



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending

Staff Working Paper #12

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About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

Executive Summary

The Affordable Care Act of 2010 (ACA, or the Act) requires most Americans to have health insurance.¹ To assure access to affordable coverage, the Act expands the Medicaid program to cover all adults living below 133 percent of the federal poverty level (FPL), including non-aged childless adults who generally are not eligible for the current Medicaid program. The Act also provides a new premium subsidy program for people living below 400 percent of the FPL (\$88,000 for a family of four).

In this study, we focus on the impact of health reform on state spending for Medicaid and the Children's Health Insurance Program (CHIP). This includes the impact of several key provisions of the Act including:

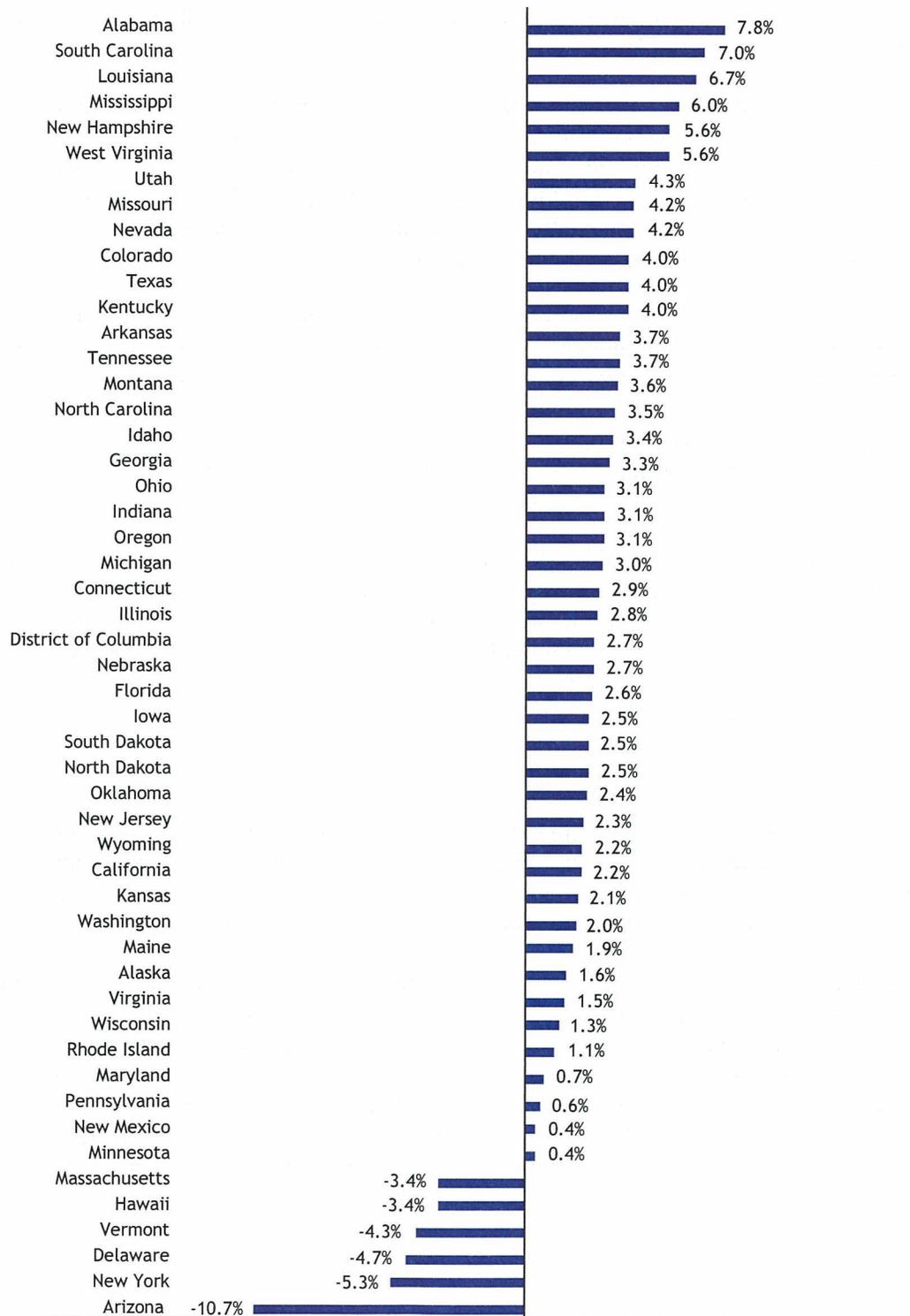
- The cost of covering newly-eligible adults;
- Increases in enrollment among currently eligible people;
- Enrollment reductions due to increased employer coverage under the Act;
- New prescription drug rebates for Medicaid Managed Care Organization (MCO) plans;
- Other increases in rebates;
- The increase in federal matching funds for states that already cover adults to at least 100 percent of the FPL (the federal matching percentage is increased to 90 percent for childless adults in these states by 2020); and
- Reductions in federal disproportionate share hospital (DSH) payments of \$14.1 billion nationally over the 2014 through 2019 period.

We estimate that the number of people enrolled in Medicaid or CHIP will increase by 17.4 million people by 2019 under the ACA. The Act will increase Medicaid spending by \$421.3 billion over the 2014 through 2019 period, of which states would pay \$17.4 billion (i.e., 4.1 percent of total new spending). For states, this is an average increase in spending of 1.1 percent over this period. However, the impact will vary across states, ranging from a spending increase of 7.8 percent in Alabama to an actual reduction in state spending of 10.7 percent in Arizona (*Figure ES-1*).

We estimate that state Medicaid spending would be reduced under the Act in Arizona, Delaware, Hawaii, New York, Massachusetts, and Vermont. All of these states see little new enrollment because they already cover most childless adults living below 133 percent of the FPL. These states also benefit from an increase in the federal match under the Act for the childless adults they already cover (reaching 90 percent by 2020, the same percentage that states that do not currently cover this group will receive for this expansion population in 2020). By contrast, states that currently have only limited coverage for adults - such as Alabama and Mississippi - will tend to see the largest percentage increases in state government spending.

¹ The bill exempts certain individuals from the requirement to have insurance including undocumented immigrants, people who do not have enough income to be able to file taxes, and people who would find that the cost of insurance exceeds 8 percent of income.

Figure ES-1
 Percent Change in State Medicaid Spending for 2014 through 2019 by State



States with large Medicaid managed care programs will also benefit substantially from the new rebates required for prescription drugs provided in managed care organizations. These include states with substantial enrollment in managed care plans such as Arizona, Pennsylvania, and California. This is especially true for Arizona, which currently enrolls all of their covered population in managed care plans.

This analysis covers only the Medicaid impacts of health reform and does not provide state level analyses of other elements of the Act that will have significant impacts on state and local government costs under the bill. For example, as employers, state and local governments that do not cover all of their full-time employees are required to pay a significant new penalty. Significant changes in employer coverage and spending will affect state tax revenues, in addition to having direct effects on the health system.

The Act will have a major impact on uncompensated care and safety net programs. Uncompensated care could be reduced by up to two-thirds as 30 million or more people become insured nationwide. Public hospitals and clinics would see increased revenues from newly insured patients that will now be covered by Medicaid or privately insured patients. Payer mix will change significantly for all types of providers now serving the uninsured. Expected increases in health services utilization for newly insured people also raise questions about the adequacy of physician supply in many areas.

All estimates of the impact of health reform are dependent upon key assumptions concerning the strength of the economy and the ways in which employers, consumers, insurers, and providers respond to elements of the Act. For example, in this analysis we relied upon economic projections developed by the Congressional Budget Office (CBO) at the national level. However, the recession and the recovery will be very different across states, with different cost implications for state governments.

The Lewin Group data and models of the health care system provide impact analyses at both the state and county levels. We have used the model to develop estimates of changes in coverage and spending for several state governments. We are also using these data to evaluate the impact of the ACA on individual counties and metropolitan areas. In particular, the models can be used to estimate the effects of reform under various assumptions and alternative economic scenarios that are specific to individual state health systems and economies.

In addition to these services, the models can be used to evaluate options for reducing the cost of state Medicaid and CHIP programs within the maintenance of effort requirements of the Act. For example, states have the option of using alternative “benchmark” benefits packages rather than the Medicaid benefit. Also, states that now have adult income eligibility levels above 133 percent of the FPL have the option of reducing eligibility to 133 percent of the FPL. We have also assisted several states in identifying ways of minimizing costs and maximizing federal matching funds. Any or all of these alternatives could impact the findings presented in this paper.

Introduction

The Affordable Care Act of 2010 (ACA) requires most Americans to have health insurance.² To assure access to affordable coverage, the Act expands the Medicaid program to cover all adults living below 133 percent of the federal poverty level (FPL), including both parents and non-aged childless adults. The Act also provides a new premium subsidy program for people living below 400 percent of the FPL (\$88,000 for a family of four).

In this study, we focus on the impact of health reform on state spending for Medicaid and the Children's Health Insurance Program (CHIP). This primarily includes the cost of covering newly-eligible adults and increases in enrollment among currently eligible people. It also includes changes in prescription drug rebates under the Act and increases in federal matching funds for state that already cover childless adults. States will also see a reduction in federal disproportionate share hospital (DSH) payments under the Act as the number of uninsured is reduced.

Our analysis differs from prior state-level estimates of Medicaid impacts in that we look at more than just the cost of expanded eligibility under the program. We include estimates of the effects of the drug rebate provisions and the reductions in DSH payments under the Act. We also present estimates that reflect changes in access to employer coverage under the Act and the impact this will have on Medicaid and CHIP enrollment. We do not, however, include the effects of the temporary increase in reimbursement rates for primary care providers required under the bill. This should have little impact on state spending because the federal government will pay the full cost of these payment increases.³

We present our analysis in the following sections:

- Current Medicaid and CHIP eligibility;
- Changes in Medicaid and CHIP eligibility under the Act;
- Changes in Medicaid and CHIP spending under health reform;
- Net impact of reform on state Medicaid spending; and
- Understanding health reform at the state level.

