nhfpi New Hampshire Fiscal Policy Institute

issue brief

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The ACA's Medicaid Coverage Option: An Affordable Way to Insure Thousands of Granite Staters

Executive Summary

In the coming months, New Hampshire policymakers will decide whether to take advantage of provisions of the Affordable Care Act (ACA) that allow for the expansion of Medicaid coverage to tens of thousands of Granite Staters. To help inform that decision, this paper describes the current Medicaid program, explains the coverage option available to New Hampshire through the ACA, and examines the benefits and costs to the state of electing to expand Medicaid. It finds that:

- Electing the Medicaid coverage option would help to provide health care to approximately 36,000 adults, all of whom currently earn less than $15,000 per year.

- Electing the Medicaid coverage option would improve not only the health of people across the state, but also the state's economic outlook, as it would bring more than $1 billion in federal funds into New Hampshire's economy.

- Expanding Medicaid under the Affordable Care Act would entail some costs for New Hampshire. NHFPI estimates that, between 2014 and 2020, the total cost to the state to expand Medicaid would be approximately $129 million, a figure that includes coverage for newly eligible adults, the likelihood that some individuals eligible under the existing Medicaid program will enroll, and administrative costs.

- Any new costs that New Hampshire would incur through the Medicaid coverage option would be at least partially offset by savings elsewhere in the budget. Based on research by the Urban Institute, New Hampshire may be able to reduce uncompensated care payments by $85 to $171 million between 2014 and 2020 as a result of Medicaid expansion. The state may also be able to lower expenditures for mental health, substance use or public health services.

- The federal government would cover the vast majority of costs associated with extending Medicaid coverage to newly eligible adults. NHFPI projects that, through the end of the decade, the federal government would provide 95 percent of the funds needed to expand Medicaid under the ACA.

- Failure to elect the Medicaid coverage option will have its own consequences. Most notably, the private vendors who signed on to administer New Hampshire's Medicaid managed care initiative assumed the additional enrollment from the expansion starting in 2014. Without the additional enrollees, vendors' assumptions about costs and profits will likely change and there is a risk they could withdraw, putting projected savings to the state at risk or making managed care untenable.

Introduction

Policymakers in New Hampshire have an opportunity to extend health care coverage to tens of thousands of Granite Staters, while simultaneously reducing costs for local hospitals and private insurers and bringing more than $1 billion in federal funds into the state's economy. As a result of the Affordable Care Act (ACA) and this summer's US Supreme Court ruling, states now have the option to extend Medicaid coverage to adults with annual incomes below $15,000 and to pass the vast majority of the costs for doing so onto the federal government. The costs that New Hampshire would incur – approximately $56 million between 2014 and 2020 for covering newly eligible adults or roughly $129 million over the same span after accounting for increased participation in the existing Medicaid program – would be offset in part, and possibly in whole, by savings elsewhere in the budget. By electing the ACA's Medicaid coverage option, New Hampshire would be able to lower payments to hospitals for care they currently provide to the uninsured and potentially to reduce expenditures for mental health, substance abuse, or public health services. In short, if New Hampshire were to take advantage of this opportunity, it would ultimately be able to provide health care coverage to at least an additional 36,000 New Hampshire residents, while spending only 2 percent more on Medicaid than it would have otherwise.

Medicaid: A Key Source of Insurance in New Hampshire

Medicaid under Current Law

Medicaid is a joint state and federal program that provides health insurance coverage to low-income children, senior citizens, and people with disabilities.[i] In an average month, approximately 132,000 New Hampshire residents relied on Medicaid for health care coverage during FY 2010, representing roughly one out of every ten people in the state during that time.[ii] The majority of New Hampshire Medicaid members are children.[iii]

New Hampshire Medicaid has very limited coverage for adults; only those who are very low-income parents, are pregnant, or have a disability are eligible to participate. As the figure below details, the income eligibility levels for each of these three categories of adults varies, with coverage for parents limited to those with incomes up to 40 percent of the federal poverty level (FPL), pregnant women with incomes up to 185 percent of FPL, and adults with disabilities with incomes up to 450 percent of FPL, if that person is working and pays a premium.

New Hampshire's Medicaid Program Curently Fails to Cover the Poorest Adults in the State

Medicaid Eligibility, 2012

Category	Income Threshold		
	Percent of Federal Poverty Line	Equivalent in Dollars (2012)	
		Individual	*Family of three*
Parents	40%	-	7,636
Pregnant women	185%	20,665	35,317
Disabled adults*	450%	50,265	85,905
Adults without children or a disability	-- *Ineligibile Regardless of Income* --		

**Disabled adults in the MEAD program required to work and to pay a premium to participate in Medicaid*

Source: NH Department of Health and Human Services; US Department of Health and Human Services

New Hampshire administers its own Medicaid program, but it shares the costs of the program with the federal government. Federal funding for Medicaid is a fixed percentage of the actual costs of the program; for New Hampshire, that fixed percentage is always at least 50 percent of the costs. In other words, for every dollar New Hampshire spends on Medicaid, the federal government reimburses the state at least 50 cents. In state fiscal year 2010, New Hampshire's Medicaid program had expenditures of approximately $1.42 billion.

In general, each state designs and administers its own Medicaid program within a broad federal framework. Eligibility standards and benefit packages are established both by federal requirements and by state policy choices. Federal law sets out the minimum benefits and groups of people all Medicaid programs must cover and allows states to elect additional groups of people and services while still receiving federal matching funds for doing so.

