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Impact Analysis: 2014-2023

State of Utah

Medicaid Expansion Assessment

Strategic Planning Process

**Table of Contents**

1. Executive Summary
2. Five Modeled Scenarios Summary
3. PCG Medicaid Expansion Simulation Model Results
   1. PCG-MESM Assumptions and Modeling
   2. Mandatory Expansion
   3. Optional Expansion
   4. Woodwork and Mandatory Expansion
   5. Crowd-Out
   6. Opportunity Costs
   7. Administrative Costs and Savings
   8. Uncompensated Care Savings
   9. Public Assistance Savings
   10. Medically Needy Savings
   11. Estimated Revenues
4. Appendixes
   1. Appendix I: Public reports participation and take-up rate assumption summary chart
   2. Appendix II: MAGI explanation
   3. Appendix III: Medicaid and Essential Health Benefit comparison
   4. Appendix IV: Utah FMAP Historical Chart
   5. Appendix V: Per Member Per Month Figures
   6. Appendix VI: Other States Expansion Study Comparison
   7. Appendix VII: Tax Revenue Allocation
   8. Appendix VIII: Detailed Tax Information

**Executive Summary**

In June of 2012 the United States Supreme Court ruled that the Affordable Care Act (ACA) requirement that states expand their Medicaid programs to an entirely new population group was unconstitutional. Thus states were allowed to keep their current federal Medicaid funding regardless of whether or not they choose to expand Medicaid.

Following this ruling many states, including Utah, identified a need to determine if expanding Medicaid would be beneficial to the state. As part of its efforts in this regard, the Utah Department of Health (DOH) contracted with the Public Consulting Group (PCG) to model and project the impacts of expanding or not expanding Utah’s Medicaid program.

The following report estimates Medicaid enrollment and costs and savings in Utah under multiple scenarios and with differing populations. The estimations include:

* The costs of the current program projected into future years,
* The costs of the “mandatory changes” due to eligibility determination conversion,
* The costs of expanding Medicaid to two different federal poverty level (FPL) groupings – 0-100% FPL and 0-138% FPL,
* The costs of the “woodwork” effect, providing coverage to the population currently eligible for Medicaid but not enrolled,
* The crowd out effect – those who drop private coverage due to an expansion in public coverage,
* Opportunity costs – the modeled losses to public health and well being if the opportunity to expand is not taken,
* Uncompensated care savings – the decrease in the amount of unreimbursed care hospitals and other providers must face due to an increase in Medicaid coverage for the uninsured,
* Public assistance savings – the need for less expenditures by state and local governments on programs to assist the indigent and uninsured as they gain Medicaid coverage,
* Medically needy savings – the gain or loss of revenue to the state as those on the current Medically needy program leave the program and enroll in expanded Medicaid, and
* Anticipated revenues – the effect the increased federal and state spending that would occur under Medicaid expansion would have on the economy of Utah.

Three different populations are included in the expansion modeling. These populations are:

* Children,
* Adults with dependent children, and
* Adults without dependent children.

Finally, the analysis is presented both yearly through 2023 and in some instances over multiple time periods as follows:

* Six months (January – June 2014),
* One year (January – December 2014),
* Three years (January 2014 – December 2016), and
* Ten years (January 2014 – Dec. 2023).

**Summary of Findings:**

This report provides a model of the future of the Utah Medicaid program under five different scenarios, which are presented and analyzed in more complete detail in the next section.

The five scenarios are:

1. Mandatory Changes and Trended Medicaid Enrollment due to ACA provisions. No Optional Expansion.
2. Optional Expansion of Medicaid to 138% FPL with Traditional Medicaid Benefits,
3. Optional Expansion of Medicaid to 138% FPL with modeled Essential Health Benefits,
4. Optional Expansion to 100% FPL with Traditional Medicaid Benefits,
5. Optional Expansion to 100% with modeled Essential Health Benefits, and

The following chart summarizes the modeling of each of these scenarios with Scenario 1’s results added to each other scenario.



Scenario 1 shows that Utah will bear increased costs in its Medicaid program due to the mandatory expansion required by the ACA, as well as the woodwork effect. After modeling these costs, PCG’s efforts focused on projecting the costs and benefits to the state of expanding Medicaid under the optional scenarios, and then moved to public programs and other areas beyond the mandatory expansion and optional expansions. The modeled costs and benefits of those areas are included in the summary chart above and in the balance sheets that follow, as well as explained in more detail in the following pages.

PCG has found that expanding Medicaid is modeled to have an overall cost to the state. This cost increases over time as the Federal Financial Participation (FFP) declines from covering 100% of the expansion population in 2014 to an eventual federal coverage of 90% of the costs in perpetuity. The affect of the reduction of the federal cost sharing can be seen across the areas of this report. It is most apparent in the optional scenario modeling for the full expansion to 138% FPL. PCG’s judgment is that enhanced cost sharing from the federal government will not be available for the partial expansion to 100% FPL, thus the current FMAP is applied here and no reduction is seen.

The reduction in federal cost sharing is important beyond the pure expansion modeling. For example, in behavioral health coverage the state is modeled to save money in the beginning years of Medicaid expansion (if the optional expansion to 138% FPL takes place) due the likely ability to move people receiving services from the state outside of Medicaid onto the Medicaid rolls. However, the savings to current state non-Medicaid programs are eventually outweighed by the state’s portion of Medicaid costs.

This affect is seen elsewhere, but not as dramatically. Moving individuals from high risk pools that offer coverage in the state to Medicaid is modeled to save the state money. However, these savings decrease as the state has to pay a higher percentage of the Medicaid expansion.

Of note, this report relies on state and public sources for its data. The State of Utah provided a significant amount of data, including information from the Department of Human Services, Department of Workforce Services, Department of Health, and the Department of Corrections. Data from state agencies was supplemented with Utah specific data from public sources. Specifically the Current Population Survey (CPS), a function of the United States Census, the Medical Expenditure Panel Survey (MEPS), a function of the United States Department of Health and Human Services, and the Kaiser Family Foundation (Kaiser), a private entity. Any errors in these data sources are replicated here without the knowledge or intention of PCG.

The PCG Medicaid Expansion Simulation Model was created using PCG experience in forecasting Medicaid spending and caseloads. As with any forecast, uncertainty surrounds many of this report’s assumptions and projections. Rather than a prediction of future costs, the results of this model are projections that are best used to begin a public discourse on the potential impacts of a Medicaid expansion in Utah.

**Five Modeled Scenarios Balance Sheets**

This report is intended to assist policy makers in the state of Utah in deciding whether or not to expand the state’s Medicaid program as mandated by the ACA and made optional by the Supreme Court.

Given the complexities and numerous scenarios that can be developed to this end, PCG worked closely with state officials to find a way to simplify the way the data is presented. It was decided to create five different pictures of the potential future of Utah Medicaid (and the subsequent impact on other sectors of the state) in completely modeled form. The selected scenarios were chosen because they are viewed as the five most plausible directions in which the state may move in terms of Medicaid expansion. The five scenarios are:

1. Mandatory Changes and Trended Medicaid Enrollment due to ACA provisions. No Optional Expansion.
2. Optional Expansion of Medicaid to 138% FPL with Traditional Medicaid Benefits,
3. Optional Expansion of Medicaid to 138% FPL with modeled Essential Health Benefits,
4. Optional Expansion to 100% FPL with Traditional Medicaid Benefits,
5. Optional Expansion to 100% with modeled Essential Health Benefits, and

For each scenario, PCG has created balance sheets that present the complete modeled picture of the impact to the state of each possible decision. For scenario one, which does not include the optional expansion, federal financial participation is assumed at 71.2% (as used elsewhere in this report). For scenarios which present optional expansion taking place, the cost of providing the care to the modeled populations (with either full Medicaid or EHB packages) is presented along with the federal and state share of providing this care. For the expansions up to 138% FPL, enhanced federal financial participation is assumed as allocated in the ACA and discussed elsewhere in this report. For the optional expansion up to 100% FPL, the modeled current Utah federal participation rate (71.2%) is assumed since the federal government has been clear that enhanced federal participation is not available to states that do not undertake full expansion.

After the cost of the expansion other costs (and/or financial benefits) to Utah are included in the balance sheets. These costs include the administrative costs to state agencies of providing services to the increased client load, potential savings coming to the state from individuals gaining insurance and no longer generating uncompensated care, savings or costs to current state public assistance programs, and finally any changes to the state’s medically needy program.

Thus, the balance sheets bring together all of these varying financial projections into one consolidated place for each of the five scenarios. The following narrative and charts describe and demonstrate this modeling activity in detail.

The per member costs in this report assume the same cost sharing for expansion populations that exist in Utah Medicaid today.

**How to read the Balance Sheets / Key Assumptions:**

The first chart in each balance sheet shows the cost of the Medicaid expansion being modeled, next is the modeled administrative costs of each expansion, and finally the potential assistance program costs / savings achieved.

The second chart shows modeled state and county revenue, from both increased taxes and the results of the IMPLAN model (detailed later in this report). The third chart shows the modeled savings to the state from decreases in uncompensated care due to Medicaid expansion. The Balance Sheets stand alone – the results of each of them are not inclusive of the results of Scenario 1 or any other scenario.

Key Assumptions:

* The mandatory expansion in Scenario 1 will have a nominal affect on public assistance savings and uncompensated care. This is because the population is largely children, many of whom are currently on the state’s CHIP program
* The expansions in Scenarios 4 and 5 to 100% FPL will not receive enhanced federal cost sharing
* Public assistance savings in Scenarios 4 and 5 are modeled as a function of total populations at the respective poverty levels, inclusive of the insured, uninsured, and Medicaid populations. This creates a discount percentage of 40.5% when moving from the 138 to the 100 FPL level
* Savings to the State / County represent Medicaid spending, administrative spending, and public program savings / costs that result from the increased benefits provided under Medicaid expansion. Tax Revenue, IMPLAN results, and uncompensated care savings stand on their own.

The data and assumptions that informed each area of the balance sheet can be found in the respective section of the following report.

**Scenario 1: No Optional Expansion, modeled Mandatory Changes and Trended Medicaid Enrollment**

Scenario 1 assumes the State of Utah does not expand Medicaid. The impact will result from expected Medicaid enrollment increases due to mandatory eligibility changes and the woodwork effect (explained later in this report). Scenario 1’s population estimate was broken into three sets of numbers: a high estimate, a low estimate, and an average of the high and low estimates. The population estimate methodology is described in more detail in this report. The average is used to model the costs and savings for all scenarios in the balance sheets but highs and lows are given to demonstrate the potential estimated variation both in the costs and population counts. Total population and cost estimates have been provided across differing time frames: six months, one year, three years and the ten years. For each time period a total figure for that period has been provided in addition to an average annual estimate for that respective period. Please note each time period is inclusive of the previous periods and each time frame can function independently. The average is used to model the costs and savings for this scenario.

The line “CHIP Children” refers to children who will move from the state’s Children’s Health Insurance Program (CHIP) to the state’s Medicaid program due to the end of the asset test for Medicaid eligibility for children under the ACA.



**Scenario 1 Balance Sheet**



**Scenario 2: Optional Expansion of Medicaid to 138% FPL with Traditional Medicaid Benefits**

Impact Analysis: 2014-2023

State of Utah

Medicaid Expansion Assessment

Strategic Planning Process

Scenario 2 assumes Utah expands Medicaid with traditional Medicaid benefits to 138% of the FPL. The population estimate was broken into three sets of numbers: a high estimate, a low estimate, and an average of the high and low estimates. The populations estimate methodology is described in more detail in this report. The average is used to model the costs and savings for all scenarios in the balance sheets but highs and lows are given to demonstrate the potential estimated variation both in the costs and population counts. Total population and cost estimates have been provided across differing time frames: six months, one year, three years and the ten years. For each time period a total figure for that period has been provided in addition to an average annual estimate for that respective period. Please note each time period is inclusive of the previous periods and each time frame can function independently.

Please note that no children will be enrolled due to the Optional Expansion, but instead are considered only in Scenario 1 – no expansion, just woodwork effect and mandatory expansion.



