State of Iowa, Department of Human Services, Iowa Medicaid Enterprise:

Medicaid Benchmark Plan

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Prepared for:
State of Iowa, Department of Human Services, Iowa Medicaid Enterprise

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I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Healthcare and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), represent Federal legislation poised to change the way health insurance products are designed, sold, and administered in the United States.

The State of Iowa, Department of Human Services, Iowa Medicaid Enterprise (IME) has engaged Milliman, Inc. (Milliman) to model the ACA defined Medicaid Benchmark Plan.

The U.S. Department of Health and Human Services (HHS), through the Center for Consumer Information and Insurance Oversight (CCIIO), is responsible for promulgating regulations and guidance to assist the states in making these decisions. This report makes extensive use of proposed regulations and guidance published by HHS and CCIIO as of the date of this report.

This executive summary provides a high-level overview of the topics covered in this report. Readers are asked to refer to specific sections of the full report for a comprehensive discussion of these matters. It should be noted that this report is limited in its scope and is not intended to be an in-depth examination of *all* decisions and options available for consideration by Iowa.

Medicaid Benchmark Plan

The ACA[1] increases Medicaid eligibility to most individuals under 138% of Federal Poverty Level (FPL) and under the age of 65. States have the option of offering this "expansion population" the State's standard Medicaid benefit package or offering this population a Benchmark (or, Benchmark-equivalent) benefit package.

[1] The Supreme Court of the United States decided on June 29, 2012 that states have the option not to participate in Medicaid expansion.

The Benchmark or Benchmark-equivalent benefit package must include essential health benefits as well as meet other Medicaid requirements. Premiums are not allowed for members with income less than 150% of FPL but nominal cost-sharing is allowed.

Potential Medicaid Benchmark Population

As of January 1, 2014, states may provide Medicaid to most non-elderly individuals with income less than 138% of FPL. Unauthorized immigrants as well as lawfully present non-citizens with five years or less of US residency are not eligible for Medicaid.

Certain population groups can be offered Benchmark coverage but it can't be mandatory. Such groups include pregnant women, medically frail, blind and disabled, dual eligibles, children in foster care, and other groups.

Funding

The Federal government will be responsible for 100% of the costs of the newly eligible individuals for calendar years 2014 – 2016. After that time, Federal match levels will decrease annually until it reaches 90% in calendar year 2020.

Summary of Findings

The selection of the largest commercial HMO plan with adjustments for Essential Benefits as required by the ACA was shown to reduce the costs of providing healthcare to the Medicaid expansion population for both the State and the Federal government as compared to using the Iowa Medicaid State plans to provide the coverage. These savings are due at least in part to the nominal cost-sharing borne by the covered individuals, which has the impact of reducing costs and managing utilization. There are also likely differences in the services offered under the State plans as compared to those included in the HMO plan.

The services that would be missing if the Benchmark Plan were to be implemented include:

- Targeted Case Management
- No coverage for out of network services except for emergencies and accidents
- Limits on numbers (not amounts) of certain services including home health visits, hospice, skilled nursing facilities, chiropractor visits, occupational therapy, physical therapy, and speech therapy.

II. STUDY PURPOSE, SCOPE, AND APPROACH

LIMITATIONS AND DATA RELIANCE

This report is intended to provide information and education about decisions, considerations, and options available to the State in terms of the Medicaid Benchmark Plan. The report may not be suitable for other purposes.

This report has been solely prepared for the use of, and is only to be relied upon by, the State of Iowa, Department of Human Services, Iowa Medicaid Enterprise (IME). Although Milliman understands that this report may be distributed to third parties, Milliman does not intend to benefit, or create a legal duty to, any third party recipient of its work. If this report is distributed to third parties, it should be distributed only in its entirety.

The information and discussion points provided in this report are technical in nature. No party should rely upon this report without a thorough understanding of the subject matter.

The contents of this report are based on Milliman's understanding of the ACA and its associated regulations issued to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of the ACA, necessitating an update to the content of this report. For this reason, this report should be considered time-sensitive material, which may change as new information becomes available.

