

Medicaid Expansion in Wyoming

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Joint Revenue Interim Committee Meeting



Wyoming
Department
of Health

May 11, 2021

Agenda

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- Background: What is Medicaid Expansion?
- Summary of costs, ARPA incentives, and effects.
- Overview of methodology
 - ◆ Enrollment
 - ◆ Morbidity
 - ◆ Claims
- Medicaid Expansion effects
 - ◆ Members
 - ◆ Providers
 - ◆ Insurance market - Exchange

Background - Medicaid and Medicaid Expansion



Background - Medicaid

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- **Medicaid** is a joint **Federal-State social insurance program** that pays for the **medical care** and **long-term care** for certain **categories of low-income** and **medically-needy** individuals and families.
- Services available to Medicaid expansion population would strictly **medical**; similar to any other health insurance plan. Differences:
 - ◆ CMS allows some (minimal) **cost sharing** (e.g., copays).
 - ◆ Premium contributions and work requirements have been allowed in the past through waivers, but **unlikely to be approved** by Biden administration.

Background - Affordable Care Act

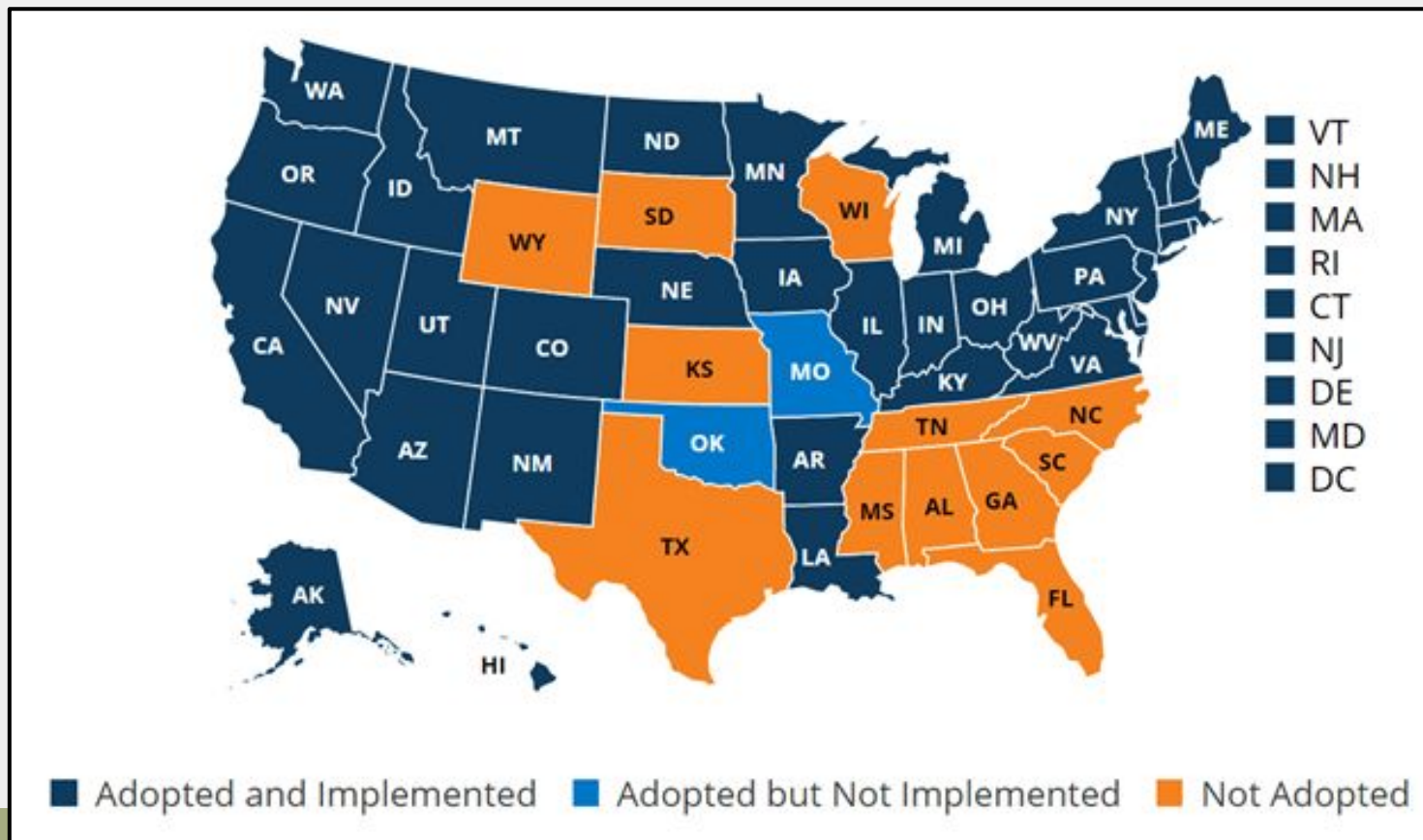
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- The 2010 Patient Protection and Affordable Care Act (PPACA, “the ACA” or “Obamacare”) originally contemplated expanding health insurance coverage to **all** low-income individuals:
 - ◆ People below 138% of the Federal Poverty Level (FPL) were supposed to be covered by Medicaid.
 - ◆ People between 138% - 400% FPL were to receive extensive subsidies to buy standardized health insurance coverage on Federal or State exchanges.
- In 2012, the Supreme Court ruled (*National Federation of Independent Businesses vs. Sebelius*) that the **mandatory expansion** of Medicaid to adults would be unconstitutionally coercive on States.

Background

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→ **Medicaid expansion to low-income adults** thus became an **optional** issue for states. Currently, 39 have expanded.



No affordable health insurance options

Income range (percent of the Federal Poverty Level)	Upper bound income for 2021 (single person)	Coverage options			
		Non-Medicaid Expansion states		Medicaid Expansion states	
		Premium subsidy	Cost-sharing subsidy	Premium subsidy	Cost-sharing subsidy
0 - 100%	\$12,880	No subsidy available		Medicaid - low to no premiums	Medicaid - low cost-sharing (plan covers >97% of average medical costs)
101 - 138%	\$17,774	Benchmark premium capped at 2.07% of income.	Plan covers 94% of average medical costs.		
139 - 150%	\$19,320	Benchmark premium capped at 3.10% of income.	Plan covers 94% of average medical costs.	Benchmark premium capped at 3.10% of income.	Plan covers 94% of average medical costs.
151 - 200%	\$25,760	Benchmark premium capped at 4.14% of income.	Plan covers 87% of average medical costs.	Benchmark premium capped at 4.14% of income.	Plan covers 87% of average medical costs.
201 - 250%	\$32,200	Benchmark premium capped at 6.52% of income.	Plan covers 73% of average medical costs.	Benchmark premium capped at 6.52% of income.	Plan covers 73% of average medical costs.
250 - 300%	\$38,640	Benchmark premium capped at 8.33% of income	No cost-sharing subsidy, multiple plans available in various levels of generosity (metal levels)	Benchmark premium capped at 8.33% of income	No cost-sharing subsidy, multiple plans available in various levels of generosity (metal levels)
300 - 400%	\$51,520	Benchmark premium capped at 9.83% of income		Benchmark premium capped at 9.83% of income	
400% +		No subsidy available			