Expanded Medicaid Eligibility and Benefits under the Affordable Care Act

As described above, eligibility for Medicaid has typically rested on two factors. First, one must have a sufficiently low income and, second, one must fall into one of three general categories - having a disability, being a senior citizen, or being a child.[iv] As a result of the June 28 US Supreme Court decision upholding the Affordable Care Act (ACA), all states now have the option of extending Medicaid coverage to adults ages 19 to 64 with incomes up to 133 percent of the federal poverty level, an annual income of $14,856 for an individual in 2012. This is distinct from past practice, because Medicaid eligibility would rest on income level alone.

The federal government would pay for the vast majority of the costs states would incur in extending such coverage. Under the ACA, from 2014 through 2016, the federal government will pay 100 percent of the costs for this newly eligible population. Federal financial support will gradually phase down to 90 percent of these costs by 2020, where it will stay unless and until Congress acts to amend the ACA.

Benefits and Costs of Expanding Medicaid

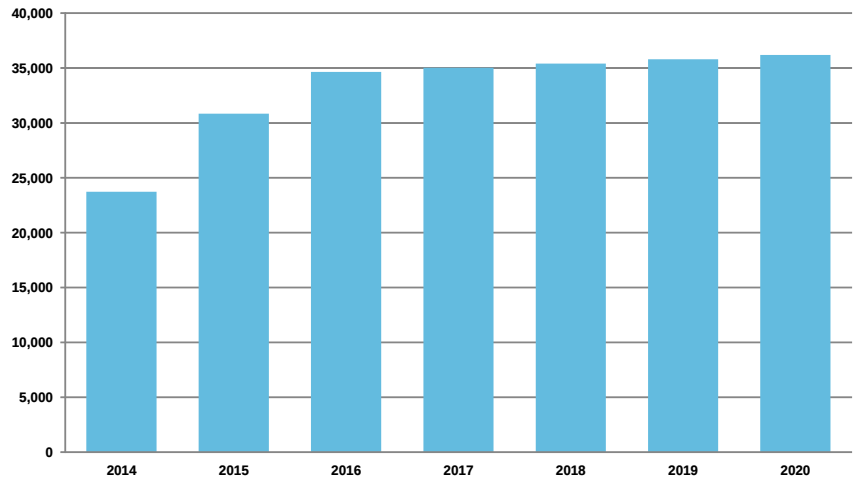
Medicaid Coverage Opportunity Would Mean Health Care Coverage for 36,000 Granite Staters

Based on data from the US Census Bureau for 2009-2011, there are currently 58,448 adults in New Hampshire who meet the eligibility requirements for the new Medicaid option. They are adults ages 19 through 64 with incomes at or below 133 percent of the federal poverty line. For an individual, this percentage is the equivalent of $14,856 in 2012; for a family of four, it works out to $30,657.[v] Census Bureau projections for the period from 2010 through 2020 indicate that New Hampshire's population will grow by 1.1 percent per year; if the number of adults eligible for the new Medicaid option increases at the same rate, they will total roughly 65,200 by 2020. (See the Appendix for the full details of NHFPI's coverage and cost estimates for the newly eligible.)

Evidence from other public programs suggests that the number of people who will ultimately participate in Medicaid if coverage is extended to this new group of adults will likely be significantly smaller than the number of people who are eligible to do so. For example, programs such as the Supplemental Nutrition Assistance Program (also known as SNAP or food stamps), Medicaid, and Financial Assistance to Needy Families (FANF) have participation rates ranging from 43 percent to 71 percent.[vi] Participation in Medicare is considerably higher, with participation rates as high as 96 percent; however, Medicare-eligible individuals are automatically enrolled in the program and sent a Medicare card three months before coverage begins on their 65th birthdays.[vii] By contrast, Medicaid does not automatically enroll new members, but rather requires them to apply to determine whether they are eligible. The application process frequently includes numerous and complex steps, such as income verification with primary documents and asset tests. Given these differences, it is very likely that the rate at which New Hampshire residents will participate in an expanded Medicaid program will be closer to participation rates in other public programs than to the much higher Medicare participation rate.

Medicaid Expansion Would Mean Health Care Coverage for Tens of Thousands

Projected participation among newly eligible NH residents in Medicaid expansion, 2014-2020



Source: NHFPI calculations based on Congressional Budget Office and Political Economy Research Institute analyses

Indeed, the Kaiser Commission on Medicaid and the Uninsured, a nationally-recognized source of health policy research and information, in constructing state-by-

state estimates of the cost of expanding Medicaid under the ACA in 2010, assumed that just 75 percent of individuals without insurance and with incomes below 133 percent of the federal poverty line would take part in the expansion. [viii] It further assumed a 25 percent participation rate by those who are income eligible who currently have employer sponsored insurance (ESI) and a 60 percent participation rate by those who are income eligible who have non-group purchased insurance.[ix] Applying these participation rates to the total pool of eligible adults and assuming somewhat lower participation rates in the initial two years of the new coverage option means that about 23,700 New Hampshire adults would likely enroll in Medicaid in 2014 and that by 2020, nearly 36,200 would likely do so.[x]

Benefits of Coverage to Individuals and Families

Extending health insurance coverage to tens of thousands of people in New Hampshire will likely have a stabilizing impact on many families and lead to improvements in their overall health and well-being. People who are uninsured are less likely to seek medical care, are less likely to obtain it, and, as a result, are more likely to be in worse health and have higher death rates than people with insurance coverage. In fact, academic studies find that uninsured people have a greater risk of death and decline and are 1.2 to 1.5 times more likely to die than insured people.[xi]