**Scenario 2 Balance Sheet**



**Scenario 3: Optional Expansion of Medicaid to 138% FPL with modeled Essential Health Benefits**

Scenario 3 assumes Utah expands Medicaid with Essential Health Benefits to 138% of the FPL. Population estimate was broken into three sets of numbers: a high estimate, a low estimate, and an average of the high and low estimates. The average is used to model the costs and savings for this scenario. The population estimate methodology is described in more detail in this report. Please note that no children will be enrolled due to the Optional Expansion, but instead are considered only in Scenario 1 – no expansion, just woodwork effect and mandatory expansion.

Please note that no children will be enrolled due to the Optional Expansion, but instead are considered only in Scenario 1 – no expansion, just woodwork effect and mandatory expansion.



**Scenario 3 Balance Sheet**



**Scenario 4: Optional Expansion of Medicaid to 100% FPL with Traditional Medicaid Benefits**

Scenario 4 assumes a Medicaid expansion to only 100% FPL with traditional Medicaid benefits. The population estimate was broken into three sets of numbers: a high estimate, a low estimate, and an average of the high and low estimates. The average is used to model the costs and savings for this scenario. The population estimate methodology is described in more detail in this report.

Please note that no children will be enrolled due to the Optional Expansion, but instead are considered only in Scenario 1 – no expansion, just woodwork effect and mandatory expansion.



**Scenario 4 Balance Sheet**



**Scenario 5: Optional Expansion of Medicaid to 100% FPL with modeled Essential Health Benefits**

Scenario 5 also assumes a Medicaid expansion to only 100% FPL, but also utilizes an Essential Health Benefits-like cost structure. The population estimate was broken into three sets of numbers: a high estimate, a low estimate, and an average of the high and low estimates. The average is used to model the costs and savings for this scenario. The population data estimation methodology is described in more detail in this report.

Please note that no children will be enrolled due to the Optional Expansion, but instead are considered only in Scenario 1 – no expansion, just woodwork effect and mandatory expansion.



**Scenario 5 Balance Sheet**



**PCG-MESM Assumptions and Modeling**

The Public Consulting Group Medicaid Expansion Simulation Model (PCG-MESM) is the foundation of this analysis. Two main sources of data were inputted into the model in order to generate results: data from the March 2012 Annual Social Economic (ASEC) supplement to the 2012 Current Population Survey (CPS) and data from the state of Utah, particularly from the Department of Health (DOH) and the Department of Workforce Services (DWS).

Data from the CPS source is all Utah specific. The CPS is part of the United States Census and thus data for each state is the building block for the national figures. All data used for population modeling purposes is specific to the state of Utah and not extrapolated from national figures. The national figures themselves are a combination of the state specific data.

**Current Population Survey Data**

Demographic data for the PCG-MESM, including statistics on the uninsured, Medicaid populations, and Federal Poverty Level (FPL) splits comes from the March 2012 Annual Social Economic (ASEC) supplement to the 2012 Current Population Survey (CPS), administered by the United States Census Bureau.  The ASEC is a supplement to the CPS survey that covers more than 75,000 additional households and provides further detail into social, income, and economic statistical data.  Data from the March 2012 ASEC supplement is collected directly from two separate sources: the Current Population Survey Table Creator and the State Health Access Data Assistance Center (SHADAC).  Both of these query tools collect data from the ASEC supplement with differing levels of granularity. The SHADAC data tool has the ability to query data from 0 – 138% of the Federal Poverty Level (FPL) in addition to 0 – 400+% FPL. The CPS Table Creator has the ability to query data only on the 0 – 100% FPL level.

In order to provide the most accurate data and incorporate the smallest level of assumptions possible, Public Consulting Group relied on both the CPS Table Creator and the SHADAC query tool to pull our baseline data figures.  Three population categories at these FPL levels were created: Uninsured, Medicaid Eligible, and Private Insurance.

Since the CPS data does not provide counts of adults with and without children, PCG utilized the SHADAC data to arrive at these percentages (see the table, below), which were then applied to the CPS data.



Inputting these data sources into the PCG-MESM produced the following population estimates by FPL and population grouping. These estimates served as the PCG-MESM’s 2012 baseline estimate.



The PCG-MESM then trended this 2012 number to arrive at the 2014, 2014-2016, and 2014-2023 population estimates. The PCG-MESM utilized a linear regression to calculate future year estimates. The trended Medicaid enrollment numbers were used in the Mandatory and Optional sections of the model.  The population figures were trended utilizing five year’s worth of Medicaid enrollment numbers from CPS (2007 – 2012).   Although the “woodwork” section of the model utilizes the same linear regression approach, the uninsured populations from CPS were used as base data.  The Adults with and without Dependent Children and Children populations were trended on 5 years of CPS data (2007 – 2012), for their respective FPL eligibility levels.

Once both current Medicaid and uninsured totals were created for future years using the trending methodology described above, “take up” rate and “lag” assumptions were applied.

The take up rate refers to the amount of people who are eligible for a program that eventually apply for coverage and enroll in it. Experience shows that programs do not often reach total enrollment of all eligible individuals. The charts in this report include “high” and “low” estimates for populations and costs. These estimates are based on take up rates. In order to create and apply take up rate estimates, PCG analyzed the current available literature, included all valid studies, and then created an average high and low estimate. Appendix I provides a chart summarizing these findings. The high take up rate is 71.09% and the low take-up rate percentage is 48.66%.

In addition to these take up rates for the entire population, it is assumed that neither take up rate will be immediately achieved. Experience with past expansions indicates that a lag will occur as the program ramps up, and that full take up rates (either high or low) will not occur immediately. Past programs indicate a three year lag is most common. In the first year, all charts assume 38% of all total eventual enrollees will be in the program, 97% in year two, and 100% in year three and all subsequent years. In other words, in the high estimate of year one, of the total universe of potential enrollees, it is assumed 38% of 71% will enroll, with 97% of the 71% in year two, and 100% of the 71% in year three and later years.

**Department of Health and Department of Workforce Services Data**

The Department of Health (DOH) and Department of Workforce Services (DWS) provided additional data that is used in the PCG-MESM. DOH provided data on Medicaid claims over a five year time horizon that was used to trend Medicaid costs into future years. This included data that was broken into differing populations which allowed costs to be broken out into different categories, including children, and adults with and without dependent children. DWS, which determines eligibility for the state, provided detailed information on cases served over a five year time horizon which allowed caseload to be trended into future years across categories.

**Cost Data**

Potential costs of the modeled populations are presented at two different benefit levels. The first is traditional Utah Medicaid. The second benefit package is an Essential Health Benefits package (EHB). Under the ACA, states have the option of offering an alternative benefit package to Medicaid expansion populations. Though a final decision on this package is pending a number of decisions, including expansion itself, it is possible that any alternative benefit package will be close to the EHB. For this report, PCG has assumed that the Public Employee Health Plan's (PEHP) "Basic Plus", which has been recommended by lawmakers for the Health Insurance Exchange in Utah (Exchange), will serve as the Medicaid EHB.

In order to model costs of this EHB package, PCG underwent a review of the PEHP Basic Plus Utah offers and compared those benefits to traditional Medicaid. It was found that the Medicaid benefit is richer than the proposed EHB plan. In the absence of cost data on the EHB package, Medicaid costs were assumed into the EHB package. Benefits that are offered in Medicaid but not in the EHB package were removed from the EHB cost information. Medicaid costs are a good benchmark for this exercise, as using them embeds Medicaid utilization into the EHB cost and utilization estimate.

For both benefit options, utilization and claims data from Utah was applied to model the costs of the varying populations. The PCG-MESM utilized Utah Medicaid enrollment and spending data from 2008 through 2011 (four years), broken out by the following population groupings (with adjustments for the EHB as noted above):

* Adult,
* Aged,
* Blind/Disabled,
* Child,
* Primary Care Network (PCN),
* Pregnant Women, and
* Qualified Medicare Beneficiaries (QMB).

PCG translated these population groupings into the three population categories requested by the DOH: Children, Adults with Dependent Children, and Adults without Dependent Children. For the PCN population, PCG utilized 2011 enrollment data to determine the number of adults with and without dependent children. PCG divided the Adult and Pregnant Women categories into the MESM’s population categories as explained above. Historical spending was assigned to the population categories in this manner.

The PCG-MESM then calculated a Per Member Per Year (PMPY) spending estimate for each of the populations and benefit packages. These PMPY estimates were used to project 10-year spending levels for each of the population groupings using a number of methods, including linear regression using different historical years and annual growth rates using different historical years. PCG staff identified the trending methodology deemed most appropriate for the population grouping. The result is a PMPY for each of the population categories for each year, 2014 through 2023. It is likely that newly eligible populations will be “less expensive” than existing Medicaid populations. The PCG-MESM discounts the calculated PMPY accordingly. Estimated PMPY calculations are assumed the same for both FPL groupings (0-100% and 0-138%)

These final PMPY spending estimates were applied to the population estimates for each of the scenarios (population methodologies described earlier).

***PCG-MESM – Cost Output Timeframes***

The PCG-MESM produced spending estimates on a yearly basis as per direction from state officials.

**Mandatory Expansion**

Modified adjusted gross income (MAGI) conversion is a mandatory requirement of the ACA. Like other states, Utah currently has varying income eligibility requirements for each of its Medicaid and Children’s Health Insurance Program (CHIP) programs. Under a standardized MAGI conversion methodology, after gross individual or family incomes are determined, a series of disregards are applied (42 CFR 435.603). Disregards are income or assets that are not counted when deciding Medicaid eligibility. In the MAGI methodology excluded disregards include veteran’s benefits, child-support income, transportation benefits, individual retirement accounts, and death benefits.

MAGI is part of the mandatory expansion of Medicaid under the ACA. In important ways, it reflects the “woodwork” population discussed in more detail later in this report. Though the mandatory expansion is the expansion of Medicaid to newly eligible individuals and the woodwork expands Medicaid to clients who are currently eligible but new applicants, the areas have two key components in common: the state must offer these populations coverage under Medicaid and both are subject to current federal financial participation, not the increased federal financing for expansion populations.

Due to the two reasons above, the difficultly in estimating the MAGI population, and the fact that Utah has yet to make a final determination for how its MAGI calculation will be performed, this population is included in the woodwork effect tables in order to simplify this narration and related tables. Appendix II provides readers who wish to know the details of MAGI conversion with a write-up on its background, how the MAGI conversion will work, and the options available to the state in determining how it will undertake MAGI determinations.

In addition to MAGI conversion, asset tests will be eliminated from the income eligibility requirements for some eligibility groups. While Utah has never had asset tests for its CHIP programs, the tests are still applicable to many of its Medicaid programs.

Previous studies have shown that eliminating asset tests has a limited impact on enrollment because few low-income families have assets.[[1]](#footnote-1) A Lewin Group study showed that the elimination of asset tests increased enrollment between 3 and 10 percent for the target populations.[[2]](#footnote-2)

Additionally, the ACA requires that Medicaid cover children ages 6 -18 with an FPL from 100 – 138%. Per discussions with the state, it was decided to include these children in the mandatory expansion section. Children currently on the state CHIP program that fall into this income range are also included in the mandatory expansion. It is assumed that the asset test, set to be eliminated by the ACA, is the reason why these children are ineligible for Medicaid and thus part of the state’s CHIP program.

CHIP population data from 2007-2011 was supplied to PCG by the Department of Health. An enrollment trend was created from this historical data, which was used for CHIP purposes in this report. Indications are that enrollment in 2012 declined in relation to the historical data PCG used to create the trend. This data was not included in order to stay consistent with the time frame of state provided data used elsewhere in this report.

Children are not present in any of the optional populations as they are all included in the mandatory expansion.

**Optional Expansion**

Changes in Medicaid eligibility under the ACA will primarily affect adults (age 19-64) without children, who are currently not eligible for Medicaid (with the exception of the limited benefit of the PCN program). It will also impact adults with dependent children whose incomes are above the current Medicaid levels in Utah (just under 50% FPL). Under expansion as envisioned by the ACA, these nonelderly persons with an effective household income less than 138% FPL will be eligible for expansion. This section of the report projects populations and costs of this optional population. The analysis is also broken into the 0-100% FPL grouping by request of the Department of Health. Guidance from CMS has indicated that the ACA’s enhanced FMAP will only be available to states that undertake full expansion. So, as noted previously, the cost of 0-100% FPL population is assumed at the current FMAP.

***Data, Methodology, and Assumptions***

The data for this section comes from the Current Population Survey (CPS) and the state of Utah. The data is further detailed in the previous explanation of the PCG-MESM.

