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THE HENRY J. KAISER FAMILY FOUNDATION

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

Prepared by:

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The Urban Institute

February 2011

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kaiser commission medicaid and the uninsured

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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.

* * *

Background

Under the Affordable Care Act (ACA) individual states will play a large role in administering, overseeing, and funding the coverage expansions called for in the Act.[1] For private insurance, states' traditional regulatory role is expanded. Each state also has the option to run new insurance Exchanges that facilitate purchase of coverage by small businesses and by individuals, many of them with new federal subsidies. Federal authorities will operate Exchanges in any state electing not to run its own. For lower-income Americans, state-federal Medicaid coverage is greatly expanded, both to categories of poor people not traditionally included and to higher income levels than many states now cover. For states, federal Medicaid funding is also greatly expanded, initially to 100 percent of the cost of newly eligible enrollees, ultimately to 90 percent (See box for more detail).

Implementing the ACA's new developments in federal-state relations has proven controversial.[2] The budgetary impact on states is a special concern, particularly at a time of state budgetary distress, because Medicaid is one of the largest budget items in all states.[3] Many state attorneys general are contesting the ACA's validity in federal court, sometimes saying that it imposes unacceptably high new costs on states.[4]

Projections of the ACA's budgetary impacts vary greatly across states making estimates.[5] Some projections have found very large net new costs for the state to finance, mainly from the law's expansion of Medicaid enrollment. Governor Rick Perry recently wrote that "Texas' share of Medicaid costs can be expected to jump as much as $27 billion over 10 years starting in 2014."[6] In sharp contrast, Maryland's Health Secretary John Colmers has noted, "If you add costs and compare with savings, over the first 10 years, the state will be a net beneficiary of $850 million."[7] A number of national estimates have suggested relatively low net new costs for states or even substantial net savings, as the ACA creates or allows some shifting of health costs from states or localities to the federal government.[8] For all estimates, the largest ACA impact on states' budgets is the cost of paying for ACA-driven increase in Medicaid and CHIP enrollment.

This paper seeks to answer three basic questions: 1) What is the range of estimates of the impact of the ACA on state budgets? 2) Why do the estimated impacts vary so widely across reported estimates? and 3) What conclusions can we draw about the fiscal impact of the ACA on states based on this analysis?

Our answers come from a thorough review of all the state budgetary impacts that can be expected to arise under the ACA. This paper begins with a description of our methods. Next, we compare and contrast the overall estimates made by five diverse states and in five national projections. Then, we examine the methodology used in the projections including the specific costs, savings and new revenues accounted for in each estimate and available indicators of their relative sizes. Finally, we review what conclusions can be drawn based on the analysis.

Brief Overview of Changes in Health Reform that Affect States

Medicaid. The ACA establishes a new, minimum standard for Medicaid eligibility that is uniform across the country and fills the biggest gaps in coverage for low-income citizens. 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). (The law applies a standard 5 percent "income disregard" to this eligibility level, effectively increasing Medicaid eligibility to 138 percent of FPL.[9] The law also calls for all states to measure income by a modified gross income test and to drop any use of assets tests. However, states can continue to use former income and asset tests for aged and disabled applicants.) For most states this will mean providing Medicaid to adults without dependent children for the first time, as well as increasing their income eligibility threshold for parents. The ACA also standardizes the calculation of incomes for eligibility for most types of applicants and bars the additional asset limits now used by many states. 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 (much higher) and for certain prior-expansion states (also much higher). The regular Medicaid match rate is determined based on a statutory formula that relies on states' relative per capita incomes. It ranges from a statutory floor of 50 percent to a high of 75 percent as of 2011. States with lower per capita incomes receive a higher federal contribution for Medicaid. For those newly eligible under reform the law eases the financing burden on states by having the federal government pay 100 percent of the costs from 2014 to 2016 and then the federal contribution phases down to 90 percent in 2020 and remains that that level. For certain states that had already expanded Medicaid coverage for childless adults prior to reform, their standard match rate previously applicable will rise in steps starting in 2014 so that by 2019 it will equal the enhanced matching rate available in other states for newly eligible adults.

The ACA also includes a number of other changes in Medicaid to help improve care coordination for duals (people in both Medicaid and Medicare) and individuals 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. Federal support is maintained at current levels through 2015, two years longer than previously enacted. The ACA also provides for higher federal matching rates for CHIP during 2016 through 2019, but does not yet fund 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 expected to set up their own state-based Exchanges, but if they choose not to, then the federal government will operate an Exchange. The ACA requires that enrollment for Medicaid and CHIP be coordinated with new coverage options offered through 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.

Sources: see note 1.

Methods and Approach to Understanding the ACA's Impacts on States

This paper is a descriptive analysis of the effects that federal health reform will have on state budgets. A particular focus is to understand and assess the wide divergence in estimated costs or savings reported to date. Our analysis began with a literature scan. We found many general descriptions of how the ACA affects states;[10] one comprehensive review of states' own estimates of specific dollar impacts, compiled by the Congressional Research Service (CRS);[11] other listings of state reports on impacts;[12] and five quantitative estimates of impacts on all states combined, from the Congressional Budget Office (CBO) and others,[13] as well as other materials.[14]

Assessing state-level information constituted the bulk of our analysis. We selected five diverse jurisdictions that had publicized varying assessments of dollar impacts. The states are Florida, Indiana, Kansas, Maryland, and Texas. We then reviewed materials from each state to assess the methods used to generate estimates; the time frame of the estimates, and the elements of costs and savings included in the estimates, along with their relative sizes. A spot check of other states' materials verified that all substantial elements of impact were represented in our review. We also interviewed key respondents in four jurisdictions that appeared to be moving early to implement and respond to changes in the ACA to increase health reform's value for their states and to decrease its budgetary costs. The interviews included Medicaid directors and others in the District of Columbia, Kansas, Maryland, and New York.

We also reviewed the five national estimates noted above. They help provide context for better understanding of the state projections and include material the states did not cover.

Our assessment included only the direct effects of the ACA on state budgets. We did not consider the estimates sometimes made of indirect ACA effects—such as how the ACA may affect the net flow of tax revenue into and out of a state or how the ACA affects economic activity within a state and hence also its revenue collections or spending needs.[15]

1. What is the Range of Estimated Impacts of the ACA on State Budgets?

The materials reviewed for this report illustrate the wide range of state budgetary impacts predicted to date. Table 1 shows the overall findings of the five state reports that we reviewed in detail as well as the five national estimates.[16] The Table shows reported estimates of total net savings or costs aggregated across the span of years included by each source.

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 and accompanying notes.

Notes: Savings are presented as negative costs. The figures are nominal dollars, not adjusted to one constant-year level. Acronyms are defined in text. Estimates vary based on state circumstances, projection methods, years included in the estimates, and the elements of costs, savings, and revenues included.

State projections

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 net costs (FL, IN, and TX), and two projected net savings (KS and MD). The reported impacts of the ACA on states budgets are affected both by states' prior circumstances and by how they choose to project impacts, as explained more below. Moreover, the magnitude of the estimates, positive or negative, tends to be larger in high-population states and of course for the national estimates.

The Florida estimates came from the state Medicaid agency.[17] Its projections focused on the costs of new Medicaid and CHIP enrollment and not on offsetting savings or new revenues. The size of its estimated net cost to the state was second highest, after Texas. For Indiana, the Secretary of Human Services relied on its commissioned actuarial analysis, which included both new costs and new savings and was updated for new developments.[18] Its estimate was the lowest of the three finding aggregate net costs. The Kansas Health Authority, the state's lead health purchasing entity, also commissioned actuarial work but reached its own conclusions.[19] It also considered more new costs than offsets but found net state savings for the covered time period, albeit very small savings. Maryland's estimates came from a newly created Health Care Coordinating Council and its contracted staff of experts.[20] It took the most comprehensive approach to estimating costs and savings, and was the only one to estimate new revenues. The Texas Medicaid agency emphasized new costs, recognizing but not estimating a number of offsets.[21] For more detail on specific state estimates, see Appendix A.

National estimates of state impacts

To provide context for reviewing the state estimates, we reviewed five national estimates. Two national estimates project only the costs of expanded Medicaid coverage in each case found to be about $20 billion countrywide (Table 1). Three national estimates include offsetting savings and find net national savings of $33 to $107 billion.

The Congressional Budget Office (CBO) estimated a national total of about $20 billion in state spending for Medicaid and CHIP benefits for new enrollees; it did not include costs of administration, other costs, or any offsets from savings beyond Medicaid coverage.[22] It and similar projections used statistical models to project affected people's insurance behavior and spending based on reliable evidence about the past behavior and costs of people with similar characteristics and circumstances.[23] An actuarial estimate from CMS (the federal Centers for Medicare & Medicaid Services) found that all states combined would save about $40 billion through 2019.[24] The underlying analysis was not detailed but did include offsets; as the report explained, state savings would occur because the ACA shifts some costs from the states to the federal government.[25]

Holahan and Headen of the Urban Institute (H & H) used CBO-like methods to generate state-specific estimates of changes in Medicaid costs for adult coverage only.[26] Their national total of $21 billion is close to the CBO estimate, although it does not include children as CBO did.[27] Dorn and Buettgens (D & B) produced estimates of three types of state savings designed to complement Holahan and Headen's cost estimates. But did not include Medicaid administration and other costs. Their report finds the large net savings shown in the table.[28] The Lewin Group's simulation model projected $100 billion in net savings to states, mainly from lower Medicaid costs and reductions in the need to support safety net programs that serve the uninsured.[29]

Thus, two national estimates (CBO and H&H) covered only the costs of expanded Medicaid coverage. They show costs of about $20 billion countrywide, less than the cost estimate from the single state of Texas. Three other national estimates (CMS, D&B, and Lewin) included not only costs but also offsetting savings. These three reports all find net national savings, ranging from $33 to $107 billion.[30]

Overall, these ten estimates range widely, and the range centers on little to no net impact. However, the aggregate values in Table 1 vary too much in their approaches to be interpreted as precisely comparable values on the same scale. Better understanding of the underlying approaches that generate these findings is needed to reach general conclusions about net impacts.

2. Why do Estimated Impacts of the ACA on States Vary so Widely?

Variation across state projections results from differences both in states' prior circumstances and in their approaches to projecting budgetary impacts.

Prior Circumstances of States

Much of the difference across states in levels of overall ACA impact results from the circumstances in each state. These include prior state decisions, like the scope of Medicaid, other economic and demographic factors, such as the prevalence of private employer coverage and of low incomes in the state, the costs of medical care delivery, and the levels of standard federal Medicaid and CHIP matching payment.

Table 2 shows a key part of these circumstances, the extent of the "uninsured gap" that the ACA asks states to fill. The gap is the share of a state's population that has Medicaid-level incomes, plus whether and how they are insured before the ACA. These factors drive the variation across state impacts in the Holahan-Headen analysis, which applies a standard projection method to each state.