Medicaid provides quality health care coverage to those with significant health care needs. A recent and ongoing study of those selected by a randomized lottery to be enrolled in Medicaid in Oregon revealed that enrollees had "substantial and statistically significant higher health care utilization…and better self-reported health than a control group that was not given the opportunity to apply for Medicaid."[xii] Evidence of increases in health care resource utilization included improved compliance with preventive care.[xiii] Another recent study examining expansions of Medicaid to low-income adults in other states found that these state expansions of Medicaid were significantly associated with reduced mortality, as well as improved coverage, enhanced access to care, and gains in self-reported health.[xiv]

The Medicaid expansion also may help to lower consumer bankruptcies related to medical debt or medical bills. A 2007 study in the American Journal of Medicine revealed that 29 to 62 percent of bankruptcies are related to medical debt or medical problems. It further demonstrated that the average household income for those with medical bankruptcies was under $27,000, potentially placing those families in the income range of those who would be newly eligible for Medicaid.[xv] The Oregon study noted above illustrates the degree to which this could occur. It revealed that those with Medicaid coverage had a 6.4 percentage point decline in the likelihood of having unpaid medical bills in collections and a 20 percentage point decline in having any out of pocket medical expenses.[xvi] According to figures from the American Bankruptcy Institute, there was an average of 4,074 consumer bankruptcies filed each year from 2007 through 2011 in New Hampshire.[xvii] Families would benefit from having more money to spend in the general economy because they have avoided medical debt.

Medicaid Expansion Would Have Significant Economic Benefits for New Hampshire

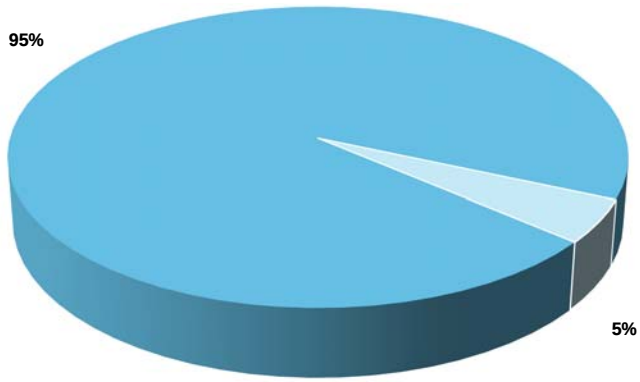
The benefits of the ACA's new Medicaid coverage option would not be limited simply to improved health among those individuals and families who would be covered by it. It would also provide a substantial economic boost to the state as a whole.

As detailed in the Appendix, if New Hampshire were to take advantage of this coverage opportunity, it would receive approximately $1.14 billion in federal aid from 2014 through 2020. The economic benefit of these hundreds of millions of dollars flowing into New Hampshire's economy would likely be quite significant. For instance, such funds will, in large measure, be directed to New Hampshire's hospitals and health care systems. In 2008, New Hampshire's acute care hospital systems directly employed 37,515 people; the average salary in those jobs was $64,566.[xviii] These same health systems drove secondary employment for an estimated additional 28,136 people that year.[xix] To put the amount federal aid New Hampshire stands to receive into a different perspective, $1.14 billion is the equivalent of more than 17,600 positions with annual salaries of $64,566 – the average salary of healthcare workers in New Hampshire. The influx of more than a billion dollars into New Hampshire's economy through the health care sector seems likely to create employment with similar wage levels.

Medicaid Expansion Would Entail New Costs for New Hampshire, but Would Lead to Offsetting Savings Elsewhere in the State Budget

Costs for Expanding Medicaid to Newly Eligible Would Total $56 Million through 2020

The Federal Government Will Bear Nearly All the Costs for Medicaid Expansion
Share of total projected costs associated with ACA Medicaid expansion in New Hampshire, 2014-2020

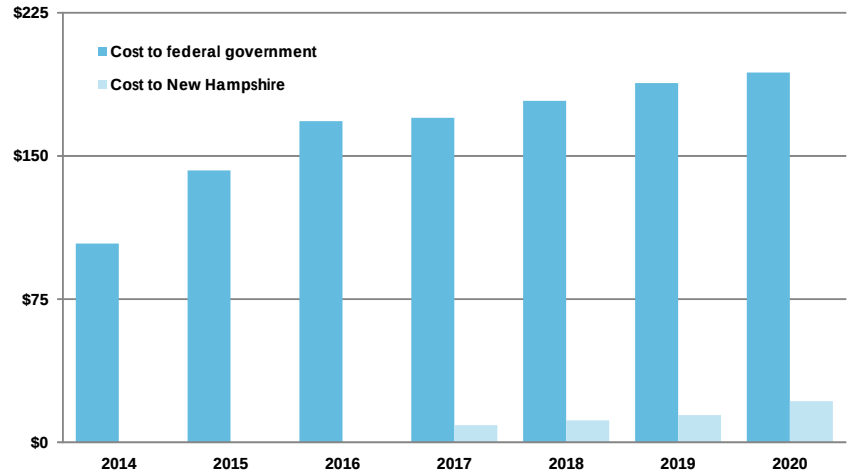


Source: NHFPI calculations based on data from the US Census Bureau and NH Department of Health and Human Services

As explained at the outset of this paper, the vast majority of the total cost for expanding Medicaid through the ACA will be met by the federal government. Federal funds will cover 100 percent of the costs for all newly eligible members between 2014 and 2016. Federal support will phase down to 90 percent of costs by 2020, a level of support that will remain in place each year thereafter, unless and until Congress amends the ACA. In total, then, as the figure below emphasizes, New Hampshire would be responsible for just 5 percent of the costs for expanding health care coverage to tens of thousands of newly eligible state residents between 2014 and 2020.