The assumptions for this section include estimates of participation rates, take up rates, and costs. Participation rates for the optional expansion were arrived at by analyzing publicly available reports. Take up rates are presented in both high and low take-up rate scenarios. The high take-up rate percentage is 71.09% and the low take-up rate percentage is 48.66%. These figures are the assumed final high and low take-up rate percentages. A lag is modeled for both the high and low participation rates. See Appendix I for a summary of public reports on participation rates.

The simulation model estimates annual impacts of the optional expansion. In order to determine a 6-month impact, PCG utilized enrollment experience that was gleaned from the implementation of a similar program and participation is assumed at a little less than 30% of the entire year’s population in those six months.

The data is presented on a yearly basis.

O**ptional Expansion Population Estimates**



**Optional Expansion Total Cost Estimates (using Medicaid cost base)**



**Optional Expansion Federal Match (using Medicaid cost base)**



**Optional Expansion State Share (using Medicaid cost base)**



**Optional Expansion Total Cost Estimate (using Essential Health Benefit estimate cost base)**



**Optional Expansion Federal Match (using Essential Health Benefit estimate cost base)**



**Optional Expansion State Share (using Essential Health Benefit estimate cost base)**



**“Woodwork” And Mandatory Expansion Populations and Costs**

The “woodwork” effect is the population that is currently eligible but not enrolled in Medicaid. Expectations and research indicate that the combination of the individual mandate and the increased attention on health care coverage in the country will encourage some of these currently eligible but not enrolled individuals to apply for coverage. They may apply for coverage via the Health Insurance Exchange that will be operating in Utah and find out they are eligible for Medicaid, or they may know they are eligible for the program and directly apply. Either way, this population is important to cost modeling exercises because whether or not the state chooses to expand Medicaid it will have to provide coverage to this population, and at current federal financial participation levels.

***Data, Methodology, and Assumptions***

The methodology for finding and trending the data found in this section can be found in previous sections of this report.

The total universe of potential enrollees reflects current Utah Medicaid standards translated into the three categories in this report (children, adults with dependent children and adults without dependent children). The total populations for children were found at 138% FPL and adults at 50% FPL. From these figures, the population covered by Medicaid was subtracted from the total, arriving at the number of applicable uninsured adults and children. This was cross checked with the number of uninsured at each poverty level. Trended numbers of total eligible but not enrolled populations were created for future years. Individuals modeled to be newly covered were removed from each potential eligible but not enrolled population to avoid double counting.

Similar to the optional expansion, the assumptions for this section include estimates of participation rates, take up rates, and costs. Publicly available reports provided information on the impact of the woodwork effect on participation. Take up rates are presented in both high and low take-up rate scenarios. The high take-up rate percentage is 71.09% and the low take-up rate percentage is 48.66%. These figures are the assumed final high and low take-up rate percentages. As discussed in a previous section, a lag is modeled for both the high and low participation rates. See appendix one for a summary of public reports on participation rates.

The simulation model estimates annual impacts of the optional expansion. In order to determine a 6-month impact, PCG utilized enrollment experience that was gleaned from the implementation of a similar program and participation is assumed at a little less than 30% of the entire year’s population in those six months. The following charts provide population and cost estimates for both the mandatory and woodwork populations, combined into the same charts on a yearly basis.

*Woodwork and Mandatory Expansion Population Estimates*



*Woodwork and Mandatory Expansion Total Cost (Medicaid benefit mandated)*



*Woodwork and Mandatory Expansion Federal Match (Medicaid benefit mandated)*



*Woodwork and Mandatory Expansion State Share (Medicaid benefit mandated)*



*Mandatory CHIP to Medicaid Enrollment and Expenditure*

Children from 6 – 18 years of age currently on CHIP will be mandatorily moved from CHIP to Medicaid due to the ACA’s provision. This creates the situation in which Utah will have the pay the marginal cost between the state’s CHIP program and Medicaid program. This marginal cost is included in the total cost for scenario one. The following spreadsheet provides details on the difference between the CHIP and Medicaid program costs and demonstrates the net cost to the state.



***PCG-MESM – FMAP Results***

Federal Medical Assistance Percentage, or FMAP, is the percentage of the Federal government’s contribution to the Utah Medicaid program. The 2013 calculated FMAP rate for Utah is 71.2%. This number is Utah’s average FMAP from 2004 – 2012. This FMAP rate is assumed to remain constant throughout all 10 years of modeling.

The FMAP rate for the Mandatory Expansion and the Woodwork impact will be equivalent to the base FMAP rate – 71.2%.

The FMAP rate for the Optional Expansion will be as follows:



The PCG-MESM applied these FMAP rates to the applicable scenarios (e.g. 71.2% for woodwork and the enhanced federal match to the optional scenarios) when producing the Federal and State share amounts.

**Crowd Out**

There is a fear that expanded access to public health insurance coverage will “crowd out” private health insurance coverage. Crowd out is the extent to which this Medicaid expansion will actually reduce private insurance coverage. Estimating the impact of crowd out is an important consideration when calculating the number of insured who will enroll in Medicaid due to the Medicaid expansion. This section of the report explains crowd out in more detail and projects the potential cost effects of the phenomena. One interesting aspect is that crowd out research to date has focused on the behavior of individuals. Given the complexities of the ACA and the impact it has on small businesses, there is an expected effect on the actions of businesses as well. Research on this area is limited to date as these effects are very challenging to measure.

The term “crowd out” was first coined in 1996 by economists David Cutler and Jonathan Gruber. Since this 1996 study there is a significant body of literature related to crowd-out. But as Lisa Dubay notes, the studies utilized different methodologies and each studied crowd-out in different ways. Gruber and Kosali Simon (2012) summarized the different crowd out studies and summarized data sources used, methodology, crowd-out definition, and results.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Article** | **Data source** | **Methodology** | **Crowd-out definition** | **Results** |
| Cutler and Gruber (1996) | 1987–1992 CPS | Instrument eligibility with simulated eligibility based on entire nation; control for state, year, age; consider family level spillovers | (Private insurance/public insurance) or (1-(uninsured/public insurance)) | Children 31%, or children: 40%, family level: 50% |
| Dubay and Kenney (1996) | 1988 and 1993 CPS | Change in insurance coverage of children relative to change for adult men | (Private insurance/public insurance) | Below poverty: 15%, 100–133%: 22% |
| Dubay and Kenney (1997) | 1988 and 1992 CPS | Change in insurance coverage of pregnant women relative to change for men | (Private insurance/public insurance) | Below poverty: 0%, 100–133%: 27%, 133–185%: 59% |
| Thorpe and Florence (1998) | 1989–1994 NLSY | Measure movement from private insurance onto Medicaid among children with privately insured parents | % of those entering Medicaid with privately insured parents | 16% |
| Blumberg et al. (2000) | 1990 SIPP Panel | Compare change in insurance coverage of children made eligible by expansions to those not made eligible | % of children made eligible losing private relative to gaining public | 4% |
| Yazici and Kaestner (2000) | 1988 and 1992 NLSY | Compare change in insurance coverage of children becoming eligible to those not becoming eligible | (1-(uninsured/public insurance)) or (private insurance/public insurance) | 55–59%, 5–24% |
| Aizer and Grogger (2003) | 1995–2002 CPS | Compare change in insurance, for those above AFDC eligibility vs. below, in states with adult expansion, before vs. after expansion | Coefficient on private coverage equation (no crowd-out calculations) | Statistically insignificant effect on private coverage for mothers and for children |
| Card and Shore-Sheppard (2004) | 1990–1993 SIPP panels | Compare changes in insurance coverage of children around income and age limits for eligibility | (Private insurance/public insurance) | Below poverty, eligible for <100: 0; below poverty, eligible for 100–133: 50%; 100–133: 0 |
| LoSasso and Buchmueller (2004) | 1996–2000 CPS | Instrument eligibility with simulated eligibility based on entire nation; control for state, year, age, state×year; interact with state waiting periods | (Private insurance/public insurance) | Average: 50% varies with state waiting periods |
| Shore-Sheppard (2005) | 1987–1995 CPS | Same as Cutler–Gruber, but add additional controls - children only | (1-(uninsured/public insurance)) or (private insurance/public insurance) | 33% (age/year controls) to 59% (all controls), 0 |
| Ham and Shore-Sheppard (2005) | 1985–1995 SIPP | Instrument eligibility with simulated eligibility based on all other states; control for state, year, age | (Private insurance/public insurance) | No crowd-out |
| Hudson et al. | (2005) 1996–2002 MEPS | Compare changes in children made eligible and remaining ineligible; instrument with simulated eligibility | (private insurance/public insurance) | Comparison: 25–55%, IV: 39–70% |

These studies utilize different data sets, different definitions of crowd out, and employ varying methodologies. The results, likewise, vary considerably – from significant 50%-60% crowd out to as little as no crowd out.

As the table illustrates, all of the research to date has been performed on expansion of eligibility for children and their families. Adults without dependent children do not have a separate published study. Evidence suggests that crowd out is a family-driven phenomenon. Cutler and Gruber’s analysis shows that crowd-out is significant, especially when family level measures are utilized.[[3]](#footnote-3)

Based on this research, PCG utilized two crowd-out measures: one for enrollment of children and one for enrollment of adults with children. For adults without dependent children, PCG identified little in the way of extensive analysis. As such, PCG utilized the children’s crowd-out measure, as no better measure was available.

No definitive studies could be identified that demonstrate a direct link between individuals dropping commercial coverage and enrolling in a Medicaid expansion. In all studies reviewed, an assumption is made that the reason for dropping commercial insurance is to enroll in Medicaid, but no data is available to validate this assumption and comparable data to measure this type of affect is very hard to obtain. Due to a lack of hard evidence, PCG is not able to make an assumption that all enrollees who drop commercial insurance will in turn enroll in Medicaid. To avoid further confusion and enable the end user of this report to apply their own assumptions, PCG provided these population figures as a standalone data point with which a user can apply their own assumption as this is a challenging data point to precisely estimate.

**Crowd-Out Population Estimates (Mandatory Expansion – low estimate intentionally admitted)**



*Crowd-Out Population Estimates (Optional Expansion)*



**Opportunity Costs**

Expanding Medicaid will provide health insurance to the currently uninsured. This would have a positive effect on those citizens of the state and has the potential to improve public health in general. This section of the report quantifies the opportunity costs of not expanding Medicaid.

***Mortality and Access to Care among Adults after State Medicaid Expansions[[4]](#footnote-4)***

Studies on healthcare coverage expansions are typically confounded by differences in populations. Medicaid populations tend to be sicker than normal populations and due to study limitations, like populations are not typically compared. Traditional expansion studies in the past have focused on low income children and pregnant women but the ACA expansion in 2014 will cover childless adults, a population not typically covered. In a 2012 study, three states that had substantially expanded adult Medicaid eligibility since 2000 (New York, Maine, and Arizona) were compared with neighboring states that did not undergo any expansions. The study population consisted of 68,012 adults without dependent children aged 20 – 64 who were observed 5 years before and after the expansions, from 1997 through 2007. The primary outcome of the study was a reduction in all-cause county-level mortality. Secondary outcomes were increased rates of insurance coverage, decreased delayed care, and improved self reported health among 169,124 persons in the Current Population Survey and 192,148 persons in the Behavioral Risk Factor Surveillance System.

A significant reduction in all-cause mortality was observed by 19.6 deaths per 100,000 adults for a relative 6.1% reduction rate. The reduction in deaths was greatest among older adults, non-whites, and residents of poorer counties. Smaller but significant reductions were observed in whites and no effects were observed in persons under the age of 35 years.

The chart below demonstrates the primary and secondary outcomes of this study.



This study is only relevant to adults (ages 20 – 64) without dependent children. A significant reduction in 19.6 deaths per 100,000 adults can be indirectly applied to our study population of childless adults from 0 - 138% FPL. The study populations below for each state and their level of expansion can be seen below.

|  |  |
| --- | --- |
| **State** | **Expansion** |
| Arizona | Childless adults with incomes below 100% FPL, and parents with incomes up to 200% FPL |
| Maine | Childless adults up to 100% FPL |
| New York | Childless adults up to 100% FPL and parents  with incomes up to 150% FPL |

Although the populations are similar, they do not match exactly to a population group within the projected expansion to Utah. These primary and secondary outcomes are relevant to the expansion in Utah, but the numbers cannot be directly applied across the different population groups as they are not in proper alignment.

