

Review and Discussion of MaineCare Expansion

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*Department of Health
and Human Services*

*Maine People Living
Safe, Healthy and Productive Lives*

Paul R. LePage, Governor

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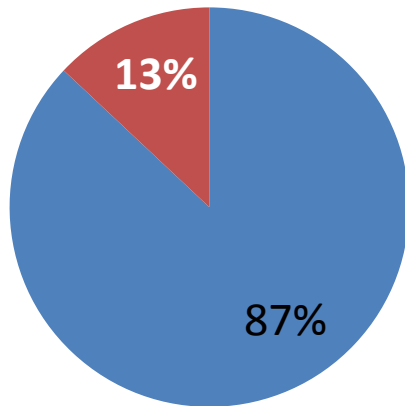
MaineCare at 50: Background and Primer

- MaineCare accounts for 24% of all General Fund expenditures.
 - In 1998, MaineCare accounted for 13% of the General Fund.
 - **The national average is 18%.*** If Maine spent that amount of its FY15 General Fund on Medicaid, Maine taxpayers would have saved \$190 million—enough to cut income taxes by 14%.
 - *As Medicaid spending in Maine has consumed an increasingly large piece of the General Fund pie, it has crowded out other core priorities such as infrastructure and economic development; lead to increased taxes; and resulted in cuts to MaineCare rates and services.*
- Approximately 280,000 Mainers are currently enrolled in the MaineCare program.
 - That is down from a peak of 354,000 in 2011 but well above the 190,000 Mainers who were enrolled in Medicaid in 2002—when our state had the same population as it does today.
 - **21% of Maine’s population is** enrolled in MaineCare—in line with the national average.
- The most significant change to MaineCare enrollment has been the removal of childless able-bodied adults from the program rolls.
 - Whereas this eligibility change has not caused gross program spending to decline, it has enabled Maine to contain its Medicaid expenditure growth at a rate of less than the national average.
 - The other significant eligibility change from 2011 is the reduction of benefits for parents of dependent children to those with incomes of up to 100% of the Federal Poverty Level (FPL). **Those with incomes above the MaineCare eligibility limit are eligible to buy federally subsidized plans on the exchange.**

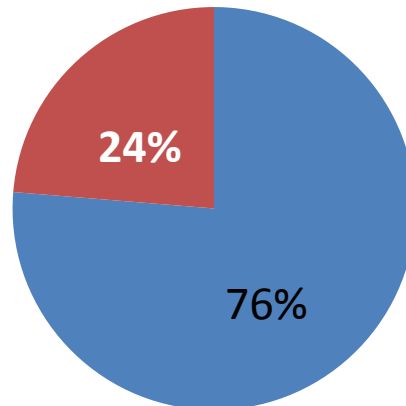
MaineCare: Crowding Out Other Spending

- The amount of Maine taxpayer dollars needed to support Medicaid spending has increased significantly in recent years, crowding out other core state priorities.
- MaineCare did not account for a double-digit percentage of Maine's annual General Fund spending until 1994. In 1986, MaineCare spending comprised 8% of the General Fund.

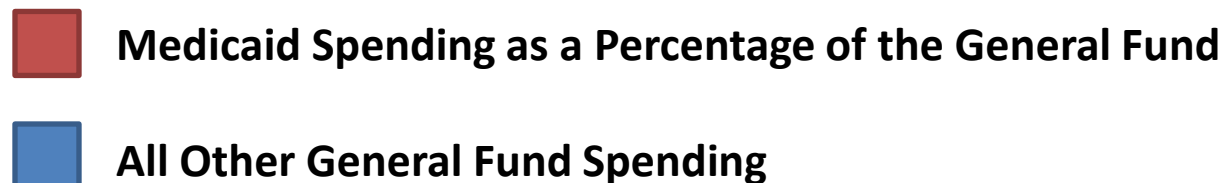
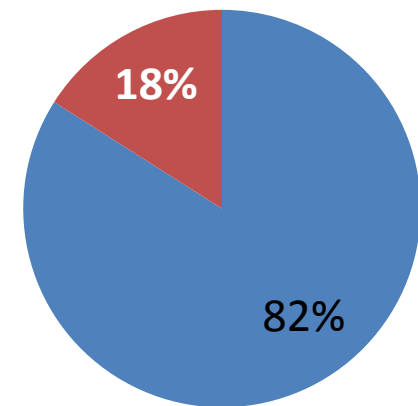
MaineCare - 1998



