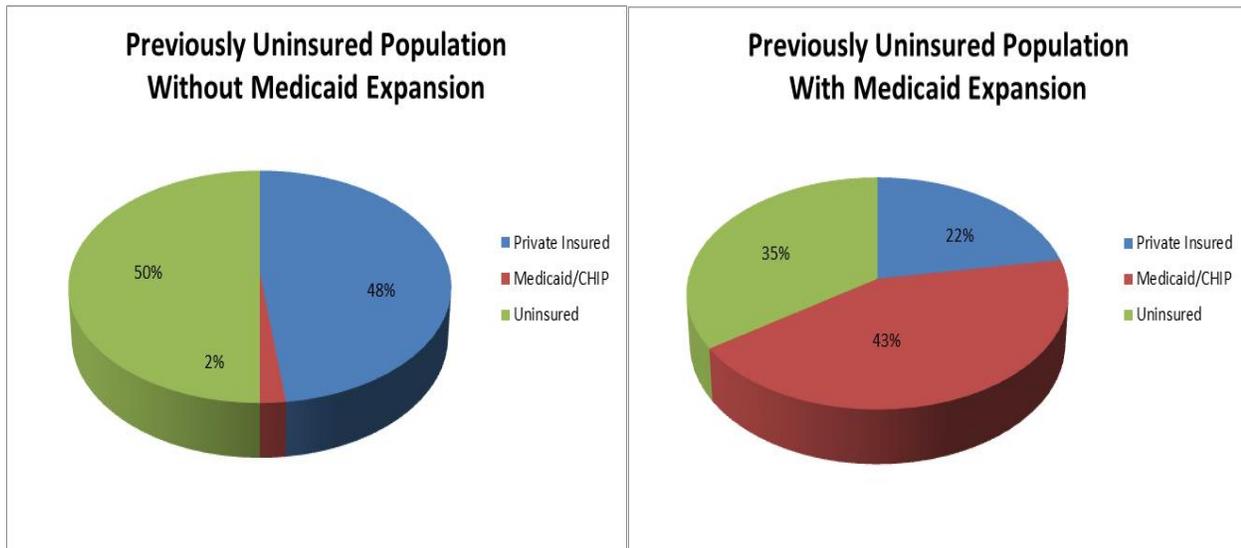
Before ACA Insurance Status	After ACA Implementation Insurance Status				Total
	ESI	Non-group	Public	Uninsured	
Employer Sponsored Insurance	874,000	29,000	2,000	5,000	910,000
Non-group	1,000	26,000	-	1,000	28,000
Public	1,000	-	182,000	-	183,000
Uninsured	42,000	86,000	3,000	115,000	246,000
Total	918,000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

Health Insurance Marketplace

The United States Supreme Court upheld most elements of the ACA in the summer of 2012. 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.

The basis of our analysis is the Gruber Microsimulation Model (“GMSIM model”) combined with actuarial models to capture the implications of each of these options for West Virginia. These models project Marketplace participation by health care status, economic, and demographic characteristics. The models project participation and cost for the Individual and Small Group Marketplace. The models allow us to project the impact on West Virginia uninsured rates through the analysis of the Marketplace and the Medicaid Expansion previously elected by West Virginia:

Key results of our analysis include:

- The number of uninsured in 2016 is projected to decrease 170,000 after the implementation of the ACA
 - Projected uninsured in 2016 without the ACA is 246,000 while the number of uninsured residents is projected to drop to 76,000 after implementation of the ACA.
- Based upon 2016 projections, there will be a small decrease in employer coverage of 0.3% as a result of the ACA
 - Total group insurance for employees and dependents will decrease from a projected 910,000 without ACA implementation to 907,000 with ACA implementation in 2016
- There are projected to be 17,000 individuals transition from employer sponsored insurance to Medicaid or CHIP with the implementation of the ACA
- Absent the ACA, the number of underinsured would grow from its current level of 103,000 to a higher level of 110,000 by 2014 without the ACA.
- After implementation of the ACA, the number of underinsured falls to 93,000 by 2014, 86,000 in 2015, and 79,000 in 2016
 - That is, by 2016, the share of the population that is underinsured falls by almost 40%. This decline is driven almost exclusively by declines in out-of-pocket costs.
- Gross Premiums in the small group market for employers sized 1-50 are projected to increase 7.3%
 - 2016 monthly premiums for employees and employers combined are projected to increase from \$960 to \$1,030