The primary finding of this study is that Medicaid expansions to cover low income adults significantly reduced all-cause mortality as well as improving coverage, access to care, and self-reported health. Individual patient characteristics and variations in insurance coverage often plague studies of this nature, but they were not factors in this study as the expansions were viewed as natural experiments. Significant improvements in self-reported health status were also a direct benefit of Medicaid expansion in addition to a reduction in all-cause mortality. Similar results can be expected after an expansion in Utah, but exact numbers cannot be extrapolated across these differing populations. The differences are too large and would require broad assumptions.

***What the Oregon Health Study Can Tell Us About Expanding Medicaid[[5]](#footnote-5)***

Oregon expanded Medicaid through a randomized lottery system for its previously closed public insurance program, the Oregon Health Plan Standard that expands Medicaid coverage to low-income adults. Analysis of the enrolled population into this program demonstrated that individuals who signed up for the waiting list were more likely to have a worse health status than those who did not sign up for the waiting list. Enrollment numbers were lower than anticipated due to both lack of eligibility and enrollment barriers that are still present across population groups.

This study represented a randomized controlled trial of Medicaid expansion as those were not selected served as a control group. We must keep in mind that the Medicaid expansion is voluntary and directly contrasts the individual mandate in which individuals must purchase health insurance or suffer a penalty. The take up rate was low across the study population which further conflicts with a mandatory expansion. To be eligible for the Oregon Health Plan Standard, you must be an adult between the ages of 19 – 64, an Oregon resident, and a US or legal resident. You must also have been without health insurance for at least six months, have an income below the federal poverty level, and have less than $2,000 in assets. Budgetary shortfalls forced an enrollment cap in 2004, but in 2008, Oregon realized they had the resources to enroll an additional 10,000 adults. Anticipating high demand for the program, Oregon received approval from CMS to create a lottery system for enrollment into the program and over 85,000 individuals applied to be on the waitlist.

Preliminary findings reveal that the individuals who signed up for the waitlist were generally older and in a worse health status when compared to the overall low income uninsured population of Oregon. Of the 29,411 individuals who were selected from the waitlist, less than one-third ended up enrolled in the Oregon Health Plan Standard. About 40% of those selected actually enrolled, and about half of those 50% who applied were found to be eligible for the program. Participation in the waitlist and take up rates in the program were higher for people in worse health which follows the logic in that these individuals have more to gain through acquiring coverage.

This same logic can be applied to Utah in that PCG expects sicker individuals to have a greater incentive to enroll when compared to the baseline uninsured population. This will ultimately impact costs and long terms savings. These new enrollments must be considered in terms of savings to the uncompensated care costs across the state. Only preliminary results are available and hard figures are not given, so no calculations can be applied, but we are able to draw associations.

***The Cost Effectiveness of Health Insurance[[6]](#footnote-6)***

This study estimates the value of providing health insurance to individuals who are currently uninsured through an incremental cost-effectiveness analysis. Individuals ages 25 to 64 across two individual surveys were examined to estimate the contribution of socio-demographic, health, and health behavior characteristics on insured persons’ quality-adjusted life years (QALYs) and healthcare costs.

A three step process was utilized in estimating the cost-effectiveness of insuring those currently uninsured. First a regression analysis of nationally representative data of privately insured individuals modeled the effects of socio-demographic and clinical variables on costs, quality of life values, and mortality. Values from this analysis were then applied to the socio-demographic and clinical characteristics of the uninsured to predict the costs and health benefits of providing insurance. Finally a Markov model was used to estimate these costs from age 25 through 64. Outcomes in this study were provided in quality adjusted life years, with a QALY of 1 representing a year spent in perfect health. Additional costs per QALY are represented as an incremental cost-effectiveness ratio (ICER).

The incremental cost effectiveness ratio for adults ages 25 through 64 is approximately $35,000 per QALY with a range of $21,000 to $48,000. Additional health care services purchased with health insurance provide gains in life quality that are on par with other medical interventions society typically chooses to fund.

Results from this study indicate that for the uninsured, actual expenditures are lower, quality of life is lower, and mortality experiences are higher. The average 25 year old gains .9 QALY over the study period or gain .6 years of life (unadjusted for quality). These gains in health and life expectancy are comparable to programs or medical interventions that are considered a “good buy.” We can also note from this study that the cost effectiveness of health insurance increases with age.

This study is relevant to expanding Medicaid in Utah in that it provides baseline numbers of the cost effectiveness of providing health insurance to the uninsured. Although these figures do not apply directly to Medicaid expansion, they do demonstrate how increased coverage yields both an increased quality of life and a greater life expectancy. This study also shows us how the cost effectiveness of these greater yields increases with age which needs to be taken into consideration when considering the expansion population for the state of Utah.

**Administrative Costs and Savings**

Any increase in Medicaid caseload leads to increased administrative costs for the departments that administer the program. This section of the report models costs of the three departments that will be the most impacted by Medicaid expansion. These are the Department of Health (DOH), the single state agency that administers the Medicaid program, the Department of Workforce Services (DWS), the state agency primarily responsible for eligibility determinations in the state, and the Department of Human Services (DHS). Other state departments likely to be affected are the Department of Technology (DOT), the Office of Medicaid Inspector General (OIG), and the Medicaid Fraud Control Unit (MFCU). The following analysis provides PCG’s estimates for the costs expected to be borne by DOH, DWS, and DHS if the state chooses to expand Medicaid. Administrative cost fiscal figures were either not available or were expected to be relatively nominal for the other entities due to expansion and therefore are not included here.

This analysis considers the three applicable Departments independently by using unit costing figures for each Department. This unit cost can then be applied to any expansion population total in order to project the additional costs the Departments will face as a function of caseload.

***Data, Methodology, and Assumptions***

**Department of Health**

The Department of Health (DOH) is the single state agency responsible for administering Utah’s Medicaid program. DOH is certain to face additional administrative costs if Utah decides to expand its Medicaid program. In order to approximate the costs to DOH of adding additional Medicaid clients, DOH’s 2010 and 2011 annual reports were analyzed for total expenditures, administrative costs, and Medicaid enrollment numbers. The following charts outline the findings:



The two year’s administrative costs by enrollee were averaged to create an administrative unit cost figure of **$10.89** for DOH.

**Department of Workforce Services**

The Department of Workforce Services (DWS) performs eligibility determinations for the state of Utah. DWS is expected to face significant costs due to Medicaid expansion. DWS supplied PCG with data that allowed a unit cost figure to be created. This data included:

* Total annual staffing costs
* Methodology for converting individuals to cases
* Estimated staffing levels on a case basis

PCG created a model using this data to create the final unit cost estimate. For illustrative purposes, an enrollment of 50,000 individuals was used. The below chart demonstrates the data used in the model:





This creates a unit cost estimate of **$80.15** per enrollee.

**Department of Human Services**

The DHS provided PCG with an estimated unit costing based on a projected increase of 111,400 total Medicaid participants (35,500 being children) from current state estimates. The DHS then estimated an increase of 22,200 child support cases.  In order to handle that caseload increase DHS anticipates requiring additional total funding of $1,214,800 ($413,000 of which would come from the state general fund and the remainder would be federal matching funds) to cover the costs. These figures were used to create a unit cost estimate of **$11.63**. This unit cost is different from DOH and DWS because it only applies to the juvenile population, and will be used in the PCG-MESM as such.



***Data Output***

The following chart summarizes the findings for each Department analyzed for this report. The numbers below were trended to the year 2014 (shown below) and applied to all future caseload projections in order to model the potential costs to the state for Medicaid expansion.





**Uncompensated Care Savings**

This section estimates the amount of uncompensated care provided in Utah and how that care is distributed among health providers. The share of the uncompensated care costs that are attributable to individuals that are estimated to gain coverage under the ACA are also estimated.

***Data and Methodology***

The American Hospital Association provides estimates of uncompensated care figures from the AHA’s Annual Survey of Hospitals.[[7]](#footnote-7) This survey focuses on direct unreimbursed hospital services and claims and does not account for many of the other services and programs that hospitals or other providers provide to meet identified community needs. Uncompensated care for a hospital is the sum of the bad debt and charity care that is provided. Charity care is defined as care for which a hospital never expects to obtain reimbursement from the patient. Bad debt consists of services for which providers anticipated but did not receive payment. Uncompensated care excludes other underfunded costs of care including underpayment from Medicaid and Medicare. Uncompensated care costs must be collected from several different providers including hospitals and local community health centers in addition to Disproportionate Share Hospital (DSH) payments.

***Hospital Uncompensated Care***

With assistance from the Utah Hospital Association, PCG was able to estimate uncompensated care costs as seen in the table below. These figures are representative of hospitals and other hospital owned entities, but not of physician offices or other independently owned surgical centers.



***Community Health Centers***

Uncompensated care data for Utah’s Federally Qualified Health Centers (FQHCs) was collected using the Uniform Data System (UDS) provided by the Health Resources and Services Administration (HRSA) which tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues.[[8]](#footnote-8) Utah’s FQHCs are required to annually report data on utilization rates, costs, and revenues. All of Utah’s 11 FQHCs are represented including Bear Lake Community Health Center, Carbon Medical Services Association, Inc., Community Health Centers, Inc., Enterprise Valley Medical Clinic, Inc., Green River Medical Center, Midtown Community Health Center, Mountainlands Community Health Center, Southwest Utah Community Health Center, Utah Navajo Health System, Inc., Wasatch Homeless Health Care/4th Street Clinic, and Wayne Community Health Centers, Inc. These data are used to ensure compliance with legislative and regulatory requirements. These eleven FQHC grantees reported **$32,881,285** in uncompensated care costs in FY 2011. This consisted of $1,353,061 that was written off as bad debt and $31,528,224 was covered through federal, state, and private grant dollars and was given to patients on a sliding fee discount.[[9]](#footnote-9)

***Disproportionate Share Hospital Payments (DSH)***

In FY 2011, Utah hospitals received **$27,582,716.15** in DSH payments. 51 out of 57 hospitals that applied received DSH payments.[[10]](#footnote-10) DSH payments are provided through the Federal government to treat indigent patients such that hospitals may receive partial reimbursement for rendered services. DSH payments typically go to large urban hospitals and teaching hospitals. The annual Disproportionate Share Hospital Survey and Uncompensated Care Survey are used to determine eligibility for the subsequent federal fiscal year DSH program. [[11]](#footnote-11) This survey calculates Uncompensated Care Costs in Section 6 from the last filed Medicare Cost Report and has a separate breakout section for uncompensated Medicaid costs. Under the terms of the ACA, DSH will be phased down.

***Total Uncompensated Care Costs***

By totaling hospital uncompensated care cost estimates ($270,891,340), FQHC uncompensated care totals ($32,881,285), and DSH payment totals ($27,582,716.15), PCG is able to estimate uncompensated care costs for FY 11 in the state of Utah at $**331,555,341.15**. The following chart demonstrates this data.



Total uninsured population counts for the state of Utah in FY 2011 can be found in the table below. These figures come from SHADAC and CPS data sources as previously described.



The Kaiser Family Foundation estimates a total of 393,300 uninsured in Utah from 2010 – 2011 across all age groups.[[12]](#footnote-12) Kaiser does not provide data on whether adults have children or not so we chose to utilize our own population data calculations.

***Additional Assumptions***

* Uncompensated care costs track across subsets of the general population.
* Patients across differing FPL brackets have the same level of healthcare utilization.

***Data Output***

Due to the absence of data on uncompensated care by poverty level, estimating uncompensated care savings requires determining the amount of uncompensated care flowing to differing individuals at differing poverty levels. The following chart summarizes the unit cost calculation.



The figure of **$814.14** can be applied to modeled expansion populations in order to calculate the projected uncompensated care savings.

**Public Assistance Savings**

Certain state and related county programs have the potential to enjoy cost savings if the state expands its Medicaid program. This is because individuals currently covered by services funded largely by state general fund money, in addition to certain Federal funds and local funds, would newly move into Medicaid coverage under the enhanced federal matching percentages in the ACA.

This report considers two areas that are likely to be impacted more than others by Medicaid expansion: state mental health and substance use disorder coverage and Medicaid claiming for inmates who leave prisons for medical coverage in hospitals.

