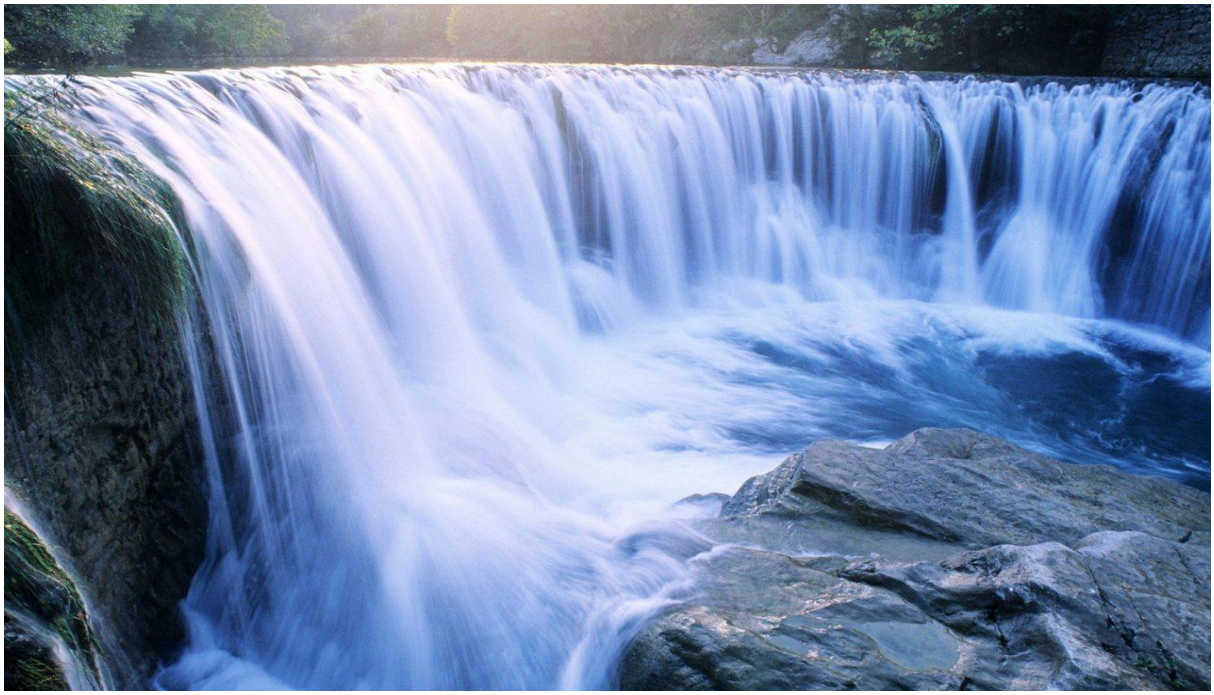
NASMHPD

# The Waterfall Effect:

## Transformative Impacts of Medicaid Expansion on States




**Joel E. Miller**

**Christy Lentz**

**Narges Maududi**

**Justin Harding**



National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314

January 2013

**This work was funded entirely by the National Association of State Mental Health Program Directors (NASMHPD), Inc. members.** 

# Table of Contents

## Foreword

In the U.S. Supreme Court's recent decision upholding the Patient Protection and Affordable Care Act (ACA) in June 2012, an important question before the High Court was whether it was coercive for the federal government to threaten to withhold current federal funding for Medicaid – the joint federal-state health insurance coverage program for poor and near poor individuals – if states did not expand the program in compliance with the new Medicaid expansion requirement in the ACA.

The Court ruled it is coercive to withhold funds, which has unleashed a policy and financial scramble on whether states should take or leave new funds offered through the Medicaid expansion under the ACA.

The Court's ruling has major implications for people with behavioral health conditions. The federal-state Medicaid program is the largest source of financing of behavioral services, covering over a quarter of all expenditures on behavioral health care in the United States and the majority of funding to safety net delivery-care systems that disproportionately serve individuals with behavioral health conditions. Medicaid plays a large role in financing behavioral health care because: its eligibility rules reach many individuals with significant need; it covers a broad range of benefits; and its financing structure allows states to expand services with federal financial assistance. Among lower-income, nonelderly adults, Medicaid beneficiaries who have a mental illness have a greater opportunity to secure mental health treatment than those who are uninsured and have a mental illness. Among the uninsured, an estimated 13.4 million people with behavioral health conditions will be newly eligible for coverage under either Medicaid or state insurance exchange plans.

Many Governors have expressed deep concerns that the new Medicaid expansion would have a deleterious effect on their state budgets. With the potential of the new Medicaid expansion under the ACA to significantly cover more people with behavioral health disorders, the National Association of State Mental Health Program Directors (NASMHPD) embarked on a research study effort to determine if states would see improved budget conditions and financial gains through the new expansion.

The primary audiences for the report include state officials such as Governors and key Cabinet Officials, State Legislatures, State Behavioral Health Agencies, other State and Local officials such as Medicaid agencies, and advocacy groups.

The methodological approach employed is a meta-analysis of recent studies and reports on the potential impact of the Medicaid expansion on state budgets and finances. We also looked at potential impacts if Governors and Legislatures do not choose to participate in the new Medicaid expansion program.

This is the first report that attempts to show in a graphic way the potential impact of several events under the Medicaid expansion that have cascading effects on state budgets, state economies and the uninsured problem.

We have tried to provide a guide on the potential impacts that would accrue to states for choosing to opt in to the Medicaid expansion and potential lost opportunities in four key sections:

**Section One** describes the differences under the current Medicaid program and the new Medicaid expansion effort, including the increased payment match by the federal government under the new Medicaid expansion.

**Section Two** estimates the potential impact of the new Medicaid expansion on state budgets if all states choose to participate in the Medicaid expansion effort.

**Section Three** examines the Medicaid expansion from the vantage point of the impact on entire state economies and opportunities to increase state-wide revenues.

**Section Four** details how the new Medicaid expansion will address the uninsured problem in each state – one-third of the uninsured population have a behavioral health condition, and one-half of this group has a serious mental illness – and the ability to improve their health status and receive high-quality health care services.

A final section of our study looks at specific concerns of state officials regarding the new Medicaid expansion program and the role of government in the health care and health insurance sectors.

This report goes beyond the recent sound bites and headlines on Medicaid expansion issues to provide a detailed evaluation of what it means for states that choose to opt in – or do not participate – in the ACA Medicaid expansion initiative. We hope this report informs those assessments and decisions.

**Robert W. Glover, Ph.D.**
**Executive Director**
**National Association of State Mental Health Program Directors**

## About NASMHPD

The National Association of State Mental Health Program Directors (NASMHPD) is home to the only member organization representing state executives responsible for the $37 billion public behavioral health service delivery system serving nearly 7 million people annually in all 50 states, 4 territories, and the District of Columbia.

NASMHPD serves as the national representative and advocate for State Behavioral Health Agencies (SBHAs) and their directors and supports effective stewardship of state mental health systems. NASMHPD informs its members on current and emerging public policy issues, informs them on research findings and best practices in behavioral health, provides consultation and technical assistance to members, collaborates with key stakeholders, and facilitates state-to-state sharing of new approaches and information on improving care for people with serious mental illnesses.

## About the Primary Author

**Joel E. Miller, M.S. ED., Senior Director of Policy and Healthcare Reform, NASMHPD**

With over 30 years of experience in healthcare and behavioral health policy, Mr. Miller has advocated for the creation of federal and state policy and regulatory solutions to improve the delivery and financing of health care and behavioral health care in the United States.

In his current role at NASMHPD, he leads the development and implementation of NASMHPD's policy agenda and regulatory strategies designed to support State Behavioral Health Agencies and the state public behavioral health systems.

Prior to his role at NASMHPD, Mr. Miller served as Senior Vice President at the National Coalition on Health Care, where he oversaw the evaluation, preparation and dissemination of innovative research and policy analysis about the nation's healthcare system.

At the National Alliance on Mental Illness (NAMI), Mr. Miller led NAMI's State Policy team, dedicated to improving the financing and delivery of mental health services at the state level for people with mental illness, and addressing mental illness issues across the lifespan.

He has published over 50 articles and reports on behavioral health and health care delivery and financing, the health care workforce, cost management, medical practice assessment, quality improvement, insurance exchanges, and public/private health insurance programs.

## Acknowledgements

The author is indebted to Christy Lentz and Narges Maududi with NASMHPD, who provided the outstanding graphics in the report and the overall design of the document. They provided many insightful comments on the content of the report. They worked above and beyond to help finalize the report.

Kathy Parker and Pat Shea provided valuable insights on the content, and Justin Harding provided additional comments and final proofing on the document.

A profound thank you goes to the Urban Institute for the remarkable and engaging work they have conducted over the last two years on Medicaid expansion issues.

The Urban Institute, the Center on Budget and Policy Priorities and the Lewin Group – as well as other Washington-based non-partisan, non-profit think tanks and public policy operations – have issued major studies that provide projections on budget gains to individual states and in total, based on the impact of the Medicaid expansion under the ACA.

The Urban Institute, in particular, has released specific statistics over the last two years on potential state budget gains across several parameters as a result of the Medicaid expansion program in the Affordable Care Act. We have tried to capture that work in this overall meta-analysis, and we are indebted to the various authors of the Institute's key Medicaid expansion studies such as Stan Dorn, Matthew Buettgens and John Holahan.

We are also indebted to Families USA and Ron Pollack for their work on Medicaid issues that are part of the Medicaid Primer section, and their work on the impact of the Medicaid program on jobs in individual states that we highlighted in Section Three. The Kaiser Family Foundation's work on the impact of the Medicaid program on statewide economies served as a key piece in Section Three of our meta-analysis.

We also want to thank the Kaiser Family Foundation for their work on opportunities for improving mental health services through the Affordable Care Act, and the work of several experts who provided inspiration including David Mechanic and John O'Brien whose recommendations are summarized in Section Four and key appendices.

## Executive Summary

**The impact of the new Medicaid expansion initiative under the Patient Protection and Affordable Care Act passed in March 2010 (Affordable Care Act or ACA) will result in significant state budget gains, increased state-wide economic activity, and increased health insurance coverage for residents of states who choose to opt in to the expansion program. This conclusion is based on a comprehensive meta-analysis of over 20 Medicaid expansion-related studies released over the last two years.**

**If all 50 states choose to opt in to the new Medicaid expansion in the Affordable Care Act, states will see budget gains of over $300 billion between 2014 and 2023. Budget gains are primarily due to the transfer of several Medicaid health insurance initiatives by the states – that have voluntarily expanded health coverage to lower-income uninsured people – to the federal government who will now incur significant costs for the expanded coverage through "enhanced" match rates (the federal government will also save money due to reductions in their financial liability dedicated to treating previously uninsured people).**

**In addition to state financial budget gains, the new expansion will generate extensive state-wide economic activity by bringing in new revenues into individual states, thereby creating new jobs and expanding incomes in many business sectors due to what is known as a "multiplier effect." Some states expect to accrue over $1 billion in new revenues over a 10-year period. If several states decide not to opt in to the Medicaid expansion, we can expect to see the multiplier effect to generate even more economic activity for states that opt in to the expansion effort as technology firms and provider organizations would be more inclined to focus new investments and job creation in the expansion states. Enterprising entrepreneurs also will be able to gain coverage more easily through public and private insurance.**

**For states that elect the full expansion of eligibility, the federal government will pay 100 percent of all Medicaid expansion costs between 2014 through 2016, eventually settling in at 90 percent beginning in 2020 and remaining at that payment range. The federal government recently announced that these coverage and match rates would not be provided to states that choose to partially expand eligibility or elect to forgo expansion. For the states electing to fully expand eligibility, these new revenues will result in a significant increase in the purchasing of consumer goods and services downstream.**

**Moreover, between 2014 and 2019, a <u>full Medicaid expansion</u> will provide health insurance coverage to 17 million people with incomes less than 138 percent of the federal poverty level (FPL) who were previously uninsured. About 40 percent of this group – <u>or 6.6 million individuals</u> – with serious or moderate mental illnesses who are currently uninsured will obtain health insurance through the Medicaid expansion between 2014 and 2019. As a result of the Medicaid health insurance expansion, researchers estimate significantly reduced mortality for people who were**

**previously uninsured and improved health status for people with mental illness, and overall enhanced productivity.**

**In addition to the Medicaid expansion, 6.8 million uninsured people with a mental illness will also gain health coverage though the implementation of state health insurance exchanges under the health care reform law, out of nearly 18-25 million projected newly-insured people through the insurance exchanges between 2014 and 2019.**

**We also examined potential drawbacks or negative consequences for states that do not participate in the new Medicaid expansion program. We have determined there are several downsides for states that do not participate including the loss of tax benefits, a diminished opportunity for a state to improve its health care infrastructure, and reduced opportunities to address the needs of lower- and moderate-income populations with high-cost chronic diseases.**

**Although there are several negative downsides for states that do not participate, NASMHPD recognizes the significant variance in perspectives among Governors related to the Medicaid expansion program. This variance includes concerns about increased federal government involvement, the perceived possibility of increased federal spending, and some Governors question whether Medicaid expansion will necessarily change how health care is practiced. NASMHPD addresses many of these concerns in Section Five of this report.**

**However, State Behavioral Health Agencies (SBHAs) who represent the needs of people with mental illness through their public behavioral health care systems, should make a strong business case to state and local officials at all levels – from cabinet members to county executives – that opting in to the Medicaid expansion is a good financial decision for their jurisdictions on three fronts:**

**First, state budget increases will help reduce state budget deficits or increase surpluses.**

**Second, a major infusion of new Medicaid funds will increase state-wide economic activity as a result of expansion. The injection of new funding will substantially offset Medicaid expansion implementation costs.**

**Third, resources will be freed up that are now being used for free care or subsidized care to uninsured and underinsured individuals. Many of the estimated 13.4 million uninsured people with behavioral health conditions who would be enrolled in Medicaid or exchange health plans are now using free care or subsidized services, often delaying access to treatment until conditions deteriorate, and driving costly emergency and inpatient interventions that are paid for with state appropriations, block grants or disproportionate share hospital (DSH) dollars. When these DSH funds are no longer required, state funds and federal contributions may be redirected to other priorities.**

**SBHAs need to make the case that the Medicaid expansion will not only save money for states, but also save lives and improve the health status for millions of newly-eligible people – especially for people with serious mental illness – through better access to health insurance and effective quality improvement approaches.**

**The financial gains and health status improvements that NASMHPD has identified through the meta-analysis are summarized in the following graphic.**

---

*A Dozen Key Takeaways from NASMHPD's Meta-Analysis*

***The New Medicaid Expansion program is a generous financial deal for the states, and will help reduce the federal budget deficit.***

- *The Medicaid Expansion will reduce state budget deficits and increase surpluses.*
- *The Medicaid Expansion will keep residents' federal taxes flowing into the state.*

***The Medicaid Expansion will have a deep and broad positive impact on state economies.***

- *The Medicaid Expansion means creating new jobs.*
- *The Medicaid Expansion will generate new revenue.*

***The Medicaid Expansion will help hospitals caring for a disproportionate share of lower-income and uninsured people.***

- *The Medicaid Expansion will significantly reduce the number of uninsured adult residents with mental health conditions.*
- *The Medicaid Expansion will reduce adult death rates.*

***The Medicaid Expansion will avoid discrimination against people with mental health disabilities.***

- *The Medicaid Expansion will help individuals with serious mental illness secure broad health benefits.*
- *The Medicaid Expansion will help homeless individuals obtain care.*

---

## Benefits to States that Opt In to the Medicaid Expansion

**The three overarching findings from our meta-analysis show:**

1. **A substantial and positive fiscal impact for states choosing to opt in to the new Medicaid expansion program under the Affordable Care Act with total state budget gains up to $304 billion between 2014 and 2023, and potentially another $60 billion in gains due to other factors, as the federal government incurs nearly all new Medicaid expansion costs over the initial 10-year period of the health care law.**

   According to Congressional Budget Office (CBO), the federal government will pay $931 billion of the cost of the Medicaid expansion, while states will pay roughly $73 billion, or 7 percent, and these implementation costs will be offset by **$377 billion in gains referenced in this report resulting in $304 billion in**

**overall state budget gains.** Due to the expansion, NASMHPD estimates that state budgets will see at a minimum an additional $12 billion in financial gains (part of $60 billion in overall budget gains not included in our final budget increases) due to a 23 percentage point increase in the federal match for the state Children's Health Insurance Program (CHIP) beginning in 2016 through 2019.

Although some states will see upfront costs for implementing the Medicaid expansion or see an enrollment uptick in the current program that are proposed in FY 2014 budgets, these funds will be significantly offset by budget gains due to the expansion beginning in 2014.

2. **The Medicaid expansion will generate extensive economic activity by bringing substantially new revenues into individual states, thereby creating new jobs and expanding incomes due to what is known as a "multiplier effect" throughout state economies. Some states have estimated over one billion dollars in new revenues through the new Medicaid expansion effort.**

   For example, the State of Michigan estimates that it will see state-wide financial gains of $1 billion overall between 2014 and 2023 due to the increased federal Medicaid match and new revenues generated due to a major infusion of Medicaid funds.

   According to an independent study by the University of Nebraska Medical Center, spending by the federal government on Medicaid expansion would generate at least $700 million in new economic activity every year in Nebraska, which could finance over 10,000 jobs each year through 2020.

   The primary reason for the increased activity is that the federal government will be paying 100 percent of all Medicaid expansion costs that are incurred by providers between 2014 and 2016 under the new Medicaid program (then gradually settling at 90 percent in 2020 and beyond). The infusion of new Medicaid dollars in a state under the expansion provisions in the ACA will have a dramatic effect on state economic activity.

3. **At the same time that significant economic activity will be generated by the new Medicaid expansion, the ACA law will provide health insurance coverage to 17 million people who were previously uninsured, if all states participate in the new Medicaid expansion initiative. Another 18-25 million people who were previously uninsured will receive coverage through the private health insurance marketplace known as "health insurance exchanges." It has been projected that 13.4 million people who have behavioral health conditions will be eligible for coverage through the new Medicaid expansion program (6.6 million people) and through the health insurance exchanges (6.8 million people) beginning in 2014 through 2019.**

The ACA has the potential to significantly expand the availability and accessibility of health care to individuals with behavioral health diagnoses. With the incentives built into the ACA, service delivery would become more integrated with other health care treatments and services – and with a more community-based, person-centered focus. Taking one snapshot of the potential impact of the expansion, of the 425,000 individuals projected to become newly eligible for Medicaid coverage in the Commonwealth of Virginia, 34 percent of these residents will need mental health and substance abuse services. And the health care quality improvement gains afforded by expanding Medicaid coverage, which is now well documented, shows such increases in coverage reduce mortality rates among new Medicaid enrollees and improve health status.

The Mental Health Parity and Addiction Equity Act of 2008 prohibits financial requirements and treatment limitations for mental health and substance abuse benefits in group health plans from being more restrictive than those placed on medical and surgical benefits. These provisions will apply to expanded Medicaid programs, coverage available under the state health insurance exchanges, as well as to Medicaid managed care programs. Most importantly, the ACA requires the inclusion of mental health and substance use treatment services in the list of the 10 essential benefits that insurance exchanges must offer, and as a consequence provided through the Medicaid expansion.

**NASMHPD believes the Medicaid expansion will serve as a substantial positive three-pronged "cascading" or compounding effect on state budgets, state economies and for people without health insurance coverage. People with serious mental illness, one of our most vulnerable populations, will see a significant increase in health insurance coverage due to the Medicaid expansion.**

## Negative Consequences for States Not Participating in the New Medicaid Expansion

If individual governors and state legislatures do not choose to participate in the new Medicaid expansion program, foregoing the substantial federal funds associated with expansion, their states will in effect have significant lost opportunities to reduce their budget deficits and increase economic activity. **States that do not participate will lose new revenues coming into their states, and at the same time, will see their tax dollars flow to states that chose to opt in to the new expansion program.** The states that opt in will then benefit in budget and revenue gains, with little accruing to the non-participating states. In other words, if the state chooses to opt out, citizens would be contributing federal tax dollars to a program their constituents would never benefit from.

Lower-income citizens in non-participating states who are uninsured and with significant health needs – many with behavioral health conditions – will be left without access to

health insurance coverage. They will, of course, access free care in emergencies, remaining unable in many cases to access preventive and routine care, delaying treatment until needing crisis intervention that often drives use of more expensive hospital based emergency and inpatient care. Many people recognize Medicaid as a program that provides coverage to the poor, but few know that millions of working adults – mainly childless – do not currently qualify for Medicaid even if they have little income. And about 25 percent of this population has serious and moderate behavioral health conditions. The Medicaid expansion will significantly increase access to health insurance which is the pass-key to receiving high-quality care.

Moreover, the decision not to participate will negatively impact major organizations in that state. For example, safety-net providers – especially inner-city and teaching hospitals who were expecting to have their costs for treating previously uninsured individuals covered through the new Medicaid expansion – will feel a combined effect of increased uncompensated care costs as the uninsured population will increase, and major reductions in federal financial support that will begin in 2014 for treating lower-income uninsured people.

## Behind the Findings:
## Impact Analysis of the Medicaid Expansion on State Budgets, State Economies and the Uninsured Population

### *The Impact of the Medicaid Expansion on State Budgets*

According to the multiple studies that NASMHPD reviewed, the significant budget gains that states will experience through the new Medicaid expansion are due to seven major policy initiatives that primarily transfer costs from the states to the federal government under the ACA:

1. Increasing the Federal Match for Certain Current Eligible Individuals: **$66 Billion;**

2. Moving Eligibility and Coverage for a) Adults Currently Covered Under State Waivers, b) Special Categories, e.g., "Medically Needy," and c) Individuals with Certain Diseases (e.g., breast cancer), to the New Medicaid Program and through Federally Subsidized Coverage in the Health Insurance Exchanges: **$69 Billion;**

3. Reducing Uncompensated Care Costs by Hospitals for Treating Uninsured People by Transferring Costs to the Federal Government: **$85 Billion;**

4. Replacing, by the Federal Government, Significant State Costs for the Treatment of Individuals with Behavioral Health Disorders under the New Medicaid Program: **$40 Billion;**

5. Increasing the Prescription Drug Rebates Received by Medicaid from Pharmaceutical Companies: **$8.3 Billion;**

   *These initial 5 areas show budget gains from 2014 through 2019 only.*

6. Improving Coordination of Care and Services for the Dual Eligible Population: **$34 Billion *(from 2014-2023);*** and

7. Combining the Net Effects of the Initial Four Policy Actions Listed Above in What Are Called the Medicaid Expansion "Out-Years" (*from 2020-2023):* **$76 Billion.**

*The total **bottom line budget gains** from the 7 actions tied to the federal government transfer of dollars to the states under the new Medicaid expansion – as well as other efforts such as better coordinated care for the dual eligible population* – is **$377 billion** between 2014 and 2023, through the cascading events identified in this report.

These overall budget gains will be reduced by **$73 billion** through state implementation spending associated with the new Medicaid expansion (cited recently by the Congressional Budget Office and the Center on Budget and Policy Priorities) resulting in a net budget gain to the states of **$304 billion between 2014 and 2023.**

Although state spending on additional Medicaid enrollees (both among those who qualify today and those who are newly eligible) will rise by $73 billion due to overall Medicaid implementation costs, these implementation costs will be offset by the significant budget increases identified in the report (see **Appendix 1 and 2**).

The major factor resulting in the state budget gains is the transfer of significant Medicaid spending (also called "enhanced payment matches") from the states to the federal government. Over the years, several states have expanded health insurance coverage through "waivers" granted by the federal government that allowed states to expand Medicaid eligibility above federal income requirements, and based on other financial needs and medical considerations. These waivers are set to expire in 2013, replaced by the ACA Medicaid eligibility expansion provisions. The vast majority of the expanded eligibility costs – above current federal requirements – that are currently paid for by the states will now be paid for by the federal government.

Despite these voluntary expansions, many childless adults with serious mental illness have not been eligible under the current Medicaid program – as well as some children in families with incomes under 138 percent of the federal poverty level (FPL), as a result of strict income provisions in several states. These costs will be paid for by the federal government at 100 percent between 2014 and 2016, in states that decide to opt in to the Medicaid expansion.

About one in six currently uninsured adults with incomes below 138 percent of the FPL has a serious mental illness such as major depression, bi-polar disorder, severe panic disorder or schizophrenia. Many other individuals have less serious behavioral health

disorders such as milder depression, but these conditions can be debilitating as well and affect daily living. Over 50 percent of the newly eligible individuals have incomes that are 50 percent of FPL (about $7,500 annual income). Many of these extremely lower-income individuals are homeless and over 25 percent of this group has a serious mental illness.

Due to severe state cutbacks over the last four years, individuals with a mental illness who are uninsured receive basic, state-funded public behavioral health care services of limited duration, and often these services and care are crisis-oriented (and many individuals go without care for their conditions altogether). The Medicaid expansion will replace a significant portion of state and local dollars that are used for the uninsured with mental illnesses, with new federal Medicaid monies approaching nearly $40 billion between 2014 and 2023.

Another major reason why states should strongly consider participating in the Medicaid expansion is due to significant changes in the Medicaid Disproportionate Share Hospitals program (or DSH – pronounced "dish"). The Medicaid DSH program provides funding allotments to states as a means to subsidize hospitals for the uncompensated costs incurred when treating uninsured and Medicaid patients. Beginning in 2014, the Secretary of Health and Human Services (HHS) is required to make aggregate reductions in the Medicaid DSH allotments.

These DSH reductions are based on the assumption that the new law will expand health insurance coverage to those now uninsured or underinsured and reduce uncompensated care. The largest reductions will take place in states that have the lowest percentage of uninsured individuals or states that fail to target DSH payments – to hospitals with the highest volume of Medicaid patients and uncompensated care. In total, states will lose about $18 billion in Medicaid DSH payments beginning in FY 2014 through FY 2020.

**It will be the worst of all worlds if some states choose not to participate in the Medicaid expansion at the same time their DSH funds are reduced. States would be caught in a tight payment vice as they provide care to uninsured patients and receive little or no compensation by government agencies.**

### *The Impact of the Medicaid Expansion on State-Wide Economies*

Based on our review of the studies on Medicaid expansion efforts, there are seven major ways that state economies will vastly improve due to the Medicaid expansion:

1. Increasing State Revenue from Taxes on Health Insurance Premiums;
2. Increasing Federal Dollars on Behalf of New Enrollees Affecting Providers;

3. Creating New Jobs Associated with Providers Delivering Care and Other Services;
4. Increasing Income Associated with Delivering Care and Services;
5. Increasing Purchases Associated with Carrying Out Health Care Services;
6. Introducing New Federal Dollars Benefitting Other Businesses and Industries Directly; and
7. Inducing Changes in Household Consumption and Tax Collection.

The Kaiser Commission on Medicaid and the Uninsured has compiled findings from 29 studies in 23 states analyzing the role Medicaid plays in state and local economies. The bottom line: Study by study shows that the current program has had a major financial simulative impact on state economies.

The key finding is that Medicaid spending generates economic activity including jobs, income and state tax revenues at the state level. Medicaid's economic impact is intensified because of federal matching dollars – state spending pulls federal dollars into the economy. Medicaid funding supports jobs and generates income within the health care sector and other sectors of the economy due to a major "multiplier effect."

In the case of the ACA, **the federal government will be providing a 100 percent match between 2014 and 2016** (then gradually settling at 90 percent in 2020 and beyond), so the infusion of new Medicaid dollars in a state under the expansion provisions in the ACA will have an even more dramatic effect as the current program match is lower. In an Alabama study – using an "intermediate" scenario – the authors projected that the Medicaid expansion would reduce the state's uninsured population by approximately 232,000 individuals while generating $20 billion in new economic activity and a $935 million increase in net state tax revenues.

### *The Impact of the Medicaid Expansion on Improved Access to Health Insurance and High-Quality Health Care*

The main reason the ACA was enacted in 2010 was to address the magnitude of the uninsured problem in the United States. The number of uninsured Americans has been hovering around 50 million over the last three years.

NASMHPD recognizes that certain policy considerations will play out over the coming months on whether states will expand their Medicaid programs, which will likely be based on budgetary considerations. However, there is a human dimension to this issue, particularly where people with behavioral health conditions are concerned, that became lost in the shuffle surrounding the Supreme Court decision on Medicaid expansion.

There are seven key cascading events that are critically important to assuring that uninsured people gain access to health coverage, and that ultimately achieves the goal of providing high-quality care (and these actions apply to all Americans):

1. Access to Health Insurance Coverage;
2. Ability to Enroll in Health Insurance Plans;
3. Access to Covered Services and Providers;
4. Choice of Health Plans and Providers;
5. Ability to Build a New Workforce and Increase Capacity;
6. Access to a Consistent Source of Primary Care; and
7. Delivery of High-Quality Health Care Services.

This section of the report highlights that people with behavioral health conditions, especially those with serious, long-term conditions – and in lower-income populations – are at high risk for poor health, disability, and premature death. Unfortunately, many of them do not have coverage and therefore do not get treatment – or get poor treatment – for conditions for which they are at high risk such as obesity, high blood pressure, diabetes, and heart conditions. Medicaid will be expanded to cover people up to 138 percent of the federal poverty level in states that choose this option thereby providing lower-income populations with severe and moderate behavioral health conditions better access to needed services as coverage opens up new service delivery doors.

**The Substance Abuse and Mental Health Services Administration (SAMHSA) has estimated that 13.4 million people who have behavioral health conditions will be eligible through the ACA's new Medicaid expansion (6.6 million people) and through the new state health insurance exchanges (6.8 million people) beginning in 2014 through 2019.**

The Medicaid expansion will substantially stop the deterioration in health access that nonelderly adults have been experiencing, especially those with behavioral health conditions, over the last decade. In addition, the Medicaid expansion also emphasizes health maintenance (also called "wellness programs") and preventive interventions. For example, it provides payments for preventive health care and health promotion in a more comprehensive way. This will benefit people without mental illness, but it is particularly important for people with serious mental illness at high risk of obesity and the diseases it drives such as hypertension, diabetes, and heart disease.

The triple cascading impact of the Medicaid expansion resulting in increased state budget gains, economic activity and health insurance coverage is displayed in **Figure ES 1**.

Figure ES 1

## The Waterfall Effect: Cascading Tri-Level Impact of Medicaid Expansion*

**State Budgets**

- State budget gains on existing Medicaid enrollees (Acute Care Only)[1] = $66 billion
- State budget gains from ending Medicaid coverage for adults >138% of the FPL currently covered by 1115 Waivers or Section 1931[2] = $69 billion
- State gains from reduced spending on uncompensated care = $85 billion

**State Economies**

- Increased state revenue from taxes on insurance premiums
- Increased federal dollars on behalf of new enrollees affecting providers
- Creating of new jobs associated with delivering services
- Increased income associated with delivering services

**Improved Access to Health Insurance & High-Quality Care**

- Access to health insurance coverage
- Ability to enroll in health insurance plans
- Access to covered services and providers

**State Budgets**

- State budget gains by replacing spending on mental health services = $39 billion
- State gains in out-years of Medicaid expansion from 2020-2023 = $76 billion
- State gains on better care coordination for dual eligibles = $34 billion
- State gains on Medicaid drug rebates = $8 billion

**State Economies**

- Increased purchases associated with carrying out health care services
- Influx of new federal dollars benefitting other businesses and industries indirectly
- Induces changes in household consumption and tax collection

**Improved Access to Health Insurance & High-Quality Care**

- Choice of health plans and providers
- Build a new workforce capacity
- Access to consistent source of primary care
- Delivery of high quality care services

*This graphic summarizes three key figures in the body of the report on state budget gains, new economic activity and reducing the number of uninsured.

Notes: State budget gains are for the 2014-2023 period.

[1] State budget gains related to Medicaid expansion are for acute care costs only (e.g., physician costs not included).

[2] Budget gains due to maintenance of effort, ending eligibility for special categories of adults (e.g., individuals with breast cancer), and shifting costs to insurance exchanges for "medically needy" adults.

## Executive Summary Conclusion

Based on the meta-analysis NASMHPD conducted, states should be encouraged to expand Medicaid eligibility, beginning January 1, 2014 at the latest for all individuals with incomes below 138 percent of the FPL, especially for people with mental illness. The challenging state economic climate of recent years has resulted in significant reductions in budgetary resources for safety net programs, limiting services for people with serious mental illness. The federal reimbursement and insurance coverage associated with Medicaid expansion represents an opportunity to improve this situation substantially – an opening that will be lost if a state fails to opt in to the Medicaid expansion.

In addressing the pressing issues associated with implementing several facets of the ACA, state policymakers may overlook the needs of uninsured people, and those with no coverage that also have a serious mental illness. State officials, such as directors of State Behavioral Health Agencies, are in a position to play a vital and active role in promoting the major, positive impact of the Medicaid expansion for people with behavioral health conditions and the financial benefits for their state.

In brief, the cascading effect of the Medicaid expansion is remarkable on several fronts. The expansion is a win-win-win for states in the form of budget gains, increased economic activity and reducing the number of uninsured people. State budgets will see large gains due to increases in federal spending to replace current state spending in their Medicaid programs. The expansion will provide a badly needed injection of revenues into state economies due to a multiplier effect of new Medicaid dollars that has a domino impact across many business sectors. And the expansion will significantly increase Medicaid coverage for adults who are currently uninsured, especially for people with mental illness and reduce mortality rates.

Simply put: The Medicaid expansion will not only increase state budgets and bring in new revenues, it will improve the health and lives of people with mental illness.

## Section One:
## *A Primer on Medicaid*

In a historic ruling on June 28, 2012, the Supreme Court said that if a state does not expand Medicaid to all residents with incomes up to 138 percent of the federal poverty level (FPL) under the Affordable Care Act (ACA), the U.S. Department of Health and Human Services (HHS) is not allowed to terminate federal funding for the state's entire Medicaid program. The Medicaid expansion provision in the ACA is now a purely voluntary measure. States can choose to participate in the expansion, or opt not to, without the loss of funding or incurring sanctions based on their participation in the current Medicaid program. Expansion is, however, an all or none proposition, with recent notice from HHS officials indicating that states will not receive any federal funds for partial expansion of eligibility. Many state officials and opponents of the ACA argued that states were being coerced into the new Medicaid program fearing that if they did not choose to opt in, they could lose current Medicaid funding. The Supreme Court agreed with that argument.

As a result of the Supreme Court decision, state officials in much of the country are deciding whether to implement the new Medicaid expansion. For many states, fiscal and political issues have been critically important to making this decision. Years of rising Medicaid costs have left state officials concerned about the financial risks of any increase in Medicaid eligibility. But this particular expansion has unusual features. Some factors would raise state costs, but several factors would result in significant budget gains and reduce budget deficits.

Since 1966, Medicaid has been the backbone of our health care and public health insurance safety net. Jointly funded by the states and the federal government, Medicaid provides health insurance coverage for lower-income Americans, including families, people with disabilities, and the elderly.

Medicaid is the nation's single largest health insurer. In fiscal year 2011, it covered an estimated 70 million children and adults—more than one-fifth of the U.S. population. Medicaid provides coverage for almost 30 million children and finances nearly one-half of all long-term care costs. Total program spending will amount to more than $430 billion in 2012, of which nearly 60 percent is federal. Since Medicaid is jointly funded, federal law requires state Medicaid programs to cover certain categories of individuals and services and programs.

Health care reform through the ACA will result in additional spending by both federal and state governments as more Americans gain access to affordable health care, typically because of publicly funded subsidies such as expanding the Medicaid program. For those newly eligible through this expansion, the federal government will cover 100 percent of costs for 2014 through 2016, gradually stabilizing at 90 percent in 2020. The federal contribution will remain at 90 percent thereafter. States have the option to implement this expansion sooner **(Table 1)**.

The federal government and states will see financial gains due to the implementation of the Medicaid expansion, thereby reducing budget deficits.

**What are the differences between the current Medicaid program and the Medicaid Expansion initiative under the Affordable Care Act?**

## Medicaid Today vs. Medicaid Expansion

While Medicaid has helped millions gain access to health insurance and health care, many lower-income people have been left out because of income eligibility standards. In 30 states, income eligibility for parents is set below 50 percent of the FPL (in 2012, that's an annual income of $15,904 for a family of four). In most states, adults without dependent children, no matter how poor, cannot get Medicaid coverage at all.

In 2014, as a result of the Affordable Care Act, states can get substantial federal funding to expand Medicaid to all residents with incomes at or below 138 percent of the FPL (an income of about $31,809 for a family of four in 2012), thus extending Medicaid coverage to individuals who have been left out of the program. (Note: Since 5 percent of income is not included – is "disregarded" – when eligibility is determined, the expansion, in effect, applies to those with incomes at or below 138 percent of the FPL, which is 5 percent above the 133 percent specified in the ACA.)