MaineCare - 2015



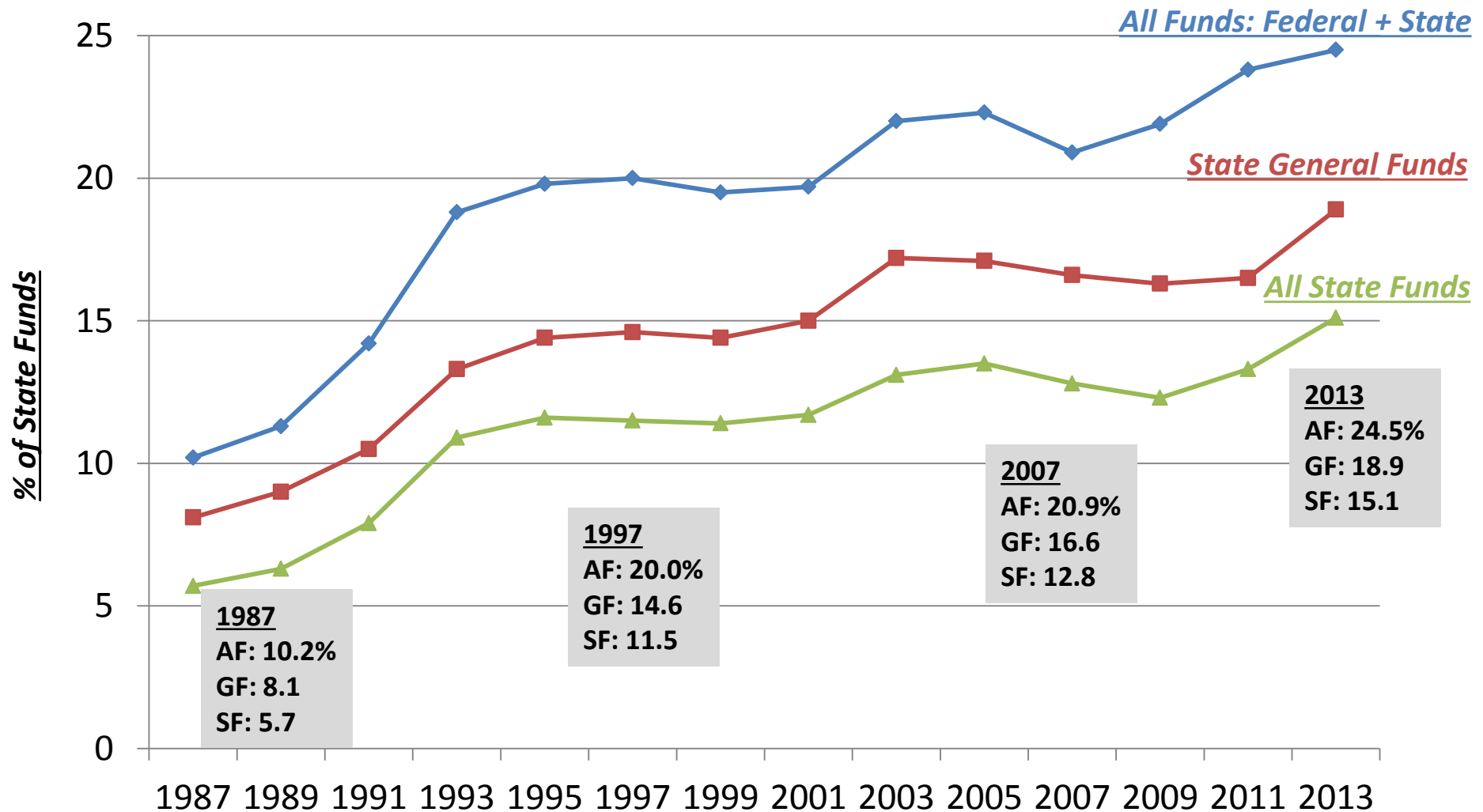
National Average



Source: National Average derived from the Kaiser Family Foundation's "State Health Facts;" <http://kff.org/other/state-indicator/distribution-of-general-fund-spending>.