- Gross Premiums in the small group market for employers sized 51-100 are projected to decrease 4.7%
 - 2016 monthly premiums for employees and employers combined are projected to decrease from \$1,480 to \$1,410
- Expanding the definition of small group market from firms with 1-50 employees to firms with 1-100 employees adds a projected 30,000 employees to the small group market in 2016
- Gross Premiums in the individual market will increase 35.3% after the implementation of the ACA
 - 2016 annual premiums are projected to increase from \$4,953 to \$6,702
- Net Premiums, subtracting expected tax credits, in the individual market will decrease 42.1% after the implementation of the ACA
 - 2016 net annual premiums after tax credits are projected to be \$2,870
- There are projected to be 183,000 individuals eligible to join the reformed non-group individual market, with 107,000 individuals purchasing insurance.
- Of 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.
- There are projected to be 99,000 individuals eligible to receive advance premium tax credits, with 86,000 of these individuals purchasing insurance and receiving tax credits.
- There are projected to be 6,300 firms with 35,000 employees eligible for the Small Business Tax Credit. Of this total, 8,000 employees are projected to enroll in SHOP and allow their employers to take advantage of the tax credit.

The models presented in the report assume that the individual mandate will create a sufficient incentive for uninsured persons to purchase health insurance. In the event that the actual take up rate does not approach those assumed in the development of the premium stabilization mechanisms of the ACA, it is conceivable that the systems will not function as designed. Issues, such as revenue shortfalls, would be exacerbated if the take up rate is significantly lower than expected in the young and healthier population or higher than assumed in the less healthy population. In essence, premium stabilization is focused at those segments and distortions in those populations could ripple through the system.

There are numerous factors that will affect the health insurance landscape going forward. These unknowns will affect both the number of insureds and the average premiums that are paid for health insurance policies. Some of the key factors that will affect projected versus actual enrollment and premiums charged in the marketplace are:

- Will the individual mandate and premium credits attract enough healthy uninsured residents to offset the anticipated number of residents with high health care utilization that will now be able to buy a health insurance plan due to the new guaranteed issue rules?
- The success of the ACA's individual mandate and premium subsidies at reducing the number of uninsured and attracting enrollees who have low health care utilization.
- Lower out of pocket costs due to actuarial value requirements will lead to higher premiums paid by members.
- Minimum Loss Ratio requirements are intended to limit the amount that insurance companies can charge for premiums. Should these requirements not be met, members will pay higher than needed premiums and receive a refund the following year.
- The decision of individual employers to offer coverage will affect the risk pool of both the individual and small group marketplaces.
- Will young, healthy populations obtain coverage or pay mandate penalties?
- Will outreach and education efforts be sufficient enough to motivate healthy populations into the marketplace?

Premium taxes associated with the ACA will add approximately 4.95% to the premiums for 2016 in the individual market.

- The *Patient-Centered Outcomes Research Institute (PCORI Fee)* is set at \$2/year/enrollee in 2014 and indexed thereafter.
- The *Transitional Reinsurance Fee* will be discontinued after 2016. It is assumed to cost \$24/enrollee for 2016.
- The *Exchange User Fee* is designed to fund the exchange in each state. The fee is 3.5% of premium charged against total premium of every insurer who offers a plan on the state exchange.
- The *Health Insurance Industry Fee* funds the cost of implementing provisions of the ACA. Insurers will be allocated their share of the national fee based on their total fully insured premiums. The collected fee nationally will be \$8 Billion in 2014 rising to \$14.3 Billion in 2018.

There are projected to be 183,000 individuals eligible to join the reformed non-group individual market, with 107,000 individuals purchasing insurance. Average gross premiums in the non-group market are expected to increase 35.3% with the implementation of the ACA. Offsetting this increase, 99,000 of these individuals are eligible to receive advance premium tax credits, with 86,000 of these individuals purchasing insurance and receiving tax credits. Factoring in the tax credits, the average premium paid by individuals is 42.1% less than premiums would have been had the ACA not been implemented. Premium taxes associated with the ACA will add approximately 4.95% to the premiums in the individual market.

