Independent Fiscal Office

An Analysis of Medicaid Expansion in Pennsylvania

April 22, 2013

Special Report 2013-3

About the Independent Fiscal Office

The Independent Fiscal Office (IFO) provides revenue projections for use in the state budget process along with impartial and timely analysis of fiscal, economic and budgetary issues to assist Commonwealth residents and the General Assembly in their evaluation of policy decisions. In that capacity, the IFO will not support or oppose any policies it analyzes, and will disclose all methodologies, data sources and assumptions used in published reports and estimates.

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INDEPENDENT FISCAL OFFICE

Second Floor, Rachel Carson State Office Building
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April 22, 2013

To: The Honorable Jay Costa and The Honorable Vincent Hughes

This report presents the results from an analysis performed by the Independent Fiscal Office (IFO) to estimate the fiscal and economic impact if the Commonwealth elects to expand its Medicaid (Medical Assistance) program under the provisions of the Patient Protection and Affordable Care Act (ACA). The scope of the analysis is limited to the impact of Medicaid expansion; it does not address the costs, savings or economic effects of the ACA generally.

The report provides annual projections of new federal funds and state costs or savings for the period 2014 to 2021. It derives these projections by taking a methodical approach to estimate the number of individuals who would be newly enrolled in Medicaid as a result of expansion. It then applies appropriate cost parameters to new enrollees and determines the relevant federal and state cost shares consistent with the ACA. It also considers administrative costs that are directly attributable to Medicaid expansion. The analysis concludes by quantifying how the new federal spending will impact the Pennsylvania economy, General Fund tax revenues and overall budget.

Per the policy of the IFO, this report will be posted to the office website no later than three days following transmittal. The IFO welcomes any questions, comments or suggestions regarding the content and methodology of this analysis.

Sincerely,

MATTHEW KNITTEL
Director

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Executive Summary

This analysis examines the economic and revenue impact from the decision to expand Medicaid. The projections included in this report are for 2014 through 2021. The final year represents the full phase-in of the Affordable Care Act (ACA) and policymakers may consider that value to be representative of future costs or savings. A summary of results is as follows (average impacts for 2016 through 2021):

Impact on Pennsylvania residents (see Table 6):

- Without expansion, roughly 175,000 adults and children would receive coverage through the new health insurance exchanges or the free Children's Health Insurance Program (CHIP). Nearly all were previously uninsured.
- Under expansion, an additional 440,000 individuals receive free Medicaid coverage: 240,000 previously uninsured and 200,000 previously insured by an employer or private insurance.
- Under expansion, 80,000 General Assistance adults and 55,000 CHIP enrollees transfer to Medicaid.

Impact on state and federal expenditures (see Table 9, calendar year basis):

- Average federal expenditures increase by $4.0 billion per annum: $800 million without expansion and an additional $3.2 billion under expansion. Those expenditures do not include any new federal funds due to the operation of the healthcare exchange under ACA.
- Average net state expenditures fall by $115 million per annum: expenditures increase by $75 million without expansion, but decline by $190 million with expansion.

Impact on Pennsylvania economy (see Table 11, expansion only):

- Gross State Product increases by $3.1 billion per annum.
- Taxable earnings and income increase by $2.1 billion per annum.

Impact on General Fund revenues (see Table 12, expansion only):

- Personal and corporate income taxes increase by $65 million per annum.
- Sales and use taxes increase by $35 million per annum.
- Gross receipts taxes increase by $115 million per annum.

Impact on the budget (see Table 13, expansion only, cash flow basis):

- The analysis finds that average expenditures fall by $220 million and General Fund revenues rise by approximately the same amount.
- This yields an average annual net budget impact of $430 million.
- The savings are concentrated in the earlier years of the expansion due to the full federal reimbursement for calendar years 2014-2016.

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Section 1: Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. The ACA represents the most substantive change to the U.S. healthcare system since passage of the Medicare and Medicaid Acts of 1965. The Act extends Medicaid coverage to lower-income adults, establishes exchanges in all states to facilitate the purchase of subsidized health insurance and implements various reforms in an effort to slow the rapid growth of healthcare expenditures.

On June 28, 2012, the U.S. Supreme Court ruled on two core provisions of the ACA. The first provision requires all individuals over a certain income threshold to purchase health insurance or be subject to penalty. The court ruled that this individual mandate was constitutional due to Congress' authority to levy taxes.[1] The second provision requires states to expand Medicaid coverage or risk losing current federal Medicaid funds. The court ruled that the Medicaid expansion was unconstitutionally coercive because states lacked adequate notice to voluntarily consent. The proposed repercussions were also deemed to be punitive. Therefore, while most provisions of the ACA remain intact, states may expand Medicaid to lower-income adults or maintain current levels of coverage.

As of April 15, 2013, 25 states declared they will expand Medicaid coverage, 14 states declared they will maintain current levels of coverage and 11 states remain uncommitted. Pennsylvania has declined to extend Medicaid coverage while the governor seeks further detail from the U.S. Department of Health and Human Services regarding the Commonwealth's flexibility on certain issues. There is no deadline for states to declare their intention. However, delays may imply that Pennsylvania will not fully capture the benefits from the 100 percent federal reimbursement for newly eligible individuals effective for 2014 to 2016. If the administration decides to expand Medicaid, it will need ample time to put the necessary infrastructure in place to extend coverage to more than a half million newly eligible residents.

Scope of Report

The ACA implements numerous changes to the U.S. healthcare system. However, this analysis focuses solely on the decision to expand Medicaid coverage and the impact that decision will have on the Commonwealth's economy and budget. Despite this limited focus, Medicaid expansion is a complex issue that will affect many residents. This report uses a methodical approach to quantify the potential economic and revenue impact from expansion so that readers will understand the various parameters and assumptions that motivate outcomes. To provide context, the next section of this report provides a brief description of the Commonwealth's current Medicaid system. Sections that follow mirror the computation of the economic and revenue impact from Medicaid expansion. That computation has five distinct parts, which correspond to the main sections of this report:

[1] The majority found that the shared responsibility payment under the individual mandate resembles a tax even though Congress did not refer to the individual mandate as a tax.

1. Groups Affected by Medicaid Expansion: This section projects the number of individuals affected by Medicaid expansion under three scenarios: (1) No ACA, (2) ACA - No Expansion and (3) ACA - Expansion. The analysis projects three scenarios to isolate the true incremental impact from Medicaid expansion. If Pennsylvania does not extend coverage, it will still incur certain costs as more currently eligible individuals enroll in Medicaid due to outreach efforts and various reforms.[2]

2. Projection of Federal and State Costs and Savings: This section applies cost parameters to new Medicaid enrollees. It also projects miscellaneous costs (e.g., administrative, personnel and information technology) and savings (e.g., transfer of the General Assistance (GA) population to Medicaid). Relevant federal Medicaid assistance percentages (FMAPs) are applied to identify federal and state costs.[3]

3. Economic Impact from Medicaid Expansion: New federal funds that flow into the Commonwealth will be funneled through managed care organizations (MCOs). This section discusses how those monies will be distributed across various healthcare expenditures such as physician offices, labs, hospitals and pharmaceutical companies. The analysis uses multipliers from the U.S. Bureau of Economic Analysis to quantify the impact that new federal spending has on the Pennsylvania economy.

4. Revenue Impact from Medicaid Expansion: This section transforms the economic activity attributable to Medicaid expansion into revenue gains from personal income, corporate income, sales and use and gross receipts taxes.

5. Net Fiscal Impact of Medicaid Expansion: This section concludes the analysis and combines the expenditure and revenue projections to derive the net budget impact for the Commonwealth.

This report does not include the economic or revenue impact from the new healthcare exchange that will be operational regardless of Medicaid expansion. Due to the significant federal subsidization of insurance premiums through refundable tax credits and cost-sharing provisions, the exchange will also inject large amounts of federal dollars into the state economy. For 2018, the Congressional Budget Office projects that 22 million U.S. residents will receive $141 billion of exchange subsidies, an average of $6,400.[4] If one assumes that Pennsylvania's share of the national total is four percent, then the exchange will inject $5.5 billion into the Pennsylvania economy through refundable tax credits ($3.5 billion), lower tax payments ($1.2 billion) and cost sharing subsidies ($0.8 billion) in 2018.

For the purpose of this report, certain assumptions were made to facilitate the analysis. Some of these assumptions represent a departure from current law, and Congress will need to take action to implement changes so that popular provisions do not expire. These assumptions are implicit throughout the analysis and are not discussed further:

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[2] Often referred to as the "woodwork" effect. Reforms include the elimination of the asset test to determine Medicaid eligibility, the "no wrong door policy" (i.e., the coordination of enrollment for programs), the single application for all programs and the ability to submit forms on-line. Researchers have found that the elimination of the asset test could increase Medicaid enrollment by three to ten percent for eligible populations. See Utah Department of Health, "Medicaid Asset Limit Study," October 2005.

[3] The FMAP is the share of expenditures that is paid by the federal government.

[4] See http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf.

- Congress permanently extends the enhanced Medicaid rate for primary care services. Under the ACA, demand for physician services will increase dramatically. To ensure sufficient supply of medical services, the ACA requires states to increase their Medicaid reimbursement fees to levels paid by Medicare for primary care services such as pediatrician, internist and family physician services.[5] The higher rates are effective for 2013 and 2014 and the federal government will fully reimburse states for the higher Medicaid rates paid to providers.[6] For 2012, a recent study found that the ratio of Medicaid to Medicare fees for these services was 0.66 for the U.S. and 0.70 for Pennsylvania.[7] If higher rates are not extended, then the supply of healthcare services may fall short of demand due to low reimbursement rates. The implications of this assumption are discussed in Section 4 of this report.

- Children's Health Insurance Program (CHIP) enrollees between 100%-138% of the Federal Poverty Line (FPL) are transferred to Medical Assistance (MA). The analysis assumes that children currently enrolled in CHIP are transferred to MA but continue to receive the CHIP FMAP. Under the ACA, individuals under age 19 do not qualify for the enhanced Medicaid FMAP.

- Congress extends CHIP funding. Under current law, CHIP funding expires on October 1, 2015.

- Pennsylvania is deemed a non-expansion state and eligible for the enhanced Medicaid FMAP. An expansion state is a state that provided healthcare coverage to non-pregnant, childless adults with incomes over 100% FPL prior to passage of ACA, thereby offering broader coverage than minimum levels required by federal law. Under ACA, non-expansion states receive an enhanced FMAP for new Medicaid recipients. Expansion states are only eligible for a phased-in increase in their FMAP based on a formula that provides less generous matching funds.

- All new Medicaid recipients enroll in current programs. The analysis assumes that new programs are not created so premiums for current plans are representative of those that will be offered to newly eligible recipients. Moreover, all new recipients receive coverage through an MCO.

- The federal government does not reduce future reimbursement rates. If desired, a future Congress could amend the ACA to provide lower reimbursement rates to states.

[5] The minimum payment level applies to "specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine." This definition has been interpreted to exclude general practitioners. See Federal Register, Vol. 17, No. 215, p. 2.

[6] However, many states have not yet submitted their State Planning Amendments (SPAs) which allows the higher federal funding to flow to the states. A State Plan is a contract between the federal government and a state that describes how the state administers its Medicaid program. States must also reprogram their claims processing systems to allow payment of the higher rates.

[7] Zuckerman et al., "How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees," Kaiser Family Foundation (December 2012). For 2013, the report projects that Medicaid fees for primary care services will increase by an average of 73 percent for the U.S. and 96 percent for Pennsylvania.

