## Title

Medi-Cal Expansion under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State



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# Medi-Cal Expansion under the Affordable Care Act:

# Significant Increase in Coverage with Minimal Cost to the State

**CalSIM**
**California Simulation of Insurance Markets**

*The California Simulation of Insurance Markets (CalSIM) model is designed to estimate the impacts of various elements of the Affordable Care Act on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. It was developed by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research, with generous funding provided by The California Endowment.*

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**UC Berkeley Center for Labor Research and Education**
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The California Endowment

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# EXECUTIVE SUMMARY

Since 2011, California has been taking steps towards expanding Medicaid under the Affordable Care Act (ACA) by implementing Low Income Health Programs (LIHPs) in most California counties. Under the "Bridge to Reform" Medicaid §1115 waiver, just over 500,000 California adults[1] are currently enrolled in coverage in advance of ACA implementation using federal and county funds. The vast majority of these LIHP enrollees can become eligible for Medi-Cal coverage under the ACA beginning January 1, 2014, and the remainder will be eligible for subsidies through Covered California (the California Health Benefit Exchange).

In early 2013, California legislators will consider bills to implement a key provision of the ACA that would expand Medi-Cal to low-income adults under age 65, including those without children living at home. Lawfully-present childless adults with income up to 138 percent of the Federal Poverty Level and parents with income between 106 percent and 138 percent of the Federal Poverty Level will be newly eligible. Some unenrolled children and parents who are already income-eligible for the program under existing eligibility rules could also enroll due to the minimum coverage requirement to obtain insurance created by the ACA, improved eligibility, enrollment and redetermination processes, and enhanced awareness of coverage options.

In this report, we estimate the growth in Medi-Cal enrollment among both the newly and already eligible using the UC Berkeley–UCLA California Simulation of Insurance Markets (CalSIM) model. We discuss the broader impact of the Medi-Cal Expansion in terms of health outcomes, providers and the economy. We estimate the federal and state spending on increased Medi-Cal enrollment, along with the state tax revenues generated by new federal Medi-Cal spending and potential savings in other areas of the budget.

With the adoption of the Medi-Cal Expansion, we predict that:

## Medi-Cal eligibility and enrollment will increase significantly.

- More than 1.4 million Californians will be newly eligible for Medi-Cal, of which between 750,000 and 910,000 are expected to be enrolled at any point in time by 2019.
- About 2.5 million Californians are already eligible for Medi-Cal but not enrolled. Between 240,000 and 510,000 of these already eligible but not yet enrolled Californians are expected to be enrolled in Medi-Cal coverage at any point in time by 2019. The increase in enrollment is due to the minimum coverage requirement for individuals; simplified Medicaid eligibility determinations and enrollment processes; annual redetermination processes that are more data-driven and automatic; the establishment of "no wrong door;" and statewide outreach and education about new coverage options. Most of the increased enrollment of those already eligible but not yet enrolled will occur as a result of these mandatory provisions of the ACA whether or not California expands Medi-Cal to cover the newly eligible.

## Expanding Medi-Cal will have far-reaching benefits for the health outcomes of Californians, providers, and the California economy.

- Research has shown that Medicaid coverage is associated with decreased mortality and increased use of preventive care.
- The Medi-Cal Expansion will make funding more stable for providers that currently care for the uninsured and low-income communities.

- Health coverage is associated with improved educational outcomes and improved worker productivity.
- The Medi-Cal Expansion will create jobs in the state.

## Of the new Medi-Cal spending, 85 percent or more will be federally-paid.

- The Medi-Cal Expansion and enrollment growth among those already eligible is predicted to bring between $2.1 and $3.5 billion in new federal Medi-Cal dollars to California in 2014, growing to between $3.4 and $4.5 billion in 2019.
- Overall, the federal government will pay for at least 85 percent of the total new Medi-Cal spending between 2014 and 2019, including:
    - 100 percent of the health care spending for the newly eligible for the first three years (and no less than 90 percent in 2017 and after);
    - 50 percent for those already eligible for Medi-Cal but not enrolled; and
    - 88 percent for children already eligible for Healthy Families but not enrolled in 2015 through 2019, and 65 percent in 2014.

## In initial years, most new state Medi-Cal spending results from required Medicaid changes and will occur whether or not the Expansion is implemented.

- New state General Fund spending for Medi-Cal will be between $188 and $453 million in 2014 and only slightly higher in 2015 and 2016.
- Most of the new state spending in 2014 through 2016 will occur whether or not the Expansion is implemented because it is mostly due to increased enrollment of those currently eligible but not enrolled. The federal government will pay all of the medical costs for the newly eligible enrollees during these years. Administrative costs for the newly eligible are estimated at 5 percent of medical costs: the state will be responsible for half of that, or 2.5 percent.
- In 2019, the new state General Fund spending for Medi-Cal will be between $443 and $788 million, which includes spending for both the newly eligible and those eligible today but not enrolled.

## New state Medi-Cal spending will be largely offset by increased state tax revenues and savings. Failure to implement the Expansion reduces most savings.

- Billions in new federal dollars will result in new state General Fund (GF) tax revenue which will offset some or most of new state spending, depending on the year.
- As uninsured Californians enroll in Medi-Cal under the Expansion, the state could incur substantial savings in other areas of the budget, including other state health programs, mental health services, and state prisons. Most of these General Fund savings result from the expansion of Medi-Cal coverage and will be considerably less if the Expansion is not implemented.
- With the Expansion, the magnitude of these anticipated savings would likely be more than enough to offset the $46 to $381 million in annual state General Fund spending for the newly eligible population through 2019.

## Background

The Affordable Care Act (ACA), signed in March 2010 by President Obama, included a key provision that required states to expand Medicaid to lawfully-present adults with family income under 138 percent of the Federal Poverty Level (including a 5 percentage point income disregard) regardless of disability status or parental status beginning in 2014. This represents the largest expansion in Medicaid eligibility since the program was created in 1965. Under the ACA, the federal government will pay 100 percent of the costs for newly eligible Medicaid enrollees in 2014 through 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and future years.

A Supreme Court ruling in June 2012 effectively made the Expansion optional for states. In a seven-to-two decision, the Court decided that the federal government could not require a state to participate in the Expansion. Under the decision, states are still required to implement other Medicaid-related ACA provisions, such as simplifying eligibility and enrollment processes, regardless of whether they participate in the Medicaid Expansion.

If a state does not implement the Medicaid Expansion, eligible individuals with family income of 100 percent or more of the Federal Poverty Level can enroll in subsidized coverage through a Health Insurance Exchange. Individuals with income below 100 percent of the Federal Poverty Level will not be eligible for Exchange subsidies, except for lawfully present immigrants who have been in the country five years or less and do not meet federal Medicaid eligibility criteria. In California, these permanent residents are currently eligible for state-only Medi-Cal.

