The Colorado Health Foundation™

Medicaid Expansion:

Examining the Impact on Colorado's Economy

Prepared for the Colorado Health Foundation by
Charles Brown Consulting, Inc.

Acknowledgements

The Colorado Health Foundation would like to thank the members of the Project Team and Advisory Committee for their assistance and guidance on this project.

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About the Colorado Health Foundation

The Colorado Health Foundation works to make Colorado the healthiest state in the nation by increasing the number of Coloradans with health insurance; ensuring they have access to quality, coordinated care; and encouraging healthy living. The Foundation invests in the community through grants and initiatives to health-related nonprofits that focus on these goals, as well as operating medical education programs to increase the health care workforce. For more information, please visit ***www.ColoradoHealth.org.***

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I. Introduction

The Patient Protection and Affordable Care Act (ACA) was signed on March 23, 2010. The legislation was challenged on grounds of constitutionality and ultimately made it to the United States Supreme Court. In the National Federation of Independent Business v. Sebelius (NFIB) case, on June 28, 2012 the Supreme Court upheld the constitutionality of most provisions of the ACA. The one part of the ACA the Supreme Court ruled unconstitutional was the requirement that states expand their Medicaid programs in accordance with the ACA's provisions or lose all federal funding for their existing Medicaid programs. The ruling effectively made Medicaid eligibility expansion to 138% of Federal Poverty Level (FPL) optional for states.

The Colorado Health Foundation engaged Charles Brown Consulting, Inc. to conduct an analysis of the full economic and state budgetary impacts to Colorado of the state's decision to either fully expand Medicaid eligibility in accordance with ACA or maintain its current Medicaid eligibility. An advisory group made up of health policy, business and economic experts provided guidance and input to the analysis.

This comprehensive study of the impact of Medicaid expansion in Colorado consists of two related studies: an assessment of the impact of expansion on the Colorado economy and an examination of the impacts of expansion on the Colorado state government's budget, with special focus on the state General Fund. The two studies are related in that the budgetary study results in outcomes provided as inputs, among others, to the economic study.

Underlying State and Federal Medicaid Policy Developments

HHS Ruling on Partial Medicaid Expansion: On December 10, 2012 the U.S. Department of Health and Human Services (HHS) ruled that states that pursue any policy other than full expansion of Medicaid eligibility to 138% of FPL would not be eligible for the enhanced federal match rates for expansion populations. Although numerous state-level studies completed prior to the decision were based on the assumption that the enhanced federal match would apply for partial expansions, the ruling rendered a partial expansion option no longer financially viable for Colorado. Therefore, only no expansion and full expansion to 138% of FPL were examined. [1]

Enhanced Federal Match for Medicaid Expansion: Colorado's current federal match for most Medicaid expenditures is 50%. If Colorado expands federal coverage to the standards of the ACA, the federal government will pay 100% of costs of newly eligible populations in 2014 through 2016, a rate that gradually declines to 90% in 2020 and subsequent years. Because Colorado already covers some groups considered expansion populations, it will receive that higher federal match for those populations it already covers, but as per the December 2012 HHS decision, only if it fully expands coverage in accordance with ACA.

[1] The ACA standardizes measures across states of what counts as income and establishes a 5% income disregard for eligibility determination purposes. A household with income of 138% of FPL will be treated as having income of 133% FPL, the official ACA income threshold for Medicaid eligibility. 133% FPL and 138% FPL both appear in the literature. This analysis used 138% FPL for consistency because it is the effective income threshold.

House Bill 09-1293 Eligibility Expansion: In 2009 the Colorado General Assembly passed HB 09-1293 which assessed a provider fee on hospitals to supplement Medicaid payment rates to hospitals and expand coverage to several additional populations including parents of eligible children from 60% to 100% of FPL and Adults without Dependent Children (AwDC) up to 100% FPL, contingent upon adequate revenue. In September 2011 the Colorado Department of Health Care Policy and Financing determined Hospital Provider Fee revenues were not adequate to expand eligibility to all AwDCs to 100% FPL and capped enrollment at 10,000 AwDCs up to 10% of FPL. This analysis assumes Medicaid eligibility will not be raised beyond this cap in the "No Expansion" scenario, although there is statutory authorization to do so.

ACA Impacts on Medicaid Enrollment without Expansion: The ACA contains numerous provisions that will increase enrollment of those who meet current Medicaid eligibility criteria regardless of whether Colorado expands eligibility. Many state-level analyses of impacts of Medicaid expansion have failed to account for enrollment increases among those currently eligible that will take place regardless of a state's decision to expand eligibility, thus overstating costs attributable to the expansion decision. This analysis attributes only enrollment growth associated with the expansion decision to Medicaid expansion and not that enrollment increase induced by ACA that will take place without eligibility expansion.

The ACA's provisions also reduce state costs for the Children's Basic Health Program (CBHP) for children and pregnant women at incomes above 138% FPL through an enhanced federal match rate and the likelihood that many of those who qualify for CBHP will purchase federally-subsidized exchange based insurance instead. Such enrollments and costs, however, are also not affected by Colorado's Medicaid expansion decision and not considered in this analysis.

Tax Changes Under ACA: The tax policy and Medicare policy changes that help fund the ACA will take place regardless of whether Colorado expands Medicaid coverage. Thus, if Colorado does not expand Medicaid coverage Colorado residents will still be subsidizing Medicaid expansion in those states that do expand without the state receiving the benefit of additional federal funding for Medicaid. Because federal taxes are the same under both the no expansion and full expansion options, this analysis treats new federal funds coming into the state as a net gain for Colorado in comparing economic impacts between expanding Medicaid coverage or maintain current eligibility levels.

Exchange Insurance Eligibility 100% to 138% FPL: Persons who are eligible for Medicaid or for employer-sponsored health insurance that is considered affordable at their income levels will not be eligible for federal subsidies to purchase health insurance through state exchanges. Thus, if Colorado expands Medicaid eligibility to 138% FPL only a small part of the population in that income range, primarily recent legal immigrants who would not be eligible for Medicaid, would qualify for subsidies for exchange-purchased insurance. If Colorado does not expand coverage, however, most residents in that income range would qualify to purchase insurance at the "silver"[2] level at 2% of their income. They

[2] Qualified plans that participate in health insurance exchanges will be required to offer a uniform benefit package at four levels of value ranging from Bronze, with benefits equal to 60% of full actuarial value of plan benefits, to Platinum, with benefits equal to 90% of full value. Income-based premium-assistance credits for qualified individuals up to 400% FPL will relate to the value of

would also be eligible for cost-sharing subsidies that would in total, cover 94% of their health care expenses on average. Because people in that income range are not subject to a federal penalty for not having insurance and because they would experience somewhat higher costs than if enrolled in Medicaid, take-up rates of exchange-purchased insurance are forecast to be about one-third lower than if those at that income were Medicaid eligible, resulting in a higher number of uninsured in Colorado.

Although there would be no state costs associated with those in the 100% to 138% FPL income range purchasing exchange insurance, this analysis includes estimates of the enrollment and value of federal subsidies for exchange-purchased insurance for the population in that income range for the purpose of the economic impact analysis.

Reduction in Disproportionate Share Hospital Payments: Because the ACA is designed to reduce the number of uninsured, it statutorily reduces Medicaid Disproportionate Share Hospital (DSH) Payments (funding for hospitals which treat large numbers of uninsured indigent patients). Colorado matches those federal payments dollar-for-dollar. The annual DSH payment reductions will occur regardless of whether Colorado expands Medicaid eligibility and reduces its uninsured population, although HHS has not yet disclosed how DSH funds will be allocated between states and to what degree those payments will relate to the remaining uninsured population in states. In this analysis the DSH funding Colorado will receive is based on a model that relates to the state's remaining uninsured population relative to the nation, which is impacted by the state's Medicaid expansion decision.

Enrollment and Cost Estimates

Enrollment and cost per enrollee forecasts included in this analysis closely follow assumptions used by the Congressional Budget Office (CBO) in its original analysis of the ACA[3] and in its July 2012 analysis of the ACA after the Supreme Court's ruling making Medicaid expansion optional for states[4], essentially applying CBO national assumptions to Colorado's population and Medicaid cost structure. The assumptions incorporated in these analyses include significant changes to insurance markets that result from changes to economic incentives to employers and individuals to take up or drop insurance coverage due to the ACA's provisions. These incentives significantly change the pool of people who will be eligible for Medicaid coverage in the years ahead relative to the past for both those who meet current eligibility criteria and those who would become eligible under expansion.

Some provisions of the ACA will result in an increase in take-up rates of employer-sponsored insurance. The CBO estimated the ACA's provisions will lead approximately 7 million people who had not been previously enrolled to take up employer-sponsored insurance. These provisions include:

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a benchmark Silver plan with benefits equal to 70% of full value. Those with incomes under 250% FPL will also be eligible for cost-sharing subsidies to help cover the out-of-pocket expenses in a Silver plan.

[3] Elmendorf, Douglas W. (March 30, 2011), "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010", Congressional Budget Office

[4] "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision", Congressional Budget Office, July 2012

- Employed people with access to employer-sponsored insurance who have not been participating because of the employee cost-share of premiums will be induced to do so to avoid paying the tax penalty included with the "individual mandate" in the ACA.
- Federal subsidies for small businesses to provide insurance to employees through small business health insurance exchanges will reduce coverage costs for some employers and lead some small businesses that had not been providing employer-sponsored insurance to begin offering it to employees.
- The requirement that young adults up to age 26, an age group that has included many who are uninsured and are low-income because they are part-time or full-time students, be covered on their parents' policies will lead many to take up such employer-sponsored insurance coverage.

Meanwhile, the CBO estimated that approximately 5.5 million people will lose employer sponsored insurance nationally as a direct result of the ACA's provisions. Although the CBO made no state-level estimates, their assumed national rate applied to Colorado's population would estimate about 90,000 losing employer-sponsored insurance. The ACA provisions that affect this include:

- Guaranteed issue of insurance may lead some employers to feel employer-sponsored insurance is less necessary since employees cannot be excluded from purchasing insurance individually because of preexisting conditions.
- Federal subsidies for exchange-purchased insurance and Medicaid expansion may lead some employers to feel employer-sponsored insurance is unnecessary since employees will be able to be insured affordably individually or through Medicaid.
- The mandate for employers to provide comprehensive health insurance to employees or pay a $2,000 fine, increasing over time with consumer price index, may lead some to choose to pay the fine rather than the higher cost of insurance.
- The mandate for employers to provide insurance or pay a fine may lead some employers to reduce hours since the mandate and fine provisions do not apply to those employed on a part-time basis. Reduced hours will tend to depress incomes for such workers and lead to more employed people meeting Medicaid eligibility income criteria.