“Crowdout”
Small “cliff” effect

Will change in 2021 under ARP

Current Healthcare Coverage Options

Children 0-5 years	Medicaid 0-154% FPL			CHIP 155-200% FPL	Marketplace 201-400% FPL
Children 6-18 years	Medicaid 0-138% FPL		CHIP 139-200% FPL	Marketplace 201-400% FPL	
Pregnant Women	Medicaid 0-154% FPL			Marketplace 155-400% FPL	
Parents / Caretakers	Medicaid 0-46% FPL	No Coverage 47-99% FPL	Marketplace 100-400% FPL		
Non- Disabled Adults	No Coverage 0-99% FPL		Marketplace 100-400% FPL		
If Medicaid Expansion occurs, the Parents/Caretakers and Non-Disabled Adults groups would change to the following.					
Parents / Caretakers	Medicaid 0-46% FPL	Medicaid Expansion 47-138% FPL	Marketplace 139-400% FPL		
Non- Disabled Adults	Medicaid Expansion 0-138% FPL		Marketplace 139-400% FPL		
FPL	0%-50%	51%-100%	101%-150%	151%-200%	201%-400%

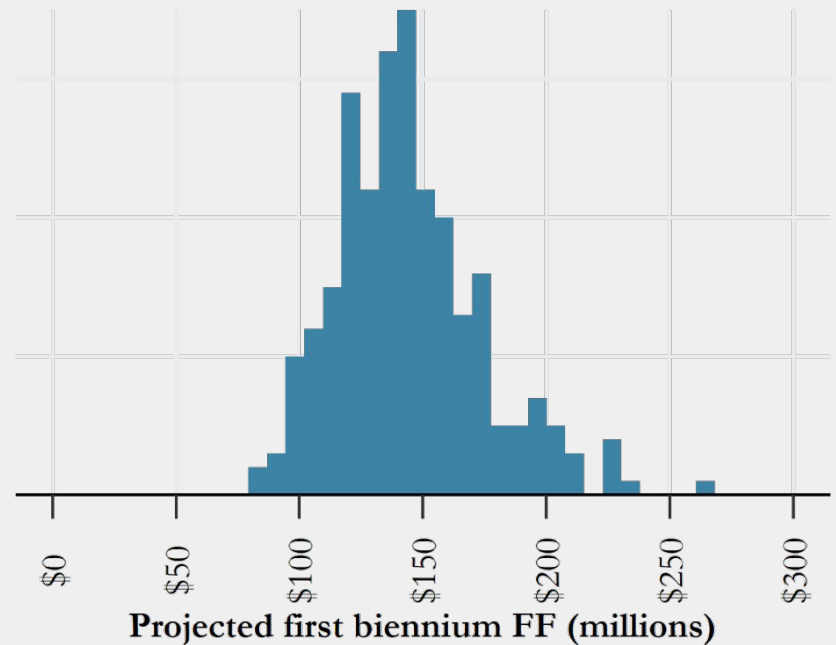
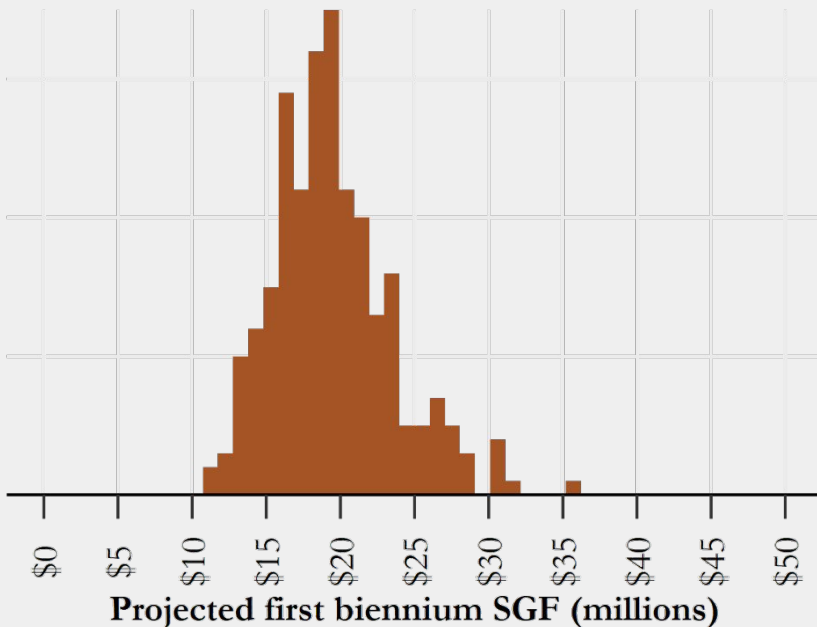
Medicaid Expansion Estimates Summary



Summary - Cost

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- Projecting **first biennium only**, due to significant uncertainty.
- First biennium cost of **~\$164M**, made up of **~\$144M federal funds** and **~\$20M State General Funds**.



American Rescue Plan - Changes

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- Section 9814 of the American Rescue Plan Act has a strong, but temporary, incentives for non-expansion states to expand Medicaid:
 - ◆ Specifically, an 8-quarter, five percentage point (5%) increase in Federal Medical Assistance Percentage (FMAP, or “federal match”) for **traditional Medicaid** expenditures.
 - ◆ We estimate this would reduce State General Fund expenditures by **\$54 million** [\$48 - \$58M] over an 8-quarter biennium.
 - ◆ If used to fund Medicaid expansion, **net savings of \$34 million over first biennium.**