### Financing

| Medicaid Today | Medicaid Expansion |
|---|---|
| Generally, each state receives matching dollars from the federal government, and those matching rates vary across the states from 50% to 76%. This means that for every dollar a state spends on Medicaid, the federal government contributes between $1.00 and $3.17. Federal matching rates are based on the per capita income of the states, so states with lower per capita incomes get higher matching rates. (1) | In 2014, the ACA gives states the opportunity to expand their Medicaid programs to cover all individuals with incomes at or below 138 percent of poverty. For those newly eligible through this expansion, the federal government will cover 100% of costs for 2014 through 2016, gradually falling to 90% in 2020. The federal contribution will remain at 90% thereafter. In states that expand Medicaid, the historic federal Medicaid matching formula will still apply to individuals who meet the Medicaid eligibility criteria in place as of December 1, 2009. |

### Eligibility

| Medicaid Today | Medicaid Expansion |
|---|---|
| **Federal Requirements**<br>Federal law requires states to cover certain categories of people in Medicaid. In general, there are six categories of so-called "mandatory" individuals: 1) children, 2) pregnant women, 3) very low-income parents, 4) the elderly, and individuals who are 5) blind or 6) disabled.<br>Eligibility levels for these groups of people vary by income:<br>• Children under age six with family incomes up to 138% of the FPL ($25,390 for a family of | In 2014, states can expand their Medicaid programs to cover virtually all individuals under the age of 65 with incomes below 138% of poverty. Income eligibility for those over 65 will remain unchanged. That will extend coverage to many lower-income adults currently left out of the program and simplify eligibility determinations across the program. States have the option to implement this expansion sooner than 2014. |

four in 2012).
- Children ages 6-19 with family incomes up to 100% of poverty ($23,050 for a family of four in 2012).
- Pregnant women with family incomes up to 138% of poverty.
- Parents whose income meets the state's AFDC (former welfare program) criteria in place as of July 1996.
- People who are elderly, blind, or who have disabilities and who receive Supplemental Security Income (SSI) with incomes up to 74% of poverty ($8,266 for an individual in 2012).
- Certain people with severe disabilities who would qualify for SSI if they did not work.
- Elderly individuals and people with disabilities whose Medicare premiums are paid by Medicaid through the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI) programs; generally speaking, these are individuals who have incomes below 150% of poverty.

**State Options**

States have the flexibility to increase these income limits to allow more people to qualify for Medicaid for several general categories of people, as follows:

- Lower-income children, parents, and pregnant women with family incomes above mandatory cutoff levels and up to whatever income limit the states decide.
- People who are blind, elderly, or disabled with incomes above the SSI level but below 100% of poverty.
- Nursing home residents with incomes above SSI levels but below 300% of poverty.
- People with disabilities that work and have incomes above the SSI limit.
- Medically needy individuals who require institutional care but who have incomes that are too high to qualify for SSI—these individuals can deduct the cost of their institutional care from their income in order to qualify for Medicaid.

The ACA requires states to maintain the Medicaid eligibility levels, policies, and procedures that were in place in March 2010 (the date the ACA enacted) until the state has an operational health insurance

| | |
|---|---|
| exchange. State-based health insurance exchanges are a key mechanism under the ACA where millions of lower- and moderate-income individuals will receive subsidies through tax credits to purchase health insurance coverage through competing health plans. | |

## Benefits

| Medicaid Today | Medicaid Expansion |
|---|---|
| **Federal Requirements**<br>Federal law requires states to provide a minimum benefit package in Medicaid. So-called "mandatory" benefits include physician services, hospital services, family planning, health center services, and nursing facility services. The benefit package for children is more comprehensive than the one for adults because federal law requires states to provide coverage for certain health screenings and services that are medically necessary. This requirement is called the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit.<br><br>**State Options**<br>States are permitted to provide coverage for certain other health care services that are approved by the federal government. Such "optional" services include dental care, mental health care, eye glasses and vision care, coverage for prescription drugs, home health care, case management, and rehabilitation services. | In states that take advantage of the new Medicaid expansion, states must provide a set of essential health benefits.<br>**Essential Benefit Classes Covered by Qualified Health Plans under the Affordable Care Act include:**<br><br>• Ambulatory patient services<br>• Emergency services<br>• Hospitalization<br>• Maternity and newborn care<br>• Mental health and substance use disorder services, including behavioral health treatment<br>• Prescription drugs<br>• Rehabilitative and habilitative services and devices<br>• Laboratory services<br>• Preventive and wellness services<br>• Chronic disease management<br>• Pediatric services, including oral and vision care<br><br>In addition to providing essential health benefits, health insurance coverage under the Medicaid expansion will have to be consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA). The MHPAEA expanded on previous federal parity legislation addressing the potential for discrimination in mental health and substance use disorder benefits to occur by generally requiring that the financial requirements or treatment limitations for mental health and substance use disorder benefits be no more restrictive than those for medical and surgical benefits. |

# Introduction

Health care reform through the Affordable Care Act (ACA) provides for the expansion of Medicaid to nearly all individuals under age 65 with incomes up to 138 percent of the FPL – $15,156 for an individual and $31,809 for a family of four. (1) For those previously uninsured and ineligible for Medicaid coverage, the federal government will pay the large majority of their costs – 100 percent from 2014 through 2016, decreasing to 95 percent in 2017 and leveling off to 90 percent after 2020 and beyond **(Table 1).**

### Medicaid Match Rates for Coverage in Health Reform Summary

The ACA establishes a new, minimum standard for Medicaid coverage that is uniform across the country and fills the biggest gaps in coverage for lower-income people. Specifically, the ACA requires states by January 1, 2014, to extend Medicaid eligibility to all groups of people under age 65 with income up to 133 percent of the FPL who are not otherwise eligible for Medicaid. For most states, this will mean providing Medicaid to adults without children for the first time, as well as increasing their income eligibility threshold for parents to 138 percent of the federal poverty line. The law specifies different match rates for individuals eligible for coverage as of December 1, 2009; those made newly eligible for coverage under health reform and for certain expansion states.

**Regular Medicaid Matching Rate:** The regular Medicaid matching rate is determined by a formula that has been in place since the program was enacted in 1965. It ranges from 50 percent to 76 percent, and is designed to provide more federal support to states with lower per capita incomes. In 2014, it will continue to be used for "already-eligible" individuals (people who qualify for Medicaid under the rules in effect on December 1, 2009).

**Newly-Eligible Matching Rate:** The newly-eligible matching rate assures that the federal government finances much of the cost of the Medicaid expansion to 138 percent of the FPL included in the health reform legislation. It is set at 100 percent in FY 2014 through FY 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond.

Beginning in 2014, it is available for non-elderly adults with income up to 133 percent of the FPL who are not eligible for Medicaid under the rules that a state had in place on December 1, 2009.

**"Expansion" States Matching Rate:** The transition-matching rate is designed to provide some additional federal help to "expansion" states (states that expanded coverage for adults to at least 100 percent of the FPL prior to enactment of health reform). These states can receive a phased-in increase in their federal matching rate for adults without children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults.

Source: *Medicaid Coverage and Spending in Health Reform, Kaiser Commission on Medicaid and the Uninsured, July 2010.*

**Table 1**

| | Federal Matching Rate for New Medicaid Eligibles & Current Eligibles with Enhanced Matching | | | | |
|---|---|---|---|---|---|
| | New Eligibles and Currently Eligible Adults in Limited Benefits States | Current Eligibles in Expansion States | | | |
| | | Transition Percentage | Enhanced Match Rates | | |
| 2014 | 100% | 50% | 75% | to | 83% |
| 2015 | 100% | 60% | 80% | to | 86% |
| 2016 | 100% | 70% | 85% | to | 90% |
| 2017 | 95% | 80% | 86% | to | 89% |
| 2018 | 94% | 90% | 90% | to | 91% |
| 2019 | 93% | 100% | 93% | | |
| 2020 on | 90% | 100% | 90% | | |

Uninsured individuals with mental illness have forgone needed preventive and routine care, resulting in clinical deterioration to the point where in crisis they access acute and expensive health and mental health emergency and inpatient care paid by the states or covered in free care pools and DSH payments, which will be greatly reduced in years ahead pursuant to provisions of the ACA. Medicaid expansion coverage will increase access to health promotion and prevention services and needed treatments, thereby lowering costs by extending the mental health system delivery system to those individuals who have lacked health coverage.

**Medicaid Expansion and the Supreme Court**

In a historic ruling on the ACA on June 28, 2012, since the U.S. Supreme Court held that if a state does not expand Medicaid to all residents with incomes up to 138 percent of the FPL under the legislation, the U.S. Department of Health and Human Services (HHS) is not allowed to terminate federal funding for the state's entire Medicaid program. State officials in much of the country are now deciding whether to implement the Medicaid expansion. For many states, fiscal issues are critically important to this decision. Years of rising Medicaid costs have left state officials understandably concerned about the financial risks of any increase to Medicaid eligibility. But this particular expansion has unusual features. Some factors will raise state costs, but several factors will significantly reduce individual state Medicaid costs and budget deficits making the expansion a good buy and investment for individual states.

Based on our meta-analysis – that entailed the review of 23 studies and reports released over the 2010 to 2012 period – there are three major events that will occur if states choose to participate in the Medicaid expansion:

1) The federal government will pay a much higher percentage – called an "enhanced match" or "increased match" for certain currently eligible adults, individual who will be eligible under the new Medicaid program who have been covered under "waivers" or are deemed

"medically needy" and other transference of costs to the federal government such as uncompensated care expenses for uninsured individuals currently paid for by states. These offsets will far exceed state implementation costs under the voluntary Medicaid expansion. State budgets will experience several significant financial gains due to the federal government incurring these costs.*

2) The Medicaid expansion will improve a state's financial fortunes through increased overall economic activity as new revenues come into the state; and

3) At the same time, the expansion will improve the ability of millions of uninsured people, especially for people with mental illness, to gain access to affordable health insurance and high-quality care.

Like the power of a waterfall, there are several positive cascading activities that will take place in each of the three major events that will generate significant budget gains to states on a macro level and for individual states, improved economic activity due to a compounding "multiplier" revenue-generating effect, and broader access to health insurance and improved health for individuals now and downstream.

* In general, one could think of states as falling into one of three categories:

- States who will have very large numbers of new eligibles starting in 2014 like Alabama and Texas. These tend to be states in the south and some in the west that have low levels of current eligibility and coverage. Most of their new enrollees will be newly eligible under the ACA and they will receive the high federal matching rates for them.

- States that have already covered large numbers of adults, mostly parents, through their Medicaid programs, using poverty related provisions of Medicaid law (these states do not cover childless adults through waiver programs). These include many states such as California and New Jersey. Because of higher participation rates among current eligibles, a smaller share of their new enrollees under ACA will be from those made newly eligible.

- States that currently cover parents and childless adults in Medicaid today like Massachusetts and New York, or "expansion states."

  - Massachusetts already covers childless adults with incomes above 138% of the FPL through Section 1115 waiver programs. These states will have no new eligibles; they will, however, receive the higher "waiver" matching rates on those currently eligible childless adults, including prior and new enrollees.

  - States that have extended coverage through Section 1115 waiver programs to childless adults but did not do so for those all the way up to 138% of the FPL. These states, Arizona, Hawaii, Delaware, Maine, and New York will receive the waiver-matching rate for the childless adults that are currently eligible under these rules. Because the ACA expands eligibility for those up to 138% of the FPL, these states will receive the law's higher matching rates for their new eligibles.

*"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."*

**Benjamin Disraeli, British Prime Minister, 1877**

## Section Two:
## *The Cascading Impact of the Medicaid Expansion on State Budgets*

The Urban Institute and the Center on Budget and Policy Priorities – as well as other Washington-based non-partisan, non-profit think tanks and public policy operations – have issued major studies that provide projections on budget gains to individual states and in total, based on the impact of the Medicaid expansion under the ACA (2). The Urban Institute, in particular, has released specific statistics over the last two years on potential state budget gains across several parameters as a result of the Medicaid expansion program in the ACA. We have tried to capture that work in this overall meta-analysis.

In all, there are seven major cascading events that will lead to significant state budget gains as the federal government will incur substantial Medicaid costs for states choosing to opt in to the Medicaid expansion **(the transference of cost liability to the federal government only applies to financing acute care services not physician services in the ambulatory setting).** With the gains based on only one cost element, as well as other factors where potential gains are expected but not included by budget experts at this time, we believe the following projections undercount the overall gains substantially.

**The seven areas where states will see budget gains primarily due to transferring costs to the federal government under the Medicaid expansion include:**

**1. Increasing the Federal Match for Current Eligible Individuals:**

Although state spending on additional Medicaid enrollees (both among those who qualify today and those who are newly eligible) will rise by $73 billion due to overall Medicaid implementation costs, these costs will be offset by **$66 billion** between 2014 and 2019 in new federal spending on existing Medicaid enrollees and a higher matching rate under the ACA, which accrues to the **states**. **(Table 2)**

The Urban Institute highlights that under the ACA: "newly eligible" adults for whom greatly enhanced federal funding is available include those who, under current law, qualify for substantially less than full Medicaid benefits. Some states currently offer Medicaid with reduced benefits to some lower-income adults through Section 1115 waivers; state spending on those adults could fall because of their reclassification as "newly eligible." (2) Further, some states that, before the ACA, already extended full Medicaid coverage to both parents and childless adults up to at least 100 percent of the FPL are identified here as "prior expansion" states. The ACA increases the federal match rate for childless adults who would have been classified as "newly eligible" in these states, starting in 2014 at halfway between the state's normal rate and

100 percent, gradually declining to 93 percent in 2019 and 90 percent in 2020 and later years **(Please also see Table 1 for more information on Medicaid match numbers)**.

**Table 2**

| New Federal Medicaid Spending and State Savings on Existing Enrollees,[1] from 2014-2019 Totals | | | |
|---|---|---|---|
| **Millions $** | **Reform** | | |
| **States/Regions** | **Limited Benefits** | **Prior Expansion** | **Total** |
| **New England:** | **3,059** | **7,346** | **10,405** |
| Connecticut | 3,059 | 0 | 3,059 |
| Maine | 0 | 981 | 981 |
| Massachusetts | 0 | 5,790 | 5,790 |
| New Hampshire | 0 | 0 | 0 |
| Rhode Island | 0 | 0 | 0 |
| Vermont | 0 | 575 | 575 |
| **Middle Atlantic:** | **10,016** | **21,534** | **31,551** |
| Delaware | 0 | 1,181 | 1,181 |
| District of Columbia | 0 | 0 | 0 |
| Maryland | 0 | 0 | 0 |
| New Jersey | 0 | 0 | 0 |
| New York | 0 | 20,354 | 20,354 |
| Pennsylvania | 10,016 | 0 | 10,016 |
| **East North Central:** | **10,394** | **0** | **10,394** |
| Illinois | 0 | 0 | 0 |
| Indiana | 5,179 | 0 | 5,179 |
| Michigan | 0 | 0 | 0 |
| Ohio | 0 | 0 | 0 |
| Wisconsin | 5,215 | 0 | 5,215 |
| **West North Central:** | **2,017** | **0** | **2,017** |
| Iowa | 1,758 | 0 | 1,758 |
| Kansas | 0 | 0 | 0 |
| Minnesota | 259 | 0 | 259 |
| Missouri | 0 | 0 | 0 |
| Nebraska | 0 | 0 | 0 |
| North Dakota | 0 | 0 | 0 |
| South Dakota | 0 | 0 | 0 |
| **South Atlantic:** | **0** | **0** | **0** |
| Florida | 0 | 0 | 0 |
| Georgia | 0 | 0 | 0 |
| North Carolina | 0 | 0 | 0 |
| South Carolina | 0 | 0 | 0 |
| Virginia | 0 | 0 | 0 |
| West Virginia | 0 | 0 | 0 |
| **East South Central:** | **0** | **0** | **0** |
| Alabama | 0 | 0 | 0 |
| Kentucky | 0 | 0 | 0 |
| Mississippi | 0 | 0 | 0 |
| Tennessee | 0 | 0 | 0 |
| **West South Central:** | **0** | **0** | **0** |
| Arkansas | 0 | 0 | 0 |
| Louisiana | 0 | 0 | 0 |
| Oklahoma | 0 | 0 | 0 |
| Texas | 0 | 0 | 0 |
| **Mountain:** | **2,352** | **4,843** | **7,195** |
| Arizona | 0 | 4,843 | 4,843 |
| Colorado | 0 | 0 | 0 |
| Idaho | 0 | 0 | 0 |
| Montana | 0 | 0 | 0 |
| Nevada | 0 | 0 | 0 |
| New Mexico | 0 | 0 | 0 |
| Utah | 591 | 0 | 591 |
| Wyoming | 0 | 0 | 0 |
| **Pacific:** | **3,812** | **715** | **4,527** |
| Alaska | 0 | 0 | 0 |
| California | 0 | 0 | 0 |
| Hawaii | 0 | 715 | 715 |
| Oregon | 3,030 | 0 | 3,030 |
| Washington | 782 | 0 | 782 |
| **Total** | **31,651** | **34,437** | **66,088** |

[1] Spending on acute care for the nonelderly.

Note: Before ACA, "limited benefit" states provided less than full Medicaid benefits to some adults through 1115 waivers; and "prior expansion" states covered parents and childless adults up to at least 100 percent FPL. These states will experience increased federal matching rates for some of these adults. This table underestimates state savings by failing to account for (a) income disregards in some states; (b) premium support programs; and (c) limited benefits provided to adults outside 1115 waiver through medically needy eligibility.

**Table 2 developed by the Urban Institute, and which is based on <u>acute care spending only</u> for the non-elderly population, highlights that "limited benefit" states provided less than full Medicaid benefits to several adults through 1115 waivers. And "prior expansion" states have covered parents and childless adults up to at least 100 percent of the federal poverty level. These states will see increased federal Medicaid matching rates under the ACA for some of these adults. The Urban Institute stated that this table undercounts budget gains because it fails to take into account premium support programs and other factors.**

**2. Eliminating Medicaid Eligibility for Adults Above 138 Percent of the Federal Poverty Level and Related Events or Otherwise Shifting Some of their Costs to Federally Subsidized Coverage in the Health Insurance Exchanges: (2)**

Under this broad umbrella of policy actions, several states will find considerable budgetary gains due to the federal government pick up of these costs. The elimination of Medicaid eligibility for certain adults with incomes above 138 percent of the FPL will be one source of state budget gains. States will accrue financial gains by ending Medicaid eligibility and coverage for adults above 138 percent of the FPL now covered in Section 1115 Waivers and in the Section 1931 provision. Between 2014 and 2019, **states** will transfer to the federal government over **$69 billion**, while the federal government overall will save $89 billion.

**Table 3 - Urban Institute, *Consider Savings as Well as Costs***

| Federal and State Spending Effects from Eliminating Medicaid Eligibility >138% FPL Under 1115 waivers and Section 1931, 2014-2019 Totals | | |
|---|---|---|
| **Millions $** | **Reform** | |
| **States/Regions** | **Federal Spending** | **State Spending** |
| **New England:** | **-1,762** | **-1,611** |
| Connecticut | -176 | -176 |
| Maine | -72 | -40 |
| Massachusetts | -1,089 | -1,089 |
| New Hampshire | 0 | 0 |
| Rhode Island | -75 | -67 |
| Vermont | -349 | -238 |
| **Middle Atlantic:** | **-1,639** | **-1,571** |
| Delaware | -2 | -2 |
| District of Columbia | -117 | -50 |
| Maryland | -157 | -157 |
| New Jersey | 1,276 | -1,276 |
| New York | -80 | -80 |
| Pennsylvania | -7 | -6 |
| **East North Central:** | **-2,438** | **-1,985** |
| Illinois | -1,045 | -1,032 |
| Indiana | 5,179 | 0 |
| Michigan | 0 | 0 |
| Ohio | 0 | 0 |
| Wisconsin | -1,393 | -953 |
| **West North Central:** | **-1,525** | **-1,221** |
| Iowa | -754 | -450 |
| Kansas | 0 | 0 |
| Minnesota | -771 | -771 |
| Missouri | 0 | 0 |
| Nebraska | 0 | 0 |
| North Dakota | 0 | 0 |
| South Dakota | 0 | 0 |
| **South Atlantic:** | **-4** | **-2** |
| Florida | 0 | 0 |
| Georgia | 0 | 0 |

| | | |
|---|---|---|
| North Carolina | -4 | -2 |
| South Carolina | 0 | 0 |
| Virginia | 0 | 0 |
| West Virginia | 0 | 0 |
| **East South Central:** | **0** | **0** |
| Alabama | 0 | 0 |
| Kentucky | 0 | 0 |
| Mississippi | 0 | 0 |
| Tennessee | 0 | 0 |
| **West South Central:** | **0** | **0** |
| Arkansas[2] | 0 | 0 |
| Louisiana | 0 | 0 |
| Oklahoma[2] | 0 | 0 |
| Texas | 0 | 0 |
| **Mountain:** | **-658** | **-374** |
| Arizona | -515 | -268 |
| Colorado | 0 | 0 |
| Idaho | 0 | 0 |
| Montana | 0 | 0 |
| Nevada | -80 | -80 |
| New Mexico | -55 | -22 |
| Utah | -9 | -4 |
| Wyoming | 0 | 0 |
| **Pacific:** | **-3,558** | **-3,503** |
| Alaska | 0 | 0 |
| California | -2,190 | -2,190 |
| Hawaii | -34 | -28 |
| Oregon[1] | 0 | 0 |
| Washington | -1,334 | -1284 |
| **Total** | **-11,585** | **-10,267** |

[1] State has potential savings but due to a small sample size, no such records exist in our data.
[2] State has premium assistance for adults that is not included as a limited benefits program in our model.

Gains in maintenance of effort costs that are included in this section come from discontinued eligibility through Section 1115 and Social Section 1931 waivers, accounting for $11.6 billion and $10.3 billion in federal and collective state gains, respectively, out of the $69 billion overall savings. **(Table 3)**

Additional financial gains due to transferring costs to the federal government come from ending eligibility for special eligibility categories for adults (e.g., breast cancer patients) and individuals who are "medically needy" whose costs will be shifted to health insurance exchanges. The federal government will also secure savings through these actions over the long term.

It should be noted that shifting coverage of these populations from Medicaid to insurance exchanges subsidies does raise some concerns around the affordability of premiums and cost-

sharing under subsidized exchange plans. Some states that are contemplating this shift are also exploring ways to mitigate the impact on beneficiaries, including providing additional subsidy assistance with premiums and cost-sharing provisions. (3)
Budget gains on Medicaid health coverage for pregnant women could be significant. As a group, pregnant women are expensive to cover; even an uncomplicated birth in a hospital is a relatively costly service, and more complicated births can be extraordinarily expensive.

With broader coverage, many more women will have insurance at the time that they become pregnant, through employers or the insurance exchange, and so will not need public insurance coverage. (4) The federal government will incur these costs.

In addition, budget gains will occur through reducing medically needed programs. Beneficiaries in the 36 states with "spend-down" programs are quite costly to cover under Medicaid; by definition, they have high medical costs. (5) Spending-down will occur much less often under the ACA because individuals will have broader health coverage options.

### 3. Reducing Uncompensated Care Costs by Hospitals for Treating Uninsured People by Transferring Costs to the Federal Government:

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or health insurer. It is the sum of a hospital's "bad debt" and the "charity care" for those who have no coverage but the institution provides necessary services. Charity care is care for which hospitals never expect to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided; this happens when patients are unable to pay their bills, but do not apply for charity care, or are unwilling to pay their bills.

## States Will See Considerable Budget Increases From Transitioning Current Medicaid Populations to the Newly Eligible Medicaid Group

**Adults Enrolled Through Waivers:** Many states have used 1115 waivers to expand coverage for childless adults or parents. In some cases these waiver populations will be considered newly eligible, (for example, where the state does not provide comprehensive benefits or limits or caps enrollment), the waiver can be eliminated and the covered adults moved into the new adult group. In this case the state will receive enhanced FMAP, allowing the state to substitute federal dollars for the state dollars previously invested in coverage of this population.

**Breast and Cervical Cancer Treatment Program (BCCTP):** Many states participate in the Centers for Disease Control (CDC) BCCTP and provide Medicaid coverage to women diagnosed with breast or cervical cancer by hospitals participating in the CDC Program. There is no upper income limit and women receive full Medicaid coverage while they are being treated for breast or cervical cancer. States can eliminate this program in connection with Medicaid expansion. Women with incomes below 138 percent of the FPL will move into Medicaid (with an enhanced match); women with incomes above 138 percent of the FPL will be eligible for tax credits and cost-sharing reductions through the Exchange (where no state expenditures are required).

**Medically Needy Spend Down:** Some states have adopted the medically needy spend down option whereby individuals who are disabled may "spend down" to the "Aged, Blind, and Disabled" (ABD) eligibility level and receive Medicaid. If the state eliminates the program, individuals who might otherwise have accessed Medicaid coverage through the ABD group with regular FMAP will stay in the new adult group and qualify for enhanced FMAP.

**Family Planning:** States will eliminate this program as individuals with incomes below 138 percent of the FPL currently participating will be eligible for full Medicaid coverage (as opposed to only family planning services) and women above 138 percent of the FPL will be eligible for tax credits and cost-sharing reductions. The current matching rate for family planning services under a waiver or SPA is 90 percent. If the program is eliminated, the state will receive an enhanced FMAP for newly eligibles and will have no costs for individuals above 138 percent of the FPL who receive tax credits and cost sharing reductions in the Exchange.

**State Spending on Hospital Inpatient Costs of Prisoners:** State corrections budgets will be reduced to the extent that Medicaid eligible prisoners are treated in an inpatient facility outside of the state correctional system.

**Other Factors:** For example, will former foster care children under age 26 be able to access Medicaid under the traditional program, or as newly eligible adults? States will also want to consider in this analysis current Medicaid populations that may transition to the Exchange.

Source: *Robert Wood Johnson Foundation – State Health Reform Assistance Network, September 2012.*

## Table 4 – Urban Institute, *Consider Savings as Well as Costs*

| | State and Federal Spending on Uncompensated Care, 2014-2019 Totals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No Reform | | | Reform | | | Low Savings[2] | | High Savings[3] | |
| | Federal Share | State Share | Total[1] | Federal Share | State Share | Total[1] | Federal Share | State Share | Federal Share | State Share |
| **New England:** | **9,172** | **6,115** | **20,383** | **4,942** | **3,295** | **10,982** | **-1,058** | **-705** | **-2,115** | **-1,410** |
| Connecticut | 3,388 | 2,259 | 7,529 | 2,033 | 1,356 | 4,519 | -339 | -226 | -677 | -452 |
| Maine | 1,599 | 1,066 | 3,553 | 916 | 611 | 2,037 | -171 | -114 | -341 | -228 |
| Massachusetts | 1,609 | 1,073 | 3,576 | 1,008 | 672 | 2,240 | -150 | -100 | -301 | -200 |
| New Hampshire | 1,079 | 720 | 2,399 | 353 | 235 | 784 | -182 | -121 | -363 | -242 |
| Rhode Island | 1,033 | 689 | 2,297 | 381 | 259 | 848 | -163 | -109 | -326 | -217 |
| Vermont | 463 | 309 | 1,029 | 250 | 167 | 555 | -53 | -36 | -107 | -71 |
| **Middle Atlantic:** | **38,803** | **25,868** | **86,228** | **19,685** | **13,124** | **43,746** | **-4,779** | **-3,186** | **-9,559** | **-6,372** |
| Delaware | 1,192 | 795 | 2,649 | 336 | 224 | 746 | -214 | -143 | -428 | -285 |
| District of Columbia | 261 | 174 | 581 | 94 | 63 | 209 | -42 | -28 | -84 | -56 |
| Maryland | 3,202 | 2,135 | 7,116 | 1,473 | 982 | 3,273 | -432 | -288 | -865 | -576 |
| New Jersey | 5,923 | 3,949 | 13,162 | 2,881 | 1,920 | 6,401 | -761 | -507 | -1,521 | -1,014 |
| New York | 17,577 | 11,718 | 39,061 | 9,185 | 6,124 | 20,412 | -2,098 | -1,399 | -4,196 | -2,797 |
| Pennsylvania | 10,647 | 7,098 | 23,659 | 5,716 | 3,811 | 12,703 | -1,233 | -822 | -2,465 | -1,643 |
| **East North Central:** | **38,931** | **25,954** | **86,512** | **16,991** | **11,327** | **37,757** | **-5,485** | **-3,657** | **-10,970** | **-7,313** |
| Illinois | 11,980 | 7,986 | 26,621 | 6,669 | 4,446 | 14,819 | -1,328 | -885 | -2,655 | -1,770 |
| Indiana | 5,574 | 3,716 | 12,387 | 2,476 | 1,650 | 5,501 | -775 | -516 | -1,549 | -1,033 |
| Michigan | 7,424 | 4,949 | 16,498 | 3,594 | 2,396 | 7,986 | -958 | -638 | -1,915 | -1,277 |
| Ohio | 9,763 | 6,509 | 21,696 | 2,823 | 1,882 | 6,274 | -1,735 | -1,157 | -3,470 | -2,313 |
| Wisconsin | 4,190 | 2,793 | 9,311 | 1,430 | 953 | 3,177 | -690 | -460 | -1,380 | -920 |
| **West North Central:** | **13,089** | **8,726** | **29,086** | **4,429** | **2,953** | **9,843** | **-2,165** | **-1,443** | **-4,330** | **-2,886** |
| Iowa | 766 | 511 | 1,702 | 532 | 235 | 783 | -103 | -69 | -207 | -138 |
| Kansas | 2,223 | 1,482 | 4,939 | 896 | 597 | 1,990 | -332 | -221 | -663 | -442 |
| Minnesota | 2,587 | 1,725 | 5,749 | 906 | 604 | 2,013 | -420 | -280 | -841 | -560 |
| Missouri | 4,360 | 2,906 | 9,688 | 1,054 | 703 | 2,342 | -826 | -551 | -1,653 | -1,102 |
| Nebraska | 1,604 | 1,069 | 3,564 | 628 | 419 | 1,396 | -244 | -163 | -488 | -325 |
| North Dakota | 662 | 441 | 1,470 | 287 | 191 | 628 | -94 | -62 | -187 | -125 |
| South Dakota | 888 | 592 | 1,974 | 307 | 204 | 681 | -145 | -97 | -291 | -194 |
| **South Atlantic:** | **54,442** | **36,295** | **120,982** | **20,645** | **13,763** | **45,878** | **-8,449** | **-5,633** | **-16,898** | **-11,266** |
| Florida | 19,331 | 12,887 | 42,958 | 5,457 | 3,638 | 12,126 | -3,469 | -2,312 | -6,937 | -4,625 |
| Georgia | 9,821 | 6,547 | 21,824 | 4,476 | 2,984 | 9,948 | -1,336 | -891 | -2,672 | -1,781 |
| North Carolina | 12,996 | 8,664 | 28,879 | 6,920 | 4,614 | 15,378 | -1,519 | -1,013 | -3,038 | -2,025 |
| South Carolina | 4,740 | 3,160 | 10,533 | 1,026 | 684 | 2,281 | -928 | -619 | -1,857 | -1,238 |
| Virginia | 5,634 | 3,756 | 12,520 | 2,421 | 1,614 | 5,381 | -803 | -535 | -1,606 | -1,071 |
| West Virginia | 1,921 | 1,280 | 4,268 | 344 | 229 | 764 | -394 | -263 | -788 | -526 |
| **East South Central:** | **20,021** | **13,347** | **44,490** | **6,607** | **4,404** | **14,681** | **-3,353** | **-2,236** | **-6,707** | **-4,471** |
| Alabama | 4,469 | 2,979 | 9,931 | 1,882 | 1,255 | 4,183 | -647 | -431 | -1,293 | -862 |
| Kentucky | 5,147 | 3,431 | 11,437 | 1,022 | 681 | 2,271 | -1,031 | -687 | -2,062 | -1,375 |
| Mississippi | 3,586 | 2,390 | 7,968 | 1,800 | 1,200 | 4,001 | -446 | -298 | -893 | -595 |
| Tennessee | 6,819 | 4,546 | 15,154 | 1,902 | 1,268 | 4,227 | -1,229 | -820 | -2,459 | -1,639 |
| **West South Central:** | **41,998** | **27,998** | **93,328** | **16,910** | **11,273** | **37,577** | **-6,272** | **-4,181** | **-12,544** | **-8,363** |
| Arkansas | 3,135 | 2,090 | 6,967 | 919 | 613 | 2,043 | -554 | -369 | -1,108 | -739 |
| Louisiana | 3,441 | 2,249 | 7,646 | 627 | 418 | 1,393 | -703 | -469 | -1,407 | -938 |
| Oklahoma | 3,537 | 2,358 | 7,859 | 974 | 650 | 2,165 | -641 | -427 | -1,281 | -854 |
| Texas | 31,885 | 21,256 | 70,855 | 14,389 | 9,593 | 31,976 | -4,374 | -2,916 | -8,748 | -5,832 |
| **Mountain:** | **19,314** | **12,876** | **42,920** | **9,398** | **6,265** | **20,884** | **-2,479** | **-1,653** | **-4,958** | **-3,305** |
| Arizona | 4,498 | 2,999 | 9,997 | 2,713 | 1,808 | 6,028 | -446 | -298 | -893 | -595 |
| Colorado | 4,773 | 3,182 | 10,606 | 2,610 | 1,740 | 5,799 | -541 | -361 | -1,082 | -721 |
| Idaho | 1,249 | 833 | 2,776 | 668 | 446 | 1,485 | -145 | -97 | -290 | -194 |
| Montana | 682 | 456 | 1,516 | 340 | 227 | 757 | -85 | -57 | -171 | -114 |
| Nevada | 3,526 | 2,350 | 7,835 | 1,474 | 982 | 3,274 | -513 | -342 | -1,026 | -684 |
| New Mexico | 1,763 | 1,175 | 3,917 | 730 | 487 | 1,623 | -258 | -172 | -516 | -344 |
| Utah | 2,363 | 1,575 | 5,250 | 712 | 475 | 1,583 | -413 | -275 | -825 | -550 |
| Wyoming | 460 | 307 | 1,023 | 151 | 101 | 335 | -77 | -52 | -155 | -103 |
| **Pacific:** | **43,820** | **29,213** | **97,377** | **23,273** | **15,515** | **51,717** | **-5,137** | **-3,425** | **-10,274** | **-6,849** |
| Alaska | 538 | 359 | 1,196 | 194 | 129 | 430 | -86 | -57 | -172 | -115 |
| California | 34,024 | 22,683 | 75,610 | 18,107 | 12,071 | 40,238 | -3,979 | -2,653 | -7,959 | -5,306 |
| Hawaii | 916 | 610 | 2,035 | 774 | 516 | 1,721 | -35 | -24 | -71 | -47 |
| Oregon | 3,278 | 2,186 | 7,285 | 1,056 | 704 | 2,346 | -556 | -370 | -1,111 | -741 |
| Washington | 5,063 | 3,375 | 11,251 | 3,142 | 2,095 | 6,982 | -480 | -320 | -960 | -640 |
| **Total** | **279,588** | **186,392** | **621,307** | **122,879** | **81,920** | **273,065** | **-39,177** | **-26,118** | **-78,354** | **-52,236** |

[1] Federal and State spending on uncompensated care do not add to the total, which also takes into account private spending.

[2] Savings if the federal and state governments, respectively, reduce spending by 25% of the decline in their share of uncompensated care.

[3] Savings if the federal and state governments, respectively, reduce spending by 50% of the decline in their share of uncompensated care.

By significantly reducing the uninsured population, the ACA will roughly reduce spending on uncompensated care by 50 percent. Conservatively, **states** collectively will see budget gains up to **$85 billion** due to the federal government picking up a sizeable tab of uncompensated care costs between 2014 and 2019, while the federal government could save up to $78 billion through this process. **(Table 4)**

Several health policy organizations have highlighted that the Medicaid expansion will help hospitals – caring for a substantial number and share of lower-income and uninsured people – save significant monies. Many community and public sector hospitals have been receiving enhanced federal funding, called Medicare and Medicaid disproportionate share hospital (DSH) funding, to compensate them for some of the costs associated with treating large numbers of uninsured patients.

Hospitals and health care systems that provide the great majority of care for society's most vulnerable people, such as the uninsured and Medicaid recipients face a daunting challenge: steep cuts to federal support for uncompensated care and millions more uninsured patients than first projected under health care reform. Using data from various nationally recognized sources, the National Association of Public Hospitals and Health Systems (NAPH) projects hospitals will see $53.3 billion more in uncompensated care costs by 2019 than originally estimated when lawmakers passed the ACA. (6)

## State Budget Gains by Reductions in State Programs for Uninsured

Many states underwrite the costs of health care programs and services for the uninsured. Under an expanded Medicaid program, most 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. The budget gains represent the reduction in the amount of state funds used to support these programs.

**Uncompensated Care Pool/Fund (e.g., Support for Public Hospitals):** By expanding Medicaid to adults with incomes below 138 percent of the FPL, the state will be able to reduce any state expenditure for uncompensated care provided by hospitals and other providers.

**State-Only Funded Coverage Programs:** To the extent the state has any state-funded coverage programs, funding for these programs will be reduced significantly as most low-income adults will gain coverage under the expansion of Medicaid.

**State High-Risk Pool Spending:** Some states have invested state dollars to subsidize the cost of coverage for individuals with pre-existing conditions that would either not have access to coverage or would be unable to afford coverage. Individuals with incomes below 138 percent of the FPL will be eligible for coverage under Medicaid expansion and here again the state will be able to substitute federal dollars for state dollars.