In dollar terms, NHFPI estimates that, to extend Medicaid coverage to state residents newly eligible under the ACA, New Hampshire would pay approximately $8.9 million in 2017, an amount that would gradually rise to $21.5 million in 2020. (The figure below illustrates the general trend, while the Appendix provides more detailed data on these estimates.) All told, NHFPI projects that, between 2014 and 2020, New Hampshire would have to pay $56 million to provide health care coverage for the upwards of 36,000 people who would be expected to take part under the Medicaid expansion.

Medicaid Expansion Would Entail Modest Cost Increases for New Hampshire
Projected costs associated with ACA Medicaid expansion to newly eligible NH residents, 2014-2020, in $M



Source: NHFPI calculations based on data from the US Census Bureau and NH Department of Health and Human Services

To arrive at these estimates, NHFPI assumes that the mix of men and women newly eligible for Medicaid mirrors the gender composition of New Hampshire's overall population. It further assumes that the per member per month cost of providing health care coverage to newly eligible state residents is consistent with similar costs included in the Medicaid managed care contracts executed by the state in mid-2012 and that such costs grow by 5.2 percent per year, the same rate at which New Hampshire Medicaid expenditures rose between FY 2007 and FY 2010.[xx] Importantly, this approach may overstate the costs of serving this particular population, as actual enrollment and costs may fall below these levels.

Costs for Those Currently Eligible but Unenrolled in Medicaid May Be as High as $70 Million Through 2020

In addition to the costs it would ultimately incur in expanding its existing Medicaid program, New Hampshire is likely to witness some increase in participation in the program as it now stands and, thus, to experience some growth in costs as well. Such enrollment growth is likely to arise from activities associated with the overall implementation of the Affordable Care Act and its affect on individuals and communities. For instance, some people who are currently eligible to take part in Medicaid but choose not to do so will hear about health care reform, see its impacts in their communities and among their friends first hand, and become aware of the individual mandate.[xxi] In addition, the Health Benefits Exchange created under the Affordable Care Act will become operational and make additional health insurance options available. These two factors – as well as any Medicaid specific outreach and enrollment activities undertaken by a state — will spur some enrollment growth in

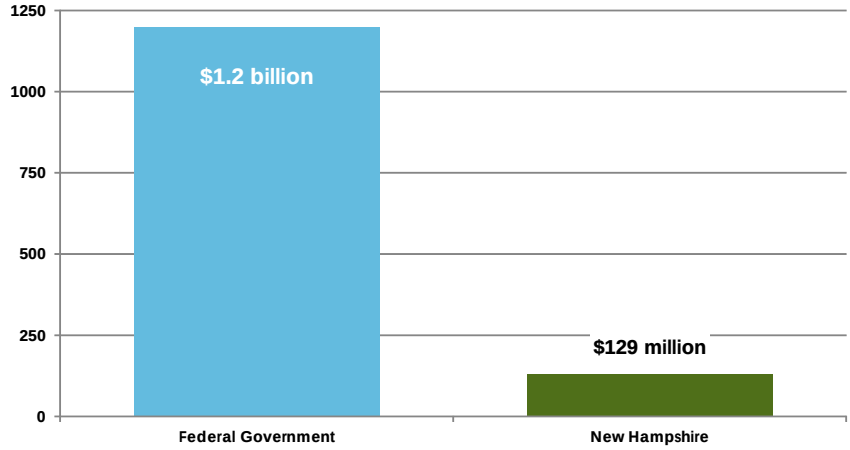
current eligibility groups, even if they have incomes too low to be subject to the penalty for remaining uninsured.[xxii]

Still, enrollment growth among people who are currently Medicaid eligible but unenrolled will likely be quite modest. New Hampshire's Medicaid coverage for low-income adults is very limited and those groups of adults for whom the state does presently offer Medicaid coverage have some of the highest motivations for utilizing any health care coverage available to them. As it stands today, New Hampshire's Medicaid program offers coverage only to those adults who are very low-income parents (with incomes below 40 percent of the federal poverty line), low-income pregnant women (with incomes up to 185 percent of poverty), and people with disabilities at a variety of income levels. It does not offer coverage to very poor adults who have no other qualifying condition. It is likely that the number of people that satisfy these eligibility criteria who are not enrolled is fairly small at best, since having a dependent child, expecting a dependent child, and having a long-term disabling condition are all highly compelling circumstances for obtaining available and affordable comprehensive health insurance coverage.[xxiii]

It is also worth noting that, to a considerable degree, the costs associated with the currently eligible but unenrolled cannot be avoided by bypassing the Medicaid coverage option the ACA provides. As noted above, such costs will arise predominantly because of the individual mandate and the operation of the Health Benefits Exchange.

The Federal Government Will Bear Nearly All the Costs for Medicaid Expansion

Total additional Medicaid expenditures in New Hampshire under the ACA, by funding source, 2014-2020, in millions of dollars



Source: NHFPI calculations based on data from the US Census Bureau and NH Department of Health and Human Services

Pinpointing the costs associated with this so-called "welcome mat" effect is difficult. To arrive at a detailed cost estimate, data on the gender, age, income levels, and insurance status by type of insurance for parents, pregnant women and people with disabilities would be required, but information from the US Census Bureau for such demographic groups is relatively limited. For instance, Census surveys do not directly record pregnancies within the population, nor do they record the presence of disabilities using the eligibility criteria that New Hampshire uses to define disability. With these constraints in mind, based on projections from the Kaiser Commission on Medicaid and the Uninsured report, NHFPI expects that the costs New Hampshire will

incur due to increased participation in its Medicaid program among individuals already eligible to do so could total $70 million from 2014 through 2020.[xxiv]

Consequently, the total costs New Hampshire would face from pursuing the Medicaid coverage option available under the ACA, which includes any costs arising from currently eligible but unenrolled state residents as well any additional administrative costs, are likely to be on the order of $129 million from 2014 through 2020. As the figure above demonstrates, this sum would be dwarfed by the associated federal dollars – roughly $1.2 billion all told – that could be expected to flow into New Hampshire. To put the additional costs New Hampshire would face into still greater perspective, $129 million through the end of the decade represents just a 2 percent increase over the expenditures New Hampshire is anticipated to make for Medicaid over that time frame, yet would result in health care coverage for 25 percent more people.

