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THE MEDICAID EXPANSION:

A Transformative and Fiscally Sustainable Policy for North Carolina

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KEY FINDINGS

- **The Medicaid expansion is projected to extend health insurance coverage to 488,867 North Carolinians in 2014.**
- **The first year of the expansion alone is expected to reduce the number of uninsured persons in North Carolina by 64 percent, from 1.3 million in 2013 to 475,185 in 2014. Over 95 percent of new enrollees in Medicaid under the expansion are expected to be previously uninsured.**
- **Determining the cost of Medicaid expansion to North Carolina involves considering not only the direct costs of providing coverage but also the savings that come from having fewer uninsured residents and an overall healthier population.**
- **Cost savings from the reduction in uncompensated medical care is estimated to reach between $1 and $2 billion between the period 2014-2019, with the most conservative estimate still outpacing the state's projected $830 million in costs associated with the Medicaid expansion.**

The federal health reform law directs states to expand Medicaid to cover nonelderly individuals with modified adjusted gross incomes up to 138 percent of the federal poverty level (FPL).[1] The June 2012 US Supreme Court decision that upheld the constitutionality of the health reform law states that the federal government can't force states out of the Medicaid program if they refuse to follow federal law ordering expansion of the program to cover millions of new enrollees.

Medicaid expansion, if implemented in all 50 states, would cover 17 million Americans who currently do not have any form of health insurance – including more than half a million adults and children living in North Carolina. Determining the cost of Medicaid expansion to North Carolina involves considering not only the direct costs of providing coverage but also the savings that come from having fewer uninsured residents and an overall healthier population.

Expanding Health Coverage to Low-Income Working Adults and Parents

Under current law, North Carolina's Medicaid program covers many low-income children through NC Health Choice, but it does not cover hundreds of thousands of low-income, working parents and adults. In fact, a full-time working parent earning minimum wage in North Carolina exceeds the income requirements for Medicaid eligibility, and a full-time worker with no children isn't eligible for Medicaid at all. However, under the Medicaid expansion, parents in families at or below $25,400 in annual income for a family of three and all adults with incomes below $14,856 will qualify for health insurance under Medicaid. Without the expansion, hundreds of thousands of low-income, working adults will continue to be cut off from access to health insurance since tax subsidies for purchasing private health insurance through the Health Insurance Exchange are only available to individuals and families earning more than 100 percent FPL.

Effect on North Carolina's Uninsured Population

With the implementation of health reform, North Carolina's total uninsured population is expected to drop by 64 percent – from 1.3 million in 2013 to 476,185 in 2014. Actuarial estimates prepared by Milliman, Inc. for the NC Department of Insurance project that 488,867 individuals will gain health insurance coverage through Medicaid in 2014 and that 95.6 percent of them will have been previously uninsured.[2] An additional 299,539 uninsured individuals are projected to gain coverage through the state's Health Insurance Exchange in 2014, including an estimated 19,736 individuals who are eligible for the Medicaid expansion who will elect to purchase subsidized private health insurance rather than enroll in Medicaid.[3]

State Fiscal Implications of the Medicaid Expansion

For the first three years of the Medicaid expansion, the federal government will pay 100 percent of the cost of newly eligible program beneficiaries. The cost to states is primarily due to the likelihood that people who are eligible for Medicaid under its current standards but are not currently participating will join the program; for most of those enrollees, the state will have to cover roughly 35 percent of the cost of their health coverage as is done under current law.

In North Carolina, the state's share of the cost of Medicaid expansion in 2014 is estimated at $70.5 million, and the aggregate cost of the expansion is estimated at $830.2 million over 6 years from 2014 to 2019.[4] In the full context of North Carolina's Medicaid program, the first year of the Medicaid expansion will require the state to appropriate 2 percent more than in FY2012-13, but will provide health coverage for almost half a million working adults and children – many of whom have never had health coverage before.

An influx of approximately $5.1 billion in new federal spending on health care in North Carolina will follow the Medicaid expansion in 2014. For the most part, these funds will go to health care providers to pay for medical care and, in so doing, will boost local economies throughout the state. Over the six years from 2014 to 2019, the North Carolina Division of Medical Assistance estimates that the Medicaid expansion will cost $16.3 billion, of which the federal government will pay 15.5 billion, or 94.9%, and the state's total share will be $830.2 million, or 5.1 percent.

Nationwide, it is estimated that states will have to spend 2.8 percent more on

Medicaid over the first five years of implementation than they would have spent simply continuing the program as it currently exists.[5] On average, people who will become eligible for Medicaid under the expansion are younger and healthier than the current adult population enrolled in Medicaid, which means they are likely to be much less costly to insure through Medicaid than existing adult populations enrolled in the program. Sixty-eight percent of projected adult enrollees under the Medicaid expansion will be 45 years old or younger, and 81.6 percent of new enrollees are projected to be in good health – and subsequently, far less costly to insure.[6]

State Savings from Participation in the Medicaid Expansion

The size of savings to state and local governments and taxpayers resulting from the Medicaid expansion are potentially large enough to offset a considerable share of new state spending on the expansion.

Under the current health care system, public dollars – state, federal, and local – pay for 75 percent of the total cost of uncompensated care in the United States.[7,8] The cost of uncompensated medical care in North Carolina in 2009 was estimated at $2.1 billion, and in the absence of health reform aggregate spending on uncompensated care was projected to reach $4.4 billion by 2019.[9] By expanding health coverage to a large share of the uninsured population and improving health outcomes through consistent and better-coordinated care, state and local governments are poised to reap sizeable cost savings over both the short and long terms.