**State Behavioral Health Spending:** States will identify state and local funds now allocated to the support of public and private mental health clinics. Most of the uninsured adults relying on these facilities will be eligible for Medicaid. The state may be able to replace state and local spending with federal Medicaid funds.

**Public Health Services:** States underwrite the cost of public health services, such as immunizations, for uninsured individuals. Some of these services and individuals relying on these programs will be able to access them through Medicaid expansion.

**Other Unique State Specific Program Spending:** Other programs might include state funds to local governments for indigent care, HIV/AIDS, homeless health services, etc. There may also be direct savings to local governments from reduced need for locally funded indigent care programs.

Source: *Robert Wood Johnson Foundation – State Health Reform Assistance Network, September 2012*.

Based on the assumption that the number of uninsured people will fall dramatically beginning in 2014 and 2019 when the individual mandate and Medicaid expansion take effect, the ACA decreases DSH payments by about $18 billion. It will be the worst of all worlds if some states choose not to participate in the Medicaid expansion at the same time the DSH funds are reduced. States would be caught in a tight payment vice as they provide care to uninsured patients and receive little compensation by government agencies.

Under the ACA, in 2019 about 36 million Americans (there are varying estimates but usually fall anywhere from 30-40 million newly insured individuals) will be able to secure coverage who would otherwise been uninsured if the ACA is fully implemented. They will utilize health care providers for treatment that produce new revenue rather than burden these providers with uncompensated care. No matter how it is estimated, this shift from unpaid to paid care will produce very large savings for providers, especially public hospitals and clinics, along with private safety net institutions. Over the last 50 years, a large percentage of uncompensated care has been subsidized by taxpayers, at all levels of government.

To estimate spending by state and local governments in each of these areas, researchers only counted State General Fund dollars, excluding all state payments financed through provider taxes or intergovernmental transfers. (6)

Projecting this amount forward to 2014-2019, and using the Center for Medicare and Medicaid Services (CMS) Office of the Actuary's 6.0 percent estimated increase in annual per capita health care spending, the resulting six-year cost amounts to $170.2 billion, according to the Urban Institute. Many of these expenditures will still be necessary even with the ACA's expansion of health coverage. There will still be a need to make disproportionate share hospital payments (including state matching dollars). State and local support for local hospitals, community health centers and clinics will still be required both because of the remaining uninsured population and because of the ACA's reduction in overall DSH payment levels. If only a quarter of the $170.2 billion can be saved, state and local uncompensated care spending would drop by $42.6 billion over the six-year period. If 50 percent were reallocated to other purposes, states and localities would save $85.1 billion. (7, 8)

There is currently no table showing the $85.1 billion state breakdown for uncompensated care savings, but **Table 4** provides a conservative estimate with a state-by-state analysis showing $52.2 billion in financial gains if all states choose to opt in to the Medicaid expansion.

## Massachusetts Shows That Expanding Coverage Reduces Costs

Massachusetts' experience with its health reform effort offers strong evidence that expanding coverage under a comprehensive health reform plan can lead to sizeable reductions in state costs for uncompensated care.

Massachusetts enacted legislation in 2006 to provide nearly universal health care coverage. The legislation combined a Medicaid expansion with subsidies to help lower- and moderate-income residents purchase insurance, an employer responsibility requirement, and a requirement for individuals to obtain coverage. All of these also are core elements of the ACA.

Expanding affordable health insurance options and instituting an individual mandate significantly decreased spending on uncompensated care in Massachusetts. The state replaced its Uncompensated Care Pool (also known as "Free Care") with the Health Safety Net, which provides financial support to public hospitals and community health centers that serve lower-income residents who are uninsured or underinsured or who have significant medical needs. In 2008, the first full year of health reform implementation, Health Safety Net payments were *$252 million, or 38 percent*, less than the previous year's Uncompensated Care Pool payments.

This reduction in uncompensated care costs coincided with a decline in the share of residents who are uninsured. Only 2.7 percent of residents were uninsured in 2009, compared to 5.7 percent in 2007.

Source: *Alan G. Raymond, "Massachusetts Health Reform: A Five-Year Progress Report," Foundation of Blue Cross and Blue Shield Association, 2012.*

*Overall Savings Due to the Initial ACA Cascading Effects through 2014-2019 (Where State-by-State Data is Available)*

***In Table 5, the Urban Institute incorporated all of the costs and budget gains associated with three key actions discussed above: 1) Financial Gains Due to Increased Federal Match for Currently Eligible Adults, 2) Gains From Eliminating Medicaid Eligibility for Certain Adults Over 138 percent of the FPL or Otherwise Shifting Some of Their Costs to Federally Subsidized Coverage in the Health Insurance Exchanges, and 3) For Uncompensated Care Budget Gains. Considering these three major factors for which state-specific estimates are available, state budget gains would increase up to $49 billion. (2) Table 5 does not include budget gains associated with treating individuals with mental illness, delivering coordinated care for dual eligibles, gains due to Medicaid drug rebates, and additional budget gains as a result of extending the actions highlighted above in the out-years 2020-2023. (2)***

## Table 5 – Urban Institute, *Consider Savings as Well as Costs*

| | Differences in Total State and Federal Spending*, ACA vs. No Reform, 2014-2019 | | | |
|---|---|---|---|---|
| | Differences in Federal Spending | | Differences in State Spending | |
| | Low Savings | High Savings | Low Savings | High Savings |
| **New England:** | **24, 408** | **23,350** | **-8,593** | **-9,298** |
| Connecticut | 6,600 | 6,251 | -1,987 | -2,213 |
| Maine | 3,581 | 3,411 | -393 | -506 |
| Massachusetts | 8,854 | 8,703 | -5,617 | -5,717 |
| New Hampshire | 2,355 | 2,173 | 102 | -19 |
| Rhode Island | 2,121 | 1,958 | 44 | -64 |
| Vermont | 897 | 844 | -743 | -779 |
| **Middle Atlantic:** | **106,698** | **101,919** | **-15,443** | **-18,629** |
| Delaware | 2,016 | 1,802 | -829 | -972 |
| District of Columbia | 1,010 | 969 | -25 | -53 |
| Maryland | 9,844 | 9,412 | 308 | 19 |
| New Jersey | 15,752 | 14,991 | -100 | -607 |
| New York | 47,080 | 44,982 | -12,051 | -13,450 |
| Pennsylvania | 30,995 | 29,763 | -2,744 | -3,566 |
| **East North Central:** | **110,267** | **104,782** | **-1,421** | **-5,077** |
| Illinois | 25,182 | 23,854 | 758 | -127 |
| Indiana | 17,796 | 17,022 | -1,184 | -1,701 |
| Michigan | 20,085 | 19,128 | 931 | 293 |
| Ohio | 33,260 | 31,525 | 1,329 | 172 |
| Wisconsin | 13,944 | 13,254 | -3254 | -3,714 |
| **West North Central:** | **44,630** | **42,465** | **475** | **-968** |
| Iowa | 3,964 | 3,861 | -1,863 | -1,932 |
| Kansas | 5,620 | 5,288 | 76 | -145 |
| Minnesota | 6,637 | 6,217 | -264 | -545 |
| Missouri | 20,113 | 19,287 | 2,309 | 1,758 |
| Nebraska | 3,764 | 3,520 | 148 | -15 |
| North Dakota | 1,904 | 1,810 | 55 | -8 |
| South Dakota | 2,627 | 2,481 | 15 | -82 |
| **South Atlantic:** | **157,295** | **148,845** | **3,528** | **-2,105** |
| Florida | 64,773 | 61,305 | 2,408 | 95 |
| Georgia | 27,852 | 26,516 | 656 | -235 |
| North Carolina | 30,096 | 28,577 | 81 | -931 |
| South Carolina | 12,447 | 11,519 | -59 | -678 |
| Virginia | 15,108 | 14,305 | 389 | -146 |
| West Virginia | 7,018 | 6,624 | 53 | -210 |
| **East South Central:** | **58,267** | **54,913** | **303** | **-1,932** |
| Alabama | 12,991 | 12,345 | 170 | -261 |
| Kentucky | 13,822 | 12,791 | -140 | -828 |
| Mississippi | 10,080 | 6,634 | 66 | -231 |
| Tennessee | 21,373 | 20,144 | 208 | -612 |
| **West South Central:** | **111,662** | **105,390** | **2,799** | **-1,382** |
| Arkansas | 9,463 | 8,909 | 7 | -362 |
| Louisiana | 15,261 | 14,558 | 370 | -99 |
| Oklahoma | 8,714 | 8,073 | 60 | -367 |
| Texas | 78,224 | 73,851 | 2,362 | -554 |
| **Mountain:** | **53,767** | **51,288** | **-4,232** | **-5,885** |
| Arizona | 13,695 | 13,248 | -3,956 | -4,253 |
| Colorado | 12,690 | 12,149 | 328 | -32 |
| Idaho | 3,832 | 3,687 | 51 | -45 |
| Montana | 2,455 | 2,370 | 42 | -15 |
| Nevada | 5,706 | 5,193 | -101 | -443 |
| New Mexico | 7,630 | 7,372 | -933 | -1,105 |
| Utah | 6,031 | 5,619 | 311 | 36 |
| Wyoming | 1,728 | 1,651 | 25 | -27 |
| **Pacific:** | **112,227** | **107,091** | **-74** | **-3,499** |
| Alaska | 1,524 | 1,437 | 50 | -7 |
| California | 88,037 | 84,058 | 1,359 | -1,294 |
| Hawaii | 2,103 | 2,068 | -190 | -213 |
| Oregon | 11,638 | 11,082 | -626 | -996 |
| Washington | 8,926 | 8,446 | -667 | -988 |
| **Total** | **779,221** | **740,044** | **-22,657** | **-48,775** |

*Note: Does not include savings on mental health costs and certain medical eligibility cutbacks over 138% of the FPL in national results.

**4. Replacing, by the Federal Government, Significant State Costs for the Treatment of Individuals with Behavioral Health Disorders under the New Medicaid Program**: **(2)**

States devote significant resources in providing mental health and substance abuse treatment to lower-income residents, including uninsured adults. On average, State General Fund dollars pay for more than 40 percent of mental health spending controlled by State Behavioral Health Agencies (SBHAs), according to the most recent available estimates. If uninsured, poor adults receive new Medicaid coverage, many of their behavioral health care costs will be shifted from states to the federal government – care costs that have been paid for through several state-funding streams. (9)

SBHAs spent an estimated $37 billion (2010); of this amount, 45.4 percent, or $16.7 billion, represented state and local costs outside Medicaid. Medicaid itself paid for 46 percent of state mental health services, or $16.9 billion. Other funds were provided by Medicare, federal block grants, and additional sources. (9)

The expansion of Medicaid will have a major impact on these state public behavioral health systems of care. Among the adults served by state mental health agencies, 79 percent are either unemployed or outside the labor force. Nevertheless, 43 percent of consumers served by these agencies have no Medicaid coverage. (10)

When the ACA is fully implemented, Medicaid coverage is expected to increase from 12.4 to 23.3 percent of individuals with mental illness or substance abuse disorders, and Medicaid's mental health spending is projected to rise by 49.7 percent. (11)

Conservatively, **states** collectively will see significant financial gains up to nearly **$40 billion** from 2014-2019 through the Medicaid expansion due to the substitution of federal dollars for state spending on services for people with mental illness, and other individuals with serious mental illness who will become eligible for coverage under the new Medicaid expansion initiative. (7)

Long term care for people with mental health conditions represents a large plurality of expenses by the state programs. The Medicaid program and the federal government will pick up a significant percentage of these costs that are currently paid for by the states. The decision to opt-out of the Medicaid program would not relieve a state from its obligation to serve these constituencies, and would likely be considered a violation of the American Disabilities Act (ADA) if the state funded safety net did not cover these individuals. By contrast, the currently uninsured in community mental health centers, whose expenses are at the moment absorbed entirely on the state, will be shifting to Medicaid under the new legislation at a FMAP rate phased down from 100 percent to 90 percent from 2014-2020. Following 2020, the FMAP rate for this population remains at 90 percent, meaning an individual state will only be paying 10 percent of the costs for the services it currently fully pays.

**Table 6 – Urban Institute, *Net Effects of the Affordable Care Act on State Budgets***

**Worst- and Best-Case Scenarios for State Budget Effects of Key Provisions of the Affordable Care Act: 2014-2019 (in Billions)**

| State Budget Gains | Worst-case Scenario in Gains | Best-case Scenario in Gains |
|---|---|---|
| Uncompensated Care Gains | +$42.6 | +$85.1 |
| Mental Health Gains | +$19.9 | +$39.7 |

By not opting in to the Medicaid expansion, states will continue to face higher costs associated with unnecessary use of emergency departments and hospitals due to admissions and readmissions of people with mental illness. States will also face continued demands on other state systems such as criminal and juvenile justice systems, social service agencies and related programs due to the lack of available behavioral health services for all age groups. (7) With the federal government picking up 100 percent of the costs from 2014 to 2016 and the enhanced match only dropping to 90 percent by 2020, the federal government will pick up nearly $40 billion in behavioral health care costs during the 2014 to 2019 period. As noted earlier, the cost of this care for this segment of the uninsured population and related behavioral health costs is currently borne by the states, illustrated in the state examples that follow.

During fiscal year 2009, Texas spent $1.1 billion in General Fund revenues on behavioral health care services. And in Michigan, $410 million in combined General Fund and local dollars were spent by the state's mental health agency in 2008. If 40 percent of these amounts were shifted to federal Medicaid dollars during the average year from 2014 through 2019, the resulting budget gains would exceed each state's "worst case" scenario of $2.4 billion and $900 million, respectively, in increased net mental health spending.

California's Department of Mental Health was projected to spend $1.47 billion in General Fund dollars in FY 2010-2011. Shifting just one-sixth of this cost to the federal government during each year from 2014 through 2019 would fully offset the state's six-year net spending rise of $1.4 billion in mental health spending under the worst-case scenario.

Advocates will need to promote and support that a significant portion of the new federal dollars should be used to restore and strengthen behavioral health systems. Many such systems have experienced severe budget cuts in recent years. Policymakers should use at least a large portion of the new federal Medicaid dollars to restore the most harmful of those cutbacks as detailed in **Table 7.**

**Table 7**

**FY2009 to FY2012 Total $4.6 Billion in Cuts***

| Year | Average | Median | Minimum | Maximum | Total |
|---|---|---|---|---|---|
| FY 2009 (39 States) | $36,849,116 | $13,226,000 | $0 | $554,003,000 | $1,216,020,843 |
| FY 2010 (38 States) | $29,123,575 | $12,300,000 | $0 | $213,591,000 | $1,019,325,136 |
| FY 2011 (36 States) | $35,294,953 | $11,633,953 | $0 | $132,000,000 | $1,270,618,291 |
| FY 2012 (31 States) | $28,074,541 | $9,040,000 | $0 | $242,500,000 | $842,236,221 |
| FY 2013 (15 States) | $17,709,032 | $13,700,000 | $0 | $82,000,000 | $247,926,447 |

*Note: Results based on 41 State Mental Health Authorities Reporting Winter 2011-2012. NASMHPD-NRI

## 5. Coordinating Care and Services for the Dual Eligible Population:

More efficient and coordinated management of care provided to seniors and people with disabilities who are dually eligible for both Medicare and Medicaid will result in state budget gains. According to a study by Emory University, better care coordination for the dual eligible population, will result in budget gains of $34 billion to the **states** over a 10-year period, and up to $125 billion for the federal government.

A recent report by Kenneth E. Thorpe, Ph.D., on *Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles*, found additional budget gains for states due to better coordination of care for persons with dual eligibility embodied in the ACA that the Urban Institute did not take into account. (12)

**There is a growing body of evidence that suggests that comprehensive, team-based care coordination models, where health plans bring together different health care providers and services across the continuum of care, have the potential to ensure that beneficiaries receive the most clinically appropriate, cost-effective services. (14)**

Dual eligibles are more prone to chronic conditions than other beneficiaries – more than one-half are under treatment for 5 or more conditions – and account for more than one-third of Medicare and Medicaid spending, even though they make up only a small percentage of the total enrollment in these programs. Using projections of Medicare and Medicaid spending from the Congressional Budget Office, federal spending on persons with dual eligibility will total nearly $3.7 trillion over the next decade. (13)

Because this group is less healthy and requires more complex care than other beneficiaries, there are tremendous opportunities for improving the health and quality of life of these individuals if

policymakers address the way in which care is delivered. These modifications will also bring much-needed budget gains to government at the state and federal levels at a critical time.

There is a growing body of evidence that suggests that comprehensive, team-based care coordination models, where health plans bring together different health care providers and services across the continuum of care, have the potential to ensure that beneficiaries receive the most clinically appropriate, cost-effective services. (14) Effective, evidence-based care coordination models share common attributes, including a team based approach to care coordination; a focus on disease management and prevention; technological innovations such as electronic medical records; patient-centric care; transitional care; medication management; and integration between primary and specialty care. (15)

Health plans are well-positioned to take the lead in coordinating the care of persons with dual eligibility –working with different providers across the continuum of care to ensure that beneficiaries receive the most clinically appropriate, cost-effective services. This provides the foundation for better health care outcomes and cost savings.

Key features include:

- All persons with dual eligibility would be enrolled in a health plan with an opportunity to opt out;
- All covered Medicaid and Medicare services would be provided through health plans; and
- Health plans will design their own approaches to care coordination, but preventive care, transitional care, and medication management and reconciliation would be included in the treatment of this category of patients.

States could also contract with other entities, such as community health teams or other forms of medical homes.

As policymakers in Congress and in the states that continue to debate deficit reduction and health care reform, care coordination has been recognized as an approach that improves the quality of care, while reducing growth in health care costs. While care coordination is not a new idea, it is an idea that promises significant results when applied to dual-eligible beneficiaries because of their health status and the implications for health care costs. A good example of this effort is detailed in the first Memorandum of Understanding signed by CMS, with the Commonwealth of Massachusetts, to implement the dual eligible demonstration. Other state agreements are pending.

**6. Increasing the Prescription Drug Rebates Received by Medicaid from Pharmaceutical Companies:**

Recent guidance from HHS indicates that many states will share in increased prescription drug rebates with states accruing budget gains of $8.3 billion over the 2014 to 2019 period under the Medicaid expansion. **(Table 8)**

Under current law, drug manufacturers are required to pay rebates to Medicaid for drugs provided under the fee-for-service Medicaid program. States will gain rebates through Medicaid managed care programs as well. In addition, many states negotiate "supplemental" rebates with drug manufacturers.

For brand name drugs, the minimum rebate is increased from 15.1 percent of average manufacturer price (AMP) to 23.1 percent of AMP. Rebates for generic drugs are increased from 11.0 percent of AMP to 13.0 percent of AMP. It also changes how the additional inflationary rebate on line extensions of a brand name drug is calculated.

Furthermore, the Act requires that the amounts "attributable" to these increased rebates be passed on (offset) to the federal government. (8) In a letter to State Medicaid Directors (SMDL#10-019), issued September 28, 2010, CMS provided guidance that this offset would apply only to rebate dollars that are collected above and beyond what would have been received under the previous rebate formulas.

The Lewin Group estimated that about half of all states will see net gains as a result of these changes in drug rebate policy. Budget gains will be particularly large for states that currently have a large portion of their covered population enrolled in MCOs with the drug expense included in the capitation amount (i.e., state where a pharmacy "carve in" model is used), where the drug manufacturers must start to pay a rebate. These include Arizona, California, and Pennsylvania.

### Table 8 – The Lewin Group

**Changes in State Medicaid and CHIP for Major Provision of the ACA: 2014-2019 (millions)** [a/]

| States | State Medicaid/ CHIP Spending Without Reform [b/] | Take Private Coverage [c/] | Currently Eligible Newly Enrolled [d/] | Newly Eligible Parents [e/] | Newly Eligible Childless Adults [f/] | Increased Match For Expansion States [g/] | Changes in Drug Rebates [h/] | Illustrative Reduction in Federal DSH Payments [i/] | Net Change in Spending Under ACA | Percent Change in Spending |
|---|---|---|---|---|---|---|---|---|---|---|
| Alabama | $14,245 | -$152 | $310 | $75 | $331 | $0 | $20 | $520 | $1,104 | 7.8% |
| Alaska | $4,726 | -$52 | $69 | $6 | $34 | $0 | $5 | $11 | $73 | 1.6% |
| Arizona [j/] | $27,901 | -$478 | $1,095 | $1 | $24 | -$2,953 | -$771 | $109 | -$2,974 | -10.7% |
| Arkansas | $10,137 | -$139 | $186 | $65 | $228 | $0 | $13 | $26 | $379 | 3.7% |
| California | $222,772 | -$2,908 | $6,051 | $172 | $1,352 | $0 | -$1,030 | $1,203 | $4,839 | 2.2% |
| Colorado | $17,855 | -$264 | $689 | $29 | $203 | $0 | -$54 | $116 | $719 | 4.0% |
| Connecticut | $23,991 | -$156 | $301 | $3 | $113 | $0 | $28 | $418 | $707 | 2.9% |
| Delaware | $5,867 | -$69 | $98 | $2 | $7 | -$324 | $8 | $3 | -$276 | -4.7% |
| D.C. | $4,595 | -$26 | $48 | $0 | $23 | $0 | -$47 | $127 | $126 | 2.7% |
| Florida | $72,587 | -$898 | $1,830 | $216 | $972 | $0 | -$422 | $201 | $1,900 | 2.6% |
| Georgia | $28,920 | -$419 | $811 | $130 | $506 | $0 | -$371 | $306 | $963 | 3.3% |
| Hawaii | $5,998 | -$68 | $70 | $5 | $41 | -$136 | -$79 | $25 | -$142 | -2.4% |
| Idaho | $4,140 | -$78 | $95 | $27 | $83 | $0 | $5 | $11 | $142 | 3.4% |
| Illinois | $64,997 | -$538 | $1,450 | $16 | $506 | $0 | $74 | $331 | $1,838 | 2.8% |
| Indiana | $22,819 | -$266 | $424 | $71 | $294 | $0 | -$192 | $365 | $696 | 3.1% |
| Iowa | $11,395 | -$198 | $267 | $32 | $133 | $0 | $12 | $43 | $287 | 2.5% |
| Kansas | $9,950 | -$135 | $213 | $31 | $120 | $0 | -$89 | $67 | $207 | 2.1% |
| Kentucky | $15,242 | -$211 | $342 | $66 | $292 | $0 | -$83 | $199 | $604 | 4.0% |
| Louisiana | $21,861 | -$182 | $352 | $93 | $380 | $0 | $31 | $783 | $1,457 | 6.7% |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Maine | $8,549 | -$61 | $86 | $1 | $40 | -$137 | $10 | $222 | $161 | 1.9% |
| Maryland | $32,246 | -$244 | $573 | $12 | $227 | $0 | -$466 | $120 | $223 | 0.7% |
| Massachusetts | $60,615 | -$682 | $35 | $1 | $17 | -$941 | -$499 | $0 | -$2,068 | -3.4% |
| Michigan | $39,625 | -$466 | $1,075 | $69 | $571 | $0 | -$537 | $460 | $1,172 | 3.0% |
| Minnesota | $37,481 | -$244 | $487 | $25 | $160 | $0 | -$378 | $89 | $140 | 0.4% |
| Mississippi | $10,555 | -$109 | $207 | $72 | $290 | $0 | $11 | $168 | $638 | 6.0% |
| Missouri | $27,012 | -$346 | $517 | $98 | $363 | $0 | -$163 | $665 | $1,133 | 4.2% |
| Montana | $2,857 | -$60 | $71 | $14 | $66 | $0 | $3 | $7 | $101 | 3.6% |
| Nebraska | $6,950 | -$77 | $131 | $21 | $83 | $0 | $9 | $23 | $189 | 2.7% |
| Nevada | $7,289 | -$129 | $279 | $26 | $109 | $0 | -$32 | $52 | $306 | 4.2% |
| New Hampshire | $6,681 | -$70 | $77 | $8 | $44 | $0 | $5 | $312 | $377 | 5.6% |
| New Jersey | $54,389 | -$283 | $844 | $8 | $231 | $0 | -$402 | $877 | $1,275 | 2.3% |
| New Mexico | $10,031 | -$87 | $226 | $14 | $105 | $0 | -$222 | $9 | $45 | 0.4% |
| New York | $210,298 | -$1,265 | $1,383 | $0 | $64 | -$13,420 | $236 | $1,777 | -$11,226 | -5.3% |
| North Carolina | $39,336 | -$464 | $730 | $136 | $555 | $0 | $50 | $374 | $1,382 | 3.5% |
| North Dakota | $2,203 | -$23 | $3 | $5 | $26 | $0 | $2 | $9 | $55 | 2.5% |
| Ohio | $52,150 | -$478 | $1,299 | $49 | $721 | $0 | -$702 | $711 | $1,599 | 3.1% |
| Oklahoma | $14,083 | -$242 | $278 | $62 | $201 | $0 | $16 | $23 | $338 | 2.4% |
| Oregon | $13,218 | -$188 | $490 | $31 | $224 | $0 | -$180 | $26 | $403 | 3.1% |
| Pennsylvania | $79,558 | -$911 | $1,013 | $95 | $537 | $0 | -$1,433 | $1,162 | $464 | 0.6% |
| Rhode Island | $9,943 | -$54 | $103 | $0 | $31 | $0 | -$84 | $117 | $113 | 1.1% |
| South Carolina | $14,169 | -$159 | $427 | $36 | $316 | $0 | -$36 | $413 | $995 | 7.0% |
| South Dakota | $2,718 | -$36 | $4 | $10 | $35 | $0 | $3 | $10 | $68 | 2.5% |
| Tennessee | $26,475 | -$218 | $628 | $43 | $341 | $0 | $32 | $143 | $969 | 3.7% |
| Texas | $100,649 | -$1,628 | $3,313 | $406 | $1,049 | $0 | $112 | $770 | $4,022 | 4.0% |
| Utah | $4,854 | -$110 | $159 | $33 | $105 | $0 | $6 | $15 | $209 | 4.3% |
| Vermont | $4,236 | -$72 | $1 | $0 | $0 | -$170 | $6 | $41 | -$184 | -4.3% |
| Virginia | $30,183 | -$333 | $561 | $77 | $328 | $0 | -$301 | $129 | $461 | 1.5% |
| Washington | $33,121 | -$437 | $797 | $26 | $255 | $0 | -$275 | $313 | $679 | 2.0% |
| West Virginia | $6,404 | -$80 | $128 | $38 | $167 | $0 | $12 | $94 | $360 | 5.6% |
| Wisconsin | $21,572 | -$217 | $408 | $6 | $174 | $0 | -$191 | $107 | $286 | 1.3% |
| Wyoming | $2,708 | -$31 | $49 | $7 | $33 | $0 | $3 | $0 | $61 | 2.2% |
| **Total US** | **$1,562,160** | **-$17,041** | **$31,166** | **$2,470** | **$13,113** | **-$18,081** | **-$8,332** | **$14,100** | **$17,395** | **1.1%** |

For explanatory notes for this table, please see the "Sources/Notes" section.

## 7. Combining the Net Effects of Medicaid Expansion Under the Initial Four Actions Listed Above in the ACA "Out-Years":

The net effect of the Medicaid expansion program initiatives will transfer costs to the federal government from the **states** up to $19 billion for the year 2020 alone (related to the first four events only), with similar amounts in later years (2021 through 2023), resulting in additional budget gains of **$76 billion** to the **states** between 2020 and 2023 (or the last 4 years of the initial 10-year ACA implementation window). (2) **(Table 9)**

**Table 9 – Urban Institute**

| Net Effect of ACA on Total State and Federal Spending, 2020 | | | | |
|---|---|---|---|---|
| **Billions $** | **Differences in Federal Spending** | | **Differences in State Spending** | |
| | **Low** | **High** | **Low** | **High** |
| Medicaid expansion[1] | 105 | 105 | 23 | 23 |
| Increased federal Medicaid match for currently eligible adults | 14 | 14 | -14 | -14 |
| Eliminating Medicaid eligibility for adults >138% FPL[2] | -18 | -18 | -14 | -14 |
| Premium and cost-sharing subsidies in the exchanges | 68 | 68 | 0 | 0 |
| Uncompensated care savings | -15 | -8 | -10 | -5 |
| Mental Health Savings[3] | 0 | 0 | -4 | -2 |
| **Total Differences** | **155** | **163** | **-19** | **-12** |

[1] Federal and state spending on uncompensated care do not add to the total, which also takes into account private spending.
[2] Savings if the federal and state governments, respectively, reduce spending by 25% of the decline in their share of uncompensated care.
[3] Savings if the federal and state governments, respectively, reduce spending by 50% of the decline in their share of uncompensated care.

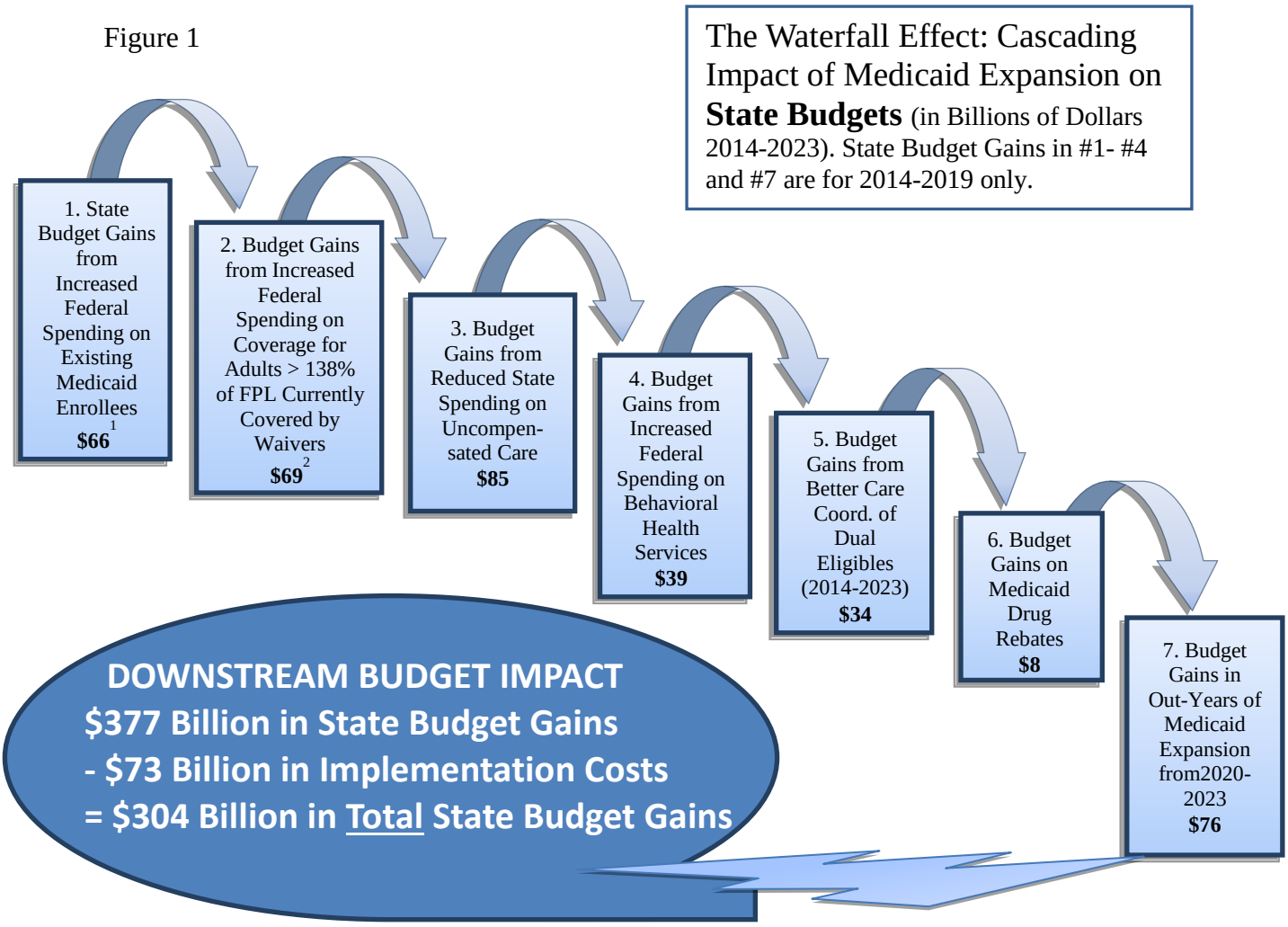
## Total Impact of the Cascading Financial Events Under the Medicaid Expansion on State Budgets

*Federal government contributions to states to implement the ACA Medicaid expansion – combined with related efforts to improve coordination of care for persons who are dually eligible - will produce total bottom line budget gains in the amount of* **$377 billion** between 2014 and 2023, through the cascading events identified in this report. These budget gains will be reduced by $73 billion through state implementation spending associated with the Medicaid expansion (cited by CBO and Center on Budget and Policy Priorities).

The Kaiser Commission on Medicaid and the Uninsured recently reported that *if all states implement the ACA Medicaid expansion, the federal government will fund the vast majority of increased Medicaid costs.* According to the Kaiser report, the Medicaid expansion and other provisions of the ACA would lead state Medicaid spending to increase by $76 billion over 2013-2022 (an increase of less than 3 percent), while federal Medicaid spending would increase by $952 billion (a 26 percent increase). Some states will reduce their own Medicaid spending as they transition already covered populations to the ACA expansion. States with the largest coverage gains will see relatively small increases in their own spending compared to increases in federal funds. (2)

Based on those offsetting implementation costs, states will see net budget gains of **$301-$304 billion** during the initial 10-year Medicaid expansion initiative. According to the authors of the studies we reviewed, the total state budgets gains of $304 billion is a conservative projection and represents a serious undercount in each of the seven Medicaid expansion factors referenced above. We estimate that **another $60 billion due to other factors, such as increases in the federal match in the state Children's Health Insurance Program (CHIP) beginning in 2015.**

Figure 1




1 All budget gains related to Medicaid Expansion referenced in this figure are for acute care costs only (e.g., physician costs not included).
2. Budget gains due to maintenance of effort, transferring eligibility for special categories of adults (e.g., individuals with breast cancer) and shifting costs to insurance exchanges for "medically needy" adults.

Furthermore, several researchers believe that other fiscal effects will bring financial gains to the states. These are projected to be due to transferring funding to the federal government as well as other initiatives, although have not been specifically quantified. Potential fiscal effects include: (2)

- The states will see substantial budget gains when the federal government takes on additional costs associated with the Children's Health Insurance Program (CHIP) in 2015, when federal matching rates will increase by 23 percentage points. Due to the expansion, we estimate that states will see an additional $12 billion in budget gains beginning from FY 2016 through FY 2019;
- State and local governments will see financial gains on Medicaid and public employee coverage resulting from **delivery system and payment reforms**; and
- Effects on Medicaid **administrative costs** for states, which will fall because of more data-driven and less labor-intensive eligibility determination.

*"It is health that is real wealth, and not the pieces of gold and silver."*

**Mohandas Gandhi, Leader of the Indian Independence Movement**

## Section Three:
## *The Cascading Impact of the Medicaid Expansion on State-Wide Economies*

Based on our review of the studies on Medicaid expansion efforts, there are seven major ways that state economies will vastly improve due to the Medicaid expansion: **(Figure 2)**

1. Increasing State Revenue from Taxes on Health Insurance Premiums;
2. Increasing Federal Dollars on Behalf of New Enrollees Affecting Providers;
3. Creating New Jobs Associated with Providers Delivering Care and Other Services;
4. Increasing Income Associated with Delivering Care and Services;
5. Increasing Purchases Associated with Carrying Out Health Care Services;
6. Flowing or Influx of New Federal Dollars Benefitting Other Businesses and Industries Directly; and
7. Inducing Changes in Household Consumption and Tax Collection.

The sheer impact to a state's economy of turning down millions of federal dollars could be problematic. The Medicaid program is a large employer for the state, and according to the Kaiser Family Foundation the average Medicaid dollar circulates seven times per year. (16)

As an example of potential state revenue and financial gains, according to the Urban Institute, $82.3 billion in new federal spending would have flowed into the states if the ACA were in place in 2011 alone – a portion due to the Medicaid expansion. Extrapolating that amount, states could potentially see over a $1 billion in new revenues between 2014 and 2023. (7)

The Kaiser Commission on Medicaid and the Uninsured has compiled findings from 29 studies in 23 states analyzing the role Medicaid plays in state and local economies. The bottom line: found in study by study, shows that the Medicaid program has had a major financial stimulative impact on state economies.

Key findings show that:

- Medicaid spending generates economic activity including jobs, income and state tax revenues at the state level. Medicaid's economic impact is intensified because of federal matching dollars – state spending pulls federal dollars into the economy. Medicaid funding supports jobs and generates income within the health care sector and throughout other sectors of the economy due to a major "multiplier effect."

