



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE.

Questions Regarding Impact of Medicaid Expansion on the State of New Hampshire: Phase II

Prepared for: New Hampshire Department of Health and Human Services

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Health Benefits Simulation Model (HBSM) Summary Documentation

- For a detailed description of the Lewin Group HBSM model see <http://www.lewin.com/publications/publication/413/>

1. Questions on HBE Enrollment in the absence of the Expansion

- What were the assumptions that led to the conclusions about the private market take-up rates in Figure E-5/Figure 6?
- For example, how many in the would-be Medicaid Enrollee population have incomes under the individual mandate threshold? How many have incomes below 100% FPL?
- How many have incomes between 100-138% FPL?
- What is the insurance status of the people in each of these income levels (uninsured, those with ESI and those with DP insurance)?

Transitions in Coverage Under the ACA for People below Poverty

		Coverage under the ACA					
Current Coverage Source		Employer	Individual	Medicaid	Other	Uninsured	
ACA with Medicaid Expansion							
< 100%	Employer	50,990	37,710	1,578	11,670		32
< 100%	Individual	9,575	692	5,566	3,221		97
< 100%	Medicaid	51,381	950	1	50,430		
< 100%	Other	92,360				92,360	
< 100%	Uninsured	47,827	5,598	3,197	27,668		11,364
< 100%	Total	252,133	44,951	10,341	92,988	92,360	11,492
ACA without Medicaid Expansion							
< 100%	Employer	50,990	48,560	2,311			119
< 100%	Individual	9,575	944	8,531			100
< 100%	Medicaid	51,381	949	1	50,431		
< 100%	Other	92,360				92,360	
< 100%	Uninsured	47,827	7,326	3,197	2,495		34,809
< 100%	Total	252,133	57,779	14,040	52,926	92,360	35,027

MAGI excludes taxable portion of Social Security income

Transitions in Coverage Under the ACA for People between 100% and 138% Poverty

			Coverage under the ACA				
Current Coverage Source			Employer	Individual	Medicaid	Other	Uninsured
ACA with Medicaid Expansion							
100-138%	Employer	18,184	12,940	465	4,753		27
100-138%	Individual	2,468	115	1,355	977		21
100-138%	Medicaid	12,884	406		12,477		
100-138%	Other	15,876				15,876	
100-138%	Uninsured	18,963	2,450	876	12,111		3,525
100-138%	Total	68,375	15,911	2,696	30,318	15,876	3,573
ACA without Medicaid Expansion							
100-138%	Employer	18,184	16,547	1,610			27
100-138%	Individual	2,468	134	2,283			51
100-138%	Medicaid	12,884	397	9	12,477		
100-138%	Other	15,876				15,876	
100-138%	Uninsured	18,962	3,508	11,620	280		3,554
100-138%	Total	68,374	20,587	15,521	12,758	15,876	3,632

MAGI excludes taxable portion of Social Security income

Transitions in Coverage Under the ACA for People above 138% Poverty

		Coverage under the ACA					
Current Coverage Source		Employer	Individual	Medicaid	Other	Uninsured	
ACA with Medicaid Expansion							
138% +	Employer	788,405	762,059	22,036	72	45	4,194
138% +	Individual	41,983	3,961	34,469	15		3,538
138% +	Medicaid	50,776	2,202	0	48,573		
138% +	Other	92,963				92,963	
138% +	Uninsured	103,616	17,816	36,164	1,182		48,454
138% +	Total	1,077,743	786,038	92,669	49,841	93,008	56,187
ACA without Medicaid Expansion							
138% +	Employer	788,405	762,185	21,981		45	4,194
138% +	Individual	41,983	3,969	34,483			3,531
138% +	Medicaid	50,776	2,202	0	48,573		
138% +	Other	92,963				92,963	
138% +	Uninsured	103,616	17,819	36,529	959		48,309
138% +	Total	1,077,743	786,176	92,994	49,532	93,008	56,034

MAGI excludes taxable portion of Social Security income

1. Questions on HBE Enrollment in the absence of the Expansion (cont.)

- What were the assumptions that led to the conclusions about the private market take-up rates?
 - For each individual/family, we estimate the cost of insurance under prior law and again under the ACA. These premiums reflect:
 - Prior law premium includes the cost of insurance for the individual in the individual market under the rating rules in New Hampshire;
 - Premiums under the ACA include the cost of insurance under community rating less premium subsidies in the exchange.
 - We estimate the likelihood of taking the coverage based upon the difference in premium before and after the ACA using a premium elasticity averaging about -3.4.
 - This means that on average a one percent reduction in premium corresponds to a 3.4 percent increase in the number of people taking coverage.