The overall net impact of these economic incentives on employer and individual choices as they relate to insurance will be to enlarge the pool of lower-income people who will meet both current and expanded eligibility criteria for Medicaid. Accounting for these changes to employer-sponsored insurance availability for lower-income workers is a likely reason this analysis forecasts somewhat higher Medicaid enrollment for both currently eligible and expansion populations than have some other analyses.

Enrollment estimates were derived using several methodologies including analyses of Census Bureau 2010 and 2011 American Community Survey (ACS) data on household composition, income, employment, and insurance type, comparisons of enrollments relative to poverty level in the small number of states that provide Medicaid coverage to Adults without Dependent Children without enrollment caps (New York, Vermont, Massachusetts), and an attempt to be consistent with enrollment forecasts in studies done in other states with similar percentages of population below or near FPL.

Table 1 displays the forecast for enrollment eligibility increase with full Medicaid expansion, without Medicaid expansion, and the difference that represents the effect of expansion for FY 2025-26, the final year included in this analysis.

Table 1
Additional ACA Medicaid Enrollment under Different Expansion Scenarios, FY 2025-26

Enrollment Category	No Medicaid Expansion	Full Medicaid Expansion	Impact of Medicaid Expansion
Currently Eligible Children	27,805	44,551	16,746
Currently Eligible Parents to 60% FPL	8,545	12,761	4,216
Currently Eligible Parents 60% to 100% FPL	4,637	6,245	1,608
Newly Eligible Parents 100% to 138% FPL	0	43,983	43,983
Newly Eligible Adults without Dependent Children to 100% FPL	0	160,728	160,728
Newly Eligible Adults without Dependent Children 100% to 138% FPL	0	47,784	47,784
Total	**40,986**	**316,052**	**275,066**

The significant increase in Medicaid enrollment among those who meet current eligibility criteria both with and without eligibility expansion may look somewhat surprising but can be attributed to a number of factors:

- The individual mandate to be insured.
- Those exploring exchange insurance who will be determined eligible for Medicaid instead.
- Increased use of part-time employees ineligible for employer-sponsored insurance by employers.
- Reduction in employer-sponsored insurance in response to the ACA's other provisions.

The last of the four contributing factors would be expected to take place to a somewhat greater degree under full Medicaid expansion than non-expansion since full expansion does not leave a so-called "doughnut hole" – part of the employed population without access to health insurance, a factor likely to make some employers reluctant to not provide employer-sponsored insurance. A fifth factor affecting enrollment of those currently eligible will also play a small role under full expansion:

- Increased enrollment of eligible children 100% - 138% FPL due to ease of insuring an entire family together under Medicaid when the income eligibility is the same for parents and children

Enrollments of newly eligible and currently eligible but not enrolled persons are projected to increase rapidly through FY 2014-15 and then more gradually to maturity through FY 2017-18. From FY 2018-19 onward enrollments are projected to increase at the rate of growth of respective populations in the state. Enrollment of newly eligible and currently eligible but not enrolled persons will likely fluctuate

upwards or downwards with economic conditions through FY 2025-26, but it is not possible to forecast when future economic downturns will take place.

Cost/Enrollee Estimates

Cost estimates for additional Medicaid enrollees are based on actual costs of similar populations of those currently enrolled in Medicaid for currently eligible but not enrolled parents and children and for newly eligible parents 100% to 138% FPL. Costs of newly eligible adults without dependent children are estimated based on similar populations in several states – New York, Vermont, and Massachusetts – that currently extend Medicaid coverage without enrollment caps to such persons up to either 100% or 138% FPL.

Costs per Medicaid enrollee are forecast to grow by 5.5% annually through FY 2025-26 as forecast for the nation by the CBO in its March 2012 baseline spending and enrollment detail[5]. The annual long-term growth rate reflects about 1.6% annual excess spending growth above nominal per capita Gross Domestic Product (GDP) growth, an estimate which is explained in the CBO's 2012 Long Term Budget Outlook Report[6]. Although states have some control over Medicaid costs through the rates they pay providers, the CBO's national cost growth estimates for Medicaid appear realistic over the long-term if Colorado is to maintain access to health care services for its Medicaid enrollees in an environment of technology-driven cost increases in health care (cost associated with innovations in medical treatments and technologies). Proposed state policies designed to drive efficiencies in health care delivery for Colorado's Medicaid enrollees may impact the long-term rate of spending growth but are not analyzed in this report.

Currently eligible but not enrolled children and parents: New enrollment of children and parents who meet current eligibility criteria are projected to have average costs that are 75% to 85% of currently enrolled populations of the same income and age levels. These estimates reflect that additional enrollment will include both those who have been eligible all along and not enrolled, who would be expected to have better health status and lower costs than those who have chosen to enroll, and those who enroll because of loss of access to employer-sponsored insurance, who are likely on average to have health status and costs similar on average to current enrollees of similar age and income.

Newly eligible parents 100% TO 138% FPL: Newly eligible parents 100% to 138% FPL are forecast to have average per/enrollee costs 95% of the average of currently enrolled parents in the 60% to 100% FPL range. This reflects experience with Medicaid parents in Colorado; with each Medicaid eligibility expansion to a higher income level for parents those in the higher income group experience somewhat lower costs on average than the income group below it.

Newly eligible adults without dependent children to 138% FPL: Many states, including Colorado, currently cover some adults without dependent children under federal Medicaid waivers, generally with a capped enrollment. In 2012 Colorado began covering up to 10,000 AwDCs with incomes up to 10% FPL

[5] – "Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline", Congressional Budget Office, March 2012

[6] "The 2012 Long-Term Budget Outlook", Congressional Budget Office, June 2012

at an average FTE cost of over $11,000/enrollee. However, programs with capped enrollments are unlikely to be good indicators of average cost of the broader population likely to enroll when eligibility is opened to all people with incomes to 138% of FPL. Cost estimates for AwDCs up to 100% FPL, excluding the 10,000 (up to 10% FPL) currently covered, and the AwDCs from 100% to 138% FPL were developed from comparisons of costs for Medicaid-enrolled AwDCs relative to Medicaid parents at similar FPL ranges from three states that have already extended Medicaid coverage to AwDCs without capped enrollment – New York, Vermont, and Massachusetts.

Table 2 displays projected average cost per new enrollee for enrollment groups affected by Medicaid expansion in FY 2014-15, the first full FY after expansion in the study. As discussed above, cost/enrollee is projected to grow by 5.5% annually. Although it appears likely that cost/enrollee figures may be somewhat higher in the initial 18 months after expansion as those with significant health conditions will tend to enroll more rapidly upon becoming eligible than those with better health status, we did not adjust cost/enrollee upwards in FY 2013-14 and FY 2014-15 to reflect this possibility.

Table 2
Average Cost per New Enrollee FY 2014-15

Medicaid Enrollment Population	Average Cost/Enrollee, FY 2014-15
Currently Eligible Children to 100% FPL & Children Age 0 - 5 to 138% FPL	$1,423
Currently Eligible Children Age 6 – 17 100% to 138% FPL	$1,529
Currently Eligible Parents to 60% FPL	$3,590
Currently Eligible Parents 60% to 100% FPL	$2,711
Newly Eligible Parents 100% to 138% FPL	$3,030
Newly Eligible Adults without Dependent Children to 100% FPL	$5,760
Newly Eligible Adults without Dependent Children 100% to 138% FPL	$3,840

Uninsured Population

One of primary purposes of the ACA is to reduce the number of uninsured and underinsured Americans. Recent estimates indicate Colorado has nearly 800,000 residents without health insurance[7], approximately 17 percent of its non-elderly population. The ACA's provisions of guaranteed insurance issue and tax credits/subsidies for purchasing health insurance in exchanges are expected to significantly reduce the number of uninsured Coloradans even if the state does not expand Medicaid eligibility. Without Medicaid eligibility expansion, however, a significantly larger number of Coloradans will remain uninsured than if the state expands Medicaid in accordance with the ACA.

With full Medicaid expansion the number of uninsured non-elderly Coloradans is forecast to drop from 17.0 percent to 7.7 percent by FY 2018-19 and remain fairly steady in subsequent years. The number of uninsured, however, would only drop to 11.1 percent by that year if Colorado chooses not to expand

[7]United States Census Bureau, American Community Survey 2011

Medicaid eligibility. By FY 2025-26 Colorado is forecast to have approximately 412,000 uninsured non-elderly residents under full Medicaid expansion but 596,000 uninsured if it does not expand Medicaid eligibility. Because people who fall into the 100% to 138% FPL range would become eligible for federal premium and cost-sharing subsidies for exchange-purchased insurance if Colorado does not expand Medicaid eligibility, most of the additional 184,000 Coloradans who would remain uninsured without expansion are adults without dependent children under 100% FPL.

These estimates of Colorado's remaining uninsured population are consistent with those made by MIT economics professor Jonathan Gruber for the Colorado Health Benefit Exchange[8]. This analysis did not analyze the composition of those remaining uninsured with full Medicaid expansion but the Gruber analysis identifies five main groups:

- Undocumented individuals ineligible for both Medicaid and exchange subsidies.
- Lower-income people exempt from the penalty associated with the "individual mandate" but ineligible for federal subsidies for exchange-based insurance because their employer offers health insurance.
- Low-income people eligible for Medicaid who are exempt from the individual mandate penalty and choose not to enroll.
- Those subject to the individual mandate who will choose to pay the penalty rather than purchase insurance.
- Newly unemployed people who lose employer-sponsored insurance and are effectively not subject to the individual mandate penalty because it does not apply to those uninsured for less than three months.

