ACA Health Insurer Fee
Estimated Impact on State Medicaid Programs and Medicaid Health Plans

January 2014 Update

Prepared for:
Medicaid Health Plans of America

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I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA), in conjunction with the Health Care and Education Reconciliation Act of 2010, represents a historic effort by the U.S. government to reform the healthcare system. Milliman was retained by the Medicaid Health Plans of America (MHPA) to provide an independent analysis of the impact of the ACA health insurer fee on state Medicaid programs and Medicaid health plans. This report is an update to our original analysis published on January 31, 2012.

In its decision of June 28, 2012, the U.S. Supreme Court upheld most of the ACA, but gave states the flexibility to decide whether to expand Medicaid program eligibility to 133% of the federal poverty level (FPL). Even though several states have already voiced their intentions for or against the Medicaid expansion, this report presents three scenarios in which various states expand their Medicaid programs to 133% of FPL (138% of FPL with the 5% income disregard).

Scenario 1 presents a "baseline expansion" scenario where 26 states expand their Medicaid program based on documented information from legislative decisions. Scenario 2 presents a "moderate expansion" scenario that includes six additional states implementing Medicaid expansion. Finally, scenario 3 models a "full expansion" scenario where all state Medicaid programs expand. Appendix A shows the details of our expansion scenarios.

The purpose of this report is to:

- Summarize the annual fee on health insurance providers under the ACA,
- Examine how the health insurer fee impacts the manner in which state Medicaid agencies set Medicaid managed care payments, and
- Quantify the financial impact of the health insurer fee on Medicaid programs under three Medicaid expansion scenarios.

SUMMARY OF THE ACA HEALTH INSURER FEE

The ACA places an $8 billion annual fee on the health insurance industry starting in 2014. The health insurer fee grows to $14.3 billion in 2018 and is indexed to the rate of premium growth thereafter. The health insurer fee is considered an excise tax and is non-deductible for income tax purposes.

The fee will be allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (e.g., the 2014 health insurer fee will be based on 2013 premium revenue). Each entity's fee is calculated as their market share multiplied by the annual fee. Market share is based on commercial, Medicare, Medicaid, and State Children Health Insurance Plan (SCHIP) premium revenue after applying dollar thresholds that reduce the market share of smaller insurers.

Nonprofit insurers that receive more than 80% of their premium revenue from Medicare, Medicaid, SCHIP, and dual eligible plans are exempt from the fee. Certain other nonprofit insurers can exclude 50% of their premium revenue from the health insurer fee calculation.

HOW THE ACA HEALTH INSURER FEE IMPACTS MEDICAID MANAGED CARE PAYMENTS

Many states rely on Medicaid managed care programs to provide cost-effective quality care to their Medicaid beneficiaries. In full-risk Medicaid managed care programs, managed care organizations (MCOs) are paid a fixed per member per month capitation payment (i.e., a monthly premium payment) to provide services to their members according to their contracts with the state.

Regulations issued by the Centers for Medicare and Medicaid Services (CMS) require premiums to be actuarially sound and that states obtain an actuarial certification from a qualified actuary. While CMS does not have set criteria to determine actuarial soundness, taxes are widely recognized as a reasonable and unavoidable cost of doing business for Medicaid MCOs.

Since the ACA health insurer fee is not deductible for corporate income tax purposes, the following two related costs should be considered by the Medicaid actuary for inclusion in Medicaid managed care payments:

1. An allowance for the ACA health insurer fee assessed to the state's Medicaid MCOs.

2. An allowance to cover the federal income tax impact on the additional revenue added to Medicaid managed care payments to cover the ACA health insurer fee. Assuming a 35% corporate income tax rate, Medicaid managed care payments would need to increase by the ACA health insurer fee divided by 0.65 (1 - 0.35).

Because the ACA health insurer fee is a federal tax, all tax revenue collected as a result of the fee will accrue to the federal government. Since Medicaid is funded by the state and federal governments, both governments share in funding the premium component that funds the tax. This situation results in the federal government taxing itself and taxing state governments to fund the higher Medicaid managed care payments required to fund the ACA health insurer fee, with no net financial impact to Medicaid MCOs.

The treatment of nonprofit Medicaid MCOs in the health insurer fee calculation may distort the competitive balance between for-profit and nonprofit MCOs, creating a situation where state governments will incur the additional cost of funding increased Medicaid managed care payments if they contract with for-profit MCOs.

FINANCIAL IMPACT OF THE ACA HEALTH INSURER FEE ON MEDICAID PROGRAMS

We estimate the ACA health insurer fee will increase Medicaid managed care payments by about 1.2% in 2014 and increasing to about 1.6% thereafter on a nationwide basis, with some states expected to see increased payments of up to 2.8% in a particular year. Given Medicaid managed care profit margins were less than 2% in CY 2012[1], increases of this magnitude are meaningful.

We project the state and federal government funding for the increase in Medicaid managed care payments related to the ACA health insurer fee will be between $36.4 billion and $39.3 billion over ten years, with between $13.3 billion and $13.9 billion of the total funding paid by state governments.

As a result of the funding differences between the current Medicaid population and the Medicaid expansion population, both the percentage of state funding and the total dollar amount of state funding decrease from the baseline expansion scenario to the moderate expansion scenario to the full expansion scenario. Under the ACA Medicaid expansion, the portion of the health insurer fee related to the expansion population is entirely paid for with federal funds in 2014 - 2016. States will need to contribute 5% in 2017, 6% in 2018, 7% in 2019, and 10% in 2020 and beyond. The portion of the fee related to a state's non-expansion Medicaid expenditures are funded according to normal FMAP rules.

Exhibit 1 summarizes important measures of the projected financial impact of the ACA health insurer fee on Medicaid programs. These results are presented in more detail in the remainder of this report.

[1] Palmer, Jeremy and Pettit, Christopher, "Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2012". http://us.milliman.com/uploadedFiles/insight/2013/medicaid-risk-based-financial-care.pdf

Exhibit 1
Impact of ACA Health Insurer Fee on Medicaid Programs
High-Level Summary of Important Financial Measures
Ten-Year Projection from 2014 to 2023

Important Financial Metric	Scenario 1: Baseline Expansion	Scenario 2: Moderate Expansion	Scenario 3: Full Expansion
Health Insurer Fee Paid by Medicaid MCOs	$24.5 billion	$25.3 billion	$26.4 billion
Percentage of Total Health Insurer Fee Paid by Medicaid MCOs	16.4%	16.8%	17.6%
Funding to Support Health Insurer Fee with Related Income Taxes Paid by Medicaid MCOs			
Federal Funding	$22.5 billion (62%)	$24.1 billion (64%)	$26.0 billion (66%)
State Funding	$13.9 billion (38%)	$13.6 billion (36%)	$13.3 billion (34%)
Total Funding	$36.4 billion	$37.7 billion	$39.3 billion
Nationwide Average Percentage Increase to Medicaid Managed Care Payments Due to Health Insurer Fee	1.6%	1.6%	1.6%
Range of State-Specific Percentage Increase to Medicaid Managed Care Payments Due to Health Insurer Fee in Any Particular Year	0.1% to 2.8%	0.1% to 2.8%	0.1% to 2.8%

UNCERTAINTY OF REPORT PROJECTIONS

There is uncertainty surrounding many of the projections presented in this report. That uncertainty stems from many sources, including evolving legislation and regulations, changing economic conditions, state-specific changes to the Medicaid program, imperfect and missing data, and interdependencies of modeling variables, just to name a few. The dynamics of the entire health insurance system are extraordinarily complex and the impending changes are unprecedented in the history of the U.S. healthcare system.

This report includes state-specific results based on publicly available information. Detailed analysis of the impact on individual states may produce different results based on the use of more specific information about a state's population, current Medicaid program, and future program changes.

II. ACA HEALTH INSURER FEE PROVISIONS

The ACA imposes an annual fee on health insurance providers. The rules for administering the health insurer fee are described in the ACA legislative text[2] and clarified in a document published by the Joint Committee on Taxation[3].

On November 29, 2013, the U.S. Department of the Treasury and Internal Revenue Service (IRS) published final regulations[4] on the health insurer fee provision of the ACA. The published regulations did not deviate from the original rules found in Section 9010 of the ACA and Section 1406 of the Reconciliation Act, but rather confirmed what the industry already assumed about the health insurer fee. The regulations did provide more detailed guidance on how the IRS will collect the health insurer fee, as follows:

- The fee is calculated at the corporate entity level
- Life and property and casualty insurance companies with U.S. health risk business are also subject to the health insurer fee
- Retiree-only health plans are included in the calculation

For the purposes of this report, we considered all premiums reported under the Medicaid line of business to be subject to the health insurer fee. We could not credibly identify premiums related to Medicaid long term care programs that can be excluded from the fee calculations as described in the final IRS rule.

This section of our report presents a summary of the insurer fee provisions.

FEE AMOUNT

The ACA places an $8 billion annual fee on the health insurance industry starting in 2014. The annual fee increases according to the schedule in Exhibit 2.

Exhibit 2
Annual Fee on Health Insurance Providers
Applicable Fee by Calendar Year

Calendar Year	Applicable Fee
2014	$ 8.0 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018	$14.3 billion
2019+	Growth of fee indexed to rate of premium growth

The health insurer fee is considered an excise tax. The health insurer fee is nondeductible for income tax purposes.

[2] Section 9010 of ACA, as amended by section 10905 of ACA and section 1406 of the Reconciliation Act
[3] Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010", as amended, in combination with the "Patient Protection and Affordable Care Act"* (JCX-18-10), March 21, 2010, page 88 – 92, retrieved from www.jct.gov
[4] https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-28412.pdf

Fee Application

The health insurer fee applies to any covered entity engaged in the business of providing health insurance with respect to U.S. health risks. Covered entities specifically exclude the following organizations:

- Employers that self-insure the health risks of their employees
- Government entities, including independent nonprofit county-organized health system entities that contract with state Medicaid agencies
- Nonprofit entities that receive more than 80% of gross revenue from government programs that target low-income, elderly, or disabled populations including Medicare, Medicaid, State Children's Health Insurance Plan (SCHIP), and dual eligible plans
- Organizations that qualify as voluntary employees' beneficiary associations (VEBAs) established by entities other than employers

FEE CALCULATION

The fee will be allocated to health insurers based on the respective market share of premium revenue in the previous year (e.g., the 2014 health insurer fee will be based on 2013 premium revenue). Each entity's fee is calculated as their market share multiplied by the annual fee shown in Exhibit 2.

