

TO: Members of the Health Reform Task Force
FROM: Mark Andrews, Office of Legislative Research and General Counsel
DATE: June 20, 2013
SUBJECT: Selected Conclusions Drawn From the Medicaid Expansion Report Prepared by PCG

EXECUTIVE SUMMARY

On May 23, 2013, the Utah Department of Health released a report by Public Consulting Group detailing the impacts of five Medicaid eligibility expansion options the state could consider in response to the federal Affordable Care Act.

This memo uses data presented in the report to produce additional estimates for a time period not included in the report. These estimates likely reflect more closely the long-term impacts of the expansion options than the estimates for the time periods included in the report.

This memo also states five conclusions that may be drawn from the report.

This memo is not a summary of the PCG report.

BACKGROUND

In March 2010, Congress passed, and President Obama signed, the Patient Protection and Affordable Care Act and the Health Care and the Education Reconciliation Act of 2010, commonly referred to jointly as the "Affordable Care Act," the "ACA," or "ObamaCare." One of the act's various objectives is to increase Americans' enrollment in health insurance. To accomplish this, it promotes the purchase of commercial health insurance and enrollment in government sponsored Medicaid.

To increase enrollment in commercial insurance, the ACA provides generous federal subsidies for the purchase of policies through online marketplaces or "exchanges." To increase enrollment in Medicaid, it creates a new category of individuals potentially eligible for the program and expands eligibility for others.

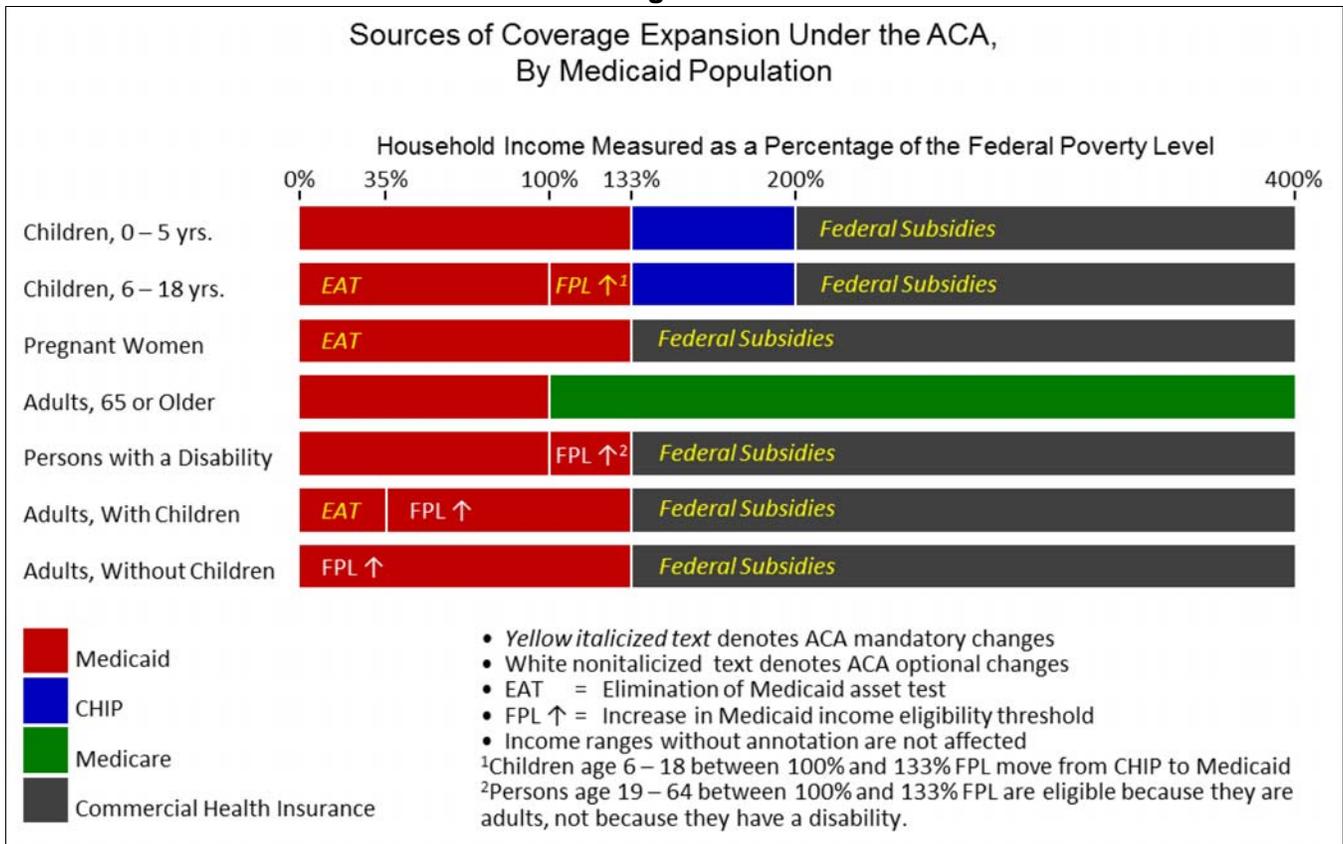
Created in 1965, Medicaid initially provided health care services to the aged (65 years and older), the blind, the disabled, and those receiving public assistance. Over the years, the program has been repeatedly expanded to include other populations. Eligibility for the program, however, has typically been limited according to a person's income and assets, although those limits have been modified as well.

