



The ACA Medicaid Expansion Option Considerations for Utah

A Utah Health Policy Project Report (*Discussion Draft*)

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SUMMARY

The Supreme Court upheld most of the Affordable Care Act last June. That means that starting in 2014 most Americans finally will have affordable options for health insurance coverage. What is less clear is whether low-income adults will enjoy that same access. That is because the Supreme Court left to the states the decision of whether to expand Medicaid to cover adults with incomes up to \$15,414 for single individuals or more for families (*see chart at right*). Utah leaders will be making that decision this fall as they prepare for the upcoming legislative session.

Federal Health Reform Medicaid Expansion WHO QUALIFIES IF UTAH EXPANDS MEDICAID		
Persons in family/household	Annual Income to Qualify (138% of poverty level)	Monthly Income
1	\$15,414	\$1,284
2	\$20,879	\$1,740
3	\$26,344	\$2,195
4	\$31,809	\$2,651
5	\$37,274	\$3,106
6	\$42,739	\$3,562
7	\$48,203	\$4,017
8	\$53,668	\$4,472

The federal government covers 100% of the cost of the expansion during the first 3 years of the program. For years 4 through 10, the Federal portion gradually phases down to 90%. Simply put, refusing the expansion means foregoing \$4.129 billion in federal funds.ⁱ The Medicaid expansion does come with some cost to the state, but the benefits greatly outweigh the nominal costs. For the first five years of the expansion Utah will be expected to pay around \$174 million.ⁱⁱ Though precise estimates are under development, we anticipate that the combined fiscal impact of the offsets, cost avoidance, participation rates and ramp up and other key variables more than pays for the costs of the expansion for the state (*for details see Appendix A*).

It is in our best interest to provide coverage to the more than 100,000 uninsured Utahns who stand to benefit from the expansion, regardless of whether Utah leaders might have devised ways to better use the federal funds,



Clarissa was born with medical conditions so severe that when they manifested at age 19 she qualified for Medicaid. *“Despite all the health challenges I have faced, I have always been determined to live a full life and become a productive member of my community,”* says Clarissa. Qualifying for Medicaid opened the doors she needed to be successful. Prescription coverage helped her afford her medications. She was supposed to be in a wheelchair by age 30. Thanks to physical therapy, Clarissa is still walking at age 32. Successfully managing her health allowed her to work part-time, go to school full-time and volunteer regularly. *“Without access to Medicaid, I never would have been able to go to school. Without my bachelor’s degree, I never would have been hired at my job, which has full health benefits.”*