State Spending on Medicaid: 1987 – 2013

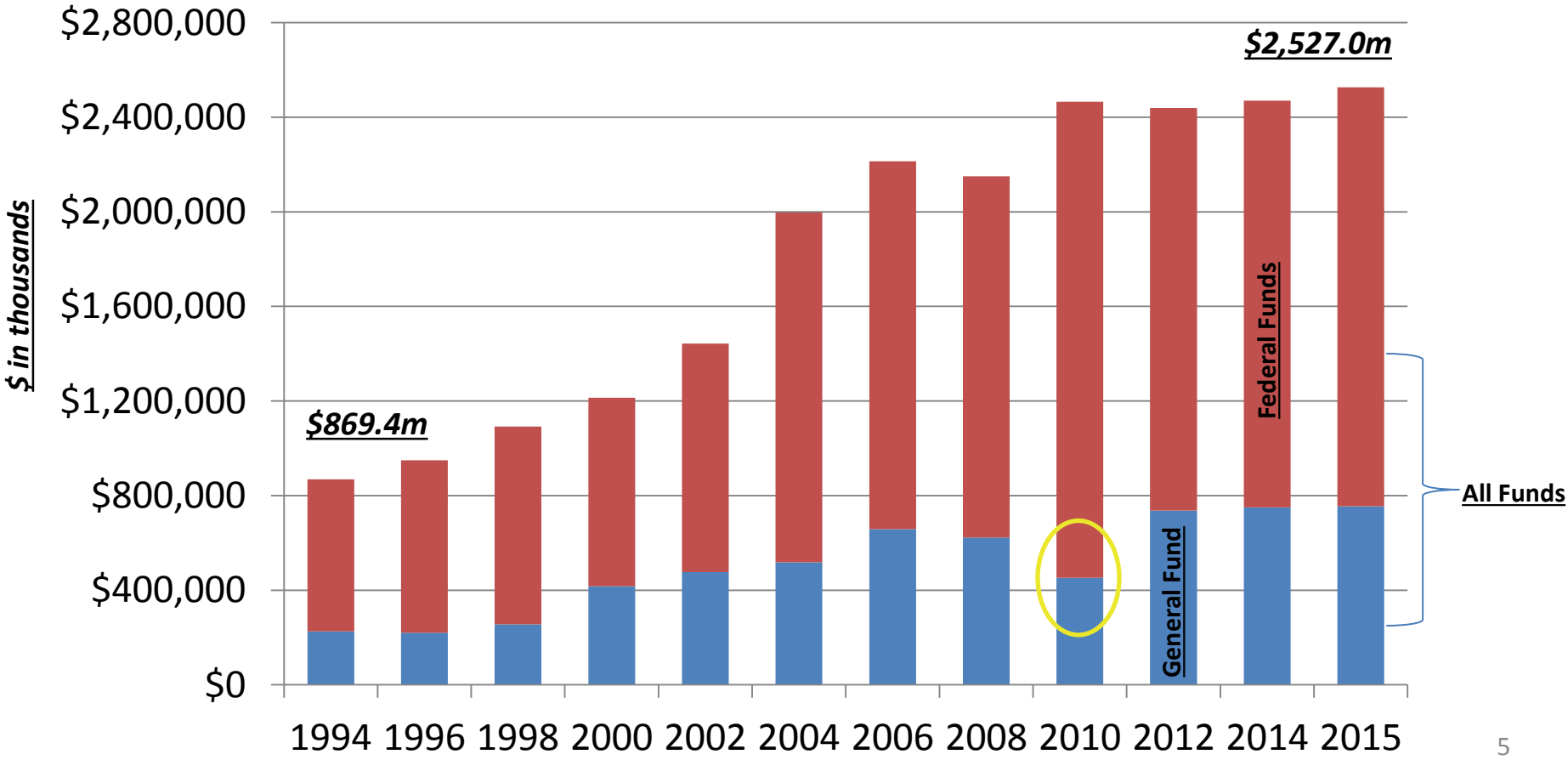
Medicaid's Share of State Budgets



Source: MACPAC Report, "Factors Driving Medicaid Spending Growth," September 2015.

Medicaid Spending in Maine: 1994 - 2015

- **MaineCare is a \$2.5 billion program that accounts for one-third of all state spending.**
- In 2015, Maine spent \$756 million General Fund on Medicaid—approximately 24% of General Fund dollars, or one-third more than the national average of 18%.
 - *Over the years, General Fund spending increases have closely tracked MaineCare funding needs.*



ACA Medicaid Expansion Mandate / Option: Terms of Expansion for Maine

Originally, the ACA required all states to expand Medicaid.

- In June 2012, the Supreme Court ruled mandated expansion unconstitutional.
- That decision set off debates in state capitols across the country that has resulted in expansion in 31 states and Washington, DC.
- The LePage Administration opposes expansion, and Maine remains one of 19 states that have not expanded Medicaid.

MaineCare Eligibility: Current versus Expansion

Category	Current Eligibility	Expansion Eligibility	<i>Enhanced FMAP?</i>
Children	208% of FPL	208% of FPL	<i>Yes</i>
Parents of Children	100% of FPL	138% of FPL	<u><i>No</i></u>
Pregnant Women	209% of FPL	209% of FPL	<u><i>No</i></u>
Non-Categorical	Ineligible	138% of FPL	<i>Yes</i>

Maine's history as an "original expansion state" actually harmed it in terms of the expansion deal CMS offered under the ACA.

- Whereas other states (that were expanding for the first time) received comprehensive enhanced FMAP reimbursement across their new populations, Maine did not.
- In a January 2014 letter to Maine, CMS confirmed that—because Maine had covered parents at up to 138% of FPL when Congress enacted the ACA—those individuals would not receive the enhanced FMAP were they to return to the Medicaid rolls.

Cost of Medicaid Expansion in Maine: Based on Prior Fiscal Notes for Expansion Bills

		FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
FMAP: Non-Cat FMAP		97.5%	94.5%	93.5%	91.5%	90.0%
Other FMAP*		63.95%	63.95%	63.95%	63.95%	63.95%
Children's FMAP*		97.77%	97.77%	97.77%	97.77%	97.77%
Claims (\$ in millions)						
Non-Cat Members		57,335	57,335	57,335	57,335	57,335
<i>State Share</i>		<i>\$10.68</i>	<i>\$24.67</i>	<i>\$30.61</i>	<i>\$42.03</i>	<i>\$51.92</i>
Parents		15,817	15,817	15,817	15,817	15,817
<i>State Share</i>		<i>\$20.65</i>	<i>\$21.68</i>	<i>\$22.76</i>	<i>\$23.90</i>	<i>\$25.10</i>
Parents Woodwork		3,460	3,460	3,460	3,460	3,460
<i>State Share</i>		<i>\$4.52</i>	<i>\$4.74</i>	<i>\$4.98</i>	<i>\$5.23</i>	<i>\$5.49</i>
Children Woodwork		5,766	5,766	5,766	5,766	5,766
<i>State Share</i>		<i>\$0.57</i>	<i>\$0.59</i>	<i>\$0.62</i>	<i>\$0.65</i>	<i>\$0.69</i>
Admin		\$2.58	\$2.58	\$2.58	\$2.58	\$2.58
Total State Share		\$39.00	\$54.26	\$61.55	\$74.39	\$85.78

* Other FMAP and Children's FMAP based on the FY 2017 blended FMAP (i.e., 4Q FFY16 + 1-3Q FFY17) for each population.

Medicaid Expansion: Enrollment in Expansion States has far Exceeded Projections

Medicaid expansion states have experienced enrollment well above projections. As ACA federal match rates begin to decline, that will put increasing pressure on budgets.

