



MEMORANDUM

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To: General Distribution Memorandum

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Subject: **Variation in Analyses of PPACA's Fiscal Impact on States**

This congressional distribution memorandum, prepared to enable distribution to more than one congressional client, summarizes existing analyses of the impact of the new federal health reform law, the Patient Protection and Affordable Care Act (PPACA), on state costs. The memorandum identifies select coverage provisions (specifically Medicaid and private health insurance) that relate directly to state costs, and discusses the challenges to producing state-level estimates. Such challenges include the pre-reform variation across states; uncertainty about future federal guidance and regulations relating to health reform implementation; state decisions regarding such implementation; data issues; and other factors outside of the health reform law and its implementation.

Introduction

The President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111-148) on March 23, 2010, which has since been amended by several laws. PPACA, as amended, makes many significant changes to the private and public markets for health insurance, and modifies aspects of the publicly financed health care delivery system. Among the major provisions, the law establishes an individual mandate for most U.S. residents to obtain health insurance, reforms the private health insurance market, establishes American Health Benefits Exchanges for individuals and small businesses to shop for private coverage; expands Medicaid eligibility; creates programs to improve quality of care; addresses healthcare workforce issues; and makes a number of other Medicaid and Medicare program and federal tax code changes. It also offers mechanisms to increase care coordination, encourage more use of preventive health, and improve the quality of care.

Enormous variation already exists across states in terms of health insurance coverage rates, generosity of coverage under state-administered public programs, generosity of state-financed programs to purchase private coverage, health insurance regulation, and other factors that affect state responsibilities and budgets. PPACA modifies many of those programs and insurance standards. Given the complexity of the health care system prior to PPACA, and the many changes generated by the new law, the impact on states will vary and will be difficult to estimate, even with the best modeling.

Another challenge in producing cost estimates of the impact of PPACA will be to disentangle such costs from the overall trend of increasing health care costs that would have occurred in its absence. In recent years, "the cost of health coverage continued its steady climb, while employer-sponsored coverage fell.

While the full impact of the recession on employer-sponsored coverage (and overall rates of uninsurance) remains to be seen, state revenues declined just when demand for services rose.”¹ Given such trends, it would be useful to identify the costs that states would face in the absence of comprehensive reform in order to understand the cost differences associated with PPACA. One study attempted to do such an analysis, modeling best, intermediate, and worst case scenarios over a 10-year span. Even in the best case, the researchers estimated that without reform, about ¼ of states would see Medicaid/CHIP cost growth of more than 65 percent over the 10 year period, and that employer spending on health insurance premiums would increase in all states.²

In response to congressional interest resulting from PPACA, we developed this memorandum to address issues related to potential costs to states. The focus of this memorandum is on health insurance coverage provisions of PPACA, specifically major provisions that permanently change existing state programs and requirements, such as Medicaid and private health insurance regulations. For ease of analysis we address Medicaid and private health insurance separately, but implementation of PPACA necessitates interaction between private and public provisions. Likewise, any thorough estimate of costs should consider these provisions in the context of the current health insurance system and its multiple moving parts.

Given that CRS does not produce cost estimates, we have no plan to produce fiscal impact statements for any state. However, individual states, CBO, and other organizations have generated national and, in some cases, state-level cost estimates based on PPACA coverage provisions (or some portion thereof).³ In general the cost estimates that we identified focused on the Medicaid program, presumably because it generally represents a substantial portion of state health care budgets, and is an existing program for which current and historical data exists. To the extent that these state studies discussed private health insurance provisions, the discussion focused on mainly descriptive analyses of state responsibilities under PPACA.

It is not our intent to evaluate the validity of the assumptions or the analytic rigor of the methodological approaches used to generate these estimates. Instead, we present the general findings as well as selected assumptions and limitations as reported in the studies that will help the reader put the results into context and better understand the complexity involved in generating estimates of the law’s impacts.

In some cases it is unclear whether the cost analyses only consider changes to existing programs and regulations, and do not account for new funding opportunities which may help states with implementation costs.⁴ In addition, analyses might not account for the interaction among provisions that could significantly affect costs. According to the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, “the actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are uncertain. The legislation would result in numerous changes in the

¹ “State of the States: The State We’re In,” Robert Wood Johnson Foundation, Jan. 2010, p. 5, available online at <http://www.statecoverage.org/files/State%20of%20the%20States%202010.pdf>.

