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The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis

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FEMALE SPEAKER: Good morning and welcome ladies and gentlemen to the updated state level estimates of the Medicaid expansions coverage and cost under the Affordable Care Act conference call. I would like to inform you that this call is being recorded today Monday, November 26, 2012. All participants are currently in a listen-only mode. After the presentation, we will conduct a question and answer session. At that time, you may indicate you have a question by pressing the pound key, followed by the three on your push button telephone. It is now my pleasure to introduce to you Diane Rowland. Go ahead.

DIANE ROWLAND: I'm pleased to be with you all this morning and hope everyone had a good Thanksgiving holiday. Now we're back to work and ready to really look at the choices ahead for the implementation of the Affordable Care Act and, specifically, the Medicaid expansion. Given the Supreme Court decision, many states are now weighing whether to proceed and how to proceed with regard to the Medicaid expansion and the report we're releasing today provides an update of an analysis we conducted in May of 2010 that looked then at the national and state-by-state impact of the Medicaid expansion.

I'm pleased today to be here with John Holahan, Matthew Buettgens, Caitlin Carroll and Stan Dorn of the Urban Institute, who conducted this updated analysis. We'll go through the key

findings with you now and then we're going to entertain some comments from Alan Weil, who's the Executive Director of the National Academy of State Health Policy, on the state's perspective on many of these findings and then open it up to your questions and discussion. Without further ado, I'll turn it over to John Holahan and his team at Urban to walk us through the key findings from this analysis, as well as the way in which the study was conducted. John.

JOHN HOLAHAN: Okay, I'm going to assume that everyone has access to the slides, which I think are available to you, and I'm not going to go through every on in detail, but I want to hit the main things in the report. Overall, the idea was to estimate the effect at the state level of the Medicaid expansion in the ACA, assuming that all states implement the expansion, and compare that to where we would be if there was no Affordable Care Act to look at the effect on federal and state spending, coverage of current and new eligibles.

The key to understanding this report, I think, is that there are really two parts. If no states expand Medicaid there will still be an increase in coverage and an increase in spending for both, not only state governments. That's because there will be exchanges. There'll be the no wrongdoer provision, which essentially when people go to the exchange and they're really eligible for Medicaid they'll be routed to Medicaid, the various outreach and enrollment

procedures, the individual mandate that could have a spillover effect. There's a lot of reasons to expect that Medicaid will grow a bit, even if no state adopts the expansion.

Then, secondly, there is a decision to expand, what would happen if states do increase coverage. We estimate both what happens with no states adopting the expansion and then the incremental effects if they do, by state, we look at the impact on federal and state spending, we estimate uncompensated care. We look, although we're not going to talk about it, at the special case of hospitals and what their revenues would be if states adopted coverage. We look at state fiscal effects, that is how much is the new state spending, relative to what they now spend in their own budgets. Finally, look at the impacts on enrollment and the impact on the uninsured.

The next figure [inaudible 00:04:01] I'm not going to really go into that too much except to mention a couple of things: that all of the ACA provisions are modeled here, that the current eligibles, if there's any new enrollment among them, that will be at the standard federal matching rates. They're all the higher ACA rates for new eligibles, the provisions for the seven waiver states where the matching rate grows over time up until 2019 and then there's the higher matching rates for [inaudible 00:04:32] eligibles. We also include in here the savings the states get that no longer continue their limited benefit programs. These people become eligible for Medicaid as

new eligibles and the seven prior expansion states, the seven waiver states that have covered childless adults, they received the enhanced matching rates. There's a number of things that we couldn't estimate. They tend to be all in the direction of having us over-rating the savings to states of the new cost to states.

If we go to figure four with the first of the slides on the findings, it shows overall Medicaid spending and it starts with the baseline and the two biggest slices of that pie saying that states would spend $2.7 trillion and the federal spending would be about $3.7 trillion, overall $7.4 trillion. On the right hand side you, can see how much of that is due to the ACA. This is assuming that all states adopt the Medicaid expansion state spending would increase by $76 billion, or by 2.4-percent. New federal spending would be $952 or 26-percent and over this 10-year period 2013 to 2022, new spending would be $1,029 trillion.

Figure five, the two bars on the left we just went over. The $952 in federal and $76 in states. If no states adopted the expansion because of the various provisions that will effect Medicaid enrollment, we estimate that state spending will go up by $68 billion or 2.5-percent in federal spending by $152 or 4.2-percent. If all states adopt the expansion, new state spending would increase by only $8 billion or 0.3-percent, federal

spending would go up by $800 billion. That $8 billion I will explain a little bit more how we get there.

If we skip to figure seven, you can see the variation that's across states. He report contains data on individual states. We tried to summarize this by using regions and use essentially the states that are at different places, states that save and states that have the largest increases in spending. On the far left side overall that $8 billion translates into a 0.3-percent increase is spending at the state level. There's a 21-percent increase in the amount of federal spending.

You can see that New England and middle Atlantic states are actual savers, they save 4.6 and 4.2-percent, respectively. They have smaller increases in federal spending than do other states. What's going on here is that the new coverage is less, but these states are also saving because this is where most of the states that have these limited benefit programs that they can now give up and enroll people in Medicaid as new eligibles. It also includes most of the seven enhanced matching states, the prior expansion states that receive an increase match because these states have already covered childless adults.