Recent guidance from the Department of Health and Human Services (HHS) clarified that states will only receive the enhanced 100 percent matching rate in 2014 through 2016 if they expand eligibility all the way up to 138 percent of the Federal Poverty Level. HHS will consider partial expansions to a lower income level, but states exercising this option would only receive the regular federal matching rate (50 percent in California).[2]

In early 2013, California legislators will consider bills enacting the Medi-Cal Expansion that would:

- Expand eligibility to eligible low-income non-elderly adults under 138 percent of the Federal Poverty Level;
- Simplify procedures for Medicaid eligibility based on income as required by the ACA, including eliminating asset tests, using Modified Adjusted Gross Income (MAGI) to determine eligibility, and verifying income and other eligibility data using electronically available resources whenever possible; and
- Outline the benchmark benefits package offered under the Expansion, including aligning benefits with the Essential Health Benefits package required by the ACA in the individual and small group insurance market.

## Eligibility and Enrollment will Increase with Expansion

We analyzed the impact that the Medi-Cal Expansion is predicted to have on coverage using the California Simulation of Insurance Markets (CalSIM) model, version 1.8. CalSIM is a microsimulation model designed to estimate the impacts of various elements of the ACA on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. It was developed by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research. In order to examine the impact of the Medi-Cal Expansion over time, this paper focuses on estimates provided by CalSIM for 2014, 2016, and 2019.

Significant uncertainty exists regarding how many and when Californians will take up Medi-Cal coverage under the ACA. This analysis reflects our best estimates under two scenarios and is guided by reasonable assumptions informed by historical experience. Our "base scenario" assumes that Medi-Cal take-up for newly eligible uninsured adults will continue at the current rate of 61 percent.[3] The base scenario also assumes that 10 percent of the uninsured Californians already

eligible for Medi-Cal but not yet enrolled will take up. We assume that these take-up rates will be achieved by 2018 under the base scenario, and will be phased in during prior years.

In developing our "enhanced scenario" we assume that eligibility determination is simplified, strong outreach and education is conducted, "no wrong door" enrollment is implemented, outreach and enrollment efforts are culturally sensitive and language appropriate, and pre-enrollment is used for Californians who already participate in categorical public programs that provide services but not full coverage. This scenario assumes 75 percent take-up of Medi-Cal for newly eligible individuals who were previously uninsured. It also assumes that 40 percent of the uninsured Californians who are already eligible for Medi-Cal but not enrolled will take up, following the Urban Institute/Kaiser Family Foundation enhanced participation estimate.[4] We assume that these take-up rates will be achieved by 2016 under the enhanced scenario.

With the Expansion, over 1.4 million Californians are expected to be newly eligible for Medi-Cal in 2014 through 2019. Approximately half of the Californians who will be newly eligible have family incomes of less than 100 percent of the Federal Poverty Level and would not be eligible for subsidies through Covered California (California's Health Benefit Exchange) if the Medi-Cal Expansion is not enacted (Exhibit 1).

Of the 1.4 million newly eligible Californians in 2014, CalSIM predicts 480,000 will enroll at any point in time in the base scenario and 780,000 will enroll in the enhanced scenario. By 2019,

Exhibit 1. Californians under Age 65 Newly Eligible for Medi-Cal by Income (Federal Poverty Level) with Expansion

| | Less than 100% FPL | 100–138% FPL | Total |
|---|---|---|---|
| 2014 | 690,000 | 720,000 | 1,420,000 |
| 2016 | 700,000 | 730,000 | 1,430,000 |
| 2019 | 720,000 | 740,000 | 1,460,000 |

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

Exhibit 2. Predicted Increase in Medi-Cal Enrollment of Californians under Age 65 with Expansion

| | Scenario | Newly eligible | Already eligible | Total |
|---|---|---|---|---|
| 2014 | Base | 480,000 | 200,000 | 680,000 |
| | Enhanced | 780,000 | 440,000 | 1,220,000 |
| 2016 | Base | 630,000 | 230,000 | 860,000 |
| | Enhanced | 880,000 | 490,000 | 1,370,000 |
| 2019 | Base | 750,000 | 240,000 | 990,000 |
| | Enhanced | 910,000 | 510,000 | 1,420,000 |

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

CalSIM estimates that 750,000 to 910,000 will enroll (Exhibit 2). The base scenario appears to be a conservative estimate for 2014 because almost 475,000 Californians or one-third of the newly eligible were already enrolled in the Medicaid Coverage Expansion portion of the Low Income Health Program (LIHP) as of October 2012.[5] These enrollees are scheduled for transition to Medi-Cal on January 1, 2014.

We predict that without the ACA, 2.5 million Californians under age 65 who are currently income-eligible for Medi-Cal or Healthy Families[6] would not enroll in 2014 through 2019. Approximately 71 percent of these Californians are children; the rest are parents. Common reasons that eligible Californians report not enrolling in Medi-Cal or Healthy Families include lack of awareness of the programs or eligibility standards, dislike of the programs, or a belief that they are already insured. A small share of eligible Californians not enrolled also report that the paperwork is too difficult.[7]

Of the Californians who are already eligible but not enrolled, between 200,000 and 440,000 are expected to take up Medi-Cal in 2014, growing to 240,000 to 510,000 in 2019 (Exhibit 2). These estimates do not include Californians who may already be eligible for Medi-Cal based on disability or other criteria beyond income.

The enrollment increase among already eligible Californians is likely to occur for a number of

reasons. First, under the ACA, individuals who do not obtain minimum essential coverage will owe a tax penalty. We estimate that in 2014 approximately 45 percent of Californians who are already income-eligible for Medi-Cal but not enrolled will be exempt from this requirement because their income falls below the tax filing threshold.[8] However, previous research from Massachusetts state health reform showed that their individual mandate was associated with an enrollment increase even among those who were exempt because "these people may be seeking coverage under the mistaken assumption that the mandate applies to them or simply because they want to comply with the new social norm of having insurance."[9]

Additionally, take-up and retention rates are likely to increase because:

- Medi-Cal eligibility and enrollment processes will be simplified as required under the ACA;
- Annual redetermination processes will be more data-driven and automated;
- The establishment of the Service Centers and the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) will create a simplified avenue for individuals to enroll online or by phone, and will determine eligibility for multiple programs—Medi-Cal, Covered California subsidies, and Healthy Families;
- Outreach and education about the new coverage options will be conducted by Covered California, largely through its contractors and community-based organizations, which will direct consumers to the CalHEERS site and Service Centers; and
- Providers are likely to improve their systems to identify and enroll patients in new coverage options at the point of service.