In developing this report, Milliman relied, in part, on information, studies, and reports completed by third parties. We have not verified the accuracy or completeness of third-party input. Milliman performed a limited review of the information used in preparing this report for reasonableness and consistency. If the information used in preparing this report is inaccurate or incomplete, the contents of this report may likewise be inaccurate or incomplete.

Milliman's consultants are not attorneys and are not qualified to give legal advice. Users of this report are advised to consult with their own legal counsel regarding interpretation of legislation and administrative rules, possible implications of specific ACA-required features, or other legal issues related to the implementation of an ACA-compliant entity/program.

The views expressed in this report are made by the authors of this report and do not represent the opinions of Milliman, Inc.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this paper who is an actuary is a member of the American Academy of Actuaries, and meets the qualification standards for performing this analysis.

APPROACH TO COMPLETING THE STUDY

In preparing this study and report, the Milliman consultants worked in conjunction with IME to develop the approach to model the impact of the Medicaid Benchmark Plan. The steps used included:

- Model the demographics of the Medicaid expansion population.
- Model the State's largest commercial HMO plan as the base plan.
    - Adjust the base plan to include any Essential Health Benefits not already included.
    - Adjust the base plan to include any State mandated benefits not already in the plan.
- Model the State's current State plan, assuming the Medicaid HMO program with adjustments made for additional required benefits.
- Consider the impact of other State programs such as IowaCare that will or might be included in the Medicaid Benchmark plan.
- Produce a report including a discussion of the impact of using the Medicaid PCCM program instead of a State-wide Medicaid HMO.

Each of these tasks is described in more detail within this report.

III. Overview of the Medicaid Benchmark Plan

This section of the report provides an overview of the Medicaid Benchmark concept and establishes context and background information.

The Affordable Care Act (ACA) expands Medicaid eligibility to most individuals with income up to 138% (133% plus 5% income disregard) of the FPL. States have the option of offering this "expansion population" the State's standard Medicaid benefit package or offering this population a Benchmark (or, Benchmark-equivalent) benefit package.

The State can choose from the following Benchmark choices:

- The standard Blue Cross/Blue Shield preferred provider option for Federal employees in the State;
- A health plan that is offered and generally available to State employees in the State;
- Coverage offered by the largest commercial, non-Medicaid HMO in the State; or
- Secretary-approved coverage.

Benchmark-equivalent benefits must have an actuarial value that is at least equivalent to one of the Benchmark options.

The ACA further states that the Benchmark and Benchmark-equivalent packages for the Medicaid expansion population must include Essential Health Benefits and comply with the Mental Health Parity and Addictions Equity Act. In December, the Health and Human Services released a bulletin giving states the flexibility to set essential benefits that would meet their specific needs. However, required benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The Benchmark or Benchmark-equivalent benefit package must also meet other Medicaid requirements such as transportation. Premiums are not allowed for members with income less than 150% of FPL but nominal cost-sharing is allowed.

Certain populations cannot be required to enroll in the Benchmark plan. These populations include pregnant women, Medicare eligibles, dual eligibles, blind and disabled eligibles, and other groups. States can offer these populations the option to enroll in the Benchmark plan but the individual can request to be moved back to the traditional Medicaid plan at any time.

Federal financing

The Federal government will pick up 100% of the costs of the newly eligible for the first three years. After that time, the Federal portion decreases until calendar year 2020. The law includes the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019; and
- 90% FMAP in CY 2020+

IV. Overview of Modeling Process

The State has requested that Milliman provide an estimate of the cost of providing benefits to the Medicaid expansion population under the following scenarios.

1. Largest Commercial HMO Plan with nominal copays
2. State's Medicaid HMO Plan with no copays

In the development of these financial impact estimates, we developed a model that projected enrollment and healthcare expenditures for this population. The results are based on census data, Milliman proprietary data and modeling tools, commercial plan design, and State data.

Future year costs are assumed to grow at a composite annual rate of 4% to 6%, varying by scenario. The composite rate includes anticipated changes in cost, utilization, and enrollment.