Summary - Members

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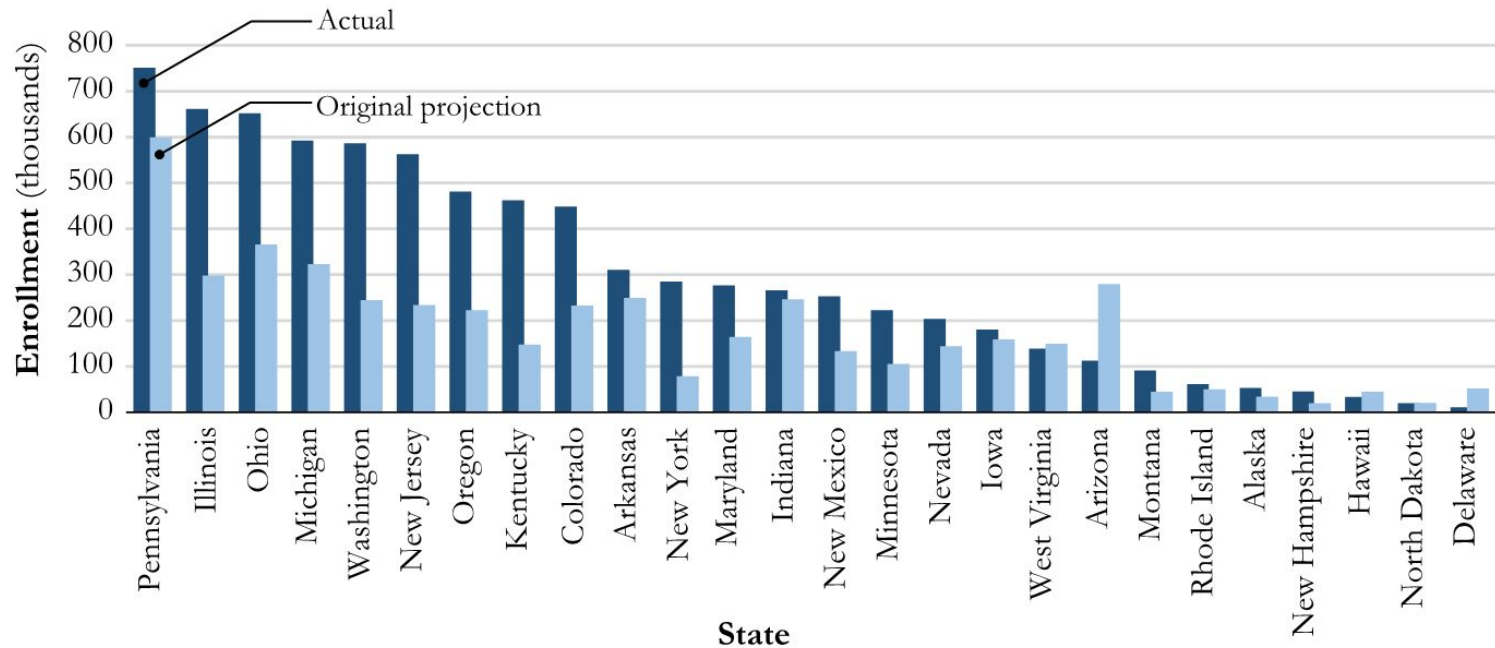
- **~24,000** expected enrollment by **24 months**. Most likely between **13,000** and **38,000**.
 - ◆ **~64%** previously **uninsured**.
 - ◆ **~50%** below **100% FPL**.
 - ◆ **~60%** employed.
- **Known impacts on members:**
 - ◆ Small decrease in mortality for uninsured between 45 and 64;
 - ◆ Increased healthcare utilization;
 - ◆ Improved mental health and increased financial stability.

Summary - Second-order effects

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- **Provider revenue will almost certainly increase**, though there is some dampening (50 - 67%) from crowdout, since Medicaid rates are lower than commercial rates.
- Probable **5 - 15% decrease in average per-person costs** for individuals remaining on the Exchange. This effect is similar to the implementation of a high-risk pool.

Enrollment and cost methodology



Motivation

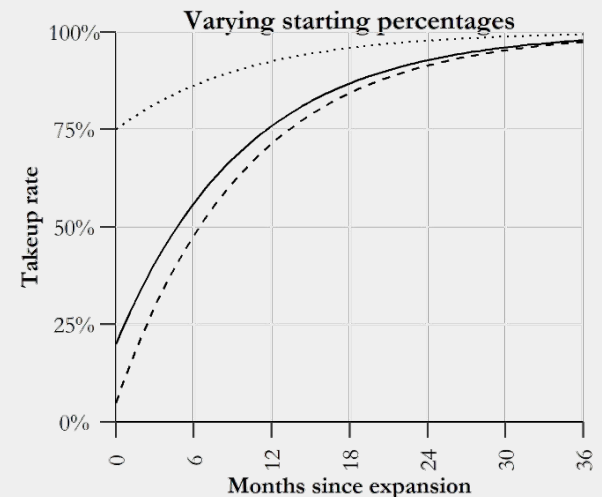
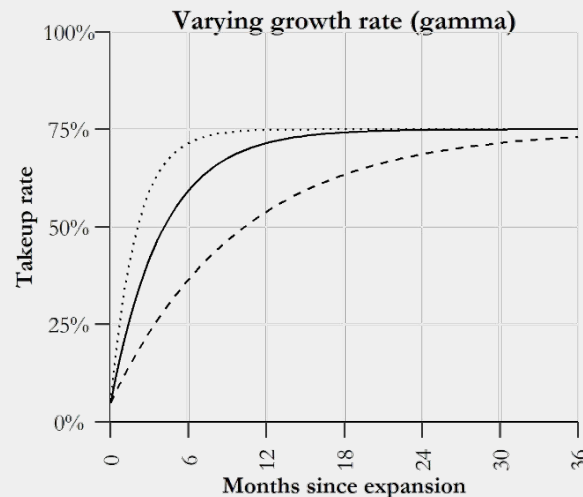
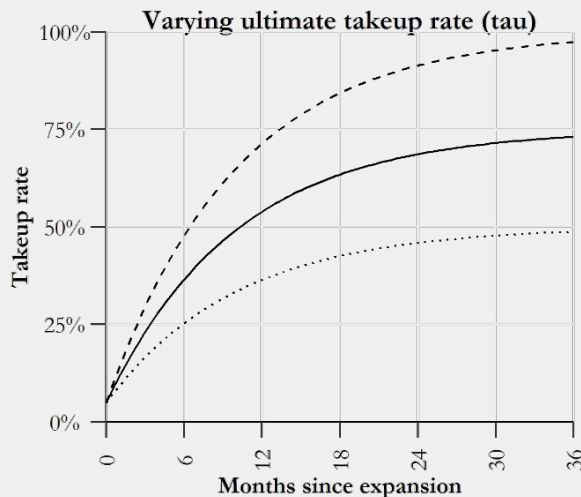
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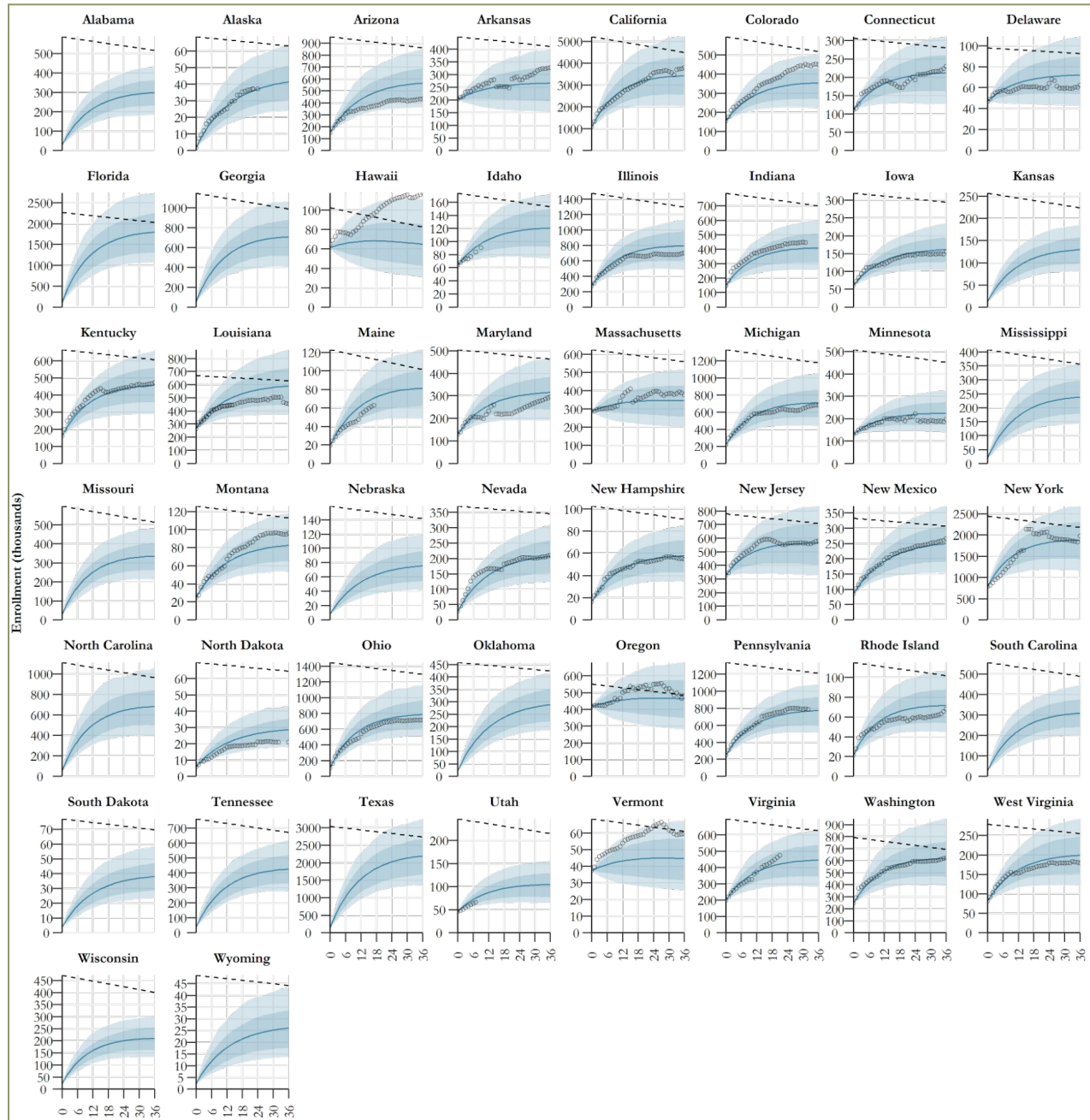
- Projections should be based on:
 - ◆ Data; or,
 - ◆ Fully-explained assumptions, grounded in economic theory.
- Modeling and quantifying **uncertainty** almost more important than making point estimates.