² J. Holohan, L. Doan, and I. Headen, “The Cost of Failure to Enact Health Reform: Implications for States,” Urban Institute, Oct. 1, 2009, available online at <http://www.urban.org/publications/411965.html>.

³ We use the phrase “coverage provisions” to refer to the provisions in PPACA that would affect existing public programs (e.g., Medicaid) or establish new coverage options (e.g., exchanges). Generally, these provisions are in Titles I and II of PPACA.

⁴ Examples of such state funding opportunities include grants for planning and implementing exchanges, and grants to establish (or expand) health insurance consumer assistance programs. See “Patient Protection and Affordable Care Act (P.L. 111-148): Potential Funding Opportunities for States,” National Association of Insurance Commissioners, April 7, 2010, available online at http://www.naic.org/documents/index_health_reform_general_nga_funding_chart.pdf.

way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation.”⁵

What follows is a summary of selected state-level cost analyses (available as of August 31, 2010) that were prepared by a variety of organizations to assess the impact of PPACA on the state’s budget. These organizations include: (1) state agencies that administer Medicaid and/or the State Children’s Health Insurance Program (CHIP); (2) state legislative support agencies, (3) independent consultants retained by the state to provide a financial review of the impacts of PPACA on the state’s budget, and (4) organizations (e.g., independent Boards established by the state legislature) whose role is to provide input into policy and planning for the state. **Table 1** (see Appendix) summarizes state-specific analyses of PPACA’s impact on enrollment in public programs, the uninsured, and costs.

State-specific cost estimates vary. This variation is a function of the fact that each state analysis employs different methods and assumptions, and considers different sets of variables in producing coverage and cost estimates. For example, the Texas study (April 2010) provides cost estimates associated with the Medicaid and CHIP provisions for the time period between state fiscal year (SFY) 2014 through SFY2023. In addition to the fact that cost estimate is reported in terms of the state’s fiscal year (as compared to federal fiscal year), it represents a timeframe that includes 4 additional years beyond the budget horizon that CBO, for example, takes into account in its cost estimate (through FY2019).⁶ In another example, the Kansas study (May 2010) reports that its cost estimates are expressed in constant dollars using 2011 as a base, but other states do not specify how their estimate is expressed. Finally, because many non-citizens are not eligible for either Medicaid or CHIP, and unlawfully present individuals are ineligible for subsidies to purchase coverage through state exchanges, imputations to account for immigration status must also be applied. In the Kaiser report (May 2010) the methodology section describes how the researchers attempted to account for legal immigrant status in their model. However, it is not clear whether or to what extent other state specific cost estimates have attempted to capture this component. Because these state-specific analyses vary considerably in terms of what they have tried to take into consideration, it is not useful or advisable to compare their results against one another. Nonetheless, the state-specific analyses do provide value in understanding the law’s provisions that states are currently focusing on the impacts on their state budgets.

Table 2 (see Appendix) summarizes studies whose state cost estimates provided a break out of the Medicaid/CHIP effects of PPACA’s coverage provisions (e.g., increases in enrollment due to the individual mandate, the mandatory expansions of the Medicaid program, and the requirement for Medicaid and CHIP to coordinate with exchange coverage). It is important to note that while these studies have attempted to answer the same basic question, variation in the findings exists. To further underscore this point, the Kaiser study (May 2010)⁷ shows that results fluctuate considerably when different

⁵ Foster, R. S., “Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended,” Centers for Medicare and Medicaid Services, Baltimore, MD, April 22, 2010, available at http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

⁶ CBO’s estimate covers the FY2010-FY2019 time frame to be consistent with the budget horizon used under S. Con. Res. 13, the Concurrent Resolution on the Budget for Fiscal Year 2010. Congressional Budget Office, letter to Honorable Nancy Pelosi, March 20, 2010.

⁷ 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, available 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>.

participation rates are assumed. In an attempt to capture a range of potential impacts, Kaiser modeled the PPACA's impacts on Medicaid and CHIP enrollment and spending based on two levels of program participation (i.e., 57% participation rate as compared to a 75% participation rate). **Table 2** shows the variation that results when these different participation rates are applied.

Major PPACA Provisions with Potential State Cost Implications

For ease of analysis we address Medicaid and private health insurance provisions separately here, but implementation of PPACA necessitates interaction between private and public provisions. Likewise, cost estimates should account for such interactions within the context of the broader health insurance system.

