kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

State Budgets under Federal Health Reform:
The Extent and Causes of Variations in Estimated Impacts

Executive Summary

Prepared by:

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The Urban Institute

February 2011

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kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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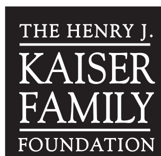

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Executive Summary

Under the Patient Protection and Affordable Care Act (ACA), states will play a large role in the implementation of the major provisions of federal health reform such as expanding Medicaid coverage, establishing state insurance Exchanges, regulating private insurance, and developing coordinated eligibility and enrollment systems and processes. States are concerned about the new costs that accompany their enhanced responsibilities, particularly as their revenues are only now beginning to recover from very troubled fiscal times. Reported fiscal impacts of the ACA on aggregate and individual state budgets have varied widely. Some estimates show high costs and others suggest that states will realize substantial net savings. This variation has contributed to the political controversy over states' role in the ACA, and high costs have also been cited in litigation. While all estimates show some new costs for states associated with the large expansion of Medicaid, the ACA also creates new savings and revenues for all states, along with opportunities for states to achieve further, often longer-term state savings.

Goals and Methods of this Report

This report seeks to answer three questions:

1. What is the range of estimates of the impact of the ACA on state budgets?

2. Why do estimated impacts of the ACA on states vary so widely across reported estimates?

3. What conclusions can we draw about the fiscal impact of the ACA on states based on this analysis?

Analysis for this report is based on a literature scan (including a Congressional Research Service report that reviewed prior state and national estimates); our own detailed review of projections made for five selected states (Florida, Indiana, Kansas, Maryland and Texas) along with five national estimates; and key-informant interviews in four jurisdictions (the District of Columbia, Kansas, Maryland and New York) that appear to be moving early to implement and respond to changes in the ACA to increase health reform's value for their states and decrease its budgetary costs. Based on this information, this report examines the estimates, discusses reasons for variation across states and across projections and highlights components of the ACA reported to affect state budgets in three categories: new costs, savings, and revenues. Finally, the report draws on the information reviewed to draw conclusions about the impact of the ACA on state budgets.

Brief Overview of Changes in Health Reform that Affect States

Medicaid. The ACA establishes a new minimum standard for Medicaid coverage that is uniform across the country. Specifically, the new law requires participating states by January 1, 2014, to extend Medicaid eligibility to nearly all individuals under age 65 with incomes up to and including 133 percent of the federal poverty level (FPL) (or 138 percent after applying a standard 5 percent "income disregard"). For most enrollees, the law calls for all states to measure income by a modified adjusted gross income test and to drop any use of asset tests. In most states this will mean providing Medicaid to adults without dependent children for the first time, as well as increasing the income eligibility level for parents. States are required to maintain current coverage levels for adults through 2014 and for children in Medicaid and CHIP through 2019.

The law specifies different federal match rates for individuals eligible for coverage as of December 1, 2009, (the regular Medicaid match rate), those made newly eligible for coverage under health reform and for certain expansion states. The regular Medicaid match rate is based on a statutory formula that relies on states' relative per capita income and ranges from a statutory floor of 50 percent to a high of 76 percent in 2010. For those newly eligible under reform, the federal government will pay 100 percent of the costs from 2014 to 2016; the federal contribution phases down to 90 percent by 2020 and remains that that level. For certain states that had expanded Medicaid coverage for adults prior to reform (Arizona, Delaware, Hawaii, Massachusetts, Maine, New York and Vermont), there is a transition match rate designed to phase-in an increase in their federal matching rate for childless adults beginning in 2014 so that by 2020 it will equal the enhanced 90 percent match rate available for newly eligible adults in all other states.

The ACA also includes a number of other changes in Medicaid to help improve care coordination for individuals dually eligible for Medicaid and Medicare or with chronic conditions, new options to expand community-based long-term care services and provisions to improve access (including an increase in physician fees for primary care to Medicare levels with federal financing for 2013 and 2014).

CHIP. The ACA also extends the Children's Health Insurance Program (CHIP), the federal-state program for low-income children with incomes too high to qualify for Medicaid. Funding is extended through 2015, two years longer than previously enacted. It also provides for higher federal matching rates for CHIP for 2016 through 2019 but does not yet appropriate funding for the program during those years.