Biggest unknown: enrollment

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- Enrollment **largest unknown** factor behind cost.
- We estimated **most likely enrollment trajectories** for Wyoming by using **data from other expansion states**, combined with **state-level predictors** of take-up and growth:





Evaluation of model fit on expansion and non-expansion states.

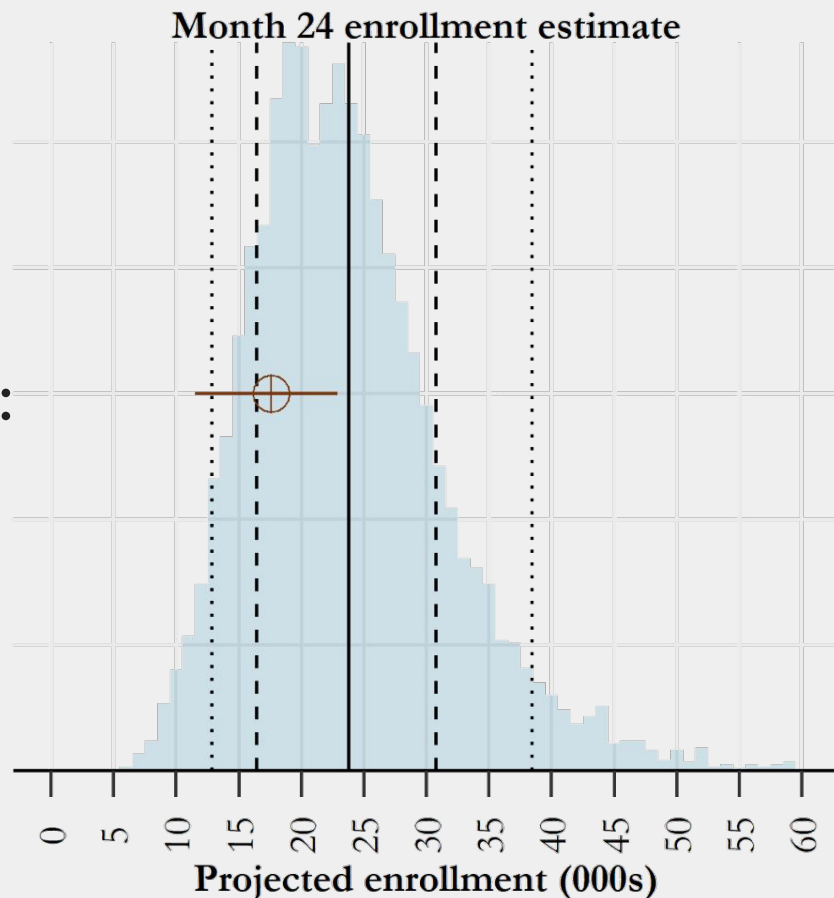
- ➔ Dots are actual enrollment.
- ➔ Blue lines and shaded cones are expectation and uncertainty.
- ➔ Dashed line is potential eligible population.