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Section 2: The Medicaid System in Pennsylvania

Medicaid plays a crucial role in the provision of healthcare services for low-income children, their parents, the elderly and individuals with disabilities. It is a means-tested program that is jointly financed by state and federal governments, but administered by states. Federal law grants states considerable flexibility to determine eligibility thresholds and the range of services offered to recipients. States also determine the rates they will pay to providers of healthcare services. As long as they maintain compliance with federal requirements, states are eligible for federal matching funds. A state's FMAP is based on a formula that compares a state's per capita income to U.S. per capita income.[8] For 2013, FMAPs ranged from a low of 50 percent (14 states, minimum rate) to a high of 73.4 percent (Mississippi). Pennsylvania's typical FMAP is 54-55 percent, implying that $1 of state funds will be matched by $1.22 of federal funds.

For Pennsylvania, the state Medicaid program is known as Medical Assistance (MA). The program provides a comprehensive array of health and long-term care services to more than 2.2 million Pennsylvania residents who fall into one of five categories: children, pregnant women, low-income families, people with disabilities and seniors. Although individuals who are elderly or disabled comprise 40 percent of MA recipients, they account for the majority (70 to 75 percent) of Medicaid spending. By contrast, low-income families and children represent over 50 percent of MA recipients, but comprise roughly one-quarter of all Medicaid spending.

For fiscal year (FY) 2013-14, the Executive Budget projects that MA expenditures will comprise 72.7 percent of the Department of Public Welfare's (DPW) General Fund spending ($8.0 billion) and 28.1 percent of the total General Fund budget ($28.4 billion).[9] To support MA spending, the Executive Budget projects that Pennsylvania will request spending authority for $9.6 billion of federal Medicaid funds in FY 2013-14. A state match is required to draw down those federal funds. The department also relies on special revenue sources to generate federal matching funds. These sources include two special funds (Lottery Fund and Tobacco Settlement Fund) and revenues collected from assessments and taxes on healthcare providers (gross receipts tax). For FY 2012-13, special revenue sources totaled $2.3 billion and comprised 12.6 percent of total Medicaid spending. (See Table 1.)

[8] The state share is equal to the square of the state's per capita income divided by the square of U.S. per capita income multiplied by 0.45. The federal share or FMAP is equal to (1 – state share). The minimum FMAP is 0.5.
[9] Department of Public Welfare FY 2013-14 budget presentation; http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/presentation/p_011986.pdf

Table 1
Medicaid Spending in Pennsylvania
$ millions

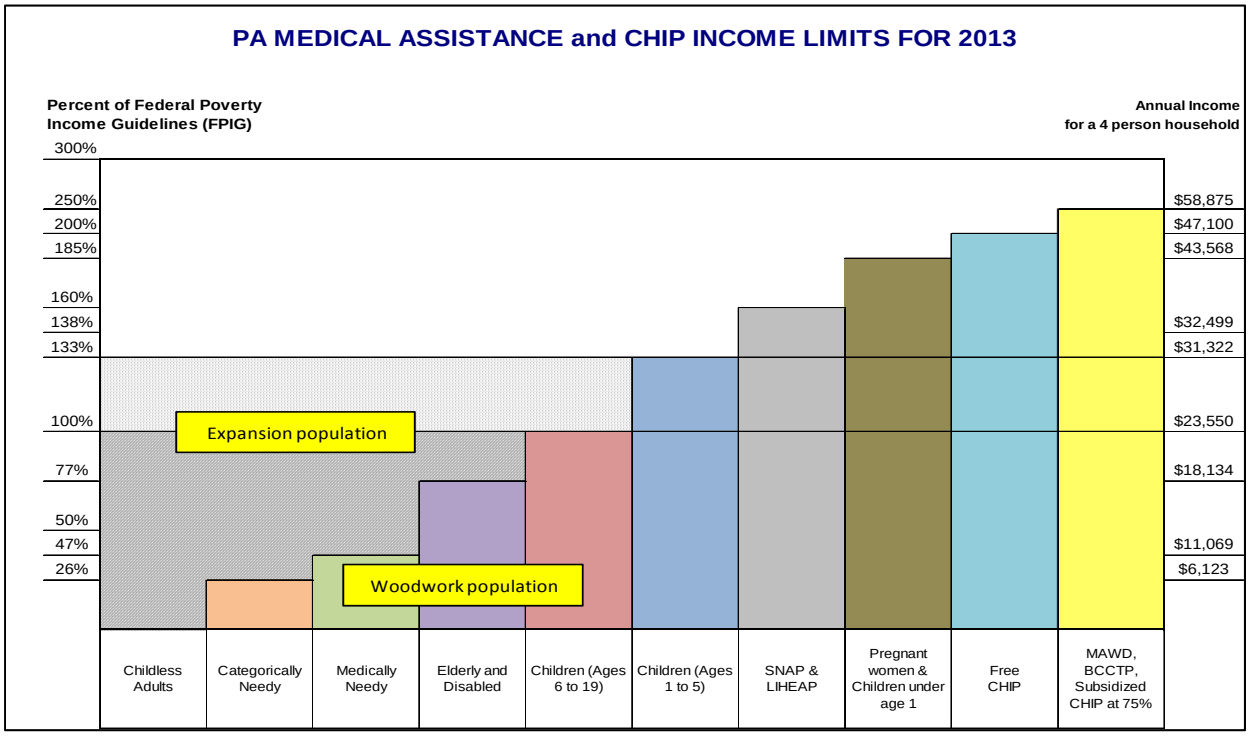
Fiscal Year Ending	Number Recipients[1]	Federal Funds	State Funds[2]	Special Funds[3]	Total	Spending Per Capita	FMAP
2004	1,620	$6,776	$3,900	$1,373	$12,049	$7,438	57.71%
2005	1,740	7,433	4,163	1,760	13,356	7,676	53.84
2006	1,830	7,260	4,740	1,579	13,579	7,420	55.05
2007	1,880	7,463	4,891	1,421	13,775	7,327	54.39
2008	1,910	7,447	4,799	1,475	13,721	7,184	54.08
2009	1,970	8,874	4,761	1,364	14,999	7,614	65.59
2010	2,070	9,544	3,920	1,528	15,042	7,267	65.85
2011	2,230	11,322	4,129	1,852	17,303	7,759	55.64
2012	2,220	9,766	5,722	1,804	17,292	7,789	55.07
2013	2,260	9,835	5,873	2,342	18,050	7,987	54.28
2014	2,320	9,568	6,001	2,489	18,058	7,784	53.52
AAG 2004-14[4]	3.7%	3.5%	4.4%	6.1%	4.1%	0.5%	n.a.

[1] Number in thousands. Average monthly eligible recipients of MA: children and families, the elderly, the disabled, and the chronically ill.
[2] Funds appropriated from the General Fund for the "Big Five" MA appropriations: outpatient, inpatient, capitation, long-term care and payments to federal government for Medicare drug program.
[3] Includes intergovernmental transfers, Tobacco Settlement Fund, Lottery Fund, assessments, gross receipts tax and miscellaneous revenues.
[4] Average annual growth rate.
Sources: FMAP data: The Henry J. Kaiser Family Foundation Statehealthfacts.org, http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=40. All other data: Executive Budget, various years.

Pennsylvanians who meet federal income, age, and healthcare needs criteria automatically qualify and cannot be denied MA coverage. States do not receive matching funds for recipients who fail to meet the criteria for one of these mandatory groups. The department uses the Federal Poverty Level (FPL) established by the Department of Health and Human Services for guidance to determine eligibility for services. Currently, MA covers children under five up to 133% FPL, children aged 6 to 18 up to 100% FPL and pregnant women and infants up to 185% FPL. (See Figure 1.) Certain medically needy (47% FPL) and categorically needy (28% FPL) adults are also covered under the General Assistance (GA) program.[10]

[10] To be eligible for GA, adults must be categorically needy or medically needy. Categorically needy adults are low-income adults between 21 to 64 years of age who meet any of the following criteria: they have a physical or mental disability that lasts more than 12 months, they are caring for a child under age 13, they are undergoing alcohol or drug treatment or are a victim of domestic violence. Medically needy adults are low-income adults who spend down to qualify for coverage. Adults between age 21 to 58 must be employed at least 100 hours per month and earn at least minimum wage. Certain income and resource limitations apply to both groups.

Figure 1



Source: Department of Public Welfare.

For FY 2013-14, the Executive Budget projects an average monthly caseload of 2.32 million MA recipients, an increase of 66,000 (2.9 percent) over the current fiscal year and 700,000 (43.2 percent) since FY 2003-04. (See Table 1.) By FY 2017-18, the Executive Budget projects that MA recipients will increase significantly (8.4 percent) due to demographic trends that imply strong demand for long-term care services. Medical Assistance provides long-term care to people with physical and/or intellectual disabilities, older Pennsylvanians, and people with mental illness through a continuum of services ranging from institutional care to community-based services that enable individuals to live independently.

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Section 3: Groups Affected by Medicaid Expansion

This section uses federal survey data to establish the number of Pennsylvania residents who would be eligible for Medicaid expansion. It also presents the economic and demographic forecasts used to project those populations through 2021 under three scenarios: No ACA, ACA - No Expansion and ACA - Expansion. Under the No Expansion scenario, the Commonwealth does not expand Medicaid, but all other provisions of the ACA, such as health insurance exchanges and various reforms, remain intact. The Commonwealth will incur various costs related to the implementation of ACA regardless of Medicaid expansion.

Demographic and Economic Forecasts

Table 2 presents the demographic and economic forecasts used for this analysis. The demographic projections are from the Pennsylvania State Data Center.[11] The projections show minimal growth (0.3 percent per annum) across all age cohorts over the next decade. While the over-64 age cohort (2.5 percent) expands rapidly, the 20-64 and 5-19 year age cohorts (-0.2 percent) contract.

The economic forecast projects a steady reduction in the unemployment rate from 7.8 percent in 2013 to 5.7 percent in 2018. Because the number of working age adults (ages 20-64) declines, labor force participation rates must generally increase to supply additional workers. The labor force participation rate is the share of adults who are employed or are actively seeking employment. The forecast projects an increase in labor force participation rates for working age adults and an increase in the Pennsylvania labor force at an average rate of 0.4 percent per annum. Due to the reduction in the unemployment rate, employment levels increase at a higher average rate (0.8 percent) than the labor force. As the unemployment rate drops, the number of residents who lack health insurance should also decline. The analysis includes an adjustment for that projected outcome.

[11] For additional detail regarding demographic trends, see the IFO's Five-Year Outlook Report: http://www.ifo.state.pa.us/Releases.cfm.

Table 2
Demographic and Economic Forecasts

	2013	2014	2015	2016	2017	2018	2019	2020	2021	AAG[1] 2013-21
Demographics (000s)										
Age 0 to 4	746	752	758	762	767	771	775	780	784	0.6%
Age 5-19	2,423	2,414	2,406	2,401	2,397	2,393	2,389	2,385	2,380	-0.2%
Age 20-64	7,566	7,566	7,567	7,551	7,535	7,519	7,503	7,487	7,471	-0.2%
Age 64 and older	2,089	2,132	2,175	2,236	2,297	2,357	2,418	2,478	2,544	2.5%
Total	12,824	12,865	12,906	12,951	12,995	13,040	13,085	13,129	13,179	0.3%
Economics										
Unemployment Rate	7.8%	7.3%	6.8%	6.4%	6.0%	5.7%	5.7%	5.7%	5.7%	n.a.
LF Part. Rate: 16-64	74.5%	74.8%	75.1%	75.3%	75.5%	75.7%	75.9%	76.1%	76.3%	n.a.
Labor Force (000s)	6,526	6,566	6,609	6,629	6,649	6,671	6,694	6,717	6,757	0.4%
Payroll Employment (000s)	5,785	5,859	5,935	5,984	6,028	6,068	6,107	6,135	6,178	0.8%

[1] Average annual growth rate.
Source: Population projections are from the Pennsylvania State Data Center. Economic assumptions are from IHS Global Insight and include minor modifications made by the IFO to align economic and demographic projections.