Most of the increase in enrollment among already eligible Californians will occur regardless of whether or not the Medi-Cal Expansion is adopted. This view is shared by a number of analysts. Jonathan Gruber of MIT said that "most of the expected increase in enrollment among people who are currently eligible but unenrolled will be due to the individual responsibility requirement and the overall "ethos" of health reform, irrespective of whether states take-up the Medicaid expansion."[10] In their analyses of the state spending on the Medicaid Expansion in Indiana and Wyoming, actuarial firm Milliman assumed that the same number of individuals already eligible for Medicaid but not enrolled would take up regardless of whether the Expansion is adopted.[11] The Urban Institute assumed that 81 percent of the already eligible who would newly enroll in Medicaid with the Expansion would enroll without the Expansion.[12] The Congressional Budget Office assumes that there would be an increase in enrollment of the already eligible but not enrolled, but that the increase in enrollment of already eligible individuals would be greater if Medicaid is expanded.[13]

## Expansion will have a Positive Impact on Health Outcomes, Providers and the Economy

Numerous studies have shown that Medicaid coverage improves access to health care and intermediate health outcomes.[14] Research on previous expansions of Medicaid to adults in Arizona, Maine, and New York found that Medicaid coverage was associated with reduced mortality.[15] Research on the Oregon Medicaid program for previously uninsured low-income adults found that, compared to similar adults who were not selected by lottery to apply for Medicaid, "people with Medicaid coverage were 70% more likely to report having a regular place of care and 55% more likely to report having a usual doctor; Medicaid coverage also increased the use of preventive care such as mammograms (by 60%) and cholesterol monitoring (by 20%)."[16] Reducing the number and proportion of the uninsured would benefit those with insurance coverage as well. The Institute of Medicine found that "insured adults in those communities [with high rates of uninsurance] are more likely to have difficulties obtaining needed health care and to be less satisfied with the care they receive."[17]

Many of the Californians who will enroll under the Expansion are currently uninsured and accessing services from health care safety net providers. When these uninsured patients become newly eligible for Medi-Cal and enroll, it will mean more stable funding for the providers that care for this population. In addition, Medi-Cal enrollees will choose a primary care provider through a Medi-Cal Managed Care Plan, which could result in greater continuity of care for patients and greater predictability for providers that serve low-income communities.

Health insurance coverage can improve educational outcomes and worker productivity. For example, a study from the National Bureau of Economic Research found that greater access to public coverage improved children's performance on standardized reading tests.[18] A study of children with Medicaid coverage in South Carolina found that those who had the recommended number of well-child visits had a 23 percent higher probability of being ready for school than those with fewer visits.[19] Researchers found reduced absenteeism among workers with health coverage compared to those who are uninsured.[20] An analysis of manufacturing plants found that workers offered health insurance had greater productivity.[21]

Expanding Medi-Cal will also create jobs in the state. According to research by the Bay Area Council Economic Institute, the provisions of the ACA including the Medi-Cal Expansion are expected to create approximately 100,000 new jobs per year in California. Nearly half of these jobs would be in the health care and social service industries, and nearly one-third would be in retail, accommodations, or food service.[22] We estimate that a significant share of the jobs created by the ACA in California will be attributable to the increase in federal spending on Medi-Cal due to the Expansion and the increased take-up among those already eligible.[23]

## Of the New Spending, 85 Percent or More will be Federally-Paid

We estimate the increase in federal Medi-Cal spending using CalSIM enrollment projections for the newly eligible and already eligible but not enrolled, and based on our estimates of monthly Medi-Cal spending per enrollee, discussed further on page 11. These spending estimates reflect that the federal government will pay:

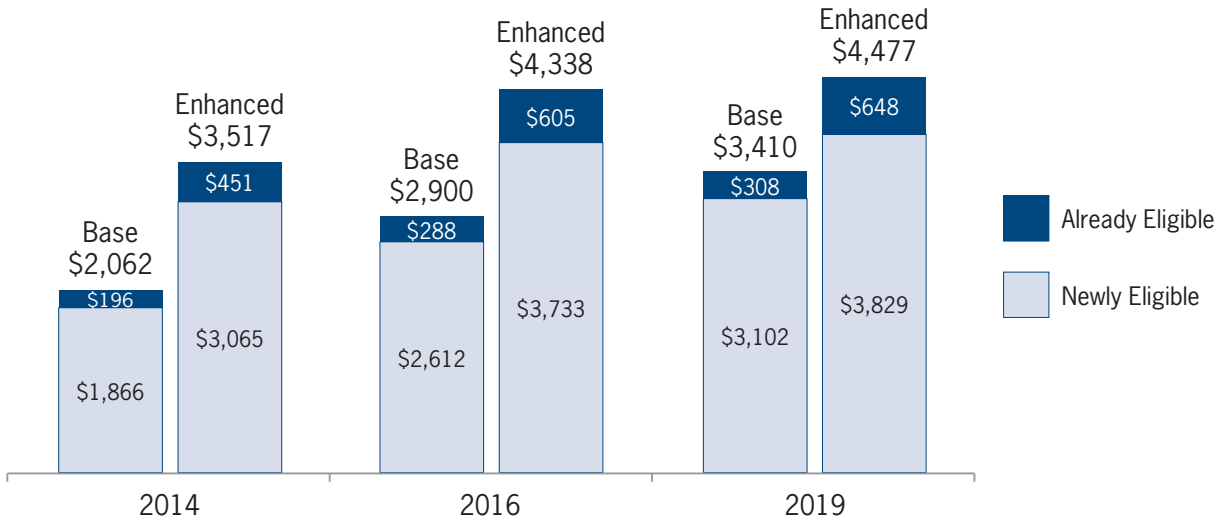
- 100 percent of the health care costs for newly eligible Medi-Cal enrollees in 2014 through 2016, phasing down to 90 percent in 2020 and future years;
- 50 percent for Medi-Cal enrollees who are already eligible;
- 88 percent for Title XXI (currently the Healthy Families program, which will transition to Medi-Cal during 2013) children in 2015 to 2019, and 65 percent in 2014; and
- 50 percent of administrative costs for all Medi-Cal enrollees and 65 percent for those eligible under Healthy Families.[24]

The estimated increase in state spending is discussed in the next section of this report.

We predict that the increase in Medi-Cal enrollment based on the Expansion and the increase in enrollment among already eligible Californians will bring between $2.1 and $3.5 billion in federal dollars to California's economy in 2014. By 2019, we predict these federal dollars to grow to between $3.4 and $4.5 billion (Exhibit 3, page 10). Most of this spending would be for newly eligible enrollees, but the estimates also include the federal spending for Californians who are already eligible but not enrolled.

Federally-funded subsidies for eligible individuals enrolled in coverage through Covered California will also bring billions of additional dollars into the state. However, this analysis does not include these federal dollars for Covered California subsidies because the focus of this report is Medi-Cal.