Wyoming enrollment estimate

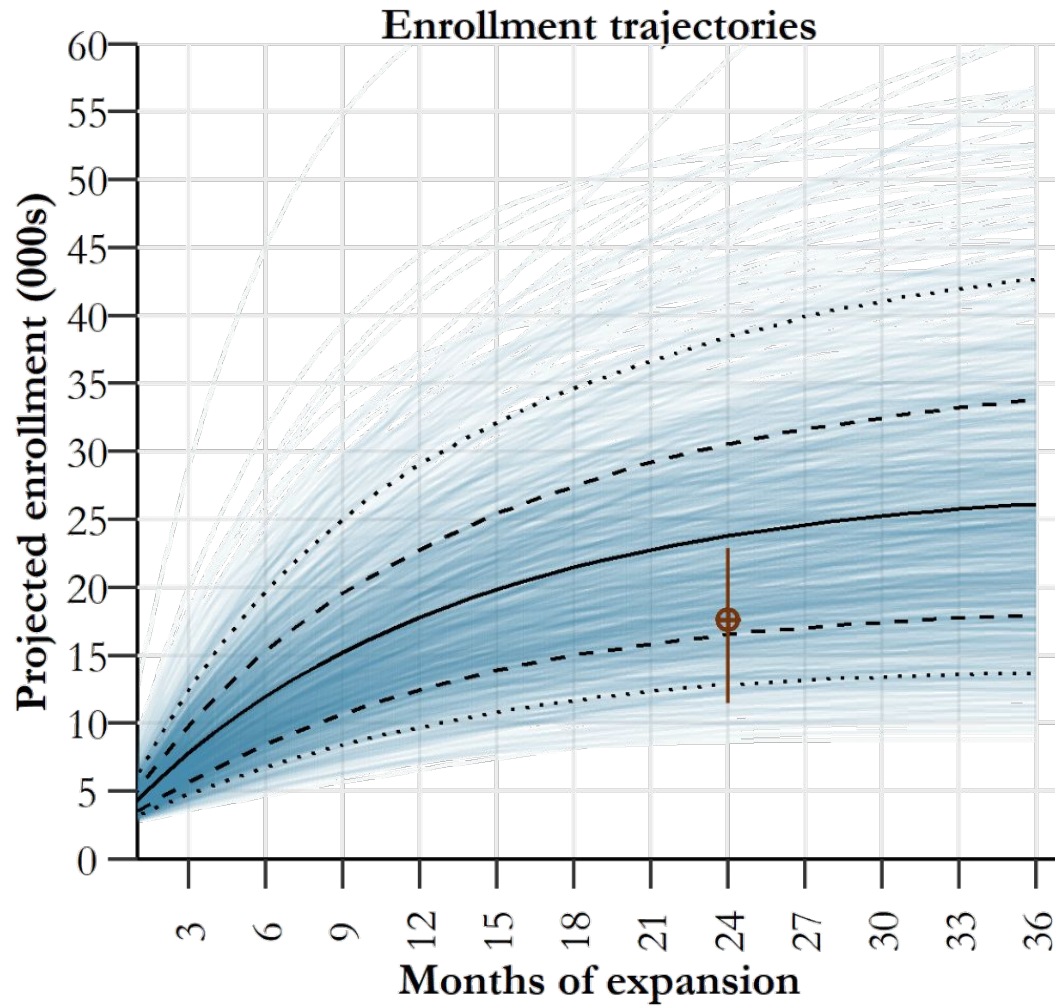
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~24,000 expected enrollment at 24 months

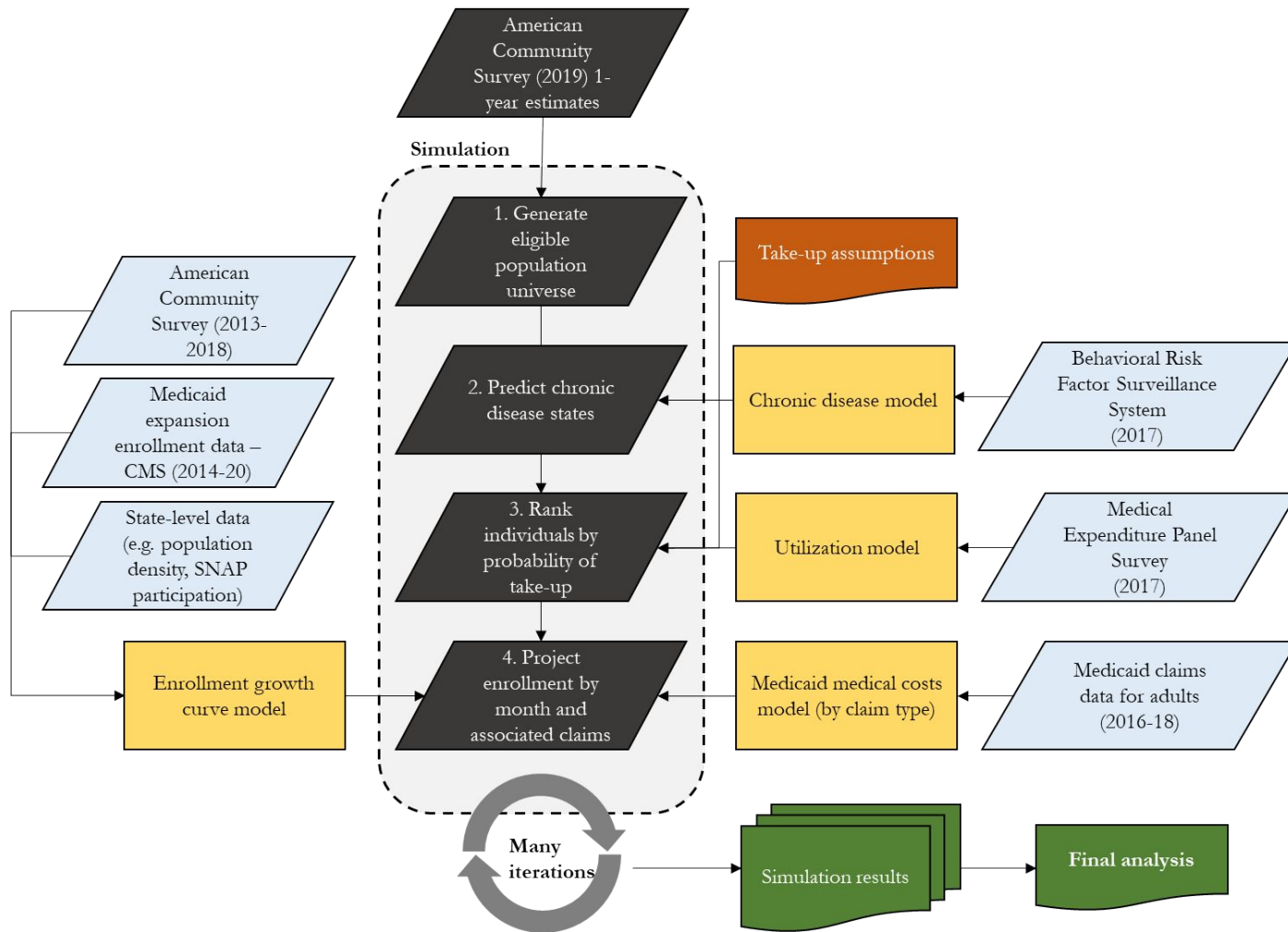
- 67% of scenarios (dashed):
16 - 31K
- 90% of scenarios (dotted):
13 - 38K
- 2011 Milliman report (brown):
Expected: 17.6K
Low: 11.5K
High: 22.9K



Enrollment expected to have a growth curve



Medicaid expansion simulation framework - 2021



Why simulation-based projections?