The Insurance Status of Pennsylvania Residents

Data from the U.S. Census Bureau's American Community Survey (ACS) and Current Population Survey (CPS) provide detail on the insurance status of Pennsylvania residents. The ACS is an annual survey mailed to a broad sample of individuals (3.3 million housing addresses for 2011) throughout the year that contains questions on economic, demographic, social and housing characteristics. The CPS is a computerized monthly survey that uses a much smaller sample (60,000 U.S. households). Due to its larger sample size, the analysis uses ACS data to establish the share of Pennsylvania residents who lack health insurance.[12] However, the ACS data are relatively new and healthcare coverage data are available only since 2008. Therefore, CPS data must be used to examine historical trends.

The ACA extends Medicaid coverage to all adults with income under 138% FPL established by the U.S. Department of Health and Human Services.[13] Table 3 lists the relevant income levels that correspond to the FPL for individuals and families with up to five members. For 2011, an individual with annual income

[12] Results from the ACS sample are pro-rated to represent outcomes for all Pennsylvania residents. The data exclude residents in "group quarters" such as individuals in correctional facilities, nursing homes and college dormitories.
[13] Technically, the ACA extends coverage to individuals with income up to133% FPL, but it also allows a five percent income disregard that effectively increases the limit to 138% FPL. The FPL is the minimum amount of gross income that an individual or family needs for food, clothing, transportation, shelter and other necessities.

of $10,890 would be at 100% FPL. A family of four with annual income of $29,730 would be at 133% FPL. For future years, FPL thresholds increase by the Consumer Price Index. For 2013, those levels increase to $11,490 and $31,320, respectively.

Table 3
Federal Poverty Levels 2011 and 2013

Number of Persons	Percent of Federal Poverty Level				
	100%	133%	200%	300%	400%
FPL - 2011					
1	$10,890	$14,484	$21,780	$32,670	$43,560
2	14,710	19,564	29,420	44,130	58,840
3	18,530	24,645	37,060	55,590	74,120
4	22,350	29,726	44,700	67,050	89,400
5	26,170	34,806	52,340	78,510	104,680
FPL - 2013					
1	11,490	15,282	22,980	34,470	45,960
2	15,510	20,628	31,020	46,530	62,040
3	19,530	25,975	39,060	58,590	78,120
4	23,550	31,322	47,100	70,650	94,200
5	27,570	36,668	55,140	82,710	110,280

Source: U.S. Department of Health and Human Services.

Table 4 presents ACS tabulations for the latest two years that published data are available for three age groups: under 18, 18 to 64 and over 64. The table lists the share of Pennsylvania residents who have employer sponsored, private, public (i.e., Medicare, Medicaid, GA or CHIP) or no health insurance coverage based on reported household income levels relative to the FPL.[14, 15] The data reveal that the share of individuals without health insurance is similar for those years across the three age groups.

[14] Because individuals may report more than one type of insurance coverage (e.g., Medicare supplemented by private insurance), the shares for each age cohort may sum to more than 100 percent. This phenomenon is most noticeable for the 64 and older age cohort. The potential double counting is not an issue when computing the share of residents without insurance because those individuals do not report multiple coverages.

[15] The ACS defines income as the sum of the amounts reported separately for wage or salary income; net self-employment income; interest, dividends, or net rental or royalty income or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); public assistance or welfare payments; retirement, survivor, or disability pensions; and all other income. Receipts from the following sources are not included: capital gains, money received from the sale of property (unless the recipient was engaged in the business of selling such property); the value of income "in kind" from food stamps, public housing subsidies, medical care, and employer contributions for individuals. The income of households includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.

Therefore, the analysis uses the 2011 ACS data because it represents the most recent year that data are available. For 2011, notable results include:

- Uninsured residents comprise the following share of residents across the three age groups: under 18 years (5.4 percent), 18 to 64 years (14.2 percent) and over 64 years (0.6 percent).
- Insurance coverage increases with income levels across all age groups. For the lowest income group (<138% FPL), nearly 30 percent of adults age 18-64 lacked health insurance coverage. For adults who report income that exceeds 400% FPL, the share uninsured is much lower (4.7 percent).
- Two-thirds of adults age 18-64 (66.3 percent) receive coverage through their employer.
- Residents over age 64 report very low uninsured rates (0.6 percent) due to Medicare coverage.

In order to quantify the impact of Medicaid expansion, it is important to consider insurance outcomes that would occur under the No ACA scenario. That outcome must be established to accurately gauge the incremental impact from ACA under the No Expansion and Expansion scenarios. For that purpose, the analysis considers historical coverage trends to ensure that scenario is an accurate reflection of insurance outcomes that would otherwise occur. As noted, Census CPS data must be used for that purpose. Table 5 shows coverage trends for the U.S. and Pennsylvania. For 2000-2011, notable trends include:

- For the U.S., the data reveal a long-term trend decline in employer insurance and increase in Medicaid/CHIP coverage rates.
- For Pennsylvania, the share of residents covered by employer insurance is considerably higher than the U.S., but other long-term trends are similar.
- Recently, the share of individuals who are uninsured has decreased slightly, likely due to lower unemployment rates.

Based on these long-term trends, the analysis assumes that the number of uninsured adults age 18 to 64 grows at a faster rate (1.5 percent per annum) than suggested by the underlying demographics (-0.2 percent per annum). This assumption implies that the share of Pennsylvania adults who lack insurance will continue to increase from 14.4 percent (2011) to 16.9 percent (2021) under the No ACA scenario. Additional detail is provided in a subsequent section of this report.

Table 4

Share of Pennsylvania Residents by Type of Insurance Coverage and FPL Percentage[1]

Healthcare Coverage	Percent of Federal Poverty Level				
	< 138%	138%-299%	300%-400%	>400%	Total
ACS 2010					
Under 18	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Employer	19.3	59.6	83.2	89.3	60.4
Private	6.2	7.3	7.3	7.6	7.1
Medicare	0.4	0.4	0.5	0.1	0.3
Medicaid	74.5	34.7	12.9	5.3	34.1
Uninsured	8.4	6.1	3.2	1.9	5.2
18-64	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer	23.8	57.9	77.5	87.0	66.8
Private	10.5	10.7	9.4	9.1	9.8
Medicare	8.3	5.0	2.6	1.3	3.7
Medicaid	38.1	12.3	4.4	1.7	11.4
Uninsured	29.1	21.4	11.6	5.0	14.5
>64	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer	18.1	31.3	42.4	51.9	36.9
Private	43.3	51.1	48.5	41.5	46.5
Medicare	97.2	98.4	97.9	96.3	97.5
Medicaid	29.4	12.5	9.0	6.9	13.2
Uninsured	1.3	0.3	0.2	0.2	0.4
ACS 2011					
Under 18	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer	15.6	58.3	82.2	89.2	58.8
Private	5.6	7.9	7.5	7.8	7.2
Medicare	1.2	0.5	0.2	0.1	0.5
Medicaid	77.1	33.9	12.1	5.3	34.5
Uninsured	8.6	6.9	3.3	1.6	5.4
18-64	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer	21.7	58.3	78.7	86.9	66.3
Private	10.0	10.8	9.2	9.0	9.7
Medicare	9.5	5.2	2.7	1.4	4.1
Medicaid	39.9	11.6	4.7	2.1	11.9
Uninsured	29.3	21.0	10.1	4.7	14.2
>64	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer	18.5	29.7	43.9	51.2	36.5
Private	40.3	49.0	44.4	38.1	43.5
Medicare	97.0	98.5	97.9	96.0	97.4
Medicaid	30.2	12.1	8.8	7.2	13.1
Uninsured	1.4	0.5	0.2	0.3	0.6

[1] Some respondents report more than one type of coverage. Therefore, detail for age cohorts may sum to more than 100%. Data exclude individuals in group quarters such as inmates and individuals in nursing homes.

Source: U.S. Census Bureau, American Community Survey.

Table 5

Trends in Health Insurance Coverage in United States and Pennsylvania[1]

Healthcare Coverage	Share of Residents by Type of Health Insurance Coverage											
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
United States												
Under 18												
Employer	66.7%	64.8%	64.1%	62.0%	61.9%	61.2%	60.1%	59.8%	58.9%	55.8%	54.8%	54.7%
Direct	5.8	5.8	6.1	6.0	6.3	6.2	5.9	5.9	5.8	5.7	5.7	5.7
Medicaid	20.6	22.6	23.8	26.3	26.9	26.7	27.1	28.2	30.3	33.8	34.8	35.5
Medicare	0.7	0.5	0.7	0.6	0.7	0.7	0.6	0.7	0.8	0.7	0.8	0.8
Military	3.5	3.3	2.9	2.8	2.8	3.1	2.8	2.8	3.0	3.2	3.3	3.5
Uninsured	10.7	10.6	10.3	10.4	9.9	10.3	11.2	10.6	9.5	9.7	9.8	9.4
Age 18-64												
Employer	70.2	68.9	67.6	66.3	65.6	65.1	64.9	64.8	63.6	60.8	60.1	59.7
Direct	7.8	7.8	8.1	7.9	7.9	7.8	7.8	7.7	7.4	7.4	7.6	7.6
Medicaid	5.8	6.1	6.5	6.7	8.1	8.2	8.0	8.2	8.9	9.9	9.9	10.7
Medicare	2.9	2.9	2.9	3.1	3.2	3.2	3.3	3.5	3.8	3.6	3.8	4.0
Military	2.9	2.8	3.1	3.2	3.3	3.4	3.1	3.3	3.4	3.6	3.8	3.8
Uninsured	16.4	17.0	17.9	18.8	18.6	19.0	19.5	18.9	19.6	21.5	21.8	21.2
Pennsylvania												
Under 18												
Employer	76.9	73.0	70.2	70.8	67.6	67.9	66.2	68.8	65.1	64.2	62.4	62.4
Direct	5.1	5.7	5.9	6.0	7.0	6.2	6.4	6.7	5.6	4.7	6.4	8.7
Medicaid	18.3	20.5	19.1	21.9	21.7	25.7	26.4	24.9	28.6	31.4	31.7	33.3
Medicare	0.2	0.1	0.5	0.6	0.8	1.5	0.2	0.5	0.4	0.1	0.2	0.7
Military	1.9	0.8	0.9	1.8	1.4	1.1	0.4	0.8	1.3	1.2	1.0	0.9
Uninsured	5.6	7.0	9.2	7.2	8.7	6.9	7.0	7.3	6.4	6.6	8.3	7.6
Age 18-64												
Employer	77.1	76.9	73.7	73.1	71.8	72.6	72.4	71.6	70.2	67.9	67.2	66.0
Direct	8.3	7.6	8.6	7.9	8.5	9.5	10.7	9.5	7.9	7.8	10.2	10.9
Medicaid	5.5	6.2	6.0	6.2	7.7	8.2	8.1	9.5	9.8	11.6	10.6	10.5
Medicare	2.6	2.9	3.1	3.2	3.6	2.7	3.7	3.7	3.9	3.6	4.2	3.9
Military	1.6	1.1	1.5	1.6	1.7	1.3	0.9	1.5	1.8	1.9	2.0	1.7
Uninsured	9.9	10.5	12.9	13.4	12.9	12.1	12.0	11.9	12.8	14.9	14.6	14.4

[1] Shares sum to more than 100 percent because some respondents have dual coverage. That potential outcome does not affect the computed share with no coverage.
Source: U.S. Census Bureau, Current Population Survey, various years.

Adjustments Made to Survey Data

Due to certain technical issues, the analysis makes three adjustments to the ACS data used to establish the number of uninsured individuals in the base year (2011). Overall, these adjustments increase the number of residents who will be eligible for coverage under Medicaid expansion. If these adjustments are not made, then the analysis will clearly understate the size of the newly eligible population.