**State Mental Health and Substance Use Disorder Coverage**

The term behavioral health is commonly used to refer to the combination of mental and substance use disorder coverage. Currently in Utah, the Division of Substance Abuse and Mental Health (DSAMH) contracts with local county governments statutorily designated as local substance abuse authorities and local mental health authorities. There are thirteen local mental health authorities in Utah.

DSAMH supervises the administration of the Utah State Hospital (USH), located in Provo, Utah. USH is a 24-hour inpatient psychiatric facility which serves adults who experience severe and persistent mental illness and children with emotional disturbance. The hospital also provides psychiatric treatment to all age groups and covers all geographic areas of the state. USH works with the local mental health authorities as part of its continuum of care. All adult and pediatric beds are allocated to the LMHAs based on population.

DSAMH contracts directly with local county governments to provide treatment and prevention centers in each county throughout the state.

Utah has multiple statewide initiatives which include:

* Recovery Plus,
* Prevention by Design Project,
* Olmstead (REDI System),
* Pre-Admission Screening Resident Review (PASRR),
* Utah’s Peer Support Services,
* Access to Recovery,
* On-Premise and Off-Premise Alcohol Sales Training, and
* DUI Education.
* PASSAGES (Progressive Adulthood: Skills, Support, Advocacy, Growth, and Empowerment = Success) is a program implemented in August 2012 that helps young people between the ages of 16 and 25 with mental health conditions successfully transition into adulthood. It employs coaches to mentor program participants to help them gain competency in a variety of domains.
* Crisis Intervention Team- Utah: This program was implemented in 2001, and trains individuals to assist law enforcement officers to effectively respond to individuals experiencing a mental health crisis. Currently, 10 of Utah’s 13 regions participate in the CIT Utah Program.
* Drug Court: Drug court provides participants intensive court supervised drug treatment as an alternative to jail. Services are provided to individuals that are identified at high risk for recidivism and in high need of substance abuse treatment services. There are four primary models of drug courts: adult felony, adult misdemeanor, juvenile, and family. In 2012, DSAMH provided funding for 29 courts, and will extend that funding to 45 courts in FY2013.
* Drug Offender Reform Act (DORA): The DORA began in 2005 as a pilot project, and since has implemented eight local substance abuse authority areas of Utah. In 2012, 668 individuals were served in the DORA program statewide.
* Utah also has many consumer and family partnerships which include *Utah Family Coalition and Family Resource Facilitators, New Frontiers for Families, Allies with Families, Utah Support Advocates for Recovery Awareness (USARA), and NAMI-Utah.*

***Data, Methodology, and Assumptions***

PCG obtained information from the Utah Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) and the Salt Lake County Division of Behavioral Health Services in order to gain an understanding of current state and local programs. The data provided included figures explaining current enrollment and benefits in the respective programs run by the two entities. Both organizations also supplied projections for future enrollment in the programs and the potential affect of the ACA. PCG analyzed and adjusted this data utilizing independent assumptions to model the ramifications of Medicaid expansion on these programs.

In order to determine the potential costs and/or savings to the state, PCG used the data it received to first project the costs to the state of administering the current program in future years without expansion. Next, PCG determined the costs to Utah to cover the expansion population. Finally, the difference in the cost to the state of the current program verses under expansion was determined over the time horizon. Only state spending in the current program was used in this analysis, federal matching and grant funds that comprise the total program costs were not included in this analysis in order to avoid confusion between the two payers.

PCG used the DSAMH original estimates for the population that will be covered by this benefit. In addition, PCG assumptions include the following:

* The behavioral health population would grow at the same rate as the general population used elsewhere in the PCG-MESM,
* Current FMAP’s will continue for the existing population and the newly eligible population will receive the ACA’s enhanced FMAP,
* The Utah expansion benefit will include full coverage for these services.
* Current state and county spending split will reflect that shown in historical data provided by the state. State officials have indicated an expectation this may change in future years with a push towards more spending on the state side. However, PCG has chosen to apply historical data in order to create the state and county spending split as historical data is preferred whenever possible. This percentage is shown in the following charts.

Savings and costs are shown on both a state and county level. Historical costs were analyzed for the respective spending by the state and counties and costs and savings were distributed to each in respective fashion.

The following charts show the data for mental health and substance use disorder (SUD) and then a combined total for all of behavioral health. Initial savings in mental health are eventually offset by the combination of increased Medicaid caseload and decreased federal financial participation for the expansion population. For SUD, savings are seen throughout the length of the analysis due to the significant increase in federal participation compared to non-expansion scenarios.

The final savings figure compares the costs to the state and county of running current programs inflated into future years (using the population growth rate shown in the charts as the inflation factor) verses the state and county share of the programs under expansion.

***Data Output: Behavioral Health Services***

Behavioral Health Summary Chart:



Mental Health Detail Chart (1/2)



Mental Health Detail Chart (2/2)



Substance Use Disorder Detail Chart (1/2)



Substance Use Disorder Detail Chart (2/2)



**Primary Care Network**

The Primary Care Network (PCN) program is a health plan for adults offered by the Utah Department of Health in which the majority of health services provided are in a primary care setting. The program falls under Utah’s Section 1115 Waiver. Although the waiver contains enrollment caps, PCN enrollment has been limited by available state funding and general averages around 18,000. Adults who qualify for the PCN program are low income individuals, ages 19 – 64 who do not met any eligibility criteria for traditional Medicaid programs.

Individuals who are currently enrolled in the Primary Care Network would be generally eligible for Medicaid under an expansion because their incomes are less than 150% FPL. Under the 100% FPL optional expansion scenarios, the Utah Department of Health has indicated it would likely close the PCN program and encourage higher income PCN clients to apply for coverage though the Health Insurance Exchange, where they would be eligible for premium and cost sharing assistance.

Individuals that lose PCN coverage and move to Medicaid would be considered newly eligible for Medicaid and they would be eligible for the enhanced FMAP. Enrollees in the PCN network were built into the optional expansion scenario in the PCG-MESM and their potential costs under Medicaid are accounted for.

In assuming these individuals will be enrolled into Medicaid under an optional expansion, the savings that will accrue pending the retirement of the program are included in the public assistance savings to the state in the balance sheets for each optional scenario. The table below demonstrates the estimated costs of the program across the expansion timeframes. These figures are subtracted from the overall expansion costs as additional savings to the state.

The chart below shows the cost estimate of the program in future years. If Medicaid were to undergo expansion, these costs would become savings.

**PCN Savings**



**Medicaid Claiming for Inmates**

Inmates who have to leave their institutions for an inpatient hospital stay in a hospital for 24 or more hours can be subject to Medicaid claiming, and thus federal matching funds, if the inmate is eligible for Medicaid coverage (e.g., a pregnant woman or an individual with a disability). Utah currently has an eligibility policy that allows for some of this claiming. Starting in 2014, if states choose to expand Medicaid, there will be an enhanced opportunity for inmate Medicaid claiming. This is because the removal of categorical eligibility will make nearly all inmates under 138% FPL eligible for Medicaid (or up to 100% FPL if Utah’s expansion follows that track).

A key assumption in this analysis is that 90% of inmates who receive inpatient services will qualify for Medicaid. 90% is an estimate based on experience in other states and across a Literature Review. Available data is varied, but it is assumed that all Elderly, Disabled, Pregnant, and Parents will qualify under the current FMAP. The population has been reduced to 90% as undocumented residents will not qualify. Other states have expressed an expectation that nearly 100% of their inmates populations will be eligible for Medicaid claiming. The figure 90% is used to be mindful of Utah’s current applicable eligibility groups and a desire to present a more conservative estimate than has been encountered elsewhere.

**Jail Inpatient Inmates**

County wide level jail information was extrapolated from Salt Lake County jail information. Statewide county jail populations were estimated based on the percentage of the Salt Lake County population compared to the overall population of the State of Utah. An estimate was used because individual county level jail inmate data could not be obtained. A constant percentage of inmates receiving inpatient services of 1.55% was applied to the extrapolated overall statewide county inmate figure. 1.55% was calculated based on Salt Lake County data.

A growth trend of Medicaid caseload was applied to the baseline 2012 inpatient inmate population figure. This was the same growth trend applied to all adults in the PCG-MESM. County jail maximum population constraints were not taken into account for this exercise. Additionally, a per member per year (PMPY) figure was obtained from Salt Lake County for all inmate services minus any private insurance contributions and this PMPY was applied to the statewide inpatient inmate extrapolated population. Contribution percentages across Salt Lake County state funds, Medicaid claiming, and county funds were also applied to the entire state wide extrapolated inpatient inmate figures.

Based on an estimate of $50,000 of current Medicaid claiming, when compared to the total inpatient claiming, approximately 8.5% of the total expenditures were currently being claimed under the current FFP. This percentage was used in estimating the total current costs to the state. Additionally, it was assumed that the counties cover 57% of the total inpatient costs and the state covers 43%, after private funding has been removed, based on totals from balance sheets supplied by Salt Lake County.

State and county level savings are achieved through claiming inmates under the enhanced Federal match under Medicaid expansion. These savings accrue to the state and counties based on their respective overall level of input. The following chart provides the detailed financial information resulting from the data provided and the above methodology.

**Jail Inmates Receiving Inpatient Services**



P**rison Inpatient Claiming**

Statewide prison information was obtained from the Utah Department of Corrections. A PMPY figure was obtained by dividing the total unique count of all prisoners with an inpatient stay by the total cost of inpatient claims. A constant percentage of inmates receiving inpatient services of 2.34 % was applied to the extrapolated overall statewide prison inmate figure. 2.34% was calculated from data received from the Department of Corrections.

A growth trend of Medicaid caseloads was applied to the baseline 2012 inpatient inmate population figure. This was the same growth trend applied to all adults in the PCG-MESM. Prison population constraints were not taken into account for this exercise. It was also assumed that 90% of all inmates receiving inpatient services will be eligible to receive Medicaid coverage. These prisoners will newly eligible under the ACA and will be receiving the enhanced Federal match of the Medicaid claiming. There was currently no significant Medicaid claiming for prisoners receiving inpatients services so the State serves to benefit from claiming inpatient Medicaid services.

The following chart provides complete financial information and demonstrates how savings were calculated from the data provided and the above assumptions.

**Prison Inmates Receiving Inpatient Services**



**High Risk Pool Savings (HIPUtah and FHRP)**

The Utah Comprehensive Health Insurance Pool (HIPUtah) and Federal Qualified High Risk Pool (FHRP / Federal HIPUtah) currently serve as an important safety net in Utah to cover individuals who have been denied health insurance coverage because of their medical status. However both must be funded (at least in part) by state dollars.

The Affordable Care Act provides changes to insurance rules by creating community ratings and in turn eliminates the need for high risk pools. The State of Utah will accrue savings due to changes in insurance law and not Medicaid expansion. Therefore, for the Medicaid expansion scenarios, it is assumed that both the HIPUtah and Federal HIP Utah programs will be dissolving on January 1st 2014. It is also assumed that 100% of all individuals who fall into the appropriate Federal Poverty Level brackets (138% and 100%) will enroll into Medicaid. Individuals above 138% of the Federal Poverty Level will be free to enroll in the health insurance exchange in the state and pre-existing condition exclusions will be prohibited. Savings for HIPUtah and Federal HIPUtah have been combined and split across 138% of FPL and 100% of FPL.

Population estimates received from the Utah Department of Insurance have been extrapolated into future years and per member per year costs have been multiplied across population estimates to obtain projected annual expenditures for both HIPUtah and Federal HIPUtah. Annual premium revenues have been removed from the annual expenditure totals and the state and federal contribution projections are realized through pending the continuation of the program. It is assumed both the state and federal program will dissolve in 2014 and the participants will enroll in either the exchange or Medicaid expansion population. The HIPUtah participants will receive the enhanced Federal match under Medicaid expansion and will no longer be responsible for a premium contribution and the Federal HIPUtah participants will received a decreasing federal match (as they are currently 100% federally funded post premium revenue).

The state will ultimately save money through dissolving the HIPUtah program through an increased Federal match on both the HIPUtah and Federal HIPUtah programs despite the absorption of additional costs from the dissolution of the Federal HIPUtah program.These savings will yield to the State General Fund and not directly to the Utah Department of Health as they are a result of insurance regulatory changes.

