Deloitte.

The Fiscal Impact to States of the Affordable Care Act (ACA): Comprehensive Analysis

Deloitte Center for Health Solutions (DCHS)

Executive summary

- States play a critical role in the Affordable Care Act (ACA); their responsibilities are broad
  - Four major categories: coverage expansion, infrastructure, benefit redesign and industry fees, and optional opportunities
- The fiscal impact[1] on states is based on the influence of many different variables
- Deloitte constructed plausible scenarios to identify cost/saving drivers and provide a range of the estimated per person[2] fiscal impact to states due to ACA requirements (estimates might inform discussion and potential decision making, but are not predictions of what will occur)
- Potential fiscal impact to states due to ACA requirements ranges from a savings of $318 to a cost of $470 per person (2011–2020)
- The most substantial costs that states could face in implementing ACA provisions relate to Medicaid expansion
  - Other requirements — health insurance exchange (HIX) systems, insurance premium oversight, employee benefit changes, etc. — appear to have a nominal cost impact

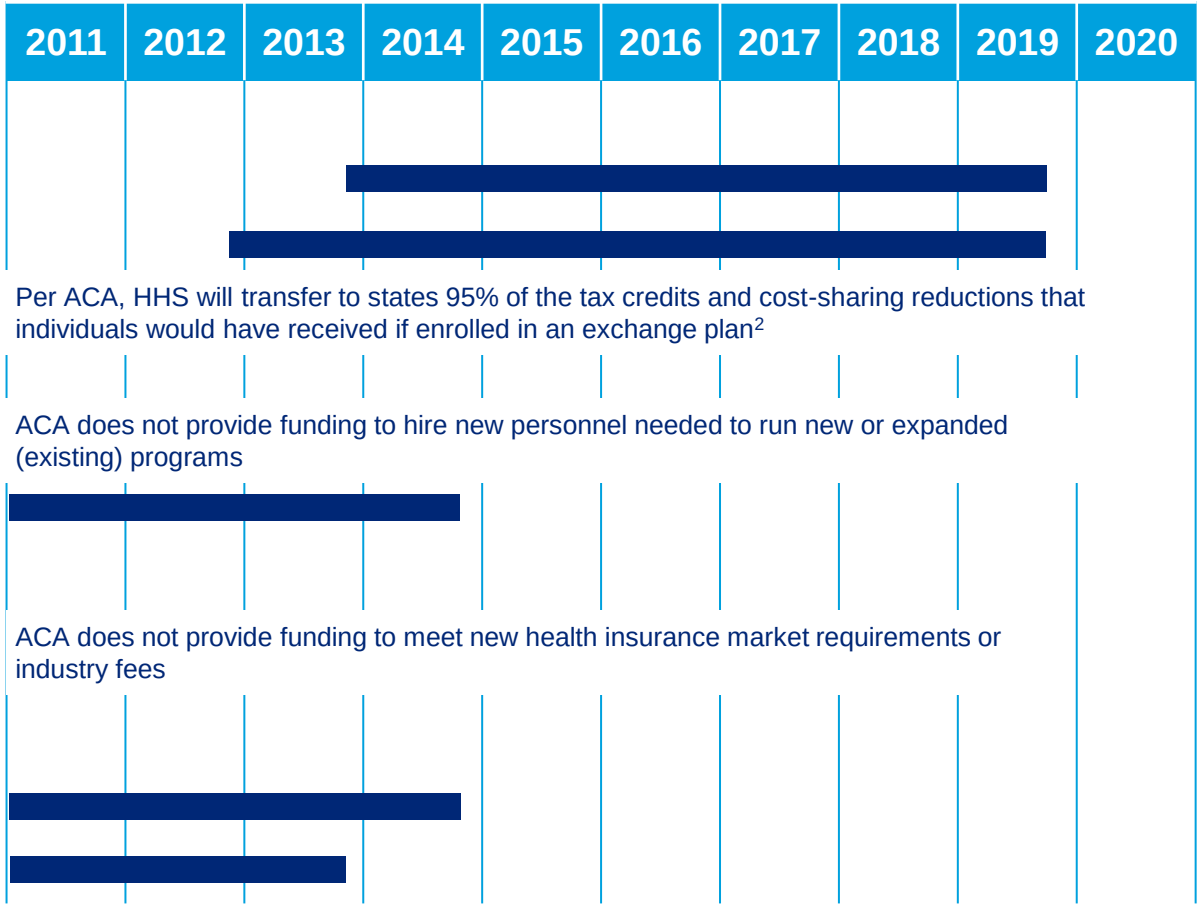
[1]Cost (+) or Saving (-).