Health Insurance Exchanges. Individuals without access to other coverage and with incomes between 133 and 400 percent of FPL can qualify for new federal subsidies to buy private coverage through an Exchange. States are required to set up a state-based Exchange, but if they fail to do so then the federal government will operate an Exchange for their citizens. The ACA requires that enrollment for Medicaid and CHIP be coordinated with new coverage options offered through these insurance purchasing Exchanges.

Other Changes. As discussed in this report, changes in the ACA will lead to other state opportunities for savings (such as reductions in payments for uncompensated care or state funded programs for indigent populations) and some increased revenues.

1. What are the estimates of the impact of the ACA on state budgets?

Summary Table 1 shows the overall findings of the five state reports that we reviewed in detail. The first row of the Table shows reported estimates of total net savings or costs aggregated across multiple years. The five state estimates were prepared by the state Medicaid agency in Florida, from commissioned actuarial analysis in Indiana, the Kansas Health Authority, the Maryland Health Care Coordinating Council and the Texas Medicaid agency. The state estimates range from a multi-year total cost of $27 billion in Texas to savings of $800 million in Maryland. Three states projected new costs (FL, IN and TX) and two projected new savings (KS and MD). As we will discuss, these estimates are not comparable, because their estimation methods are so different. The reported impacts of the ACA on states budgets are affected both by state circumstances—most notably the size of a state's uninsured and income-eligible population—and by projection methods.

To provide context for reviewing the state estimates, we reviewed five national estimates from: the Congressional Budget Office, the Centers for Medicare and Medicaid Services, John Holahan and Irene Headen from the Urban Institute, Stan Dorn and Matthew Buettgens and the Lewin Group. Two national estimates (CBO and H&H) that covered only the costs of expanded Medicaid coverage , show costs of about $20 billion countrywide. Three national estimates (CMS, D&B and Lewin) included offsetting savings and found net national savings of $33 to $107 billion.

SUMMARY TABLE 1. STATE BUDGETARY IMPACTS: PROJECTED COSTS OR SAVINGS

	----------STATE PROJECTIONS-----------					-----------ALL STATES TOTAL-----------				
	FL	**IN**	**KS**	**MD**	**TX**	**CBO**	**CMS**	**D&B**	**H&H**	**Lewin**
Reported multi-year tot. ($billion)	$5.7	$2.5	-$0.2	-$0.8	$27.0	$20.0	-$33.0	-$40.9	$21.1	-$106.8

Sources: See text of report.

Notes: Savings appear as negative values. CBO = Congressional Budget Office. CMS = Centers for Medicare and Medicaid Services. D&B = Dorn and Buettgens report. H&H = Holahan and Headen report. Lewin = Lewin Group report. Estimates vary based on state circumstances, projection methods, years included in the estimates, and the elements of costs, savings, and revenues included.

2. Why do estimated impacts of the ACA on states vary so widely?

There are a number of reasons why the estimates of the ACA on states varies so widely. Expanding Medicaid naturally costs more in states where there are more uninsured residents with Medicaid income levels, and the magnitude of the estimates tend to be larger in high-population states. Moreover, the estimates use different methodologies in projecting costs of new enrollment and in including or omitting other costs, savings, or revenues.

Prior Circumstances of States

The ACA will expand Medicaid enrollment and hence both state and federal costs (box above). One of the primary factors affecting the extent of states' increases is affected by the size of states' "uninsured gap" that the ACA asks them to close--that is, their under-65 year old population that is uninsured and income eligible. The gap is 7.7 percent of this population nationally but varies widely by state because of differences in incomes and extent of insurance coverage. In Texas, the gap is 11.4 percent, but in Maryland it is only 5.4 percent. Therefore Texas has twice the share of population likely eligible for Medicaid under the ACA as Maryland does (Summary Table 2). It also matters to what extent the gap consists of people previously eligible for Medicaid who remained uninsured because such people do not receive the higher match rate applied to those who are newly eligible under the ACA.