A. Current Medicaid and CHIP Eligibility

Eligibility for the existing Medicaid and the Children's Health Insurance Program (CHIP) varies substantially across states. Under current law, children are typically eligible for either Medicaid

² The ACA exempts certain individuals from the requirement to have insurance including undocumented immigrants, people who do not have enough income to be able to file taxes, and people who would find that the cost of insurance exceeds 8 percent of income.

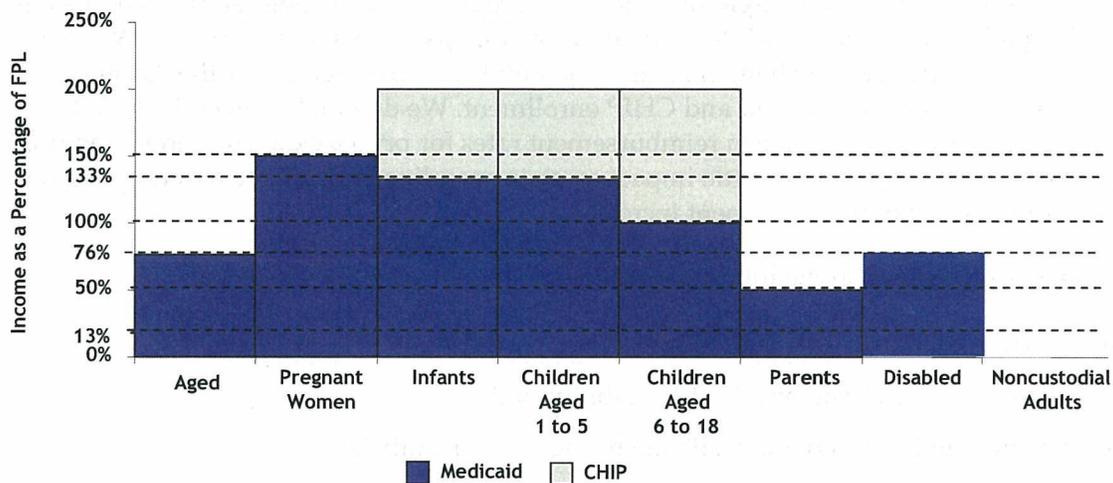
³ The Act requires states to increase provider reimbursement rates for primary care providers to 100 percent of Medicare payment levels for similar services for 2013 and 2014, after which, states are permitted to return to lower payment rates for these services. The federal government will pay the full amount of the cost for increasing these payment rates.

or the CHIP programs if their family income is less than 200 percent of the FPL, although many states have raised the eligibility level to 300 percent or more of the FPL. Pregnant women are typically eligible through 150 percent of the FPL.

Custodial parents are typically eligible for Medicaid if their income is below an average of about 50 percent of the FPL, although this varies widely by state. For example, the income eligibility level for parents varies from 17 percent of the FPL in Arkansas to 206 percent of the FPL in Maine. Also, in all but seven states, non-disabled adults without custodial responsibilities for children (i.e., childless adults) are not eligible at *any* level of income (*Figure 1*).⁴

The federal government currently matches state spending for Medicaid and CHIP according to a Federal Medical Assistance Percentage (FMAP). Federal matching rates vary across states based upon differences in state per capita personal income levels and other factors. Although the federal contribution varies by state, the federal government currently pays for about 57 percent of the Medicaid program and about 71 percent of the CHIP program.

Figure 1: Medicaid and CHIP Eligibility for a “Typical State” Under Current Law^{a/}



a/ Figures are roughly based upon average income eligibility levels across states by eligibility group. Source: Program data from the Centers for Medicare and Medicaid Services.

In *Figure 2* we present state-level projections of enrollment and spending under the existing Medicaid and CHIP programs without health reform for each state over the 2014 through 2019 period.⁵ These are the first six years that eligibility expansions under the health reform legislation will apply. These estimates are based upon enrollment and expenditure data for Medicaid and CHIP for 2008 and 2009, which we projected through 2019 based upon

⁴ Childless adults are defined to include people age 19 to 64 who are not qualified as disabled and who do not have custodial responsibilities for children.
⁵ The March 2010 CBO projections of enrollment and spending without the ACA reflect that without the ACA, federal funding for CHIP is authorized through 2013 only.

enrollment and spending trends assumed by the Congressional Budget Office (CBO) in their March 2010 baseline budget assumptions.

The CBO develops a baseline projection of average monthly enrollment and spending which includes enrollment and spending projections for Medicaid and CHIP for the next ten years. In their March 2010 baseline projections, CBO projects that average monthly enrollment in Medicaid and CHIP would reach 63.6 million people in 2010 (57.6 million Medicaid and 6.0 million CHIP). CBO projects that without the ACA, enrollment would have declined to 60.2 million people by 2014 based on their assumption that the economy will improve after 2010, thus reducing enrollment. After 2014, the CBO assumes a return to historical growth rates, with steady enrollment growth through 2019, when enrollment will reach 62.4 million people.

We need to adjust these figures to limit our analysis to only those qualifying for full coverage under Medicaid. The CBO estimates include all people receiving benefits under Medicaid and CHIP including those with only partial coverage, such as people receiving family planning services only and Medicare recipients for whom Medicaid pays only the Medicare Part B premium. When we exclude those with only partial coverage, we estimate total enrollment in Medicaid and CHIP would have reached 54.7 million in 2019 without health reform.⁶ Based on CBO projections, total spending without health reform would be about \$3.6 trillion over the 2014 through 2019 period. The state share of spending over this period would be \$1.5 trillion with the federal government paying \$2.0 trillion.

⁶ Our enrollment estimates are based upon enrollment for December 2009 as compiled by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. The Kaiser numbers have been standardized to comparable definitions of enrollment, which excludes people receiving partial benefits, such as family planning or Medicare Part B payments only. We did not use enrollment data for 2010 because the programs are expected to reach a peak level of enrollment during 2010 due to the recession and will start to fall in 2011. Our judgment was that the 2009 data are more indicative of enrollment in the years of recovery following 2010.

Figure 2: Projections of Enrollment and State and Federal Spending for Medicaid and CHIP by State Without Health Reform: 2014-2019

	Medicaid/CHIP Enrollment in 2019 Without Reform (thousands) ^{a/}	Expenditures for Medicaid/CHIP Without Reform: 2014-2019 (millions) ^{b/}		Total Expenditures Without Reform (millions)	Federal Matching Percentage (FMAP) ^{c/}	
		State Share	Federal Share		Medicaid	CHIP
Alabama	839.2	\$13,408	\$28,793	\$42,201	68.01%	77.98%
Alaska	105.8	\$4,494	\$4,799	\$9,293	51.43%	65.00%
Arizona	1,323.9	\$26,617	\$51,407	\$78,024	65.75%	76.10%
Arkansas	597.1	\$9,489	\$25,614	\$35,103	72.78%	79.96%
California	7,985.3	\$207,062	\$210,938	\$418,000	50.00%	65.00%
Colorado	563.1	\$16,747	\$16,997	\$33,744	50.00%	65.00%
Connecticut	497.6	\$23,176	\$23,241	\$46,418	50.00%	65.00%
Delaware	191.0	\$5,635	\$5,716	\$11,350	50.21%	67.21%
District of Columbia	157.9	\$4,433	\$10,368	\$14,800	70.00%	79.00%
Florida	2,990.8	\$68,890	\$84,918	\$153,808	54.98%	68.82%
Georgia	1,651.9	\$27,096	\$51,149	\$78,245	65.10%	75.73%
Hawaii	253.0	\$5,721	\$6,825	\$12,545	54.24%	66.25%
Idaho	225.5	\$3,893	\$8,914	\$12,808	69.40%	78.20%
Illinois	2,537.9	\$61,023	\$62,330	\$123,353	50.17%	65.14%
Indiana	1,047.7	\$21,735	\$42,343	\$64,078	65.93%	76.56%
Iowa	443.3	\$10,814	\$18,963	\$29,777	63.51%	73.84%
Kansas	314.8	\$9,419	\$14,476	\$23,896	60.38%	71.34%
Kentucky	848.5	\$14,501	\$35,670	\$50,171	70.96%	80.04%
Louisiana	1,059.2	\$20,640	\$43,361	\$64,001	67.61%	74.53%
Maine	296.6	\$8,162	\$15,233	\$23,394	64.99%	74.66%
Maryland	815.4	\$30,190	\$30,664	\$60,853	50.00%	65.00%
Massachusetts	1,263.4	\$57,000	\$57,790	\$114,790	50.00%	65.00%
Michigan	1,954.9	\$37,662	\$65,214	\$102,876	63.19%	76.05%
Minnesota	742.1	\$35,923	\$36,139	\$72,062	50.00%	65.00%
Mississippi	673.8	\$9,859	\$30,971	\$40,830	75.67%	82.31%
Missouri	904.0	\$25,901	\$47,277	\$73,178	64.51%	74.30%
Montana	112.5	\$2,677	\$5,599	\$8,276	67.42%	76.77%
Nebraska	226.6	\$6,567	\$10,170	\$16,736	60.56%	70.91%
Nevada	267.7	\$6,880	\$7,015	\$13,895	50.16%	66.13%
New Hampshire	141.6	\$6,434	\$6,460	\$12,894	50.00%	65.00%
New Jersey	967.7	\$50,470	\$51,450	\$101,921	50.00%	65.00%
New Mexico	484.9	\$9,329	\$23,496	\$32,825	71.35%	78.85%

Figure 2: Projections of Enrollment and State and Federal Spending for Medicaid and CHIP by State Without Health Reform: 2014-2019 (continued)

