Estimated Financial Effects of Expanding Oregon's Medicaid Program under the Affordable Care Act (2014-2020)

February 2013

Prepared for:
The Oregon Health Authority

Prepared by:
The State Health Access Data Assistance Center
Oregon Health Sciences University's Center for Health Systems Effectiveness
Manatt Health Solutions

Funded by:
Robert Wood Johnson Foundation's State Health Reform Assistance Network

shadac
State Health Access Data Assistance Center

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Summary

The Patient Protection and Affordable Care Act (ACA) calls for states to expand Medicaid to low income adults and provides federal funds to cover 100 percent of the costs of these "newly eligibles" from 2014 through 2016. The federal matching rate will then decrease over the next four years to 90 percent in 2020. In June 2012, the U.S. Supreme Court ruled on the constitutionality of key provisions of the ACA, and while the ruling did not change the Medicaid expansion provisions, it effectively made expansion optional for states. The purpose of this report is to provide information to Oregon policy makers as they consider the decision whether to expand Medicaid. The analysis was produced in collaboration by the State Health Access Data Assistance Center (SHADAC), Oregon Health Sciences University's Center for Health Systems Effectiveness (CHSE), and Manatt Health Solutions.

This analysis estimates the potential costs and benefits of the ACA Medicaid expansion to the State of Oregon. It assesses the effect on state general funds, other state funds and the overall impact on health care expenditures. The expenditure estimates incorporated in this analysis are net of the effects of Oregon's health system transformation. Without health system transformation, the costs of expansion would increase.

In summary, if Oregon chooses to expand Medicaid, it will provide coverage to more than 240,000 newly eligible Oregonians and encourage approximately 20,000 previously eligible Oregonians to enroll in coverage. This will generate $11.3 billion in federal health care expenditures and a net savings of $79 million to the state general fund.

$79 million savings to the state general fund results from:

- $591 million in spending on new coverage;
- $321 million in general fund savings due to enhanced federal matching funds from transitioning some adults into the newly eligible group and reduced state costs to serve the uninsured and cover public employees and educators; and
- $349 million in tax revenue due to increased economic activity generated by this new federal investment in Oregon ($320 million in personal income tax and $29 million in corporate).

$11.3 billion in new federal Medicaid spending results from:

- $10.2 billion for new coverage; and
- $1.1 billion funding OHP Standard and select other current Medicaid eligibles at the new federal matching rate.

Tables 1 and 2 summarize these effects by funding source. **Table 1** presents the information by biennium and **Table 2** provides a summary by type of effect. In both tables, expenditures currently covered by general or other funds that would be replaced by federal funds under an expansion are included both as savings to the general or other fund and as new federal funding.

In addition to the financial benefits to the State, it is important to consider the effect of health insurance on the 240,000 newly eligible individuals who will receive coverage. The Oregon Health Study found that individuals with coverage increased their perceived mental and physical health status and decreased medical debt. The text box on page three highlights some of the benefits that health insurance will provide to newly covered Oregonians.

Table 1. ACA Medicaid Expansion Projected Financial Effect on Oregon, 2014 to 2020 *(Dollars in millions)*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium	SFY 2020	SFY 2014-2020
Effect on general fund expenditures	($89)	($112)	$49	$73	($79)
Effect on other/lottery funds expenditures	($214)	($339)	($364)	($192)	($1,109)
New federal funding and tax revenue	$1,882	$3,811	$3,922	$2,021	$11,635
Net effect on health care expenditures	**$1,578**	**$3,359**	**$3,607**	**$1,903**	**$10,448**

Note: Positive numbers represent expenditures; negative numbers (in parentheses) represent program savings or revenue offsets.

Table 2. ACA Medicaid Expansion Projected Financial Effect on Oregon by Funding Source, 2014 to 2020
(Dollars in millions)

Type of Effect	Effect on General Fund Expenditures	Effect on Other/Lottery Funds Expenditures	New Federal Funding and Tax Revenue	Net Effect on Health Care Expenditures
Expansion to newly eligible (excludes OHP Standard)	$433		$9,913	$10,346
New enrollment by previously eligible (welcome mat effect)	$158		$278	$436
New Coverage Subtotal	***$591***	***-***	***$10,191***	***$10,782***
Transitioning select Medicaid enrollees to newly eligible category	($24)		$24	-
Savings to state programs for uninsured	($204)			($204)
Transitioning OHP Standard to newly eligible category		($1,072)	$1,072	-
Premium reductions for PEBB & OEBB	($93)	($37)		($130)
Savings Subtotal	***($321)***	***($1,109)***	***$24***	***($334)***
Net Cost of Coverage	**$270**	**($1,109)**	**$11,286**	**$10,448**
State tax revenue from economic activity	($349)		$349	-
Net Effect of Expansion	**($79)**	**($1,109)**	**$11,635**	**$10,448**

Notes: Positive numbers represent expenditures; negative numbers (in parentheses) represent program savings or revenue offsets. Numbers that appear twice in a row represent a change in funding source (general or other funds to federal funds).

About SHADAC
The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is an independent health policy research center that helps states collect and use data to inform health policy. For information about SHADAC, please visit www.shadac.org.

About The Center for Health Systems Effectiveness
The Center for Health Systems Effectiveness (CHSE) at Oregon Health and Science University serves health services researchers at OHSU and throughout the region. The Center undertakes research to achieve the Triple Aim of improving the population health, improving patient experience, and reducing the per capita costs of care. The Center focuses on quantitative analyses, with a particular emphasis on state health policy and health economics.