California: 910,000 projected / 2 million enrolled

Colorado: 187,000 / 340,000

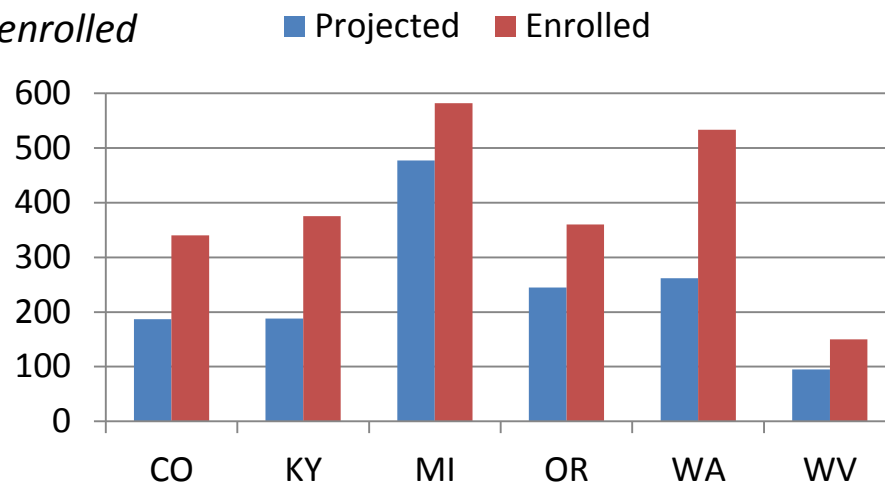
Kentucky: 188,000 / 375,000

Michigan: 477,000 / 582,000

Oregon: 245,000 / 360,000

Washington: 262,000 / 533,000

West Virginia: 95,000 / 150,000



In Maine, where the enhanced federal match would not have applied to most of our populations, we would have felt those pressures immediately.

- From FY 2016-2019, Maine would have spent \$53m in FY 16-17 and \$116m in FY 18-19.

State Scenario	% Over	FY 16-17 Impact	FY 18-19 Impact
Michigan	22%	\$65 million	\$142 million
West Virginia	59%	\$84 million	\$184 million
California	120%	\$117 million	\$255 million

Medicaid Expansion is already Driving Significant Pressures on State Budgets

Vermont: Medicaid shortfall of \$30 million in FY16; \$50 million in FY17.

- *“In recent years, Vermont has dramatically increased the number of people receiving Medicaid benefits, and it’s resulted in this state having one of the lowest rates of uninsured residents in the nation. The problem is that it’s costing a lot more than elected officials previously estimated, and the governor’s new plan to cover the deficit isn’t sitting well with independent physicians.” (Vermont Public Radio, February 5)*
 - RE: Gov. Shumlin’s plan to tax private practices 2.35% on net patient revenue—only Minnesota imposes such a tax, and it is set to expire in 2019.
- ***“In a stunning policy reversal, Gov. Peter Shumlin is dropping his plan to tighten Medicaid eligibility rules for pregnant women.” (Vermont Public Radio, January 22)***
 - RE: Gov. Shumlin’s plan to remove from the Medicaid rolls pregnant women with FPL 138% to 209%.

New Mexico: Medicaid shortfall of \$78 million in FY17; General Fund spending on the program to grow 33% by 2020—\$900 million to \$1.2 billion.

- *“Spending on Medicaid in New Mexico would reach \$928 million, but that would not be enough to support current services for the 800,000 patients in the program. As a result, the state will likely be cutting reimbursement rates to hospitals, doctors and social workers, as well as increase copays for those patients in the government insurance program.”*
- ***“What we’ve done, unfortunately, is double down on borrowed money to pay for the state operating expenses,”*** said Rep. Brian Egolf, a Santa Fe Democrat who serves as the House minority leader.” (The Santa Fe New Mexican, February 18)

Medicaid Expansion is already Driving Significant Pressures on State Budgets (cont'd)

Kentucky: \$125 million shortfall in the current fiscal year; \$611 million deficit over the next two years. *"Traditional Medicaid is hemorrhaging. It's not bleeding, it's hemorrhaging."* - Kentucky Health and Family Services Secretary Vickie Glisson

- ***"Kentucky's Medicaid program is facing a \$125 million deficit this year and a \$611 million deficit over the next two years as it struggles to keep up with an aging population, a flood of new enrollees and the end of 100 percent federal funding for its expanded eligibility requirements."*** (Associated Press, February 24)
- ***"Kentucky's Medicaid commissioner told state lawmakers the program's costs will jump by 20% over the next two years to \$3.7 billion as a result of Medicaid expansion. Stephen Miller said the Medicaid program is likely not sustainable at that cost."*** (Healthcare Dive, February 19)

Delaware: \$28 million FY17 Medicaid budget shortfall on top of an increase of \$40 million for the program already in Governor Markell's budget proposal. \$698m → \$770m.

- ***"Officials told lawmakers Wednesday that while Markell's budget proposal includes \$40 million in additional Medicaid spending, they now expect they'll need more than \$68 million... Meanwhile, \$13.2 million in Medicaid funding that officials thought they would be able to carry over from this year has been eaten up by cost increases."*** (Delaware Public Radio, Feb. 25)
- ***The abrupt increase comes after the Medicaid department recalculated its funding projections and crunched open enrollment numbers for Highmark Blue Cross and Blue Shield of Delaware, one of the state's two Medicaid-managed care organizations. They found Highmark had enrolled more clients with complex medical needs than expected and would need to spend more money to treat them.*** (Delaware News Journal, February 24)
- ***"When we negotiated [the budget] last year we were in the middle of an open enrollment, so we had to make assumptions about who was going to enroll where and what their medical costs were going to look like. Some of those assumptions held pretty well, some of them not so much,"*** [State Medicaid Director Steve] Groff said. (Delaware Public Media, February 24)