The first adjustment addresses certain biases in the CPS data that have been documented by numerous studies.[16] A recent study also finds similar biases for ACS data. For various reasons, these studies find that the surveys overstate the number of individuals with private insurance and uninsured individuals, but understate Medicaid coverage. The Independent Fiscal Office (IFO) made minor adjustments to the ACS data to correct these well-known biases.[17]

The second adjustment is based on a recent study that compares populations that will be newly income eligible for Medicaid using the revised income definitions mandated by the ACA.[18] The ACA mandates that states use Modified Adjusted Gross Income (MAGI) to determine Medicaid eligibility.[19] That income concept is based on tax return information. Prior to ACA, states had discretion to define their own income measure to determine Medicaid eligibility.

The study identifies four factors that suggest Census surveys will substantially understate the number of individuals who will be income eligible for Medicaid expansion using MAGI: (1) the Census income concept includes certain non-taxed income such as worker's compensation and public assistance; (2) the Census groups individuals into families as opposed to "tax units" or filers, which are generally smaller; (3) the Census income definition includes income from all family members, while MAGI only includes income from primary and secondary taxpayers and (4) technical issues that cause survey data to differ from administrative data. For 2007, the study finds that:

- The use of MAGI to determine Medicaid eligibility (as opposed to Census definitions) increases the share of individuals under 138% FPL from 19.3 percent to 27.4 percent.
- Roughly 10 percent of individuals (adults and children) classified as having income greater than 138% FPL would be reclassified as having income under 138% FPL.

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[16] Klerman et al., "Understanding the Current Population Survey's Insurance Estimates and the Medicaid Undercount, Health Affairs (2009). See http://content.healthaffairs.org/content/28/6/w991.full.pdf+html.

[17] See Call et al., "Replication of the Medicaid Undercount Experiment" State Health Access Data Assistance Center (September 2006) and Lynch et al., "Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits," Urban Institute (September 2011). The study attributes the under and overstatements to the wording of specific questions and confusion if individuals must identify the insurance coverage of others in the household. For this analysis, children with private insurance (-8,000) and uninsured (-4,000) were shifted to Medicaid coverage (+12,000). Uninsured adults (-10,000) and adults with private coverage (-10,000) were also shifted to Medicaid coverage (+20,000). These adjustments pertain only to children and adults < 138% FPL. The adjustments have a minor impact on the analysis and are not reflected in Table 4.

[18] Lurie, Ithai and James Pearce, "The Effects of ACA on Income Eligibility for Medicaid and Subsidized Insurance Coverage: Income Definitions and Thresholds across CPS and Administrative Data." Working Paper. U.S. Department of Treasury. See https://appam.confex.com/appam/2012/webprogram/Paper3086.html.

[19] MAGI is equal to adjusted gross income reported on the individual tax return plus income from tax-exempt bonds, excluded foreign-earned income and non-taxable Social Security income.

- The reclassification increases the number of uninsured under 138% FPL by roughly 30 percent, individuals with employer insurance by roughly 50 percent and individuals with private insurance by roughly 40 percent.

Because the study is not specific to Pennsylvania, the analysis makes only partial adjustments based on these results. For adults and children under 138% FPL, the analysis increases the number uninsured and the number with employer or private insurance by 15 percent. However, it is noted that the impact could be much larger.

The final adjustment is for the remnant of the adultBasic population captured in the 2011 ACS data. The adultBasic program offered health coverage to certain adults who were not eligible for Medicaid and had income less than 200% FPL. Enrollees paid monthly premiums of $33.50 and copays of $5-$25 per office visit. The program was terminated in February 2011. However, some adultBasic recipients were still classified as insured in the 2011 ACS data used for this analysis. The analysis assumes that the 2011 data includes 4,600 adultBasic recipients who lost coverage in future years.[20] Therefore, the analysis adds 4,600 individuals to the uninsured population for the 2011 base year.

Projection of Groups Affected by Medicaid Expansion

Although many Pennsylvanians will be affected by the implementation of the ACA, this analysis limits its focus to those impacted by Medicaid expansion. Medicaid expansion could affect three groups: (1) insured and uninsured children ages 6-18 under 138% FPL, (2) insured and uninsured adults ages 19-64 under 138% FPL and (3) various other groups currently enrolled in non-Medicaid plans such as GA and SelectPlan. The analysis does not consider residents with incomes under 400% FPL who qualify for subsidized coverage under the exchange because expansion does not affect those individuals.

An important exception is adults and children with incomes between 100%-138% FPL. Adults would receive highly subsidized coverage through the exchange under the No Expansion scenario or free Medicaid under the Expansion scenario.[21] Children are eligible for free CHIP (and federal matching funds) and coverage would increase under both scenarios.[22] Therefore, most uninsured individuals in this group will likely receive coverage, and substantial federal funds will flow into the state under either scenario. Under No Expansion, the funds will be received as lower taxes and refundable exchange credits. Under Expansion, the funds will be received through the enhanced Medicaid FMAP.

Because outcomes for this group are similar under both scenarios, the incremental impact from Medicaid expansion on new federal funds is much smaller. To facilitate this computation, the analysis makes three simplifying assumptions: (1) adult take-up rates are the same under the Expansion and No Expansion scenarios (i.e., the same number of individuals receive coverage), (2) gross premiums are the same and

[20] For 2010, there were 24,400 enrollees in adultBasic. Because the program was terminated at the end of February 2011 and the ACS survey is sent out every month, the analysis assumes that 17 percent (two out of twelve months) of adultBasic recipients would be classified as insured in 2011.
[21] Individuals under 100% FPL do not qualify for exchange coverage.
[22] To qualify for exchange coverage, parents must ensure that children have coverage.

(3) the heavy federal subsidization of the exchanges effectively pays for 90 percent of gross premiums.[23] Based on these assumptions, incremental federal funds from Medicaid expansion would be equal to the additional 10 percent of premiums paid by the federal government. After 2016, that differential would approach zero as the state pays for up to 10 percent of the cost for newly eligible recipients.[24]

The remainder of this section considers each group affected by Medicaid expansion and discusses briefly (1) the methodology used to project the number of individuals in that group and (2) the number of individuals who opt for coverage. For most groups, the analysis assumes that Medicaid expansion will be fully phased-in over a three-year period. The phase-in factors are as follows: 60 percent (2014), 80 percent (2015) and 100 percent (2016 and all future years). The analysis uses a phase-in assumption because outreach efforts and other reforms require several years to have full effect. Moreover, individuals who switch to Medicaid coverage from employer or private plans might delay their migration to allow the new system to become fully operational and eliminate inefficiencies that will occur from such a fundamental change to the healthcare delivery system. The phase-in rates are applied to all groups except transfers to Medicaid from the GA and CHIP programs.

Group 1: Uninsured Adults Ages 19-64, Newly Eligible

The largest group affected by Medicaid expansion is uninsured adults below 138% FPL. For Pennsylvania, ACS data show that roughly three quarters of uninsured adults age 16 and older are part of the labor force and are actively employed or seeking employment. The data also reveal that three-quarters of uninsured adults in the labor force are employed. Hence, most uninsured adults (roughly 60 percent) are employed in some capacity, although many might have only part-time employment.[25] To extrapolate this group from 2011 through 2021 under the No ACA scenario, the analysis uses the growth in payroll employment (0.8 percent per annum), but assumes that the uninsured adult population below 138% FPL expands at a rate that is twice as fast (1.5 percent per annum). This assumption is consistent with historical coverage trends. It implies that the economy will produce relatively more part-time jobs or jobs in occupations that do not offer health insurance (e.g., service sector). Consistent with the projected decline in the unemployment rate, the analysis also assumes that certain unemployed individuals without insurance will secure employment and insurance coverage under the No ACA scenario (approximately 20,000 in 2016). Table 6 shows the net projection for this group from 2014 (473,000) through 2021 (507,000) under the No ACA scenario.

[23] The take-up rate is the share of eligible individuals who utilize a provision. In reality, the take-up rate may be somewhat higher under the Expansion scenario. The analysis is not sensitive to that assumption. Children are assumed to be routed to free CHIP coverage in either scenario, so there is no cost differential for them.

[24] It is not necessary to account for the impact of additional healthcare spending by new enrollees who receive exchange coverage. Individuals will likely divert those funds from other spending, so there will be little net impact on the Pennsylvania economy (although there could be minor sales tax implications if spending on taxable items is shifted towards non-taxable healthcare).

[25] For both the ACS and the household survey upon which the unemployment rate is based, part-time workers are counted as employed.

The ACS data do not distinguish between uninsured adults who are currently eligible for Medicaid and those who become newly eligible under expansion.[26] For an adult to be currently eligible for Medicaid, they must be enrolled in certain federal relief programs (Temporary Aid to Needy Families (TANF) or Supplemental Security Income (SSI)), have a disability, be medically needy, or care for a child with a disability and report income less than 42% FPL. It is likely that the number of uninsured adults who are currently eligible for Medicaid but not enrolled is rather small. It is also likely that most would occupy the lowest income category in the ACS data (0%-50% FPL). The analysis assumes that 15 percent of uninsured adults in the lowest FPL category are currently eligible for Medicaid, but for various reasons, do not enroll.[27] The analysis must separately track currently eligible individuals because that group (1) receives the regular Medicaid FMAP (as opposed to the enhanced FMAP) and (2) many would likely enroll under the No Expansion scenario due to enhanced outreach efforts and other reforms (i.e., the woodwork effect).

Under the No Expansion scenario, the analysis assumes a 75 percent "take-up" rate for uninsured adults with income between 100%-138% FPL who receive coverage through an exchange. Those under 100% FPL do not qualify for exchange coverage. Under the Expansion scenario, the analysis assumes a 75 percent take-up rate for all uninsured adults with income less than 138% FPL. The take-up rate is the share of individuals eligible for coverage who actually enroll. (See the technical appendix for a comparison of take-up rates used by the IFO and other studies. See Table 7 for a list of take-up rates and applicable FMAPs by group.) Medicaid expansion does not change coverage rates for individuals between 100%-138% FPL; they merely move to Medicaid from the exchange.

The analysis then makes an adjustment for adults age 19-29 who obtain coverage under a covered parent to avoid Medicaid registration or payment of the penalty if their income is between 100%-138% FPL.[28] Demographic data show that adults age 19-29 comprise roughly 26 percent of the 18-64 year age cohort. The analysis assumes that 30 percent of those adults obtain coverage under their parents' policy and do not require separate coverage. Those individuals are removed from all computations. Upon full phase-in (2016), the analysis projects that 327,000 uninsured adults who are newly eligible will enroll in Medicaid.

[26] According to the Congressional Budget Office, research finds that roughly half of eligible non-participants have private coverage and half are uninsured. See "How Many People Lack Health Insurance and For How Long," CBO (May 2003).

[27] To the extent that assumption is incorrect, most of those individuals would instead be counted as newly eligible and would enroll in Medicaid under expansion.

[28] See Public Law 42, No. 5, Session of 2009. The law states that insurers must provide coverage to children of policyholders up through and including the age of 29 if the child is not married, has no dependents, is a resident or full-time student and is not otherwise covered.