Each insurer's market share is based on commercial, Medicare, Medicaid, and SCHIP premium revenue, with a few limited exceptions[5].

The amount of net premiums that are taken into account for the purposes of determining a covered entity's market share is subject to the dollar thresholds shown in Exhibit 3. The dollar thresholds serve to lower the market share, and therefore the fee, for smaller insurers.

Exhibit 3
Dollar Thresholds for Determining Premiums Taken Into Account

Net Premiums Written	Percentage Taken Into Account
Not more than $25 million	0%
$25 million - $50 million	50%
More than $50 million	100%

For example, a covered entity with:

- $20 million of net premiums would have $0 in net premiums taken into account
- $40 million of net premiums would have $7.5 million in net premiums taken into account (0% of $25 million + 50% of $15 million)
- $100 million of net premiums would have $62.5 million in net premiums taken into account (0% of $25 million + 50% of $25 million + 100% of $50 million)

[5] Insurer market share excludes premiums related to accident and disability insurance, coverage for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, long-term care insurance, and Medicare supplement insurance.

Certain covered entities can exclude an additional 50% of their net premium because of their status as a public charity, social welfare organization, high-risk health insurance pool, or a consumer operated and oriented plan (CO-OP). For example, a qualifying organization with $40 million of net premiums would have $3.75 million taken into account (50% x [0% of $25 million + 50% of $15 million]).

Note that related entities under common control will be considered a single entity for the calculation of the health insurer fee.

Section 9010 of the ACA does not define net premiums written. However, the IRS regulations define the term net premiums written to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year. Net premiums written for the health insurer generally will equal the amount reported on the Supplemental Health Care Exhibit (SHCE) as direct premiums written minus MLR rebates with respect to the data year, subject to any applicable exclusions under section 9010 such as exclusions from the term health insurance.

FEE IMPLEMENTATION

According to the final IRS regulations, each health insurer is required to report its net premiums written to the IRS annually by April 15 of the fee year on Form 8963, "Report of Health Insurance Provider Information". Most health insurers will file the SHCE form, which supplements the annual statement filed with the National Association of Insurance Commissioners (NAIC) under applicable state law.

The IRS will then send each insurer a notice of preliminary fee calculation each fee year that will include the insurer's allocated fee, net premiums written for health insurance of United States health risks, net premiums written taken into account, and aggregate net premiums written taken into account for all insurers. The regulations provide that the IRS will send each covered entity its final fee calculation for a fee year no later than August 31 of that fee year, and that the covered entity must pay the fee by September 30 by electronic funds transfer.

The ACA also imposes a penalty for any failure to report the required information by the date prescribed and an accuracy-related penalty for any understatement of the covered entity's net premiums written. These penalties are not discussed in this report.

OTHER CONSIDERATIONS

Also from Section 9010, plans that are not providing health insurance for any United States health risk in the year the fee is due will not be required to pay the fee.

The IRS final rule clarifies that in cases where a health insurer is exempt from tax by section 501(a), the 50% exemption applies to the net premiums written of that entity that are attributable to its exempt activities. This means that for health insurers with multiple subsidiaries with one or more entities eligible for the 50% exemption and one or more that are not, the exemption only applies to the exemption eligible entities. Exhibit 4 provides an illustration of the application of the exemption factor in the case of a health insurer with multiple subsidiaries.

Exhibit 4 50% Exemption Application Illustration		
A	Subsidiary #1 Total Health Insurance Premium Revenue (Not-for-Profit)	$100.0 million
B	Subsidiary #2 Total Health Insurance Premium Revenue (For-Profit)	$300.0 million
C	Total Health Insurance Premium Revenue (A + B)	$400.0 million
D	Total Premiums Taken Into Account	$362.5 million
E	Exemption Percentage (50% * A / (A + B))	12.5%
F	Final Premiums Taken Into Account (D * [1 – E])	$317.2 million

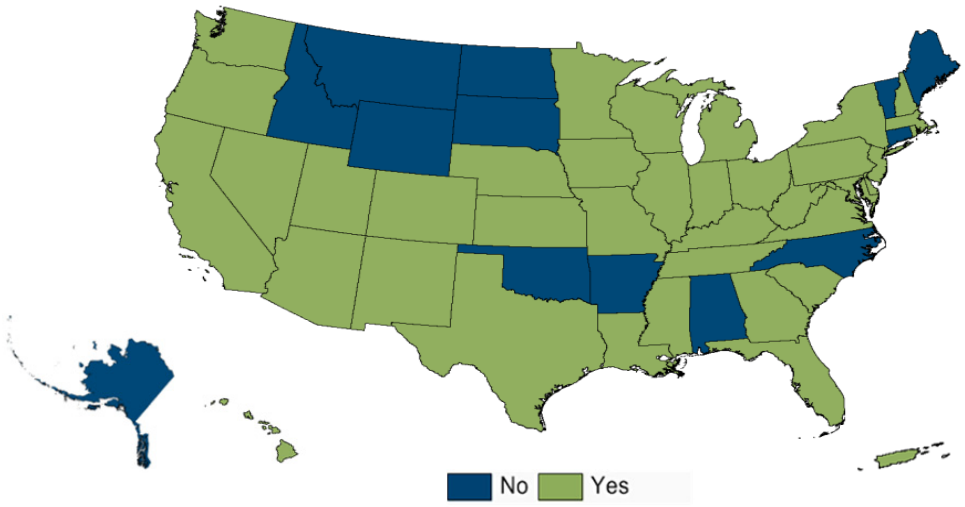
For example, an entity with $100 million of net premium under a non-profit subsidiary and $300 million additional net premiums under a for-profit subsidiary would have a total premium taken into account of $317.2 ([1 – 12.5%] x [0% of 25 million, 50% of 25 million and 100% of 350 million]). In this example, the exemption is only 12.5% of total premiums taken into account because 25% of the net premiums are for exempt activities (12.5% = 50% x [100 / (100 + 300)]).

Finally, the Treasury Department and the IRS note that the term United States health risk includes the health risks of individuals in the possessions of the United States since they will either be United States citizens or considered as located in the United States.

III. HEALTH INSURER FEE IMPACT ON MEDICAID MANAGED CARE PAYMENTS

Many states rely on Medicaid managed care programs to provide cost-effective quality care to their Medicaid beneficiaries. In 2011, the most recent year for which CMS provided data, approximately 51% of all Medicaid beneficiaries were enrolled in full-risk capitated Medicaid managed care programs (excluding enrollment in primary care case management programs). Exhibit 5 shows the 39 states and territories that operated full-risk capitated Medicaid managed care programs in 2013.

Exhibit 5
States Operating Full-Risk Medicaid Managed Care Programs in 2013



With recent state budget pressures, many states are expanding enrollment in existing or new Medicaid managed care programs. Since 2011, the following states have expanded Medicaid managed care enrollment or announced plans to do so within the next several years: California, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, New Hampshire, New Jersey, New York, Ohio, South Carolina, Texas, Utah, Virginia, and Washington. Connecticut is the only state that ended its full-risk capitated managed care program in favor of an administrative services only (ASO) arrangement. With these Medicaid managed care expansions, we estimate the nationwide Medicaid managed care penetration rate will increase from 51% in 2011 to approximately 57% in 2013.

The optional expansion of Medicaid coverage under ACA to people under the age of 65 at or below 138% of FPL coupled with the probable continued expansion of Medicaid managed care programs means that enrollment in Medicaid MCOs is likely to increase over time. Appendix A shows the details of our expansion scenarios.

STATE AND FEDERAL FUNDING OF MEDICAID MANAGED CARE

In full-risk Medicaid managed care programs, MCOs are paid a fixed monthly capitation payment (i.e., a premium payment) to provide services to their members according to their contracts with the state. The Medicaid program is funded jointly by the state and federal government.

The federal share of the cost of Medicaid is known as the Federal Financial Participation (FFP). The FFP is defined as a percentage amount and referred to as the Federal Medical Assistance Percentage (FMAP). FMAP varies by state and is calculated annually according to the rules in the Social Security Act. FMAP generally ranges from 50% to 73% with a nationwide average FMAP of about 59%. State government funds an average of about 41% of the Medicaid program, with state-specific funding percentages between 25% and 50%.

Federal funding of Medicaid will increase for the population newly eligible for Medicaid as a result of the ACA 2014 Medicaid expansion to 138% of FPL. Under the ACA Medicaid expansion, the portion of the health insurer fee related to the expansion population is entirely paid for with federal funds in 2014 - 2016. States will need to contribute 5% in 2017, 6% in 2018, 7% in 2019, and 10% in 2020 and beyond. The portion of the fee related to a state's non-expansion Medicaid expenditures are funded according to normal FMAP rules.

As a result of the increased federal funding of the expansion population, our projections assume an average FMAP of 98% for 2014 - 2018 and 90% for 2019 - 2023 for the Medicaid expansion population and FY 2014 FMAP for the non-expansion Medicaid population. This increase in federal funding results in a nationwide average FMAP of 66% in the "full expansion" scenario, or 7% higher than historical levels.

ACTUARIAL SOUNDNESS REQUIREMENT

CMS regulations govern the development and approval of premiums paid by state Medicaid agencies to Medicaid MCOs under full-risk contracts as described in the Code of Federal Regulations, 42 CFR 438.6(c).