The ACA's expansion of Medicaid continues a long-established pattern of broadening the program to include those previously excluded because they either fall outside authorized eligibility categories or exceed specified income or asset limits. In particular, the ACA *allows* states to expand Medicaid to adults without children, a category of individuals not previously covered. Further, the ACA *requires* states to increase the maximum income limits for certain categories of individuals already eligible. Specifically, the ACA expands Medicaid eligibility in Utah as follows:

Mandatory Expansion Under the ACA, the state is required to modify its Medicaid eligibility requirements as follows:

- (1) For children 6 to 18 years old:
 - (a) If the child is in a household with income not exceeding 100% of the federal poverty level (FPL), the asset test is eliminated.
 - (b) If the child is in a household between 100% FPL and 133% FPL, the child, previously eligible for the Children's Health Insurance Program (CHIP), is now eligible for Medicaid instead.
- (2) For pregnant women, the asset test is eliminated.

Figure1



(3) For adults who have children and are eligible under the income limits of the former Aid for Families With Dependent Children Program (AFDC), the asset test is removed.

Figure 1 illustrates these mandatory changes to Medicaid eligibility.

Optional Expansion The ACA also allows states to expand eligibility to include *all* adults up to 133% FPL, regardless of whether an adult has a disability or is living with a child in the home. In effect, this increases the income limit for an adult with a disability from 100% to 133% FPL. It also increases the limit for an adult with a child in the home from the AFDC limit to 133% FPL. And, it extends Medicaid to adults who were not previously eligible for the program because they had neither a child in the home nor a disability.

Figure 1 illustrates these optional changes.

Evaluating the Optional Expansion Decision

Although the Utah Department of Health prepared an initial estimate of the ACA's impact on state spending and Medicaid enrollment, it became clear that additional information was needed, particularly in light of the complexities introduced by the U.S. Supreme Court's June 2012 ruling that a portion of the Medicaid eligibility expansion was now optional. In the latter part of 2012, the department contracted with Boston-based Public Consulting Group (PCG) to evaluate the impacts of five potential expansion options. On May 23, 2013, the department released PCG's report to the public.

PCG ANALYSIS

PCG's analysis does not definitively answer the question, "Should the state expand Medicaid beyond the mandatory expansion?" Rather, it analyzes various impacts of the decision, providing information that could support various conclusions, depending on one's

objectives and priorities. Specifically, the report analyzes the impacts of five expansion options:

Option 1 Do not expand Medicaid eligibility beyond the mandatory expansion, which will increase eligibility for several categories of adults and children.

(This option is shown in Figure 2, row A, and Figure 4, row E.)

Option 2 Expand Medicaid eligibility to include adults with household incomes up to 133% FPL, providing the same benefits typically enjoyed by other Medicaid enrollees.

(This option is shown in Figure 2, row B, and in Figure 5, row C. It is also shown in combination with the mandatory expansion in Figure 2, row C; Figure 3, rows A – G; and Figure 4, row C.)

Option 3 Expand Medicaid to include adults up to 133% FPL, but provide a less generous benefit package that matches the package Utah has elected as the benchmark for commercial coverage under the ACA (Public Employees Health Program's *Utah Basic Plus* plan).

(This option is shown in Figure 5, row D, and in combination with the mandatory expansion in Figure 4, row D.)