Table 6

New Medicaid Enrollees Under No Expansion and Expansion Scenarios

Income < 138% FPL, Thousands of Recipients

	2014	2015	2016	2017	2018	2019	2020	2021
1. Uninsured Adults, Newly Eligible	469	471	473	477	482	490	499	507
a. Newly Insured – No Expansion	70	94	117	119	120	122	124	126
b. Newly Insured – Expansion	125	167	210	212	214	217	221	225
Total New Enrollees	195	261	327	330	333	339	345	350
2. Insured Adults, Newly Eligible								
a. Move from Employer	42	56	71	71	72	72	73	73
b. Move from Private	61	83	104	105	106	107	107	108
3. Adults Currently Eligible, Not Enrolled								
a. Newly Insured - No Expansion	4	6	7	7	7	8	8	8
b. Newly Insured - Expansion	3	4	5	5	5	5	5	5
c. Move from Employer	1	1	1	1	1	1	1	1
d. Move from Private - No Expansion	2	3	4	4	4	4	4	4
e. Move from Private - Expansion	1	2	2	2	2	2	2	2
4. Uninsured Children								
a. Newly Insured - No Expansion	24	32	41	41	42	42	43	44
b. Newly Insured - Expansion	9	12	15	16	16	16	16	17
5. Insured Children								
a. Move from Employer	7	9	12	12	12	12	12	12
b. Move from Private	5	6	8	8	8	8	8	8
c. CHIP Transfers	55	55	56	56	57	57	58	58
6. General Assistance Transfer	76	76	77	77	78	79	79	80
7. SelectPlan, Foster Care, MAWD-BCCPT	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Increase in Medicaid Recipients								
1. Occurs Without Expansion	100	134	169	171	173	176	179	182
2. Occurs With Expansion	253	339	427	430	434	440	446	451
3. CHIP and GA Transfers With Expansion	131	132	133	134	135	136	137	138
TOTAL	**483**	**605**	**729**	**735**	**742**	**752**	**761**	**771**

Table 7
Take-up Rates and Applicable FMAP

Group	Age	Insurance Status	Eligibility	Applicable FMAP	Scenario	Take-Up Rate
1	Adult	Uninsured	New	Enhanced	No Expansion	0% / 75%[1]
		Uninsured	New	Enhanced	Expansion	75% / 75%[1]
2	Adult	Employer	New	Enhanced	Expansion	20%
		Private	New	Enhanced	Expansion	70%
3	Adult	Uninsured	Current	Regular	No Expansion	30%
		Uninsured	Current	Regular	Expansion	50%
		Employer	Current	Regular	Expansion	5%
		Private	Current	Regular	No Expansion	40%
		Private	Current	Regular	Expansion	60%
4	Children	Uninsured	Current	Regular	No Expansion	40% / 75%[2]
		Uninsured	Current	Regular	Expansion	75% / 75%[2]
5	Children	Employer	Current	Enhanced	Expansion	13%
		Private	Current	Enhanced	Expansion	14%
6	Adult	Gen. Assist	New	Enhanced	Expansion	100%

[1] Dual rates pertain to adults with income between 0%-100% FPL and 100%-138% FPL. Uninsured adults who receive coverage under the No Expansion scenario receive coverage through the exchange.
[2] Dual rates pertain to children with income between 0%-100% FPL and 100%-138% FPL. Children with family income between 100%-138% FPL assumed to receive free CHIP.

Group 2: Adults Currently Insured, Newly Eligible: Employer-Sponsored or Private Insurance

For currently insured adults, the analysis assumes that (1) the group expands at the same rate as total employment (0.8 percent per annum) and (2) 15 percent of the lowest ACS income bracket is currently eligible for Medicaid coverage. The analysis assumes that 20 percent of individuals with employer coverage will be dropped and 70 percent with private coverage will voluntarily move to Medicaid. These rates are generally consistent with national studies.[29] (See technical appendix.)

[29] Holahan et al., "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," The Urban Institute (November 2012).

Group 3: Adults Currently Eligible, Not Enrolled

For various reasons, certain adults who are eligible for Medicaid elect to forgo coverage. This group has been referred to as "woodwork" individuals. The analysis assumes that 15 percent of uninsured adults in the lowest income bracket are currently eligible for Medicaid but elect to forgo coverage, regardless of their current coverage status. See Table 7 for separate take-up rates under the No Expansion and Expansion scenarios. These rates are generally consistent with national studies. (See technical appendix.) None of these individuals qualify for the enhanced FMAP because they are currently eligible for Medicaid coverage.

Group 4: Uninsured Children

Under the No ACA scenario, all children under 100% FPL are eligible for Healthy Beginnings, Pennsylvania's Medicaid for children. For 2011, the ACS data show that 39,200 children with family income under 100% FPL were not enrolled in Medicaid. Another 24,600 children with family income between 100%-138% FPL lacked health insurance.[30] The analysis extrapolates these groups through 2021 using the same growth rate used for uninsured adults (1.5 percent per annum).

Under the No Expansion scenario, many uninsured children would become enrolled in Healthy Beginnings due to enhanced outreach efforts and other reforms. Children with family income between 100%-138% FPL would also become enrolled in free CHIP because adults who seek to purchase coverage from the exchange must also secure coverage for their children. The analysis assumes that 40 percent of uninsured children in the 0%-100% FPL category enroll in Healthy Beginnings, and 75 percent in the 100%-138% FPL category enroll for free CHIP coverage. The latter group has a higher take-up rate because coverage is automatically triggered by the parents' enrollment in the exchange. No such trigger exists for children with family income between 0%-100% FPL.

Under the Expansion scenario, the analysis assumes another 35 percent of currently eligible children in the 0%-100% FPL category enroll in Healthy Beginnings (total of 75 percent). The free coverage extended to parents triggers additional coverage for their children.

Group 5: Insured Children: Employer-Sponsored, Private Insurance and CHIP Transfers

The number of children whose parents have insurance coverage but move to Medicaid is based on two factors. First, the analysis considers the ratio of children to adults for these two covered groups. For employer-sponsored insurance, that ratio is equal to 0.40, so that each adult with employer-sponsored coverage and income under 138% FPL has, on average, 0.40 children. For private plans, the ratio is 0.29. Then, the adult take-up rate is applied to yield the number of children who move from employer or private plans to Medicaid with their parents. See Table 7 for implied take-up rates from this computation.

The analysis also assumes that children insured through CHIP with family income between 100%-138% FPL are transferred to MA and enrolled in Healthy Beginnings. The Healthy Beginnings premium is

[30] These are published figures and do not include the adjustments discussed earlier in this section.

higher than the CHIP premium, yielding a modest cost due to the transfer. However, the CHIP FMAP still applies.

Other Groups Affected by Medicaid Expansion

Other groups will also be affected by the ACA. While certain groups transfer to Medicaid (e.g., General Assistance), other groups simply expand due to enhanced outreach efforts and other reforms (e.g., Medical Assistance for Workers with Disabilities (MAWD) and Breast and Cervical Cancer Prevention Treatment (BCCPT)).

- General Assistance: Adults receiving GA transfer to Medicaid. The analysis assumes that DPW facilitates this transition so that all current recipients receive Medicaid coverage (i.e., 100 percent take-up rate).
- SelectPlan: SelectPlan provides family planning services for women ages 18-44 that have income less than 185% FPL. The analysis assumes that 20 percent of current recipients will move to Medicaid (newly eligible) and will not require these services.
- Foster Care Age Outs: The ACA requires states to extend coverage to former foster care children who were receiving Medicaid when they aged out of foster care. For those individuals, the ACA extends coverage through age 26.
- MAWD and BCCPT: Certain SSI beneficiaries qualify for Medicaid through the MAWD program if they have incomes below 250% FPL, work in some paid capacity and have resources less than $10,000. Premiums are equal to five percent of monthly income. The BCCPT program provides full health care benefits to women needing treatment for breast or cervical cancer who are uninsured and under age 65. The analysis assumes that enhanced outreach and other reforms will increase the number of enrollees in these programs by 15 percent.

The counts from Table 6 do not include the SelectPlan, Foster Care Age Outs and MAWD-BCCPT groups because the per capita costs or savings are much smaller for those groups relative to Medicaid recipients.[31] However, those amounts are included in the federal and state expenditure tabulations presented in the next section.

Summary

For 2016 (first year of full phase-in), the analysis projects that Medicaid coverage will expand by 169,000 recipients under the No Expansion scenario. An additional 427,000 individuals enroll due to Medicaid expansion and 133,000 adults and children transfer to Medicaid from the CHIP and GA programs.

[31] Total foster care age outs and MAWD-BCCPT enrollees increase by roughly 4,000 per annum, while SelectPlan enrollment falls by roughly 20,000 per annum. The per capita savings from the SelectPlan reduction is approximately $200-$250 per annum, much smaller than the typical premium for Medicaid coverage.

Section 4: Projection of Federal and State Costs

This section applies cost parameters to the groups affected by Medicaid expansion identified in the prior section. It also includes projections of other costs (e.g., administrative and personnel costs) and savings (e.g., the transfer of the GA population to Medicaid) that will be incurred or realized as part of Medicaid expansion.

Projection of Medicaid Premiums

Table 8 lists projections of annual Medicaid premiums used for this analysis. Federal match assistance percentages are also listed. The analysis used two sources to establish physical and behavioral health premiums for children, non-GA adults and GA adults. The 2011 MCO Databooks were used to determine physical health premiums for non-GA adults and children. The databooks list the monthly physical health premiums, as well as the spending categories that comprise those premiums, across MA recipients who receive TANF, Healthy Beginnings, SSI or GA benefits.[32, 33] The databooks cover five sectors: (1) Philadelphia, (2) the four counties that surround Philadelphia, (3) Allegheny County, (4) the nine counties that surround Allegheny County and (5) the Lehigh/Capital Zone sector (10 counties). For 2011, those five sectors comprised roughly 60 percent of all MA recipients.[34]

Physical health premiums for GA adults and all behavioral health premiums across the three groups are from DPW. The analysis also makes the following assumptions:

- From the 2011 base rates, all physical and behavioral health premiums grow by 3.0 percent per annum.[35]
- However, in 2014, premiums grow by 5.0 percent as the new health insurer fee is embedded in premiums. A recent national study finds that the fee will increase premiums of Pennsylvania MCOs by roughly two percent.[36]
- New Medicaid enrollees have the same average health status as current MA recipients who receive TANF benefits: they are neither healthier nor sicker.

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[32] The rates are not risk adjusted, which could increase or decrease actual rates by roughly 5 to 10 percent. See http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm.

[33] The IFO used the databooks to compute weighted average premiums for physical healthcare coverage. The weights are based on the share of "member months" across the five sectors. Member months represent the number of months that recipients in a particular sector were enrolled in Medicaid.

[34] The analysis assumes that the weighted average rates computed for these sectors would be representative of all Pennsylvania Medicaid recipients.

[35] This assumption may prove conservative. The Center for Medicare and Medicaid Services projects that per capita health care expenditures will increase at an average rate of 5.3 percent per annum from 2014 to 2021. The analysis assumes that the Commonwealth will be able to restrain premium growth due to its purchasing power.

[36] See "PPACA Health Insurer Fee Estimated Impact on State Medicaid Programs and Medicaid Health Plans" Milliman (January 2012) at http://www.mhpa.org/_upload/MillimanReport.pdf.

- The 2011 base premium for children uses the Healthy Beginnings weighted average premium.
- The 2011 base premium for non-GA adults uses premiums paid for adults who receive TANF benefits. The computation excludes adults who receive SSI benefits and have much higher premiums due to various disabilities.
- The 2011 base premium for GA adults uses a weighted average premium for categorically and medically needy individuals. These individuals will be newly eligible for Medicaid under expansion.