Exhibit 3. New Federal Medi-Cal Spending in California with Expansion ($ millions)



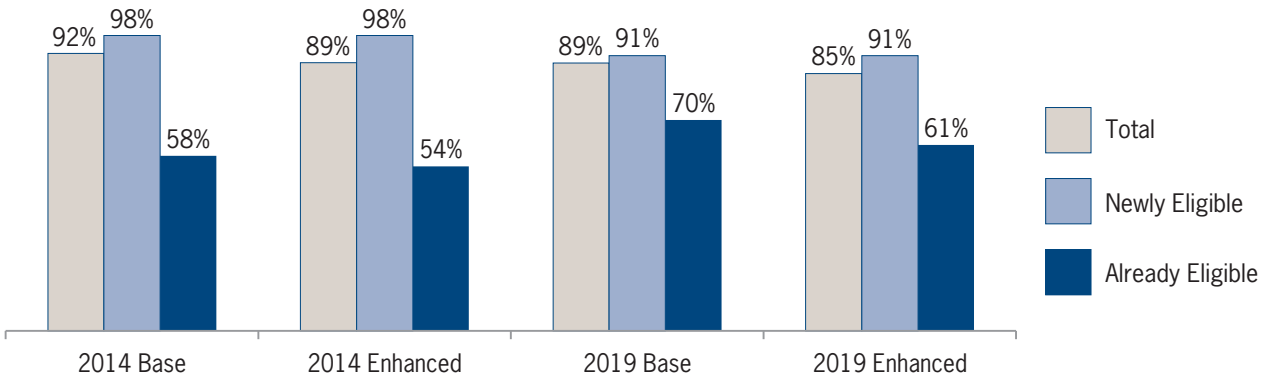

Source: UC Berkeley–UCLA CalSIM model, Version 1.8 and authors' analysis of estimated Medi-Cal spending per enrollee

Federal dollars will account for at least 85 percent of the total new Medi-Cal spending and an even higher share of spending for the newly eligible. Exhibit 4 shows the federal share of spending by eligibility category and in total in 2014 and 2019 under both scenarios.[25]

The federal infusion of dollars into the state can be examined in another way. Every state dollar spent on newly eligible enrollees will bring 41 federal dollars to California in 2014 and ten dollars in 2019. If the enrollment increase among already eligible Californians is included, every new dollar spent by the state on Medi-Cal is predicted to bring between eight and eleven federal dollars to California in 2014 and between six and eight dollars in 2019, depending on the scenario.[26]

Implementing the Medi-Cal Expansion in 2014 will ensure taking full advantage of the higher federal match in the early years. Uninsured individuals who newly enroll in Medi-Cal are likely to have

Exhibit 4. Share of New Medi-Cal Spending Paid by Federal Government with Expansion




Source: UC Berkeley–UCLA CalSIM model, Version 1.8 and authors' analysis of estimated Medi-Cal spending per enrollee
Note: Includes administrative costs for newly eligible and already eligible but not enrolled Californians

higher costs initially than they will on an ongoing basis due to pent-up demand for health care services.[27] Although individuals enrolled in the LIHP "are likely to have significant care provided now through their LIHP enrollment and should have relatively stable health services use,"[28] they comprise only approximately one-third of the Californians who will be newly eligible for Medi-Cal. From a state budget perspective, it would be more advantageous for the pent-up health care needs of newly eligible enrollees to be addressed when the Medi-Cal Expansion is fully federally-funded in 2014 through 2016 than to delay the Expansion.

## Most New State Spending Not Due to Expansion in 2014 through 2016

Although the federal government will be responsible for most of the new Medi-Cal spending, California will incur some new spending. Exhibit 5 (page 12) shows the projected increase in state Medi-Cal spending with the Expansion, calculated using the CalSIM enrollment projections and our estimates of per-enrollee Medi-Cal spending. We find that in 2014 through 2016 the majority of the new state spending is not due to the Expansion, but due to the increase in enrollment among the already eligible. Much of this state spending will likely be offset by new state tax revenues and savings to the state budget for other programs, as discussed later in this report.

### Medi-Cal Spending per Enrollee

These federal and state spending estimates are highly dependent on the amount spent per Medi-Cal enrollee. Medi-Cal managed care capitation rates have not yet been determined for 2014 and actual capitation rates will depend on a number of factors which are still unknown, including the state's decision on benchmark benefits. Our spending estimates for children and parents are based on our analysis of recent capitation rates, managed care carve-out expenditures, and dental costs for children from Department of Health Care Services data. We assume monthly spending of $129 for children and $186 for parents in 2014, growing at 2.3 percent annually thereafter.

We assume that monthly costs for newly eligible childless adults will be approximately 1.9 times those of currently-enrolled parents,[29] or $359 in 2014. The variation in cost is based on analysis using our CalSIM model that suggests that newly eligible childless adults predicted to enroll in 2014 will be nine years older and have slightly worse health status, on average, than currently-enrolled parents.

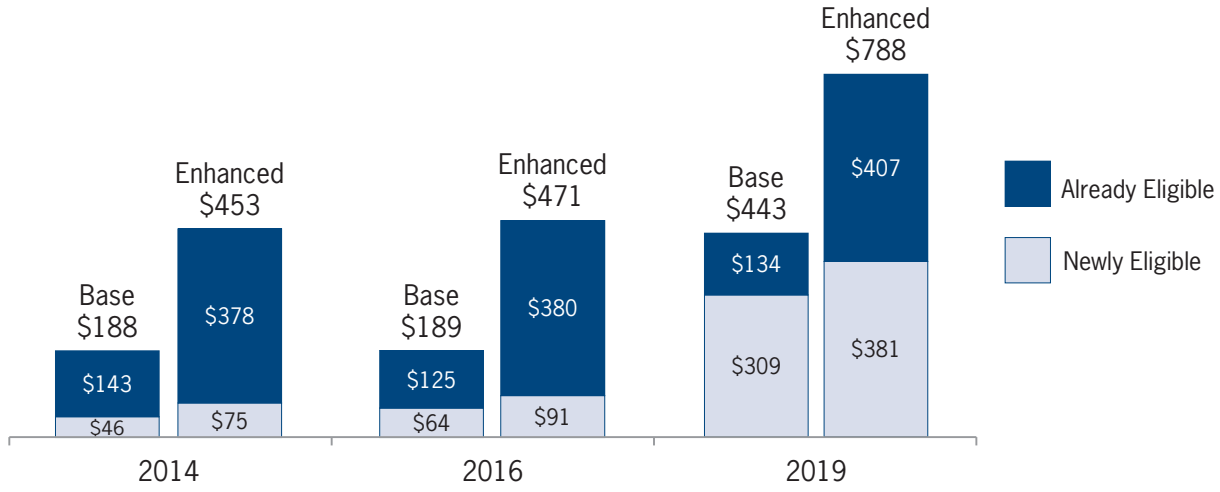
A high degree of uncertainty exists about the Medicaid costs for childless adults. Research on childless adults covered through Medicaid waivers in other states also suggests that childless adults may have higher costs than parents[30] in part because childless adults in these waivers were found to be older than parents enrolled in Medicaid, according to a separate study by Mathematica Policy Research.[31] However, the childless adults in the waivers examined may not be comparable to the Medi-Cal Expansion population because waiver benefits packages may be lower, income eligibility levels may differ, and some of the waivers have enrollment caps. Some experts, such as the State Health Reform Assistance Network, predict that costs for newly eligible are likely to be similar to those for parents.[32] A national analysis by the Urban Institute found that "new enrollees will not be markedly different than the nondisabled adults currently on Medicaid"[33] and an analysis by the Public Policy Institute of California had similar results.[34]

We conservatively assume that costs for already eligible parents and children who were not enrolled are the same as costs for those who are currently enrolled. Individuals who were already eligible for Medicaid but did not sign up are likely to have lower health care needs because those with greater health needs are more likely to enroll in order to get care.[35] If the costs of the already eligible but not enrolled are lower per capita than we estimate here, then the General Fund costs would be lower as well.

