Medicaid Expansion Baseline Assumptions:

Lisa Carruth & Stephanie Muth

Beginning January 2014, adults with incomes under 139 percent of the federal poverty level (FPL) became an optional Medicaid population, referred to as the expansion population. To date, Texas has not opted to expand Medicaid. This analysis provides estimates of the costs and offsets (savings) for expanding Medicaid based on identified assumptions for participation and costs, beginning September 2022 (fiscal year 2023). The first year is ramped-up gradually, assuming 50 percent of the expected participation of 50 percent for uninsured citizens.

Population of Interest: Medicaid Expansion

	Total Uninsured	Percent of Population*	Uninsured Adults, 0-138% FPL, Age 19-64	Percent of Group (Adults, 0-138% FPL)	Medicaid Eligible Under Expansion	Percent of Total Population Eligible Under Expansion
FY 2023	5,372,269	18%	1,627,069	46%	**1,252,600**	**4.1%**
FY 2024	5,459,697	18%	1,655,452	46%	**1,272,990**	**4.1%**
FY 2025	5,544,769	18%	1,682,942	46%	**1,292,667**	**4.1%**

*Data sources: 2018 American Community Survey, Texas Sample, U.S. Census (2010 Baseline). Texas Health and Human Services Commission. *Population is non-institutionalized Texas residents. Medicaid eligible adjusts to remove undocumented persons and Legal Permanent Residents who have not met the 5-year timeframe for eligibility*

While 18 percent of the non-institutionalized population is estimated to be uninsured, only 4.1 percent of the population is eligible for Medicaid expansion. However, 46 percent of the group eligible for expansion – adults under 139 percent of poverty – are estimated to be uninsured, so a high participation rate in expansion can move the needle on uninsured rates. Additionally, when Medicaid expands, there will be groups who are categorically ineligible such as prisoners or certain non-citizens who will still have some of their expenses paid by Medicaid. This is discussed in greater detail later in the document.

Medicaid Expansion

The baseline Medicaid expansion estimate shows a net cost to the state of $4.9 million for the first year of ramped-up implementation[1]. The net cost in the first full year without ramp-up,

[1] The net cost(savings) is based on all costs to the program, including cost shifts from regular Medicaid, minus all offsets which include Medicaid general revenue (GR) shifts due to a better match rate, as well as savings from other state programs, and revenue from premium tax. The premium tax revenue is calculated based on accrual, which does not align with actual collection timing/cash flow of the tax to the state treasury (there is a significant lag).

fiscal year 2024, is actually a savings of about $320,000. There are various offsets and premium tax revenue contributing to a net state savings. Offsets to the general revenue (GR) costs include savings from the shift in federal match for regular Medicaid clients who are enrolled in expansion, such as Pregnant Women and Medicaid for Breast and Cervical Cancer clients (MBCC), explained in more detail later in the document. Other savings to the state include community mental health, institutionalized populations, HIV medication assistance, substance abuse treatment, and savings to the kidney health program. From a net state perspective, the federal component of premium tax is also offset. For comparison, premium tax revenue is estimated based on actual percentage and not the tax collection schedule.

The population, cost, and savings assumptions were made with the best available information, and based on discussions and information gathered from stakeholders and state agencies, however, given the large dollar amounts in the estimate and the smaller overall savings and costs, it is expected that even slight changes to assumptions or expected behavior can swing a savings to a cost, and vice versa. In particular, administrative costs can change as policies are refined and implemented.

Assumptions: Medicaid Expansion Baseline Model

Population/Caseload

Medicaid expanded coverage for adults ages 19 – 64 with incomes at or below 138 percent of the Federal Poverty Level (FPL), who are citizens or legal permanent residents (LPRs) and have held that status for a minimum of five years. Potential enrollees include persons who are:

- Uninsured, including women receiving family planning/women's health services through the (limited) Women's Health Program.
- Insured through ACA Marketplace or other insurance.
- Receiving Medicaid via Pregnant Women or the Medicaid for Breast and Cervical Cancer program.
- These last two groups are not newly-insured, but will contribute to savings as a result of differential FMAP.

Baseline assumptions for take-up and movement into expansion Medicaid for these enrollees are listed below. The first year, fiscal year 2023, beginning September 2022, will have a 'ramp-up' component of 50 percent, except where noted when clients are transferred.

Uninsured:

- Based on 2018 American Community Survey (ACS), Texas Sample, U.S. Census[2]
- 50 percent participation (or "take-up") of uninsured citizens ages 19-64, at/below 138 FPL

[2]United States Census Bureau, 2018 American Community Survey (ACS) (Texas Sample). Projected population growth ratios developed by the Office of the State Demographer/Texas Demographic Center at the University of Texas at San Antonio and the Health and Human Services Commission (HHSC). Updated March 11, 2020.

