Medicaid Expansion in Indiana

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None

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The views expressed herein are those of the authors and do not necessarily reflect the views of collaborating organizations or funders, or of the Regents of the University of Nebraska.

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Center for Health Policy

Summary

- The estimated number of new Medicaid enrollees in Indiana under the Affordable Care Act expansion through 2020 is 406,717.
- The estimated cost of Medicaid expansion for the State of Indiana is $503 million through 2020.
- The estimated revenue that will come to the State of Indiana from the federal government as a result of the Medicaid expansion is $10.45 billion through 2020.
- Spending by the federal government on Medicaid expansion would generate an estimated $2.4 to $3.4 billion in new economic activity in Indiana from 2014 to 2020, which could finance over 30,000 jobs through 2020.
- Spending on Medicaid expansion will generate at least $108 million in state and local tax revenue each year.
- The decrease in the number of uninsured resulting from the Medicaid expansion is estimated to save individuals $236 and families $677 in annual health insurance premiums beginning in 2014. These savings can also be viewed as a “silent tax” that individuals and families would potentially pay if a state chooses to not expand Medicaid.

Introduction

On June 28, 2012, the Supreme Court upheld the Affordable Care Act (ACA) but ruled that the federal government cannot enforce the ACA provision that expands the Medicaid program for individuals with an annual income within 133% of the federal poverty level (FPL) by eliminating other Medicaid funding in a state. This ruling allows each state to decide whether to expand its Medicaid program based on the costs and benefits of doing so.[1] The ACA provides federal tax credits and subsidies for persons to purchase insurance in health insurance exchanges, but these benefits are not available for most people who would be eligible for the Medicaid expansion. States that decide not to expand Medicaid eligibility could face a coverage gap or “doughnut hole” of insurance coverage options for the poor and uninsured. The Medicaid expansion holds particular importance for state governments because the ACA paired it with reductions in other programs that provide charity care, under the assumption that Medicaid expansion would compensate for these reductions. Regardless of whether a state decides to expand Medicaid, the federal government will phase out one such program, Disproportionate Share Hospital (DSH) payments, beginning in 2014. Currently, Indiana receives over $214 million annually in Medicaid DSH allotments, but the ACA will cut these payments over 10 years starting in 2014.[2] Given the potential impact that Medicaid expansion could have on a state’s economy, each state should assess the expected impact on the state government budget, and other public health and financial impacts. This report forecasts the impact of Medicaid expansion for the State of Indiana.[3,4]

Number of Medicaid Enrollees Expected with Medicaid Expansion

Under the ACA, Medicaid eligibility will be expanded to nonelderly adults (age 19-64) with household income less than 133% FPL. The law regarding eligibility disregards 5% of income, thereby increasing FPL eligibility to 138% from 133% (Appendix 1). Recent immigrants (those with less than 5 years of residency) and those who are undocumented do not qualify for Medicaid under federal law. We calculated expected enrollment of newly eligible persons using population estimates from the 2010 American Community Survey state data files (Exhibit 1). In addition, we factored in annual population growth of 0.4% based on US Census Bureau projections for Indiana and on the potential for 45% of persons below 139% FPL with private insurance to switch to Medicaid, which is referred to as "crowd-out." We assumed an 85% participation rate in Medicaid among the newly eligible starting in 2014. This participation rate is higher than historical averages in part because of the individual mandate for insurance coverage and also because of a more efficient enrollment system under a state or federally run health insurance exchange. To estimate enrollment in the current Medicaid program, we used data from the Centers for Medicare and Medicaid Services.

Exhibit 1: Estimated Number of Medicaid Enrollees, Indiana 2014–2020

Enrollees	2014	2015	2016	2017	2018	2019	2020
Newly eligible adults	397,091	398,679	400,274	401,875	403,483	405,097	406,717
Currently eligible adults	251,945	252,952	253,964	254,980	256,000	257,024	258,052
Children	660,722	663,365	666,019	668,683	671,357	674,043	676,739
Elderly	86,005	86,349	86,695	87,041	87,390	87,739	88,090
Blind/Disabled	160,880	161,524	162,170	162,819	163,470	164,124	164,780

Source: US Census Bureau 2010 American Community Survey; 2011 Centers for Medicare and Medicaid Services.

State and Federal Spending on Medicaid Expansion

Based on the projected number of new enrollees, we calculated the cost of Medicaid expansion and revenue received by the State of Indiana from the federal government (Exhibits 2 and 3). The current Federal Medical Assistance Percentage (FMAP) for the nonexpansion Medicaid population is 67%. The ACA instituted an enhanced FMAP for the Medicaid expansion population (Exhibit 4).

Previous research suggests that the uninsured tend to have lower risks than those currently on Medicaid because current enrollees are typically less healthy than the general population; therefore, new enrollees who were previously uninsured have been shown to have a 46% lower cost than the current average Medicaid beneficiary because of their lower health risks.[5] To be conservative and to account for pent-up health care demand and some level of adverse selection, we assumed that newly eligible adults would have 10% lower health care costs than currently eligible adults. The FMAP rate for each year under the new expansion rules was then applied. An estimated 5% administrative overhead cost was also added for State management of the Medicaid program.