High Risk Pool Savings (HIPUtah and FHRP) 138% FPL



High Risk Pool Savings (HIPUtah and FHRP) 100% FPL



**Medically Needy Savings**

**Analysis of Cost of Adding Current Medically Needy to Regular Medicaid**

The purpose of the analysis is to estimate the cost or savings to the state if and when persons on the current Medically Needy program receive Medicaid eligibility under the provisions of the Affordable Care Act (ACA). The major conclusion of this analysis is that the state will incur a new Medicaid expense of $681,086 because some persons that were previously on the Medically Needy program and had a spend down will now be eligible for Medicaid services without a spend down.

PCG received information on the Medically Needy program from Utah staff. This information contained data, by aid category on:

* The number of enrollee months in 2012;
* The average length of stay (ALOS) persons were on Medically Needy program, and
* The average annual Medicaid cost per person.

This information was used to calculate the total funds spent on Medically Needy participants as reflected in the information provided. The calculation is presented in the table below.



PCG also received a data base of 30,682 records of monthly information at the individual level containing:

* The number of persons in the household;
* The age of the person;
* The countable income of the person, and
* The amount of the person’s spend down obligation.

From this data base, the aggregate spend down was calculated as follows:



**Analysis of the Spend Down of Persons Aged 65 and older**

After the ACA, except for persons aged 65 and older, persons under 138% will be eligible for Medicaid without a spend down. Persons aged 65 and older are not an optional expansion group under the ACA and presumably will continue to remain on the Medically Needy program; which means the persons will continue to be responsible for their spend down. To estimate their spend down, the analysis first estimated how many persons aged 65 and older on the ABD program had income under 100% and how many had income over 100%. The countable income reported for the person was used to estimate their corresponding FPL. “Countable income” is the income remaining after disregards and deductions have been applied. The countable income was used because information on disregards and deductions was not readily available.

This methodology identified 1,256 unique persons aged 65 and older on the ABD program with countable income greater than 100% of the FPL and their spend down amount was $846,361. Persons aged 65 and older in other programs, such as on waivers, were not included in the estimation. The majority of persons aged 65 and older were above 100% FPL.

**Analysis of the 138% FPL Level**

Excluding persons aged 65 and older on the ABD program, the number of persons over 138% of the Federal Poverty Level (FPL) was estimated. The spend down data received by PCG simply listed ABD as the aid category for persons aged 65 and older, persons with visual disabilities, and persons with disabilities. However, PCG also received data on the age of each person and used the age data to back out persons aged 65 and older that were enrolled in the ABD program. Aged persons comprise approximately .30% of the aged, blind and persons with disabilities that are on the Medically Needy program.

Countable income was compared to the FPL for the household size of the person. This methodology identified a spend down of $2,119,970 generated by approximately 560 persons whose countable income exceeded the 138% FPL for a household of the size lived in by the person. While the number in the 138% group is smaller, they have larger spend down requirements as contrasted with persons aged 65 and older.

**Summary of Results**

The table below summarizes these results



Assuming the state continues to keep its Medically Needy program, this analysis implies that persons who will continue in the program will pay approximately $2,966,003 dollars after the implementation of the ACA. Before the ACA these persons paid for their own medical treatment until they “spent down.” After the ACA, except for persons aged 65 and older, persons under 138% will be eligible for Medicaid without a spend down and the state will pay the state share of their Medicaid expenses.

At a 2012 federal funds participation (FFP) rate of 71.03%, the state is required to pay 28.97% of the Medicaid expense or $681,086, ($2,351,003\*.2897). This is a new obligation that the state will have to fund.

It is true that persons made newly eligible under the ACA will have 100% of their costs picked up by the Federal Medicaid program. In the overall expansion analysis, PCG assumes Medically Needy persons are covered under the optional expansion. This means they will receive the enhanced FMAP percentage.

The above section on Medically Needy was provided as a more in-depth analysis on a granular programmatic level. Individuals enrolled in the Medically Needy program were included in our optional Medicaid expansion population in order to maintain consistency throughout the modeling process across populations. In the overall model, these individuals have been grouped into the optional expansion and are modeled at receiving the enhanced FMAP across the two differing benefit packages.

**Estimated Revenues**

Health care funds filter throughout state and local communities and will have short run direct and/or indirect impacts (2014 - 2019) on multiple areas, including:

* State and local government budgets,
* The health care industry (hospitals, physicians, labs, and pharmacists etc. recognizing the two main impacts here are revenues and potential cost shifting), and
* The general economy, in particular the money multiplier impact of various rounds of spending, including any off-setting impacts relating to where the federal funding comes from (reduced Medicare spending, increased taxes, increased deficit, etc.).

The goal of this section of the report is to analyze how increased funds being spent by the government will affect the general economy. This includes net increased revenue from the federal government that will come to the state via increased federal financial participation while removing the state’s share of Medicaid costs and increased state government administrative spending.

**Methodology and Assumptions**

This section estimates the potential economic impacts of Medicaid expansion in the state of Utah across five varying scenarios of expansion. This analysis was performed using the IMPLAN 3.0 model. IMPLAN is an input-output model that is used to examine the impact of changes that occur in an economy given modeled events. In this case, the modeled event is the increased revenue to the state of Utah projected across five different expansion scenarios for which balance sheets were presented earlier in this report. Those five scenarios are:

1. No Optional Expansion, modeled Mandatory Changes and Trended Medicaid Enrollment
2. Optional Expansion of Medicaid to 138% FPL with Traditional Medicaid Benefits,
3. Optional Expansion of Medicaid to 138% FPL with modeled Essential Health Benefits,
4. Optional Expansion to 100% FPL with Traditional Medicaid Benefits, and
5. Optional Expansion to 100% FPL with modeled Essential Health Benefits.

The IMPLAN model was utilized to analyze how each option would potentially affect the state’s economy. This section of the report follows the same key assumptions as previously stated, and additionally contains several unique assumptions. Key assumptions that remain constant for economic modeling as were made previously in the report include:

* Medicaid caseload assumptions remain constant,
* Assumptions related to cost of the Medicaid benefit and Essential Health Benefit package remain constant,
* Federal and state financial participation for each option remain constant, and
* The same average of the high and low estimates from the balance sheets is utilized.

Using the IMPLAN model requires several new assumptions that are unique to this section of the report. In order to remove the variability that comes from the projected cost savings of Medicaid expansion and focus on increased incoming revenue, the following financial figures were included and loaded into the IMPLAN model: projected FMAP on Est. Services Costs and increased FFP on Est. administrative costs while removing any increased state costs, both administrative and public assistance savings (called “modeled Medicaid spending” in the remainder of this report).

The total financial figure in each scenario had to be allocated (these allocations are demonstrated later in this report) to differing sectors on the economy. The sectors of the Utah economy into which the increased health care spending must be allocated are:

* Administrative expenses,
* Offices of physicians, dentists, and other health practitioners,
* Home health services,
* Medical and diagnostic labs and other outpatient ambulatory services,
* Private hospitals, and
* Nursing and residential care facilities.

The total estimated modeled Medicaid spending was placed into these categories on a percentage basis using data from the 2011 annual Utah Medicaid report. Only applicable categories of current Medicaid spending were included in the allocation total. They are as follows:

|  |  |  |
| --- | --- | --- |
| **2011 Utah Medicaid Spending** | | |
| Sector | Total Spend | Percent Spend |
| Inpatient Hospital | $319,920,600.00 | 21.60% |
| Nursing Home | $160,983,700.00 | 10.87% |
| Contracted Health Plan Services | $204,569,800.00 | 13.81% |
| Physician Services | $94,763,000.00 | 6.40% |
| Outpatient Hospital | $98,479,600.00 | 6.65% |
| Medical Supplies | $14,044,000.00 | 0.95% |
| Pharmacy | $166,316,000.00 | 11.23% |
| Home and Community Based Services | $157,761,100.00 | 10.65% |
| Mental Health | $143,517,700.00 | 9.69% |
| Dental | $35,658,400.00 | 2.41% |
| Intermediate Care Facilities | $82,712,900.00 | 5.59% |
| Vision | $2,248,300.00 | 0.15% |
| Total | $1,480,975,100.00 | 100.00% |

In the following chart, the IMPLAN sector total reflects the total Medicaid spending from the 2011 Medicaid annual report in the Medicaid categories that are shown beneath each IMPLAN sector line.

The Medicaid spending was then placed into the applicable IMPLAN sectors as demonstrated in the following chart:



This methodology for allocating the modeled Medicaid spending was then used for each of the five scenarios. Each scenario was modeled over three time periods:

* The modeled Medicaid spending in 2014,
* The yearly average modeled Medicaid spending from 2014-2016, and
* The yearly average modeled Medicaid spending from 2014-2023.

**Results**

The charts below detail the results of the IMPLAN model for each scenario. Two overarching results are shown. First, the total impact to the state economy is shown. This demonstrates how all industries across the state are affected by increased Medicaid spending. This result is shown in the following three areas: employment gain, labor income, and value added. Dollar figures for each projected year are demonstrated in the respective year.

Secondly in order to show the information on a more granular level the top ten industries of Utah's economy in terms of value added due to the increased revenue to the state from Medicaid expenditures are shown. For reference, the IMPLAN model defines “value added” as follows:

“The difference between an industry’s or an establishment’s total output and the cost of its intermediate inputs. It equals gross output (sales or receipts and other operating income, plus inventory change) minus intermediate inputs (consumption of goods and services purchased from other industries or imported). Value added consists of compensation of employees, taxes on production and imports less subsidies (formerly indirect business taxes and nontax payments), and gross operating surplus (formerly “other value added”). (BEA); Gross value added is the value of output less the value of intermediate consumption; it is a measure of the contribution to GDP made by an individual producer, industry or sector; gross value added is the source from which the primary incomes of the SNA are generated and is therefore carried forward into the primary distribution of income account.[[13]](#footnote-13)”

These charts demonstrate net job additions for each of the top ten industries, net labor income in each industry, and finally additions to the Gross State Product (GSP). The ten industries that are the most effected by Medicaid expansion remain largely the same across scenarios and over time periods, but there is some divergence in the degree to which the spending affects the industries and thus their ranking. Eleven industries make the lists. The following list presents the industries in alphabetical order:

* Employment and payroll only (state and local government, non-education),
* Food services and drinking places,
* Home health care services,
* Imputed rental activity for owner-occupied dwellings,
* Medical and diagnostic labs and outpatient and other ambulatory care services,
* Monetary authorities and depository credit intermediation activities,
* Nursing and residential care facilities,
* Offices of physicians, dentists, and other health practitioners,
* Private hospitals,
* Real estate establishments, and
* Wholesale trade businesses.

**Total Revenues by Scenario Across all Industries**



**Scenario 1 Revenues by Top Ten Industries (1/2)**

**Scenario 1 Revenues by Top Ten Industries (2/2)**



**Scenario 2 Revenues by Top Ten Industries (1/2)**



**Scenario 2 Revenues by Top Ten Industries (2/2)**



**Scenario 3 Revenues by Top Ten Industries (1/2)**



**Scenario 3 Revenues by Top Ten Industries (2/2)**



**Scenario 4 Revenues by Top Ten Industries (1/2)**



**Scenario 4 Revenues by Top Ten Industries (2/2)**



**Scenario 5 Revenues by Top Ten Industries (1/2)**



**Scenario 5 Revenues by Top Ten Industries (2/2)**



**Tax Revenues**

Tax revenues across state, local and federal entities are found in the chart below.



**Appendix I**

Public reports participation and take-up rate assumption summary chart.



The following data comes from the 2010 annual Medicaid report.



**Appendix II**

This section models the MAGI-equivalent income standards for the following eligibility groups: children, adults with dependent children, and adults without dependent children. MAGI standards do not apply to the elderly and disabled. Non-MAGI groups include the medically needy, 65 and older, long-term care users, Medicare cost sharing, blind, disabled, and SSI/QMB populations.

***Background, Data, Methodology, and Assumptions***

MAGI Conversion

According to a SFY2012 Medicaid annual report, there are 397,813 distinct enrollees in Utah’s Medicaid program[[14]](#footnote-14). The report provides the percentages of Medicaid eligibles in each category of assistance. The following chart replicates the report’s data and also provides a count of Medicaid eligibles by category of assistance:



*\* The 40-count difference between the 397,813 persons listed in the Utah Medicaid report and the 397,853 persons listed in table above is due to rounding.*

Current income eligibility requirements for children, parents, pregnant women, and adults on PCN will be subject to MAGI conversion standards. This population represents approximately 84% of Utah’s SFY 2012 Medicaid population.