Without full Medicaid eligibility expansion the additional category of those remaining uninsured in Colorado will be:

- Adults without dependent children to 100% FPL who are neither eligible for Medicaid nor to receive federal subsidies for Exchange-purchased insurance and are not subject to the individual mandate

[8] Gruber, Jonathan, "Background Research to Support the Development of the Colorado Health benefit Exchange", January 2012

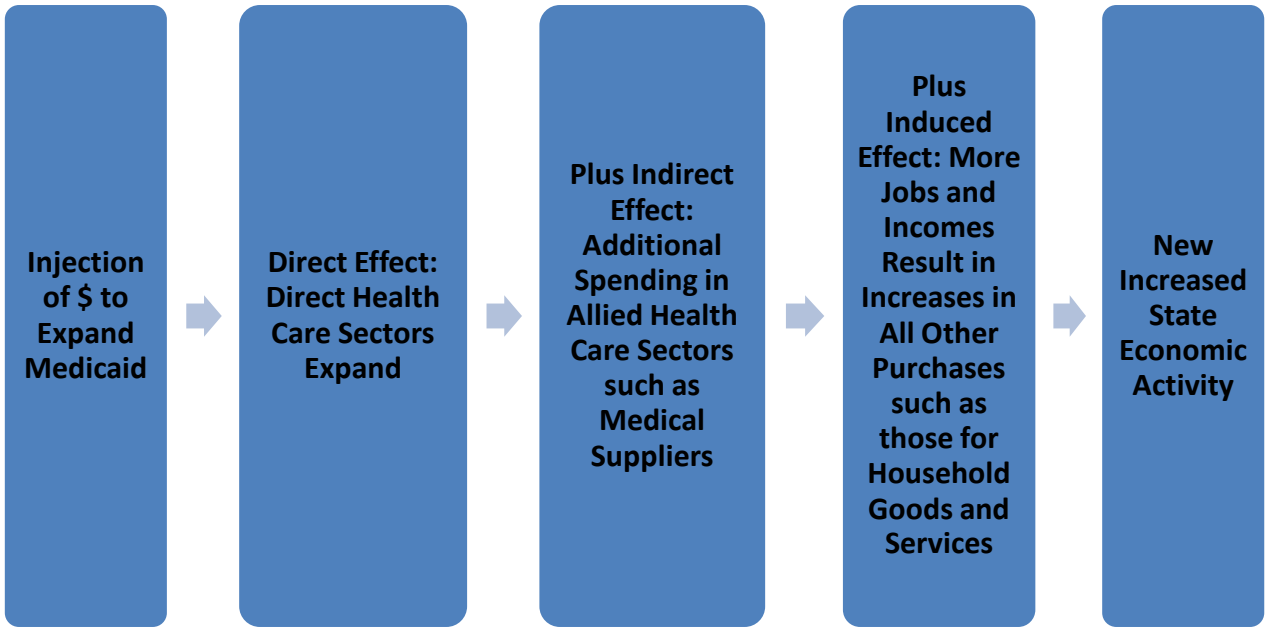
II. Assessing the Economic Impacts of Medicaid Expansion

Methodology

Economic impacts occur when a policy change results in a change in patterns and/or levels of spending within an economy. In the case of Medicaid expansion, both levels and patterns of spending will change with a decision for full expansion. Levels will change largely because of the large infusion of federal dollars to support expansion populations and spending patterns will change as the state and households, through their respective budgets, rededicate spending in response to the requirements and incentives provided by Medicaid expansion.

Multiplier analysis quantifies the direct, indirect, and induced effects of an infusion or redirection of additional dollars into a state or regional economy. In the case of Medicaid expansion, the initial infusion is spent by health care providers and a direct spending effect is created. The impact on economic activity does not end, however, with the direct payment to health care providers. Instead, the increased demand for medical services also creates a demand for health supplies and other allied health care spending. This secondary health care spending is referred to as the indirect effect. In the case of direct and indirect health care spending, much of the spending is made within the state and local economy, resulting in higher employment levels and household incomes for those in the health care and allied health care sectors. When health care related workers spend additional income on household related purchases, they create an induced effect by creating demand for items such as restaurant meals, consumer goods and personal services. As a result, workers in those induced sectors have additional income and employment opportunities, and the cycle continues. This process is referred to as the multiplier effect and the full quantification of that effect measures the economic impact of a policy decision such as Medicaid expansion. Figure C depicts this effect. In the case of Medicaid expansion in Colorado, much of the direct injection of spending into the economy is the result of federal funds flowing into the state.

Figure C
The Multiplier Effect from Public Investment



There are several different tools that combine the direct, indirect, and induced effects to quantify the overall impact of public and private investments. For this analysis of the economic impact of Medicaid expansion in Colorado, the Regional Input-Output System II (RIMS II) created by the Bureau of Economic Analysis (BEA) of the United States Department of Commerce was used. This methodology has been widely used for approximately 40 years to assess economic impacts at the regional, state, and local levels of government throughout the United States.

Regional Input Output Modeling System (RIMS II)

In order to gauge the economic impact of the Medicaid expansion decision, it is necessary to account for both the spending impacts that expand the state economy, predominately the large infusion of federal dollars to support expansion, as well as those that contract it. Among the factors causing offsetting or contractionary economic impacts are the reductions in spending in the portions of state and federal programs that will no longer be necessary once Medicaid is expanded and the drag to the economy from the financing of the state share of the costs for expansion populations. To better account for all the changes in spending patterns, we report the net economic impact as measured by the expansionary effect less the contractionary effect.

The economic analysis evaluated the effect of full Medicaid expansion in comparison to a baseline of full implementation of all other aspects of the ACA except for Medicaid expansion. The economic impacts reported are the marginal impacts over the "no Medicaid expansion but implementation of all other aspects of the ACA" scenario. As explained in the budget analysis section, the "no expansion" scenario still assumes some expansion in Medicaid coverage as currently eligible but not enrolled populations take up Medicaid coverage. The spending associated with that take-up of coverage has positive

economic effects, and those effects will occur regardless of the expansion decision. So, the economic impact we attribute to Medicaid expansion is the difference between the "no expansion" state of the world and a policy decision to fully expand Medicaid

The RIMS II Multipliers in More Detail

The RIMS II dataset includes two different classes of multipliers, "direct effect" multipliers and "final demand" multipliers. The available data drives the selection of the appropriate class. In the case of Medicaid expansion, the data represent the change in final demand for health care services associated with serving those newly enrolled in Medicaid. These data come largely from the analysis of the budgetary impacts of Medicaid expansion for which we estimated the increased enrollment in the program and the per-enrollee cost, essentially an estimate of the dollar value of the final demand for medical services resulting from a decision to expand Medicaid. Therefore, for this analysis, we used "final demand" multipliers.

For each class there are also two types of multipliers: Type I and Type II. Type II multipliers are more commonly utilized because:

> These multipliers not only account for the direct and indirect impacts based on how goods and services are supplied within the region, but they also account for the induced impacts based on changes in the spending of earnings by labor within the region.[9]

For health care related expenditures, it is particularly important to use multipliers that include the impact of the earnings of labor within the analysis because many health care jobs are relatively high paying, primary to the region, and generally result in earnings of labor being re-spent locally. The Type II final demand health care related multipliers, used to quantify the impact on output (Gross Domestic Product or GDP) in the Colorado economy, employment in the Colorado economy, and household earnings for Colorado households are presented in Table 3.

Table 3
RIMS II Statewide Multipliers for Health Care Related Spending

	Output	Employment	Earnings
Hospitals	2.3384	17.9788	0.7876
Ambulatory Health Services	2.2471	19.2284	0.879

These multipliers are interpreted in the following way. Every dollar spent on hospitals increases the total output of the Colorado economy, as measured by GDP, by $2.34 as that investment cycles through the economy. The employment column presents the number of jobs that are created by each $1 million of hospital spending and the earnings column the amount of additional household earnings created by each dollar of hospital spending. So, for example, if $1 million were introduced into the hospital sector

[9] Bureau of Economic Analysis, "Regional Multipliers: A User Handbook for the Regional Input-Output Modeling System (RIMS II)," *Department of Commerce* (Third Edition, 1997).

in Colorado, it ultimately would create $2.34 million in state GDP ($1 million x 2.3384 output multiplier), 17.979 jobs ($1 million/$1 million x 17.9788 employment multiplier), and $787,600 in additional household earnings ($1 million X 0.7876 earnings multiplier). The same reasoning applies for ambulatory health services.

Medicaid expansion, however, creates a demand for service that does not fit perfectly into any particular category of health care spending. A representative Medicaid participant will use both hospital and ambulatory services, as well as create a small additional administrative burden on the system. To account for this, we created a blended multiplier that better represents the pattern of spending for a Medicaid participant.

In addition, we estimate that the decision to expand Medicaid will have some effect on participation in the health insurance exchanges created by the ACA. Exchange enrollees who qualify financially are eligible for federal subsidies for premium and cost sharing support. The federal dollars associated with exchange subsidies also will have economic impacts, but be characterized by a slightly different blended multiplier. The blended multipliers for Medicaid and Exchange spending are presented in Table 4.[10]

Table 4
Blended RIMS II Colorado Multipliers for Medicaid and Exchange Spending

	Output	Employment	Earnings	Blend Ratio
Medicaid	2.2697	19.2289	0.8463	30% Hospital, 65% Ambulatory, 5% Administrative
Exchange	2.2601	19.9798	0.8358	30% Hospital, 55% Ambulatory, 15% Administrative

Finally, other changes in spending patterns will result from a decision to expand Medicaid. The first of these is the increased demand for services of those who administer Medicaid programs at the state and county levels (note this is different than the health care administration captured in the blended multipliers above). The increased state administration is characterized by the RIMS II multiplier for administrative and support services. In addition, there will be changes in the pattern of household spending as a result of Medicaid expansion. Some newly Medicaid eligible households that previously were contributing to their health care expenses from their household budget now will have freed up household budget to dedicate to household purchases. This change in household spending will be characterized by a reduction in household spending on health care and an increased offsetting expenditure on other household spending. The contraction in household health care spending will create a drag on the economy that offsets the economic expansion associated with Medicaid spending

[10] The administrative component of the blended multipliers is from the RIMS II final demand multipliers for administrative and support services. Their values are as follows:

- Output – 2.151
- Employment -26.7371
- Earnings – 0.7739

for these newly eligibles. This economic contraction is characterized by the blended Medicaid multiplier described above. However, the resulting additional household spending on non-health care related goods stimulates the economy according to the household multiplier.