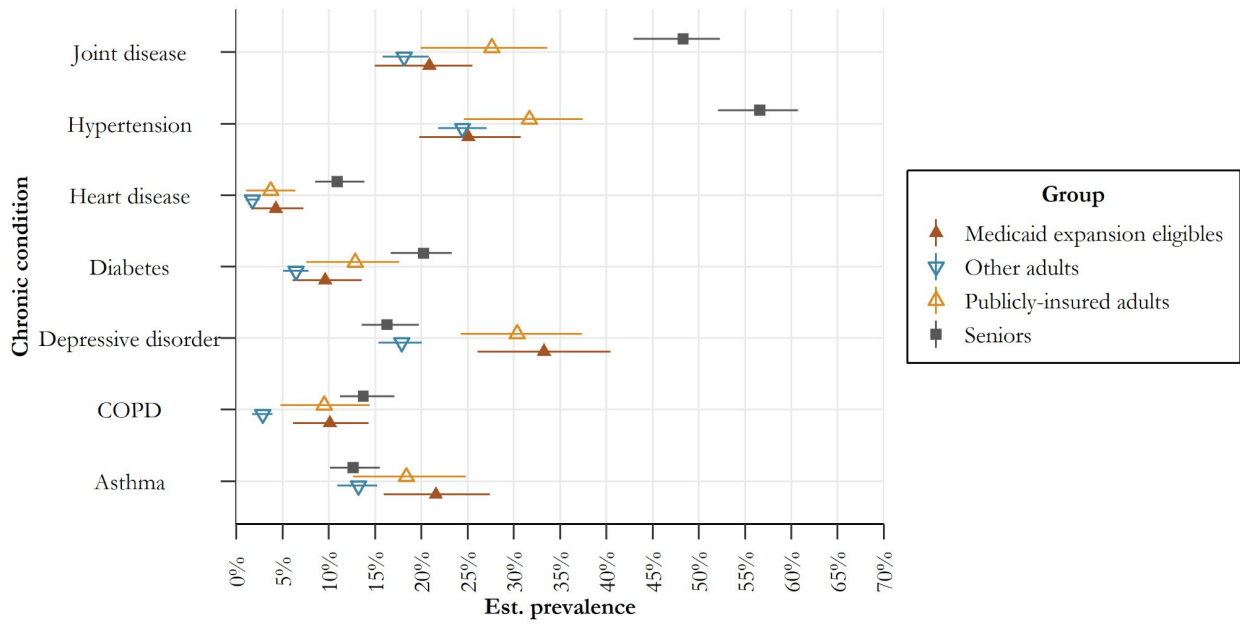
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- **“How many people will enroll?”** is not the only question that matters;
- **“What kind of people will enroll? Who will enroll first?”**
 - ◆ We assume sicker people — those with a demonstrated need for insurance — will likely enroll first
 - ◆ Affects overall cost and PMPM over time.
- **“How many of these people will be uninsured? How many will already have insurance?”**
 - ◆ I.e., how much ‘crowd out’ in the program, which affects providers will see re: reduction in effective rates paid.
- **“What services will they use?”** Provider revenue varying by type; inpatient vs. medical vs. pharmacy.
- **Demographics, poverty, employment**
 - ◆ Affects enrollment with different program designs.

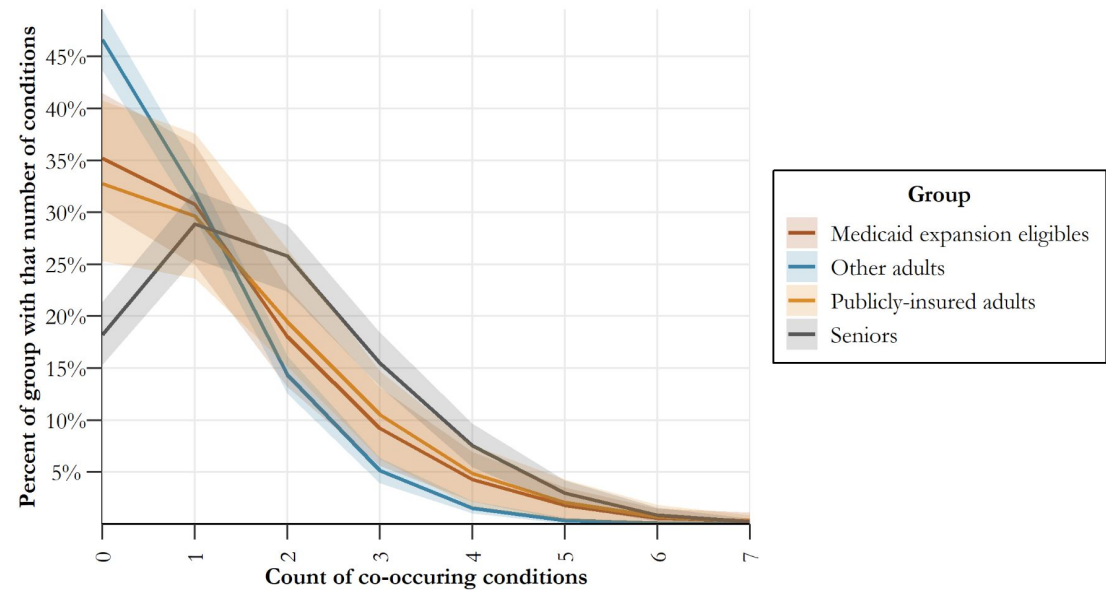
Why simulation-based projections?

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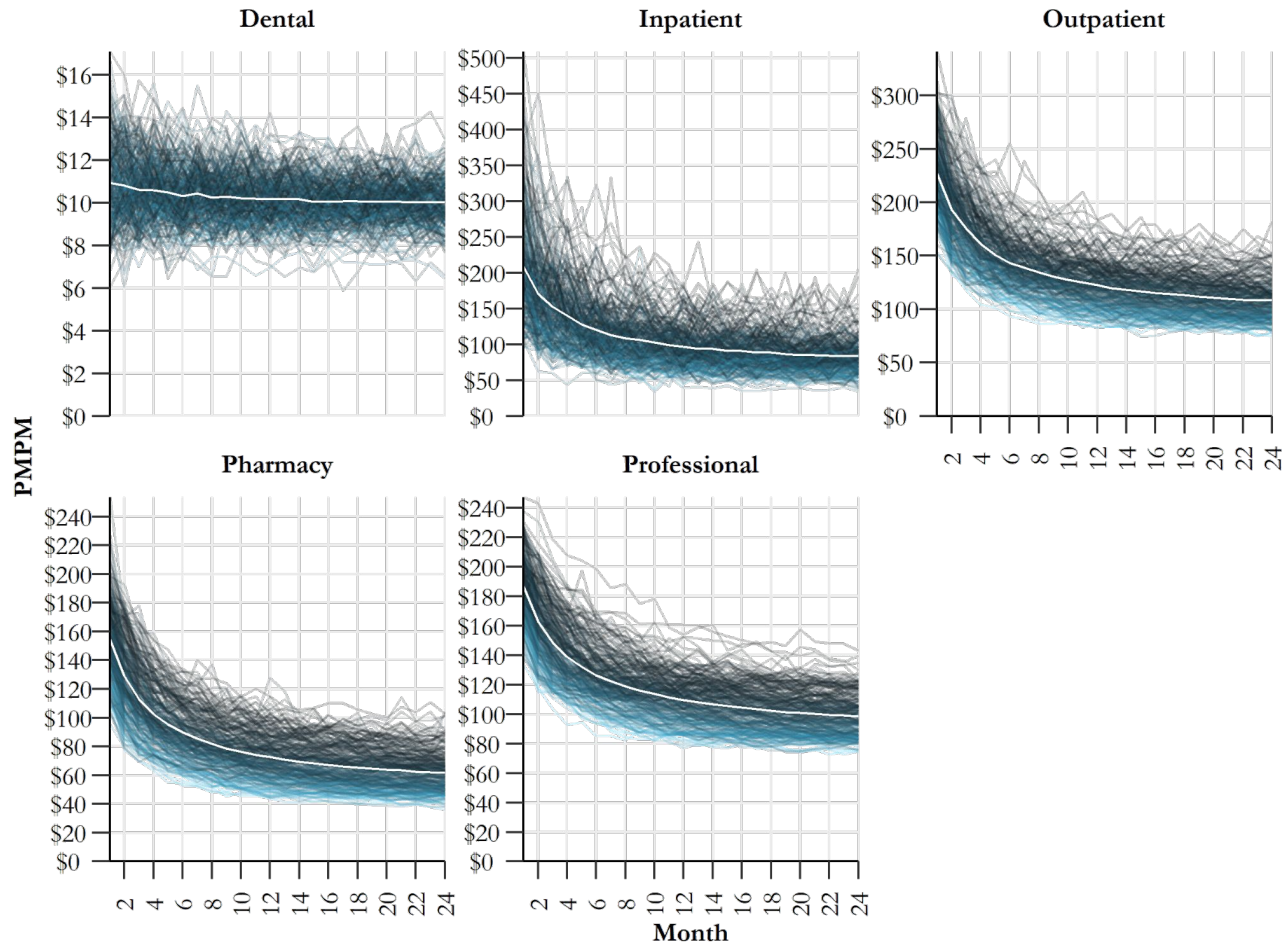
- **Flexibility.** Simulation-based estimates allows us to set ‘the rules of the game,’ and see what happens.
 - ◆ Limit enrollment to 100% FPL?
 - ◆ Cost sharing?
- **Propagates the uncertainty** inherent in all component models to the final estimates.
 - ◆ Uncertainty is just as important as expected averages.



