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Implementation of the Affordable Care Act: Medicaid Expansion Options and Their Impacts

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HIGHLIGHTS

The federal Affordable Care Act (known as "ObamaCare" or the "ACA") requires the state of Utah to expand Medicaid eligibility beginning January 1, 2014. It also authorizes the state to expand eligibility further and receive enhanced federal funding. This brief highlights conclusions that may be drawn from a recent analysis of these and other expansion options by Public Consulting Group (PCG). This brief also reviews the processes established by the Utah Legislature and Governor Gary R. Herbert for determining whether an optional Medicaid eligibility expansion should be implemented.

PCG's recent analysis addresses the impacts of five expansion options on state and county budgets, the state's economy, uncompensated care, and individuals' health. It also covers four periods of implementation: the first six months (January–June, 2014), Year 1 (2014), Years 1–3 (2014–16), and Years 1–10 (2014–2023).

Because PCG's analysis addresses multiple options, impacts, and time periods, it cannot be summarized with one or two statistics alone, or even five or ten. Instead, various conclusions may be drawn, including these:

- The impacts of expansion on state and county revenues and expenditures vary substantially by expansion option, implementation period, and level of government.
- Revenue impacts are substantial and may lead policymakers to different conclusions than if expenditures alone are considered.
- The impacts of optional expansions authorized by the ACA are affected greatly by the phase-in of the state's long-term Medicaid funding obligations.
- The long-term, ongoing impacts of optional expansions—after the state's Medicaid funding obligations have been fully phased in—could differ considerably from estimates published for other periods.
- Actual Medicaid enrollment could be much lower or higher than assumed in PCG's analysis and could significantly affect revenue, expenditure, and other impact estimates reported by PCG.
- Optional expansions would reduce uncompensated care, but the mandatory expansion will not.
- Impacts on Utah's economy, including job gains, vary by expansion scenario but are greatest for the mandatory expansion paired with one of the optional expansions authorized by the ACA.
- Expanding Medicaid will improve individuals' health status, but the improvement cannot be quantified.
- "Crowd Out"—the displacement of commercial health insurance by government programs—is possible but not quantifiable and is omitted from PCG's impact analysis.
- Further analysis of PCG's estimates is possible.

The Legislature and the governor are each studying whether eligibility for Utah's Medicaid program should be expanded beyond what is required by the ACA. A report

from the governor's workgroup is expected in September, and a report from the Legislature's task force is expected by November. At this point, Governor Herbert has not indicated when he will announce his decision on expansion.

Any decision to expand eligibility to the optional population under the ACA may not be implemented unless the following statutory requirements have been met:

- PCG has completed and published its analysis;
- the Legislature's Health Reform Task Force has completed a thorough analysis of a statewide charity care system;
- the governor has reported to the Legislature on the effects of the proposed expansion; and
- the governor has complied with the federal funds request process by receiving legislative approval during a general or special session of the Legislature.

Neither the state nor the federal government has imposed a deadline for when a decision about expansion must be made, although implementation of some options later than January 1, 2014, would reduce the amount of enhanced federal funding for which the state would be eligible.

As with the PCG report itself, this brief does not argue either for or against an optional expansion nor adoption of any particular option.

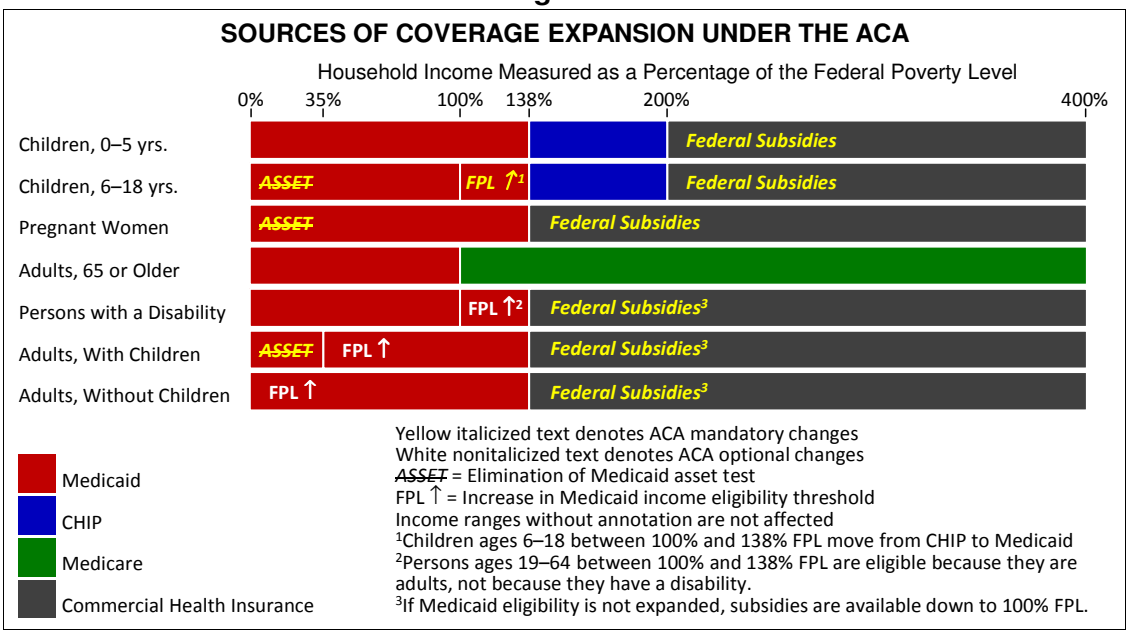
BACKGROUND

In March 2010, Congress passed, and President Obama signed, the Patient Protection and Affordable Care Act, commonly known as the "Affordable Care Act," the "ACA," or "ObamaCare." One of the ACA's various objectives is to increase Americans' enrollment in health insurance. To accomplish this, it promotes the purchase of commercial health insurance and enrollment in government sponsored Medicaid.

To increase enrollment in commercial insurance, the ACA provides generous federal subsidies for the purchase of policies through online marketplaces, or "exchanges." To increase enrollment in Medicaid, it creates a new category of individuals potentially eligible for the program and expands eligibility for others.

Created in 1965, Medicaid initially provided health care services to the aged (65 years and older), the blind, the disabled, and those receiving public assistance. Over the years, the program has been repeatedly expanded to include other populations. Eligibility for the program, however, has typically been limited according to a person's income and

Figure 1



assets, although those limits have been modified as well. The ACA's expansion of Medicaid continues a long-established pattern of broadening the program to include those previously excluded because they either fall outside authorized eligibility categories or exceed specified income or asset limits. In particular, the ACA *allows* states to expand Medicaid to adults without children, a category of individuals not previously covered. Further, the ACA *requires* states to increase the maximum income limits for certain categories of individuals already eligible. Specifically, the ACA expands Medicaid eligibility in Utah as follows:

Mandatory Expansion Under the ACA, the state is required to modify its Medicaid eligibility requirements as follows:

(1) For children 6 to 18 years old:

(a) If the child is in a household with income not exceeding 100% of the federal poverty level (FPL), the asset test is eliminated.