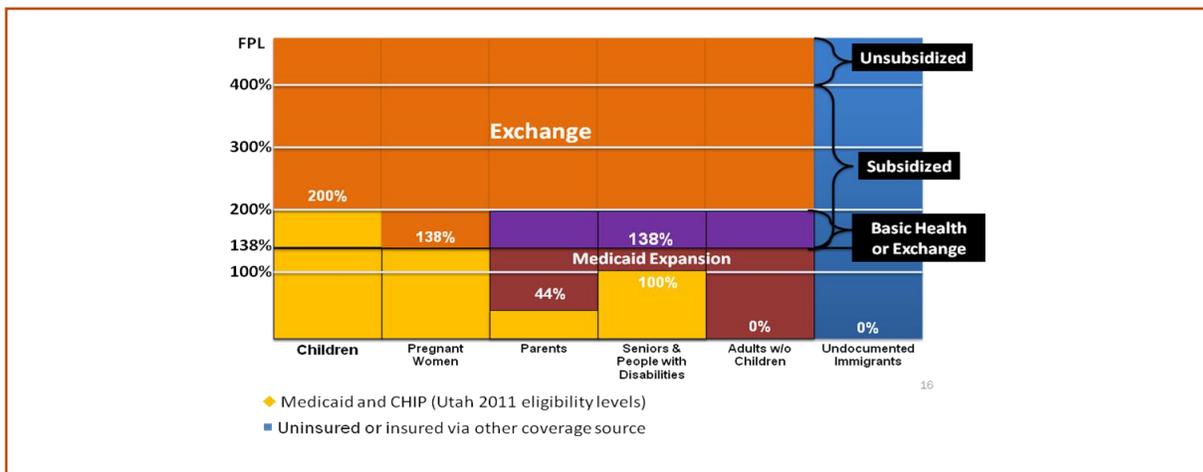
BACKGROUND: THE COVERAGE CANYON

Insurance coverage in Utah today is a patchwork of private coverage purchased by individuals or by employers, Medicare for seniors, and publicly funded care through Medicaid and CHIP for low income families and individuals, especially children. This fragmented system leaves an estimated 377,700 Utahns with no insurance.ⁱⁱⁱ If there are *any* private insurance options within reach for low wage earners, these are generally high deductible plans covering catastrophic events, with little or no coverage for preventive care. Preventive care should be a centerpiece of any reform policy that has cost savings in mind.

When the coverage provisions of the ACA kick in starting in 2014, more comprehensive and affordable coverage will be available through the private market along with premium subsidies to help middle income Utahns. However, the lowest income Utahns (under 100% of the Federal Poverty Line, or FPL) will not qualify for the subsidies, leaving them unable to afford private insurance on their own. Utah currently provides Medicaid or CHIP coverage to children in families with incomes up to 200% FPL, pregnant women up to 133% FPL, seniors and people with disabilities up to 100% FPL, and parents up to 44% FPL. Full Medicaid coverage is not provided to childless adults at any income levels, though some have access to the Primary Care Network (minimal coverage for primary care, discussed below). The graph below illustrates how Utahns will be covered under the ACA. Those who would receive coverage under the Medicaid expansion are shown in red. If the Medicaid expansion is not implemented in Utah, Utah will clearly have a coverage canyon. *Individuals who are most in need of assistance for their health care costs will be left with nothing.*

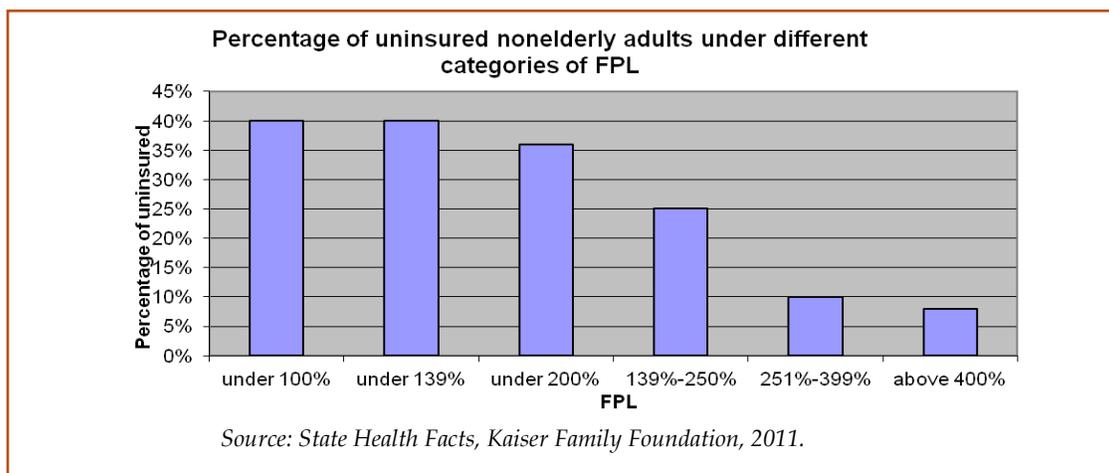
As fiscal analysts assemble more refined estimates and various stakeholders determine where they stand on the expansion, the following factors should be considered:

1. The population in question: affordability and coverage rates
2. Utah's experience helping the 0-138% FPL group: the Primary Care Network
3. Cost of the expansion
4. Health system impacts and cost avoidance
5. Impact of coverage on health status and mortality
6. Economic and budgetary impacts of Medicaid spending
7. Avoiding confounding of factors irrelevant to the Medicaid expansion



THE POPULATION IN QUESTION: AFFORDABILITY AND COVERAGE RATES

The percent of Utahns with no health insurance has been on the rise since 2008, the first year of the national recession.^{iv} Low income earners make up the vast majority of the uninsured, and this is because they have a difficult time finding affordable insurance options. In 2011, fully 64% of employees of firms paying low wages that offered health coverage did not buy into that coverage.^v The Medicaid expansion will significantly decrease the number of uninsured Utahns. The exact number of newly insured Utahns depends in part upon participation rates discussed below.



UTAH'S EXPERIENCE HELPING THE 0-138% FPL GROUP: THE PRIMARY CARE NETWORK

Utah's coverage solution for low-income adults is the Primary Care Network (PCN). The PCN provides a limited benefit package to working poor adults. The PCN may be a useful temporary solution for young, healthy people. Unfortunately, the PCN is not reliably funded and does not cover inpatient hospital care or specialty care. Medicaid offers much better and more appropriate insurance coverage for low income earners.

COSTING OUT THE MEDICAID EXPANSION

Citing huge costs, a number of [Governors are saying "no" to the expansion](#).^{vi} [Utah leaders are weighing their options](#) and wisely delaying their decision until after the November election.^{vii} This is enough time to calculate the true or net costs—along with the benefits (including cost avoidance) of the Medicaid expansion for Utah. So far Utah's policy conversation has been about the cost—not just the cost of the Medicaid expansion but also the cost of covering those who are currently eligible for Medicaid but not enrolled. These costs can add up quickly, especially if considered in isolation from the many variables that should be figured into a neutral cost estimate. Appendix A includes a descriptive list of key variables that should be considered in this process.

The cost of the expansion is essentially a function of (a) how many people enroll and (b) the cost of the care they will need. As mentioned earlier, the state's expenditure was estimated to be around \$174

million^{viii}, but this preliminary amount is being updated and reevaluated. Around 105,000 Utahns will be eligible for the Medicaid expansion, but not all will choose to participate.^{ix} Historically, the percentage of people eligible for Medicaid who actually enroll varies. Children and people with disabilities, for example, sign up at a higher rate than other populations.^x So it will be important to come up with an assumption that is not one-size-fits-all.

The health status of those who choose to sign up is another very important factor to consider. The costs the state are likely to incur as newly enrolled Utahns get care should be carefully projected based on the extensive data accumulated by states as they have brought new populations into the program. The state should resist the temptation to make broad assumptions about how sick the new Medicaid enrollees are likely to be when other states and private actuaries have experience data that will paint a more realistic picture.

It is further important to note that health care inflation varies geographically as well as from year to year. The state should develop an inflation assumption that reflects experience in Utah's healthcare marketplace rather than a national number. Those producing estimates must also resist projecting too far into the future as factors like inflation become difficult to estimate correctly.

HEALTH SYSTEM IMPACTS AND COST AVOIDANCE

Uninsured people are less likely to seek preventive care and other cost-effective forms of care. They are thus more likely to delay care until it is either too late or they must visit the emergency room, where treatment is guaranteed—and paid for by taxpayers—until the patient is stabilized. The Medicaid expansion means that critical components of the health care system on which *all* Utahns depend will get paid for care they currently provide for free or at sharply discounted rates. Bloomberg analysis projects that in the first 8 years (2013-2020), \$3.6 billion would go to Utah health care sectors, including:

- \$130 million to Medicaid Managed care plans;
- \$755 million to nursing homes;
- \$1.7 billion to hospitals; and
- \$821 million to home health providers.^{xi}

According to the Utah Department of Health, heart disease, influenza and pneumonia, and stroke are among the leading causes of poor health in Utah. Heart disease, cancer, and stroke accounted for more than half of the deaths in the state in 2008. The expansion would have a direct impact in reducing and managing these conditions.^{xii} The Institute of Medicine in 2009 summarized research on the positive impact that coverage has on health status. For people with any one of a range of medical conditions – from stroke to cancer to diabetes– the chances of a good outcome are considerably higher for people who have coverage.^{xiii} And good outcomes mean lower costs to the health care system and to society as a whole.