Iowa's current Medicaid income eligibility standards are summarized below:

- Non-Disabled Children, Age <1 = 300% of FPL
- Non-Disabled Children, Age 1-5 = 133% of FPL
- Non-Disabled Children, Age 6-18 = 100% of FPL
- Non-Disabled Children, Age 19-20 = 32% net income, 82% of FPL gross income
- Pregnant Women = 300% of FPL
- Parents = 32% net income, 82% of FPL gross income
- SSI, Aged, Blind, Disabled = 75% of FPL
- Breast and Cervical Cancer = 250% of FPL
- Medicaid for Employed People with Disabilities (MEPD) with Premiums = 600% of FPL
- CHIP/*hawk-i* = children up to 300% of FPL who are not covered under Medicaid
- IowaCare = limited benefit program for adults up to 200% of FPL
- Family Planning = family planning benefits only, up to 300% of FPL
- Foster Children and Children in Subsidized Adoption, up to age 21

We modeled the demographics of the Medicaid expansion population.

Using a number of sources, Milliman has estimated Iowa's Medicaid expansion eligible population. The primary source of data is the United States Census Bureau[2]. This data provided the non-Medicaid population in certain Federal Poverty Level categories. We interpolated the number of individuals within these categories to estimate the desired 0-138% FPL population currently not covered in the Medicaid program.

[2] http://www.census.gov/cps/

The census data was reduced for a few categories that are not eligible for Medicaid expansion. The first considered was the ineligible portion of the immigrant population. This includes unauthorized immigrants and lawfully present immigrants with five years or less of US residency. Using the most recent data from two sources: the Department of Homeland Security (DHS)[3] and Federation for American Immigration Reform (FAIR)[4], we estimated that approximately 34% of all immigrants are unauthorized residents. Then we estimated that of the remaining 66%, approximately 78% are eligible for Medicaid benefits (naturalized citizens, legal permanent residents with more than five years residency, refugees, asylees, etc.). This resulted in about 1/2 of Iowa's immigrant population inside the relevant FPL range being subtracted from the original Non-Medicaid group. Also, we excluded the currently eligible but not enrolled Medicaid portion of the population even if they had not applied for Medicaid.

Table 1
Iowa's Newly Eligible Medicaid Population 0-138% FPL
Calendar Year 2011

	Insured					Uninsured			
	Caretakers		Non-Caretakers			Caretakers		Non-Caretakers	
	Male	Female	Male	Female		Male	Female	Male	Female
19 to 24	1,165	4,521	8,723	14,607		1,825	1,221	4,664	9,167
25 to 29	1,201	2,690	4,444	6,364		2,150	3,793	1,737	3,436
30 to 34	2,230	3,305	2,578	300		43	4,426	3,757	2,232
35 to 39	1,641	3,197	0	924		2,541	2,723	1,866	611
40 to 44	1,977	1,268	1,555	996		1,862	3,020	2,412	3,472
45 to 49	181	0	4,199	3,939		2,144	423	3,045	5,030
50 to 54	657	890	2,518	3,726		909	410	3,961	3,410
55 to 59	1,026	542	2,472	1,183		44	120	6,363	2,387
60 to 64	633	632	5,916	6,168		0	0	5,605	6,436
Total	10,711	17,045	32,405	38,207		11,518	16,136	33,410	36,181
	Total number of insured			98,368		**Total number of uninsured**			97,245

[3] http://www.dhs.gov

[4] http://www.fairus.org

The analysis presented in this report includes two scenarios that reflect the percentage of the Medicaid expansion eligible population that are assumed to choose to enroll in Medicaid.

Table 2 Participation/Take-Up Assumptions		
	Low Scenario	**High Scenario**
Insured Caretakers below 100% of FPL	50%	75%
Insured Caretakers 100%-138% of FPL	60%	85%
Insured Non-Caretakers below 138% of FPL	25%	50%
Uninsured Caretakers below 100% of FPL	60%	85%
Uninsured Caretakers 100%-138% of FPL	70%	95%
Uninsured Non-Caretakers below 138% of FPL	55%	80%

Note that the "insured" status in our analysis applies to individuals currently insured in the commercial or individual markets.