The three groups of states to the right are states that have the biggest coverage expansions. They see the biggest increases in federal spending and they see increases of state spending in the neighborhood of about 4-percent. This is

relative to what they would have spent had there been no decision to adopt coverage.

Figure eight shows this at the individual state level. The states in white are those who save either because they're waiver states or because they had limited benefit programs. The states in black are those that have tend to have the biggest coverage expansions and the biggest increases in state level spending, relative to what they would have spent in the absence of the expansion.

Figure 9 again takes that $8 billion dollar number on the left side and repeats that, that's the increase in spending in the aggregate at the state level. We then have an estimate of the amount of uncompensated care, how much less uncompensated care spending by states would be. We take estimates of the amount of care that is used perform and a second estimate coming from our model of how many fewer uninsured would be and how much less uncompensated care would be. We use previous research by Jack Hadley and others that found that about 30-percent of uncompensated care is financed by state and local governments. We made the assumption that states couldn't save all of this because of the expansion of coverage, but could save about a third. This means, overall we're saving about 10-percent of the amount of uncompensated care, relative to where we are without reform.

This saves $18.3 billion, more than offsetting it in the aggregate the new spending so the net savings is about 10.1 billion dollars for states. This varies a lot among states, as you can see in figure 10. Again, on the left side that's the US average where these numbers are really quite small in the aggregate. The New England and Middle Atlantic States, as we saw before, saw savings; now their savings are a little bit greater because they get some increase in coverage, because of the Medicaid expansion. The states in the South Atlantic, East South Central and West South Central have the largest increases in the Medicaid, thus the most savings on uncompensated care. When that's taken into consideration, their net new spending is down around 2.5 to 3-percent, relative to their baseline expenditures.

Figure 11 is quite important because the previous slide says what is new Medicaid spending relative to what Medicaid spending would have been. This on figure 11 is what is new Medicaid spending relative to general fund expenditures. That is what they would have spent in the absence of what they're spending on their entire budget. When you look at this then the new state spending is really quite small as the percentage of general funds. It falls at bed about 1-percent in the New England and Middle Atlantic regions and increases by about 1-percent in the states with the largest coverage expansions.

Those states, when you take into account the uncompensated care savings, it falls below to less than a 1-percent increase.

What do we get from this new spending? In figure 12 there'll be 52.4 million people on Medicaid without the ACA. With the various provisions, but with no state adopting the expansion to 138-percent, we would get 5.7 million new enrollees. If all states adopted the expansion, we'd go to 21.3 million.

Figure 13 shows that we'd see quite a reduction in the uninsured. Most of this would happen simply because of the mandate, the exchange, and the subsidies that are in the law, but also the Medicaid coverage that would occur even without an expansion. That would reduce the number of uninsured by 8-percent. The reduction of the uninsured increases to 48-percent of the uninsured or 25.3 million people if all states adopted the explanation.

Again, this varies a bit by state as shown in figure 14. Where the increase is the states that adopted the expansion would get to about 40-percent reduction in the uninsured in New England and Middle Atlantic. Remember that these states have low uninsured rates to begin with so there's less room for new coverage. In the South Atlantic, East South Central and West South Central, where the Medicaid expansions are the greatest, you see reductions in the uninsured of over

50-percent if they adopted the expansion, down around 30-percent if they did not.

The key findings are that if they do adopt the expansion the federal government will pay for most of this. There'll be large gains of Medicaid coverage and substantial reductions in the uninsured. There will be changes in Medicaid enrollment and spending even without adopting the Medicaid expansion but I think the key finding of this is the additional state costs of the Medicaid expansion is pretty small relative to what spending would be without the expansion relative to the large increases in federal spending and relative to state budgets.

This picture gets even more favorable if you count the reductions in spending on uncompensated care. And then there's a number of other things that we couldn't account for in this report, just the data was not available, that I would think bring additional savings to states. Overall, it's hard to conclude anything other than this is a pretty attractive and should be pretty hard for states eventually, not right away, but eventually to walk away from.

DIANE ROWLAND: Thank you John. I'm going to turn to Alan Weil for some overview comments.

ALAN WEIL: Thank you Diane and once again I offer my congratulations to Kaiser Family Foundation for supporting this kind of work and the Urban Institute for conducting it. I

think there are really sort of four observations I would make based on the report and the data that have been presented. The first is that it's always very important to look at the cost estimates in context. We are talking about healthcare, healthcare is expensive, and it's fairly easy to have a little sticker shock at the potential cost of various policy options in this area. What this report does I think very effective is place the spending burden that states would face if they choose to expand Medicaid in the context of overall spending, particularly general fund spending at the state level.

I think many states will be surprised at the results showing that the cost to them of the coverage expansion in the Affordable Care Act come largely from things that they must do and that the choice about expanding Medicaid actually is a fairly small share of the ultimate cost that states may face. I think that finding is also a reminder of the importance of not just looking at total costs, but desegregating where they come from, because many states when they talk about the potential cost of the Medicaid expansion are actually lumping together all costs and not just looking at the effect of the expansion.