[2]U.S. Census Bureau's National Population Projections. Available at: http://www.census.gov/population/www/projections/natproj.html.

Framework: Major ACA requirements for states

Category	Sub-category	Details
Coverage Expansion	Medicaid expanded enrollment	Coverage for adults up to 133% Federal Poverty Level (FPL), plus a 5% income disregard, under age 65 who were not eligible for Medicaid as of 12/01/2009 (*Note: excludes pregnant women and Medicare beneficiaries)*
	Medicaid/CHIP enrollment	• Coverage for individuals previously eligible for Medicaid and CHIP, but not enrolled • Coverage through expansion states[1] (those providing Medicaid coverage for parents and non-pregnant, childless adults with incomes at least up to 100% FPL)
	Medicaid benefits, quality, payment, program integrity	Improving offered benefits; medical management (not required, but allowed); adjusting provider payments to improve quality; efforts to prevent fraud, waste, and abuse
	New state coverage options	Coverage through the federal Pre-Existing Condition Insurance Plan (temporary high risk pool) and state basic health programs (for individuals up to 200% FPL, not eligible for Medicaid)
	Disproportionate Share Hospital (DSH) payments	Providing care for uninsured individuals through safety net hospitals
Infrastructure	Administrative personnel	Individuals to: • Administer health insurance exchanges (HIX), expansion of Medicaid, and Medicaid program integrity • Conduct consumer assistance programs and consumer outreach and education • Conduct annual insurance premium rate reviews
	Medicaid IT systems	Medicaid-related information technology systems, software, and hardware
	Health insurance exchange (HIX) systems	HIX-related information technology systems, software, and hardware for this new style of insurance market
Benefit Redesign and Industry Fees	State employees	Providing coverage that meets new market requirements and levy of industry fee
Optional Opportunities	Other state programs	Accessing optional federal ACA programs and modifying state programs aimed at enhancing or expanding access to coverage prior to ACA (e.g. state-subsidized insurance plans, home and community-based services programs, state high risk pools)

Timeline: ACA federal funding opportunities and responsibilities



Details of Medicaid/CHIP, administration, IT systems, and governance federal funding located in Appendix.

[1]Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of federal-matching funds for state Medicaid medical and medical insurance expenditures.

[2]ACA, Title I, Sec. 1331

Methodology: Two tools used

- Deloitte's Health Reform Impact Model[1] and ACA Provision Mapping Tool were used to evaluate the net financial impact to states of ACA (measured as the net cumulative cost on a per person basis)
- Health Reform Impact Model assesses the impact of key economic, behavioral, political, and strategic variables on insurance coverage under ACA
  - Uses extensive underlying data and detailed assumptions of future events to produce 10-year (2011–2020), annual projections of market configuration in terms of insured (by health insurance market segment) and uninsured
  - Customizable/flexible by national or state, regional, and potential scenarios to estimate sensitivity to specific actions and reactions of market players
  - Assesses impact on multiple sectors: focused on health plans, but applications for state and federal government, health care providers, and suppliers
  - Multiple scenarios evaluate variables that drive results
- ACA Provision Mapping Tool
  - The framework for all cost, saving, and revenue variables; created as analysis template/tool
    - Captures each provision assigned to states or for which states could be impacted
      - Each provision is financially evaluated based on the proposed impact (based on a set of assumptions)

[1]Health Reform Impacts: Modeling Health Plan Projection Scenarios Over 10 Years. Deloitte Dbriefs Webcasts. Jul y19, 2011. Available at: http://www.deloitte.com/us/dbriefs/archive.