1. Questions on HBE Enrollment in the absence of the Expansion (cont.)

- What were the assumptions that led to the conclusions about the private market take-up rates?
 - The effect of the mandate is simulated on the basis of the penalty the individual/family would pay under the ACA if they remain uninsured.
 - We treat the penalty as an increase in the cost of remaining uninsured, which has the effect of reducing the net new cost of taking coverage.

Logit Coverage Equation	
Variable	Parameter Estimate
Intercept	-2.2193 *
Black	-0.2473 *
Hispanic	-0.4089 *
Asian	-0.2549 *
Married Family Head	0.0324 *
Spouse of Family Head	-0.4789 *
Age/100	5.1666 *
Age/100 Squared	-4.3975 *
Earnings/100,000 ^{c/}	3.1224 *
Full-Time Worker	1.2653 *
Premium Amount/1000 ^{d/}	-0.7579 *

Take up of non-group coverage is based on the change in the likelihood of coverage at different premium amounts.

Probability of taking coverage at current premium price in the market

Probability of taking coverage at ACA premium price accounting for subsidies and penalties

Take up rate = Change in likelihood of taking coverage ((PROB ACA-PROB current)/(1.0-PROB current))

1. Questions on HBE Enrollment in the absence of the Expansion (cont.)

- What assumptions were made about the relative affordability of these products for this low-income group?
 - Current price for insurance was simulated for this group using rating rules in the state for a “Silver” tier plan
 - Price for insurance under ACA is capped at percent of income as defined in the law:
 - Up to 133% FPL 2% of income
 - 133 - 150% FPL 3 - 4% of income
 - 150 - 200% FPL 4 - 6.3% of income
 - 200 - 250% FPL 6.3 - 8.05% of income
 - 250 - 300% FPL 8.05 - 9.5% of income
 - 350 - 400% FPL 9.5% of income
 - This generates a significant change in the cost of insurance for low income families

2. Questions on Medicaid Participation and Crowdout

- Out of pocket spending - clarification about whether these are just financial liabilities or actual amounts paid by people at or below 138% FPL. For the income level of this population, it seems unlikely they are based on actual spending.
 - Out of pocket spending estimates for uninsured (Figure 8) are for health care services paid by the individual.
 - Estimates were produced using data from the Medicaid Expenditure Panel Survey, which is a national sample of households that collects data on health care events for each individual and the amount that was paid by various sources including out-of-pocket.
 - Our model incorporates these data but adjusts spending amounts to match CMS State Health Expenditure estimates in New Hampshire by type of service and source of payment. Spending is also inflated to 2014.
 - Our model assumes that health services continued to be purchased by individuals similar to the 2005 data even though health inflation has increased much faster than general inflation since that period.

3. Questions on Medicaid Participation and Crowdout

- Further explanation on the range of circumstances and data used to determine when an insured member would drop commercial coverage to receive coverage from Medicaid.
- The estimation suggests that 35 percent of the Medicaid expansion population would come from otherwise insured populations.
- It seems unlikely that this population is purchasing insurance in the individual market, and the assumption that members of this population would drop employer coverage preferring enrollment in Medicaid seems unlikely at this rate.

Medicaid Participation Function used for Modeling estimates lower participation rates for people with access to private coverage

Logistic Estimate of Medicaid Participation Function^{a/}

Variable Name	Variable Definition	Parameter Estimate	Pr> Chi-Square
Intercept		1.0597	0.0001
Age 6	Age less than 6	-0.7273	0.0001
Age 12	Age 6 - 12	-0.6338	0.0001
Age 18	Age 13 - 18	-0.8527	0.0001
Age 24	Age 19 - 24	-0.6029	0.0001
Age 34	Age 25 - 34	-1.0297	0.0001
Age 45	Age 35 - 45	-1.0604	0.0001
Poor H	In poor health	1.1464	0.0001
FairH	In fair health	0.9178	0.0001
GoodH	In good health	0.3957	0.0001
Vgood	In very good health	0.2044	0.0001
WorkFam	Worker in family	-0.3383	0.0001
Fincome	Family income/100,000	1.9258	0.0001
Black	Black	0.1602	0.0001
Asian	Asian	-0.0991	0.0001
Hispanic	Hispanic	-0.2242	0.0001
CashElig	Also eligible for cash assistance	0.4432	0.0001
PrivateC	Parent with private coverage	-1.0829	0.0001
PrivateS	Self or Spouse with private coverage	-0.6872	0.0001

a/ The omitted age group is age 55 and older.