	Medicaid/CHIP Enrollment in 2019 Without Reform (thousands) ^{a/}	Expenditures for Medicaid/CHIP Without Reform: 2014-2019 (millions) ^{b/}		Total Expenditures Without Reform (millions)	Federal Matching Percentage (FMAP) ^{c/}	
		State Share	Federal Share		Medicaid	CHIP
New York	5,163.3	\$243,775	\$244,766	\$488,542	50.00%	65.00%
North Carolina	1,499.8	\$37,146	\$70,008	\$107,154	65.13%	75.30%
North Dakota	69.9	\$2,077	\$3,568	\$5,646	63.01%	72.25%
Ohio	2,088.2	\$49,606	\$86,633	\$136,239	63.42%	74.58%
Oklahoma	664.3	\$13,250	\$24,263	\$37,513	64.43%	75.46%
Oregon	482.8	\$12,524	\$21,270	\$33,794	62.74%	74.00%
Pennsylvania	2,302.1	\$76,058	\$92,869	\$168,927	54.81%	68.95%
Rhode Island	184.8	\$9,261	\$10,467	\$19,727	52.63%	67.08%
South Carolina	727.9	\$13,571	\$32,294	\$45,865	70.32%	79.03%
South Dakota	111.7	\$2,565	\$4,354	\$6,919	62.72%	72.88%
Tennessee	1,377.7	\$25,404	\$48,590	\$73,994	65.57%	76.10%
Texas	3,591.5	\$94,004	\$135,871	\$229,875	58.73%	72.39%
Utah	285.3	\$4,548	\$11,628	\$16,176	71.68%	79.79%
Vermont	145.6	\$4,095	\$5,840	\$9,934	58.73%	71.10%
Virginia	863.1	\$28,371	\$28,769	\$57,141	50.00%	65.00%
Washington	1,097.4	\$32,008	\$32,247	\$64,255	50.12%	65.00%
West Virginia	367.0	\$6,116	\$17,525	\$23,641	74.04%	81.27%
Wisconsin	1,084.9	\$20,568	\$31,333	\$51,901	60.21%	72.11%
Wyoming	71.5	\$2,568	\$2,595	\$5,163	50.00%	65.00%
Total US	54,663.3	\$1,519,362	\$2,039,192	\$3,558,553	57.07%	71.00%

a/ Based upon average monthly enrollment in December 2009 projected to 2019 using CBO March 2010 baseline assumptions on enrollment growth through 2019. These estimates reflect the CBO assumptions that the economy improves by the middle of the decade. Estimates exclude people receiving only partial benefits such as recipients of family planning services and Medicare beneficiaries receiving payment of their Medicare Part B premium. Estimates include enrollment in the CHIP program.

b/ Based upon state-level spending in 2008 projected through 2019 using CBO assumptions on enrollment and expenditure growth through 2019. Expenditures do not include administrative costs, accounting adjustments, or expenditures in the U.S. Territories.

<http://www.statehealthfacts.org/comparamtable.jsp?ind=177&cat=4>

c/ Original FMAP for 2010 without additional amount included in the American Recovery and Reinvestment Act (ARRA).

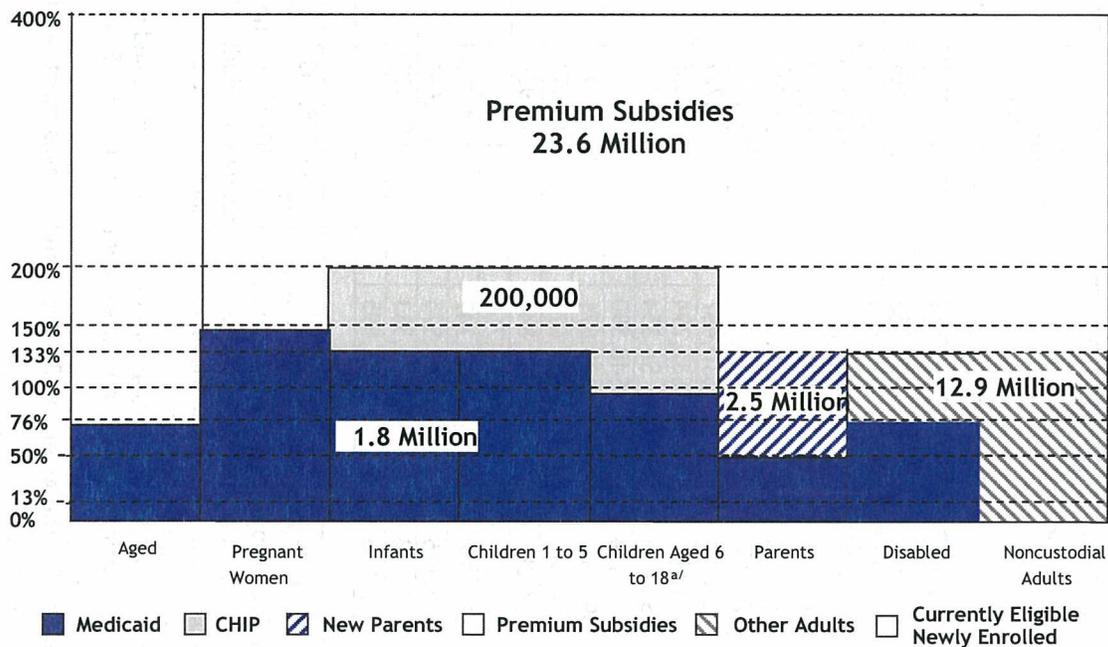
<http://www.statehealthfacts.org/comparamtable.jsp?ind=695&cat=4>

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

B. Changes in Medicaid and CHIP Eligibility under the Act

Effective January 1, 2014, the Act requires states to cover all adults under age 65 with incomes up to 133 percent of the FPL (\$14,404 single; \$19,378 married couples), including parents with children and non-aged individuals without custodial responsibilities for children (Figure 3). The federal government will pay 100 percent of the cost of this expansion for adults through 2016. Starting in 2017, the percentage of costs paid by the federal government for these adults will phase down to 90 percent by 2020, leaving states to pay the remaining 10 percent.

Figure 3: Number of People Affected by Expansions in Publicly Subsidized Coverage under the Act



a/ Children age 6 through 8 must be covered up to 133 percent of the FPL under Reform

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

States are required to maintain existing Medicaid eligibility levels until the new premium subsidies become available in 2014. At that time, states that already cover adults above 133 percent of the FPL are permitted to reduce these eligibility levels to 133 percent of the FPL. These individuals would be eligible for the premium and cost-sharing subsidies available through the newly established exchanges. States must also cover children between 100 percent and 133 percent of the FPL under Medicaid rather than under the CHIP program.

States are also required to maintain their CHIP programs through 2019. Federal CHIP funds are authorized through 2015 only, although many states will draw down their allotment of CHIP funding after 2016. Beginning in 2016, the match rate for CHIP is increased by 23 percentage points, up to a maximum of 100 percent, to permit states to draw down their federal CHIP funds more quickly. When a state's federal CHIP funds are exhausted, the matching rate for these children reverts to the regular Medicaid matching rate.

We estimate that these changes will result in a net increase in Medicaid enrollment of about 17.4 million people by 2019. These include 2.5 million newly eligible parents and 12.9 million newly eligible childless adults. This also includes a net increase in enrollment of 2.0 million people among currently eligible but not enrolled groups. In addition, we estimate that about 23.6 million people will receive premium subsidies through the exchange. *Figure 4* presents our estimates of changes in enrollment for the 50 states and the District of Columbia.

These estimates also reflect changes in the availability of employer coverage as a result of the Act. For example, the Act provides a small employer tax credit to encourage employers to offer coverage. The Act also creates a penalty of up to \$2,000 per worker for firms that do not offer insurance to their workers. On the other hand, many firms are likely to discontinue their coverage once subsidized coverage becomes available to their workers.

In an earlier Lewin Group analysis of the health reform bill, we estimated that up to 14 million people would acquire employer coverage nationally, largely as a result of newly created employer plans.⁷ This includes about 1.6 million people shifting from Medicaid to private insurance (*Figure 4*). However, we also estimated that 17 million people would lose employer coverage in cases where employers choose to discontinue their plans. This would result in about 3.7 million people who now have employer coverage shifting to Medicaid nationwide.

Methods: Estimation of Eligibility and Enrollment

We estimated the impact of these coverage expansions using the March Current Population Survey (CPS) data for 2007 through 2009. These data provide the detailed health coverage information required to estimate the number of people potentially eligible for Medicaid and CHIP under current law and under the expansions for people in each of the 50 states and the District of Columbia.

We used the Lewin Group Health Benefits Simulation Model (HBSM) to estimate eligibility using the income eligibility rules used in each state. We incorporate a correction for underreporting of Medicaid enrollment in surveys such as the CPS for each individual state. We projected coverage to future years based upon the March 2010 baseline projections developed by the Congressional Budget Office, which assume an improved economy by 2014.

We simulated the decision for newly eligible people to enroll in the program based upon a multivariate model of enrollment in the existing program which reflects differences in enrollment by age, income, employment status, and demographic characteristics. The simulation results in average enrollment of about 75 percent of newly eligible uninsured people and 39 percent for newly eligible people who have access to employer health insurance. HBSM simulates eligibility on a month-by-month basis to capture part-year eligibility for the program.

⁷ "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Government, Employer, Families and Providers," Staff Working Paper # 11, June 8, 2010.
<http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf>

Figure 4: Changes in the Number of People Covered under Medicaid and CHIP under the ACA in 2019 (thousands) ^{a/}