The only other bit of context that is of course important at the state level is that even 1-percent of general funds is a lot of money. States are still digging their way out of the major fiscal downturn that occurred in their

finances three or four years ago. States have not fully recovered even though the trend lines right now are quite positive in the overwhelming majority of states. It means that there's a great deal of deferred attention to other priorities like education, infrastructure, public safety that have been lining up for years. Even though the relative shares are small, the absolute demands on state government are really quite significant.

The second major observation out of this report is the importance as particularly the reporters are looking at the various estimates [inaudible 00:17:55] putting out to help analyze this issue. The importance of understanding the assumptions that are built into the estimates and two of them particularly stand out here as ones that I think are handled in a far more sophisticated and honest way and appears in some of the results that have been reported in various places.

First is the estimates with respect to take up rate, the cost of the expansion is very sensitive to the percentage of those who are made eligible to actually select to be covered. As the report notes in these [inaudible 00:18:39]. These are not just plugged in estimated numbers they are actually calculated numbers based on the characteristics of the people who are going to gain coverage. That's a much more sophisticated and helpful way to think about what [inaudible

00:18:56] then just picking some round number that sits in a spreadsheet to say how many people will take up the coverage.

Similarly, the cost estimates for the newly covered play a huge role in estimating the overall cost to do expansions. Again, I think in many instances people take fairly broad brush historical estimates to try to figure out what feature costs will be. I would just encourage reporters who are comparing these numbers with those it may come out from other sources to look at all of the assumptions that are built in but, in particular, I think these two, or the microsimulation really shows its power.

The third observation is that as much as we can't help but coming back to the numbers, we all know that this is far more than a fiscal exercise and looking at the cost in the context of the number of people who are being probably just critical. We know that being uninsured leads to excess illness burden and premature death. We know that many states for decades have been working using either their own funding or options provided by the federal government to try to reduce the number of people without health insurance. While figuring out the cost of this policy it's very important, there is a human dimension that needs to be a part of the discussion far beyond just the dollars.

My final observation is really based on the debates today in Washington, which is how critical confidence at the

state level about how the federal government is going to handle Medicaid spending in the future, how critical that is to states making decisions that they can feel comfortable about. These estimates are built around a financing model that is in current statute and that's the appropriate model to use.

States are very nervous about the possibility of matching formulas changing and although it is certainly the case that a state can change their mind they can adopt the Medicaid expansion at one point and then if the federal funding becomes more limited, they can reverse that decision. That is a painful course of action and states really do want to be able to plan ahead. The sooner we can reach some closure on whether or not the financial arrangements in the ACA is going to be stable I think the easier it will be for states to make decisions for the long run.

Those are my observations, but overall I just think it's very timely and very useful information. States are going to be running this decision mostly in early 2013 and this will be very helpful [inaudible 00:22:03].

DIANE ROWLAND: Thank you Alan and I would encourage all on the call to actually look to the full report where there are tables that break down these regional differences by state so that you can really see how the numbers work at the state level.

With that, we're going to open the phone to your questions. If you have a particular person you want to address it to, in terms of John or Alan, please do that. Otherwise, we will try to field the questions as best we can.

FEMALE SPEAKER: Thank you. The question and answer session will begin at this time. If you are using a speakerphone, please pick up the hand set before pressing any numbers. Should you have a question please press the pound key followed by the three on your push button telephone. If you wish to withdraw your question, you can do so again by pressing the pound key followed by the three on your telephone. Your questions will be taken in the order they are received. Please stand by.
Our first question comes from Caleb Hellerman, go ahead sir.

CALEB HELLERMAN: Hi thank you. Thank you all. I guess this question is really for John. I realize the analysis only goes to—

DIANE ROWLAND: Caleb, could you identify the organization you're with.

CALEB HELLERMAN: I'm sorry. This is Caleb Hellerman with CNN. Thanks for taking the question. I realize the analysis runs only to 2022 but once the federal government share goes down to 90-percent I mean how, generally speaking, do

you have a sense of how the picture changes if we are talking about long-term projections.

JOHN HOLAHAN: Yes, actually in the report, and there was only so much we could cover, here but we present results for about 2016 and 2022, 2016 being an example of when state [inaudible 00:23:59] 100-percent max and they should be pretty close to the fully phasing in their coverage expansion and then also 2022. Clearly, the state share goes up a bit but not tremendously so but it is definitely more so and maybe I could point to particular numbers later if you wanted to reach me. We do have that and that is an issue when you present 10 year numbers people say well what does it really look like when we have to pay the full 10-percent. We are pretty careful to present that in a number of the tables.

CALEB HELLERMAN: Thank you.

FEMALE SPEAKER: Thank you. Our next question comes from Jim Angle from Fox News.

JIM ANGLE: Hi there, I think this is for you John. I'm not quite clear what happens to people who would had the states expanded to 138-percent but if they do not what happens to that population of people? Do they have to purchase insurance on their own in order to get subsidies? What happens to those people who would have been in the covered population if the states do not expand?