These regulations require premiums to be actuarially sound and that states obtain an Actuarial Certification from a qualified actuary. CMS does not have set criteria to determine actuarial soundness of premiums and relies on qualified actuaries to certify the soundness of the rates in an Actuarial Certification. However, CMS uses a checklist to assist the regional offices in reviewing the materials prepared and submitted by the states and their consulting actuaries in support of their proposed Medicaid managed care premiums. The checklist is also used to document the premium methodology and assumptions used in developing the premiums. Following its review, CMS either approves the rates, methodology, and assumptions or asks states to make revisions.

In 2005, the American Academy of Actuaries published a nonbinding Practice Note[6] to be used as guidance to actuaries certifying Medicaid premiums. The goals of the Practice Note were to:

- Provide guidance to the actuary when certifying rates or rate ranges as meeting the requirements of 42 CFR 438.6(c) for capitated Medicaid managed care programs
- Provide examples of responses to certain situations and issues

However, practice notes do not have the same standing as an Actuarial Standard of Practice (ASOP) in determining what constitutes generally accepted actuarial principles and practices. ASOPs are considered part of an actuary's professional code of conduct and have the highest standing. In contrast, practice notes are not a definitive statement as to what constitutes generally accepted practice.

Currently, no ASOP applies specifically to actuarial work performed to comply with CMS requirements for Medicaid rate certification. However, several ASOPs apply to certain components of a Medicaid managed care premium development methodology. For example, ASOP No. 23 on Data Quality addresses the binding guidance to an actuary surrounding the topic of data.

[6] American Academy of Actuaries (August 2005). Health Practice Counsel Practice Note, Actuarial Certification of Rates for Medicaid Managed Care Programs.

The Practice Note includes the following definition of actuarial soundness related to Medicaid managed care premiums:

> *"Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation payments, including expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, state-mandated assessments and taxes, and the cost of capital."*

In other words, Medicaid managed care premiums are actuarially sound if they provide the participating plans an opportunity to cover their projected expenses and generate a modest profit if they are operated in an efficient manner.

CONSIDERATION OF THE ACA HEALTH INSURER FEE IN ACTUARIAL CERTIFICATION

The American Academy of Actuaries Practice Note indicates that "state-mandated assessments and taxes" are to be considered in an actuary's certification of Medicaid managed care premiums. Taxes are widely recognized as a reasonable and unavoidable cost of doing business for Medicaid MCOs. It is common practice for states and their actuaries to include an explicit rate component for items such as state premium taxes and other taxes that are assessed on Medicaid managed care premium rates. If the tax amount varies by MCO or type of MCO (e.g., for-profit vs. nonprofit), the tax is typically handled as a different rate component specific to each different situation.

The ACA health insurer fee is a cost that should be treated in a manner consistent with how premium taxes or other fees and assessments are now treated. Since the ACA health insurer fee is not deductible for corporate income tax purposes, the following two related costs should be considered by the Medicaid actuary for inclusion in Medicaid managed care payments:

1. An allowance for the ACA health insurer fee assessed to the state's Medicaid MCOs.

2. An allowance to cover the federal income tax impact on the additional revenue added to Medicaid managed care payments to cover the ACA health insurer fee. Assuming a 35% corporate income tax rate, Medicaid managed care rates would need to increase by the ACA health insurer fee divided by 0.65 (1 - 0.35).

IMPACT OF THE ACA HEALTH INSURER FEE ON STATE FUNDING OF MEDICAID MANAGED CARE

Because the ACA health insurer fee is a federal tax, all tax revenue collected as a result of the fee will accrue to the federal government. Since Medicaid is funded by the state and federal governments, both governments share in funding the premium component that funds the tax. This situation results in the federal government taxing itself and taxing state governments to fund the higher Medicaid managed care premiums required to fund the ACA health insurer fee, with no net financial impact to Medicaid MCOs.

Exhibit 6 illustrates the flow of funds related to a $1.00 ACA health insurer fee for Medicaid MCOs. Because of the non-deductibility of the health insurer fee, every $1.00 of health insurer fee paid by a for-profit MCO will need to be funded at $1.54 (equal to $1.00 / [1 - 0.35]) to keep the net financial impact on the for-profit MCO at zero.

Exhibit 6
Flow of Funds for ACA Health Insurer Fee Under Medicaid Managed Care
Example: State with 66% FMAP and $1.00 ACA Health Insurer Fee Paid to a For-Profit MCO

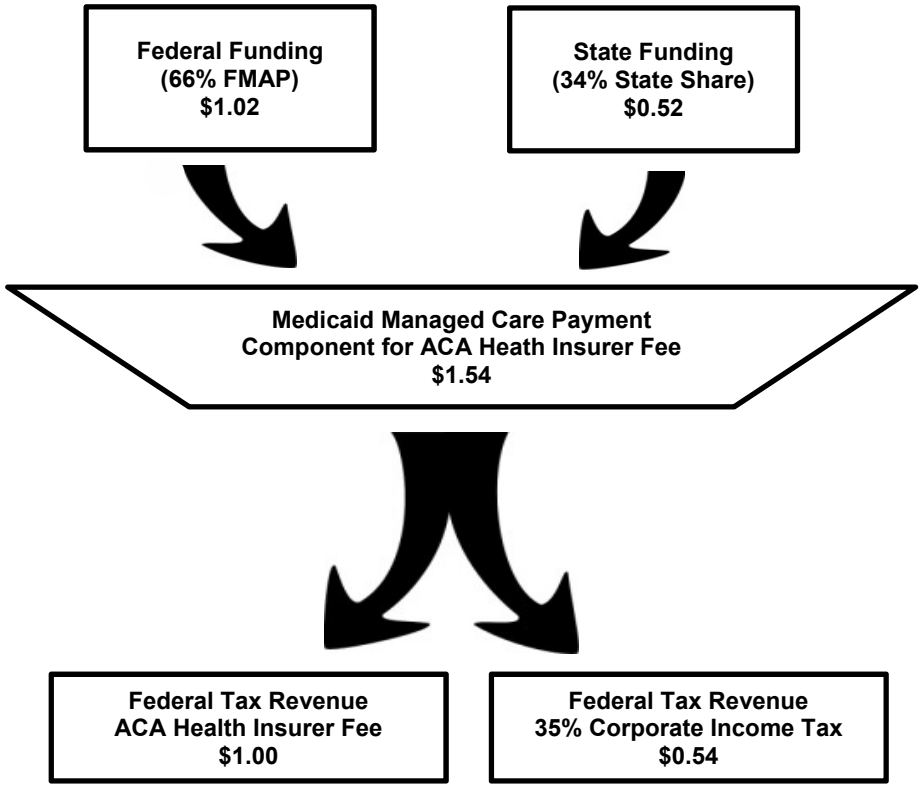


Exhibit 7 shows the net impact of the Medicaid managed care rate flow of funds on each party: The federal government, the state government, and the Medicaid MCO. The result is a transfer of $0.52 from state government to the federal government for every $1.00 of ACA health insurer fee.

Exhibit 7
Net Financial Impact of Medicaid Managed Care Flow of Funds
Example: State with 66% FMAP and $1.00 ACA Health Insurer Fee Paid to a For-Profit MCO

	Federal Government	State Government	Medicaid MCO
Funding of Managed Care Payment	($1.02)	($0.52)	$1.54
Cash Flow from ACA Health Insurer Fee	1.00	0.00	(1.00)
Cash Flow from 35% Corporate Income Tax	0.54	0.00	(0.54)
Net Impact	**$0.52**	**($0.52)**	**$0.00**

IV. FINANCIAL IMPACT ON MEDICAID PROGRAMS

This section of the report presents our estimates of the financial impact of the health insurer fee on Medicaid programs.

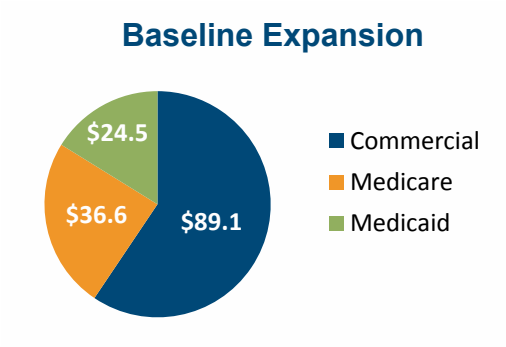
SUMMARY OF MODELING RESULTS – MEDICAID SHARE OF ACA HEALTH INSURER FEE

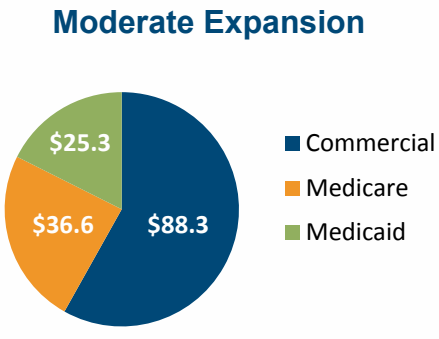
Exhibit 8 shows the share of the total ACA health insurer fee paid as a result of commercial, Medicaid, and Medicare Advantage / Part D premiums. Over a ten-year period from 2014 to 2023, we project that Medicaid managed care organizations will pay $24.5 billion to $26.4 billion in ACA health insurer fees (excluding the related income tax impact), representing 16.4% - 17.6% of the total health insurer fee.

The state and federal government fund Medicaid managed care premiums and will share the cost of the Medicaid managed care health insurer fees according to state-specific FMAP percentages in place each year. Based on the estimated FMAP levels in Appendices B – D, state governments will pay $9.0 billion to $9.3 billion in ACA health insurer fees (excluding the related income tax impact) over the ten-year period from 2014 to 2023.

The health insurer fee is expected to impact a large number of Medicaid MCOs. If the health insurer fee was in effect for 2011, over 110 Medicaid MCOs would have paid a fee (after combining MCOs under common control).