Exhibit 2: Monthly Cost per Enrollee of Medicaid Expansion for Newly Eligible Population, Indiana 2014–2020

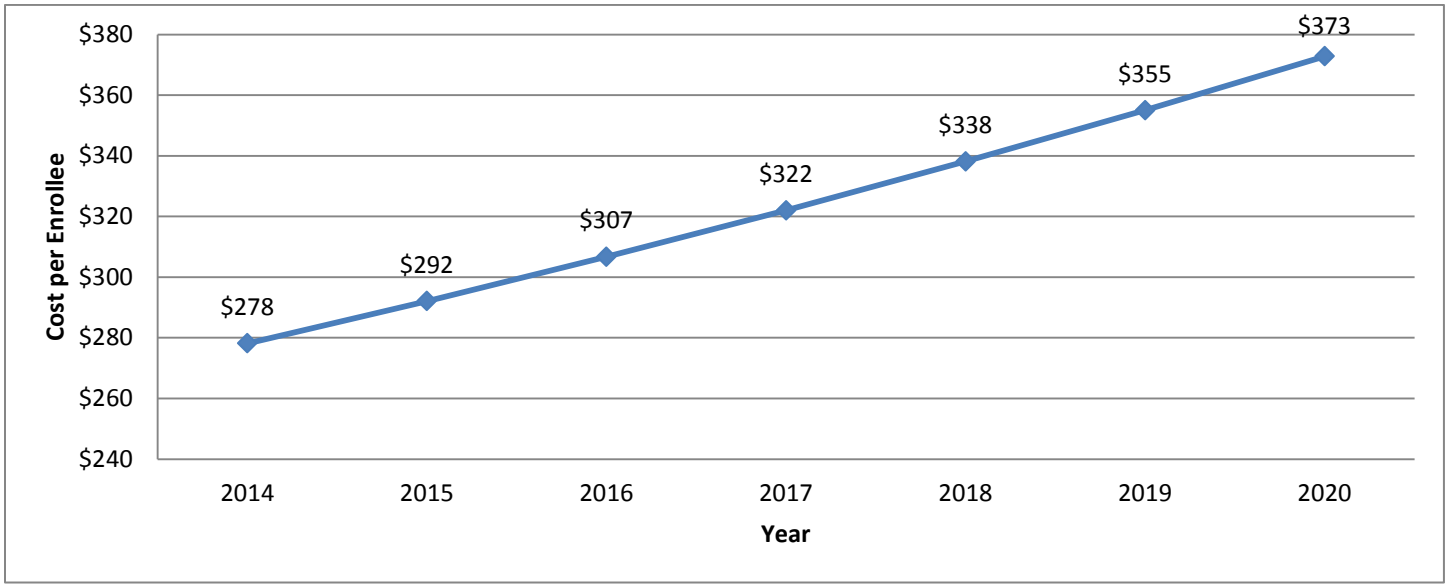


Exhibit 3: State and Federal Government Spending on Medicaid Expansion ($ Millions), Indiana 2014–2020

	2014	2015	2016	2017	2018	2019	2020	Total
State Spending	$0	$0	$0	$82	$103	$127	$191	$503
% Share of State Medicaid Spending	0%	0%	0%	3.2%	4.0%	4.8%	7%	2.8%
Federal Spending	$1,326	$1,397	$1,473	$1,475	$1,539	$1,605	$1,637	$10,453
% Share of Federal Medicaid Spending	22.0%	22.6%	23.1%	22.8%	23.1%	23.4%	23.6%	23.0%

Exhibit 4: Federal Medical Assistance Percentage for Medicaid Expansion under the Affordable Care Act, 2014–2020

	2014	2015	2016	2017	2018	2019	2020
FMAP	100%	100%	100%	95%	94%	93%	90%

We compared our estimates for enrollees and spending to other benchmarks for the State of Indiana (Exhibit 5). Each analysis used different assumptions and timeframes, but the estimates are in range of each other and indicate that the Milliman report had the highest estimate for state spending and enrollees, and the Urban Institute had the lowest estimate for state spending and enrollees, after adjusting for the difference in the number of years.[1,6,7] Therefore, the UNMC Center for Health Policy estimate is in the middle of the estimates for enrollees and state spending, after adjusting for differences in the number of years in each estimate.

Exhibit 5: Comparison of Estimates for Average Annual Enrollees and Government Spending ($ Millions) on Medicaid Expansion, Indiana

	Average Annual Enrollees & Spending		
	Enrollees	State Spending	Federal Spending
Urban Institute (2013-2022)	42,700	$54	$1212
UNMC Center for Health Policy (2014-2020)	58,102	$72	$1493
Milliman (2014-2020)	74,143	$88	No data

Economic Impact of Spending on Medicaid Expansion

We analyzed the expected employment and economic impact of spending from the Medicaid expansion (Exhibits 6-8). The estimates were generated with the IMPLAN version 3.0 software and the 2011 Indiana state data package. IMPLAN is a standard software package used by government and private sector entities to estimate the economic and employment impacts of projected spending. Direct spending is the governmental money used to provide care to the expanded Medicaid population in Indiana. For example, federal direct spending provides the health care industry with resources to hire health care workers and to purchase goods and services from suppliers in order to meet the increased demand for health care. These suppliers, in turn, purchase goods and services and hire employees and so on, thereby generating an indirect economic impact from the initial government spending. This direct and indirect hiring and spending also results in higher overall household income—an effect called induced economic impact. More details on the methodology of the economic impact analysis can be found in Appendix 2.

Exhibit 6: Employment Impact of Federal and State Spending on Medicaid Expansion, Indiana 2014–2020

