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ISSUE BRIEF

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Health Care Reform and the State Budget:

Savings Likely to Partly or Fully Offset Modest New Costs

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SPECIAL POINTS OF INTEREST

- Most studies of the impact of the Affordable Care Act have concluded that increases to state Medicaid budgets will be modest.
- Some studies have concluded that overall state spending will decrease as a result of the new law.
- Analysis by experts at the Urban Institute and by the Oklahoma Health Care Authority project that Oklahoma Medicaid costs will increase between $212 and $789 million in the coming years.
- Estimates by the Oklahoma Council of Public Affairs and Cato Institute that the Affordable Care Act will impose additional state costs of $11 billion by 2023 are way out of line with other estimates and are based on mistaken assumptions and methodologies.

As state policymakers struggle with ongoing budget shortfalls in the aftermath of the Great Recession, the cost of health care is an issue of particular concern. State health care spending has grown rapidly in Oklahoma and other states in recent years due to a number of factors, including rising costs across the entire health care system; policy changes that have expanded Medicaid eligibility for children; the erosion of employer-based coverage, and increases in Medicaid reimbursement rates for doctors, hospitals, and other providers to ensure access to services. For state governments, as for the federal government and the private sector, containing health care spending is essential for long-term fiscal sustainability.

In this context, the new federal health law presents challenges and opportunities for state budgets in the coming years. Under the Patient Protection and Affordable Care Act (ACA), one major strategy for providing health insurance coverage to the 50 million Americans who are currently uninsured is an expansion of eligibility in the Medicaid program. Even

though the federal government will assume the lion's share of the costs of insuring those who gain Medicaid coverage, this expansion has created concern and uncertainty about the impact the law will have on state budgets. Some worry that the ACA will significantly increase the state's Medicaid obligations, which will squeeze funding for other services or require new revenues. In particular, a recent report from the Oklahoma Council of Public Affairs (OCPA) and Cato Institute contends that Oklahoma's Medicaid spending will increase by a mind-boggling $11.4 billion during 2014-2023 as a result of the ACA, and grow 35 percent more than without the new federal law.[1]

Careful scrutiny of the OCPA/Cato report reveals, however, that it is based on faulty assumptions that greatly exaggerate the likely impact of health reform on the state budget. Studies from leading national experts and the Oklahoma Health Care Authority suggest

that the fiscal impact of the Affordable Care Act on Oklahoma is likely to be only a small fraction of the amount estimated by OCPA/Cato. In addition, the cost to the state associated with increased Medicaid enrollment is likely to be offset, in part or in whole, by savings to other components of the state health care budget as the uninsured gain coverage. Overall, the new health care law is likely to require only modest new costs on the state budget and generate net benefit for the state and citizens of Oklahoma.

1. Expanding Coverage in the Affordable Care Act

One of the primary goals of the Affordable Care Act is to make health insurance coverage accessible and affordable to the 50 million Americans who are uninsured.[2] The two primary mechanisms for providing coverage, both of which take effect in 2014, are: (1) an expansion of Medicaid to all individuals under the age of 65 with incomes up to 133 percent of the federal poverty level; and (2) the creation of state-based Health Insurance Exchanges for the purchase of coverage by individuals and small businesses. Coverage purchased through an Exchange will be eligible for premium subsidies on a sliding scale basis to individuals with family income up to 400 percent of the federal poverty level. Beginning in 2014, most individuals will be required to have insurance coverage or face a penalty – the 'individual mandate' – although there are exceptions for various populations, including Native Americans, those with religious objections, and those for whom purchasing coverage would impose a financial hardship.[3]

The Congressional Budget Office (CBO) has estimated that the ACA will provide coverage to 32 million people who are currently uninsured by 2019. Of these, half are expected to enroll in Medicaid and half will purchase private insurance coverage through an Exchange.[4] The remaining uninsured will include individuals who are exempted from the coverage mandate or elect to pay the tax penalty for going without insurance, and undocumented immigrants, who are ineligible for public coverage or subsidies.