Option 4 Expand Medicaid eligibility to include adults up to 100% FPL, providing the same benefits typically enjoyed by other Medicaid enrollees, as under Option 2.

(This option is shown in Figure 5, row A, and in combination with the

mandatory expansion in Figure 4, row A.)

Option 5 Expand Medicaid eligibility to include adults up to 100% FPL, but use the *Utah Basic Plus* benefits package, as under Option 3.

(This option is shown in Figure 5, row B, and in combination with the mandatory expansion in Figure 4, row B.)

Option 1 is implementation of the mandatory expansion only and will occur if the state does not elect any other option. One of the other options, however, *may* be implemented *in addition to* the mandatory expansion.

Options 2 and 3 are accompanied by enhanced federal funding under the ACA (90%–100% federal reimbursement for Medicaid service costs rather than the usual 70% or so). Options 4 and 5 were available to the state prior to passage of the ACA and are not expected to be accompanied by enhanced federal funding.

Option 1 must be implemented beginning January 1, 2014. Options 2 through 5 do not have an implementation deadline. However, enhanced federal funding for Options 2 and 3 is limited by the schedule shown on page 4.

For each option, PCG analyzed the option's impact on:

- State spending for Medicaid and Corrections
- State tax revenues
- County spending for behavioral services and jails
- County tax revenues
- Medicaid enrollment
- Uncompensated care provided by hospitals
- Employment
- Gross state product (income)

PCG also reported estimates of potential "crowd out," or shifts from commercial coverage to government

sponsored coverage, but did not use those estimates to model the other impacts of each option.

CONCLUSIONS

The PCG report allows one to evaluate five expansion options from multiple perspectives. This memo focuses on the fiscal perspective of state and county governments. It does not address impacts on individuals' health, crowd out, uncompensated care, employment, and gross state product (income). Nor does it rehearse PCG's assumptions or the relationships between various factors and effects. Instead, what follows are a few conclusions that may be drawn from the data presented in the report. Many other equally valid conclusions could be drawn, but are beyond the scope of this brief analysis.

Conclusion 1: Whether the Net Impact of the Mandatory Expansion (Option 1) Is Positive or Negative Depends on the Level of Government

For Years 4–10 (2017–23) of implementation, the expected increase in state expenditures due to the mandatory expansion is more than 10 times the expected increase in state revenues, resulting in a *negative* average annual net fiscal impact of \$23.4 million. On the other hand, the average annual net impact to counties for the same period is a *positive* \$2.0 million. Considered together, the net result for the state and counties is a *negative* \$21.4 million. (Figure 2, row A.)

Conclusion 2: The Net Impact of Option 2 (Optional Expansion to 133% FPL, With Traditional Benefits) Differs for State and County Governments As Well

Similarly, for the same period, Option 2 creates a *negative* annual impact of \$17.0 million for the state, but a *positive* annual impact of \$7.5 million for counties. The overall effect for the state and counties as a whole is a negative fiscal impact of \$9.5 million. (Figure 2, row B.)

If the effects of Option 2 and the mandatory expansion are considered together, the result is a *negative* average

annual impact of \$40.4 million for the state, a *positive* average annual impact of \$9.5 million for counties, and a *negative* overall impact for the state and counties of \$30.8 million. (Figure 2, row C.)

Similar analyses could be made for Options 3 through 5. This example is simply meant to be illustrative.

Conclusion 3: Estimates Vary Widely According to the Period Measured.

The estimates in Figure 2 are for Years 4–10 (2017–2023) of ACA implementation. These estimates were not included in the PCG report but were calculated by subtracting PCG's estimates for Years 1–3 (2014–16) from its estimates for Years 1–10 (2014–2020). Figure 3 compares PCG's estimates for the combined impact of the mandatory and Option 2 expansions across four periods. The figure includes other periods (without data) for which estimates also would be useful.

The combined impact of the mandatory and Option 2 expansions varies by period for several reasons, but most significantly because of differences in federal Medicaid reimbursement rates. Specifically, under Option 2, the federal government will reimburse the state for Medicaid service costs (not administrative costs) at the following rates:

	Medicaid Service Costs Under Options 2 and 3	
	Federal	State
2014–16	100%	0%
2017	97%	3%
2018	96%	4%
2019	95%	5%
2020–23	90%	10%

PCG's report includes impact estimates for the first six months of implementation, Year 1, Years 1–3, and Years 1–10, but not for periods beginning on or after

2020 when the state's funding share is fully phased in. As a result, it is not possible to determine the long-term, ongoing impact to the state following the phase-in, undiluted by the influence of higher federal match rates in Years 1–6 (2014–19). The report does, however, permit the reader to calculate impacts for Years 4–10. Estimates for Years 4–10 are presented in Figures 2, 4, and 5 because they more closely approximate the long-term, ongoing impacts of Options 2 and 3 than estimates reported for other periods.

