

PRIMER

EXPANDING MEDICAID IN COLORADO

Understanding the Costs and Benefits

Prepared for The Colorado Trust by the Colorado Health Institute

This primer offers information for Colorado's leaders as they consider expanding Medicaid eligibility to the state's most vulnerable residents as part of the Affordable Care Act (ACA). The data include a study supported by The Colorado Trust and conducted by the Colorado Health Institute (CHI) that estimates the costs and reach of the Medicaid expansion. This study also provides comparison by CHI of its findings to earlier analyses conducted by the Colorado Department of Health Care Policy and Financing (HCPF) and the Kaiser Commission on Medicaid and the Uninsured (Kaiser).

The information is framed around five questions designed to help policymakers arrive at a decision that is best for Colorado.

The Affordable Care Act (ACA) provides financial incentives for states to expand Medicaid – the federal-state insurance program for low-income children, parents, pregnant women, individuals with disabilities and the elderly – by filling in coverage gaps that have left hundreds of thousands of Coloradans without health insurance.

Expanding Medicaid eligibility became optional, rather than mandatory, in the U.S. Supreme Court's 2012 opinion on the ACA.

In Colorado, the proposed expansion covers people between the ages of 19 and 64 with annual incomes below 133 percent of the federal poverty level (FPL), which effectively becomes 138 percent using a new income formula specified by the law. This is an annual income of \$15,856 for an individual and \$32,499 for a household of four.

The federal government will pay all costs of covering the newly-insured in 2014, 2015 and 2016. After 2016, the ACA specifies that the federal share will not drop below 90 percent.

Understanding Colorado's share of the expansion cost is one consideration for policymakers. It is also important to weigh the potential benefits on the individual level as well as the community level. This primer addresses all of these questions.

FIVE QUESTIONS TO ASK ABOUT MEDICAID EXPANSION



Who would be covered?



What would it cost?



How would the state's share be financed?



What savings might we expect from this investment?



How would Colorado best implement this policy?

HOW ARE THE COSTS ESTIMATED?

We project the number of people who will become eligible for Medicaid between 2013-2022, and how many can be expected to enroll based on historic patterns. Then, we estimate the cost of providing their health care. The complexity derives from differences in the health care needs – and costs – of the varied groups.



Price

Per person cost



Quantity

Number of Coloradans anticipated to enroll



Cost to Colorado

Annually or over a range of years

WHY ARE THE ESTIMATES DIFFERENT?

- **Price:** HCPF has details about per capita costs. CHI and Kaiser rely on public information.
- **Quantity:** Varied expectations of how many people would enroll, how quickly they would enroll and how long they would stay in Medicaid.
- **Other:** HCPF included populations such as the disabled and foster kids. The Colorado Health Institute chose a more limited population. Kaiser did not include such Colorado-specific variables as the impact of the provider fee.

FIVE QUESTIONS TO ASK ABOUT MEDICAID EXPANSION



QUESTION ONE:

Who Would Be Covered?

The Colorado Health Institute estimates that **240,000** residents will gain Medicaid coverage by 2022 – **140,000** newly eligible uninsured Coloradans, **27,000** uninsured Coloradans who are already eligible but will enroll, and **73,000** who will switch from commercial insurance.

Studies have shown that having health insurance can decrease needless illness, suffering and even, in some cases, death.ⁱ For Colorado, there would be economic benefits in having a lower level of uncompensated health care, a healthier workforce and an infusion of billions of dollars in federal funding.

More than half (51.7 percent) of those who will become newly eligible are uninsured low-income adults who don't have dependent children, according to our projections. This will be about **124,000** people.

Another large group of the newly eligible will be uninsured parents of dependent children between 101 percent and 133 percent FPL.

There are two other groups to consider:

- People who are already eligible for Medicaid but haven't enrolled. Publicity about the expansion, as well as outreach efforts, will most likely lead some people in this group to finally sign up. This is often called the **welcome mat** or **woodwork** effect.
- People who have commercial insurance but become newly eligible for Medicaid and opt to enroll. This is commonly called **crowd out**.

For its analysis, the Colorado Health Institute segmented the potential population into 18 groups, estimated what percentage would enroll and projected the costs of caring

for them. The model assumes the expansion population won't be fully enrolled until 2017. The final step is estimating the average number of months an enrollee is expected to remain in Medicaid.

The other estimates:

- HCPF: **271,000** Medicaid enrollees – **160,800** from the expansion and **110,200** who are currently authorized but not yet enrolled.
- Kaiser: **297,000** Medicaid enrollees. This includes **225,000** new enrollees plus **71,000** expected to enroll even if the state does not expand the program.



QUESTION TWO:

What Would It Cost?