Scenarios: Deloitte modeled three likely scenarios to examine the potential fiscal impact on states

Scenario assumption details

Category	Sub-category	Advantageous Scenario: "law as anticipated plus great favorability achieved"	Conservative Scenario: "law as anticipated, but conservative actions taken"	Disruptive Scenario: "more pressure on states"
Coverage Expansion	Medicaid expanded enrollment	Enrollment take-up among new eligibles: 74% of all new eligibles enrolled by 2020 (stepwise growth over the 10-year period)		
		Expansion occurs under **higher ACA** federal reimbursement rates (per law)		Expansion occurs under **lower, pre-reform** federal reimbursement rates (change in law)
	Medicaid/CHIP enrollment	Enrollment take-up among prior eligibles (individuals who are currently eligible but not enrolled): 15% growth (stepwise) over the ten year period		
		Higher ACA federal reimbursement rates for expansion states received (per law)		**Lower, pre-reform** federal reimbursement rates for expansion states received (change in law)
	Medicaid benefits, quality, payment, program integrity	**Aggressive** shift to Managed Medicaid from fee-for-service: stepwise growth to 75% for dual eligibles and 80% for remaining enrollees over the ten year period	**Moderate** shift to Managed Medicaid from fee-for-service: stepwise growth to 20% for all enrollees over the ten year period	
		Use of Patient Centered Medical Homes (PCMH)	**No** use of Patient Centered Medical Homes (PCMH)	
		Higher PCP reimbursements do **not** continue after 2014		Higher PCP reimbursements **continue** after 2014 and states pay share of that cost
		Eliminate coverage for certain adults over 133% Federal Poverty Level (FPL) plus, a 5% income disregard	**Continue** coverage for certain adults over 133% Federal Poverty Level (FPL) plus, a 5% income disregard	
	New state coverage options	Coverage for eligible applicants through 2013 in federal temporary high-risk pool instead of state high-risk pool		
	DSH payments	Reduction in DSH payments (matchable Medicaid expenses) in proportion to reduction in federal DSH payments		
Infrastructure	Administrative personnel	Increase in Medicaid/CHIP administration based on factors relative to the growth in Medicaid		
		Federal funds to conduct annual rate reviews **received** (per law)		Federal funds to conduct rate reviews **cease** (change in law)
	Medicaid IT systems	Eligibility and Enrollment (E&E) systems development between 2012–2015; E&E systems maintenance		
	Health insurance exchange (HIX) systems	Federal funds to establish exchanges **received** until 1/1/2015 (per law)		Federal funds to establish exchanges **cease** (change in law)
Benefit Redesign and Industry Fees	State employees	**No** premium increase for ACA insurance requirements, because already comply	Premium increase in order to comply with ACA insurance requirements	
		Premium increase due to industry fee in 2014 onward		
Optional Opportunities	Other state programs	**All** optional ACA programs accessed; **Modification** to state programs	**No** optional ACA programs accessed; **No** modification to state programs	

Results: Fiscal impact to states due to ACA requirements ranges from a savings of $318 to a cost of $470 per person (2011–2020)

Estimated per person fiscal impact to states related to ACA (undiscounted 2011–2020)[1,2]