ECONOMIC IMPACTS OF MEDICAID SPENDING

The state dollar expenditures required to expand Medicaid will more than pay for themselves. According to the economic impact calculator developed by the University of Utah's Bureau of Economic and Business Research, the \$4.3 billion in total funding for the expansion over the first five years would generate more than...

- \$466 million in state tax revenues;
- \$3.3 billion in salaries and wages; and
- 120,000 jobs.^{xiv}

The cost of the expansion would be further offset by savings in the provision of mental health services and of medical services currently delivered in the criminal justice system. State and local tax dollars currently funding those services would be replaced with federal Medicaid dollars.

AVOIDING CONFOUNDING OF FACTORS IRRELEVANT TO THE MEDICAID EXPANSION

The ACA has a number of provisions and programs. The Medicaid expansion is just one of many. It is important to avoid muddling the analysis and decision on the Medicaid expansion with other separate and distinct ACA provisions. Many states analyses have inappropriately included the cost of covering people eligible for Medicaid before the expansion but not enrolled. Although it is correct to assume many of these approximately 40,000 people will enroll as the mandate and exchange are implemented, they would have enrolled regardless of the Medicaid expansion.^{xv} Jonathan Gruber, a renowned MIT economist, explained in a recent memo that the ethos of health reform and the individual mandate are attributable to the increase in the enrollment of currently eligible individuals, not the Medicaid expansion.^{xvi}

Another issue that has been inappropriately described as a state cost is the enhanced primary payment rate for providers under the ACA. The ACA mandates payment of Medicare rates for certain primary care Medicaid services. The federal government pays the full cost of this increase for 2014 and 2015, and if states wish to continue the program they can elect to do so with state revenue. This is not a mandatory program after 2015.

CONCLUSION

The decision to expand Medicaid should be based upon a careful assessment of the health care needs of Utahns, how they might be improved with the Medicaid expansion and whether Utah can find a better solution at less expense to the state. Any estimates related to the Medicaid expansion should endeavor to be neutral and include all relevant information. UHPP looks forward to working with the state and other advocates on the best path forward.