Table 1

2016 Non-group Market

	<u>No Reform</u>	<u>With ACA Pre-Credit</u>	<u>With ACA Post-Credit</u>
Premium Value	\$4,953	\$6,702	\$2,870
AV Value	71%	71%	71%
% Rise in Premium		35.3%	-42.1%
% Change in AV		0.2%	0.2%

The 35.3% gross premium increase was developed by analyzing the various changes made to the insurance marketplace by the ACA. The actuarial value in the current market is represented by the first column at 71%. The change in actuarial value of plans contributes only 0.2% to the expected premium increase. The primary drivers of this increase are outlined in Table 2 below:

Table 2

<u>Driver</u>	<u>Percent Increase</u>
Benefit Plan Changes	8.30%
Change in Actuarial Value	0.20%
Limiting of Rating Factors	1.00%
End of Underwriting	17.60%
ACA Taxes	4.95%

Various cohorts of individuals will see different changes in their premiums. This is due to the age rating compression, unisex rates, and the inability for insurers to charge by health status and other underwriting criteria.

Individuals whose family income is below 400% of the FPL are eligible for tax credits if their health care premium exceeds a percentage of their income. For individuals below 250% FPL, modified Silver plans will be offered with higher actuarial values and lower cost sharing requirements in addition to the premium tax subsidies.

The table below summarizes the required premium contribution and the actuarial value based on income level:

(1) Summary of Required Premium Contribution and Cost Share Modifications

<u>Income Level</u>	<u>Required Premium Contribution Percentage of Income</u>	<u>Actuarial Value of Coverage</u>
100 - 133%	2%	94%
133 - 150%	3-4%	94%
150 - 200%	4-6.3%	87%
200 - 250%	6.3-8.1%	73%
250 - 300%	8.1-9.5%	70%
300 - 350%	9.5%	70%
350 - 400%	9.5%	70%

Actual premiums will be determined by each insurance company, and have not been established yet. Appendix B shows the projected gross premium for non-group insurance for various age and family size cohorts for three different levels of income based on the Federal Poverty Level.

On the next page Table 3 shows the projected gross premium for three sample ages with varying family size cohorts for three different levels of income based on the Federal Poverty Level. Families above 400% of the FPL will have to pay the full amount of the Gross Premium shown in the third column. The displayed tax credits available to an individual are at the midpoint of the range of FPL, but not the additional savings associated with the reduced cost share.

The chart shows the gross premium increase of the impact of the ACA, as well as the net premium increase after premium assistance. Premium assistance subsidies will be available to offset the total amount an individual or family needs to pay for health insurance coverage through a tax credit. The tax credit is available for the Silver plan, and is provided on a sliding scale, based on income as shown in the chart above.

If the premium is below the limit in the chart above, no premium assistance will be offered. This is the case for single 20-year olds in the highest FPL category.

The FPL is assumed to be \$12,555 in 2016. For an individual with 350% FPL, this would equate to \$43,944 in income. This same individual's premium is capped at 9.5% of income, or \$4,175. For a 60-year old individual, the net premium after tax credit will be \$4,175 instead of the gross premium of \$10,360.

**Table 3
Non-Group Insurance Premiums - 2016**

<u>Age</u>	<u>Pre-ACA</u>	<u>Post-ACA</u>	2016			
			<u>Percent Increase</u>	<u>Net Percent Increase After Subsidy</u>		
				<u>Based on Income(percent of FPL)</u>		
				<u>138% - 200%</u>	<u>201% - 300%</u>	<u>301% - 400%</u>
Male						
20	1,988	3,817	92.0%	-46.3%	27.1%	92.0%
40	3,512	4,878	38.9%	-69.6%	-28.1%	18.9%
60	7,681	10,360	34.9%	-86.1%	-67.1%	-45.6%
Female						
20	2,648	3,817	44.1%	-59.7%	-4.6%	44.1%
40	4,616	4,878	5.7%	-76.9%	-45.3%	-9.6%
60	7,320	10,360	41.5%	-85.4%	-65.5%	-43.0%
Family - Two Adults						
20	4,636	7,635	64.7%	-68.9%	-26.4%	21.5%
40	8,129	10,908	34.2%	-82.3%	-58.0%	-30.7%
60	15,001	20,171	34.5%	-90.4%	-77.3%	-62.4%
Family - Two Adults, Two Children						
20	8,283	13,254	60.0%	-73.6%	-37.5%	3.3%
40	11,775	16,528	40.4%	-81.4%	-56.0%	-27.3%
60	18,647	25,791	38.3%	-88.3%	-72.2%	-54.1%