Table 3 Estimated Population Enrollment Calendar Year 2014				
	Low Scenario		**High Scenario**	
Age	**Male**	**Female**	**Male**	**Female**
19 to 24	5,823	10,786	9,852	18,104
25 to 29	3,652	6,592	5,989	10,629
30 to 34	3,758	5,231	6,048	7,748
35 to 39	3,099	3,366	4,567	5,028
40 to 44	3,446	4,224	5,321	6,389
45 to 49	3,495	3,601	5,724	5,936
50 to 54	3,088	3,202	4,955	5,285
55 to 59	3,953	1,703	6,305	2,706
60 to 64	3,990	4,805	6,740	8,048
Total	34,304	43,510	55,501	69,873
Total by Take-Up Ratio	77,814		125,374	

We modeled the State's largest commercial HMO plan as the base plan.

Milliman's Managed Care Rating Model (MCRM) was used to estimate the costs of providing Benchmark coverage based on the HMO plan with the largest commercial enrollment in the State.

According to the Deficit Reduction Act (DRA) of 2005 and CMS's application of this act to Medicaid Benchmark Plan, states must adhere to complex rules concerning what they can charge newly-eligible adult Medicaid beneficiaries for coverage and services. These rules vary depending on a beneficiary's income and the service that is being used. Generally speaking, states are strictly limited in the premiums, deductibles, and the cost-sharing amounts that they can charge adult Medicaid beneficiaries, with exceptionally stringent rules for those below 100% of FPL. For these adults in the lowest income range, states may not charge more than a nominal amount for most services, they may also not impose premiums or any charge for emergency services, pregnancy services or family planning services. However, the State may impose additional cost-sharing charges on adults with more income. For most services, they may impose up to 10% of the cost of the service for those with income 100-138% of FPL.

Additionally, the total cost of Medicaid premiums, deductibles, and cost-sharing charges for a family in a year may not exceed 5% of the family's income.

The modeled Benchmark plan was based on two cost-sharing scenarios that divided the population by two levels of FPL. The first covers household incomes below 100% of FPL and the second covers the range from 100-138% of FPL, and assumed Medicaid fee level of provider reimbursement. Nominal charges for out-of-pocket expenses are subject to a cap not exceeding 5% of family income.

Table 4 below shows the schedule of copayments that was assumed in modeling the Benchmark plan[5].

Table 4 Maximum Allowable Copayment Federal Fiscal Year 2012		
Service Copay	**0 to 100% of FPL**	**100 to 138% of FPL**
Inpatient Hospital Stay	$3.80	10% of costs
Inpatient Mental Health	$3.80	10% of costs
Emergency Room	$3.80 (waived if admitted)	$7.60 (waived if admitted)
Outpatient Surgical Procedures	$3.80	10% of costs
Physician Office	$3.80	10% of costs
Chiropractor	$3.80	10% of costs
Eye Exam	$3.80	10% of costs
Physical Therapy	$3.80	10% of costs
Generic Drugs	$3.80	$3.80
Non-preferred Drugs $25.01-$50.00	$3.80	$3.80
Non-preferred Drugs $50.01-more	$3.80	$3.80
Emergency Services	$0.00	$0.0
Pregnancy Related Services	$0.00	$0.0
Preventative Services	$0.00	$0.0
Out-of-Pocket Max (5% of family income)	$279	$662

[5] Nominal charges are the latest available from http://www.medicaid.gov. They will fluctuate to follow inflation and medical care cost.

We adjusted the base plan to include any Essential Health Benefits not already included.

These adjustments included making sure that habilitative benefits were covered, that dollar maximums were removed and that there was mental health parity.

We also adjusted the base plan to include any State mandated benefits not already in the plan.

The mandated benefit information was provided to us by the State. Since this plan was sold in the State of Iowa, it already included any mandated benefits.

We created two versions of the Benchmark Plan with two different sets of benefits that vary by level of FPL. The two modeled Benchmark plans as described above produced actuarial values[6] that are presented in the Table 5 below.

Table 5
Benchmark Plan Actuarial Values

Income Level	Actuarial Values
0 to 100% FPL	98%
100 to 138% FPL	95%

Table 6 below shows the Benchmark Plan per member per month (PMPM) expenditures projected to CY 2014 at a 4%-6% trend rate.

Table 6
Benchmark Plan Healthcare Expenses
PMPM
Calendar Year 2014

Income Level	Low Scenario	High Scenario
0 to 100% FPL	$377.04	$378.85
100 to 138% FPL	$422.92	$431.32

[6] Actuarial Value is the percentage of total average costs for covered benefits that a plan will cover

We then modeled the cost using the current Medicaid State plan coverage and the current levels of Medicaid fees for the projected range of the ACA Medicaid expansion population.