APPENDIX A: KEY VARIABLES FOR MEDICAID EXPANSION COST ESTIMATE

Variables	Definition	Short Explanation
Participation Rate	Of those who are Medicaid eligible how many (what %) actually enroll	One of the reasons why the Utah Department of Health’s cost estimate is so high is because it assumes a 90% participation rate. ^{xvii} The participation rate should reflect historical experience, while accounting for the minimal impact of the mandate. Utah’s Medicaid/CHIP participation rate is 66.2%, much lower than the national average of 81.8%. ^{xviii} However, it is important to note, single, childless adults are typically less likely than other beneficiaries to participate. ^{xix}
Crowd Out	The effect of people moving from the private insurance market to Medicaid	Some private insurance customers will become eligible for Medicaid after the expansion, but that number is expected to be relatively insignificant. State officials must be wary of the tendency for private insurers to overinflate “crowd-out.” Concerns about crowd out were raised about the Children’s Health Insurance Program when it was introduced in 1997. Since then, study after study has shown that public program expansions lead to substantial reductions in uninsurance without significant erosion of private coverage. ^{xx}
Health Status	The per enrollee cost of covering people newly enrolled in Medicaid as determined by health and prospective insurance usage	In calculating increased state Medicaid expenditures, health status is used to help predict the medical costs of the newly enrolled. Single childless adults, the new category to be covered under the expansion, are expected to have a similar health status to covered parents. Thus health status cost estimates should align accordingly. Using health status of people with disabilities or other risk categories is not appropriate. ^{xxi}
State Administration Cost	Cost associated with administering of the Medicaid program	The Medicaid expansion will incur state administration costs. These costs are usually around 3 to 8%. It is important that only expansion related administration costs are considered in the development of a cost estimate for the expansion—not other ACA administration costs. ^{xxii}
Previously Eligible, Not Enrolled	The number of people eligible for Medicaid under state rules previous to the Medicaid expansion requirement to cover single childless adults up to 138% Federal poverty level	Utah has a significant number of residents eligible for Medicaid, but for whichever reason, do not enroll. With the creation of and ACA mandated exchange many Utahns previously eligible for Medicaid will enroll. This will happen regardless of the Medicaid expansion.
Estimate Timeline	The amount of time a cost estimate covers	Cost estimates should be consistent in the use of a timeline. For example, estimates or statements must not confound aggregate 10 years totals with annual budgets.
Primary Care Provider Rates	The rates state pays primary care providers for Medicaid services	The ACA mandates that states pay Medicare rates for a number primary care services for Medicaid beneficiaries. The federal government covers the full cost for this additional amount for 2014 through 2015. States may elect to continue paying the Medicare rates for later years.
CHIP to Medicaid	The CHIP beneficiaries that will move from the state CHIP program to the state Medicaid program.	The Medicaid expansion will make some current CHIP beneficiaries eligible for Medicaid. The difference, however, is immaterial, as the same match rate would be used for children’s coverage.
Limited Benefit	Medicaid beneficiaries	With the Medicaid expansion, many currently limited

Medicaid Beneficiaries	currently covered by state Medicaid	benefit Medicaid beneficiaries will be eligible for Medicaid. These newly eligible/enrolled beneficiaries will be paid for by the Federal government as newly eligible, and garner the 100% match for 2014 – 2016, and phasing down to 90% for 2017 – 2023.
Uncompensated Care	Costs incurred at state and local level for hospital care of the uninsured.	State and local government stand to gain significant amounts of revenue for care that has historically gone uncompensated as many uninsured people get Medicaid coverage through the Medicaid expansion.
Uncompensated Mental Health and Substance Abuse Treatment Services	Costs incurred at state and local level for mental health and substance abuse treatment services of the uninsured.	State and local government stand to gain significant amounts of revenue for services that have historically gone uncompensated as many uninsured people living with mental illness or substance use disorders gain Medicaid coverage through the expansion.
Public Health Services	Preventive care provided in publicly funded clinics.	Many services provided by public health clinics are reimbursable through Medicaid. The Medicaid expansion will increase the number of reimbursable visits as the number of insured people increases.
Economic Impact Generates State Revenue	Impact Medicaid expansion will bring to state economy.	The Medicaid expansion brings \$4.3 billion into Utah's economy, supporting or creating jobs in the health care sector. These jobs stimulate significant economic activity that generates \$466 million in state tax revenue. ^{xxiii}
Job Creation	Health sector jobs and other job creation that will result from Medicaid expansion.	The Medicaid expansion presents the need for more health care workers and workers in related fields.
Other State Offsets	Budgetary savings the state generates by the Medicaid expansion.	State revenue will be saved within the criminal justice system, and within other state departments that will either be unneeded or reimbursable through Medicaid. Further, PCN participants will be eligible for Medicaid—eliminating that program.

ⁱ Kaiser Family Foundation's 2010 estimates show expansion related federal spending in Utah to be \$4.129 billion for 2014 - 2019. State spending was estimated to be around \$174 million for the same time period. Available at: <http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>.

ⁱⁱ Ibid.

