PPACA Health Insurer Fee
Estimated Impact on State Medicaid Programs and Medicaid Health Plans

Prepared for:
Medicaid Health Plans of America

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I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (PPACA), in conjunction with the Health Care and Education Reconciliation Act of 2010, represents a historic effort by the U.S. government to reform the healthcare system. Milliman was retained by the Medicaid Health Plans of America (MHPA) to provide an independent analysis of the impact of the PPACA health insurer fee on state Medicaid programs and Medicaid health plans. The purpose of this report is to:

- Summarize the annual fee on health insurance providers under PPACA,
- Examine how the health insurer fee impacts the manner in which state Medicaid agencies set Medicaid managed care rates, and
- Quantify the financial impact of the health insurer fee on Medicaid programs under three Medicaid managed care growth scenarios.

SUMMARY OF PPACA HEALTH INSURER FEE

PPACA places an $8 billion annual fee on the health insurance industry starting in 2014. The health insurer fee grows to $14.3 billion in 2018 and is indexed to the rate of premium growth thereafter. The health insurer fee is considered an excise tax and is nondeductible for income tax purposes.

The fee will be allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (e.g., the 2014 health insurer fee will be based on 2013 premium revenue). Each entity's fee is calculated as their market share multiplied by the annual fee. Market share is based on commercial, Medicare, Medicaid, and State Children Health Insurance Plan (SCHIP) premium revenue after applying dollar thresholds that reduce the market share of smaller insurers.

Nonprofit insurers receive preferential treatment under health insurer fee rules. Nonprofit insurers that receive more than 80% of their premium revenue from Medicare, Medicaid, SCHIP, and dual eligible plans are exempt from the fee. Other nonprofit insurers can exclude 50% of their premium revenue from the health insurer fee calculation.

HOW THE PPACA HEALTH INSURER FEE IMPACTS MEDICAID MANAGED CARE RATES

Many states rely on Medicaid managed care programs to provide cost-effective quality care to their Medicaid beneficiaries. In full-risk Medicaid managed care programs, managed care organizations (MCOs) are paid a fixed per member per month capitation payment (i.e., a monthly premium payment) to provide services to their members according to their contracts with the state.

Regulations issued by the Centers for Medicare and Medicaid Services (CMS) require premiums to be actuarially sound and that states obtain an actuarial certification from a qualified actuary. While CMS does not have set criteria to determine actuarial soundness, taxes are widely recognized as a reasonable and unavoidable cost of doing business for Medicaid MCOs.

Since the PPACA health insurer fee is not deductible for corporate income tax purposes, the following two related costs should be included in Medicaid managed care rates:

1. An allowance for the expected PPACA health insurer fee assessed to the state's Medicaid MCOs.

2. An allowance to cover the federal income tax impact on the additional revenue added to Medicaid managed care premiums to cover the PPACA health insurer fee. Assuming a 35% corporate income tax rate, Medicaid managed care rates would need to increase by the estimated PPACA health insurer fee divided by 0.65 (1 - 0.35).

Because the PPACA health insurer fee is a federal tax, all tax revenue collected as a result of the fee will accrue to the federal government. Since Medicaid is funded by the state and federal governments, both governments share in funding the premium component that funds the tax. This situation results in the federal government taxing itself and taxing state governments to fund the higher Medicaid managed care premiums required to fund the PPACA health insurer fee, with no net financial impact to Medicaid MCOs.

The treatment of nonprofit Medicaid MCOs in the health insurer fee calculation may distort the competitive balance between for-profit and nonprofit MCOs, creating a situation where state governments would incur the additional cost of funding increase Medicaid premiums if they contract with for-profit MCOs.

FINANCIAL IMPACT OF THE PPACA HEALTH INSURER FEE ON MEDICAID PROGRAMS

We estimate the PPACA health insurer fee will increase Medicaid managed care premiums between 1.5% and 1.6% on a nationwide basis, with some states expected to see increased premiums of up to 2.5%. Increases of this magnitude are meaningful given that recent annual Medicaid managed care premium increases have generally averaged 1% – 2%, with some states implementing premium decreases.

We project the state and federal government funding for the increase in Medicaid managed care premiums related to the PPACA health insurer fee will be between $36.5 billion and $41.9 billion over ten years, with between $13.0 billion and $14.9 billion of the total funding paid by state governments.

Exhibit 1 summarizes important measures of the projected financial impact of the PPACA health insurer fee on Medicaid programs. These results are presented in more detail in the remainder of this report.

Exhibit 1 Impact of PPACA Health Insurer Fee on Medicaid Programs High-Level Summary of Important Financial Measures Ten-Year Projection from 2014 to 2023			
Important Financial Metric	**Baseline Growth Scenario**	**Moderate Growth Scenario**	**High Growth Scenario**
Health Insurer Fee Paid by Medicaid MCOs	$24.3 billion	$25.5 billion	$27.8 billion
Percentage of Total Health Insurer Fee Paid by Medicaid MCOs	16%	16%	18%
Nationwide Average Percentage Increase to Medicaid Managed Care Premiums Due to Health Insurer Fee	1.6%	1.6%	1.5%
Range of State-Specific Percentage Increase to Medicaid Managed Care Premiums Due to Health Insurer Fee	0.1% to 2.5%	0.1% to 2.5%	0.1% to 2.4%
Federal Funding to Support Increase to Medicaid Managed Care Premiums Due to Health Insurer Fee	$23.5 billion	$24.7 billion	$27.1 billion
State Funding to Support Increase to Medicaid Managed Care Premiums Due to Health Insurer Fee	$13.0 billion	$13.6 billion	$14.9 billion

UNCERTAINTY OF REPORT PROJECTIONS

There is uncertainty surrounding many of the projections presented in this report. That uncertainty stems from many sources, including evolving legislation and regulations, changing economic conditions, state-specific changes to the Medicaid program, imperfect and missing data, and interdependencies of modeling variables, just to name a few. The dynamics of the entire health insurance system are extraordinarily complex and the impending changes are unprecedented in the history of the U.S. healthcare system.

This report includes state-specific results based on publicly available information. Detailed analysis of the impact on individual states may produce different results based on the use of more specific information about a state's population, current Medicaid program, and future program changes.

II. PPACA HEALTH INSURER FEE PROVISIONS

PPACA imposes an annual fee on health insurance providers. The rules for administering the health insurer fee are described in the PPACA legislative text[1] and clarified in a document published by the Joint Committee on Taxation[2]. This section of our report presents a summary of the insurer fee provisions.

PPACA places an $8 billion annual fee on the health insurance industry starting in 2014. The annual fee increases according to the schedule in Exhibit 2.

Exhibit 2
Annual Fee on Health Insurance Providers
Applicable Fee by Calendar Year

Calendar Year	Applicable Fee
2014	$ 8.0 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018	$14.3 billion
2019+	Growth of fee indexed to rate of premium growth

The health insurer fee is considered an excise tax. The health insurer fee is nondeductible for income tax purposes.

The health insurer fee applies to any covered entity engaged in the business of providing health insurance with respect to U.S. health risks. Covered entities specifically exclude the following organizations:

- Employers that self-insure the health risks of their employees
- Government entities, including independent nonprofit county-organized health system entities that contract with state Medicaid agencies
- Nonprofit entities that receive more than 80% of gross revenue from government programs that target low-income, elderly, or disabled populations including Medicare, Medicaid, State Children's Health Insurance Plan (SCHIP), and dual eligible plans
- Organizations that qualify as voluntary employees' beneficiary associations (VEBAs) established by entities other than employers

The fee will be allocated to health insurers based on the respective market share of premium revenue in the previous year (e.g., the 2014 health insurer fee will be based on 2013 premium revenue). Each entity's fee is calculated as their market share multiplied by the annual fee shown in Exhibit 2.

[1] Section 9010 of PPACA, as amended by section 10905 of PPACA and section 1406 of the Reconciliation Act
[2] Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010", as amended, in combination with the "Patient Protection and Affordable Care Act"* (JCX-18-10), March 21, 2010, page 88 – 92, retrieved from www.jct.gov

Each insurer's market share is based on commercial, Medicare, Medicaid, and SCHIP premium revenue, with a few limited exceptions:

- Accident and disability insurance
- Coverage for a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance
- Long-term care insurance
- Medicare supplement insurance

The amount of net premiums that are taken into account for the purposes of determining a covered entity's market share is subject to the dollar thresholds shown in Exhibit 3. The dollar thresholds serve to lower the market share, and therefore the fee, for smaller insurers.