Figure 3 highlights how the combined impact of the mandatory and Option 2 expansions varies by measurement period. For example, the average annual net impact for the state is a *positive* \$16.3 million in Year 1, a *positive* \$13.2 million in Years 1–3, a *negative* \$24.3 million in Years 1–10, and a *negative* \$40.4 million in years 4–10. For counties, the estimates range from a *positive* \$9.5 million to a *positive* \$14.2 million. Clearly, the period over which the estimate is made has a large impact on the result.

Users of the PCG report may have reasons to use estimates for one time period rather than another. However, they should study PCG's analysis carefully to understand how various factors may affect the estimates (for example, Medicaid enrollment rates, medical spending growth rates, and federal Medicaid reimbursement rates).

Conclusion 4: Impacts of the Five Expansion Options Vary Widely: Figures 4 and 5 highlight the wide variation in impacts across the five expansion options analyzed by PCG. Figure 4 ranks the options according to the combined state and county impacts of the mandatory expansion alone (Option 1) and the mandatory expansion in combination with each optional expansion (Options 2 through 5). By contrast, Figure 5 ranks the same impacts for each optional expansion alone (without the mandatory expansion).

Several examples illustrate the variation in impacts. In Figure 4, the average annual net impact to the state for Years 4–10 (2017–23) ranges from a *negative* \$23.4

million for the mandatory expansion alone, to a *negative* \$62.4 million for the mandatory expansion in combination with Option 4 (FPL = 100%, with a traditional benefits package). The net impact for counties ranges from a *positive* \$2.0 million for the mandatory expansion alone, to a *positive* \$9.5 million for the mandatory expansion in combination with Option 2 (FPL = 133%, with a traditional benefits package).

Figure 5 is the same as Figure 4, except that the impacts of each optional expansion are shown alone rather than in combination with the mandatory expansion.

Conclusion 5: Estimates for Other Periods Could be Very Useful For those who wish to understand the impacts of Options 2 and 3 once the federal Medicaid match rate is phased down to 90%, additional estimates for Years 7–10 (2017–23) would be very useful.

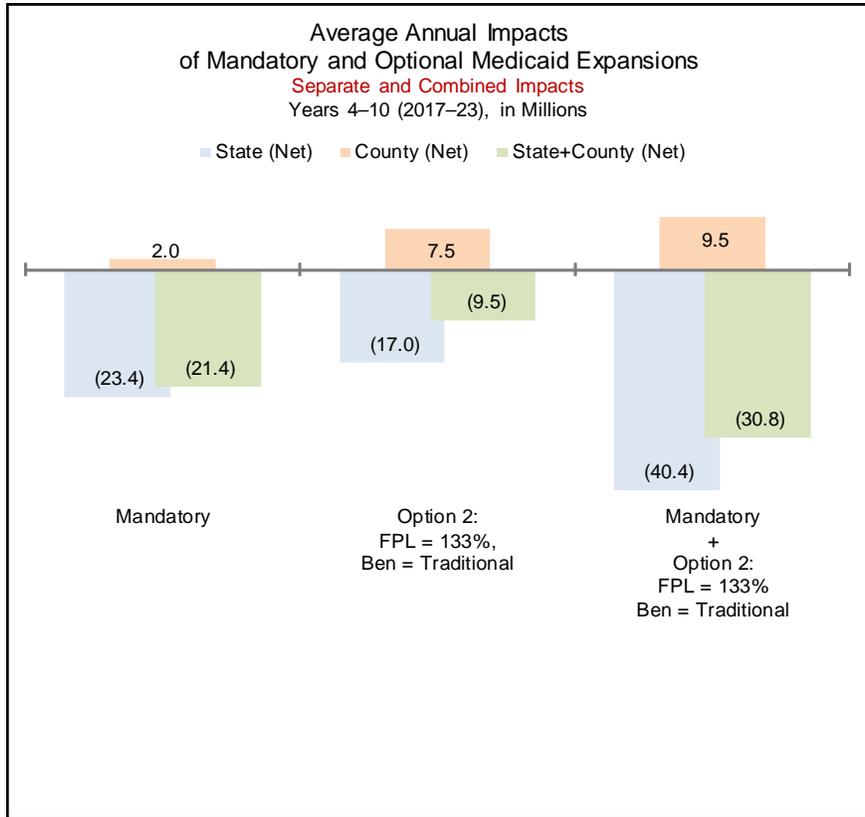
Year by year estimates for Years 7–10 (2017–23), and for Years 1–3 (2014–16) as well, would help users isolate the impacts of the options from other factors used to produce the estimates. Year by year estimates would also allow users to calculate the net present value of the impacts over ten years or other periods.