Exhibit 8
ACA Health Insurer Fee Paid by Market
Excluding the Impact of Corporate Income Taxes
Total for Ten-Year Projection
From 2014 to 2023 (in billions)





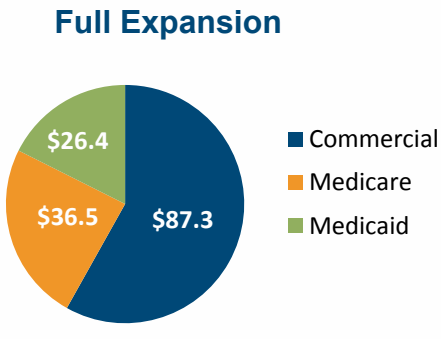


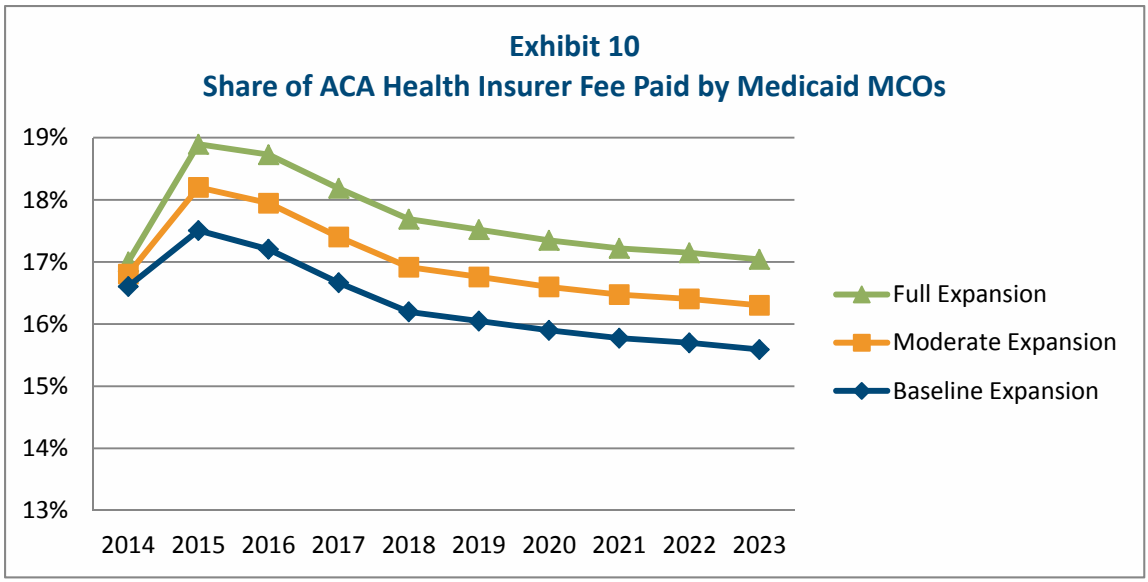
Exhibit 9 shows the amount of the ACA health insurer fee paid by Medicaid MCOs in each year.

Exhibit 9
Share of ACA Health Insurer Fee Paid by Medicaid MCOs
Excluding the Impact of Corporate Income Taxes
in Billions of Dollars

Year	Total Health Insurer Fee	Health Insurer Fee Paid by Medicaid MCOs			Percentage of Total Health Insurer Fee Paid by Medicaid MCOs
		Baseline Expansion Scenario	Moderate Expansion Scenario	Full Expansion Scenario	
2014	$8.0	$1.3	$1.3	$1.4	16.7% - 17.0%
2015	11.3	2.0	2.1	2.1	17.7% - 18.9%
2016	11.3	2.0	2.0	2.1	17.4% - 18.7%
2017	13.9	2.3	2.4	2.5	16.8% - 18.2%
2018	14.3	2.3	2.4	2.5	16.3% - 17.7%
2019	15.5*	2.5	2.6	2.7	16.2% - 17.5%
2020	16.8*	2.7	2.8	2.9	16.1% - 17.3%
2021	18.2*	2.9	3.0	3.1	15.9% - 17.2%
2022	19.7*	3.1	3.2	3.4	15.8% - 17.1%
2023	21.3*	3.4	3.5	3.6	15.7% - 17.0%
Total	**$150.2***	**$24.5**	**$25.3**	**$26.4**	**16.4% - 17.6%**

** Estimated based on growth in premiums*

Exhibit 10 shows the share of the ACA health insurer fee paid by Medicaid MCOs in each year from 2014 to 2023 under each scenario. The increase in the Medicaid MCO share from 2014 to 2015 is caused by increased Medicaid managed care premiums related to the 2014 Medicaid expansion population. The share paid by Medicaid MCOs drops after 2015 as the projected growth in commercial and Medicare Advantage / Part D premiums outpaces the projected growth in Medicaid MCO premiums.



SUMMARY OF MODELING RESULTS – IMPACT ON MEDICAID MANAGED CARE RATES

As discussed in Section III of this report, Medicaid managed care premiums will increase as a result of the ACA health insurer fee. The impact will vary by state based on the characteristics of the MCOs in each state's Medicaid managed care program. In general, states that contract with more nonprofit MCOs will pay a lower health insurer fee. The impact is lower for nonprofit insurers because:

- Nonprofit entities that receive more than 80% of gross revenue from government programs that target low-income, elderly, or disabled populations are exempt from the fee
- Certain covered entities can exclude 50% of their net premium for the health insurer fee calculation because of their status as a public charity, social welfare organization, high-risk health insurance pool, or a consumer operated and oriented plan (CO-OP)
- Nonprofit insurers are exempt from corporate income tax

The treatment of nonprofit MCOs in the health insurer fee calculation may distort the competitive balance between for-profit and nonprofit MCOs, creating a situation where state governments would incur the additional cost of funding increased Medicaid managed care payments if they contract with for-profit MCOs.

Approximately 42% of nationwide Medicaid managed care premiums in 2011 were paid to nonprofit MCOs. Exhibit 11 is a map of the United States showing the estimated percentage of Medicaid managed care premiums for nonprofit MCOs in each state in 2014.

Exhibit 11
Estimated Percentage of Medicaid Managed Care Premium Paid to Nonprofit MCOs

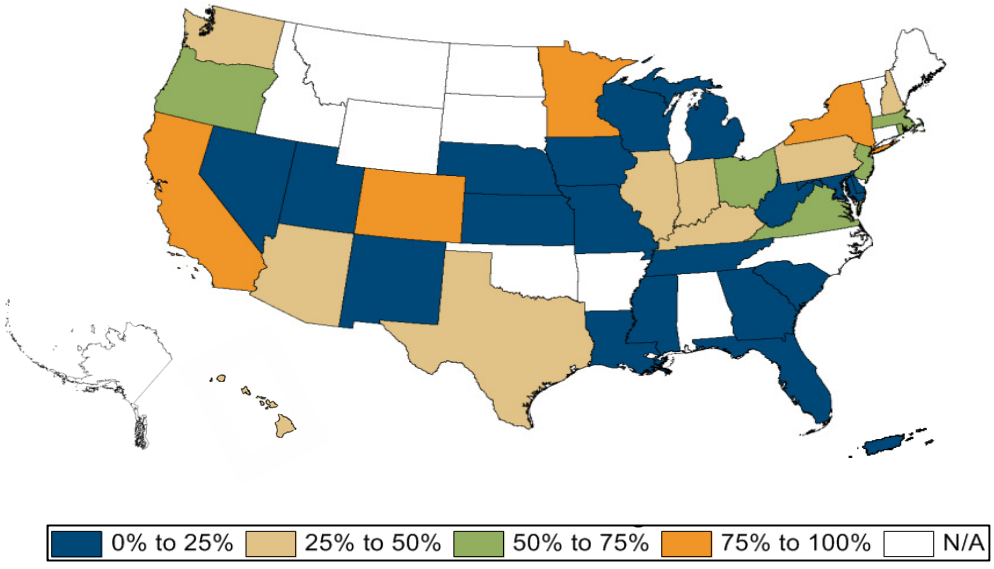
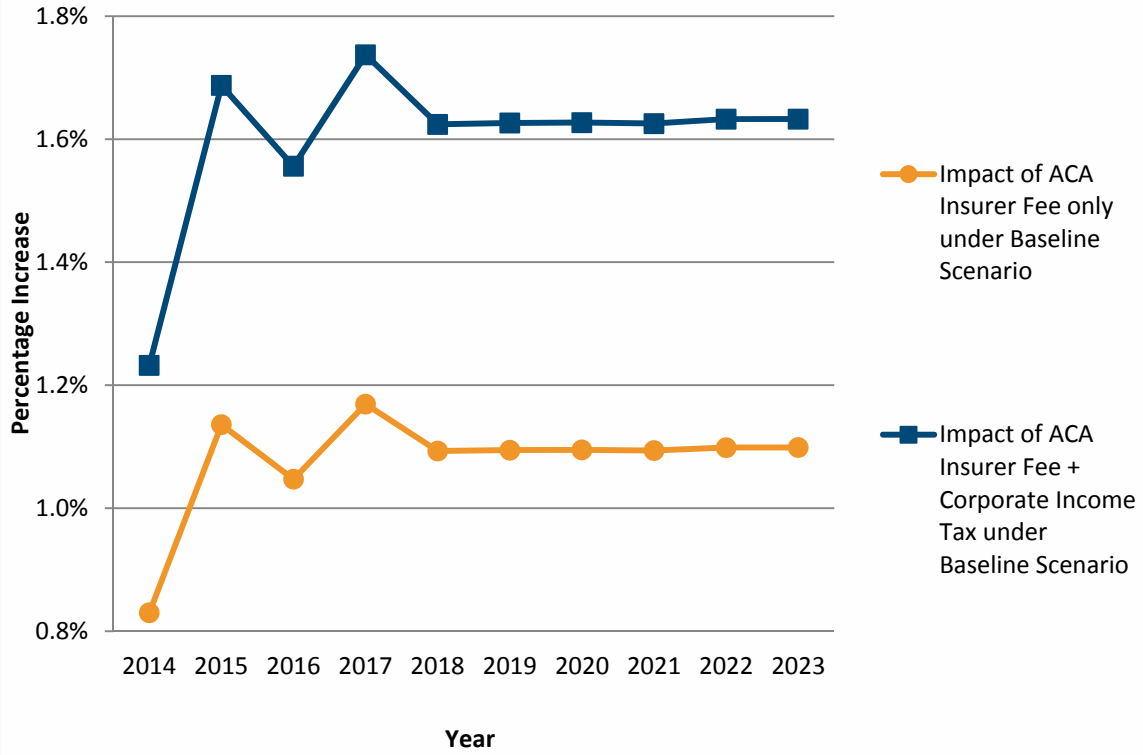


Exhibit 12 shows the nationwide average percentage increase to Medicaid managed care payments related to the ACA health insurer fee. The lower line shows the impact of only the health insurer fee. The upper line shows the impact of the health insurer fee plus an allocation for corporate income tax due to the non-deductibility of the health insurer fee. Medicaid managed care payments will increase for both components, so the upper line in Exhibit 12 is the total increase to Medicaid managed care payments.