	Medicaid/CHIP Enrollment Without Reform ^{b/}	Current Enrollees Shifting to Private ^{c/}	Currently Eligible ^{d/}		Newly Eligible ^{e/}		Total Net Change in Enrollment	Percent Change in Enrollment
			Children: Medicaid and CHIP	Parents	Parents	Non-custodial Adults ^{f/}		
Alabama	839.2	-16.4	17.8	26.6	70.6	244.1	342.7	40.8%
Alaska	105.8	-2.6	2.7	3.8	5.8	36.7	46.4	43.8%
Arizona	1,323.9	-57.6	49.1	90.8	1.1	14.3	97.8	7.4%
Arkansas ^{g/}	597.1	-17.9	11.1	17.9	56.7	161.7	229.5	38.4%
California	7,985.3	-251.3	219.7	374.2	193.6	1,791.2	2,327.3	29.1%
Colorado	563.1	-18.6	31.9	39.6	33.0	218.1	304.2	54.0%
Connecticut	497.6	-16.8	8.1	19.9	3.0	149.3	163.5	32.9%
Delaware	191.0	-4.4	2.4	6.3	1.8	4.7	10.8	5.6%
District of Columbia	157.9	-3.6	1.1	4.4	0.0	29.1	31.0	19.6%
Florida	2,990.8	-78.2	131.2	86.5	239.3	824.9	1,203.6	40.2%
Georgia	1,651.9	-47.0	61.7	49.4	135.9	463.6	663.7	40.2%
Hawaii	253.0	-4.7	3.1	6.3	6.8	55.9	67.4	26.6%
Idaho	225.5	-8.4	9.8	7.2	24.8	65.7	99.1	44.0%
Illinois	2,537.9	-62.8	43.0	77.4	14.5	652.8	724.9	28.6%
Indiana	1,047.7	-27.4	22.0	33.5	65.0	240.4	333.4	31.8%
Iowa	443.3	-13.9	9.3	16.8	25.1	104.1	141.5	31.9%
Kansas	314.8	-12.1	14.1	13.3	29.5	118.1	163.0	51.8%
Kentucky	848.5	-19.5	14.8	30.9	54.9	217.3	298.5	35.2%
Louisiana	1,059.2	-22.0	32.3	28.1	91.9	279.3	409.6	38.7%
Maine	296.6	-6.8	2.3	8.6	1.2	51.0	56.2	18.9%
Maryland	815.4	-18.7	15.6	26.4	10.3	257.4	291.0	35.7%
Massachusetts	1,263.4	-42.8	0.6	3.0	1.6	14.5	-23.1	-1.8%
Michigan	1,954.9	-36.7	29.6	91.4	66.6	524.2	675.1	34.5%
Minnesota	742.1	-26.8	20.1	35.1	31.0	206.2	265.6	35.8%
Mississippi	673.8	-15.7	18.2	22.5	65.8	185.3	276.1	41.0%
Missouri	904.0	-30.7	27.7	34.0	80.6	278.3	390.0	43.1%
Montana	112.5	-4.0	4.0	5.7	11.9	52.3	69.9	62.1%
Nebraska	226.6	-6.9	8.5	7.8	19.5	72.3	101.3	44.7%
Nevada	267.7	-10.5	20.7	10.9	28.0	106.9	156.0	58.3%
New Hampshire	141.6	-4.9	2.5	5.0	8.5	51.4	62.5	44.2%
New Jersey	967.7	-35.5	38.6	44.1	8.0	350.6	405.8	41.9%
New Mexico	484.9	-13.3	17.8	23.6	16.5	109.6	154.2	31.8%

Figure 4: Changes in the Number of People Covered under Medicaid and CHIP under the ACA in 2019 (thousands) ^{a/} (continued)

	Medicaid/CHIP Enrollment Without Reform ^{b/}	Current Enrollees Shifting to Private ^{c/}	Currently Eligible ^{d/}		Newly Eligible ^{e/}		Total Net Change in Enrollment	Percent Change in Enrollment
			Children	Parents	Parents	Non-custodial Adults ^{f/}		
New York	5,163.3	-166.6	53.1	170.0	0.2	121.1	177.8	3.4%
North Carolina	1,499.8	-44.0	45.8	56.1	132.0	450.5	640.4	42.7%
North Dakota	69.9	-1.8	2.2	2.5	4.8	24.7	32.5	46.6%
Ohio	2,088.2	-37.7	34.8	86.4	36.7	639.6	759.7	36.4%
Oklahoma	664.3	-19.3	20.9	19.5	58.6	169.1	248.9	37.5%
Oregon	482.8	-16.0	17.5	38.3	29.3	199.1	268.3	55.6%
Pennsylvania	2,302.1	-51.9	42.8	68.2	99.1	563.1	721.3	31.3%
Rhode Island	184.8	-5.6	3.2	7.3	0.0	47.0	51.9	28.1%
South Carolina	727.9	-15.5	16.3	39.1	30.6	242.9	313.3	43.0%
South Dakota	111.7	-3.3	3.8	3.0	9.0	31.3	43.8	39.3%
Tennessee	1,377.7	-31.8	22.4	58.2	42.2	295.6	386.6	28.1%
Texas	3,591.5	-182.7	306.7	153.3	491.4	1,129.0	1,897.7	52.8%
Utah	285.3	-12.0	19.3	10.6	31.7	98.5	148.1	51.9%
Vermont	145.6	-5.3	1.5	5.0	0.5	2.5	4.3	2.9%
Virginia	863.1	-25.8	31.2	25.4	76.3	300.8	407.9	47.3%
Washington	1,097.4	-27.0	19.1	49.2	25.0	265.5	331.7	30.2%
West Virginia	367.0	-8.1	4.4	11.5	27.4	104.0	139.2	37.9%
Wisconsin	1,084.9	-25.6	13.5	32.5	5.6	234.0	260.0	24.0%
Wyoming	71.5	-1.9	2.2	2.4	6.7	26.1	35.4	49.5%
Total US	54,663.3	-1,620.2	1,552.3	2,089.4	2,510.3	12,875.2	17,407.1	31.8%

a/ Estimates include Medicaid and CHIP enrollment.

b/ Based upon enrollment in December 2009 projected to 2019 using CBO assumptions on enrollment growth through that year.

c/ Includes currently enrolled working families who take coverage from an employer who decides to start offering coverage as a result of the ACA. These include employers who start to offer coverage due to the small employer tax credit, the penalty for not offering coverage, or in response to changes in premiums due to rating reforms.

d/ Includes currently eligible but not enrolled children who automatically become covered as a newly eligible parent becomes covered under the expanded Medicaid program. Also includes increased enrollment among currently eligible but not enrolled people in response to the penalty for remaining uninsured. Under the Act, the penalty applies only to adults with incomes over the tax filing threshold.

e/ Based upon an HBSM simulation of expanding eligibility for Medicaid in each state. We simulate the decision for newly eligible people to enroll in the program based upon a multivariate model of enrollment in the existing program which reflects differences in enrollment by age,

income, employment status, and demographic characteristics. The simulation results in average enrollment of about 75 percent of newly eligible uninsured people and 39 percent for newly eligible people who have access to employer health insurance.

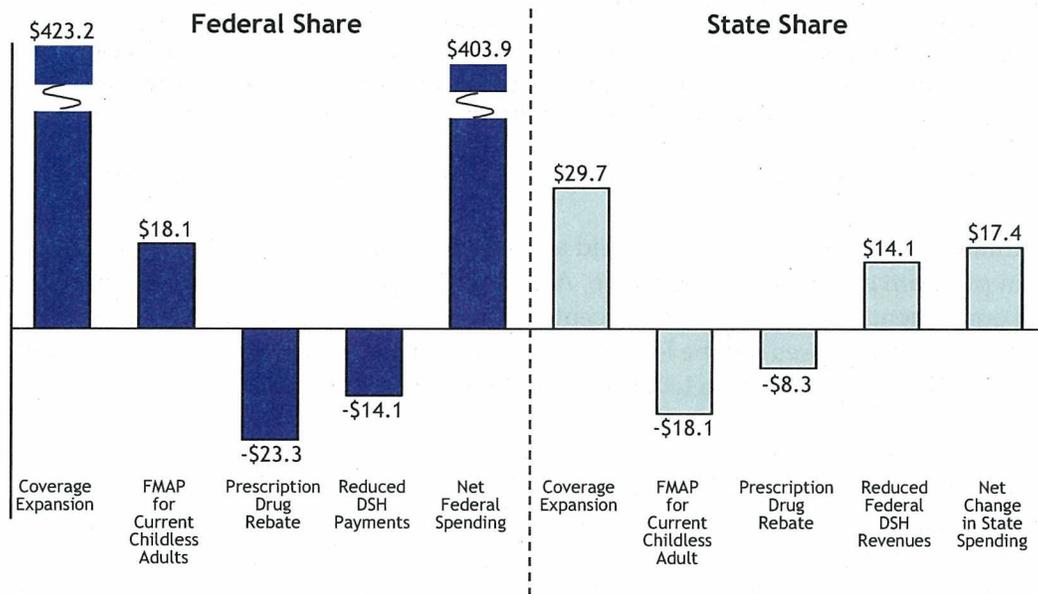
- f/ Includes adults who do not otherwise qualify as aged, disabled, or a parent with custodial responsibilities for children.
- g/ Estimates are relative to the Arizona 2010 baseline spending projection, which predates the state's discontinuation of CHIP and the proposition 204 Section 1115 eligibility expansion.

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

C. Changes in Medicaid and CHIP Spending under Health Reform

Total spending under the Medicaid and CHIP programs will increase by \$421.3 billion over the 2014 through 2019 period under the Act (see *Attachment A*). This is roughly a 12 percent increase in total program spending of \$3.6 trillion over this period without health reform. The federal share of spending would increase by \$403.9 billion (19.1 percent) over this period, while state Medicaid spending would increase by \$17.4 billion (1.1 percent).

Figure 5: Summary of Changes in Spending for States and the Federal Government for Medicaid and CHIP: 2014-2019 (billions)



Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

These estimates include the cost of increased enrollment in Medicaid and three other major features of the Act. These include the increase in Medicaid enrollment, the increase in prescription drug rebates under the ACA, and a scheduled reduction in Federal Disproportionate Share Hospital (DSH) payments of \$14.1 billion. It also reflects increased federal matching funds for states that already cover childless adults under an 1115 Medicaid Waiver.

1. Expanded Enrollment

Most of the increase in spending for both the federal and state governments would be attributed to the expansion in eligibility and other enrollment shifts under the Act. As discussed above, we estimate that Medicaid enrollment will increase by 17.4 million people under the act by 2019. Total spending for these people would be \$452.9 billion over the 2014 through 2019 period, with the federal government paying \$423.2 billion, which does not include the effect of other provisions affecting spending such as the changes in drug rebates. States would pay \$29.7 billion of the costs for these newly enrolled people, which is about 6.6 percent of total spending under the Medicaid expansion.

The 17.4 million newly enrolled people include 2.5 million newly eligible parents and 12.9 million newly eligible childless adults. We also project an increase in enrollment among currently eligible but not enrolled children and adults. This includes 1.5 million children under Medicaid or CHIP and about 2.1 million parents of children now enrolled in Medicaid. This would be partly offset by a shift of 1.6 million current enrollees to private insurance in cases where employers decide to start offering insurance in response to the small employer tax credit and the penalties for non-insuring employers.

Methods: Enrollment for Currently Eligible Children and Parents

We assume that currently eligible but not enrolled children will be enrolled as a newly eligible parent becomes covered under Medicaid. Also, we assume that eligible families will enroll in instances where the parent loses employer coverage because their employer decides to discontinue their health plan (discussed above). We also simulated a small increase in enrollment due to the penalty for Medicaid eligible people with income high enough to be required to pay taxes.