Exhibit 3
Dollar Thresholds for Determining Premiums Taken Into Account

Net Premiums Written	Percentage Taken Into Account
Not more than $25 million	0%
$25 million - $50 million	50%
More than $50 million	100%

For example, a covered entity with:

- $20 million of net premiums would have $0 in net premiums taken into account
- $40 million of net premiums would have $7.5 million in net premiums taken into account (0% of $25 million + 50% of $15 million)
- $100 million of net premiums would have $62.5 million in net premiums taken into account (0% of $25 million + 50% of $25 million + 100% of $50 million)

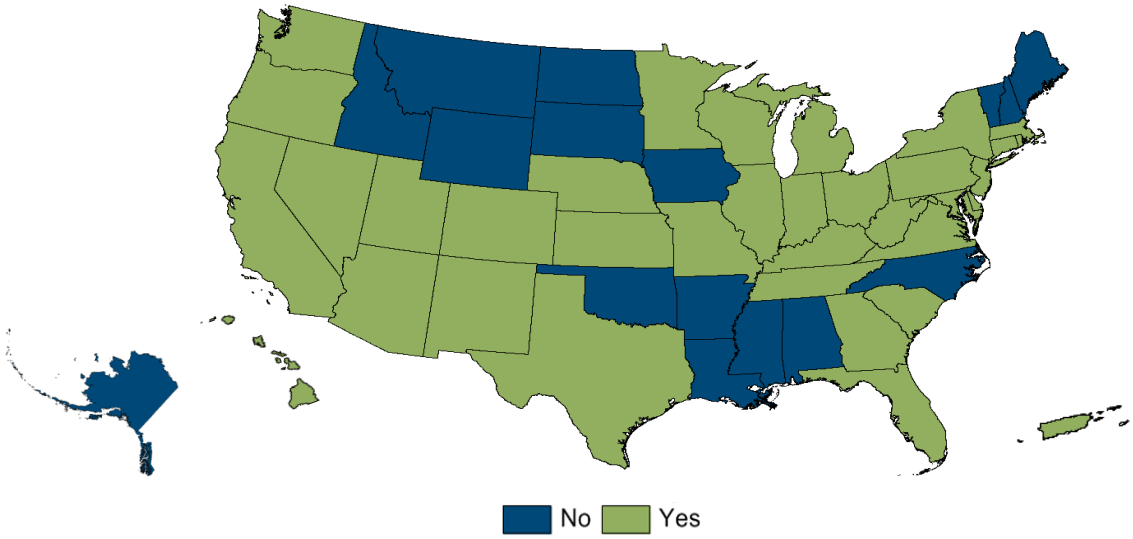
Certain covered entities can exclude an additional 50% of their net premium because of their status as a public charity, social welfare organization, high-risk health insurance pool, or a consumer operated and oriented plan (CO-OP). For example, a qualifying organization with $40 million of net premiums would have $3.75 million taken into account (50% x [0% of $25 million + 50% of $15 million]).

Note that related entities under common control will be considered a single entity for the calculation of the health insurer fee.

III. HEALTH INSURER FEE IMPACT ON MEDICAID MANAGED CARE RATES

Many states rely on Medicaid managed care programs to provide cost-effective quality care to their Medicaid beneficiaries. In 2010, approximately 50% of all Medicaid beneficiaries were enrolled in full-risk capitated Medicaid managed care programs (excluding enrollment in primary care case management programs). Exhibit 4 shows the 36 states and territories that operated full-risk capitated Medicaid managed care programs in 2010.

Exhibit 4
States Operating Full-Risk Medicaid Managed Care Programs in 2010



With recent state budget pressures, many states are expanding enrollment in existing or new Medicaid managed care programs. In 2011 alone, the following states have expanded Medicaid managed care enrollment or announced plans to do so within the next several years: California, Florida, Georgia, Illinois, Kansas, Kentucky, Louisiana, Michigan, Mississippi, New Hampshire, New Jersey, New York, Ohio, South Carolina, Texas, Utah, Virginia, and Washington. Connecticut is the only state that has announced plans to end its full-risk capitated managed care program in favor of an administrative services only (ASO) arrangement. With these Medicaid managed care expansions, we estimate the nationwide Medicaid managed care penetration rate will increase from 50% in 2010 to approximately 61% in 2013.

The expansion of Medicaid coverage under PPACA to people under the age of 65 at or below 138% of FPL coupled with the probable continued expansion of Medicaid managed care programs means that enrollment in Medicaid MCOs is likely to increase over time.

STATE AND FEDERAL FUNDING OF MEDICAID MANAGED CARE

In full-risk Medicaid managed care programs, managed care organizations (MCOs) are paid a fixed monthly capitation payment (i.e., a premium payment) to provide services to their members according to their contracts with the state. The Medicaid program is funded jointly by the state and federal government.

The federal share of the cost of Medicaid is known as the Federal Financial Participation (FFP). The FFP is defined as a percentage amount and referred to as the Federal Medical Assistance Percentage (FMAP). FMAP varies by state and is calculated annually according to the rules in the Social Security Act. FMAP generally ranges from 50% to 75% with a nationwide average FMAP of about 59%. State government funds an average of about 41% of the Medicaid program, with state-specific funding percentages between 25% and 50%.

Federal funding of Medicaid will increase for the population newly eligible for Medicaid as a result of the PPACA 2014 Medicaid expansion to 138% of FPL. FMAP for newly eligible enrollees will equal 100% in 2014 to 2016, grading down to 90% in 2020 and thereafter. As a result of this increased federal funding of the expansion population, our projections assume the average nationwide FMAP over the ten-year period from 2014 to 2023 will be 64%, or 5% higher than historical levels.

A state's Medicaid managed care expenditures are funded according to normal FMAP rules.

ACTUARIAL SOUNDNESS REQUIREMENT

CMS regulations govern the development and approval of premiums paid by state Medicaid agencies to Medicaid MCOs under full-risk contracts, including:

- Code of Federal Regulations, 42 CFR 438.6(c)
- The CMS rate-setting checklist, also known as "Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting"

These regulations require premiums to be actuarially sound and that states obtain an actuarial certification from a qualified actuary. CMS does not have set criteria to determine actuarial soundness of premiums and relies on qualified actuaries to certify the soundness of the rates in an actuarial certification. However, CMS uses a checklist to assist the regional offices in reviewing the materials prepared and submitted by the states and their consulting actuaries in support of their proposed Medicaid managed care premiums. The checklist is also used to document the premium methodology and assumptions used in developing the premiums.

In 2005, the American Academy of Actuaries published a nonbinding Practice Note[3] to be used as guidance to actuaries certifying Medicaid premiums. The goals of the Practice Note were to:

- Provide guidance to the actuary when certifying rates or rate ranges as meeting the requirements of 42 CFR 438.6(c) for capitated Medicaid managed care programs
- Provide examples of responses to certain situations and issues

However, practice notes do not have the same standing as an Actuarial Standard of Practice (ASOP) in determining what constitutes generally accepted actuarial principles and practices. ASOPs are considered part of an actuary's professional code of conduct and have the highest standing. In contrast, practice notes are not a definitive statement as to what constitutes generally accepted practice.

Currently, no ASOP applies specifically to actuarial work performed to comply with CMS requirements for Medicaid rate certification. However, several ASOPs apply to certain components of a Medicaid managed care premium development methodology. For example, ASOP No. 23 on Data Quality addresses the binding guidance to an actuary surrounding the topic of data.

[3] American Academy of Actuaries (August 2005). Health Practice Counsel Practice Note, Actuarial Certification of Rates for Medicaid Managed Care Programs.

The Practice Note includes the following definition of actuarial soundness related to Medicaid managed care premiums:

> *"Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation payments, including expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, state-mandated assessments and taxes, and the cost of capital."*

In other words, Medicaid managed care premiums are actuarially sound if they provide the participating plans an opportunity to cover their projected expenses and generate a modest profit if they are operated in an efficient manner.

CONSIDERATION OF THE PPACA HEALTH INSURER FEE IN ACTUARIAL CERTIFICATION

The American Academy of Actuaries Practice Note indicates that "state-mandated assessments and taxes" are to be considered in an actuary's certification of Medicaid managed care premiums. Taxes are widely recognized as a reasonable and unavoidable cost of doing business for Medicaid MCOs. It is common practice for states and their actuaries to include an explicit rate component for items such as state premium taxes and other taxes that are assessed on Medicaid managed care premium rates. If the tax amount varies by MCO or type of MCO (e.g., for-profit vs. nonprofit), the tax is typically handled as a different rate component specific to each different situation.