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The overwhelming share of the total cost of expanding coverage, estimated by the CBO at $938 billion over ten years, will be borne by the federal government. The costs will be paid for through savings in the Medicaid and Medicare programs, along with new taxes and fees that will be assessed primarily on the health care industry.[5] The federal government will assume the full cost of the premium subsidies for eligible individuals who purchase coverage through the Exchange, as well as the full cost of tax credits that will be extended to small businesses to encourage them to offer employer-based coverage. As we will discuss below, a small portion of the cost of those who will be covered through Medicaid will be shared by state governments.

2. Medicaid in the Affordable Care Act

Medicaid is the federal-state program that is a primary source of health insurance for low-income children, pregnant women, seniors, and individuals with disabilities. The program covers 47 million Americans, or just under one in five of all those with health insurance coverage (2009).[6] In Oklahoma, 733,285 persons are covered by Medicaid as of August 2011, of whom the majority (65 percent) are low-income children.[7] Medicaid is administered by the states, with the federal government paying a portion of Medicaid costs. In FY '10, Medicaid expenditures in Oklahoma totaled $4.3 billion, of which $1.17 billion came from state appropriations.[8]

The ACA extends Medicaid coverage to all individuals under the age of 65 with incomes up to 133 percent of the federal poverty level (FPL) as of January 2014.[9] While Medicaid eligibility for children and pregnant women already extends above 133 percent FPL, non-disabled working-age adults are eligible in most states only if they are parents of dependent children and have very low incomes. Currently in Oklahoma, working-age adults qualify for Medicaid only if

they are parents of dependent children with household income below 37 percent of the federal poverty level - which is less than $7,000 per year for a family of three.[10] As a result, fewer than 70,000 working-age adults receive Medicaid benefits in Oklahoma, most of whom are pregnant women.[11] The Affordable Care Act will thus make adults without dependent children and parents with incomes between 37 percent and 133 percent FPL. This population that will be newly eligible for Medicaid in Oklahoma represents a sizable segment of the currently uninsured.

Medicaid funding is a shared federal-state responsibility with the federal government paying a set share for eligible expenditures. In Oklahoma, the basic federal share of Medicaid costs for FFY '11 is 64.9 percent (the federal share varies for certain populations, such as Native Americans and some children, and for certain services, such as administrative costs, family planning services, and others). *The Affordable Care Act will provide states with a greatly enhanced federal match for individuals who become newly eligible for Medicaid coverage under the law's expansion to 133 percent of the federal poverty level*. For those newly eligible for Medicaid, the federal government will pay 100 percent of the costs in 2014-2016; states will initially be responsible for 5 percent of the expenditures of newly-eligible Medicaid recipients in 2017, phasing up to 10 percent from 2020 on [see Table 1]. In addition, expanded outreach efforts, along with the legal requirement for most individuals to have insurance or be subject to a fine (the individual mandate), will lead some children and very-low income adults who are currently eligible for Medicaid but not participating to enroll in the program starting in 2014. States will receive their basic federal match for this "welcome mat", or "old-eligible" population.

3. The State Fiscal Impact of the Affordable Care Act

The Affordable Care Act's Medicaid expansion, as well as some other provisions of the new health care law, will involve some additional costs for Oklahoma and other state governments. There is no definitive estimate of the fiscal impact of the ACA on Oklahoma's state budget: much depends on assumptions about the number, mix, and cost of individuals who enroll in the program, the time frame considered, as well as which set of factors related to costs and savings for the state budget are included. *However, most studies that have explored the impact of health reform on state budgets have concluded that the increases to state Medicaid spending will be modest; some studies that have considered a broader range of elements associated with the health reform law have concluded that overall state spending will decrease as a result of the Affordable Care Act.*

The official estimate of the fiscal impact of the ACA was prepared by the Congressional Budget Office (CBO). Of the total cost of Medicaid expansion under health reform between 2014 and 2021, the federal government will assume 92 percent. The costs for all states is projected to be $60 billion, which will increase states' Medicaid spending by just 2.6 percent compared to what state Medicaid expenditures would be in the absence of health reform.[12] The CBO's estimate includes the cost of covering individuals who are already eligible for Medicaid but are not enrolled, as well as those