Medicaid and CHIP

PPACA makes significant changes to the Medicaid⁸ and CHIP⁹ programs.¹⁰ Although not an exhaustive list, some of the major changes that could potentially increase state costs include:

- State requirement to expand Medicaid to nonelderly, nonpregnant adults with income up to 133% of the federal poverty level (FPL).¹¹ From 2014 to 2016, the federal government will cover 100% of the Medicaid costs of “newly eligible”¹² individuals, with the percentage dropping to 90% by 2020. States cover the percentage not paid by the federal government.
- State requirement to maintain existing Medicaid and CHIP eligibility levels (MOE) for adults until exchanges are fully operational (presumably CY 2014) and for children through 2019 as a condition of receiving federal matching funds for Medicaid expenditures.
- State requirement to improve outreach, streamline enrollment, and coordinate with CHIP and the proposed exchanges that may result in increases in applications and enrollment

⁸ Medicaid is a federal and state matching program that finances the delivery of health care services for certain populations with limited incomes. Each state that chooses to participate designs and administers its own version of Medicaid under broad federal rules. Individuals who meet state eligibility requirements are entitled to services covered under the state plan. To qualify, an individual must meet both categorical (i.e., must be a member of a covered group such as children, pregnant women, families with dependent children, the elderly, or the disabled), and financial eligibility requirements.

⁹ CHIP, also a federal and state matching program, provides health care coverage to certain low-income, uninsured children in families with income above Medicaid income standards. States may also extend CHIP coverage to pregnant women when certain conditions are met. In designing their CHIP programs, states may choose to expand Medicaid, create a stand-alone program, or use a combined approach.

¹⁰ For more information on PPACA's changes to Medicaid and CHIP see CRS report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP): Summary and Timeline*, Coordinated by Julie Stone, August 19, 2010.

¹¹ For individuals whose income will be determined using new income counting rules, the law also specifies that an income disregard in the amount of 5% FPL be deducted from an individual's income when determining Medicaid eligibility. This income counting rule effectively raises the upper income eligibility threshold for the new Medicaid eligibility group to 138% FPL.

¹² “Newly eligible” individuals are defined as nonelderly, nonpregnant individuals with family income below 133% FPL who (1) are not under the age of 19 (or such higher age as the state may have elected), and (2) are not eligible under the state plan (or a waiver) for full Medicaid state plan benefits or for Medicaid benchmark or benchmark-equivalent coverage, or are eligible but not enrolled (or are on a waiting list) in such coverage as of December 1, 2009.

among those who were previously eligible but not yet enrolled, as well as increases in administrative costs in the short run.

- Federal requirement to apply reductions in Medicaid disproportionate share hospital (DSH) allotments. While the health reform law is designed to reduce the number of low-income and patients whose care would otherwise be funded in part by DSH payments to hospitals who treat such individuals, with the law's requirement to apply aggregate reductions in DSH payments going forward it remains to be seen if the states will have to finance care that was previously paid in part through federal DSH allotments.
- Federal requirement to increase the amount of Medicaid drug rebates going to the federal government. Medicaid law requires prescription drug manufacturers who wish to sell their products to Medicaid agencies to enter into rebate agreements with the Secretary on behalf of states. Beginning January 1, 2010, with certain exceptions, PPACA increases the flat rebate percentage used to calculate Medicaid's basic rebate by an amount that varies by drug class. PPACA also requires the Secretary to recover the additional funds states received from drug manufacturers from increases in the basic Medicaid rebates (some of which were previously retained by states).

However, there are also a number of changes to Medicaid and CHIP that may offset some of the increased state costs. Some examples include:

- States that currently finance care for childless adults with state-only dollars will now have access to federal matching funds for those individuals under Medicaid.
- With the expiration of the adult coverage MOE requirement in 2014, states may opt to cut back on some of their prior law income eligibility levels for certain groups with annual income greater than 133% FPL, and move them into state exchange coverage where they would be eligible for federal subsidies to share in the cost of their care.
- CHIP allotments were extended through FY2015. This extension guarantees states access to the program's enhanced federal matching rate for two years beyond the prior expiration date of FY2013.
- The law requires states to set Medicaid payments for primary care services relative to Medicare payment rates, and fully finances the payment rate increase for a temporary period (i.e., 2013 and 2014). After this two year period, it is unclear whether states will continue to pay primary care physicians at the higher rate.
- The law also provides additional options for states to expand home and community-based services as an alternative to institutional care and provides states with increased matching rates for certain long-term care services.