Table 8
Average Cost and FMAP Parameters

	2013	2014	2015	2016	2017	2018	2019	2020	2021
Annual Premiums									
Children	$2,877	$3,020	$3,111	$3,204	$3,300	$3,399	$3,501	$3,606	$3,715
Non-GA Adult	4,679	4,912	5,060	5,212	5,368	5,529	5,695	5,866	6,042
GA Adult	5,366	5,634	5,803	5,977	6,157	6,341	6,532	6,728	6,930
CHIP	2,513	2,639	2,718	2,800	2,884	2,970	3,059	3,151	3,245
Applicable FMAPs									
Regular Medicaid	54.3%	54.3%	54.3%	54.3%	54.3%	54.3%	54.3%	54.3%	54.3%
Enhanced Medicaid	54.3	100.0	100.0	100.0	95.0	94.0	93.0	90.0	90.0
Regular CHIP	68.6	68.6	68.6	68.6	68.6	68.6	68.6	68.6	68.6
Enhanced CHIP	68.6	68.6	74.3	91.6	91.6	91.6	85.8	68.6	68.6
SelectPlan	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0
BCCPT	68.6	68.6	68.6	68.6	68.6	68.6	68.6	68.6	68.6

Table 9 applies the cost parameters and relevant FMAPs to derive the total federal and state costs from Medicaid expansion. All groups (except transfers) use the 60-80-100 phase-in described in the previous section. The groupings from Table 9 correspond to those from Table 6. The table lists the total costs or savings under the Expansion scenario. See the bottom of Table 9 for an incremental breakdown of the No Expansion and Expansion scenarios and the technical appendix for further detail across the various categories. Relevant details are as follows:

- Newly eligible uninsured and currently insured adults (Groups 1 and 2) comprise the great majority of new expenditures.
- The so-called “woodwork” costs (generally Group 3) range from $100 to $150 million per annum. However, much of those costs would be incurred under the No Expansion scenario. (See technical appendix.)
- The Commonwealth realizes significant savings from the transfer of the GA population to Medicaid.

The figures from the top half of Table 9 represent direct costs or savings to federal or state governments from insuring individuals. However, the Commonwealth would also incur or realize indirect costs and savings. The subsections that follow describe those costs and savings. See the technical appendix for further detail of these costs and savings under the No Expansion and Expansion scenarios.

Manufacturer Drug Rebate

Participation in the Medicaid program requires drug manufacturers to pay rebates for covered outpatient drugs reimbursed under Medicaid. Drugs dispensed by Medicaid MCOs were excluded from this requirement until March 23, 2010, when the ACA expanded the rebate requirement to include drugs prescribed through a Medicaid MCO. The ACA also increased rebates from 15.1 to 23.1 percent for brand name drugs and 11.0 to 13.0 percent for generic drugs. States remit the increase in the rebate percentage to the federal government, but retain the state portion of pre-ACA levies.

For FY 2010-11, the Commonwealth collected approximately $550 million in drug rebates across 1.2 million residents enrolled through Medicaid MCOs.[37] The expansion of Medicaid will increase drug rebates remitted to state and federal governments, thereby reducing costs. States compute the rebates due on a quarterly basis and invoice manufacturers for those amounts based on drugs prescribed to state Medicaid recipients. Much of the rebates will flow out of the state economy and back to the federal government. The analysis deducts those rebates from new federal and state expenditures for previously uninsured individuals only.

Table 9 includes savings from the reduction in SelectPlan enrollees and additional costs from increased MAWD and BCCPT recipients with the drug rebate. See the technical appendix for individual detail.

[37] Figure supplied by the Department of Public Welfare.

Table 9
Change in State and Federal Expenditures Under Medicaid Expansion
$ millions

	2014	2015	2016	2017	2018	2019	2020	2021
1. Uninsured Adults, Newly Eligible								
Federal	$956	$1,319	$1,705	$1,683	$1,732	$1,795	$1,820	$1,906
State	0	0	0	89	111	135	202	212
2. Insured Adults								
Federal	507	701	910	898	922	947	952	988
State	0	0	0	47	59	71	106	110
3. Uninsured Adults, Currently Eligible								
Federal	30	41	54	56	58	61	63	66
State	25	35	45	47	49	51	53	56
4. Uninsured Children								
Federal	59	86	125	130	136	138	129	135
State	39	51	54	57	59	67	85	89
5. Insured Children (includes transfers)								
Federal	33	42	54	56	59	59	57	59
State	22	27	30	31	33	35	41	43
6. General Assistance Transfer								
Federal	533	554	574	580	636	651	650	673
State	0	0	0	36	46	55	81	84
State Savings	-533	-554	-574	-616	-682	-706	-731	-757
Gross Federal Expenditures	**2,118**	**2,744**	**3,422**	**3,403**	**3,543**	**3,651**	**3,670**	**3,827**
Gross State Expenditures	**-447**	**-441**	**-445**	**-309**	**-326**	**-291**	**-162**	**-163**
7. Net Drug Rebate and Other								
Federal	-8	-11	-14	-14	-15	-15	-15	-16
State	6	8	10	10	10	10	10	10
8. Medicare Rates for Primary Care Services								
Federal	0	248	276	279	287	295	300	310
State	0	149	155	164	170	176	184	190
9. Mental Health and Other								
Federal	-24	-24	-24	-24	-24	-24	-24	-24
State	-61	-62	-63	-64	-65	-66	-67	-69
10. Personnel and Information Technology								
Federal	76	92	59	60	62	49	51	54
State	32	42	49	50	52	49	51	54
TOTAL FEDERAL	**2,162**	**3,048**	**3,718**	**3,704**	**3,853**	**3,956**	**3,982**	**4,149**
TOTAL STATE	**-471**	**-304**	**-294**	**-149**	**-159**	**-123**	**16**	**21**
Addendum: Incremental Impacts								
Federal								
No Expansion	412	564	689	716	745	761	782	819
Expansion	1,750	2,485	3,029	2,988	3,108	3,194	3,200	3,330
Pennsylvania								
No Expansion	43	60	62	64	67	70	89	93
Expansion	-514	-364	-356	-213	-226	-193	-73	-72

Extension of Medicare Rates for Certain Medicaid Services

The ACA increased Medicaid payments for certain primary care services to prepare for the influx of new patients from Medicaid expansion. The ACA requires states to pay primary care physicians no less than 100 percent of Medicare rates for calendar years (CY) 2013 and 2014.[38] The rate increase is fully funded by the federal government through 2014 for all Medicaid recipients. When the provision expires, states can exercise discretion as to whether they continue to reimburse primary care physicians at the higher rate or revert to prior reimbursement policies.

A simulation performed by DPW finds that enhanced Medicaid rates for these services could cost $350-$400 million for CY 2013. Due to the low reimbursement rates offered for Medicaid services, the analysis assumes that it will be necessary to pay enhanced rates to ensure sufficient supply of services to meet increased demand under Medicaid expansion. The analysis assumes that (1) Congress permanently extends enhanced Medicaid rates and (2) the state receives the regular FMAP for currently eligible recipients and the enhanced FMAP for newly eligible recipients. However, if the state does not expand, then normal rates would be paid after 2014. If Pennsylvania does not expand, there is no incentive for the federal government to reimburse the state for enhanced Medicaid rates.

Mental, Behavioral Health and Other Savings

For FY 2013-14, the Executive Budget proposes $732 million for mental ($689 million) and behavioral health ($43 million) services. Mental health expenditures include outlays for county-based health services, substance abuse services and state mental hospitals. Some of these services would be covered under Medicaid expansion. However, because the composition of the new health plans is not currently known, projected cost savings are speculative. The analysis assumes a five percent reduction in these expenditures from Medicaid expansion.

Savings would likely also be realized for drug and alcohol abuse programs. For FY 2013-14, the Executive Budget proposes $41.7 million in state funds for the Department of Drugs and Alcohol. The analysis assumes a five percent reduction in funding necessary to fulfill the department's mission under Medicaid expansion. Finally, the analysis also assumes that Medicaid expansion will provide $3 million in annual savings to the Department of Corrections because a larger share of prisoners would qualify for Medicaid coverage.

Loss of Certain Federal Disproportionate Share Hospital (DSH) Payments Due to GA Transfer

All states receive reimbursement from the federal government to offset a portion of their cost to provide Medicaid services. Expenditures eligible for reimbursement include any DSH payments made by states. The federal Medicaid statute requires states to make DSH payments to hospitals that treat large numbers

[38] The minimum payment level applies to "specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine." This definition has been interpreted to exclude general practitioners. See Federal Register, Vol. 17, No. 215, p. 2.

of low-income patients because they are more likely to be uninsured or Medicaid enrollees (who generally have low reimbursement rates).[39]

Most federal Medicaid funds are provided on an open-ended basis, but federal DSH funds are capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that the state can claim for Medicaid DSH payments. For FY 2012, Medicaid DSH allotments totaled $11.3 billion and Pennsylvania received an allotment of approximately $575 million (5.1 percent).[40] Combined federal and state DSH funds available for reimbursement totaled $1.04 billion for FY 2012.

Under Medicaid expansion, hospitals should provide less uncompensated care and require less Medicaid DSH payments.[41] Therefore, the ACA directs the Secretary of the Department of Health and Human Services to make the following general reductions in total Medicaid DSH allotments: $500 million (federal FY 2014), $600 million (2015), $600 million (2016), $1.8 billion (2017), $5.0 billion (2018), $5.6 billion (2019) and $4.0 billion (2020). Currently, it is not known how these reductions will be allocated across states or the manner in which they will be allocated within states.

Under the Expansion scenario, the GA population will be transferred to Medicaid and federal DSH allotments will fall. The precise magnitude of that reduction is difficult to determine because the state will lose significant DSH funds regardless. Under the No Expansion scenario, the analysis assumes that total DSH allotments will fall by the following percentages: 5 percent (2014), 6 percent (2105), 6 percent (2016), 17 percent (2017), and 40 percent (2018-2021). Those percentage reductions are informed by the ACA mandated reductions relative to CBO projections of baseline DSH allotments. The analysis assumes that GA-related DSH allotments would fall by the same percentage under the No Expansion scenario. To keep reimbursements for GA services constant, the analysis also assumes that premiums would increase by the full amount of the reduction in DSH payments.

Upon transfer to Medicaid, the analysis further assumes that remaining GA DSH payments fall another 80 percent. To keep reimbursements constant, the analysis allows premiums to rise to offset the reduction. However, those higher premiums are now reimbursed by the federal government using the enhanced Medicaid FMAP. The decline in DSH funds due to the GA transfer to Medicaid is counted as a reduction in federal expenditures (federal DSH portion) and a savings to the Commonwealth (state DSH portion). In essence, the analysis assumes that the cost to insure GA recipients does not change, and the total costs are shifted to the federal government for 2014 to 2016, after which the state assumes a small share of the costs. Those amounts are included in Table 9.

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[39] For a discussion of these issues, see "Medicaid Disproportionate Share Hospital Payments," CRS Report R42865 (December 2012) at https://www.fas.org/sgp/crs/misc/R42865.pdf

[40] Ibid.

[41] If all states expand Medicaid, the Kaiser Foundation estimates that uncompensated care would fall by $183 billion from 2014 to 2021. See Holahan et al., "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," Kaiser Commission on Medicaid and the Uninsured, Publication No. 8384 (November 2012).

Personnel, Operating and Information Technology Costs

To compute the costs related to additional personnel needed to support Medicaid expansion, the analysis considered historical MA caseworker loads. The great majority of additional support staff needed to implement the ACA will occur in the County Assistance Offices (CAO). For FY 2011-12, the ratio of CAO personnel to MA recipients was approximately 390 recipients per worker. The analysis assumes a 10 percent increase in productivity (430 recipients per worker) for new workers due to reforms and technology upgrades.[42] For 2016, the analysis projects that 596,000 new recipients (excludes transfers) will require support, implying 1,396 additional CAO staff. A weighted average salary and benefit package was computed for FY 2011-12 ($45,800) and is assumed to grow by three percent per annum. For 2016, the analysis projects additional personnel costs of $72 million from Medicaid expansion. That amount is further increased by 10 percent to capture other personnel necessary to implement expansion (e.g., headquarters support personnel, office of administration). Those costs are split evenly between the state and federal governments. The computations do not include any costs related to the health insurance exchange because the Commonwealth has deferred administration of the exchange to the federal government.