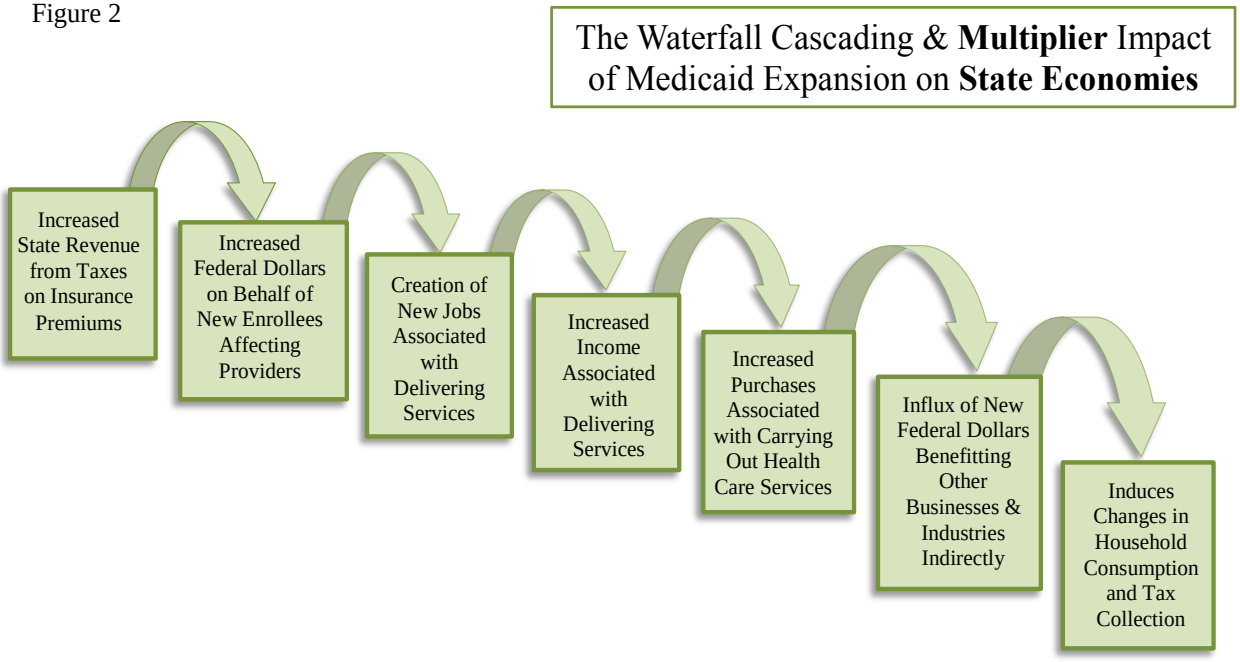
- The federal Medicaid matching rate currently ranges from 50 percent to 76 percent among states – meaning that for every dollar a state spends on Medicaid, *the federal government*

*contributes from one to nearly three and one half dollars.* The higher the matching rate – the stronger the financial incentive for states!

- If a state's matching rate is set at 70 percent, then for every $100 of expenditure, the state covers $30 and the federal government contributes $70 dollars; or for each $1 the state spends on Medicaid, the federal government contributes $2.33.

- Conversely, for every $1 that the state cuts in Medicaid spending, it will forgo the $2.33 match from the federal government. Therefore, the state is actually reducing its overall Medicaid spending by $3.33 to save $1 in state funds. (16)

Figure 2




In the case of the ACA, **the federal government will be providing a 100 percent match between 2014 and 2016** (then gradually settling at 90 percent in 2020 and beyond), so the infusion of new Medicaid dollars in a state under the expansion provisions in the ACA will have an even more dramatic effect. Beginning in 2020 and beyond, for every $10 dollars out of $100 spent by the state on Medicaid services, the federal government will pay $90 to provide care.

One illustration of potential budget gains is exemplified by a study conducted by the Arkansas Department of Public Health that found that if the state chooses to opt in to the Medicaid expansion, it will save $372 million between 2015 (one year into the expected expansion) and 2021. This amount includes revenue gains from additional tax revenue, offsetting gains through Medicaid transitions (outlined in the previous section) and reductions in uncompensated care.

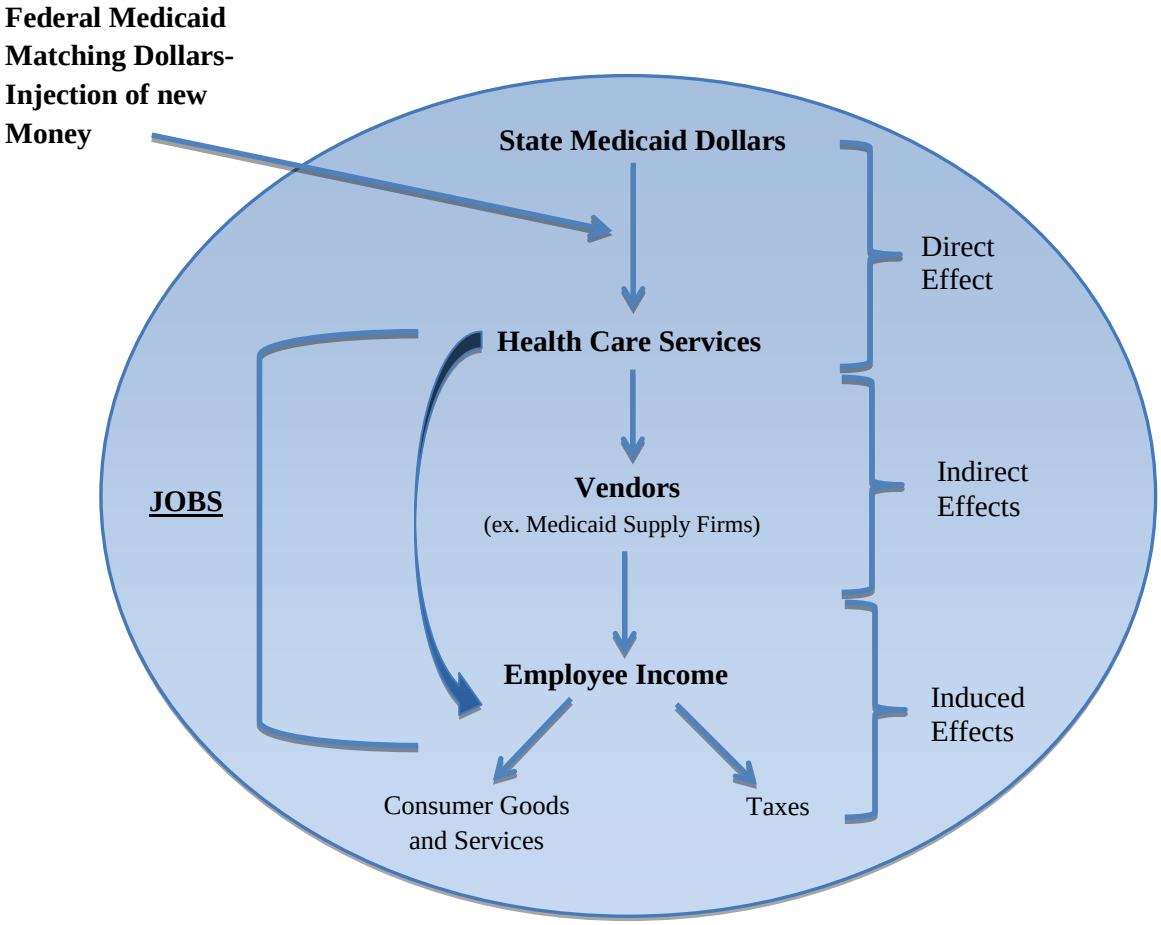
**Economic Impact Measures and the <u>Multiplier Effect</u>**

Both state and federal Medicaid spending have a multiplier effect. State spending alone yields multiplier effects as money is injected into the state's economy and used to conduct business,

make purchases and support salaries. However, because of the matching arrangement, the economic impact of Medicaid spending is intensified by the infusion of new dollars from the federal government that would otherwise not exist in the state — a dollar of state Medicaid spending attracts at least one federal dollar. **(Figure 3)**

Many economists view the countercyclical nature of government spending as a good thing, since it protects household income and promotes consumption of goods, which are considered important for economic recovery.

**Figure 3** – Kaiser Commission on Medicaid & the Uninsured, ***Flow of Medicaid Dollars***




Thus the total impact multiplier, relative to the multiplier of the state dollar alone, is considerably larger. Not including any temporary federal fiscal relief, the Federal Medical Assistance Program (FMAP) ranges from 50 to 76 percent among states — meaning that for every dollar a state spends on Medicaid, the federal government contributes at least one dollar and up to roughly three and one half dollars. The higher the matching rate, the stronger the financial incentive for states.

**Back to the Future: A Different Look at the Impact of Opting Out of the Medicaid Expansion**

Another way of looking at the impact of Medicaid expansion on the state's economic activity is to look at the impact of Medicaid cuts to the current program. A *Families USA* report highlights the amount of revenue lost to states, in cascading events, and serves as an illustration and lesson learned of potential lost business activity if states opt out of the Medicaid expansion.

*Families USA* found that business activity would suffer, as illustrated below in hypothetical 5 percent and 33 percent cut to Medicaid spending, as laid out in their report.

**Example – 5 Percent Cut in Federal Medicaid Spending**

Business Activity Lost Due to a 5 Percent Medicaid Cut **(Table 10)**

- In 2011, even a 5 percent cut in federal Medicaid spending would have meant that the 50 states and the District of Columbia would lose a total of $13.75 billion that is needed to support health care for vulnerable residents. These cuts would have suppressed business activity and job creation in every state. (17)

- The 10 states with the largest potential loss of business activity attributed to a 5 percent cut in federal Medicaid spending would be New York ($3.8 billion), California ($3.7 billion), Texas ($2.1 billion), Pennsylvania ($1.5 billion), Florida ($1.2 billion), Ohio ($1.2 billion), Illinois ($1.2 billion), Massachusetts ($1.0 billion), North Carolina ($942.1 million), and Michigan ($861.9 million).

- Even in the two states with the smallest Medicaid budgets, North Dakota and Wyoming, the potential loss of business activity from a 5 percent cut in federal Medicaid spending would be valued at $36.1 million and $30.7 million, respectively.

**Table 10 – Families USA**

| Dollars at Risk Under Various Federal Medicaid Spending Cuts Scenarios, 2011 | | | |
|---|---|---|---|
| **State** | **5 Percent Cut** | **15 Percent Cut** | **33 Percent Cut** |
| Alabama | $165,681,000 | $497,044,000 | $1,093,497,000 |
| Alaska | $40,132,000 | $120,397,000 | $264,873,000 |
| Arizona | $325,121,000 | $975,363,000 | $2,145,799,000 |
| Arkansas | $129,501,000 | $388,503,000 | $854,706,000 |
| California | $1,563,964,000 | $4,691,891,000 | $10,322,159,000 |
| Colorado | $133,389,000 | $400,168,000 | $880,371,000 |
| Connecticut | $226,444,000 | $679,332,000 | $1,494,530,000 |
| Delaware | $45,467,000 | $136,402,000 | $300,084,000 |
| District of Columbia | $61,013,000 | $183,038,000 | $402,684,000 |
| Florida | $566,124,000 | $1,689,372,000 | $3,736,418,000 |
| Georgia | $288,654,000 | $865,963,000 | $1,905,119,000 |
| Hawaii | $49,084,000 | $147,252,000 | $323,955,000 |
| Idaho | $47,895,000 | $143,686,000 | $316,109,000 |
| Illinois | $493,027.000 | $1,479,082,000 | $3,253,981,000 |
| Indiana | $221,612,000 | $664,835,000 | $1,462,637,000 |
| Iowa | $111,064,000 | $333,191,000 | $733,019,000 |

| | | | |
|---|---|---|---|
| Kansas | $91,687,000 | $275,060,000 | $605,133,000 |
| Kentucky | $202,642,000 | $607,926,000 | $1,337,436,000 |
| Louisiana | $244,376,000 | $733,128,000 | $1,612,881,000 |
| Maine | $94,475,000 | $283,424,000 | $623,533,000 |
| Maryland | $244,778,000 | $734,335,000 | $1,615,537,000 |
| Massachusetts | $468,274,000 | $1,404,822,000 | $3,090,609,000 |
| Michigan | $397,082,000 | $1,191,247,000 | $2,620,744,000 |
| Minnesota | $277,176,000 | $831,529,000 | $1,829,363,000 |
| Mississippi | $148,122,000 | $444,365,000 | $977,603,000 |
| Missouri | $290,693,000 | $872,078,000 | $1,918,571,000 |
| Montana | $32,859,000 | $98,577,000 | $216,869,000 |
| Nebraska | $60,642,000 | $181,926,000 | $400,237,000 |
| Nevada | $51,890,000 | $155,167,000 | $342,476,000 |
| New Hampshire | $49,795,000 | $149,386,000 | $328,649,000 |
| New Jersey | $362,714,000 | $1,088,142,000 | $2,393,912,000 |
| New Mexico | $123,455,000 | $370,365,000 | $814,804,000 |
| New York | $1,852,308,000 | $5,556,923,000 | $12,225,230,000 |
| North Carolina | $431,710,000 | $1,295,129,000 | $2,849,285,000 |
| North Dakota | $21,465,000 | $64,396,000 | $141,167,000 |
| Ohio | $527,411,000 | $1,582,233,000 | $3,480,912,000 |
| Oklahoma | $147,739,000 | $443,993,000 | $975,077,000 |
| Oregon | $137,998,000 | $413,993,000 | $910,785,000 |
| Pennsylvania | $646,528,000 | $1,939,585,000 | $4,267,088,000 |
| Rhode Island | $71,036,000 | $213,109,000 | $486,840,000 |
| South Carolina | $191,297,000 | $573,891,000 | $1,262,559,000 |
| North Dakota | $26,765,000 | $80,295,000 | $176,649,000 |
| Tennessee | $273,530,000 | $820,589,000 | $1,805,296,000 |
| Texas | $889,405,000 | $2,668,216,000 | $5,870,076,000 |
| Utah | $61,130,000 | $183,389,000 | $403,456,000 |
| Vermont | $36,562,000 | $109,686,000 | $241,310,000 |
| Virginia | $216,678,000 | $650,034,000 | $1,430,074,000 |
| Washington | $247,748,000 | $743,244,000 | $1,635,137,000 |
| West Virginia | $91,326,000 | $273,978,000 | $602,751,000 |
| Wisconsin | $250,787,000 | $752,361,000 | $1,655,193,000 |
| Wyoming | $19,744,000 | $59,233,000 | $130,313,000 |
| **U.S. Total** | **$13,750,000,000** | **$41,250,000,000** | **$90,750,000,000** |

Jobs Lost Due to a 5 Percent Medicaid Cut **(Table 11)**

- The loss of business activity due to a 5 percent cut in federal Medicaid spending would result in a loss of jobs in every state across the country.

- The 10 states with the largest potential number of jobs lost due to a 5 percent cut in federal Medicaid spending would be New York (28,830), California (28,440), Texas (18,160), Pennsylvania (12,230), Florida (11,320), Ohio (11,270), Illinois (9,280), North Carolina (8,890), Michigan (7,670), and Massachusetts (7,600). **(Table 11)**

- Even in the two states with the smallest Medicaid budgets, North Dakota and Wyoming, the potential loss of jobs due to a 5 percent cut in federal Medicaid spending would be 410 and 300, respectively. (17)

**Table 11 – Families USA**

| What Would a 5 percent Cut to the Medicaid Program in 2011 Mean? | | |
|---|---|---|
| **State** | **Business Activity At Risk** | **Jobs At Risk** |
| Alabama | $337,651,000 | 3,220 |
| Alaska | $71,019,000 | 630 |
| Arizona | $690,393,000 | 5,660 |
| Arkansas | $242,436,000 | 2,460 |
| California | $3,697,229,000 | 28,440 |
| Colorado | $310,302,000 | 2,56 |
| Connecticut | $463,506,000 | 3,690 |
| Delaware | $87,455,000 | 630 |
| District of Columbia | $81,723,000 | 190 |
| Florida | $1,220,507,000 | 11,320 |
| Georgia | $670,208,000 | 5,820 |
| Hawaii | $98,376,000 | 890 |
| Idaho | $84,199,000 | 870 |
| Illinois | $1,186,779,000 | 9,280 |
| Indiana | $469,400,000 | 4,290 |
| Iowa | $199,529,000 | 2,010 |
| Kansas | $171,841,000 | 1,600 |
| Kentucky | $416,088,000 | 3,670 |
| Louisiana | $467,236,000 | 4,650 |
| Maine | $190,697,000 | 1,920 |
| Maryland | $510,581,000 | 4,080 |
| Massachusetts | $1,033,835,000 | 7,600 |
| Michigan | $861,877,000 | 7,060 |
| Minnesota | $610,938,000 | 5,070 |
| Mississippi | $273,996,000 | 2,900 |
| Missouri | $633,668,000 | 5,330 |
| Montana | $59,048,000 | 640 |
| Nebraska | $106,724,000 | 1,080 |
| Nevada | $98,064,000 | 830 |
| New Hampshire | $100,995,000 | 820 |
| New Jersey | $833,058,000 | 6,250 |
| New Mexico | $231,698,000 | 2,250 |
| New York | $3,807,007,000 | 28,830 |
| North Carolina | $942,133,00 | 8,890 |
| North Dakota | $36,062,000 | 410 |
| Ohio | $1,194,963,000 | 11,270 |
| Oklahoma | $299,373,000 | 3,080 |
| Oregon | $285,943,000 | 2,460 |
| Pennsylvania | $1,505,722,000 | 12,230 |
| Rhode Island | $1,43,484,000 | 1,180 |
| South Carolina | $410,627,000 | 3,970 |
| South Dakota | $44,588,000 | 450 |
| Tennessee | $621,693,000 | 4,940 |
| Texas | $2,145,569,000 | 18,160 |
| Utah | $140,818,000 | 1,350 |
| Vermont | $66,764,000 | 630 |
| Virginia | $462,344,000 | 3,890 |
| Washington | $532,348,000 | 4,250 |
| West Virginia | $166,172,000 | 1,640 |
| Wisconsin | $519,261,000 | 4,830 |
| Wyoming | $30,710,000 | 300 |

**Example – 33 Percent Cut in Federal Medicaid Spending**

Business Activity Lost Due to a 33 Percent Medicaid Cut **(Table 12)**

- In 2011, a 33 percent cut in federal Medicaid spending would mean that the 50 states and the District of Columbia would lose a total of $90.75 billion that is needed to support health care for vulnerable residents. These cuts would substantially dampen business activity and job creation in every state.

- The 10 states with the largest potential loss of business activity attributed to a 33 percent cut in federal Medicaid spending would be New York ($25.1 billion), California ($24.4 billion), Texas ($14.2 billion), Pennsylvania ($9.9 billion), Florida ($8.1 billion), Ohio ($7.9 billion), Illinois ($7.8 billion), Massachusetts ($6.8 billion), North Carolina ($6.2 billion), and Michigan ($5.7 billion). (17)

**Table 12 – Families USA**

| What Would a 33 Percent Cut to the Medicaid Program in 2011 Mean? | | |
|---|---|---|
| **State** | **Business Activity Risk** | **Jobs at Risk** |
| Alabama | $2,228,497,000 | 21,250 |
| Alaska | $468,726,000 | 4,160 |
| Arizona | $4,556,591,000 | 37,340 |
| Arkansas | $1,600,079,000 | 16,210 |
| California | $24,401,712,000 | 187,690 |
| Colorado | $2,047,990,000 | 16,890 |
| Connecticut | $3,059,139,000 | 24,350 |
| Delaware | $577,202,000 | 4,140 |
| District of Columbia | $539,372,000 | 1,260 |
| Florida | $8,055,344,000 | 74,740 |
| Georgia | $4,423,374,000 | 38,420 |
| Hawaii | $649,280,000 | 5,850 |
| Idaho | $555,712,000 | 5,750 |
| Illinois | $7,832,742,000 | 61,220 |
| Indiana | $3,098,039,000 | 28,310 |
| Iowa | $1,316,895,000 | 13,280 |
| Kansas | $1,134,148,000 | 10,540 |
| Kentucky | $2,746,178,000 | 24,190 |
| Louisiana | $3,083,755,000 | 30,720 |
| Maine | $1,258,602,000 | 12,680 |
| Maryland | $3,369,835,000 | 26,930 |
| Massachusetts | $6,823,312,000 | 50,180 |
| Michigan | $5,688,385,000 | 50,650 |
| Minnesota | $4,032,193,000 | 33,490 |
| Mississippi | $1,808,370,000 | 19,140 |
| Missouri | $4,182,211,000 | 35,210 |
| Montana | $389,717,000 | 4,250 |
| Nebraska | $704,377,000 | 7,110 |
| Nevada | $647,221,000 | 5,480 |
| New Hampshire | $666,568,000 | 5,410 |
| New Jersey | $5,498,184,000 | 41,260 |
| New Mexico | $1,529,209,000 | 14,830 |
| New York | $25,126,245,000 | 190,260 |
| North Carolina | $6,218,078,000 | 58,650 |

| | | |
|---|---|---|
| North Dakota | $238,008,000 | 2,710 |
| Ohio | $7,886,756,000 | 74,370 |
| Oklahoma | $1,975,859,000 | 20,320 |
| Oregon | $1,887,221,000 | 16,260 |
| Pennsylvania | $9,937,766,000 | 80,750 |
| Rhode Island | $946,996,000 | 7,760 |
| South Carolina | $2,710,141,000 | 26,170 |
| South Dakota | $294,278,000 | 2,960 |
| Tennessee | $4,103,171,000 | 32,580 |
| Texas | $14,160,754,000 | 119,890 |
| Utah | $929,398,000 | 8,880 |
| Vermont | $440,644,000 | 4,130 |
| Virginia | $3,051,472,000 | 25,680 |
| Washington | $3,513,499,000 | 28,030 |
| West Virginia | $1,096,734,000 | 10,830 |
| Wisconsin | $3,427,121,000 | 31,890 |
| Wyoming | $202,685,000 | 1,980 |

Jobs Lost Due to a 33 Percent Medicaid Cut

- The loss of business activity due to a 33 percent cut in federal Medicaid spending would result in a loss of jobs in every state across the country. **(Table 13)**

- The 10 states with the largest potential number of jobs lost due to a 33 percent cut in federal Medicaid spending would be New York (190,260), California (187,690), Texas (119,890), Pennsylvania (80,750), Florida (74,740), Ohio (74,370), Illinois (61,220), North Carolina (58,650), Michigan (50,650), and Massachusetts (50,180). (17)

**Table 13 – Families USA**

| Jobs at Risk under Various Medicaid Spending Scenarios, 2011 | | | |
|---|---|---|---|
| **State Rank by Number of Jobs at Risk** | **5 Percent Cut** | **15 Percent Cut** | **33 Percent Cut** |
| New York | 28,830 | 86,480 | 190,260 |
| California | 28,440 | 85,320 | 187,690 |
| Texas | 18,160 | 54,490 | 119,890 |
| Pennsylvania | 12,230 | 36,700 | 80,750 |
| Florida | 11,270 | 33,970 | 74,740 |
| Ohio | 11,270 | 33,800 | 74,370 |
| Illinois | 9,280 | 27,830 | 61,220 |
| North Carolina | 8,890 | 26,660 | 58,650 |
| Michigan | 7,670 | 23,020 | 50,650 |
| Massachusetts | 7,600 | 22,810 | 50,180 |
| New Jersey | 6,250 | 18,750 | 41,260 |
| Georgia | 5,820 | 17,460 | 38,420 |
| Arizona | 5,660 | 16,970 | 37,340 |
| Missouri | 5,330 | 16,000 | 35,210 |
| Minnesota | 5,070 | 15,220 | 33,490 |
| Tennessee | 4,940 | 14,810 | 32,580 |
| Wisconsin | 4,830 | 14,490 | 31,890 |
| Louisiana | 4,650 | 13,960 | 30,720 |
| Indiana | 4,290 | 12,870 | 28,310 |
| Washington | 4,250 | 12,740 | 28,030 |
| Maryland | 4,080 | 12,240 | 26,930 |

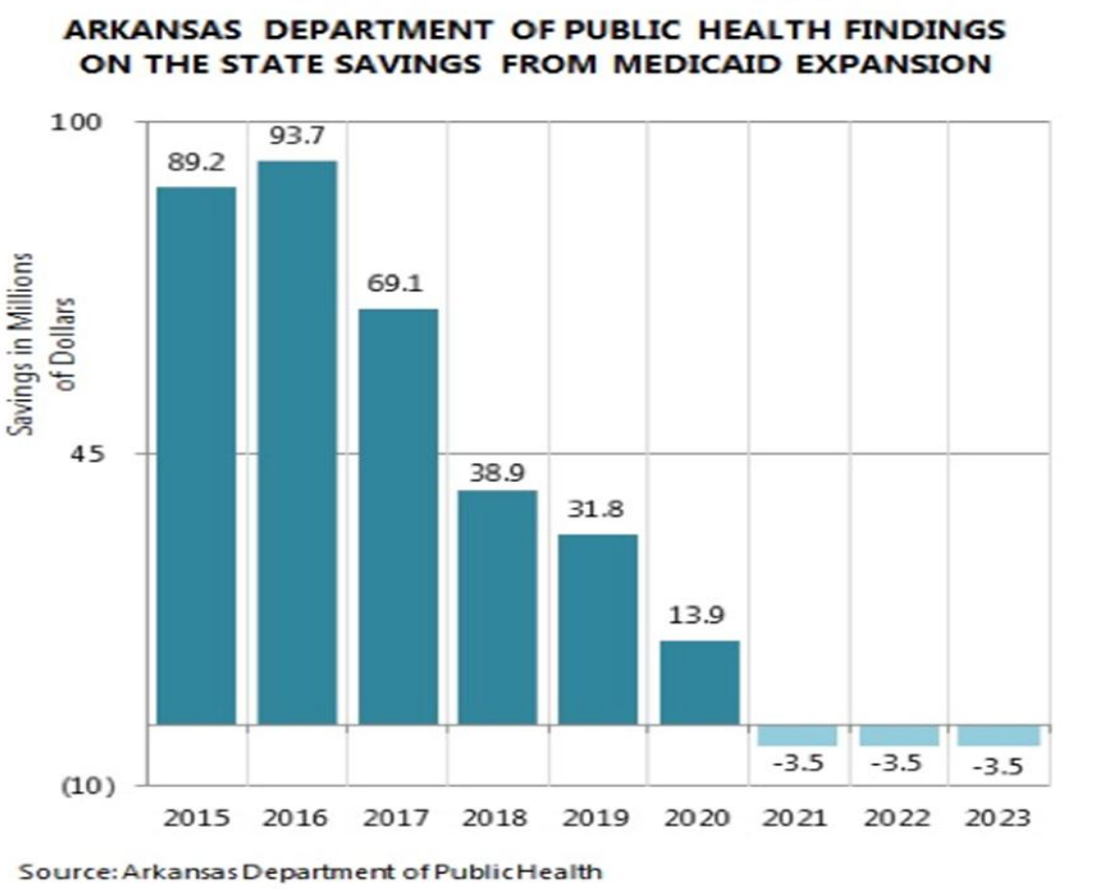
| | | | |
|---|---|---|---|
| South Carolina | 3,970 | 11,900 | 26,170 |
| Virginia | 3,890 | 11,670 | 25,680 |
| Connecticut | 3,690 | 11,070 | 24,350 |
| Kentucky | 3,670 | 11,000 | 24,190 |
| Alabama | 3,220 | 9,660 | 21,250 |
| Oklahoma | 3,080 | 9,240 | 20,320 |
| Mississippi | 2,900 | 8,700 | 19,140 |
| Colorado | 2,560 | 7,680 | 16,890 |
| Oregon | 2,460 | 7,390 | 16,260 |
| Arkansas | 2,460 | 7,370 | 16,210 |
| New Mexico | 2,250 | 6,740 | 14,830 |
| Iowa | 2,010 | 6,040 | 13,280 |
| Maine | 1,920 | 5,760 | 12,680 |
| West Virginia | 1,640 | 4,920 | 10,830 |
| Kansas | 1,600 | 4,790 | 10,540 |
| Utah | 1,350 | 4,040 | 8,880 |
| Rhode Island | 1,180 | 3,530 | 7,760 |
| Nebraska | 1,010 | 3,230 | 7,110 |
| Hawaii | 890 | 2,660 | 5,850 |
| Idaho | 870 | 2,610 | 5,750 |
| Nevada | 830 | 2,490 | 5,480 |
| New Hampshire | 820 | 2,460 | 5,410 |
| Montana | 640 | 1,930 | 4,250 |
| Alaska | 630 | 1,890 | 4,160 |
| Delaware | 630 | 1,880 | 4,140 |
| Vermont | 630 | 1,880 | 4,130 |
| South Dakota | 450 | 1,350 | 2,960 |
| North Dakota | 410 | 1,230 | 2,710 |
| Wyoming | 300 | 900 | 1,980 |
| District of Columbia | 190 | 570 | 1,230 |

Some states are beginning to develop estimates of potential budget gains to their locales if state officials decide to opt in to the Medicaid expansion.

Recently the Arkansas Department of Public Health released findings that that Medicaid expansion would save the state of **Arkansas** $340 million through 2021. After 2021, Arkansas projects that extending health insurance coverage to thousands of low-income adults will cost $3.5 million more than if Arkansas chose not to extend Medicaid coverage to more residents. (18)

The graphic below reflects Arkansas projections of year-by-year cost gains through 2021 and the projected costs after 2021. **(Figure 4)**

**Figure 4**




How did Arkansas Department of Public Health determine the cost savings associated with expanding Medicaid? The agency compared costs with three areas of potential savings including:

- A reduction in the financial losses hospitals face when they care for uninsured patients. As more individuals become eligible for Medicaid, hospitals do not lose as many resources because more adults have health insurance coverage to help cover their costs.
- As millions of dollars come into a state through Medicaid expansion, those funds generate state tax revenue which goes into the state's General Fund to offset some of the state's cost of expanding Medicaid coverage.
- Savings are also generated when families who previously spent a substantial portion of their income on health care bills receive health insurance coverage.

In a new study released in October 2012 by the non-partisan Center for Healthcare Research and Transformation, the state of **Michigan** could save $1 billion over 10 years by expanding the Medicaid program under the ACA. The study looked at savings due to the federal government incurring additional costs as well as savings to employers who will see lower health insurance premiums. In addition, the state is expected to receive revenues for the newly eligible Medicaid population from various provider taxes in existence today.

The state currently has 1.9 million people in its Medicaid program, and expanding eligibility as the ACA proposes could add 289,000 in 2014 and another 331,000 by 2020. The combination of higher federal reimbursement rates for the newly eligible Medicaid recipients and the expected health care cost reductions from having more people in the state insured would mean a net revenue gain of $1 billion from 2014 through 2023 according to the Center. (19)

The report showed that new recipients would cost the state $3 million for their benefits in 2014. However, those costs would be offset by $271 million in federal reimbursements and reductions in health care costs, in that year alone.

The study highlights that significant financial gains would accrue through new eligibility that includes coverage of patients in the community mental health system and for prisoners receiving care in non-correctional facilities. But the report also expected the state would save through reductions in health care premiums because health plans would be spreading their risk across more people, and hospitals had less uncompensated care being passed on to insurers.

Several news accounts have reported that **Florida** officials have said that they are unlikely to choose to opt in to the Medicaid expansion. But a new study by Georgetown University shows that the state can expand health insurance coverage without assuming any new net cost by achieving gains in other areas of the state's budget. In fact, according to the report, overall state costs are likely to be reduced by some $100 million annually because several safety net programs will become less necessary.

Furthermore, an estimated 800,000 to 1.3 million uninsured adults and children in Florida will gain coverage if the state moves forward on the Medicaid expansion. If the state does not expand Medicaid coverage, Florida's hospitals will lose significant federal revenue without offsetting gains in coverage for their patients. Florida hospitals are expected to lose $1 billion in cuts imposed by the Florida legislature over the next 10 years. (20)

A recent study conducted by the University of Nebraska Medical Center identified the following actions if the state of **Nebraska** chooses to opt in to the Medicaid Expansion:

- The estimated number of new Medicaid enrollees in the state under the expansion through 2020 ranges from 90,000 to 108,000;
- The estimated cost of Medicaid expansion for the State of Nebraska ranges from $140 million to $168 million;
- The estimated revenue from the federal government coming to the State of Nebraska from the Medicaid expansion ranges from $2.9 billion to $3.5 billion through 2020;
- Without the Medicaid expansion, more than $1 billion in uncompensated care through 2019 would be incurred in Nebraska. With the Medicaid expansion, health care providers would save at least $163 million and as much as $325 million from costs associated with uncompensated care; and
- Spending by the federal government on Medicaid expansion would generate at least $700 million in new economic activity every year in Nebraska, which could finance over 10,000 jobs each year through 2020. (19)

According to a new study conducted by The Perryman Group in Waco, Texas, expanding Medicaid under ACA provisions would directly add almost 1.5 million Texans to the insured population by 2017, according to recent Texas Health and Human Services Commission (HHSC) estimates.

The cost to **Texas** in terms of general revenue for the newly eligible adults is estimated to be $1.3 billion through fiscal year 2017, while federal funding for that purpose is expected to be $24 billion. With a 90 percent federal reimbursement rate going forward, for every $10 of health care services obtained under the program, the state pays $1 and the federal funds pay the other $9.

Over the first 10 years of the program, based on the results of the Perryman report (including both the increased coverage in the current program and the expansion), it is estimated that Texas would contribute about $15.6 billion, while the federal government would increase its payments into the Texas health care system by $89.9 billion. (19) It appears that the economic effect of expanding Medicaid would be clearly a positive one for Texas.

During the first 10 years after implementation, The Perryman Group estimates that the total cumulative gross benefits to the state economy include $270.0 billion (in 2012 dollars) in output (real gross product) and 3,174,640 person-years of employment. These overall gains stem from the following major sources:

- Spending for health care which would be provided through the expansion would generate sizable economic gains including $156.6 billion (in 2012 dollars) in output (real gross product) and 1,986,830 person-years of employment over the first 10 years of implementation.
- Reducing uncompensated care (and, thus, the local government and private funds needed to pay for it) would lead to gains of another $23.2 billion (in 2012 dollars) in output (real gross product) and 277,060 person-years of employment over the 10-year period.
- Improving outcomes through better care (reducing morbidity and mortality and thus increasing productivity) would lead to gains of $90.2 billion (2012 dollars) in output (real gross product) and 910,750 person-years of employment over the period.
- By not expanding Medicaid coverage as envisioned under the ACA, Texas LOSES an opportunity to enhance access to health care for about 1.5 million Texans and foregoes almost $90 billion in federal health care funds over the first 10 years.
- The economic benefits of improving access to care far more than outweigh the costs. The Perryman Group found that for every dollar the state spends for Medicaid expansion under the ACA, $1.29 is returned in dynamic state government revenue. Over the first 10 years of implementation, economic gains (even when fully adjusted for the diversion of state funding for other purposes) include an estimated $255.8 billion (2012 dollars) in output (real gross product) and 3,031,400 person-years of employment (an average of over 300,000 per year).

A new report by the Department of Health Care Organization and Policy School of Public Health, University of Alabama at Birmingham, provides a detailed assessment of the potential effects of an expansion of **Alabama's** Medicaid program under the Affordable Care Act. The study provided estimates of the number of new expansion enrollees, the costs of the coverage

expansion to state and federal governments, the impact of the expansion on the Alabama economy and budgetary impact on the state during the first seven years of the program (2014-2020). Using an "intermediate" scenario the authors projected that a coverage expansion would reduce the state's uninsured population by approximately 232,000 individuals while generating $20 billion in new economic activity and a $935 million increase in net state tax revenues. (19)

In a study prepared by University of Missouri School of Medicine Department of Health Management and Informatics for the Missouri Hospital Association, the following findings were highlighted:

- **Increased Jobs:** Expansion of Medicaid in **Missouri** is projected to generate an additional 24,000 jobs in Missouri in 2014. In one year, this is more than the employment of Missouri's 10 Fortune 500 companies in the state. It also is 12.8% of the total unemployment number in Missouri in 2011.
- **Increased Payroll:** Labor income in the state is projected to increase by nearly $7 billion during the period 2014 to 2020.
- **Increased GSP:** In 2011, the Missouri gross state product (GSP) was $249.5 billion. If Missouri participates in the Medicaid expansion, it has the potential of adding another $9.6 billion in value-added output to the economy from 2014-2020 (an approximate 0.53% increase to the total GSP).
- **Total Impact:** The total effects (direct, indirect and induced) of the original $8.6 billion Medicaid expansion is an additional $9.6 billion of value-added output to the state.
- **Increased Tax Revenue:** The Medicaid expansion will generate $856 million in additional state and local taxes from 2014 to 2020 and $1.4 billion in federal taxes due to the increase in jobs and economic activity, for a total tax collected of $2.3 billion. (19)

The Wyoming Department of Health predicts that a gain to the State General Fund will occur if **Wyoming** Medicaid offers coverage to both the mandatory and optional groups. The budget gains made possible by an expanded Medicaid are estimated to total $47.4 million from FY 2014-2020. (19)

A recent analysis conducted for **Idaho's** Department of Health and Welfare estimates that the expansion would save the state $6.5 million from 2014 through 2024. (19)

In **Louisiana**, participating in the Medicaid expansion would cost the state an additional $1.8 billion over the 2013-2022 timeframe, while the federal government would deliver $16.7 billion, the Urban Institute projects. Some 400,000 now-ineligible Louisiana residents would be able to enroll in Medicaid.