JOHN HOLAHAN: Well those with incomes between 100 and 138 can go into exchanges and some of them will and some could get coverage through their own employers. Those below 100-percent have very few options. Matt, do you want to add anything to that?

MATTHEW BUETTGENS: Yes. A lot of those below 100-percent would also be exempt from the individual mandate. Those between 100 and 138 if they had an offer of coverage from their employer that is deemed affordable under the law that would be their option. Otherwise, they would be eligible for subsidized private coverage in the exchanges.

JIM ANGLE: They would have to buy insurance in order to get the subsidy.

DIANE ROWLAND: [Interposing] likely remain uninsured.

JIM ANGLE: I'm sorry.

DIANE ROWLAND: The people who are below 100-percent of poverty would likely remain uninsured.

JIM ANGLE: Okay and those above would have to buy insurance in order to get the subsidy.

DIANE ROWLAND: Correct.

JIM ANGLE: Okay.

MATTHEW BUETTGENS: [Interposing] not available below 100.

JOHN HOLAHAN: Right, right. They could choose not to [interposing].

DIANE ROWLAND: Those above 100.

MATTHEW BUETTGENS: Right.

JOHN HOLAHAN: They could choose not to purchase. Some of them would be example from the individual mandates, some of them would not be.

JIM ANGLE: Thank you.

FEMALE SPEAKER: Thank you. Our next question comes from Elizabeth Stawicki from Minnesota Public Radio. Go ahead ma'am.

ELIZABETH STAWICKI: I had just a quick question and I apologize if you've covered this before but is there any reason why the Midwest states are not included in some of the figures like 7, 11 and 14?

JOHN HOLAHAN: Yes, we were trying to not have too much information on the slides. We picked the states that were least effected and those that were most effected and they tended to be, in the first case, in New England and Middle Atlantic states, and the other point about for them is to show that actually most of them were saving. Then the states in the south had the biggest coverage exchange and we showed them. In this report, there are detailed tables that show the results for every single state.

DIANE ROWLAND: Including Minnesota.

JOHN HOLAHAN: Definitely including Minnesota.

DIANE ROWLAND: Next question.

FEMALE SPEAKER: Thank you. Okay, our next question comes from David Morgan from Reuters.

DAVID MORGAN: Hi, thanks for taking the question. It's simply this, what is the latest count on the number of states that have said they will not participate in the Medicaid expansion?

DIANE ROWLAND: That's actually unclear. Many of the states are making their decision now as they look at the results of the election and as the governors start to put together their budgets for introduction in January. Some states have declared that they won't go forward but I think what we would hope is that they would take a look at the results in this report and be able to really deal with their legislatures and their other groups in the state to decide whether to go forward or not.

JOHN HOLAHAN: I think that's a very good point. I mean what they decide to do at first very well may not be where they end up. The economics of this are very strongly in favor of adopting the expansion and if for political reasons people don't want to do it clearly I think providers will and other groups will eventually put pressure on states and so early decisions that are made are not likely. It could be very different from the ones that are made a few years out.

DIANE ROWLAND: There are eight states that have said they would not participate. I think now one would expect

everybody to be reevaluating and to move forward depending on the way in which they provide their analysis at the state level and we hope these numbers are helpful to the state to say look both at the impact on the number of uninsured in the states as well as the state costs.

DAVID MORGAN: Thanks very much.

ALAN WEIL: This is Alan Weil, if I could just jump in. All of that is correct I'd just add two things. One is that with the exchanges, there's a firm deadline that the federal government has set up for states to express their intention and the expression need to come from the governor. That's different in Medicaid where states can submit their plans and intentions to change their Medicaid program at any time. It doesn't create quite the same forcing deadlines. And, second of all, the decision making process is much more complex or potentially more complex here where it may be a budget that is the expression of the decision here. There may be a state statute. There're actually states that already have on the books that states will implement federal changes in Medicaid law. It becomes a more complex dynamic and most of what people are going on when they say whether the state is going to do it is the governors public announcement often made just a couple of days after the Supreme Court's decision when this was a brand new issue. I think we all expect this to play out over time.

DIANE ROWLAND: Next question.

FEMALE SPEAKER: Thank you. Our next question comes from Sarah Kliff from The Washington Post.

SARAH KLIFF: Hi, thank you for taking my question. I think this is for John. I was curious if you could explain figure five a little more. Kind of the part I was curious about is the $68 billion in increased state Medicaid spending if no one does the expansion kind of what that's coming from and if you could walk through in a little more detail why the difference seems to be relatively small with state spending in terms of the expansion versus not the expansion.

JOHN HOLAHAN: Okay, so what this slide does in the second and third set of bars is to decompose the overall effect into what would happen if they don't adopt the expansion and what happens if they decide to go to 138. The middle bars are saying that there's a lot of provisions in the law that will affect Medicaid even without an expansion. For example, if you go to an exchange and you have an income below 138-percent in your family you will be directed to Medicaid.

