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WASHINGTON DC

SCHOOL OF PUBLIC HEALTH & HEALTH SERVICES

DEPARTMENT OF HEALTH POLICY
PROF. LEIGHTON KU, PHD, MPH

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Bruce Lesley
President, First Focus

Dear Mr. Lesley,

As we discussed, I recently conducted an assessment of the August 16 budget analysis conducted by Robert Damler of the Indianapolis office of Milliman, Inc., concerning the impact of the Patient Protection and Affordable Care Act (PPACA) on Nebraska's Medicaid program and budget, which has been cited by Gov. Heineman.

Before proceeding, let me explain my qualifications. I am a Professor of Health Policy at the School of Public Health and Health Services at the George Washington University and Director of the Center for Health Policy Research. I have been engaged in research and analysis about Medicaid and health care for low-income populations for about 20 years and am generally viewed as a national expert on Medicaid. I have conducted a number of budget analyses regarding Medicaid over the years, am a former federal budget analyst, have consulted with the Congressional Budget Office, and have trained Medicaid budget analysts in over 20 states. I have authored a number of articles about Medicaid, including costs and budget impacts, including a June 2010 article about state implementation of the Medicaid expansion under health reform.[1]

In brief, Milliman concludes that PPACA will increase Nebraska's state share of Medicaid costs by about $526 to $757 million from state fiscal year 2011 to 2020. In contrast, a report by John Holahan and Irene Headen of the Urban Institute estimated that the expansion of coverage for adults would cost Nebraska between $106 and $155 million from 2014 to 2019, but would also help the state earn between $2,345 and $2,732 million in new federal matching funds.[2] I should note that Dr. Holahan, Director of the Health Policy Center at the Urban Institute, is probably the most experienced and respected Medicaid analyst in the nation. (In addition, in December 2009 the state of Nebraska itself estimated the health reform bill would increase state costs by $45.5 million from 2014 to 2019, while Nebraska would gain $2.44 billion in additional federal revenue over those years.[3])

Let me first note that there are some obvious reasons for the discrepancies in these estimates. The Milliman analysis is for a different time period (2011-2020) than the Urban Institute analysis (2014-2019). However, since the main costs of the PPACA are not felt until 2014, the primary difference is the 2014-20 vs. 2014-19 periods, or the addition of one more year (2020) in the Milliman report. The Milliman analysis encompasses some additional provisions of PPACA, while the Urban Institute analysis focuses on the most expensive portion: the expansion of Medicaid coverage for

[1] Ku, L. "Ready, Set, Plan, Implement. Executing Medicaid's Expansion" *Health Affairs*, 29(6): 1173-77, June 2010.
[2] Holahan, J. and Headen, I., Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. Kaiser Commission on Medicaid and the Uninsured May 2010.
[3] Estimates attached to a letter from Gov. Dave Heineman to Sen. Ben Nelson, Dec. 16, 2009.

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low-income adults. On the other hand, the Urban Institute analysis also presents the new federal revenue the state will gather, which will have positive economic consequences for Nebraska. It is worth noting that neither report expects major effects in the next couple of years; the main effects do not occur until 2014.

Forecasting future costs is always subject to uncertainty, not least of which because we do not know how the economy will fare in the future. If the economy strengthens (as most expect) then the number of poor people will be lower and current estimates of participation may be too high, while if the economy deteriorates further, participation could be higher than expected. Some of the future costs will depend on how states implement the reform. For example, does the state try to make enrolling in Medicaid simpler or make it easier to retain Medicaid coverage? How easy would it be for people to flow between Medicaid and the health insurance exchanges? These are subject to future state programmatic decisions.

That being said, for the areas in common, the Urban Institute analyses are much more credible than the Milliman estimates. The Milliman estimates have some serious flaws that lead to substantial overestimates of the cost borne by the state of Nebraska.

- Milliman provides mid-range and full participation assumptions. In the mid-range, it assume participation rates of 80% to 85% for the newly eligible uninsured adults (childless and parents) and 100% in the full participation scenario. First of all, let me state that no voluntary program **ever** experiences 100% participation; that is just an over-the-top assumption which can only lead to overestimates. **The full participation scenario should just be ignored.**

- Milliman notes that there is a new requirement that individuals either have health insurance coverage or pay a tax penalty (the individual "mandate"), but they fail to mention that, under PPACA, this does not apply to those who do not pay federal income tax or who have other hardships. This will exclude virtually all those who are newly eligible with incomes below 138% of poverty. More may join because they believe they ought to, but those who do not enroll will generally not incur any tax penalties.