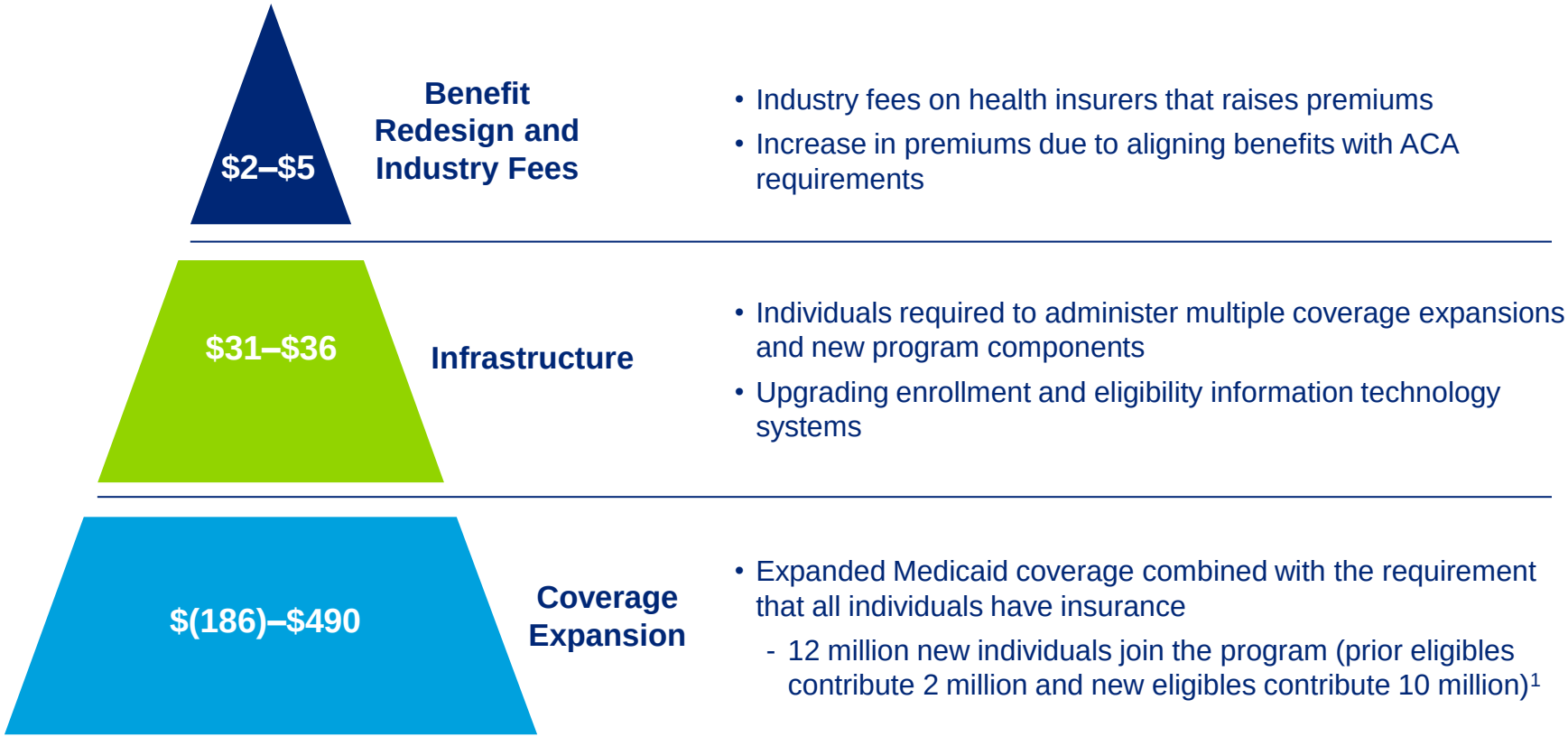
Cost (+) or Saving (-)			
Categories	Scenario		
	Advantageous	Conservative	Disruptive
States' outlays due to ACA			
Coverage expansion	$886	$886	$886
Infrastructure	$304	$304	$283
Benefit redesign and industry fees	$11	$14	$14
Optional opportunities	$15	$0	$0
Subtotal	**$1,216**	**$1,204**	**$1,183**
Federal funding & additional revenues to states due to ACA			
Coverage expansion	$(1,072)	$(844)	$(396)
Infrastructure	$(273)	$(273)	$(248)
Benefit redesign and industry fees	$(9)	$(9)	$(9)
Optional opportunities	$(184)	$(64)	$(64)
Premium taxes[3]	$3	$3	$3
Subtotal	**$(1,534)**	**$(1,187)**	**$(713)**
Net to states due to ACA			
Coverage expansion	$(186)	$41	$490
Infrastructure	$31	$31	$36
Benefit redesign and industry fees	$2	$5	$5
Optional opportunities	$(169)	$(64)	$(64)
Premium taxes[3]	$3	$3	$3
Total	**$(318)**	**$17**	**$470**

[1]Source: Deloitte Center for Health Solutions analysis, Deloitte's Health Reform Impact Model, and ACA Provision Mapping Tool: 2011–2020.

[2]Not all numbers add due to rounding.

[3]Premium taxes slightly reduced, despite increased coverage in market, due to a shift toward administrative services only contracts which are not subject to state premium taxes.