  - 50 % take-up estimate is based on prior HHSC estimates of the take-up rate. Users may vary the estimate within certain bounds.
  - 64% take-up ceiling is derived from the 2019 take-up of Pregnant Women, based on HHSC data that shows 64% enrollees in Medicaid Pregnant Women, based on age and income of the potential eligible population, using data from HHSC and the 2018 ACS (138,000/214,000). Prior years showed the same approximate take-up for Pregnant Women.
- 12.5 percent participation of Legal Permanent Residents (LPRs)
  - LPR potential population is reduced to account for the 5-year bar, where eligibility is contingent on having had LPR status for a minimum of five years. According to data from the Department of Homeland Security (DHS)[3] 74% of LPRs currently in the US have had that status for more than 5 years
  - LPR take-up is lower than that of citizens, 25% of the citizen take-up, based on current low numbers of LPRs in programs and concerns with public charge rule, which holds that legal status may be denied if a family member receives public benefits. The public charge rule may be changed under the Biden administration, but confusion around the rule will likely have a long-term impact.

SUMMARY: 50% take-up among uninsured citizens, ages 19-64, at/below 138% FPL; 12.5% take-up among eligible non-citizen LPRs.

Adjustment to Uninsured Population for Healthy Texas Women:

- A component of the uninsured population are women who are enrolled in the Healthy Texas Women (HTW) program, a part of which recently received approval for Medicaid federal match. HTW is a limited benefit program for only family planning (matched at 90 percent) and some women's health services (matched at regular FMAP, approximately 61 percent).
  - HTW provides women's health and family planning to women who would become eligible for full Medicaid benefits, thus making them ineligible for HTW. Based on directives from the Centers for Medicare and Medicaid Services (CMS), these clients would need to be moved into full Medicaid, thus resulting in a take-up rate that is much higher than 50%.
  - Therefore, these clients must be removed from the uninsured population that receives the 50 percent take-up and brought in separately.
  - An average of 269,000 HTW enrollees are served in the expansion population monthly. These enrollees are not brought in more gradually (as a "ramp-up" over the course of the year) since they are moved as an established group in the first month.

[3]Estimates of the Lawful Permanent Resident Population in the United States and the Subpopulation Eligible to Naturalize: 2015-2019. Office of Immigration Statistics, Office of Strategy, Policy, and Plans, U.S. Department of Homeland Security, September 2019. Table A6. LPRs by Period of Entry: Jan. 2015-2019.

Current Affordable Care Act Subsidy Recipient Caseload:

- Because Texas did not expand Medicaid initially, there are individuals ages 19-64, above 100 percent FPL up to/at 138 percent who qualify for the ACA marketplace with a subsidy. These individuals will be moved to Medicaid Expansion.
- As with the HTW clients, there will be no ramp-up, but initial movement of these clients
- The number of ACA enrollees is taken from CMS reports for 2020, approximately 220,000, grown using the ACS Census growth rate to 226,000 by FY 2025.

Other caseloads:

There are other clients who will have the opportunity to move to Medicaid Expansion, whether as a move to this population from another Medicaid group, or through natural progression and movement among groups. These are Pregnant Women in regular Medicaid (PW) and Medicaid for Breast and Cervical Cancer (MBCC) clients.

- Pregnant Women at/below 138% FPL may be enrolled in Medicaid Expansion, with their costs matched at 90 percent FPL. However, at several points in time they may be moved to/enrolled in PW Medicaid.
    - If an otherwise expansion-eligible woman presents for enrollment due to pregnancy, she will be enrolled in regular Medicaid PW. After the birth and post-partum period, she would be enrolled in expansion Medicaid (previously the enrollment was to HTW).
    - If a woman is already in expansion and becomes pregnant, she may remain in expansion, with a 90 percent match on expenses, until recertification, unless she opts to enter regular PW Medicaid.
    - Assumptions for this model:
        - Using potential eligible population of women over age 18 estimated to be eligible for PW Medicaid (from 2018 ACS, see footnote 2), there are 217,000 eligible women up to 198 percent FPL, with an assumed 75% of those at/below 138% FPL.
        - Assume 40 percent of women enter Medicaid already expecting; 25% come in to Expansion prior to pregnancy, and spend their entire pregnancy in Expansion; 35% come in to expansion prior to pregnancy and move to Pregnant Women, spending half time in each.
        - The average length of stay (LOS) in Pregnant Women Medicaid, including 2 months post-partum is 7 months.
            - The assumed LOS for expansion pregnancy is 9 months as pregnant (for cost purposes).
        - Summary: 75% of potential population is at/below 138%, 64% take-up of these, with 40% going to regular Medicaid, 25% staying full-term in Expansion, and 35% moving to regular Medicaid, with equal time in regular and expansion.
            - Only the 25% full-term in expansion have the birth costs included in expansion costs (called Delivery Supplemental Payments)

