

## **Additional explanation of the actuarial cost comparison between traditional Medicaid and private coverage in the state exchange**

DHS' March 18 estimates of the incremental costs (or savings) of the emerging low-income premium assistance QHP buy-in option concluded that the net increase in federal Medicaid costs could be as much as 13-14%, but taking all considerations into account, the overall net impact on federal spending could be negligible or even zero.

The analysis supporting the March 18 estimates began with an actuarial projection of the costs of the existing Medicaid program in 2014. Using complete and recent claims information from the Arkansas Medicaid program, actuaries projected 2014 Medicaid costs at a monthly total of approximately \$366 (\$4,392 per year) for adults with demographic and health characteristics similar to the adults who would enroll in QHPs under the emerging premium assistance option. That monthly cost excludes high-risk, high-cost individuals, which make up an estimated 10% of the new population. "Medically frail" individuals with exceptional health service needs who gain coverage in 2014 are not expected to participate in the QHP buy-in program, but are instead likely to receive services in the traditional Medicaid program.

The \$366 per-member-per-month (PMPM) amount is the starting point for an estimate of likely costs for the QHP buy-in option. To the 2014 Medicaid-equivalent cost estimate of approximately \$366 PMPM, actuarial conversion factors are applied to arrive at an expected PMPM cost for private QHP coverage in the exchange. Those factors are described in the earlier press release and briefly reproduced here:

- An actuarial review reveals that the provider rate differential between Arkansas' private market and its Medicaid program is expected to be less than 25%. This estimate incorporates the likelihood that introducing 250,000 low-income adults into the private market in the state exchange will lead to enhanced competition among carriers and some price pressure on providers who will now be compensated at competitive rates for all participants. This price pressure is estimated to result in a 5% reduction in private reimbursement rates in the exchange as compared to current rate differentials in Arkansas.
- The competitive nature of health-plan management within the exchange in combination with allowable cost sharing and sharper consumer health care decision making is expected to further reduce the cost differential to approximately 20%.

Therefore, health plan PMPM costs for the QHP buy-in population are expected to be no more than 20% higher than the (unadjusted) costs for a similar population served in the Medicaid population – before adjusting Medicaid comparison costs to reflect reimbursement rate increases that would likely be needed to secure access for the new population. In dollar terms, this 20% differential in health plan costs results in an expected monthly cost of approximately \$438 in the exchange (\$5,260 per year).

Because the 20% health plan cost differential does not apply to all spending associated with the new population, the net difference in Medicaid costs for the federal government is expected to be approximately 13-14%.

- Excluding the most costly 10% of the new population from the QHP buy-in reduces the total amount of coverage that could potentially be purchased through QHPs on their behalf by 20% or more, since average costs for high-risk individuals are more than twice the costs of low-risk individuals.
- Excluding other high-risk groups also lowers the base against which any QHP cost differential would be applied. High risk adults in Medicaid transition populations as well as some of the woodwork population of current eligibles who newly enroll would be affected by the extension of coverage to adults below 138% of poverty, but would not be affected by the QHP buy-in. For those individuals, the federal costs of extending coverage to low-income adults would be the same with and without the QHP buy-in.
- Finally, total administrative costs associated with extending coverage to adults below 138% of poverty would be *lower* with the QHP option, saving both the state and federal government money in comparison to a traditional Medicaid expansion.

As described in the March 18 press release, the potential federal Medicaid costs of 13-14% are further reduced – potentially to zero – by two significant factors:

1. Appropriately adjusting the comparison costs of a traditional Medicaid expansion to account for likely provider rate increases needed to secure access to health services. Accounting for the likely increase in projected federal Medicaid costs associated with a new population reduces the differential costs associated with the private QHP buy-in; and
2. Taking into account the favorable rate relief that the premium assistance option would provide to the federal government. That rate relief would reduce the amount of U.S. Treasury-financed subsidies for 80% or more of exchange participants with incomes above 138% of the poverty level. Because the Federal treasury is potentially liable for the full marginal costs of premiums above fixed, income-related subsidies, the Federal government should gain the *full* benefit of this rate relief for the vast majority of exchange participants. It is also worth noting that the Federal government will be responsible for *less* than 100% of any added Medicaid costs associated with the QHP buy-in after 2017 (when the federal match rate begins its slide to 90%), so that in the out-years any rate relief inside the exchange pays even greater dividends to the Federal treasury.