(b) If the child is in a household between 100% FPL and 138% FPL, the child, previously eligible for the Children's Health Insurance Program (CHIP), is now eligible for Medicaid instead.

(2) For pregnant women, the asset test is eliminated.

(3) For adults who have children and are eligible under the income limits of the former Aid for Families With Dependent Children Program (AFDC), the asset test is eliminated (the income limit for a family of four in 2014 is 37% FPL).

Figure 1 illustrates these mandatory changes to Medicaid eligibility.

Optional Expansion The ACA also allows states to expand eligibility to include *all* adults up to 138% FPL, regardless of whether an adult has a disability or is living with a child in the home. In effect, this increases the income limit for an adult with a disability from 100% to 138% FPL. It also increases the limit for an adult with a child in the home from the AFDC limit (37% FPL in 2014 for a family of four) to 138% FPL. And, it extends Medicaid to adults who were not previously eligible for the program because they had neither a child in the home nor a disability.

Figure 1 illustrates these optional changes.

PCG Report Although the Utah Department of Health prepared an initial estimate of the ACA's impact on state spending and Medicaid enrollment, it became clear that additional information was needed, particularly in light of the complexities introduced by the United States Supreme Court's June 2012 ruling that a portion of the Medicaid eligibility expansion was now optional. In the latter part of 2012, the department contracted with Boston-based Public Consulting Group (PCG) to evaluate the impacts of five potential expansion options. On May 23, 2013, the department released a preliminary version of the report, and on June 20, 2013, PCG representatives presented the final report to the governor's Medicaid Options Community Workgroup and the Legislature's Health Reform Task Force.

FIVE EXPANSION OPTIONS

PCG's analysis does not answer whether the state should expand Medicaid beyond what is required by the ACA. Rather, it estimates the impacts of the decision from multiple perspectives, providing information that may be used to support various conclusions, depending on one's objectives and priorities. Specifically, the report analyzes the impacts of the following five expansion options.

Option 1 Implement the mandatory Medicaid expansion, which will increase eligibility for several categories of adults and children.

Option 2 Expand Medicaid eligibility to include adults up to 138% FPL, using the same benefits package typically provided to other Medicaid enrollees.

Option 3 Expand Medicaid to include adults up to 138% FPL, but use a less generous benefit package that matches the package Utah has elected as the benchmark for commercial coverage under the ACA (Public Employees Health Program's *Utah Basic Plus* plan).

Option 4 Expand Medicaid eligibility to include adults up to 100% FPL, using the same benefits package typically provided to other Medicaid enrollees, as under Option 2.

Option 5 Expand Medicaid eligibility to include adults up to 100% FPL, but use the *Utah Basic Plus* benefits package, as under Option 3.

Option 1 is implementation of the mandatory expansion only and will occur even if the state does not elect any other option. Any one of the other options, however, *may* be implemented *in addition to* the mandatory expansion.

Options 2 and 3, which expand eligibility to 138% FPL, are explicitly authorized by the ACA and are accompanied by enhanced federal funding (90%–100% federal reimbursement for medical service costs rather than the usual 70% or so). Options 4 and 5, which do *not* expand eligibility to 138% FPL and are not accompanied by enhanced federal funding, are not authorized by the ACA but could be implemented with approval from the United States Department of Health and Human Services. Options 4 and 5 were included in the report as alternatives to a full expansion to 138% FPL. **Figure 2** summarizes the similarities and differences between each of the options.

Figure 2

EXPANSION OPTIONS							
			State Share of Medicaid Expansion Costs (Medical Services Only, Not Administration)				
Option	FPL	Benefits	2014–16	2017	2018	2019	2020–23
Option 1 (Mandatory)	No Change	Traditional	29%	29%	29%	29%	29%
Option 2	133%	Traditional	0%	5%	6%	7%	10%
Option 3	133%	Utah Basic	0%	5%	6%	7%	10%
Option 4	100%	Traditional	29%	29%	29%	29%	29%
Option 5	100%	Utah Basic	29%	29%	29%	29%	29%

Option 1 must be implemented beginning January 1, 2014. Options 2 through 5 do not have an implementation deadline. However, enhanced federal funding for Options 2 and 3 is limited by the schedule shown in **Figure 2.**

BACKGROUND ON IMPACTS

For each option, PCG analyzed the option's impact on

- State spending for Medicaid and Corrections
- State tax revenues
- County spending for behavioral services and jails
- County tax revenues
- Medicaid enrollment
- Uncompensated care provided by hospitals
- Employment
- Gross state product

PCG also estimated the potential "crowd out," or shift from commercial coverage to government sponsored coverage. However, due to uncertainty about the extent to which crowd out would actually occur, PCG omitted the effects of crowd out from its estimates. Similarly, PCG evaluated impacts on individual health status and access to health care, but was unable to quantify those effects.

Revenues and Expenditures In the tables and graphs included in this paper, "revenue" denotes the *change* in state or county revenue resulting from increased federal funding flowing into the state, as estimated by an economic input/output model used by PCG. "Expend" denotes the expected *change* in spending on all state or county programs and is the sum of expected expenditure increases and reductions. And "net" is the difference between revenue changes and expenditure changes, or the net fiscal impact to the state or counties.

Positive expenditure figures represent an increase in expenditures; *negative* figures represent a decrease in expenditures. *Positive* net fiscal impacts—where revenue changes exceed expenditure changes—are shown as

positive numbers. *Negative* net fiscal impacts—where revenue changes are less than expenditure changes—are shown as negative numbers.

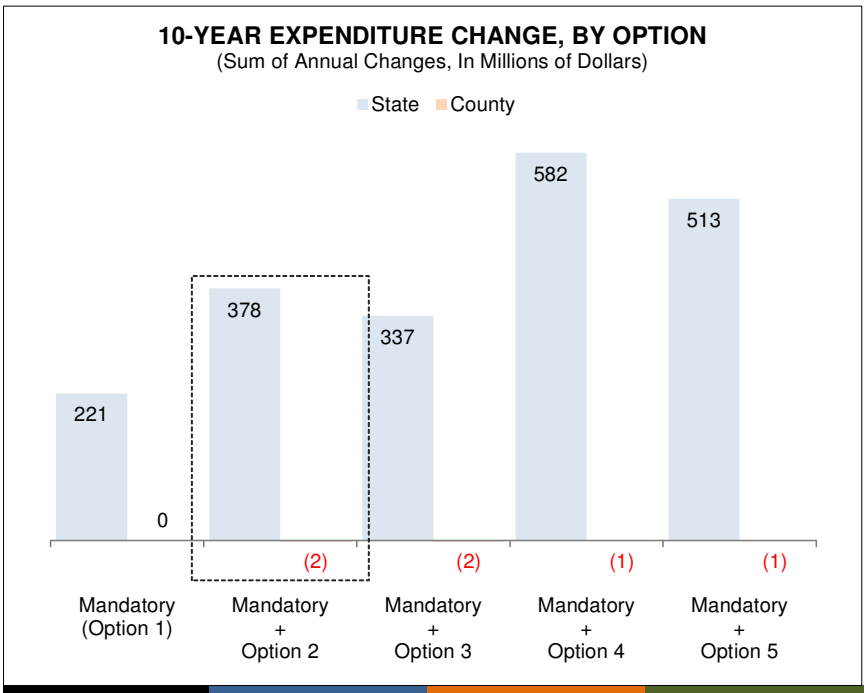
Which Estimates to Use PCG's report allows policymakers and others to evaluate the impacts of expansion from many different perspectives. For example, some readers of the report may wish to focus on the impacts to state spending while others may wish to also consider offsetting revenue increases. Some may wish to consider the impacts to counties or the impacts to both levels of government combined.