Results: Coverage expansion drives most of the additional per person fiscal impact to states due to ACA



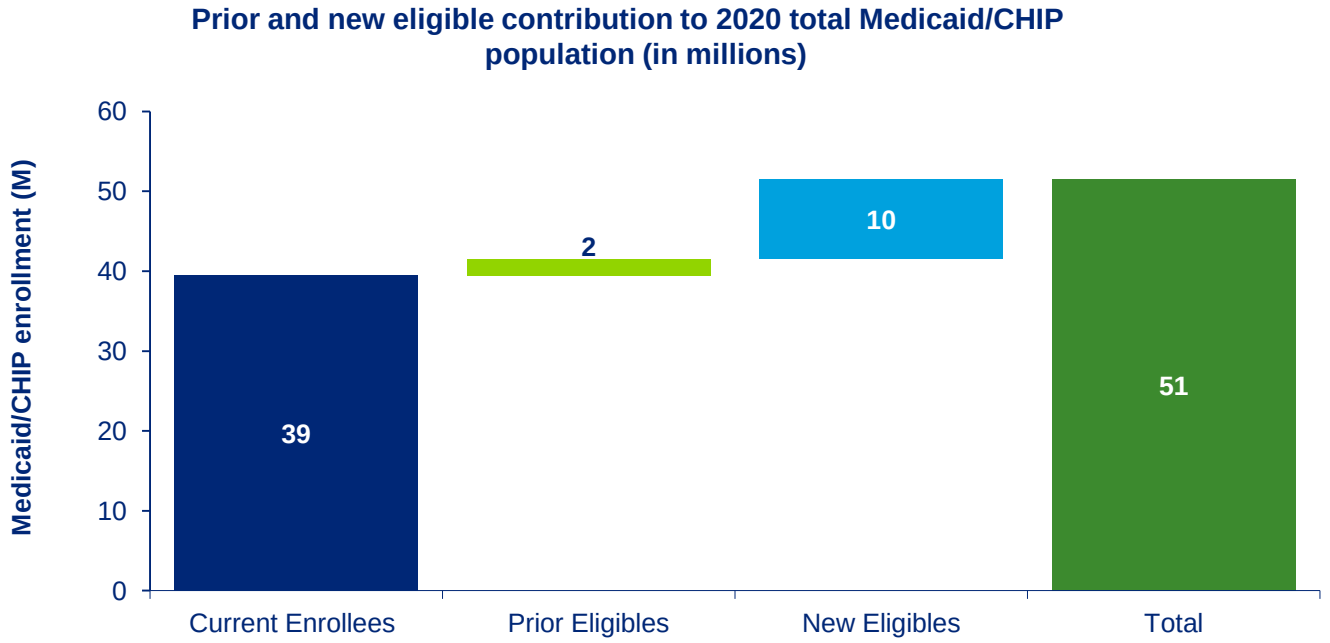
Range of estimated per person fiscal impact to states related to ACA (undiscounted 2011–2020)[1,2]

[1]Source: Deloitte Center for Health Solutions analysis, Deloitte's Health Reform Impact Model, and ACA Provision Mapping Tool: 2011–2020.

[2]Cost (+) or Saving (-).

Results: Medicaid enrollment changes are the big unknown

- Despite potential favorable ACA federal funding, possible costs to states are due to the volume of enrollment increase
  - Enrollment is likely to increase from 39 million in 2011 to 51 million in 2020[1]
    - 12 million new individuals join the program by 2020



[1]Source: Deloitte Center for Health Solutions analysis, Deloitte's Health Reform Impact Model, and ACA Provision Mapping Tool: 2011–2020.

Key implications: The bottom line for states

1st

ACA implementation could add costs for states, especially if Medicaid enrollment increases are substantial. Other elements of reform — health insurance exchange systems, insurance premium oversight, employee benefit changes, et al — appear to have a marginal cost impact

2nd

Managed care and medical management programs/services in Medicaid, as well as modification of state programs,[1] have the potential to substantially lower costs

3rd

Given states' budget deficits, lagging economic recoveries, and political realities, deficits from Medicaid could force cuts in other programs, unless states implement innovative methods for managing Medicaid administratively and clinically

[1]Modify existing state health insurance and medical programs if ACA provides them and target populations are the same.