The 17.4 million person increase in Medicaid and CHIP enrollment represents a 31.8 percent increase in program enrollment nationwide. All states except Massachusetts would experience increased enrollment ranging from 2.9 percent in Vermont to 62.1 percent in Montana (*Figure 4 above*). Enrollment increases will be less than 6 percent in states that already cover childless adults to the FPL or higher income levels such as New York, Delaware, and Vermont.

Enrollment in Massachusetts actually declines by 1.8 percent, which reflects the state's existing program to cover the uninsured. Massachusetts already has a coverage mandate and has expanded eligibility for parents and childless adults under Medicaid, resulting in only a small increase in enrollment due to the ACA eligibility expansions. At the same time, we estimate that about 43,000 Massachusetts Medicaid and CHIP recipients will become covered by an employer plan under the Act, in response to the small group tax credit and the penalty for not offering coverage. This results in a net reduction in enrollment of 23,100 people in 2019.

2. State Spending for Medicaid

As discussed above, we estimate that state Medicaid spending will increase by \$17.4 billion nationwide. *Figure 6* presents our estimates of the impact the program will have on state Medicaid spending including changes due to increased drug rebates, changes in federal DSH payments, and changes in federal matching rates for states that already cover childless adults through 100 percent of the FPL under an 1115 Medicaid Waiver.

We show that the state share of Medicaid spending would increase over the 2014 through 2019 period for all states except Delaware, New York, Hawaii, Massachusetts, Vermont, and Arizona. These states do not experience an increase in state costs because they have already extended eligibility to parents and childless adults and generally benefit from the increased federal match for the childless adults they now cover.

Figure 6: Changes in State Medicaid and CHIP Spending for Major Provisions of the ACA: 2014-2019 (millions) ^{a/}

	State Medicaid/CHIP Spending Without Reform ^{b/}	Take Private Coverage ^{c/}	Currently Eligible Newly Enrolled ^{d/}	Newly Eligible Parents ^{e/}	Newly Eligible Childless Adults ^{e,f/}	Increased Match For Expansion States ^{g/}	Changes in Drug Rebates ^{h/}	Illustrative Reduction in Federal DSH Payments ^{i/}	Net Change in Spending Under ACA	Percent Change in Spending
Alabama	\$14,245	-\$152	\$310	\$75	\$331	\$0	\$20	\$520	\$1,104	7.8%
Alaska	\$4,726	-\$52	\$69	\$6	\$34	\$0	\$5	\$11	\$73	1.6%
Arizona ^{j/}	\$27,901	-\$478	\$1,095	\$1	\$24	-\$2,953	-\$771	\$109	-\$2,974	-10.7%
Arkansas	\$10,137	-\$139	\$186	\$65	\$228	\$0	\$13	\$26	\$379	3.7%
California	\$222,772	-\$2,908	\$6,051	\$172	\$1,352	\$0	-\$1,030	\$1,203	\$4,839	2.2%
Colorado	\$17,855	-\$264	\$689	\$29	\$203	\$0	-\$54	\$116	\$719	4.0%
Connecticut	\$23,991	-\$156	\$301	\$3	\$113	\$0	\$28	\$418	\$707	2.9%
Delaware	\$5,867	-\$69	\$98	\$2	\$7	-\$324	\$8	\$3	-\$276	-4.7%
District of Columbia	\$4,595	-\$26	\$48	\$0	\$23	\$0	-\$47	\$127	\$126	2.7%
Florida	\$72,587	-\$898	\$1,830	\$216	\$972	\$0	-\$422	\$201	\$1,900	2.6%
Georgia	\$28,920	-\$419	\$811	\$130	\$506	\$0	-\$371	\$306	\$963	3.3%
Hawaii	\$5,998	-\$68	\$70	\$5	\$41	-\$136	-\$79	\$25	-\$142	-2.4%
Idaho	\$4,140	-\$78	\$95	\$27	\$83	\$0	\$5	\$11	\$142	3.4%
Illinois	\$64,997	-\$538	\$1,450	\$16	\$506	\$0	\$74	\$331	\$1,838	2.8%
Indiana	\$22,819	-\$266	\$424	\$71	\$294	\$0	-\$192	\$365	\$696	3.1%
Iowa	\$11,395	-\$198	\$267	\$32	\$133	\$0	\$12	\$43	\$287	2.5%
Kansas	\$9,950	-\$135	\$213	\$31	\$120	\$0	-\$89	\$67	\$207	2.1%
Kentucky	\$15,242	-\$211	\$342	\$66	\$292	\$0	-\$83	\$199	\$604	4.0%
Louisiana	\$21,861	-\$182	\$352	\$93	\$380	\$0	\$31	\$783	\$1,457	6.7%
Maine	\$8,549	-\$61	\$86	\$1	\$40	-\$137	\$10	\$222	\$161	1.9%
Maryland	\$32,246	-\$244	\$573	\$12	\$227	\$0	-\$466	\$120	\$223	0.7%
Massachusetts	\$60,615	-\$682	\$35	\$1	\$17	-\$941	-\$499	\$0	-\$2,068	-3.4%
Michigan	\$39,625	-\$466	\$1,075	\$69	\$571	\$0	-\$537	\$460	\$1,172	3.0%
Minnesota	\$37,481	-\$244	\$487	\$25	\$160	\$0	-\$378	\$89	\$140	0.4%
Mississippi	\$10,555	-\$109	\$207	\$72	\$290	\$0	\$11	\$168	\$638	6.0%
Missouri	\$27,012	-\$346	\$517	\$98	\$363	\$0	-\$163	\$665	\$1,133	4.2%
Montana	\$2,857	-\$60	\$71	\$14	\$66	\$0	\$3	\$7	\$101	3.6%
Nebraska	\$6,950	-\$77	\$131	\$21	\$83	\$0	\$9	\$23	\$189	2.7%
Nevada	\$7,289	-\$129	\$279	\$26	\$109	\$0	-\$32	\$52	\$306	4.2%
New Hampshire	\$6,681	-\$70	\$77	\$8	\$44	\$0	\$5	\$312	\$377	5.6%

Figure 6: Changes in State Medicaid and CHIP Spending for Major Provisions of the ACA: 2014-2019 (millions) ^{a/} (continued)

	State Medicaid/CHIP Spending Without Health Reform ^{b/}	Take Private Coverage ^{c/}	Currently Eligible Newly Enrolled ^{d/}	Newly Eligible Parents ^{e/}	Newly Eligible Childless Adults ^{e, f/}	Increased Match For Expansion States ^{g/}	Changes in Drug Rebates ^{h/}	Illustrative Reduction in Federal DSH Payments ^{i/}	Net Change in Spending Under ACA	Percent Change in Spending
New Jersey	\$54,389	-\$283	\$844	\$8	\$231	\$0	-\$402	\$877	\$1,275	2.3%
New Mexico	\$10,031	-\$87	\$226	\$14	\$105	\$0	-\$222	\$9	\$45	0.4%
New York	\$210,298	-\$1,265	\$1,383	\$0	\$64	-\$13,420	\$236	\$1,777	-\$11,226	-5.3%
North Carolina	\$39,336	-\$464	\$730	\$136	\$555	\$0	\$50	\$374	\$1,382	3.5%
North Dakota	\$2,203	-\$23	\$36	\$5	\$26	\$0	\$2	\$9	\$55	2.5%
Ohio	\$52,150	-\$478	\$1,299	\$49	\$721	\$0	-\$702	\$711	\$1,599	3.1%
Oklahoma	\$14,083	-\$242	\$278	\$62	\$201	\$0	\$16	\$23	\$338	2.4%
Oregon	\$13,218	-\$188	\$490	\$31	\$224	\$0	-\$180	\$26	\$403	3.1%
Pennsylvania	\$79,558	-\$911	\$1,013	\$95	\$537	\$0	-\$1,433	\$1,162	\$464	0.6%
Rhode Island	\$9,943	-\$54	\$103	\$0	\$31	\$0	-\$84	\$117	\$113	1.1%
South Carolina	\$14,169	-\$159	\$427	\$36	\$316	\$0	-\$36	\$413	\$995	7.0%
South Dakota	\$2,718	-\$36	\$47	\$10	\$35	\$0	\$3	\$10	\$68	2.5%
Tennessee	\$26,475	-\$218	\$628	\$43	\$341	\$0	\$32	\$143	\$969	3.7%
Texas	\$100,649	-\$1,628	\$3,313	\$406	\$1,049	\$0	\$112	\$770	\$4,022	4.0%
Utah	\$4,854	-\$110	\$159	\$33	\$105	\$0	\$6	\$15	\$209	4.3%
Vermont	\$4,236	-\$72	\$11	\$0	\$0	-\$170	\$6	\$41	-\$184	-4.3%
Virginia	\$30,183	-\$333	\$561	\$77	\$328	\$0	-\$301	\$129	\$461	1.5%
Washington	\$33,121	-\$437	\$797	\$26	\$255	\$0	-\$275	\$313	\$679	2.0%
West Virginia	\$6,404	-\$80	\$128	\$38	\$167	\$0	\$12	\$94	\$360	5.6%
Wisconsin	\$21,572	-\$217	\$408	\$6	\$174	\$0	-\$191	\$107	\$286	1.3%
Wyoming	\$2,708	-\$31	\$49	\$7	\$33	\$0	\$3	\$0	\$61	2.2%
Total US	\$1,562,160	-\$17,041	\$31,166	\$2,470	\$13,113	-\$18,081	-\$8,332	\$14,100	\$17,395	1.1%

a/ These estimates reflect the phase-in of provisions under the law and reflect lags in enrollment that are expected in the early years of the program. Costs are based upon reported spending amounts in the Medical Expenditures Panel Survey (MEPS) data for people with similar characteristics, which reflect the unique demographic characteristics of the newly eligible populations. The MEPS data are adjusted to simulation year based upon CBO projections of expenditure growth for adults. Estimates include the CHIP program.

b/ Based upon state-level spending in 2008 projected to 2019 using CBO assumptions on enrollment and expenditure growth through 2019.