Income Disregards

The clients found in the eight categories of assistance listed above belong to one of several Medicaid programs. Programs have different income level maximums, spend-down amounts, income disregards, and asset limits. The following table lists all of Utah’s Medicaid programs that use percentages of federal poverty level to determine income eligibility. The table has been separated into MAGI and non-MAGI eligible programs. Programs subject to MAGI conversion are also divided between those that currently do and do not allow income or asset disregards[[15]](#footnote-15):

|  |  |  |
| --- | --- | --- |
| **Programs not subject to MAGI conversion** | **Programs subject to MAGI conversion** | |
| **Programs with Disregard** | **Programs Without Disregard** |
| 1. Aged and Disabled 2. Qualified Medicare Beneficiaries Program (QMB) 3. Specified Low-Income Medicare Beneficiaries (SLMB) 4. Qualifying Individuals (QI) 5. Qualified Disabled Working Individual (QDWI) 6. Medicaid Work Incentive | 1. LIFC 12 month earned incomes disregard 2. LIFC transitional during 2nd six months 3. Child 0-5 4. Child 6-18 5. Pregnant Women | 1. Primary Care Network (PCN) 2. CHIP (Plans A-C) 3. Utah’s Premium Partnership for Health Insurance (UPP): Kids and Adults |

In Utah, programs that allow disregards usually exclude $30 plus one third of working income when determining eligibility. As part of the MAGI conversion process, all relevant Medicaid programs will be subject to the same disregards. The next section will describe the conversion calculations necessary for all MAGI-eligible programs.

**Approaches to MAGI Conversion:**

By June 2013, all states must have Centers for Medicare & Medicaid Services (CMS) approved MAGI-based eligibility standards. States have the option of approving one of two conversion methodologies: standardized or state specific.

Option 1: Standardized MAGI Conversion Methodology

CMS will determine the MAGI equivalent standards for each state using national Survey of Income and Program Participation (SIPP) data. Each eligibility group (adults with dependent children, children, and adults without dependent children) will have a MAGI eligibility standard. CMS describes this process in two main steps:

1) “Calculating the average size of the disregards for people whose net income falls within 25 percentage points of the federal poverty level (FPL) below the net income standard; and

2) Adding the average disregard amount, expressed as a percentage of the FPL, to the net income eligibility standard, also expressed as a percentage of the FPL.” [[16]](#footnote-16)

States also have the option of using their own data to perform the same standardized MAGI conversion. The state data must provide enough detail on gross and net income as well as information needed to determine income and asset disregards. CMS will provide technical assistance to any state that uses its own data[[17]](#footnote-17).

Option 2: State Proposal Option

States can also propose and implement their own alternative methodology. States with unique disregard and income standards may find this option more useful. Examples of such alternative methodologies include:

1. “Adjusting for differences in income counting and household composition rules (if a state adjusts for MAGI income and household composition rules, it must do so using all MAGI rules for all eligibility groups); and
2. Adopting a different marginal band (25 percentage points) based on its own state specific disregards, data, eligibility standards, and population analysis.” [[18]](#footnote-18)

To receive approval, states must provide all of the necessary data to CMS and demonstrate how the proposed methodology will meet the MAGI objectives.

MAGI Conversion Timeline

CMS developed the following 5-step process for all states to adhere to[[19]](#footnote-19):



\* *States will be notified of their plan’s approval or disproval by June 15, 2013.*

At this time, Utah has submitted a plan using state data. Generally, CMS anticipates on-going dialogue with states about the selection of an appropriate MAGI conversion methodology. As a result, it is preparing several technical assistance documents that explain:

* The standardized MAGI conversion methodology and SIPP data,
* How states can use their own data in the standardized methodology, and
* The eligibility thresholds for any Medicaid group subject to the MAGI conversion.

All states will be able to review the SIPP data (as CMS will provide data analyses on a rolling basis prior to the April 2013 MAGI conversion results) and explore other options before submitting their MAGI conversion plans.

**Appendix III** *(Medicaid vs. Essential Health Benefit Comparison)*



**Appendix IV**

Federal Financial Participation in Utah Medicaid Average.

To be more representative of current years, the average figured was reduced to **71.2%** because the FMAP in FY 2009 and FY 2010 was viewed as trending the data higher than should be expected in future years.



**Appendix V**

Below the Per Member Per Year (PMPY) figures used for calculating future year costs are provided. These figures represent total costs of the program divided by total enrollees in the year. These figures have been discounted by 20% per the PCG – MESM.

**Medicaid PMPYs**



**EHB PMPYs**



# Appendix VI

Below is an appendix detailing the Medicaid expansion studies of 15 other states.











**Appendix** **VII – Tax Revenue Allocation**

Tax revenues for state and local entities have been allocated according to the chart below.

|  |  |
| --- | --- |
| **Allocation** | **Description** |
| State | Dividends |
| State | Social Ins Tax- Employee Contribution |
| State | Social Ins Tax- Employer Contribution |
| Split (70/30) | Indirect Bus Tax: Sales Tax |
| Local | Indirect Bus Tax: Property Tax |
| Local | Indirect Bus Tax: Motor Vehicle Lic |
| State | Indirect Bus Tax: Severance Tax |
| Local | Indirect Bus Tax: Other Taxes |
| Local | Indirect Bus Tax: S/L NonTaxes |
| State | Corporate Profits Tax |
| State | Personal Tax: Income Tax |
| State | Personal Tax: NonTaxes (Fines- Fees |
| State | Personal Tax: Motor Vehicle License |
| State | Personal Tax: Property Taxes |
| State | Personal Tax: Other Tax (Fish/Hunt) |

Sales tax has been allocated according to the chart below.

|  |  |  |
| --- | --- | --- |
| **Utah Sales Tax** | | |
|  | Sales tax | Percent of total |
| State | 4.70% | 0.699404762 |
| Local | 2.02% | 0.300595238 |
| **Total** | **6.72%** | **1** |

**Appendix** **VIII – Detailed Tax Information**

Scenario 1 2014 (1/2)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **State and Local Tax** | | | | | | |
| Allocation | Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| State | Dividends |  |  |  |  | $868 |
| State | Social Ins Tax- Employee Contribution | $563 | $0 |  |  |  |
| State | Social Ins Tax- Employer Contribution | $998 |  |  |  |  |
| Split (70/30) | Indirect Bus Tax: Sales Tax |  |  | $427,201 |  |  |
| Local | Indirect Bus Tax: Property Tax |  |  | $290,900 |  |  |
| Local | Indirect Bus Tax: Motor Vehicle Lic |  |  | $14,097 |  |  |
| State | Indirect Bus Tax: Severance Tax |  |  | $10,487 |  |  |
| Local | Indirect Bus Tax: Other Taxes |  |  | $18,223 |  |  |
| Local | Indirect Bus Tax: S/L NonTaxes |  |  | $76,636 |  |  |
| State | Corporate Profits Tax |  |  |  |  | $29,232 |
| State | Personal Tax: Income Tax |  |  |  | $250,975 |  |
| State | Personal Tax: NonTaxes (Fines- Fees |  |  |  | $38,968 |  |
| State | Personal Tax: Motor Vehicle License |  |  |  | $21,687 |  |
| State | Personal Tax: Property Taxes |  |  |  | $4,556 |  |
| State | Personal Tax: Other Tax (Fish/Hunt) |  |  |  | $13,730 |  |
|  | Total State and Local Tax | $1,562 | $0 | $837,544 | $329,916 | $30,101 |
|  |  |  |  |  | **Total** | **$1,199,123.00** |

Scenario 1 2014 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $512,205 | $59,073 |  |  |  |
| Social Ins Tax- Employer Contribution | $665,535 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $69,727 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $29,422 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $216,170 |
| Personal Tax: Income Tax |  |  |  | $673,415 |  |
| Total Federal Tax | $1,177,740 | $59,073 | $99,149 | $673,415 | $216,170 |
|  |  |  |  | **Total** | **$2,225,547** |

Scenario 1 2016 (1/2)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **State and Local Tax** | | | | | | |
| Allocation | Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| State | Dividends |  |  |  |  | $1,597 |
| State | Social Ins Tax- Employee Contribution | $1,036 | $0 |  |  |  |
| State | Social Ins Tax- Employer Contribution | $1,836 |  |  |  |  |
| Split (70/30) | Indirect Bus Tax: Sales Tax |  |  | $786,931 |  |  |
| Local | Indirect Bus Tax: Property Tax |  |  | $535,855 |  |  |
| Local | Indirect Bus Tax: Motor Vehicle Lic |  |  | $25,967 |  |  |
| State | Indirect Bus Tax: Severance Tax |  |  | $19,318 |  |  |
| Local | Indirect Bus Tax: Other Taxes |  |  | $33,567 |  |  |
| Local | Indirect Bus Tax: S/L NonTaxes |  |  | $141,168 |  |  |
| State | Corporate Profits Tax |  |  |  |  | $53,785 |
| State | Personal Tax: Income Tax |  |  |  | $461,720 |  |
| State | Personal Tax: NonTaxes (Fines- Fees |  |  |  | $71,690 |  |
| State | Personal Tax: Motor Vehicle License |  |  |  | $39,897 |  |
| State | Personal Tax: Property Taxes |  |  |  | $8,381 |  |
| State | Personal Tax: Other Tax (Fish/Hunt) |  |  |  | $25,260 |  |
|  | Total State and Local Tax | $2,872 | $0 | $1,542,807 | $606,948 | $55,382 |
|  |  |  |  |  | **Total** | **$2,208,009.00** |

Scenario 1 2016 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $942,053 | $108,877 |  |  |  |
| Social Ins Tax- Employer Contribution | $1,224,061 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $128,441 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $54,197 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $397,729 |
| Personal Tax: Income Tax |  |  |  | $1,238,884 |  |
| Total Federal Tax | $2,166,114 | $108,877 | $182,638 | $1,238,884 | $397,729 |
|  |  |  |  | **Total** | **$4,094,242** |

Scenario 1 2023 (1/2)



Scenario 1 2023 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $1,547,456 | $180,135 |  |  |  |
| Social Ins Tax- Employer Contribution | $2,010,694 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $212,094 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $89,495 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $654,194 |
| Personal Tax: Income Tax |  |  |  | $2,036,903 |  |
| Total Federal Tax | $3,558,151 | $180,135 | $301,588 | $2,036,903 | $654,194 |
|  |  |  |  | **Total** | **$6,730,971** |

Scenario 2 2014 (1/2)



Scenario 2 2014 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $3,108,692 | $368,050 |  |  |  |
| Social Ins Tax- Employer Contribution | $4,039,292 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $431,382 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $182,025 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $1,318,838 |
| Personal Tax: Income Tax |  |  |  | $4,100,849 |  |
| Total Federal Tax | $7,147,984 | $368,050 | $613,407 | $4,100,849 | $1,318,838 |
|  |  |  |  | **Total** | **$13,549,128** |

Scenario 2 2016 (1/2)



Scenario 2 2016 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $6,500,253 | $770,335 |  |  |  |
| Social Ins Tax- Employer Contribution | $8,446,133 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $902,663 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $380,885 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $2,758,084 |
| Personal Tax: Income Tax |  |  |  | $8,575,920 |  |
| Total Federal Tax | $14,946,386 | $770,335 | $1,283,548 | $8,575,920 | $2,758,084 |
|  |  |  |  | **Total** | **$28,334,273** |