RESOURCES

The PCG analysis, "State of Utah: Medicaid Expansion Assesment," is available at http://health.utah.gov/documents/PCGUtahMedicaidExpansionAnalysis6_17_13_FINAL.pdf.

A Utah Department of Health summary of PCG's report is available at <http://health.utah.gov/medicaid/pdfs/MedExpansionOption/PCGReportOverview.pdf>.

Figure 2



Expansion Scenario				State			Counties			State + County		
	Optional			Revenue	Expend	Net	Revenue	Expend	Net	Revenue	Expend	Net
	FPL	Benefits	State Share (Option #)									
A	Mandatory	No Optional Expansion	1	2.5	25.9	(23.4)	2.0	-	2.0	4.5	25.9	(21.4)
B	No Mandatory	133% Traditional	Mixed ¹ 2	12.5	29.5	(17.0)	9.9	2.4	7.5	22.5	31.9	(9.5)
C	Mandatory +	133% Traditional	Mixed ¹ 2	15.1	55.4	(40.4)	12.0	2.4	9.5	27.0	57.8	(30.8)

Data in red boxes shown in graph above.

"State Share" refers to the state's share of optional expansion Medicaid service costs not reimbursed by the federal government.

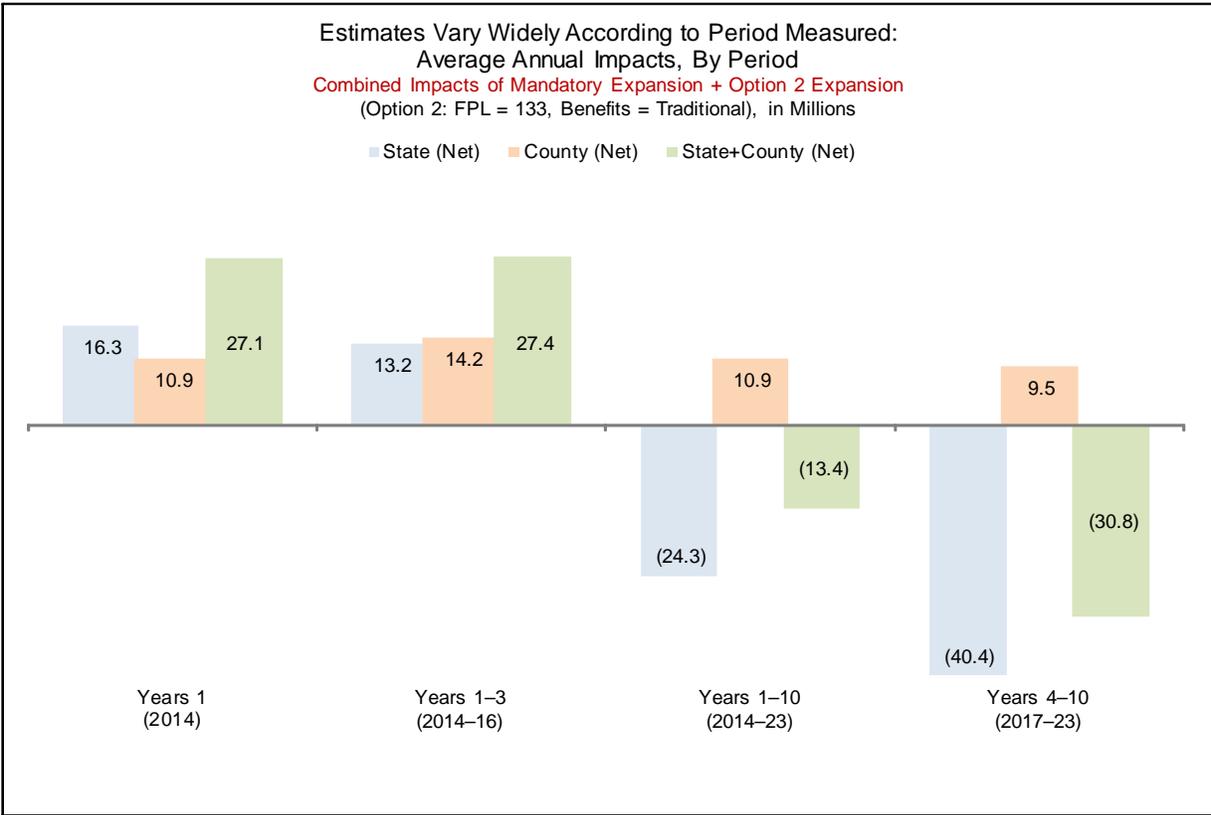
Row A is the same as row E in Figure 4.