Similarly, some readers may wish to focus on first-year impacts, while others may want to evaluate the first through third years of implementation (the period with the most favorable federal reimbursement rates), the fourth through sixth years of implementation (the period with the second most favorable federal reimbursement rates), or the seventh through tenth years of implementation (the period with the third most favorable federal reimbursement rates). Still others may wish to simply look at the aggregate impact over 10 years.

PCG's report also allows one to consider the impacts of each option on uncompensated care, job growth, and gross state product.

The estimates one uses will depend on one's objective. For example, for purposes of budgeting for the first year of implementation, 2014 estimates may be sufficient. If one wishes to evaluate the impact of an expansion over a longer period of time, estimates for that period are appropriate. And if one wishes to evaluate the long-term impacts of an expansion, estimates based on the long-term federal Medicaid reimbursement rate may be most appropriate (e.g., estimates for Year 7 of implementation or later).

Figure 3



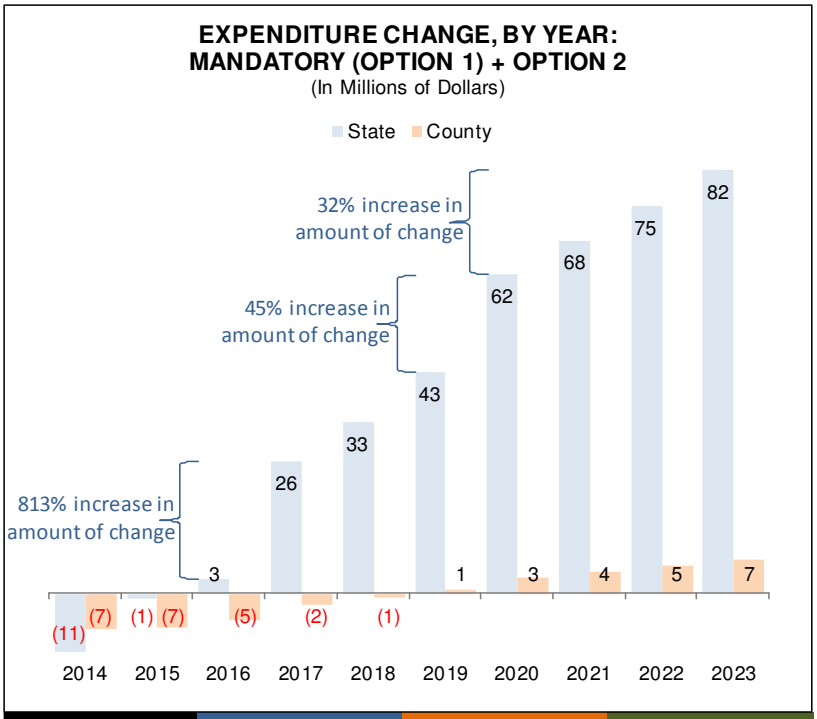
	Scenario	State Expenditures	Counties Expenditures	State + County Expenditures
A	Option 1 (Mandatory)	221	0	221
B	Options 1 + 2	378	(2)	377
C	Options 1 + 3	337	(2)	335
D	Options 1 + 4	582	(1)	581
E	Options 1 + 5	513	(1)	512

- Year-by-year expenditure changes for Options 1 + 2 are shown in Figure 4.
- Ten-year revenue changes and net fiscal impacts for Options 1 + 2 are shown in Row D of Figure 5, Row H of Figure 10, and Row Q of Figure 11.
- Due to rounding, not all figures may add up.

In an attempt to make its project manageable, and to not overwhelm readers by reporting every possible estimate, PCG limited its published estimates to the first six months of implementation (January–July, 2014), Year 1 (2014), Years 1–3 (2014–16), and Years 1–10 (2014–2023). Year-by-year estimates were also provided to the Utah Department of Health but are limited to state and county expenditure changes. (They do not address changes in government revenue, uncompensated care, jobs, gross state product, etc.) As a result, while complete impact estimates are available for the first six months of implementation, Year 1, Years 1–3, and Years 1–10, they are not available for Years 2, 3, 4, 5, 6, 7, 8, 9, and 10 individually, nor in the aggregate for Years 1–6, Years 4–6, Years 7–10, and other combinations of years. Thus, evaluating impacts over certain periods, for example, Year 10 or Years 7–10, is not possible.

This brief highlights *how* and some of the reasons *why* estimates vary according to the period measured. **Figure 3** contrasts the 10-year impacts of five options. **Figure 4** contrasts the annual impacts of one pair of those options. **Figures 5** contrasts the same pair of options over four periods of different lengths. **Figures 7 through 9** contrast the *average annual impacts* of five option combinations across the same four periods. **Figure 6** contrasts the same option combinations for Year 10. And **Figures 10 and 11** contrast the same option combinations across the same four periods used in other figures. Viewing impacts over different periods helps one avoid the pitfalls of trying to describe a multidimensional issue with a single statistic.

Figure 4



	Year	State Expenditures	Counties Expenditures	State + County Expenditures
A	2014	(11)	(7)	(18)
B	2015	(1)	(7)	(8)
C	2016	3	(5)	(2)
D	2017	26	(2)	23
E	2018	33	(1)	33
F	2019	43	1	43
G	2020	62	3	65
H	2021	68	4	72
I	2022	75	5	80
J	2023	82	7	88
K	TOTAL	378	(2)	377

- Row K shows 10-year totals for Options 1 + 2 (see Row B of Figure 3).
- 10-year revenue changes and net fiscal impacts for Options 1 + 2 are shown in Row D of Figure 5, Row H of Figure 10, and Row Q of Figure 11.
- Due to rounding, not all figures may add up.

Options Highlighted in this Brief Because the mandatory expansion will occur regardless of whether the state chooses to implement an optional expansion, and because policymakers deciding whether to implement an optional expansion will likely consider the combined impacts of both the mandatory and any optional expansion, at least if the optional expansion is implemented in the immediate future, the graphs and tables in this paper show the impacts of each optional expansion (Options 2 through 5) in combination with the mandatory expansion (Option 1). In particular, estimates for Option 2, combined with the mandatory expansion, are highlighted.

Conclusions Presented in this Brief Because PCG's analysis addresses multiple options, impacts, and time periods, it cannot be summarized with one or two statistics alone, or even five or ten. Instead, various conclusions may be drawn, including those that follow. Other conclusions, equally valid, could be drawn but are beyond the scope of this brief.