Private Health Insurance

PPACA makes significant changes to private health insurance and therefore directly affects multiple stakeholders. States are impacted by the private market provisions through the various roles they play: as sponsors of health benefits to state employees, dependents, and retirees; as administrators of coverage; and financial assistance programs, and as the primary regulators of the insurance industry. Among the major private market provisions in PPACA that permanently affect these state roles are the new federal insurance standards, establishment of health insurance exchanges, and monitoring and enforcement activities related to the regulation of the health insurance industry.

- The federal market reforms that *may* impact private coverage offered to state employees include the prohibition on certain annual and lifetime dollar limits, coverage of preventive health services with no cost-sharing requirements, extension of dependent coverage, use of uniform coverage documents, prohibition of salary-based discrimination, quality of care provisions, reporting of medical loss ratios and rebates, grievance and appeals processes, standards for electronic billing and other administrative transactions, patient protections, and prohibition on excessive waiting periods.¹³ Such requirements may add to the cost of coverage in the private market, which, in turn, may affect states' costs related to offering such health benefits.
- PPACA requires the states to establish exchanges (with federal fallback) to facilitate the purchase of private insurance by individuals, families, and small businesses. PPACA provides appropriations (no specified amount), prior to 2015, for state grants to establish and run exchanges. The general assumption is that states will have to provide ongoing funding for exchanges through assessments on insurers or other means, except in those states that fail to establish their own exchange, in which case the HHS Secretary is required to establish it.¹⁴
- While PPACA does not include specific enforcement provisions, the addition of the federal market reforms discussed above expands the scope of existing state enforcement responsibilities, which may have implications for state costs. In addition, PPACA establishes a federal standard in a regulatory area that has been solely under the jurisdiction of states: review of health insurance rates submitted by insurance carriers. While PPACA requires an insurer to justify "unreasonable" premium increases to both HHS and the relevant state, it is the state's responsibility to review the materials and provide information to the Secretary based on the rate review. PPACA appropriates \$250 million in grants to states to support this effort, however total state costs are not known, in part because HHS guidance on the rate review process is still forthcoming and states vary in their existing authority and resources to conduct rate reviews.

However, despite these potential sources of increased state costs, interactions of various provisions may lead to cost offsets in other areas. Examples include:

- The Texas Health and Human Services Commission noted in its presentation to the Texas House Select Committee on Federal Legislation that a potential cost offset resulting from health reform may be increased premium revenue.¹⁵ Estimates of the impact of PPACA on health insurance coverage generally finds substantial growth in private coverage, including through exchanges. Given that states currently generate revenue through

¹³ This list of reforms was generated based on these assumptions: state employee health benefit plans include fully and self-insured plans, and would be provided to large groups only. The list excluded reforms that largely duplicate existing requirements in the group market (e.g., non-discrimination based on health factors), are not permanent (e.g., temporary high-risk health insurance pool), or likely would not have a direct impact on state employee health benefits plans (e.g., guaranteed issue).

¹⁴ On July 29, 2010, HHS issued a Funding Opportunity Announcement (FOA) that announced the availability for the first round of funding for these state grants. Each state and D.C. could apply for up to \$1 million in grant money during this first round. The filing date for applications was September 1, 2010. For additional information, see "State Planning and Establishment Grants," at <http://www.hhs.gov/ociio/initiative/index.html>.

¹⁵ "Federal Health Care Reform – Impact to Texas Health and Human Services," Texas Health and Human Services Commission, April 22, 2010.

premium taxation, growth in private coverage is assumed to lead to increased revenue to states.

- California's Legislative Analyst's Office noted that once the full implementation date of PPACA is reached, the state could likely terminate an existing state-financed health insurance program because other programs under health reform would be established by then.¹⁶

Analysis

While Medicaid and CHIP differ from private health insurance, both public programs and private coverage share similar challenges with respect to producing state-level cost estimates. Such challenges include pre-reform variation across states; uncertainty about future federal guidance and regulations relating to health reform implementation; state preferences regarding implementation; data issues; and factors outside of health reform. The following discussion describes these challenges in more detail and provides examples from Medicaid and CHIP, as well as private health insurance.

Pre-Reform Variation across States

State impacts will vary based on current coverage levels across states, generosity of the state's Medicaid/CHIP eligibility rules and other state-financed coverage programs, existing private insurance regulatory authority, standards, and resources, current state fiscal health, and other factors. Such variation creates difficulties in accurately estimating costs across states.