There is one final household impact. As noted in the budgetary analysis, Medicaid expansion is not free. In FY 2020-21, the state net General Fund cost for full expansion will begin to exceed the cost of no expansion. While we cannot predict the exact source of funding for the state share of expansion costs, we conservatively assume that households will bear the burden either through a tax increase or a reduction in state services elsewhere. In the model, the economic drain created by this need to finance the state share is characterized as a reduction in spending on other household goods and is analyzed with the household multiplier.

The final two multipliers used in the analysis, the Administrative and Support Services and Household multipliers are presented in Table 5. Note that the household multipliers are significantly lower than any other used in this analysis. This is because household purchases are most likely to be those that create leakage from the state economy. That is, while health care services are accessed locally and the associated expenditures remain and circulate in the local economy, household goods are increasingly manufactured outside of the Colorado or even the US economy. Therefore an expenditure on a household good is more likely to leak out to other states or nations, reducing the re-spending effect in the Colorado economy.

Table 5
Administrative and Support Services and Household Multipliers

	Output	Employment	Earnings
Administrative and Support Services	2.151	26.7371	0.7739
Household	1.4176	11.814	0.41

Spending Changes Subject to the Multiplier Effect

A decision to expand Medicaid will change the level and pattern on health care spending in Colorado. There are a myriad of spending changes that taken together characterize the fiscal impact of the Medicaid policy change. Some of these spending changes have expansionary effects on the economy, and others have offsetting contractionary effects. In all cases when identifying the changes in level and patterns of spending that will result from Medicaid expansion, we assumed current law. Most notably, this assumption means that the level of federal support for Medicaid expansion will not change and that the split between the General Fund and the Hospital Provider Fee as state funding sources for Medicaid will remain as in the law today. Specifically, we assumed that the Hospital Provider will not fund the state share of Medicaid populations over 100% FPL.

Changes Resulting in Expansionary Effects on the Economy

By far the largest change associated with a decision to expand Medicaid is the increase in direct health care spending for newly eligible Medicaid enrollees. As the budgetary analysis shows, the majority of this spending will be of federal funds that will come to Colorado to support expansion. In the later years of the study, the federal funds will be matched by the state at a rate of 90% federal, 10% state for expansion populations. In addition, expansion populations covered by HB 09-1293 and previously paid for 50% with federal dollars and 50% with state hospital provider fee dollars will transition to the enhanced federal match that ultimately results in a 90%/10% federal/state split. This direct health care spending, whether federal or state funded has an expansionary effect on the economy.

There are other sources of expansionary spending that will result from the Medicaid expansion decision. First, the expansion decision will affect exchange participation. If the state chooses not to expand Medicaid, individuals with incomes between 100% and 138% FPL will be eligible for participation in the exchanges with federal subsidy support. This federal spending has expansionary effects, albeit in different magnitudes due to different patterns of subsidy, in both the no expansion and full expansion models. Additionally, exchange participation will require a small household contribution toward premiums and care. This household health care spending will have an expansionary effect.

Second, increased Medicaid enrollment will drive additional program administration. The increased federal and state spending for Medicaid administration, although very small relative to the direct health care spending, will serve to expand the economy. Also under the expansion scenario, federal funds will flow to the state to cover prisoner hospitalizations for newly Medicaid eligible prisoners. This federal expenditure will be offset by an equal reduction in state spending for prisoner hospitalizations. Finally, newly eligible Medicaid households will have freed up spending power as Medicaid coverage pays for medical care that previously uninsured households paid for out of pocket.

All of these factors, taken together, unambiguously serve to expand the Colorado economy. However, the analysis recognizes that there are offsetting impacts that result from the decision around Medicaid expansion that also contract the economy. In order to fully quantify the net economic impact, we offset the expansionary spending with changes that are contractionary.

Changes Resulting in Offsetting Contractionary Effects on the Economy

Contractionary effects happen mostly from reductions in spending deemed no longer necessary with a decision to expand Medicaid. While these reductions in spending have positive budgetary effects, they have negative economic impacts since reductions in spending serve to shrink the economy. In the models, we accounted for the contractionary effect from reduced federal and state General Fund spending in the following programs (see further explanation in Section III):

- Federal disproportionate share (DSH) and state indigent care (CICP) programs. These programs jointly compensate hospitals for the uncompensated care given to the uninsured. With a reduction in uninsured this funding for uncompensated care will decrease as mandated by the ACA.

- Federal and state spending in community mental health programs. As more Coloradans become Medicaid eligible, their mental health needs will be covered by Medicaid. This will reduce the need for community mental health programs.
- Federal and state spending for alcohol and drug abuse programs. As more Coloradans become Medicaid eligible, their alcohol and drug abuse treatment needs will be covered by Medicaid. This will reduce the need for other state alcohol and drug abuse programs.
- State spending for Colorado's Old Age Pension Health and Medical Program. The Old Age Pension Health and Medical Care Program provides limited medical care for individuals receiving Old Age Pension grants who currently do not qualify for Medicaid. With expansion of Medicaid to adults without dependent children up to 138% FPL, many Coloradans currently receiving medical coverage under this program will qualify for Medicaid, reducing the need in the Old Age Pension Health and Medical Care Program.
- State spending for prisoner hospitalizations. Medicaid expansion will extend coverage to certain incarcerated Coloradans. For those prisoners, off site hospitalizations of prisoners will be covered by Medicaid instead of the Department of Corrections budget.

In the models, state savings from the programs listed above are first captured to support the state's share of the cost of Medicaid expansion. In the early years of the analysis, the state obligation is largely associated with eligible but not enrolled Coloradans enrolling in Medicaid. Since those enrollees are not eligible for the enhanced federal match, the state share of their costs is 50%. In later years, savings are used to support both currently eligible and expansion populations. In the early years of the analysis when savings are more than sufficient to cover the state obligation, excess savings are assumed unspent in the state budget and thus create a contractionary effect on the economy.

For years in which savings elsewhere in the General Fund budget are insufficient to cover the state's share of expansion costs, the model assumes that the General Fund will finance the remainder of the state cost of expansion.[11] There are two options for this General Fund support: cuts elsewhere in the budget or increased revenue though a tax increase. Analytically, either of these options has the result of reducing household spending. The burden of a tax increase ultimately reduces household disposable income and thus spending. Likewise, cuts to the budget, which reduce spending on other programs that benefit Colorado households, will result in households reallocating their budgets, leaving less for general household purchases. Therefore, we modeled the effect of financing the state share of Medicaid expansion with a contractionary reduction in household spending characterized by the household multiplier.

[11] Note that there are other options for financing the state share of expansion, notably the Hospital Provider Fee (HPF). However, current law does not yet permit the HPF to be used to populations over 100% FPL. As such, under the assumption of current law, we assumed that the General Fund would be responsible for the state cost of the expansion populations.

Findings

RIMS II multipliers are available to assess the economic impacts on state GDP, employment, and household income. We assessed the impact of Medicaid expansion on all three. In addition, we recognized that a larger state economy resulting from the infusion of federal dollars supporting Medicaid expansion will yield additional state tax revenue without a tax rate increase. While not directly a multiplier analysis, we also estimated the increase in the major sources of tax revenue to the General Fund.

In all cases, the assessment of the larger economy is relative to a "no Medicaid expansion but full implementation of all other aspects of the ACA" baseline and the future years are stated in non-inflation adjusted or nominal dollars. The economic impact we report is relative to the baseline trend forecast for GDP, employment and household earnings in Colorado. We do not attempt to forecast the business cycle. Under these assumptions, the overall conclusion is as follows:

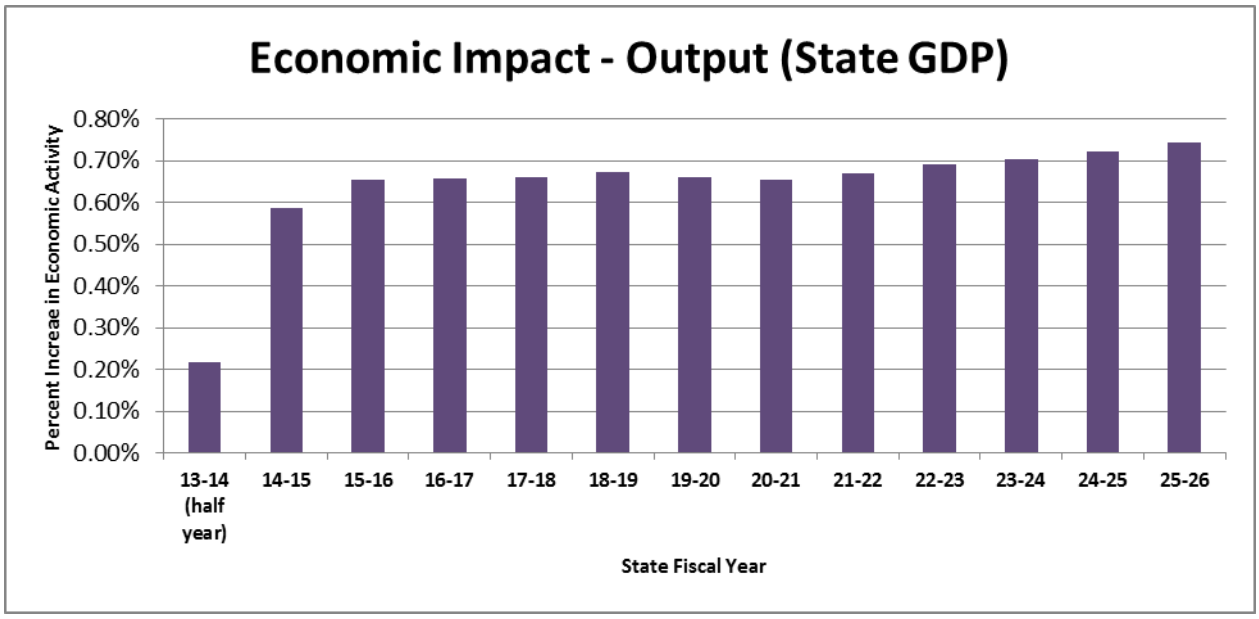
> ***Relative to a baseline of no expansion, the decision to expand Medicaid fully yields a larger Colorado economy, more jobs, and an increase in average household income for all years of the study period.***

The following sections delineate this overall finding in more detail.

