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May 7, 2010

Ms. Anne W. Murphy
Secretary
State of Indiana
Family and Social Services Administration
402 W. Washington Street
Indianapolis, IN 46204

RE: HEALTH CARE REFORM – COMPARISON OF RESULTS

Dear Secretary Murphy:

Milliman, Inc. (Milliman) has been retained by the State of Indiana, Family and Social Services Administration to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act (Act) as it relates to the provisions impacting the State's Medicaid program and budget. Milliman provided our initial analysis in a December 3, 2009 letter. In a letter dated May 6, 2010, Milliman provided an update with the inclusion of the House Reconciliation Bill.

This letter presents follow-up information related to comparisons of Milliman's fiscal analysis and federal fiscal analyses prepared by the Federal Funds Information for States (FFIS) and the Congressional Budget Office (CBO).

EXECUTIVE SUMMARY

In response to recent discussions regarding the fiscal analysis prepared by Milliman and other publicly available analyses, Milliman has provided a brief discussion of differences between Milliman's analysis and the fiscal analyses prepared by the FFIS and the CBO.

Milliman prepared an updated fiscal analysis of the Act with modifications to reflect the House Reconciliation Bill (Reconciliation Bill). The updated fiscal analysis was presented in our May 6, 2010 correspondence. The following identifies key differences between the initial estimate presented in our December 3, 2009 correspondence and the updated analysis.

- **Fiscal Impact of Expansion Population** – The fiscal impact of the expansion population has increased due to several factors, including:

- The Reconciliation Bill has reduced the enhanced Federal match for the expansion population; therefore, increasing the cost to the State of Indiana.
 - The updated fiscal analysis reflects expansion to include individuals up to 138% FPL, as compared to the initial analysis that included individuals up to 133% FPL.
 - The initial fiscal impact offset the cost of the expansion with the costs of the Healthy Indiana Plan. The updated fiscal analysis reflects that the Healthy Indiana Plan will be discontinued on December 31, 2012.
 - The initial fiscal impact offset the cost of the expansion with the enhanced match rate for the CHIP population, as noted below.
- **Pharmacy Rebate Impact** – The fiscal impact to Indiana for the pharmacy rebate has been modified to reflect change in assumptions regarding the Healthy Indiana Plan, as well as the pharmacy services fully on a fee-for-service basis.
 - **Physician Fee Schedule Impact** – Milliman has refined the development of the physician fee schedule impact.
 - **Medicare Part D Claw-back Impact** – Milliman’s initial analysis anticipated that the Medicare Part D claw-back payment may be impacted due to provisions of the Act. The current analysis does not anticipate any adverse financial impact on the Medicare Part D claw-back payment.
 - **Foster Children Expansion to Age 26** – The updated analysis reflects the provision requiring the expansion to provide coverage to Foster Children through Age 26.
 - **CHIP Enhanced Match** – The initial analysis had used the enhanced match for the CHIP population as an offset to the cost of the expansion. For the updated fiscal analysis impact, Milliman has itemized the CHIP enhanced match as a separate line item. This allows for the understanding of the full impact of the expansion.
 - **Breast and Cervical Cancer Program and Pregnant Women above 138% FPL** – The updated analysis reflects savings associated with the termination of these programs. It is anticipated that with either the expansion to 138% or the creation of the Exchanges that women currently covered by these programs will either receive full Medicaid coverage or insurance in the Exchange.

Prior to discussing the differences between Milliman’s analysis and the CBO estimate, I do want to clarify that Milliman does not have access to full details regarding the CBO estimates. We have reviewed the CBO report; however, the report only provides national values for the Federal fiscal impact on Medicaid and CHIP, as well as the national values for the number of those enrolling. We have compared those values to a report prepared by the FFIS in August 2009 when the initial proposals of the expansion to 133% FPL were first discussed. It appears that the FFIS calculations and the CBO estimates are consistent; although not exactly the same. With that stated, the remainder of this letter discusses Milliman’s understanding of the where the assumptions used in the analyses differ significantly.



MEDICAID EXPANSION

1. Enrollment: Insured vs. Uninsured below 138% FPL

The primary differential related to the fiscal impact addresses enrollment of the currently insured population. In the development of the fiscal impact, Milliman included all individuals below 138% of the Federal Poverty Limit. *{Note: Throughout this letter, we will be utilizing 138% of the Federal Poverty Limit. This reflects that the expansion provides coverage to 133% of FPL plus a 5% income allowance.}* This included Children, Parents, and Adults – both those currently insured through non-Medicaid programs and the uninsured. The following provides the number of lives in each of the population types below 138% FPL.