ⁱⁱⁱ Office of Public Health Assessment, Utah Healthcare Access Survey; Utah Behavioral Risk Factor Surveillance System (BRFSS), 2009-2011, Utah Department of Health, August 9, 2012. Available online at http://health.utah.gov/oph/publications/2011brfss/Highlights_2011.pdf.

^{iv} Source: Utah Dept. of Health IBIS-PH BRFSS

^v *Medical Expenditure Panel Survey, Agency for Health Research and Quality, US Department of Health and Human Services, accessed 8/7/2012.*

^{vi} Elise Vieback, "Fifteen Governors Reject or Leaning Against Expanded Medicaid Program," *The Hill*, July 3, 2012.

Available online at <http://thehill.com/blogs/healthwatch/health-reform-implementation/236033-fifteen-governors-reject-or-leaning-against-expanded-medicaid-program>.

^{vii} Andrea Smardon, "Utah Lawmakers Undecided on Medicaid Expansion," KUER 90.1, July 10, 2012. Available online at <http://www.kuer.org/post/utah-lawmakers-undecided-medicaid-expansion>.

^{viii} See Endnote i.

^{ix} Genevieve M. Kenney, Lisa Dubay, Stephen Zuckerman, and Michael Huntress, *Opting out of the Medicaid Expansion*, The Urban Institute, July 5, 2012. Available online at: <http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf>.

^x *Guidance on Analyzing and Estimating the Cost of Expanding Medicaid*, Center for Budget and Policy Priorities, August 9, 2012.

^{xi} Matt Barry, Supreme Court Ruling May Undermine Increase in Medicaid Spending, Bloomberg Government, March, 2012.

- xii Utah Health Status Update: Leading Causes of Mortality and Morbidity in Utah, Utah Department of Health, October 2010. Available online at http://health.utah.gov/opha/publications/hsu/10Oct_LCMM.pdf
- xiii Institute of Medicine, *Coverage Matters: Insurance and HealthCare* (Washington, DC, October, 2001). Available online at <http://www.iom.edu/Reports/2001/Coverage-Matters-Insurance-and-Health-Care.aspx>.
- xiv Jan Crispin, Senior Economist, Bureau of Economic and Business Research, University of Utah, February 2009. Available online at http://www.healthpolicyproject.org/Publications_files/Medicaid/2010/FY2010Calculator.pdf. This calculator uses the standard 70% Federal Medical Assistance Percentage (FMAP) for Utah. The economic impact would actually be greater using the 90-100% FMAP rate that is tied to the Medicaid expansion.
- xv Genevieve M. Kenney, Lisa Dubay, Stephen Zuckerman, and Michael Huntress, *op. cit. Opting out of the Medicaid Expansion*, The Urban Institute, August 2012,
- xvi *Guidance*, CBPP, August 9, 2012.
- xvii Utah Department of Health, *Estimated Impact of ACA on Medicaid*, July 2012. Available online at: <http://www.healthpolicyproject.org/Medicaid%20Page/DOHExpansion.pdf>.
- xviii Genevieve M. Kennedy, Victoria Lynch, Allison Cook, and Samantha Phong, *Who and Where are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?* *Health Affairs*, 29, no. 10 (2010): 1920-1929. Available online at: <http://content.healthaffairs.org/content/29/10/1920.abstract>.
- xix Holahan, John, Genevieve Kenney and Jennifer Pelletier, "The Health Status of New Medicaid Enrollees Under Health Care Reform" The Urban Institute, August 2010.
- xx Lisa Dubay and Genevieve M. Kenney, "The Impact of CHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families," *Health Services Research* 44 (December 2009): 2040-2059. Available online at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2796313/>.
- xxi Stan Dom, *Considerations in Assessing State-Specific Fiscal Effects of the ACA's Medicaid Expansion*, Urban Institute, August 2012.
- xxii *Guidance*, CBPP.
- xxiii Jan Crispin-Little, *op. cit.*