About Manatt Health Solutions
Manatt Health Solutions is a division of Manatt, Phelps & Phillips, LLP. Its interdisciplinary team provides strategic business advice, policy analysis, project implementation, and coalition-building and advocacy services to clients in the areas of, healthcare access and coverage, development of new healthcare delivery system models and health information technology. MHS professionals also provide counsel on financing, reimbursement, restructurings, and mergers and acquisitions to clients in the healthcare sector. For more information, visit www.manatthealthsolutions.com.

About The State Health Reform Assistance Network
The State Health Reform Assistance Network (State Network) is a Robert Wood Johnson Foundation (RWJF) funded program dedicated to providing technical assistance to states in order to maximize coverage expansion under the Affordable Care Act (ACA). For information and resources, visit http://www.statenetwork.org.

Background

The Affordable Care Act (ACA) calls for states to expand Medicaid to non-disabled adults aged 19-64 with incomes at or below 138 percent of the federal poverty level (FPL).[1] States will receive 100 percent Federal Medical Assistance Percentage (FMAP) for this "newly eligible" population from 2014 through 2016.[2] Starting in 2017, match rates for the newly eligible will decline gradually until they reach 90 percent for 2020 and future years.

In June 2012, the U.S. Supreme Court ruled on the constitutionality of key provisions of the ACA, and while the ruling did not change the Medicaid expansion provisions, it held that the federal government could not withhold other federal matching funds in states that choose not to expand their Medicaid programs.[3] This ruling effectively allows states to opt out of the Medicaid expansion at any time.

To determine whether to opt out of the expansion, Oregon seeks to examine the economic effect of the expansion as well as its effect on the health and welfare of the residents of the State.

The following analysis is intended to provide information to Oregon policy makers as they consider the decision whether to expand Medicaid. The analysis was produced in three parts by the State Health Access Data Assistance Center (SHADAC), Oregon Health Sciences University's Center for Health Systems Effectiveness (CHSE) and Manatt Health Solutions. Part I examines the enrollment effects of the expansion and the associated costs of this new enrollment (SHADAC and Manatt); Part II projects the estimated savings to Oregon's budget as a result of the coverage expansion (SHADAC, Manatt, CHSE); and Part III projects the impact of new federal spending on employment and tax revenue (CHSE).

The analysis focuses specifically on the effects associated with a decision to implement the Medicaid expansion. It does not address the fiscal impacts of other mandatory components of the ACA (e.g., the effect of implementing a streamlined application for Medicaid and the health insurance exchange).

In addition, the analysis focuses on a seven-year time horizon (using the state fiscal year from June to July) to account for changes in the federal matching rate that are phased in between 2014 and 2020.

The Personal Impact of Health Insurance: The Benefits of Coverage

Health insurance provides a clear benefit to the people receiving coverage. While health insurance is valuable to people for many reasons, several specific benefits have been researched using the Oregon Health Study (OHS).[4] Investigators compared individuals who were randomly assigned coverage to individuals without coverage and found that coverage had the following key health and financial outcomes:

- 24 percent increase in individuals rating their overall health as good/very good/excellent
- 16 percent increase in individuals rating their health as stable or improving over the last 6 months
- 12 percent increase in individuals who are not depressed (based on a clinical score)
- 21 percent decrease in the likelihood of having a medical bill in collections
- 20 percent decrease in the average amount owed in medical collections

In addition to the short term results found in the OHS, other studies have shown that expanding access to Medicaid is associated with fewer people dying. In a recent study, Harvard researchers found that states that expanded Medicaid eligibility for adults in the past decade reduced overall mortality rates.[5]

[1] The ACA expands coverage to 133 percent FPL but includes a mandatory income disregard of 5% FPL, effectively extending eligibility for the Medicaid expansion to 138 percent FPL ($15,415 for an individual and $31,809 for a family of four in 2012).

[2] The Federal Medical Assistance Percentage (FMAP) determines the federal share of the cost of Medicaid services in the state. It is based on a formula in the federal Medicaid statute that is derived from state per capita income, with lower income states receiving higher FMAPs. Rates range from 50 percent to 74 percent across the U.S. Currently, Oregon's FMAP is 63.14 percent for adults and 66.34 percent for children.

[3] *NFIB v. Sebelius. Letter of interpretation* from Secretary of Health and Human Services Kathleen Sebelius to Governors, US Department of Health and Human Services, July 10, 2012. Available at http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf

[4] "Preparing for Medicaid Expansion: How the Oregon Health Study can Help Oregon Prepare for 2014". Oregon Health Authority.

[5] Sommers, B., Baicker, K., and Epstein, A. 2012. "Mortality and Access to Care among Adults after State Medicaid Expansions". New England Journal of Medicine. 367:1025-1034.

Part 1: Enrollment and Associated New Costs of the ACA Medicaid Expansion

This section of the analysis projects the potential enrollment gains from the ACA Medicaid expansion in Oregon and new costs associated with this increase in coverage. To assess the cost of the Medicaid expansion, two areas of new enrollment must be considered (discussed in detail below):

1. The newly eligible population
2. Those who were previously eligible but not enrolled (i.e., those who enrolled due to the "welcome mat effect")

Cost of the Newly Medicaid Eligible

This portion of the analysis outlines the costs of new enrollment among those newly eligible for Medicaid.[6] As shown in **Table 3**, Medicaid enrollment in 2020 by newly eligible adults in Oregon is estimated at 245,000. These enrollees will receive a higher federal matching rate than will enrollees who were eligible under pre-ACA eligibility rules, and all of the health care costs for this group will be borne by the federal government for the first three years.