How States Choose to Make Projections

Time periods covered in the estimates. Covering more or later years increases the size of estimated impact. Years before 2014 are least expensive because the new requirements to expand coverage do not go into effect until 2014. Years starting in 2020 are more expensive because the federal share for newly eligible enrollees declines to 90 percent in that year, down from 100 percent in 2014 through 2016. Texas covers 10 years, 4 of them on or after 2020; Maryland also covers 10 years, but only one of them a later year (2011 through 2020). The national estimate from CBO covers 6 years ending in 2019 (because it made a standard 10 year projection from time of issue and could benchmark only against its model of Medicaid baseline spending that ended with 2019).

Elements included in the estimates. Another clear difference across estimates is the extent to which they account for new costs as against offsetting savings or new revenues. As Summary Table 2 shows, the three states that project high total costs include more cost elements than savings or revenue offsets, whereas the two states that project savings include relatively more offsets. How each element is estimated also matters. In particular, as is discussed more in the following subsection, assumptions about participation rates and the cost per enrollee have significant implications for the cost of expanding enrollment, which is the largest single element of cost.

SUMMARY TABLE 2. FACTORS THAT AFFECT PROJECTED IMPACTS

	----------STATE PROJECTIONS-----------				
	FL	**IN**	**KS**	**MD**	**TX**
Reported multi-year total ($billion)	$5.7	$2.5	-$0.2	-$0.8	$27.0
Gap to be filled by expansion*					
Share of <65 pop'n that is ≤ 138% of FPL	26.1%	26.9%	24.1%	19.3%	29.3%
Share of ≤ 138% that is uninsured	40.3%	27.7%	30.4%	28.0%	38.9%
Share of of <65 pop'n both ≤ 138% and uninsured	10.5%	7.4%	7.3%	5.4%	11.4%
Projection Methods					
*Years Included ** *					
# of Years	6	7	10	10	10
Range of Years	2014-19	2014-20	2014-23	2011-20	2014-23
*Number of elements included ** *					
# Cost Elements Included	3	6	4	7	6
# Saving Elements Incl.	1	3	2	5	1
# Revenue Elements Incl.	0	0	0	2	0

***Sources:* *** Authors' calculations from CPS data, see text at Table 2; ** state reports discussed and cited in text of full report.

Notes : See summary table 1. The specific elements included are detailed in the following table.

Specific Elements of Cost, Savings, and Revenues Included in the Estimates

Different state reports include more or fewer elements that affect overall impacts, as just noted. Summary Table 3 lists all substantial elements as determined by our review of the five state reports as well as other materials. All states project the main cost of reform, which is paying for new enrollees, but no other element is so uniformly included. Each listed element is explained in turn, next.

SUMMARY TABLE 3. DETAILED LISTING OF ELEMENTS

New Costs	**FL**	**IN**	**KS**	**MD**	**TX**
Expansion of Medicaid Enrollment	**x**	**x**	**x**	**x**	**x**
Administrative Costs for Medicaid		**x**	**x**	**x**	**x**
assumed percentage of medical costs		3.75-6%	6%	5%	8%
Administrative Costs for State Exchanges		**x**	**x**	**x**	
Higher Physician Fees	**x**	**x**			**x**
Reduction in federal DSH Payments				**x**	
State Employees Benefit Plans Costs				**x**	
Medicaid to cover foster children to 26		**x**			**x**
Transfer CHIP to Medicaid <133%	**x**			**x**	**x**
Lost Pharmaceutical Rebate: FFS			**x**	**x**	**x**
Change of Eligibility Criteria for 209(b) States		**x**			
New Savings	**FL**	**IN**	**KS**	**MD**	**TX**
Savings on Uncompensated Care					
Medicaid Savings					
Shift of Pregnant Women / Adults > 133 % FPL		**x**			
Add'l Federal Match for Current Medicaid					
Breast & Cervical Cancer Prog.		**x**		**x**	
Benefits redesign for newly eligible					
Reduced State Match for DSH			**x**		
New Pharmaceutical Rebate: MCOs				**x**	
Reductions in State Funded Programs					
Pre-existing state coverage					
Direct state support for services				**x**	
State High Risk Pools				**x**	
Higher federal CHIP Match after 2016	**x**	**x**	**x**	**x**	**x**
Efficiencies in Care Delivery or Payment Methods					
Obtain Federal Grants or Similar Funding					
New Revenues	**FL**	**IN**	**KS**	**MD**	**TX**
Increased Collection of Insur. Prem. Tax				**x**	
Increased Collection of Provider Taxes				**x**	
Potential Revenues from Basic Health option					

Sources: State reports and other materials discussed and cited in the full text of this report.
Note: More detail appears in the text and accompanying notes.