Appendix

Limitations

- There are cost, saving, and revenue variables that were not included in our model, due to unknown parameters
  - Such as supply-induced demand of Medicaid beneficiaries (cost) and potential revenues from the Basic Health Plan (BHP) option (revenue)
- We did not model any future cost shifting from Medicaid to commercial markets in this analysis (past cost shifting has been substantial, but it was assumed that those levels of shifting would not continue because it would cause the Medicaid provider supply to decrease to unacceptable levels)
- We did not estimate any potential changes to uncompensated care (saving) beyond what was estimated in the DSH payments section
- Modest efficiencies in the health delivery system (saving) — heightened regulatory scrutiny of rate increases and effective competition that may result from HIX — were built into an assumed 6.5% medical cost trend in the near term (which is somewhat lower than recent and long-term past historical averages). Other efficiency factors may arise in the future
  - As additional variables become known or available, or current variables are clarified, either through availability of regulations or updated data, they will be included in future updates of this analysis

Details: Medicaid/CHIP federal funding

- Non-expansion states
  - **New eligibles:** enhanced federal match (FMAP) of 100% in 2014–2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and onward per ACA
- Expansion states
  - **New eligibles:** new FMAP based on the following formula (State's Base FMAP) + [(Transition Percentage) x (FMAP for New Eligibles — State's FMAP)], where the transition percentage is 50% in 2014, 60% in 2015, 70% in 2016, 80% in 2017, 90% in 2018, and 100% in 2019 and beyond per ACA
    - Since the new FMAP is based on a formula until 2018, the rates for each expansion state will vary based on the state's regular FMAP, but will be at least 75% in 2014 (and up to 90%), at least 80% in 2015 (and up to 92%), at least 85% in 2016 (and up to 94%), at least 86% in 2017 (and up to 92%), and at least 90% in 2018 (and up to 92.6%)) per ACA
    - In 2019 and 2020, the rate will be equal to the FMAP for new eligibles for non-expansion states: 93% 2019 and 90% 2020 per ACA
  - **No new eligibles:** if an expansion state does not have any new eligibles "because they already cover people up to 133% of FPL or higher will also receive a temporary (January 1, 2014 through December 31, 2015) 2.2 percentage point increase in their federal-matching rate for all populations. It is likely that these states will include at least Massachusetts and Vermont, which already use Medicaid to provide coverage to people with income at or above 133% of FPL"[1]
- All states (expansion and non-expansion)
  - **Prior eligibles:** regular FMAP per ACA

[1]Kaiser Family Foundation. Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and States. Focus on Health Reform. 2010 May.

Details: Medicaid/CHIP federal funding (cont.)

Medicaid definitions

- **New eligible:** "adult aged 19 (or a higher age if a state has opted to cover older children) and up to age 65 who was not eligible for Medicaid, as of December 1, 2009, including under a Medicaid waiver"[1]
  - However, "if the waiver only covered a limited benefit package or capped enrollment, a state may be able to treat the adult as new eligible and qualify for the much higher new eligible match rate"[1]
- **Prior eligible:** individual older than 19 who are eligible, but not enrolled under the rules a state had in place on December 1, 2009, per ACA
- **Expansion state:** defined as a state that, on the date of ACA enactment (March 23, 2010), was already providing Medicaid coverage for parents and non-pregnant childless adults with incomes at least up to 100% of FPL that provides more benefits than premium assistance, hospital-only benefits, a high deductible plan, or health opportunity accounts
  - Although HHS will make the official determination of which states will be considered expansion states it is likely that seven states will be eligible for this special expansion state match rate (Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont)[1]
- **Post-ACA enactment but prior to January 1, 2014, expansion state:** using the new ACA option and/or by obtaining a waiver, some states are expanding coverage, such as California and New Jersey
- **Non-expansion state:** On the date of ACA enactment (March 23, 2010), was not providing Medicaid coverage for parents and non-pregnant childless adults with incomes at least up to 100% of FPL

[1]Kaiser Family Foundation. Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and States. Focus on Health Reform. 2010 May.