which are approximately $3,900 per birth[4] with the remaining DSPs part of Pregnant Women's Medicaid
        - There is no ramp-up for the movement of pregnant women, as it is built in to the overall modeling assumptions.
        - Overall, savings for pregnant women are approximately $70 million in GR per year
- Medicaid for Breast and Cervical Cancer is shifted to expansion through costs only, based on the cost forecast from the Health & Human Services Commission using their legislative appropriation request (LAR) 2021 forecast.
    - This movement is not done as a ramp-up, but done immediately, like the ACA movement.
    - Savings for this are smaller, as MBCC is matched at the Enhanced FMAP (same EFMAP as CHIP clients).
    - Overall savings for this shift of MBCC is approximately $20 million GR per year.

- Emergency Services for Non-Citizens costs are costs for emergency treatment for persons who would otherwise qualify for Medicaid except for citizenship status. When a patient presents with an emergent condition, treatment must occur regardless of ability to pay. If otherwise Medicaid eligible, Medicaid will reimburse for the emergency care (only), and any remaining care will be uncompensated care.
    - Expanding Medicaid will expand the pool of non-citizens and related emergent condition costs.
    - Costs (all funds) are approximately $325 million.
    - Costs were estimated from:
        - The percentage of non-fatal accidents requiring emergency care, based on the WISQARS database of the Centers for Disease Control[5] for adults ages 19-64 (4.6%), and the average costs for hospitalization for these accidents (traffic, falls, cuts, exertion), using 50% with the assumption that the remainder of the stay is non-emergent (life-threatening)
            - WISQARS is Web-Based Injury Statistics Query and Reporting System
        - This percentage is applied to the uninsured population of LPRs who had not met the 5-year eligibility level, and those persons who are undocumented (not considered earlier as they are ineligible for Medicaid) from the 2018 ACS, and multiplied by the cost.
        - These costs are not ramped-up in the first year, since this is based almost entirely on hospital costs as traumatic events occur.

[4]FY2022-23 Texas Medicaid Caseload and Cost Forecast, July 2020. Health & Human Services Commission, Forecasting, Financial Services.

[5]Web-Based Injury Statistics Query and Reporting System, Centers for Disease Control (WISQARS).

Costs

Costs are applied to each population and are based on similar costs from current Medicaid populations, and knowledge of cost trends from states that expanded Medicaid. Medicaid costs are grown based on historical trends from HHSC forecasts. Some of the offset costs are flat and based on current amounts appropriated for certain programs (and potentially capped). All costs are approximate.

Costs – Uninsured Adults:

- Temporary Assistance for Needy Families (TANF)-level Medicaid costs are used as a starting point, removing the cost for pregnant women (this is added in the pregnant women module), then adding in an increase of 16.0 percent for pent-up demand[6], with second year demand at half that amount, dropping to 4.0 percent for the remaining years.
- The pmpm cost is adjusted for vendor drug rebate revenue, reducing the drug cost component by 50 percent, based on historical revenue collections. Historically rebate revenue offsets are approximately half the vendor drug premium. This is done in the cost because rebate revenue is part of the method of finance for drug costs.
- The enrollees who come over from the ACA are cost at a pmpm with only an 8 percent increase with an assumption that much of the pent-up demand has been met. However, there are indications that overall pmpm costs have not declined as much as expected after meeting pent-up demand, as enrollees who stay insured may have higher acuity.[7]
- Pregnant Women in the expansion program are cost at the same pmpm as regular Pregnant Women's Medicaid, approximately $785 pmpm, with a delivery supplemental payment of $3,900 per birth.
- All pmpm costs are from the Health and Human Services 2020 LAR forecast, July 2020, HHSC Forecasting, Office of the CFO[8].
- Costs for MBCC are taken directly from the HHSC forecast, with half assumed to be offset
- Costs for Emergency Services for Non-Citizens are derived as described above from the CDC WISQARS system.
- The FMAP, or Federal Medical Assistance Percentage, is 61.45 percent, with state share of 38.55 percent for regular Medicaid for all years (2023 – 2027). The enhanced FMAP, used for MBCC is 73.02 percent with 26.98 state share. Expansion FMAP is 90/10.