Medicaid Expansion is Not Functioning as Expected: Connecticut Case Study

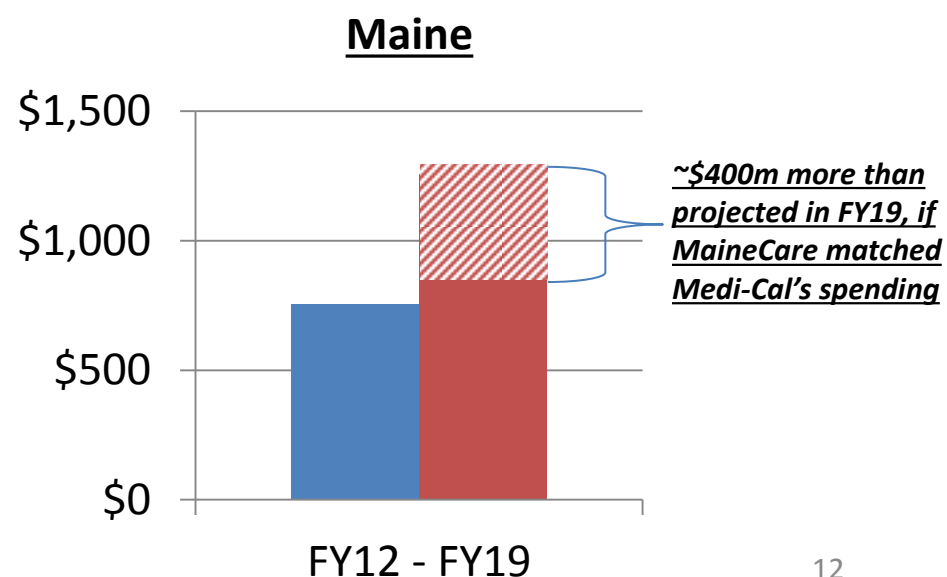
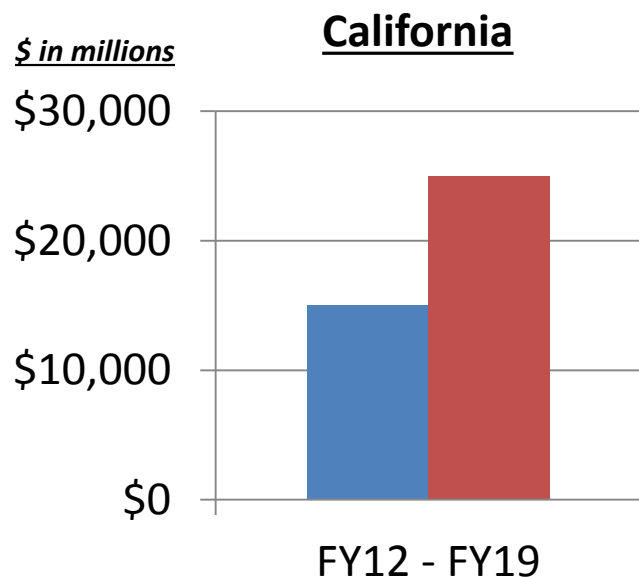
Connecticut is facing a current year deficit of \$266 million and \$900 million in FY17.

- The shortfall that Connecticut is facing presents a cautionary tale for states expecting to recognize significant General Fund (GF) savings from Medicaid expansion.
 - Proponents of expanding MaineCare have argued that Maine could achieve large GF savings by shifting certain costs currently borne exclusively by the state to Medicaid.
 - The report that Manatt Health Solutions presented last year claimed that our state could save \$20.3 million in substance abuse and mental health GF spending in CY 2016 by expanding MaineCare.
- To close its budget deficit, that is exactly what Connecticut is trying to do right now—Gov. Malloy has called for a 5.75% cut to GF social services funding.
 - *“Gov. Dannel P. Malloy’s proposed **budget calls for cutting funding for mental health and substance abuse treatment, hospitals, community health centers, school-based health clinics, asthma treatment, and respite programs for those who care for people with dementia**—and counts on millions more in unspecified cuts to health care and social service systems that advocates say are already stretched thin.”*
 - To providers expressing opposition, the Malloy Administration has said they should bill Medicaid instead.
- Providers have responded that services, such as substance abuse treatment, are too expensive to cover under Medicaid.
 - *“But providers have said [billing private insurance is] not possible because the rates paid by Medicaid—the coverage source of most newly covered clients—generally fall below the cost of providing services. Past analyses by the Department of Mental Health and Addiction Services have backed up that position.”*
- These are exactly the kind of cuts that Manatt argued Maine could make to save GF dollars.
 - **Creates the ultimate “golden circle” around the least vulnerable at the expense of those truly in need.**

Medicaid Expansion Costs will Rise Significantly: California Case Study

California: General Fund Medicaid spending will increase to \$25 billion in 2019—an increase of two-thirds from 2012.

- **If Maine saw the same increase over that time period costs would rise from FY12 \$754 million to FY19 \$1.26 billion—\$400 million more than DHHS currently projects for that year.**
- *“While the benefits of these programs are enormous, so too are the costs - both now and into the future. In four years, total Medi-Cal costs have grown by \$23 billion. As the state begins to pay for its share of the millions of new enrollees, the cost to the General Fund will also rise. In 2012, the General Fund paid \$15 billion for Medi-Cal, but by 2019, that number is expected to be \$25 billion, an increase of two-thirds.” (Governor Jerry Brown, California State of the State Address, January 21)*



Medicaid Expansion: “The Private Option”

The “**Private Option**” is a Medicaid expansion vehicle that would use taxpayer dollars to purchase commercial insurance policies for those with incomes of 100% to 138% of FPL.