**Indiana Population Estimates
 Under 138% FPL, Insured and Uninsured
 From the Census Bureau’s Current Population Survey, 2008 Income**

Population	Insured – non-Medicaid below 138% FPL	Uninsured below 138% FPL	Total below 138% FPL
Children	72,000	37,000	109,000
Parents	76,000	110,000	186,000
Adults	100,000	127,000	227,000
Total	248,000	274,000	522,000

The following table provides Indiana and National estimates of anticipated Medicaid enrollment due to expansion.

Comparison of Medicaid Enrollment Expansion Estimates

	Indiana Only	United States
Milliman (Current Population Survey)	522,000	28.0 million
FFIS (up to 133% FPL)	219,000	14.1 million
CBO	Not Available	15 to 17 million*

*Note: Based on limited documentation of the CBO estimate, this may or may not include a portion of the currently insured under 133% FPL.

Milliman has chosen to include both the currently insured and the uninsured population in our analysis. We have included those below 138% of the Federal Poverty Level. The FFIS estimates only included those currently uninsured through 133% FPL. It appears, although it is not clearly documented, that the CBO may have included only those uninsured in their fiscal analysis. We have included both the insured and the uninsured populations to reflect that the legislation does not provide strong "crowd-out" protection, or, in other words, individuals are not prevented from choosing Medicaid coverage rather than employer offered coverage. It is anticipated that current low income workers receiving health insurance through their employer or other private source will opt for Medicaid coverage due to no premium sharing and limited or no copayments.

2. Enrollment: Participation Rate

Milliman utilized a 100% participation rate assumption for the development of the fiscal estimate. The FFIS utilized assumptions of 80% participation rate for Uninsured Childless Adults and 85% participation rate for Uninsured Parents and Children. The CBO did not document the participation rate assumption. However, the CBO estimate appears to be consistent with the FFIS estimates.

Milliman utilized a 100% participation rate to illustrate the State's full budget exposure. However, it is reasonable to anticipate that less than 100% of the eligible population will enroll in Medicaid. The 80% / 85% participation rate utilized by the FFIS is a reasonable value. The 100% participation rate illustrates the maximum with full participation.

3. Cost per Recipient

Milliman utilized cost per recipient values that are specific to the Indiana populations of Uninsured Adults / Parents who were participating in the Healthy Indiana Plan. Milliman also utilized an Indiana specific assumption for the Children population. The FFIS developed a cost per recipient that was representative of the entire Medicaid population for Indiana, including high cost disabled and institutionalized individuals. Although two thirds of current Medicaid expenditures are for aged and disabled enrollees, these high cost individuals are not expected to make up a significant portion of the expansion population.

Cost per recipient values used by the FFIS were 26% higher for the Adult / Parent population and 183% higher for the Children population than the Milliman assumptions. The higher cost per recipient used in the federal analyses served to partially offset the discrepancy due to lower enrollment estimates.

4. Trend Assumptions

Milliman chose a 6% trend rate to move the cost per recipient forward for the expansion population. Milliman chose a long-term trend rate consistent with the Indiana Medicaid program. Milliman reviewed the medical trend rate from 2004 to 2010 for the Indiana Medicaid program. The observed trend rate was approximately 4.8% per year. However, during this period, OMPP implemented multiple cost saving initiatives that reduced the trend rate. The cost saving initiatives reduced trends by an average of 1% to 3% per year. Milliman also reviewed the Medicaid trend rates projected by the CMS Office of the Actuary for 2009 to 2014. The CMS Office of the Actuary projections reflects a national Medicaid annual trend rate to be approximately 7.5% per year. Milliman chose the 6% trend rate as a mid-point trend, which is below the Office of the Actuary trend for Medicaid and is higher than the recently observed experience. However, given the many cost containment initiatives that occurred during the historical time period, it would be expected to have a slightly higher trend in next several years.

The FFIS chose a trend rate of approximately 4.65% per year (it varied slightly on an annual basis). The 4.65% annual trend rate was comprised of approximately 0.9% per year for population growth and 3.75% per year for medical inflation. FFIS chose the 3.75% per year trend rate as the medical CPI for the

time period. My comments related to the FFIS using the CPI as the base trend is that the CPI only reflects cost per unit increases in medical services. However, cost per unit as defined by the CPI is only one component of the overall medical inflation. The other component not reflected in the CPI is the utilization increase component of medical inflation. In general, utilization trend ranges from 1% to 3% per year. Adding the additional utilization trend to the base trend rates utilized by the FFIS, the total trend rate would be 5.65% to 7.65%, which is consistent with Milliman's estimate and the CMS Office of the Actuary trend rate.