- The mid-range Milliman estimates of 80%-85% for the uninsured are outside the range of plausibility. The Urban Institute used estimates of 57%-75% participation, which are more credible and consistent with previous estimates of Medicaid participation. The lower level is consistent with Congressional Budget Office estimates.

- Equally problematic, Milliman appears to use an exaggerated base of the number of people eligible. They do not appear to discount the uninsured figures for ineligible legal and undocumented immigrants, as Urban Institute did. In addition, the use of the Current Population Survey for administrative estimates is a little problematic since most analysts agree that the number of uninsured people is overestimated in the CPS and the number of Medicaid participants is underestimated.

- Milliman also adds estimates of additional people who may join, even though they are already eligible or who have private health insurance. For example, Milliman assumed that 50% to 75% of low-income adults who already have private insurance drop that coverage to

join Medicaid; a situation known as "crowd out" (i.e., public insurance crowds out private insurance). The Urban Institute also included estimates of such people, but assumed more moderate and reasonable levels of switching (25% for those with employer-sponsored insurance and 54-60% for those with individual coverage). I will note that even the Urban Institute estimates may be too high. Evidence from Massachusetts – the only state which has experienced a health reform expansion comparable to the PPACA – showed no measurable loss of private insurance when public insurance expanded.[4]

- Finally, the Urban Institute assumed that the effects of Medicaid expansion are gradually felt, so that participation ramps up over time, while Milliman appears to assume enrollment expands radically from day one.

- The per-person cost of medical benefits is as important as the number of participants. Milliman based assumptions on data from the state's Division of Medicaid and Long-term Care, but does not explain what assumptions are made to generate these estimates. It is noteworthy that they assume that the cost for an uninsured adult ($5,467) is higher than for newly and currently eligible parents ($4,881). I'd venture that the parent cost is based on current costs for parents served in Nebraska's Medicaid program, but the basis for the cost for uninsured adults is unclear since Nebraska does not currently serve this population. These estimates appear much too high for two reasons:

    - Under PPACA, the benefit package for newly eligible adults is to be less generous than the current Medicaid benefit. It is to be based on a benchmark equivalent to private insurance and will not be as comprehensive as the current Medicaid benefit. In this regard, the Milliman estimate appears to be at odds with the statutory requirements of PPACA. This alone should make the costs for the newly eligible less expensive than current Medicaid costs. (The fact that the new benefits will have limits comparable to private insurance may also reduce the extent to which people switch from current private coverage to Medicaid.)

    - More important, prior research shows that low-income people who are uninsured tend to be healthier than those who are now on Medicaid. As Medicaid expands, it will pick up more people who are working (and are therefore healthier) and more of those who are healthy, but who did not manage to enroll before. The net result is that the newly covered (both those newly eligible and those who were already eligible but decide to join) will tend to be much less expensive than current beneficiaries, even if they received the same benefits. I demonstrated this in a 2008 article[5], and similar assumptions have made by the Urban Institute in its analysis and by the Congressional Budget Office in estimates for health reform. Most credible analysts agree on this point.

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[4] Long. S. On the Road to Universal Coverage: Impacts Of Reform in Massachusetts at One Year, *Health Affairs*, 27(4): w270-w284, June 2008. Long. S. and Masi, P. How Have Employers Responded To Health Reform In Massachusetts? Employees' Views at the End of One Year, *Health Affairs*, 27(6): w576-w583, Oct. 2008.

[5] Ku, L. and Broaddus, M. "Public and Private Health Insurance: Stacking Up the Costs," *Health Affairs*, 27(4):w318-327, June 2008.

Some of the newly eligible adults will have serious chronic health problems (as reflected in Milliman's discussion of medically needy adults) but they will be far outnumbered by relatively healthy adults who use medical care sparingly.

In summary, the Milliman mid-range estimates appear to be much too high in terms of both the number of new participants and the cost per enrollee. The net effect is a serious overestimate of net costs of the Medicaid expansion to the state. The full participation scenario is just ridiculous and should be ignored. The Urban Institute's estimates are more credible.