[6]Centers for Medicare and Medicaid Services, Office of the Actuary, Actuarial Reports 2016, 2017. States show varying levels of increase for pent-up demand.

[7]Avalere Health Medicaid Expansion Press Release, January 24, 2017. Avalere Analysis Shows That Health Needs and Cost of Medicaid Expansion Populations Grow Over Time.

[8]FY2022-23 Texas Medicaid Caseload and Cost Forecast, July 2020. Health & Human Services Commission, Forecasting, Financial Services.

Offsets

- Offset amounts are based on analysis done for the Episcopal Health Foundation for the General Revenue (GR) amounts for the Kidney Health program ($8.4m), Substance Abuse Treatment ($12m), and HIV Medication Assistance ($16.5m), for a total of $36.9m savings offsets.[9]
- Offset of approximately $200 million is anticipated for community mental health services, based on analysis conducted by Texas Council of Community Centers.[10]
- Offset of approximately $137.9 million for Medicaid payments offsetting general revenue for inpatient stays for institutionalized individuals in the Texas Department of Criminal Justice.[11] To qualify for a Medicaid reimbursement for institutionalized inmates, the inpatient stay must be greater than 24 hours, at a unit that is a separate entity (hospital) and not part of a prison unit.
- Total of $370 million in offsets for GR programs at TDCJ, and Department of State Health Services and Health and Human Services, in addition to the offsets to the Regular Medicaid program at HHSC of approaching $90 million.

Revenue

- An additional component, included in the capitation, but with an offset for revenue-generation, is the premium tax revenue. Premium tax is 1.75% and is paid by the health plans.
    - The premium tax of 1.75% is added to the capitation for Medicaid – so it is initially an All Funds cost.
    - As this is matched (FMAP), the federal share is returned to the state as revenue. (Note – the state receives the total premium tax payment, but since the state share is part of the capitation/cost, the actual 'gain' is only the federal component).
    - This revenue is state revenue – and does not go to the Medicaid program, but into state treasury.
- An additional "revenue-like" component, vendor drug rebate, is not considered here, but is subtracted from the overall pmpm cost, at the rate of 50% of total drug spend for TANF adults, based on historical rebate details.
    - Vendor drug rebate revenue is different than premium tax revenue, as it comes to the Medicaid (or CHIP) programs directly, and is used as a method of finance for the programs.

[9] State Budget Impact of Providing Health Insurance to Low-Income Adults with 90% Federal Funding, Prepared by Randy Fritz, John R. Pitts, and John R. Pitts, Jr. for the Episcopal Health Foundation, September 14, 2020.

[10] Discussion and analysis with the Texas Council of Community Centers staff and analysts, October 2020.

[11] Texas Department of Criminal Justice, Chief Financial Officer. Estimates based on General Appropriations Act funding 2020-21.

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Other Considerations

Hospital / Supplemental funding and 1115 Waiver Programs

Expanding Medicaid to hundreds of thousands of adults will shift the dynamics of supplemental funding – which is a mix of federal and local funding in Medicaid to address payment shortfalls and providing charity care and care to the underinsured. As of January 2021, HHSC received an extension through September 30, 2030 for the 1115 Transformation Demonstration Waiver, that extends some of the supplemental programs and allows continuation, in part, of one component of the demonstration. The extension does not preclude adding populations or expanding Medicaid, although there would be shifts in the supplemental funds for a number of programs. Without the extension, Texas was potentially facing a 'cliff' where some funding for supplemental programs would have been lost.

Any changes to the populations covered by Medicaid needs to be considered in light of a Medicaid program that is not in distress, and facing a severe funding shortfall, otherwise program integration would only increase need in all areas. Adding expansion adults to a more robust Medicaid program, including the supplemental components mentioned below, would allow shifts to occur where new populations served in expansion Medicaid could potentially free supplemental funds for other populations, although that is an unknown.

- Reduction in Uncompensated Care/Charity Care resulting from increased numbers of Medicaid enrollees
    - ***The reduction in UC will reduce the "new" federal funding component brought in to the state by Medicaid expansion, but the amount of the reduction is unknown. The "Medicaid Shortfall" would be increased, and overall funding for health care, including expansion Medicaid and supplemental programs would increase in totality.***
- Interaction with waiver programs such as UHRIP (rate improvement), now renamed CHIRP, a Medicaid program funded through the 1115 Transformation Waiver that provides increased funding through managed care for rates paid to hospitals.
- Interaction with Disproportionate Share Hospital funds (DSH) – DSH need will not go down as much due to increase in Medicaid Shortfall (the difference between Medicaid payments and cost).