With Medicaid Expansion State GDP will be 0.74% Larger in FY 2025-26

Colorado's economy will be larger as a result of a decision to expand Medicaid. The largest discrete impact will happen in the first full year of expansion, FY 2014-15, when the economy will be $2.04 Billion larger than it would have been without expansion. By FY 2025-26, the economy will be $4.39 Billion larger. In those same years, without expansion but accounting for other economic impacts of the ACA, the state GDP is projected to be $348.8 billion and $591.8 billion, respectively. Expanding Medicaid will add a 0.59% positive impact to state GDP in FY 2014-15, growing to a 0.74% impact in the last year of the study, FY 2025-26. Figure D shows the net economic impact of expanding Medicaid.

Figure D
Economic Impact of Expansion on State GDP



Medicaid expansion supports more than just larger state output. The larger economy will also have higher levels of employment and that increased employment will result in higher average household wages.

With Medicaid Expansion Colorado will have 22,388 Additional Jobs in FY 2025-26

As a result of Medicaid expansion, the Colorado will add jobs in each year of the study period. However, the largest impact will occur in the first eighteen months of Medicaid expansion (January 1, 2014 – June 30, 2015) when 14,357 jobs will be created. While we did not directly assess the distribution of these jobs across employment sectors, we estimate that the majority of the jobs will occur in the direct health care and allied health care (for example medical supply) sectors. It is important to note that health care related jobs are less affected by economic cycles and thus the jobs created as a result of Medicaid expansion are likely ones that will persist, even if the economy were to go into recession.

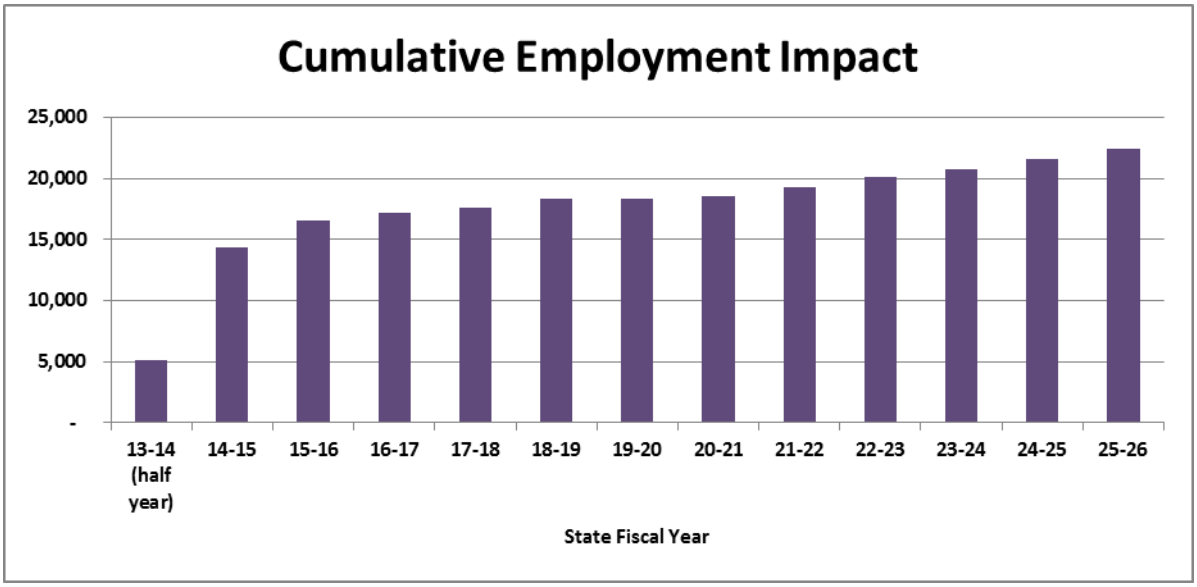
The latest forecasts for Colorado employment growth from the Legislative Council Staff and the State Office of Planning and Budgeting project job gains of 37,200 and 38,000, respectively in 2014. These baseline forecasts do not assume an impact from Medicaid expansion. Averaging those two 2014 forecasts and assuming an employment growth rate of 2.5%[12] for Colorado for the first half of 2015 yields a baseline forecast of employment growth in Colorado for the eighteen months subsequent to Medicaid expansion of approximately 67,000. While the national forecast may implicitly account for some impact from the ACA, we conservatively estimate that the Colorado employment gains of 14,357 are largely above what has been forecast for Colorado over the same time period. Medicaid expansion

[12] This is consistent with the Moody's Economy.com forecast growth rate for US jobs in 2015.

could result in as much as a 20% increase over projected baseline employment growth in the eighteen months following Medicaid expansion.

Cumulatively over the study period, the jobs created as a result of Medicaid expansion will grow to 22,238. Figure E shows this cumulative effect.

Figure E
Cumulative Employment Gains Resulting from Medicaid Expansion

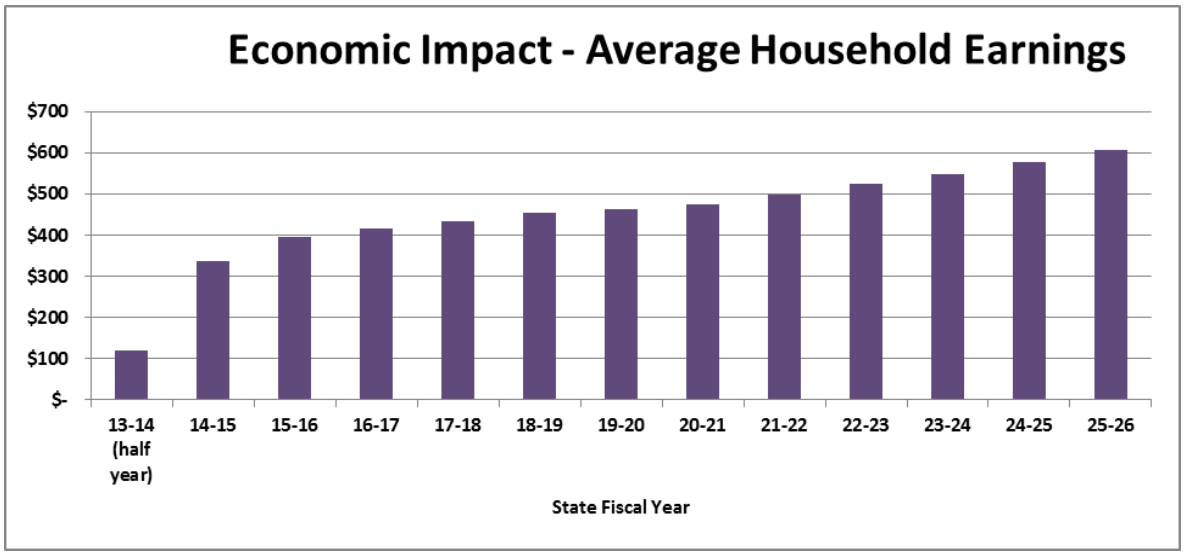


With Medicaid Expansion Average Household Earnings will be $608 Higher in FY 2025-26

The larger economy will also result in an increase in household earnings. The model estimates that in FY 2025-26 household earnings will be, on average, $608 higher as a result of Medicaid expansion. As with employment, we cannot directly assess the distribution of the increase in earnings across Colorado households, but the pattern is likely to follow the pattern of employment gains. Therefore, we believe that the biggest household impact will be for households directly or indirectly employed in health care related fields with the secondary effects accruing to households employed in sectors that serve household needs for goods and services. Figure F shows the average annual increase in household earnings that will result from a decision to expand Medicaid.

Figure F

Annual Increases in Average Household Earnings Resulting from Medicaid Expansion

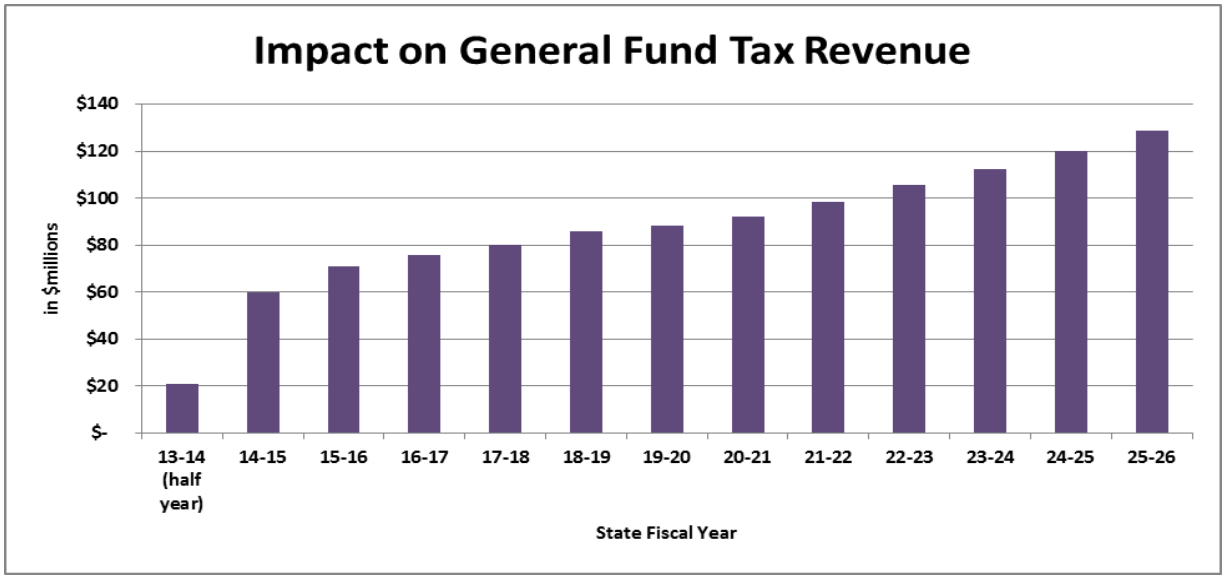


With Medicaid Expansion the Larger Economy Will Result in $128 Million in Additional State General Fund Tax Revenue

There is one final effect of the larger economy that will result from Medicaid expansion. The larger economic base generates additional tax revenue, without an increase in tax rates. We estimate that the four major taxes that fund the General Fund, the individual income tax, the sales tax, the use tax, and the corporate income tax, will together generate an additional $128 Million in FY 2025-26 as a result of the larger economy. Figure G shows the incremental General Fund tax revenue that will result from a decision to expand Medicaid.