c/ Includes currently enrolled working families who take coverage through an employer who decides to start offering coverage as a result of the incentives created under the ACA. These include employers who start to offer coverage due to the small employer tax credit, the penalty for not offering coverage, or in response to changes in premiums due to rating reforms.

d/ Includes currently eligible but not enrolled children who automatically become covered as a newly eligible parent becomes covered under the expanded Medicaid program. Also includes increased enrollment among currently eligible but not enrolled people in response to the penalty for remaining uninsured. (This applies only to adults with incomes over the tax filing thresholds that are subject to penalties.)

e/ Based upon an HBSM simulation of expanding eligibility for Medicaid in each state. We simulated the decision for newly eligible people to enroll in the program based upon a multivariate model of enrollment in the existing program which reflects differences in enrollment by age, income, employment status and demographic characteristics. The simulation results in average enrollment of about 75 percent for newly eligible uninsured people and 39 percent for newly eligible people who have access to employer health insurance.

f/ Includes adults who do not otherwise qualify as aged, disabled, or a parent with custodial responsibilities for children.

g/ The law would gradually increase the federal matching percentage to 90 percent by 2020 for non-custodial adults already covered under a Medicaid 1115 Waiver. These states include Arizona, Delaware, Hawaii, Maine, Missouri, New York, and Vermont.

h/ The Act increases the rebates received by Medicaid from prescription drug companies, including increases in rebate amounts and rebates for Medicaid beneficiaries covered by states under private health plans. Recently released guidance from the Department of Health and Human Services (DHHS) indicate that many states will share in these increased rebates.

i/ The ACA would reduce federal Medicaid Disproportionate Share Hospital Payments by \$14.1 billion over the 2014 through 2019 period. (DSH are supplemental payments to hospitals serving a disproportionate share of Medicaid beneficiaries and/or uninsured people). The ACA requires the Secretary of DHHS to develop rules for allocating the cuts to states in proportion to the number of uninsured in the state, which is reduced for states designated as “low” DSH states. The reduction does not apply to DSH funds used to fund an expansion under an 1115 Waiver. We illustrated the potential impact of this provision using a formula that is generally consistent with what is required in the legislation.

j/ Estimates are relative to the Arizona 2010 baseline spending projection, which predates the state’s discontinuation of CHIP and the proposition 204 Section 1115 eligibility expansion.

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

Our estimate of the effect of health reform in Arizona is complicated by the fact that just prior to the ACA, Arizona eliminated its CHIP program beginning June 15, 2010, and its adult coverage expansion (proposition 204) beginning January 1, 2011. Under the maintenance of effort (MOE) provisions of the ACA, the state must maintain its current Medicaid and CHIP programs as of March 23, 2010. This means that the state must reinstate these programs to continue to qualify for federal Medicaid funding. Arguably, the net cost of the ACA for Arizona should include the cost of reinstating this coverage due to the ACA MOE provisions. This would more than offset the savings we present in *Figure 6* for Arizona, resulting in a substantial net increase in estimated spending.⁸

3. Prescription Drug Rebates

States will save \$8.3 billion over the 2014 through 2019 period from increased prescription drug rebates under the Act. Under current law, drug manufacturers are required to pay rebates to Medicaid for drugs provided under the fee-for-service Medicaid program. In addition, many states negotiate “supplemental” rebates with drug manufacturers.

The ACA requires manufacturers to begin paying rebates on drugs provided through Medicaid managed care organizations (MCOs).⁹ For brand name drugs, the minimum rebate is increased from 15.1 percent of average manufacturer price (AMP) to 23.1 percent of AMP. Rebates for generic drugs are increased from 11.0 percent of AMP to 13.0 percent of AMP. It also changes how the additional inflationary rebate on line extensions of a brand name drug is calculated.

In addition, the Act requires that the amounts “attributable” to these increased rebates be passed on (offset) to the Federal government. In a recent letter to State Medicaid Directors (SMDL#10-019), issued September 28, 2010, CMS provided guidance that this offset would apply only to rebate dollars that are collected above and beyond what would have been received under the previous rebate formulas.

Methods: Modeling the Prescription Drug Rebate Provisions of the ACA

To estimate the impact of the drug rebate provisions in ACA, we estimated state-level pharmacy expenditures under fee-for-service (FFS) and Medicaid managed care using Medicaid Statistical Information System (MSIS) data. For Medicaid FFS expenditures, we estimated a net increase in pharmacy costs of approximately 1.5 percent due to a decrease in supplemental rebates. For Medicaid MCO expenditures, we estimated savings of approximately 30 percent as MCO utilization will now have access to the large Federally-mandated rebates. These impacts will be shared by the states and the Federal government. In addition, we estimated that the Federal government will save an additional 4 percent due to increased rebate levels mandated by the ACA.

⁸ The Joint Legislative Budget Committee (JLBC) of the Arizona state legislature estimated that if the cost of reinstating these programs is included, the coverage provisions of the Act will actually increase by \$6.7 billion over the 2011 through 2019 period. See: “Analysis of the Cost of Federal Health Care Legislation,” JLBC report, March 30, 2010.

⁹ This will only affect plans where prescription drugs are included in the MCO capitation. Medicaid already receives rebates for prescription drugs provided as a “carve out” from the MCO plan.

We estimate that about half of all states will see net savings as a result of these changes in drug rebate policy. Savings will be particularly large for states that currently have a large portion of their covered population enrolled in MCOs with the drug expense included in the capitation amount (i.e., state where a pharmacy “carve in” model is used), where the drug manufacturers must start to pay a rebate. These include Arizona, California, and Pennsylvania.

However, in response to these increases in required rebates, drug manufacturers are expected to be less willing to provide supplemental rebates to states. Consequently, we estimate that when these reductions in supplemental rebates are included, about half of the states will experience a net reduction in rebates.

4. Disproportionate Share Hospital Payments (DSH)

The ACA will reduce payments to states under the Disproportionate Share Hospital (DSH) program. Under the DSH program, the federal government makes payments to states that are intended to provide additional funds for hospitals treating a disproportionate share of the Medicaid and uninsured populations. However, several states have used some or all of these funds to pay for an expansion in eligibility and coverage under a Medicaid 1115 Waiver program. The Congressional Budget Office (CBO) estimates that payments will be \$8.1 billion in 2010 (excluding amounts added under the economic recovery legislation), rising to \$10.5 billion by 2019.¹⁰

The Act specifies that total federal DSH payments will be reduced by \$14.1 billion over the 2014 through 2019 period, reflecting the expected reduction in the number of uninsured under the ACA. Reductions will be as follows:

- \$0.5 billion in 2014
- \$0.6 billion in 2015
- \$0.6 billion in 2016
- \$1.8 billion in 2017
- \$5.0 billion in 2018
- \$5.6 billion in 2019
- \$4.0 billion in 2020

The Act does not specify the amount of the reductions by state, but directs the Secretary to develop a methodology subject to several guidelines specified in the legislation. The methodology must:

- Impose the largest percentage reductions on states with the largest projected percentage reductions of uninsured or those that do not target funds to hospitals with high volumes of Medicaid recipients or uncompensated care;

¹⁰ “Spending and Enrollment Data for CBO’s March 2010 Baseline: Medicaid”, Congressional Budget Office, <http://www.cbo.gov/ftpdocs/115xx/doc11521/CHIP.pdf>

- Take into account the extent to which the DSH allotment is included in the budget neutrality calculation for an expansion in coverage under an 1115 Waiver; and
- Impose a smaller percentage reduction on the 16 states designated as “low-DSH” states.

For illustrative purposes, we estimated the amount of the DSH reduction for each state using an algorithm that meets the general requirements specified in the legislation. We assumed the DSH reductions would not apply to the portion of DSH used to fund 1115 Waiver expansions. We assumed that the percentage reduction in DSH is in proportion to the percentage of the population without insurance. We also assumed that the DSH reductions are reduced by 50 percent for low-DSH states and that the amounts are then adjusted to the amount of the DSH reduction required under the Act. These estimates should be treated as illustrative only because the algorithm developed by the Secretary is likely to differ from our assumed specifications.

We present our illustrative estimates of these DSH reductions by state in *Figure 6* above. DSH payments would be reduced by about \$1.2 billion in California, \$1.8 billion in New York, and \$1.2 billion in Pennsylvania. However, six states would see a reduction in DSH of less than \$10.0 million over the 2014 through 2019 period, primarily because they currently receive little DSH funding.

5. Increased Match for Childless Adults in Expansion States

As discussed above, the federal matching percentage is increased for states that already cover all adults to at least 100 percent of the FPL under an 1115 Waiver. These are called “expansion states” and include: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York, and Vermont. The Act would gradually increase the federal matching percentage for non-custodial adults from the current state matching percentage (typically 50 percent) to 90 percent between 2014 and 2019. Thus, by 2020, the federal matching percentage will be 90 percent for all non-custodial adults in all states, including those now covering some portion of this group.

Although consistently defined data for these populations are difficult to obtain, we developed estimates of the amount of spending attributed to these groups from published studies of coverage for childless adults. We estimate that this provision will reduce state spending for Medicaid by \$18.1 billion over the 2014 through 2019 period (*Figure 6 above*). State savings from this provision will be \$13.4 billion in New York, \$3.0 billion in Arizona, and \$941 million in Massachusetts.¹¹

¹¹ The Joint Legislative Budget Committee (JLBC) of the Arizona state legislature has estimated that the change in FMAP for childless adults will reduce state spending by \$3.6 billion over this same period, compared with our estimate of \$3.0 billion. See: Analysis of the Cost of Federal Health Care Legislation,” JLBC report, March 30, 2010.

Methods: Estimating Impact of Increased Federal Match for Childless Adults

Our estimates of the impact of increasing the federal matching rate for childless adults is based upon enrollment data and spending figures from several sources. Because enrollment and cost data generally are not reported separately for non-custodial adults, we relied on prior studies of the impact of covering childless adults under Medicaid. For this reason, the actual figures may differ from those presented here.