Expanding Medicaid Would Produce Substantial Savings Elsewhere in the Budget

Taking advantage of the opportunities available under the ACA would lead to a modest increase in the size of New Hampshire's Medicaid budget, but it is also likely to lead to a reduction in expenditures elsewhere in the budget, such as in appropriations for uncompensated care or for mental health, substance abuse, or public health services. These reductions, in turn, would compensate for higher Medicaid costs at least in part and could, perhaps, offset them entirely.

Coverage Gains from Expansion Would Lead to Reductions in Uncompensated Care Payments

In addition to paying the state share for Medicaid coverage, New Hampshire also directs some state dollars – financed by the Medicaid Enhancement Tax – toward reimbursing hospitals for some of the care they provide to the uninsured, otherwise known as uncompensated care. Prior to the current biennium, New Hampshire's annual General Fund contribution towards uncompensated care ranged from about $75 to $125 million and averaged roughly $98 million per year.[xxv]

Some estimates indicate that the amount of uncompensated care consumed in states will decrease by more than half as a result of the number of uninsured dropping by half under the ACA.[xxvi] However, it is not realistic to assume that the decrease in the amount of uncompensated care consumed would result in a corresponding amount of savings, given the complexity of uncompensated care funding streams and the political difficulty of reducing payments to providers at the same rate as the decrease in need in uncompensated care.[xxvii] The Urban Institute projects that New Hampshire could save 12.5 to 25 percent of current spending on uncompensated care due to the ACA.[xxviii] If New Hampshire were otherwise to return to the trend of uncompensated care expenditures of $98 million per year, such savings would amount to anywhere from $85 million to $171 million between 2014 and 2020.[xxix]

Coverage Gains Would Likely Help to Lower Other Program Costs

New Hampshire appropriated $240 million to non-Medicaid substance use treatment and mental health programs from the General Fund in its FY 2012-2013 budget. If the individuals and families served by these programs qualify for the Medicaid expansion, some portion of those services will be covered through Medicaid and thus could reduce General Fund expenditures – even by a percentage point or two – in these areas. Additional savings should result for courts, jails, and state prisons if mental health and substance abuse problems can be addressed before people end up in the criminal justice system.

Changes to Existing Medicaid Program May Yield Some Savings, but Pose Risks

Under the provisions of the ACA, states will have the authority to end Medicaid eligibility for any optional population on January 1, 2014. Theoretically, these populations would purchase insurance coverage through a Health Benefits Exchange. Two optional adult populations in New Hampshire are pregnant women and people with disabilities. Some initial estimates suggest that a savings of $42 million between 2014 and 2020 is possible by terminating eligibility for some of these groups in New Hampshire.[xxx]

However, Exchange-based coverage for former Medicaid members could prove problematic for at least three reasons. First, unlike Medicaid, traditional insurance benefit packages do not typically include long-term care benefits for permanent special health care needs, such as personal care attendants that help people with disabilities get out of bed, bathe, dress, and get ready for work. Shifting to private market coverage could thus leave people with disabilities without the supports they need to remain independent and in the workforce. Second, some Medicaid recipients have more than one form of health care coverage; they use Medicaid to obtain critical long-term care supports that are not provided through a typical private market health plan. These same people may be ineligible for the subsidies that will be available in the Health Benefits Exchange because the insurance they have through their employers, even though that insurance is not sufficient to meet their needs, makes them ineligible. Third, cost-sharing increases may make Exchange based coverage unaffordable. A person with an income equal to 150 percent of the federal poverty level – $16,755 in 2012 – could theoretically be responsible for paying as much as four percent of his or her income ($670 in this instance) towards a premium for coverage in the Exchange. This may simply be unaffordable for many people and force them to choose to remain uninsured. In short, any approach to generating savings by ending Medicaid eligibility for people over 133 percent of FPL should acknowledge that additional assistance with benefit packages and cost-sharing will likely be necessary, especially for those who are living with a disability and for those with incomes nearest the federal poverty level.

Failure to Expand Medicaid Would Leave Many without Affordable Care, Potentially Undermine New Hampshire's Move to Managed Care

Should New Hampshire elect to expand its Medicaid program, the decision will bring with it both costs and benefits. Should it choose to forego the expansion, it will still face substantial consequences. Most directly, the failure to take advantage of the ACA's Medicaid expansion option would continue to leave thousands of New Hampshire residents without access to affordable health care. Foregoing the expansion could also jeopardize efforts to implement managed care throughout New Hampshire's existing Medicaid program, as the contracts the state has executed with private companies to carry out the initiative are premised on the expansion.

In Absence of Medicaid, Low-Income Residents Will be Unable to Afford Insurance through an Exchange

If New Hampshire does not move forward with the Medicaid expansion, the insurance coverage needs of approximately 36,000 Granite Staters will remain largely unaddressed, as will the collateral budget issues associated with unreduced uncompensated care costs, which includes uncompensated care liability for providers and cost-shifting to those with private insurance.