There're various provisions to simplify eligibility for Medicaid. There's a lot of outreach efforts. There's the individual mandate that doesn't apply to most of these people but are what we know from Massachusetts is that people are aware of it and may think it applies to them or may think it is what they're expected to do. For a variety of reasons, there

will be new enrollment. I think the number was 5.7 million new enrollees we estimate would come in to Medicaid even if a state says "no, I'm not going to expand". That is matched at the standard matching rates, which means that it's not 100-percent federal match for those people, its new enrollment among people who are currently eligible. Those various provisions I mentioned will bring in more enrollment in people who now are eligible for Medicaid.

That new enrollment or that high participation is what will most states some money and bring in federal money. There's also the increase in the matching rate in the chip program, which will save states some money and add to federal money.

DIANE ROWLAND: Sarah just going back to Alan's point earlier participation rates are what's important. Many of the current eligible Medicaid population in the state may not be fully participating. All the other activities going around the setting up of the exchange, the simplification of the Medicaid eligibility process and enrollment process means that more of those who are not participating but currently eligible will be coming into the program. This especially affects children because the eligibility levels for children in the state have been much higher than those of the adults. This is really boosting participation among children who are currently eligible for the Medicaid program as well as a few of the

adults who gets left out if the state elects not to expand coverage is really largely an adult population for which the federal government was going to be paying the bulk of the cost as new eligibles. Those are mostly individuals who are adults without dependent children or parents who were substantially below the eligibility levels for the children who qualify for Medicaid.

SARAH KLIFF: If I could ask one quick follow up question. Can you walk through what's in the $8 billion? Is that just when the match drops in a few years, that's funding, or what's in the $8 billion that's the difference?

JOHN HOLAHAN: The $8 billion is the new state costs for new eligibles so it's zero at first. It grows to 10-percent. What else is in that?

MATT BUETTGENS: Yes, so yes, so that's the—

DIANE ROWLAND: Identify yourself.

MATT BUETTGENS: Yes, this is Matt. That is the accumulative cost to the state for those made newly eligible by the expansion.

JOHN HOLAHAN: It also includes the savings from states that are now paying for a program with limited benefits that they will no longer cover and then those people will be covered as new eligibles so their savings stays there.

DIANE ROWLAND: The net.

MATT BUETTGENS: Right.

SARAH KLIFF: Great, thank you so much.

DIANE ROWLAND: Next question.

FEMALE SPEAKER: Thank you. As a reminder ladies and gentleman, should you have a question please press the pound key followed by the three on your pushbutton telephone. Our next question comes from Jerry Zremski from the Buffalo News.

JERRY ZREMSKI: Hi, thank you for doing the call. You talked a little bit generally about why some of the states will benefit from this but I was wondering if someone could be specific about New York and why New York would stand to benefit?

JOHN HOLAHAN: New York is an interesting state in that they have already covered childless adults up to 100-percent of poverty. Those people are considered a prior expansion group so the matching rate on them will increase from the current 50-percent to 75-percent and then on up to eventually 90-percent. They will have a small number of new enrollees among the childless adults between 100 and 138-percent of poverty and for those that will be the very high matching rates starting at 100 that phase down to 90-percent.

Then New York will also experience new enrollment among current eligibles that we just talked about. For those they will have a standard matching rate. New York sort of has all three of the different kinds of populations the states could have.

MATTHEW BUETTGENS: This is Matt. We actually issued a report focusing on New York state and the ACA this past spring.

JERRY ZREMSKI: Okay.

MATTHEW BUETTGENS: You can get that on our website healthpolicycenter.org and that's a more detailed New York specific look at the effects of the ACA.

JERRY ZREMSKI: Okay, great thanks.

DIANE ROWLAND: Okay, next question.

FEMALE SPEAKER: Thank you. Our next question comes from Robert Pear from the New York Times.

ROBERT PEAR: Thank you. I think this may be for Diane. Does [inaudible 00:38:39] employer sponsored insurance for some people? Do you [interposing]—

DIANE ROWLAND: Robert, we're having a little trouble hearing you.

ROBERT PEAR: Okay, I'll try again. Does Medicaid not supplement the employer-sponsored insurance for some people and do you see any role for Medicaid in the future in supplementing employer sponsored insurance for employees who get premium tax credits?

DIANE ROWLAND: John.

JOHN HOLAHAN: I'm not sure I understand that.

DIANE ROWLAND: Is the question rather Medicaid currently supplements employer based insurance?

ROBERT PEAR: Yes.

JOHN HOLAHAN: Is that the premium assistance program. Is that what he's talking about?

DIANE ROWLAND: Well currently there are in some states premium assistance programs but—

ROBERT PEAR: Right.

MATTHEW BUETTGENS: Yes, this is Matt. Under the ACA, states are required to evaluate whether or not premium assistance will be cost effective if extended to adults. States will be looking at whether or not that is an option for them, but those estimates I'm not aware that they have currently been done. Possibly but it's a bit too early to tell.

ROBERT PEAR: Thank you.

DIANE ROWLAND: That is not a factor in the analysis we presented today.

MATTHEW BUETTGENS: Correct.

ALAN WEIL: This is Alan. Just to note that although Medicaid is a payer of last resort it also can wrap around even if it's not a premium support option. If you have people particularly in need of long-term services and supports who have employer coverage they certainly may get some Medicaid benefits that provide services not covered by the employer.