The PPACA health insurer fee is a cost that must be treated in a manner consistent with how premium taxes or other fees and assessments are now treated. Since the PPACA health insurer fee is not deductible for corporate income tax purposes, the following two related costs should be included in Medicaid managed care rates:

1. An allowance for the expected PPACA health insurer fee assessed to the state's Medicaid MCOs.

2. An allowance to cover the federal income tax impact on the additional revenue added to Medicaid managed care premiums to cover the PPACA health insurer fee. Assuming a 35% corporate income tax rate, Medicaid managed care rates would need to increase by the estimated PPACA health insurer fee divided by 0.65 (1 - 0.35).

IMPACT OF THE PPACA HEALTH INSURER FEE ON STATE FUNDING OF MEDICAID MANAGED CARE

Because the PPACA health insurer fee is a federal tax, all tax revenue collected as a result of the fee will accrue to the federal government. Since Medicaid is funded by the state and federal governments, both governments share in funding the premium component that funds the tax. This situation results in the federal government taxing itself and taxing state governments to fund the higher Medicaid managed care premiums required to fund the PPACA health insurer fee, with no net financial impact to Medicaid MCOs.

Exhibit 5 illustrates the flow of funds related to a $1.00 PPACA health insurer fee for Medicaid MCOs. Because of the non-deductibility of the health insurer fee, every $1.00 of health insurer fee will need to be funded at $1.54 (equal to $1.00 / [1 - 0.35]) to keep the net financial impact on the Medicaid MCO at zero.

Exhibit 5
Flow of Funds for PPACA Health Insurer Fee Under Medicaid Managed Care
Example: State with 64% FMAP and $1.00 Estimated PPACA Health Insurer Fee

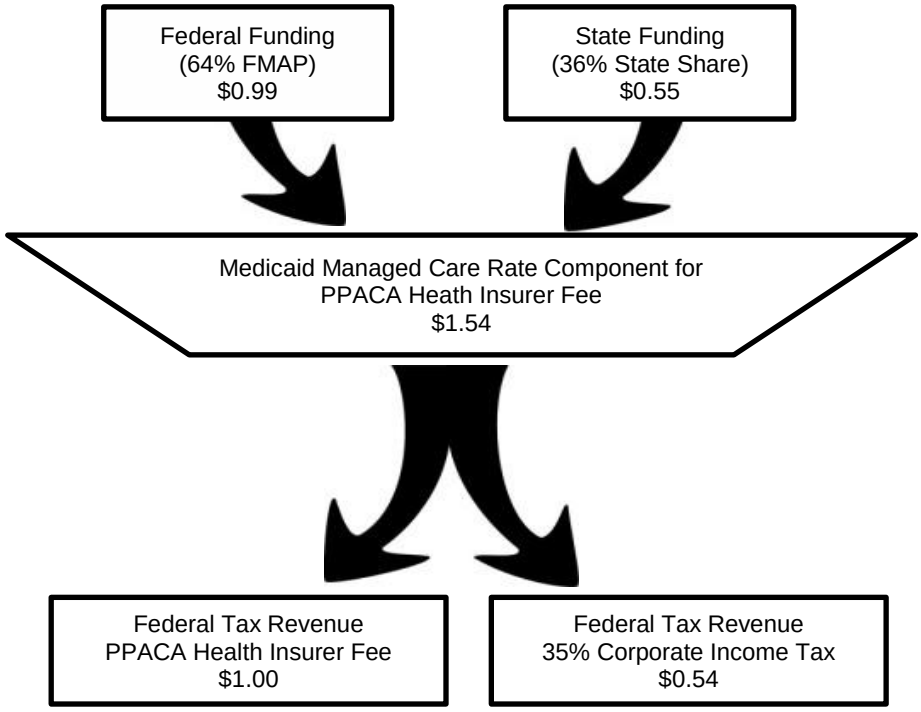


Exhibit 6 shows the net impact of the Medicaid managed care rate flow of funds on each party: the federal government, the state government, and the Medicaid MCO. The result is a transfer of $0.55 from state government to the federal government for every $1.00 of PPACA health insurer fee.

Exhibit 6
Net Financial Impact of Medicaid Managed Care Flow of Funds
Example: State with 60% FMAP and $1.00 Estimated PPACA Health Insurer Fee

	Federal Government	State Government	Medicaid MCO
Funding of Managed Care Rate	($0.99)	($0.55)	$1.54
Cash Flow from PPACA Health Insurer Fee	1.00	0.00	(1.00)
Cash Flow from 35% Corporate Income Tax	0.54	0.00	(0.54)
Net impact	**$0.55**	**($0.55)**	**$0.00**

IV. FINANCIAL IMPACT ON MEDICAID PROGRAMS

This section of the report presents our estimates of the financial impact of the health insurer fee on Medicaid programs.

MODELING SCENARIOS

The expansion of Medicaid coverage under PPACA to people under the age of 65 at or below 138% of FPL coupled with the probable continued expansion of Medicaid managed care programs means that enrollment in Medicaid MCOs is likely to increase over time. Our results are based on three scenarios for Medicaid managed care growth, as outlined in Exhibit 7.

Exhibit 7
Description of Medicaid Managed Care Growth Scenarios

Scenario	Growth Due to 2014 PPACA Medicaid Expansion to 138% of FPL	Growth Due to Managed Care Expansion by States with Medicaid Managed Care Programs
Baseline Growth	Moderate	None
Moderate Growth	Moderate	Moderate
High Growth	High	High

All scenarios assume a higher managed care penetration rate for 2014 PPACA Medicaid expansion population

Exhibit 8 summarizes the nationwide Medicaid enrollment growth assumptions for each scenario compared to projected 2013 Medicaid enrollment. The Exhibit 8 enrollment growth includes normal demographic trends in addition to the 2014 Medicaid expansion population. The 2014 expansion population is assumed to phase in to enrollment over several years. Growth assumptions vary by state according to current Medicaid eligibility rules and other demographic factors. As a comparison, CMS[4] projects nationwide enrollment growth rates compared to 2013 of 22% for 2014 and 42% for 2019.

Exhibit 8
Nationwide Medicaid Enrollment Growth Compared to 2013

Scenario	2014	2019	2023
Baseline Growth	18%	39%	50%
Moderate Growth	18%	39%	50%
High Growth	25%	45%	55%
CMS Projection	22%	42%	N/A

Exhibit 9 summarizes the nationwide Medicaid managed care penetration rate (i.e., the percentage of all Medicaid beneficiaries enrolled in full-risk managed care) for each scenario. Managed care penetration assumptions vary by state according to current program characteristics and the national trend towards expanding Medicaid managed care to cover new populations.

Exhibit 9
Nationwide Medicaid Managed Care Penetration Rates

Scenario	2013	2014	2019	2023
Baseline Growth	61%	63%	63%	63%
Moderate Growth	61%	64%	67%	69%
High Growth	61%	65%	72%	75%

[4] Centers for Medicare and Medicaid Services, *2010 Actuarial Report on the Financial Outlook for Medicaid, December 2010*, page 19, retrieved from https://www.cms.gov/actuarialstudies/downloads/MedicaidReport2010.pdf

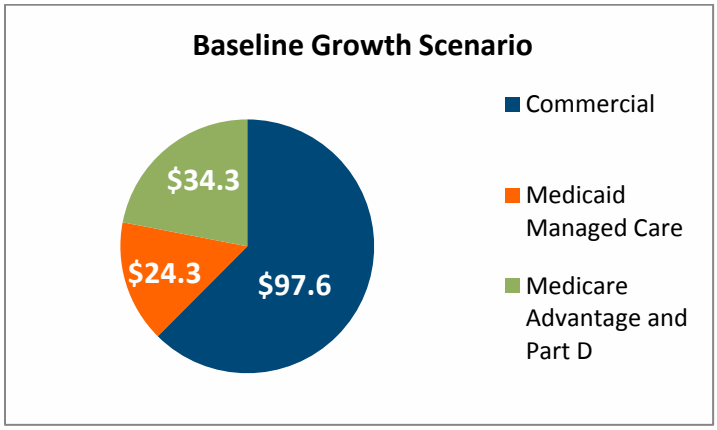
SUMMARY OF MODELING RESULTS – MEDICAID SHARE OF PPACA HEALTH INSURER FEE

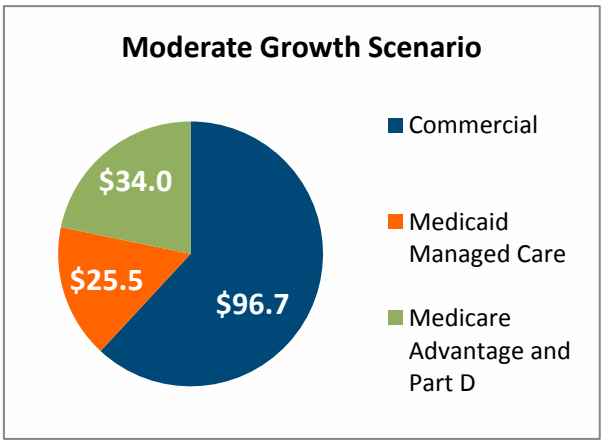
Exhibit 10 shows the share of the total PPACA health insurer fee paid as a result of commercial, Medicaid, and Medicare Advantage / Part D premiums. Over a ten-year period from 2014 to 2023, we project that Medicaid managed care organizations will pay $24.3 billion to $27.8 billion in PPACA health insurer fees, representing 16% - 18% of the total health insurer fee.