TABLE 2. THE UNINSURED GAP, BY STATE

The Population Targeted by New Coverage under the ACA

size of subpopulations aged <65	**National**	DC	FL	IN	KS	MD	NY	TX
Share of state population that is ≤ 138% of FPL	**25.3%**	29.2%	26.1%	26.9%	24.1%	19.3%	26.4%	29.3%
Share of population ≤ 138% that is or has:								
Uninsured	**30.5%**	19.4%	40.3%	27.7%	30.4%	28.0%	22.0%	38.9%
Medicaid coverage	**42.9%**	58.2%	30.9%	47.4%	35.5%	35.4%	53.0%	40.5%
Other public coverage	**4.0%**	2.2%	5.0%	3.0%	4.0%	3.0%	2.0%	4.0%
Employer group insurance	**16.9%**	12.9%	17.0%	17.6%	19.3%	27.1%	17.0%	13.6%
Non-group insurance	**5.8%**	7.3%	6.5%	4.0%	10.6%	6.5%	6.0%	3.1%
Share of population that is both:								
≤ 138% & Uninsured	**7.7%**	5.6%	10.5%	7.4%	7.3%	5.4%	5.8%	11.4%

Source: Authors' analyses based on Census Bureau's 2009 and 2010 Annual Social and Economic Supplements to the Current Population Survey. State population data is restricted to non-institutionalized, civilian citizens; state data

Note: Other public insurance coverage includes Medicare or military-related insurance. CHIP is included in Medicaid.

Nationally, a quarter of the population might qualify for Medicaid under the ACA.[31] The District of Columbia and Texas have the highest shares of low-income people among the states reviewed for this paper, four percentage points over the national average. Maryland is the lowest, at only 19 percent, well below average. Maryland thus has a higher share of people likely to be net contributors through state taxes (people with higher incomes) and a lower share of people in potential need of state help. The share of the population under 138 percent of poverty that is uninsured reflects the primary gap to be filled by the ACA's expansions. Nationally, 30 percent of US citizens with incomes at or below the ACA's Medicaid income level are uninsured and 6 percent have non-group private insurance (unsubsidized by employers) that they might readily give up to enroll at almost no cost in Medicaid. These are the two subpopulations that can be expected to generate the highest new enrollment into Medicaid.

There are noticeable differences across the states examined in this report. Florida and Texas are each well above the national average in the sizes of their uninsured gaps because of their limited Medicaid eligibility levels and the relatively small share of their low income population with private insurance. So, Florida and Texas can expect a higher number of new Medicaid enrollees as a result of ACA. DC and New York have quite low uninsurance levels, which supports the expectation that the number of new enrollees would be relatively low even though these states have made no formal estimates.

Thus, how many potential new enrollees are in the gap affects new Medicaid costs. It also matters to what extent they are newly eligible versus those who are currently eligible because of the differential federal match rates (box above).

How States Choose to Make Projections

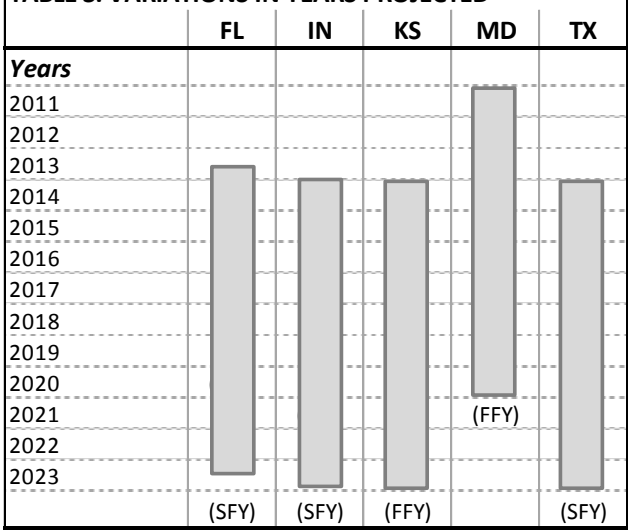
There are a number of differences in methodology that affect the estimates of the impact on ACA on state budgets. It is important to understand these differences in evaluating the estimate.

Time periods covered in the estimates

Covering more or later years increases the size of any projected impact. Years before 2014 are least expensive because the new requirements to expand coverage do not go into effect until 2014. The years 2014-2016 have relatively low costs of Medicaid expansion because the federal share for new eligibles is 100 percent, and many estimates project increasing take-up of coverage over time. Years starting in 2020 are more expensive because the federal share for newly eligible enrollees declines to its permanent level of 90 percent in that year.

As shown in Table 3, Texas covers 10 years, 4 of them on or after 2020. Maryland covers 9 years (2011 through 2020) and expects savings from 2011 through 2014; new costs are not incurred until 2014. Kansas estimates that its state budgetary impacts even in years after 2019 will be very small, despite the lower although still high standard federal match. The Maryland report includes the cautionary observation that (like Kansas) the state is projected to face net new costs beginning in 2020, when the federal match for newly eligible enrollees falls to its ultimate level of 90 percent. Conversely, the other three states project very high costs from the start.

TABLE 3. VARIATIONS IN YEARS PROJECTED



Source: State reports discussed and cited in text

Only slight differences across state projections seem attributable to whether they assess impacts using state fiscal years (July-June) or federal fiscal years (October-September). The national estimates all begin in either 2010 or 2014 and end in 2019—because they all benchmark against the standard CBO model of Medicaid baseline spending that ended with 2019.

Populations covered in the estimates

Most state estimates consider all populations that will be affected by changes in the ACA. At the national level, the Holahan and Headen estimates only looked at changes in coverage for adults and not children. Including children brings in CHIP as a source of new costs through (a) somewhat higher participation of children previously eligible but not enrolled and (b) the shift of CHIP enrollees to Medicaid when they have

incomes of 100-133 percent of FPL.[32] It also brings in a new offset, that is, state savings from a higher federal share of CHIP funding under the ACA.

Elements of impact accounted for in the estimates

Table 4 summarizes the content of the five reports' fiscal estimates. The number of elements of impact specifically accounted for ranged from 5 (in Florida) to 14 (in Maryland). All five state reports include at least 4 components of new costs, but only Maryland includes more than 3 new savings and revenues. Overall, far more cost elements are accounted for in these five reports than savings or revenues, and the imbalance is higher in the three states projecting high net costs than in the two states finding net savings.

TABLE 4. NUMBER OF ELEMENTS OF IMPACT ACCOUNTED FOR

	--------STATE PROJECTIONS---------				
	FL	**IN**	**KS**	**MD**	**TX**
# Cost Elements Included	3	6	4	7	6
# Saving Elements Included	1	3	2	5	1
# Revenue Elements Included	0	0	0	2	0

Sources: state reports discussed and cited in text.
Notes : Authors' tabulation; see also breakout of specific elements in the next tables

New Costs

Our review of state projections and other materials suggests that states believe that their Medicaid costs would be increased in a number of ways (Table 5), as detailed in this section.

TABLE 5. NEW COSTS OF THE ACA: INCLUSION IN STATE PROJECTIONS

	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			

Sources: Authors' compilation from state reports and other materials discussed and cited in text
Notes: This table tallies cost elements that states may or may not include in making estimates; some small impacts are excluded. An "X" indicates that an element was scored by that state's projection. More detail appears in the text and accompanying notes.

Increased enrollment in Medicaid. The largest single new impact estimated by the five states is the cost of paying for the medical benefits or health plan enrollment of new enrollees.[33] The ACA raises eligibility standards to a new national level (box above). For a large majority of states this will mean an increase in eligibility for parents and for adults without dependent children. 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, which will likely raise take-up rates.

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. Despite the significantly higher federal funding for new eligibles, every estimate shows new enrollment as the largest new cost for states under the ACA.

Different estimates include different assumptions in projecting costs of expanded enrollment. In projecting enrollment costs, some states explicitly assume very high levels of participation among the eligible population, often 100 percent. Given historic experience and the fact there is no penalty for not participating for most of those eligible for Medicaid, 100 percent participation, even among the uninsured made newly eligible for Medicaid seems very optimistic. The Holahan and Headen main estimates assume (similar to CBO) that there would be 57 percent take up among newly eligible uninsured and 54 percent take up among those enrolled in non-group coverage. Participation among those eligible for employer sponsored coverage was lower at 25 percent and for those already eligible but not enrolled participation was only 10 percent. Holahan and Headen also estimated another scenario with more robust participation among those newly eligible and currently eligible. In this scenario, participation among those newly eligible who were uninsured was 75 percent. None of the national estimates assume 100 percent participation.

The Florida estimate assumed 100 percent Medicaid participation both for people currently eligible but not enrolled and for those newly made eligible under the ACA.[34] The take-up rate among eligible people was assumed to increase from 40 percent in the initial ACA expansion year of 2014 to 100 percent in 2016 and beyond. The most recent report from Indiana estimated costs of new enrollment using its prior assumption of 100 percent participation in Medicaid by the uninsured and the privately insured and an "alternative" projection based on somewhat lower take-up rates that differ between childless adults versus parents and children and between people with private coverage versus otherwise uninsured.[35] The Texas estimates also assumed high Medicaid participation (94 percent take-up among eligibles).

Cost per enrollee is the other key component of projecting enrollment costs. Some state estimates appear to assume a relatively high cost per enrollee relative to national studies that are based on evidence about characteristics of the uninsured, although explicit explanations are not provided. Research finds that new enrollees under the ACA should cost less than current enrollees, particularly the expensive elderly and disabled enrollees.[36] Insurers' practical experience with adverse selection suggests the same effect. Part of the differential in what cost per enrollee to expect is linked to assumed participation rates. Given that the older and less healthy are most likely to enroll, higher participation rates mean that more healthy individuals must be participating which should lower average costs. The Indiana report notes a different reason for higher than average cost: Pent-up demand among the previously uninsured may initially increase utilization under new coverage, and hence costs per person.[37] However, as it also notes, that effect applies only in early years after enrollment, when all costs for the newly eligible will be covered by the 100 percent federal match in the initial years of the ACA.[38]

Why Kansas Estimates Lower Costs per Enrollee

The Kansas estimate assumed not only modest costs among new enrollees, but also reduced costs among traditional enrollees. The main reason is that its projection anticipated that under the ACA most very sick or injured people with higher incomes will obtain and retain coverage from their employer group or through the Exchange. Most privately insured people will also have comprehensive benefits, with out-of-pocket stop-loss provisions and without annual or lifetime limits on insured payouts. Accordingly, high-cost people will seldom qualify for Medicaid coverage as they now do in Kansas by "spending down" their income and assets on uncovered care and thus reaching Medicaid levels of income eligibility. In a way, this phenomenon is the reverse of the often-cited crowd out that many expect to occur under a public expansion, when people leave private coverage for expanded Medicaid or CHIP. The expectation in Kansas is that care received under private coverage will mainly displace public programs for these expensive people.[39] Many other Medicaid programs also have spend-down eligibility and might see such effects.[40]

New Medicaid administrative costs. Four states show administrative costs for new Medicaid enrollment as the second largest new cost faced by states, although 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 MCO premiums. [41] This component of new state cost is sizable because the 5 to 8 percent rate applies to all new spending on benefits or MCO premiums, including the increased federal share, which dwarfs the state increases.[42] Moreover, with some exceptions, the federal matching rate for administration is only 50 percent for all states and all types of enrollees, not the much higher ACA matching rate or even the standard federal Medical match rate, which is above 50 percent for most states.[43]

Beyond the percentage-of-spending estimate for ongoing administration, Maryland and Indiana add a flat dollar amount for time-limited startup expenses. Kansas expects to incur such costs as well, but has raised private funds to cover design and implementation of new enrollment systems both for Medicaid and for the Exchange.[44] Some states have expressed concerns about high costs associated with new requirements to simplify and coordinate eligibility and enrollment for Medicaid and the Exchanges. Some relief may come from a federal regulation proposed by CMS in November 2010 that could pay a 90 percent match rate for new eligibility and enrollment systems[45]—too recent a development to have affected these projections.