Results of Medicaid Crowdout Studies Vary but many are consistent with our estimates

Authors	Date	Article	Definition of Crowd-Out	Estimate
J. Ham, L. Shore-Sheppard	2005	The Effect of Medicaid Expansions for Low-Income Children on Medicaid Participation and Private Insurance Coverage: Evidence From the SIPP	Private Insurance/ Public Insurance	0%
L.D. Shore-Sheppard	2005	Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance	Private Insurance/ Public Insurance	0%
A. Aizer, J. Grogger	2003	Parental Medicaid Expansions and Child Medicaid Coverage	Coefficient on private coverage equation (no crowd-out calculations)	Statistically insignificant effect on private coverage for mothers and for children
E. Yazici, R. Kaestner	2000	Medicaid Expansions and the Crowding out of Private Health Insurance Among Children	Private Insurance/ Public Insurance	55-59%
L.J. Blumberg, L. Dubay, S.A. Norton	2000	Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis using the SIPP	% of children made eligible losing private relative to gaining public	4%
Cutler and Gruber (original study)	1996	Health Insurance Eligibility, Utilization of Medical Care, and Child Health	1) The reduction in private insurance relative to the growth in public insurance (private insurance/public insurance) 2) 1-(uninsured/public insurance)	31%-40%; 50% w/ family spillovers

Results of CHIP Crowdout Studies are consistent with out estimates

Authors	Date	Article	Definition of Crowd-Out	Estimate
J. Gruber, K. Simon	2008	Crowd-out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?	Number of privately insured falls by 60% as much as the number of publicly insured rises.	60%
C. Bansak, S. Raphael	2006	The Effects of State Policy Design Features on Take-Up and Crowd-Out Rates for the State Children's Health Insurance Program	Rate of crowd out = absolute value of (decline in private health insurance coverage / program take-up rate)	25-33%
J.L.Hudson, T.M. Selden, J.S. Banthin	2005	The Impact of SCHIP on Insurance Coverage in Children	Reduction in any private insurance coverage / Increase in public insurance coverage	19%-56%: Using difference-in-trends analysis (varying central groups) 39% -70%: Using instrumental variable analysis (linear v. non-linear trends)
A.T. LoSasso, T. Buchmueller	2004	The Effect of the State Children's Health Insurance Program on Health Insurance Coverage	Reduction in private insurance coverage/ Increase in public insurance coverage	46.6%
P. Cunningham, J. Hadley, J. Reschovsky	2002	The Effects of SCHIP on Children's Health Insurance Coverage: Early Evidence from the Community Tracking Study	(Decrease in private) - (Decrease in private assuming no change in eligibility) / Increase in Medicaid and other state coverage	38%

Results of CHIP Crowdout Studies are consistent with out estimates (cont.)

Authors	Date	Article	Definition of Crowd-Out	Estimate
Congressional Budget Office	2007	The State Children's Health Insurance Program	Reduction in private coverage as a percent of increase in public program enrollment	25-50%
A. Sommers, S. Zuckerman, L. Dubay, G. Kenney	2005	Substitution Of SCHIP For Private Coverage: Results From A 2002 Evaluation In Ten States	Percent of recently enrolled children who had private coverage prior to SCHIP enrollment	14%
J. Nogle, E. Shenkman	2004	Florida KidCare Program Evaluation Report, 2003	Percent of newly enrolled children where family coverage is available to a parent through their employer	18%
A.R. Allison et al.	2003	Do Children Enrolling in Public Health Insurance Have Other Options	Percent of new SCHIP enrollees who were eligible to be enrolled in job-based insurance through a parent.	51%

4. Questions on Commercial Insurance Market Impact Analysis

- Clarification regarding allowed costs on page 11 - are these costs just those contributing to premiums (paid vs. allowed)?
 - The average costs described in the report include all health care spending for individuals including patient cost-sharing, non-covered services and services that were provided free from provider. This would closely resemble an allowed amount.
- Additional information on the calculation of baseline insurance market membership numbers. The numbers provided as baseline in 2014 for the small group (215,469) seem high, and the large group either too high (589,091) if just including fully-insured members, or too low if including self-funded members.
 - For this analysis, we defined small group as under 100 workers to match the definition in the ACA for SHOP Exchange eligibility.
 - Membership is presented as the average monthly number of New Hampshire residents covered by employer insurance and is derived from Current Population Survey data.