The state has not yet determined the benchmark benefits for the newly eligible population, but we conservatively assume that the benefits are the same as those received by current enrollees. If benefits are less generous for newly eligible enrollees, the spending could be lower.

More information about the methodology used to estimate these costs is included in Appendix A.

Exhibit 5. New State General Fund Medi-Cal Spending with Expansion ($ millions)




Source: UC Berkeley–UCLA CalSIM model, Version 1.8 and authors' analysis of estimated Medi-Cal spending per enrollee

## Small Investment will Enable Large Coverage Increase

In 2014, state Medi-Cal General Fund spending is expected to increase by 3 percent with the Expansion, a small investment compared to the 19 percent growth in Medi-Cal enrollment under the enhanced scenario (Exhibit 6). Under the base scenario in 2014, we predict a 1 percent increase in Medi-Cal General Fund spending, compared to 10 percent growth in Medi-Cal enrollment. The trends are similar in 2016 and 2019.[36] The change in General Fund spending does not take into account any of the potential new tax revenues or other budget savings discussed later in this report.

These estimates are based on $15.1 billion in budgeted Medi-Cal General Fund spending in Fiscal Year 2012–2013, which is assumed to grow by 6 percent annually without the ACA.[37] We predict that 6.5 million Californians would be enrolled in Medi-Cal in the absence of the ACA in 2014, increasing to 6.7 million in 2019.[38]

Exhibit 6. Increase in Medi-Cal General Fund Spending Compared to Increase in Medi-Cal Enrollment with Expansion, 2014, Enhanced Scenario


Source: UC Berkeley–UCLA CalSIM model, Version 1.8 and authors' analysis of estimated Medi-Cal spending per enrollee
Note: Includes newly eligible and already eligible but not enrolled Californians

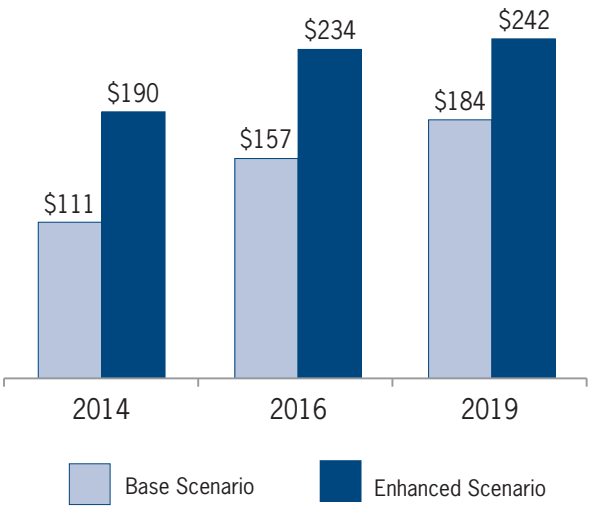
## State Spending will be Partly Offset by Tax Revenue

The new federal spending on Medicaid under the ACA will also increase state tax revenues, offsetting some of the new state spending. Federal spending on Medicaid supports jobs in the health care industry, including at hospitals and clinics and suppliers. The income that these health care workers spend locally supports jobs in a variety of industries, such as food services and retail, and the dollars continue to circulate through the economy until they are spent out of state. The Californians who hold these health care, food services, retail, and other jobs pay state income and sales taxes.[39] The spending also increases the state's corporate profit tax revenues, along with some other smaller taxes and fees.[40]

We estimate that every new dollar the federal government spends on Medi-Cal will generate 5.4 cents in state General Fund tax revenue.[41] This estimate is derived using IMPLAN 3.0, an industry-standard modeling software package that allows computation of the direct impact of spending and the indirect impact on suppliers, along with the induced effect resulting from changes in household income and resulting spending patterns. IMPLAN estimates multiple rounds of effects as the dollars cycle through the economy, continuing until all of the money is spent outside the state. IMPLAN estimates the impact that a change in spending would have on state and local tax revenue in aggregate. We developed assumptions about each tax revenue category in order to isolate the estimated effect on the General Fund.

Exhibit 7 shows predicted General Fund tax revenue generated by the new federal spending. We predict that $111 to $190 million in new General Fund tax revenue will be generated in 2014, increasing to $184 to $242 million in 2019. This does not include the new state tax revenue that will be generated by the billions of federal dollars that will be spent on Covered California subsidies. It also assumes that no new General Fund tax revenue is generated based on the new state Medi-Cal spending because those dollars would likely have been spent in California on other budget categories regardless of the ACA.

Exhibit 7. New State General Fund Tax Revenue Generated by Federal Medi-Cal Spending with Expansion ($ millions)




Source: Authors' analysis of IMPLAN 3.0, 2010 and authors' estimate of federal spending

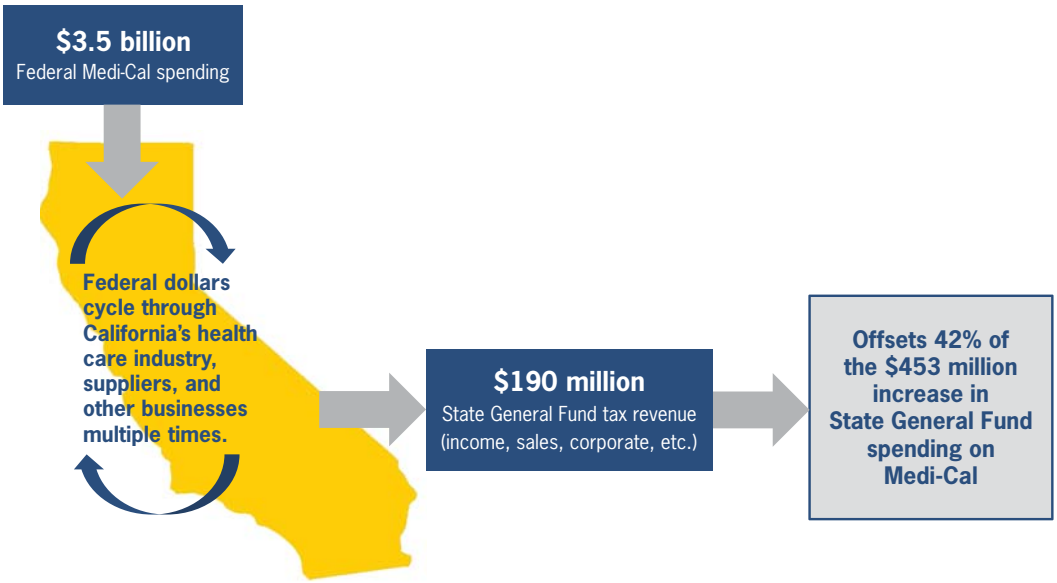
Note: Includes tax revenue from federal spending on newly eligible and already eligible but not enrolled Californians

We estimate that new state tax revenues will offset 42 percent of new state spending in 2014 under the enhanced scenario, as shown in Exhibit 8 (page 14), which diagrams the step-by-step flow of dollars. State tax revenues would offset 59 percent of spending under the base scenario in 2014. The share of state spending offset is estimated at between 50 and 83 percent in 2016 and between 31 and 42 percent in 2019, depending on the scenario.