We expect morbidity to be similar to currently Medicaid non-disabled adult population (“Family Care” adults)



Existing Medicaid claims data used to model experience for expansion population, adjusted for age, sex and estimated number of chronic conditions.



Effects of Medicaid Expansion: Members



Effects on members

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- **Many observational studies** on the effects of Medicaid expansion since 2014.
- **Two rigorous randomized controlled studies** on the effects of insurance on medical care and overall health:
 - ◆ Oregon Medicaid Experiment
(<https://www.nber.org/oregon>)
 - ◆ ACA IRS mailing

(Goldin, Lurie and McCubbin, “Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach”), NBER working paper No. 26533

Oregon Study

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- Increased health utilization
 - ◆ Hospitalization, ED visits, prescription drugs
 - ◆ Office visits, preventive screenings.
- Decreased financial hardship (e.g. catastrophic medical expenditures, debt);
- Self-reported health status increase and decrease in reported depression;
- No detected effects on physical health markers (e.g. blood pressure, cholesterol, glycated hemoglobin)
- No detected effect on employment, earnings, receipt of cash welfare. Small increase in SNAP.

IRS - ACA Mailing Study

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- **Small reduction in mortality** detected in 45-64 year olds (1 death for every 1,648 individuals sent reminder letter)
- We estimate there are **~6,000 uninsured who are under 138% FPL and between 45 and 64** in Wyoming.
 - ◆ Estimated baseline mortality of 50 - 70 deaths / year.
 - ◆ Assuming expansion of Medicaid is analogous to IRS mailing letter, would likely **avoid 3 -4** of these deaths.

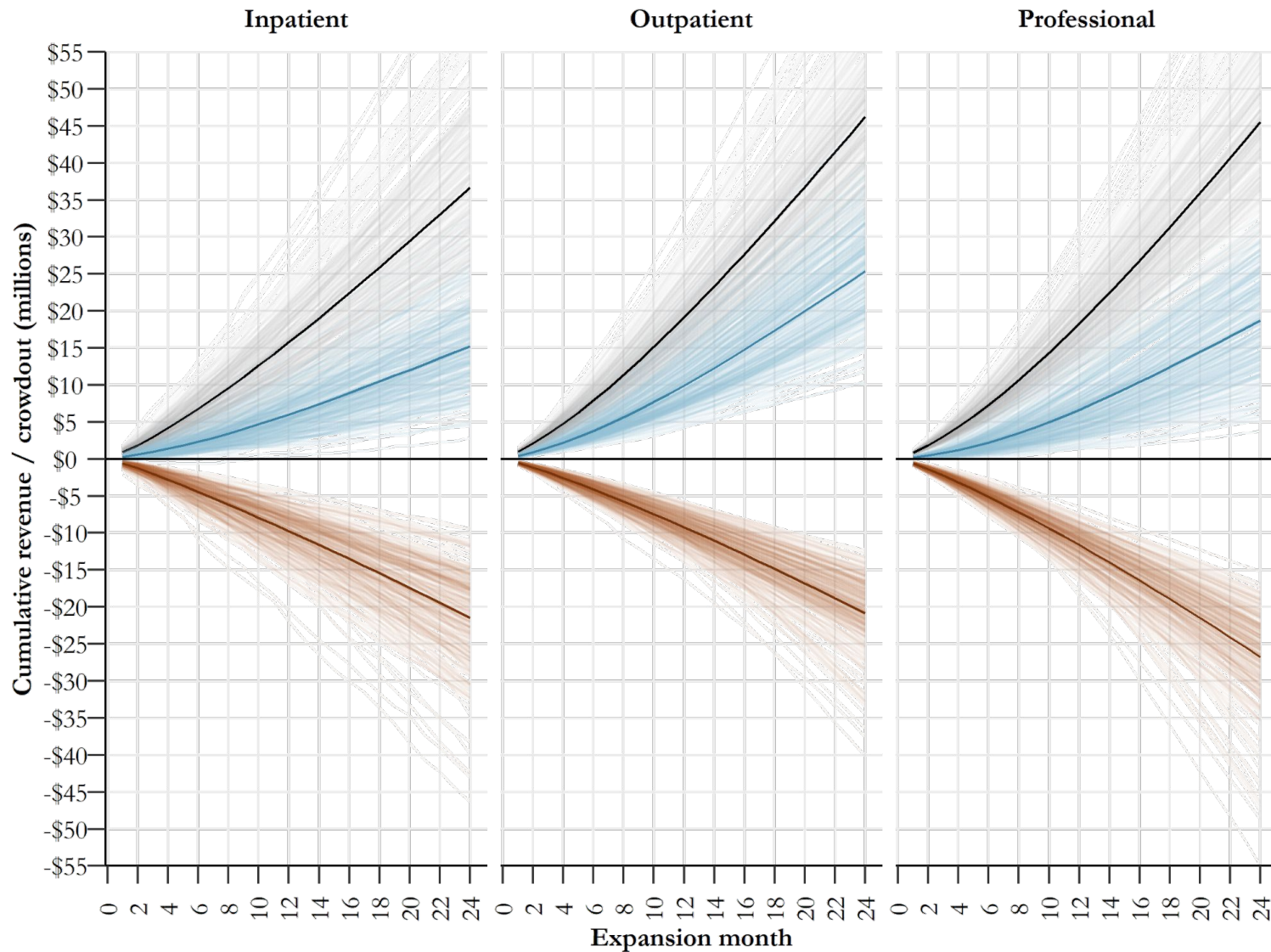
Effects of Medicaid Expansion: Providers