- *The private option isn't private—it uses the same taxpayer dollars that would fund traditional Medicaid expansion.*
- **It is more expensive than traditional Medicaid expansion.**
 - Last year, when Nebraska considered implementing the private option, that state's DHHS found that Qualified Health Plans would cost the state **94% more than traditional Medicaid expansion.***
- Whereas proponents of the private option cite accountability reforms that states can implement, such as work requirements, asset testing and premiums and copays, the Obama Administration has rejected outright most of these measures.
- The Administration has also said that states would need to approve any proposed changes before CMS would review and consider such changes—again significantly curbing states' autonomy to implement accountability reforms.
 - ***Given the same use of taxpayer dollars and the lack of state autonomy, the private option is no different than traditional Medicaid expansion—it is just a more expensive, complex version of it.***

* <http://www.platteinstitute.org/Library/DocLib/Arkansas-Failed-Medicaid-Experiment.pdf>

Medicaid Expansion: “The Private Option” (cont’d)

Arkansas: Expansion would cost state taxpayers \$656 million over the next five years.

- Gov Asa Hutchison has been told that any asset test is off the table and that the state will not be permitted to implement a work requirement.
- *DHHS Secretary Burwell recently sent Gov Hutchison a letter stating that its proposed reforms “push the bounds of what's allowable under federal Medicaid law and raise concerns about potential impacts on beneficiaries.”*
- The letter also makes clear that **Arkansas would need to approve any changes to the program before CMS would determine whether those changes are permissible.**

Indiana: Medicaid will cost state taxpayers \$500 million more in 2017 than in 2014.

- Gov Mike Pence is calling on the state’s Congressional Delegation to push back on CMS’ effort to review the HIP 2.0 program—Indiana’s expansion vehicle.
- From the *Indianapolis Star* (February 20):
 - Gov Pence “wants Congress to get involved in his dispute with the Obama administration over the evaluation of Indiana’s alternative Medicaid program.” Gov Pence said: “We have no confidence in any result that would be generated by” a Federal evaluation of the Healthy Indiana Plan 2.0 (HIP 2.0). “The administration wanted Indiana – and still wants every state – to just expand traditional Medicaid...”

Sources: http://www.in.gov/fssa/files/MAC_February_13_2015_presentation.pdf;

<http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14099/TSG%20Volume%20I%20Findings%20Report%20amended%20to%20include%20all%20Appendix%20references.pdf> 14

MaineCare 2016: Summary Thoughts on Expansion

- **Medicaid expansion would cost Maine hundreds of millions of dollars—\$315 million over the next five years alone.**
 - *The group that would have benefited most from MaineCare expansion is childless able-bodied adults.*
 - Under the ACA, uninsured individuals who fall into that category—and earn at least 100% of FPL (\$11,770 in FY15)—are eligible to purchase subsidized health insurance policies on the exchange.
 - Parents of dependent children are eligible to enroll in MaineCare if they earn less than 100% of FPL; if they earn at least 100% of FPL, they are eligible to purchase exchange policies.
- **The LePage Administration is focused on serving Maine’s neediest and most vulnerable. Not only has rejecting Medicaid expansion enabled DHHS to put MaineCare on sound financial footing, it has enabled the Department to invest in key healthcare priorities.**
 - In Governor LePage’s FY16-17 Biennial Budget proposal, DHHS requested more than \$93 million in funding to reduce waitlists for services for the intellectually and developmentally disabled; to increase funding rates for nursing facilities; and to enhance access to primary care. The Legislature appropriated \$40 million of that request.
 - These investments would not have been possible had Maine opted to expand Medicaid—instead, those dollars would have funded healthcare for able-bodied childless adults and others who are eligible to purchase federally subsidized health insurance policies.
- **Numerous expansion states are facing—or will soon face—budgetary challenges due to enrollment levels that have far exceeded projections and savings estimates that were overly optimistic.**
 - As the ACA enhanced match declines, inflated healthcare costs driven by increased Medicaid rolls are likely to cannibalize key spending priorities in expansion states and force them to raise taxes or neglect services for those most in need.

Appendix

MaineCare Expansion Debate, 127th Legislature: Manatt Report

- In April 2015, Manatt Health Solutions prepared a report for the Maine Health Access Foundation entitled, “Estimated State Budget Impact of a MaineCare Expansion in 2016.”
- The report was based on an April 2015 issue brief that the firm authored entitled, “States Expanding Medicaid See Significant Budget Savings and Revenue Gains.”
- The Maine report argued that our state—like others from the national issue brief—could, by expanding Medicaid, derive significant savings and revenue gains through the following areas:
 - State savings from accessing enhanced federal matching funds; i.e., replacing state share of Medicaid expenditures almost exclusively with federal funds.
 - State savings from replacing General Funds with Medicaid funds; i.e., using expansion dollars from the federal government to cover services the Maine taxpayer currently funds directly.
 - Revenue gains from hospital tax; i.e., increases in expansion-fueled revenue gains at Maine hospitals would yield increased revenues from Maine’s 2.23% hospital tax.

2016 State Savings and Revenue Gains from Medicaid Expansion	\$ CY16
State Savings from Accessing Enhanced Federal Funds	\$12.6 million
State Savings from Replacing General Funds with Medicaid Funds	\$27.9 million
Revenue Gains from Hospital Tax	\$3.4 million
Total State Savings and Revenue Gains (Less Costs of Expansion)	\$26.7 million

MaineCare Expansion Debate, 127th Legislature: Manatt Report (cont'd)

- DHHS reviewed the Manatt report carefully and generally concurred with its estimated costs of expansion for CY 2016 but notes that 2016 is the last year that the ACA covers 100% of costs for newly eligible enrollees.
- *By contrast, DHHS disagrees with Manatt's projected savings and revenue gains.*
- Specifically, DHHS strongly questions the savings estimates for hospital inpatient costs for prisoners (\$5.4m) and mental health and substance abuse treatment services (\$20.3m)—more than half of Manatt's projected cost reductions.