Table 1
Federal and State Medicaid Shares for Newly Eligible Adults up to 133% FPL, 2014 and beyond

Year	Federal Share	State Share
2014	100%	0%
2015	100%	0%
2016	100%	0%
2017	95%	5%
2018	94%	6%
2019	93%	7%
2020 on	90%	10%

Table 2: Medicaid Projections under the Affordable Care Act, Various Studies

Study	Scope	Period	Participation Rate	# of New Participants	New Participants - Newly Eligible	New Participants - Old Eligible	Total Cost (in $millions)	State Share (in $millions)	Federal Share (in $ millions)	% Federal
Holahan & Heady	Oklahoma	2014-2019	Standard (57%)	357,150			$ 12,728	$ 549	$ 12,179	95.7%
Holahan & Heady	Oklahoma	2014-2019	Enhanced (75%)	470,358			$ 14,225	$ 789	$ 13,436	94.5%
OHCA	Oklahoma	2014-2020	Standard (57%)	137,370	112,290	25,080	$ 2,564	$ 212	$ 2,352	91.7%
OHCA	Oklahoma	2014-2020	Enhanced (75%)	180,751	135,000	45,750	$ 3,374	$ 279	$ 3,095	91.7%
OCPA/Cato	Oklahoma	2014-2023	unspecified	340,000	217,000	142,000	unspecified	$ 11,400	unspecified	unspecified

*: % increase for OHCA projections based on Holahan and Heady baseline spending 2014-2019, inflated by 4% to include 2020

who will become newly-eligible. The CBO study did not provide a state-level breakdown of state costs.

A report by John Holahan and Irene Headen of the Urban Institute in May 2010 developed two state-level estimates based on a standard participation scenario (57 percent of eligibles participating) that corresponds to the CBO estimates and an enhanced outreach scenario (75 percent of eligibles participating).[13] Under a standard participation scenario, spending for all states will increase by $21.1 billion from 2014-2019, an increase of 1.4 percent compared to state expenditures in the absence of the health care law. State spending in Oklahoma is projected to increase by $549 million from 2014-2019, an increase of 4.0 percent over the baseline. Under an alternative "enhanced outreach scenario", spending for all states would rise $43.2 billion, or 2.9 percent, from 2014-2019 compared to expenditures in the law's absence. Oklahoma's Medicaid spending would increase by $789 million from 2014-2019, an increase of 5.8 percent.

The Oklahoma Health Care Authority (OHCA), the state Medicaid agency, developed two cost scenarios based on 57 percent and 75 percent of those eligible for Medicaid enrolling in the program, which correspond to the standard and enhanced participation scenarios developed by the Holahan-Headen study.[14] Although covering a one-year longer period (2014-2020) than Holahan–Headen, OHCA's cost projections are considerably lower: $251 million under the 57 percent participation scenario, and $331 million under the 75 percent participation scenario.

While the dollar amounts are different in the each of the scenarios modeled by Holahan-Headen and OHCA, they are all in agreement with the CBO's findings that the state share of increased Medicaid expenditures would be minimal, with the federal government assuming somewhere between 92 percent and 96 percent of the total cost.

A May 2011 report released by the Oklahoma Council of Public Affairs (OCPA) and co-authored by Jagadeesh Gokhale and Angela Erickson of the Cato Institute departs wildly from these national and state-specific studies in contending that the Affordable Care Act will impose enormous new spending obligations on the state budget.[15] The OCPA/Cato study concludes that "implementation of [the ACA] would increase Oklahoma's Medicaid spending by $11.4 billion during the law's first ten years (2014-2023), which would represent a 35 percent increase over estimated Medicaid spending" in the absence of the law. As a result, they contend that total state Medicaid expenditures in the first decade under the law would exceed $40 billion, which would clearly place huge and unmanageable strains on the state budget.