New Costs

Increased enrollment in Medicaid. For most states, the ACA-established a national floor for Medicaid eligibility of 138 percent of FPL, which will mean an increase in income eligibility levels for parents and especially for adults without dependent children who have been historically barred from Medicaid. The ACA also calls for improved eligibility and enrollment processes that coordinate with the new insurance Exchanges to enroll Medicaid-eligible people who seek coverage there. The cost of this increase in Medicaid enrollment is affected by the uninsured gap (discussed above) as well as assumptions about participation rates and cost per enrollee.

The largest increases in enrollment are to be expected in states where Medicaid eligibility and enrollment are now lowest. Conversely, increases should be lowest where coverage is now high, notably in the small number of states that had already used waivers to extend coverage to childless adults. The federal government will pay 100 percent of the costs of those newly eligible from 2014 through 2016 and then the federal contribution will phase down to 90 percent by 2020. States will receive the regular Medicaid match rate for individuals currently eligible but newly enrolled. Despite significant new federal funding for the expansion, most estimates show new enrollment as the largest new costs for states under the ACA.

Some states explicitly assume very high levels of participation in Medicaid and CHIP relative to the national studies like that of CBO. While the goal of health reform is to reduce the number of uninsured, there is no evidence to support assumptions that all or nearly all eligible people will enroll. Some individuals will not enroll and some will elect to participate in employer-based coverage, especially with the ACA-mandated improvements in comprehensiveness of coverage and inducements for expansions of employer offer rates. It appears that the estimates also differ significantly on assumptions about cost per enrollee, although insufficient information is presented to assess these differences.

New Medicaid administrative costs. A number of states show administrative costs for new Medicaid enrollment as the second largest new cost they face, although typically much lower than new costs for coverage. Administration is often projected as a flat 5 to 8 percent of all new spending on benefits or managed care organization (MCO) premiums. Another Medicaid administrative cost is related to creating new systems to simplify and coordinate eligibility and enrollment for Medicaid and the Exchanges. Many states have expressed concern about these costs, but they were not explicitly included in any of the state estimates we reviewed. States may receive some help in paying for these new systems due to a federal regulation proposed by CMS in November 2010 that could pay a 90 percent match rate for new eligibility and enrollment systems.

Increases for Medicaid physician fees. Four states in this study include Medicaid physician fee increases as a cost of the ACA. In 2008, Medicaid physician fees averaged 72 percent of Medicare fees for all physicians and 66 percent for primary care physician services. In an effort to promote provider participation and access, the ACA calls for Medicaid programs to pay physician fees for certain primary care services during calendar years 2013-2014 at least at Medicare levels, with any increase over prevailing fees to be 100 percent federally funded. While there is no requirement to maintain this fee increase after 2014, some states anticipate that it may be difficult to return to prior low levels. The expected costs would be applicable only to fees for services for those currently eligible for Medicaid. For those newly eligible for Medicaid, the costs would be borne largely at least initially by the federal government under the 100 percent federal match rate for 2014 to 2016.

Administrative costs for the state Exchanges. Setting up and running the insurance Exchanges for people not eligible for Medicaid will also require state spending. These costs are expected to be smaller than those of administering Medicaid, and federal grants are available to offset some of the start-up costs. Some of the ongoing costs of coordinating Medicaid and Exchange intake and enrollment also qualify for federal Medicaid matching funds.

Transfer of some children from CHIP to Medicaid. States that currently cover children between 100 and 133 percent of FPL under CHIP will be required to transition this coverage to Medicaid, where the federal match rate is lower, by January 1, 2014. State estimates suggested that this is a small element of new costs. Moreover, since CHIP funds can be used for Medicaid expansions, it is possible that states will be able to continue to secure the higher CHIP enhanced matching rate for the cost of covering these children even after they move to Medicaid.