Under Proposition 98, a certain share of General Fund tax revenues are guaranteed for school districts, community college districts, and other state education agencies. According to the California Department of Finance, the Proposition 98 share averages 54 percent.[42]

If California does not adopt or delays the Medi-Cal Expansion, we estimate that in 2014 and 2016 new General Fund tax revenues are likely to be lower than shown in Exhibit 7. In 2019, the tax revenues would be somewhat greater. Without the

Exhibit 8. Flow of Federal Medi-Cal Dollars through State Economy with Expansion, 2014, Enhanced Scenario




Source: Authors' analysis of IMPLAN 3.0, 2010 and authors' estimate of state and federal spending

Expansion, federal Medi-Cal funds for the newly eligible would be eliminated, but the federal government would spend more on Covered California subsidies for individuals with income between 100 and 138 percent of the Federal Poverty Level. While the total number of Californians with coverage would be lower without the Expansion, the federal spending per subsidized Covered California enrollee with income between 100 and 138 percent of the Federal Poverty Level is likely to be significantly greater than the federal spending per newly eligible Medi-Cal enrollee.[43] As noted earlier, the enrollment increase among Californians who are already eligible is likely to occur to a similar degree with or without the Expansion, leading to small differences in the level of federal spending for that population.

## Remainder of State Spending could be Offset by Budget Savings

The Medi-Cal Expansion and other coverage provisions of the ACA will yield significant savings in several state budget categories. These savings could be in the magnitude of hundreds of millions of dollars annually and therefore enough to more than offset the $46 million (2014 base scenario) to $381 million (2019 enhanced scenario) in General Fund spending for the newly eligible population, before even taking into account the additional state tax revenues. However, the budget savings are not fully quantified in this report because the exact savings amounts will depend on state policy decisions that have not yet been made.

It will take several years for these savings to be achieved: enrollment in Medi-Cal and subsidized coverage through Covered California will grow over time as Californians learn about their coverage options and as eligibility and enrollment processes are streamlined and refined. The CalSIM model assumes that it will take several years for the take-up rates discussed at the beginning of this paper to be fully achieved—leveling off in 2018 under the base scenario and in 2016 under the enhanced scenario, with the latter assumption based on the experience in Massachusetts.

Some examples of state budget savings that could occur are discussed below. These savings will be considerably less without the Medi-Cal Expansion. While this paper is focused on the impact on the

state budget, counties will also likely incur savings as a result of the Medi-Cal Expansion.

### *State Health Program Savings*

California will still have a significant need for other state health programs. As many as four million Californians are predicted to remain uninsured under the base scenario after the ACA is fully implemented, including more than 1.5 million Californians who will lack access to affordable coverage.[44] However, significant savings are likely to occur as some individuals newly enroll in full-scope Medi-Cal and subsidized coverage through Covered California.

In Medi-Cal, some beneficiaries currently enrolled in programs that offer limited scope benefits, such as Family PACT and the Breast and Cervical Cancer Treatment Program, may become eligible for full-scope benefits under the Expansion. The state can receive the enhanced federal match for these beneficiaries,[45] compared to the lower federal match the state is currently receiving. Some of these beneficiaries may also enroll in subsidized coverage through Covered California and no longer enroll in Medi-Cal benefits. In addition, enrollees in other state health programs, such as the Major Risk Medical Insurance Program and the AIDS Drug Assistance Program, may newly enroll in Medi-Cal or subsidized coverage through Covered California, thus reducing state spending.

The California Legislative Analyst's Office (LAO) predicts annual ongoing savings of approximately $200 million due to "reduced General Fund spending for some non-Medi-Cal state health programs, such as the Breast and Cervical Cancer Treatment Program and the Family PACT Program. These programs currently pay for services for populations that will become newly eligible for Medi-Cal or other subsidized health insurance coverage in 2014." The LAO notes that "there is a significant amount of uncertainty surrounding these estimates" because they depend on state policy decisions yet to be made.[46]

Some savings may also be associated with Share of Cost Medi-Cal, a program for Californians with high medical expenses but income that exceeds eligibility standards for other Medi-Cal programs. Under the program, once an individual's medical expenses for the month reach a certain level, the Medi-Cal program pays the rest of the costs. The Medi-Cal Expansion and potentially the availability of Covered California subsidies are expected to reduce demand for this program to some extent.[47] Under the ACA, individuals who are eligible for Medicaid are generally ineligible for Exchange subsidies, but federal guidance has not yet clarified whether this eligibility restriction will apply to Share of Cost Medi-Cal.

The Medi-Cal Genetically Handicapped Persons Program (GHPP) pays for services for eligible enrollees that are not covered by public or private insurance and also pays for basic services for enrollees who are uninsured. Some enrollees in GHPP may become eligible for Medi-Cal under the Expansion or for subsidized coverage through Covered California. As a result, the federal government may pay a higher share of costs for some enrollees than it is currently paying. General Fund spending for GHPP is currently around $70 million annually,[48] but it is not known how much state spending would decline under the ACA with the Medi-Cal Expansion.

### *Health Realignment Funds*

We estimate that of the three to four million Californians predicted to remain uninsured when the ACA is fully implemented, more than half will have incomes at or below 200 percent of the Federal Poverty Level, the typical income range of safety net users.[49] These remaining uninsured will need a strong system of health care safety net providers. Some state funds are currently used to partially pay for care organized and delivered at the local level to the uninsured, but those funds typically do not fully cover the cost of providing that care. Specifically, counties receive Health Realignment funds from the state which they use in a variety of ways, including on public health measures and indigent health care.

Some but not all of the individuals served by the indigent health care programs at the county level

will be newly eligible for Medi-Cal under the Expansion or subsidized coverage through Covered California. If many uninsured Californians enroll in the new ACA coverage options and continue to seek care with the county health system, counties' uninsured costs would likely decrease. It is not yet known how counties' net costs for uninsured care will change after ACA implementation. Given that counties expect to retain Section 17000 responsibility,[50] costs will depend on how many uninsured Californians enroll in the new coverage options and from which providers the remaining uninsured seek care. To the extent indigent health care costs are reduced, the resulting savings would accrue directly to counties and could be reallocated to other priority health care and public health programs. The savings could only be redirected to Medi-Cal through a change in state policy.

Reductions in both Medicare and Medicaid Disproportionate Share Hospital payments under the ACA should be considered in any policy discussion related to Health Realignment funds. Another consideration is that the 1115 "Bridge to Reform" Waiver provided $3.4 billion in funding, primarily to public hospitals for delivery system reform initiatives,[51] and that funding expires in 2015. Finally, existing gaps in the health care safety net system, such as barriers to timely access to specialty care in many counties,[52] should also be considered in determining adequacy of funding for the health care safety net.