Details: Administration, IT systems, and governance federal funding[1]

Federal Funding	Amount	Dates	Description	Planning and Development	Operations
HIX Planning Grant	$49 million in grants to 49 states	Awarded on September 30, 2010	HIX research and planning	✓	
HIX Innovator Grant	$241 millions awarded to 12 states	Awarded on February 16, 2011	Development of cutting-edge technologies and models for insurance eligibility and enrollment (E&E)	✓	
HIX Establishment Grant	Will vary according to states' needs and progress	Level 1 due by December 30, 2011; Level 2 due by June 29, 2012	Development and implementation of HIX operations	✓	✓
FMAP for Eligibility and Enrollment (E&E) Development	90 percent Federal Financial Participation (FFP)	Through the end of 2015	Design, development, and installation or enhancement of E&E systems	✓	
FMAP for Eligibility and Enrollment (E&E) Maintenance	75 percent FFP	After 2015 (available to December 31, 2015 for E&E systems in compliance with new rules)	Maintain and operate E&E systems that comply with federal standards		✓
Medicaid Administration: Non-compliant E&E systems and Ongoing Medicaid (FFS) administration	50 percent FFP	Available continuously	Build, maintain, and operate E&E systems that do not meet standards necessary for enhanced matching funds; ongoing administrative expense reimbursement for FFS	✓	✓
Medicaid Administration: Managed Medicaid administration	State-specific FMAP	Available continuously	State capitated payments to commercial insurers are inclusive of health care and administration costs; payments reimbursed at FMAP (e.g., non-expansion state for new eligibles: 100 percent FMAP 2014–2016)		✓
Medicaid fraud, waste, and abuse programs	FFP	Available continuously	Medicaid Fraud Control Units (MFCUs) can use FFP to identify fraud through data mining (screening and analyzing state Medicaid claims data)		✓
CHIP outreach and enrollment	Additional $40 million	Available through FY2015	Finding and enrolling eligible children and ensuring that they stay enrolled for as long as they are eligible		✓

[1]Bachrach D, Boozang P, Dutton M, and Manatt Health Solutions. Medicaid's Role in the Health Benefits Exchange: A Road Map for States, A Maximizing Enrollment Report. National Academy for State Health Policy and Robert Wood Johnson Foundation. 2011 March.

Available at: www.nashp.org/sites/default/files/maxenroll%20Bachrach%20033011.pdf.

Resources

Relevant additional materials from DCHS

- Medicaid Long-term Care: The Ticking Time Bomb
  - Available at: http://www.deloitte.com/view/en_US/us/Industries/health-care-providers/center-for-health-solutions/1ad0826ddaa49210VgnVCM200000bb42f00aRCRD.htm
- Medicaid Medical Management: A Potential Savings for States Facing a Budget Crunch
  - Available at: http://www.deloitte.com/view/en_US/us/Industries/health-care-providers/center-for-health-solutions/research/19ed10a8b410e110VgnVCM100000ba42f00aRCRD.htm
- Monday Memo: Health Reform Update (weekly)
  - Available at: http://www.deloitte.com/view/en_US/us/Insights/centers/center-for-health-solutions/health-care-reform/health-care-reform-memo/index.htm

Authors and contributors

- Paul H. Keckley, PhD, Executive Director, Deloitte Center for Health Solutions
- Elizabeth L. Stanley, MPH, Research Manager, Deloitte Center for Health Solutions
- Jac Joubert, Manager, Deloitte Consulting LLP
- Cynthia Vasquez, Reform Analyst, Deloitte Center for Health Solutions
- Robert Campbell, Management Principal, U.S. State Government Sector, Deloitte LLP
- Patrick Howard, Principal, Deloitte Consulting LLP
- James Whisler, Principal, Deloitte Consulting LLP

This presentation contains general information only and is based on the experiences and research of Deloitte practitioners. Deloitte is not, by means of this presentation, rendering business, financial, investment, or other professional advice or services. This presentation is not a substitute for such professional advice or services, nor should it be used as a basis for any decision or action that may affect your business. Before making any decision or taking any action that may affect your business, you should consult a qualified professional adviser. Deloitte, its affiliates, and related entities shall not be responsible for any loss sustained by any person who relies on this presentation.

The Deloitte Center for Health Solutions (DCHS) is the health services research arm of Deloitte LLP. Our goal is to inform all stakeholders in the health care system about emerging trends, challenges and opportunities using rigorous research. Through our research, roundtables and other forms of engagement, we seek to be a trusted source for relevant, timely and reliable insights.

To learn more about the DCHS, its research projects and events, please visit: www.deloitte.com/centerforhealthsolutions.