Eligibility, Systems, and Administrative Costs:

HHSC costs for eligibility and administration, including rate-setting costs and increases to actuarial contract, as well as system changes and increased staff needs.

- There are administrative costs included for staffing needs, however these are estimates and would need further examination by the agency as any expansion is planned.

NOTES:

[1] The net cost(savings) is based on all costs to the program, including cost shifts from regular Medicaid, minus all offsets which include Medicaid general revenue (GR) shifts due to a better match rate, as well as savings from other state programs, and revenue from premium tax. The premium tax revenue is calculated based on accrual, which does not align with actual collection timing/cash flow of the tax to the state treasury (there is a significant lag).

[2]United States Census Bureau, 2018 American Community Survey (ACS) (Texas Sample). Projected population growth ratios developed by the Office of the State Demographer/Texas Demographic Center at the University of Texas at San Antonio and the Health and Human Services Commission (HHSC). Updated March 11, 2020.

[3]Estimates of the Lawful Permanent Resident Population in the United States and the Subpopulation Eligible to Naturalize: 2015-2019. Office of Immigration Statistics, Office of Strategy, Policy, and Plans, U.S. Department of Homeland Security, September 2019. Table A6. LPRs by Period of Entry: Jan. 2015-2019.

[4]FY2022-23 Texas Medicaid Caseload and Cost Forecast, July 2020. Health & Human Services Commission, Forecasting, Financial Services.

[5]Web-Based Injury Statistics Query and Reporting System, Centers for Disease Control (WISQARS)

[6]Centers for Medicare and Medicaid Services, Office of the Actuary, Actuarial Reports 2016, 2017. States show varying levels of increase for pent-up demand.

[7]Avalere Health Medicaid Expansion Press Release, January 24, 2017. Avalere Analysis Shows That Health Needs and Cost of Medicaid Expansion Populations Grow Over Time.

[8]FY2022-23 Texas Medicaid Caseload and Cost Forecast, July 2020. Health & Human Services Commission, Forecasting, Financial Services.

[9]State Budget Impact of Providing Health Insurance to Low-Income Adults with 90% Federal Funding, Prepared by Randy Fritz, John R. Pitts, and John R. Pitts, Jr. for the Episcopal Health Foundation, September 14, 2020.

[10]Discussion and analysis with the Texas Council of Community Centers staff and analysts, October 2020

[11]Texas Department of Criminal Justice, Chief Financial Officer. Estimates based on General Appropriations Act funding 2020-21.

Additional References

https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets

https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

https://www.texastribune.org/2020/07/14/texans-health-insurance-jobs-pandemic/

https://www.familiesusa.org/wp-content/uploads/2020/07/COV-254_Coverage-Loss_Report_7-17-20.pdf?referringSource=articleShare

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https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/

State-Based Exchange 5-Year Budget Estimate Methodology:

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Abstract

This budget estimate was developed using actual budget data from a comparable state that recently established its own state-based exchange. In addition, multiple current and former state exchange executives, as well as a number of private sector exchange vendors were consulted regarding assumptions, budget categories, scaling factors, etc.

After identifying primary cost categories for which estimates would be developed, the sample state budget was divided into fixed and variable costs expressed as percentages of the overall cost. To account for the unique qualities and characteristics of Texas, scaling factors were applied to the variable costs based on population, population centers, distinct regions, and geography. After combining the baseline fixed costs and scaled variable costs, the contract costs were calculated as a percentage of the appropriate cost category. Finally, all individual cost category estimates for each year were rounded for simplification and discussion purposes.

Assumptions and Disclosures

This methodology relied on a set of high-level assumptions, including:

- Costs are for state exchange implementation and operation only; no additional functionality included
- For a 5-year budget, it's assumed Years 1 and 2 comprise the Design, Development, and Implementation (DDI) period and the Maintenance and Operation (M&O) period begins in Year 3, continuing for the duration.
- Based on other SBE budgets, Independent Verification & Validation (IV&V) and Project Management Office (PMO) costs are calculated as a percentage of tech/call center costs (10% and 25%, respectively).
- IV&V and PMO are contracted services and associated costs are temporary
- Administration and Staffing budget includes all infrastructure, rent, equipment, D&O/E&O insurance, and personnel salaries and benefits
- Outreach and marketing efforts will not begin until Year 2; ongoing thereafter
- Year 2 (DDI2) Outreach and Marketing costs include additional funds for initial widespread public awareness campaign

Benchmark Budget Identification

Budget methodology development took into consideration state-based exchange (SBE) costs for the three states that most recently contracted to transition from HealthCare.gov to a state

model (Nevada, New Jersey, and Pennsylvania). Pennsylvania, in particular, served as the best sample state for benchmarking and comparative purposes given its population size, number of major metropolitan areas, and distinct geographical regions. Pennsylvania was also the state for which the most complete, relevant, and recent budgetary information was available. (See slide 24 of attached deck for Pennsylvania Calendar Year 2021 Budget Estimates.)