### *Mental Health and Substance Use Disorder Services*

The General Fund contributes to mental health and substance use disorder services provided to uninsured Californians through programs run by the state and through Mental Health Realignment dollars provided to counties. Many uninsured Californians currently utilizing these state and local services could become eligible for Medi-Cal, resulting in some reduction in demand for these existing programs. The exact impact on General Fund spending will depend in part on the level of mental health and substance use disorder services included in the benefits package for the newly eligible enrollees. The state is awaiting federal guidance clarifying mental health parity requirements for benchmark benefits.

### *State Prisons*

The Medi-Cal Expansion could result in state prison savings of two types: increased federal matching dollars for health care services provided off-grounds to eligible state inmates, and a reduction in state prison spending based on reduced incarceration and recidivism rates due to improved access to mental health and substance use disorder services in the community.

First, states can currently use Medicaid to pay for off-grounds inpatient care for inmates who meet existing Medicaid eligibility criteria, such as disability status. In California, these services may be paid for under the Medi-Cal Inmate Eligibility Program (MCIEP). In addition, as many as 90 percent of state inmates who receive off-grounds inpatient services may be eligible for the State Inmate Low Income Health Program based on the LIHP eligibility criteria in their last county of residence.[53] Under MCIEP and the State Inmate LIHP, the federal government and the California Department of Corrections and Rehabilitation split the cost for eligible services. Data is not available on what share of services provided to state inmates off-grounds are currently paid through MCIEP or LIHP.

Under the Expansion, the federal government will pay 100 percent of the costs for eligible off-grounds services in 2014 to 2016 and no less than 90 percent in later years. We estimate that savings could be in the magnitude of tens of millions of dollars in General Fund spending if California takes full advantage of this higher match rate and identifies all eligible services and claims federal funds.[54]

Second, increased Medi-Cal coverage among individuals with mental illness or a substance use disorder—whether on parole, probation, or not previously incarcerated—could lead to a reduction in the number of prisoners in California over the long-term, as a result of both reduced incarceration rates and recidivism rates.[55] According to a report by the federal Substance Abuse and Mental Health Services Administration, "many people

with mental illness and substance use disorders housed in jails or prisons are there as the result of nonviolent minor crimes, often a consequence of their untreated behavioral disorder." The study reported that between 60 and 80 percent of parolees and probationers have a substance use related issue.[56]

The Institute of Medicine reported that "although health insurance coverage alone will not remedy the inadequacies of treatment of those who have severe mental illness, continuous and permanent health insurance coverage would improve the chances that persons with severe mental illness receive appropriate treatment that maintains their ability to function and reduces symptoms that lead to arrest,"[57] suggesting a potential for reducing arrest rates. Recidivism rates could also improve. According to a study published in *Health Affairs*, "having health insurance after release may be associated with lower rates of rearrest and drug use." The authors of the study, Cuellar and Cheema, predicted that one-third of inmates released nationally could be eligible for Medicaid with the Expansion.[58]

The magnitude of the potential reduction in the state prison population is not known, but even a 1 percent reduction in General Fund spending related to Corrections and Rehabilitation would mean significant budget savings equivalent to nearly $90 million annually.[59]

### *State Employee Health Benefits*

To the extent that uninsurance and uncompensated care lead to higher premiums for job-based coverage, a reduction in uninsurance under the Medi-Cal Expansion could result in state savings in premiums paid on behalf of state employees and retirees.

### *Potential Revenue Offsets*

Potential taxes on managed care organizations and hospitals, which may be considered by the legislature in 2013, would yield additional revenue under the Medi-Cal Expansion. California levied a tax on Medi-Cal Managed Care Organizations equivalent to 2.35 percent of gross premiums until June 2012, when the tax expired. If this tax were renewed, the state tax revenues generated on the premiums of newly eligible enrollees under the Expansion could be in range of $43 million under the base scenario in 2014 to $94 million under the enhanced scenario in 2019.[60] California has also levied a Hospital Quality Assurance fee on most hospitals since 2009. The most recent hospital fee expires on December 31, 2013. If the fee is renewed, the Medi-Cal Expansion may result in additional revenue based on the increase in Medi-Cal patient days, depending on how the fee is structured. Both fees would be subject to federal approval.

## Conclusion

The Medicaid Expansion under the Affordable Care Act offers California the opportunity to provide coverage to more than 1.4 million Californians, improving their health outcomes and strengthening the California economy by bringing in several billion dollars in federal Medi-Cal funding annually. At least 85 percent of the spending related to the Medi-Cal changes, including increased enrollment among those who are already eligible, will be paid by the federal government. Most of the new General Fund spending will occur because of mandatory changes to Medicaid rules and will occur whether or not California expands coverage to newly eligible low-income adults, many of whom are without children under age 18 at home.

State General Fund spending can be offset entirely or almost entirely by enhanced state tax revenue and savings to other programs. These program savings are largely contingent on the Expansion and are diminished if Medi-Cal eligibility is not expanded. Possible program savings include existing limited benefit coverage programs such as the Breast and Cervical Cancer Treatment Program as well as significant savings for mental health and substance use disorder treatment and prison-related spending. A decision to forego or delay the Medi-Cal Expansion would sacrifice the opportunity to make real improvements in the health of low-income Californians with minimal impact on the state's budget.

In 2013, state policymakers will set the benefits package offered to newly eligible enrollees. All of the estimates in this paper assume that newly eligible enrollees receive the same level of benefits as parents and children who are currently enrolled. Even with this assumption, state spending for the newly eligible is likely to be offset by new state tax revenues and other savings.

The level of Medi-Cal enrollment achieved under the ACA will be influenced by the benefits package chosen and other state decisions and actions in 2013, such as how effectively Medi-Cal eligibility and enrollment processes are streamlined and how smoothly Low Income Health Program enrollees are transitioned into Medi-Cal. The estimates in the paper reflect a range of enrollment scenarios and demonstrate that even with greater take-up under the enhanced scenario, the net state spending related to the Expansion is expected to be minimal.

## Appendix A: Methodological Notes

### *CalSIM*

The California Simulation of Insurance Markets (CalSIM) model is designed to estimate the impact of various elements of the ACA on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. The CalSIM model uses four data sources: the 2004–2008 Medical Expenditure Panel Survey Household Component (MEPS-HC) public use data files, the 2009 California Health Interview Survey (CHIS), California Employment Development Department (EDD) 2007 wage distribution, insurance offer, and firm size data, and the 2010 California Employer Health Benefits Survey (CEHBS). CHIS, EDD, and CEHBS provide weights and wage distributions that adjust the nationally-representative MEPS data to build a California-specific model. Once reweighted, the MEPS-HC respondents are then assumed to represent the population of California. The California Simulation of Insurance Markets (CalSIM) model was created by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research with funding from the California Endowment. For further information, please visit http://www.healthpolicy.ucla.edu/pubs/files/calsim_methods.pdf.

### *IMPLAN*

Medi-Cal spending is modeled as flowing to a set of IMPLAN industry sectors using the default IMPLAN 432-industry sector system. The spending amount is distributed across five health care related IMPLAN sectors. The distribution of these funds is weighted across these five sectors according to the relative share of economic output in 2010.

