

2019 Health Insurance Enrollment Projections for Indiana

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BACKGROUND

Milliman was requested by the Indiana Health Care Exchange Policy Committee (the Committee) to provide projections for Indiana enrollment by source of health insurance coverage in 2019, incorporating anticipated impacts of the numerous provisions of the Patient Protection and Affordable Care Act of 2010 (ACA). The Committee will use these projections to assist with the design of the Indiana health insurance exchange. Though the Indiana health insurance exchange is anticipated to begin operations for 2014 effective dates, these projections were developed for 2019 recognizing that it will take a few years for the health insurance markets to transition to a new steady-state environment.

This issue paper presents the projections for 2019 and discusses key drivers and assumptions underlying the projected changes in Indiana enrollment by source of health insurance coverage. A comprehensive report detailing the methodology, considerations, and assumptions underlying the projections is available upon request.

2019 PROJECTIONS

Our 2019 enrollment projections by source of health insurance coverage for Indiana residents ages 0 to 64 are provided in Table 1. Table 1 also shows 2010 enrollment estimates for comparison purposes. Indiana residents over age 64 have been excluded from this analysis because most of them are covered by Medicare. The Medicare eligible population will continue to be covered through the federal program in 2019.

Table 1

Indiana Health Insurance Coverage Profile for Residents Ages 0 - 64

Source of Health Insurance	2010 Estimate	2019 Projections	
		Total	Exchange
Uninsured	875,000	300,000 - 525,000	N/A
Public Programs	950,000	1,450,000 - 1,625,000	N/A
Individual Insurance	200,000	450,000 - 875,000	300,000 - 675,000
Employer-Sponsored Insurance			
Insured Small Group (2-50 employees)	300,000	225,000 - 300,000	0 - 50,000
Insured Small Group (51-100 employees)	150,000	100,000 - 150,000	0 - 20,000
Insured Large Group (101+ employees)	325,000	250,000 - 325,000	N/A
Self-Funded (all employer sizes)	2,825,000	2,850,000 - 3,125,000	N/A
Total Indiana Residents, Age 0 to 64	5,625,000	6,200,000 - 6,500,000	300,000 - 745,000

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The most significant changes in source of health insurance coverage for Indiana residents ages 0 to 64 between 2010 and 2019 are driven by four key ACA provisions. An additional ACA provision, the employer mandate, will help to maintain the employer-sponsored insurance (ESI) market.

- **Individual mandate.** Federal tax penalties for most United States individual taxpayers who do not have minimum essential health coverage.
- **Medicaid expansion.** Expansion of Medicaid coverage to all United States citizens with household income up to 138% of the federal poverty level (FPL).
- **Subsidies via Exchange.** Availability of premium tax credits and cost-sharing subsidies for individuals with household income up to 400% of the FPL when individual health insurance coverage is purchased through a health insurance exchange. Said individuals cannot have access to employer sponsored health coverage or the required contribution to participate in employer sponsored health coverage must be more than 9.5% of household income.
- **Health Insurance Market Reforms.** Health insurance market rules apply to both the individual and small group (up to 100 employees) markets and include guaranteed issue, no medical underwriting, no pre-existing condition limitations, and premiums differentiated only by geography, family size, smoking status, and age (with a 3:1 ratio limitation).
- **Employer mandate.** Assessment on employers with more than 50 full-time employees who do not offer their full-time employees and their dependents the opportunity to enroll in minimum essential health coverage under an employer-sponsored plan.

The following discussion covers key drivers and assumptions underlying the projections for each subpopulation and the health insurance exchange.

UNINSURED

Since much of the current uninsured population is low income, it is projected to decline mostly due to the expanded eligibility requirements for Medicaid coverage and the availability of subsidies for health coverage purchased through a health insurance exchange, combined with the individual mandate and health insurance market reforms.

PUBLIC PROGRAMS

The projected increase in public program enrollment is largely attributable to the expanded eligibility requirements for Medicaid coverage. Much of the increase in public program enrollment will come from the currently uninsured population. Some additional enrollment will come from those currently insured in the individual and ESI markets since Medicaid coverage is less costly to the enrollee and eligibility for ESI does not preclude Medicaid eligibility.