Cost Categories

This exercise is not intended to present a detailed budget for Texas; rather, the intent was to identify major cost categories for which a reasonable 5-year budget estimate could be determined. The categories are:

- Technology/Call Center
- Project Management Office (PMO)
- Independent Verification and Validation (IV&V)
- Administration and Staffing
- Outreach and Marketing

Factors for Appropriate Scaling of Costs

In order to acknowledge and account for Texas' uniqueness in terms of population size, population centers, expansive geography, etc. this methodology included scaling factors intended to more accurately estimate costs appropriate for the state.

Some state exchange costs are fixed while other costs are variable and are higher or lower depending on the state's profile. Based on conversations with current and former state exchange CEOs as well as private sector exchange vendors, and using Pennsylvania's SBE budget as a benchmark, this methodology estimated fixed costs at 40% and variable costs at 60%.

Table 1. PA Annual Budget by Variable and Fixed Costs

COST CATEGORY	PA Annual Budget	Variable (60%)	Fixed (40%)
Technology/Call Center	$ 33,274,350	$ 19,964,610	$ 13,309,740
Admin and Staffing (Gen Ops + Personnel)	$ 8,100,924	$ 4,860,554	$ 3,240,370
Outreach and Marketing (External Affairs)	$ 8,583,356	$ 5,150,014	$ 3,433,342
TOTAL	**$ 49,958,630**	$ 29,975,178	$ 19,983,452

In order to account for a population size that is more than double that of Pennsylvania's, a scaling factor of 2.3 was applied to the variable costs.

Table 2. Variable Costs by Category; Scaled for Population

COST CATEGORY	Variable (60%)	Variable x 2.3
Technology/Call Center	$ 19,964,610	$ 45,918,603
Admin and Staffing (Gen Ops + Personnel)	$ 4,860,554	$ 11,179,275
Outreach and Marketing (External Affairs)	$ 5,150,014	$ 11,845,031
TOTAL	$ 29,975,178	$ 68,942,909

The benchmark fixed costs were then added to the population-scaled costs in order to determine the total cost by category for the non-contracted cost categories.

Table 3. Fixed Costs and Population Scaled Variable Costs by Category

COST CATEGORY	Fixed Costs	Variable Costs (Scaled for Population)	Fixed + Variable Costs by Category
Technology/Call Center	$ 13,309,740	$ 45,918,603	$ 59,228,343
Admin and Staffing (Gen Ops + Personnel)	$ 3,240,370	$ 11,179,275	$ 14,419,645
Outreach and Marketing (External Affairs)	$ 3,433,342	$ 11,845,031	$ 15,278,374
TOTAL	$ 19,983,452	$ 68,942,909	$ 88,926,361

Outreach and Marketing costs can be significantly affected based on topography, population centers, media markets, language and cultural diversity, etc. While not an exact proxy, the number of distinct geographical regions is generally a reasonable gauge to determine what the cost multiplier might be for public awareness, outreach, and marketing.

Pennsylvania can (arguably) be divided into 4-6 distinct geographical regions. Texas, which is more than five times larger than Pennsylvania in terms of area, is generally divided into 6-8 geographical regions. With this in mind, an additional geography scaling factor of 2.0 was applied to the Outreach and Marketing cost category.

Table 4. Outreach and Marketing Costs; Scaled for Geography

COST CATEGORY	Fixed + Variable Costs by Category	Fixed + Variable Costs by Category x 2
Outreach and Marketing (External Affairs)	$ 15,278,374	$ 30,556,748

Adjusting and combining the three major cost categories provided a baseline budget for a normal operating year. As a general rule, IV&V and PMO services are priced as percentage of the Technology/Call Center budget, as reflected in Table 5.

Table 5. Contracted Costs

COST CATEGORY	Fixed + Variable Costs	Contracted Costs
Technology/Call Center	$ 59,228,343	
PMO		$ 14,807,086
IV&V		$ 5,922,834

Within a 5-year budget, the costs of establishing and operating a state-based exchange can vary from year to year. For instance, IV&V and PMO services are temporary contract costs (two and three years, respectively). Furthermore, Outreach and Marketing costs typically don't begin until Year 2 (the year prior to the first year of operation); in addition, these costs are generally greater the first year because states engage in a more robust public awareness campaign prior to initial launch. For purposes of this exercise, the first year of Marketing and Outreach costs (Year 2) were estimated at 30% more than during a standard operating year. With all these factors in mind, a high-level 5-year budget estimate was developed.