### Increased State Revenue from Taxes on Insurance Premiums from Insured Expansion

If states have an insurance premium tax, a health care claims tax, or another industry-specific tax, those states would produce more revenue if additional residents received Medicaid coverage.

For example, some states apply insurance premium taxes to payments that certain health plans receive from Medicaid. If the Medicaid expansion boosts enrollment in such plans, premium tax revenues increase.

**Georgia's** Department of Community Health estimates that, due to higher Medicaid and CHIP enrollment, full ACA implementation would raise the state's premium tax revenues by more than $70 million a year, once the law's effects are fully felt. (20)

From one vantage point, such premium taxes simply increase the amount that Medicaid must pay, some of which is taken from the state General Fund. But with the ACA's Medicaid expansion, the vast majority of such increased payments – hence the vast majority of new premium tax revenue – will come from the federal government.

*"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."*

**Dr. Martin Luther King, Jr., Leader of the American Civil Rights Movement**

*"Whoever Saves One Life, Saves the Entire World."*

**The Talmud**

## Section Four:

## *The Cascading Impact of the Medicaid Expansion on Access to Health Insurance and High-Quality Health Care*

The previous sections have focused on state budgetary and economic issues and the significant gains that states could realize by expanding their Medicaid programs under the ACA due to the transference of funding liability to the federal government.

However, purely monetary estimates ignore the potential benefits associated with improved access to affordable health care for millions of lower-income adults without health insurance, especially for those with serious mental illness and behavioral health conditions.

The main reason the ACA was enacted in 2010 was to address the magnitude of the uninsured problem in the United States. The number of uninsured Americans has been hovering around 50 million over the last few years. (21)

We recognize that certain policy considerations will play out over the coming months concerning whether states will expand their Medicaid programs, which will likely be based on budgetary considerations alone. However, there is a human face to this issue that has become lost in the shuffle due to state budget problems and the Supreme Court decision on Medicaid expansion.

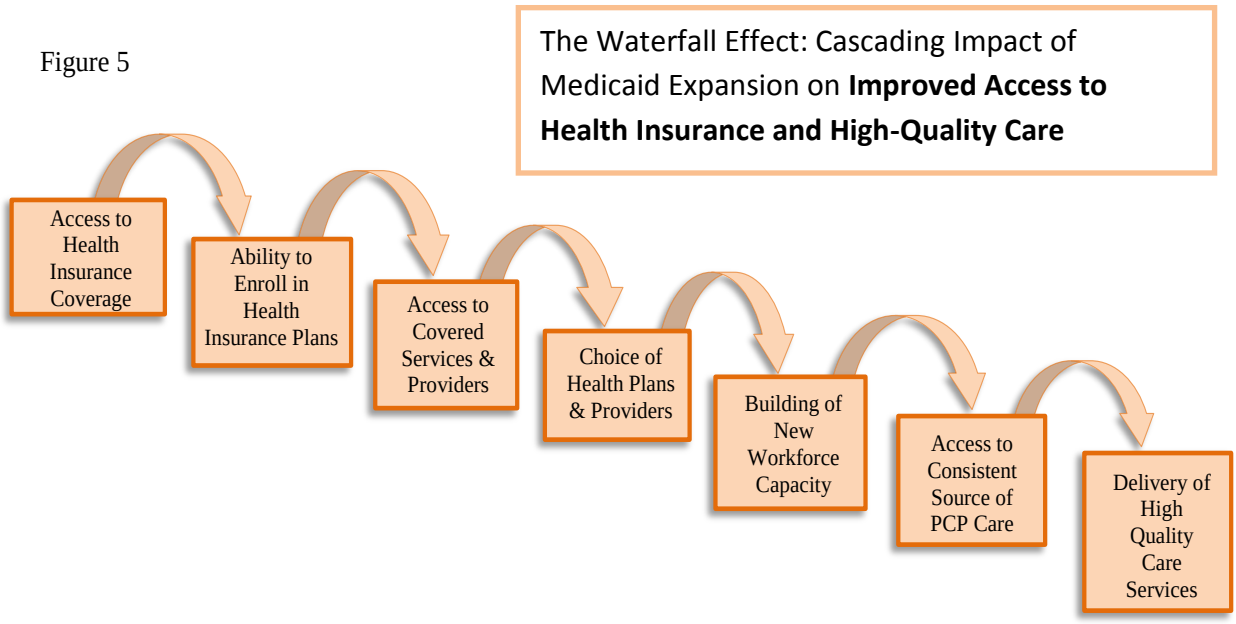
The lack of health care for the poor is a national problem that the federal government was trying to fix and one that only the federal government can fix. States cannot solve national problems. With health insurance exchanges open to all legal residents and Medicare providing coverage for elderly adults, the addition of all low-income, nonelderly adults to Medicaid by the ACA would give virtually the entire population access to affordable health insurance. The decision of the Court to allow the states to reject the Medicaid expansion, however, creates a substantial gap in the comprehensive-coverage design of the ACA. States such as Florida and Texas, whose governors have already pledged to reject the Medicaid expansion, have large uninsured populations.

Such states may leave their uninsured populations doubly burdened. They will deny impoverished citizens the coverage that the federal government was willing to finance and also leave many (who are above the tax-filing threshold) subject to the new tax on the uninsured. The ACA does not provide tax subsidies to individual below 100 percent of the poverty level, because those individuals were going to be covered by Medicaid. Their impoverished legal residents must continue to rely on the charity of safety-net providers, which is the very problem that the ACA was designed to solve.

Similar to the impacts of the Medicaid expansion on state budgets and the state economies, there are seven key cascading events that are critically important to assuring that uninsured people gain access to health coverage, and the ultimate goal of providing high-quality care (and many of these actions apply to all Americans): **(Figure 5)**

1. Access to Health Insurance Coverage;
2. Ability to Enroll in Health Insurance Plans;
3. Access to Covered Services and Providers;
4. Choice of Health Plans and Providers;
5. Build a New Workforce and Increase Capacity;
6. Access to a Consistent Source of Primary Care; and
7. Delivery of High-Quality Health Care Services.

Figure 5




## 1. Access to Health Insurance Coverage

Being uninsured increases the likelihood that the opportunities to receive good health care and improve health will be missed. About 20 percent of non-elderly Americans are uninsured. Lack of insurance is associated with inadequate care and poorer health outcomes, including higher rates of adverse events, such as receiving the wrong medication in hospitals, and higher mortality rates. Over 50 million Americans have no health insurance coverage, and millions more have inadequate coverage with minimal benefits and high out-of-pocket costs. (21, 22)

Health insurance coverage is the "pass-key" to high-quality health care in America. Despite considerable – and well-intentioned – efforts to improve access to health insurance coverage by individual states, nearly one in five Americans under age 65 lack the first basic step in obtaining high quality care – health insurance coverage which is stable and continuous.

According to estimates from the 2010 American Community Survey, nearly one-half (47 percent) of the nation's uninsured could qualify for Medicaid under the Affordable Care Act based on their incomes and immigration status – or a total of 22.3 million uninsured with incomes below 138 percent of the FPL are potentially eligible for Medicaid. (23) **(Table 14)**

Table 14

Uninsured Potentially Eligible for Medicaid under the ACA, by State (Number in 1,000's)

| | Medicaid Eligible Uninsured, by Income | | | | |
|---|---|---|---|---|---|
| | Less Than 100 Percent FPL[1] | Between 100 and 138 Percent FPL[1] | All Less than 138 Percent FPL[1] | All Uninsured[2] | Share of Uninsured Potentially Medicaid Eligible |
| **United States** | **17,782** | **4,565** | **22,347** | **47,346** | **47.2%** |
| Alabama | 358 | 77 | 435 | 701 | 62.0% |
| Alaska | 40 | 14 | 53 | 123 | 43.5% |
| Arizona | 350 | 113 | 463 | 1,068 | 43.3% |
| Arkansas | 217 | 58 | 275 | 497 | 55.3% |
| California | 2,263 | 612 | 2,875 | 6,844 | 42.0% |
| Colorado | 264 | 87 | 351 | 796 | 44.1% |
| Connecticut | 96 | 26 | 122 | 319 | 38.4% |
| Delaware | 33 | 9 | 42 | 90 | 47.2% |
| District of Columbia | 18 | 3 | 21 | 48 | 43.9% |
| Florida | 1,430 | 365 | 1,795 | 3,938 | 45.6% |
| Georgia | 792 | 181 | 974 | 1,876 | 51.9% |
| Hawaii | 44 | 8 | 51 | 100 | 51.2% |
| Idaho | 112 | 38 | 150 | 281 | 53.3% |
| Illinois | 646 | 135 | 782 | 1,754 | 44.6% |
| Indiana | 410 | 108 | 517 | 947 | 54.6% |
| Iowa | 116 | 32 | 148 | 283 | 52.2% |
| Kansas | 153 | 47 | 200 | 387 | 51.8% |
| Kentucky | 324 | 75 | 399 | 653 | 61.0% |
| Louisiana | 345 | 77 | 422 | 793 | 53.2% |
| Maine | 47 | 17 | 64 | 142 | 44.8% |
| Maryland | 205 | 46 | 251 | 651 | 38.6% |
| Massachusetts | 95 | 22 | 117 | 302 | 38.7% |
| Michigan | 581 | 149 | 730 | 1,228 | 59.5% |
| Minnesota | 159 | 43 | 202 | 472 | 42.7% |
| Mississippi | 279 | 54 | 333 | 528 | 63.2% |
| Missouri | 352 | 100 | 452 | 780 | 58.0% |
| Montana | 67 | 20 | 88 | 169 | 51.9% |
| Nebraska | 84 | 26 | 110 | 216 | 51.1% |
| Nevada | 213 | 53 | 266 | 599 | 44.4% |
| New Hampshire | 48 | 16 | 64 | 143 | 44.7% |
| New Jersey | 325 | 70 | 395 | 1,146 | 34.5% |
| New Mexico | 157 | 30 | 187 | 406 | 46.1% |
| New York | 731 | 172 | 903 | 2,295 | 39.4% |
| North Carolina | 632 | 172 | 804 | 1,584 | 50.7% |
| North Dakota | 24 | 12 | 35 | 68 | 52.3% |
| Ohio | 627 | 161 | 789 | 1,384 | 57.0% |
| Oklahoma | 281 | 66 | 348 | 697 | 49.9% |
| Oregon | 256 | 69 | 325 | 658 | 49.4% |
| Pennsylvania | 532 | 149 | 682 | 1,293 | 52.7% |
| Rhode Island | 47 | 9 | 57 | 126 | 45.1% |
| South Carolina | 369 | 78 | 447 | 801 | 55.8% |
| South Dakota | 46 | 13 | 59 | 97 | 60.9% |
| Tennessee | 409 | 92 | 501 | 906 | 55.3% |
| Texas | 1,955 | 547 | 2,502 | 5,840 | 42.8% |
| Utah | 143 | 46 | 190 | 428 | 44.3% |
| Vermont | 14 | 4 | 18 | 50 | 35.9% |
| Virginia | 378 | 84 | 462 | 1,002 | 46.1% |
| Washington | 337 | 82 | 419 | 948 | 44.2% |
| West Virginia | 134 | 32 | 166 | 265 | 62.5% |
| Wisconsin | 217 | 57 | 274 | 545 | 50.2% |
| Wyoming | 28 | 7 | 34 | 81 | 42.2% |

**Notes:** Urban Institute tabulations of the 2010 American Community Survey (ACS). Estimates adjust for the underreporting of Medicaid and CHIP on the ACS. Universe limited to nonelderly (0-64) civilian non-institutionalized population. [1] indicates estimates only include US citizens and noncitizens with at least five years US residency. [2] indicates estimates include the entire nonelderly population. Standard errors are available upon request.

State decisions regarding whether to expand Medicaid under the ACA will directly affect the 15.1 million uninsured adults (children not included in the table below) with incomes below 138 percent of the FPL who are not currently eligible for Medicaid. Of these newly eligible uninsured adults – taking a snapshot of the potential that the Medicaid expansion means for some states – 1.8 million live in California and 550,000 million live in Illinois. (23) **(Table 15)**

Table 15

## Uninsured Adults with Incomes Below 138% of the FPL by Medicaid Eligibility Status

| | Newly Eligible for Medicaid Under the ACA | | Currently Eligible for Medicaid | Total Eligible Uninsured |
|---|---|---|---|---|
| | Less Than 138% FPL | *Less than 100% FPL* | Less than 138% FPL | Less than 138% FPL |
| **United States** | **15,060** | ***11,483*** | **4,370** | **19,430** |
| Alabama | 321 | *254* | 76 | 397 |
| Alaska | 41 | *30* | 5 | 46 |
| Arizona | 89 | *32* | 265 | 354 |
| Arkansas | 218 | *167* | 36 | 254 |
| California | 1,873 | *1,415* | 583 | 2,456 |
| Colorado | 225 | *161* | 66 | 291 |
| Connecticut | 88 | *71* | 25 | 113 |
| Delaware | 9 | *3* | 29 | 37 |
| District of Columbia | 17 | *15* | 2 | 20 |
| Florida | 1,295 | *995* | 257 | 1,552 |
| Georgia | 684 | *534* | 159 | 843 |
| Hawaii | 37 | *33* | 8 | 45 |
| Idaho | 108 | *79* | 18 | 126 |
| Illinois | 522 | *431* | 178 | 700 |
| Indiana | 374 | *288* | 64 | 438 |
| Iowa | 106 | *80* | 23 | 130 |
| Kansas | 141 | *103* | 30 | 171 |
| Kentucky | 288 | *223* | 78 | 366 |
| Louisiana | 330 | *260* | 62 | 392 |
| Maine | 46 | *32* | 13 | 59 |
| Maryland | 167 | *142* | 57 | 224 |
| Massachusetts | 88 | *70* | 21 | 108 |
| Michigan | 564 | *430* | 112 | 676 |
| Minnesota | 130 | *103* | 39 | 168 |
| Mississippi | 231 | *183* | 62 | 293 |
| Missouri | 351 | *267* | 51 | 402 |
| Montana | 59 | *43* | 14 | 73 |
| Nebraska | 78 | *56* | 21 | 99 |
| Nevada | 163 | *127* | 41 | 204 |
| New Hampshire | 51 | *37* | 7 | 58 |
| New Jersey | 307 | *245* | 42 | 349 |
| New Mexico | 127 | *102* | 34 | 162 |
| New York | 170 | *62* | 641 | 811 |
| North Carolina | 587 | *438* | 133 | 720 |
| North Dakota | 24 | *14* | 5 | 29 |
| Ohio | 578 | *445* | 127 | 705 |
| Oklahoma | 225 | *172* | 77 | 303 |
| Oregon | 252 | *193* | 41 | 292 |
| Pennsylvania | 520 | *398* | 92 | 613 |
| Rhode Island | 38 | *31* | 13 | 51 |
| South Carolina | 297 | *232* | 92 | 389 |
| South Dakota | 40 | *30* | 9 | 49 |
| Tennessee | 361 | *284* | 98 | 459 |
| Texas | 1,748 | *1,326* | 289 | 2,036 |
| Utah | 105 | *73* | 40 | 145 |
| Vermont | <1* | *<1** | 17 | 18 |
| Virginia | 342 | *271* | 69 | 412 |
| Washington | 308 | *237* | 66 | 375 |
| West Virginia | 131 | *101* | 23 | 154 |
| Wisconsin | 181 | *145* | 53 | 235 |
| Wyoming | 24 | *18* | 6 | 31 |

**Source:** Urban Institute Tabulations of the 2010 American Community Survey (ACS). Estimates adjust for the underreporting of Medicaid and CHIP on the ACS. The universe is limited to civilian, non-institutionalized non-elderly adults 19 to 64 who are US citizens or noncitizens with at least five years US residency, since the Maintenance of Effort provision under the Affordable Care Act for children extends through 2019. Potential Eligibility for Medicaid is determined by having income for the Health Insurance Unit below 138 percent of the Federal Poverty Level and meeting the immigration requirements for Medicaid coverage. Total estimates may not add up due to rounding. Current Eligibility for Medicaid is defined as eligibility for comprehensive Medicaid benefits in 2010 based a model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation. The model simulates eligibility for Medicaid using available information on eligibility guidelines, including income thresholds for the appropriate family size, the extent of income disregards, etc. for each state. Modeling Medicaid eligibility for adults based on a household survey is subject to measurement error due to the complexity of the rules in place that govern Medicaid eligibility for adults, gaps in the information that is available on income, assets, household structure, immigration status etc., and difficulties measuring eligibility for certain pathways, such as pregnancy and disability.
* Indicates that the standard error is greater than 30 percent of the estimate and should be interpreted with caution.

Another study highlighted that although newly Medicaid eligible individuals would make up about 20 percent of total enrollees, they would only account for 15.4 percent of costs. This occurs due to newly eligible adults being, on average, less expensive to cover than currently

enrolled adults. Currently, adults who are not parents enrolled in Medicaid gained eligibility and coverage through disability associated with higher medical needs. (24)

The Urban Institute also projected that if the ACA was operational in 2011, nearly 24 million people would have joined non-group health insurance exchanges. (25) **(Table 16)**

**Table 16**

| | Coverage in the Non-group Exchanges | | | | | | |
|---|---|---|---|---|---|---|---|
| | Total nonelderly (thousands) | Total covered in non-group exchanges | | Income Distribution (% of total covered) | | | |
| | | N (thousands) | % of nonelderly | <200% FPL | 200-300% FPL | 300-400% FPL | 400% + FPL |
| **New England:** | **12,167** | **865** | **7.1%** | **28.6%** | **17.8%** | **11.8%** | **41.8%** |
| Connecticut | 3,031 | 246 | 8.1% | 30.3% | 18.9% | 6.5% | 44.3% |
| Maine | 1,112 | 98 | 8.8% | 30.8% | 19.8% | 13.1% | 36.3% |
| Massachusetts | 5,434 | 296 | 5.4% | 27.4% | 17.3% | 13.8% | 41.4% |
| New Hampshire | 1,145 | 95 | 8.3% | 22.7% | 15.5% | 17.8% | 44.0% |
| Rhode Island | 914 | 83 | 9.0% | 28.5% | 17.6% | 11.2% | 42.6% |
| Vermont | 531 | 48 | 9.0% | 34.4% | 15.2% | 13.2% | 37.2% |
| **Middle Atlantic:** | **41,438** | **3,558** | **8.6%** | **33.5%** | **30.6%** | **12.1%** | **33.8%** |
| Delaware | 755 | 61 | 8.1% | 26.9% | 21.4% | 12.4% | 39.3% |
| District of Columbia | 544 | 49 | 9.1% | 38.8% | 13.1% | 15.1% | 33.1% |
| Maryland | 5,066 | 405 | 8.0% | 29.1% | 15.4% | 15.8% | 39.6% |
| New Jersey | 7,670 | 597 | 7.8% | 28.2% | 18.3% | 10.1% | 43.4% |
| New York | 17,047 | 1,415 | 8.3% | 36.4% | 23.5% | 10.5% | 29.6% |
| Pennsylvania | 10,355 | 1,030 | 9.9% | 34.4% | 20.2% | 13.8% | 31.6% |
| **East North Central:** | **40,309** | **3,519** | **8.7%** | **32.3%** | **23.5%** | **13.9%** | **30.2%** |
| Illinois | 11,343 | 957 | 8.4% | 33.0% | 20.5% | 13.2% | 33.4% |
| Indiana | 5,460 | 406 | 7.4% | 30.2% | 23.6% | 13.7% | 32.5% |
| Michigan | 8,645 | 792 | 9.2% | 27.8% | 26.2% | 15.0% | 31.0% |
| Ohio | 9,944 | 941 | 9.5% | 36.3% | 24.6% | 12.2% | 26.9% |
| Wisconsin | 4,825 | 423 | 8.8% | 32.5% | 22.7% | 18.0% | 26.8% |
| **West North Central:** | **17,416** | **1,786** | **10.3%** | **32.0%** | **21.9%** | **13.3%** | **32.8%** |
| Iowa | 2,613 | 252 | 9.7% | 34.1% | 22.6% | 10.4% | 32.9% |
| Kansas | 2,367 | 248 | 10.5% | 28.7% | 22.9% | 16.3% | 32.1% |
| Minnesota | 4,492 | 426 | 9.5% | 32.4% | 20.0% | 9.4% | 38.2% |
| Missouri | 5,139 | 528 | 10.3% | 33.5% | 24.2% | 14.1% | 28.2% |
| Nebraska | 1,564 | 174 | 11.1% | 29.5% | 18.3% | 17.4% | 34.8% |
| North Dakota | 548 | 76 | 13.9% | 27.2% | 16.9% | 18.2% | 37.7% |
| South Dakota | 693 | 82 | 11.9% | 33.2% | 22.9% | 15.5% | 28.4% |
| **South Atlantic:** | **44,614** | **3,734** | **8.4%** | **34.9%** | **24.3%** | **11.0%** | **29.9%** |
| Florida | 15,305 | 1,516 | 9.9% | 33.0% | 26.6% | 12.4% | 28.1% |
| Georgia | 8,828 | 630 | 7.1% | 38.7% | 23.4% | 7.2% | 30.6% |
| North Carolina | 8,252 | 640 | 7.8% | 34.3% | 20.5% | 10.3% | 34.8% |
| South Carolina | 3,836 | 309 | 8.0% | 33.0% | 26.2% | 18.4% | 22.3% |
| Virginia | 6,909 | 546 | 7.9% | 37.7% | 23.5% | 7.2% | 31.6% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| West Virginia | 1,484 | 93 | 6.3% | 32.4% | 15.8% | 15.9% | 35.9% |
| **East South Central:** | **15,668** | **1,211** | **7.7%** | **39.6%** | **24.0%** | **13.2%** | **23.1%** |
| Alabama | 4,035 | 275 | 6.8% | 38.9% | 22.2% | 12.8% | 26.0% |
| Kentucky | 3,683 | 306 | 8.3% | 31.5% | 28.1% | 10.9% | 29.5% |
| Mississippi | 2,544 | 203 | 8.0% | 41.8% | 26.0% | 14.0% | 18.2% |
| Tennessee | 5,406 | 427 | 7.9% | 44.9% | 21.4% | 14.8% | 18.9% |
| **West South Central:** | **32,227** | **2,772** | **8.6%** | **36.0%** | **23.8%** | **10.7%** | **29.5%** |
| Arkansas | 2,457 | 216 | 8.8% | 37.8% | 28.8% | 11.0% | 22.4% |
| Louisiana | 3,861 | 317 | 8.2% | 36.2% | 15.3% | 14.5% | 34.0% |
| Oklahoma | 3,125 | 259 | 8.3% | 32.8% | 22.5% | 16.7% | 28.0% |
| Texas | 22,783 | 1,981 | 8.7% | 36.2% | 24.8% | 9.3% | 29.7% |
| **Mountain:** | **19,810** | **1949** | **9.8%** | **31.6%** | **22.9%** | **15.5%** | **30.1%** |
| Arizona | 5,925 | 503 | 8.5% | 34.6% | 19.0% | 18.7% | 27.8% |
| Colorado | 4,510 | 482 | 10.7% | 28.1% | 20.6% | 17.7% | 33.5% |
| Idaho | 1,340 | 170 | 12.7% | 29.0% | 3.1% | 14.6% | 33.3% |
| Montana | 847 | 111 | 13.1% | 29.8% | 26.5% | 13.6% | 30.0% |
| Nevada | 2,353 | 198 | 8.4% | 35.7% | 25.3% | 11.3% | 27.7% |
| New Mexico | 1,839 | 177 | 9.6% | 33.1% | 28.7% | 10.1% | 28.0% |
| Utah | 2,496 | 250 | 10.0% | 29.0% | 27.6% | 13.9% | 29.5% |
| Wyoming | 473 | 58 | 12.2% | 37.7% | 22.2% | 11.9% | 28.2% |
| **Pacific:** | **45,114** | **4,440** | **9.8%** | **35.6%** | **19.9%** | **12.0%** | **32.5%** |
| Alaska | 618 | 61 | 9.9% | 29.2% | 25.6% | 14.1% | 31.1% |
| California | 34,154 | 3,435 | 10.1% | 36.6% | 19.3% | 11.4% | 32.7% |
| Hawaii | 1,103 | 64 | 5.8% | 28.7% | 21.1% | 12.8% | 37.4% |
| Oregon | 3,354 | 342 | 10.2% | 35.9% | 23.0% | 12.4% | 28.8% |
| Washington | 5,886 | 538 | 9.1% | 31.1% | 20.4% | 15.3% | 33.2% |
| **Total** | **268,762** | **23,835** | **8.9%** | **34.1%** | **22.2%** | **12.4%** | **31.3%** |

Note: The Urban Institute simulated the provision of the Affordable Care Act fully implemented in 2011.

Of the 19.4 million uninsured adults with incomes less than 138 percent of the FPL, 67 percent (15.1 million) are not currently eligible for Medicaid but would be made eligible under the ACA's new Medicaid expansion. There are about 2.9 million children who are currently eligible for Medicaid or the Children's Health Insurance Program but not enrolled, and there are about 4.3 million adults who are currently eligible for Medicaid but not enrolled.

**The Impact of ACA's Medicaid Expansion on Coverage for Individuals with Behavioral Health Conditions**

Improvements in behavioral health care under the Medicaid expansion have not been a prominent part of the discussions and debates about health care reform over the last 20 years. Probably because spending on behavioral health is under 7 percent of all health spending, mental and substance use disorders have not been of the same order of importance as physical health conditions. In our view this is unfortunate for several reasons:

- Behavioral health conditions are a source of suffering for the people who have them and often for their family members as well.

- They are the leading cause of long-term disability as measured by disability adjusted life years (DALYS).
- People with co-occurring chronic physical disorders such as heart disease and mental disorders – especially depression – are at substantially elevated risk for disability and premature mortality.
- Care for people with co-occurring physical and behavioral disorders is considerably more expensive than care for people without co-occurring disorders, driving up the overall cost of health care in the United States.
- Disabled older adults with co-occurring disorders are more likely to be placed in nursing homes than cared for in community settings, driving up the cost of long-term care.
- People with serious mental illness often do not get the physical health care that they need for obesity, high blood pressure, diabetes, and heart conditions for which they are at high risk and which contribute to low life expectancy for this population.
- Improved overall health of Americans, such as reduced obesity, depends on changes in lifestyle and behavior, which rarely happen unless motivation and other psychological issues are addressed. (26)

Approximately 26.2 percent of adults experience a diagnosable behavioral health disorder each year. Approximately 6 percent, or 1 in 17 adults, have a serious mental illness, such as schizophrenia, major depression or bipolar disorder. (26)

Mental illness and substance use disorders affect an individual's ability to work or care for themselves. As a result, large numbers of these individuals are unemployed or underemployed, and they and their families do not have the benefit of employer-sponsored health plans. Many are single adults who do not meet the disability requirements or low income limits currently needed to qualify for Medicaid. (27)

In addition, research conducted by NASMHPD found that adults with serious mental illness have a life expectancy averaging 25 years below that of the general population, due in large part to chronic medical conditions, such as diabetes, heart disease, pulmonary disease, asthma and cancer, with little to no access to primary care. (28)

Without access to treatment, people with mental illnesses and substance use disorders experience crisis more frequently and must rely on expensive emergency room care and inpatient psychiatric care. Moreover, individuals with untreated mental illness are disproportionately at risk for engagement with the criminal justice system, and are 4 to 6 times more likely to be incarcerated for crimes related to mental illness. (29) A 2005 survey of jail inmates in Virginia revealed that 16 percent had serious mental illness. (30) Substance use disorders also contribute significantly to crime and incarceration rates throughout the country. (31) Furthermore, 20 to 25 percent of the homeless population has some form of serious mental illness. (32)

The ACA with the Medicaid expansion will have the most significant impact on the service delivery system for people with mental illness and substance use disorders. (33) For example, for those eligible for Medicare, the doughnut hole for prescription drugs provided under Medicare Part D is being phased out allowing seniors to obtain expensive psychiatric medications they may need. (34)

Currently, many people with mental illness and substance use disorder diagnoses are excluded from obtaining coverage due to their pre-existing conditions, or if they can obtain insurance, the premiums are so exorbitant as to be out of reach. Beginning in 2014, pre-existing condition exclusions will be prohibited in all health plans, and premiums may no longer be based on health status. More than half of all individuals currently served by state substance abuse agencies are uninsured and most, if not all, will be eligible for Medicaid coverage.

In addition, the Mental Health Parity and Addiction Equity Act of 2008 prohibits group health plans from imposing financial requirements and treatment limitations for mental health and substance abuse benefits that are more restrictive than those placed on medical and surgical benefits. These provisions will apply to coverage available under the health benefits exchanges, as well as to Medicaid managed care programs and expanded Medicaid programs. Most importantly, the ACA requires the inclusion of mental health and substance use treatment services in the list of the ten essential benefits that health care exchanges must offer, and as a consequence provided through the Medicaid expansion.

Other mandated benefits include rehabilitative services, prescription drugs and preventive services—services extensively needed by individuals with mental illness and substance use disorders.

The Medicaid expansion will greatly increase the number of individuals eligible for the Medicaid benefits package, which must include the essential benefits package listed above, but only if states opt in. That means all adults under age 65 with income less than 138 percent of the FPL will qualify. Currently, that level in Virginia is 80 percent for those eligible adults with disabilities, and 30 percent for adults with dependent children. In many states, including Virginia, childless adults are excluded. Many of these adults have a behavioral health diagnosis, especially those with substance use disorders who currently do not qualify for Social Security Disability Insurance ("SSDI") or Supplemental Security Income ("SSI") due to their primary substance use disorder diagnosis.

As we will discuss later in this section on payment, quality and access issues, the ACA could have the most significant impact on the administration and delivery of substance use treatment services as a result of the requirements of expanded substance abuse coverage along with the expansion of Medicaid eligibility, if the states opt in.

Under the ACA, Medicaid expenditures would greatly increase while state revenue and funding under the Substance Abuse Prevention and Treatment Block Grant will decline in importance, due to the high rate of federal Medicaid reimbursement under the Medicaid expansion. This change will cause a fundamental shift in the way substance abuse services are organized and delivered. Currently, these services are generally administered by state substance abuse authorities which primarily fund designated providers through grants and contracts that support a specified number of treatments. (35)

This model will be replaced through payment methods and requirements characteristic of a health plan. Services are currently delivered primarily by many small providers with little

competition. This new financing dynamic could lead to the consolidation of services with these small providers being acquired by larger, better-operated programs with better information technology investment, business administration, and newer evidence-based practices. Because these services will be paid for through private health plans and Medicaid, services will be more medically-oriented with greater participation by physicians, psychologists and other health care professionals. Services that now consist mainly of education and psychosocial support, often provided by peer or lay counselors, will not qualify for Medicaid reimbursement as medical services. (35)

**Working Poor Will Suffer and Women Will Lose Key Benefits If States Do Not Participate in the Medicaid Expansion**

Under the old Medicaid rules, only certain categories of poor people such as pregnant women, parents with dependent children, the disabled, and the elderly could qualify for Medicaid. But under the Medicaid expansion, anyone can qualify for Medicaid as long as their annual income is less than 138 percent of the federal poverty level. In addition, the Affordable Care Act offers tax credits that help people with incomes between 100 percent and 400 percent of the federal poverty level ($11,170 to $43,320 for an individual) purchase private health insurance.

Two groups of people will be left out if a state chooses not to expand its Medicaid program: 1) those who make less than 100 percent of the federal poverty level but do not fit into one of the traditional Medicaid categories, including people who are single, childless, or do not live with their children; and 2) low-income people who qualify for premium assistance under the ACA but nevertheless cannot find insurance that they can afford to purchase or use. The majority of people in both these categories are low-wage workers.

Women make up a disproportionately high share of Medicaid recipients for three reasons: the traditional categorical eligibility requirements (such as being pregnant or a parent), women's longer lifespans, and the fact that women are more likely than men to be poor. Indeed, women currently constitute 68 percent of all adult Medicaid enrollees.

Many more men will be able to join Medicaid once eligibility is determined solely by income level. But of the approximately 15 million adults eligible for coverage under the Medicaid expansion, around 10 million of them—or two-thirds of the expanded Medicaid population—are nonelderly women.

Because poor women who are pregnant or parenting already qualify for Medicaid in many instances, most of the women living under the poverty level who qualify for the expansion do not have children. But many of those whose incomes are between 100 percent and 138 percent of the federal poverty level likely do. Furthermore, many of the women who qualify for the expansion are among the working poor—maids, waitresses, and home health aides whose jobs do not offer benefits and who earn too much to currently qualify for Medicaid but too little to purchase private insurance on their own.

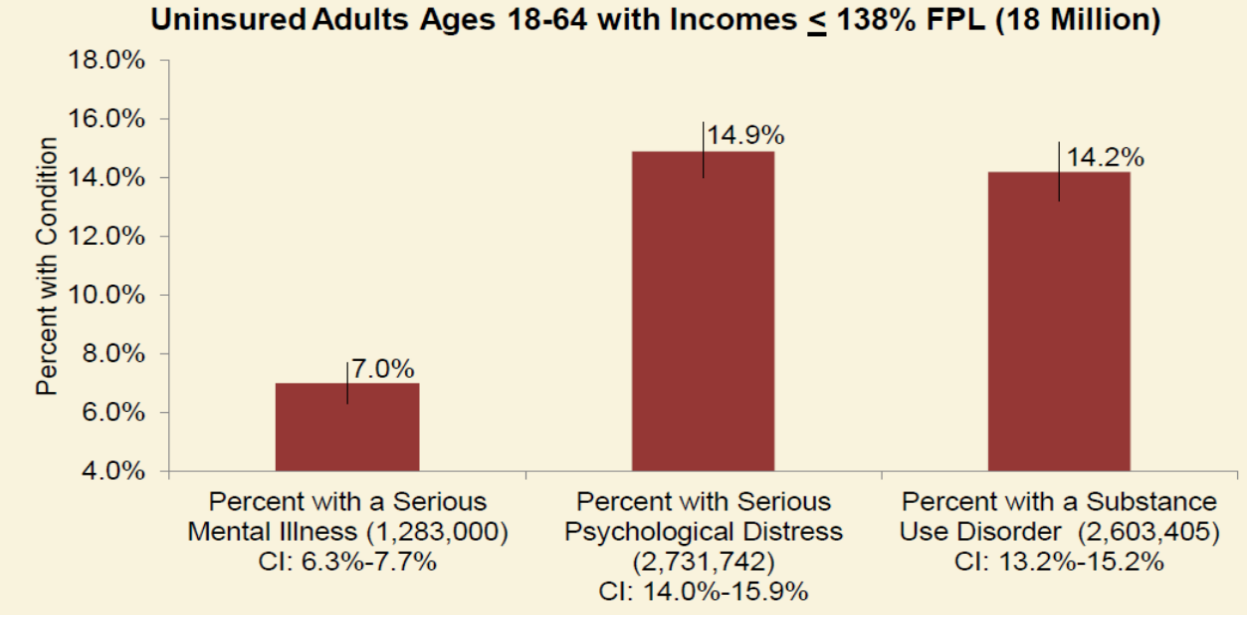
Source: *Center for American Progress. Six Things You Need to Know About the Supreme Court's Ruling on Medicaid Expansion, July 2012.*

Health homes will also provide more integrated, person-centered services and more generalized health centers will expand into the substance abuse service system. Additional funding for federally qualified health centers from 2011 to 2015 will significantly expand the number and capacity of these centers that provide a variety of medical and support services for the medically underserved. These centers will begin to incorporate substance abuse treatment into the services they offer. Substance abuse services and providers will therefore likely be treated more like other health care professionals and less like a separate subsystem of care. (35)

The ACA also contains a number of state plan options, grants and demonstration projects. These provisions are designed to increase service delivery through integrated systems of care, with a whole-person orientation to care, including the integration of substance abuse and mental health services with general medical care. For example, a new Medicaid plan option will permit Medicaid enrollees with at least two chronic conditions, or at least one serious mental illness, to designate a provider as a "health home." These primary and specialty care services could be co-located in community-based mental health and behavioral health settings.