ROBERT PEAR: Thank you.

DIANE ROWLAND: Okay.

FEMALE SPEAKER: Thank you.

DIANE ROWLAND: Next question.

FEMALE SPEAKER: Our next question comes from Becca Aaronson from ACA Medicaid Expansion.

BECCA AARONSON: Hi, I'm actually from the Texas Tribune. My question today I was wondering if you could give us some more details about Texas given that we have the highest rate of uninsured and pretty low eligibility requirements. Then I also had a question for Alan more specifically about people in Texas seem to be looking at ways to go around the Governor and expand Medicaid anyways either at the local level through counties or through a Constitutional Amendment. Are any of these possible and if so what could they look like?

JOHN HOLAHAN: Let me answer the question about Texas. I could probably guide you to number specifically on Texas if you were to call later today or one of my colleagues could. You get a pretty good idea what happens to Texas if you look at the West South Central region in each of the slides where we show regional effects and Texas tends to dominate that region. The other states in there are Louisiana, Arkansas and Oklahoma, and they're not all that different so you get a pretty good idea what would happen to Texas if you looked at the West South Central Results in the figures.

ALAN WEIL: This is Alan. Under federal law, Medicaid has to be administered by a single state agency and so all Medicaid policy has to be set and approved at the state level.

The state submits the plans to the federal government. We do have an experience right now with California having received a waiver to do some county-based expansions, but that's a very different context. It was granted prior to the Supreme Court's decision. It was granted as a way for counties to ramp up towards the Medicaid expansion which is a fundamentally different idea than having a patchwork of some counties in the state having an expansion and some counties not. There's really no president for that kind of approach.

I'm not sure what the Constitutional Amendment is that you're thinking about but at the end of the day any waiver based policy would have to be approved not only by the federal government but submitted by the state.

MATTHEW BUETTGENS: This is Matt. Just looking at Texas state specific numbers this is table ES2 in our full report Texas would see a 3.5-percent increase in state spending and a 27.4-percent increase in federal spending so it is like the region that John pointed out. Though the state spending increase is actually a little bit lower than that region overall.

JOHN HOLAHAN: To put it in dollar terms it's $5.7 billion in new state dollars and it would bring in $65.6 billion in federal dollars.

DIANE ROWLAND: Cover lots of people.

BECCA AARONSON: How does that compare to other states generally?

JOHN HOLAHAN: That is typical of states in the south that they would put up somewhere in the order of 3.5 to 4.5-percent over what they would have otherwise spent and brings in pretty substantial amounts of federal dollars. That is fairly typical of southern and a number of the mountain region states.

DIANE ROWLAND: As a result would have over half of their uninsured population [inaudible 00:44:41].

JOHN HOLAHAN: Yes, absolutely.

BECCA AARONSON: Thank you.

DIANE ROWLAND: Next question.

FEMALE SPEAKER: Thank you. Our next question comes from Phil Galewitz from KHN.

DIANE ROWLAND: Not sure what that is.

PHIL GALEWITZ: John, can you talk about why is the 21 million figure on how many people will gain Medicaid, why is that different from the 17 million figure we've heard from CBO. Is that because the timeframe is different or what's going on there? I have a follow up for Alan.

JOHN HOLAHAN: CBO yes, our enrollment numbers are different. If I remember right, they have very little growth in their estimate of Medicaid enrollment out over time. We didn't find that plausible and we have pretty much the same increase in coverage in 2014 but in our model it grows a bit as

it has been because of income declines and so on that we expect will continue to draw more and more people into Medicaid. Anything you want to add to that Matt.

MATTHEW BUETTGENS: Yes, well they are two separate models and the assumptions we made are in the method section of this paper and if there are more detailed questions the full methodology documentation of our model is publically available.

PHIL GALEWITZ: [Inaudible 00:46:22] another specific question, what is the take-up or participation rate that you assume? What percentage of people who would be eligible will actually sign up?

MATTHEW BUETTGENS: Okay, now that as Alan pointed out earlier the take up on our model depends on the characteristics of the actual people who have the choice whether or not to enroll. Looking at it more broadly the take up rates depends for example the biggest single factor is whether or not you have coverage now. For those who are uninsured and who become newly eligible the overall take up rate is about 73-percent.

PHIL GALEWITZ: Okay.

MATTHEW BUETTGENS: That varies depending on who you are and what you would gain from coverage in the model, but as an overall rate for those who start out uninsured and who gain eligibility that's the level.

PHIL GALEWITZ: Alan, I wonder if you could just touch on briefly about the idea that states will still have a

significant increase in their Medicaid costs even if they decide to not expand. Do you think most states legislatures and governors realize that or are they looking at this as an, if they don't expand, they don't have any expansion, they don't have any extra costs?