Illustration of Impact on the Individual Market with and without the expansion

Individual Commercial Market: Members and Average Allowed Costs With and Without Medicaid Expansion (2014)

	With Medicaid Expansion		Without Medicaid Expansion	
	Members	Average Allowed Costs	Members	Average Allowed Costs
Current Individual Market	50,189	\$339	50,189	\$339
Leave Individual Market	11,860	\$243	8,187	\$261
To Medicaid	3,947	\$196	0	\$0
To Other Coverage	7,913	\$266	8,187	\$261
Retain Individual Market Coverage	38,329	\$369	42,002	\$354
Leave Other Coverage for Individual	67,827	\$518	82,934	\$530
From Uninsured	40,417	\$313	51,828	\$307
From High-Risk Pool	3,329	\$2,390	3,594	\$2,689
From Other Coverage	24,080	\$603	25,912	\$692
Individual Market Under ACA	106,156	\$464	124,936	\$471

5. Questions on analysis performed comparing hospital payments between commercially insured below 138% FPL and Medicaid

- Most likely, all hospitals in New Hampshire write off receivables for any patient liabilities from this population, usually incomes below 200% FPL as charity care. Cost sharing subsidies would greatly increase the payment levels to providers, but since this is a population assumed to be covered by a Medicaid expansion, what does the model assume about eligibility for these subsidies above and below 100 percent FPL? Also, what were the assumptions about the coverage levels (metal level and/or catastrophic coverage)?
 - We assume most people between 100% and 138% FPL will enroll in the silver plan, but will receive cost sharing subsidies that effectively increases the actuarial value of the plan to 94%.
 - This group will also receive reduced out-of-pocket limits of (\$1,983/individual; \$3,967/family) compared to (\$5,950/individual; \$11,500/family) for higher income families.

Illustration of Benefit Packages used in the model based on income

	Without Cost Sharing	Senate Bill - Benefits Packages					Subsidy Plans			
		Platinum Package	Gold Package	Silver Package	Bronze Package	Bronze Small Business	Less than 150% FPL	150-200% FPL	200-250% FPL	250-400% FPL
Actuarial Value	100%	90%	80%	70%	60%	60%	94%	87%	73%	70%
Hospital Deductible	\$0	\$100	\$400	\$1,500	\$4,500	\$2,000	\$0	\$200	\$1,500	\$1,500
Hospital Coinsurance	0%	10%	15%	25%	35%	80%	8%	10%	20%	25%
Medical Deductible										
Single	\$0	\$100	\$400	\$1,500	\$4,500	\$2,000	\$0	\$200	\$1,500	\$1,500
Family	\$0	\$200	\$800	\$3,000	\$9,000	\$4,000	\$0	\$400	\$3,000	\$3,000
Medical Coinsurance	0%	10%	25%	25%	50%	80%	8%	15%	25%	25%
Prescription Drugs	0%	10%	25%	25%	50%	80%	8%	15%	25%	25%
Preventive Care	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Out-of-Pocket Limit										
Single	\$0	\$5,950	\$5,950	\$5,950	\$5,950	\$5,950	\$5,950	\$5,950	\$5,950	\$5,950
Family	\$0	\$11,900	\$11,900	\$11,900	\$11,900	\$11,900	\$11,900	\$11,900	\$11,900	\$11,900
Per Member Per Month (PMPM) in 2011	\$424	\$382	\$339	\$297	\$254	\$254	\$398	\$369	\$310	\$297

Assumes benefit package includes the following services: Inpatient hospital services; Outpatient hospital services; Physician services; Equipment and supplies incident to physician services; Preventive services; Maternity services; Prescription drugs; Rehabilitative and rehabilitative services; and Well baby and well child visits and dental, vision, and hearing services for children.