IMPLAN estimates the impact that a change in spending would have on state and local tax revenue in aggregate. In order to isolate the estimated effect on state tax revenue, we developed assumptions about the portion of each tax revenue category that goes to the General Fund. Taxes on corporate profits and personal income are allocated 100 percent to the state. Sales tax revenues are allocated 70 percent to the state and 30 percent to local governments based on tax information compiled by the California Legislative Analyst's Office.[61] Revenue for several indirect business tax categories and "personal nontaxes and other taxes" are split between state and local governments because the category definition is ambiguous and data is not available on the correct split. These categories comprised approximately 13 percent of state tax revenues for the spending categories analyzed.

### *Medi-Cal Spending per Enrollee*

Monthly Medi-Cal spending per parent or child is estimated based on three components, each of which is adjusted to 2014 based on inflation:

1. **Capitation Rate.** "Family" Medi-Cal Capitation Rates of $112 per month are based on a weighted average of rates paid across the state in October 2012.[62] "Family" rates are broken into Parent ($159) and Child ($83) rates based on the ratio used in a 2009 DHCS analysis[63] and DHCS enrollment data showing that 38 percent of "Family" enrollees are parents and 62 percent are children.[64]
2. **Carve-Out Expenditures.** Monthly managed care carve-out expenditures of $28 for children and $18 for parents are based on data from Fiscal Year 2010–2011.[65] Carve-out expenditures for parents are based on a weighted average of costs for adult enrollees in Medically Needy Families and Public Assistance Families aid categories. Expenditures for children are calculated in a similar way.
3. **Dental.** Monthly dental costs for children are assumed to be $11.46 per month in 2013.[66]

We assume that monthly spending for newly eligible childless adults will be approximately 1.9 times spending on currently-enrolled parents. The variation in cost is based on analysis using our CalSIM model which suggests that newly eligible childless adults predicted to take up in 2014 will be nine years older and have slightly worse health status, on average, than currently-enrolled parents.

Spending is inflated by 2.3 percent annually. This is based on 6.0 percent annual Medi-Cal growth assumed in the state budget,[67] minus 3.7 percent annual caseload growth based on analysis of DHCS enrollment data between 2007 and 2011.[68] Caseload growth is included separately in our CalSIM enrollment estimates.

Other key assumptions:

- All new enrollees will be in Medi-Cal managed care.
- These estimates do not take into account that pent-up demand may result in higher costs per newly eligible enrollee in initial years. For newly eligible enrollees who transition from LIHP, some of this demand may already have been met.
- These estimates do not take into account that Californians who are already eligible but not enrolled are likely to have lower costs than those already enrolled.
- These estimates assume that newly eligible enrollees receive the same benefits as those who are currently enrolled, but the benefits package for newly eligible enrollees has not yet been determined.
- In 2013 and 2014, the ACA requires states to pay certain Medicaid primary care providers rates that are equivalent to Medicare rates. This rate increase is fully federally-funded, therefore the impact of this provision is not incorporated into this analysis. If the state decides to continue these rate increases beyond 2014, spending will be higher.
- Newly eligible individuals who are considered "medically frail" cannot be limited to benchmark benefits and must receive standard Medi-Cal benefits.[69] These estimates do not include any additional costs beyond benchmark benefits for medically frail individuals.

We assume that administrative costs will be equivalent to 5.0 percent of medical costs, an assumption consistent with national estimates and estimates by the California Senate.[70] States will also incur some up-front costs related to redesigning information technology systems and enrollment processes to comply with the ACA requirements but these costs will be incurred regardless of the Medi-Cal Expansion and the federal government will fund 90 percent of these costs[71] so they are not included in this analysis.

Exhibit A1. Estimated Medi-Cal Per-Member Per-Month Spending

| | 2014 | 2016 | 2019 |
|---|---|---|---|
| Children | $129 | $135 | $144 |
| Parents | $186 | $195 | $209 |
| Childless adults | $359 | $390 | $417 |

Source: UC Berkeley–UCLA CalSIM model, Version 1.8 and authors' analysis of DHCS data

## Appendix B: Comparison to Other Estimates of State Spending

The California Legislative Analyst's Office (LAO) and the Urban Institute recently estimated how California spending on Medicaid is predicted to change under the ACA. This Appendix compares their estimates to the estimates in this report.

The LAO estimates that state Medi-Cal spending for newly eligible Californians will be in the "low hundreds of millions of dollars" in 2016–17, slightly higher than our estimate for calendar year 2016 because their Fiscal Year estimate includes half of 2017 during which the state will be responsible for 5 percent of medical costs for newly eligible enrollees. For already eligible but not enrolled Californians, the LAO predicts that state Medi-Cal spending will be in the "low hundreds of millions of dollars" in the initial years of ACA implementation,[72] falling between our base and enhanced scenario estimates.

In an analysis for the Kaiser Family Foundation, Holahan and colleagues from the Urban Institute predict state-by-state changes in Medicaid spending under the ACA using the Health Insurance Policy Simulation Model (HIPSM), which is based on national data sources.[73] In California, they predict that state Medi-Cal spending will grow by $14 billion over 10 years (2013 to 2022) with the Expansion, $6.3 billion of which reflects the incremental impact of the Expansion. While we do not estimate the change in state Medi-Cal spending over 10 years, the Urban Institute estimates are significantly higher than our estimates.

The difference in our estimates is in large part due to the use of different data sources and methodologies. Our model is specific to California and uses data unique to California. The Urban Institute model is a national one, covering all 50 states. As researchers who seek to make the most accurate possible estimates for a single state, we respect the challenges of providing national estimates for every state.

Both HIPSM and CalSIM rely on the Medical Expenditure Panel Survey (MEPS). HIPSM also relies on the Current Population Survey (CPS) whereas CalSIM uses the California Health Interview Survey (CHIS), California Employment Development Department (EDD) data, and the California Employer Health Benefits Survey (CEHBS). Our models use different methodologies in predicting individuals' immigration status, which affects our eligibility estimates. As a result of these differences and others not detailed here, some of the key assumptions underlying our estimates of state Medi-Cal spending differ from those of the Urban Institute. Examples of key differences between the models follow:

- The Urban Institute enrollment estimates reflect full- or partial-year enrollment, while our estimates reflect enrollment at a point in time. The Urban Institute predicts that 9.5 million Californians would be enrolled in Medi-Cal without the ACA in 2022, while our estimate is 6.7 million in 2019. The Urban Institute predicts an enrollment increase of nearly 2.7 million Medi-Cal enrollees in 2019, including nearly 1.9 million who are newly eligible. By contrast, we predict a Medi-Cal enrollment increase of 1.4 million in 2019, including 910,000 newly eligible enrollees under the enhanced scenario.
- The Urban Institute predicts that the national average cost for newly eligible Medicaid enrollees will be $6,058 in 2016, whereas we Predict that it will be between $4,040 and $4,140 in California in 2016, depending on the scenario. For new Medicaid enrollees Who are already eligible, the Urban Institute predicts an average cost of $4,179 in 2016 nationally, whereas we predict an average cost of between $1,710 and $1,920 in California in 2016, depending on the scenario.

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