Row B is the same as row C in Figure 5.

Row C is the same as row G in Figure 3 and row C in Figure 4. Figure 3, rows A–F, shows the impacts of this scenario over other periods.

¹2017-23 state shares, by year: 3%, 4%, 5%, 10%, 10%, 10%

Figure 3



Period	Date	State Share	State			Counties			State + County			
			Revenue	Expend	Net	Revenue	Expend	Net	Revenue	Expend	Net	
A	Year 1	2014	0%	4.9	(11.3)	16.3	3.9	(7.0)	10.9	8.8	(18.3)	27.1
B	Year 10	2023	10%	---	---	---	---	---	---	---	---	---
C	Years 1-3	2014-16	0%	10.0	(3.2)	13.2	7.9	(6.2)	14.2	17.9	(9.5)	27.4
D	Years 4-6	2017-19	Mixed ¹	---	---	---	---	---	---	---	---	---
E	Years 7-10	2020-23	10%	---	---	---	---	---	---	---	---	---
F	Years 1-10	2014-23	Mixed ²	13.5	37.8	(24.3)	10.7	(0.2)	10.9	24.3	37.7	(13.4)
G	Years 4-10	2017-23	Mixed ³	15.1	55.4	(40.4)	12.0	2.4	9.5	27.0	57.8	(30.8)

Data in red boxes shown in graph above.

"State Share" refers to the state's share of optional expansion Medicaid service costs not reimbursed by the federal government.

Row G is the same as row C in Figure 2 and row C in Figure 4.

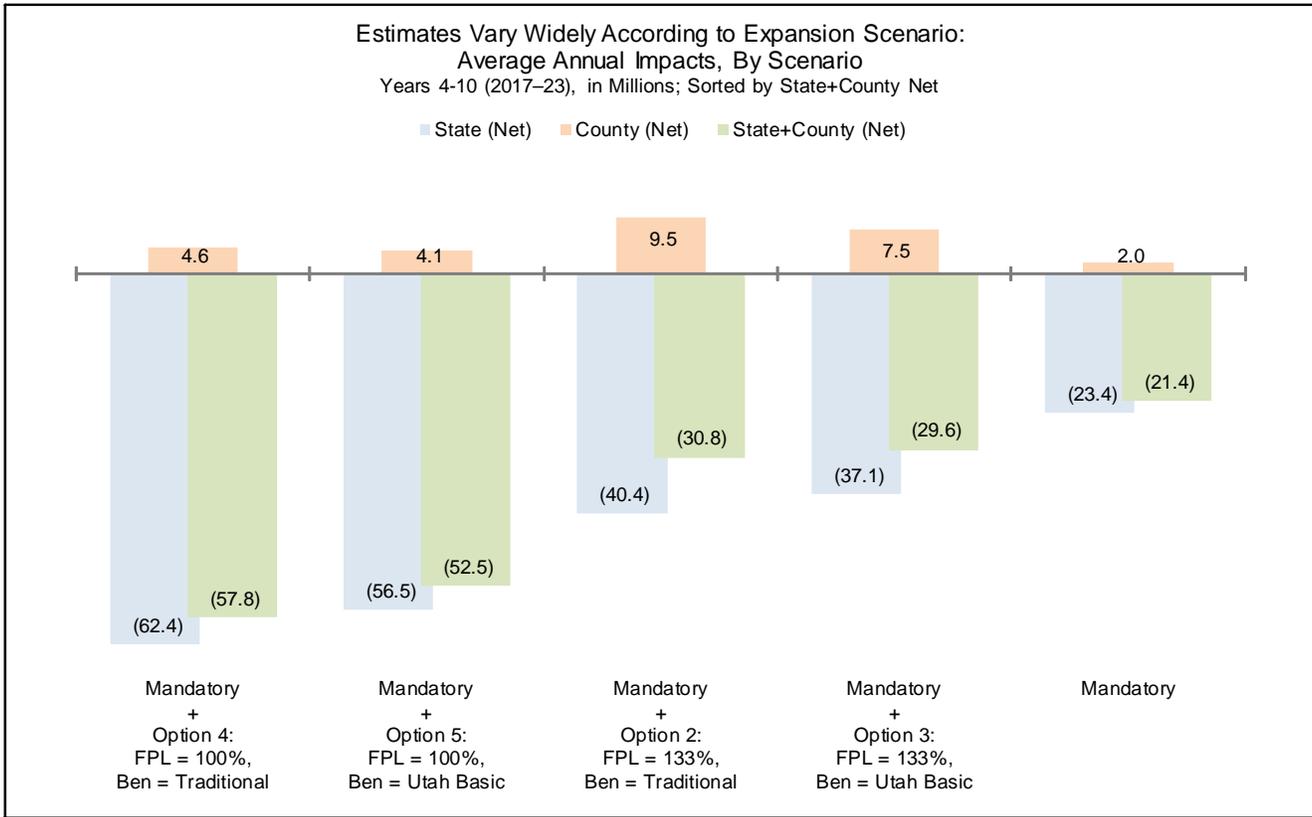
¹2017-19 state shares, by year: 3%, 4%, 5%.