All fiscal and economic estimates included in this brief have been rounded to the nearest million dollars for ease of comparison. As a result, all "net" figures are accurate but may differ slightly from the difference between rounded revenue figures and rounded expenditure figures. Similarly, summations of state and county figures may differ slightly from the sum of the rounded figures used to produce them.

BUDGET AND ENROLLMENT IMPACTS

Conclusion 1: The 10-Year Impact of Expansion on State and County Expenditures Varies Substantially by Option and by Level of Government

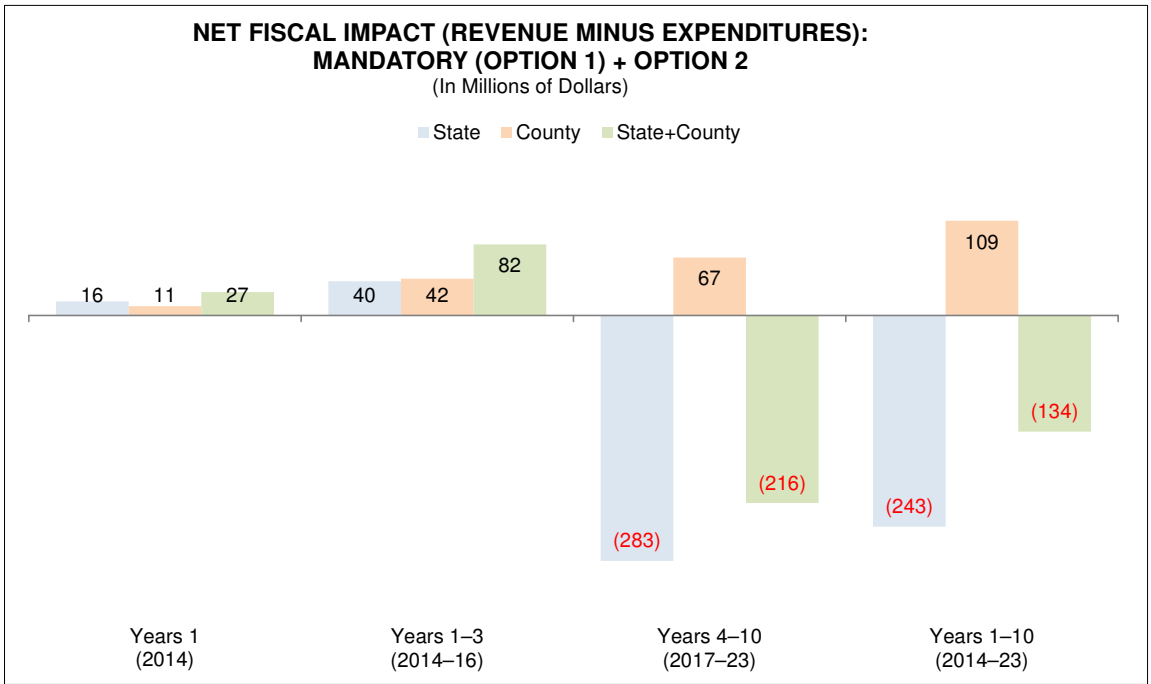
As shown in **Figure 3**, PCG estimates that for Years 1–10 (2014–23) of implementation, the increase in total state program expenditures for the period ranges from $221 million for the mandatory expansion alone to $582 million if Option 4 is implemented as well. Implementation of Option 2 in combination with the mandatory expansion would increase expenditures by $378 million. Implementation of Option 3 with the mandatory expansion would increase expenditures somewhat less.

In contrast, total spending by counties during the same period would decrease by $2 million for Options 2 and 3 and by $1 million for Options 4 and 5. By itself, the mandatory expansion would neither increase nor decrease total county expenditures.

Clearly, the magnitude of state expenditure increases is hundreds of times greater than the magnitude of county expenditure decreases. Further, Options 4 and 5, which expand eligibility to only 100% FPL, are far more costly to the state than Options 2 and 3, which expand eligibility to 138% FPL. Even though Options 4 and 5 expand eligibility less than Options 2 and 3, they cost more due to the greater portion of Medicaid costs borne by the state.

Conclusion 2: Year-by-Year Expenditure Estimates Differ Significantly and are Affected by the Phase-in of the State's Long-term Medicaid Funding Commitment By themselves, the aggregated data in **Figure 3** fail to disclose significant year-to-year differences in expenditures. Annual data in **Figure 4** show that for the mandatory expansion paired with Option 2, state expenditures actually decrease for the first two years and significantly increase thereafter. The increase is particularly pronounced in Year 4 (2017), when the state's share of Medicaid costs for the Option 2 population

Figure 5



	Period	State			Counties			State + County		
		Revenue	– Expend	= Net	Revenue	– Expend	= Net	Revenue	– Expend	= Net
A	Year 1	5	(11)	16	4	(7)	11	9	(18)	27
B	Years 1–3	30	(10)	40	24	(19)	42	54	(28)	82
C	Years 4–10	105	388	(283)	84	17	67	189	405	(216)
D	Years 1–10	135	378	(243)	107	(2)	109	243	377	(134)

- Expenditure figures in Row D are shown in Row B of Figure 3 and Row K of Figure 4.
- Each row in this table also appears in Figures 10 and 11. For example, Row A of this table is the same as Row E of Figure 10 and Row B of Figure 11.
- Due to rounding, not all figures may add up.

increases from 0% to 5% (requiring an increased expenditure of $26 million that year), and in Year 7 (2020), when the state's share of Medicaid costs increases from 7% to 10% (requiring an increased expenditure of $62 million). The Year 4 increase in expenditures is more than eight times greater than the increase of the previous year, and the Year 7 increase is 45% greater than the increase of the year before.

Similarly, for counties, the 10-year totals in **Figure 3** mask significant savings occurring during the first five years of implementation. **Figure 4** shows that county savings range from $7 million in 2014 to $1 million in 2018.

Figure 4 also illustrates the long-term impact of the 90/10 division of costs between the federal government and the state for the Option 2 population. Estimates for 2020 through 2023 reflect the 90/10 split fully phased-in. These estimates provide a much more accurate picture of long-term impacts than the 10-year estimate or a 10-year average annual estimate, both of which understate long-term costs due to savings or unusually low expenditure increases in the early years of implementation. If the mandatory and Option 2 expansions are both implemented, state expenditures in 2023 will increase by $82 million and county expenditures for the same year will increase by $7 million.

Conclusion 3: Revenue Impacts are Substantial and May Lead Policymakers to Different Conclusions Than if Expenditures Alone are Considered **Figures 3 and 4** address only part of the fiscal impact equation—expenditures. Neither addresses potential revenues. **Figure 5**, however, shows the net impact of revenue *and* expenditures.

As already explained, PCG estimated revenue changes due to each expansion option for the first six months of implementation, Year 1, Years 1–3, and Years 1–10. **Figure 5** shows revenue, expenditures, and the net fiscal impact for Option 2 combined with the mandatory expansion. The net fiscal impact to the state and counties is shown in the chart above the table, by period. Similar data for other expansion options are included in **Figures 10 and 11**.