The OCPA/Cato Institute's cost estimates cover a longer time period – from 2014 to 2023 – than do either the CBO and Holahan-Heady studies (2014-2019) or the Oklahoma Health Care Authority (2014-2020). The additional three or four years covered by OCPA/Cato includes a period where the federal share of costs for newly-eligible Medicaid enrollees declines to 90 percent. Still, even accounting for the inclusion of the additional years at a slightly higher state share, their conclusion that state Medicaid costs will rise by $11 billion and 35 percent due to the ACA is far out of line with the other studies that all project additional state costs of less than $1 billion and an increase of no more

than 6 percent (under the Holahan-Heady "enhanced outreach scenario").

Despite the inclusion of a two-page methodological appendix, one cannot determine exactly how the OCPA/Cato Institute study arrives at its estimates based on the information in its report. However, there are at least two ways in which their calculations appear to be based on fundamentally flawed assumptions, both of which contribute to inflated estimates of the state cost of the ACA.

Participation Assumptions: The OCPA/Cato report assumes an additional 321,000 Medicaid recipients in 2014, which is in between the number of new Medicaid recipients assumed by Holahan-Heady (357,000 under the standard participation scenario and 470,000 under enhanced outreach) and by OHCA (137,000 standard, 180,000 enhanced). The significant difference is that OCPA/Cato assumes that a very high proportion of those who will sign up for Medicaid will be 'old eligibles', who will be reimbursed at the regular federal match rate (approx. 65 percent) rather than the enhanced rate (90 to 100 percent). OCPA/Cato projects that by 2014, there will be 104,000 'old eligibles' enrolled in Medicaid, rising to 142,000 by 2023. By 2023, "old eligibles" will constitute 40 percent of their total increased Medicaid population of 359,000.

Their paper states:

> Oklahoma's Medicaid spending will surge because the federal government will provide only the state's regular match rate for those who were Medicaid eligible but not enrolled under pre-PPACA laws, also known as the "old eligibles".

But given that Oklahoma's Medicaid program currently covers only adults who are parents of dependent children with incomes below 37 percent of the federal poverty level, how many 'old eligibles' are there in the state who are not enrolled? According to OHCA, there are only 61,000 uninsured individuals who are currently eligible but unenrolled in Medicaid – 44,000 children and 17,000 adults.[16] This total 'old eligible' population is less than half of the 142,000 'old eligibles' on which OCPA/Cato bases its projections. The surge in enrollment among the 'old eligibles' assumed by OCPA/Cato goes well beyond any "woodwork effect" due to enhanced outreach efforts and the individual mandate that all other studies take into account in calculating state costs, and appears to be more of a pure "thin air" effect.

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Expenditure Assumptions – The OCPA/Cato brief provides very limited data to explain how it calculates Medicaid costs under the ACA. However, it starts by asserting:

> Currently, 23 percent of the Oklahoma population is enrolled in Medicaid (828,000 enrollees) at an average cost of $4,195 per person. A non-disabled adult on Medicaid in Oklahoma costs nearly $4,500 annually.

Both the population figure of 828,000 and the per person costs of $4,500 are overstated. Currently as of August 2011, there are just over 733,000 total enrollees in Medicaid; for the last complete fiscal year, OHCA reported an average of 707,453 members enrolled each month.[17] The OCPA-Cato number thus overstates enrollment by some 13 to 17 percent, which affects their projections of the program's cost from 2014 to 2023.

Even more significantly, their average annual cost for a nondisabled adult – the population that will account for the great bulk of the growth in Medicaid enrollment under the ACA – is fundamentally flawed. It appears from the report that their baseline average cost of nearly $4,500 per adult recipient reflects the *average cost per enrollee who receives Medicaid-paid health services* rather than the

average cost of all enrollees in the program, including the significant percentage of enrollees who receive no services. The average cost of all Medicaid enrollees, including those who are enrolled but do not receive services in a given year, is much lower: for FY 2007, the average cost per adult enrollee was $2,716, or 40 percent less than the OCPA-Cato figure, according to the Kaiser Commission on Medicaid and the Uninsured.[18] However, it appears that OCPA-Cato carries forward their substantially higher per-care-recipient cost across the entire population of enrollees in projecting Medicaid expenditures from 2014-2023. This substantially inflates their projections of the total cost of Medicaid expansion.