Costs to the State related to the newly eligible include higher administrative costs due to increased enrollment and, beginning in 2017, state matching funds for health care services. The estimated seven-year state cost of the newly eligible is $433 million, which is accompanied by an influx of 10 billion in federal dollars.

Key Data and Assumptions

The newly eligible enrollment projection was developed using the SHADAC Projection Model (additional information below). Existing research does not provide clear and consistent evidence regarding how many newly eligible individuals are likely to enroll in Medicaid. The high newly eligible participation rate assumed in this analysis was developed in consultation with state officials and is supported by the State's experience of high participation among Oregon

Table 3: Effect of ACA Medicaid Expansion – Newly Eligible
(Dollars in millions with the exception of per member per month (PMPM) rates)

State Fiscal Years (July – June)	SFY 13-14	SFY 14-15	SFY 15-16	SFY 16-17	SFY 17-18	SFY 18-19	SFY 19-20	2013-2020 Total
Newly eligible enrollees (excludes OHP Standard)	18,100	222,700	241,600	242,400	243,300	244,200	245,000	---
PMPM	$527	$541	$560	$579	$599	$619	$640	---
Cost of health benefits	$115	$1,447	$1,623	$1,684	$1,748	$1,813	$1,882	**$10,312**
FMAP – health benefits	100%	100%	100%	98%	95%	94%	92%	---
Administrative costs	$4	$8	$8	$6	$5	$3	$2	**$34**
FMAP – administrative	50%	50%	50%	50%	50%	50%	50%	---
Total cost of newly eligible	**$118**	**$1,455**	**$1,631**	**$1,690**	**$1,752**	**$1,816**	**$1,883**	**$10,346**
Federal share	**$116**	**$1,451**	**$1,627**	**$1,645**	**$1,654**	**$1,697**	**$1,723**	**$9,913**
State share	**$2**	**$4**	**$4**	**$45**	**$98**	**$119**	**$161**	**$433**

Notes: Calendar year federal matching rates specified in the ACA have been averaged to reflect Oregon's fiscal year (July-June). Federal and state spending includes allocated administrative costs. Numbers may not sum to total due to rounding.

[6] In addition to new enrollment among those newly eligible, those currently in the Oregon Health Plan (OHP) Standard program will be treated as "newly eligible" adults for the purposes of FMAP claiming and will receive enhanced FMAP rates. The savings from the current OHP Standard program are discussed later in the brief.

children who are eligible for Medicaid and the Children's Health Insurance Program (CHIP).[7] The assumed participation rate results in 95 percent of Oregonians having some type of insurance coverage.

The per member per month (PMPM) cost estimate for the newly eligible population is based on expenditure and caseload projections provided by state officials for the Oregon Health Plan (OHP) Standard population and the presumed newly eligible population.[8] These expenditures were increased by six percent to reflect benefit changes needed to align the OHP Standard benefit package with ACA requirements.[9] The growth in per member per month expenditures incorporates the health system transformation targets agreed upon between the state and CMS under the approved OHP demonstration waiver. [10]The increase in newly eligible enrollees produced by the model was adjusted to assume a phased-in effect that would occur over a three year period, starting in January 2014.[11]

With increased enrollment, administrative costs to the State will also increase. In this analysis, SHADAC uses preliminary budget estimates provided by Oregon officials. Officials project that 99 additional limited duration staff will be needed in the early years of the expansion (2014 to 2016) to handle increases in enrollment.[12] In later years, the need for enhanced staffing is projected to decline to 20 additional staff needed in 2020. Administrative costs will be shared 50/50 between the state and federal government.

Cost of the Previously Eligible but Not Enrolled (Welcome Mat Effect)

Not everyone who is eligible for means-tested public programs participates in them, and Medicaid is no exception. When public programs are expanded, new enrollment often occurs not only among the newly eligible, but also among the previously eligible populations. This is termed the "welcome mat" effect and was seen after CHIP was created in 1997 and more recently as several states have expanded coverage for children.[13]

There is consensus among experts and policymakers that the implementation of the ACA will generate a welcome mat effect. This is attributed to the new coverage paradigm that will include the individual mandate and insurance exchanges as well as enhanced outreach that will increase the visibility of Medicaid and enrollment simplifications that will make it easier to sign up for coverage. The cost implications of this welcome mat effect in relation to the ACA are particularly important, because these new enrollees will not receive the enhanced federal matching rate.

Many of the provisions assumed to drive the welcome mat effect, such as the individual mandate to purchase insurance coverage, do not depend on a state's decision to pursue the Medicaid expansion. As a result, there is uncertainty about how much welcome mat enrollment should be attributed to the Medicaid expansion decision. For the present analysis, just over one-third of the welcome mat effect on enrollment is attributed specifically to the Medicaid expansion decision.[14]

Driven by the Medicaid expansion, an estimated 10,100 previously eligible but not enrolled adults will be enrolled in Medicaid in Oregon by 2020 (**Table 4**). The State will receive the standard FMAP rate for these enrollees (i.e., not the enhanced federal match that the newly eligible will receive). The estimated seven-year cost to the State for these "previously eligible" adults is $134 million. This will be matched by 229 million in federal dollars. The model projections estimate an increase in enrollment of previously eligible children attributable to the expansion as well – 5,200 will be enrolled by 2020. These previously eligible children will receive the regular Medicaid and CHIP match rates and are estimated to cost the State $25 million by 2020. The federal match for these children is projected at $49 million.