In addition to personnel costs, the analysis includes certain one-time costs for new employees ($5,000 per employee) and ongoing operating costs equal to 10 percent of salary/benefits. Finally, the ACA requires that MAGI be used to determine Medicaid eligibility. To facilitate that change, DPW will need to implement program changes and purchase new equipment and software. Most of those costs would be incurred under the No Expansion scenario and the federal government funds 90 percent of the costs.[43]

Gross Receipts Tax (GRT)

Act 48 of 2009 enacted a GRT levied on the payments that MCOs receive pursuant to a DPW Medicaid contract. The GRT rate is equal to 59 mills (5.9 percent). Although MCOs remit GRT on payments received, any tax remitted is eventually reimbursed and the GRT has no effect on MCOs except to alter the timing of their cash flows. The state's share of the tax also has no net impact on the budget: any tax reimbursed by the Commonwealth is fully offset by revenues received. However, the federal government treats the GRT similar to the underlying premium, and provides matching funds using the applicable FMAP. Therefore, the GRT simply pulls in additional federal funds to the Commonwealth equal to the federal share of MCO expenditures times 5.9 percent. The analysis assumes that the federal government will continue to allow the GRT to be used for this purpose under Medicaid expansion. For recent years, the MCO GRT has generated the following General Fund revenues: $505 million (FY 2009-10), $582 million (FY 2010-11) and $643 million (FY 2011-12).

The analysis characterizes the net gain from the additional federal monies as new GRT revenues. It does not include the GRT levy in any federal or state expenditures from Table 9. Moreover, the analysis only counts the federal portion of GRT and only the incremental funds under the Expansion scenario due to

[42] Presumably, current workers would also realize productivity improvements. However, those savings are not dependent upon Medicaid expansion.
[43] Information technology cost projections are from DPW.

previously uninsured individuals. There is no incremental GRT gain from those previously insured who move to Medicaid.[44]

Currently, it is unclear whether the federal government will allow this tax to be levied on new federal spending. Because the federal government reimburses at 90-100 percent, they may disallow these types of levies. If disallowed, that outcome will have a significant budgetary impact. The analysis itemizes new GRT revenues in Section 6 to quantify the impact of disallowance.

Summary of Net Costs to Federal and State Governments

The bottom of Table 9 sums up net federal and state costs. The analysis finds that new federal funds will range from $2.2 billion to $4.1 billion per annum. Due to the large savings from the transfer of the GA population, the Commonwealth realizes a savings under full federal reimbursement, and a modest cost under 90 percent federal reimbursement. These amounts are calendar year amounts and have not been aligned to correspond to the state fiscal year. That adjustment is made in the final section of the analysis.

The bottom of Table 9 disaggregates the total change into the No Expansion and Expansion scenarios. The incremental impact of Medicaid expansion increases federal funds by $1.8 to $3.3 billion per annum. For Pennsylvania, the incremental impact from Medicaid expansion is larger than the total impact because most of the savings occur only under the Expansion scenario. The analysis projects that state expenditures will decline in all years.

[44] Although the GRT is only remitted by MCOs, the state healthcare system will largely move to MCOs exclusively over the next year or two and eliminate the fee-for-service model. Hence, MCOs will remit GRT on all insured individuals.

Section 5: The Impact of Medicaid Expansion on the Pennsylvania Economy

This section quantifies how federal funds attributable to Medicaid expansion will impact the Pennsylvania economy. The analysis considers only incremental federal funds from Table 9. It does not include new federal funds that would be received under the No Expansion scenario. The analysis from the prior section finds that the state will realize savings from Medicaid expansion. The analysis assumes that those savings will be used for other needs, such as education or transportation.[45] Hence, total state spending does not change, and the analysis focuses only on the change in federal funds under the Expansion scenario.

This section contains two sub-sections. The first sub-section apportions the new federal funds into various spending categories. These categories represent the first round of spending from Medicaid expansion. The analysis must identify those categories because different types of spending (i.e., physician offices versus hospitals) could have different impacts on the Pennsylvania economy depending upon industry characteristics and the share of economic activity that is assumed to leak from the state. The second sub-section applies Pennsylvania industry specific multipliers to new federal funds across the spending categories to derive the final impact on the Pennsylvania economy. The multipliers capture the additional rounds of spending that result from the new federal funds injected into the economy.

Allocation of New Federal Funds

Table 10 lists the six spending categories that will receive new federal funds: (1) offices of physicians, dentists and other practitioners, (2) medical and diagnostic labs and other outpatient services, (3) hospital and other inpatient services, (4) pharmaceuticals, (5) MCO administration and (6) MCO profit. In order to apportion new federal funds into the first four spending categories, the analysis uses premium data from the MCO databooks. Those data detail the spending composition for all premiums based on type of recipient: non-GA adult, Healthy Beginnings child and GA adult. For example, the databooks show that one-third of physical health premiums for non-GA adults and children are used to pay for the services of a physician, dentist or other health care practitioner.[46]

However, before new federal funds can be allocated across spending categories, the analysis deducts administrative costs and profits of MCOs since the new funds flow through those organizations and those amounts are built into premiums. The analysis assumes that MCO administrative costs and profits comprise eight percent of total new funds, split evenly between profits and administrative costs. The analysis applies a multiplier to the administrative costs of MCOs, but not profits. The next section discusses revenue impacts, which includes taxation of those profits.

[45] The analysis assumes that the economic impact from the different mix of state spending is the same.
[46] Due to lack of data, the analysis assumes that behavioral health premiums are spread the same as physical health premiums. For children and non-GA adults, physical health premiums are considerably larger.

Table 10 displays the apportionment of new federal funds across various healthcare industries. Hospitals receive approximately one-third of new funds. Relatively minor expenses for home healthcare and hospice services are included with hospitals.

Table 10
Industry Spending Allocation and Multipliers

	Industry Shares		Industry Multipliers	
	GA Adults	All Other	Value Added	Earnings
Office of Physicians	22.0%	32.0%	1.42	0.88
Diagnostic and Outpatient	9.0	9.0	1.39	0.84
Hospitals	33.0	36.0	1.32	0.76
Pharmaceuticals	28.0	15.0	1.02	0.38
MCO Administration	4.0	4.0	1.39	0.84
MCO Profit	4.0	4.0	n.a.	n.a.
TOTAL	100.0	100.0	n.a.	n.a.

Sources: Industry shares based on premium data from MCO Databooks. Industry multipliers from U.S. Bureau of Economic Analysis.

The Impact of New Federal Funds on the Pennsylvania Economy

The spending categories listed above show the direct recipients of new federal funds that are injected into the Pennsylvania economy. However, the total impact on the economy will be greater than those new funds because recipients do not remain inactive; they will re-spend most of the new funds they receive. This dynamic is no different than a new firm that chooses to locate in Pennsylvania; the new investment and hiring would also have ripple effects that impact other parts of the Pennsylvania economy as various industries expand output and workers spend their incomes.

In order to quantify these ripple effects, the analysis uses Type II final demand multipliers computed by the U.S. Bureau of Economic Analysis for the Pennsylvania economy. For this analysis, two types of multipliers are used. They are as follows:

- Value-Added Multiplier: Value-added represents the value that each firm adds to a service or product in the production process. Purchases from other firms are excluded from the value added computation to eliminate double counting. Depending on the region, the sum of value added is equal to Gross Domestic Product (U.S. economy) or Gross State Product (Pennsylvania economy).
- Earnings Multiplier: The earnings multiplier transforms the new economic activity into income. The earnings include any wage, sole proprietorship and partnership income, as well as employer contributions to health insurance. It does not include certain returns to capital such as corporate earnings, rents and dividends, which are much smaller and require a separate computation.

Table 10 lists the industry multipliers used to determine total value added and earnings. The value-added multiplier for physician offices is equal to 1.42, indicating that a dollar of new federal spending received

by that industry increases the size of the state economy by $1.42: the original dollar plus an additional 42 cents as income is respent and supplier industries expand production.[47] Earnings multipliers are generally less than one due to savings, taxes and out-of-state leakages.

Prior to applying industry multipliers, the analysis assumes that five percent of new federal spending immediately leaks from the state economy. This would occur if residents receive healthcare services from an out-of-state provider. Although certain federal funds will also leak into Pennsylvania, that outcome would occur regardless of Medicaid expansion.

It is noted that not all new federal funds represent new healthcare spending. Some funds merely replace household or business spending on healthcare. For example, newly eligible individuals who had purchased private coverage but now enroll in Medicaid. Alternatively, a small business drops coverage if many employees qualify for free Medicaid coverage. In these cases, the federal funds largely replace prior spending on healthcare and effectively increase household or business income. For various reasons, those changes have much smaller effects on the economy. In technical terms, the additional income only has "induced effects," and does not have direct or indirect effects.[48] The analysis treats federal spending that replaces current spending on healthcare as an increase to household or business income.[49]

Table 11 presents the results from the application of Pennsylvania industry-specific multipliers to new federal spending due to Medicaid expansion. For 2016 (full phase-in), the analysis projects the following impacts:

- Gross State Product increases by $3.1 billion.
- Total taxable income increases by $2.1 billion. That amount includes wages, pass through business income (partnerships and sole proprietors), corporate profits and other returns to capital (e.g., interest, dividends and rental income).

[47] Expenditures for pharmaceutical products will affect both retailers and manufacturers. However, the data do not include a separate multiplier for healthcare expenditures on pharmaceutical products, but do include multipliers for general retail sales and pharmaceutical manufacturing. Although these expenditures affect both industries, the analysis uses the pharmaceutical manufacturing multiplier because it is not technically accurate to average multipliers in order to obtain a "composite" industry.

[48] Direct effects represent the impact from the first round of spending on businesses. Indirect effects represent the response of businesses that supply inputs to firms that receive the initial spending. Induced effects represent the impact from households spending new wage and business income.

[49] The business income is largely modeled as "pass through" income that has the same effect as an increase in household income. Because healthcare is a deductible business expense, the additional income is subject to Pennsylvania personal or corporate income tax.

Table 11
Economic Impact on Pennsylvania Economy
$ billions

	2014	2015	2016	2017	2018	2019	2020	2021
New Federal Spending[1]	$1.7	$2.4	$2.9	$2.9	$3.0	$3.0	$3.0	$3.2
Increase in Gross State Product	1.8	2.6	3.1	3.1	3.2	3.3	3.3	3.4
Increase in Taxable Income[2]	1.2	1.7	2.1	2.1	2.2	2.2	2.2	2.3

[1] Net of five percent leakage to out-of-state providers.
[2] Includes corporate profits and other returns to capital. Excludes employer contributions for health insurance.

In general, it is likely that the impact of new federal spending is somewhat understated. The analysis assumes that the new federal spending does not trigger the need for additional investment spending by industries that supply inputs to the healthcare industry. If supply industries must expand to meet additional demand, then the economic impact would be larger.

Section 6: Revenue Impact of Medicaid Expansion

This section converts the economic impacts from the prior section into tax revenues. For that purpose, the analysis considers only income taxes, sales taxes and gross receipts taxes. As noted, only the federal share of GRT that is due to incremental federal spending for previously uninsured individuals is included. The analysis makes the following assumptions across the three revenue sources:

- For wage income, the effective tax rate is 3.07 percent. Three percent of wage income is paid to non-resident workers who will not remit personal income tax due to reciprocal agreements with their state of residence.
- For non-corporate business income, the effective tax rate is 2.7 percent (as opposed to the statutory rate of 3.07 percent) because some business income merely reduces tax losses and is not taxable.
- For corporate income, the effective tax rate is 8.0 percent (statutory rate of 9.99 percent). The analysis also assumes an average apportionment factor of 75 percent.
- For sales and use taxes, the analysis assumes that 31 percent of wages, business income and other capital income is spent on taxable items. That share is based on data from the Consumer Expenditure Survey published by the U.S. Department of Labor.[50]

Table 12
Revenue Impact from Medicaid Expansion[1]
$ millions

	2014	2015	2016	2017	2018	2019	2020	2021
Personal Income	$32	$46	$56	$55	$57	$59	$59	$61
Corporate Income	4	6	7	7	7	7	7	8
Gross Receipts	78	94	112	111	115	119	120	125
Sales and Use	20	29	36	35	37	38	38	39
Total Revenues	**134**	**175**	**210**	**209**	**216**	**223**	**224**	**234**

[1] Calendar or tax year basis.