Figure G

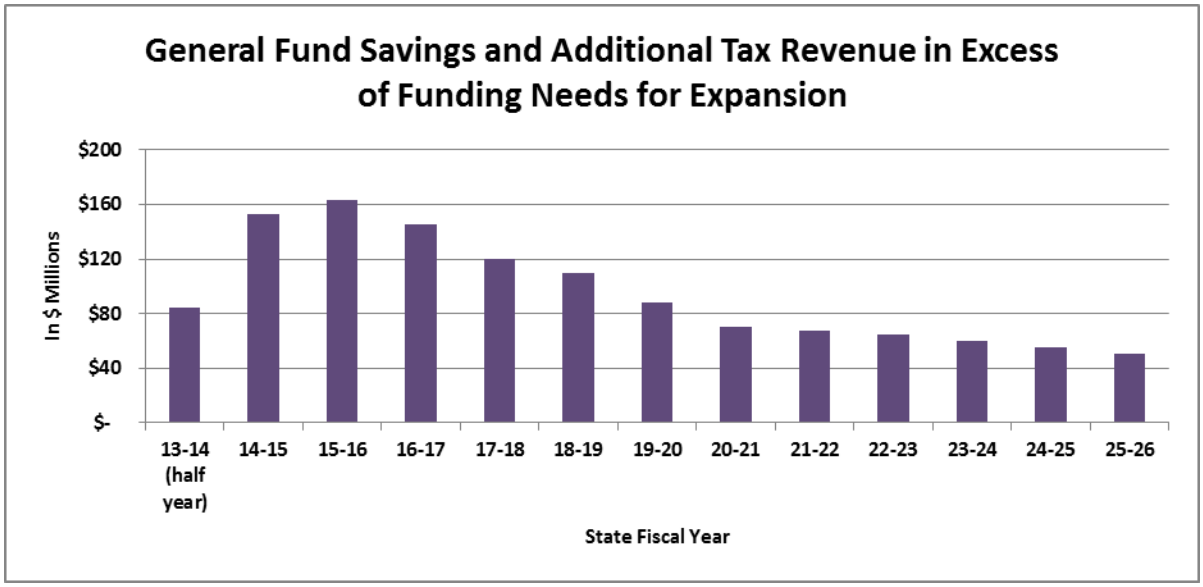
Annual Increases in General Fund Tax Revenue Resulting from Medicaid Expansion



With Medicaid Expansion Additional Tax Revenue and GF Savings are Sufficient to Fund Expansion

Medicaid expansion, even with the large infusion of federal dollars, is not free to the state. However, the analysis finds that savings elsewhere in the General Fund combined with the additional tax revenue generated by the larger economy are sufficient to cover the state's share of the costs of covering both the currently eligible but not enrolled populations as well as the expansion populations between 100% and 138% of FPL. Since the increase in tax revenue is uniquely dependent on no other changes to the economy or tax policy in the state, we did not factor it directly into the multiplier analysis. Instead in the multiplier analysis we assumed, as described above, that Colorado households would have to finance the Medicaid expansion. However, under favorable economic conditions, the combination of savings elsewhere in the General Fund and the increase in tax revenue is more than sufficient to fund expansion through the endpoint of the study, FY 2025-26. Figure H demonstrates this finding.

Figure H
Combined General Fund Savings and Additional Tax Revenue in Excess of Expansion Costs



III. Assessing the Budgetary Impacts of Medicaid Expansion

The six components of the budget impact analysis include:

- New enrollment of those currently eligible for Medicaid but not enrolled
- Enrollment of newly eligible Medicaid populations
- Higher federal match rate for currently covered expansion populations
- Administrative Costs
- Indigent Care Costs and Supplemental Hospital Payments
- Cost savings in other programs that serve the population that will become Medicaid eligible

All impacts listed above were analyzed for two scenarios:

- Scenario 1: Colorado makes no changes to its Medicaid program but must still pay for costs induced by the ACA's other provisions which affect Medicaid and some other state programs;
- Scenario 2: Colorado expands Medicaid eligibility in accordance with the ACA.

The difference between these two scenarios represents the true cost or impact of the state's Medicaid expansion decision.

Budgetary impacts are presented for the net impact of expansion in terms of federal and state funds, the proportions of which differ greatly between the two scenarios because Colorado will receive the enhanced federal match rate (100% gradually declining to 90%) if it expands Medicaid fully in compliance with ACA but only the current standard federal match rate (50%) if it does not undertake expansion. Discussion of the six components follows presentation of budgetary impact tables and charts.

State budgetary impacts are further apportioned to two main funding sources according to current Colorado statute – the General Fund and the Hospital Provider Fee. Some state costs associated with additional enrollment of those who are currently eligible but not enrolled are technically funded by tobacco tax revenues per Amendment 35. However, as tobacco tax revenues have become inadequate to cover costs associated with programs they are intended to fund, any such additional costs should be treated as an effective General Fund obligation.

This analysis treats state costs associated with expanding Medicaid coverage to adults in the 100% to 138% FPL income range as a General Fund obligation. However, funding such expansion could be done with Hospital Provider Fee funds if statutes are revised, a policy option discussed at the end of this report.

During calendar years 2014 through 2016, the federal match for Medicaid expansion populations will be 100%, resulting in large reduction of state funds financed by the Hospital Provider Fee necessary to fund two Medicaid populations Colorado already covers that are considered "expansion populations" under ACA. This analysis assumes Hospital Provider Fee revenues will be reduced through lower assessed rates during that time rather than collected and "banked" for future availability.

New Enrollment of Those Currently Eligible for Medicaid but not Enrolled

Most of the costs associated with the enrollment of those currently eligible but not enrolled take place regardless of the state's Medicaid expansion decision because they are induced by other provisions in the ACA. Costs associated with new enrollment of currently eligible children and parents are predominantly funded by General Fund with the state's standard 50% federal match. An exception is additional enrollment of parents from 60% to 100% FPL, considered an expansion population, funded by Hospital Provider Fee, and eligible for the higher federal match rate if the Colorado expands Medicaid eligibility.

Enrollment of Newly Eligible Medicaid Populations

The bulk of the cost of Medicaid expansion is associated with newly eligible populations. However, assuming full expansion in accordance with ACA, the federal match rate for newly eligible populations will be 100% in 2014 through 2016 declining gradually to 90% by 2020 as shown in Table 6.

Table 6
Federal Match for Expansion Populations under Different Expansion Scenarios

Calendar Year	Federal Enhanced Match (Full Expansion)	Federal Match (No Expansion Scenario)
2014	100%	50%
2015	100%	50%
2016	100%	50%
2017	95%	50%
2018	94%	50%
2019	93%	50%
2020 & Beyond	90%	50%

Higher Federal Match Rate for Currently Covered Expansion Populations

HB 09-1293 expanded Medicaid coverage in Colorado to parents of eligible children between 60% and 100% of FPL and to childless adults up to 100% of FPL, although funding limitations have led to a capped enrollment of 10,000 individuals up to 10% of FPL for the latter group. These are both considered expansion populations under the Affordable Care Act that are eligible for the enhanced federal match rate. Cost estimates for this population reflect reduced state funding and increased federal funding for these enrollment categories only in the full Medicaid expansion scenario but not in the no expansion scenario.

Administrative Costs

Administrative costs of 2 percent of the Medicaid medical service premium and community mental health costs associated with increased enrollment in each expansion scenario are assumed to reflect greater county administration and benefits management information system costs of higher enrollment. Federal funding of administrative costs is 50%. Medicaid expansion studies for other states have applied varying rates of administrative costs. The 2 percent figure for administrative costs, however, has been used in Legislative Council fiscal notes for past Medicaid expansion legislation including HB 09-1293.

Indigent Care Costs and Medicaid Supplemental Hospital Payments

Within the Colorado Indigent Care Program (CICP) there are two types of payments that compensate hospitals for uncompensated care provided to indigent state residents. Additionally, assessments on hospitals are also used to make up for low Medicaid payment rates to hospitals by increasing payments to hospitals that provide a high proportion of their services to Medicaid patients. The state share of Disproportionate Share Hospital (DSH), CICP and Medicaid Supplemental Hospital Payments is financed entirely by Hospital Provider Fee assessed on hospital revenues. State spending on such supplemental hospital payments is matched with federal funds at Colorado's 50% federal Medicaid match rate.

Although arguably "off-budget" in the sense that changes to CICP and Supplemental Hospital Payments affected by Colorado's Medicaid expansion decision do not impact General Fund expenditures, they were estimated for this analysis because they impact the federal matching funds that flow to Colorado and, thus, the economic impact to Colorado of the Medicaid expansion decision.

- Medicaid DSH Payments compensate hospitals that treat a disproportionate share of uninsured and indigent patients from whom they receive little in payment for the services they provide. With the expectation that the number of uninsured will be greatly reduced, the ACA statutorily reduces the federal pool of funds for DSH payments. States will likely lose much of their Medicaid DSH funding whether or not they expand Medicaid eligibility and reduce the number of uninsured in their populations. DSH federal and state funds are estimated for both expansion and non-expansion scenarios using a model which allocates federal DSH funds to states based on their remaining uninsured population. However, this estimate is somewhat speculative because the Department of Health and Human Services has not (as of this writing) announced a formula for allocation of DSH funds.
- CICP Supplemental Hospital Payments compensate hospitals for care provided to participants in Colorado's Indigent Care Program, uninsured state residents with incomes up to 250% of FPL. The state's Medicaid expansion decision will impact the number of people in the state remaining uninsured and thus the size of the CICP program and payments to hospitals under its auspices. CICP Supplemental Hospital Payments, federal and Hospital Provider Fee funds, will decline by more under full Medicaid expansion than non-expansion along with Colorado's uninsured population.
- Medicaid Supplemental Hospital Payments raise compensation to hospitals for the care they provide to Medicaid patients because of low Medicaid payment rates and are designed to bring the compensation hospitals receive for treating Medicaid patients on par with that they receive

for Medicare patients. As the amount of hospital care compensated by Medicaid will increase with Medicaid expansion, the value of such supplemental payments, federal and Hospital Provider Fee funds will increase substantially more under full-Medicaid expansion than non-expansion.