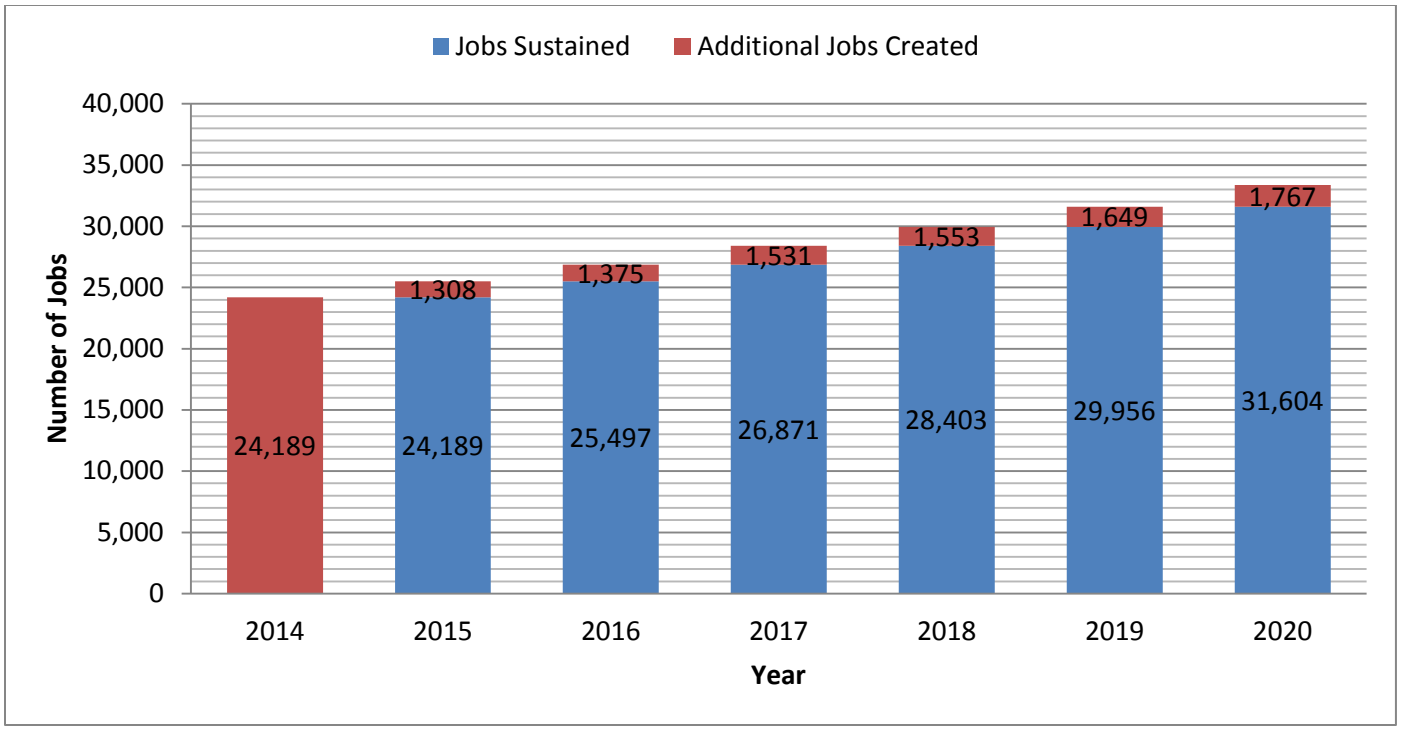


Exhibit 7: Labor Income Impact of Federal and State Spending on Medicaid Expansion, Indiana 2014–2020