Exhibit 12
Nationwide Percentage Increase to Medicaid Managed Care Premiums
Due to ACA Health Insurer Fee
Baseline Scenario



On average, states can expect that their Medicaid managed care premiums will increase 1.6% because of the ACA health insurer fee. States that contract exclusively with for-profit Medicaid MCOs can expect that their Medicaid managed care premiums will increase by up to 2.8% in any particular year. Given Medicaid managed care profit margins were less than 2% in CY 2012, increases of this magnitude are meaningful.

Exhibit 13 shows a map of the United States with the expected payment increases by state over the ten-year period from 2014 to 2023 for the Baseline Expansion scenario, reflecting the impact of both the ACA health insurer fee and the associated allowance for corporate income tax. The projections assume states continue to contract with the same MCOs as they did in 2011 except in specific situations where plan composition changes are already known. The states with higher increases in Exhibit 13 currently contract with more for-profit Medicaid MCOs. The states with lower increases in Exhibit 13 currently contract with more nonprofit Medicaid MCOs.

Exhibit 13
Impact of Health Insurer Fee on Medicaid Managed Care Premiums Including Associated Allowance for Corporate Income Tax
Ten Year Projection from 2014 to 2023
Baseline Expansion Scenario

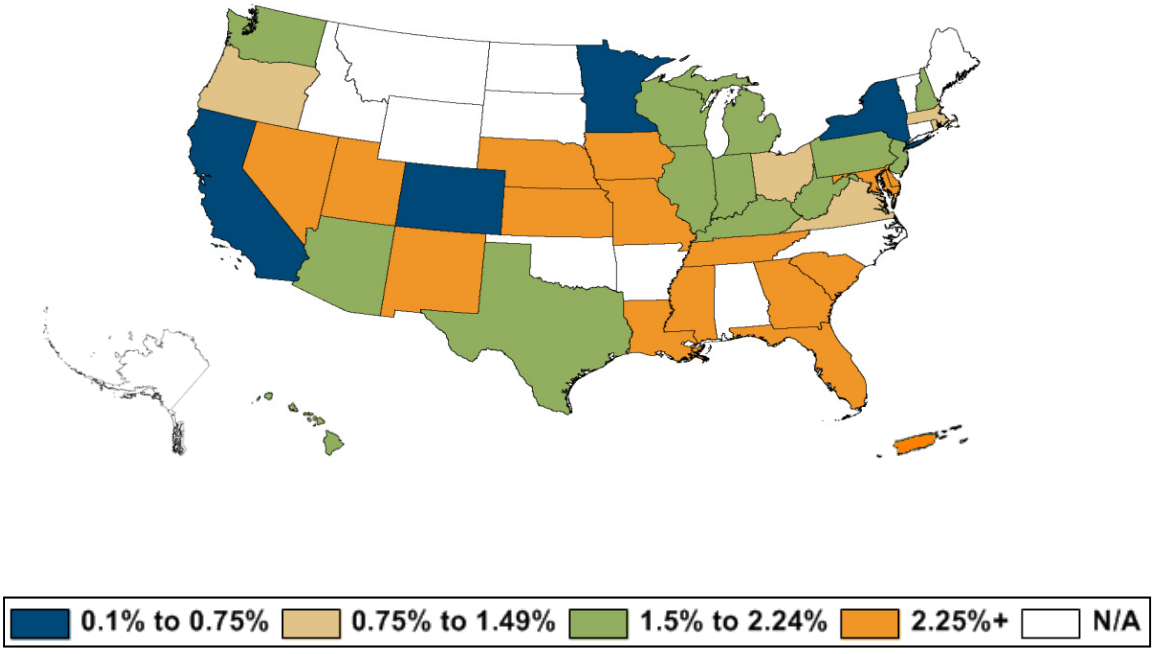
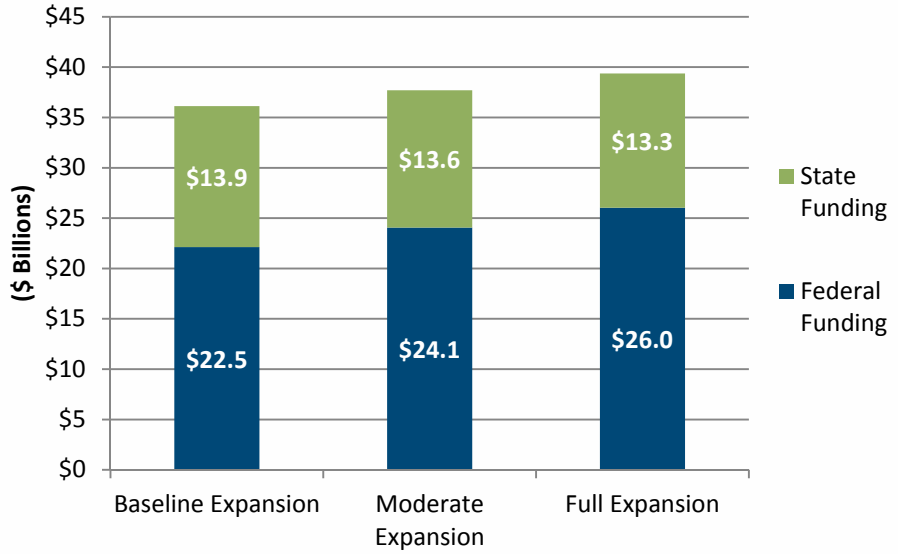


Exhibit 14 shows the nationwide government expenditures necessary to fund the increased Medicaid managed care premiums due to the ACA health insurer fee for each of the three expansion scenarios. Since Medicaid managed care premiums are funded jointly by state and federal government, we show state and federal funding separately based on the estimated FMAP levels in Appendices B – D.

Exhibit 14
Nationwide Funding of Increased Medicaid Managed Care Premiums Due to ACA Health Insurer Fee
Ten Year Projection from 2014 to 2023
Based on Estimated FMAP Levels



As a result of the funding differences between the current Medicaid population and the Medicaid expansion population, both the percentage of state funding and the total dollar amount of state funding decrease from the baseline expansion scenario to the moderate expansion scenario to the full expansion scenario. The state funded portion of the health insurer fee decreases slightly over time while the federally funded portion increases because the portion attributable to the Medicaid expansion population is largely funded through enhanced FMAP of 100% for 2014 – 2016, grading down to 90% in 2020 and thereafter.

Appendices B – D show state-specific results for each scenario for 2014 – 2018, 2019 – 2023, and in total for 2014 – 2023. Results include:

- Assumed FMAP for each state
- Percentage increase to Medicaid managed care premiums
- Total funding of increased Medicaid managed care premiums
- State funding of increased Medicaid managed care premiums

The assumed FMAP is a weighted average of the FY 2014 FMAP for the non-expansion population and the average enhanced FMAP (98% for 2014 - 2018 and 90% for 2019 - 2023) for the Medicaid expansion population.

The appendices include state-specific results based on publicly available information. Detailed analysis of the impact on individual states may produce different results based on the use of more specific information about a state's population, current Medicaid program, and future program changes.

MODELING SCENARIOS

The expansion of Medicaid coverage under ACA to people under the age of 65 at or below 138% of FPL coupled with the probable continued expansion of Medicaid managed care programs means that enrollment in Medicaid MCOs is likely to increase over time.

Exhibit 15 summarizes the nationwide Medicaid MCO enrollment growth assumptions for each scenario compared to projected 2013 Medicaid MCO enrollment. The Exhibit 15 MCO enrollment growth includes normal demographic trends in addition to the 2014 Medicaid expansion population. The 2014 expansion population is assumed to phase in to enrollment over several years. Growth assumptions vary by state according to current Medicaid eligibility rules and other demographic factors. As a comparison, CMS[7] projects nationwide enrollment growth rates compared to 2013 of 15% for 2014 and 35% for 2019.

Exhibit 15
Nationwide Medicaid MCO Enrollment Growth Compared to 2013

Scenario	2014	2019	2023
Baseline Expansion	14%	22%	28%
Moderate Expansion	15%	23%	30%
Full Expansion	18%	26%	32%
CMS Projection*	15%	35%	N/A

**The CMS projections include Medicaid managed care and fee-for-service populations while the growth percentages for our scenarios only account for the managed care population.*

[7] Centers for Medicare and Medicaid Services, *2012 Actuarial Report on the Financial Outlook for Medicaid,* page 22, retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2012.pdf

V. DESCRIPTION OF METHODOLOGY

The range of results presented in this report estimates the impact of the ACA health insurer fee on Medicaid MCOs based on several assumptions and scenarios. This section of our report documents the methodology and the scenarios used to present the range of results.

At a high level, our methodology can be summarized into the following steps:

1. Establish 2011 base year enrollment and expenditures for all insurance market sectors
2. Increase Medicaid managed care penetration in states that have announced new or expanded programs
3. Project enrollment and expenditures in each insured market during 2013 – 2023 based on the Milliman *Health Care Reform Financing Projection Model*
4. Calculate each insurer's market share and allocate the ACA health insurer fee to each insurer and market

STEP 1: ESTABLISH 2011 BASE YEAR ENROLLMENT AND EXPENDITURES FOR ALL INSURANCE MARKET SECTORS

In order to establish base year enrollment and premium volume by insurer and market, we gathered premium and enrollment data for the insurers associated with each major market identified below from 2011 National Association of Insurance Commissioners (NAIC) annual statement filings collected and published by SNL Financial (SNL) licensed by Milliman.