Row D of the table in **Figure 5** indicates that the 10-year expenditure increase of $378 million shown in **Figure 3** is accompanied by a $135 million revenue increase. Thus, revenue for Option 2 and the mandatory expansion is less than expenditures, creating a *negative* fiscal impact to the state of $243 million.

Again, by contrast, for the same period and combination of options, the $2 million reduction in county expenditures is also accompanied by a $107 million increase in county revenue, creating a *positive* fiscal impact of $109 million. Thus, when revenue is considered, the positive impact to counties is more than 50 times greater than when only expenditures are considered.

As pointed out in **Figure 3**, the impacts of the first three years of implementation are markedly different than the aggregate impact over 10 years for both counties and the state. However, in contrast to when only expenditures are considered, when revenue is also considered the net fiscal impact to counties becomes *more positive* rather than negative.

Conclusion 4: Net Fiscal Impact Estimates Also Differ Significantly by Period and Are Affected by the Phase-in of the State's Long-term Medicaid Funding Commitment **Figure 5** highlights how net fiscal impacts vary significantly according to the particular period of implementation measured. For the state, these differences are attributable largely to differences in the portion of Medicaid costs paid by the state. In Years 1–6, the state pays a significantly smaller share of costs for the expansion population than the ongoing 10% share it pays beginning in Year 7 (see **Figure 1**).

Conclusion 5: Long-term, Ongoing Fiscal Impacts to Counties and the State Could Differ Considerably from Estimates Published in PCG's Report. For policymakers wanting to identify the long-term, ongoing net impact of expansion, estimates not

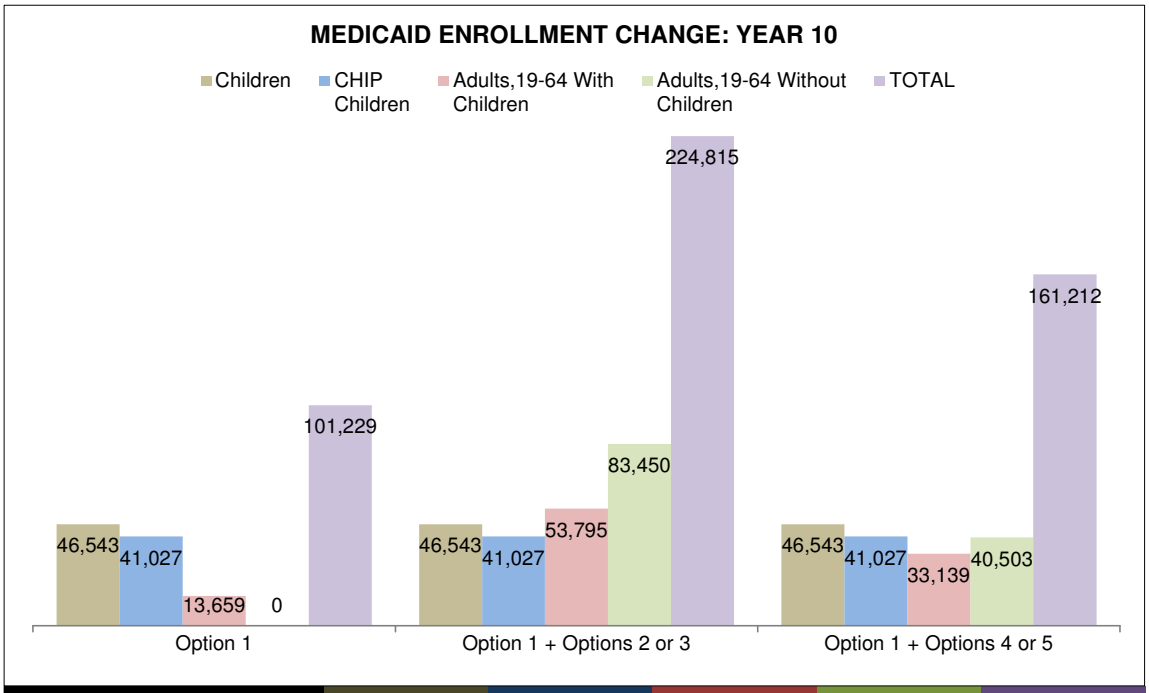
influenced by the more favorable cost-sharing provisions (and lower enrollment and medical costs) of the first six years of implementation would be ideal. However, except for expenditure estimates, separate impact estimates for Years 7, 8, 9, and 10 were not produced by PCG.

In the absence of revenue estimates for Years 7–10, the Office of Legislative Research and General Counsel has calculated revenue and expenditure estimates for Years 4–10 by subtracting Years 1–3 estimates from Years 1–10 estimates. The results are shown in **Figure 5**. Although these estimates do not eliminate the influence of favorable cost sharing attributable to Years 4–6, they at least eliminate the influence of favorable cost sharing attributable to Years 1–3. The result is that when compared with Years 1–10 estimates, the negative fiscal impact to the state is greater (-$283 million vs. -$243 million), and the positive fiscal impact to the counties is less (+$67 million vs. +$109 million). These differences represent a 66% increase in the estimate of the average annual negative fiscal impact to the state and a 13% reduction in the estimate of the average annual positive impact to the counties. (Average annual impacts are calculated by dividing Years 1–10 estimates by 10 and Years 4–10 estimates by 7.) It is expected that these differences would be magnified considerably if Years 4–6 were eliminated from the calculation as well.

Conclusion 6: The Mandatory Expansion Will Cover Primarily Children; the Optional Expansions, Only Adults As **Figure 6** illustrates, in Year 10 of implementation, 101,229 additional persons will be enrolled in Medicaid as the result of the mandatory expansion. Of that total, 41,027 will be children who would have otherwise been enrolled in the Children's Health Insurance Program (CHIP), 46,543 will be other children, and 13,569 will be adults with children. In other words, the mandatory expansion will affect primarily children, including a large number who would have been covered anyway by CHIP.

In contrast, increases in enrollment as a result of the optional expansions affect only adults under 65, not

Figure 6



	Scenario	Children	CHIP Children	Adults,19-64 With Children	Adults,19-64 Without Children	TOTAL
A	Option 1	46,543	41,027	13,659	0	101,229
B	Option 1 + Options 2 or 3	46,543	41,027	53,795	83,450	224,815
C	Option 1 + Options 4 or 5	46,543	41,027	33,139	40,503	161,212

children. **Figure 6** shows that if either Option 2 or Option 3 is implemented in addition to the mandatory expansion, total Medicaid enrollment in Year 10 will be 224,815 greater than if neither expansion was implemented. This includes an additional 53,795 adults with children and an additional 83,450 adults without children. Similarly, if Option 4 or Option 5 is implemented with the mandatory expansion, enrollment of adults with children will increase by 33,139, and enrollment of adults without children will increase by 40,503. Enrollment of adults under Options 2 or 3 is greater than enrollment under Options 4 or 5 because of the difference in income eligibility levels for each pair of options (138% FPL for Options 2 and 3 vs. 100% FPL for Options 4 and 5).

Although nearly half the children covered under the mandatory expansion would have been covered anyway under CHIP, the additional adults enrolling under any of the expansions—mandatory or optional—are expected to come from the ranks of the uninsured.