Overall, the per member per month calendar year 2014 healthcare expenditures were assumed to be $464.16-$468.71 for a childless adult or parent. This estimate includes an amount based on IME's SFY 2011 Medicaid expenditures for current Medicaid enrollees in the Family Medical Assistance Program (a program covering families with dependent children meeting financial limits) category of eligibility, adjusted for the expected demographics of the expansion population. To this amount, mental health, substance abuse, and behavioral health services were added at an estimated amount of $31.26-$31.49 per member per month, overall. This estimate was based on costs in the Iowa Plan for Family Medical Assistance Program members. The costs for Non-Emergency Transportation (NEMT), Pharmacy, and Remedial Services (RSP) were added to produce the total Medicaid cost for this population. The total expenditures were projected forward at a rate of 4% to 6% per year, varying by scenario and including healthcare inflation and anticipated enrollment growth. We anticipate that during the first one to two years of the program, the new enrollees may have higher costs that are due to pent-up demand, a characteristic of other Medicaid expansion programs. Because the Federal government will be 100% responsible for the cost of the expansion for the first three years, we *did not* include an explicit amount for pent-up demand.

Increase in Primary Care Physician Fees to 100% of Medicare

The Federal government will fund an increase in some fees paid to primary care physicians to equal 100% of Medicare reimbursement in calendar years 2013 and 2014. No additional Federal funding is allocated after 2014. Our projections assume that IME will continue to pay primary care physicians at 100% of Medicare reimbursement after calendar year 2014 at normal FMAP rates because it would be very difficult to reduce fees once they are increased to 100% of Medicare.

Foster Care Expansion to Age 26

Iowa currently provides Medicaid eligibility coverage to foster care children up to age 21. The ACA includes coverage for foster care children up to age 26 beginning January 1, 2014. Foster care children cannot be subject to mandatory enrollment in the Benchmark coverage. A portion of this population is assumed to be covered under both the State plan and the Benchmark plan.

Pregnant Women and Infants

Iowa currently provides Medicaid eligibility for pregnant women and infants up to 300% of FPL. After January 1, 2014, states can offer pregnant women the option of Benchmark coverage.

The impact of eliminating this program and allowing a portion of the population to enroll under Medicaid expansion was assumed to cancel out in examining the difference between the two Medicaid expansion options.

Breast and Cervical Cancer

Iowa currently provides Medicaid eligibility under the Breast and Cervical Cancer Program. The program will not be required to be continued with the expansion requirements for those with incomes below 138% of FPL. We assume that if the program is terminated beginning January 1, 2014, 75% of these individuals will become eligible under the new Medicaid eligibility requirements.

The impact of eliminating this program and allowing a portion of the population to enroll under Medicaid expansion was assumed to cancel out in examining the difference between the two Medicaid expansion options.

Transition of Family Planning Waiver and IowaCare

The Family Planning Waiver and IowaCare are limited benefit programs. It is assumed that on January 1, 2014, members participating in these two programs who are less than 138% of FPL will transition to Medicaid where they will be treated as part of Medicaid expansion.

The impact of allowing a portion of the IowaCare population to enroll under Medicaid expansion was assumed to cancel out in examining the differences between the two Medicaid expansion options. Family planning services are assumed to be included under the two Medicaid expansion options.

General Assumptions

We used the following key assumptions in our analysis:

- Iowa's CHIP program will continue through SFY 2019 under Maintenance of Effort (MOE). Milliman has assumed that the program will be continued by Congress through SFY 2020.
- The reform legislation will not prevent crowd-out from the currently insured population that is below 138%.
- There will be no net impact because of the pharmacy rebate provisions in the ACA.

Milliman prepared this report, which brings together the results of the tasks described above. A draft of this report was provided to IME for review and comment.

V. SUMMARY OF RESULTS

Table 7[7] below shows the total projected cost of two options for covering the Medicaid expansion population. The option of using a Medicaid HMO to provide coverage under the State Plan to this population is compared to using an HMO to provide coverage under a Medicaid Benchmark plan as described earlier in this report. The option of providing this coverage through the MediPASS PCCM program is addressed in section VII.