Scenario 2 2023 (1/2)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **State and Local Tax** | | | | | | |
| Allocation | Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| State | Dividends |  |  |  |  | $14,594 |
| State | Social Ins Tax- Employee Contribution | $9,414 | $0 |  |  |  |
| State | Social Ins Tax- Employer Contribution | $16,688 |  |  |  |  |
| Split (70/30) | Indirect Bus Tax: Sales Tax |  |  | $7,290,931 |  |  |
| Local | Indirect Bus Tax: Property Tax |  |  | $4,964,713 |  |  |
| Local | Indirect Bus Tax: Motor Vehicle Lic |  |  | $240,589 |  |  |
| State | Indirect Bus Tax: Severance Tax |  |  | $178,982 |  |  |
| Local | Indirect Bus Tax: Other Taxes |  |  | $311,000 |  |  |
| Local | Indirect Bus Tax: S/L NonTaxes |  |  | $1,307,928 |  |  |
| State | Corporate Profits Tax |  |  |  |  | $491,344 |
| State | Personal Tax: Income Tax |  |  |  | $4,210,563 |  |
| State | Personal Tax: NonTaxes (Fines- Fees |  |  |  | $653,761 |  |
| State | Personal Tax: Motor Vehicle License |  |  |  | $363,833 |  |
| State | Personal Tax: Property Taxes |  |  |  | $76,433 |  |
| State | Personal Tax: Other Tax (Fish/Hunt) |  |  |  | $230,350 |  |
|  | Total State and Local Tax | $26,102 | $0 | $14,294,143 | $5,534,940 | $505,938 |
|  |  |  |  |  | **Total** | **$20,361,123.00** |

Scenario 2 2023 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $8,561,999 | $1,015,868 |  |  |  |
| Social Ins Tax- Employer Contribution | $11,125,071 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $1,190,011 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $502,134 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $3,633,413 |
| Personal Tax: Income Tax |  |  |  | $11,297,753 |  |
| Total Federal Tax | $19,687,070 | $1,015,868 | $1,692,145 | $11,297,753 | $3,633,413 |
|  |  |  |  | **Total** | **$37,326,249** |

Scenario 3 2014 (1/2)



Scenario 3 2014 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $1,826,454 | $213,278 |  |  |  |
| Social Ins Tax- Employer Contribution | $2,373,212 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $250,901 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $105,870 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $772,727 |
| Personal Tax: Income Tax |  |  |  | $2,405,104 |  |
| Total Federal Tax | $4,141,318 | $201,783 | $359,712 | $2,359,387 | $776,731 |
|  |  |  |  | **Total** | **$7,838,931** |

Scenario 3 2016 (1/2)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **State and Local Tax** | | | | | | |
| Allocation | Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| State | Dividends |  |  |  |  | $7,067 |
| State | Social Ins Tax- Employee Contribution | $4,569 | $0 |  |  |  |
| State | Social Ins Tax- Employer Contribution | $8,100 |  |  |  |  |
| Split (70/30) | Indirect Bus Tax: Sales Tax |  |  | $3,508,254 |  |  |
| Local | Indirect Bus Tax: Property Tax |  |  | $2,388,924 |  |  |
| Local | Indirect Bus Tax: Motor Vehicle Lic |  |  | $115,767 |  |  |
| State | Indirect Bus Tax: Severance Tax |  |  | $86,123 |  |  |
| Local | Indirect Bus Tax: Other Taxes |  |  | $149,647 |  |  |
| Local | Indirect Bus Tax: S/L NonTaxes |  |  | $629,350 |  |  |
| State | Corporate Profits Tax |  |  |  |  | $237,943 |
| State | Personal Tax: Income Tax |  |  |  | $2,040,574 |  |
| State | Personal Tax: NonTaxes (Fines- Fees |  |  |  | $316,833 |  |
| State | Personal Tax: Motor Vehicle License |  |  |  | $176,325 |  |
| State | Personal Tax: Property Taxes |  |  |  | $37,042 |  |
| State | Personal Tax: Other Tax (Fish/Hunt) |  |  |  | $111,635 |  |
|  | Total State and Local Tax | $12,669 | $0 | $6,878,064 | $2,682,410 | $245,011 |
|  |  |  |  |  | **Total** | **$9,818,154.00** |

Scenario 3 2016 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $4,155,749 | $487,282 |  |  |  |
| Social Ins Tax- Employer Contribution | $5,399,791 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $572,610 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $241,617 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $1,759,555 |
| Personal Tax: Income Tax |  |  |  | $5,475,255 |  |
| Total Federal Tax | $9,555,541 | $487,282 | $814,227 | $5,475,255 | $1,759,555 |
|  |  |  |  | **Total** | **$18,091,860** |

Scenario 3 2023 (1/2)



Scenario 3 2023 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $6,497,372 | $766,500 |  |  |  |
| Social Ins Tax- Employer Contribution | $8,442,389 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $899,266 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $379,452 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $2,754,093 |
| Personal Tax: Income Tax |  |  |  | $8,567,082 |  |
| Total Federal Tax | $14,939,761 | $766,500 | $1,278,718 | $8,567,082 | $2,754,093 |
|  |  |  |  | **Total** | **$28,306,154** |

Scenario 4 2014 (1/2)



Scenario 4 2014 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employees Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $1,027,410 | $120,527 |  |  |  |
| Social Ins Tax- Employer Contribution | $1,334,970 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $141,613 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $59,755 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $435,070 |
| Personal Tax: Income Tax |  |  |  | $1,353,709 |  |
| Total Federal Tax | $2,362,380 | $120,527 | $201,368 | $1,353,709 | $435,070 |
|  |  |  |  | **Total** | **$4,473,054** |

Scenario 4 2016 (1/2)



Scenario 4 2016 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $2,150,108 | $252,573 |  |  |  |
| Social Ins Tax- Employer Contribution | $2,793,752 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $296,656 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $125,176 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $910,694 |
| Personal Tax: Income Tax |  |  |  | $2,833,463 |  |
| Total Federal Tax | $4,943,860 | $252,573 | $421,832 | $2,833,463 | $910,694 |
|  |  |  |  | **Total** | **$9,362,422** |

Scenario 4 2023 (1/2)



Scenario 4 2023 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $3,042,388 | $358,601 |  |  |  |
| Social Ins Tax- Employer Contribution | $3,953,141 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $420,812 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $177,565 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $1,289,377 |
| Personal Tax: Income Tax |  |  |  | $4,011,078 |  |
| Total Federal Tax | $6,995,529 | $358,601 | $598,377 | $4,011,078 | $1,289,377 |
|  |  |  |  | **Total** | **$13,252,962** |

Scenario 5 2014 (1/2)



Scenario 5 2014 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $643,546 | $74,192 |  |  |  |
| Social Ins Tax- Employer Contribution | $836,194 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $87,582 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $36,956 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $271,580 |
| Personal Tax: Income Tax |  |  |  | $846,053 |  |
| Total Federal Tax | $1,479,740 | $74,192 | $124,538 | $846,053 | $271,580 |
|  |  |  |  | **Total** | **$2,796,103** |

Scenario 5 2016 (1/2)



Scenario 5 2016 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $1,466,886 | $170,088 |  |  |  |
| Social Ins Tax- Employer Contribution | $1,906,005 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $200,474 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $84,591 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $619,708 |
| Personal Tax: Income Tax |  |  |  | $1,929,885 |  |
| Total Federal Tax | $3,372,891 | $170,088 | $285,065 | $1,929,885 | $619,708 |
|  |  |  |  | **Total** | **$6,377,637** |

Scenario 5 2023 (1/2)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **State and Local Tax** | | | | | | |
| Allocation | Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| State | Dividends |  |  |  |  | $10,606 |
| State | Social Ins Tax- Employee Contribution | $6,003 | $0 |  |  |  |
| State | Social Ins Tax- Employer Contribution | $10,641 |  |  |  |  |
| Split (70/30) | Indirect Bus Tax: Sales Tax |  |  | $5,236,073 |  |  |
| Local | Indirect Bus Tax: Property Tax |  |  | $3,565,471 |  |  |
| Local | Indirect Bus Tax: Motor Vehicle Lic |  |  | $172,782 |  |  |
| State | Indirect Bus Tax: Severance Tax |  |  | $128,538 |  |  |
| Local | Indirect Bus Tax: Other Taxes |  |  | $223,348 |  |  |
| Local | Indirect Bus Tax: S/L NonTaxes |  |  | $939,305 |  |  |
| State | Corporate Profits Tax |  |  |  |  | $357,084 |
| State | Personal Tax: Income Tax |  |  |  | $2,693,611 |  |
| State | Personal Tax: NonTaxes (Fines- Fees |  |  |  | $418,228 |  |
| State | Personal Tax: Motor Vehicle License |  |  |  | $232,754 |  |
| State | Personal Tax: Property Taxes |  |  |  | $48,896 |  |
| State | Personal Tax: Other Tax (Fish/Hunt) |  |  |  | $147,361 |  |
|  | Total State and Local Tax | $16,644 | $0 | $10,265,517 | $3,540,851 | $367,690 |
|  |  |  |  |  | **Total** | **$14,190,702.00** |

Scenario 5 2023 (2/2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Federal Tax** | | | | | |
| Description | Employee Compensation | Proprietor Income | Indirect Business Tax | Households | Corporations |
| Social Ins Tax- Employee Contribution | $5,459,563 | $664,037 |  |  |  |
| Social Ins Tax- Employer Contribution | $7,093,908 |  |  |  |  |
| Indirect Bus Tax: Excise Taxes |  |  | $854,621 |  |  |
| Indirect Bus Tax: Custom Duty |  |  | $360,614 |  |  |
| Indirect Bus Tax: Fed NonTaxes |  |  | $0 |  |  |
| Corporate Profits Tax |  |  |  |  | $2,640,579 |
| Personal Tax: Income Tax |  |  |  | $7,227,478 |  |
| Total Federal Tax | $12,553,471 | $664,037 | $1,215,235 | $7,227,478 | $2,640,579 |
|  |  |  |  | **Total** | **$24,300,800** |

1. National Academy for State Health Policy, “Maximizing Kids’ Enrollment in Medicaid and SCHIP”, February 2009. [↑](#footnote-ref-1)
2. The Lewin Group, “An Evaluation of the Impact of Medicaid Expansion in New Hampshire”, November 2012. [↑](#footnote-ref-2)
3. Crowd out effect: Gruber, Jonathan, and Kosali Simon. "Crowd‐out 10 years later: Have recent public insurance expansions crowded out private health insurance?" Journal of Health Economics 27): 201‐217, 2008. [↑](#footnote-ref-3)
4. Sommers BD et al. Mortality and access to care among adults after state Medicaid expansions. N Engl J Med 2012 Jul 25; http://www.nejm.org/doi/full/10.1056/NEJMc1212920 [↑](#footnote-ref-4)
5. Heidi Allen, Katherine Baicker, Amy Finkelstein, Sarah Taubman, Bill J. Wright and the Oregon Health Study Group. *What the Oregon Health Study Can Tell Us About Expanding Medicaid.* Health Affairs, 29, no.8 (2010):1498-1506. DOI: 10.1377/hlthaff.2010.0191 [↑](#footnote-ref-5)
6. Muennig, Peter et al. The Cost Effectiveness of Health Insurance.

   American Journal of Preventive Medicine. 1 January 2005 (volume 28 issue 1 Pages 59-64 DOI: 10.1016/j.amepre.2004.09.005 [↑](#footnote-ref-6)
7. http://www.aha.org/research/policy/finfactsheets.shtml [↑](#footnote-ref-7)
8. http://bphc.hrsa.gov/healthcenterdatastatistics/index.html#what [↑](#footnote-ref-8)
9. http://bphc.hrsa.gov/uds/doc/2011/UDS\_2011\_Rollups\_UT\_Universal.pdf [↑](#footnote-ref-9)
10. http://health.utah.gov/medicaid/stplan/Inpatient/WebDSHFY2011.pdf [↑](#footnote-ref-10)
11. http://health.utah.gov/medicaid/stplan/inpatient.htm [↑](#footnote-ref-11)
12. http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=40&rgn=46 [↑](#footnote-ref-12)
13. http://implan.com/v4/index.php?option=com\_glossary&task=list&glossid=13&letter=V&Itemid=57 [↑](#footnote-ref-13)
14. Utah Medicaid, “Utah Annual Report of Medicaid & CHIP: SFY 2012” December 2012 http://www.health.utah.gov/medicaid/pdfs/annual\_report2012.pdf [↑](#footnote-ref-14)
15. Utah Department of Health, “Utah Medical Programs Summary” December 2011 [↑](#footnote-ref-15)
16. Ibid, Page 4 [↑](#footnote-ref-16)
17. Department of Health and Human Services, “RE: Conversion of Net Income Standards to MAGI Equivalent Income Standards” December 2012 http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf [↑](#footnote-ref-17)
18. Department of Health and Human Services, Page 5 [↑](#footnote-ref-18)
19. [↑](#footnote-ref-19)