- There are substantial differences among states in terms of the percentages of the states' populations that would meet the definition of "newly eligible" under the mandatory Medicaid expansion as compared to previously eligible individuals. Federal matching rates to share in the cost of Medicaid/CHIP coverage for these individuals under health reform will vary by state, by year, and by eligibility status. Although from 2014-2016, the federal government will cover 100% of the Medicaid costs of "newly eligible" individuals.
- It could be argued that PPACA will require limited changes to the benefits of state and local government employee health plans, as current employment-based health plans are grandfathered. Grandfathered plans are exempt from all but a handful of reforms under PPACA. That said, it is difficult to assess the impact of the changes that are required, as some requirements may already be in place. For example, one new requirement under PPACA is that children up to age 26 (and until 2014, who are not offered coverage through their own employer) can remain/enroll on their parent's plan. Some plans may not necessarily see a difference because some states already impose requirements beyond age 26, and may continue to do so. For states that do not have a dependent coverage requirement already in place, insurers may see this as adding to the cost of coverage and *may* pass such costs along to consumers and employers (e.g., states as employers providing health benefits to state employees).

¹⁶ "The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs," Legislative Analyst's Office, May 13, 2010.

Federal Guidance to Shape Implementation

State-by-state impacts of PPACA's program and regulatory changes will depend, in part, on future federal guidance and interaction with states in implementing the new law.

- Medicaid program participation rates are among the many moving parts that are relevant in assessing the impacts of PPACA. While PPACA includes provisions to encourage states to improve outreach, streamline enrollment, and coordinate with exchanges, states face mixed fiscal priorities that may inhibit their ability and/or willingness to maximize program enrollment. As a result, federal guidance laying out the minimum requirements in these areas will ultimately affect state costs.
- There is a great deal of uncertainty regarding state costs associated with establishing and running exchanges, in part because HHS has not issued guidance regarding the form and structure of exchanges. Moreover, PPACA appropriated an unspecified amount for the purpose of providing grants to the states for planning and establishment of the exchanges.¹⁷ The grants can be renewed if states comply with specific requirements, but no grant may be awarded after January 1, 2015 when exchanges must be self-sustaining. This lack of specificity regarding the amount of federal funding is another source of uncertainty regarding potential state costs.

State Preferences Regarding Implementation

PPACA provides states with some flexibility regarding implementation of many of the law's coverage provisions. Given that states are still formulating their approach to implementation, this creates uncertainty in the scope of future state activities and associated costs.

- PPACA gives states some flexibility regarding implementation and operation of exchanges. A state may opt to have HHS establish its exchange. States also have the option to establish separate exchanges for individuals and small businesses, or establish just one exchange for both. Individual states also may decide to allow large businesses in the exchange. These decisions, individually and collectively, may impact state spending on exchanges.
- The PPACA insurance reforms do *not* uniformly apply to all employer-provided coverage. The type of plan matters with respect to which market reforms it must comply with. For example, a self-insured plan does not have to comply with the medical loss ratio provisions, but a fully-insured plan does.¹⁸ Thus, the decision states make in

¹⁷ See footnote 14.

¹⁸ Organizations that self-insure (or self-fund) do not purchase health insurance from an insurance carrier. Self-insurance refers to coverage that is provided by the organization seeking coverage for its members (e.g., an employer offering health benefits to his employees). Such organizations set aside funds and pay for health benefits directly. (Enrollees may still be charged a premium.) Under self-insurance, the organization itself bears the risk for covering medical expenses. Firms that self-fund health benefits typically contract with third-party administrators to handle administrative duties such as enrollment, premium collection, customer service, and utilization review. With fully insured plans, the insurance carrier charges the plan sponsor (e.g., employer) a fee for providing coverage for the benefits specified in the insurance contract. The fee typically is in the form of a monthly premium. (In turn, the sponsor may decide that each person or family who wishes to enroll must pay part of the premium cost.) Under the fully insured scenario, the insurance carrier bears the insurance risk; that is, the carrier is responsible for covering the applicable costs associated with covered benefits.

funding employee health benefits plans has implications for what insurance reforms such plans are subject to. As mentioned previously, insurers may see these additional requirements as adding to the cost of coverage and *may* pass such costs along to consumers and employers in the form of higher premiums (or higher cost-sharing or reduced benefits).

Data Issues

Data issues range from limitations of existing data sources to a lack of data.