State	Childless Adults	Average Cost in 2010	Total Cost (millions)
Arizona ^{a,b/}	212,941	\$7,361	\$1,560
Delaware ^{c,d/}	21,307	\$5,240	\$111
Hawaii ^{d,e/}	11,550	\$4,792	\$54
Massachusetts ^{d,f/}	68,200	\$4,750	\$324
Maine ^{b,c/}	13,594	\$4,872	\$66
New York ^{a,b,g/}	782,638	\$5,904	\$4,621
Vermont ^{h/}	18,142	\$4,016	\$73

a/ "Expanding Medicaid to Low-income Childless Adults under Health Reform: Key Lessons from State Experiences," Kaiser Commission on Medicaid and the Uninsured, July 2010.

b/ "Covering Low-income Childless Adults in Medicaid: Experiences from Selected States," Center for Health Care Strategies, Inc. August 2010.

c/ "Medicaid Enrollment in 50 States," The Kaiser Commission on Medicaid and the Uninsured, September 2009.

d/ Per-capita costs for adults adjusted to 2010, Kaiser Commission, State Health Facts.

e/ Lewin Group estimate using the Current Population Survey data for data Hawaii in 2008-2010.

f/ MassHealth Essential Program, Governors Budget FY2011,

http://www.mass.gov/bb/h1/fy11h1/brec_11/act_11/ho40001405.htm; and

http://www.massmedicaid.org/~media/MMPI/Files/2009_04_30%20masshealth%20enrollment%20by%20plan%20type.pdf

g/ "Enrolling Childless Adults in Medicaid: Lessons from the New York Experience and opportunities in Health Reform," Medicaid Institute at United Hospital Fund, October 2010.

h/ Overview of Health Care Programs, "Medicaid Budget Document, state fiscal year 2010", Office of Vermont Health Access. Lewin Group allocation of enrollees to childless adults category using CPS data for Vermont.

D. Net Impact of Reform on State Spending

As discussed above, state Medicaid spending will increase by \$17.4 billion over the 2014 through 2019 period under the ACA, which is an average increase of about 1.1 percent over that period. However, the impact of health reform on Medicaid and CHIP spending varies from an increase of 7.8 percent in Alabama, which has the nation's second lowest eligibility level for parents (24 percent of FPL), to actual savings of 10.7 percent in Arizona (*Figure 7*).

In general, states that have covered parents and childless adults to higher income levels (e.g., 100 percent of the FPL) tend to do better than states that currently have only very limited eligibility for non-aged adults. Also, states with large Medicaid managed care programs will tend to see substantial increases in rebates under the managed care drug rebate provisions of the Act, such as Arizona, California, and Pennsylvania.

Medicaid spending would actually be reduced under the Act in six states including Arizona, Delaware, Hawaii, New York, Massachusetts, and Vermont. All six of these states already cover a substantial portion of adults below 133 percent of the FPL. In particular, Arizona's program (under MOE coverage levels) covers both parents and adults to 200 percent of the FPL and, therefore, benefits from the increased matching rate for this group under the Act. Arizona also

sees substantial savings from the managed care rebates because most of the Arizona Medicaid population is covered under managed care.

The Act includes another provision that could result in savings to states. Under the Act, states with eligibility levels above 133 percent of the FPL for parents and/or childless adults are permitted to reduce their income eligibility levels to the minimum level of 133 percent of the FPL. This could affect 417,600 people in twelve states (*Figure 7*). State spending for Medicaid would be reduced by \$3.8 billion over the 2014 through 2019 period if all states exercised this option.

A summary of the changes in Medicaid spending for states and the federal government by state is presented in *Attachment A*.

E. Understanding Reform at the State Level

The estimates presented here are dependent upon key assumptions concerning the strength of the economy and the ways in which employers, consumers, insurers, and providers respond to elements of the Act. We relied upon economic projections developed by the Congressional Budget Office (CBO) at the national level. These assumptions predict a decline in Medicaid enrollment after 2010 with enrollment growth returning to historical growth rates after 2014. We also used CBO assumptions on per-capita benefits cost growth of about 3 percent. However, the recession and the recovery are likely to differ across states with different cost implications for state governments.

Our estimates are also sensitive to assumptions about how the program will be implemented and the ways in which employers, health plans, and consumers respond to the Act. In general, we rely upon economic studies of historical enrollment for eligible people and we assume little net change in the number of people with employer coverage. All of these assumptions are somewhat speculative and may differ from actual behavior.¹² It will be important to show the range of impacts the Act will have under alternative assumptions. These include:

- Participation rate for newly eligible people;
- Take-up among currently eligible but not enrolled;
- Enrollment and spending under alternative assumptions on the number of employers offering/discontinuing coverage;
- The impact of alternative economic assumptions; and
- The rules ultimately adopted for setting the reductions in DSH funding by state.

¹² For a discussion of methods used to model the Act see: "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers," The Lewin Group, June 8, 2010; <http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf>

Figure 7: Potential Savings From State Option to Discontinue Medicaid Coverage for Adults over 133 Percent of the Federal Poverty Level: 2014-2019 ^{a/}

	Required Changes in Spending for States Under the ACA: 2014-2019 ^{b/}		Currently Covered Adults over 133% of FPL in 2014 (thousands) ^{c/}	State Savings From Eliminating Coverage for Adults over 133% of FPL: 2014-2019 (millions) ^{d/}	Net Change in Spending Assuming Coverage for this Group is Eliminated: 2014-2019 (millions)
	Amount (millions)	Percent Change in State Spending			
Alabama	\$1,104	7.8%	0.0	\$0	\$1,104
Alaska	\$73	1.6%	0.0	\$0	\$73
Arizona	-\$2,974	-10.7%	0.0	\$0	-\$2,974
Arkansas	\$379	3.7%	0.0	\$0	\$379
California	\$4,839	2.2%	0.0	\$0	\$4,839
Colorado	\$719	4.0%	0.0	\$0	\$719
Connecticut	\$707	2.9%	-20.8	-\$211	\$497
Delaware	-\$276	-4.7%	0.0	\$0	-\$276
District of Columbia	\$126	2.7%	-4.7	-\$37	\$89
Florida	\$1,900	2.6%	0.0	\$0	\$1,900
Georgia	\$963	3.3%	0.0	\$0	\$963
Hawaii	-\$142	-2.4%	0.0	\$0	-\$142
Idaho	\$142	3.4%	0.0	\$0	\$142
Illinois	\$1,838	2.8%	-73.3	-\$684	\$1,154
Indiana	\$696	3.1%	-7.0	-\$74	\$622
Iowa	\$287	2.5%	-0.4	-\$6	\$281
Kansas	\$207	2.1%	0.0	\$0	\$207
Kentucky	\$604	4.0%	0.0	\$0	\$604
Louisiana	\$1,457	6.7%	0.0	\$0	\$1,457
Maine	\$161	1.9%	-12.8	-\$125	\$36
Maryland	\$223	0.7%	0.0	\$0	\$223
Massachusetts	-\$2,068	-3.4%	0.0	\$0	-\$2,068
Michigan	\$1,172	3.0%	0.0	\$0	\$1,172
Minnesota	\$140	0.4%	-37.6	-\$373	-\$233
Mississippi	\$638	6.0%	0.0	\$0	\$638
Missouri	\$1,133	4.2%	0.0	\$0	\$1,133
Montana	\$101	3.6%	0.0	\$0	\$101
Nebraska	\$189	2.7%	0.0	\$0	\$189
Nevada	\$306	4.2%	0.0	\$0	\$306
New Hampshire	\$377	5.6%	0.0	\$0	\$377
New Jersey	\$1,275	2.3%	-46.4	-\$403	\$872
New Mexico	\$45	0.4%	0.0	\$0	\$45
New York	-\$11,226	-5.3%	-167.1	-\$1,384	-\$12,610
North Carolina	\$1,382	3.5%	0.0	\$0	\$1,382
North Dakota	\$55	2.5%	0.0	\$0	\$55
Ohio	\$1,599	3.1%	0.0	\$0	\$1,599
Oklahoma	\$338	2.4%	0.0	\$0	\$338
Oregon	\$403	3.1%	0.0	\$0	\$403
Pennsylvania	\$464	0.6%	0.0	\$0	\$464

Figure 7: Potential Savings From State Option to Discontinue Medicaid Coverage for Adults over 133 Percent of the Federal Poverty Level: 2014-2019 ^{a/} (continued)

	Required Changes in Spending for States Under the ACA: 2014-2019 ^{b/}		Currently Covered Adults over 133% of FPL in 2014 (thousands) ^{c/}	State Savings From Eliminating Coverage for Adults over 133% of FPL: 2014-2019 (millions) ^{d/}	Net Change in Spending Assuming Coverage for this Group is Eliminated: 2014-2019 (millions)
	Amount (millions)	Percent Change in State Spending			
Rhode Island	\$113	1.1%	-8.9	-\$94	\$19
South Carolina	\$995	7.0%	0.0	\$0	\$995
South Dakota	\$68	2.5%	0.0	\$0	\$68
Tennessee	\$969	3.7%	0.0	\$0	\$969
Texas	\$4,022	4.0%	0.0	\$0	\$4,022
Utah	\$209	4.3%	0.0	\$0	\$209
Vermont	-\$184	-4.3%	-5.3	-\$79	-\$263
Virginia	\$461	1.5%	0.0	\$0	\$461
Washington	\$679	2.0%	0.0	\$0	\$679
West Virginia	\$360	5.6%	0.0	\$0	\$360
Wisconsin	\$286	1.3%	-33.2	-\$307	-\$21
Wyoming	\$61	2.2%	0.0	\$0	\$61
Total	\$17,395	1.1%	-417.6	-\$3,777	\$13,618

a/ Beginning in 2014, states that cover adults above 133 percent of the FPL have the option of discontinuing this coverage, leaving these individuals eligible for coverage in the exchange, where premium subsidies are available.

b/ Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

c/ Estimated from the CPS survey data on incomes for people reporting Medicaid coverage by state. Estimates are based upon a month-by-month simulation of eligibility using the state's income eligibility rules, which enables us to identify beneficiaries with incomes between 133 percent of the FPL and the state's upper income eligibility level.

d/ Estimated savings are based upon MEPS data on spending for people with similar characteristics.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

This analysis covers only the Medicaid impacts of health reform and does not provide state level analyses of other elements of the Act that will have significant impacts on State and Local government costs under the bill. These effects on state government and the state health care system include:

- As employers, state and local governments that do not cover all of their full-time employees are required to pay a significant new penalty;
- Changes in employer coverage and spending will affect state tax revenues, in addition to direct effects on the health system;
- Uncompensated care could be reduced by up to two-thirds as 30 million or more people become insured nationwide;
- Public hospitals and clinics would see increased revenues from newly insured patients that will now be covered by Medicaid or privately insured patients;

- Payer mix will change significantly for all types of providers now serving the uninsured; and
- Expected increases in health services utilization for newly insured people raise questions about the adequacy of physician supply in many areas.