[50] See http://www.bls.gov/cex/tables.htm. The analysis uses the cross-tabulated table for age (35 to 44) and income before taxes ($50,000 to $69,999). The share of expenditures assumed to be taxable is based on spending patterns for that cohort.

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Section 7: Net Fiscal Impact of Medicaid Expansion

This section concludes the analysis and combines the budget impact from Section 4 with the revenue impact from Section 6 to derive the net budget impact of Medicaid expansion. Table 13 combines the revenue and expenditure projections. The top portion of Table 13 corresponds to the calendar year in which new enrollees receive coverage or the tax year in which tax liability is generated. The analysis assumes that Medicaid expansion is effective January 1, 2014 and applies a phase-in assumption of 60 percent (2014), 80 percent (2015) and 100 percent (2016 and later years) for reasons noted earlier in this report.

The bottom half of Table 13 converts the calendar year figures to the state fiscal year. Those amounts represent cash flows, or when funds are actually spent or revenues received. The conversion uses the following simple conventions:

- For expenditures, 33 percent of CY 2014 expenditures remain in fiscal year ending (FYE) 2014, and the remainder goes to FYE 2015. All other years apply a 33/67 split to convert calendar years to fiscal years.
- Gross receipts taxes are lagged one year from the tax year they are generated.
- Because multipliers require time to phase-in and delays in tax remittances, only 20 percent of CY 2014 revenues remain in FYE 2014, and the remainder is realized in FYE 2015. All other years apply a 40/60 split (e.g., 40 percent of CY 2015 revenues are realized in FYE 2015 and 60 percent in FYE 2016).

Table 13
Net Budget Impact of Medicaid Expansion
$ millions

	2014	2015	2016	2017	2018	2019	2020	2021
Calendar or Tax Year								
Reduced Expenditures	-$514	-$364	-$356	-$213	-$226	-$193	-$73	-$72
Gross Receipts	78	94	112	111	115	119	120	125
Other Tax Revenues	56	81	99	97	101	104	104	108
Net Budget Impact	648	539	566	421	442	415	297	305
Fiscal Year Ending								
Reduced Expenditures	-170	-465	-361	-309	-217	-215	-153	-73
Gross Receipts	0	78	94	112	111	115	119	120
Other Tax Revenues	11	77	88	98	99	102	104	106
Net Budget Impact	181	620	543	518	427	432	376	299

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Section 8: Summary

The analysis finds a significant budget impact from Medicaid expansion for Pennsylvania. That result is driven by two factors: (1) the transfer of the General Assistance (GA) population to Medicaid and (2) tax revenues that result from roughly $3 billion of new federal funds that flow into the Pennsylvania economy.

Due to the ACA, the analysis assumes that Pennsylvania will lose significant DSH funds. As noted in Section 4, it is not clear how those funds will be allocated across DSH categories such as hospitals and institutions for mental disease. The hospital DSH allotments include uncompensated care for the GA population. The analysis assumes that GA DSH funds will be proportionately reduced with the total DSH reductions that will occur. Hence, under current law, the Commonwealth will need to adjust the funding mechanism for GA care, and the great majority of costs will be borne by the Commonwealth. Under Medicaid expansion, those costs are almost entirely shifted to the federal government. This single outcome drives most of the expenditure savings over the forecast window.

For tax revenues, the analysis assumes that Pennsylvania will levy the 5.9 percent MCO GRT on new federal spending, thereby generating significant revenues. The analysis makes that assumption because it represents current law. However, it is possible that the federal government would disallow states from applying these types of levies, especially when the federal government fully funds new expenditures. Many states levy these taxes in an effort to create additional federal matching funds. Currently, the federal government has not ruled on the status of these levies. The disallowance of the GRT would have a material impact on budgetary outcomes.

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Technical Appendix: Table of Acronyms

ACA	Patient Protection and Affordable Care Act
ACS	American Community Survey (U.S. Census Bureau)
BCCPT	Breast Cancer and Cervical Cancer Prevention Treatment
CAO	County Assistance Offices
CHIP	Children's Health Insurance Program
CPS	Current Population Survey
CY	Calendar Year
DPW	Department of Public Welfare
DSH	Disproportionate Share Hospital (Payments)
FPL	Federal Poverty Line/Level
FMAP	Federal Match Assistance Percentage
FY	Fiscal Year
FYE	Fiscal Year Ending
GA	General Assistance
GRT	Gross Receipts Tax
IFO	Independent Fiscal Office
MA	Medical Assistance
MAGI	Modified Adjusted Gross Income
MAWD	Medicaid Assistance for Workers with Disabilities
MCO	Managed Care Organization
SSI	Supplemental Security Income
TANF	Temporary Aid to Needy Families

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Technical Appendix: Change in State and Federal Expenditures Under Medicaid Expansion

$ millions

	2014	2015	2016	2017	2018	2019	2020	2021
1. Uninsured Adults								
No Expansion								
Federal (exchange)	$309	$426	$551	$573	$595	$624	$653	$684
State	0	0	0	0	0	0	0	0
Expansion								
Federal	647	893	1,154	1,111	1,136	1,171	1,166	1,221
State	0	0	0	89	111	135	202	212
2. Insured Adults								
Federal	507	701	910	898	922	947	952	988
State	0	0	0	47	59	71	106	110
3. Uninsured Adults, Currently Eligible								
No Expansion								
Federal	19	27	34	36	37	39	40	42
State	16	22	29	30	31	33	34	36
Expansion								
Federal	11	15	19	20	21	22	23	24
State	9	13	16	17	18	18	19	20
4. Uninsured Children								
No Expansion								
Federal	44	65	98	103	107	107	97	102
State	27	34	32	33	35	41	59	61
Expansion								
Federal	15	20	27	28	29	31	32	33
State	12	17	22	23	25	26	27	28
5. Insured Children								
Expansion - CHIP Transfers								
Federal	19	26	34	35	36	38	39	41
State	16	22	28	29	30	32	33	34
Expansion - Employer and Private								
Federal	14	16	21	22	22	22	18	19
State	7	6	2	2	2	4	8	9
6. General Assistance Transfer								
Federal	533	554	574	580	636	651	650	673
State	0	0	0	36	46	55	81	84
State Savings	-533	-554	-574	-616	-682	-706	-731	-757
Gross Federal Expenditures	**2,118**	**2,744**	**3,422**	**3,403**	**3,543**	**3,651**	**3,670**	**3,827**
Gross State Expenditures	**-447**	**-441**	**-445**	**-309**	**-326**	**-291**	**-162**	**-163**
7. Manufacturer Drug Rebate								
No Expansion								
Federal	-5	-8	-10	-10	-11	-11	-12	-12
State	-1	-1	-2	-2	-2	-2	-2	-2
Expansion								
Federal	-9	-12	-16	-16	-16	-17	-17	-18
State	0	0	0	-1	-1	-1	-2	-2

Technical Appendix Table (Continued…)

	2014	2015	2016	2017	2018	2019	2020	2021
8. SelectPlan-Foster Care-MAWD/BCCPT								
Federal	$6	$9	$11	$12	$12	$13	$13	$14
State	7	9	12	13	13	13	14	15
9. Mental/Behavioral Health								
No Expansion								
Federal	0	0	0	0	0	0	0	0
State	-4	-4	-4	-4	-5	-5	-5	-5
Expansion								
Federal	0	0	0	0	0	0	0	0
State	-37	-38	-39	-40	-41	-42	-43	-44
10. Medicare Rates for Primary Care Services								
No Expansion								
Federal	0	0	0	0	0	0	0	0
State	0	0	0	0	0	0	0	0
Expansion								
Federal	0	248	276	279	287	295	300	310
State	0	149	155	164	170	176	184	190
11. General DSH Savings								
No Expansion								
Federal	-2	-2	-2	-2	-2	-2	-2	-2
State	-2	-2	-2	-2	-2	-2	-2	-2
Expansion								
Federal	-22	-22	-22	-22	-22	-22	-22	-22
State	-18	-18	-18	-18	-18	-18	-18	-18
12. Personnel and Administration								
No Expansion								
Federal	3	3	4	5	5	5	5	5
State	3	3	4	5	5	5	5	5
Expansion								
Federal	24	31	40	41	42	44	46	48
State	24	31	40	41	42	44	46	48
13. Information Technology								
No Expansion								
Federal	45	52	14	14	14	0	0	0
State	5	7	5	5	5	0	0	0
Expansion								
Federal	5	6	2	2	2	0	0	0
State	1	1	1	1	1	0	0	0
TOTAL FEDERAL - Expansion	**2,162**	**3,048**	**3,718**	**3,704**	**3,853**	**3,956**	**3,982**	**4,149**
TOTAL STATE - Expansion	**-471**	**-304**	**-294**	**-149**	**-159**	**-123**	**16**	**21**
Addendum: Incremental Impacts								
Federal								
No Expansion	412	564	689	716	745	761	782	819
Expansion	1,750	2,485	3,029	2,988	3,108	3,194	3,200	3,330
Pennsylvania								
No Expansion	43	60	62	64	67	70	89	93
Expansion	-514	-364	-356	-213	-226	-193	-73	-72

Technical Appendix: Take-up Rate Comparisons

Group	Age	Insurance Status	Eligibility	Applicable FMAP	Scenario	Take-Up Rate[1]		
						Kaiser[2]	Lewin[3]	IFO
1	Adult	Uninsured	New	Enhanced	No Expansion	n.a.	n.a.	0% / 75%[4]
		Uninsured	New	Enhanced	Expansion	74%	77%	75% / 75%[4]
2	Adult	Employer	New	Enhanced	Expansion	11%	40%	20%
		Private	New	Enhanced	Expansion	85%	40%	70%
3	Adult	Uninsured	Current	Regular	No Expansion	40%	22%	30%
		Uninsured	Current	Regular	Expansion	40%	22%	50%
		Employer	Current	Regular	Expansion	4%	n.a.	5%
		Private	Current	Regular	No Expansion	69%	n.a.	40%
		Private	Current	Regular	Expansion	69%	n.a.	60%
4	Children	Uninsured	Current	Regular	No Expansion	n.a.	n.a.	40% / 75%[5]
		Uninsured	Current	Regular	Expansion	n.a.	n.a.	75% / 75%[5]
5	Adult	GA	New	Enhanced	Expansion	n.a.	n.a.	100%
6	Children	Employer	Current	Enhanced	Expansion	n.a.	n.a.	13%
		Private	Current	Enhanced	Expansion	n.a.	n.a.	14%

1 Other studies generally do not provide separate take-up rates for children. It is not clear whether other studies counted exchange coverage for individuals between 100%-138% FPL when computing incremental federal funds that flow into the state economy.

2 Kaiser Commission on Medicaid and the Uninsured, November 2012.

3 The Lewin Group study performed on behalf of New Hampshire, November 2012.

4 Uninsured adults who receive coverage under the No Expansion scenario receive coverage through the exchange. Only impacts adults with income between 100%-138% FPL who have same outcomes under both scenarios. Expansion scenario only impacts uninsured adults <100% FPL. Dual rates pertain to adults with income (1) between 0%-100% FPL and (2) 100%-138% FPL.

5 Children with family income between 100%-138% FPL assumed to receive free CHIP. Analysis assumes same coverage outcomes under both scenarios for that group. Dual rates pertain to children with income (1) between 0%-100% FPL and (2) 100%-138% FPL.