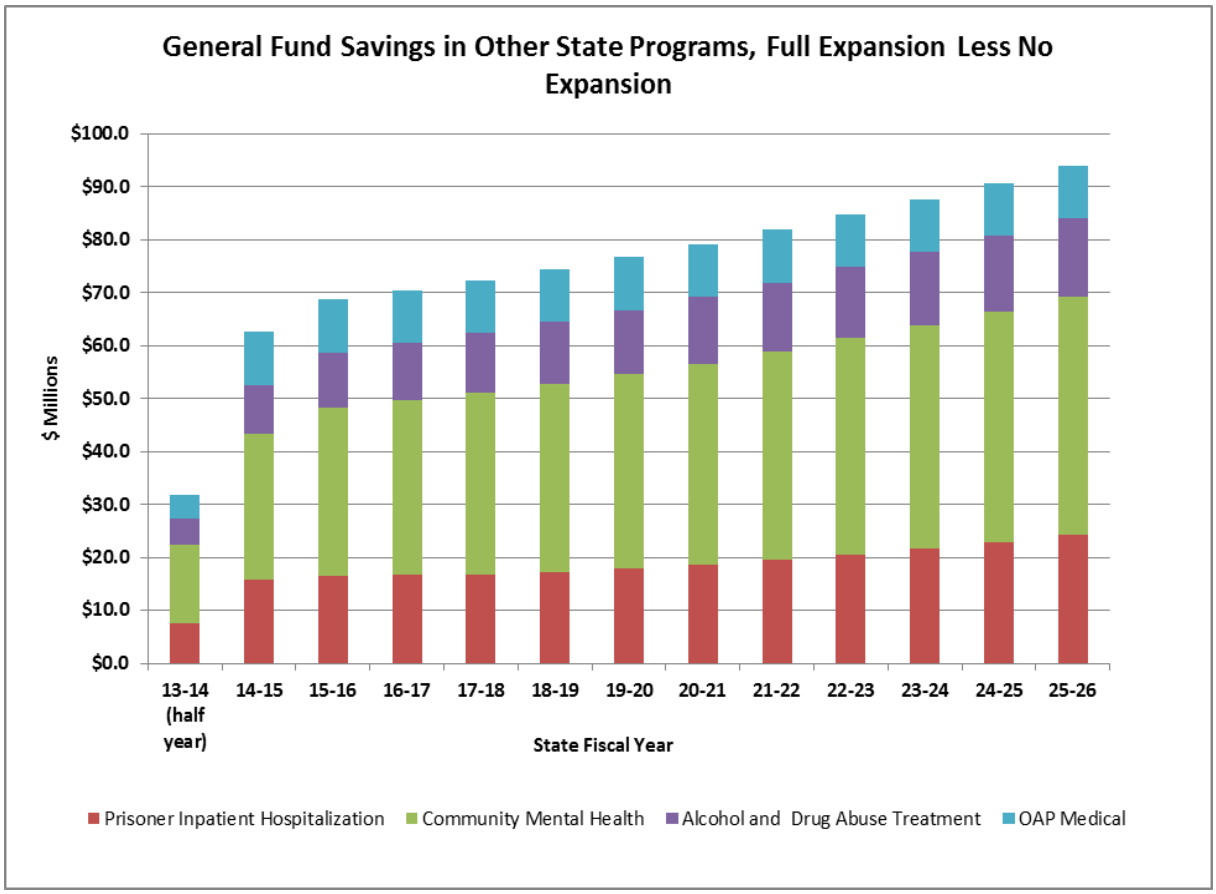
In terms of net impact on supplemental hospital payments, this analysis finds Colorado will receive reduced federal funding because of the reduction in DSH payments under the non-expansion scenario. Under full Medicaid expansion Colorado would on net draw additional federal matching funds, matched by state Hospital Provider Fee funds, as the value of Supplemental Medicaid Payments to hospitals for Medicaid-covered care would exceed the diminished federal DSH funds and reduced matching funds for CICP-compensated care.

Cost Savings in Other State Programs

Colorado operates several state social service and medical programs that currently serve the needs of Colorado's medically indigent population. There will be a reduced need for these programs under the ACA and Medicaid expansion as the populations served become insured through federally-subsidized insurance purchased through the exchange and through Medicaid. Current funding for the Old Age Pension Medical program, medical services for prison inmates, Community Mental Health and Drug and Alcohol Abuse Treatment programs is primarily from the General Fund.

The state social service programs impacted are not entitlements and arguably do not fully meet the needs of the state's uninsured and indigent population. Thus, in the Medicaid non-expansion scenario this analysis assumes relatively little reduction in need for the programs and associated cost, even though the number of uninsured in the state declines. Under the full-expansion scenario, however, most of those who are currently being served are eligible to enroll in Medicaid, so the level of need for the programs declines greatly. Although a significant number of people in Colorado will remain uninsured under full Medicaid expansion, that pool of uninsured will consist more of undocumented immigrants not eligible for state programs and those with better health status who choose to remain uninsured. Figure I displays annual state General Fund savings in four programs under full Medicaid expansion.

Figure I
General Fund Savings in Other Programs



Old Age Pension (OAP) Health and Medical Program

Colorado operates a state program to provide limited medical care to those receiving Old Age Pension (OAP) grants who do not qualify for Medicaid. The annual appropriation is $10.0 million. The population served consists of those who are non-disabled aged 60 to 64. Under full Medicaid expansion almost all current beneficiaries will qualify for Medicaid and state expenditures could be reduced.

Medical Services for Prison Inmates

With Medicaid eligibility expansion the Colorado Department of Corrections (DOC) will likely experience significant cost savings on inmate medical expenses if it moves to qualify inmates for Medicaid. Under Medicaid expansion the vast majority of DOC inmates will qualify for Medicaid as adults without dependent children. Medicaid benefits are generally suspended once an enrollee is incarcerated. However, there is an exception for inmates who require inpatient hospital care in non-correctional facilities for at least 24 hours. In such cases, federal rules allow Medicaid to receive a federal match for costs associated with the admission if the inmate is already enrolled in Medicaid.

In FY 2012-13 Colorado appropriated $29.6 million for inmate medical services purchased from other medical facilities. Past DOC estimates have been that approximately 65 to 70 percent of the services of

the medical services purchased from other medical facilities, including those it characterizes as catastrophic medical expenses, meet the inpatient care criteria. This analysis assumes 60 percent of such services would qualify for a federal Medicaid match since we did not receive current estimates and some inmates, such as those with undocumented alien status, will not qualify for Medicaid. This analysis assumes that under the non-expansion scenario no inmates would qualify.

It should be noted that these savings will not occur automatically. Colorado will have to enroll eligible inmates in Medicaid to receive the federal match for such services, and there may be some administrative cost associated with such enrollment activity.

Community Mental Health Programs

Colorado operates state community mental health programs in the Department of Human Services (DHS) which serve mental health needs of medically indigent residents with incomes up to 300% FPL who don't qualify for Medicaid. In FY 2012-13 Colorado appropriated $44.5 million in state funds for Community Mental Health Services for the Medically Indigent. Most funding is state General Fund but includes some cash funded programs. Approximately $6.5 million additional funding is from a federal Mental Health Services Block Grant.

DHS was unable to provide data on income ranges on clients served by the program but indicated most are at the lower end of the income eligibility range, which would make them eligible for Medicaid rather than subsidies to purchase insurance in the exchange under health care reform. Non-Medicaid state mental health programs are not an entitlement, operate with waiting lists, and arguably do not meet all needs, so any estimate in reduction in need in such state programs under different Medicaid expansion scenarios is an approximation. Under a full Medicaid expansion almost all clients currently served would be eligible for Medicaid or for federal subsidies to purchase insurance in the exchange.

If Colorado does not expand Medicaid beyond those currently covered, most of the needs served by its non-Medicaid community mental health programs would remain. This analysis assumes some reduction in such need to reflect that those currently served with incomes above 100% FPL would be receiving mental health services through subsidized exchange-based insurance.

Alcohol and Drug Abuse Treatment Services

Colorado funds services for alcohol and drug abuse treatment targeted mostly toward uninsured and underinsured residents. In FY 2012-13 Colorado appropriated $14.6 million in state funds, mostly General Fund for such services. This appropriation was supplemented by $10.3 million in federal funds from the Substance Abuse Treatment and Prevention Block Grant.

Under the provisions of ACA the need for a separate state alcohol and drug abuse treatment program declines since insurance coverage for such treatment services is required and the number of uninsured will decline regardless of Colorado's decision on Medicaid expansion. Currently, however, such treatment services are not an entitlement, so any estimates of reduction in need under alternative Medicaid expansion scenarios are very uncertain. Under full Medicaid expansion most clients served would be eligible for Medicaid or for federal subsidies to purchase insurance in the exchange. If

Colorado does not expand Medicaid beyond those currently covered, substantial need for state substance abuse treatment programs will continue. It is unclear whether federal block grants for substance abuse treatment and prevention will be reduced in the future as more treatment is covered under Medicaid and other insurance or if more of those grant funds can be repurposed toward prevention programs.

Net Impact of Medicaid Expansion

The net budgetary impact to Colorado of expanding Medicaid eligibility in accordance with ACA is shown in Table 7. The table shows average annual costs for four periods: FY 2013-14, the first state fiscal year affected by the expansion decision; FYs 2014-15 and 2015-16, the two state fiscal years envisioning a 100% federal match; FYs 2016-17 through FY 2019-20, the years with a federal match rate declining in stages to 90%; and FYs 2020-21 through 2025-26, the years of a stable 90% federal match rate. For each period, total costs, federal and state costs, and state costs broken down by General Fund and Hospital Provider Fee are shown.