The Act also reduces the out-of-pocket limits for families in the exchange below 400% FPL.

Source: Lewin Group estimates.

6. Question on Medicaid Payment Rates and Delivery System Capacity

- What were the assumptions and impact on the findings, if any, about changes to the currently covered Medicaid population that result in a higher match rate or dollars to the state?
 - None, we assumed that the newly enrolled would receive the standard Medicaid benefit for TANF adults and provider payment rates would be the same as current Medicaid.
- Could the higher match rate for the expansion population result in higher provider payments?
 - This was not examined in the study.
- Was any analysis of the delivery system capacity constraints performed?
 - This was not examined in the study.

7. Questions regarding assumptions about uncompensated care spending for low-income

- What assumptions were made relative to how those who are insured at or below 138% FPL may contribute to bad debt or charity care?
- Is there a percentage of people in the crowd-out population (those who migrate from private to public coverage in the event of a Medicaid expansion) who were assumed to drive bad debt or charity care costs?
- Is there a percentage of people who are privately insured at these low income levels who don't migrate to public programs who are assumed to drive bad debt or charity care?
- What assumptions were made about the relative generosity of the insurance products people at these income levels have?
- Are these assumptions reflected in the uncompensated care cost reductions?
- How sensitive are these assumptions to relaxation and how would any relaxation of those assumptions impact the projections of this analysis?

Assumptions on Uncompensated Care for the Medicaid Expansion Modeling

- We used data from the Medical Expenditure Panel Survey (MEPS) in our model which provides an estimate of the amount of free care received by insured and uninsured patients.
- We adjusted these amounts to match data provided by NHHA - \$252.7 million BD & CC provided in 2011, 75% was for uninsured patients and 25% for insured patients.
- Calculated the portion of Uncompensated Care that would be reduced as people become covered under ACA with and without the expansion.

	Distribution of Hospital Uncompensated Care Costs in 2011	Percent Reduction in Uncompensated Care Costs		Reduction in Uncompensated Care Costs	
		With Medicaid Expansion	Without Medicaid Expansion	With Medicaid Expansion	Without Medicaid Expansion
Insured Patients	\$63.2	4%	0%	\$2.5	\$0.0
Uninsured Patients	\$189.5				
< 100% FPL	\$91.4	74%	24%	\$67.8	\$22.0
100-200% FPL	\$50.2	81%	80%	\$40.6	\$40.4
200%+ FPL	\$47.9	48%	48%	\$22.9	\$22.9
Total	\$252.7			\$133.9	\$85.4

8. Questions regarding Medicaid premium tax assessment under managed care scenario

- Is it possible to clarify what amount of revenue is generated by the insurance premium tax assessment in a managed care context and to confirm that it is paid to the General Fund?
 - Study assumes a two percent premium assessment will be levied on all participating health plans contracted under the state's Medicaid managed care program, if the state chooses to implement Medicaid expansion under a managed care arrangement.
 - The study only looked at the amount of the tax that would be associated with the expansion population and not the entire Medicaid program.
 - The Hew Hampshire Insurance Department confirmed that revenue from the assessment would go to the General Fund.

Calculation of Health Plan Assessment Amount on Expansion Population under a Managed Care Arrangement

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	44,169	51,548	59,157	59,895	60,674	61,455	62,237	
Health Plan Payments								
State Cost	-\$2,075,113	-\$2,743,784	-\$17,439,567	\$538,800	\$4,176,886	\$8,018,446	\$37,207,597	\$27,683,266
Federal Cost	\$272,283,669	\$307,886,500	\$374,398,425	\$367,435,619	\$374,947,340	\$382,400,117	\$364,641,663	\$2,443,993,334
Subtotal	\$270,208,557	\$305,142,716	\$356,958,859	\$367,974,419	\$379,124,226	\$390,418,564	\$401,849,260	\$2,471,676,600
Health Plan Assessment Amount	\$5,404,171	\$6,102,854	\$7,139,177	\$7,359,488	\$7,582,485	\$7,808,371	\$8,036,985	\$49,433,532

9. Question on the economic impact analysis

- A more detailed explanation of how the \$2.5B in federal revenue is accounted for in the second half of the report would be beneficial. Which economic sectors would this federal aid go to and in what relative percentages? In general, how is it distributed in the state economy and what assumptions were used in that distribution?
 - To estimate the overall economic impact of the Medicaid expansion in New Hampshire, we estimated net change in revenues to New Hampshire providers due to all provisions of the ACA with and without the Medicaid expansion in order to isolate the effects of the Medicaid expansion itself.
 - Also incorporated changes in household health spending under the ACA with and without the Medicaid expansion. Since households would spend less for health care under the expansion, these savings would be reintroduced into New Hampshire's economy as more consumer spending for other goods and services.