ALAN WEIL: That's a really good question. I have not done a systematic enough look at what analysis have been prepared about costs and to answer that with any sort of general statement about what states are looking at. I think states have done a lot of work on the costs of bringing up exchanges because the federal government is paying for that in the short run, but they have to be self-sustaining in the long run. I think much of the Medicaid analysis has been focused on the expansion but I do know states have been looking at the costs even without. Remember also that part of, as John noted earlier, one of the big factors is the simplification of eligibility standards and that doesn't happen automatically states have to go through major information technology enhancements and investments to reprogram. They've been doing a lot of work in this area. How much they've actually tried to estimate enrollment effects I'm not for certain.

DIANE ROWLAND: This is Diane. Those are also provisions that are not subject to the Supreme Court decision they are part of the standing ACA that was upheld so that much

of the simplification activity as John has noted will go on whether its state elects to expand or not to the new eligible population.

PHIL GALEWITZ: Diane, can you just touch on specifically simplification in layman's terms like what changes that would make it easier for people to sign up?

DIANE ROWLAND: Well clearly it's the simplification of the way in which eligibility will be determined in terms of the income reforms is also the screen and enroll that if they show up at an exchange they can be screened and enrolled there for the Medicaid program. They can do applications online. It's all of the things that have been tried and worked on for many years with regard to children that would now be applied to parents, the end of face-to-face interviews and other things.

PHIL GALEWITZ: Okay, thank you.

FEMALE SPEAKER: Thank you.

DIANE ROWLAND: Next question.

FEMALE SPEAKER: Our next question comes from Maureen Groppe from Gannet.

MAUREEN GROPPE: Hi, I wondered if you could go into more detail on what is different in this report from the one you did two years ago. Are you doing different types of calculations or are you using updated figures or something else?

JOHN HOLAHAN: The model is a lot more sophisticated because of the various improvements we've made. This two-part

issue is dealt with. That was never an issue before that is that much of the expansion of coverage among current eligibles will occur, regardless of whether states make this decision to adopt. Then, the second part is the decision to adopt coverage. There is more recent data, more up to date cost information. In the previous report if you're familiar with it, we made two different estimates. One that calibrated it closely to CBO and another one that was somewhat higher. We started out somewhat with the same intention but our basic model estimates of federal spending increases were so close to CBO that we didn't do a second set. What else?

FEMALE SPEAKER: This report includes children, whereas the first report focused only on adults.

JOHN HOLAHAN: Right.

MATTHEW BUETTGENS: Correct, and there were different assumptions made about the ramp up of new enrollment in the first years of expansion. In this report we looked carefully at what kinds of potential new enrollees would enroll at what rate because they're not all going to come on board in 2014. That enrollment will gradually ramp up through the first years of implementation.

JOHN HOLAHAN: One other thing that's important to mention is that in the previous report we didn't make any estimates of the state savings because of reductions in the uninsured and less on compensated care. It didn't really have

much of a discussion of various other ways that we couldn't measure where states could save money. That discussion is in there as are estimates of the savings from reduction in uncompensated care.

DIANE ROWLAND: Okay, next question.

FEMALE SPEAKER: Thank you. Okay, our next question comes from Jonathan Shapiro from WABE.

JONATHAN SHAPIRO: Hi, thank you for taking the call. I wanted to talk to you about figure nine in particular. I [inaudible 00:52:51] specific numbers for Georgia, we're Atlanta's NPR station. Do you have specific numbers for Georgia in terms of its savings and uncompensated care costs if the state goes ahead with the expansion?

JOHN HOLAHAN: Well we do, they're in the report. Let me see if I can find them.

JONATHAN SHAPIRO: While you're looking for that I mean if you could just talk in general about given the state's high uninsured rate, I mean I heard you talking about Texas's, Georgia's are the second or third on that list in uninsured rates. How many would be newly covered regardless of the expansion according to the report?

DIANE ROWLAND: In Georgia.

JOHN HOLAHAN: In Georgia. That would probably be an easier thing to deal with later. I mean we'd have to dig around and try to find it. The other numbers you asked about,

we estimated that this would be billions, $2.5 billion in new spending over the 10 years in Georgia. The offsetting savings would be $726 million, so a net increase of 1.8 billion or 4.1-percent increase in state spending.

JONATHAN SHAPIRO: Can you break down where those savings of uncompensated care will come from?

JOHN HOLAHAN: Not on a state-by-state basis. The uncompensated care first of all its saved for in different ways but it's saved for through state grants to hospitals and clinics, states share a disproportionate share of hospital payments as is state support of medical schools and teaching hospitals much of which or some of which exists because of uncompensated care. Then some states have indigent care programs or support localities. Indigent care programs, it depends on the state. This is sort of an average applied in the same way to all states.

MATTHEW BUETTGENS: There's a question on enrollment as well. That is on table nine of the main report so other states can look at the lines for their state. For Georgia, if Georgia does not expand under the ACA there'll be an increased enrollment of about 157,000 and, if they do expand, the increase in their enrollment will be 855,000. You can look at the enrollment numbers in more detail and those from other states can look at table nine.

DIANE ROWLAND: Okay. Alan, are you still on?

ALAN WEIL: I am.

DIANE ROWLAND: I know you need to go so I was wondering if you wanted to make any final comment and then we'll take another question.

ALAN WEIL: No, I think this has been a great set of questions and I think the state specific questions to follow up separate are terrific. I appreciate being a part of the conversation.