Administrative costs for the state Exchanges. Setting up and running the insurance Exchanges for people not eligible for Medicaid will also require state spending. (There may be separate Exchanges for individual purchasers and for small businesses, or states may combine them.) States have the option to allow the federal government to operate the Exchanges, but they would then have less control over how the Exchange relates to their Medicaid and CHIP programs. Three states estimated these costs, which are expected to be modest for states in part because there are federal grants available to offset some of the start-up costs, some ongoing costs are chargeable to Medicaid, and the Exchanges are to be self-supporting. States would have the option of assessing user fees explicitly or as part of the premiums paid, as is done in Massachusetts.[46] Moreover, the cost of overseeing insurance sales should be lower than of actively administering Medicaid, and Exchanges will handle fewer enrollees than Medicaid, certainly at first and possibly thereafter as well.[47]

Increases for Medicaid physician fees. Medicaid physician fee increases may be counted as a cost of implementing the ACA. In 2008, Medicaid physician fees averaged 72 percent of all Medicare fees and 66 percent for primary care services. [48] 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 2013-2014 at least at Medicare levels, an increase in almost all states. However, for these two years, any increase over prevailing fees is to be 100 percent federally funded. Thereafter, there is no specific requirement in the ACA

that states maintain this level of fees, but some new costs may persist because it may be difficult to return to prior low levels.[49]

The Florida, Indiana, and Texas reports all list the need to raise provider fees as a new cost of the ACA; Kansas notes that increases are a state option. The associated costs can be substantial, depending upon how low fees now are and what the state share of Medicaid costs now is. The Indiana estimate was nearly a quarter of all projected net costs to the state over 10 years; it presumed that all physician fees would be increased, not just for primary care, to 80 percent of Medicare levels.[50] Because services for those newly eligible would be reimbursed at the new very high federal match rate, the cost of their higher physician fees would be largely paid by the federal government. States would pay the regular match rate for any rate increases for those currently eligible for coverage.[51]

Reduction in Federal DSH Support. Medicaid provides funding for disproportionate share hospital payments (DSH) for hospitals that serve a "disproportionate" share of uninsured people or Medicaid enrollees. Federal allotments for DSH funding are fixed by year rather than open ended and totaled over $11 billion nationally in 2009. Although federal DSH payments are capped, states must still provide a state share to draw down federal DSH funds. The amount and distribution of DSH funds is uneven across states, reflecting how actively each state has sought DSH funding in the past and how much prior federal reforms cut back growth in allotments to high-DSH states.[52] States often require localities to contribute the state share or impose a provider assessment to raise the state funds. The ACA calls for reductions of federal DSH funds totaling about $18 billion during 2014-2020.[53]

Some observers and state reports count the lost federal dollars as a cost to the state, albeit a minor one. The cuts certainly constitute a reduction in the federal dollars now coming into a state for distribution to hospitals. However, if states opt to reduce state spending for DSH as a result of the federal reductions this would translate into a savings in state dollars.

New costs for state employees' coverage. The ACA calls on all employers to improve benefits, for example, by including children up to age 26 on their parents' coverage. States as employers need to make conforming changes under coverage that they provide to state employees and retirees. Maryland estimated this effect as a relatively small element of new cost; other reports did not, although all states are in the same situation.[54] A similar possible new cost not mentioned by any of the state reports is the potential that some people already eligible for state employees' coverage, but that have not participated, might take up the coverage because of the ACA's new mandate or enhanced publicity about coverage. On the other hand, states may transfer much or most of these cost increases to their workers. In recent years employers have raised the share of total health costs borne by employees.[55] There is also a possible offset available from pre-ACA, transitional federal reinsurance that covers a large share of especially high per person costs for early retirees who are not eligible for Medicare.[56] The potential budgetary impacts here appear to be small and need to be regarded as uncertain.[57]

New Medicaid Coverage for Foster Children up to Age 26. State Medicaid programs under the ACA need to add coverage for foster children up to age 26. This is a small-dollar impact itemized for Indiana and Texas, but not for the other states.

Transfer of some children from CHIP to Medicaid. States that currently cover children (ages 6-19) between 100 and 133 percent of FPL under CHIP will be required to transition this coverage to Medicaid 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.[58] 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.

Change in eligibility for 209(b) states. Indiana and ten other states are currently section 209(b) states,[59] meaning that they use more restrictive 1972 standards for determining Medicaid eligibility for individuals with disabilities instead of linking their eligibility to receipt of Supplemental Security Income (SSI) payments. The Indiana report reviewed here has assumed that the ACA will require it to convert to the SSI eligibility standards, which it expects to raise state costs. The projected impact is sizeable, over a fifth of the overall net cost estimated in the state. Whether CMS will require these changes and how this will ultimately affect state costs remains unclear.[60]

New Savings

Our review of state projections and other materials suggests that new savings and revenues are available to states to offset the new costs (Table 6), as explained in this and the next section.

TABLE 6. SAVINGS AND NEW REVENUES: INCLUSION IN STATE PROJECTIONS

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 [a]					
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	

Sources: Authors' compilation from state reports and other materials discussed and cited in text

Notes: This table tallies elements of budgetary impact that states might estimate; some small or idiosycratic impacts are excluded. An "X" indicates that an element was scored by a state projection; some elements were not scored. More detail appears in the text and accompanying notes.

a. this savings comes from the higher federal match for some enrollees in waiver expansion states

Reductions in state support for uncompensated care. Under the ACA, in 2019 about 32 million Americans will have coverage who would otherwise have been uninsured.[61] They will then produce new revenue for the health care providers who treat them, rather than burden these providers with uncompensated care. No matter how it is estimated, this shift from unpaid to paid care will produce very large savings for providers, especially public hospitals and clinics, along with private safety net institutions.[62] Much of that care has long been subsidized by taxpayers at all levels of government. The details of how taxpayers now support uninsured people's uncompensated care vary from state to state.[63]

None of the five state reports reviewed here made a projection of savings from reduced support for uncompensated care, although two mentioned their existence.[64] This omission unfortunately deprives us of the benefit of states' own explanations of how subsidy arrangements might change under the ACA. Accordingly, for dollar estimates we must rely solely on information from other sources, including three of the national estimates reviewed here as well as our own prior work.[65] Growth in uncompensated care without health reform would be high, approximately doubling nationwide during 2009-2019, more in some states.[66] The ACA will greatly reduce that growth, including the state-local share.[67] States and localities should see savings on support for uncompensated care, even though maintaining some level of support will be important under the ACA—for example, to support care for the remaining uninsured population as well as DSH payments to some providers.[68] Those needs will vary by state, influenced by such factors as the size of the non-citizen population.[69]

Dorn and Buettgens estimate that without the ACA states and localities would spend about $170 billion on subsidies for uncompensated care during 2014-2019. If states and localities could reallocate a quarter or half of this amount to other uses once insurance is expanded, they reason, savings would be $43 or $85 billion over these six years. The Lewin estimate is that states and localities together would save $100 billion in safety net spending during 2010-2019.[70] Any of these amounts exceeds the costs of medical services for new public program enrollment as projected by CBO or Holahan and Headen (even if higher participation estimates are assumed). Some of these savings may occur automatically, where state spending is tied to providers' actually incurred amounts of uncompensated care. Other savings may require some state action to realize in state budgets, through adjustments in funding flows to providers and local governments.

Medicaid savings. Within Medicaid, states may achieve additional savings in multiple ways. Seven elements of savings are listed in Table 6 and described next section.

Shift of higher-income adults and pregnant women now in Medicaid into an Exchange. Most states provide Medicaid 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, so states would be able 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.[71] 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. State savings on Medicaid coverage for pregnant women could be substantial. As a group, pregnant women are very expensive to cover; even an uncomplicated birth in a hospital is a relatively costly service, and problem births are extraordinarily expensive.[72] The Indiana report estimated a medium level of savings for such a transfer.[73] There are fewer opportunities for shifting other adult enrollees to Exchange coverage, as only a few states extend eligibility for them beyond the 133 percent level.[74]

Additional Federal Match for Adults Currently Covered by Medicaid. Expansion states and those with Medicaid waivers for adults are expected to receive new federal revenues for coverage that they are currently providing. As noted earlier, seven states qualify as "expansion states" and will receive a phased-in higher match rate for

coverage previously extended to childless adults not covered in most states.[75] None of our five states qualify in this way, but the effect is large for the states whose prior expansions qualify them for the new higher federal match (see box).

How New York's Prior Medicaid Expansion Helps Its Budget under the ACA

New York provides a good example. Although state policymakers have not publicized budget estimates, its higher match as an expansion state will considerably reduce its current Medicaid spending.[76] New York now pays for half the cost of some 940,000 childless adults, but in 2014 its share of these costs will fall to 25 percent, declining further to 10 percent in 2020 and thereafter. These savings will offset the new costs of additional enrollment of those currently eligible at the regular match rate[77] and the smaller costs of expanding coverage to about 90,000 newly eligible childless adults with incomes of 100-133 percent of FPL (who will draw down the match rate for new eligibles).

A few other states, like Maryland and also Wisconsin, have Medicaid waivers, but do not qualify as expansion states because the benefits packages under their waiver programs are more limited than under Medicaid. For these states, some adults covered by the waiver will qualify as new eligibles and receive the high match rate for new eligibles. This will be a savings relative to the costs states are incurring to cover these populations in their current programs. Maryland's report notes this effect but provides no dollar figure of savings; they are offset against new costs of expanded Medicaid enrollment and subsumed within that estimate.

Breast & cervical cancer programs run within Medicaid can be folded into regular coverage after the ACA. Need for the programs will wither under the ACA, so this past support can be shifted to fund future Medicaid expansion. The anticipated savings are small.[78] This issue was noted only in Indiana and Maryland.

Reduce Medically Needy Programs. Spend-down enrollees in the 36 states with spend-down programs are quite costly to cover under Medicaid;[79] by definition, they have high medical costs. Our Kansas sources said that spending-down will occur much less often under the ACA because individuals will have broader coverage options. However, to assure reductions, a state can end this route to eligibility for Medicaid. Because Medicaid has more comprehensive coverage for individuals with disabilities than will be available in the Exchanges and seniors are not eligible for coverage in the Exchanges, states may consider maintaining these programs. None of the state reports reviewed considered this option as an element of savings.