- Some state specific cost estimates use national surveys such as the Current Population Survey (CPS), the American Community Survey (ACS) or the National Health Interview Survey (NHIS) to simulate eligibility for Medicaid, CHIP, or exchange subsidies. However, these national surveys have their own limitations many of which have been well documented and acknowledged by the Census Bureau and other research organizations.¹⁹ For example, the CPS and NHIS have historically undercounted Medicaid enrollees and are less reliable for small states.²⁰ With much larger sample sizes than that of the CPS or NHIS, the ACS does a better job of reducing error associated with small sample size. However, regardless of the survey used, discrepancies exist between survey estimates of enrollment in Medicaid and the number of enrollees reported in state and national administrative data.
- Given that so many aspects of exchanges are as of yet not known, costs cannot be attributed to the various components with a sufficient degree of confidence. In addition, the exchanges, as specified in the statute, are new entities. While a few states have created similar entities, none have the federal-state design of those established under PPACA. Therefore, there is no dataset from an existing program that could be used to accurately model the initial experience of the exchanges. This contrasts with, for example, the Medicaid program, which has existed for many years and has past administrative data that provides a baseline for state costs.

Factors Outside of Health Reform

Given that health insurance coverage in the U.S. traditionally has been linked with employment, changes in the labor market generally lead to changes in coverage rates. Typically, when the general economy is in decline and unemployment rises, individuals and families lose access to their primary source of insurance. Data on coverage trends typically find that when employment-based coverage decreases, enrollment in

¹⁹ For links to the results of research projects conducted by the University of Minnesota's State Health Access Data Assistance Center (SHADAC), the National Center for Health Statistics (NCHS), the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare and Medicaid Services (CMS), and the U.S. Census Bureau to explain why discrepancies exist between survey estimates of enrollment in Medicaid and the number of enrollees reported in state and national administrative data, see <http://www.census.gov/did/www/snacc/>

²⁰ U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," Current Population Reports P60-236(RV), Washington, DC, 2009, at [<http://www.census.gov/prod/2009pubs/p60-236.pdf>], p. 20, and p. 57.

Medicaid increases.²¹ The public-private mix of enrollment will affect state spending related to both types of coverage.

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²¹ “Losing a job often means that people lose health insurance. Many individuals, especially children will become eligible for Medicaid... We estimate that if unemployment rises from an average of 4.6 percent in 2007 to 7 percent in 2009, the number of people with employer sponsored insurance (ESI) would decline by 5.9 million, Medicaid and SCHIP enrollment would increase by 2.4 million and there would be an additional 2.6 million uninsured.” John Holahan and A. Bowen Garrett, “Rising Unemployment, Medicaid, and the Uninsured,” Jan. 2009, p. i.