The state and federal government fund Medicaid managed care premiums and will share the cost of the Medicaid managed care health insurer fees according to state-specific FMAP percentages in place each year. Assuming an average FMAP percentage of 64%, state governments will pay $8.7 billion to $10.0 billion in PPACA health insurer fees over the ten-year period from 2014 to 2023.

The health insurer fee is expected to impact a large number of Medicaid MCOs. If the health insurer fee was in effect for 2011, over 110 Medicaid MCOs would have paid a fee (after combining MCOs under common control).

Exhibit 10
PPACA Health Insurer Fee Paid by Market
Total for Ten-Year Projection from 2014 to 2023 (in billions)





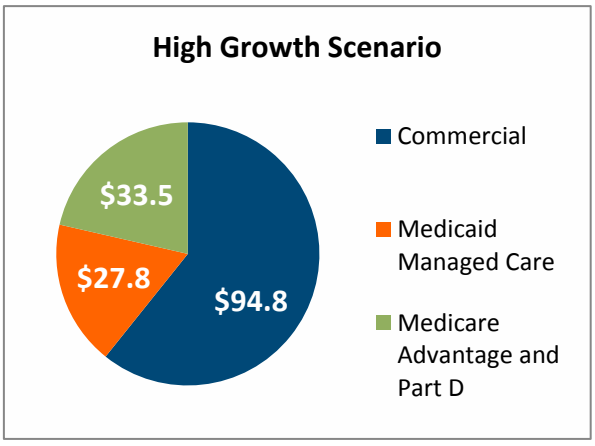


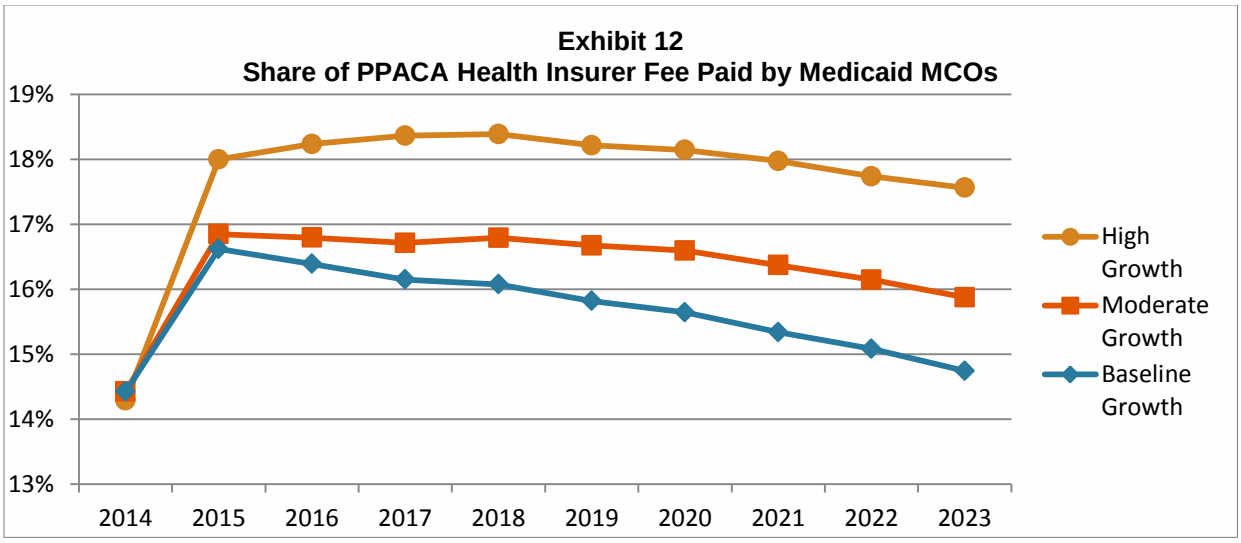
Exhibit 11 shows the amount of the PPACA health insurer fee paid by Medicaid MCOs in each year.

Exhibit 11
Share of PPACA Health Insurer Fee Paid by Medicaid MCOs
in Billions of Dollars

Year	Total Health Insurer Fee	Health Insurer Fee Paid by Medicaid MCOs			Percentage of Total Health Insurer Fee Paid by Medicaid MCOs
		Baseline Growth Scenario	Moderate Growth Scenario	High Growth Scenario	
2014	$8.0	$1.2	$1.2	$1.1	14% – 14%
2015	11.3	1.9	1.9	2.0	17% – 18%
2016	11.3	1.9	1.9	2.1	16% – 18%
2017	13.9	2.2	2.3	2.6	16% – 18%
2018	14.3	2.3	2.4	2.6	16% – 18%
2019	15.8*	2.5	2.6	2.9	16% – 18%
2020	17.5*	2.7	2.9	3.2	16% – 18%
2021	19.3*	3.0	3.2	3.5	15% – 18%
2022	21.3*	3.2	3.4	3.8	15% – 18%
2023	23.5*	3.5	3.7	4.1	15% – 18%
Total	**$156.2***	**$24.3**	**$25.5**	**$27.8**	**16% – 18%**

** Estimated based on growth in premiums*

Exhibit 12 shows the share of the PPACA health insurer fee paid by Medicaid MCOs in each year from 2014 to 2023 under each scenario. The increase in the Medicaid MCO share from 2014 to 2015 is caused by increased Medicaid managed care premiums related to the 2014 Medicaid expansion population. The share paid by Medicaid MCOs drops after 2015 as the projected growth in commercial and Medicare Advantage / Part D premiums outpaces the projected growth in Medicaid MCO premiums.



SUMMARY OF MODELING RESULTS – IMPACT ON MEDICAID MANAGED CARE RATES

As discussed in Section III of this report, Medicaid managed care premiums will increase as a result of the PPACA health insurer fee. The impact will vary by state based on the characteristics of the MCOs in each state's Medicaid managed care program. In general, states that contract with more nonprofit MCOs will pay a lower health insurer fee. The impact is lower for nonprofit insurers because:

- Nonprofit entities that receive more than 80% of gross revenue from government programs that target low-income, elderly, or disabled populations are exempt from the fee
- Certain covered entities can exclude 50% of their net premium for the health insurer fee calculation because of their status as a public charity, social welfare organization, high-risk health insurance pool, or a consumer operated and oriented plan (CO-OP)
- Nonprofit insurers are exempt from corporate income tax

The treatment of nonprofit MCOs in the health insurer fee calculation may distort the competitive balance between for-profit and nonprofit MCOs, creating a situation where state governments would incur the additional cost of funding increased Medicaid premiums if they contract with for-profit MCOs.

Approximately 30% of nationwide Medicaid managed care premiums in 2010 were paid to nonprofit MCOs. Exhibit 13 is a map of the United States showing the estimated percentage of Medicaid managed care premiums for nonprofit MCOs in each state in 2014.

Exhibit 13
Estimated Percentage of Medicaid Managed Care Premium Paid to Nonprofit MCOs
2014