Adjust Medicaid benefits provided to newly eligible people. The ACA allows states to vary the benefits provided to newly eligible populations from their standard Medicaid packages, so long as they meet the standards set by the Deficit Reduction Act (DRA) and federal regulations.[80] If those can be made more cost-effective or value-oriented, states could save on their coverage, that is, after 2016 when the federal match begins to decline.

Moreover, a particular goal may be to redesign benefits (and payments) to promote community care rather than institutional care. For example, Kansas assumes that a number of individuals who are currently eligible under the state's home and community based services waiver will become newly eligible for full Medicaid coverage. The state could elect to offer rehabilitative and habilitative services as a covered benefit for newly eligible enrollees. The analysis done in Kansas suggests that doing so will lead to covering some high-cost people as expansion enrollees with a high federal match who would otherwise generate only the lower standard Medicaid match. In this way, careful benefits design can reduce the state's own-source spending.. The state did not estimate savings from this possible option.

Reduced state match for DSH. As noted above, any federal cuts to DSH in a state will reduce the state's budgetary obligations. An advisory report in New York noted that if DSH reductions occurred, there would be a simultaneous reduction in the state obligation to put up its 50 percent share.[81] The state could then choose to "retain the dollars as budget savings." Alternatively, it might "want to revise its allocation formula to ensure that hospitals continuing to see large numbers of uninsured patients receive additional financial support." Finally, the Medicaid program could also choose to "shift state DSH dollars to support Medicaid rates and draw down federal matching dollars" in a different way. For new eligibles, the match would be at least 90 percent. This strategy reduces state savings relative to doing nothing in response to a federal DSH cut, but it also increases the funding flow to medical care providers in the state and likely improves access for beneficiaries. Only the Kansas projection of fiscal impacts took this view, and it did so without detailed explanation or separate estimation of savings.

Recoup new pharmaceutical rebates for managed care. Under 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. Only Maryland estimates this element of savings, which constitutes about 10 percent of its total in new savings.

Reductions in other state funded programs. Three elements of savings are available to states because under the ACA their health program spending outside of Medicaid will decline as a matter of course or can be reduced by active state program management (Table 6).[82]

Pre-existing state coverage programs. Many states or localities run non-Medicaid coverage programs, such as medical general assistance, that provide some level of medical benefits to enrollees at state or local expense.[83] Demand for such coverage will decline once broader coverage is available at low cost from Medicaid or an Exchange. None of the five reports included savings from reductions in such coverage, and in most states any impact is likely to be small because the programs are small.[84]

Greater savings are achievable in a small number of states that previously had had large programs of non-Medicaid coverage. Such jurisdictions can benefit from shifting state-funded enrollees into state-federal Medicaid support through "early expansion" of enrollment, even prior to 2014 (box). The ACA allows any state Medicaid program to begin enrolling people up to and including 133 percent of FPL upon passage of the reform law using a state's regular match rate.[85] A shift into Medicaid draws down new federal matching funds, although it also requires providing full Medicaid benefits and treating enrollment as an entitlement not subject to state budget limits.

How Early Expansion Helped the District of Columbia

Taking advantage of this provision has already helped the District's 2010 budget. A news account put the savings to DC at $56 million over four years starting this past July.[86] Beginning in 2001, DC ceased direct support for its traditional public hospital and associated city clinics and used a somewhat smaller level of funds to support a new coverage program known as the Alliance, which covered all residents not eligible for other coverage up to 200 percent of FPL.[87] DC moved some 32,000 people from the Alliance into Medicaid on July 1, 2010.[88] It then began receiving its standard 70-percent federal match for those costs—hence the substantial savings.[89] Beginning in 2014, such newly eligible Medicaid enrollees should qualify for the higher ACA matching rate, and savings will increase.[90]

DC (see box) and Connecticut have implemented this option to shift state-funded coverage to Medicaid and draw down federal funds, and Minnesota is planning to do so.[91] California's recent waiver appears in part to attempt much the same shift from state-local support of safety-net coverage.[92] Other states may also benefit from shifting state or local coverage programs to Medicaid. However, if the programs are very limited or if their enrollment is capped well below the estimated number of eligibles (which was not true in DC or Connecticut), shifting to Medicaid benefits on an entitlement basis might increase spending by more than enough to offset the gain in federal matching payments. The CRS report suggests that five states including DC can benefit from exercising this option.[93]

Direct state support for services. Beyond offering Medicaid and other coverage programs, most states have other programs that either directly provide free or reduced-fee services to certain populations or make grants to service providers that do so. Numerous such programs are funded within public health, mental health, and substance abuse agencies at state and also local levels.[94] Under the ACA, many or most of current clients for such services will become eligible for new Medicaid coverage or private insurance, which should pay for the services. The new enrollees may then seek care from private providers not previously available to them, so that the public providers or programs now covering them should see lower costs of service. If the enrollees instead continue to visit publicly funded providers, the latter will be able to bill to the new coverage. Either alternative will yield substantial state-local savings. Estimates for Maryland suggest that such spending will fall by about half; there, more than $400 million in state savings were projected for 2011-2020, about one quarter of the total net savings from all impacts estimated. Lesser savings were estimated separately for existing prescription drug assistance for seniors. Local programs also contribute, with funding from states as well as own-source revenue. Dorn and Buettgens' national estimate projected state-local savings on mental health services of $20 to $40 billion nationwide during 2014-2019.[95]

The growth of state Medicaid programs has long been accompanied by such "Medicaid maximization" by state agencies—for example, billing Medicaid for services formerly provided for free or at a reduced fee at a public medical clinic or in schools.[96] The ACA will extend coverage to people at higher income levels, and the new, higher federal match rates of 90 to 100 percent for the newly eligible may lead to new maximization efforts.

State high risk pools. More than 30 states run high risk pools to subsidize coverage for residents unable to obtain private health insurance because of their pre-existing medical conditions. This function will be met by the ACA's ban on such refusals, and enrollment costs for higher risk people will be held down by expanded Medicaid coverage and the ACA's modified community rating for private non-group coverage. Thus, starting in 2014, applications for pool coverage should decline because it is priced substantially above standard rates.

How savings will be incurred will vary by state financing arrangements. Maryland finances its subsidy from a state assessment on hospitals, and its report estimated substantial savings after ACA implementation—$1.1 billion over 7 years, half of the new savings identified.[97] Most other states have smaller pools, funded by a surcharge on health insurers that operate in the state. Insurers can either take the cost of those subsidies as deductions against income tax or, sometimes, as a full credit against premium tax otherwise payable to the state. In states other than Maryland, savings would thus accrue in the form of increased collections of insurers' taxes. No other report that we reviewed included this component of savings.

New federal funds for CHIP. Under ACA, the federal share for CHIP is slated to rise starting in 2016. Every state report reviewed includes a factor for reduced state spending on CHIP, but the expected savings are modest.[98] This savings assumes that CHIP is again extended with adequate funding to support the increased match rate, which the state reports did assume.

Seek various efficiencies in care delivery or payment methods. Many opportunities to promote efficiency or enhance value exist under the ACA, according to interviewees and others taking an activist approach,[99] but benefits tend to be achievable only in the long run and are difficult to predict. None of the five state reports makes an estimate for such savings, perhaps because of these uncertainties. For example, the ACA allows states to integrate care for "dual eligibles," people jointly enrolled in Medicaid and Medicare, and thereby achieve improved value or efficiency.[100] Coordinating care for duals has been challenging and while these individuals account for about 15 percent of total enrollees, they account for 40 percent of Medicaid spending.[101] Enrollees with multiple chronic conditions are another group for whom better management of care can improve outcomes and may also save money. The ACA provides for a new Medicaid state option to establish "health homes" to coordinate care for people with chronic conditions and federal grant funding to help states design their programs. These initiatives focus on the high need and high cost populations covered by Medicaid.

The detailed analysis of ACA implementation issues in New York, from the NYS Health Foundation highlights many ways that the ACA can help New York meet its own policy goals, while saving state money relative to an unchanged set of programs.[102] The report lists opportunities to obtain additional enhanced federal matching rates by adopting health homes within Medicaid, expanding community-based long-term care, and providing certain preventive care services, for example. As a non-fiscal document, it can freely consider promising ideas for long-run efficiencies without the need to estimate specific budgetary impacts.

Obtain federal grants or similar funding. In addition to the large coverage changes made by the ACA, the law creates a large number of much smaller ways for states to receive new federal funds. (If used to promote more efficient delivery or financing of care, as just noted, these small short run dollars could become larger longer-run savings.) For example, 48 states and the District of Columbia have already applied for and received federal grants to plan for or study the feasibility of operating an Exchange (states can decide instead to have federal administrators run an Exchange for their residents),[103] and seven states have received grants as "early innovators."[104] The ACA also creates a transitional reinsurance program to help employers afford to maintain coverage until 2014. The federal reinsurance helps employers cover high claims costs of early retirees.[105] Some 3600 groups were participating as of October 28, 2010,[106] but total program funding is limited (to $5 billion) and the program will operate only until 2014. Private foundation or other grants can also be sought to help fund ACA-related activities, as has occurred in Kansas. Maryland authorities have listed 68 "grants and other funding opportunities"[107] to support many efforts related to payment reform, promotion and support of improved health information systems, and integration of clinical health services with public health promotion.

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 report was the only one to estimate this impact.[108] Its tax rate is 2 percent of premium, a common level. Its revenue estimate for 2013 through 2020 was almost $600 million, over two thirds of the entire net savings that the state projected.

Increased revenue from taxes on medical providers. [109] States have increasingly assessed providers on their revenues, similar to Maryland's 1 percent assessment on hospital revenues for its high risk pool (above). Any state with any provider tax would likely see increased collections after the ACA because utilization of care will rise. The effect seems likely to be modest, as rates of assessments seem to be lower than premium taxes, as in Maryland.

3. What Conclusions Can be Drawn? Summary and Concluding Discussion

Large variations in the estimates of the effect of the ACA on state budgets have been identified in this analysis. These differentials result from state circumstances, the time period of each estimate, the estimating methodology and the specific components included in the estimate. A review of the state estimates and other materials shows that, while the ACA's obligations impose a number of substantial new costs on states, states also have opportunities to achieve major savings and some new revenues as health reform is implemented. States have included more cost elements than savings elements in their estimates, which may make sense as a matter of prudence in forecasting, but which makes the costs to states look higher than they are likely to be in practice.

Prior state circumstances and choices drive much of the variation across states in projected state budgetary impact of the ACA. The size of the uninsured population at or below 138 percent of poverty who will be eligible for Medicaid coverage under the ACA and the extent of Medicaid coverage chosen by a state prior to the ACA are examples of key state circumstances and choices that affect estimates. These factors will largely drive the size of new enrollment and what federal match rates will apply. States that have low participation among those currently eligible for coverage will experience relatively higher costs because the ACA will encourage higher take-up of coverage, and only the regular Medicaid match rate (50 to 75 percent) applies to those who are currently eligible for coverage. For states with previously limited Medicaid coverage for adults, most of the new enrollment will be matched at the higher federal match rate for newly eligible people (100 percent for 2014-2016 phased down to 90 percent by 2020)—which will limit state costs and bring in larger amounts of new federal revenues.