Conclusion 7: Actual Medicaid Enrollment Could Be Much Lower or Higher than Assumed in PCG's Analysis and Could Significantly Affect Revenue, Expenditure, and Other Impact Estimates PCG estimates that actual enrollment changes could be as much as 9% higher or lower for the mandatory expansion and as much as 19% higher or lower for the optional expansions than the estimates shown in **Figure 6**. PCG does not estimate the probability that actual enrollment will differ from the estimates. Nor does PCG report how state and county revenues and expenditures, and other impacts, would be affected by actual enrollments that differ from the assumptions used in its analysis.

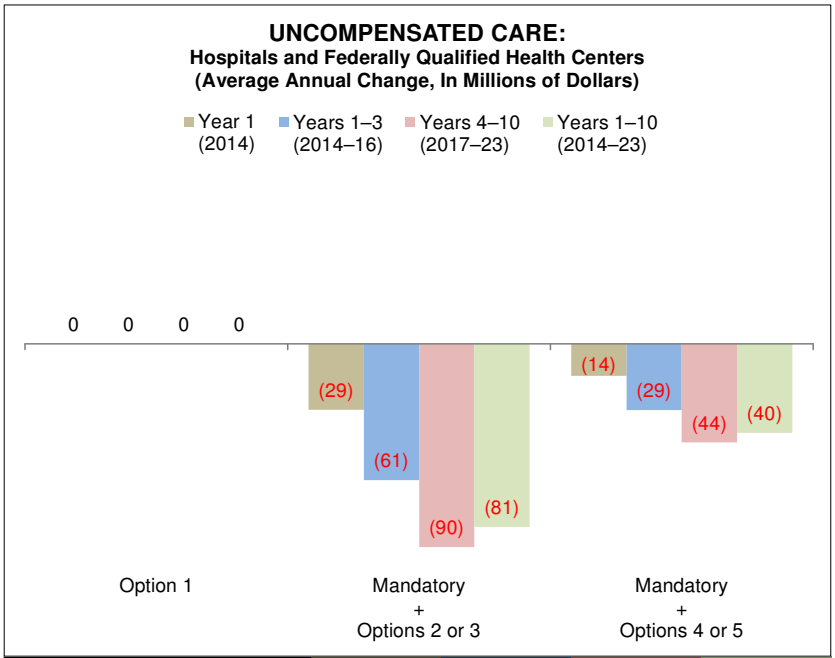
OTHER IMPACTS

In addition to changes in government revenues and expenditures, PCG addressed other impacts associated with each expansion option.

Conclusion 8: Optional Expansions Would Reduce Uncompensated Care, But the Mandatory Expansion Will Not Medical care providers of various types provide services for which they are not compensated either because they choose not to bill for the services or because they are unable to collect all or part of the amount billed. **Figure 7** includes PCG's estimates of how the mandatory expansion alone and paired with each of the optional expansions would affect the amount of uncompensated care provided by Utah's hospitals and 11 federally qualified health centers.

The mandatory expansion alone does not reduce uncompensated care. For Years 1–10, Options 2 and 3 each reduce the average annual amount of uncompensated care by $81 million. Options 4 and 5 each reduce the average annual amount by $40 million. However, as with other estimates, these amounts change substantially when the first three years of implementation are excluded. For Years 4–10, the average annual amount of uncompensated care is reduced $90 million under Options 2 and 3, and $44 million under Options 4 and 5. In both cases, these

Figure 7



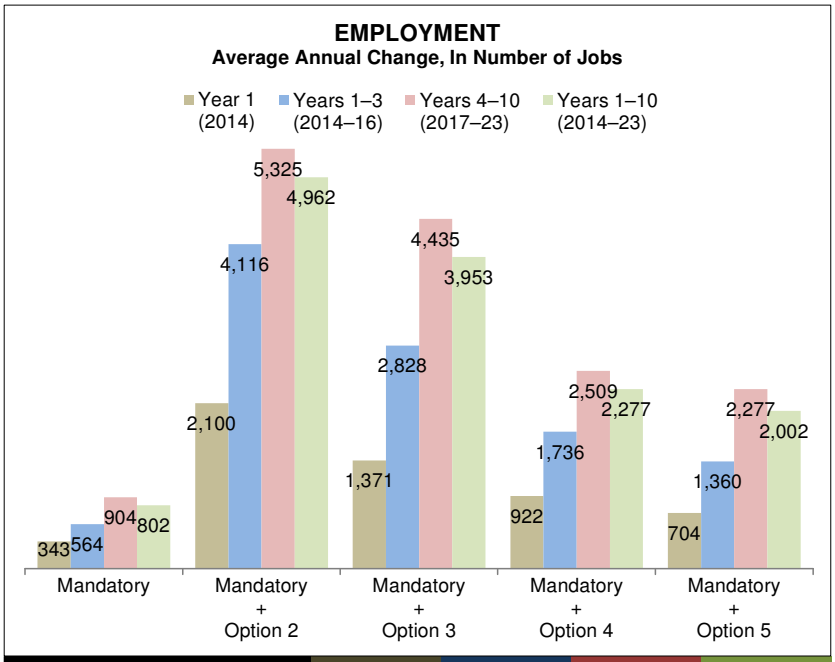
	Scenario	Year 1 (2014)	Years 1–3 (2014–16)	Years 4–10 (2017–23)	Years 1–10 (2014–23)
A	Option 1 (Mandatory)	0	0	0	0
B	Options 1 + Options 2 or 3	(29)	(61)	(90)	(81)
C	Options 1 + Options 4 or 5	(14)	(29)	(44)	(40)
	Years Averaged:	1	3	7	10

estimates are larger than Years 1–10 estimates.

PCG's analysis does not spell out who will benefit from the reductions in uncompensated care—whether those savings will be passed on to consumers in the form of lower prices for medical care and insurance, to hospital and clinic employees in the form of higher compensation, or to owners of capital in the form of higher returns on investment.

Conclusion 9: Impacts on Utah's Economy, Including Job Gains, Vary by Expansion Scenario But Are Greatest for the Mandatory Expansion + Option 2 PCG estimated the impacts of expansion on Utah's economy by modeling estimated changes in employment and gross state product. These changes are attributable to the increased federal funding flowing into the state under each expansion option.

Figure 8



	Scenario	Year 1 (2014)	Years 1–3 (2014–16)	Years 4–10 (2017–23)	Years 1–10 (2014–23)
A	Option 1 (Mandatory)	343	564	904	802
B	Options 1 + 2	2,100	4,116	5,325	4,962
C	Options 1 + 3	1,371	2,828	4,435	3,953
D	Options 1 + 4	922	1,736	2,509	2,277
E	Options 1 + 5	704	1,360	2,277	2,002
	Years Averaged:	1	3	7	10

Figure 8 shows the estimated impacts of expansion on Utah employment. As a result of the mandatory expansion, 343 new jobs will be added to the state's economy in 2014 and annual employment will increase by an average of 802 jobs through 2023. If Option 2 is also implemented, annual employment will increase on average by 4,962 jobs through 2023. However, if this change is measured over Years 4–10 rather than Years 1–10, the average change in annual employment increases to 5,325.