[7] Participation rate assumptions were also informed by Oregon's 95 percent participation rate for the Supplemental Nutrition Assistance Program (SNAP) (for individuals with incomes less than 130 percent FPL) and the size of the reservation list for OHP Standard.
[8] PMPM expenditure and caseload projections were generated on October 16, 2012.
[9] Newly Eligible Mandatory Individuals: The Affordable Care Act (ACA). Division of Medical Assistance Programs, Oregon Health Authority, August 20, 2012.
[10] Under Oregon's approved Medicaid Section 1115 demonstration waiver, the state has agreed to a 2% reduction target in per capita spending growth by the third year of the demonstration (SFY 2014-15) under health system transformation.
[11] The projection assumes that the full impact of the law will phase in over a three year period – 15 percent in SFY 2014, 70 percent in SFY 2015, and 15 percent in SFY 2016.
[12] OHA 2013-2015 Governor's Recommended Budget.
[13] "Putting out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children", Georgetown University Health Policy Institute, Center for Children and Families, September 2008.
[14] The estimated full impact of the ACA on enrollment by previously eligible but unenrolled individuals is 21,200 adults and 20,800 children in 2020. Under these assumptions, 36 percent of welcome mat enrollment is attributed to the Medicaid expansion, which computes to 27 percent of the costs. The total state cost associated with this enrollment is estimated at $381 million by 2020.

Table 4: Effect of ACA Medicaid Expansion – Previously Eligible But Not Enrolled (Welcome Mat Effect)
(Dollars in millions with the exception of PMPM rates)

Previously Eligible Adults	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	2014-2020 Total
New enrollment	800	9,400	10,100	10,100	10,100	10,100	10,100	---
PMPM	$439	$454	$470	$486	$502	$519	$537	---
FMAP	62.97%	63.14%	63.14%	63.14%	63.14%	63.14%	63.14%	---
Total cost of previously eligible adults	$4	$51	$57	$59	$61	$63	$65	**$362**
Federal share	$3	$32	$36	$37	$39	$40	$41	**$229**
State share	$2	$19	$21	$22	$23	$23	$24	**$134**
Previously Eligible Children								
New enrollment	700	4,900	5,200	5,200	5,200	5,200	5,200	---
FMAP	66.34%	67.18%	67.18%	67.18%	67.18%	67.18%	64.47%	---
PMPM	$174	$180	$186	$192	$199	$205	$212	---
Total cost of previously eligible children	$1	$11	$12	$12	$12	$13	$13	**$74**
Federal share	$1	$7	$8	$8	$8	$9	$9	**$49**
State share	$0.5	$3	$4	$4	$4	$4	$5	**$25**
All Previously Eligible								
Total cost of previously eligible	**$6**	**$62**	**$69**	**$71**	**$74**	**$76**	**$79**	**$436**
Federal share	**$4**	**$40**	**$44**	**$45**	**$47**	**$49**	**$50**	**$278**
State share	**$2**	**$22**	**$25**	**$26**	**$27**	**$28**	**$29**	**$158**

Note: Numbers may not sum to total due to rounding.

Key Assumptions

Projected enrollment among previously eligible but not enrolled adults and children was developed using the SHADAC Projection Model. As with the assumptions for the newly eligible, the model assumes a high level of participation among previously-eligible adults and children and, as noted, projects a 95 percent statewide coverage rate.

Projected PMPM costs were constructed using weighted averages of PMPM costs for current Medicaid/CHIP eligibility categories. Current expenditure and caseload information, including annual projections, were provided by state officials and incorporate the targets for reduced spending growth agreed to by the state and CMS.[15] As with the newly-eligible enrollees, the enrollment and fiscal effects of the increase in previously eligible but not enrolled individuals is phased in over a three year period, starting in 2014.[16]

Projected federal matching rates for the previously eligible populations were provided by Oregon officials. The rate for children reflects a weighted average of the Medicaid and CHIP matching rates, per assumptions provided by the State; the increase in CHIP match rates that was included in the ACA for 2015 to 2019 is also reflected.

Part II: Potential State Savings Resulting from the ACA Medicaid Expansion

This section of the analysis projects the potential savings from the ACA Medicaid expansion. Total savings are comprised of savings in three areas (discussed in detail below):

1. The savings from transitioning current Medicaid populations to the "newly eligible group" (thus garnering a higher federal match).
2. The savings from reducing demand for state programs for the uninsured.
3. Savings to Oregon's Public Employee Benefit Board (PEBB) and Oregon Educator's Benefit Board (OEBB) due to premium reductions driven by reductions in uninsurance.

[15] PMPM expenditure and caseload projections were generated on October 16, 2012.
[16] The projection assumes that the full impact of the law will phase in over a three year period – 15 percent in 2014, 70 percent in 2015, and 15 percent in 2016.

Table 5: Effect of the ACA Medicaid Expansion - Savings from Current Medicaid Populations (*Dollars in millions*)

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	2014-2020 Total
Breast and Cervical Cancer Treatment Program	$1	$3	$3	$3	$3	$3	$3	**$21**
Presumptive eligibility due to disability	$0.20	$0.50	$0.50	$0.50	$0.60	$0.60	$0.60	**$3.50**
Total general fund savings from Medicaid	**$2**	**$4**	**$4**	**$4**	**$4**	**$4**	**$4**	**$24**
Total other fund savings - OHP Standard	**$62**	**$147**	**$161**	**$167**	**$172**	**$178**	**$184**	**$1,072**

Note: Numbers may not sum to total due to rounding.