- Commercial market: Includes the comprehensive (hospital and medical), vision, dental, Federal Employees Health Benefit Program, and other health lines of business
- Medicare market: Title XVIII Medicare line of business (excludes Medicare Supplement policies)
- Medicaid market: Title XIX Medicaid line of business (includes Title XXI SCHIP coverage)
- We excluded the Medicare supplement and other non-health annual statement lines of business because they are excluded from the ACA health insurer fee calculation

For states where the NAIC filing requirements are not as pervasive (i.e., Arizona and California), we supplemented the missing data with filings collected and reported by other state government sources. Finally, we compared the starting data to multiple summaries of the current commercial, Medicare, and Medicaid markets compiled by CMS and the Kaiser Family Foundation. Using these comparisons, we supplemented our financial statement data for any Medicaid health plans whose enrollment and premiums were not filed with the NAIC (e.g., the plan is a nonprofit that is not required to submit a filing).

After summarizing the enrollment in insurance plans in each market, we summarized enrollment and expenditures in large group self-funded plans, Medicaid fee-for-service (FFS), Medicare FFS, and the uninsured market from figures collected from CMS and Kaiser State Health Facts.

The data collection and validation process for the January 2014 update of this report included updates of the following items compared to our initial January 31, 2012 report:

- The base financial statement data was updated from 2010 to 2011
- Life and property and casualty insurer financial statements were more thoroughly reviewed for health insurance business falling under the ACA health insurer fee
- Commercial and Medicare Advantage market results were more thoroughly reviewed compared to other projections

Note that there are data limitations that may impact our base year estimates. While we attempted to adjust the base data to compile as accurate a starting point as possible, certain insurers may not be fully represented in our 2011 base year data. Given the uncertain nature of ten-year projections, we do not believe any data irregularities would have a material impact on our projections.

STEP 2: INCREASE MEDICAID MANAGED CARE PENETRATION IN STATES THAT HAVE ANNOUNCED NEW OR EXPANDED PROGRAMS

The following states have expanded Medicaid managed care enrollment or announced plans to do so within the next several years: California, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, New Hampshire, New Jersey, New York, Ohio, South Carolina, Texas, Utah, Virginia, and Washington. Because these program expansions are not reflected in the 2011 base data from Step 1, we increased the Medicaid managed care penetration rates in these states based on high-level estimates of the scope of each state's program expansion as provided by MHPA member organizations.

Connecticut is the only state that ended its full-risk capitated managed care program in favor of an administrative services only (ASO) arrangement. We removed the Connecticut Medicaid managed care enrollment from our analysis.

STEP 3: PROJECT ENROLLMENT AND EXPENDITURES IN EACH INSURED MARKET DURING 2013 - 2023 BASED ON THE MILLIMAN HEALTH CARE REFORM FINANCING PROJECTION MODEL

Step 3 projects the enrollment and expenditures per member per year (PMPY) by insurer, state, and market for each year from 2013 to 2023 using Milliman's Health Care Reform Financing Projection Model. In order to efficiently model each state, we created state groupings based on current Medicaid eligibility standards and uninsured population characteristics and selected appropriate assumptions to best fit each state's grouping.

Using projections from Milliman's Health Care Reform Financing Projection Model, we created enrollment and expenditure PMPY projection factors for each market and state. Upon determining enrollment and expenditure PMPY for each year from 2013 to 2023, we summarized total expenditure and calculated the total premium taken into account for use in calculation of each plan's market share for determination of the health plan fee allocation.

The Health Care Reform Financing Projection Model uses the following information to make its projections.

CPS Data

The initial census data at the core of the Health Care Reform Financing Projection Model was developed using the Current Population Survey (CPS). We used the data to determine the composition of the United States population by age, gender, income level, insurance coverage type, and family status. We also used its data on self-reported health status.

MEPS Data

The Health Care Reform Financing Projection Model uses Medical Expenditure Panel Survey (MEPS) data to supplement the census data and include splits regarding whether the employer insurance is small group, large group, self-insured, or fully insured.

Medical Costs

Medical cost curves by age and gender were developed using an assumed set of benefits and research underlying Milliman's *Health Cost Guidelines™.* The medical cost curves vary by market and level of benefit richness. Premiums were developed from the estimated medical costs, minus the estimated cost sharing in the modeled benefit plans, plus an estimated administrative load based on data collected nationally.

Pent-up Demand

The Health Care Reform Financing Projection Model assumes that people moving from an uninsured status to insured status would have first-year costs that are 10% higher than normal for their age and gender, which is due to pent-up demand for healthcare services.

Trend

We estimated annual medical trend rates for each market and major service category (inpatient, outpatient, professional, prescription drug, and other) based on Milliman's ongoing trend research.

Births and Mortality

We used birth assumptions based on the distribution of newborns in the CPS data, and mortality assumptions as reported in the 2008 U.S Mortality Tables.

Take-Up Rates

Take-up rates describe the probability of people changing from uninsured to insured, or from one market to another (e.g., from the individual non-exchange market to the individual exchange market). Milliman has conducted research to determine what percentage of people (for each combination of representative age, gender, and health status) will tend to move to switch markets, based on ACA provisions and the modeled individual's expected healthcare costs, subsidies, and premium rate choices. Using that research, we modeled movements into the health benefit exchanges from other markets and movements into Medicaid from other markets

Movement Between Markets

The causes of age-related movements between markets are formerly dependent children who reach an age where they are emancipated to other markets, adults who reach age 65 and join the Medicare market, and individuals in other markets who lapse to the uninsured market because of premium rate increases they can no longer tolerate.

Medical Loss Ratio Adjustment

Another provision of the ACA is the implementation of a minimum medical loss ratio (MLR) requirement. This portion of the law requires that individual and small group lines of business use at least 80% of premium dollars to pay for claims and healthcare quality improvement activity. Large group and Medicare Advantage plans have to achieve at least an 85% MLR. Most states do not require managed Medicaid plans to adhere to a minimum MLR requirement; however, there are a few states that have implemented minimum MLR standards in the 80% to 92% range. Dental and vision lines of business are not subject to minimum MLR requirements. If a plan fails to meet the minimum MLR requirement, they must issue rebates by August of the following year.

We modeled the minimum MLR requirement in each year from 2013 to 2023 by forcing plans to adjust their revenue downward to achieve the specified MLR standard in each respective market, as applicable in their states—commercial, Medicare, and Medicaid—as detailed above. For the commercial market, we were unable to split out individual, small group, and large group lines of business, so we assumed a minimum MLR of 83.5% for the entire market, based on the mix of individual and group business in the commercial market collected from other data sources.

STEP 4: CALCULATE EACH INSURER'S MARKET SHARE AND ALLOCATE THE ACA HEALTH INSURER FEE TO INSURER AND MARKETS

Steps 1 – 3 establish projections of each insurer's premium volume by state and market for 2013 – 2023. Step 4 calculates each insurer's ACA health insurer fee based on the rules summarized in Section II of this report. The health insurer fee is allocated to each line of business in proportion to premium volume. Note that we did not distinguish between 501(c)(3) and 501(c)(4) organizations for the purposes of assigning nonprofit status.

The corporate income tax impact of the ACA health insurer fee was based on a 35% corporate tax rate for insurers with a for-profit status.

VI. CAVEATS AND QUALIFICATIONS

CAVEATS AND LIMITATIONS

The views expressed in this report are made by the authors and do not represent the opinion of Milliman. Other Milliman consultants may hold different views.

This report was prepared for the specific purpose of analyzing the impact of the ACA health insurer fee on state Medicaid programs and Medicaid managed care organizations. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, MHPA. We anticipate the report will be shared with MHPA members, federal and state policymakers, and other interested parties. Milliman does not intend to benefit, or create a legal duty to, any third-party recipient of its work. This report should only be reviewed in its entirety.

Differences between the report 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. The projections in this report are based on our understanding of the ACA and its associated regulations issued to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of the ACA, necessitating an update to the projections in this report.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

In preparing this information, we relied on information published by SNL Financial Data, the Kaiser Family Foundation, the Centers for Medicare and Medicaid Services (CMS), and other state government data sources. We accepted this information without audit, but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate. 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.

The terms of Milliman's Consulting Services Agreement with MHPA signed on August 12, 2011, apply to this report and its use.

QUALIFICATIONS

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 in this report.

Appendix A

Detailed Listing of Expansion Scenarios by State

Appendix A Detailed Listing of Expansion Scenarios by State			
State	**Baseline Expansion**	**Moderate Expansion**	**Full Expansion**
Alabama	No Expansion	No Expansion	**Expansion**
Alaska	No Expansion	No Expansion	**Expansion**
Arizona	Expansion	Expansion	Expansion
Arkansas	Expansion	Expansion	Expansion
California	Expansion	Expansion	Expansion
Colorado	Expansion	Expansion	Expansion
Connecticut	Expansion	Expansion	Expansion
Delaware	Expansion	Expansion	Expansion
District of Columbia	Expansion	Expansion	Expansion
Florida	No Expansion	**Expansion**	Expansion
Georgia	No Expansion	No Expansion	**Expansion**
Hawaii	Expansion	Expansion	Expansion
Idaho	No Expansion	No Expansion	**Expansion**
Illinois	Expansion	Expansion	Expansion
Indiana	No Expansion	No Expansion	**Expansion**
Iowa	Expansion	Expansion	Expansion
Kansas	No Expansion	No Expansion	**Expansion**
Kentucky	Expansion	Expansion	Expansion
Louisiana	No Expansion	No Expansion	**Expansion**
Maine	No Expansion	No Expansion	**Expansion**
Maryland	Expansion	Expansion	Expansion
Massachusetts	Expansion	Expansion	Expansion
Michigan	Expansion	Expansion	Expansion
Minnesota	Expansion	Expansion	Expansion
Mississippi	No Expansion	No Expansion	**Expansion**
Missouri	No Expansion	No Expansion	**Expansion**
Montana	No Expansion	**Expansion**	Expansion
Nebraska	No Expansion	No Expansion	**Expansion**
Nevada	Expansion	Expansion	Expansion
New Hampshire	No Expansion	**Expansion**	Expansion
New Jersey	Expansion	Expansion	Expansion
New Mexico	Expansion	Expansion	Expansion
New York	Expansion	Expansion	Expansion
North Carolina	No Expansion	No Expansion	**Expansion**
North Dakota	Expansion	Expansion	Expansion
Ohio	Expansion	Expansion	Expansion
Oklahoma	No Expansion	No Expansion	**Expansion**
Oregon	Expansion	Expansion	Expansion
Pennsylvania	No Expansion	**Expansion**	Expansion
Rhode Island	Expansion	Expansion	Expansion
South Carolina	No Expansion	No Expansion	**Expansion**
South Dakota	No Expansion	No Expansion	**Expansion**
Tennessee	No Expansion	**Expansion**	Expansion
Texas	No Expansion	No Expansion	**Expansion**
Utah	No Expansion	No Expansion	**Expansion**
Vermont	Expansion	Expansion	Expansion
Virginia	No Expansion	**Expansion**	Expansion
Washington	Expansion	Expansion	Expansion
West Virginia	Expansion	Expansion	Expansion
Wisconsin	No Expansion	No Expansion	**Expansion**
Wyoming	No Expansion	No Expansion	**Expansion**