As the figure below makes clear, the ACA will effectively limit the amount that people with incomes between 100 percent and 400 percent of the federal poverty level have to pay for health care, as it will provide them with premium and cost-sharing subsidies to buy coverage through the Health Benefit Exchanges.

ACA Limits Health Care Costs for Most Low- and Middle-Income Individuals, But Not the Very Poorest

Maximimum Payment from Individual when Purchasing Insurance through Health Benefit Exchange (HBE)

Annual Income as Percent of Federal Poverty Line (FPL)	Maximum Percentage of Annual Income Paid Toward Premium in HBE
0 to 100%	No limit
100 to 133 %	2.00%
134 to 150 %	4.00%
151 to 200 %	6.30%
201 to 250 %	8.05%
251 to 400 %	9.50%

Source: Patient Protection and Affordable Care Act

Due to the recent Supreme Court ruling on the ACA, which made the Medicaid expansion optional, rather than mandatory for states, there is now a potential gap in coverage assistance for working people with incomes above the current Medicaid eligibility limits. The ACA had envisioned that most people with incomes up to 133 percent of the FPL would automatically be eligible for Medicaid, since states were originally required to

enact such an expansion. As a result, for the most part, the statute provides no subsidies to those with incomes below 100 percent of the federal poverty limit. For states that choose not to pursue the now optional Medicaid expansion, people with incomes above the current Medicaid eligibility limit but below the poverty line would have neither Medicaid nor subsidized exchange coverage. (In New Hampshire, this includes parents with incomes between 40 and 100 of FPL and all childless, non-disabled non-pregnant adults under 100 of FPL.) In other words, many working poor would have incomes too high to qualify for Medicaid but too low to qualify for subsidies to buy coverage in the Exchanges. In fact, 68 percent of the New Hampshire residents who would be eligible for the Medicaid expansion will be ineligible for premium subsidies available through the Health Benefits Exchange because their incomes are below 100 percent of the federal poverty limit.[xxxi] Without additional financial assistance, many of them will remain uninsured.

Medicaid Managed Care Predicated on Expansion

In 2011, the New Hampshire legislature enacted changes in law to implement a system of managed care throughout the state's Medicaid program. The success of this initiative is largely dependent on New Hampshire electing the Medicaid expansion, since the managed care organizations with which the state has contracted to carry it out expect to see a substantial increase – driven by the ACA's Medicaid expansion – in the populations for which they are receiving monthly payments. In the absence of such an increase, the initiative may not be financially viable for these carriers.

New Hampshire executed contracts in the spring of 2012 to have the Medicaid program administered under a full-risk capitated rate agreement with three managed care organizations (MCOs). The contracts specify that in the third agreement year, the managed care organizations will provide coverage to those eligible through the Medicaid expansion.[xxxii] The capitated rate agreement promises a fixed monthly payment to a MCO for every person that enrolls. The promise of a 25 percent increase in covered lives due to the expansion – and, by extension, a roughly 25 percent jump in per member per month payments – was likely a significant factor in the MCOs' financial analyses of whether to participate in New Hampshire's care management initiative.

New Hampshire has – and even with the expansion, will have – a relatively small Medicaid population; the more lives the MCOs cover, the more financially viable the managed care program will be for them. Without the Medicaid expansion population, it may be difficult for all three of the MCOs to participate in the initiative. This could, in turn, create difficulties for the broader care management program, since federal law requires the state to offer Medicaid members a choice of no fewer than two managed care organizations under the managed care model New Hampshire has chosen. If the state were unable to maintain the participation of two managed care organizations, it would have to reconsider the model of managed care it will employ or pursue federal waivers to suspend the choice of vendor requirement. This may jeopardize the long-term savings that managed care could potentially achieve.

Conclusion

In the coming months, New Hampshire policymakers will decide whether to take advantage of provisions in the federal Affordable Care Act and allow many of the poorest adults in the state to receive health care coverage through New Hampshire's Medicaid program. While the decision to do so would entail some additional costs for the state in future years, such costs would be offset in part – and possibly, in whole – by savings elsewhere in the budget, through lower payments to hospitals for care they currently provide to the uninsured and through fewer expenditures for mental health, substance abuse, or public health services. What's more, New Hampshire's contribution to health care coverage for as many as 36,000 of the state's most vulnerable residents will be matched many times over by funds provided by the federal government. In fact, as this paper has demonstrated, between 2014 and 2020, the federal government would pay 95 percent of the costs of expanding New Hampshire's Medicaid program to newly eligible adults. Given these factors, New Hampshire should not pass up this opportunity.

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[i] New Hampshire Medicaid does offer coverage to low-income parents of children with incomes up to 40 percent of the federal poverty level.

[ii] New Hampshire Department of Health and Human Services, New Hampshire Medicaid Annual Report, State Fiscal Year 2010, Office of Medicaid Business and Policy, April 20, 2011, p. 1.

[iii] Ibid. Table 4, pp. 9.

[iv] New Hampshire Medicaid does offer coverage to low-income parents of children with incomes up to 40 percent of the federal poverty level.

[v] Approximately 29,799 are uninsured; another 20,723 are currently insured through employer sponsored insurance, while 8,376 are insured through directly purchased insurance.

[vi] "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health*, Remler D. and Glied S., Table 1, pp. 68, January 2003.

[vii] Those who do not wish to participate in Part B must actively opt-out.

[viii] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL" Holahan J. and Headen I., May 2010.

[ix] *Ibid.*, pp. 8.