Savings for Current Medicaid Populations

The ACA definition of "newly eligible" includes some groups that are currently covered by Medicaid (e.g., those with limited benefits or capped enrollment who are made eligible via demonstration waivers). By transitioning these current Medicaid beneficiaries into the ACA's "newly eligible" category, states will be able to access the enhanced federal match, thereby replacing state dollars with federal dollars. For states that choose to expand Medicaid, these dollars can be counted as cost savings.[17]

As part of this analysis, Oregon's Medicaid programs were reviewed to determine whether current enrollees could access Medicaid through the "newly eligible" group or the Exchange in 2014 and to identify the considerations that would inform the State's decision to maintain or eliminate the program. Two Medicaid coverage programs where the non-federal share was financed by the general fund were identified as potential candidates for state savings since beneficiaries would have alternative coverage options in 2014: the Oregon Breast and Cervical Cancer Treatment (BCCT) Program and the presumptive eligibility (PE) for disability program. State officials estimated that enrollment would decrease by 40 percent for BCCT and by 75 percent for PE due to disability by transitioning these enrollees to the "newly eligible" group. This shift would result in a cumulative state general fund savings of $24 million by 2020 (see **Table 5**). In addition, current enrollees in the OHP Standard program are considered "newly eligible" for the purposes of the enhanced federal match, which would result in a further savings of $1.1 billion between 2014 and 2020.

Key Assumptions

Based on guidance from Manatt Health Solutions and input from state officials, existing Medicaid programs were reviewed to determine whether enrollees might be considered "newly eligible" in 2014.

Although Oregon has not received a definitive determination from the federal government that these enrollees will be eligible for the enhanced match rate, the analysis assumes that these groups meet the definition of "newly eligible" because they meet the definition under section 2001 of the ACA – enrollees with limited benefits or capped enrollment.[18] For each of the three programs, uniform data were collected to estimate the number of enrollees likely to transition to the "newly eligible" group. Projections assume that these enrollees will transfer to the newly eligible category in 2014 without a phase in.[19]

The estimated state cost savings from the BCCT program assumes a 40 percent reduction in enrollment in 2014. Since these programs cover women up to 250 percent FPL, savings are achieved by transitioning women below 138 percent FPL to Medicaid and those above 138 percent FPL to the exchange. Cost savings projections are based on 2011 demonstration year spending in 2014, with two percent growth thereafter.

Savings from enrollees' presumptively eligible for Medicaid due to disability are based on projected reductions in this means of enrollment due to expanded coverage options under Medicaid. Projections assume that a majority of individuals who currently apply for Medicaid based on a disability will be eligible for Medicaid in the "newly eligible" group and will therefore not need coverage under the

[17] In some cases, states might choose to eliminate programs entirely if the majority of enrollees can either gain coverage through the Medicaid new adult group or through qualified health plans with tax credits in the exchange.

[18] This analysis could be affected by future Centers for Medicare and Medicaid Services decisions about how states can claim enhanced federal matching funds for newly eligible adults.

[19] State officials are currently re-assessing the existing OHP Standard Reservation List for applicants interested in health coverage through the OHP, which may shift more "newly eligible" enrollment to 2014.

Table 6: Effect of the ACA Medicaid Expansion – General Fund Savings from State Programs for the Uninsured
(Dollars in millions)

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	2014-2020 Total
Non-Medicaid substance abuse	$4	$8	$8	$8	$8	$8	$8	**$52**
Community mental health	$11	$22	$23	$23	$24	$24	$25	**$152**
Total savings state programs for the uninsured	**$15**	**$30**	**$31**	**$31**	**$32**	**$33**	**$33**	**$204**

presumptive eligible group while their disability status is being determined.

Potential Savings from Current State Programs for the Uninsured

Like many states, Oregon supports the costs of health care programs and services for the uninsured. Under an expanded Medicaid program, many of the individuals receiving care from these programs and providers will enroll in Medicaid, thus reducing the uncompensated care costs required to be subsidized by the State.

Key Assumptions

Manatt Health Solutions assisted state officials in identifying where state funding for certain programs could be reduced or eliminated as the costs for these programs were increasingly covered by Medicaid as a result of the Medicaid expansion. Cost saving estimates related to state-funded chemical dependency programs relied on administrative data, client health insurance status (self-report to provider) and income to project those likely to gain coverage under an expansion. Savings projections assume a reduction in program costs and state spending commensurate with the increase in Medicaid coverage. State general fund spending costs in 2014 are set at the 2010-2011 fiscal year level and are subject to a two percent annual increase.[20]

State general fund savings resulting from reductions in spending on community mental health are based on the assumption that a reduction in the number of uninsured due to the Medicaid expansion will result in a reduced client load. These assumptions were developed in consultation with state staff familiar with client demographics and applied to administrative data on annual spending. The projections assume a 50 percent savings to programs for non-residential adults as well as those targeted at older adults. The projections assume a 65 percent reduction for all other programs including the regional acute care program, the supported employment program and community support services for the homeless. [21]

Potential Premium Reductions from a Reduced Uninsured Population

The reduction in the number of uninsured can reduce premiums for state and private purchasers of insurance to the extent that providers shift a portion of the cost of uncompensated expenses to the insured. Under the Medicaid expansion, the uncompensated care burden—and resulting cost-shifting—would be expected to decline along with the number of uninsured. This analysis uses estimates from the work of Hadley et al. in Health Affairs from 2009.[22] Their analysis found that approximately 1.7 percent of the cost of an insured premium is due to costs from the uninsured. While some studies have found cost shifting percentages that are much higher, the Hadley study is more careful about including other revenue sources, such as: charity, disproportionate share hospital (DSH) payments from Medicaid and Medicare, state and local spending, and other federal programs. [23]

For this analysis we assume that if the uninsured population is reduced, these costs (i.e., 1.7 percent of premiums) could be reduced (proportionately) from the price paid by state purchasers of health insurance. **Table 7** summarizes the estimated premiums and savings resulting from the reduction in uninsurance for the Oregon Employee Benefits Board (OEBB) and Public Employee Benefits Board (PEBB) and how they accrue to the general fund and other funds.