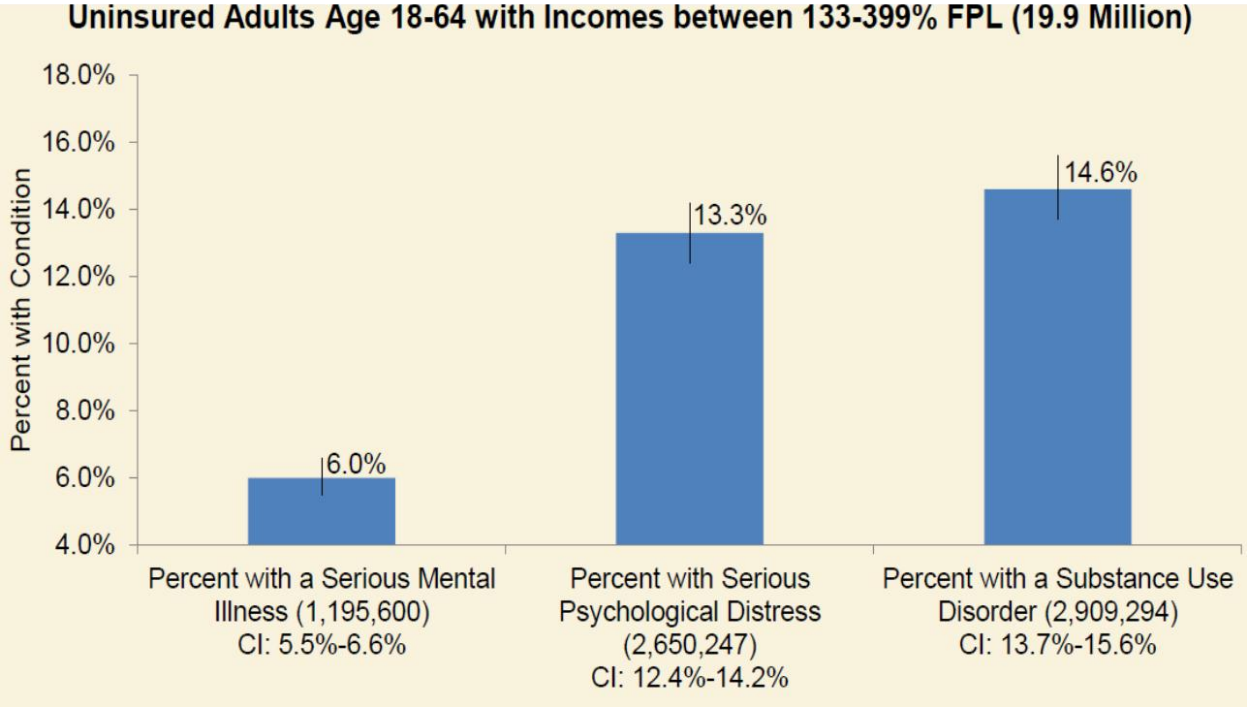
SAMHSA has estimated that about 13.4 million uninsured people who have behavioral health conditions will be eligible through a combination of the ACA's Medicaid expansion (6.6 million people) **(Figure 6)** and in the state health insurance exchanges (6.8 million people) beginning in 2014 through 2019. (26) **(Figure 7)**

**Figure 6**




Note: CI=Confidence Interval

**Figure 7**




Note: CI=Confidence Interval

Specifically, many childless adults with serious mental illness have not been eligible under the current Medicaid program – as well as some children in families with incomes under 138 percent of the FPL due to strict income provisions in several states.

About one in six currently uninsured adults with incomes below 138 percent of the FPL has a serious mental illness such as major depression, bi-polar disorder, severe panic disorder or schizophrenia. Many other individuals have less serious behavioral health disorders such as mild depression or anxiety disorders, but these conditions can be debilitating and affect daily living.

Over one-half of the newly eligible individuals have incomes that are 50 percent of poverty (about $7,500 annual income). Many of these extremely lower-income individuals are homeless and over 25 percent of this group has a serious mental illness.

Due to severe state cutbacks over the last four years, individuals with a mental illness who are uninsured receive basic, state-funded public behavioral health care services of limited duration, and often these services and care are crisis-oriented. As we reported, the Medicaid expansion will replace state and local dollars that fund behavioral health services with new federal Medicaid monies.

States can recoup significant budget gains through the Medicaid expansion because the federal government will pay nearly 100 percent of all of the costs for the newly-eligible group over the initial 10 years of the expansion.

The Medicaid expansion will substantially stop the deterioration in health access that nonelderly adults have been experiencing, especially those with behavioral health conditions, over the last decade. Several reports show that over the last 10 to 12 years, having a usual source of care and routine office visits has declined while the likelihood of having an emergency room visit has increased. Nonelderly adults were 66 percent more likely to report having unmet medical needs in 2010 compared to 2000.

There are costs associated with not providing services. Soumerai et al. demonstrate that limiting Medicaid drug reimbursement benefits for individuals with Schizophrenia increased the use of emergency mental health services and the rate of partial hospitalizations and psychiatric hospital admissions, at an increased cost to a state (not to mention increased pain and suffering to lower income individuals with mental illness). (36)

**Impact of Medicaid Expansion on Health Status**

The *New England Journal of Medicine* recently released a major study that attempted to quantify the **health status** benefits of expanding Medicaid to those who are currently uninsured. (37) It compared six states with similar population sizes and demographic characteristics, three of which expanded Medicaid and three that did not. The report concluded that the expansion of Medicaid "coverage reduced the mortality rate among adults in those states, especially for people between the ages of 35 and 65, minorities and those living in poorer counties."

The results showed that nearly 3,000 deaths were prevented each year in states where at least 500,000 adults had acquired Medicaid coverage. Based upon these findings, one death was averted for every 170 previously uninsured adults who gained coverage. (37)

The non-partisan CBO quantified the national consequences of states opting out of the Medicaid expansions. According to the CBO, in 10 years, as many as six million fewer people will be covered by Medicaid and the Children's Health Insurance Program as a result of states opting out. Of that number, an estimated three million people will purchase subsidized private coverage through insurance exchanges, and the remaining three million will stay uninsured.

In 2022, based on a rough calculation using data from the CBO and the *New England Journal of Medicine*, the inclusion of an additional 3 million under Medicaid could ward off as many as 17,000 deaths across the United States. (37)

As for improving quality of life, results are more difficult to quantify. But evidence suggests that gaining insurance coverage improves both health outcomes and quality of life. In 2009, 45 percent of those living under the FPL were uninsured. In that same year, adults without health insurance coverage were more likely to be diagnosed with late stage cancers and to die from trauma or other serious acute conditions, such as heart attacks or strokes, according to the Institute of Medicine. (38) Uninsured children who had less access to preventive services – e.g., immunizations, prescription medicine and dental care – more often suffered unmet health care needs, avoidable hospitalizations and missed school days. The Medicaid expansion would substantially stop the deterioration in health access that nonelderly adults have been experiencing over the last decade.

The ACA has the potential to significantly expand the availability and accessibility of health care to individuals with behavioral health diagnoses. Service delivery would become more integrated with other health care treatments and services – and with a more community-based, person-centered focus. Taking one snapshot of the potential impact of the expansion, of the 425,000 individuals projected to become newly eligible for Medicaid coverage in the Commonwealth of Virginia, 34 percent of these residents will need mental health and substance abuse services. And the health status benefits afforded by expanding Medicaid coverage are well documented which shows such increases in coverage reduce mortality rates among new Medicaid enrollees. (39)

**The homeless population with mental illnesses and substance use conditions present particular challenges for outreach, enrollment, and service delivery under ACA-related Medicaid expansions. The homeless population has high rates of serious mental illness, and most are uninsured adults who will become eligible for Medicaid under the ACA.**

The Medicaid expansion is especially good for children. In the typical state, parents lose eligibility for Medicaid when their incomes reach just 63 percent of the federal poverty line (approximately $12,000 for a family of three in 2012). Medicaid Expansion will increase coverage for parents; thus, their health status is expected to improve. When parents and caretakers are insured, their children are more likely to be insured and to make more effective use of their coverage. (39) Coverage of parents also improves continuity of children's coverage and reduces the likelihood of breaks in coverage. Children coming onto Medicaid will be eligible for the program's tailored child health benefit package, Early and Periodic Screening, Diagnosis and Treatment (EPSDT). (39)

The coverage provisions slated to be implemented under the ACA in 2014 could increase coverage among the U.S. population, including many uninsured veterans. Nearly one-half of uninsured veterans would qualify for expanded Medicaid coverage. Another 40 percent of uninsured veterans could potentially qualify for subsidized coverage through health insurance exchanges if they do not have access to affordable employer coverage. We find higher rates of uninsurance among veterans in those states that have thus far made the least progress in expanding coverage; nearly 40 percent of uninsured veterans and their family members live in these states. To the extent that the ACA Medicaid expansion can achieve dramatic reductions in uninsurance among veterans and their family members, success will depend on aggressive ACA implementation and enrollment efforts nationwide (39).

### 2. Enrollment in Health Insurance Plans

According to national and state experts convened by the Bazelon Center for Mental Health Law and the Kaiser Commission on Medicaid and the Uninsured, targeted outreach and enrollment will be necessary to reach newly-eligible adults, especially individuals with behavioral health disorders. (40) Under the ACA, states are responsible for determining eligibility and conducting outreach and enrollment to populations potentially eligible for Medicaid. Most of the newly

eligible with mental illness – especially those with serious mental illness – will most likely be reached through their current mental health provider when they access services, rather than through general outreach initiatives. Since many of these providers operate as direct service providers, these efforts will require education about the shift from a service delivery to an insurance model.

The homeless population with mental illnesses and substance use conditions present particular challenges for outreach, enrollment, and service delivery under ACA-related Medicaid expansions. The homeless population has high rates of serious mental illness, and most are uninsured adults who will become eligible for Medicaid under the ACA.

## Enrollment Issues and the Homeless

Given their lower incomes and the high-uninsured rate, individuals experiencing homelessness could significantly benefit from this coverage expansion under the Medicaid expansion. However, it will be important to address the barriers they face to enrolling in coverage and accessing needed care. The Kaiser Family Foundation has issued a report that draws on the experience of administrators and frontline workers serving the homeless population to identify outreach, enrollment and access barriers, strategies to overcome these barriers, and considerations for the Medicaid expansion.

According to the report, each year, millions of individuals across the United States experience housing insecurity and homelessness. On a single night it is estimated that 640,000 people are homeless, of which 63 percent are individuals and 37 percent are part of a family. Nearly two-thirds were in shelters, while the remaining one-third remained unsheltered.

Individuals experiencing homelessness are a diverse group with individuals of all races, ethnicities, and immigration statuses and clients also vary in age, family status, and length of homelessness. They represent a range of backgrounds and personal experiences, including military veterans, domestic violence victims, and previously incarcerated individuals.

Many individuals experiencing homelessness have complex and significant mental health conditions and physical disorders. The high prevalence of mental health conditions and substance and alcohol abuse among the homeless population frequently co-occur with physical conditions. Individuals experiencing homelessness have high rates of chronic disease, such as HIV/AIDS, diabetes, and heart disease; some individuals suffer from other conditions, such as traumatic brain injury and cancer, as well as conditions that stem from lack of housing, such as skin infections and hypothermia. These individuals are often dealing with multiple conditions at one time, which are often compounded and exacerbated by their living conditions.

Currently, Medicaid coverage is very limited among the homeless population because non-disabled adults are not eligible for the program. While adults with dependent children can qualify through eligibility pathways for parents, other adults are not eligible unless they qualify through a disability category, which requires them to complete the long and complex disability determination process to qualify for Supplemental Security Income (SSI).

Many homeless individuals are disengaged from and distrustful of public systems. While some individuals are readily willing to apply for services and benefits, many others are distrustful of public systems and reluctant to apply for assistance. Helping individuals overcome this disengagement often requires significant time and effort and can sometimes take months or years of relationship-building.

Source: *Kaiser Commission on Medicaid and the Uninsured. Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion, September 2012.*

Key strategies to overcome Medicaid enrollment barriers for individuals experiencing homelessness include:

- Having staff dedicated to outreach, education, and enrollment assistance.
- Building community partnerships to assist with outreach and enrollment activities.
- Meeting individuals where they are and addressing immediate needs first.
- Providing small items, such as bus passes, socks, and toiletries, to establish trust.
- Educating individuals about the specific benefits of coverage and the overall enrollment process.
- Providing direct hands-on, one-on-one assistance through each step of the enrollment process.
- Providing clinic contact information to serve as a secondary point of contact on the application form.
- Assisting in obtaining documentation by helping to fill out paperwork, going with or providing transportation to the offices, and covering the cost of replacing documents.
- Storing originals or copies of documents in client file to keep them safe and secure.
- Providing transportation and accompanying individuals on visits to the eligibility office.
- Maintaining contact over time to assist in the renewal of coverage.
- Engaging providers to remind individuals about steps needed to complete enrollment during patient visits.

The Medicaid expansion has the potential to significantly benefit the homeless population by improving their access to care and the management of their health conditions. The new requirements to simplify Medicaid enrollment processes, which will alleviate some enrollment barriers currently faced by the homeless population, but significant outreach and enrollment efforts, including direct one-on-one assistance, will remain key. Moreover, as individuals gain coverage, it will be important to connect them to care, and for providers and plans serving the population to address their unique circumstances and intense and wide-ranging health care needs.

**Why Don't People Enroll?**

People who are eligible for public programs frequently do not participate in them, and Medicaid is no exception. There are a variety of reasons that eligible individuals might not sign up for coverage: They might not be aware of their eligibility, they might be averse to government programs, they might not feel like they need assistance, or they might not know where or how to apply. An analysis from the Urban Institute shows Medicaid participation rates among adults by state differ significantly– from a high of 93.5 percent in Massachusetts to a low of 54.4 percent in Nevada.

The recent experience of the Children's Health Insurance Program (CHIP) provides a prime example of what some analysts call the "woodwork effect." Because of extensive outreach and enrollment activities triggered by incentives in the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, many children showed up to enroll in CHIP who were unaware that they were actually eligible for the Medicaid program, which has lower income thresholds than CHIP. The program's efforts worked to insure 42 million children in Fiscal Year 2010 through enrollment in CHIP (7.7 million) but also in the Medicaid program (34.4 million children), which actually saw a larger enrollment jump than did CHIP.

Nationally, Sommers and Epstein estimate that more than 9 million uninsured Americans were already eligible for Medicaid, pre-ACA, while failing to enroll. Although only a portion of these people are likely to enroll in Medicaid now that the program has been expanded, adding them to the program's rolls could increase spending on Medicaid at the regular match. Most affected would be states that currently have generous eligibility criteria for Medicaid, lower participation rates, a higher prevalence of low-income uninsured residents, or some combination of these factors (Note 37 and see **Appendix 3**).

### 3. Access to Covered Services and Benefits and Providers

Being covered does not guarantee access to all services and all caregivers and institutional providers. Certain services may not be covered; specific doctors and hospitals may not be included among those participating in a plan or contracting with it; and a caregiver may be unwilling to accept reimbursement. All of these factors represent a potential interruption in receiving high quality care. Interruptions in care transitions can have devastating consequences for people with serious mental illness.

It is important to consider the unique needs of people with mild, moderate, and severe behavioral health disorders, respectively, in making decisions about the scope of benefits available under Medicaid expansions.

As highlighted in the Bazelon forum, under the ACA, states have the option to provide newly-eligible Medicaid beneficiaries with a "benchmark" benefits package – which is typically more limited than traditional Medicaid benefits – rather than the full Medicaid benefit package. (40) Research shows a high rate of mental health disorders among the newly eligible group, and many newly eligible with mental health service needs will have mild or moderate disorders.

Experts believe that the full, traditional Medicaid benefits package is more appropriate for those with serious mental illnesses. The significant difference in service needs between those with mild/moderate and serious mental illness highlights the key challenges that states face in trying to develop health insurance benefit packages under the ACA.

Experts have noted particular challenges in operating two benefits packages for groups with different levels of mental health impairment and conclude that states will have to assess whether the expected actuarial difference between benchmark coverage and full Medicaid benefits merits the transaction costs of screening and assessment for running parallel programs. We believe that it does not make sense from many delivery and quality of care perspectives to implement two levels of benefits for people with mental health conditions.

All newly eligible individuals should have coverage for all of the services covered under the "State Medicaid Plan." If the state has determined it will not adopt that policy, then at a minimum, individuals with serious mental illness should have full state plan coverage. This can be done because states may, under the law, adopt different coverage policies for different groups. (41)

The benefit in any benchmark plan should include, at a minimum, case management services for individuals with serious mental disorders.

In addition, the following services, all of which states already cover under Medicaid for other populations, could be required as part of a wraparound benefit:

- Skills training to address functional impairments resulting from a serious mental disorder and furnished in any appropriate setting, including in the home or on the job (this should include social, daily living, communication, personal care and other skills);
- Peer Support Services;
- Family education, such as Family Psycho-education (an evidence-based practice);
- Integrated treatment for individuals with co-occurring mental illness and substance use disorders, such as Integrated Dual Disorder Treatment (an evidence-based practice);
- Intensive in-home services for children;
- Crisis residential services for adults;
- Therapeutic foster care for children; and
- Outreach, engagement and mobile crisis services for people who are homeless. (41)

**4. Choice of Health Plans and Providers**

With millions of Americans enrolling in health insurance pools between 2014 and 2019, a strong navigation system will be needed to inform people about their new insurance options and help them enroll. A Navigator function has been created to help people who will obtain health coverage through their state's insurance pools, such as small businesses, self-employed or people who do not have access to insurance through their employers. (40)

The Navigator's job is to provide individuals and families with the information necessary to determine which health insurance option best fits their needs and then help them enroll in their plan of choice. All states will need to fund the Navigator process.

**5. Build a New Workforce and Increase Capacity**

There is insufficient capacity and coordination in the current system to adequately serve the newly-eligible population with mental health needs. A major area of concern is having enough providers to ensure access to behavioral health services. Effectively serving newly-eligible adults with serious mental health needs calls for building capacity in the current mental health system. (40)

State behavioral health agencies need to continue to serve an important role in the delivery of mental health services, particularly for the remaining uninsured or for services that fall outside the scope of Medicaid benefits.

Effective workforce development strategies must address the following challenges: (a) recruitment and retention; (b) accessibility, relevance, and effectiveness of training; (c) staff competency in integrated care, evidence-based practices, and recovery-oriented approaches; (d) attitudes and skills in prevention and treatment of persons with mental and substance use conditions; (e) leadership development; and (f) workforce roles for persons in recovery and family members.

## 6. Access to a Consistent Source of Primary Care

Individuals can choose a plan and be covered for a service but still have difficulty finding a place where they can receive health care regularly. People with a regular source of care are much more likely to receive preventive services and more likely to receive care for acute and chronic conditions as well.

The concept of a single point of clinical responsibility has long been a foundation of sound community behavioral healthcare systems, although the execution of coordinating services has been challenging given the fragmentation in financing for care in behavioral health systems.

SBHAs pioneered the concept of a single point of clinical and financial responsibility in the 1970s and 1980s, creating local, area and/or regional mental health authorities within their states that managed all funding sources and access to care. Many SBHAs created single points of access to their care via systems embedded at the local level and provided those entities with control over service planning, allocation of resources, and use of high-end services. In those early efforts to integrate access and financial responsibility, the SBHAs were bending the cost curve, away from crisis and institutional care and toward more affordable home- and community-based services.

Health homes are collaborative care models that offer the opportunity to improve coordination and integration of behavioral health and primary care systems. Highly functioning and responsive health homes can enhance efficiency and quality while improving access to needed healthcare and support services, including appropriate referral and linkage with specialty services such as community behavioral health care.

In 2008, NASMHPD called for the creation of a "patient-centered medical home" for individuals who have mental illnesses, as these individuals so often have co-morbid substance use and other serious medical conditions.

**Many SBHAs have created single points of access to their care via systems embedded at the local level and provided those entities with control over service planning, allocation of resources, and use of high end services.**

The call is contained in a report, "*Measurement of Health Status for People with Serious Mental Illnesses.*" The report described the medical home as a platform for bringing together a primary care/physical health provider and specialty behavioral health services practitioners to provide collaborative care using disease management strategies based on the chronic care model. SBHAs should assure that financing mechanisms align with, and promote, a single, integrated point of clinical responsibility for the individual, moving away from fragmented, fee-for-service reimbursement. (42)

A key component of health home effort is the availability beginning in 2011 of a new Medicaid state plan option for the provision of health homes under the ACA for Medicaid enrollees with chronic conditions, including mental health disorders under the oversight of

SAMHSA. State behavioral health agencies should promote health homes that meet certain defined standards, consult with SAMHSA about addressing behavioral health issues, monitor and report on performance and outcomes, and develop and implement a proposal for using health information technology in provision of health home services.

In addition to promoting the use of health homes for Medicaid individuals with behavioral health disorders, SAMHSA supports and promotes the community behavioral health provider's role in establishing health homes that promote coordination of care for individuals with serious behavioral health disorders.

Although the health home concept has been around for 40 years, there has been new attention to this model of care delivery. In a health home, an individual is assigned to a personal physician who manages the individual's whole healthcare by coordinating with other qualified professionals, including specialists. The personal physician in the health home guides the patient through preventive, chronic, and acute care, and will work with the individual and his or her family to provide appropriate referrals to hospitals, ancillary care services, community care and residential services.

SBHAs should begin to promote connections between behavioral health specialists and primary care physicians who provide care within a health home. To further incentivize states to select this option, CMS has been awarding planning grants to states for the purposes of developing a Medicaid state plan amendment and will provide a 90 percent payment match for new services provided during the first eight quarters in which any eligible recipient is enrolled in a health home program pursuant to the Medicaid state plan.

Importantly, two of the six chronic conditions defined in the law are a serious mental health condition and a substance use disorder. The 90 percent match is significant as Medicaid rates have historically been low and health home services related to behavioral health services that are eligible for the substantial match include: comprehensive care management; care coordination and health promotion, comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to community and social support services; and the use of health information technology (HIT) to link services.

**In an effort to improve access to primary care in the Medicaid program, the ACA provides for increased Medicaid payments for primary care services provided by general medicine, family medicine and pediatric practices in 2013 and 2014.**

It is critically important to design the Medicaid expansion in a way that promotes high quality behavioral health services. The Medicaid expansion provides a window of opportunity to revisit coverage and payment policies and to implement strategies to promote high quality mental health care.

**Payment Reform Opportunities**

The ACA provides a number of opportunities for payment reform demonstrations, focused on moving from the current fee-for-service system to payments that reward value, quality and outcomes rather than utilization. These opportunities extend to the Medicaid program and include demonstrations for:

- Bundled payments for integrated care around a hospitalization;
- Global capitated payment models for safety net hospitals;
- Pediatric Accountable Care Organizations (ACOs);
- Payment, through a demonstration, to an Institute for Mental Disease (IMD); stabilization of an emergency medical condition for a psychiatric patient;
- Center for Medicare and Medicaid Innovation grants to improve delivery; and system and payment models for dually eligible individuals.

In an effort to improve access to primary care in the Medicaid program, the ACA provides for increased Medicaid payments for primary care services provided by general medicine, family medicine, and pediatric practices in 2013 and 2014. The enhanced payments will be equal to the Medicare rate in a given geographic area; and the difference between the state's rate and the Medicare rate will be fully funded with federal dollars.

ACA establishes several demonstration projects that address quality issues in Medicaid. These include:

**Integrated Care Hospitalization Demonstration**, an eight-state demonstration project to evaluate the use of bundled payments for integrated care for a Medicaid beneficiary during a hospitalization. This project began on January 1, 2010 and ends December 31, 2016. States selected for the demonstration project may target particular categories of beneficiaries, diagnoses or geographic regions, and focus on conditions where there is evidence of an opportunity for providers to improve the quality of care and reduce expenditures. Other requirements include robust discharge planning and assurance that patients receive all services they are entitled to and are not subject to more extensive cost-sharing under the program.

**Medicaid Global Payment Demonstration**, a five-state demonstration project that, under evaluation by the CMS Innovation Center, permits states to adjust their current safety net hospital payment structure from fee-for-service to a global capitated payment model.

**Pediatric Accountable Care Organization Demonstration**, a program that allows participating states to permit pediatric medical providers that meet specified standards to be considered accountable care organizations (ACOs). ACOs that meet performance guidelines and achieve savings will receive incentive payments of a percentage of the saving realized. This demonstration project began on January 1, 2012 and ends December 31, 2016.

**The Medicaid Emergency Psychiatric Demonstration,** a three-year, $75-million project that would fund up to eight states to reimburse non-governmental freestanding psychiatric hospitals under Medicaid for emergency psychiatric stabilization and treatment for Medicaid beneficiaries between the ages of 21 and 65. Currently, such hospitals are prohibited from receiving federal matching payments under Medicaid. Funded states must collect and report data and HHS must conduct an evaluation of the demonstration project in order to determine its impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program. The evaluation will assess inpatient services, including duration of stay and emergency room usage, as well as discharge planning, cost impact and hospital admission rates.

**State Demonstrations to Integrate Care for Dual Eligible Individuals**, a program where 15 states across the country have been selected to develop new ways to meet the often complex and costly medical needs of the approximately nine million Americans who are eligible for both the Medicare and Medicaid programs, known as "dual eligibles." States received funding to design strategies for implementing person-centered models that fully coordinate primary, acute, behavioral and long-term supports and services for dual eligible individuals. States will work with beneficiaries, their families and other stakeholders to develop their demonstration proposals. The goal of the program is to eliminate duplication of services for these patients, expand access to needed care, and improve the lives of dual eligibles, while lowering costs.

### 7. Improving the Delivery of High-Quality Health Care Services: The Capability of Reinventing Behavioral Health Care Through the New Medicaid Expansion

Delivery and payment innovations introduced by the Affordable Care Act – and through the Medicaid expansion – could facilitate the provision of behavioral health services that are not usually reimbursable, including comprehensive care management, care coordination, social support, transition care, collaborative care, and other evidence-based interventions. Another example is supported employment programs, which encourage the most severely disabled clients to pursue competitive employment – in other words, employment in jobs that pay at least minimum wage and that are open to anyone in the community – by providing them with support for an unlimited period of time.

Below are five reasons why the Medicaid Expansion has made reinventing and improving behavioral health (incorporating both mental health and substance abuse care) more likely now if states pursue the expansion initiative. Following are some examples of opportunities that the Center for Medicare and Medicaid Innovation which is housed in the Centers for Medicare and Medicaid Services (CMS), and the states can continue to build on.

First, the Medicaid expansion provisions enable states and federal agencies to test and evaluate improved financial and organizational tools in order to address the fragmentation of services that lead to poor quality and high cost.

Second, many provisions, such as health homes, are directed toward chronic disease comorbidities. These provisions make it possible for care providers to be more responsive to

clients who not only have serious mental illnesses but also have other serious chronic diseases or disease risks.

Third, provisions allow providers to better coordinate Medicaid behavioral services with social service and housing programs that seek to prevent and manage homelessness among people with serious mental illnesses.

Fourth, the act encourages the use of preventive services and substance abuse education, evaluation, and treatment, and it allows providers treating people with serious mental illnesses to pay more attention and receive payments to substance abuse problems.

Fifth, by extending the concepts of treatment and related supportive care to such entities as health homes, Medicaid provisions provide new pathways for incorporating evidence-based treatments, such as supported employment, that are commonly neglected. (43)

**Redesigning Organizational and Financing Arrangements**

Studies and reports on the quality of behavioral care find poor continuity and coordination of care and little adherence on the part of providers to practice standards. Typically, care is episodic and makes limited use of evidence-based health care, social, and rehabilitative interventions. This results in a very costly, inefficient and inconsistent pattern of care.

New approaches and forms of adjusted capitation and the related use of bundled or episodic payments encourage consistency, continuity and efficiency. These new approaches and mechanisms include fixed payments per-client per-time period, adjusted for age, illness severity, and other patient characteristics. Bundled or episodic payments use a single payment for a package or bundle of services as an incentive for health care providers to take greater responsibility for longer episodes of care.

These new payment approaches, more common to the behavioral health sector than to general medical care, offer varied opportunities to test innovative strategies aimed at improving care for patients with chronic illnesses. Similar payment arrangements have already been used by behavioral health "carve-outs" – specified services that are organized and administered separately from the service mix – in which managed behavioral health care organizations and some community behavioral health centers function under various forms of capitation. Nevertheless, a great deal remains to be learned about using these financing models for populations with behavioral health illnesses. Some attempts have been made to improve services and reduce wasteful spending in the behavioral health sphere and have showed promise. However, they were rarely supported by existing organizational arrangements, incentives, and professional cultures.

One example is in an early effort in Rochester, New York, that the New York State Office of Mental Health provided funds to a central planning agency, Integrated Mental Health, which made a prospective payment to community agencies to manage care for individuals who had recently been admitted to a state psychiatric facility. The program served as a health home, providing not only all psychiatric care but also medical, dental, and other services necessary for

community living, including housing. But the innovative aspects could not be replicated elsewhere or even sustained over time under the existing reimbursement and organizational arrangements.

There is a greater chance for successful redesign now because of the substantial commitment of CMS and its Innovation Center. The commitment is to a broader service mix, including care coordination, rehabilitative services, and assertive case management; the design of more coherent and stable organizational arrangements and financial incentives; and continuing performance monitoring, assessment and evaluation.

Coordinating the management of serious chronic behavioral health conditions and comorbidities and improving the transition from one type of service to another are challenging under the existing delivery system. But Section 2703 of the ACA encourages state Medicaid programs to offer a health home option, which is supported by a federal funding match of 90 percent for the first two years. Under this option, states can pay an individual-designated health home provider who provides care management, makes necessary referrals, provides individual and family support as needed, and uses health information technology and electronic health records to monitor and coordinate the various service providers involved. (43)

Health homes designed for people with severe mental illnesses make it possible for community mental health centers and other appropriate behavioral health agencies to manage the integration of services over the full range of individual needs, even when a variety of health care providers and agencies are involved. Two of the first states approved for enhanced federal matching funds, Missouri and Rhode Island, are organizing services for people with severe mental illnesses with the help of community mental health centers. Medicaid enrollees eligible for participation in health homes must have two chronic conditions, one such condition and a risk for a second, or a serious and persistent mental condition. (43)

**Addressing the Challenge of Comorbid Substance Use Conditions**

A particularly challenging population that is at very high risk is made up of people with serious mental illnesses and comorbid substance abuse. Many of them suffer from other serious chronic conditions as well. These individuals in this population are at very high risk for treatment hospitalization, emergency care, non-adherence to treatment, homelessness, and incarceration. They require an integrated and coordinated long-term treatment program and often need assertive case management, attention to their risk of homelessness, and interventions to prevent risk of engagement. The new Medicaid expansion coverage will provide consistent and reliable coverage for this population.

An appropriate care delivery system for this group must be actively involved; accessible around the clock; and well connected to a wide array of community agencies and services, including those in the areas of housing and criminal justice. Some clients may need highly specialized health homes designed for their needs. Well-constituted and organized teams will be central to the successful implementation of these models. The teams must be responsible for monitoring clients and their continuing care. In addition, team members must be flexible and prepared to

respond to critical events, such as a psychotic episode over a holiday weekend or an altercation requiring the team's collaboration with police.

Assertive community treatment and case management successfully reduce hospitalization and retain patients in care, often improving their general functioning and employment and preventing them from becoming homeless. Policymakers could build on these approaches. The advent of improved design and organization brings new opportunities to implement cost effective elements of care. (43)

**Integrating Mental Illness and Substance Abuse Treatments**

Organizing community treatment of mental illness may be complicated by the affected population's use and abuse of drugs and alcohol. The Medicaid expansion enables a transformation in the management of substance abuse, whether occurring along with a serious mental illness or as a condition in its own right. The ACA and Medicaid expansion does this through its "whole person" perspective by focusing on the integration and coordination of services, as well as by encouraging care coordination through health and medical homes, and collaborative teams and services. (43)

Substance abuse treatment is a mandated service under the ACA, which includes a provision for new workforce development and training. Substance abuse evaluation and treatment must be incorporated into the central process of monitoring and managing medications and educating clients about their medication and condition. This is one of the most challenging areas of behavioral treatment, requiring a mix of integrated services that includes assertive case management; psycho-education, or a combination of therapy and family-centered education; supportive employment; and a harm-prevention orientation.

As we discussed in the previous section, the evidence base remains undeveloped, but promising and effective approaches have been identified, such as social skills training, motivational learning, and rewards for clean urine test results. The lack of integration between mental health and substance abuse treatment has been a persistent deterrent to appropriate care, but the Medicaid expansion provides numerous opportunities to better address this issue. (43)

**Engaging Homeless People with Mental Health**

Addressing the risk of homelessness and victimization and providing stable housing are critical to the effective and efficient long-term management of serious mental illness. There are a large number of programs to prevent or reduce homelessness, and seven different federal agencies administer such programs. Many homelessness programs are authorized by federal legislation designed to assist the homeless and are available to people in varying circumstances.

These programs can be coordinated with other needed behavioral health services, and the various provisions of the Affordable Care Act and the Medicaid expansion program present an important opportunity to prevent homelessness and incarceration of people with mental illnesses.(43)

**Implementing Evidence-Based Treatments**

Evidence-based treatments that contribute to high levels of social functioning and recovery often are not used in the care of people suffering from behavioral health conditions. Individuals must be involved in meaningful daily activities for them to avoid restlessness, isolation, boredom, and lack of self-regard.

The population eligible for both Medicare and Medicaid (the dual eligible population), most of whom have annual incomes below $10,000 as well as more severe disabilities and greater needs than the Medicare population overall, should be an important focus of reinvented care for people with mental illness. In 2010 there were 9.2 million people in the dual-eligibility category. Over 40 percent of them had serious mental illnesses. The dual-eligible population with mental illness – 16 percent of all Medicare enrollees and 15 percent of all Medicaid enrollees – accounted for over 27 percent and nearly 40 percent, respectively, of the expenditures in these programs. (43)

CMS established a Medicare-Medicaid Coordination Office in an effort to ensure "full access to seamless, high quality care and to make the system as cost-effective as possible" for the dual-eligible population. CMS also provided funding to 15 states for developing models to integrate care for this population. The goal is to create new approaches to care coordination for these people, including primary, acute, and behavioral health care and long-term supports and services. These model programs seek to identify, develop, and validate coordinated approaches to care delivery and payment. But a key to this process is enrolling in the Medicaid expansion program so individuals have consistent and reliable coverage. (43)

For a description of the overall services and programs that could embody a new behavioral health care delivery system, please see **Appendix 4.**

*****

Even when all of the seven transitions or factors are in place as described in this section – from achieving insurance coverage to accessing primary care physicians – evidence abounds that the care delivered is not as good as it should be in the United States.

Medical errors cause unnecessary deaths. Providers continue to rely on basic measures of quality to establish a minimum level below which a provider may not be allowed to deliver services. And identifying that a technology or service is effective is an important part of the evidence base for quality improvement interventions, but it is not enough to overcome problems of underuse, overuse, or misuse. (44)

It is critically important that if we are going to achieve a high quality health care system in the United States, services should be performed in the right way, by the right caregiver, and in the right setting. And failure to satisfy the individual's (and the family's) desires for information and confidentiality, comfort and related expectations is another way in which quality of care transitions and the overall cascading effect of coverage and access described in this section can drop.

To encourage improved quality of care in Medicaid, the law requires HHS to develop a recommended core set of evidence-based health quality measures for adults who are eligible for Medicaid, similar to an existing requirement regarding child health quality measures. Initial quality-measure recommendations have been published. A Medicaid Quality Measurement program will be established to develop, test and validate emerging and innovative evidence-based measures for Medicaid. Results will be used to inform the revision, and to strengthen and improve initial core recommendations. Updated recommendations will be promulgated no later than two years after the program's establishment and annually thereafter.

Currently, there is considerable need to improve the quality of community mental health services furnished by Medicaid programs to people with serious mental illnesses. It is hoped that these provisions will help CMS improve this situation.

**To encourage improved quality of care in Medicaid, the ACA requires HHS to develop a recommended core set of evidence-based health quality measures for adults who are eligible for Medicaid, similar to an existing requirement regarding child health quality measures.**

## Other Considerations in Support of States Choosing to Opt in to the Medicaid Expansion

**This study has emphasized three major factors – improved budget gains, increased revenues and increased health insurance coverage – that provide strong evidence why states should consider participating in the ACA's Medicaid expansion effort. In addition, we have identified several reasons beyond the immediate comprehensive budget and financial arguments that states should consider as they assess their participation, including:**

- **Tax Benefits:** If the state chooses to opt out, citizens would be contributing Federal Tax dollars to a program from which their constituents would never benefit.

- **Grant Opportunities:** Several federal grants to states are contingent on the recipients providing mandated services to Medicaid eligible patients. If a state chose to opt-out, it could lose funding for Rural Health and Primary Care Initiatives, Safety and Quality Assurance programs, etc.

- **Addressing Chronic Care:** Hot-Spotting is a new concept that demonstrates there are significant cost-savings associated with actively targeting the highest-cost regions of the state where lower-income populations have the largest incidence of chronic disease, alongside the health care benefits to individuals of focusing on prevention and close monitoring by caregivers.

- **Health Care Modernization:** A study by Harvard economist David Cutler and Commonwealth Fund President Karen Davis attributes very large savings to overall health expenditures and to state budgets due to a more subjective, and less proven, measure of savings of health care modernization. (45)

  The concept is that the correction of misaligned incentives, increases in efficiency, decreases in waste (shift from supply-sensitive to evidence based services), the enormous capacity for productivity improvement in the health care industry noted by business scholars (if health care reform drives health care to act like other industries), can save the industry billions. The savings due to these health care modernization mechanisms projected by The Commonwealth Fund was $406 billion from 2010-2019.

*"States must stop cutting mental health funding and start recognizing the importance of preventing and treating mental illness. Mental illnesses won't disappear by pretending they're a failure of personal will, any more than congestive heart disease will disappear by pretending people diagnosed with the disease could run a marathon if they'd only try."*

**Paul Gionfriddo, Former Member of the Connecticut House of Representatives and Mayor of Middletown, CT. (From "Narrative Matters" in *Health Affairs*, September 2012)**

## Section Five: *The Role of Government and the New Medicaid Expansion Program*

### Introduction: Role of Government and Health Insurance

Support and opposition of the ACA has been almost split down the middle since its enactment in March 2010, although recent polls since the November 2012 Presidential Election show Americans more in favor of the law than against its implementation.