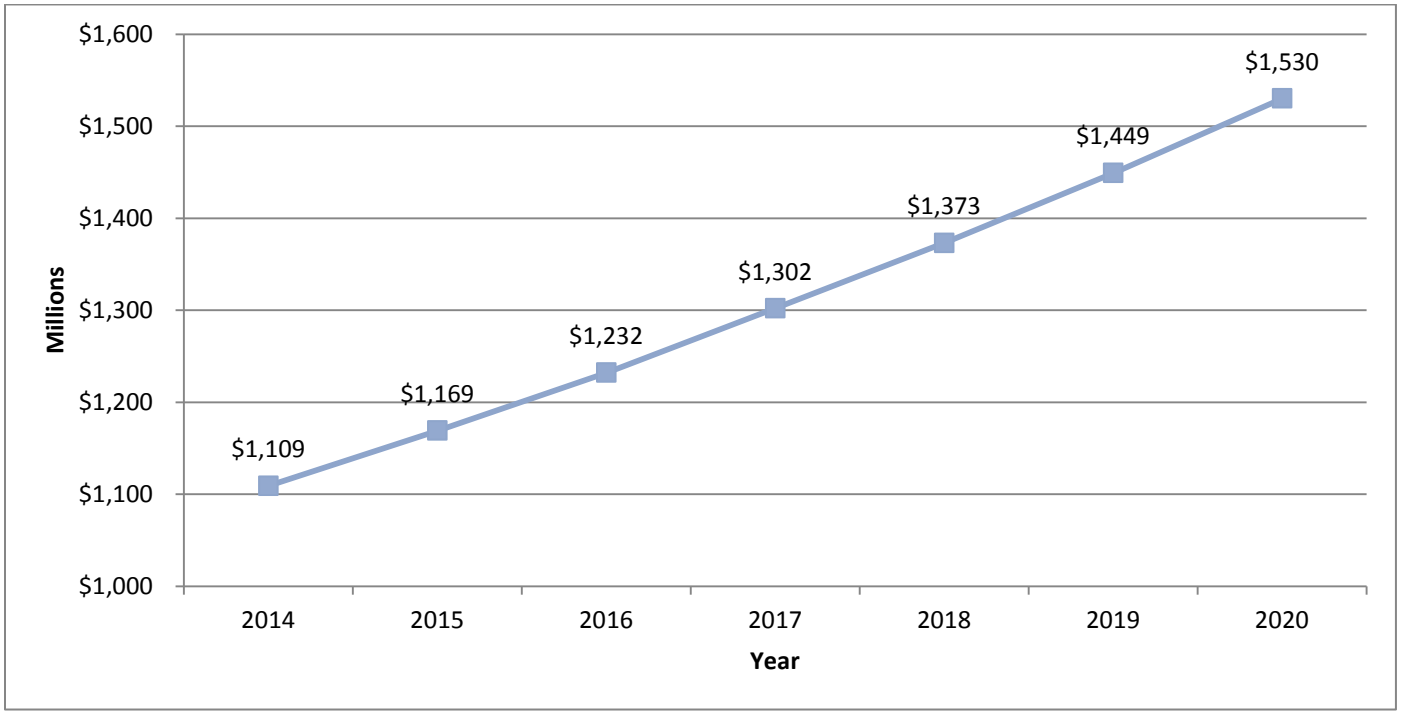
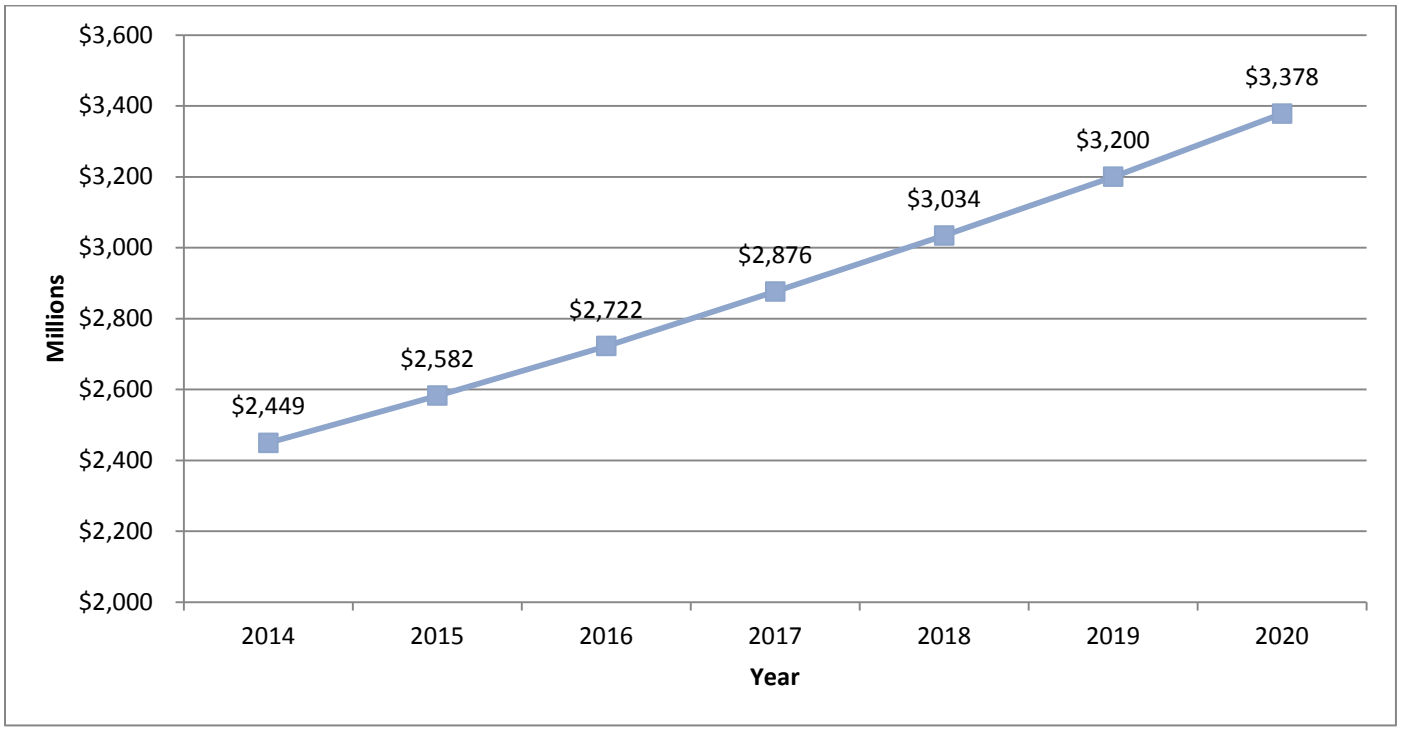
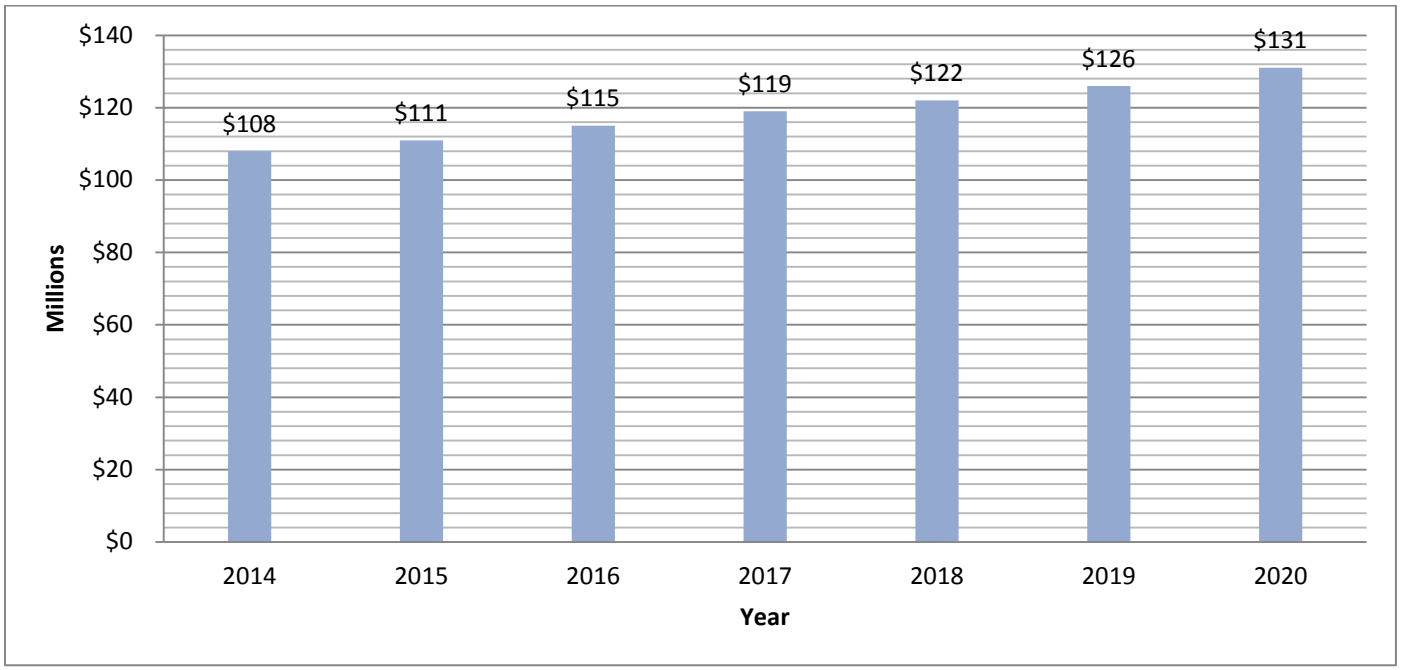


Exhibit 8: Overall Impact of Federal and State Spending on Medicaid Expansion on the Economy, Indiana 2014–2020



We simulated the expected state and local tax revenue resulting from the ripple effect of having more federal dollars circulating in the Indiana economy due to the Medicaid expansion. Over $832 million in state and local tax revenue would be generated from 2014-2020 from the spending on Medicaid expansion in Indiana (Exhibit 9). Given that the total cost for the expansion is estimated to be $503 million, this tax revenue could be used to offset some of the state spending on Medicaid expansion.