The Colorado Health Institute estimates that the state's cost of the expansion over the 10 years between 2013 and 2022 will be **\$1.0 billion**. The federal share will be an estimated **\$11.4 billion** for a total 10-year cost of **\$12.4 billion**.

The model consisted of assumptions about Coloradans who would be newly eligible, those who are already eligible for Medicaid and would likely enroll, and those who would join the program because of the crowd out effect. Assumptions regarding medical care each group is anticipated to use affect the total cost.

Other 10-year estimates:

- HCPF: State cost of **\$1.4 billion**. Federal share of **\$12.3 billion**. Total cost of **\$13.5 billion**.ⁱⁱⁱ (Note: The breakdown of state cost for those who are newly eligible and populations anticipated to enroll even without expansion have not yet been publicly released.)
- Kaiser: State cost of \$858 million for those who

are newly eligible, plus \$639 million for populations anticipated to enroll even without expansion, for a total state cost of **\$1.5 billion**. Federal share of **\$11.6 billion**. Total cost of **\$13.1 billion**.



QUESTION THREE:

How Would The State's Share Be Financed?

Governor Hickenlooper has pledged that expanding Medicaid will not cost Colorado additional general fund money, even after the federal government is no longer covering all of the costs.

HCPF estimates the hospital provider fee created by the Colorado Health Care Affordability Act (House Bill 09-1293) would help to pick up nearly \$1.3 billion of the state cost, with the remaining \$128 million being funded through the provider fee or other public funds. The fee, which by federal law can't be more than six percent of net patient revenues or higher than the upper payment limit, is assessed on hospitals and is targeted toward expanding the Medicaid and Child Health Plan Plus (CHP+) programs. This fee is then matched by federal dollars. In turn, the state is able to increase Medicaid payments to hospitals.

As well, Colorado anticipates substantial savings from the CHP+ program.

Because most CHP+ enrollees are expected to be eligible for subsidies to purchase private health insurance through Colorado's new health insurance exchange, Connect for Health Colorado, there may be changes to the CHP+ program. Colorado had been sharing the cost of CHP+ with the federal government, but the federal government will pick up the entire cost of the subsidies.

Meanwhile, managers of the state Medicaid program have identified \$280 million in savings to be achieved by streamlining the delivery and payment of Medicaid services, making them more efficient and effective. Governor Hickenlooper has said these savings would help offset new costs.

The Colorado Health Institute did not answer the question of state financing in its model.



QUESTION FOUR:

What Savings Might We Expect From This Investment?

Kaiser estimates that Colorado would save \$277 million in uncompensated care during the 10-year period.

States and communities finance about 30 percent of uncompensated care costs for the uninsured, according to the Kaiser report, which was prepared by The Urban Institute.ⁱⁱ Kaiser conservatively estimates that the states and communities would recover a third of those costs.

Kaiser also anticipates that health care providers would receive more revenue if more people had access to health care. Hospitals nationwide would receive an additional \$314 billion between 2013 and 2022, Kaiser estimates.

The Colorado Health Institute did not answer this question in its model.



QUESTION FIVE:

How Would Colorado Best Implement This Policy?

Colorado has a track record of taking innovative actions to control costs and increase efficiencies and health outcomes in its Medicaid program.

Colorado has launched a program to control the growth of Medicaid costs through greater coordination of care. The Accountable Care Collaborative (ACC) funds regional organizations to coordinate Medicaid care, providing rewards based on achieving key performance indicators. The program has aggressive enrollment goals and targeted overall savings, particularly in high-cost, resource-intensive areas.

During its first year, progress was made toward reaching interim goals of reducing re-hospitalizations, inappropriate emergency department visits and expensive tests. Early results showed gross savings of up to \$20 million. Factoring in administrative costs meant smaller net savings or even a small loss.

The state estimates it will achieve savings in these areas:

- Ensuring the most effective care at the lowest cost
- Increasing effectiveness in care delivery
- Reforming payment systems to reward value rather than volume
- Using health information technology more extensively
- Reducing waste, fraud and abuse.

The Colorado legislature has shown interest in ensuring that the state's Medicaid program is run smoothly and effectively. HB12-1281, passed during the 2012 session on a bipartisan basis, calls for pilot projects that could further change the way Colorado pays for Medicaid services.

MEDICAID EXPANSION: WHO WOULD BE COVERED UNDER THE CHI MODEL?