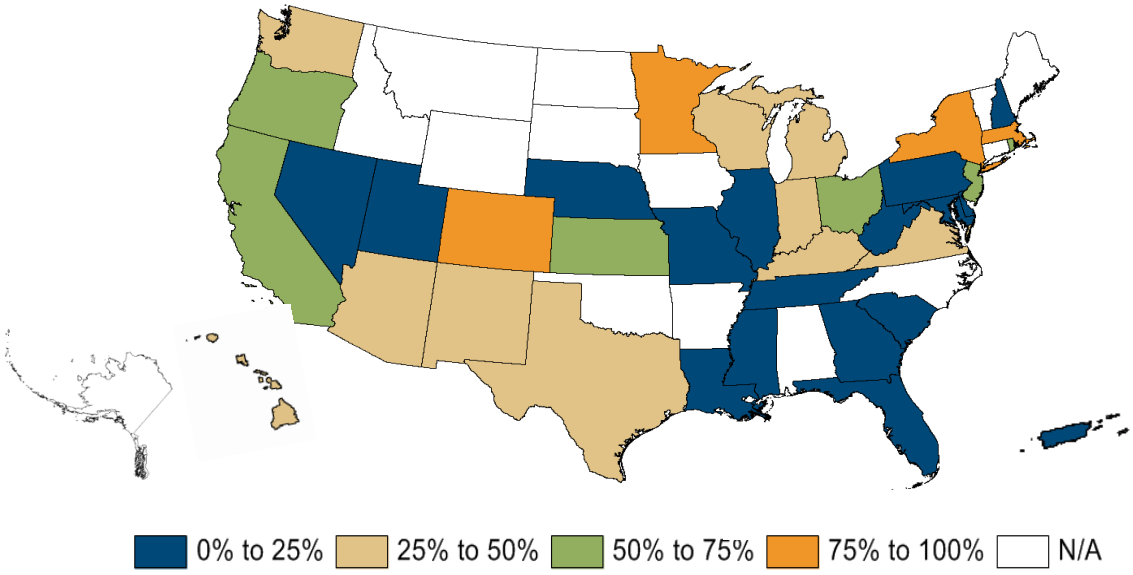
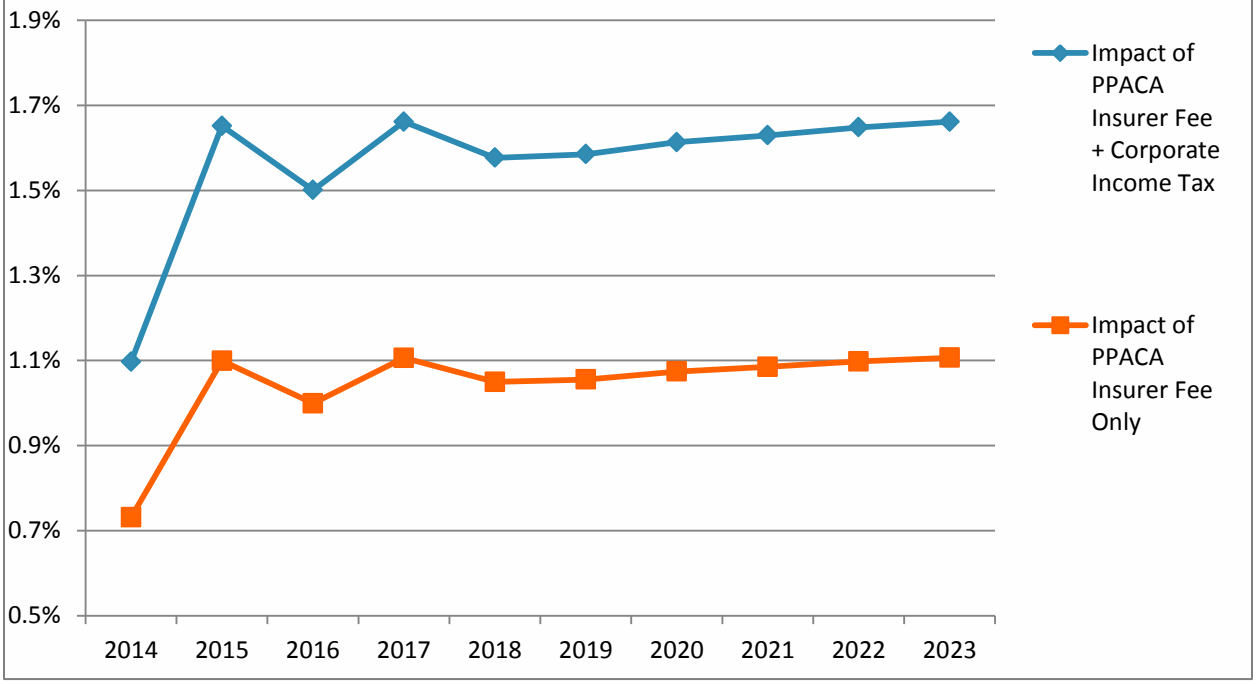


Exhibit 14 shows the nationwide average percentage increase to Medicaid managed care premiums related to the PPACA health insurer fee. The lower line shows the impact of only the health insurer fee. The upper line shows the impact of the health insurer fee plus an allocation for corporate income tax due to the non-deductibility of the health insurer fee. Medicaid managed care premiums will increase for both components, so the upper line in Exhibit 14 is the total increase to Medicaid managed care premiums.

Exhibit 14
Nationwide Percentage Increase to Medicaid Managed Care Premiums
Due to PPACA Health Insurer Fee
Moderate Growth Scenario



On average, states can expect that their Medicaid managed care premiums will increase 1.6% because of the PPACA health insurer fee. States that contract exclusively with for-profit Medicaid MCOs can expect that their Medicaid managed care premiums will increase by 2.5%. Increases of this magnitude are meaningful given that recent annual Medicaid managed care premium increases have generally averaged 1% – 2%, with some states implementing premium decreases.

Exhibit 15 shows a map of the United States with the expected premium increases by state over the ten-year period from 2014 to 2023 for the Moderate Growth scenario, reflecting the impact of both the PPACA health insurer fee and the associated allowance for corporate income tax. The projections assume states continue to contract with the same MCOs as they currently do. The states with higher increases in Exhibit 15 currently contract with more for-profit Medicaid MCOs. The states with lower increases in Exhibit 15 currently contract with more nonprofit Medicaid MCOs.

Exhibit 15
Impact of Health Insurer Fee on Medicaid Managed Care Premiums
Including Associated Allowance for Corporate Income Tax
Ten Year Projection from 2014 to 2023
Moderate Growth Scenario

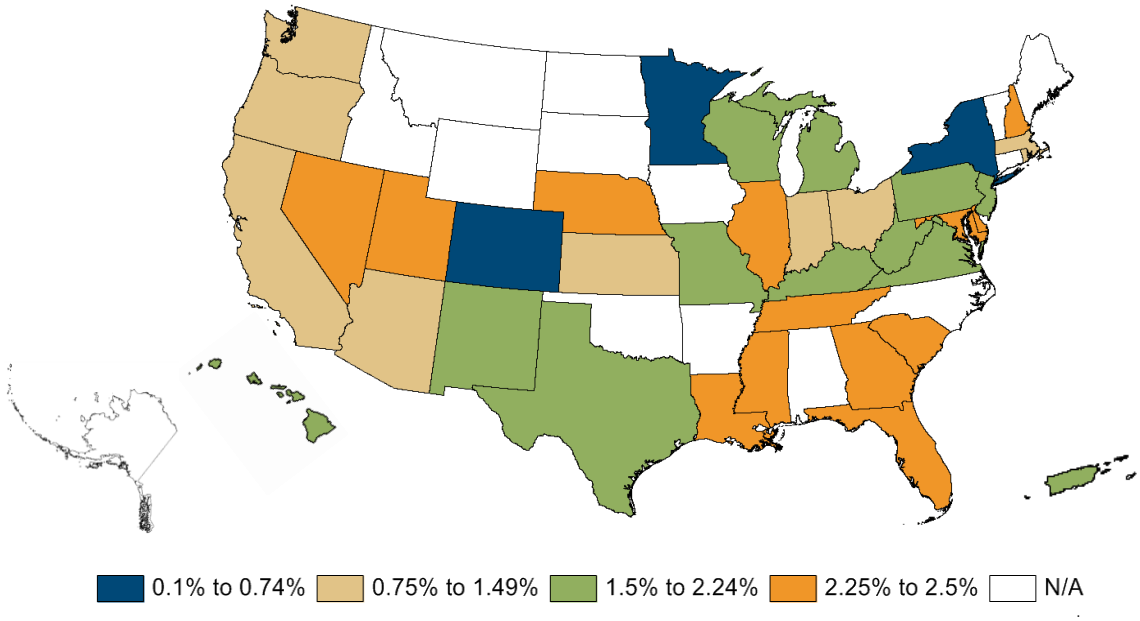
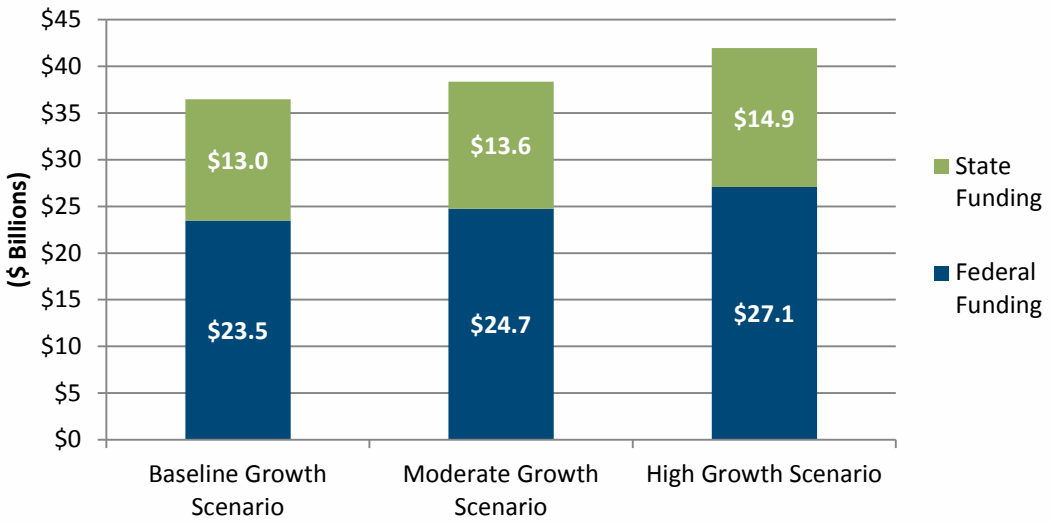


Exhibit 16 shows the nationwide government expenditures necessary to fund the increased Medicaid managed care premiums due to the PPACA health insurer fee for each of the three growth scenarios. Since Medicaid managed care premiums are funded jointly by state and federal government, we show state and federal funding separately based on a national average FMAP of 64%.