Table 6. High-Level 5-Year Budget Estimate

COST CATEGORY	YEAR 1 (DDI1)	YEAR 2 (DDI2)	YEAR 3 (MO1)	YEAR 4 (MO2)	YEAR 5 (MO3)
Technology/Call Center	$59,228,343	$59,228,343	$59,228,343	$59,228,343	$59,228,343
PMO	$14,807,086	$14,807,086	$14,807,086	$0	$0
IV&V	$5,922,834	$5,922,834	$0	$0	$0
Admin and Staffing	$14,419,645	$14,419,645	$14,419,645	$14,419,645	$14,419,645
Outreach and Marketing	$0	$39,723,772	$30,556,747	$30,556,747	$30,556,747
TOTAL	**$94,377,908**	**$134,101,679**	**$119,011,821**	**$104,204,735**	**$104,204,735**

As a final step, all the figures in the high-level budget estimate were rounded for purposes of simplicity in general discussion.

Table 7. High-Level 5-Year Budget Estimate; Rounded

COST CATEGORY	YEAR 1 (DDI1)	YEAR 2 (DDI2)	YEAR 3 (MO1)	YEAR 4 (MO2)	YEAR 5 (MO3)
Technology/Call Center	$60,000,000	$60,000,000	$60,000,000	$60,000,000	$60,000,000
PMO	$15,000,000	$15,000,000	$15,000,000	$0	$0
IV&V	$6,000,000	$6,000,000	$0	$0	$0
Administration and Staffing	$16,000,000	$16,000,000	$16,000,000	$16,000,000	$16,000,000
Outreach and Marketing	$0	$40,000,000	$30,000,000	$30,000,000	$30,000,000
TOTAL	**$97,000,000**	**$137,000,000**	**$121,000,000**	**$106,000,000**	**$106,000,000**

In order to calculate the net impact to state finances, it was assumed that ACA Insurers would be assessed the current 2.25% exchange fee by the state. This fee percentage was applied to the projected premiums from the ACA methodology projections below. Any projected revenue generated from that fee assessment over and above these budgeted amounts was considered to be a net savings to the state. The other option available is that Texas could choose to lower the fee to match costs, but this option was not modeled.

ACA-Related Methodology:

Greg Fann & Daniel Cruz, Axene Health Partners

The ACA marketplace model was developed to analyze a variety of policy decisions and the resulting impact on consumer costs and behavior. Each set of unique policy decisions were modeled in a two-step process utilizing a consistent consumer price sensitivity assumption which allowed for analysis of the policy outcomes relative to each other. The two-step process consisted of modeling the policy impact to the gross premiums available in the market followed by modeling the impact to enrollment based on the changes to consumer net premiums[12]. The baseline scenario represents no change to current policies for both the Medicaid and ACA policy options. Plan year 2020 premiums available on healthcare.gov[13] and 2020 exchange enrollment numbers reported by CMS[14] were used as the starting point for modeling the future impact of policy decisions.

For each policy scenario, the changes to the underlying 2020 gross premiums were modeled at the carrier level and subsidies were recalculated based on the change to the benchmark premium[15] for each county. Based on the recalculated subsidies, net premiums for each age and income range were calculated at the county level and then aggregated to the state level[16]. The change in ACA enrollment estimates utilized the modeled changes in the lowest bronze net premiums by age and income. Increased ACA enrollment reflects the currently uninsured enrolling in ACA coverage given a decrease in net premiums and decreased ACA enrollment reflects the opposite effect given an increase in net premiums. Marketing and outreach improvements were modeled by estimating the impact on the amount of currently uninsured who have access to free or nearly free net premiums.

The lowest bronze net premiums represent individual consumer options for purposes of estimating percent of the federal poverty level and the subsidies available to them. Improvements in net premiums for those in the 0-18 age range were assumed to also impact consumers in the 19-54 age range who would potentially be purchasing products for themselves and their children. Average gross premiums, net premiums, and subsidies available in the market were calibrated to match the 2020 exchange enrollment information published by CMS. A constant population and health care cost trend was applied annually to the projections starting with plan year 2020. The following subsections provide further detail on the methodology surrounding select ACA policy options.

[12] Net Premium = Gross Premium - Subsidy

[13] https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

[14] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files

[15] Benchmark is equal to the second lowest cost silver plan

[16] State averages use county population as the weight.