Key assumptions have significant implications for the estimated costs of ACA to states. Various assumptions in the methodology for calculating the estimates have significant implications for costs. Including more or later years in the estimates, higher rates of participation and higher costs per enrollee all add additional costs to the estimate. All of the state projections reviewed assume higher participation rates than supported by experience to date (the basis for the CBO and Holahan and Headen estimates), and three states (Florida, Indiana, and Texas) assume that all or almost all of those eligible for Medicaid will enroll. Health reform strives to enroll all who are eligible, but there is no evidence to support an assumption of 100 percent participation, even with an individual mandate and robust enrollment efforts. While the details are less specific, it also appears likely that several states have based per enrollee costs on the costs of those currently enrolled, whereas research shows that new enrollees will likely be less expensive because the uninsured have generally better health status than those who have already enrolled in Medicaid or private coverage.[110]

Differences in assumptions can result in either higher or lower projected net impacts. On the cost side, for example, some state reports assume that the ACA will make them spend more on physician fees, although this is not an express requirement of the ACA. On the savings side, projecting savings on uncompensated care and also reduced spending on state public or mental health may overlap. Once federal guidelines have been issued and provide greater clarity on ACA implementation, the need for states to make assumptions about budget impacts is reduced—which can be expected to reduce the variation in state estimates. In some instances, CMS guidance on ACA implementation has already reduced expected costs from what states had previously projected, as with the guidance on pharmaceutical rebates.

All state estimates include more cost elements than savings or revenues. Including mainly new costs associated with the ACA without accounting for many of the opportunities for savings or new revenues increases the size of net costs estimated. The largest omission is any savings related to reduced payments for uncompensated care costs that will surely fall in all states.

Every estimate that we reviewed accounts for the Medicaid expansion in coverage as the single largest element of new costs. Every state estimate but one (for Florida) also accounts for increased costs for Medicaid administration as the second largest component of new costs.

In contrast, only the report for Maryland estimated more than three types of new savings or revenues as offsets to the estimated new costs. None of the state reports explicitly estimated arguably the largest offset, that is, reductions in uncompensated care. These savings are likely to follow ACA expansions of both private and Medicaid coverage and to be highest in states where the costs of expanding Medicaid are highest. The state-specific projections account for some of the impacts of the ACA, but none account for all elements. The under-accounting for savings and revenues makes the estimates seem not merely prudent forecasting but almost worst-case scenarios. The three national estimates that included not only new costs but also offsets for new savings and revenues all found net savings.

Ultimately, the effect of ACA on state budgets depends heavily on how individual states choose to implement the law. For instance, 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 revenue raising; 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.

Appendix A: Summary of State Estimates Reviewed in the Report

This appendix provides additional detail about each of the five states focused upon in this report. Each state's projection approach is sketched, and the resulting estimate is compared with that of Holahan and Headen, which is a useful benchmark, as it projects the cost of covering Medicaid expansion enrollees in a uniform manner for every state.

Florida's projections were made by the state's Medicaid agency, issued initially in April 2010 and then again with technical corrections in August 2010.[111] The more recent assessment assumed 100 percent Medicaid participation both for people currently eligible but unenrolled and for those newly made eligible under the ACA. (The take up rate among those who otherwise would purchase private nongroup coverage, a small population, was assumed to be 80 percent.) Over time, the take-up rate among eligible people was assumed to increase from 40 percent in the initial ACA expansion year of 2014 to 100 percent in 2016 and beyond. Beyond the costs of such higher enrollment, the estimate also included higher physician fees for primary care, although there was no allowance for higher Medicaid administrative costs. Only CHIP-related savings were identified. The state's year-by-year projections totaled $5.7 billion during state FY 2014 through FY 2019. The corresponding Holahan-Headen projections for calendar years 2014-2019 were some $1.2 billion for standard participation rates similar to past Medicaid experience (e.g., 57 percent take up among uninsured new eligibles) and $2.5 billion with enhanced state outreach (e.g., 75 percent among uninsured new eligibles).[112]

Indiana's estimates come from its commissioned actuarial projections, of which three were done from December 2009 through October 2010.[113] The most recent report estimated costs of new enrollment using its prior assumption of 100 percent participation in Medicaid by the uninsured and the privately insured and an "alternative" projection based on somewhat lower take-up rates that differ between childless adults versus parents and children and between people with private coverage versus otherwise uninsured. Administrative costs and a number of other cost elements were included, most notably higher fees for all physicians, not only for primary care. Net new state costs totaled $2.6 billion during state FY 2014-2020 in the lower-participation scenario (the level presented in Table 1 above) and $3.1 billion with full participation.

These estimates are much larger than the corresponding two Holahan-Headen projections for calendar years 2014-2019 They estimated less than $0.5 billion under their lower-participation scenario and about $0.9 billion for higher participation.[114]

The **Kansas** Health Policy Authority, the lead health agency in the state, also commissioned actuarial analysis.[115] The Authority concluded that the state will spend about $200 million less on Medicaid and CHIP during 2014-2019 than it would spend to maintain the current program.[116] In 2020 and beyond, when the federal match for new eligibles declines to 90 percent, state spending will be higher, but only by about $4 million per year in 2011 dollars, approximately half of one percent of the state share of Medicaid spending. The agency noted that Kansas could also spend more or less than this amount, depending upon what it decides to do about provider rate increases and safety net programs after the ACA expands coverage. By 2020, demographic shifts and continuing inflation in medical costs were estimated to cause far larger budget increases in non-ACA, baseline costs, about $327 million. This amount combines $138 million to cover the natural growth in the number of disabled and aged Kansans now covered under Medicaid (4.3% per year) and $189 million to cover baseline growth in costs (3% per year).

By way of comparison, Holahan and Headen projected higher costs totaling $0.2 or $0.3 billion during 2014-2019.[117] The state's projected savings are all the more remarkable in that they include new costs for children and for administering expansion coverage, which were not part of the Holahan-Headen estimates. Kansas also

assumed higher take-up of coverage among eligible people. For example, the state assumed that 98 percent of now-uninsured eligibles at or below 50 percent of FPL would enroll under the ACA, whereas Holahan-Headen expected 10 or 40 percent (the lower and higher assumptions) for this subpopulation.

The **Maryland** Health Care Reform Coordinating Council estimated that the state will save more than $800 billion during 2011-2020.[118] The biggest single new cost was increased spending on benefits for previously eligible but unenrolled Medicaid beneficiaries, for whom the state share is 50 percent rather than the zero to 10 percent for newly eligible enrollees. The second largest new cost is higher administrative spending. The state had already budgeted to increase physician fees, so the ACA did not add to that cost. The largest saving is reduced usage of the state's sizable high-risk pool after the ACA coverage expansions. The second largest is reduced spending under state programs that now pay for health services but that will be covered by improved Medicaid or private coverage starting in 2014. Maryland also expects higher premium tax revenues from the expansion of private insurance. The report says that it is "conservatively" estimating savings by not including, for example, reductions in uncompensated care or offsets to new costs from new federal grants received.

The state's estimate of net savings constitutes about 2.8 percent of Medicaid spending, compared with the Holahan-Headen projection of net costs of 1.7 or 3.4 percent under its two participation rate assumptions.[119] The Maryland report cautions, however, that the state will incur net new costs each year beginning in 2020. It emphasizes the need for "bending the cost curve" before then.[120]

The **Texas** estimate reviewed here was released by the state Medicaid agency in April 2010,[121] but its numbers were cited as authoritative as recently as December 2010.[122] In estimating costs of expansion, the projection assumed high Medicaid participation (94 percent take-up among eligibles), higher provider payment rates for primary care, and other items of cost. One source of savings was included, lower CHIP spending because of a higher federal match. The assessment listed but did not estimate six additional sources of potential savings or new revenues.[123]

Overall, the estimated ten-year total cost was $27 billion, assuming rate increases for both Medicaid and CHIP, which maintains the traditional parity of fees between the two programs (this is the amount used by the Governor and included in Table 1).[124] Without CHIP parity, the total was $21.2 billion; without any fee increase, the total was $18.1 billion. The estimates all included an offset for savings from a decrease in the state matching rate for CHIP after 2015, whose amount was not separately indicated. The Holahan-Headen six-year estimates were much lower—$2.6 and $4.5 billion.[125]

Endnotes

[1] The Patient Protection and Affordable Care Act, Public Law 111-148, 124 Stat. 119-1025, March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 124 Stat. 1029-1083, March 30, 2010, both accessible from http://www.gpo.gov. Most provisions relevant to this paper appear in Title II—Role of Public Programs, Subtitle A—Improved Access to Medicaid. Many useful descriptions of the ACA are available. For a systematic description of provisions from a state perspective, see National Governors Association, Health Reform Implementation Resource Center, accessible from http://www.nga.org; National Association of State Medicaid Directors, Summary of Provisions Affecting Medicaid and SCHIP in the Patient Protection and Affordable Care Act (P.L. 111-148) as Amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), April 23, 2010. http://www.nasmd.org/home/doc/SummaryPatProtAct.pdf; National Conference of State Legislatures, Health Reform Implementation, http://www.ncsl.org; Council of State Governments, Federal Health Care Reform, http://www.csg.org/policy/federalhealthcarereform.aspx.

[2] Dan Diamond, "State of Contention as Officials Wrestle Over Reform Law," California Healthline, August 4, 2010, http://www.californiahealthline.org/road-to-reform/2010/state-of-contention-as-officials-wrestle-over-reform-law.aspx. Federal and state roles have long intertwined in health care, with no shortage of disputation, See Randall R. Bovbjerg, Joshua M. Wiener, and Michael Housman, "State and Federal Roles in Health Care: Rationales for Allocating Responsibilities," 25-57 in *Federalism and Health Policy*, edited by John Holahan, Alan Weil, and Joshua M. Weiner (Washington, DC: The Urban Institute Press, July 2003).

[3] National Association of State Budget Officers, State Expenditure Report, Fiscal Year 2009, Washington, DC: NASBO, Published Fall 2010, http://www.nasbo.org/Publications/StateExpenditureReport/tabid/79/Default.aspx.

[4] See the list of lawsuits at http://21statelawsuit.com (2011).