Exhibit 16
Nationwide Funding of Increased Medicaid Managed Care Premiums
Due to PPACA Health Insurer Fee
Ten-Year Projection from 2014 to 2023
National Average FMAP = 64%



Appendices A – C show state-specific results for each scenario for 2014 – 2018, 2019 – 2023, and in total for 2014 – 2023. Results include:

- Assumed FMAP for each state (equal to the FY 2012 FMAP plus 5%)
- Percentage increase to Medicaid managed care premiums
- Total funding of increased Medicaid managed care premiums
- State funding of increased Medicaid managed care premiums

The appendices include state-specific results based on publicly available information. Detailed analysis of the impact on individual states may produce different results based on the use of more specific information about a state's population, current Medicaid program, and future program changes.

V. DESCRIPTION OF METHODOLOGY

The range of results presented in this report estimates the impact of the PPACA health insurer fee on Medicaid MCOs based on several assumptions and scenarios. This section of our report documents the methodology and the scenarios used to present the range of results.

At a high level, our methodology can be summarized into the following steps:

1. Establish 2010 base year enrollment and expenditures for all insurance market sectors

2. Increase Medicaid managed care penetration in states that have announced new or expanded programs

3. Project enrollment and expenditures in each insured market during 2013 – 2023 based on the Milliman *Health Care Reform Financing Projection Model*

4. Calculate each insurer's market share and allocate the PPACA health insurer fee to each insurer and market

STEP 1: ESTABLISH 2010 BASE YEAR ENROLLMENT AND EXPENDITURES FOR ALL INSURANCE MARKET SECTORS

In order to establish base year enrollment and premium volume by insurer and market, we gathered premium and enrollment data for the insurers associated with each major market identified below from 2010 NAIC annual statement filings collected by Highline Data through their Insurance Analyst Pro licensed by Milliman. Highline Data is the premier provider of insurance industry financial performance data. They publish detailed financial information on more than 8,000 U.S. insurance companies, more than 1 million pension plans, and more than 600,000 group benefit and welfare plans.

- Commercial market: Includes the comprehensive (hospital and medical), vision, dental, Federal Employees Health Benefit Program, and other health lines of business.

- Medicare market: Title XVIII Medicare line of business (excludes Medicare Supplement policies).

- Medicaid market: Title XIX Medicaid line of business.

- We excluded the Medicare supplement and other non-health annual statement lines of business because they are excluded from the PPACA health insurer fee calculation.

For states where the NAIC filing requirements are not as pervasive (i.e., Arizona and California), we supplemented the missing data with filings collected and reported by other state government sources. Finally, we compared the starting data to multiple summaries of the current commercial, Medicare, and Medicaid markets compiled by CMS and the Kaiser Family Foundation. Using these comparisons, we supplemented our financial statement data for any Medicaid health plans whose enrollment and premiums were not filed with the NAIC (e.g., the plan is a nonprofit that is not required to submit a filing).

After summarizing the enrollment in insurance plans in each market, we summarized enrollment and expenditures in large group self-funded plans, Medicaid fee-for-service (FFS), Medicare FFS, and the uninsured market from figures collected from CMS and Kaiser State Health Facts.

Note that there are data limitations that may impact our base year estimates. While we attempted to adjust the base data to compile as accurate a starting point as possible, certain insurers may not be fully represented in our 2010 base year data. Given the uncertain nature of ten-year projections, we do not believe any data irregularities would have a material impact on our projections.

STEP 2: INCREASE MEDICAID MANAGED CARE PENETRATION IN STATES THAT HAVE ANNOUNCED NEW OR EXPANDED PROGRAMS

The following states have expanded Medicaid managed care enrollment or announced plans to do so within the next several years: California, Florida, Georgia, Illinois, Kansas, Kentucky, Louisiana, Michigan, Mississippi, New Hampshire, New Jersey, New York, Ohio, South Carolina, Texas, Utah, Virginia, and Washington. Because these program expansions are not reflected in the 2010 base data from Step 1, we increased the Medicaid managed care penetration rates in these states based on high-level estimates of the scope of each state's program expansion as provided by MHPA member organizations.

Connecticut is the only state that has announced plans to end its full-risk capitated managed care program in favor of an administrative services only (ASO) arrangement. We removed the Connecticut Medicaid managed care enrollment from our analysis.

STEP 3: PROJECT ENROLLMENT AND EXPENDITURES IN EACH INSURED MARKET DURING 2013-2023 BASED ON THE MILLIMAN *HEALTH CARE REFORM FINANCING PROJECTION MODEL*

Step 3 projects the enrollment and expenditures per member per year (PMPY) by insurer, state, and market for each year from 2013 to 2023 using Milliman's *Health Care Reform Financing Projection Model*. In order to efficiently model each state, we created state groupings based on current Medicaid eligibility standards and uninsured population characteristics and selected appropriate assumptions to best fit each state's grouping.

Using projections from Milliman's *Health Care Reform Financing Projection Model*, we created enrollment and expenditure PMPY projection factors for each market and state. Upon determining enrollment and expenditure PMPY for each year from 2013 to 2023, we summarized total expenditure and calculated the total premium taken into account for use in calculation of each plan's market share for determination of the health plan fee allocation.

The *Health Care Reform Financing Projection Model* uses the following information to make its projections.

CPS Data

The initial census data at the core of the *Health Care Reform Financing Projection Model* was developed using the Current Population Survey (CPS). We used the data to determine the composition of the United States population by age, gender, income level, insurance coverage type, and family status. We also used its data on self-reported health status.

MEPS Data

The *Health Care Reform Financing Projection Model* uses Medical Expenditure Panel Survey (MEPS) data to supplement the census data and include splits regarding whether the employer insurance is small group, large group, self-insured, or fully insured.

Medical Costs

Medical cost curves by age and gender were developed using an assumed set of benefits and research underlying Milliman's *Health Cost Guidelines*™. The medical cost curves vary by market and level of benefit richness. Premiums were developed from the estimated medical costs, minus the estimated cost sharing in the modeled benefit plans, plus an estimated administrative load based on data collected nationally.

Pent-up Demand

The *Health Care Reform Financing Projection Model* assumes that people moving from an uninsured status to insured status would have first-year costs that are 10% higher than normal for their age and gender, which is due to pent-up demand for healthcare services.

Trend

We estimated annual medical trend rates for each market and major service category (inpatient, outpatient, professional, prescription drug, and other) based on Milliman's ongoing trend research.

Births and Mortality

We used birth assumptions based on the distribution of newborns in the CPS data, and mortality assumptions as reported in the 2008 U.S Mortality Tables.

Take-up Rates

Take-up rates describe the probability of people changing from uninsured to insured, or from one market to another (e.g., from the individual non-exchange market to the individual exchange market). Milliman has conducted research to determine what percentage of people (for each combination of representative age, gender, and health status) will tend to move to switch markets, based on PPACA provisions and the modeled individual's expected healthcare costs, subsidies, and premium rate choices. Using that research, we modeled movements into the health benefit exchanges from other markets and movements into Medicaid from other markets. We compared our Medicaid expansion take-up rates to other national studies and found our results to be generally consistent by state.

Movement Between Markets

The causes of age-related movements between markets are formerly dependent children who reach an age where they are emancipated to other markets, adults who reach age 65 and join the Medicare market, and individuals in other markets who lapse to the uninsured market because of premium rate increases they can no longer tolerate.