The Lewin Group data and models of the health care system provide a platform for simulating these effects at both the state and county levels. In particular, the models can be used to estimate the effects of reform under various assumptions and alternative economic scenarios that are specific to individual state health systems and economies.

In addition to these services, we can evaluate options for reducing the cost of state Medicaid and CHIP programs within the maintenance of effort requirements of the Act. For example, states have the option of using alternative "benchmark" benefits packages rather than the Medicaid benefit. Also, states that now have adult income eligibility levels above 133 percent of the FPL have the option of reducing eligibility to 133 percent of the FPL. We have also assisted several states in identifying ways of minimizing costs and maximizing federal matching funds.

Attachment A: Changes in Spending For Medicaid and CHIP under the ACA for States and the Federal Government (millions) ^{a/}

	Changes in State Spending under ACA				Changes in Federal Spending under ACA				Total Spending under ACA		
	Without Health Reform	Change in Spending	Total Spending under ACA	Without Health Reform	Change in Spending	Total Spending under ACA	Spending under the ACA	Without Health Reform	Change in Spending	Total Spending under ACA	
Alabama	\$14,245	\$1,104	\$15,349	\$30,573	\$10,191	\$44,818	\$40,764	\$44,818	\$11,295	\$56,113	
Alaska	\$4,726	\$73	\$4,799	\$5,044	\$1,036	\$9,770	\$6,080	\$9,770	\$1,110	\$10,880	
Arizona	\$27,901	-\$2,974	\$24,928	\$53,873	\$2,850	\$81,774	\$56,723	\$81,774	-\$124	\$81,651	
Arkansas	\$10,137	\$379	\$10,517	\$27,347	\$7,592	\$37,484	\$34,938	\$37,484	\$7,971	\$45,455	
California	\$222,772	\$4,839	\$227,611	\$226,648	\$38,974	\$449,420	\$265,622	\$449,420	\$43,813	\$493,233	
Colorado	\$17,855	\$719	\$18,574	\$18,105	\$6,145	\$24,251	\$24,251	\$24,251	\$6,864	\$42,824	
Connecticut	\$23,991	\$707	\$24,698	\$24,056	\$2,602	\$48,046	\$26,658	\$48,046	\$3,309	\$51,356	
Delaware	\$5,867	-\$276	\$5,591	\$5,950	\$420	\$11,817	\$6,370	\$11,817	\$144	\$11,961	
District of Columbia	\$4,595	\$126	\$4,721	\$10,748	\$493	\$15,343	\$11,241	\$15,343	\$619	\$15,962	
Florida	\$72,587	\$1,900	\$74,487	\$89,434	\$30,611	\$162,022	\$120,045	\$162,022	\$32,510	\$194,532	
Georgia	\$28,920	\$963	\$29,884	\$54,552	\$15,884	\$83,473	\$70,437	\$83,473	\$16,848	\$100,320	
Hawaii	\$5,998	-\$142	\$5,856	\$7,153	\$1,134	\$13,150	\$8,287	\$13,150	\$992	\$14,142	
Idaho	\$4,140	\$142	\$4,282	\$9,475	\$2,820	\$13,615	\$12,295	\$13,615	\$2,962	\$16,577	
Illinois	\$64,997	\$1,838	\$66,835	\$66,332	\$13,768	\$131,329	\$80,099	\$131,329	\$15,605	\$146,934	
Indiana	\$22,819	\$696	\$23,515	\$44,441	\$8,834	\$67,260	\$53,275	\$67,260	\$9,531	\$76,790	
Iowa	\$11,395	\$287	\$11,682	\$19,973	\$4,269	\$31,368	\$24,242	\$31,368	\$4,556	\$35,924	
Kansas	\$9,950	\$207	\$10,157	\$15,285	\$3,733	\$25,234	\$19,018	\$25,234	\$3,940	\$29,175	
Kentucky	\$15,242	\$604	\$15,846	\$37,480	\$8,951	\$52,723	\$46,431	\$52,723	\$9,555	\$62,278	
Louisiana	\$21,861	\$1,457	\$23,317	\$45,908	\$11,601	\$67,769	\$57,510	\$67,769	\$13,058	\$80,827	
Maine	\$8,549	\$161	\$8,710	\$15,951	\$964	\$24,499	\$16,915	\$24,499	\$1,125	\$25,625	
Maryland	\$32,246	\$223	\$32,469	\$32,720	\$5,717	\$64,966	\$38,437	\$64,966	\$5,940	\$70,906	
Massachusetts	\$60,615	-\$2,068	\$58,547	\$61,405	-\$44	\$122,021	\$61,361	\$122,021	-\$2,112	\$119,909	
Michigan	\$39,625	\$1,172	\$40,797	\$68,584	\$15,850	\$108,209	\$84,434	\$108,209	\$17,022	\$125,231	
Minnesota	\$37,481	\$140	\$37,621	\$37,698	\$4,374	\$75,179	\$42,072	\$75,179	\$4,514	\$79,693	
Mississippi	\$10,555	\$638	\$11,194	\$33,136	\$9,410	\$43,691	\$42,546	\$43,691	\$10,048	\$53,739	
Missouri	\$27,012	\$1,133	\$28,145	\$49,296	\$10,969	\$76,308	\$60,264	\$76,308	\$12,102	\$88,410	
Montana	\$2,857	\$101	\$2,958	\$5,972	\$2,067	\$8,828	\$8,039	\$8,828	\$2,169	\$10,997	
Nebraska	\$6,950	\$189	\$7,139	\$10,759	\$2,687	\$17,710	\$13,446	\$17,710	\$2,876	\$20,586	
Nevada	\$7,289	\$306	\$7,595	\$7,426	\$3,515	\$14,715	\$10,941	\$14,715	\$3,820	\$18,536	
New Hampshire	\$6,681	\$377	\$7,058	\$6,708	\$1,014	\$13,389	\$7,722	\$13,389	\$1,391	\$14,780	
New Jersey	\$54,389	\$1,275	\$55,664	\$55,369	\$5,146	\$109,758	\$60,515	\$109,758	\$6,421	\$116,179	

Attachment A: Changes in Spending For Medicaid and CHIP under the ACA for States and the Federal Government (millions) ^{a/} (continued)

	Changes in State Spending under ACA			Changes in Federal Spending under ACA			Total Spending under ACA		
	Without Health Reform	Change in Spending	Total Spending under ACA	Without Health Reform	Change in Spending	Total Spending under ACA	Without Health Reform	Change in Spending	Total Spending under ACA
New Mexico	\$10,031	\$45	\$10,075	\$25,243	\$2,747	\$27,989	\$35,273	\$2,792	\$38,065
New York	\$210,298	-\$11,226	\$199,072	\$211,289	\$12,396	\$223,685	\$421,587	\$1,171	\$422,757
North Carolina	\$39,336	\$1,382	\$40,719	\$74,100	\$17,724	\$91,824	\$113,437	\$19,106	\$132,542
North Dakota	\$2,203	\$55	\$2,257	\$3,782	\$824	\$4,606	\$5,984	\$879	\$6,863
Ohio	\$52,150	\$1,599	\$53,749	\$91,044	\$18,988	\$110,032	\$143,194	\$20,587	\$163,781
Oklahoma	\$14,083	\$338	\$14,421	\$25,773	\$6,760	\$32,533	\$39,857	\$7,098	\$46,954
Oregon	\$13,218	\$403	\$13,621	\$22,438	\$6,667	\$29,105	\$35,656	\$7,070	\$42,725
Pennsylvania	\$79,558	\$464	\$80,022	\$97,114	\$13,027	\$110,141	\$176,673	\$13,491	\$190,163
Rhode Island	\$9,943	\$113	\$10,056	\$11,225	\$606	\$11,831	\$21,168	\$719	\$21,887
South Carolina	\$14,169	\$995	\$15,165	\$33,713	\$9,066	\$42,779	\$47,882	\$10,062	\$57,944
South Dakota	\$2,718	\$68	\$2,786	\$4,612	\$1,149	\$5,761	\$7,330	\$1,217	\$8,547
Tennessee	\$26,475	\$969	\$27,444	\$50,630	\$10,379	\$61,008	\$77,105	\$11,347	\$88,453
Texas	\$100,649	\$4,022	\$104,671	\$145,328	\$38,691	\$184,018	\$245,977	\$42,712	\$288,689
Utah	\$4,854	\$209	\$5,062	\$12,404	\$3,651	\$16,055	\$17,258	\$3,860	\$21,117
Vermont	\$4,236	-\$184	\$4,052	\$6,040	\$27	\$6,067	\$10,276	-\$157	\$10,119
Virginia	\$30,183	\$461	\$30,644	\$30,581	\$10,132	\$40,713	\$60,765	\$10,593	\$71,358
Washington	\$33,121	\$679	\$33,800	\$33,365	\$6,788	\$40,153	\$66,485	\$7,467	\$73,953
West Virginia	\$6,404	\$360	\$6,765	\$18,348	\$5,262	\$23,610	\$24,753	\$5,623	\$30,375
Wisconsin	\$21,572	\$286	\$21,858	\$32,854	\$4,380	\$37,233	\$54,426	\$4,665	\$59,091
Wyoming	\$2,708	\$61	\$2,769	\$2,734	\$1,049	\$3,784	\$5,442	\$1,110	\$6,553
Total US	\$1,562,160	\$17,395	\$1,579,555	\$2,110,015	\$403,891	\$2,513,906	\$3,672,175	\$421,286	\$4,093,461

a/ Includes changes in spending due to expansions in eligibility, member movement due to new employer coverage, changes in drug rebates, increased federal matching percentage for expansion states, and changes in federal Disproportionate Share Hospital (DSH) payments. Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

