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## NEW MEDICAID CLIENTS UNDER AFFORDABLE CARE ACT: EXPLANATION OF ENROLLMENT NUMBERS

### How HFS derived the potential enrollment numbers

- Consultant team was selected in 2011 – HMA/Wakely – analyzed 2009 American Community Survey updated by 2010 census information, Illinois Department of Commerce and Economic Opportunity, and Federal Department of Homeland Security data—projected to 2013.
- HMA/Wakely/HFS determined that Illinois has 1 million - 1.2 million uninsured citizens under 65 and roughly 50% have incomes above 133% Federal Poverty Level (FPL), and will be eligible to shop on the Exchange; 50% have incomes below 133% FPL and will be eligible for Medicaid
- Assumptions:
  - 2/3 will be newly eligible (90-100% federal match) = 342,000
  - 1/3 will be old eligible – adults and children (50% federal match) = 171,000
  - 10% will never enroll
  - 50% of eligibles (old and new) will enroll in 1<sup>st</sup> year; enrollment will ramp up over 4 years

### Why HFS enrollment numbers differ from other consultant reports

- A. Rand Corporation and Urban Institute estimates show large growth rates from current Medicaid.
- They are multi-state estimates relying on regression estimates based on some past historic data; both start with estimates of Medicaid enrollment significantly below our actual enrollment, i.e. Urban Institute starts with assumption of 2.1 M on Medicaid, but actual number is 2.7 M+.
  - Lower starting estimates may be a function of methodology which imputes national data across all states; in fact, Illinois had a very high take-up rate due to the aggressive outreach campaigns for All Kids in 2006-2008.
  - Total post-ACA enrollment numbers in each come close to HMA/Wakely numbers (or in the case of the Urban Institute, even lower than our estimate) but because they started with artificially low current enrollment, they predict more enrollment **growth**.

- B. Cato Institute estimates large growth rates of low income people in our society.
- The Cato model predicts growth in Medicaid incompatible with current estimates of low income individuals through census data, i.e. it assumes Medicaid enrollment that is 50% larger than the total number of people now believed to have incomes below 133% of the Federal Poverty Level.
  - In other words, their model apparently assumes a substantial economic decline in the future.
- C. Illinois Policy Institute report believes a take-up rate of 50% is too low.
- The primary issue is that they are looking at a version that includes only first year take up. Estimates of 342,000 new eligibles between now and 2017 assumes a take-up rate greater than 90 % but spread over four years.
  - Massachusetts had a high take up rate, but only after a major marketing campaign not expected or budgeted here.
  - Experience in outreach for low-income people both in Illinois and other states suggests that a 50% first year take-up rate is plausible; the *New England Journal of Medicine* article by Sommers and Epstein concludes that it will require sustained effort to even get Medicaid take-up rate over 60% in the ACA expansion.
  - Given the structure of the Federal match — 100% during first three years — there is no fiscal impact on State if first year take-up is higher. Only impacts cost estimates if take-up rate after 2017 is greater than 90%, and even then the cost impact would be marginal.
- D. Cost estimates from the reports are all over the map, with some suggesting higher costs than we estimated.
- In general, this is same issue as estimating enrollment because cost estimates are calculated by multiplying costs per client times number of new clients. Since they overestimate number of new clients, they overestimate new costs.
  - Issue of costs is further clouded by differences among the reports in whether they are measuring before or after federal match, by whether they are including old eligibles, and what are their basic assumptions about costs.
  - Attached to this sheet is a clear estimate of how we are estimating costs, based on actual per capita costs of Medicaid clients (with adjustments in case the new eligibles are “sicker” than current clients and for inflation).

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## MEDICAID FINANCING FOR THE UNINSURED: HOW THE REVENUES AND COSTS ARE COMPUTED

1. It is estimated that 342,000 total “newly eligibles” in IL will enroll by 2017: mostly adults without dependent children who have not qualified for Medicaid, but who have income under 133% federal poverty level

2014	199,000	
2015	298,000	
2016	328,000	
2017	342,000	Assumes a stable population after 2017 (10% will never enroll)

2. It is estimated that the “newly eligibles” will receive the same service package as the adults in FamilyCare; however, since this population’s medical history is unknown, 10% was added to accommodate for potential differences in health status

The cost for FamilyCare clients is \$412 per member/per month (PMPM)  
The cost for the “newly eligibles” is therefore \$454 PMPM, inflated by 2% per year

3. The federal government will pay 90%-100% of the costs for this new population.

	<u>Federal match</u>	<u>Federal revenues</u>	<u>State portion</u>
2014	100%	\$1,081,863,840	-0-
2015	100%	\$1,656,168,574	-0-
2016	100%	\$1,858,408,187	-0-
2017	95%	\$1,877,271,898	\$98,803,784
2018	94%	\$1,894,661,364	\$120,935,832
2019	93%	\$1,911,995,499	\$143,913,640
2020	90%	\$1,887,324,590	\$209,702,732

4. The new funds being provided by the Federal government will replace spending by hospitals, clinics, other providers, state GRF and local governments who have absorbed huge healthcare costs for the uninsured as uncompensated care.