Table 7
Expansion Population Costs Summary of Results
($millions)
CY 2014 through CY 2020

	Low Scenario	High Scenario
Total Cost using State Plan	$3,340.0	$5,810.9
Total Cost using Benchmark Plan	$2,922.9	$5,095.6
Savings with Benchmark	$417.1	$715.3
Federal Savings	$393.2	$673.2
State Savings	$23.9	$42.1

[7] Costs reflected in the Table 7 include the administrative expenses

VI. Administrative Expenses

Administrative expenses for the Benchmark plan were calculated by using 4.2% pro rata share of Iowa estimated budget for Medicaid expansion. Currently Iowa is waiting for guidance from CMS regarding the administrative costs for the Benchmark Plan.

Table 8

Administrative Costs

($millions)

CY 2014 through CY 2020

	Low Scenario	High Scenario
Total Cost using State Plan	$133.43	$232.13
Total Cost using Benchmark Plan	$116.76	$203.56
Savings	$16.67	$28.57
Federal Savings	$11.03	$18.91
State Savings	$5.63	$9.66

VII. DESIGN DECISIONS

In this report we have modeled the costs of the Medicaid expansion population assuming that a Medicaid HMO provides the coverage under the existing State plan and compared that cost to the situation where a defined Medicaid Benchmark Plan is also provided through a Medicaid HMO but with different coverages and associated copays.

The State has also asked us to comment on the cost to the State of coverage provided by an HMO versus coverage provided on a fee-for-service basis (FFS) under the Primary Care Case Management program (PCCM).

Milliman had previously prepared such an analysis for IME and at that time found that considering the fact that the increased savings through the management of health care costs by a Medicaid HMO were essentially offset by their higher administrative costs, typically 13% to 15%, the cost to the State was virtually the same for the two options of delivery of health care services to the Family Medical Assistance Program population.

VIII. CONCLUSION

The selection of the largest commercial HMO benefit plan with adjustments for Essential Benefits as required by ACA was shown to reduce the costs of providing healthcare to the Medicaid expansion population for both the State and the Federal government as compared to using the Iowa Medicaid State plan benefits.

Appendix A

Financial Impact Analysis for Calendar Years 2014 – 2020

Low and High Scenarios

Resulting from Medicaid Benchmark Plan Federal Savings/(Costs) ($millions) Calendar Years 2014 - 2020								
Low Scenario	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Medicaid State Plan Cost	$222.9	$463.1	$481.7	$476.6	$490.5	$504.9	$508.6	$3,148.3
Benchmark Plan Cost	$195.1	$405.3	$421.5	$417.0	$429.3	$441.8	$445.1	$2,755.1
Savings	$27.8	$57.8	$60.2	$59.6	$61.2	$63.1	$63.5	$393.2
High Scenario	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Medicaid State Plan Cost	$362.7	$768.5	$815.1	$822.5	$863.5	$906.4	$931.3	$5,470.0
Benchmark Plan Cost	$318.0	$673.9	$714.8	$721.3	$757.2	$794.9	$816.7	$4,796.8
Savings	$44.7	$94.6	$100.3	$101.2	$106.3	$111.5	$114.6	$673.2

Resulting from Medicaid Benchmark Plan State Savings /(Costs) ($millions) Calendar Years 2014 – 2020								
Low Scenario	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Medicaid State Plan Cost	$2.8	$6.4	$6.6	$31.3	$37.6	$44.4	$62.6	$191.7
Benchmark Plan Cost	$2.5	$5.6	$5.8	$27.4	$32.9	$38.8	$54.8	$167.8
Savings	$0.3	$0.8	$0.8	$3.9	$4.7	$5.6	$7.8	$23.9
High Scenario	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Medicaid State Plan Cost	$4.6	$10.6	$11.2	$54.0	$66.2	$79.7	$114.6	$340.9
Benchmark Plan Cost	$4.0	$9.3	$9.8	$47.3	$58.0	$69.9	$100.5	$298.8
Savings	$0.6	$1.3	$1.4	$6.7	$8.2	$9.8	$14.1	$42.1