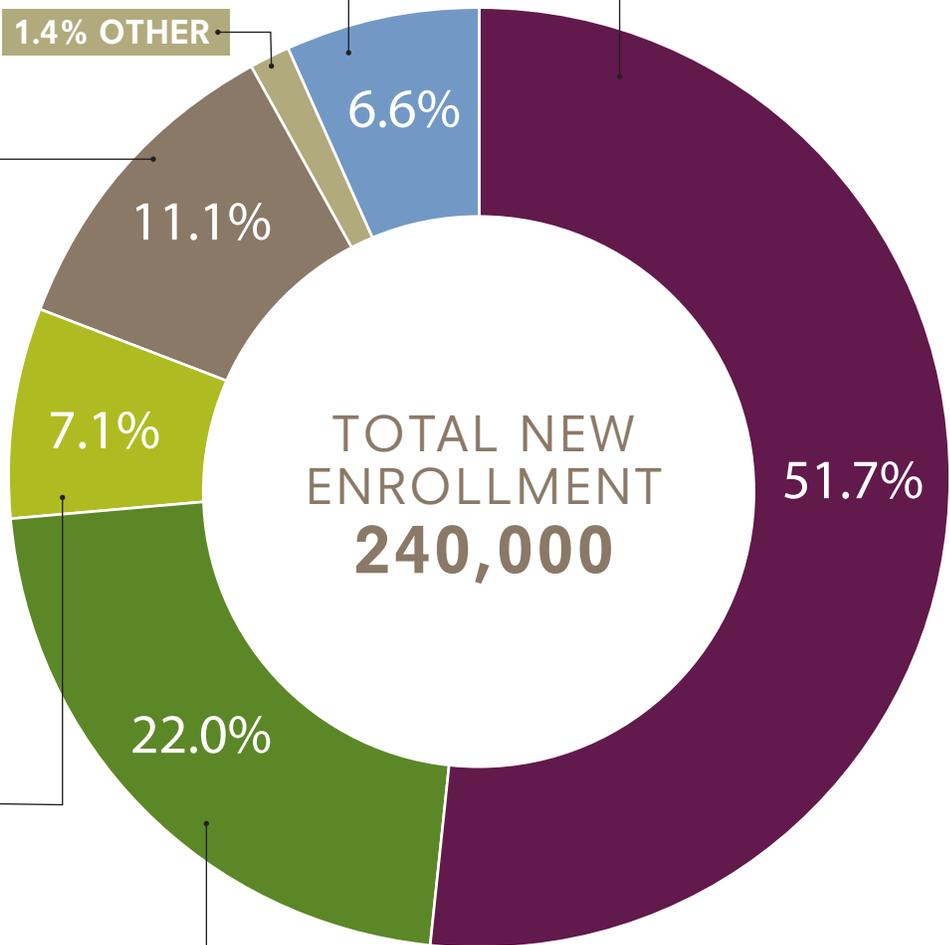
UNINSURED PARENTS
FPL: 101-133%
Status: Not eligible for Medicaid.
Current Financing: N/A
ACA Financing: Federal funds until 2017, when state begins to assume a share not to exceed 10%.

UNINSURED ADULTS WITHOUT DEPENDENT CHILDREN
FPL: 0-133%
Status: Medicaid coverage authorized up to 100% FPL under HB 09-1293, but enrollment capped at 10,000 and 10% FPL because of anticipated costs.
Current Financing: 50-50 federal-state match. Hospital provider fee covers state share.
ACA Financing: Federal funds until 2017, when state begins to assume a share not to exceed 10%.

UNINSURED CHILDREN (0-18 YEARS) AND PARENTS
FPL: 0-133% (Children); 0-100% (Parents)
Status: Eligible but not enrolled. The "welcome mat" effect.
Current Financing: 50-50 federal-state match. Hospital provider fee covers state share of parents 61-100% FPL.
ACA Financing: No change except for parents (61-100% FPL), who will be financed by federal funds until 2017, when state begins to assume a share not to exceed 10%.

INSURED PARENTS AND ADULTS WITHOUT DEPENDENT CHILDREN
FPL: 101-133%
Status: Not eligible for Medicaid.
Current Financing: Private market.
ACA Financing: Federal funds until 2017, when state begins to assume a share not to exceed 10%.

INSURED PARENTS AND ADULTS WITHOUT DEPENDENT CHILDREN
FPL: 0-100%
Status: The "crowd out" effect. Currently insured but will migrate to Medicaid for financial reasons.
Current Financing: Private market.
ACA Financing: Federal funds until 2017, when state begins to assume a share not to exceed 10 percent. Exception is parents 0-60% FPL, financed by 50-50 federal-state match.



» ENDNOTES

- ⁱ Institute of Medicine. (February 23, 2009). "America's Uninsured Crisis: Consequences for Health and Health Care." (Retrieved January 29, 2013, from: <http://www.iom.edu/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx>.)
- ⁱⁱ Holahan, J, et al., The Urban Institute. (November 2012). "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Kaiser Commission on Medicaid and the Uninsured. (Retrieved January 28, 2013, from: <http://www.kff.org/medicaid/8384.cfm>.)
- ⁱⁱⁱ HCPF. (January 2013): "Expanding Colorado Medicaid: Caseload and Cost Projections." State and federal costs do not sum to total due to savings projections.