Those who are opposed are generally concerned that the ACA is unnecessary government intervention in the lives of Americans and too expensive during tough economic times.

Supporters have argued, in general, that an active and reasonably sized government has been essential to growth and prosperity in the United States. Moreover, programs like the ACA create the tools and assets that enable the private markets to better function, with the health insurance market being a case in point.

The ACA rewrites the insurance market. Under the old rules, health insurers have been free to deny health insurance coverage to people they deem too great a risk – such as those with a behavioral health condition – and to charge however much they want based on health status, age, or other characteristics such as family medical history, or job location. The old rules of the insurance market gave health insurers an incentive to design every aspect of their business so as to avoid individuals with high health costs or potentially higher utilization. People working for small businesses or purchasing coverage through the individual or "non-group" insurance market have felt the brunt of the system's limitations and faced high prices for spotty health insurance coverage or going uninsured.

The ACA introduces new rules for insurers as well as new requirements and subsidies for individuals. The new rules require insurers to issue policies and renew them for all legal applicants regardless of health status, and the rules prohibit the companies from refusing to cover pre-existing conditions or charge according to an individual's health. And to increase the number of people in insurance pools, the law extends eligibility for Medicaid to all citizens with incomes at 138 percent of the federal poverty level (FPL), and subsidizes private insurance for people earning up to four times the FPL.

The law's policy innovation adapted from earlier congressional Republican bills and Conservative foundation reports and the law's central organizational structure – the creation of state health insurance exchanges – is aimed at improving access to coverage and reducing insurance costs for people who purchase health coverage individually or through small groups. Those earlier reports also called for expanding Medicaid to fill in the uninsured blanks that the marketplace could not address.

The ACA accomplishes two main policy goals that can only occur through federal legislation and government implementation: It requires insurers to take on all comers who apply for coverage and requires all Americans who can afford coverage to purchase health insurance so all who are healthy and sick participate to keep costs down and protect those who are healthy from potential catastrophic costs. This process provides for a true insurance marketplace that all stakeholders participate in – consumers, insurers, providers, and government.

*The key to this process is the government provides the overall rules, but coverage and care are provided in the private marketplace.*

Further, times have changed since the United States adopted an employment-based insurance system and the new economy where people move from job-to-job more frequently which has left millions of people uninsured. Many policy observers believe that more Americans will now enjoy more freedom and independence as they will have increased ability to create new businesses or move to another job (known as job-lock) without fear of losing their health insurance coverage or pay higher costs. Due to the ability to obtain more affordable coverage, Americans will not face medical bankruptcies that have been on the rise since the beginning of the 2007 economic recession.

In addition, many observers believe the ACA will make us a healthier society, thus more free. Health itself is a matter of personal freedom. To be sick or disabled is to be less free. To be made destitute by an illness, and therefore dependent on others, is also to be less free. Illness cannot be avoided, but policy and other arrangements can increase our freedom by providing access to care and preventing illness from destroying our means of independence. The ACA – a government initiative as it increases the ability of Americans to access health promotion programs, preventive measures and wellness initiatives – promotes freedom. Currently, the health insurance market constrains that ability.

The ACA also encourages shared responsibility where individuals contribute to the cost of care except for lower-income populations. The ACA attempts to extend shared responsibility without entirely banishing actuarial fairness and it makes the health insurance system more inclusive without flattening its tiered structure. Rather than superseding Medicaid as earlier reform proposals had sought to do, the law extends Medicaid and CHIP to cover all those with incomes up to 138 percent of the FPL and serves as a boundary dividing public and private coverage for the population under 65 years of age.

**Medicaid Expansion and Historical Concerns of Governors**

If the ACA was a federal power grab, it would have simply extended the Medicare program to the entire population. Instead, the ACA builds on Medicaid (and the private marketplace), which the states run and extends the political philosophy of federalism, and the law calls for the states also to establish insurance exchanges, with the Department of Health and Human Services (HHS) serving as a back-stop in case a state fails to act. Yet the federal government pays for almost all the costs of expanded Medicaid eligibility and all of the subsidies for insurance in the exchanges.

The ACA, as we point out in this study, will affect different states in different ways. States that have funded more generous health programs on their own will likely see greater budgetary relief; for example, if a state previously offered Medicaid coverage to adults earning more than 138 percent of the FPL, it can move those beneficiaries in to the exchanges and off the state's budget. But, in an unusual twist, the ACA also rewards states that have the most limited Medicaid eligibility because the federal match for newly eligible is higher than those who were previously eligible. Ironically, the very states that have resisted the law – with historically low Medicaid eligibility and large uninsured populations – stand to see the greatest influx of federal revenue into their health care systems. These states could be the ACA's biggest fans.

But we recognize that many governors, legislatures, and other state officials do see the Medicaid expansion as a source not of new revenue but potential constraints. That state response partly reflects a flaw in Medicaid's original matching formula – and not the 100 percent matching rate under the initial three years of the new program and settling in at 90 percent in the ACA – which is highlighted during recessionary times when more workers lose their job-based health insurance coverage and become eligible for Medicaid coverage. While the federal share varies across states from 50 to 75 percent in the current program, it does not change due to economic conditions that affect a state's fiscal capacity that we witnessed during the 2007 recession and previous economic downturns. Although the federal stimulus package passed in 2009 temporarily increased the match, it expired in 2011. The failure of Congress to retain the increased match has colored state officials' response to long-term reforms envisioned in the new Medicaid expansion. Since Medicaid has become the largest state budget expense, a permanent recession-related adjustment could go a long way toward assuring state officials that they can manage Medicaid through tough economic times.

Some of the key concerns of governors also include that the Medicaid program needs substantial reform not an expansion. Furthermore, there is a fear by state officials of "risk of bait and switch" in federal matching funds as Congress will make cuts to the Medicaid program due to the "fiscal cliff" and that once a state opts in, it will be politically impossible to opt out later when the feds cut back funding.

Under the rules of the Budget Control Act of 2011, Congress cannot cut Medicaid funding under any "fiscal cliff" agreement and as discussed below, the Medicaid expansion is paid for through the ACA's funding arrangement. And during the history of the Medicaid program, Congress has not cut back on funding or benefits; it has only expanded. But we recognize there are still budget concerns related to the woodwork effect where more eligible citizens will enroll in the current

Medicaid program where the federal match is lower than in the new program as well as other obligations such as the current maintenance-of-effort provision in the ACA.

Although the ACA does impose some constraints such as maintaining eligibility for most classes of beneficiaries until 2014, the law also provides states with several resources and flexibility to adapt the program to local conditions. While making eligibility more uniform, the ACA leaves the states with flexibility in organizing Medicaid and supports new options such as the ACA's "Basic Health Program" for people with incomes up to twice the FPL (an alternative to subsidizing health insurance in the exchange for those with incomes between 133 percent and 200 percent of the FPL). The ACA also provides general waivers for the states as of 2017. After the 100 percent federal match is slightly reduced to 95 percent in 2017, states can opt out of any of the law's provisions as long they provide as comprehensive coverage to as many people as the ACA would otherwise insure, at no greater cost to the federal government.

The lack of health care for the poor is a national problem that the federal government was trying to address and one that only the federal government can fix. States cannot solve national problems. With health insurance exchanges open to all legal residents and Medicare providing coverage for elderly adults, the addition of all lower-income, nonelderly adults to Medicaid by the ACA would give virtually the entire population access to affordable health insurance coverage; a goal shared by both Republicans and Democrats over the last 50 years. The decision of the Supreme Court to allow the states to reject the Medicaid expansion, however, creates a substantial gap in the comprehensive-coverage design of the ACA. States such as Florida and Texas, whose governors have already pledged to reject the Medicaid expansion, have large uninsured populations.

Such states may leave their uninsured populations doubly burdened. They will deny impoverished citizens the coverage that the federal government was willing to finance and also leave many (who are above the tax-filing threshold) subject to the new tax on the uninsured. The ACA does not provide tax subsidies to those below 100 percent of the poverty level, because they were expected to be covered by Medicaid. Their impoverished legal residents would continue to rely on the charity of safety-net providers, which is the very problem that the ACA was designed to solve through the Medicaid expansion program.

The new Medicaid expansion program will address the needs of millions of lower-income Americans who are currently uninsured primarily due to out-of-pocket health insurance costs as well as previous illnesses that excludes many from the health insurance marketplace. Their health – and their pocketbook – depends on states to participate in the Medicaid expansion program.

**Implementation of ACA's Medicaid Expansion will Reduce the Federal Budget Deficit**

Several governors have also expressed concerns that even if state budgets are improved as a result of adopting the Medicaid expansion program, the overall ACA effort will hurt the federal budget and will lead to broken Medicaid financing promises.

Congressional budget rules adopted in 1990 known as "PAYGO" compels that new spending – such as the Affordable Care Act program – or tax changes, not add to the federal budget deficit.

PAYGO is not to be confused with pay-as-you-go financing, which is when a government saves up money to fund a specific project. Under the PAYGO rules a new proposal or program like the Affordable Care Act, must either be "budget neutral" or offset with savings derived from existing funds. The goal of this budget rule is to require those in control of the budget to engage in the diligence of prioritizing expenses and exercising fiscal restraint. The Medicare Part D Prescription Drug Program that was enacted in 2003 bypassed the PAYGO rules and added nearly $600 billion to the federal budget deficit.

ACA's provisions are intended to be funded by a variety of taxes and offsets, including the individual mandate tax. Major sources of new revenue include a much-broadened Medicare tax on incomes over $200,000 and $250,000, for individual and joint filers respectively, an annual fee on insurance providers, and a 40 percent excise tax on "Cadillac" insurance policies. There are also taxes on pharmaceuticals, high-cost diagnostic equipment, and a 10 percent federal sales tax on indoor tanning services. Other budget offsets are from intended cost savings such as changes in the Medicare Advantage program relative to traditional Medicare.

**Summary of ACA Tax Increases: (10-year Projection)**

- Increase Medicare tax rate by .9% and impose added tax of 3.8% on unearned income for high-income taxpayers: $210.2 billion
- Charge an annual fee on health insurance providers: $60 billion
- Impose a 40% excise tax on health insurance annual premiums in excess of $10,200 for an individual or $27,500 for a family: $32 billion
- Impose an annual fee on manufacturers and importers of branded drugs: $27 billion
- Impose a 2.3% excise tax on manufacturers and importers of certain medical devices: $20 billion
- Raise the 7.5% Adjusted Gross Income floor on medical expenses deductions to 10%: $15.2 billion
- Limit annual contributions to flexible spending arrangements in cafeteria plans to $2,500: $13 billion
- All other revenue sources: $28 billion

**Summary of ACA Spending Offsets: (10-year Projection)**

- Reduce payments on hospital services: $263 billion
- Reduce funding for Medicare Advantage policies: $156 billion
- DSH payment cuts and other Medicare provisions: $145 billion
- Reduce Medicare home health care payments: $66 billion
- Reduce skilled nursing payments: $39 billion
- Reduce certain Medicare hospital payments: $22 billion
- Reduce payments for hospice services: $17 billion

The Congressional Budget Office (CBO) estimates that the insurance coverage provisions of the ACA – such as tax credits and the Medicaid expansion – will have a net cost of $1.153 trillion over the 2012–2022 period – compared with $1.252 billion in federal budget gains and savings

projected for that 11-year period – or a net deficit reduction of nearly $100 billion. (Those figures do not include the budgetary impact of other provisions of the ACA, which in the aggregate will likely reduce budget deficits such as scaling up new delivery systems embodied in the ACA like Accountable Care Organizations, Health Homes, as well as new financing arrangements such as Prospective Payment Systems and Bundling).

For further federal guidance and rules for states applying for the new Medicaid expansion (issued on December 10, 2012 by HHS) please see **Appendix 5.**

## Conclusion

Overall, the ACA should have an extremely positive effect for people with behavioral health conditions by providing new coverage options for people with mental illnesses to obtain health insurance. The health care reform law expands Medicaid eligibility, creates a way for lower-income and other uninsured individuals to purchase health insurance and makes a number of changes to how the health care system operates through delivery and payment reforms. SAMHSA has estimated that 13.4 million people with mental illness will gain coverage under the ACA out of the 36 million people who will likely gain coverage. Although additional people are eligible for coverage beyond the 36 million who are expected to obtain coverage, some may not take the opportunity to enroll in programs despite their eligibility.

The cascading waterfall effect of the Medicaid expansion is remarkable. The expansion is a win-win-win for state budgets, entire state economies and for uninsured lower- and moderate-income individuals. State budgets will see large gains in federal spending to replace current state spending in their Medicaid programs in exchange for a small increase in state spending. The expansion will provide a badly needed injection of new revenues into state economies due to a multiplier effect. And the expansion can significantly expand Medicaid coverage for adults who are currently uninsured.

The Medicaid expansion effort is simply a great deal all the way around for states as NASMHPD has highlighted in several downstream effects through the new coverage expansion's "Waterfall Effect" – significant budget gains that will accrue, state economies that are energized with new revenues and a new coverage funding stream for millions of currently uninsured adults.

## Notes

(1) Families USA, "About Medicaid," August 2012.

(2) Matthew Buettgens, Stan Dorn and Caitlin Carroll, "Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014 to 2019," The Urban Institute, July 2011; John Holahan, et al, The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis, Kaiser Commission on Medicaid and the Uninsured, November 2012.

(3) Center for Budget on Budget and Policy Priorities, "Guidance on Analyzing and Estimating the Cost of Expanding Medicaid," August 9, 2012.

(4) Randall R. Bovbjerg, Barbara A. Ormond, and Vicki Chen, "State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts." Kaiser Commission on Medicaid and the Uninsured, February 2011.

(5) U.S. Department of Health and Human Services, "Spouses of Medicaid Long-Term Care Recipients," 2005.

(6) http://www.naph.org/Links/ADV/NAPHuncompensatedcareanalysis.aspx; Jack Hadley, John Holahan, Teresa A. Coughlin, Dawn M. Miller, "Covering the Uninsured in 2008: Current Costs, Sources Of Payment, And Incremental Costs," The Urban Institute, 2008.

(7) Stan Dorn and Matthew Buettgens, "Net Effects of the Affordable Care Act on State Budgets," prepared by the Urban Institute for First Focus, December 2010.

(8) John Sheils, Kathy Kuhmerker, Randy Haught, Joel Menges and Chris Park, "The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending," The Lewin Group, December 9, 2010. (includes the effects of other Medicaid provisions in the Affordable Care Act, including state savings from increased Medicaid drug rebates and reduced federal funding for states for Disproportionate Share Hospital payments to hospitals serving the uninsured.); The Lewin Group, "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers," Staff Working Paper #11, June 8, 2010.

(9) This total includes General Fund expenditures (40 percent), other state expenditures outside Medicaid (3 percent), and local expenditures (2.4 percent). Ted Lutterman, The Impact of the State Fiscal Crisis on State Mental Health Systems: Fall 2010 Update, NASMHPD Research Institute, Inc. (NRI).

(10) Theodore C. Lutterman, Bernadette E. Phelan, Ph.D., Azeb Berhane, Robert Shaw, and Verda Rana, Funding and Characteristics of state Mental Health Agencies, 2007, prepared by the National Association of State Mental Health Program Directors for the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, HHS Pub. No. (SMA) 09-4424, 2009. http://store.samhsa.gov/shin/content//SMA09-4424/SMA09-4424.pdf

(11) Jeffrey A. Buck, Medicaid Spending for Behavioral Health Treatment Services, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, June 23, 2010. www.nationalgranteeconference.com/presentations/2010/J.%20Buck.pdf.

(12) Kenneth E. Thorpe, "Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles," September 2011.

(13) Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012.

(14) David Bronson, Statement of Written Testimony, Hearing before the House Energy & Commerce Subcommittee on Health "Using Innovation to Reform Medicare Physician Payment," President, American College of Physicians, July18, 2012.

(15) Anthony Shih, Karen Davis, Stephen C. Schoenbaum, Anne Gauthier, Rachel Nuzum, and Douglas McCarthy, "Organizing the U.S. Health care Delivery System for High Performance," August 2008.

(16) The Kaiser Commission on Medicaid and the Uninsured, "The Role of Medicaid in State Economies: A Look at the Research," January 2009.

(17) Families USA, "Jobs at Risk: Federal Medicaid Cuts Would Harm State Economies," June 2011.

(18) Arkansas Department of Human Services, "Estimated Medicaid-Related Impact of the Affordable Care Act with Medicaid Expansion," July 17, 2012.

(19) Marianne Udow-Phillips, Joshua Fangmeier, Thomas Buchmuell, Helen Levy. The ACA's Medicaid Expansion: Michigan Impact. Center for Healthcare Research & Transformation. Ann Arbor, MI. October, 2012; Jim Stimpson. Medicaid Expansion in

Nebraska Under the Affordable Care Act. University of Nebraska Medical Center, Center for Health Policy, August 2012; David J. Becker, Ph.D. and Michael A. Morrisey, Ph.D. An Economic Evaluation of Medicaid Expansion In Alabama under the Affordable Care Act. Department of Health Care Organization and Policy School of Public Health University of Alabama at Birmingham, November 5, 2012; University of Missouri School of Medicine Department of Health Management and Informatics & Dobson DaVanzo & Associates, LLC for the Missouri Hospital Association and the Missouri Foundation for Health. THE ECONOMIC IMPACTS OF MEDICAID EXPANSION ON MISSOURI, November 2012; Only One Rational Choice: Texas Should Participate in Medicaid Expansion Under the Affordable Care Act, Provided as a Public Service by THE PERRYMAN GROUP, Waco Texas, October 2012.

(20) www.wphf.org and at hpi.georgetown.edu/floridamedicaid; Georgia Department of Community Health, "Medicaid Financial Update: Presentation to: DCH Board," June 14, 2012.

(21) U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States in 2010," September 13, 2011.

(22) Ellen Montz, MPA, Office of Health Reform, Department of Health and Human Services, Meena Seshamani, MD, PhD, Director of Policy Analysis, Office of Health Reform, Department of Health and Human Services, "Out-of-Pocket Expenses: Americans Shoulder the Burden of Growing Health Care Costs."

(23) Genevieve Kenney, Lisa Dubay, Stephen Zuckerman and Michael Huntress, "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid?" The Urban Institute, July 5, 2012.

(24) Genevieve M. Kenney, Lisa Dubay, Stephen Zuckerman, Michael Huntress, "Making the Medicaid Expansion an ACA Option: How Many Low-Income Americans Could Remain Uninsured?" The Urban Institute, June 29, 2012.

(25) Matthew Buettgens, John Holahan, Caitlin Carroll, Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," The Urban Institute March 2011.

(26) Substance Abuse and Mental Health Services Administration, 2010 NSDUH Survey and 2010 American Community Survey, 2010. (Data presented by Pamela Hyde, SAMHSA, at NASMHPD Annual Meeting, Challenges and Opportunities in a Changing Health Care Environment on July 16, 2012).

(27) CMHS/SAMHSA Uniform Reporting System, 2009 and NASMHPD and NASADAD estimates, 2011.

(28) http://namivirginia.org/assets/pdfs/NAMIVirginiaHealthCareReformReport.pdf.

(29) National Association of State Mental Health Program Directors, Medicaid Directors Council, Morbidity and Mortality in People with Serious Mental Illness, October 2006, available at: http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.

(30) http://namivirginia.org/assets/pdfs/NAMIVirginiaHealthCareReformReport.pdf.

(31) James J., Morris, Ph.D., 2005 Survey of Jail Mental Health Treatment Needs and Services, Department of Behavioral Health and Developmental Services, available at: http://www.dbhds.virginia.gov/documents/reports/adm-JCHCMorris061206.pdf.

(32) http://namivirginia.org/assets/pdfs/NAMIVirginiaHealthCareReformReport.pdf.

(33) http://psychcentral.com/blog/archives/2012/06/29/what-the-affordable-care-act-means-to-mental-health/.

(34) http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform/issue-brief-health-care-reform/issue-brief-health-care-reform.

(35) Buck, Jeffrey A. The Looming Expansion and Transformation of Public Substance Abuse Treatment under the Affordable Care Act, Health Affairs, Vol. 30, No. 8, 1402, 1403, August 2011.

(36) Stephen B. Soumerai, et al, Use of Atypical Antipsychotic Drugs for Schizophrenia in Maine Medicaid Following a Policy Change, Health Affairs, Vol. 27 No., 185-195 May 2008.

(37) Benjamin D. Sommers, Katherine Baicker, and Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions, New England Journal of Medicine," July 25, 2012.

(38) Committee on Health Insurance Status and Its Consequences, Institute of Medicine. "3 Coverage Matters." *America's Uninsured Crisis: Consequences for Health and Health Care*. Washington, DC: The National Academies Press, 2009.

(39) http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/NovemberMeetingDocs/MedicaidReformInVirginia.pd; Martha Heberlein, et al, Georgetown Univ. Center for Children and Families, *Medicaid Coverage for Parents under the Affordable Care Act* (June 2012). J. Haley and G.M. Kenney, Uninsured Vets and Family Members: Who Are They and Where Do They Live? Urban Institute, May 2012.

(40) The Kaiser Commission on Medicaid and the Uninsured, Health Reform Roundtables: Charting a Course Forward, "MEDICAID POLICY OPTIONS FOR MEETING THE NEEDS OF ADULTS WITH MENTAL ILLNESS UNDER THE AFFORDABLE CARE ACT," April 2011. (This brief was prepared by Chris Koyanagi of the Bazelon Center for Mental Health Law and Rachel Garfield, Jhamirah Howard, and Barbara Lyons of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured).

(41) Take Advantage of New Opportunities to Expand Medicaid Under the Affordable Care Act, Bazelon Center for Mental Health Law, July 2012.

(42) Joe Parks, MD, et al, Measurement of Health Status for People with Serious Mental Illnesses**,** National Association of State Mental Health Program Directors, Alexandria VA.

(43) David Mechanic. ANALYSIS & COMMENTARY: Seizing Opportunities Under The Affordable Care Act For Transforming The Mental And Behavioral Health System, Health Affairs, 31:2376-382, February 2012.

(44) Institute of Medicine, "To Err is Human," 1999.

(45) David Cutler and Karen Davis. The Impact of Health Reform on Health System Spending. The Commonwealth Fund, 1-14, 2010.

(46) Wendy K. Mariner, J.D., M.P.H., Leonard H. Glantz, J.D., and George J. Annas, J.D., M.P.H.,; Reframing Federalism – The Affordable Care Act (and Broccoli) in the Supreme Court, New England Journal of Medicine, 367:12, September 20, 2012.

# Table and Figure Sources/Notes

Tables 1, 2, 3, 4, 5, 9:
Urban Institute analysis, HPSM 2014-2019.

These tables are extracted from Matthew Buettgens, Stan Dorn and Caitlin Carroll, "Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014 to 2019," The Urban Institute, July 2011.

Table 6:
The Urban Institute, Net Effects of the Affordable Care Act on State Budgets, Report by Stan Dorn and Matthew Buettgens, Dec. 2010.

Table 7:
Ted Lutterman, The Impact of the State Fiscal Crisis on State Mental Health Systems: Fall 2010 Update, NASMHPD Research Institute, Inc. (NRI).

Table 8:
Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).
Notes: [a/] These estimates reflect the phase-in of provisions under the law and reflect lags in enrollment that are expected in the early years of the program. Costs are based upon reported spending amounts in the Medical Expenditures Panel Survey (MEPS) data for people with similar characteristics, which reflect the unique demographic characteristics of the newly eligible populations. The MEPS data are adjusted to simulation year based upon CBO projections of expenditure

[b/] Based upon state-level spending in 2008 projected to 2019 using CBO assumptions on enrollment and expenditure growth through 2019.

[c/] Includes currently enrolled working families who take coverage through an employer who decides to start offering coverage as a result of the incentives created under the ACA. These includes employers who start to offer coverage due to the small employer tax credit, the penalty for not offering coverage, or in response to changes in premiums due to rating reforms.

[d/] Includes currently eligible but not enrolled children who automatically become covered as a newly eligible parent becomes covered under the expanded Medicaid program. Also includes increased enrollment among currently eligible but not enrolled people in response to the penalty for remaining uninsured. (This applies only to adults with incomes over the tax filing thresholds that are subject to penalties.)

[e/] Based upon an HBSM simulation of expanding eligibility for Medicaid in each state. We simulated the decision for newly eligible people to income, employment status and demographic characteristics. The simulation results in average enrollment of about 75% for newly eligible uninsured people and 39% for newly eligible people who have access to employer health

insurance.

[f/] Includes adults who do not otherwise qualify as aged, disabled, or a parent with custodial responsibilities for children

[g/] The law would gradually increase the federal matching percentage to 90% by 2020 for non-custodial adults already covered under a Medicaid 1115 waiver. These states include Arizona, Delaware, Hawaii, Maine, Missouri, New York and Vermont.

[h/] The Act increases the rebates received by Medicaid from prescription drug companies, including increases in rebate amounts and rebates for Medicaid beneficiaries covered by states under private health plans. Recently released guidance from the U.S. Department of Health and Human Services (HHS) indicates that many states will share in these increased rebates.

[i/] The ACA would reduce federal Medicaid Disproportionate Share (DSH) Hospital Payments by $14.1 billion over the 2014 through 2019 period. (DSH are supplemental payments to hospitals serving a disproportionate share of Medicaid beneficiaries and/or uninsured people). The ACA requires the Secretary of HHS to develop rules for allocating the cuts to states in proportion to the number of uninsured in the state, which is reduced for states designated as "low" DSH states. The reduction does not apply to DSH funds used to fund an expansion under an 1115 waiver. We illustrated the potential impact of this provision using a formula that is generally consistent with what is required in the legislation.

[j/] Estimates are relative to the Arizona 2010 baseline spending projection, which predates the state's discontinuation of CHIP and the proposition 204 Section 115 eligibility.

Table 9
Source: Urban Institute analysis, HIPSM 2014-2019.
Note: Does not include the high MOE savings scenario or savings on mental health spending.
1Spending on acute care for the nonelderly

Tables 10, 11, 12, 13:
Families USA, "Jobs at Risk: Federal Medicaid Cuts Would Harm State Economics," June 2011.

Figure 3:
The Kaiser Commission on Medicaid and the Uninsured, "The Role of Medicaid in State Economies: A Look at the Research," January 2009.

Figure 4:
Arkansas Department of Human Services, "Estimated Medicaid-Related Impact of the Affordable Care Act with Medicaid Expansion," July 17, 2012.
http://mepconline.com/blog/category/affordable-care-act/

Figures 6, 7:
2008-2010 National Survey of Drug Use & Health 2010 American Community Survey.

# Appendix 1

| Total State and Federal Medicaid Spending (Assuming Current State Financial Responsibilities Continue)[1] 2014-2019 Totals | | | | | | |
|---|---|---|---|---|---|---|
| **Millions $** | **No Reform** | | **Reform** | | **Difference** | |
| **States** | **Federal Spending** | **State Spending** | **Federal Spending** | **State Spending** | **Federal Spending** | **State Spending** |
| **New England:** | **70,603** | **63,347** | **78,384** | **67,475** | **7,781** | **4,127** |
| Connecticut | 10,653 | 10,554 | 12,174 | 12,028 | 1,520 | 1,474 |
| Maine | 11,147 | 6,143 | 12,706 | 6,885 | 1,558 | 742 |
| Massachusetts | 34,323 | 34,152 | 35,766 | 35,513 | 1,443 | 1,362 |
| New Hampshire | 3,611 | 3,602 | 5,285 | 3,826 | 1,675 | 224 |
| Rhode Island | 6,754 | 6,088 | 8,151 | 6,309 | 1,397 | 221 |
| Vermont | 4,116 | 2,808 | 4,304 | 2,914 | 188 | 106 |
| **Middle Atlantic:** | **236,667** | **221,346** | **275,855** | **242,221** | **39,189** | **20,865** |
| Delaware | 3,230 | 3,222 | 3,750 | 3,718 | 519 | 496 |
| District of Columbia | 4,628 | 1,983 | 5,339 | 2,036 | 711 | 53 |
| Maryland | 11,531 | 11,531 | 18,121 | 12,284 | 6,590 | 753 |
| New Jersey | 24,653 | 24,524 | 35,374 | 26,207 | 10,721 | 1,683 |
| New York | 121,851 | 121,239 | 132,180 | 131,020 | 10,329 | 9,781 |
| Pennsylvania | 70,774 | 58,846 | 81,092 | 66,946 | 10,318 | 8,100 |
| **East North Central:** | **255,607** | **177,984** | **321,216** | **192,598** | **65,609** | **14,615** |
| Illinois | 55,118 | 54,185 | 71,317 | 56,860 | 16,199 | 2,675 |
| Indiana | 52,011 | 28,924 | 60,464 | 33,435 | 8,453 | 4,511 |
| Michigan | 56,754 | 37,172 | 68,953 | 38,742 | 12,199 | 1,570 |
| Ohio | 67,430 | 41,084 | 91,273 | 43,569 | 23,843 | 2,485 |
| Wisconsin | 24,293 | 16,619 | 29,209 | 19,992 | 4,916 | 3,373 |
| **West North Central:** | **103,835** | **71,172** | **131,440** | **76,329** | **27,606** | **5,157** |
| Iowa | 13,765 | 8,228 | 14,432 | 8,643 | 668 | 415 |
| Kansas | 12,596 | 8,283 | 15,864 | 8,580 | 3,269 | 297 |
| Minnesota | 20,966 | 20,966 | 24,201 | 22,012 | 3,235 | 1,046 |
| Missouri | 41,680 | 24,276 | 56,987 | 27,136 | 15,307 | 2,860 |
| Nebraska | 7,046 | 4,788 | 9,148 | 5,098 | 2,102 | 310 |
| North Dakota | 1,817 | 1,060 | 3,053 | 1,177 | 1,235 | 117 |
| South Dakota | 5,966 | 3,571 | 7,755 | 3,683 | 1,790 | 112 |
| **South Atlantic:** | **194,958** | **128,110** | **311,715** | **137,273** | **116,757** | **9,163** |
| Florida | 62,884 | 50,634 | 109,659 | 55,354 | 46,776 | 4,720 |
| Georgia | 34,631 | 18,902 | 55,851 | 20,449 | 21,220 | 1,547 |
| North Carolina | 46,585 | 25,511 | 69,433 | 26,608 | 22,848 | 1,096 |
| South Carolina | 17,987 | 7,675 | 27,700 | 8,235 | 9,713 | 560 |
| Virginia | 21,550 | 21,379 | 31,374 | 22,303 | 9,824 | 925 |
| West Virginia | 11,321 | 4,008 | 17,697 | 4,323 | 6,376 | 315 |
| **East South Central:** | **137,441** | **62,513** | **182,596** | **65,052** | **45,155** | **2,539** |
| Alabama | 26,721 | 12,552 | 37,352 | 13,153 | 10,631 | 601 |
| Kentucky | 43,605 | 18,541 | 54,725 | 19,088 | 11,120 | 547 |
| Mississippi | 24,037 | 7,656 | 31,609 | 8,020 | 7,572 | 364 |
| Tennessee | 43,078 | 23,765 | 58,910 | 24,792 | 15,832 | 1,027 |
| **West South Central:** | **153,894** | **90,577** | **228,223** | **97,557** | **74,329** | **6,980** |
| Arkansas | 15,030 | 5,613 | 21,810 | 5,989 | 6,781 | 377 |
| Louisiana | 19,781 | 7,958 | 32,175 | 8,797 | 12,394 | 839 |
| Oklahoma | 24,324 | 12,586 | 30,095 | 13,073 | 5,771 | 487 |
| Texas | 94,760 | 64,420 | 144,143 | 69,697 | 49,383 | 5,277 |
| **Mountain:** | **81,558** | **48,268** | **107,067** | **53,258** | **25,509** | **4,990** |
| Arizona | 33,298 | 17,354 | 37,037 | 18,807 | 3,740 | 1,453 |
| Colorado | 11,769 | 11,749 | 19,800 | 12,438 | 8,031 | 689 |
| Idaho | 6,715 | 2,905 | 8,818 | 3,054 | 2,102 | 148 |
| Montana | 3,486 | 1,630 | 4,736 | 1,729 | 1,250 | 99 |
| Nevada | 5,242 | 5,231 | 8,863 | 5,552 | 3,620 | 320 |
| New Mexico | 11,566 | 4,752 | 14,262 | 5,774 | 2,696 | 1,023 |
| Utah | 8,209 | 3,376 | 11,292 | 4,4557 | 3,083 | 1,181 |
| Wyoming | 1,272 | 1,270 | 2,260 | 1,347 | 988 | 77 |
| **Pacific:** | **185,320** | **178,762** | **243,789** | **190,142** | **58,469** | **11,380** |
| Alaska | 1,496 | 1,464 | 2,460 | 1,572 | 964 | 108 |
| California | 148,487 | 147,955 | 196,451 | 154,157 | 47,965 | 6,202 |
| Hawaii | 3,892 | 3,171 | 4,660 | 3,747 | 768 | 576 |
| Oregon | 11,291 | 6,776 | 16,315 | 9,551 | 5,024 | 2,775 |
| Washington | 20,154 | 19,396 | 23,903 | 21,116 | 3,749 | 1,719 |
| **Total** | **1,419,883** | **1,042,078** | **1,880,287** | **1,121,895** | **460,404** | **79,816** |

Source: Urban Institute analysis, HIPSM 2014-2019.

[1]Spending on acute care for the nonelderly. Assumes all current eligibility categories continue, without any enhanced federal funding.