[5] Evelyne Baumrucker and Bernadette Fernandez, *Variation in Analyses of PPACA's Fiscal Impact on States*, Washington, DC: Congressional Research Service, general distribution memorandum, September 8, 2010, copy accessible from http://wonkroom.thinkprogress.org/wp-content/uploads/2010/09/PPM153_bb_090910.pdf; National Conference of State Legislatures, State Reports and Research: Federal Health Reform Implementation, Updated: December 1, 2010, http://www.ncsl.org/?TabId=21448. It may strike a commentator within a state that "the numbers are the numbers," Stacey Singer, "Update: What health reform will mean for Florida's budget," *Palm Beach Post*, blog, March 24, 2010. However, looking across state projections, what is striking is how much variation exists in estimates. http://blogs.palmbeachpost.com/on-call/2010/03/24/update-what-health-reform-will-mean-for-floridas-budget/

[6] Rick Perry, "States Need Freedom to Solve Healthcare Challenges," Health Reform Report [column in online newsletter], December 9, 2010, http://healthreformreport.com/2010/12/states-need-freedom-to-solve-healthcare-challenges.php. The amount that Governor Perry cited matches the projection discussed in this report, starting with Table 1 below.

[7] Stephen Majors, "In Q and A, Maryland's Health Secretary Colmers Says State To Save $850 Million Under Health Reform In First 10 Years," IBM Center for The Business of Government, Washington, DC, September 7th, 2010, http://www.businessofgovernment.org/blog/making-health-care-reform-work/q-and-marylands-health-secretary-colmers-says-state-save-850-mil. This amount also matches that of the Maryland projection discussed in this report.

[8] These are discussed below, with Table 1.

[9] This report follows the common convention of referring to 133 percent of the FPL as the standard.

[10] See National Governors Association, National Association of State Medicaid Directors, National Conference of State Legislatures, and Council of State Governments, all cited above [note 1].

[11] See CRS September 2010 (prepared by Baumrucker and Fernandez), above. The National Conference of State Legislature (NCSL) maintains a website with even more complete and up to date listings but does not summarize findings as CRS does. NCSL, State Reports and Research: Federal Health Reform Implementation, Updated: November 8, 2010, http://www.ncsl.org/?TabId=21448.

[12] See CRS September 2010 (prepared by Baumrucker and Fernandez), above. The National Conference of State Legislature (NCSL) maintains a website with even more complete and up to date listings but does not summarize findings as CRS does. NCSL, State Reports and Research: Federal Health Reform Implementation, Updated: November 8, 2010, http://www.ncsl.org/?TabId=21448.

[13] The five national estimates are discussed and cited after Table 1 below.

[14] For example, an early CEA report provides case studies of 16 states. It describes a number of impacts. The report's estimated savings are obsolete, but not its descriptions; the estimates were based on early bills, not the final ACA. See Council of Economic Advisors, "The Impact of Health Insurance Reform on State and Local Governments," September 15, 2009, http://www.whitehouse.gov/administration/eop/cea/Impactofhealthinsurancereform.

[15] Understanding all the macroeconomic effects of health reform would require a very complex analysis. It is beyond the scope of this paper to assess the sources and uses of all tax funds, state and federal, inflows and outflows across borders, and to model impacts of shifting funds from one set of uses within an economy to another.

[16] The Kansas estimates were presented in 2011 dollars; based on their presentations, other projections all appear to present their estimates in current-year, or nominal dollars.

[17] Agency for Health Care Administration, Overview of Federal Affordable Care Act, August 18, 2010, http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/national_health_care_reform_to_SSEC_081810.pdf. The April 1st estimates remain online at http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/National_Health_Care_Reform_040110.pdf. However, unlike the

August 18th estimates, as of December 2010, they are no longer linked from the agency's page on "2010 Estimated Medicaid Projections," http://ahca.myflorida.com/Medicaid/Estimated_Projections/medicaid_projections.shtml.

[18] See Milliman Inc., "Affordable Care Act (ACA)—Financial Analysis Update," Letter to Ms Ann W. Murphy, Secretary, State of Indiana, from Robert M. Damler, October 18, 2010 (most recent of three reports), accessible from http://www.in.gov/aca/; see also Niki Kelly, "State's burden from health care law eases: Update reduces bill by $330 million," [Fort Wayne, IN] *Journal Gazette*, October 26, 2010, http://www.journalgazette.net/article/20101026/NEWS07/310269988/1002/LOCAL.

[19] See the several state documents posted at the webpage *KHPA Analysis of the Impact of Federal Health Reform in Kansas*, Presentations to the Board of Directors, Kansas Health Policy Authority, May 18, 2010, accessible from http://www.khpa.ks.gov/ppaca/KHPA_Analysis.html.

[20] Maryland Health Care Reform Coordinating Council (HCRCC), *Interim Report*, July 26, 2010. Appendix F presents the group's Financial Model that was used to generate estimates for 2011-2020. A number of other materials have also been generated, all accessible from http://www.healthreform.maryland.gov. The model projects a total state savings of $829 million over 10 years.

[21] See Texas Health and Human Services Commission (HHSC), "Federal Health Care Reform – Impact to Texas Health and Human Services," presentation to the House Select Committee on Federal Legislation, by Executive Commissioner Thomas M. Suehs, April 22, 2010, http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf. An earlier version contained some differences, but a very similar overall estimate of state costs. Health and Human Services Commission, "Federal Health Care Reform – Impact to Texas Health and Human Services," presentation to a Joint Hearing of the Senate Health and Human Services and State Affairs Committees by Executive Commissioner Thomas M. Suehs, March 31, 2010, http://www.hhsc.state.tx.us/news/presentations/2010/FedHlthReform_0310.pdf.

[22] CBO, Cost Estimate for the Amendment in the Nature of a Substitute for H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation), letter to the Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, March 20, 2010, note c to Table 4, p.2, accessible at http://cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

[23] Holahan and Headen provide more information about their methods than does the CBO, which focused on estimating impacts on the federal budget. See John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2010, accessible at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

[24] Centers for Medicare & Medicaid Services (CMS), *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended*, Baltimore, MD: CMS Office of the Actuary, April 22, 2010, memorandum from Richard S. Foster, Chief Actuary, at p.12,

[25] It is clear that the CMS estimate (above) included many elements not estimated by Holahan and Headen, but its methods are not explained, and it does not make estimates for individual states. A Heritage Foundation "backgrounder" extrapolates an earlier set of CMS analyses to states, arguing that there will be high new costs, but not considering any offsets. Edmund F. Haislmaier and Brian C. Blase, *Obamacare: Impact on States*, Washington, DC: The Heritage Foundation, Backgrounder No. 2433, July 1, 2010, http://www.heritage.org/research/reports/2010/07/obamacare-impact-on-states.

[26] Holahan and Headen, above (see Box 1: Methods Summary, at p.8, pdf. p.10.

[27] Table 1 presents the dollar total associated with the CBO-like assumptions of take-up rates, termed a "limited outreach scenario." Under an "enhanced outreach scenario," states would face new Medicaid costs of $43.2 billion. See discussion of participation below.

[28] The authors explain that states will save at least $40.6 billion of Table 1 (the "worst-case scenario" for state budgets). States could save as much as $131.9 billion ("best case scenario"), Stan Dorn and Matthew Buettgens, "Net Effects of the Affordable Care Act on State Budgets," Washington, DC: The Urban Institute, report to First Focus, December 2010 (national estimates of three large components of savings), http://www.firstfocus.net/library/reports/net-effects-of-the-affordable-care-act-on-state-budgets.

[29] The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, Staff Working Paper # 11, June 8, 2010, http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf. The report gives little detail on why Medicaid will cost states less.

[30] Dorn and Buettgens' high estimate is above this range, $131.9 billion, note 28 above.

[31] Table 2 includes income eligibility of up to and including 138 percent of FPL, not the 133 percent level routinely described in this paper and other references. As noted above, the effective level of the 133 percent standard is 138 percent because of the mandatory 5 percent income disregard in the ACA. Also, Table 2's figures are limited to citizens because its focus is Medicaid and CHIP eligibility, which does not extend to all residents. Most of the reports reviewed do not discuss whether or how they adjusted for non-citizen populations.

[32] The latter assumes that the state reports are correct and that the CHIP match rate will not accompany the movement to Medicaid, which may not prove true, as noted above.

[33] The following notes apply to the state projections in Table 5: Florida's presentation mentioned administrative costs but did not estimate them. Indiana is a section 209(b) state, and IN assumed that 209(b) states would need to upgrade eligibility requirements for individuals with disabilities to the SSI standard. The Kansas report noted what it would cost to increase provider fees by 5% and cut back safety net support but did not include these figures when presenting findings. Maryland expressly did not compute savings on uncompensated care to keep estimates conservative. Administrative costs included estimated outreach costs in state departments outside Medicaid. The Texas presentation recognized numerous additional savings, e.g., on uncompensated care, but did not estimate them; it also recognized but did not categorize federal DSH reductions.