[20] Fiscal year 2010-2011 program data were generated October 10, 2012. The analysis includes data on clients served in the 2010 -2011 biennium and excludes clients with incomplete administrative records or those whose records were terminated because their appointment wasn't kept, because they passed away, or for other administrative reasons.

[21] Estimates were based on the 2011-2013 Legislative Approved Budget and were provided by Oregon Health Authority staff on November 2, 2012.

[22] Hadley, J., Holahan, J., Coughlin, T., and Miller, D., 2008. Costs Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs. Health Affairs, 27, no.5 : w399-w415.

[23] Families USA. "Hidden Health Tax: Americans Pay a Premium". 2009. Available online at http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf.

Table 7: Premium Reduction from a Reduced Uninsured Population (*Dollars in millions*)

Source	Item	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	2014-2020 Total
OEBB	Premiums	$805	$866	$930	$1,000	$1,075	$1,156	$1,243	**$7,075**
	Adjusted premiums	$805	$857	$920	$989	$1,064	$1,143	$1,229	**$7,007**
	Savings general fund	$1	$8	$9	$10	$11	$12	$12	**$62**
	Savings other funds	-	$1	$1	$1	$1	$1	$1	**$5**
PEBB	Premiums	$925	$994	$1,069	$1,149	$1,235	$1,328	$1,427	**$8,126**
	Adjusted premiums	$924	$984	$1,057	$1,136	$1,222	$1,313	$1,412	**$8,048**
	Savings general fund	-	$4	$5	$5	$5	$6	$6	**$30**
	Savings other funds	-	$4	$5	$5	$5	$6	$6	**$32**
Total	**Premiums**	**$1,730**	**$1,860**	**$1,999**	**$2,149**	**$2,310**	**$2,483**	**$2,670**	**$15,201**
	Adjusted premiums	**$1,729**	**$1,841**	**$1,977**	**$2,126**	**$2,285**	**$2,457**	**$2,641**	**$15,055**
	Savings general fund	**$1**	**$12**	**$14**	**$15**	**$16**	**$17**	**$18**	**$93**
	Savings other funds	**-**	**$5**	**$6**	**$6**	**$6**	**$7**	**$7**	**$37**

Notes: Premiums include medical expenditures for non-fully-insured products. PEBB premiums have 20 percent of costs covered by the federal government and thus those savings are not tabulated.

Key Assumptions

The premiums are reduced by 1.7 percent in proportion to the reduction in uninsurance for each year from the projection model. Thus, if uninsurance is reduced by 70 percent (as is the case in 2020), premiums are projected to decline by 1.2 percent. This calculation assumes that providers will not need to shift the cost of care for those previously uninsured since they are now paid through Medicaid. If Medicaid payment rates do not fully compensate providers, the savings would be proportionately smaller.

Part III: Employment and Tax Revenue Effects of the ACA Medicaid Expansion

This section of the analysis estimates the employment and tax revenue effects that will occur from SFY 2014 to SFY 2020 as a result of the new federal spending generated by the ACA Medicaid expansion. The analysis is consistent with the projection results from SHADAC's analysis of the effect of the Medicaid expansion on state spending. This analysis was produced by Oregon Health Sciences University's Center for Health Systems Effectiveness (CHSE).

Table 8: New Federal Spending in Oregon (*Dollars in millions*)

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	2014-2020 Total
Federal spending on new enrollees	$120	$1,491	$1,671	$1,691	$1,701	$1,746	$1,772	**$10,191**
Increased federal spending for OHP-Standard	$62	$147	$161	$167	$172	$178	$184	**$1,072**
Breast and Cervical Cancer Treatment Program	$1	$3	$3	$3	$3	$3	$3	**$21**
Reduced coverage through presumptive eligibility	-	-	$1	$1	$1	$1	$1	**$3**
Total new federal spending	**$184**	**$1,641**	**$1,836**	**$1,861**	**$1,877**	**$1,928**	**$1,961**	**$11,286**

Note: Numbers may not sum to total due to rounding.