The CBO did not publish the trend rates used for the Medicaid program. However, the following statement was issued regarding the Medicare program:

"Under the legislation, CBO expects that Medicare spending would increase significantly more slowly during the next two decades than it has increased during the past two decades (per beneficiary, after adjusting for inflation). It is unclear whether such a reduction in the growth rate of spending could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or through reductions in access to care or the quality of care."

If this assumption was also utilized by the CBO for the Medicaid program, this would indicate that the Medicaid trend rates are also below historical trend rates and below the CMS Office of the Actuary trends for the Medicaid program. However, Milliman is unable to verify if the CBO used this same type of assumption for the Medicaid program.

5. General Comment on Medicaid Enrollment Expansion Fiscal Estimate

The most significant differential between the two fiscal analyses (*i.e.*, Milliman and FFIS) relates to the enrollment of the currently insured population below 138% of the Federal Poverty Level. It does not appear that the FFIS included the currently insured population at the lower income levels and we are uncertain to how the CBO reflected the currently insured population. The crowd-out provisions related to Medicaid appear much weaker than those related to individuals eligible for the premium tax credits or subsidies. Employer assessments (fines) appear to reference those eligible for tax credits or subsidies, and not those eligible for Medicaid. With regard to the individual, Medicaid expansion eligibility language does not appear to specifically require lack of access to an employer plan.

The differentials due to the trend rate and the participation rate are much less significant components. The fiscal analysis differential is decreased by the higher cost per recipient assumption used by the FFIS.

OTHER ISSUES

The overall impact developed and documented in prior correspondence included other components expected to result from Health Care Reform legislation and may or may not be directly identified in the legislation. These include:

- a. **Administrative Costs** – Milliman has included the fiscal impact of the additional administrative costs associated with implementation of the health care reform provisions. Milliman included an initial cost of implementing the Exchange, system changes, additional personnel, and personnel training of \$80 million. It was anticipated that on-going costs would be an additional \$75 million per year to provide services to the additional 500,000 enrollees. The on-going costs are \$150 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenditures will begin to be incurred by the State of Indiana within the next 12 to 24 months. The FFIS estimates from August 2009 did not specifically identify any additional administrative costs. The CBO has included funding for administrative expenditures for the Exchange; although, these expenditures are listed outside the Medicaid and CHIP fiscal impact.
- b. **Provider Reimbursement** – Milliman has included an increase in provider reimbursement to ensure access to physicians for the current Medicaid eligible population and the expansion population. We have included an estimate at 80% of the current Medicare reimbursement as a target for increasing physician fees to increase access even though future reimbursement may need to be greater than this target for individual specialists. The FFIS did not include any increase in provider reimbursement. The CBO included 100% federal funding for two years for an increase to a limited group of providers and services. The legislation includes reimbursement to 100% of Medicare for primary care physicians for a limited set of primary and preventive care services. As a point of further discussion with regard to access, physicians will be concerned with reimbursement due to the scheduled reduction of 21% to the Medicare physician fee schedule beginning on June 1, 2010. With the significant reduction in the Medicare physician fee schedule, an increase in the Medicaid fee schedule will become even more important to ensure access to care.
- c. **Partial capture of current pharmacy rebates by the federal government** – The fiscal impact to the State of Indiana represents a transfer of rebate revenue from the State to the Federal Government. This transfer is used as a savings to offset the cost of health care reform legislation. Milliman is not aware of a comparable rebate transfer analysis performed by the FFIS. The CBO estimated the total fiscal impact associated with Subtitle F of Title II as \$38.1 billion in revenue to the Federal Government over the ten year projection period (2010 – 2019). The CBO documentation is not sufficient to allow Milliman to determine how much of this revenue pertains to Indiana, but of the \$38.1 billion savings due to Subtitle F, approximately \$11 billion appears to be from Drug Rebate Equalization (DRE), an extension of Medicaid rebates to Medicaid managed care plans. The remaining \$27.1 billion would presumably be due to rebate capture, much of which is revenue that would otherwise have been received by the states.

Each of these components adds additional financial burden to OMPP with several of these costs occurring prior to the implementation in 2014.



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LIMITATIONS

The information contained in this correspondence has been prepared for the State of Indiana, Family and Social Services Administration, related Divisions, and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

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Milliman has relied upon certain data and information provided by FSSA and its vendors. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Indiana Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.



If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

A handwritten signature in black ink that reads 'Robert M. Damler'. The signature is written over a faint, light blue watermark that says 'ELECTRONIC SIGNATURE'.

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/sds