Exhibit 9: State and Local Tax Revenue from Medicaid Expansion Spending, Indiana 2014–2020



Impact of Medicaid Expansion on Private Insurance Premiums

Medicaid expansion may also reduce the burden of uncompensated care. One of the primary concerns with the size of the uninsured population is the level of uncompensated care that is provided by hospitals and other providers. Typically, these costs are financed by the providers, and by state and federal government.[8,9] Eventually, this cost is shifted to individuals and employers in the form of higher insurance premiums, sometimes referred to as a "silent tax."[10] Increased numbers of persons participating in the health insurance market could have a significant impact on individual and group insurance premiums. The reduction in uncompensated care spending would aid hospitals and other health care providers and also have the potential to reduce (or hold constant) health insurance premiums. A recent report calculated that Medicaid expansion would reduce the amount of uncompensated care provided in Indiana by more than $2 billion from 2014-2019.[11] However, if hospital-reported data is greater than the data in the cited study, then the estimated savings could be greater, which suggests our estimate should be viewed as conservative.

We estimated the impact of Medicaid expansion on private health insurance premiums based on the expected decrease in uncompensated care. The impact of providing health care to the uninsured has been estimated to increase—or "markup"—private health insurance premiums by an average of 9% for Indiana residents.[11] We calculated that the number of uninsured residents will decrease by 51% after the Medicaid expansion in Indiana. Using data on average private health insurance premiums paid by Indiana residents, we estimate that

in 2014, Medicaid expansion would reduce this markup in annual private health insurance premiums from $481 to $245 for individuals by decreasing the number of uninsured (Exhibit 10). For families, the markup would decrease from $1,380 to $703 after the Medicaid expansion (Exhibit 11). Thus, the decrease in the number of uninsured resulting from the Medicaid expansion is estimated to save individuals $236 and families $677 in annual health insurance premiums beginning in 2014 (Exhibit 12). These savings can also be interpreted as a "silent tax" that individuals and families would potentially pay if a state chooses to not expand Medicaid.

Exhibit 10: Markup in Annual Individual Private Health Insurance Premiums with and without Medicaid Expansion, Indiana 2014–2020

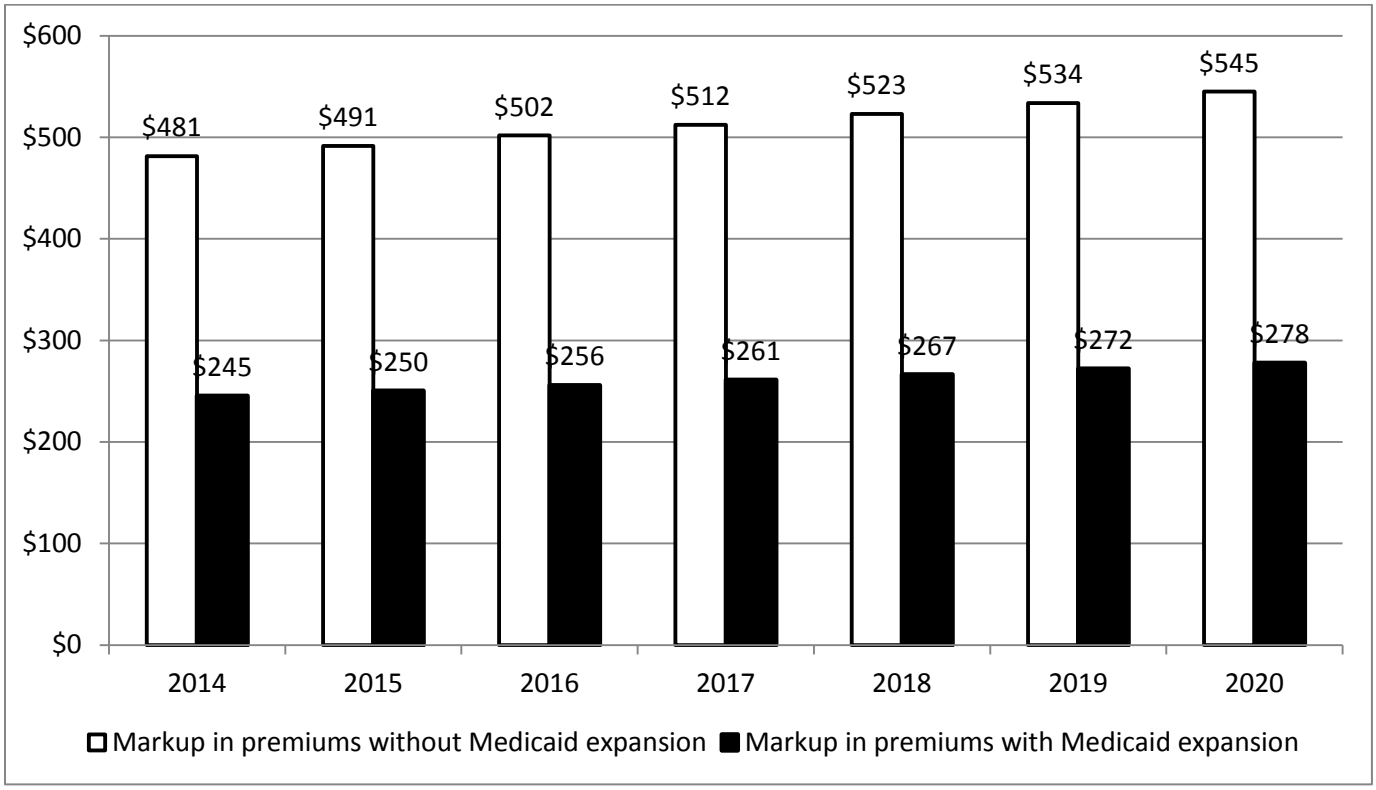


Exhibit 11: Markup in Annual Family Private Health Insurance Premiums with and without Medicaid Expansion, Indiana 2014–2020