Medicaid costs are mostly (95%) provider revenue

Claim type	Expected biennial cost	Provider category	Percent of claim type ⁵		Expected Expenditures	
			In-State	Out-of-State	In-State	Out-of-State
Dental	\$3.9	Dental	96.6%	3.4%	\$3.8	\$0.1
Inpatient	\$36.7	Hospital	71.3%	28.7%	\$26.2	\$10.5
Professional	\$41.6	Ambulance	3.2%	0.4%	\$1.3	\$0.2
		Behavioral Health	19.2%	0.1%	\$8.0	\$0.0
		Dental	0.1%	0.0%	\$0.0	\$0.0
		Equipment / Supplies	3.2%	1.3%	\$1.3	\$0.5
		Laboratory/Imaging	4.2%	3.2%	\$1.7	\$1.3
		Other	11.4%	0.7%	\$4.7	\$0.3
		PT/OT	4.2%	0.1%	\$1.7	\$0.0
		Primary Care	17.8%	2.5%	\$7.4	\$1.0
		Specialist	24.6%	2.5%	\$10.2	\$1.0
		Vision	1.0%	0.2%	\$0.4	\$0.1
Outpatient	\$46.2	Ambulatory Surgical Center	3.8%	0.1%	\$1.8	\$0.0
		Hospital	52.0%	4.4%	\$24.0	\$2.0
		Other	1.2%	0.4%	\$0.6	\$0.2
		PT/OT	0.1%	0.0%	\$0.0	\$0.0
		Primary Care	37.8%	0.3%	\$17.5	\$0.1
Pharmacy	\$27.2	Pharmacy	83.1%	16.9%	\$22.5	\$4.6
Total medical	\$155.6		85.4%	14.6%	\$132.9	\$22.7
Administrative	\$7.8					
Total cost	\$163.4					

Effects of “crowdout” on providers



Effects of Medicaid Expansion: Insurance



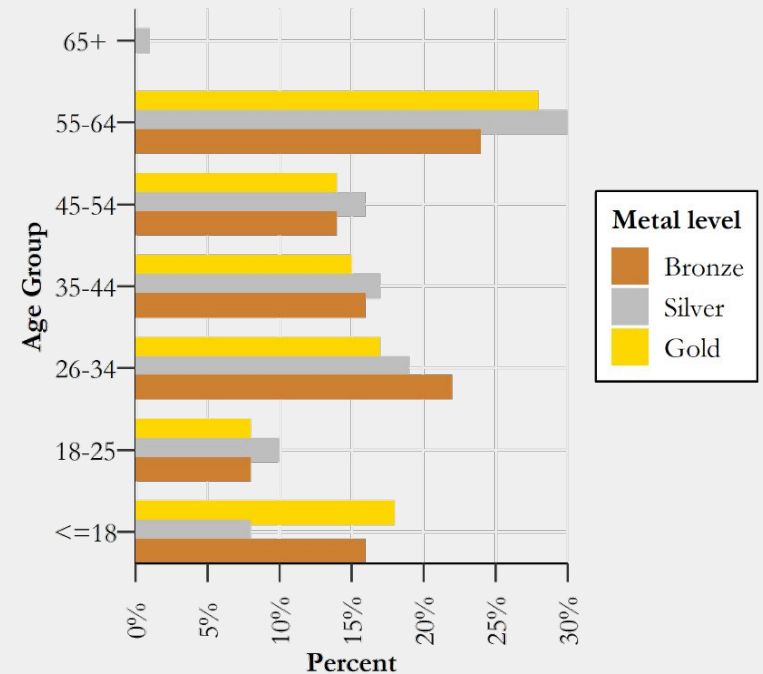
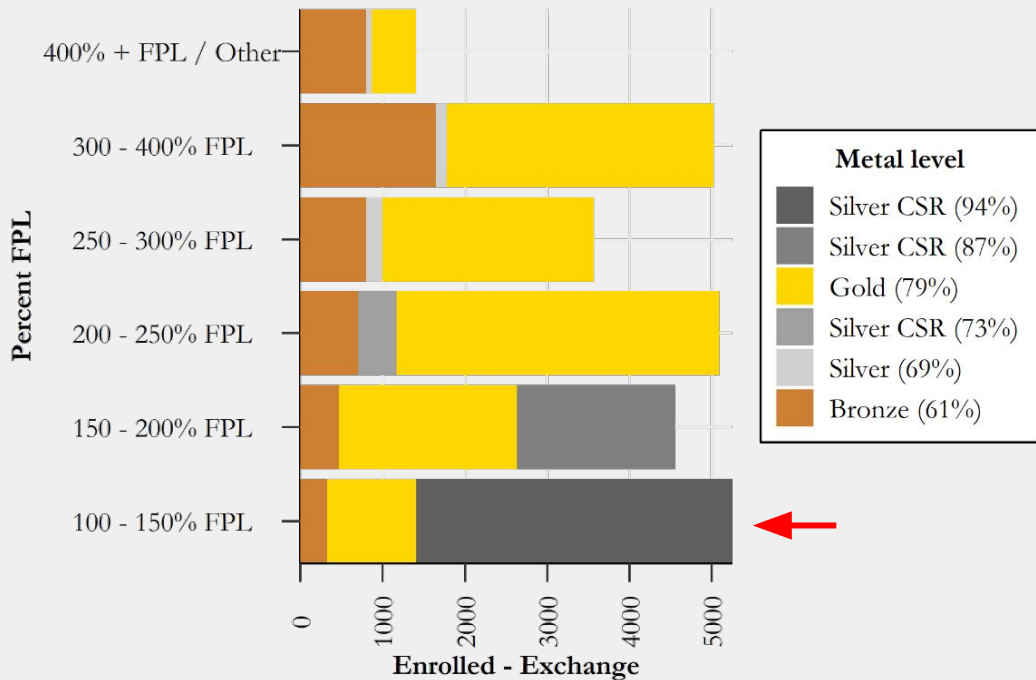
Expansion - effect on Exchange

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- “Crowdout” moves **lowest-income people** on Exchange to Medicaid (100 to 138% FPL).
 - ◆ Strong correlation between income and health: lower-income folks are, on average, less healthy.
 - ◆ Plans available to 100 - 138% FPL are also extremely subsidized: very little cost-sharing. Likely higher-utilization.
- Medicaid Expansion thus likely to take **more expensive-than-average** individuals off the Exchange.
- Most evidence suggests ~ 10% reduction (5 - 15%) of pool costs.

Expansion - effect on private insurance

2019 plan enrollment by income and age



Expansion - effect on private insurance

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- Cost decrease not guaranteed.
 - ◆ Large subsidies may distort income-health gradient at lower incomes (low-to-zero cost plans may attract healthier members at lower income brackets than at higher)
- Also unclear if this cost decrease will translate into perceptibly lower premiums.
 - ◆ Decrease in silver-level plan enrollment may have unpredictable effects due to “silver loading” pricing strategy.
 - ◆ Insurers not required to pass along unless below (current) 80% Medical Loss Ratio rebate threshold.
 - ◆ Most premiums, particularly after ARPA, are heavily subsidized -- people may not notice.

Questions?



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