Appendix B

Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments Including Associated Allowance for Corporate Income Tax Ten Year Projection from 2014 to 2023 Baseline Expansion Scenario

Appendix B
Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Baseline Expansion

	2014 - 2018				2019 - 2023				Total		
State	Assumed FMAP* 2014-2018	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Assumed FMAP* 2019-2023	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)
AL	68.1%	0.0%	$0	$0	68.1%	0.0%	$0	$0	0.0%	$0	$0
AK	50.0%	0.0%	0	0	50.0%	0.0%	0	0	0.0%	0	0
AZ	72.0%	1.6%	703	197	70.8%	1.6%	1,052	295	1.6%	1,755	492
AR	77.4%	0.0%	0	0	75.3%	0.0%	0	0	0.0%	0	0
CA	57.4%	0.7%	754	321	56.2%	0.7%	1,122	477	0.7%	1,876	798
CO	57.4%	0.7%	7	3	56.2%	0.8%	11	5	0.7%	18	8
CT	52.1%	0.0%	0	0	51.8%	0.0%	0	0	0.0%	0	0
DE	59.3%	2.5%	224	91	58.5%	2.6%	324	132	2.6%	547	223
DC	71.5%	2.5%	91	26	71.1%	2.5%	136	39	2.5%	227	65
FL	58.8%	2.4%	1,208	498	58.8%	2.5%	1,719	708	2.5%	2,927	1,206
GA	65.9%	2.5%	756	258	65.9%	2.6%	1,142	389	2.6%	1,899	647
HI	58.9%	1.6%	168	69	57.7%	1.7%	247	101	1.6%	415	171
ID	71.6%	0.0%	0	0	71.6%	0.0%	0	0	0.0%	0	0
IL	52.6%	1.9%	336	159	52.1%	1.9%	494	234	1.9%	830	394
IN	66.9%	1.5%	136	45	66.9%	1.6%	199	66	1.6%	336	111
IA	65.3%	2.5%	12	4	63.8%	2.6%	18	6	2.6%	30	10
KS	56.9%	2.6%	487	210	56.9%	2.6%	701	302	2.6%	1,188	512
KY	75.8%	1.8%	456	110	74.1%	1.9%	656	158	1.9%	1,111	268
LA	61.0%	2.6%	488	190	61.0%	2.6%	717	280	2.6%	1,205	470
ME	61.6%	0.0%	0	0	61.6%	0.0%	0	0	0.0%	0	0
MD	57.3%	2.5%	643	275	56.1%	2.6%	944	403	2.6%	1,587	678
MA	51.4%	1.0%	225	109	51.2%	1.0%	313	152	1.0%	538	262
MI	72.1%	2.0%	696	194	70.7%	2.0%	1,027	286	2.0%	1,723	480
MN	52.1%	0.3%	79	38	51.8%	0.3%	113	54	0.3%	192	92
MS	73.1%	2.6%	91	25	73.1%	2.6%	134	36	2.6%	225	61
MO	62.0%	2.4%	190	72	62.0%	2.5%	280	106	2.5%	470	178

Appendix B
Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Baseline Expansion

	2014 - 2018				2019 - 2023				Total		
State	Assumed FMAP* 2014-2018	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Assumed FMAP* 2019-2023	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)
MT	66.3%	0.0%	$0	$0	66.3%	0.0%	$0	$0	0.0%	$0	$0
NE	54.7%	2.6%	50	23	54.7%	2.6%	73	33	2.6%	122	55
NV	70.5%	2.5%	84	25	68.8%	2.6%	121	36	2.6%	204	60
NH	50.0%	2.0%	130	65	50.0%	2.0%	188	94	2.0%	318	159
NJ	51.4%	1.7%	494	240	51.2%	1.7%	682	331	1.7%	1,176	572
NM	75.3%	2.5%	504	124	73.6%	2.6%	728	180	2.6%	1,233	304
NY	51.4%	0.4%	364	177	51.2%	0.4%	503	244	0.4%	867	422
NC	65.8%	0.0%	0	0	65.8%	0.0%	0	0	0.0%	0	0
ND	59.4%	0.0%	0	0	57.8%	0.0%	0	0	0.0%	0	0
OH	69.9%	1.1%	637	192	68.3%	1.1%	941	283	1.1%	1,578	475
OK	64.0%	0.0%	0	0	64.0%	0.0%	0	0	0.0%	0	0
OR	71.5%	0.9%	155	44	69.6%	1.0%	249	71	1.0%	404	115
PA	53.5%	1.8%	1,105	514	53.5%	1.8%	1,601	744	1.8%	2,707	1,258
RI	52.2%	0.9%	45	21	51.9%	0.9%	64	31	0.9%	109	52
SC	70.6%	2.5%	275	81	70.6%	2.6%	392	115	2.6%	667	196
SD	53.5%	0.0%	0	0	53.5%	0.0%	0	0	0.0%	0	0
TN	65.3%	2.6%	1,027	357	65.3%	2.6%	1,519	527	2.6%	2,547	884
TX	58.7%	1.7%	1,035	427	58.7%	1.8%	1,560	644	1.8%	2,595	1,072
UT	70.3%	2.6%	67	20	70.3%	2.6%	96	28	2.6%	162	48
VT	56.3%	0.0%	0	0	56.1%	0.0%	0	0	0.0%	0	0
VA	50.0%	1.4%	216	108	50.0%	1.4%	313	156	1.4%	529	264
WA	58.8%	1.5%	220	91	57.3%	1.6%	326	134	1.5%	546	225
WV	77.1%	2.1%	72	16	75.3%	2.3%	108	25	2.2%	180	41
WI	59.1%	2.0%	270	111	59.1%	2.0%	401	164	2.0%	671	275
WY	50.0%	0.0%	0	0	50.0%	0.0%	0	0	0.0%	0	0
PR	55.0%	2.6%	308	138	55.0%	2.6%	441	199	2.6%	749	337
Total	**61.7%**	**1.6%**	**$14,809**	**$5,668**	**61.8%**	**1.6%**	**$21,653**	**$8,272**	**1.6%**	**$36,462**	**$13,940**

** Our projections assume the average FMAP of 98% for 2014-2018 and 90% for 2019-2023 for the Medicaid expansion population and FY 2014 FMAP for the non-expansion Medicaid population.*

Appendix C

Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments Including Associated Allowance for Corporate Income Tax Ten Year Projection from 2014 to 2023 Moderate Expansion Scenario

Appendix C
Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Moderate Expansion

	2014 - 2018				2019 - 2023				Total		
State	Assumed FMAP* 2014-2018	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Assumed FMAP* 2019-2023	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)
AL	68.1%	0.0%	$0	$0	68.1%	0.0%	$0	$0	0.0%	$0	$0
AK	50.0%	0.0%	0	0	50.0%	0.0%	0	0	0.0%	0	0
AZ	72.0%	1.6%	701	196	70.8%	1.6%	1,051	294	1.6%	1,752	491
AR	77.4%	0.0%	0	0	75.3%	0.0%	0	0	0.0%	0	0
CA	57.4%	0.7%	753	320	56.2%	0.7%	1,120	477	0.7%	1,872	797
CO	57.4%	0.7%	7	3	56.2%	0.8%	11	5	0.7%	18	7
CT	52.1%	0.0%	0	0	51.8%	0.0%	0	0	0.0%	0	0
DE	59.3%	2.5%	223	91	58.5%	2.6%	323	132	2.6%	546	223
DC	71.5%	2.5%	91	26	71.1%	2.5%	136	39	2.5%	227	65
FL	67.2%	2.4%	1,340	440	65.4%	2.5%	1,941	637	2.5%	3,281	1,078
GA	65.9%	2.5%	755	257	65.9%	2.6%	1,140	389	2.6%	1,895	646
HI	58.9%	1.6%	168	69	57.7%	1.7%	246	101	1.6%	414	170
ID	71.6%	0.0%	0	0	71.6%	0.0%	0	0	0.0%	0	0
IL	52.6%	1.9%	335	159	52.1%	1.9%	493	234	1.9%	829	393
IN	66.9%	1.5%	136	45	66.9%	1.6%	199	66	1.6%	335	111
IA	65.3%	2.5%	12	4	63.8%	2.6%	18	6	2.6%	30	10
KS	56.9%	2.6%	486	209	56.9%	2.6%	700	301	2.6%	1,185	511
KY	75.8%	1.8%	455	110	74.1%	1.9%	655	158	1.9%	1,109	268
LA	61.0%	2.6%	487	190	61.0%	2.6%	716	279	2.6%	1,203	469
ME	61.6%	0.0%	0	0	61.6%	0.0%	0	0	0.0%	0	0
MD	57.3%	2.5%	642	274	56.1%	2.6%	942	402	2.6%	1,585	677
MA	51.4%	1.0%	225	109	51.2%	1.0%	312	152	1.0%	537	261
MI	72.1%	2.0%	695	194	70.7%	2.0%	1,025	286	2.0%	1,720	479
MN	52.1%	0.3%	79	38	51.8%	0.3%	113	54	0.3%	192	92
MS	73.1%	2.6%	91	25	73.1%	2.6%	134	36	2.6%	225	61
MO	62.0%	2.4%	190	72	62.0%	2.5%	279	106	2.5%	469	178