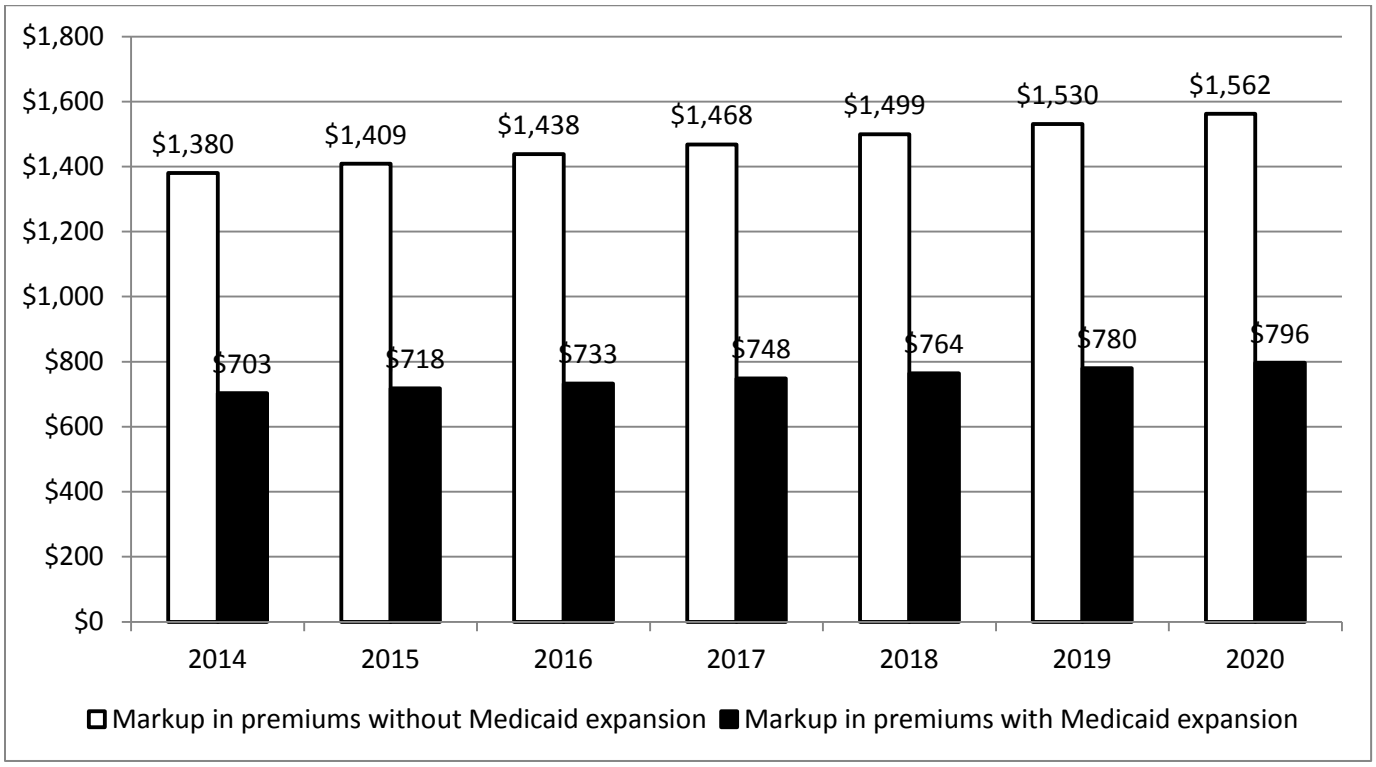
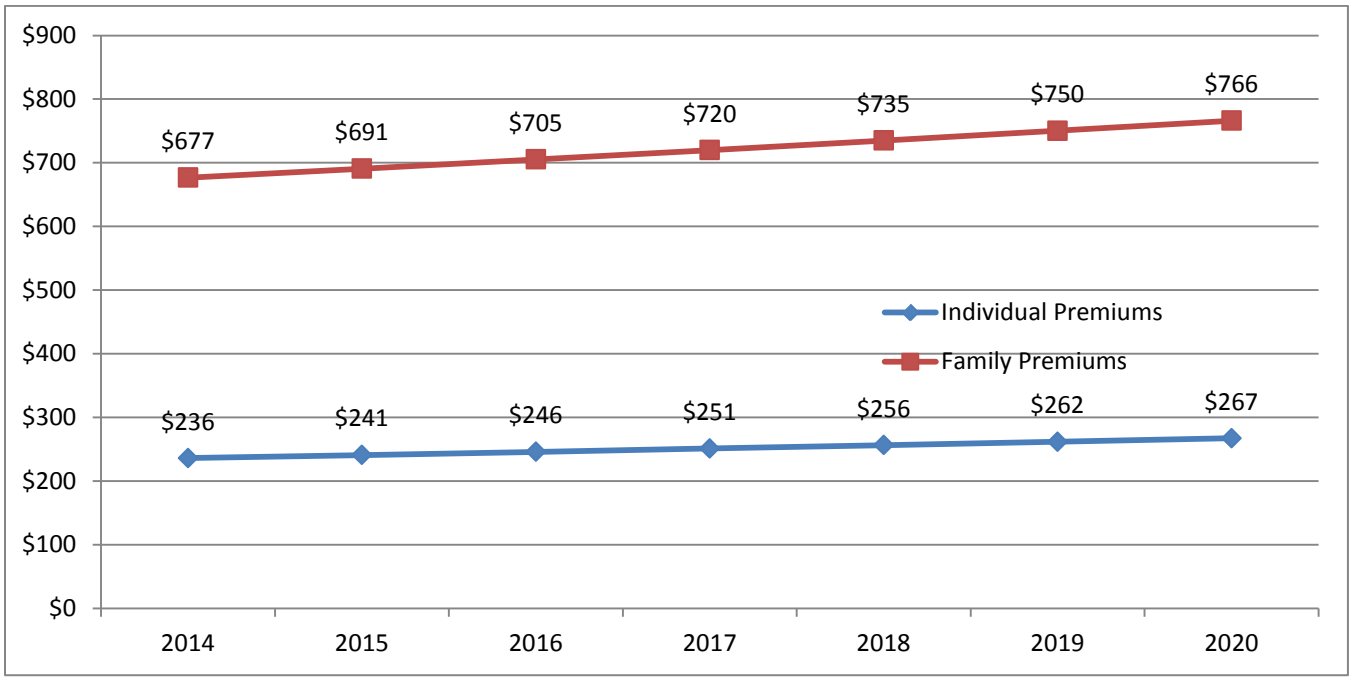