[34] The take up rate among those who otherwise would purchase private coverage (a small population) was assumed to be 80 percent.
[35] Table 1 presents the dollar value associated with the lower participation rate used in the third actuarial report; assuming higher rates leads to overall estimated net costs of $3.1 billion.
[36] See John Holahan, Genevieve Kenney, and Jennifer Pelletier, "The Health Status of New Medicaid Enrollees Under Health Reform," Urban Institute, August 2010, http://www.urban.org/UploadedPDF/412206-health-status.pdf. The Lewin Group report, above, provides data estimated ages and per member per month costs of different groups of enrollees (Figures 16 & 17).
[37] Milliman, above, October 2010.
[38] Another key assumption is what levels of enrollment and cost are projected for continuation of the current Medicaid and CHIP programs. The national reports all appear to use the CBO Medicaid spending baseline or similar standard, pre-existing projection. The state-specific reports typically do not describe their assumptions. Finally, various other ACA-related changes may also occur within the overall state costs of Medicaid expansion. The Indiana report counts as a new state cost under the ACA a CMS ruling that will continue the state's pre-existing match rather than raising it to the much higher level of new eligibles for the state's "Healthy Indiana Program." The state reports give too little detail to determine to what extent other state estimates include or do not include such intra-Medicaid changes in estimating costs of coverage expansion.
[39] Kansas's actuarial projections assume minimal crowd out, that is, movement from employer coverage to Medicaid. The projection for 2020 vs. 2010 shows an increase of 96,000 in large employer coverage (100+ employees), offset by a drop of 108,000 in small employer coverage. See slide 9, "Federal Health Care Reform - Kansas Change in Insurance Coverage," in Steve Schramm and Gabe Smith, "Kansas: Impact of Federal Health Reform-Preliminary Estimates on Cost and Coverage," presentation by schramm-raleigh HEALTH STRATEGY (srHS, now known as Optumas) to the Kansas Health Policy Authority Topeka, Kansas, May 18, 2010, http://media.khi.org/news/documents/2010/05/18/5-18-10_SRHealth_Presentation.pdf. Evidently, the underlying assumptions come from experience with prior reforms in Massachusetts and Wisconsin. The shift does not result from new federal subsidies within the exchange, only available to people not eligible for Medicaid.
[40] See "Medicaid Medically Needy" at www.statehealthfacts.org. The Milliman report for Indiana (October 2010, above) mentions savings on spend down among people with incomes above 133 percent of FPL, but like Kansas does not separately estimate them.
[41] Nationwide, the ratio of Medicaid administrative spending to benefits and other spending was 0.058 in 2008, as calculated from dollar amounts in US Social Security Administration (SSA), Annual Statistical Supplement, 2009 (prepared by Office of the Actuary, CMS), http://www.ssa.gov/policy/docs/statcomps/supplement/2009/medicaid.html.
[42] The Holahan-Headen estimates, above, find that over 95 percent of new enrollment costs nationwide will be federal, less than 5 percent state.
[43] State estimates typically showed new administrative costs that were half or more as large new benefits spending. This somewhat non-intuitive finding is the result of the need to apply administrative costs to both new state spending and new federal spending on benefits.
[44] Since these reports were developed, CMS has proposed a new rule that would raise federal matching support to 90 percent of the cost of creating and implementing new eligibility systems that would comply with the ACA's call for simplified application and enrollment procedures for Medicaid and CHIP that coordinate with the insurance exchange. Centers for Medicare & Medicaid Services, "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, A Proposed Rule," 75 Federal Register 68583, November 8, 2010, http://www.federalregister.gov/articles/2010/11/08/2010-27971/medicaid-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities.
[45] CMS. "Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities," proposed rule, 42 CFR Part 433, Federal Register 75(215):68583-68595, November 8, 2010, http://www.gpo.gov/fdsys/pkg/FR-2010-11-08/pdf/2010-27971.pdf.
[46] Amy Lischko, "Health Insurance Connectors and Exchanges: A Primer for State Officials," Washington, DC: AcademyHealth/State Coverage Initiatives Program, accessible from http://www.statecoverage.org/node/1640.
[47] Other administrative costs would also occur if a state opted to run a "Basic Health Program" (ACA sect. 1331, as modified by sect. 10104). A BHP is a Medicaid-like public coverage program for people with near-poor levels of income. According to our interviews, a few states are considering whether to operate a BHP. BHPs are discussed in Patricia Boozang, Melinda Dutton, Alice Lam, Deborah Bachrach, *Implementing Federal Health Care Reform: A Roadmap for New York State*, New York, NY: NYS Health Foundation, August 2010, at pp.21-35, http://www.nyshealthfoundation.org/userfiles/file/RoadmapPaper_Aug2010.pdf
[48] Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends In Medicaid Physician Fees, 2003–2008," *Health Affairs* 28(3):w510-9, Epub (2009).
[49] Stephen Zuckerman and Robert Berenson, "How Will Physicians Be Affected by Health Care Reform?" Washington, DC: The Urban Institute, July 2010, http://www.urban.org/uploadedpdf/412158-Physicians-Affected-by-Reform.pdf. For California, where Medicaid primary care fees averaged only 47 percent of Medicare levels in 2008, second lowest to New Jersey's 41 percent, the Legislative Analyst's Office (LAO) has noted that "it is possible that California will be required to maintain the greater level of reimbursement rates, given the history of legal cases that have thwarted or hindered past budgetary efforts to reduce Medi-Cal provider rates," LAO, *The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs*, May 13, 2010, at p. 20, http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.pdf. Haislmaier and Blase take this supposition further, arguing that "state lawmakers will likely find it politically difficult to limit Medicaid payment rate increases to primary care physicians," above, at p. 8.

[50] Milliman report for Indiana, October 2010, above, at p. 7. The non-primary-care increases were estimated to start in 2014, the second year of the federal primary care increase. Milliman estimated the costs of fee increases from a baseline of fees at "approximately 60% to 65%" of Medicare levels; the Zuckerman et al. finding for all physicians was 69 percent, above, Table 3.
[51] The Maryland report, Appendix F above, includes a state savings for the ACA's increasing payment rates for primary care fees to Medicare levels during 2013 and 2014. The ACA calls for 100 percent federal coverage of this incremental cost for these two years. Before the ACA, the state had already scheduled permanent increases of this level, paying its normal share with state funds. Hence the two year federal increase will save the state money; the situation is likely unique to this state.
[52] Courtney Burke and Erika Martin, Health Reform: Uncompensated Care Costs And Reductions In Medicaid DSH Payments, Health Affairs Blog, posted on Friday, October 15th, 2010, available at http://healthaffairs.org/blog/2010/10/15/health-reform-uncompensated-care-costs-and-reductions-in-medicaid-dsh-payments/.
[53] The allotments are to be reduced by $500 million in FY 2014, $600 million in FYs 2015-2016, $1.8 billion in FY 2017, $5 billion in FY2018, $5.6 billion in FY2019, and $4 billion in FY 2020. All dollar values from www.statehealthfacts.org.
[54] A subsequent report from the Texas Comptroller estimates some but not all of the impacts of the ACA on state employees' health plans and hence on the state budget, during the years 2010-2019. Texas Comptroller of Public Accounts, *Diagnosis: Cost – An Initial Look at the Federal Health Care Legislation's Impact on Texas*, June 2010, http://www.window.state.tx.us/specialrpt/healthFed/hr3590Cost.pdf.
[55] See *Employer Health Benefits 2010 Annual Survey*, Washington, DC: The Kaiser Family Foundation, http://ehbs.kff.org.
[56] The federal reimbursement will cover up to 80 percent of an enrollee's annual spending above $15,000, up to $90,000. The White House, Office of the Press Secretary, "Fact Sheet: The Early Retiree Reinsurance Program," release of May 04, 2010, http://www.whitehouse.gov/the-press-office/fact-sheet-early-retiree-reinsurance-program.
[57] The CEA report, above, also estimates a savings on what it terms the "hidden tax" that uninsurance imposes on state employee health premiums (along with all other private payors), to pay a share of the uncompensated care generated by the uninsured. Again, we consider this kind of savings to be uncertain.
[58] Maryland, for example, estimated new costs of $167 million in lost pharmaceutical rebates, a cost of about a fifth the size of the overall net savings projected. In September 2010, a federal clarification indicated that there will be no such impact, so the state's July projection undercounted Maryland's ten-year savings, which "should" have been about one billion dollars. CMS, Medicaid Prescription Drugs, State Medicaid Director letter, SMDL#10-019, ACA# 9, September 28, 2010, https://www.cms.gov/smdl/downloads/SMD10019.pdf, summarized in CMS, CMCS Informational Bulletin, October 1, 2010, https://www.cms.gov/CMCSBulletins/downloads/10-01-2010-Recent-Policy-Developments.pdf.
[59] See www.stateheathfacts.org (based on 2009 report).
[60] CMS has suggested that just how the ACA is to be interpreted in this regard is an issue for further consideration. CMS, Letter to Anne W. Murphy, Secretary, Indiana Family and Social Services Administration from Cindy Mann, Director of the CMS Center for Medicaid, CHIP and Survey & Certification, November 10, 2010, http://www.in.gov/aca/files/209(b)_Letter_from_CMS.pdf.
[61] Douglas W. Elmendorf, Congressional Budget Office, letter to the Honorable Nancy Pelosi, March 20, 2010, p. 9. Available at http://cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.
[62] Not only will providers no longer have to cross-subsidize as much of the care for uninsured people (the focus of most policy research on uncompensated care), but they will also likely experience much lower levels of bad debt incurred in caring for insured patients, because the ACA will increase the comprehensiveness of coverage. See "CFOs & Healthcare Reform: The Changes, Benefits and Challenges," Healthcare Financial Management Association, August 11, 2010, http://www.hfma.org/Templates/InteriorMaster.aspx?id=22399. On the other hand, the ACA also calls for reductions in the rate of growth of Medicare payment levels. Any fiscal improvements for providers do not directly affect state budgets, but they may indirectly influence the pressure that states experience to increase provider payment rates.
[63] For example, see John Holahan, Randall R. Bovbjerg, and Jack Hadley, *Caring for the Uninsured in Massachusetts: What Does it Cost, Who Pays and What Would Full Coverage Add to Medical Spending?* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, November 16, 2004, http://www.urban.org/url.cfm?ID=1000981. Similar findings appear in subsequent reports on Maine, Missouri, and New York, all accessible at www.urban.org.
[64] The Texas presentation notes, for example, "Public hospitals will have less uncompensated care" (at slide 16), but does not estimate a savings. Maryland's HCRCC explicitly declined to make an estimate in order to keep its projections conservative. see Appendix F, above, at p.1. Impacts in Maryland would be "significant," according to a pre-ACA estimate of impacts under the Senate bill, Maryland Department of Legislative Services, Office of Policy Analysis, "Updated Estimate of the Cost to Maryland Medicaid of Federal Health Care Reform," Annapolis, Maryland, January 14, 2010, http://dls.state.md.us/data/polanasubare/polanasubare_heaandhumser/011410_Updated-Estimate-of-the-Cost-to-Maryland-Medicaid-of-Federal-Health-Care-Reform-report1.pdf.
[65] See note 54 above.
[66] Doubling occurs under the intermediate set of economic assumptions. See Bowen Garrett, John Holahan, Lan Doan, and Irene Headen, *The Cost of Failure to Enact Health Reform: Implications for States*, Washington DC: The Urban Institute, October 01, 2009 (low, intermediate, and high projections), http://www.urban.org/url.cfm?ID=411965.
[67] John Holahan and Bowen Garrett, "The Cost of Uncompensated Care with and without Health Reform," Washington DC: The Urban Institute, March 2010, http://www.urban.org/url.cfm?ID=412045.