Job creation is much greater under Options 2 and 3 (with their expansion of eligibility to 138% FPL and more favorable federal funding) than under Options 4 and 5.

Figure 9 shows the estimated impacts of expansion on Utah's gross state product. Again, GSP growth increases over time and is greater under Options 2 and 3 than under Options 4 and 5. And as with employment, the average annual growth in GSP is greater for Years 4–10 than Years 1–10. PCG estimates that during Years 1–10, annual GSP will increase on average by $55 million as a result of the mandatory expansion and by $342 million if Option 2 is also implemented. These figures increase to $64 million and $380 million, respectively, if the first three years of implementation are not considered.

Conclusion 10: Expanding Medicaid Will Improve Health Status, But the Improvement Cannot be Quantified Based on 10-year studies of three states that expanded Medicaid eligibility between 1997 and 2007, PCG reported that expanding eligibility in Utah would decrease delays in individuals receiving health care, improve self-reported health status, and decrease mortality. PCG noted, however, that it was unable to quantify these effects.

Conclusion 11: Crowd Out Is Possible, but Not Quantifiable "Crowd Out" refers to the displacement of commercial health insurance by government programs. Based on its literature review, PCG concluded that

estimates of crowd out vary widely, that studies do not conclusively link disenrollment in commercial coverage to enrollment in a Medicaid expansion, and that studies do not adequately address how the effect applies to the population affected by the optional expansions—adults without children. For these reasons, PCG did not include the impacts of crowd out in its estimates. Instead, it reported wide ranges of potential crowd out for those wishing to perform their own calculations of crowd out impacts.

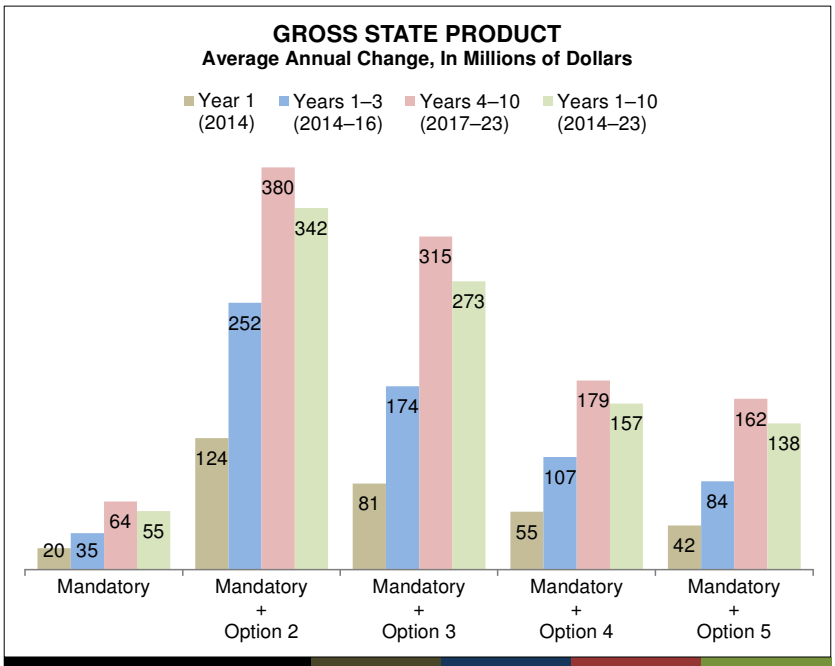
Conclusion 12: Additional Analysis Is Possible Although PCG's analysis covers a wide range of potential impacts, other analyses—beyond the scope of PCG's report or contract with the state—are possible. For example, policymakers, stakeholders, or others may wish to evaluate the magnitude of revenue and expenditure estimates within the context of total state and county budgets for Medicaid or other health and human services programs. Some may wish to compare options using a net present value analysis. And others may wish to weigh the fiscal impacts to government against broader impacts to the economy and the value of new or increased insurance coverage to individuals.

Others may wish to determine how sensitive PCG's estimates are to various underlying assumptions, and the extent to which PCG's report permits such an analysis. And still others may wish to determine how potential changes to Medicaid provider payment and enrollee cost-sharing provisions might affect impact estimates.

TO EXPAND, OR NOT TO EXPAND—WHAT'S NEXT?

Optional Expansion Since the United States Supreme Court's ruling that a portion of the ACA's Medicaid eligibility expansion is optional, there has been considerable debate over whether to implement the optional portion. According to the Kaiser Family Foundation, as of July 1, 2013, 23 states (and the District of Colombia) were moving forward with an optional expansion, 21 were not, and 6 were still debating the issue (http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/).

Figure 9



	Scenario	Year 1 (2014)	Years 1–3 (2014–16)	Years 4–10 (2017–23)	Years 1–10 (2014–23)
A	Option 1 (Mandatory)	20	35	64	55
B	Options 1 + 2	124	252	380	342
C	Options 1 + 3	81	174	315	273
D	Options 1 + 4	55	107	179	157
E	Options 1 + 5	42	84	162	138
	Years Averaged:	1	3	7	10

In Utah, the Legislature has directed its Health Reform Task Force to "review and make recommendations on . . . options for the state regarding Medicaid expansion and reform." Likewise, Governor Gary R. Herbert has created a Medicaid Expansion Options Community Workgroup to conduct a similar review. The reviews by either group are not limited to the five expansion options and factors evaluated by PCG.

The governor's workgroup is expected to report on its work in September and the task force is scheduled to report on its work in November. At this point, Governor Herbert has not indicated when he will announce his decision on expansion.

During its 2013 General Session, the Legislature considered legislation that would have required the state to implement an optional expansion. That legislation did not pass. Instead, the Legislature amended a 2010 statute prohibiting implementation of the ACA unless certain conditions are met by creating additional requirements. As a result, an expansion of Medicaid eligibility to "the optional population under the [ACA]," may not be implemented unless:

(1) PCG has completed and published its analysis;

(2) the Health Reform Task Force has completed a thorough analysis of a statewide charity care system;

(3) the governor, or his designee, has reported on the effects of the proposed expansion to the Social Services Appropriations Subcommittee and to the Business and Labor Interim Committee, the Health Reform Task Force, or the Executive Appropriations Committee; and

(4) the governor receives approval during a general or special session of the Legislature in compliance with the federal funds request process, which was expanded in 2013 to include Medicaid.

An optional Medicaid eligibility expansion to persons other than "the optional population under the [ACA]" would be subject only to the Social Services Appropriations Subcommittee reporting requirement above. Arguably, this type of expansion might include Options 4 and 5 discussed in this brief.

The Mandatory Expansion State agencies have been preparing for many months to implement the *mandatory* portion of the ACA eligibility expansion and have been reporting their progress to the Legislature's Health Reform Task Force.