Loss in Rebates for Prescription Drugs. Some states anticipated a loss in their pharmaceutical rebate collections, which they now obtain for Medicaid prescriptions paid on a fee-for-service basis, because of the ACA's increase in rebates due to the federal treasury. However, CMS issued ACA-implementing guidance in September 2010, after the state estimates were made, that clarifies that the federal government will not obtain rebate revenues at the expense of states. Indiana subsequently revised its cost estimate downward, but other states did not make similar revisions.

Other new costs. Some states estimated costs associated with other ACA provisions: State employees' coverage could become more costly because states, like other employers, must improve benefits. Foster children up to age 26 will be added to Medicaid programs. Federal support for Medicaid DSH payments will be cut. Indiana projects a higher cost related to linking eligibility for the aged, blind and disabled to receipt of Supplemental Security Income (SSI) instead of using more restrictive eligibility standards ("section 209(b)" eligibility, now used in some 11 states).

New Savings

Reductions in state support for uncompensated care. ACA-driven increases in coverage will reduce uncompensated care, especially for public hospitals and clinics, along with private safety net institutions. States could share in the associated savings by making changes in the various ways that they support localities and safety net institutions. No state report estimates savings of this type, perhaps in part because of the complexity of funding flows, although two of our five recognize that they will occur. Given that states did not make such estimates, we have to rely upon national studies and our prior knowledge of state arrangements for subsidizing local care outside of Medicaid. This is a very large offset, however it is estimated. The national estimates from the Lewin Group and from Dorn and Buettgens projected very large savings of this type, up to $100 billion over ten years, enough to generate overall net savings to states under the ACA, although savings will vary by state.

Medicaid savings. A number of states may be able to transition some higher-income individuals from Medicaid to coverage in the Exchanges. A number of states provide coverage for pregnant women and other adults with incomes above 133 percent FPL. In the Exchange, people with near-Medicaid incomes will receive heavy federal subsidies at no cost to the state, allowing states to save the state share of Medicaid that they currently pay for these populations. As of December 2010, all but 6 states had eligibility levels for pregnant women above 133 percent of FPL. With broader coverage, many more women will have insurance at the time that they become pregnant, through employers or the Exchange, and so will not need public coverage. About one-third of states currently have some type of Medicaid coverage for non-pregnant, childless adults above 133 percent of poverty. States that have waivers to cover childless adults through Medicaid may be able to recoup a higher federal match for this coverage. There are seven of these expansion states that will receive the "expansion state match rate" that scales up to 90% by 2019 from the current Medicaid match rate for childless adults. There are also a number of states with Medicaid waivers for adults that may be able to count these individuals as "new eligibles" and claim the higher federal match. The designation depends on how comprehensive the waiver program is; individuals covered in the Indiana and Wisconsin waivers, for example, may be in this category.

Within Medicaid, states may be able to eliminate some breast and cervical cancer programs or medically-needy programs as broader coverage may eliminate the need for this targeted coverage. Under the ACA, states will be able to recoup rebates for prescription drugs included in capitated managed care plans like the rebates available in fee-for-service. States currently receive these rebates for drugs in fee-for-service or for drugs "carved-out" of the managed care capitation. Maryland estimates this new rebate will constitute about 10 percent of total new savings.

States may also be able to achieve savings by redesigning Medicaid benefits for some new eligibles. For example, Kansas expects that individuals currently covered under home and community based services waivers who are receiving a limited set of services will be eligible for full Medicaid coverage in 2014 under the Medicaid expansion. Using benefit design flexibility provided under the Deficit Reduction Act of 1995, Kansas anticipates that they can provide a more generous benefit package to this group of new eligibles and still draw down the "newly eligible" match rates. This could achieve savings relative to what the state was already paying for these individuals under the current program, although these savings were not formally estimated.

Reductions in other state funded programs. A few states have run substantial state-funded coverage programs for people ineligible for Medicaid, which will become less necessary with new coverage options. States can shift such enrollees into Medicaid starting immediately, as the District of Columbia and Connecticut have done and draw down federal funds at the states' regular Medicaid match rate instead of using all state funds. (Minnesota has passed legislation and submitted a state plan amendment to shift state-funded coverage to Medicaid). The expansion of coverage and benefits under the ACA will very likely mean that people will seek much less care from existing state and local programs, such as those now funded through public health or mental health departments. States that operate high-risk pools should also see reduced demands and therefore savings in these programs.