This projection assumes that Indiana maintains the current CHIP. The projection also assumes that Indiana does not offer a federal basic health program, as permitted by ACA Section 1331.

INDIVIDUAL INSURANCE

Enrollment in the individual insurance market is projected to increase due to the effect of the individual mandate, individual insurance market reforms, and the availability of subsidies for health coverage purchased through a health insurance exchange. Much of the increase in individual insurance market enrollment will come from the current uninsured population. Additional enrollment will come from those currently covered by ESI, either due to the availability of subsidies in the health insurance exchange if the required ESI contribution exceeds 9.5% of household income or from employers who choose to terminate their ESI programs, including early retiree programs. The projection assumes that Indiana does not offer a federal basic health program, as permitted by ACA Section 1331.

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EMPLOYER SPONSORED INSURANCE

Enrollment in ESI is projected to hold steady, with a bias toward decline in the small group market (up to 100 employees) and a bias toward growth in the large group and self-funded markets. Normal population growth between 2010 and 2019 will drive overall growth across the sub-segments of the ESI market. This population growth will be offset by decline that is expected due to the expanded eligibility requirements for Medicaid coverage since Medicaid coverage is less costly to the enrollee and eligibility for ESI does not preclude Medicaid eligibility. Additionally, employees eligible for subsidies in the health insurance exchange will enroll if it is a lower cost alternative than their ESI offering.

Termination of ESI programs, including early retiree programs, will also lead to enrollment decline across the sub-segments of the ESI market. Employers with less than 50 full time employees will not be subject to an assessment if they do not offer ESI to their full time employees, so they will be more likely to terminate their ESI programs than employers with at least 50 full time employees. There is no mandate to retain early retiree programs for any employer size.

Enrollment is expected to shift within ESI from insured to self-funded. The small group insurance market reforms and increased assessments on insured business will cause self-funding to be more attractive to insured groups.

Enrollment growth is not anticipated from new ESI programs because nearly all Indiana employers with more than 100 employees and a significant majority of Indiana employers with 51-100 employees already offer ESI programs. The assessment will encourage many of these employers to continue to offer ESI coverage, though their programs may change from their current offerings. Indiana employers with less than 50 full time employees that do not offer ESI today are unlikely to begin to offer ESI since they are not subject to an assessment.

EXCHANGE ENROLLMENT

Health insurance exchange rules, carrier and plan design availability, and other exchange design considerations will ultimately influence how many people enroll in the exchange. For purposes of these projections, we have assumed that the Indiana health insurance exchange is designed to be sufficiently attractive and meet the needs of the majority of individual insurance market participants. A significant majority of participants with household income below 400% FPL are therefore projected to enroll in a health insurance exchange because premium tax credits and cost-sharing subsidies can only be accessed through the exchange. Assuming that individual insurance is also available outside the health insurance exchange, the exchange will be in more head-to-head competition for participants with household income above 400% FPL.

The exchange will also be in head-to-head competition for small groups (defined by ACA as employers with 1 to 100 employees beginning in 2014, with state option to elect to limit to 50 employees until 2016), assuming that small group insurance is available outside the health insurance exchange. Small group health insurance exchange enrollment is expected to be limited unless the exchange can offer a competitive advantage over the insured and self-insured small group broker distribution systems outside the exchange.

We have assumed that Indiana will not permit large group employers to participate in the health insurance exchange. ACA provides states the flexibility to make this decision beginning in 2017.



LIMITATIONS

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Differences between our 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. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In developing the projections, we relied on data and other information from 2010 annual statements of life and health insurance companies and HMOs doing business in Indiana, other public sources, and a March 10, 2011 memorandum from the State Health Access Data Assistance Center to the Indiana Family and Social Services Administration. We have not audited or verified this data and other information. We performed a limited review of the data used directly in our analysis for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

The projections included in this issue brief are based on our understanding of ACA and its associated regulations issued to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of ACA, necessitating an update to the projections included in this issue brief.

The views expressed in this issue brief are made by the authors of this issue paper and do not represent the opinion of Milliman, Inc. Other Milliman consultants may hold different views.

QUALIFICATION

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