Table 9: Economic Effects from New Federal Spending Attributable to Medicaid Expansion (*Dollars in millions)*

		SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	2014-2020 Total
Health Care (Direct)	Employment	1,300	11,600	13,000	13,200	13,300	13,700	13,900	
	Wages & salaries	$99	$878	$982	$996	$1,004	$1,031	$1,049	**$6,040**
	Spending	$184	$1,641	$1,836	$1,861	$1,877	$1,928	$1,961	**$11,286**
Other Industries (Indirect)	Employment	500	4,300	4,800	4,800	4,900	5,000	5,100	
	Wages & salaries	$21	$188	$211	$213	$215	$221	$225	**$1,295**
	Spending	$59	$529	$592	$600	$605	$621	$632	**$3,637**
Household (Induced)	Employment	900	8,400	9,400	9,600	9,600	9,900	10,100	
	Wages & salaries	$39	$344	$385	$390	$393	$404	$411	**$2,365**
	Spending	$112	$995	$1,113	$1,129	$1,138	$1,169	$1,189	**$6,846**
Total	**Employment**	**2,700**	**24,300**	**27,200**	**27,600**	**27,800**	**28,600**	**29,100**	
	Wages & salaries	**$158**	**$1,410**	**$1,577**	**$1,599**	**$1,613**	**$1,656**	**$1,685**	**$9,699**
	Spending	**$355**	**$3,165**	**$3,541**	**$3,589**	**$3,620**	**$3,718**	**$3,782**	**$21,770**

The estimated tax revenues resulting from the Medicaid expansion are calculated by first estimating the economic effect of new federal spending in Oregon. These are dollars that are spent in the State due to the Medicaid expansion.

This spending is entered as input into an IMPLAN economic model to estimate the effect on employment, income, and output.[24] The IMPLAN software calculates output results at three different levels of impact –direct, indirect, and induced—using state-specific matrices of how dollars spent in health care transfer through the economy between industries and people.

- Health care spending (direct effect): For example, increased health care spending may result in increased hospital bed purchases, of which a percentage is purchased from Oregon hospital-bed manufacturers. Because health care is a labor-intensive industry, a large percentage of the spending appears as health care worker income.
- Spending by other local industries (indirect effect): For example, a hospital bed manufacturer may need to hire more workers and buy fabricated metal.
- Household spending (induced effect): the household spending of the employee income (from both direct and indirect effects) in the economy.

Through these three effects (direct, indirect, and induced), spending on Medicaid benefits has a greater economic effect than just the amount of new health care spending. The resulting "multiplier" (the ratio of total effects divided by spending) depends primarily on whether the industry purchases local goods and services.[25] This type of effect analysis has been carried out for understanding Medicaid spending in many state-level analyses.[26]

Table 8 shows how the spending values used in the IMPLAN model are calculated. The new federal spending is based on the federal spending on new enrollees attributed to expansion and federal spending for existing coverage programs whose enrollees would be newly eligible under expansion.[27] Total new federal spending attributable to Medicaid expansion ranges from $184 million in 2014 to $1.9 billion in 2020.

The economic effects from this spending are shown in **Table 9**. By the time the expansion reaches full implementation in 2016, the $1.8 billion in health care spending is projected to support 13,000 jobs and $982 million in salaries and wages. This activity leads to $592 million in spending in other local industries, which supports an additional 4,800 jobs and $211 million in salaries and wages by 2016. In the same time period, households are expected to spend $1.1 billion in the Oregon economy, supporting 9,400 jobs and $385 million

[24] IMPLAN was developed by the USDA and follows accounting conventions used by the Bureau of Economic Analysis. Its use in policy analysis is described in "Using Implan to Assess Local Economic Impacts" found at https://edis.ifas.ufl.edu/pdffiles/FE/FE16800.pdf.

[25] In Oregon, the sectors involved in health care had an average multiplier of 1.97 which is in the 80th percentile for largest impact across all 440 sectors. The highest multiplier is for State and Local Government Passenger Transit at 2.7 and lowest is for Lessors of Nonfinancial Intangible Assets at 1.24.

[26] Kaiser, 2009. "The Role of Medicaid in State Economies." Kaiser Commission on Medicaid and the Uninsured: A Look at Research. January, 2009. Note: Over one-half of the studies used IMPLAN, the remainder used RIMS II or other models.

[27] This percentage assumes that 50 percent of the enrollment of eligible adults is attributable to Medicaid expansion. Similarly, 25 percent of children and childless adults enrolling is attributable to Medicaid expansion. The OHP-Standard and newly eligible populations are 100 percent attributable to the expansion.

Table 10: State Tax Revenue from Economic Effect of Medicaid Expansion *(Dollars in millions)*

		SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	2014-2020 Total
Health Care (Direct)	Personal income tax	$3.30	$29.40	$32.90	$33.30	$33.60	$34.50	$35.10	**$202.00**
	Corporate profits tax	$0.10	$0.60	$0.70	$0.70	$0.70	$0.70	$0.70	**$4.10**
	Total	$3.40	$30.00	$33.50	$34.00	$34.30	$35.20	$35.80	**$206.10**
Other Industries (Indirect)	Personal income tax	$0.70	$6.10	$6.80	$6.90	$6.90	$7.10	$7.20	**$41.70**
	Corporate profits tax	$0.20	$1.30	$1.50	$1.50	$1.50	$1.60	$1.60	**$9.20**
	Total	$0.80	$7.40	$8.30	$8.40	$8.50	$8.70	$8.80	**$50.90**
Household (Induced)	Personal income tax	$1.20	$11.00	$12.30	$12.50	$12.60	$13.00	$13.20	**$75.90**
	Corporate profits tax	$0.30	$2.30	$2.60	$2.60	$2.70	$2.70	$2.80	**$16.00**
	Total	$1.50	$13.40	$14.90	$15.10	$15.30	$15.70	$16.00	**$91.90**
Total	**Personal income tax**	**$5.20**	**$46.50**	**$52.00**	**$52.70**	**$53.10**	**$54.60**	**$55.50**	**$319.50**
	Corporate profits	**$0.50**	**$4.30**	**$4.80**	**$4.80**	**$4.90**	**$5.00**	**$5.10**	**$29.30**
	Total	**$5.70**	**$50.70**	**$56.70**	**$57.50**	**$58.00**	**$59.60**	**$60.60**	**$348.80**

more in salaries and wages. The total effect in 2016 is to support 27,200 jobs, $1,577 million in wages and salaries, and $3.5 billion in total spending.