New federal funds for CHIP. Under the ACA, the federal match rate for CHIP is slated to rise starting in 2016. The state reports assume that CHIP will be extended with adequate funding to support the increased match rate and so estimated associated savings.

Additional state savings. Some states and researchers have also pointed to many opportunities to promote efficiency or enhance value through initiatives in care management, coordination, and payment methods. Significant benefits from some of these opportunities tend to be achievable over a longer time frame and are often difficult to predict. For example, the ACA provides a new health home initiative to better coordinate care for individuals with chronic conditions with 90 percent match rate for these services. The ACA also allows states to integrate care for "dual eligibles," people jointly enrolled in Medicaid and Medicare, and thereby improve value or efficiency. Many approaches exist for "bending the curve" of future cost growth, but they go beyond the scope of this paper and are not reflected in the budgetary estimates reviewed here. Many different opportunities exist to obtain federal funding such as grants, incentive payments, or demonstration support. In the short run, the funding obtained will be small, and no projections include such offsets.

New Revenues

Revenue from state taxes on insurance premiums. Such revenues will be higher because the extent of insurance coverage will rise under the ACA. Maryland's revenue estimate found that this would generate over two-thirds of the net savings that the state projected.

Increased revenue from taxes on medical providers. Where states have imposed taxes on providers, modest increases in revenue can be expected as provider revenues increase with new coverage.

3. What conclusions can we draw about the fiscal impact of the ACA on states based on this analysis?

This analysis shows that while the ACA imposes a number of new costs on states, states can also expect offsetting savings and new revenues as health reform is implemented. Whether the states identify these new savings and revenues and whether and how they account for them affects the projected fiscal impact. Thus, there are large variations in the estimates of the effect of ACA on state budgets. These differentials are a result of state circumstances, the time period of the estimate, the estimating methodology and the specific components included in the estimate. They seem also to reflect how states intend to implement the ACA.

A state's uninsured gap also affects the number of new enrollees. Including more or later years in the estimates, higher rates of participation and higher costs per enrollee all add additional costs to the estimate. Including only new costs associated with ACA without accounting for opportunities for savings or new revenues also increases the overall estimates of the net effect. This review shows that some states base their estimates of enrollment expense on very high participation rates, and no state included savings related to reduced payments for uncompensated care costs. Significant savings for uncompensated care are likely to be realized in all state economies as the number of uninsured declines; however, how these savings will be distributed across state and local governments as well as providers is not clear.

Beyond projections, the actual impact of the ACA on individual states will vary depending on how states choose to implement the new law. Income eligibility is fixed, but achieving the assumed high participation rates in the Medicaid expansion will require outreach as well as simple and effective enrollment processes. Paying higher physician fees may be projected and intended, but often in the past has not occurred. Similarly, achieving savings related to reductions in uncompensated care costs or other state funded programs will require state actions to change budgets, programs, and administration. States may also obtain new federal grants and achieve savings with new opportunities to coordinate care or test new payment and delivery systems. Some of these changes may require initial investments but yield savings only over a relatively long time period. Making many changes can be difficult because of states' balanced budget requirements, especially in states with limitations on raising revenue; and implementation can be administratively demanding.

Despite the challenges that lie ahead in implementing health reform, there are many opportunities and new options for states to offset the costs of Medicaid coverage expansions. There is some consensus that the largest new costs for states will be related to the Medicaid coverage expansion and the most significant source of savings to offset these costs will be related to reductions in necessary payments for uncompensated care. National estimates also show that aggregate savings related to reductions in uncompensated care outweigh national estimates of new state costs under the ACA, although the level and ability of states to realize these savings will vary. States that achieve higher participation in Medicaid should see larger decreases in the uninsured and commensurately greater opportunities for savings related to uncompensated care. Finally, while enrollment expansion is merely a cost in terms of budget impacts, in the lives of new enrollees, expansion of coverage adds major value, as it also does for the providers who serve them; such value is not reflected in an assessment like this one.

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