[x] NHFPI follows the same practice as that used by the Congressional Budget Office (CBO) in estimating the costs associated with the Affordable Care Act. That is, CBO assumes 70 percent of the ultimate participation rate in the first year of the Medicaid expansion, 90 percent of the ultimate participation rate in second year, and full anticipated participation in the third year. It should also be noted that under a less conservative, standard participation scenario, the projections of participation fall to 19,436 in 2014 and 29,649 by 2020.

[xi] "Employers' Benefits from Workers' Health Insurance," The Millbank Quarterly, O'Brien, E., Vol 81, No 1, 2003, pp. 18-20, and Table 3.

[xii] "Oregon Health Insurance Experiment, Evidence from the First Year," NBER Working Paper, Finkelstein, A., et al, Working Paper 17190, 2011, pp. 3.

[xiii] *Ibid.*

[xiv] "Mortality and Access to Care among Adults after State Medicaid Expansions," Sommers B., et al, New England Journal of Medicine, July 25, 2012.

[xv] "Medical Bankruptcy in the United States, 2007: Results of National Study," Himmelstein, D. et al., The American Journal of Medicine (2009) 122, 741-746 at 743, Tables 1 and 2.

[xvi] "Oregon Health Insurance Experiment, Evidence from the First Year," NBER Working Paper, Finkelstein, A., et al, Working Paper 17190, 2011, pp. 3.

[xvii] American Bankruptcy Institute, Annual Business and Non-business Filings by State (2007-11), accessed at http://www.abiworld.org/AM/Template.cfm?Section=Filings_by_State1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=61&ContentID=36299 on August 15, 2012.

[xviii] Economic Impact of Hospital Systems in New Hampshire, New Hampshire Hospital Association, December 2009, pp. ii.
[xix] *Ibid*.
[xx] For these calculations, NHFPI used the capitation rates outlined in the New Hampshire Medicaid Care Management Services Contract contracts, at Exhibit B. Specifically, it used capitation rates for males ages 19 to 44, females ages 19 to 44, and adults ages 45 to 64.
[xxi] People will become aware that there may be a financial penalty for failing to have adequate health insurance. However, people who are income eligible for Medicaid will not be subject to the penalty for remaining uninsured due to their low income level. Fines will begin at $95 per year and increase to $695 or 2 percent of income by 2016.
[xxii] Many of the newly eligible for Medicaid will not be subject to a fine for remaining uninsured because the individual mandate applies to people with incomes high enough to be required to file taxes. For example, a single person with no dependents with an adjusted gross income of $9,500 was typically not required to file a federal tax return for 2011.
[xxiii] People with disabilities are particularly likely to have taken advantage of any Medicaid coverage available to them. In general, health insurance benefit packages in the private market do not provide robust long-term care supports or services. Medicaid does offer long-term care supports and services for qualifying individuals. Such supports and services enable members with disabilities to work and remain independent, making those benefits central to the livelihood and well-being of the person who receives them.
[xxiv] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL" John Holahan and Irene Headen, May 2010. The Kaiser report projects a cost of $60 million for the six-year period from 2014 through 2019. As all other estimates in this paper cover the seven-year period from 2014 through 2020, NHFPI adds one more year, at an annualized cost of $10 million to the original Kaiser estimate. It should also be noted that the Kaiser report assumes that eligibility for Medicaid for people with incomes over 133 percent of the FPL will end in 2014.
[xxv]Traditionally, the state has appropriated $150 to $250 million state dollars on uncompensated care each biennium – or $75 to $125 million each year. In the 2012-2013 budget, the state appropriated only $51 million in state dollars for uncompensated care for the total biennium.
[xxvi] "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid" Buettgens, et al, (Washington D.C.: The Urban Institute, 2011).
[xxvii] "Consider Savings as Well as Costs - State Governments Would Spend at Least $90 Billion Less with the ACA than Without It," Urban Institute, Buettegens, et al, July 2011, pp. 10.
[xxviii] *Ibid*., pp. 10.
[xxix] One other issue to consider in examining the interaction between uncompensated care costs and the Medicaid coverage option now available under the Affordable Care Act is the impact of the ACA on Disproportionate Share Hospital (DSH) payments. In brief, DSH payments are payments to compensate hospitals for the costs they face in treating the uninsured and to cover the difference between Medicaid reimbursements and the actual costs of care for Medicaid members. DSH payments are made using state funds matched by federal dollars. Each state is provided an amount of federal dollars it can match for these payments in a DSH allotment, which is annually determined by federal formula. Each state can draw down federal matching dollars up to the amount in that state's DSH allotment. New Hampshire's DSH allotment has been approximately $150 million each year for the last several years.

The ACA requires DSH allotments to be reduced for all states beginning in 2014. However, NHFPI has not attempted to calculate the impact of that requirement on New Hampshire, as the Secretary of Health and Human Services has not yet released the methodology by which the reductions in DSH payments will be calculated. What's more, New Hampshire's uncompensated care appropriations, which use DSH funds, were significantly changed in the FY12-13 budget; whether such changes will be maintained in the FY14-15 budget is unclear. Finally, New Hampshire has rarely used its full DSH allotment in the past, a practice which may influence the way DSH reductions affect the state budget.
[xxx] New Hampshire Medicaid Impact Estimate for Reconciliation, New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy, March 24, 2010
[xxxi] NHFPI calculations based on Economic Policy Institute analysis of American Community Survey data for 2008-2010
[xxxii] New Hampshire Medicaid Care Management Services Contract, Exhibit A., §8.1

APPENDIX
NHFPI Cost Estimates for Extending Medicaid Coverage to Newly Eligible State Residents under the ACA, 2014-2020

