American Academy of Actuaries
DECISION BRIEF
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Implications of Medicaid Expansion Decisions on Private Coverage

Key Points

The Affordable Care Act includes a provision to expand Medicaid eligibility. The recent Supreme Court decision, however, gives states the option of implementing the Medicaid expansion. Whether and to what extent states choose to expand Medicaid can have implications for private coverage. State and federal policymakers and regulators should consider several issues as they are making their Medicaid expansion decisions:

- Individual market premiums could increase in states that opt out of the Medicaid expansion, due to health status differences of new enrollees.
- Exchange premiums also may increase due to spreading fixed reinsurance subsidies over a larger enrollee population.
- Basic Health Program decisions by states, pending clarifications from HHS, can affect the risk profile of enrollees in an exchange.
- Employers may be at greater risk of penalties in states that don't expand Medicaid eligibility.

The Affordable Care Act (ACA) includes a provision to expand Medicaid eligibility to 133 percent of the federal poverty level (FPL). This would effectively expand Medicaid eligibility to 138 percent of the FPL because Medicaid eligibility determinations would disregard 5 percent of income. The recent Supreme Court decision, however, gives states the option of whether to implement the Medicaid expansion. U.S. Department of Health and Human Services officials have subsequently indicated that states will have the flexibility of whether and when to implement the expansion, and that states choosing to implement the expansion can decide later to roll it back. In addition, although states will have the flexibility to implement partial Medicaid expansions, enhanced funding would be available only for states that implement the full expansion.

Whether and to what extent states expand Medicaid eligibility will affect not only access to coverage and costs to the federal government and the states, but also the premiums for private insurance coverage. This decision brief highlights some of the issues that federal and state policymakers and regulators should consider as they are making their Medicaid expansion decisions.

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Individual market premiums could increase in states that opt out of the Medicaid expansion, due to health status differences of new enrollees.

The ACA provides for premium subsidies to individuals purchasing coverage in an Affordable Insurance Exchange if they have income between 100 percent and 400 percent of FPL and are neither eligible for Medicaid nor offered employer-sponsored coverage that meets minimum value and affordability requirements. Individuals below 100 percent of FPL who are not eligible for Medicaid are not eligible for subsidies in an exchange. If a state opts not to extend Medicaid eligibility to 138 percent of FPL, then individuals 100 percent to 138 percent of FPL who otherwise would have been eligible for Medicaid will have access to premium subsidies. This population can be expected to have higher health care needs than higher-income exchange enrollees. The Congressional Budget Office (CBO) estimates that due to the likely higher health spending among lower-income enrollees, average individual market premiums will be 2 percent higher than projections made under the assumption that all states expand Medicaid to 138 percent of FPL.[1,2] Note that this estimate reflects the increase in average premiums overall, including not only states that opt out of the Medicaid expansion but also those that do expand Medicaid. Therefore, premium increases would be even higher among those states that do not expand Medicaid.[3] Premium increases would be borne by nonsubsidized purchasers and by the federal government for subsidized enrollees.

Exchange premiums also may increase due to spreading fixed reinsurance subsidies over a larger enrollee population.

The CBO estimate reflects premium increases due only to expected higher health spending among lower-income enrollees. Premiums also would be higher during the initial years of implementation due to lower per-enrollee reinsurance subsidies. The temporary reinsurance program for years 2014-2016, designed to stabilize premiums for coverage in the individual market, provides payments to individual market plans for their high-cost enrollees. Because the funding for the reinsurance program is fixed, an influx of additional individual market enrollees would mean that a lower payment would be available on a per-enrollee basis.[4] The reduction in the reinsurance subsidy as a percent of the premium could exceed that due solely to higher enrollment if, as discussed above, average premiums increase due to the greater health costs of new enrollees. Clarification is needed on whether and how the reinsurance subsidy amount will be allocated across states based on their Medicaid expansion decisions. The offsetting impact of lower reinsurance fees per insured life, which are levied not only on individual market plans

[1]Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." July 2012. Available at: http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf

[2]Because risk pooling for premium setting purposes includes those purchasing coverage both inside and outside of an exchange, participation of a higher-cost population in the exchange also will affect premiums for plans purchased outside of the exchange.

[3]In addition to any premium effects, states also may need to consider recalibrating the risk adjustment methodology to reflect the private enrollee population resulting from its Medicaid expansion decision.

[4]Take-up rates greater than expected, even without an influx of individuals who otherwise would have been eligible for a Medicaid expansion, also would have the effect of lowering the per-enrollee reinsurance subsidy, thereby increasing the premium.

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but also on group plans, would likely be small in comparison.

Basic Health Program decisions by states, pending clarifications from HHS, can affect the risk profile of enrollees in an exchange.

The ACA gives states the option of using federal subsidies toward a state Basic Health Program (BHP) for individuals 133 percent to 200 percent of FPL who neither are eligible for Medicaid nor offered employer-sponsored coverage that meets minimum value and affordability requirements.[5] The BHP must cover at least the essential health benefits that exchange plans must cover. In addition, BHP enrollee premiums cannot exceed those in the exchange and cost sharing is limited, based on income. The federal subsidy that states could use toward the BHP would be 95 percent of the premium and cost-sharing subsidies that would be available in an exchange.

If states that expand Medicaid to 138 percent of FPL develop a BHP for the 138 percent to 200 percent of FPL population through contracts with private plans or providers at discounted rates compared with private plans in the exchange, then the BHP potentially could offer richer benefits at a lower cost than plans in the exchange. The BHP could reduce the number of participants who need to transition between Medicaid coverage and subsidized private plan coverage in an exchange.

For states not expanding Medicaid eligibility to 138 percent of FPL, federal clarification is needed in several areas, including:

- Whether federal exchange subsidies would be available for states to use toward the BHP for the 100 percent to133 percent of FPL population (the ACA does not appear to allow this);
- Even if federal exchange subsidies would not be available for the BHP, whether states would be allowed to cover at their own cost the 100 percent to 133 percent of FPL population; and
- Whether non-expansion states would be prohibited from implementing a 133 percent to 200 percent of FPL BHP altogether.

If non-expansion states are allowed to develop a BHP to cover those at 133 percent to 200 percent of FPL, but not those at 100 percent to 133 percent of FPL, a discontinuity in coverage would occur. Individuals at 100 percent to 133 percent of FPL would be covered in an exchange, individuals at 133 percent to 200 percent of FPL would be covered by the BHP, and individuals at 200+ percent of FPL would be covered in an exchange.

Federal guidance will influence state decisions on BHPs which, in turn, will affect enrollee risk profiles and premium levels in an exchange.

Employers may be at greater risk of penalties in states that don't expand Medicaid eligibility.

Under the ACA, employers with 50 or more workers are subject to penalties if any full-time employees receive a premium subsidy for coverage in the exchange. Employees are eligible for premium subsidies only if they don't have access to Medicaid and their employer does not offer coverage that meets minimum value requirements and is deemed to be affordable to the employees (i.e., less than 9.5 percent of income). In states that opt out of the Medicaid expansion, low-income workers who otherwise might have enrolled in Medicaid might access premium subsidies thereby putting the employer at risk of penalties.

[5]Unlike eligibility for the Medicaid expansion, which reflects a 5 percent income disregard, eligibility for the BHP does not include a 5 percent income disregard. Thus, while the full Medicaid expansion extends eligibility to 138 percent of FPL, BHP eligibility begins at 133 percent of FPL.

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