Regarding the Milliman estimates of the costs to support the coverage expansion and other provisions in health care reform, a few things stood out.

- It was not entirely clear how Milliman estimated administrative costs of $82 to $107 million, but it appeared this includes up to $25 million for developing the health insurance exchange. Whether Medicaid is expanded or not, Nebraska will have to consider whether to develop a health insurance exchange or to leave it to the federal government. This is not a Medicaid cost whether the state or federal government administers the exchange.

- While there is some additional cost for new enrollment services, these costs should be less expensive per person than they are currently. Most of the newly enrolled parents are probably members of families in which children are already participating in Medicaid or CHIP and it is relatively low cost to add them to the cases. There are also some economies of scale as a program grows: the cost of developing a computer system is about the same whether it will process 50,000 or 100,000 people. It is not clear if Milliman considered these factors.

- Milliman assumes $68 to $74 million loss in pharmacy rebates under PPACA. As the report notes, the new law increases drug rebates, but says the federal government will gain all of the additional revenue beyond the current rebate levels. It appears that Milliman estimated the difference in the state share of the higher rebates vs. the current rebates and declares this difference a loss. If so, that is a bad assumption. Unless Nebraska currently has substantial supplemental drug rebates (above the federal rebates), it should not see a reduction in rebate revenue when the federal rebates are increased: the state should collect about as much as it does now. It is unclear from the report whether Nebraska has such supplemental state drug rebates or not.

- In its high range estimate of the cost of increasing the Medicaid physician fee schedule, Milliman assumes that the state not only increases payments for primary care services but for all physician services, including specialty care, and continues these higher payments beyond 2014. While the state has the option of doing these things, these cannot be considered costs of PPACA since they are not required by the federal law.

Finally, let me mention three other issues.

- The Milliman report does not mention the additional federal revenue brought to Nebraska under PPACA. The Urban Institute estimated $2.3 to $2.7 billion in new federal revenue from 2014 to 2019, or more than twenty times the additional state expenditures. Since

Milliman assumes even higher participation and costs, it would yield even higher estimates of federal revenue collected. A substantial body of economic research has shown that because of the additional federal revenues, Medicaid expansions have positive effects on state economies by increasing employment in the health care sector and by secondary economic effects as health professionals and facilities purchase goods and services, pay rent, purchase good, and pay state and local taxes.[6] **Together, these effects lead to substantial increases in state employment and business activity, both inside and outside the health sector. The new federal revenue will expand Nebraska's economy and increase state revenues to largely offset the additional state costs of Medicaid expansion; they might even completely offset the higher state costs.**

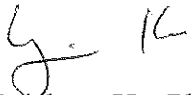
- The Milliman report does not discuss other potential Medicaid savings that might offset some of these costs under PPACA. The new law includes some potential ways for states to save money, such as options for health home demonstration projects, expansion of family planning services or premium assistance. Virtually every state is constantly reviewing ways to reduce the growth of Medicaid costs and I have no doubt that Nebraska will be reviewing such options as potential offsets.

- Nebraska currently operates a state comprehensive high-risk pool for individuals with pre-existing conditions, called NECHIP. State data show this program cost $27.2 million in 2008 and $25 million in 2009. Because of the ban on pre-existing conditions beginning in 2014 with the advent of the state exchanges, it seems likely that the need for this program will disappear (or at least be minimized). If this program is no longer needed, the state could save about $180 million from 2014 to 2020.

- Finally, there are yet other opportunities for Medicaid savings under health reform. We recently released a report looking at the impact of the growth of community health centers under PPACA on reducing medical costs, including federal and state Medicaid costs.[7] We estimated that this change alone could reduce state Medicaid costs nationwide by more than $30 billion from 2010 to 2019. If the state can help expand the number of community health centers and otherwise strengthen primary care services in the state, it could help substantially reduce Medicaid costs in the future.

If you have any questions, please feel free to contact me.

Yours truly,



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[6] Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid in State Economies: A Look at the Research, Jan. 2009.

[7] Ku, L., Richard, P., Dor, A., Tan, E., Shin, P., Rosenbaum, S. "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform," Brief No. 19. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, June 30, 2010.