Economic inputs due to ACA with and without expansion - provider revenues and household spending

	2014	2015	2016	2017	2018	2019	2020	Total
Total impact in provider payments due to the ACA with the Medicaid expansion								
hospitals	\$135.4	\$155.1	\$183.9	\$180.4	\$178.2	\$176.6	\$183.5	\$1,193.0
prescriptions	\$70.2	\$84.6	\$99.9	\$103.9	\$108.1	\$112.4	\$116.9	\$696.1
other ambulatory	\$162.5	\$195.7	\$231.2	\$240.5	\$250.1	\$260.1	\$270.5	\$1,610.7
Total	\$368.1	\$435.3	\$515.1	\$524.8	\$536.4	\$549.1	\$570.9	\$3,499.8
Total impact in provider payments due to the ACA without the Medicaid expansion								
hospitals	\$153.2	\$177.8	\$212.7	\$213.2	\$215.9	\$219.0	\$228.9	\$1,420.7
prescriptions	\$51.6	\$62.3	\$73.8	\$76.9	\$80.2	\$83.6	\$87.2	\$515.6
other ambulatory	\$141.2	\$170.3	\$201.5	\$209.8	\$218.4	\$227.3	\$236.7	\$1,405.2
Total	\$346.0	\$410.3	\$488.0	\$499.9	\$514.4	\$529.9	\$552.8	\$3,341.4
Net impact in provider payments due to the ACA without the Medicaid expansion								
hospitals	-\$17.8	-\$22.7	-\$28.8	-\$32.8	-\$37.7	-\$42.4	-\$45.5	-\$227.7
prescriptions	\$18.7	\$22.3	\$26.1	\$27.0	\$27.9	\$28.8	\$29.7	\$180.5
other ambulatory	\$21.2	\$25.4	\$29.7	\$30.7	\$31.8	\$32.8	\$33.8	\$205.5
Total	\$22.1	\$25.0	\$27.1	\$25.0	\$21.9	\$19.2	\$18.1	\$158.3
Net change in health spending for households due to Medicaid expansion (millions)								
with expansion	\$53.1	\$65.2	\$78.5	\$83.3	\$88.2	\$93.5	\$99.2	\$561.1
w/o expansion	\$123.1	\$151.1	\$182.0	\$192.9	\$204.5	\$216.8	\$229.8	\$1,300.3
Net difference	-\$70.0	-\$85.9	-\$103.5	-\$109.7	-\$116.3	-\$123.3	-\$130.6	-\$739.3

Economic Model Outputs

- Used REMI Tax-PI model - dynamic, multi-sector regional economic simulation model used for economic forecasting and measuring the impact of public policy changes on economic activity. Tax-PI uses several different economic modeling approaches, including input-output analysis, econometrics, computable general equilibrium, and economic geography.
- The outputs from the simulation reflected the economic growth created by the ACA with and without the Medicaid expansion. Also accounts for some leakage that would go outside the state.
- These outputs provided information on an array of economic and demographic indicators including total state employment, gross state product, personal income, and total revenues.

Economic outputs due to ACA with and without expansion - GSP and personal income

Change in Gross State Product from Baseline, 2014-2020 (in millions)

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Expansion	\$316.09	\$374.57	\$436.17	\$433.90	\$429.16	\$423.73	\$425.44	\$2,839.05
No Expansion	\$274.26	\$323.45	\$376.65	\$374.06	\$370.23	\$365.57	\$366.57	\$2,450.78
Difference	\$41.83	\$51.13	\$59.52	\$59.84	\$58.93	\$58.16	\$58.87	\$388.27

Change in Personal Income from Baseline, 2014-2020 (in millions)