Hospital Inpatient Costs for Prisoners

State	Population	Correctional HC Spend	Inpatient Prisoner Savings - FY15
Maine	1.330m	\$17.049 million	\$5.4 million – projected (32%)
Arkansas	2.966	\$66.888	\$2.75 (4%)
Kentucky	4.413	\$62.972	\$11.0 (17%)
Michigan	9.910	\$330.400	\$13.2 (4%)
Colorado	5.356	\$102.355	\$5.0 (5%)
Washington	7.062	\$119.253	\$1.4 (1%)

Sources: *Manatt Health Solutions*, “States Expanding Medicaid See Significant Budget Savings and Revenue Gains;” Issue Brief, April 2015. Note: Correctional Healthcare Spending cited in the report is sourced from the following **Pew Charitable Trusts** report: 18 “State Prison Health Care Spending: An Examination;” July 2014.

MaineCare Expansion Debate, 127th Legislature: Manatt Report (cont'd)

State Mental Health and Substance Abuse Program Costs

- Largest source of Manatt's projected savings for Maine, \$20.3 million.
- Just four sentences—two substantive ones—in the report justify these savings. No analysis of where Maine would achieve these savings; or the contracts DHHS would eliminate; or the services DHHS covers that MaineCare expansion would supplant.
- Additionally, cutting general fund spending—and MOE—could jeopardize respective Substance Abuse and Mental Health Block Grant funding (\$8.1m / year).
 - *"State funds for mental health and substance abuse services of \$44 million could be reduced, as many individuals served by these programs qualify for an expanded MaineCare program. This brief assumes a reduction of 50% in this spending based on experience in other states. While this is a rough estimate, given the inability to access State data on funding for direct services to the uninsured, it is not an aggressive one: other states have found this to be a significant area of savings. The brief estimates that Maine could save up to \$20.3 million in 2016 in this category."* (Manatt Health Solutions)

- **Of the eight states reviewed in Manatt's April 2015 issue brief, four show estimated savings in mental health and substance abuse costs in FY14 and FY15: AR, KY, MI, WA.**
 - **AR: \$7m, FY15.** *"All numbers are budget estimates and are based on expansion experiences to date."*
 - **KY: \$9m, FY14 / \$21m, FY15.** *FY14 is an estimate built off six months of data. FY15 is estimated.*
 - **MI: \$180m, FY14 / \$190m, FY15.** *FY14 is an estimate built off six months of data. FY15 is estimated.*
 - **WA: \$13m, FY14 / \$51m, FY15.** *"Based on estimates from the state's Forecast Model."* (Kaiser)

Sources: *Manatt Health Solutions, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains;" Issue Brief, April 2015. Manatt Health Solutions, "Estimated State Budget Impact of MaineCare Expansion in 2016;" April 2015. The Kaiser Commission on Medicaid and the Uninsured, "The Effects of the Medicaid Expansion on State Budgets." Issue Brief, March 2015.* 19

MaineCare Expansion Debate, 127th Legislature: Manatt Report (cont'd)

Revenue Gains

- The Manatt report states that, in 2016, Maine would gain additional revenues of \$3.4 million by expanding Medicaid.
 - Gains would result from increased tax revenue from the hospital tax, which assesses a 2.23% levy on hospital revenues.
- Whereas other states may see increased revenue derived from a larger tax base, the Maine Legislature statutorily dictates Maine's base and has most recently pegged the base to hospital revenues from FY 2012.
 - This means that the Legislature would need to act, updating the base year to the present, for Maine to see any revenue gains from the hospital tax.
 - This is something that the Legislature has been reluctant to do, and that Maine hospitals would most likely oppose.

Summary Thoughts on Manatt Report

- DHHS specifically disputes more than two-thirds of the report's cost savings and revenue gains.
- Limiting cost estimates to CY 2016—the last year that the ACA covers 100% of expansion costs—understates projected costs.
- Maine has been through this before:
 - Any savings achieved during the previous expansion proved ephemeral or diminished.
 - Medicaid costs exploded under the last expansion—during a period when Maine's population increased by less than 3%, and prices increased by 25%, Maine's Medicaid expenditures increased 85%.

Medicaid Expansion in Maine: Prior Decade Results

Original Expansion State: Maine was one of the original Medicaid expansion states when it expanded Medicaid eligibility in 2002.

- At the time, DHS officials projected 11,000 additional MaineCare members would enroll.
- Within two years, new enrollment reached 25,000—exceeding the projections by 127%.
- Medicaid enrollment in Maine jumped from 190,000 in 2002 to more than 354,000 in 2011—**an increase of 86% at a time when Maine’s population increased 2.5%.**

Maine’s History & The California Experience: MaineCare expansion in 2002 produced over enrollment results similar to those seen recently in California, which has exceeded projections by 120%.

- **Rather than \$169 million over the next two biennials, that expansion scenario would result in \$372 million in additional General Fund expenditures for Maine.**
- *Note: Each state has diligent analysts creating these projections. Across the country, budget analysts, legislators, journalists, academics, think tanks and others review and assess these projections. And yet, across the country, we have seen them miss.*

The Economic Growth Argument: Medicaid expansion proponents argue that large injections of federal dollars will boost economic growth—Maine did not experience that result during the state’s previous expansion.

- Inflation adjusted, Maine’s GDP grew 4% from 2002 to 2012 (\$40.05 billion to \$52.01b)
- Annual economic growth averaged 2.96% over a period when annual inflation was 2.51%.
 - Maine experienced 0.45% annual real economic growth over nine years following Medicaid expansion.