The tax revenue due to the effects is shown in **Table 10**. The results show direct effects of taxes of $32.9 million in 2016 (i.e., at full implementation) and $202.0 million from 2014 through 2020. Nearly all of the revenue is due to the personal income tax, and a small amount is due to corporate profits tax.[28] In total, the general fund would be increased by $348.8 million between 2014 and 2020 (the sum of$319.5 million from personal income taxes and $29.3 million from corporate profit taxes).

Key Assumptions

While some reductions in federal spending in the form of disproportionate share hospital payments or other programs may occur, those changes in spending have not been specified and are excluded from the total new spending estimated here.

The federal spending figures are distributed across the four health care sectors in the IMPLAN software and analyzed as new activity.[29] The IMPLAN software calculates how spending will transpire in terms of 15 different types of taxes ranging from income taxes to business taxes to fees. For this analysis, taxes that are most likely to be collected by the State for the general fund include personal income tax and corporate profits tax. Other tax revenue may also affect the State's general fund but such revenue is expected to be small and its projection would require many additional assumptions.[30]

The state tax revenue is dependent on whether the industry can accommodate the new spending. The results in this analysis assume that sufficient qualified workers are available to fill any new jobs projected from the new spending; a shortfall in available labor to fill new jobs would result in lower income tax revenue.

Other elements of federal reform designed to save federal spending, such as increasing Medicare premiums for upper income individuals, will occur regardless of the Medicaid expansion and are thus considered as part of the baseline. If these other elements of federal reform extract money from Oregon in the form of taxes or less spending, the State would avoid losses in state income tax revenue of the same magnitude by pursuing the Medicaid expansion, thus maintaining the net effect on the budget.

Net Effect of the ACA Medicaid Expansion

Based on the analysis above, if Oregon chooses to expand Medicaid, approximately 240,000 newly eligible Oregonians

[28] The health care sector includes a greater share of non-profit companies and thus a lower profit is observed compared to general spending. This can be seen by comparing the profit as percent of output for direct impacts that are all health care spending (0.04%) and the indirect impacts (0.25%) that are distributed across more industries.

[29] The sectors included: Offices of physicians, dentists, and other health practitioners; home health care services; medical and diagnostic labs and outpatient and other ambulatory care services; and private hospitals. It excluded the nursing home sector as the coverage is not intended to provide care to the elderly.

[30] For example, some sales taxes (cigarette, alcohol, and gasoline) also are included in the general fund but large portions are dedicated to other funds and thus are excluded for simplicity.

will gain health care coverage through OHP. In addition, 20,000 individuals who were previously eligible for OHP, but not enrolled, are likely to gain coverage. The coverage expansion will cost the State $591 million in general funds, but it will be offset by savings and increased tax revenue generated from increased economic activity. Specifically, the State will save $32 million in general funds. Savings to the general fund include transitioning current Medicaid enrollees to the newly eligible group, reductions in state spending to support services for the uninsured, and premium reductions for PEBB & OEBB. In addition, transitioning current OHP Standard enrollees to the "newly eligible" group and the enhanced federal match rate will result in $1.1 billion other fund savings between 2014 and 2020.

In addition to the net financial gain to the state, research shows, that individuals who gain access to coverage are likely to experience personal and financial benefits. Benefits include, better self-reported health status, reductions in depression and reductions in medical debt. In addition, research shows that having greater access to Medicaid reduces overall mortality.

Appendix A: SHADAC Projection Model

Enrollment projections were developed using the State Health Access Data Assistance Center (SHADAC) Projection Model, a complex spreadsheet model that that predicts the coverage effects of the ACA at the state level. The model uses high-level assumptions about behavior changes and then translates these assumptions into effects on groups of individuals that have similar characteristics (e.g. age, insurance type, income, employer size). Specifically, the model analyzes how policy changes affect individual and employer behaviors, and how these behavior changes translate into shifts in health insurance coverage.

The SHADAC Projection Model for Oregon is based on data from three federal surveys: the 2010 American Community Survey (ACS), the 2009 Medical Expenditure Panel Survey Household Component (MEPS-HC), and the 2010 Medical Expenditure Panel Survey Insurance Component (MEPS-IC). Data from the ACS and MEPS-IC are specific to Oregon; because state estimates are not available from MEPS-HC, the model uses national data matched to Oregon ACS data using statistical matching techniques. The baseline data were adjusted to match public coverage enrollment data from Oregon's Medicaid and CHIP enrollment files.

To the extent possible, the assumptions used in the model for Oregon are based on Oregon-specific data or developed in consultation with state officials. For example, the population and employment growth projections are based on the August 2012 Oregon Economic and Revenue Forecast.[31] Public program participation rates among the newly and previously eligible are based on discussions with senior policy staff. Other assumptions are based on empirical evidence (e.g. peer reviewed literature) or other reputable sources (e.g. Congressional Budget Office).

For more information about the development of the baseline data and the model structure and assumptions, please see the July 2012 State Health Reform Assistance Network issue brief, "Predicting the Health Insurance Impacts of Complex Policy Changes: A New Tool for States."

[31] Oregon Economic and Revenue Forecast, August 2012, annual average growth rate for 2010 to 2015.