Appendix

Table I. State-Specific Analyses of PPACA’s Impact on State Costs

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
California	<p>“The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs”</p> <p>Provides an estimate of the impact of PPACA on Medicaid enrollment and state spending on Medicaid.</p> <p>Cost estimate attributed to increase in Medicaid enrollment, accounting for eligible but not enrolled and expansion populations (eligibility up to 133 percent FPL and former foster children), and increased primary care provider payments.</p> <p>Prepared by the Health Section of the Legislative Analyst’s Office, a state governmental office providing fiscal and policy information to the California Legislature.</p> <p>http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.pdf</p>	2,000 (no timeframe provided)	N/A	“low billions of dollars” (annual)
Florida	<p>“Overview of National Health Reform Legislation”</p> <p>Provides an estimate of the impact of PPACA on enrollment in the state’s Medicaid and CHIP programs and the increase in Medicaid primary care provider payments.</p> <p>Does not include impacts associated with increases in administration costs, changes to the federal pharmacy rebate or changes to state disproportional share hospital payment allowances. Takes into account potential shift of individuals with annual income <133% FPL who are currently enrolled under private health plans to shift to the Medicaid program. Assumes CHIP children with annual income <133% FPL will shift to Medicaid program. Assumes SFY 2012-2013 Medicaid expenditures program expenditures and caseloads for non- expansion populations and uses Census data increase by 1.6% through 2014 for expansion population.</p> <p>Prepared by The Agency For Health Care Administration, the chief health policy and planning entity for the state.</p>	1,772 (by 2019)	N/A	\$1,203 (by 2019)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
Indiana	<p>http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/National_Health_Care_Reform_040110.pdf</p> <p>“Patient Protection and Affordable Care Act with House Reconciliation – Financial Analysis”</p> <p>Provides a financial review of PPACA as it relates to the provisions impacting the state’s Medicaid program and budget.</p> <p>The study considered the following components when generating their assessment of the impacts of health reform on the state budget: the Medicaid Expansion to 133% FPL, the impact of the reduced federal medical assistance percentage (FMAP) rate for their Healthy Indiana Plan eligibles, spend down and their SSI eligible population, the state’s projected pharmacy rebate loss, the impact of the physician fee schedule increase, the mandatory expansion to foster care children, administrative costs, the enhanced match rate under the CHIP program, the state’s current thoughts on the treatment of their Breast and Cervical Cancer program and pregnant women coverage for individuals with annual income greater than 133% FPL at full implementation.</p> <p>Prepared by Milliman, Inc., a consulting service retained by the State of Indiana, Family and Social Services Administration to provide consulting services related to the financial review of PPACA.</p> <p>http://www.in.gov/fssa/files/Milliman_financial_analysis_May2010.pdf</p>	1,554 (SFYs 2011 through 2020)	N/A	\$3,579 (SFYs 2011 through 2020)
Kansas	<p>“Preliminary Estimates of the Impact of Federal Health Reform on State Spending in Kansas”</p> <p>Provides preliminary estimates of the impact of PPACA on state spending in Kansas.</p> <p>Estimates represent the most likely outcome of PPACA reforms. Assumes state takes no additional actions to expand coverage or reduce spending, and increased costs in program administration. Cost estimate is for spending on medical care only in the Medicaid program. Excludes administrative costs and changes in DSH spending. Estimates are expressed in constant dollars using 2011 as a base.</p> <p>Prepared by the Kansas Health Policy Authority, an independent Board comprised of members selected by the Governor and the leadership of the state legislature to provide governance and thoughtful policy direction for the state’s health care-related agenda.</p> <p>http://www.khpa.ks.gov/ppaca/download/Impact%20of%20Federal%20Health%20Reform%20on%20Kansas%20-%20allison%20presentation.pdf</p>	131 (by 2020)	191 (by 2020)	\$621 (by 2020)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
Kansas	<p>“Kansas: Impact of Federal Health Reform”</p> <p>Provides presentation of preliminary estimates of PPACA’s impact on coverage and state costs based on 4 scenarios.</p> <p>Four scenarios modeled using two different counts of remaining uninsured (98,000 and 143,000) and two different provider reimbursement rate increases (0% increase and 5% increase). Medicaid enrollment includes both Medicaid and CHIP, according to just one of the scenarios modeled. Study did not attribute the cost estimate to any particular program or coverage initiative. It is unclear what this state costs estimate represents.</p> <p>Prepared by Schramm-Raleigh Health Strategy for the Kansas Health Policy Authority, the state’s main health policy agency.</p> <p>http://media.khi.org/news/documents/2010/05/18/5-18-10_SRHealth_Presentation.pdf</p>	120 (“post-reform”)	191-237 (“post-reform”)	\$2-36.3 (“post-reform”)
Maryland	<p>“Interim Report”</p> <p>Provides estimates of PPACA’s impact on the uninsured rate and costs associated with changes to both public and private coverage.</p> <p>Savings estimate is the net result of cost increases due to Medicaid expansion, increased spending for state employee/retiree health benefits, and administrative costs (e.g., establishing exchange), and revenue growth/savings from increased federal support of state’s CHIP program, new hospital assessments, increased premium taxation revenue, and reduction in state funding for safety net programs.</p> <p>Prepared by the state’s Health Care Reform Coordinating Council for submission to the Governor.</p> <p>http://www.healthreform.maryland.gov/documents/100726interimreport.pdf</p>	N/A	Decrease of 7.3 percentage points (by 2017)	Savings of \$829 (FY 2011-2020)
Michigan	<p>“Fiscal Analysis of the Federal Health Reform Legislation”</p> <p>Examines the fiscal impacts of PPACA on state and local government in Michigan.</p> <p>Assumes a Medicaid federal matching rate of 66.7%. Discusses the cost to the state to continue the Medicaid primary care physician payment rates at the Medicare levels beyond the two years during which the federal government will fully fund this payment rate increase, but not clear if these amounts are included in the state’s expenditure estimate. Provides impacts on the CHIP program beyond the</p>	375 (by 2019)	N/A	\$200 (by 2019)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
North Dakota	<p>PPACA funding (i.e., through FY2015) appropriation, but it is unclear if these amounts are included in the state’s expenditure estimates. Acknowledges impacts of Medicaid drug rebate provisions, but does not provide a state specific cost estimate of the impacts. Acknowledges the potential impacts of the various long-term care related provisions and provisions directed at increasing care coordination, encouraging more use of health prevention, and improving the quality of care. However, the state did not report a dollar figures associated with these potential costs. Acknowledges impacts of Medicaid DSH reduction provisions, but does not provide a state specific cost estimate of the impacts.</p> <p>Prepared by the Senate Fiscal Agency whose role is to provide technical, analytical, and preparatory support to the state’s Senate Appropriation Committee and other members of the Senate.</p> <p>http://www.senate.michigan.gov/sfa/Publications/Issues/HealthReform/FedHealthReformLegislation.pdf</p> <p>Provides preliminary estimates of the overall cost of implementing health reform.</p> <p>The cost estimates are based on the following assumptions: current enrollees in private market will remain in grandfathered plans (based on Blue Cross/Blue Shield enrollment that represents 80+% of the market) throughout the study period (2010-2019), and all covered public-sector employees will remain in grandfathered plans through that period. The cost estimate does not include possible offsets from grants or subsidies. The analysis states that "estimates should be used with caution, as amounts will change when additional guidance and policy decisions are made at the federal level."</p> <p>Prepared for North Dakota’s Industry, Business, and Labor Committee.</p> <p>http://www.legis.nd.gov/assembly/61-2009/interim-info/minutes/ib080310minutes.pdf</p>	N/A	N/A	\$1,114 (2010-2019)
Texas	<p>“Federal Health Care Reform – Impact to Texas Health and Human Services”</p> <p>Discusses PPACA requirements, describes model, and provides estimates of PPACA’s impact on enrollment in and state spending on Medicaid.</p> <p>The enrollment estimate includes the eligible but not enrolled and Medicaid expansion populations. The cost estimate includes costs associated with the eligible but not enrolled and Medicaid expansion populations, and full rate increases for primary care providers. The provider rate increase is assumed to apply to both Medicaid and CHIP.</p> <p>Prepared by the Texas Health and Human Services Commission for the House Select Committee on Federal Legislation.</p>	2,345 (by 2023)	N/A	\$27,000 (SFY 2014-2023)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
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<http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf>