ADDITIONAL INFORMATION

This brief does not provide a comprehensive summary of PCG's findings, but only highlights them. Nor does this brief restate the many assumptions underlying PCG's analysis or present details of how various factors might affect impacts (except for how the reduction of enhanced federal funding between 2014 and 2020 could affect state and county budgets). For these reasons, readers of this brief are encouraged to review PCG's report at http://health.utah.gov/documents/PCGUtahMedicaidExpansionAnalysis6_17_13_FINAL.pdf. Readers are also encouraged to review two brief summaries of the report prepared by the Utah Department of Health, available at http://health.utah.gov/medicaid/pdfs/MedExpansionOption/PCGReportOverview.pdf and http://le.utah.gov/interim/2013/pdf/00002370.pdf.

Additional information about the PCG study is also available from the Office of Legislative Research and General Counsel and the Utah Department of Health.

Information about fiscal notes prepared for legislation related to Medicaid expansions is available from the Office of the Legislative Fiscal Analyst. The fiscal note for 2013 H.B. 153 Medicaid Amendments, which would have expanded eligibility for the state's Medicaid program to include all adults up to 138% FPL, is available at http://le.utah.gov/~2013/bills/static/HB0153.html. The note assumes the use of the same benefits package typically provided to other Medicaid enrollees, as Option 2 does in this paper. An analysis by the Fiscal Analyst of the General Fund impacts for the mandatory expansion (Option 1) is available at http://le.utah.gov/interim/2012/pdf/00002730.pdf

Additional information about Medicaid expansions is available from the Office of Legislative Research and General Counsel, the Legislature's Health Reform Task Force (http://le.utah.gov/asp/interim/Commit.asp?Year=2013&Com=TSKHSR), the governor's Medicaid Expansion Options Community Workgroup (http://health.utah.gov/ medicaid/provhtml/options.html and http://www.utah.gov/ open/), and many academic, advocacy, and government organizations.

Figure 10
NET FISCAL IMPACT
By Expansion Scenario and Implementation Period (In Millions of Dollars)

Option 1 (Mandatory)

	Period	State			Counties			State + County		
		Revenue	– Expend	= Net	Revenue	– Expend	= Net	Revenue	– Expend	= Net
A	Year 1	1	7	(6)	1	0	1	1	7	(6)
B	Years 1–3	4	39	(35)	3	0	3	7	39	(32)
C	Years 4–10	18	181	(164)	14	0	14	32	181	(150)
D	Years 1–10	22	221	(199)	17	0	17	39	221	(181)

Options 1 + 2

	Period	State			Counties			State + County		
		Revenue	– Expend	= Net	Revenue	– Expend	= Net	Revenue	– Expend	= Net
E	Year 1	5	(11)	16	4	(7)	11	9	(18)	27
F	Years 1–3	30	(10)	40	24	(19)	42	54	(28)	82
G	Years 4–10	105	388	(283)	84	17	67	189	405	(216)
H	Years 1–10	135	378	(243)	107	(2)	109	243	377	(134)

Options 1 + 3

	Period	State			Counties			State + County		
		Revenue	– Expend	= Net	Revenue	– Expend	= Net	Revenue	– Expend	= Net
I	Year 1	3	(11)	15	3	(7)	9	6	(18)	24
J	Years 1–3	21	(10)	30	16	(19)	35	37	(28)	65
K	Years 4–10	87	347	(259)	69	17	52	156	363	(207)
L	Years 1–10	108	337	(229)	85	(2)	87	193	335	(142)

Options 1 + 4

	Period	State			Counties			State + County		
		Revenue	– Expend	= Net	Revenue	– Expend	= Net	Revenue	– Expend	= Net
M	Year 1	2	12	(10)	2	(3)	5	4	9	(5)
N	Years 1–3	13	96	(83)	10	(8)	18	23	88	(66)
O	Years 4–10	49	486	(437)	39	7	32	89	493	(404)
P	Years 1–10	62	582	(520)	49	(1)	50	111	581	(470)

Options 1 + 5

	Period	State			Counties			State + County		
		Revenue	– Expend	= Net	Revenue	– Expend	= Net	Revenue	– Expend	= Net
Q	Year 1	2	7	(6)	1	(3)	4	3	5	(2)
R	Years 1–3	10	72	(62)	8	(8)	15	18	65	(47)
S	Years 4–10	45	440	(396)	35	7	29	80	447	(367)
T	Years 1–10	55	513	(458)	43	(1)	44	98	512	(414)

- Excerpts from this table appear in Figures 3 through 5. For example, Rows E through H of this table appear as Rows A through D in Figure 5.
- All data in this table appear in Figure 11. For example, Row H of this table appears as Row Q of Figure 11.
- Descriptions of each option appear on page 3 and are summarized in Figure 2.
- Due to rounding, not all figures may add up.

Figure 11
NET FISCAL IMPACT
By Implementation Period and Expansion Scenario (In Millions of Dollars)

Year 1 (2014)

	Scenario	State			Counties			State + County		
		Revenue	Expend	Net	Revenue	Expend	Net	Revenue	Expend	Net
A	Option 1 (Mandatory)	1	7	(6)	1	0	1	1	7	(6)
B	Options 1 + 2	5	(11)	16	4	(7)	11	9	(18)	27
C	Options 1 + 3	3	(11)	15	3	(7)	9	6	(18)	24
D	Options 1 + 4	2	12	(10)	2	(3)	5	4	9	(5)
E	Options 1 + 5	2	7	(6)	1	(3)	4	3	5	(2)

Years 1–3 (2014–16)

	Scenario	State			Counties			State + County		
		Revenue	Expend	Net	Revenue	Expend	Net	Revenue	Expend	Net
F	Option 1 (Mandatory)	4	39	(35)	3	0	3	7	39	(32)
G	Options 1 + 2	30	(10)	40	24	(19)	42	54	(28)	82
H	Options 1 + 3	21	(10)	30	16	(19)	35	37	(28)	65
I	Options 1 + 4	13	96	(83)	10	(8)	18	23	88	(66)
J	Options 1 + 5	10	72	(62)	8	(8)	15	18	65	(47)

Years 4–10 (2017–23)

	Scenario	State			Counties			State + County		
		Revenue	Expend	Net	Revenue	Expend	Net	Revenue	Expend	Net
K	Option 1 (Mandatory)	18	181	(164)	14	0	14	32	181	(150)
L	Options 1 + 2	105	388	(283)	84	17	67	189	405	(216)
M	Options 1 + 3	87	347	(259)	69	17	52	156	363	(207)
N	Options 1 + 4	49	486	(437)	39	7	32	89	493	(404)
O	Options 1 + 5	45	440	(396)	35	7	29	80	447	(367)

Years 1–10 (2014–23)

	Scenario	State			Counties			State + County		
		Revenue	Expend	Net	Revenue	Expend	Net	Revenue	Expend	Net
P	Option 1 (Mandatory)	22	221	(199)	17	0	17	39	221	(181)
Q	Options 1 + 2	135	378	(243)	107	(2)	109	243	377	(134)
R	Options 1 + 3	108	337	(229)	85	(2)	87	193	335	(142)
S	Options 1 + 4	62	582	(520)	49	(1)	50	111	581	(470)
T	Options 1 + 5	55	513	(458)	43	(1)	44	98	512	(414)

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