It is worth noting that the average adult cost for current recipients in both the OCPA/Cato and Kaiser Commission data are based on a population composed largely of pregnant women, who will have relatively high per person expenditures than other adults. A good case can be made that the expansion population will be less expensive than the current population because it will include a large number of young and healthy adults.

In its calculations, OHCA projects the annual per person costs of those newly enrolled in Medicaid at $2,529 in FY 2014, rising to $2,916 by FY 2010. This is also some 40 percent less than OCPA/Cato's baseline figure of $4,500 per person in 2009.

Compounded together, the faulty assumptions in the OCPA-Cato Institute report that exaggerate the share of new Medicaid recipients who are 'old eligibles', the number of current Medicaid recipients, and the expenditure per recipient produce highly inflated estimates of the future cost of the Medicaid budget.

Finally, we should note that the OCPA/Cato Institute report looks only at state Medicaid costs and fails to consider any anticipated savings or offsetting revenue associated with implementation of the ACA. However, several studies at both the national and state levels that have considered a broader range of cost, savings, and revenue factors associated with the law have concluded that *the cost of the health care law will be less for states and could even yield net savings*. A July 2011 report from the Robert Wood Johnson Foundation (RWJF) states that, "State governments will collectively save between $92 billion and $129 billion from 2014 to 2019 because of provisions in the Affordable Care Act that are designed to reduce the uninsured population and provide federal funding for functions that, in the past, have been financed by states and localities."[19] A number of components of the ACA will contribute to savings for state governments, including:

- Reduced state spending on mental health care as the ACA extends Medicaid and federal subsidies to many low-income people with mental illness who previously were uninsured;
- Reduced state spending on uncompensated care for the uninsured;

"State governments will collectively save between $92 billion and $129 billion from 2014 to 2019 because of provisions in the Affordable Care Act that are designed to reduce the uninsured population and provide federal funding for functions that, in the past, have been financed by states and localities."

- Reduction in Medicaid coverage for pregnant women who will have subsidized private coverage through the Exchange or their employers;
- Increased state premium tax revenue as more individuals gain subsidized private coverage.

The July 2011 RWJF report, which examined some of the most significant sources of additional costs and savings to the states, calculated that the impact for Oklahoma from 2014 – 2019 would range from net costs of $60 million to net savings of $367 million – without considering state mental health cost savings, for which they were unable to produce state-level estimates.

The RWJF report is in line with other research that considers a broader range of fiscal factors than just expanded Medicaid enrollment. A February 2011 survey by Randall R. Bovberg, Barbara A. Ormond and Vicki Chen of the Ur-

ban Institute found that three of five national-level studies that addressed a broader range of elements contained in the new health law have projected the ACA to have *net savings* for states. Similarly, two of five state-specific studies, in Kansas and Missouri, have determined that the health law will provide net benefit for the state budget.[20]

Conclusion

The study from the OCPA and Cato Institute estimating state costs of $11 billion and a 35 percent increase in Medicaid spending is wildly out of line with other estimates and is based on exaggerated and unsupported assumptions about who will enroll in Medicaid and how much they will cost. In addition, it fails to consider various ways that additional state costs will be partly or fully offset by savings to the state budget under various provisions of the Affordable Care Act that reduce the uninsured population and provide federal funding for functions previously financed by the state.

We do not yet have a comprehensive study of the projected costs and savings of the Affordable Care Act for Oklahoma's state budget. However, national studies from the Urban Institute and projections developed by the Oklahoma Health Care Authority have estimated that state spending on Medicaid may grow by $200 to $800 million between 2014 and 2019 or 2020, depending on various assumptions. This will increase state Medicaid spending by under 10 percent. To cite the conclusion of the study by John Holahan and Irene Headen, the Urban Institute's experienced and widely-respected health policy analysts:

> Most of the cost of the new expansion will be borne by the federal government. States will have relatively small increases in state spending, but these will be swamped by new federal dollars that they will receive because of the reform. This is particularly true of the states that have low coverage today and will experience the largest increases in individuals newly eligible for the program.[21]

There is no doubt that paying for health care at a time of scarce resources will remain an ongoing challenge for state leaders in the years ahead. However, by significantly reducing the number of Oklahomans without health insurance, the Affordable Care Act will reduce the strains that uncompensated care places on our health care providers across the state and will provide better health care and greater financial security to Oklahoma families. These benefits may ultimately be seen to far outweigh the likely modest cost to the state budget of paying a small portion of the total bill.