Source: CRS analysis of existing state-level cost analyses prepared by a variety of organizations including: (1) state the Agencies that administer Medicaid and/or the State Children’s Health Insurance Program (CHIP), (2) state legislature support agencies, (3) independent consultants retained by the state to provide a financial review of the impacts of PPACA on the state’s budget, and (4) organizations (e.g., independent Boards established by the state legislature) whose role is to provide input into policy and planning for the state.

Table 2. Summary of Published Estimates of the Impact of PPACA’s Coverage Provisions on Medicaid and CHIP

Study (publication date)	Summary of Analysis	Estimates of Increase in Medicaid Enrollment in millions (time frame)	Expenditure Estimates in billions (time frame)		Selected Assumptions
			Overall State Spending	Federal Spending	
CBO Cost Estimate (March 2010) ^a	National estimate of effects of all of the insurance coverage provisions in health reform on Medicaid/CHIP	16 million (by CY2019)	\$20 billion ^b (FY2010-2019)	\$434 billion (FY2010-2019)	Detailed assumptions not provided in cost estimate.
Kaiser Commission on Medicaid and the Uninsured (May 2010) ^c	State-by-state ^c estimates of impact of coverage provisions on Medicaid/CHIP for adults relative to enrollment and spending on such adults in absence of health reform for the period between 2014 and 2019.	15.9 (CY2014-CY2019)	\$21.1 (CY2014-2019)	\$443.5 (CY2014-2019)	Assumes moderate (57%) participation levels among uninsured in the new eligibility group and lower participation among other coverage groups.
		22.8 (CY2014-CY2019)	\$43 (CY2014-2019)	\$532 (CY2014-2019)	Assumes robust (75%) participation levels among uninsured in the new eligibility group, and lower participation among other coverage groups.

Source: CRS analysis of various national estimates of the impacts of PPACA’s coverage provisions on Medicaid and CHIP enrollment and spending.

Notes:

- a. Congressional Budget Office, letter to Honorable Nancy Pelosi, March 20, 2010.
- b. The Congressional Budget Office does not prepare state-by-state estimates.
- c. 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.
- d. The Kaiser report shows results for three general groupings (i.e., states with low prior law Medicaid eligibility rates for adults, states that have broader prior law coverage for parents, but no coverage for childless adults, and states that cover both parents and childless adults under prior law). See the report for trends by state groupings as well as state-by-state results.