²2014-23 state shares, by year: 0%, 0%, 0%, 3%, 4%, 5%, 10%, 10%, 10%, 10%.

³2017-23 state shares, by year: 3%, 4%, 5%, 10%, 10%, 10%, 10%.

"---" denotes data not included in PCG report.

Figure 4



Expansion Scenario					State		Counties			State + County					
	Optional				Revenue	- Expend	= Net	Revenue	- Expend	= Net	Revenue	- Expend	= Net		
	FPL	Benefits	State Share	(Option #)											
A	Mandatory	+	100%	Traditional	29%	4	7.1	69.5	(62.4)	5.6	1.0	4.6	12.7	70.4	(57.8)
B	Mandatory	+	100%	Utah Basic	29%	5	6.4	62.9	(56.5)	5.0	1.0	4.1	11.4	63.9	(52.5)
C	Mandatory	+	133%	Traditional	Mixed ¹	2	15.1	55.4	(40.4)	12.0	2.4	9.5	27.0	57.8	(30.8)
D	Mandatory	+	133%	Utah Basic	Mixed ¹	3	12.5	49.5	(37.1)	9.9	2.4	7.5	22.3	51.9	(29.6)
E	Mandatory	+	No Optional Expansion			1	2.5	25.9	(23.4)	2.0	-	2.0	4.5	25.9	(21.4)

Data in red boxes shown in graph above.

"State Share" refers to the state's share of optional expansion Medicaid service costs not reimbursed by the federal government.

Row C is the same as row C in Figure 2 and row G in Figure 3.

Row E is the same as row A in Figure 2.

¹2017-23 state shares, by year: 3%, 4%, 5%, 10%, 10%, 10%, 10%

Figure 5



Expansion Scenario				State			Counties			State + County		
Optional				Revenue	Expend	Net	Revenue	Expend	Net	Revenue	Expend	Net
FPL	Benefits	State Share	(Option #)									
A	100%	Traditional	29% 4	4.5	43.5	(39.0)	3.6	1.0	2.6	8.1	44.5	(36.4)
B	100%	Utah Basic	29% 5	3.8	37.0	(33.1)	3.0	1.0	2.1	6.9	38.0	(31.1)
C	133%	Traditional	Mixed ¹ 2	12.5	29.5	(17.0)	9.9	2.4	7.5	22.5	31.9	(9.5)
D	133%	Utah Basic	Mixed ¹ 3	9.9	23.6	(13.7)	7.9	2.4	5.5	17.8	26.0	(8.2)

Sort Key ↓

Data in red boxes shown in graph above.

"State Share" refers to the state's share of optional expansion Medicaid service costs not reimbursed by the federal government.

Row C is the same as row B in Figure 2.

¹2017-23 state shares, by year: 3%, 4%, 5%, 10%, 10%, 10%, 10%