Medicaid Expansion Case Study: Illinois

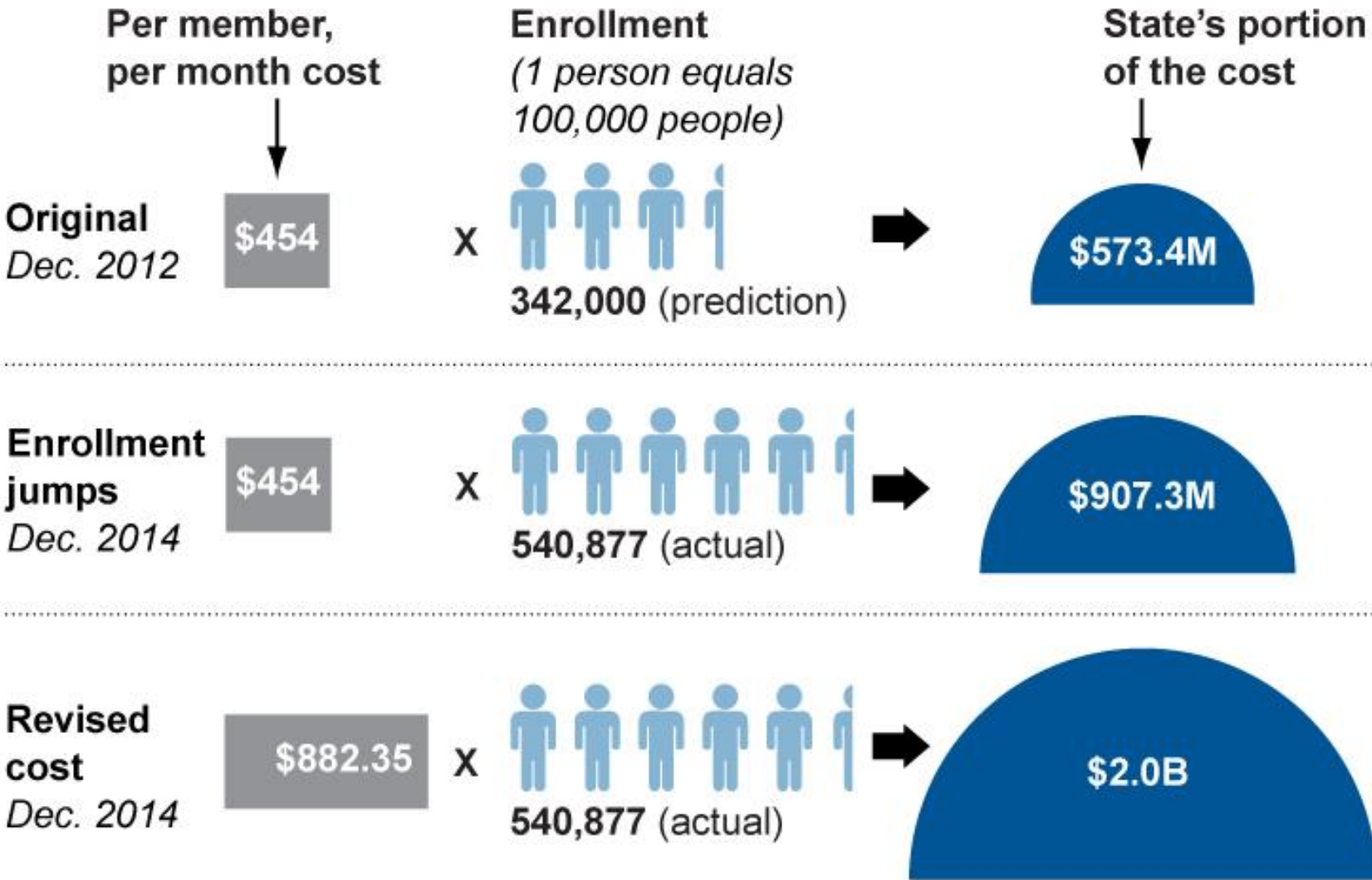
Medicaid Expansion in Illinois: Over Enrolled / Over Budget

- Illinois Department of Healthcare and Family Services (HFS) projected that expansion would add 342,000 Illinoisans to the state's Medicaid rolls.
- HFS projected costs of \$573 million to Illinois taxpayers from 2017 to 2020; i.e., after the federal government's 100% match ended in 2016.
 - **Instead, as of August 2015, more than 600,000 new members had enrolled.**
 - The *Chicago Tribune* projects that the bill for enrollment will be “at least” \$907 million in state funding from 2017-2020 rather than the original projection of \$573 million.
 - *Due to an increase in its “per member per month” calculation that HFS submitted to the federal government in June 2014, costs could reach \$2 billion greater than initial projections.*

Implications of Medicaid Expansion in Illinois

- Whether it faces additional costs of \$907 million, \$2 billion or more, Illinois will need to fund that gap through reprioritizing existing resources or raising taxes.
- Or it will need to roll back benefits, potentially at the expense of the higher cost disabled, elderly and otherwise most vulnerable.
 - **Expansion population receives at least 90% federal funding; original Medicaid population receives standard federal matching rate—50.76% for FY 2015.**
 - Facing multi-billion dollar budget shortfalls, Illinois—and other like states—will be tempted to cut benefits for those who need them most, falling victim to the ACA's “golden circle effect.”

Medicaid Expansion Case Study: Illinois (cont'd)



Sources: Department of Healthcare and Family Services, Illinois; June 2014 1115, waiver proposal. As posted on the **Chicago Tribune** website: <http://www.chicagotribune.com/chi-medicaid-cost-estimates-soar-graphic-20150202-htmlstory.html>. 23

Questions?

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