Exhibit 12: Estimated Savings on Private Health Insurance Premiums After Medicaid Expansion for Individuals and Families, Indiana 2014–2020



Conclusion

The estimates in this report can be used as a guide for the expected number of new enrollees under Medicaid expansion, the cost of providing care to the expanded population, and projections of the economic impact and tax revenue resulting from the Medicaid expansion. Overall, we found that Medicaid expansion would represent 2.8% of the increased spending on Medicaid for the State of Indiana over the 2014–2020 period and would generate more tax revenue (from federal spending) than expenditures. However, the tax revenue offset alone is not sufficient on an annual basis to compensate for the expenditures from the expanded program. Further offsets would be required by the year 2020 and beyond. Additional savings to the state budget could be found from other health programs that would see reduced spending or potentially be phased out starting in 2014 under the ACA, such as transitioning currently eligible adults to the expanded Medicaid program, delivery system reforms, and reduced payments for mental health services out of the State's general fund as more citizens gain health insurance coverage through Medicaid or health insurance exchanges that cover mental health services.[3,4] Finally, one significant funding option discussed in Indiana is the cigarette tax revenue established to fund the Healthy Indiana Plan, which has funds in reserve and is expected to generate approximately $100 million in annual revenue.

Questions remain about how Medicaid expansion might impact administrative costs. The ACA's nonexpansion provisions will increase state administrative costs in the following ways: changes to Medicaid and CHIP eligibility, including major investments in information technology (IT); provider payment increases and other requirements; and Medicaid processing applications that arrive from the health insurance exchange (although a state can apply for federal funding to offset the higher costs for IT). It is unclear whether the expansion itself would raise or lower overall state administrative costs. Factors that will increase costs include some additional increase in initial applications, more eligibility redeterminations, and more fee-for-service claims. Factors that will reduce costs include fewer spend-down determinations, fewer disability determinations, and fewer fair hearings for eligibility denials.[11]

A final consideration is that Medicaid expansion has historically been shown to impact other outcomes. For example, a recent study in the New England Journal of Medicine concluded that for every 176 adults covered under expanded Medicaid, 1 death per year could be prevented.[12] In 2010, there were 499 deaths in Indiana due to lack of coverage among persons age 25-64.[13] Another study found that a 10% expansion of Medicaid eligibility has been shown to reduce bankruptcies by 8%.[14] The impact on other financial and public health outcomes should be included in the discussion about whether states should participate in the Medicaid expansion.

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Appendix 1: 2012 FEDERAL POVERTY GUIDELINES

		Percentage of Poverty				
		100%	**138%**	**200%**	**250%**	**400%**
Household Size	**1**	$11,170	$15,415	$22,340	$27,925	$44,680
	2	$15,130	$20,879	$30,260	$37,825	$60,520
	3	$19,090	$26,344	$38,180	$47,725	$76,360
	4	$23,050	$31,809	$46,100	$57,625	$92,200

Note: Annual guidelines for all states except Alaska, Hawaii, and DC

Source: Federal Register, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035

Appendix 2: DETAILED ECONOMIC IMPACT ANALYSIS

The US Department of Agriculture in conjunction with the Minnesota IMPLAN Group (MIG) developed (and MIG continues to refine) a complete integrated analysis tool for economic planning efforts called IMPLAN (IMpact analysis for PLAN- ning). IMPLAN is a microcomputer-based system for constructing regional economic models. It generates input-output multipliers by geographic region and by industry, combined with a county/ state database (using the North American Industry Classification System (NAICS) developed jointly by the United States, Canada, and Mexico to provide new comparability in statistics about business activity across North America), which allows the assessment of change in overall economic activity. IMPLAN can be used to estimate the impact of organizational projects and expenditures by industry on regional output, household earnings, and jobs, both inside and outside of a given industry.

IMPLAN's output is aggregated based on direct, indirect, and induced economic effects:

- Direct effects: represents the response for a given industry (in this case, the total government spending on the Medicaid expansion population).
- Indirect effects: represents the response by all local industries caused by the iteration of health care spending.
- Induced effects: represents the response by all local industries to the expenditures of new household income generated by the direct and indirect effects.

Direct spending by state and federal governments was allocated using standard guidance provided by the Centers for Medicare and Medicaid Service as shown in the following figure.