[68] Dorn and Buettgens, above.
[69] See, for example, Texas's explanation of the burdens of serving its undocumented population, which exceed the special federal Medicaid assistance for that purpose. Texas Health and Human Services Commission, *Report to the United States Congress on Services and Benefits Provided to Undocumented Immigrants*, Required Reporting for Rider 59, House Bill 1, Eightieth Texas Legislature, Regular Session, 2007, http://www.hhsc.state.tx.us/reports/Rider59_1208.pdf.
[70] Lewin Group, above
[71] See www.statehealthfacts.org.
[72] Hospitals are obligated to serve women in active labor if they present for care in the emergency room of any hospital that participates in Medicare or Medicaid under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, generally known as EMTALA (Emergency Medical Treatment and Labor Act), 42 U.S. Code §1395dd, added by Public Law P.L. 99-272. Accordingly, state Medicaid coverage greatly benefits both private and public hospitals, providing a stronger incentive for states to cover pregnant women than other adults. Moreover, providing prenatal coverage improves childbirth outcomes and holds down subsequent costs.
[73] The item constituted over 20 percent of identified savings, but Indiana's three items of savings were very much smaller than the new costs of expanded enrollment as estimated in its report.
[74] Analogous savings would be available if such Medicaid eligibles were shifted into a new Basic Health Program, if a state opted to run such a program for near-poor enrollees in lieu of their getting federal subsidies to buy a private health plan through the exchange. As already noted (see note 49), this was not relevant for any of our five states.
[75] The states are listed in note [72] above; states qualify leading or expansion states under the ACA by virtue of having provided a full package of health benefits for parents and childless adults up to incomes of at least 100% of FPL as of the date the ACA was enacted, under sec. 2001 of the ACA. See also Boozang, et al., above, p. 9
See Boozang et al., above, and in Office of Health Insurance Programs, NYS Department of Health, Federal Health Care Reform: Implications for New York, presentation to the Health Care Reform Advisory Committee, September 16, 2010, http://www.healthcarereform.ny.gov/advisory_committee/2010-09-16/; the impact of this increased federal share of Medicaid costs is accounted for in the estimates of Holahan and Headen, above, although not presented as a separate offset to the costs of expanded enrollment.
[77] Boozang et al., above, at Table 1, suggest that 100,000 to 440,000 currently eligible but unenrolled New Yorkers may take up Medicaid coverage under the ACA. Other evidence suggests that they will be less expensive to serve than prior enrollees.
[78] This program is run within Medicaid but not as part of the normal entitlement to full services. Many of its beneficiaries from 2014 will receive Medicaid or exchange-based coverage, and their post-ACA costs are subsumed within the general estimates made for those state efforts.
[79] See "Medicaid Medically Needy" at www.statehealthfacts.org.
[80] See page 23076, Federal Register, Vol. 75, No. 83, April 30, 2010.
[81] Boozang et al., p. 62.
[82] To some extent, this type of saving may overlap with savings on uncompensated care as estimated by Dorn and Buettgens because the latter estimate includes the extent of "state and local tax-based appropriations for hospitals and general assistance programs." The overlap will likely vary by state.
[83] See Kate Tormey and Debra Miller, "Health Care Reform: Six Ways It Will Affect States," in Council of State Governments, The Book of the States 2010, Table A, http://knowledgecenter.csg.org/drupal/system/files/TormeyMiller.pdf; National Conference of State Legislatures, "State Health Programs To Cover The Uninsured," 2009, http://www.ncsl.org/?tabid=13878#Medicaid.
[84] Maryland had three such limited programs prior to 2006. They were already brought within Medicaid as a combined Primary Care Assistance program under a waiver. Stacey Davis, "Overview of the Maryland Primary Adult Care (PAC) Program," presentation by Deputy Director of Planning, Maryland Medicaid Program, to the Rhode Island Policy Makers Breakfast, November 17, 2010, accessible from http://www.rihca.org/about-rihca/news-and-reports.aspx. The state report on ACA impacts assumes that PCA enrollees will be considered new eligibles under the ACA, so that the state will receive the new, higher federal match rate. The report does not present the savings separately; they offset the other costs of expanded enrollment. See Maryland HCRCC report's Appendix F, above, at pp. F-8 and F-9.
[85] Section 2001(a)(1) of the ACA allows states to begin immediately to phase in Medicaid coverage for previously uncovered populations below 133 percent of FPL, without having to use new standards for determining income eligibility but also without access to the new higher federal matching rate that will start in 2014 for newly eligible groups. (CMS, Center for Medicaid and State Operations, letter to state health officials and state Medicaid Directors (SMDL# 10-005, PPACA #1), New Option for Coverage of Individuals Under Medicaid, April 9, 2010, accessible at https://www.cms.gov/smdl/downloads/SMD10005.pdf. See also "The Affordable Care Act: Immediate Benefits for the District of Columbia," http://www.healthreform.gov/reports/statehealthreform/districtofcolumbia.html.
[86] See Darryl Fears, "D.C. jumps at health-care savings in expanded Medicaid," *Washington Post*, May 14, 2010 14, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/05/13/AR2010051304995.html, and Jessica
[87] Jack Meyer, Randall R. Bovbjerg, Barbara A. Ormond, and Gina M. Lagomarsino, Expanding Health Coverage in the District of Columbia: DC's Shift from Providing Services to Subsidizing Individuals and its Continuing Challenges in Promoting Health, 1999-2009, Washington, DC: The Brookings Institution, December 2010, http://www.brookings.edu/papers/2010/1210_dc_healthcare.aspx.

[88] Marcy, "D.C. In Front Of The Health Reform Curve, Officials Say," *Kaiser Health News*, Aug 24, 2010, http://www.kaiserhealthnews.org/Stories/2010/August/24/dc-health-shorttake.aspx.
[89] The stated level of savings may be an underestimate, as the annual Alliance budget was traditionally higher than this four year savings. See Meyer et al., above. Per person, Medicaid managed care costs somewhat more than the Alliance did, which seems to somewhat reduce the savings. No detailed explanations are available for DC.
[90] The District's situation is noted by CRS, August 2010, (prepared by Baumrucker and Fernandez), above, at note to table 1, p. 24 (pdf p.29).
[91] "Connecticut First in Nation to Expand Medicaid Coverage to New Groups under the Affordable Care Act," Washington, DC: U.S. Department of Health and Human Services, news release, June 21, 2010, http://www.ct.gov/dss/lib/dss/pdfs/2010newsrelease/connecticut_first_in_nation_6.21.10.pdf. Martiga Lohn, "Minn. gov's Medicaid order turns into town hall," - Associated Press/Bloomberg.com, Jan 5, 2011, http://www.bloomberg.com/news/2011-01-05/minn-gov-s-medicaid-order-turns-into-town-hall.html.
[92] Centers for Medicare and Medicaid Services Special Terms and Conditions, California Bridge to Reform Demonstration. November, 2, 2010
[93] CRS, August 2010, above, at Table 1, p.24; the jurisdictions are DC, Minnesota, Pennsylvania, Washington, and Wisconsin.
[94] For example, San Francisco runs a city-sponsored coverage-like program that mainly pays for service provision not covered by insurance, so it would fit in this category, and the state would share in the city's savings only by adjusting some other intergovernmental funding flow. See http://www.healthysanfrancisco.org/. Howard County, Maryland, also runs a subsidized coverage program for residents who have no insurance options. See http://www.healthyhowardplan.org/.
[95] Dorn and Buettgens, above.
[96] Teresa A. Coughlin, Stephen Zuckerman, Susan Wallin, and John Holahan, "A conflict of strategies: Medicaid managed care and Medicaid maximization," *Health Services Research* 34(1 Pt 2):281–293, 1999; Teresa A. Coughlin and Stephen Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," Urban Institute discussion paper 02–09, June 2002 http://www.urban.org/uploadedPDF/310525_DP0209.pdf.
[97] See Appendix F, cited above. According to the head of the MD pool, it is sixth largest of the 34 state pools now operational. Richard Popper, "Implementation of Federal High Risk Pool Under Patient Protection and Affordable Care Act," Presentation to Maryland Health Care Reform Coordinating Council, May 6, 2010, http://www.healthreform.maryland.gov/documents/100506presentation_popper.pdf.
[98] In Indiana, for example, the savings are estimated at $195 million over 7 years, a very small offset to net new costs estimated as about fifteen times larger than this.
[99] Boozang et al, pp.72-83, above list dozens of opportunities for delivery system reform in many different sectors and for many types of care and patients.
[100] ACA Section 2602.
[101] The share for federal FY 2005 nationwide was 46 percent, including long-term care spending, 'Duals Share of Medicaid Spending," www.statehealthfacts.org
[102] Boozang et al. above.
[103] Noam N. Levey, "Grants awarded for state health insurance exchanges," *Los Angeles Times*, September 30, 2010, http://articles.latimes.com/2010/sep/30/nation/la-na-health-grants-20101001.
[104] http://www.kaiserhealthnews.org/Daily-Reports/2011/February/16/health-exchanges.aspx
[105] See White House "Fact Sheet," above.
[106] Jerry Geisel, More groups approved for early retiree reimbursement, Business Insurance, Oct. 28, 2010, http://www.businessinsurance.com/apps/pbcs.dll/article?AID=/20101028/NEWS/101029909/1233.
[107] Maryland HCRCC, "Appendix G. Potential Grants and Funding Opportunities," see *Interim Report*, above.
[108] Texas Comptroller of Public Accounts, above, estimates that increased collections of insurers' premium taxes would total about $1.3 billion during 2010-2019.
[109] Despite the extent of the potential savings and revenues available to offset increased costs, many states have expressed concerns about the budgetary impacts of federal health reform. A full understanding of this issue is beyond the bounds of this report. Possible explanations include the mismatch between costs that occur as a matter of course in the near term and savings that require administrative action and take longer, the political challenges inherent in making any adjustments to the established fiscal flows between states and localities, about reduced state control over Medicaid, and variations across states in political culture and administrative capabilities.
[110] See Holahan, Kenney, and Pelletier, above.
[111] Agency for Health Care Administration, Overview of Federal Affordable Care Act, August 18, 2010, http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/national_health_care_reform_to_SSEC_081810.pdf. The April 1st estimates remain online at http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/National_Health_Care_Reform_040110.pdf.
[112] See Holahan and Headen, above, at Tables 8 & 12.
[113] See Milliman Inc., "Affordable Care Act (ACA)—Financial Analysis Update," Letter to Ms Anne W. Murphy, Secretary, State of Indiana (Family and Social Services Administration), from Robert M. Damler, October 18, 2010 (most recent of three reports), accessible from

http://www.in.gov/aca/; see also Niki Kelly, "State's burden from health care law eases: Update reduces bill by $330 million," [Fort Wayne, IN] *Journal Gazette*, October 26, 2010, http://www.journalgazette.net/article/20101026/NEWS07/310269988/1002/LOCAL.

[114] See Holahan and Headen, above, at Tables 8 & 12.

[115] See About KHPA, http://www.khpa.ks.gov/about_us/default.htm.

[116] See *KHPA Analysis of the Impact of Federal Health Reform in Kansas*, Presentations to the Board of Directors, Kansas Health Policy Authority, May 18, 2010, accessible from http://www.khpa.ks.gov/ppaca/KHPA_Analysis.html.

[117] See Holahan and Headen, above, at Tables 8 & 12.

[118] Maryland Health Care Reform Coordinating Council (HCRCC), *Interim Report*, July 26, 2010. Appendix F presents the group's Financial Model that was used to generate estimates for 2011-2020; a summary table appears at p. F-23. A number of other materials have also been generated, all accessible from http://www.healthreform.maryland.gov.

[119] See Holahan and Headen, above, at Tables 8 & 12; the dollar amounts were net costs of $533 million under the standard participation scenario, $1.1 billion with enhanced state outreach.

[120] HCRCC Report at pp. iv, 5.

[121] See Texas Health and Human Services Commission (HHSC), "Federal Health Care Reform – Impact to Texas Health and Human Services," presentation to the House Select Committee on Federal Legislation, by Executive Commissioner Thomas M. Suehs, April 22, 2010, http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf. An earlier version contained some differences, but a very similar overall estimate of state costs. Health and Human Services Commission, "Federal Health Care Reform – Impact to Texas Health and Human Services," presentation to a Joint Hearing of the Senate Health and Human Services and State Affairs Committees by Executive Commissioner Thomas M. Suehs, March 31, 2010, http://www.hhsc.state.tx.us/news/presentations/2010/FedHlthReform_0310.pdf.

[122] Governor Rick Perry, Dec. 2010, above.

[123] See HHSC, slides 15 & 16. Some of these savings and revenues were estimated in a subsequent report from the state Comptroller, see note 54 above.

[124] See HHSC, above, slide 7.

[125] See Holahan and Headen, above, at Tables 8 & 12.

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