Key Assumptions

Description	*Value*	Source
Annual growth in eligible population	1.1%	US Census Bureau
Participation rate - uninsured	75.0%	Kaiser Commission on Medicaid and the Uninsured
Participation rate - employer sponsored insurance (ESI)	25.0%	Kaiser Commission on Medicaid and the Uninsured
Participation rate - direct purchase	60.0%	Kaiser Commission on Medicaid and the Uninsured
Male share of population age 19-44	49.0%	US Census Bureau
Female share of population age 19-44	51.0%	US Census Bureau
Annual growth in PMPM	5.2%	NHFPI calculations based on data from the NH Department of Health and Human Services
Implementation phase-in (2014)	70.0%	Congressional Budget Office
Implementation phase-in (2015)	90.0%	Congressional Budget Office
Implementation phase-in (2016 and later)	100.0%	Congressional Budget Office

Potentially Newly Eligible Population (NH residents aged 19-64 with incomes less than 133% of FPL, by type of insurance coverage, 2009-2011)

Source: Political Economy Research Institute (PERI) analysis of US Census Bureau Current Population Survey data

	Uninsured	Employer Sponsored	Direct Purchase	Total
Age 19-44	21,405	12,503	5,836	39,744
Age 45-64	8,394	7,770	2,540	18,704
Total	**29,799**	**20,273**	**8,376**	**58,448**

Potentially Newly Eligible Population (NH residents aged 19-64 with incomes less than 133% of FPL, by type of insurance coverage, 2011-2020)

Source: NHFPI calculations based on US Census Bureau population projections and above PERI analysis

	2010	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*	*2019*	*2020*
Age 19-44											
Uninsured	21,405	21,640	21,878	22,119	22,362	22,608	22,857	23,108	23,362	23,619	23,879
ESI	12,503	12,641	12,780	12,920	13,062	13,206	13,351	13,498	13,647	13,797	13,949
DP	5,836	5,901	5,965	6,031	6,097	6,165	6,232	6,301	6,370	6,440	6,511
Age 45-64											
Uninsured	8,394	8,487	8,580	8,675	8,770	8,866	8,964	9,063	9,162	9,263	9,365
ESI	7,770	7,855	7,942	8,029	8,117	8,207	8,297	8,388	8,481	8,574	8,668
DP	2,540	2,568	2,596	2,624	2,653	2,682	2,712	2,742	2,772	2,802	2,833
Total	**58,448**	**59,091**	**59,741**	**60,398**	**61,063**	**61,734**	**62,413**	**63,100**	**63,794**	**64,496**	**65,205**

Projected Newly Eligible Participants in Medicaid Expansion

Source: NHFPI calculations based on Kaiser Commission and Congressional Budget Office analyses

	2014	*2015*	*2016*	*2017*	*2018*	*2019*	*2020*
Age 19-44							
Uninsured	11,740	15,260	17,142	17,331	17,522	17,714	17,909
ESI	2,286	2,971	3,338	3,375	3,412	3,449	3,487
DP	2,561	3,329	3,739	3,781	3,822	3,864	3,907
Age 45-64							
Uninsured	4,604	5,985	6,723	6,797	6,872	6,947	7,024
ESI	1,421	1,847	2,074	2,097	2,120	2,143	2,167
DP	1,114	1,449	1,627	1,645	1,663	1,681	1,700
Total	**23,726**	**30,840**	**34,644**	**35,025**	**35,411**	**35,800**	**36,194**
Subtotal: Age 19-44 Male	8,128	10,565	11,868	11,998	12,130	12,264	12,399
Subtotal: Age 19-44 Female	8,459	10,996	12,352	12,488	12,625	12,764	12,905
Subtotal: Age 45-64	7,139	9,280	10,424	10,539	10,655	10,772	10,891

Projected Per Member Per Month Costs

Source: NHFPI calculations based on Medicaid Managed care contract capitated rates

	2013	*2014*	*2015*	*2016*	*2017*	*2018*	*2019*	*2020*
Age 19-44 Male	264	278	292	307	323	340	358	376
Age 19-44 Female	345	363	382	402	422	444	468	492
Age 45-64	446	469	494	519	546	575	604	636

Projected Annual Program Costs for Expansion to Newly Eligible State Residents

Source: NHFPI calculations based on above participation projections and per member per month costs

	2014	*2015*	*2016*	*2017*	*2018*	*2019*	*2020*
Age 19-44 Male	27,085,764	37,036,605	43,765,738	46,545,731	49,502,310	52,646,689	55,990,799
Age 19-44 Female	36,840,911	50,375,623	59,528,306	63,309,535	67,330,947	71,607,799	76,156,316
Age 45-64	40,193,637	54,960,083	64,945,710	69,071,052	73,458,435	78,124,504	83,086,962
Total	**104,120,312**	**142,372,310**	**168,239,754**	**178,926,319**	**190,291,692**	**202,378,993**	**215,234,077**

Breakdown in Projected Annual Program Costs for Expansion to Newly Eligible State Residents, by Funding Source

	2014	*2015*	*2016*	*2017*	*2018*	*2019*	*2020*
Federal match	100%	100%	100%	95%	94%	93%	90%
Federal	104,120,312	142,372,310	168,239,754	169,980,003	178,874,191	188,212,463	193,710,669
New Hampshire	-	-	-	8,946,316	11,417,502	14,166,529	21,523,408

Breakdown in Projected Program Costs for Expansion to Newly Eligible State Residents, by Funding Source, 2014 through 2020

Federal	1,145,509,703
New Hampshire	56,053,755
Total	**1,201,563,457**