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Expansion	\$223.41	\$282.81	\$343.84	\$359.59	\$370.35	\$377.79	\$388.51	\$2,346.30
No Expansion	\$197.67	\$249.03	\$302.83	\$316.48	\$326.53	\$333.60	\$343.24	\$2,069.38
Difference	\$25.73	\$33.78	\$41.01	\$43.12	\$43.82	\$44.19	\$45.27	\$276.92

Economic outputs due to ACA with and without expansion - employment

Change in Total Employment from Baseline, 2014-2020

	2014	2015	2016	2017	2018	2019	2020
Expansion	4,304	4,995	5,672	5,501	5,287	5,073	4,943
No Expansion	3,730	4,310	4,898	4,747	4,571	4,391	4,279
Difference	574	685	773	754	717	682	664

Average Change in Employment for Top 5 Sectors from Baseline, 2014-2020

	With Expansion	Without Expansion	Difference, with Expansion
Ambulatory health care services	1,578	1,315	263
Hospitals	1,035	1,212	-177
Retail trade	721	489	232
Construction	450	367	83
Administrative and support services	173	151	22

10. Potential impact of an alternative UCC Pool distribution assumption

- There is a concern that it would have been useful to have projected scenarios relative to the uncompensated care pool distribution that reflected a distribution schedule similar to the one that existed prior to the 2012-2013 budget, given that the 12-13 budget represented a dramatic departure from how the UCCP was typically distributed, that the budget is passed every two years, and the statute that governs the UCCP distribution can be amended that frequently.

10. Potential impact of an alternative UCC Pool distribution assumption (cont.)

- How would such an analysis have impacted the uncompensated care cost reduction projections?
 - We did not model this but speculate that there would be no impact on the reduction in uncompensated care, but there would be an impact on hospital revenues. Our analysis showed that the reduction in uncompensated care was not materially different with or without the expansion when you include Medicare and Medicaid shortfalls.
 - Hospitals would have received additional UCC Pool funding through 2020 under the scenario described in the absence of the ACA.
 - The ACA federal DSH allotment cuts would have reduced the future federal matching funds for the UCC pool, thus reducing the amount that could be paid to hospitals.
 - This would represent a loss of revenue relative to the baseline, but would have occurred with or without the expansion.

11. Questions on direct payments for care by the uninsured

- Further examination of the low-income insured would be useful. Out-of-pocket health spending and medically-related bankruptcy were analyzed for the uninsured, but were they analyzed for those who are insured but whose insurance coverage may change given the Medicaid expansion?
 - New Hampshire specific data on medically related bankruptcy did not exist for this analysis, but conclusions on potential impacts were drawn based on studies and evidence from other states.

12. Questions on program cost offsets

- With respect to the savings offsets, what assumptions were made about how many services or people would be covered by the Medicaid expansion in the first two years? For example, for the Cypress Center, is the offset the entire General Fund appropriation for the Cypress Center? What assumptions were made about the percentage of the clients of the Cypress Center would be covered by Medicaid in the first year? What type of services does the Cypress Center provide? Would they all be Medicaid covered services?
 - For state employees opting for Medicaid, we assumed the same lag in take-up as for all other groups (76% of ultimate enrollment in year 1, 88% in year 2 and 100% in year 3)

12. Questions on program cost offsets (cont.)

- For state corrections use of Medicaid funds for inpatient services for prisoners, we assumed the state would take full advantage of the option beginning in 2014. Thus, all inpatient services for prisoners were assumed to be paid through Medicaid.
- The New Hampshire Bureau of Behavioral Health cited that an annual sum of \$675,000 is contributed by the state towards providing indigent care for patients at the Cypress Center to help fund indigent care for short-term crisis stabilization services. However, information on actual services provided using those funds was not available.
 - The state funding is not paid on a per service basis so would not automatically be reduced, but would require the state to discontinue this funding.

13. Questions on program cost offsets

- How was Medicaid utilization projected for the expansion population, e.g. were long term care services perhaps overly weighted because they are such a big part of current population usage?
 - For estimating the cost for the expansion population, we assumed their utilization would be similar to current non-Medicare Dual Temporary Assistance for Needy Families (TANF) enrollees.
 - We based cost estimates on summary data supplied by DHHS for this group as well as other supplemental sources including our Health Benefits Simulation Model (HBSM), the Office of the Actuary's 2011 report, and a prior published New Hampshire study.
 - Although we did not look at utilization across service types, this population historically has very low utilization of long term care services. So this should not have been a factor in the cost estimates.