Focused Rate Review

Focused rate review[17] assumes that the state of Texas will implement state rate review and will optimize current ACA rating rules to deliver maximum consumer value through stricter enforcement of current regulations. Subsidies in the ACA market are based on silver level premiums. Silver products are also used to provide low-income consumers (under 200% of FPL[18]) access to Platinum level coverage through Cost Sharing Reduction (CSR) plans. In 2018, federal funding to carriers for these CSR plans ceased and carriers were forced to increase Silver premiums to account for providing Platinum level coverage. While this increased Silver premiums and therefore increased subsidies, Silver premiums remain artificially low due to competitive pressures and do not currently reflect Platinum level benefits.

Focused rate review will allow the state to move the individual market to equilibrium where all silver enrollees will have either the CSR 87 or CSR 94 Platinum level plans. This action can effectively create Platinum level benchmarks and substantially increase subsidies available to consumers as well as funds available for future 1332 waivers. To model the revised gross premiums, non-CSR 87/94 Silver enrollment was assumed to migrate to either Bronze or Gold plans. Bronze, Silver and Gold pricing relationships were realigned to reflect CMS risk adjustment relativity assumptions. When realigning metal level premiums, total revenue was calibrated to remain neutral in comparison to current enrollment and premiums.

1332 Waiver - Reinsurance

The 1332 reinsurance waiver options model the impact of establishing a reinsurance program funded through federal pass throughs and supplemental state funding. These waiver options will reduce gross premiums, reducing net premiums for consumers making above 400% of the FPL and slightly increasing net premiums for those making between 100%-400% of the FPL. The policy options allow the user to select the average premium reduction desired. The average premium reflects an average across all carriers. Based on the targeted average premium reduction, we modeled the overall costs of the program, the change in subsidies, the change in enrollment and the resulting net cost to the state.

Two types of reinsurance waivers were modeled, a condition-based approach and a claims-based approach. The condition-based approach was assumed to impact carriers evenly as a percentage of premiums resulting in an even reduction between carriers. The claims-based approach was assumed to impact the high-cost carriers to a greater degree than the low-cost carriers since low-cost carriers typically have a lower cost structure. Since low-cost carriers are also typically the benchmark plan, a smaller reduction in subsidies and therefore a smaller amount of federal pass-through funds was assumed in the claims-based approach. When there

[17] Focused ACA Rate Review: Tangible Ways for States to Address Metalball – Axene Health Partners, LLC (axenehp.com)

[18] CSR products are available for incomes up to 250% of the FPL but the 200%-250% income range only gives access to a 73% actuarial value product. Given the increase in Silver premiums, the CSR 73% product (like the standard silver 70% product) no longer provides good value and these consumers should purchase non-Silver products to maximize their subsidy value.

is a lower federal pass through, a higher amount of state funds will be necessary to cover the cost of the program.

1332 Waiver - Subsidy Optimization

The 1332 Subsidy Optimization waiver modeled a restructuring of the allocation of subsidies (currently in the form of tax credits, but would be converted to account-based subsidies in the model) to subsidize premiums. The current structure allocates subsidies by income which favors older consumers and cuts off at 400% of the FPL. The Subsidy Optimization structure allocates subsidies by age and income to better align subsidies with cost and extends the subsidies to 800% of the FPL. The waiver allows for a full federal pass through of all ACA subsidies to be administered by the state through an account-based system. Each consumer will be given an amount in an account that can be used for premiums or cost sharing. CSR plans are waived and can be replaced with increased subsidies for consumers making under 200% of the FPL. These consumers can then choose to purchase a plan with lower deductibles and cost-sharing, use the funds to cover out of pocket costs directly, or some combination of both.

It was assumed that this age-based account would be unavailable to people eligible for Medicaid or affordable employer-based coverage from large employers. Small employers could utilize these new available subsidies by either dropping coverage or contributing to an ICHRA on top of the account-based subsidies. We modeled both the impact to the uninsured who have a change in net premiums available to them and the impact on those currently receiving coverage through a small employer. Both were modeled to project the increase in ACA enrollment. The web tool allows for the user to input the amount of state funding desired which ranges from $0 to $1B. Depending on the input chosen, the amount of age-based subsidies were calibrated to match the desired state funding with more state funding resulting in more subsidies but also more ACA enrollment which incrementally lessens the total subsidies available. Subsidies were scaled by age to match the CMS age curve and scaled by income using a linear relationship between FPL percentiles. The increase to subsidies for under 200% of FPL was designed to mirror the increase of benefits from a Silver plan to a Platinum plan.