DIANE ROWLAND: Alright, thank you. Okay, we'll move to a next question, we'll take two more questions, and then we'll have to wrap up.

FEMALE SPEAKER: Okay. Our next question comes from Rose Hoban from NC Health News.

ROSE HOBAN: When I talk to the law makers in my state about their misgivings about expanding Medicaid one of the things I hear from them continually is that they're worried that after the six year period where the fed is paying most of this that it will revert back to a higher rate. Then the state will be 'slammed' by high costs. I am sorry that Alan jumped off because he mentioned during his portion of the call that this is a concern by states and that there needs to be some clarification at the federal level. That's kind of keeping that clarification from taking place. What are the factors that are [interposing]—

DIANE ROWLAND: This is Diane. The federal government, the law is quite clear that this matching rate continues at 90-percent infinitely. I think what Alan was referring to is that we're also in the process of a debate over the fiscal cliff and over balancing the budget and the deficit and that states are concerned there that in those negotiations they not either lose some of their current Medicaid financing or have reductions in what might be available. It's more a concern about how the fiscal deficit discussions are going to go on as opposed to concern about needing clarification that the ACA will go on infinitely.

ROSE HOBAN: That's very clear in the law because I was hearing that even before there were really large discussions about the fiscal cliff.

DIANE ROWLAND: Well it is clear in the law that the matching goes on, but Congress obviously can change laws and I think that was where the concern you were hearing came from.

ROSE HOBAN: Thank you.

JOHN HOLAHAN: [Inaudible 00:58:24] the federal matching structure has been in place for a very long time and despite budget issues and there's never been change. I mean it's something that one can't rule out but it seems fairly implausible particularly since people from these same states would have to vote on it.

MATTHEW BUETTGENS: This is Matt. Not expanding Medicaid would not insulate your state from those sorts of Medicaid cuts. As you can see in our figures most of the spending on Medicaid is for the population that would enroll even without the ACA. It's just the question of will expanding Medicaid leave the state open to higher cuts than otherwise and that actually isn't clear. That depends on how those cuts, which are currently hypothetical, are issued.

ROSE HOBAN: Got you.

DIANE ROWLAND: I also think that the concern over Medicaid reduction is not limited to the ACA related provisions it's a concern about the program as a whole and what might come out of any fiscal cliff debate and changes. There's a lot more at stake in the state's share and the state's contribution from the federal government to the current Medicaid program then to either the current eligibles who might come on under the ACA or the new eligibles coming on from the ACA. That's where I would think Alan would say and all of us would say much of the state concern is to that.

Okay, our final question.

FEMALE SPEAKER: Thank you. Our final question comes from Mary Sheddon from the Tampa Tribune.

MARY SHEDDON: Hi, thank you. We were looking a lot at the different state numbers but I'm really curious why the states would really significant cost increases like Florida are

being affected. Is it more about the population or the economics of the state or is it about the policies and the way the states are administering Medicaid currently? Can you give a little idea of why the states that are really impacted significantly are so?

JOHN HOLAHAN: Well the states that have the biggest impact are states that have the strictest eligibility standards. To go to a uniform standard of 138-percent of poverty means a bigger expansion of coverage for them and more federal dollars and more even though it's still small, those are the sates that would see some increase in their own spending. I mean where states would go with the expansion is set and uniform nationally at 138-percent but the difference between where you are now and 138-percent depends on your current coverage standards. States in the south tend to cover people at the lower percents of poverty and so therefore would have the biggest coverage expansions.

DIANE ROWLAND: In effect, the states with the largest uninsured populations who gain the most coverage also have somewhat more costs because they haven't had the coverage in the past so it's closing this gap that causes the increase.

MARY SHEDDON: Okay.

FEMALE SPEAKER: It's not just one factor it's multiple factors.

DIANE ROWLAND: It's multiple factors but it's largely related to as John put it how many people are covered under the current standards. If you're a state that only covers adults up to 35-percent of the federal poverty level you're going to be adding a lot more people between 35-percent in the 138-percent of the poverty then a state like New York that's already covering people well over the poverty level.

JOHN HOLAHAN: I mean one footnote to that is a state like Florida would have a big coverage expansion but all of those new people will be at the much higher federal matching rates. If a comparable state, let's say one in the Northeast, had much broader coverage and has a much smaller increase in their eligibility standards to get to 138 they would have more people covered at the lower current matching rates and a smaller share at the new matching rates. It really is very advantageous to the states with low levels of coverage today.

DIANE ROWLAND: Thank you.

FEMALE SPEAKER: Well I want to thank everyone who joined us on the conference call. Especially to thank John and his team for this analysis and for the presentation today and to encourage those of you who have the full report to look up the states you're interested in the full report. To see how much more detail is there then we were able to present in this brief period and please let us know if you have additional questions and would like any follow up because

we think this is a very important report and hope that you'll digest it and also help to disseminate the results. Thank you all for participating today.

FEMALE SPEAKER: Ladies and gentlemen this concludes the conference for today. Thank you all for participating. You may now disconnect.

[END RECORDING]