NOTES

[1] Jagadeesh Gokhale, Angela C. Erickson, and Jason Sutton, *Projecting Oklahoma's Medicaid Expenditure Growth Under the Patient Protection and Affordable Care Act*, Oklahoma Council of Public Affairs, May 2011; at: http://s3.amazonaws.com/assets.ocpa.com/articles/pdfs/1179/original/Projecting%200K%20Medicaid%20Expenditures%20Under%20PPACA.pdf?1305725075

[2] Kaiser Family Foundation, *The Uninsured: A Primer. Key Facts About Americans Without Health Insurance*, December 2010; at: http://www.kff.org/uninsured/upload/7451-06.pdf

[3] Kaiser Family Foundation, *Summary of Coverage Provisions in the Patient Protection and Affordable Care Act*, April 2011; at: http://www.kff.org/healthreform/upload/8023-R.pdf

[4] Douglas Elmendorf, *Letter to Speaker Nancy Pelosi*, Congressional Budget Office (on H.R. 4872), March 20, 2010, Table 4; at: http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf An additional 8 million people who currently have individual and employer coverage are expected to purchase coverage through an Exchange.

[5] Ibid

[6] Kaiser Family Foundation, *Health Insurance Coverage of the Total Population*, states (2008-2009), U.S. (2009) Statehealthfacts.org

[7] Oklahoma Health Care Authority, *SoonerCare Fast Facts*, August 2011; at: http://okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=13193

[8] Oklahoma Health Care Authority, *Annual Report State Fiscal Year*

2010, p. 29; at: http://okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=12262

[9] Under the ACA, 5 percent of family income will be disregarded for determining Medicaid eligibility, which raises the effective eligibility level to 138 percent FPL. See Kaiser Commission on Medicaid and the Uninsured, *Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014*, June 2011; at: http://www.kff.org/healthreform/upload/8194.pdf

[10] See note 8, p. 21

[11] See note 8.

[12] Douglas Elmendorf, *Letter to John Boehner*, Congressional Budget Office, February 18, 2011 (on H.R. 2, which repealed the Affordable Care Act); at: *www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf*

[13] John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, Kaiser Commission on Medicaid and the Uninsured, May 2010; at: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf

[14] Oklahoma Health Care Authority, *Health Reform Estimate of Cost at 75% Participation* and *Health Reform Estimate of Cost at 57% Participation*, May 26, 2010. Unpublished spreadsheets; posted at: http://dl.dropbox.com/u/19732897/OHCA_Health_Reform_Cost_Estimate_75percentparticipate.xls and http://dl.dropbox.com/u/19732897/OHCA_Health_Reform_Cost_Estimate_57percent_participation.xls Unless otherwise noted, all subsequent references to OHCA are to this source.

[15] See note 1 for this and all subsequent reference to the OCPA/Cato study.

[16] Ibid

[17] See note 7 for August enrollment and note 8, p. 27 for FY '10 average monthly enrollment.

[18] Kaiser Family Foundation, *Medicaid Payments per Enrollee (2007),* Statehealthfacts.org; at: http://www.statehealthfacts.org/comparemaptable.jsp?ind=858&cat=4

[19] Matthew Buettgens, Stan Dorn and Caitlin Carroll, *Consider Savings as Well as Costs: State Governments Would Spend At Least $90 Billion Less With the ACA than Without It from 2014 to 2019*, Robert Wood Johnson Foundation, July 2011; at: http://www.rwjf.org/healthpolicy/product.jsp?id=72582

[20] Randall R. Bovbjerg, Barbara A. Ormond and Vicki Chen, *State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts*, Kaiser Commission on Medicaid and the Uninsured, February 2011; at: *www.kff.org/healthreform/upload/8149_ES.pdf*

[21] See note 14, p. 33.

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