Table 7

Budgetary Impact of Medicaid Expansion ($ in millions)

	Total Cost	Federal Cost	State Cost		
			Total	GF	HPF
FY 2013-14 (First Half Year of Expansion)					
New Enrollment of Those Currently Eligible for Medicaid but not Enrolled	$9.5	$7.1	$2.5	$3.8	-$1.4
Enrollment of Newly Eligible Medicaid Populations	$269.5	$269.5	$0.0	$0.0	$0.0
Higher Federal Match Rate for Currently Covered Expansion Populations	$0.0	$63.2	-$63.2	$0.0	-$63.2
Administrative Costs	$5.6	$2.8	$2.8	$2.8	$0.0
Indigent Care Costs and Medicaid Supplemental Hospital Payments	$42.6	$21.3	$21.3	$0.0	$21.3
Cost Savings in Other State Programs	-$29.8	$2.1	-$31.8	-$31.8	$0.0
Total	**$297.4**	**$365.9**	**-$68.5**	**-$25.2**	**-$43.2**
FY 2014-15 & FY 2015-16 (Fiscal Years with 100% Federal Match for Expansion Populations)					
New Enrollment of Those Currently Eligible for Medicaid but not Enrolled	$33.7	$25.0	$8.7	$13.5	-$4.8
Enrollment of Newly Eligible Medicaid Populations	$954.4	$954.4	$0.0	$0.0	$0.0
Higher Federal Match Rate for Currently Covered Expansion Populations	$0.0	$140.5	-$140.5	$0.0	-$140.5
Administrative Costs	$19.8	$9.9	$9.9	$9.9	$0.0
Indigent Care Costs and Medicaid Supplemental Hospital Payments	$142.8	$71.4	$71.4	$0.0	$71.4
Cost Savings in Other State Programs	-$60.6	$5.0	-$65.6	-$65.6	$0.0
Total	**$1,090.1**	**$1,206.2**	**-$116.1**	**-$42.2**	**-$73.9**
FY 2016-17 through FY 2019-20 (Fiscal Years with declining Federal Match for Expansion Populations)					
New Enrollment of Those Currently Eligible for Medicaid but not Enrolled	$47.6	$34.3	$13.4	$19.1	-$5.7
Enrollment of Newly Eligible Medicaid Populations	$1,346.4	$1,266.4	$80.0	$20.4	$59.6
Higher Federal Match Rate for Currently Covered Expansion Populations	$0.0	$148.9	-$148.9	$0.0	-$148.9
Administrative Costs	$27.9	$13.9	$13.9	$13.9	$0.0
Indigent Care Costs and Medicaid Supplemental Hospital Payments	$207.0	$103.5	$103.5	$0.0	$103.5
Cost Savings in Other State Programs	-$69.5	$4.0	-$73.5	-$73.5	$0.0
Total	**$1,559.5**	**$1,571.0**	**-$11.5**	**-$20.1**	**$8.6**
FY 2020-21 through FY 2025-26 (Fiscal Years with 90% Federal Match for Expansion Populations)					
New Enrollment of Those Currently Eligible for Medicaid but not Enrolled	$68.0	$47.8	$20.2	$27.3	-$7.1
Enrollment of Newly Eligible Medicaid Populations	$1,908.0	$1,717.2	$190.8	$48.6	$142.2
Higher Federal Match Rate for Currently Covered Expansion Populations	$0.0	$183.7	-$183.7	$0.0	-$183.7
Administrative Costs	$39.5	$19.8	$19.8	$19.8	$0.0
Indigent Care Costs and Medicaid Supplemental Hospital Payments	$296.3	$148.1	$148.1	$0.0	$148.1
Cost Savings in Other State Programs	-$79.1	$7.2	-$86.3	-$86.3	$0.0
Total	**$2,232.7**	**$2,123.8**	**$108.9**	**$9.3**	**$99.6**

Budget Bottom Line

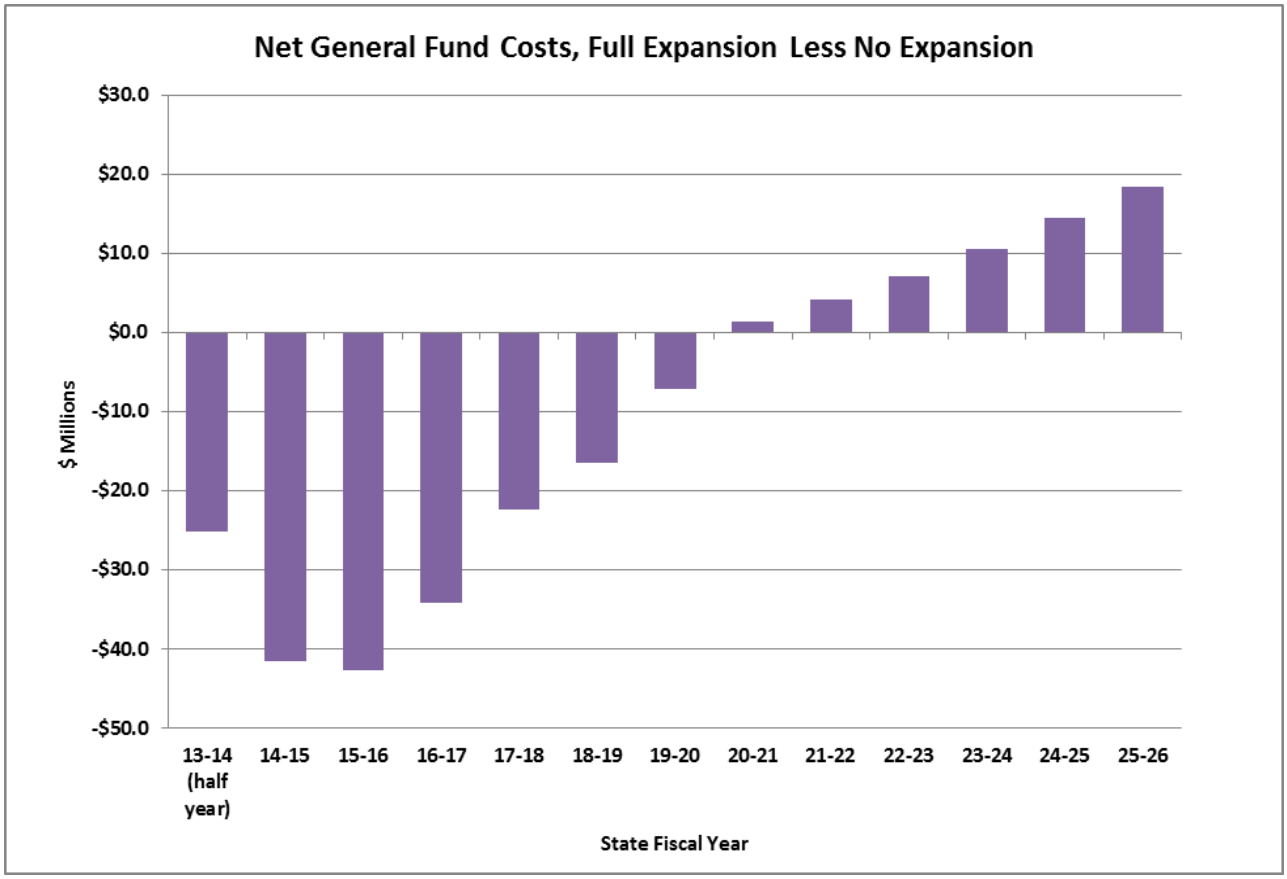
Figure J shows the annual net cost impact of full Medicaid expansion to the General Fund, a graphical representation on an annualized basis of the General Fund totals displayed in Table 7. The totals are based on an assumption that the state share of costs for eligibility expansion from 100% to 138% FPL will be financed by General Fund appropriations.

We expect substantial savings to the state budget of Medicaid expansion relative to no expansion in the first several fiscal years after implementation, FY 2013-14 through FY 2015-16, during which time the federal match for expansion populations is 100%. General Fund savings diminish as the state share of funding for expansion populations rises gradually to 10% from FY 2016-17 through FY 2019-20. Once the

state share of expansion population financing reaches its full 10% in FY 2020-21 we anticipate Medicaid expansion to result in a net General Fund cost to the state. In the analysis that net cost gradually rises to $18.4 million by FY 2025-26. Despite the somewhat higher costs in later years, for the period from FY 2013-14 through FY 2025-26, the cumulative net General Fund cost of full expansion is $133.8 million lower than the cost of no expansion.

The gradual increase in net cost in the years after Colorado's share of cost for expansion population stabilizes at 10% reflects assumptions about cost growth in Medicaid that somewhat differ from assumptions underlying savings in the state programs Medicaid expansion will partially replace. Medicaid expenditures for expansion populations reflect enrollment growth and cost cost/enrollee growth rising faster than consumer price index. Meanwhile, the baseline forecasts for state programs include somewhat slower growth; the prison inmate population has stabilized and has even declined recently; the annual state OAP medical appropriation is set in statute; and state community mental health and substance abuse programs are discretionary spending whose expenditures we forecast to grow only with population plus consumer price index as they are subject to state budget constraints.

Figure J
Net General Fund Costs



IV. Other Policy Options for Funding Expansion of Medicaid

Throughout the analysis of the budgetary and economic impacts of Medicaid expansion, we assumed current law as written. With respect to the state budget, this assumption means that the responsibility to pay for the state's share of Medicaid expansion will be a responsibility of the General Fund. There are, perhaps, other options for meeting the state's responsibility for Medicaid expansion.

The first option is to use the Hospital Provider Fee, which was used for a previous Medicaid expansion. Beginning in 2010, the state expanded Medicaid largely to parents earning between 60% and 100% FPL and adults without dependent children earning up to 10% FPL capped at 10,000 enrollees. The 50% state share for this expansion was funded with the Hospital Provider Fee. Starting in 2014, these expansion populations will be eligible for enhanced federal matching dollars, reducing the burden on the Hospital Provider Fee and freeing up capacity to fund further expansion populations. This would, however, require a change to state law.

Another option is to capture excess savings in other General Fund programs and reserve them for future spending for expansion. In the model, savings are assumed to cover expansion costs in any given budget year, but in the early years of the analysis when savings exceed the state's responsibility for expansion, we do not assume that those savings are reserved for future years.

And finally, we did not assume specific efficiencies to the Medicaid program which may bend the cost curve. Implementing efficiencies such as delivery, payment and benefit reforms may stretch health care dollars and reduce the cost burden on the state General Fund.