## Appendix 2

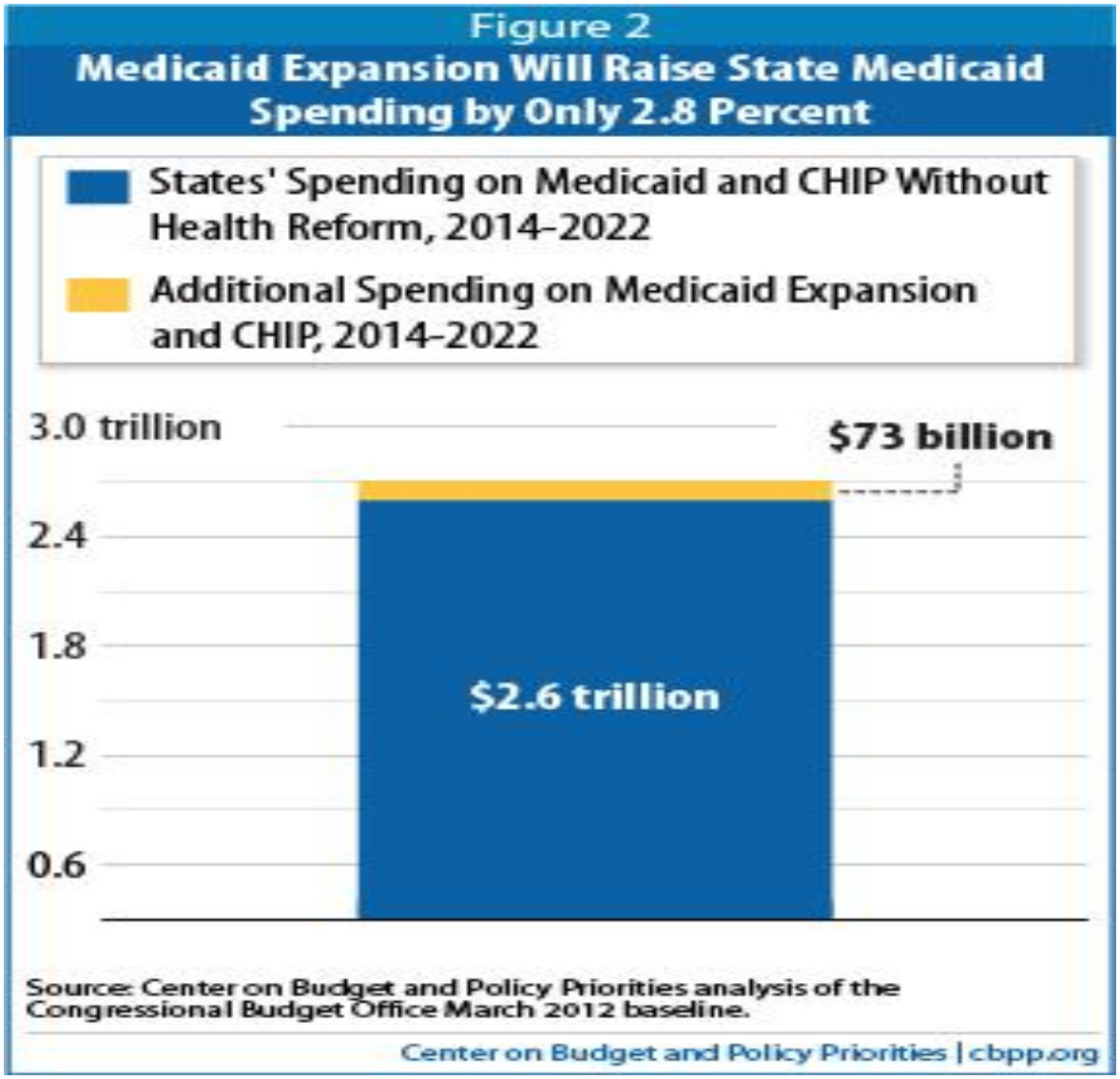
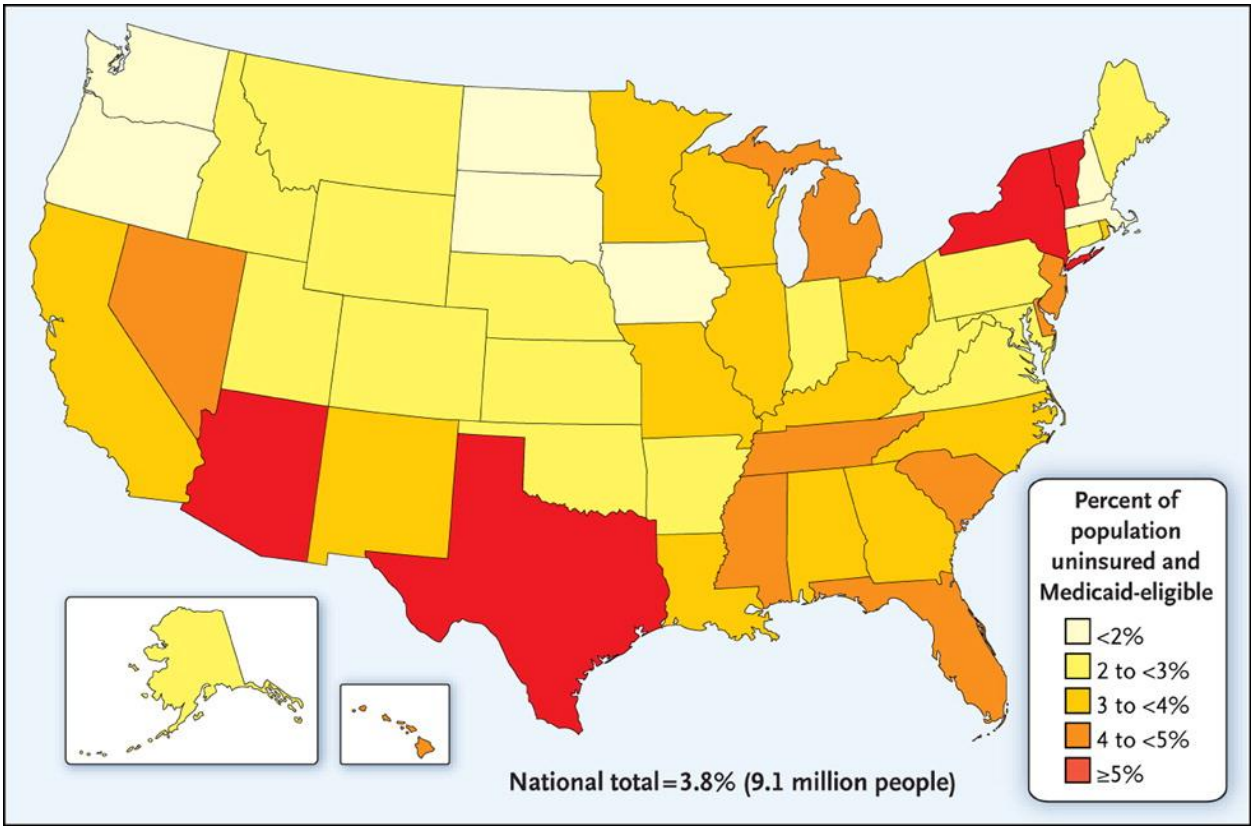


Figure 2
Medicaid Expansion Will Raise State Medicaid Spending by Only 2.8 Percent
States' Spending on Medicaid and CHIP Without Health Reform, 2014–2022
Additional Spending on Medicaid Expansion and CHIP, 2014–2022
3.0 trillion
2.4
1.8
1.2
0.6
$73 billion
$2.6 trillion
Source: Center on Budget and Policy Priorities analysis of the Congressional Budget Office March 2012 baseline.
Center on Budget and Policy Priorities | cbpp.org

# Appendix 3

## Percentages of States' Populations 0–64 Years of Age That Are Currently Uninsured and Eligible for Medicaid.




The sample is restricted to U.S. citizens. Individuals who are theoretically eligible for Medicaid as part of a Section 1115 waiver but who live in states that have closed enrollment owing to legislative caps are not included.

Source: Benjamin D. Sommers, Katherine Baicker, and Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions, New England Journal of Medicine," July 25, 2012.

# SAMHSA Description of a Modern Addictions and Mental Health Service System

## Introduction

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010—together referred to as "The Affordable Care Act (ACA)" recognizes that prevention, early intervention and when necessary, treatment of mental and substance use disorders are an integral part of improving and maintaining overall health. In articulating how these conditions should be addressed in a transformed and integrated system, SAMHSA must describe what services are included in a modern addiction and mental health system in order to clarify the roles and responsibilities associated with its structure, financing and operation.

As outlined in this brief, a modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective. It is a public health asset that improves the lives of Americans and lengthens their lifespan.

This document is designed to describe the basic services required for such a system and foster discussion among the Department of Health and Human Service Operating Divisions and other federal agencies on how best to integrate mental and substance use disorders into the health reform implementation agenda. This document can provide clarity to federal agencies that regulate or purchase services for individuals with mental and substance use disorders; offer guidance to agencies that are presently making decisions about expanding services to these populations; and assist in planning possible changes to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Mental Health Services Block Grant. It will assist SAMHSA to implement its strategic initiatives including supporting military families, prevention, housing and homelessness, and workforce development.

## Vision

The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a "good" and "modern" system of care is to provide a full range of high quality services to meet the range

of age, gender, cultural and other needs presented. The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidenced-informed practice; the system should recognize the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, etc. A good system should also promote healthy behaviors and lifestyles, a primary driver of health outcomes.

This vision recognizes that the U.S. health system includes publicly and privately funded organizations and managed care components that must work well together to produce desired outcomes. The integration of primary care, mental health and addiction services must be an integral part of the vision. Mental health and addiction services need to be integrated into health centers and primary care practice settings where most individuals seek health care. In addition, primary care should be available within organizations that provide mental health and addiction services, especially for those individuals with significant behavioral health issues who tend to view these organizations as their health homes. Providing integrated primary care and behavioral health services will allow for cost effective management of co-morbid conditions.

**System Results**

In order to accomplish the vision, SAMHSA will be committed over time to achieving the following system results:

- People avoid illnesses that can be prevented.
- People get well and stay well.
- A continuum of services benefit package, within available funding, that supports recovery and resilience, including prevention and early intervention services, an emphasis on cost-effective, evidence-based and best practice service approaches, with special consideration for service delivery to rural and frontier areas and to other traditionally un-served and underserved populations, like populations of color.
- A system that integrates high quality medication management and psychosocial interventions, including supports for community living, so that all are available to consumers as their conditions indicate. Services are available and provided in the appropriate "therapeutic dose."
- Promoting program standards, including common service definitions, utilization management measurements/criteria, quality requirements, system performance expectations, and consumer/family/youth outcomes.
- Creation and maintenance of an adequate number and distribution of appropriately credentialed and competent primary care and behavioral health care providers.
- Local systems of care in which primary care and behavioral health providers and practitioners care are aligned with one another and with other systems.
- High organizational capacity in all service sectors to access, interpret, and apply performance data and research findings on an ongoing basis to improve care. Funding strategies that will be sufficiently flexible to promote efficiency, control costs, and pay for performance.
- Creation of an adequate number and distribution of appropriately credentialed and competent primary care and behavioral health care providers.

## Principles

A good and modern mental health and substance use system should be designed and implemented using a set of principles that emphasizes behavioral health as an essential part of overall health in which prevention works, treatment is effective and people recover. These principles should apply to the provision of mental health and addiction services and cross the lifespan of individuals who need and use these services. At a minimum, these principles should recognize that:

- Preventing and treating mental and substance use disorders is integral to overall health.
- Services shown to be effective must be available to address current health and behavioral health disparities and be relevant to, and respond to, the diverse cultures and languages of individuals and families.
- A wide range of effective services and supports should be available based on a range of acuity, disability, engagement levels and consumer preferences. The consumer's resilience and recovery goals in their individualized service plan should dictate the services provided.
- The system should use information and science to deliver services. Services should be provided in convenient locations in order to reduce barriers, identify needs as early as possible, and engage individuals in care as early and as easily as possible.
- Wherever possible, the health system should support shared decision making with adult consumers, with youth and with families.
- Effective care management that promotes independence and resilience is key to coordinating health and specialty care.
- Service delivery must achieve high quality standards and results as well as outcomes that are measurable and are measured.
- Technology will be an important tool in delivering services. This includes tele-health, web-based applications and personal digital assistants that assist individuals in their recovery. Increased use of technology will expand access to and coordinate care rather than always relying on location-based service delivery.
- Services that are proven effective or show promise of working will be funded and should be brought to scale; ineffective services and treatments that have not shown promise will not be funded.

## The Evidence

The system should be guided by principles and evidence that mental illness and substance abuse prevention, treatment, and recovery and resiliency-based services work. Over the past thirty years the body of evidence supporting what systems should provide, and for whom, has evolved significantly. While the list of evidence is voluminous, there are several hallmark programs and research efforts that have shaped effective practice. These programs and efforts include: the Comprehensive Community Mental Health Services Program for Children and Families and the Community Support Program (CSP); the National Quality Forum's Standards of Care for Treatment of Substance Use Disorders. Various Institute of Medicine (IOM) reports, including "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities;" and "Improving the Quality of Health Care for Mental and Substance Use

Conditions: the U.S. Preventive Services Task Force (USPSTF); and several Surgeon General Reports, including "Mental Health: A Report of the Surgeon General" and Mental Health: Culture, Race and Ethnicity." These reports, as well as others, continue to document the effectiveness of treatment for and prevention of mental health and substance use disorders. SAMHSA will issue a companion document detailing research on service effectiveness and its application to the services in the continuum of care.

**Service Elements of a Mental Health and Addictions Service System**

The system should include activities and services that go beyond traditional interventions such as the current acute care residential or outpatient services. Coordination, communication, and linkage with primary care can no longer be optional given the prevalence of co-morbid health, mental health and substance use disorders.

The good and modern system must incorporate the different functions that are performed within various parts of the mental health and addiction delivery system. General hospitals, state mental health hospitals, community mental health centers, psychiatric/psychosocial rehabilitation center, child guidance centers, private acute inpatient treatment facilities, licensed addiction agencies, opioid treatment providers, individually licensed practitioners, primary care practitioners, recovery and peer organizations all have key roles in delivering mental health and substance use services. Health care reform will push the specialty system to coordinate care among providers of different levels and modalities of care and the mainstream health care delivery system, especially for children and youth, for whom many of the services are provided outside of the specialty mental health and addiction treatment delivery system, requiring linkages with education, child welfare or juvenile justice systems.

A small percentage of adults with serious mental illness and children with serious emotional disturbances consume a majority of resources. An integrated system should develop improved strategies for these individuals who may be underserved or poorly served in the current system. Strategies should be consistent with provisions in the health care reform bill that seek to develop special needs plans, health homes and accountable care organizations.

An array of services must be designed to incorporate the concept of community integration and social inclusion for individuals/families. Community integration ensures that people with behavioral health problems, disabilities and other chronic illnesses have the supports and services they need to live in a home/family/community setting. This includes services to help people live in housing of their choice and support them in school, work, families and other important relationships; both paid and unpaid community supports can help achieve these goals. This will require public purchasers to take a comprehensive look at how its policies impact the way urban, rural and frontier areas develop and how well those places support the people who live there, in all aspects of their lives—education, health, housing, employment, and transportation. This "place-based" approach should be taken to help communities work better for people.

Discussed below are the service elements that should comprise a mental health and substance use system.

**Health Promotion.** Health promotion is a significant component of a comprehensive prevention and wellness plan, and plays a key role in efforts to prevent substance abuse and mental illness. Since health promotion efforts have been traditionally community- and school-based in the public sector, there is an opportunity to engage the private sector (particularly employers and insurers) in health promotion initiatives.

**Prevention.** The field of prevention science, well known for advancing the health of people at risk for illnesses such as cancer, diabetes, and heart disease, has also produced effective strategies for the mental health and substance abuse fields. The system must have three levels of prevention practice: Universal, which addresses populations at large; selective, which targets groups or individuals who are at higher risk of developing a substance abuse problem or mental illness; and indicated, which addresses individuals with early symptoms or behaviors that are precursors for disorder but are not yet diagnosable. Prevention efforts can support safer schools and communities, better health outcomes, and increased productivity. Prevention science tells us that a comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavioral or normative change. Health reform recognizes that prevention is a critical element in bending the cost curve and in improving the overall health of all Americans. All health-related prevention efforts should recognize and address the interrelated impact of mental health and substance use on overall well-being.

Significantly increased focus should be placed on promoting prevention prepared communities as proposed by the Office of National Drug Control Policy. Prevention programs should be made available to all individuals through appropriate channels including healthcare providers, media, employers, public agencies, communities, and schools. SAMHSA should continue efforts to identify effective prevention services that can be feasibly implemented in community settings, as well as clearly defined, coded and reimbursed.

**Screening and Early Intervention.** Appropriate screening should be vetted with the USPSTF so that it becomes part of the standard benefit plan and is available without cost to consumers. Screening services must include, at a minimum, services from the A and B list developed by the USPSTF which includes depression screening and Screening, Brief Intervention and Referral to Treatment (SBIRT) for alcohol use. Services should also include mental and substance use screens available through Early and Periodic Screening Diagnosis and Treatment (EPSDT). Screening may also be used to identify warning signs for suicide to enable early intervention and suicide prevention.

**Care Management.** Effective care management integrates primary care and specialty health services through approaches that coordinate an individual's medical care and provide assistance in navigating other healthcare providers and systems, including behavioral health. Different designs need to be considered that will include components of specific models (such as intensive case management or community support) since it is not likely that a "one size" fits all care management model exists. Regardless of the approach, individuals performing care management must be well trained and appropriately paid and reimbursement systems/strategies must recognize the importance of collateral contacts.

**Self Help and Mutual Support.** Self/mutual help support groups have been defined as a network of 12- step and abstinence-based groups for persons recovering from various addictions, as well as groups for family members of people with substance use disorders. In recent years support groups specifically for individuals with serious mental illness have grown significantly, as have 'family to family' and 'youth to youth' efforts. These groups provide a social network offering their members: support in managing their lives, role models and the strong belief that they can recover. These voluntary supports will continue to be needed in a good and modern system that creates strong relationships with self-help and mutual supports.

**Proposed Continuum of Services.** A modern mental health and addiction system should have prevention, treatment and recovery support services available both on a stand-alone and integrated basis with primary care and should be provided by appropriate organizations and in other relevant community settings. SAMHSA's proposed continuum comprises of nine domains, including:

- Health Homes
- Prevention and Wellness Services
- Engagement Services
- Outpatient and Medication Assisted Treatment
- Community Supports and Recovery Services
- Intensive Support Services
- Other Living Supports
- Out of Home Residential Services
- Acute Intensive Services

**Core Structures and Competencies for a Modern System**

While appropriate, quality services are a critical piece of constructing a modern behavioral health system, there will need to be capacity and infrastructures to ensure that individuals who seek services can access them successfully. Easy and open access to care for all individuals and families, at all points on the continuum of need for care, and through any service sector, will require further development of core structures and competencies, as described below.

**Workforce.** The modern system must have experienced and competent organizations with staff that can deliver the services described in the previous section. SAMHSA in conjunction with the Health Resources and Services Administration and provider associations will need to develop strategies for creating learning models to ensure the workforce has the information, supervision, technical assistance, and culturally relevant training to effectively implement improved practices. Recruitment and retention efforts will need to be enhanced, especially to increase the available pool of culturally, ethnically and racially diverse practitioners. Providers will need to embrace team-based care and collaboration with other systems as a way of doing business. Licensure requirements need to evolve and certification requirements need to be strengthened for those professions that do not currently require formal licensure. The workforce must also develop an improved ability to use technology to provide, manage and monitor quality care.

In addition, SAMHSA and other federal partners must continue to advance the development and

use of peer/family specialists and recovery organization staff to address the demand for mental health and addiction services. Four critical efforts loom large: (1) redeployment of the shrinking professional workforce to positions of consultation and oversight; (2) augmentation of the existing workforce to include trained family, youth and peer supports as part of the paid workforce; (3) a more concerted pre-professional training effort to prepare new frontline and professional providers for the modern delivery system that is consumer- and family-driven, youth- guided, recovery/resiliency-oriented and evidence-based; and (4) a robust continuing training effort to develop, enhance, and sustain providers' capacity to access, interpret, and apply performance data and research findings on an ongoing basis to improve care.

**Empowered Health Care Consumers.** Health care consumers/families will need information and tools to allow them to promote and reinforce their role as the center of the health care system. At a minimum, this will include a system that supports health literacy, shared decision making, and strategies for individuals and families to direct their own care. Health literacy is the first building block of self-care and wellness. Shared decision making should become the standard of care for all treatment services. Participant direction of services allows individuals and their caregivers (when appropriate) to choose, supervise and in some instances, purchase the effective supports they need rather than relying on professionals to manage these supports. Health care consumers and families will also need access to user-friendly information on the effectiveness of available services in order that they may truly make informed health care decisions.

**Information Technology.** To achieve optimum individualized care, a modern health system should include a structure in which all holistic outcomes, measures and indicators of health are collected, stored and shared with the individual and all of those providers who are associated with care of the individual. To that end, interoperable, integrated electronic health records will be necessary, as will community-wide indicators of mental health and substance use disorders. This will be challenging given that many behavioral health providers have limited or no modern information technology and need resources to make this transition. Furthermore, appropriate security mechanisms and informed consent should drive this system while taking into account protection of individual rights and support to ensure appropriate linkages to services.

**Funding and Payment Strategies.** In the public sector, individuals/families/youth with complex mental and substance use disorders receive services funded by federal, state, county and local funds. These multiple funding sources often result in a maze of eligibility, program and reporting specifications that create funding silos featuring complicated administrative requirements. If services are to be integrated, then dollars must be also intertwined. In the same way that Medicaid will be required to streamline eligibility and enrollment, the good and modern system must either blend or braid funds in support of comprehensive service provision for consumers, youth and families.

Health care payment reform is intended to align quality and cost and reinforce desired client and system outcomes. The ACA envisions a variety of new purchasing strategies, including episode-based payments, risk-based inpatient/outpatient bundled payments, shared savings, and financial consequences for "never events." These changes in methodology and requirements will be restructured to support achievement of the outcomes associated with primary care and specialty care integration.

**Quality and Performance Management.** Quality improvement through the use of outcomes and performance measures is a cornerstone of the Affordable Care Act. It will be critical that SAMHSA clarify the outcome measures that help define a good system of care; use this information to shape programs and practices; and operationalize SAMHSA's message of "a life in the community for everyone." A renewed focus on quality will also help payers link performance improvement with payment while moving away from the current incentives to provide more care without evidence of improved outcomes.

**Sustainable Practice Improvement.** The key to a modern behavioral health system will be an ethic of – and standard operating procedures for – continuous practice improvement to incorporate new evidence and to ensure more accountability, with a focus on "practice-based evidence" as well as evidence-based practice. Standards being developed by national organizations can guide providers (agencies, group practices and individual practitioners) in their efforts to reshape their practice and to sustain changes over time.

**Continued Partnerships.** While the good and modern system focuses on the need for better integration of primary care and behavioral health, this does not supplant the continued need to work with other systems that serve individuals with mental and substance use disorders. Links between the good and modern system and the child welfare, criminal and juvenile justice, education and aging systems will be more critical than ever.

## Challenges

There are many challenges to achieving a good and modern mental health and addiction system. While much progress has been made, stigma still exists regarding mental illness and substance use disorders. Policy makers and payers have limited knowledge and to some degree continued skepticism regarding the efficacy of available prevention strategies, treatments and approaches. Payers will continue to rely on risk based approaches to contain costs. It is imperative to ensure that special protections are in place to address issues regarding adverse selection. The workforce is graying and is struggling to develop adult learning models that can train staff on delivering evidenced-based and promising practices. There are still significant boundary issues within and among the mental health, addiction, primary care and other social service systems. More permeable boundaries will need to be created.

## Conclusion

The elements described in this document should serve as a starting place for discussion among the various policy-makers and stakeholders concerned about services, reimbursement and infrastructure. There will always be differences of what should be included in a modern mental health and addiction system. However, these differences need to be mediated immediately with an understanding that what is modern in 2011 will change in five, ten or twenty years.

# Appendix 5

## Medicaid Expansion Guidance

FROM THE SECRETARY OF HEALTH AND HUMAN SERVICES

December 10, 2012

Dear Governor:

For more than two years, we have worked with you to implement the Affordable Care Act and strengthen our health care system. Thanks to the law, Americans will have access to new marketplaces where they will have more high quality insurance choices. Additionally, the law allows your state to expand your Medicaid program and the federal government will pay 100% of the cost of all newly eligible residents in Medicaid for 3 years, beginning in 2014. We continue to encourage all states to fully expand their Medicaid programs and take advantage of the generous federal matching funds to cover more of their residents.

As we continue to move forward with implementation of the Affordable Care Act, I have heard from a number of governors and other state leaders with questions about the new marketplaces called Exchanges, Medicaid, and other aspects of the health care law. As both a former governor and state insurance commissioner, I believe that states are in the best position to make decisions about their health insurance marketplaces. As such, I am committed to providing you with as much guidance and information as I can over the coming weeks and months to help with the significant decisions you must make.

It is my hope that all states will seriously consider establishing a State-based Exchange, or running components of an Exchange, but regardless of a state's decision, my Department stands ready to help. To that end HHS developed the enclosed document providing answers to many of the questions raised by governors, state legislators, and others over the past few months, which we hope will be helpful in your decision-making process.

As always, my staff is available to help your state officials to better understand the information we are providing today. I also reiterate my offer to meet with you to discuss implementation issues, should that be helpful.

I look forward to working with you toward our ultimate goal of ensuring that every American has access to affordable, high quality health care. Please do not hesitate to contact me if you have any further thoughts or concerns.

Sincerely,

Kathleen Sebelius

**Provisions in the December 10 HHS Guidance Letter to Governors on Medicaid Expansion Issues Only (Beginning with #24)**

**Date** : December 10, 2012

**Subject**: Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid

## MEDICAID

### Expansion

***24. Is there a deadline for letting the federal government know if a state will be proceeding with the Medicaid expansion? How does that relate to the Exchange declaration deadline? Is HHS intending to provide guidance to states as to the process by which state plan amendments are used to adopt Medicaid expansion under the Affordable Care Act?***

**A.** No, there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion. Nor is there any particular reason for a state to link its decision on the Exchange with its decision on the Medicaid expansion. States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions.

As with all changes to the Medicaid state plan, a state would indicate its intention to adopt the new coverage group by submitting a Medicaid state plan amendment. If a state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS. The state plan amendment process is itself undergoing modernization. As part of an overall effort to streamline business processes between CMS and states, in early 2013 CMS will begin implementing an online state plan amendment system to assist states in filing state plan amendments. We will be discussing the submission process for Affordable Care Act-related state plan amendments on our monthly State Operations and Technical Assistance calls with states and will be available to answer questions through that process.

While states have flexibility to start or stop the expansion, the applicable federal match specific calendar years outlined in the statute: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent by 2020, remaining at that level thereafter.

***25. If a state accepts the expansion, can a state later drop out of the expansion program?***

**A.** Yes. A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.

***26. Can a state expand to less than 133% of FPL and still receive 100% federal matching funds?***

**A.** No. Congress directed that the enhanced matching rate be used to expand coverage to133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate. For the newly eligible adults, states will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations. We also intend to propose further changes related to cost sharing.

In 2017, when the 100% federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstrations. This demonstration authority offers states significant flexibility while ensuring the same level of coverage, affordability, and comprehensive coverage at no additional costs for the federal government. We will consider section 1115 Medicaid demonstrations, with the enhanced federal matching rates, in the context of these overall system demonstrations.

***27. Do you still support the Medicaid blended FMAP (matching rate) proposal in your budget?***

**A.** No. We continue to seek efficiencies and identify opportunities to reduce waste, fraud and abuse in Medicaid, and we want to work with Congress, states, and stakeholders to achieve those goals while expanding access to affordable health care. The Supreme Court decision has made the higher matching rates available in the Affordable Care Act for the new groups covered even more important to incentivize states to expand Medicaid coverage. The Administration is focused on implementing the Affordable Care Act and providing assistance to states in their efforts to expand Medicaid coverage to these new groups.

***28. How does the Supreme Court ruling affect the interaction between the Exchanges and Medicaid? Will a state's decision whether or not to proceed with the Medicaid expansion have implications for the Exchange's ability to make Medicaid eligibility determinations?***

A. As the letter from Secretary Sebelius to Governors sent on July 10, 2012 and the letter from the CMS Acting Administrator Marilyn Tavenner sent on July 13, 2012 stated, the Supreme Court's decision affects the financial penalty that applies to a state that does not expand Medicaid coverage to 133% of the federal poverty level under the Affordable Care Act. Other provisions of the law were affected. Thus regardless of whether a state adopts the Medicaid expansion, the provisions related to coordination with the Exchange, including the use of standard income eligibility methods, apply. An Exchange in each state will make either a Medicaid eligibility determination or a Medicaid eligibility assessment (at the state's option) based on the Medicaid rules in the state, including the income levels at which the state's Medicaid program provides coverage.

***29. What help will be available to states to accommodate the added administrative burdens and costs they will have to bear if they expand coverage in Medicaid?***

**A.** We have provided 90 percent federal matching funds for the new or improved eligibility systems that states are developing to accommodate the new modified adjusted gross

income rules and to coordinate coverage with the Exchange. To further reduce system costs, we have promoted ways for states to share elements of their system builds with each other, and we will be sharing the business rules for adopting modified adjusted gross income in the new eligibility systems. In addition we are designing, with extensive state and stakeholder consultation, a new combined and streamlined application that states can adopt (or modify subject to Secretarial approval). And, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes. These and other initiatives relating to state systems development will lower administrative costs.

Implementation of the on-line application system, the new data-based eligibility rules, verification and renewal procedures and states' access to the federally-managed data services hub ("the hub") will collectively help defray states' ongoing costs and result in greater efficiency in the long term. For example, states will be able to electronically verify eligibility factors through the hub, where previously they had to verify through multiple federal venues. This is expected to lower the per-person administrative costs of enrollment and renewal for both newly and currently eligible individuals. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there. In addition, it is anticipated that many individuals—both those who are eligible under current state eligibility rules as well as those who are eligible under the adult expansion—will apply for coverage via the Exchange. Our rules provide states the option to have the Exchange determine eligibility for Medicaid or to assess eligibility for Medicaid, in both cases using the state's eligibility rules and subject to certain standards. No charge will be imposed on states for the Medicaid determinations or assessments conducted by the Exchanges.

***30. CMS has released 90/10 funding in order for states to improve their eligibility systems for Medicaid. Will that funding continue?***

**A.** Yes. "90/10" funding remains available through December 31, 2015 for Medicaid eligibility system design and development, and the enhanced 75 percent matching rate will be available indefinitely for maintenance and operations of such systems as long as the systems meet applicable program requirements.

In previous guidance, we have assured states that the 90/10 and 75/25 percent funding for eligibility systems will be available without regard to whether a state decides to expand its program to cover newly eligible low-income adults. We reiterate that system modernization will be supported and the enhanced matching funds will be available regardless of a state's decision on expansion. Additionally, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes.

**31. Will low-income residents in states that do not expand Medicaid to 133 percent of the FPL be eligible for cost sharing subsidies and tax credits to purchase coverage through an Exchange?**

**A.** Yes, in part. Individuals with incomes above 100 percent of the federal poverty level who are not eligible for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage will be eligible for premium tax credits and cost sharing

reductions, assuming they also meet other requirements to purchase coverage in the Exchanges.

**32. Can states that are "expansion states" under the law receive newly eligible matching rate for some populations in their state?**

**A.** Yes. The expansion state Federal Medical Assistance Percentage, or matching rate, described in section 1905(z)(2) of the Social Security Act is available to some states that expanded Medicaid coverage prior to enactment of the Affordable Care Act, but does not exclude those states from receiving the increased newly eligible match for expenditures for beneficiaries who meet the statutory qualifications. If a population covered by a state that qualifies as an expansion state meets the criteria for the newly eligible matching rate, the state will receive the newly eligible matching rate for that population. States will receive the highest matching rate possible for a given population; being an expansion state will never disadvantage the state in terms of matching rates for that population. The following are several examples of circumstances in which an expansion state will receive the newly eligible matching rate for some beneficiaries: • States are considered expansion states if, as of March 23, 2010, they provided coverage that meets the standards specified in section 1905(z)(3) of the Act to both childless adults and parents up to at least 100 percent of the federal poverty level. If a state provided Medicaid coverage up to 100 percent of the federal poverty level but not above, expenditures for individuals between 100 and 133 percent of the federal poverty level would qualify for the newly eligible matching rate. • States that qualify as expansion states may have offered less than full benefits, benchmark benefits, or benchmark-equivalent benefits. Individuals who received limited benefits under a Medicaid expansion will qualify as "newly eligible" individuals and the newly eligible matching rate will apply. • States that qualify as expansion states based on the provision of state-funded coverage will receive the newly eligible matching rate for people previously covered by the state-only program, since they will be newly eligible for Medicaid coverage. The expansion state matching rate is only available for expenditures for non-pregnant, childless adult populations described in the new low-income adult group. CMS will work with states to ensure that the correct matching rate is applied to expenditures for populations in expansion states that qualify as newly eligible.

## Flexibility for States

***33. What specific plans and timeline do you have for enacting the reforms and flexibility options for Medicaid that you spoke of in 2009? When can states give further input on the needed reforms?***

**A.** CMS continues to work closely with states to provide options and tools that make it easier for states to make changes in their Medicaid programs to improve care and lower costs. In the last six months, we have released guidance giving states flexibility in structuring payments to better incentivize higher-quality and lower-cost care, provided enhanced matching funds for health home care coordination services for those with chronic illnesses, designed new templates to make it easier to submit section 1115 demonstrations and to make it easier for a state to adopt selective contracting in the program, and developed a detailed tool to help support states interested in extending managed care arrangements to long term services and supports. We have also established six learning collaboratives with states to consider together improvements in data analytics, value-based purchasing and other topics of key concern to states and stakeholders, and the Center for Medicare and

Medicaid Innovation has released several new initiatives to test new models of care relating to Medicaid populations. Information about these and many other initiatives are available on Medicaid.gov

We welcome continued input and ideas from states and others. States can implement delivery system and payment reforms in their programs whether or not they adopt the low-income adult expansion. With respect to the expansion group in particular, states have considerable flexibility regarding coverage for these individuals. For example, states can choose a benefit package benchmarked to a commercial package or design an equivalent package. States also have significant cost-sharing flexibility for individuals above 100% of the federal poverty level, and we intend to propose other cost-sharing changes that will modernize and update our rules.

***34. Will the federal government support options for the Medicaid expansion population that encourage personal responsibility?***

**A.** Yes, depending on its design. We are interested in working with states to promote better health and health care at lower costs and have been supporting, under a demonstration established by the Affordable Care Act, state initiatives that are specifically aimed at promoting healthy behaviors. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and state Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite states to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes. We note in particular that states have considerable flexibility under the law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100% of the federal poverty level, to accomplish these objectives, including Secretary-approved benchmark coverage

***35. Will CMS approve global waivers with an aggregate allotment, state flexibility, and accountability if states are willing to initiate a portion of the expansion?***

**A.** Consistent with the guidance provided above with respect to demonstrations available under the regular and the enhanced matching rates, CMS will work with states on their proposals and review them consistent with the statutory standard of furthering the interests of the program.

**MAGI** ***36. Will states still be required to convert their income counting methodology to Modified Adjusted Gross Income (MAGI) for purposes of determining eligibility regardless of whether they expand to the adult group? If so, how do states link the categorical eligibility criteria to the MAGI?***

**A.** Yes, as required by law. Conversion to modified adjusted gross income eligibility rules will apply to the nonelderly, nondisabled eligibility groups covered in each state, effective January 2014, without regard to whether a state expands coverage to the low-income adult group. The new modified adjusted gross income rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through Exchanges; the application of modified adjusted gross income to

Medicaid and CHIP will promote a simplified, accurate, fair, and coordinated approach to enrollment for consumers. CMS has been working with states to move forward with implementation of the modified adjusted gross income rules, and consolidation and simplification of Medicaid eligibility categories.

**DSH** ***37. The Disproportionate Share Hospital allotments will be reduced starting in 2014 using a methodology based on the reduction in the number of uninsured. One, when will HHS issue the regulations and methodology for this reduction? Two, for a state that does not see a decrease in its uninsured population, will the remaining states absorb the full reduction? Is HHS planning any modification to the manner in which it will reduce DSH allotments as it relates to states that do not expand?***

**A.** The law directs HHS to develop a methodology to reduce Disproportionate Share Hospital (DSH) funding over time in a way that is linked to reductions in the number of uninsured or how states target their funds. We have heard from states and health care providers about their concerns related to this change and are exploring all options. The Department will propose this methodology for public comment early next year.

## COORDINATION BETWEEN EXCHANGES AND OTHER PROGRAMS

***38. How can states use premium assistance to help families that are split among the Exchange, Medicaid, and the Children's Health Insurance Program (CHIP) enroll in the same plans?***

***A.*** In 2014, some low-income children will be covered by Medicaid or CHIP while their parents obtain coverage on the Exchange with advance payments of the premium tax credit. Premium assistance, an option under current law, provides an opportunity for state Medicaid and CHIP programs to offer coverage to such families through the same coverage source, even if supported by different payers. Under Medicaid and CHIP statutory options, states can use federal and state Medicaid and CHIP funds to deliver Medicaid and CHIP coverage through the purchase of private health insurance. Most commonly, states have used premium assistance to help Medicaid/CHIP eligible families pay for available employer-based coverage that the state determines is cost effective. There are cost sharing assistance and benefit wrap-around coverage requirements, to the extent that the insurance purchased with Medicaid and/or CHIP funds does not meet Medicaid or CHIP standards. In both Medicaid and CHIP, premium assistance is authorized for group health coverage and, under some authorities, for health plans in the individual market, which, in 2014 would include qualified health plans available through the Exchange. Please note that advance payments of the premium tax credit and cost-sharing reductions are not available for an individual who is eligible for Medicaid or CHIP. The statutory authorities that permit use of title XIX or title XXI funds to be used for premium assistance for health plans in the individual market, including qualified health plans in the Exchange, are sections 1905(a)and 2105(c)(3) of the Social Security Act.

For example, beginning in 2014, when a child is eligible for Medicaid/CHIP and the parent is enrolled in a qualified health plan through the Exchange, a state Medicaid or CHIP program could use existing premium assistance authority to purchase coverage for a Medicaid or CHIP-eligible child through that qualified health plan. The premium tax credit would not be available to help cover the cost of coverage for these children. As noted above, with respect to the children, the state would adhere to federal standards for premium assistance,

including providing wrap-around benefits, cost sharing assistance, and demonstrating cost-effectiveness, as appropriate. A State-Based Exchange may be able to support such an option, and in states where a Federally-Facilitated Exchange is operating, a State Medicaid or CHIP agency may be able to take this approach by making arrangements with qualified health plans to pay premiums for individuals. We will be working with states interested in this option to consider how the state Medicaid and CHIP agency can coordinate with the Exchange to establish and simplify premium assistance arrangements.

***39. How can states use premium assistance to promote continuity of care when individuals move between Exchange, CHIP, and Medicaid coverage?***

**A.** The Affordable Care Act envisions and directs that there be a coordinated system for making eligibility determinations between Medicaid, CHIP and the Exchange to avoid gaps in coverage as individuals' income fluctuates. Smooth eligibility transitions will not necessarily prevent people from having to select a new plan and/or provider when they lose eligibility for one insurance affordability program and gain eligibility for another. The extent to which such changes in plans and providers occur will depend on whether and to what degree plans participate in both the Exchange and in Medicaid and CHIP, and the networks in such plans.

Premium assistance can help address this issue, while encouraging robust plan participation in Medicaid, CHIP, and the Exchange. As discussed above, this option permits state Medicaid or CHIP programs to use premium assistance to enroll a Medicaid or CHIP eligible individual or family in a qualified health plan through the Exchange. States may be most interested in this option for families close to the top of the Medicaid income limit. Under this arrangement, if a family's income changes such that some or all members of the family become ineligible for Medicaid or CHIP and eligible for a premium tax credit to help cover the cost of a qualified health plan through the Exchange, it would be less likely that members moving into Exchange coverage would need to change plans or providers. Similarly, premium assistance could help increase the likelihood that individuals moving from Exchange coverage into Medicaid or CHIP may remain in the same qualified health plan in which they had been enrolled through the Exchange.

As discussed above, premium assistance options in Medicaid and CHIP are subject to federal standards related to wrap around benefits, cost sharing and cost effectiveness. There may also be an opportunity for states to promote continuity of coverage through "bridge plans" as described earlier.


National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
Phone: 703-739-9333 Fax: 703-548-9517
www.nasmhpd.org