STEP 4: CALCULATE EACH INSURER'S MARKET SHARE AND ALLOCATE THE PPACA HEALTH INSURER FEE TO INSURER AND MARKETS

Steps 1 – 3 establish projections of each insurer's premium volume by state and market for 2013 – 2023. Step 4 calculates each insurer's PPACA health insurer fee based on the rules summarized in Section II of this report. The health insurer fee is allocated to each line of business in proportion to premium volume. Note that we did not distinguish between 501(c)(3) and 501(c)(4) organizations for the purposes of assigning nonprofit status.

The corporate income tax impact of the PPACA health insurer fee was based on a 35% corporate tax rate for insurers with a for-profit status.

VI. CAVEATS AND QUALIFICATIONS

CAVEATS AND LIMITATIONS

The views expressed in this report are made by the authors and do not represent the opinion of Milliman. Other Milliman consultants may hold different views.

This report was prepared for the specific purpose of analyzing the impact of the PPACA health insurer fee on state Medicaid programs and Medicaid managed care organizations. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of and is only to be relied upon by MHPA. We anticipate the report will be shared with MHPA members, federal and state policymakers, and other interested parties. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. It should only be reviewed in its entirety.

Differences between the report projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. The projections in this report are based on our understanding of PPACA and its associated regulations issued to date. Forthcoming PPACA-related regulations and additional legislation may materially change the impact of PPACA, necessitating an update to the projections in this report.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

In preparing this information, we relied on information published by Highline Data, the Kaiser Family Foundation, the Centers for Medicare and Medicaid Services (CMS), and other state government data sources. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

The terms of Milliman's Consulting Services Agreement with MHPA signed on August 12, 2011, apply to this report and its use.

QUALIFICATIONS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Appendix A

Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums Including Associated Allowance for Corporate Income Tax
Ten Year Projection from 2014 to 2023
Baseline Growth Scenario

Appendix A
Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Baseline Growth Scenario

		2014 - 2018			2019 - 2023			Total		
State	Assumed FMAP*	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)
AL	73.6%	0.0%	$0	$0	0.0%	$0	$0	0.0%	$0	$0
AK	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
AZ	72.3%	1.3%	645	179	1.4%	1,028	285	1.3%	1,673	463
AR	75.7%	0.0%	0	0	0.0%	0	0	0.0%	0	0
CA	55.0%	0.8%	536	241	0.8%	855	385	0.8%	1,391	626
CO	55.0%	0.1%	4	2	0.1%	7	3	0.1%	11	5
CT	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
DE	59.2%	2.4%	196	80	2.5%	295	120	2.5%	491	200
DC	75.0%	2.3%	71	18	2.5%	109	27	2.4%	180	45
FL	61.0%	2.3%	1,294	504	2.5%	2,069	806	2.4%	3,363	1,310
GA	71.2%	2.4%	887	256	2.5%	1,406	405	2.5%	2,293	661
HI	55.5%	1.5%	163	73	1.6%	258	115	1.6%	421	187
ID	75.2%	0.0%	0	0	0.0%	0	0	0.0%	0	0
IL	55.0%	2.4%	283	127	2.5%	435	196	2.5%	718	323
IN	72.0%	1.4%	155	44	1.5%	242	68	1.4%	397	111
IA	65.7%	0.0%	0	0	0.0%	0	0	0.0%	0	0
KS	61.9%	0.7%	37	14	0.8%	56	21	0.8%	93	35
KY	76.2%	1.5%	372	89	1.6%	594	141	1.6%	965	230
LA	66.1%	2.3%	465	158	2.6%	742	252	2.4%	1,206	409
ME	68.3%	0.0%	0	0	0.0%	0	0	0.0%	0	0
MD	55.0%	2.3%	514	231	2.5%	828	372	2.4%	1,342	604
MA	55.0%	0.7%	162	73	0.8%	230	103	0.8%	392	176
MI	71.1%	1.7%	711	205	1.8%	1,141	329	1.8%	1,851	534
MN	55.0%	0.4%	100	45	0.4%	153	69	0.4%	253	114
MS	79.2%	2.3%	155	32	2.6%	257	53	2.4%	411	86
MO	68.5%	1.9%	231	73	2.1%	373	118	2.1%	604	191

Appendix A
Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Baseline Growth Scenario

		2014 - 2018			2019 - 2023			Total		
State	Assumed FMAP*	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)
MT	71.1%	0.0%	0	0	0.0%	0	0	0.0%	0	0
NE	61.6%	2.4%	54	21	2.5%	87	33	2.5%	141	54
NV	61.2%	2.4%	82	32	2.6%	131	51	2.5%	213	83
NH	55.0%	2.4%	223	101	2.5%	356	160	2.5%	579	261
NJ	55.0%	1.6%	419	189	1.6%	713	321	1.6%	1,132	509
NM	74.4%	1.9%	391	100	2.0%	598	153	1.9%	988	253
NY	55.0%	0.4%	386	174	0.5%	586	264	0.5%	972	438
NC	70.3%	0.0%	0	0	0.0%	0	0	0.0%	0	0
ND	60.4%	0.0%	0	0	0.0%	0	0	0.0%	0	0
OH	69.2%	1.1%	546	168	1.1%	867	267	1.1%	1,413	436
OK	68.9%	0.0%	0	0	0.0%	0	0	0.0%	0	0
OR	67.9%	0.7%	115	37	0.9%	199	64	0.8%	314	101
PA	60.1%	1.9%	1,174	469	2.0%	1,728	690	1.9%	2,902	1,159
PR	55.0%	2.1%	255	115	2.2%	389	175	2.2%	644	290
RI	57.1%	0.8%	42	18	0.9%	64	27	0.8%	106	46
SC	75.2%	2.4%	327	81	2.5%	523	130	2.5%	850	211
SD	64.1%	0.0%	0	0	0.0%	0	0	0.0%	0	0
TN	71.4%	2.4%	958	274	2.6%	1,509	432	2.5%	2,466	706
TX	63.2%	1.6%	1,092	402	1.7%	1,738	639	1.6%	2,830	1,041
UT	76.0%	2.4%	132	32	2.6%	209	50	2.5%	342	82
VT	62.6%	0.0%	0	0	0.0%	0	0	0.0%	0	0
VA	55.0%	1.9%	369	166	2.1%	589	265	2.0%	958	431
WA	55.0%	1.4%	211	95	1.7%	348	156	1.6%	559	251
WV	77.6%	2.1%	77	17	2.3%	123	28	2.2%	200	45
WI	65.5%	1.8%	325	112	2.0%	498	172	1.9%	823	284
WY	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
Total	64.37%	**1.5%**	**$14,160**	**$5,044**	**1.7%**	**$22,329**	**$7,947**	**1.6%**	**$36,488**	**$12,991**

** Assumed FMAP equals FFY 2012 FMAP plus 5% to account for increased federal funding for the PPACA 2014 Medicaid expansion.*

Appendix B

Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums Including Associated Allowance for Corporate Income Tax Ten Year Projection from 2014 to 2023 Moderate Growth Scenario

Appendix B
Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Moderate Growth Scenario

		2014 - 2018			2019 - 2023			Total		
State	Assumed FMAP*	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)
AL	73.6%	0.0%	$0	$0	0.0%	$0	$0	0.0%	$0	$0
AK	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
AZ	72.3%	1.3%	645	179	1.4%	1,031	286	1.3%	1,676	464
AR	75.7%	0.0%	0	0	0.0%	0	0	0.0%	0	0
CA	55.0%	0.8%	554	249	0.8%	932	420	0.8%	1,487	669
CO	55.0%	0.1%	5	2	0.1%	11	5	0.1%	15	7
CT	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
DE	59.2%	2.3%	198	81	2.5%	303	124	2.4%	501	204
DC	75.0%	2.3%	72	18	2.5%	113	28	2.4%	185	46
FL	61.0%	2.3%	1,292	503	2.4%	2,069	806	2.4%	3,361	1,309
GA	71.2%	2.4%	884	255	2.5%	1,398	403	2.5%	2,282	658
HI	55.5%	1.5%	162	72	1.6%	255	113	1.6%	417	185
ID	75.2%	0.0%	0	0	0.0%	0	0	0.0%	0	0
IL	55.0%	2.3%	323	145	2.5%	589	265	2.4%	912	410
IN	72.0%	1.4%	157	44	1.5%	251	70	1.4%	408	114
IA	65.7%	0.0%	0	0	0.0%	0	0	0.0%	0	0
KS	61.9%	0.7%	37	14	0.8%	56	21	0.8%	92	35
KY	76.2%	1.5%	393	94	1.7%	679	162	1.6%	1,072	255
LA	66.1%	2.1%	602	204	2.4%	1,262	428	2.3%	1,864	632
ME	68.3%	0.0%	0	0	0.0%	0	0	0.0%	0	0
MD	55.0%	2.3%	519	234	2.5%	852	383	2.4%	1,371	617
MA	55.0%	0.7%	180	81	0.8%	292	131	0.8%	472	212
MI	71.1%	1.7%	721	208	1.8%	1,184	342	1.8%	1,904	550
MN	55.0%	0.4%	102	46	0.4%	160	72	0.4%	262	118
MS	79.2%	2.1%	216	45	2.4%	496	103	2.3%	712	148
MO	68.5%	1.9%	240	76	2.1%	413	130	2.0%	653	206