Cost savings for the state of North Carolina resulting from lower uncompensated medical care is estimated to range from $1 billion to $2 billion over the six years from 2014 to 2019.[10] As a result of the expansion of health coverage, existing Medicaid payments that directly or indirectly support care for the uninsured can be reduced, as can other types of existing tax-financed appropriations from state and local governments that go to pay for uncompensated care. There also will be less need to shift the cost of uncompensated care to private insurers[11] and health providers.[12]

Other sources of potentially significant cost savings for state and local governments include reductions in tax-financed appropriations for mental health care, substance abuse services, and to some extent, public health. As more individuals obtain health coverage through Medicaid and the health insurance exchange, the cost of these services to states and local governments is expected to decrease significantly. North Carolina committed $665.7 million in state General Fund appropriations to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and $190.4 million to the Division of Public Health in the FY2011-12 state budget. It is likely that cost savings will be realized within both agencies as health reform is implemented.

Conclusion

Having roughly one in five Americans uninsured is a drain on the American workforce and the American economy. The Medicaid expansion directly addresses this problem by extending insurance coverage to nearly 17 million Americans, more than half a million of whom live in North Carolina. Implementing the Medicaid expansion quickly, effectively, and responsibly will not only improve the lives of hundreds of thousands of struggling North Carolinians through greater access to coordinated care – it will also save the state, and its taxpayers, a great deal of money.

1 The law states 133 percent as the upper threshold for individuals to be eligible for Medicaid under the expansion, but in effect eligibility is up to 138 of the federal poverty level because there is a 5 percent income disregard in the eligibility determination. To qualify, a person must be a United States citizen or a lawfully present immigrant who has been in the United States for five years or more. Undocumented immigrants will not qualify for Medicaid coverage.

2 Milliman, Inc., December 9, 2011. North Carolina Benefit Exchange Study. Prepared for the North Carolina Department of Insurance by Milliman, Inc.: Brookfield, WI.

3 Ibid.

4 North Carolina Institute of Medicine, May 2012. Examining the Impact of the Patient Protection and Affordable Care Act in North Carolina: Draft Final Report Pending US Supreme Court Decision. See Table 3.2, Estimated Costs of Medicaid Expansion (SFY 2014-2019).

5 Angeles, January, July 25, 2012. *How Health Reform's Medicaid Expansion Will Impact State Budgets.* Center on Budget and Policy Priorities: Washington, D.C.

6 Holahan, John, Kenney, Genevieve, and Pelletier, Jennifer, August 2010. *The Health Status of New Medicaid Enrollees Under Health Reform.* Urban Institute: Washington, D.C. See Table Table 7. Projected Age and Health Status of Medicaid Eligible Adults Under Reform According to Whether They Enroll in Medicaid or Remain Uninsured.

7 Holahan, John, and Garrett, Bowen, March 2010. *The Cost of Uncompensated Care with and without Health Reform*. Urban Institute: Washington, D.C.

8 A significant amount of public dollars – federal, state, and local – goes towards the cost of uncompensated care through the Medicare and Medicaid disproportionate share hospital programs, indirect medical education payments, and Medicaid supplemental provider payment programs. Beyond these public funds, 25 percent of the total national cost of uncompensated care was borne by tax-financed appropriations by state and local governments for hospital and state public assistance programs, and an additional 25 percent was borne by community health providers, including the Veterans Health Administration (VHA), maternal and child health program, and community health centers. Physicians accounted for 13.6 percent of uncompensated care costs in the form of in-kind contributions or lost revenue, and the remaining 11 percent was shifted onto private insurers. See Holahan, John, and Garrett, Bowen, March 2010. *The Cost of Uncompensated Care with and without Health Reform.* Urban Institute: Washington, D.C.

9 Garrett, Bowen, et al, May 21, 2009. *The Cost of Failure to Enact Health Reform: Implications for States*. Robert Wood Johnson Foundation and Urban Institute: Washington, D.C.

10 This estimate is specific to state-level expenditures on uncompensated care in North Carolina, and does not include likely federal cost savings attributable to reductions in total uncompensated care in North Carolina, which are estimated to range from $1.5 billion to $3.0 billion. See Holahan, John, and Garrett, Bowen, March 2010. *The Cost of Uncompensated Care with and without Health Reform.* Urban Institute: Washington, D.C.

11 Private payers were estimated to bear approximately 11 percent of the total cost of uncompensated care.The amount of cost shifting to private payers was limited because a large share of the community health centers and public hospitals that provide care to the uninsured had relatively small shares of private payers, and thus, there were not many private payers on which these costs could be shifted. This does not imply that hospitals with considerable market clout could not increase charges to private payers, but rather that this was not a dominant source of financing for uncompensated care. See Holahan, John, and Garrett, Bowen, March 2010. *The Cost of Uncompensated Care with and without Health Reform.* Urban Institute: Washington, D.C.

12 Health providers are estimated to bear approximately 13.6 percent of the total cost of uncompensated care. See Holahan, John, and Garrett, Bowen, March 2010. *The Cost of Uncompensated Care with and without Health Reform.* Urban Institute: Washington, D.C.

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