Appendix C
Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Moderate Expansion

	2014 - 2018				2019 - 2023				Total		
State	Assumed FMAP* 2014-2018	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Assumed FMAP* 2019-2023	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)
MT	73.1%	0.0%	$0	$0	71.4%	0.0%	$0	$0	0.0%	$0	$0
NE	54.7%	2.6%	50	22	54.7%	2.6%	72	33	2.6%	122	55
NV	70.5%	2.5%	84	25	68.8%	2.6%	120	35	2.6%	204	60
NH	60.9%	2.0%	150	59	59.1%	2.0%	223	87	2.0%	373	146
NJ	51.4%	1.7%	493	240	51.2%	1.7%	681	331	1.7%	1,174	571
NM	75.3%	2.5%	503	124	73.6%	2.6%	727	179	2.6%	1,230	303
NY	51.4%	0.4%	364	177	51.2%	0.4%	502	244	0.4%	865	421
NC	65.8%	0.0%	0	0	65.8%	0.0%	0	0	0.0%	0	0
ND	59.4%	0.0%	0	0	57.8%	0.0%	0	0	0.0%	0	0
OH	69.9%	1.1%	636	192	68.3%	1.1%	939	283	1.1%	1,575	474
OK	64.0%	0.0%	0	0	64.0%	0.0%	0	0	0.0%	0	0
OR	71.5%	0.9%	155	44	69.6%	1.0%	249	71	1.0%	403	115
PA	63.6%	1.7%	1,322	482	61.8%	1.8%	1,972	718	1.8%	3,294	1,200
RI	52.2%	0.9%	45	21	51.9%	0.9%	64	31	0.9%	109	52
SC	70.6%	2.5%	275	81	70.6%	2.6%	392	115	2.6%	666	196
SD	53.5%	0.0%	0	0	53.5%	0.0%	0	0	0.0%	0	0
TN	70.4%	2.5%	1,096	325	69.1%	2.6%	1,626	482	2.6%	2,723	807
TX	58.7%	1.7%	1,033	427	58.7%	1.8%	1,558	643	1.8%	2,590	1,070
UT	70.3%	2.6%	66	20	70.3%	2.6%	96	28	2.6%	162	48
VT	56.3%	0.0%	0	0	56.1%	0.0%	0	0	0.0%	0	0
VA	60.8%	1.4%	262	103	59.0%	1.4%	389	152	1.4%	650	255
WA	58.8%	1.5%	220	91	57.3%	1.6%	325	134	1.5%	545	225
WV	77.1%	2.1%	71	16	75.3%	2.3%	108	25	2.2%	180	41
WI	59.1%	2.0%	270	110	59.1%	2.0%	400	164	2.0%	670	274
WY	50.0%	0.0%	0	0	50.0%	0.0%	0	0	0.0%	0	0
PR	55.0%	2.6%	307	138	55.0%	2.6%	441	198	2.6%	748	336
Total	**63.8%**	**1.6%**	**$15,271**	**$5,527**	**63.9%**	**1.6%**	**$22,436**	**$8,108**	**1.6%**	**$37,706**	**$13,636**

** Our projections assume the average FMAP of 98% for 2014-2018 and 90% for 2019-2023 for the Medicaid expansion population and FY 2014 FMAP for the non-expansion Medicaid population.*

Appendix D

Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments Including Associated Allowance for Corporate Income Tax Ten Year Projection from 2014 to 2023 Full Expansion Scenario

Appendix D
Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Full Expansion

	2014 - 2018				2019 - 2023				Total		
State	Assumed FMAP* 2014-2018	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Assumed FMAP* 2019-2023	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)
AL	74.9%	0.0%	$0	$0	73.1%	0.0%	$0	$0	0.0%	$0	$0
AK	61.7%	0.0%	0	0	59.7%	0.0%	0	0	0.0%	0	0
AZ	72.0%	1.6%	699	196	70.8%	1.6%	1,048	293	1.6%	1,747	489
AR	77.4%	0.0%	0	0	75.3%	0.0%	0	0	0.0%	0	0
CA	57.4%	0.7%	750	319	56.2%	0.7%	1,117	475	0.7%	1,867	795
CO	57.4%	0.7%	7	3	56.2%	0.8%	11	5	0.7%	18	7
CT	52.1%	0.0%	0	0	51.8%	0.0%	0	0	0.0%	0	0
DE	59.3%	2.5%	223	91	58.5%	2.6%	322	131	2.5%	545	222
DC	71.5%	2.5%	91	26	71.1%	2.5%	136	39	2.5%	226	64
FL	67.2%	2.4%	1,336	439	65.4%	2.5%	1,936	636	2.5%	3,272	1,075
GA	73.7%	2.5%	884	232	71.8%	2.6%	1,344	353	2.6%	2,228	585
HI	58.9%	1.6%	167	69	57.7%	1.6%	246	101	1.6%	413	170
ID	78.0%	0.0%	0	0	76.1%	0.0%	0	0	0.0%	0	0
IL	52.6%	1.9%	334	159	52.1%	1.9%	492	234	1.9%	826	392
IN	73.9%	1.5%	166	43	72.1%	1.6%	249	65	1.6%	415	108
IA	65.3%	2.5%	12	4	63.8%	2.6%	18	6	2.5%	30	10
KS	66.2%	2.5%	577	195	64.4%	2.6%	855	289	2.6%	1,432	484
KY	75.8%	1.8%	453	110	74.1%	1.9%	653	158	1.9%	1,106	267
LA	69.9%	2.5%	575	173	68.0%	2.6%	872	263	2.6%	1,447	436
ME	62.6%	0.0%	0	0	62.4%	0.0%	0	0	0.0%	0	0
MD	57.3%	2.5%	640	273	56.1%	2.6%	940	401	2.5%	1,580	675
MA	51.4%	1.0%	224	109	51.2%	1.0%	312	151	1.0%	536	260
MI	72.1%	2.0%	693	193	70.7%	2.0%	1,022	285	2.0%	1,715	478
MN	52.1%	0.3%	79	38	51.8%	0.3%	113	54	0.3%	192	92
MS	79.0%	2.5%	104	22	77.1%	2.6%	158	33	2.6%	263	55
MO	70.1%	2.4%	233	70	68.3%	2.5%	351	105	2.5%	584	175

Appendix D
Impact of ACA Health Insurer Fee on Medicaid Managed Care Payments
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Full Expansion

	2014 - 2018				2019 - 2023				Total		
State	Assumed FMAP* 2014-2018	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Assumed FMAP* 2019-2023	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)
MT	73.1%	0.0%	$0	$0	71.4%	0.0%	$0	$0	0.0%	$0	$0
NE	62.7%	2.5%	56	21	61.2%	2.6%	83	31	2.6%	139	52
NV	70.5%	2.5%	83	25	68.8%	2.6%	120	35	2.6%	204	60
NH	60.9%	1.9%	150	59	59.1%	2.0%	222	87	2.0%	372	146
NJ	51.4%	1.7%	492	239	51.2%	1.7%	679	330	1.7%	1,171	569
NM	75.3%	2.5%	502	124	73.6%	2.6%	725	179	2.6%	1,227	303
NY	51.4%	0.4%	363	176	51.2%	0.4%	501	243	0.4%	863	420
NC	74.2%	0.0%	0	0	72.1%	0.0%	0	0	0.0%	0	0
ND	59.4%	0.0%	0	0	57.8%	0.0%	0	0	0.0%	0	0
OH	69.9%	1.1%	634	191	68.3%	1.1%	937	282	1.1%	1,571	473
OK	72.3%	0.0%	0	0	70.4%	0.0%	0	0	0.0%	0	0
OR	71.5%	0.9%	154	44	69.6%	1.0%	248	71	1.0%	402	115
PA	63.6%	1.7%	1,318	480	61.8%	1.8%	1,967	716	1.8%	3,285	1,196
RI	52.2%	0.9%	45	21	51.9%	0.9%	64	30	0.9%	108	52
SC	76.4%	2.5%	316	75	74.7%	2.6%	459	108	2.6%	775	183
SD	61.7%	0.0%	0	0	60.2%	0.0%	0	0	0.0%	0	0
TN	70.4%	2.5%	1,093	324	69.1%	2.6%	1,622	481	2.6%	2,715	805
TX	69.0%	1.7%	1,230	381	66.9%	1.8%	1,892	586	1.7%	3,122	967
UT	76.6%	2.5%	75	18	74.8%	2.6%	112	26	2.6%	187	44
VT	56.3%	0.0%	0	0	56.1%	0.0%	0	0	0.0%	0	0
VA	60.8%	1.4%	261	102	59.0%	1.4%	388	152	1.4%	648	254
WA	58.8%	1.5%	219	90	57.3%	1.6%	324	134	1.5%	544	224
WV	77.1%	2.1%	71	16	75.3%	2.3%	108	25	2.2%	179	41
WI	61.1%	2.0%	273	106	60.7%	2.0%	406	158	2.0%	679	264
WY	59.4%	0.0%	0	0	57.8%	0.0%	0	0	0.0%	0	0
PR	56.9%	2.6%	301	130	56.5%	2.6%	431	186	2.6%	732	316
Total	**66.1%**	**1.6%**	**$15,884**	**$5,384**	**66.2%**	**1.7%**	**$23,479**	**$7,937**	**1.6%**	**$39,363**	**$13,321**

** Our projections assume the average FMAP of 98% for 2014-2018 and 90% for 2019-2023 for the Medicaid expansion population and FY 2014 FMAP for the non-expansion Medicaid population.*