Figure 1: State Spending on Medicaid Expansion by Type of Service, Indiana 2014-2020

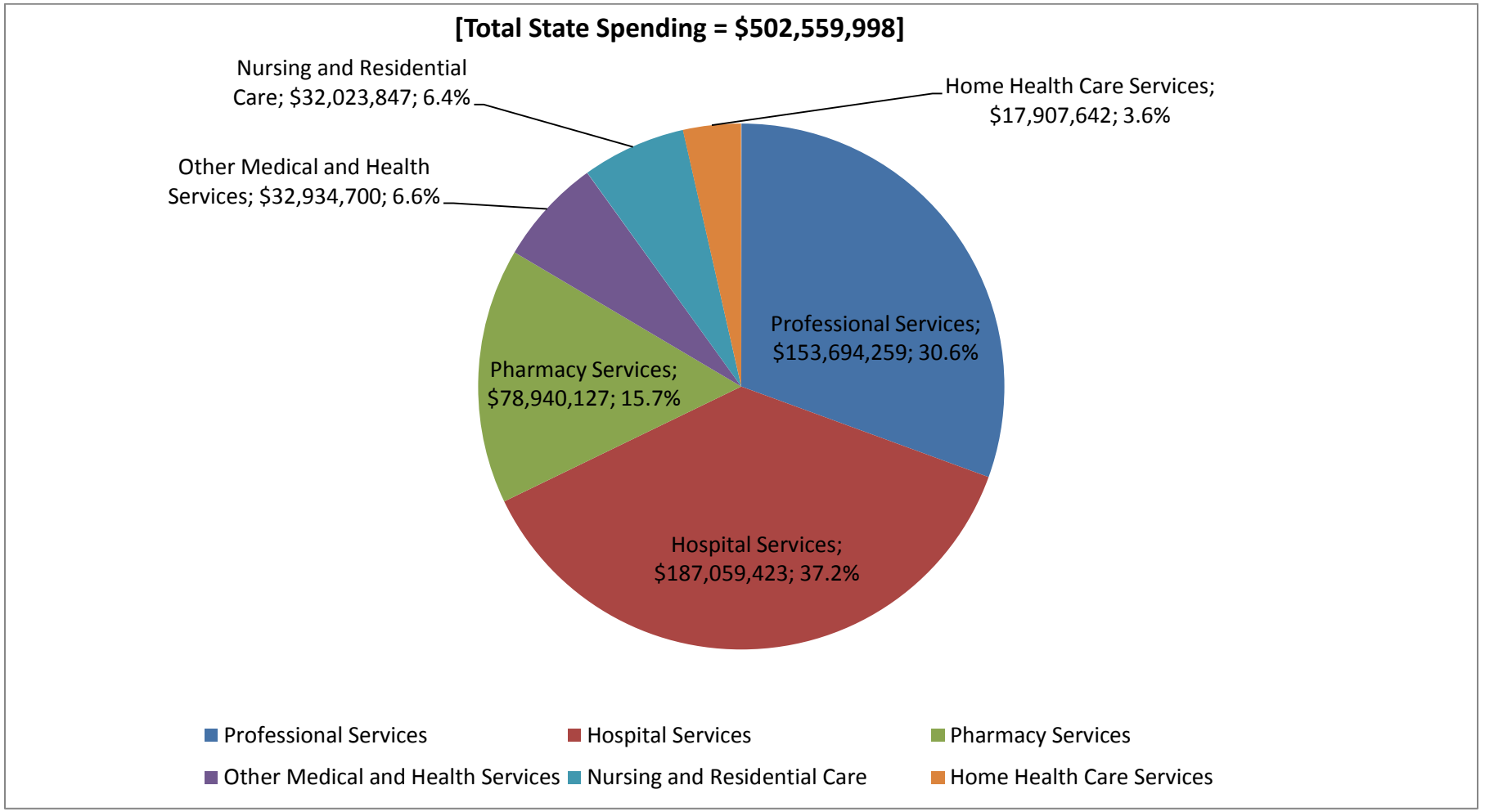

Table 1. Indiana Medicaid Expansion Total (State & Federal) Personal Health Care Expenditures Projections, 2014 – 2020

	2014	2015	2016	2017	2018	2019	2020
Professional Services[1]	$406,940,870.45	$428,158,634.89	$449,891,710.07	$476,395,639.46	$502,466,765.05	$529,791,330.76	$558,792,305.33
	30.7%	30.6%	30.5%	30.6%	30.6%	30.6%	30.6%
Hospital Services[2]	$497,077,610.49	$523,041,047.77	$552,862,995.39	$582,261,337.12	$612,483,997.93	$643,924,213.06	$678,925,336.94
	37.5%	37.4%	37.5%	37.4%	37.3%	37.2%	37.1%
Pharmacy Services[3]	$206,784,285.96	$219,389,378.84	$230,396,409.48	$244,425,213.71	$257,801,575.53	$271,909,901.70	$287,441,591.62
	15.6%	15.7%	15.6%	15.7%	15.7%	15.7%	15.7%
Other Medical and Health Services[4]	$82,183,498.27	$88,035,228.45	$93,985,236.09	$99,638,303.68	$106,733,136.37	$113,959,691.28	$121,230,136.92
	6.2%	6.3%	6.4%	6.4%	6.5%	6.6%	6.6%
Nursing and Residential Care	$87,485,659.45	$91,249,212.98	$95,458,358.92	$99,638,303.68	$105,091,088.12	$110,495,870.88	$115,927,461.25
	6.6%	6.5%	6.5%	6.4%	6.4%	6.4%	6.3%
Home Health Care Services	$45,068,370.02	$47,511,075.67	$50,528,112.82	$54,489,697.32	$57,471,688.81	$61,829,194.21	$66,192,020.46
	3.4%	3.4%	3.4%	3.5%	3.5%	3.6%	3.6%
TOTAL	**$1,325,540,295**	**$1,397,384,579**	**$1,473,122,823**	**$1,556,848,495**	**$1,642,048,252**	**$1,731,910,202**	**$1,828,508,853**
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Indiana expenditure projections based on National Personal Health Care Expenditures Projections (National Centers for Medicare & Medicaid Services. (2012). National health expenditure projections, 2011 – 2021. Baltimore, MD. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf)
Expenditure Model Output (2014-2020)

1. Professional services include: physician and clinical; dental; and other professional services.
2. Hospital services include services provided by inpatient hospitals.
3. Pharmacy services include retail outlet sales of medical products (e.g., prescription drugs, durable medical equipment, and other non-durable medical products).
4. Other medical and health services include: medical or diagnostic labs, outpatient or other ambulatory care.