Appendix B
Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
Moderate Growth Scenario

		2014 - 2018			2019 - 2023			Total		
State	Assumed FMAP*	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)	Percentage Impact	Total Funding ($Millions)	State Funding ($Millions)
MT	71.1%	0.0%	0	0	0.0%	0	0	0.0%	0	0
NE	61.6%	2.3%	57	22	2.5%	96	37	2.4%	153	59
NV	61.2%	2.3%	84	33	2.5%	138	54	2.4%	222	86
NH	55.0%	2.3%	227	102	2.5%	371	167	2.4%	598	269
NJ	55.0%	1.5%	417	188	1.6%	705	317	1.6%	1,122	505
NM	74.4%	1.8%	394	101	1.9%	615	158	1.9%	1,009	259
NY	55.0%	0.4%	393	177	0.5%	617	277	0.5%	1,010	454
NC	70.3%	0.0%	0	0	0.0%	0	0	0.0%	0	0
ND	60.4%	0.0%	0	0	0.0%	0	0	0.0%	0	0
OH	69.2%	1.0%	544	168	1.1%	864	266	1.1%	1,408	434
OK	68.9%	0.0%	0	0	0.0%	0	0	0.0%	0	0
OR	67.9%	0.7%	116	37	0.8%	202	65	0.8%	318	102
PA	60.1%	1.9%	1,184	473	2.0%	1,777	709	1.9%	2,961	1,182
PR	55.0%	2.1%	254	114	2.2%	384	173	2.2%	638	287
RI	57.1%	0.8%	43	18	0.8%	65	28	0.8%	108	46
SC	75.2%	2.3%	339	84	2.5%	574	142	2.4%	913	226
SD	64.1%	0.0%	0	0	0.0%	0	0	0.0%	0	0
TN	71.4%	2.4%	953	273	2.5%	1,491	427	2.5%	2,443	700
TX	63.2%	1.5%	1,096	403	1.7%	1,759	647	1.6%	2,855	1,050
UT	76.0%	2.4%	132	32	2.5%	207	50	2.5%	338	81
VT	62.6%	0.0%	0	0	0.0%	0	0	0.0%	0	0
VA	55.0%	1.9%	376	169	2.0%	617	278	2.0%	993	447
WA	55.0%	1.4%	215	97	1.5%	338	152	1.5%	553	249
WV	77.6%	2.0%	80	18	2.2%	135	30	2.1%	215	48
WI	65.5%	1.8%	334	115	1.9%	534	184	1.9%	867	299
WY	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
Total	64.42%	**1.5%**	**$14,538**	**$5,172**	**1.6%**	**$23,831**	**$8,453**	**1.6%**	**$38,369**	**$13,626**

** Assumed FMAP equals FFY 2012 FMAP plus 5% to account for increased federal funding for the PPACA 2014 Medicaid expansion.*

Appendix C

Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums Including Associated Allowance for Corporate Income Tax Ten Year Projection from 2014 to 2023 High Growth Scenario

Appendix C
Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
High Growth Scenario

		2014 - 2018			2019 - 2023			Total		
State	Assumed FMAP*	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)
AL	73.6%	0.0%	$0	$0	0.0%	$0	$0	0.0%	$0	$0
AK	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
AZ	72.3%	1.2%	683	189	1.3%	1,097	304	1.3%	1,780	493
AR	75.7%	0.0%	0	0	0.0%	0	0	0.0%	0	0
CA	55.0%	0.7%	631	284	0.8%	1,137	511	0.8%	1,767	795
CO	55.0%	0.1%	6	3	0.1%	13	6	0.1%	19	8
CT	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
DE	59.2%	2.3%	211	86	2.5%	329	134	2.4%	540	221
DC	75.0%	2.2%	75	19	2.4%	124	31	2.3%	199	50
FL	61.0%	2.2%	1,376	536	2.4%	2,186	852	2.3%	3,562	1,388
GA	71.2%	2.3%	937	270	2.5%	1,464	422	2.4%	2,401	692
HI	55.5%	1.5%	169	75	1.6%	265	118	1.5%	434	193
ID	75.2%	0.0%	0	0	0.0%	0	0	0.0%	0	0
IL	55.0%	2.2%	356	160	2.4%	674	303	2.3%	1,030	464
IN	72.0%	1.3%	173	49	1.4%	278	78	1.4%	451	127
IA	65.7%	0.0%	0	0	0.0%	0	0	0.0%	0	0
KS	61.9%	0.7%	38	15	0.8%	57	22	0.7%	96	36
KY	76.2%	1.5%	435	104	1.7%	751	179	1.6%	1,185	282
LA	66.1%	2.1%	755	256	2.4%	1,565	531	2.3%	2,320	787
ME	68.3%	0.0%	0	0	0.0%	0	0	0.0%	0	0
MD	55.0%	2.2%	565	254	2.4%	945	425	2.3%	1,510	680
MA	55.0%	0.4%	112	50	0.5%	218	98	0.5%	330	148
MI	71.1%	1.6%	796	230	1.8%	1,331	384	1.7%	2,127	614
MN	55.0%	0.4%	107	48	0.4%	178	80	0.4%	285	128
MS	79.2%	2.0%	284	59	2.4%	634	132	2.3%	918	191
MO	68.5%	1.9%	283	89	2.1%	505	159	2.0%	787	248

Appendix C
Impact of PPACA Health Insurer Fee on Medicaid Managed Care Premiums
Including Associated Allowance for Corporate Income Tax
Ten Year Projection From 2014 to 2023
High Growth Scenario

		2014 - 2018			2019 - 2023			Total		
State	Assumed FMAP*	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)	Percentage Premium Increase	Total Funding ($Millions)	State Funding ($Millions)
MT	71.1%	0.0%	0	0	0.0%	0	0	0.0%	0	0
NE	61.6%	2.2%	66	25	2.4%	119	46	2.4%	185	71
NV	61.2%	2.3%	93	36	2.5%	158	61	2.4%	251	97
NH	55.0%	2.3%	253	114	2.5%	418	188	2.4%	671	302
NJ	55.0%	1.5%	421	189	1.6%	729	328	1.6%	1,150	518
NM	74.4%	1.8%	427	109	1.9%	673	173	1.9%	1,100	282
NY	55.0%	0.4%	414	186	0.4%	689	310	0.4%	1,103	496
NC	70.3%	0.0%	0	0	0.0%	0	0	0.0%	0	0
ND	60.4%	0.0%	0	0	0.0%	0	0	0.0%	0	0
OH	69.2%	1.0%	579	179	1.1%	906	280	1.1%	1,485	458
OK	68.9%	0.0%	0	0	0.0%	0	0	0.0%	0	0
OR	67.9%	0.7%	129	41	0.8%	219	70	0.8%	347	111
PA	60.1%	1.8%	1,275	509	1.9%	1,924	768	1.9%	3,199	1,277
PR	55.0%	2.1%	253	114	2.2%	388	175	2.1%	642	289
RI	57.1%	0.8%	44	19	0.8%	70	30	0.8%	114	49
SC	75.2%	2.2%	392	97	2.4%	698	173	2.4%	1,090	270
SD	64.1%	0.0%	0	0	0.0%	0	0	0.0%	0	0
TN	71.4%	2.3%	993	284	2.5%	1,559	447	2.4%	2,552	731
TX	63.2%	1.5%	1,151	423	1.6%	1,860	684	1.6%	3,011	1,107
UT	76.0%	2.3%	138	33	2.5%	212	51	2.4%	350	84
VT	62.6%	0.0%	0	0	0.0%	0	0	0.0%	0	0
VA	55.0%	1.8%	417	188	2.0%	696	313	1.9%	1,113	501
WA	55.0%	1.4%	236	106	1.5%	381	172	1.5%	617	278
WV	77.6%	2.0%	92	21	2.2%	162	36	2.1%	254	57
WI	65.5%	1.7%	357	123	1.9%	613	211	1.8%	970	334
WY	55.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0
Total	64.55%	**1.5%**	**$15,720**	**$5,573**	**1.6%**	**$26,223**	**$9,284**	**1.5%**	**$41,943**	**$14,857**

** Assumed FMAP equals FFY 2012 FMAP plus 5% to account for increased federal funding for the PPACA 2014 Medicaid expansion.*