The Nelson A. Rockefeller Center at Dartmouth College
The Center for Public Policy and the Social Sciences
Policy Research Shop

Opting Out of Medicaid in New Hampshire

A Study of the Costs and Benefits Facing the Granite State in Choosing to Opt Out of the Federally-Matched Medicaid Program

Presented to the New Hampshire House of Representatives
Committee on Finance—Division III,
Rep. Neal Kurk, Chairman

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Prepared by:

Catherine Meyers
Natalia Agredo
Paul Dellorusso
Joseph Singh

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Contact:
Nelson A. Rockefeller Center, 6082 Rockefeller Hall, Dartmouth College, Hanover, NH 03755
http://rockefeller.dartmouth.edu/shop/ • Email: Ronald.G.Shaiko@Dartmouth.edu

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EXECUTIVE SUMMARY

Given the large structural deficit of the State of New Hampshire and the significantly increased eligibility standards for Medicaid under the Patient Protection and Affordable Care Act (PPACA), the Rockefeller Center has been tasked with assessing the impact of the decision to opt-out of Medicaid in favor of a state-funded safety net. A comprehensive literature review was conducted to obtain an overall understanding of the current state of the New Hampshire Medicaid program, any legal precedent surrounding the ability to opt-out and the individual mandate, estimated costs and savings to the State General Funds under the Affordable Care Act, and other considerations that might influence the decision to opt-out. The compiled sources were used as the basis for our analysis.

The New Hampshire Medicaid program has witnessed increased enrollment correlated to economic stagnation, but decreased costs per enrollee over the past three fiscal years. Although the program has, as a whole, become more expensive, the state funded share of the program's expenditures has actually decreased over the past three years due to increases in federal dollars under the American Recovery and Reinvestment Act. According to available research, the PPACA provides short term cost savings and a lack of concrete future cost burdens to the state share of New Hampshire's Medicaid program. Importantly, the estimates used in calculating savings and costs under federal legislation are subject to significant variation and noteworthy future uncertainty. With respect to the legality of opting out, a chief obstacle would be to what extent the State Funded Safety Net would reduce services to the mentally and physically disabled, and whether this would constitute a violation of the Americans with Disabilities Act. We also raise the question of whether a state funded safety net would be sustainable under current eligibility requirements for the physically and mentally disabled, which make up the largest plurality of NH Medicaid expenses. We have bulleted a list of considerations that could have substantial consequences for the sustainability of the NH Medicaid program, but were not factored in to the analysis on costs and savings from the PPACA.

The decision to opt out of the Medicaid program would require giving up over $800 million in annual federal matching funds; whereas the health care needs of the poor would not go away. Moreover, the federal government has absorbed the majority of the up front costs of enrolling the new adult population coming into the Medicaid program, and has absorbed a significantly greater percentage of the costs of providing care to Medicaid eligible children and the mentally disabled. Additionally, the degree to which health care reform and associated private sector initiatives will correct misaligned incentives, reduce waste, and increase value in the health care industry is of chief importance to the sustainability of the Medicaid program.

1. INTRODUCTION

New Hampshire faces a projected $600 million budget gap over the biennium, which has become a chief concern for state policymakers. This structural deficit has become an acute problem during the recession, as the expectation and scope of services has dramatically increased along with rising unemployment, poverty, and decreased revenue. The problem facing New Hampshire, simply put, is that the State is being asked to fund an established and increasingly demanding "social contract" with decreased revenue to pay for programs.

The top five drivers of New Hampshire state spending have crowded out all other sources of important investment, including capital development, mental health, and economic development initiatives that can't keep pace with inflation or the needs of the State.[1] Medicaid has been one of the biggest drivers of this crowding out effect, and has seen an 8.3 percent increase in caseload over the past two-and-a-half years, due largely to increased enrollment as a result of economic stagnation and increased unemployment.[2] The countercyclical nature of the Medicaid and other social service programs impose serious challenges for reconciling the structural deficit, especially with the June 2011 expiration of the "one-time" money from the American Reinvestment and Recovery Act (ARRA) and as the state's fiscal pressure continues. Importantly, although there was an increase in total expenditures for the NH Medicaid program from SFY 2008-2010, the state share of those expenditures actually decreased over the three years following the beginning of the recession. From SFY 2008-2009, NH realized a -3.4 percent change in expenditures for Medicaid, and from SFY 2009-2010 NH realized a -6.5 percent change in Medicaid expenditures, compared to a respective 14.8 percent and 13.6 percent increase in federal funds from the ARRA.[3]

There has been considerable apprehension that the sizeable expansion of Medicaid coverage under the Patient Protection and Affordable Care Act (PPACA) to 133 percent of the Federal Poverty Level (FPL) will undermine the State of New Hampshire's ability to fund what is considered by many an already unsustainable social service program. This sentiment is shared by a cohort of policy makers in every state, and has prompted several to look into the decision to "opt out" of the federal Medicaid program. The authors of this report have been tasked with analyzing the potential and probable impacts of such a decision and the different constituencies likely affected. Additionally, the authors have been asked to look at the possible legal issues should the State of New Hampshire decide to pursue this policy option.

This Report Seeks To:

1. Provide background on New Hampshire's approach to Medicaid: history, trends in funding levels and sources, and numbers and proportions of recipients and recipient classes
2. Provide background on the question of "opting out"
3. Investigate and analyze the legal issues associated with "opting out"

4. Investigate and report on the direct and immediate effects of "opting out"
5. Consider some of the long term and unexpected effects of "opting out"[4]

2. OVERVIEW OF THE NEW HAMPSHIRE MEDICAID PROGRAM

2.1 Eligibility

Medicaid eligibility is determined by whether or not a patient meets two requirements – a categorical requirement and a financial requirement. Medicaid primarily serves five categories of patients: children, pregnant women, poor adults in families with dependent children, individuals with disabilities, employed adults with disabilities (MEAD), and the elderly. As a means tested program, financial eligibility is expressed as a percentage of the Federal Poverty Level, currently defined as $22,350/year for a family of four.[5] **Figure 1** shows the different percentages of the Federal Poverty Level required for each category of patients to qualify for Medicaid in New Hampshire.

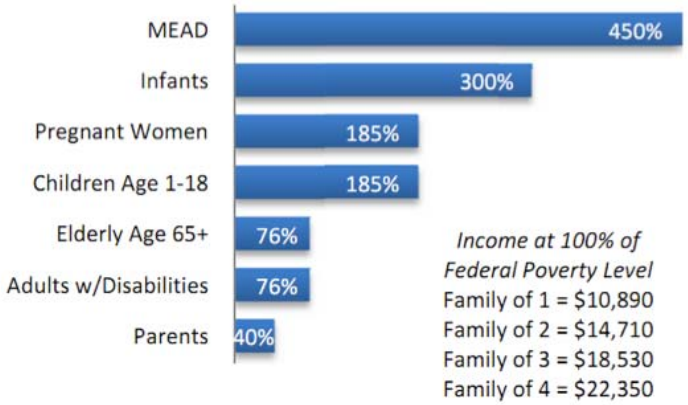

Figure 1 –Medicaid Eligibility by Income in terms of Federal Poverty Level

Figure 1 – New Hampshire Medicaid eligibility for different groups in terms of their income and its percentage of the Federal Poverty Level. MEAD stands for Medicaid for Employed Adults with Disabilities.

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2.2 Budget and Spending

Medicaid spending makes up 25.9 percent of the total budget spending of New Hampshire, second only to education, at 26.9 percent, as shown below in **Figure 2**.

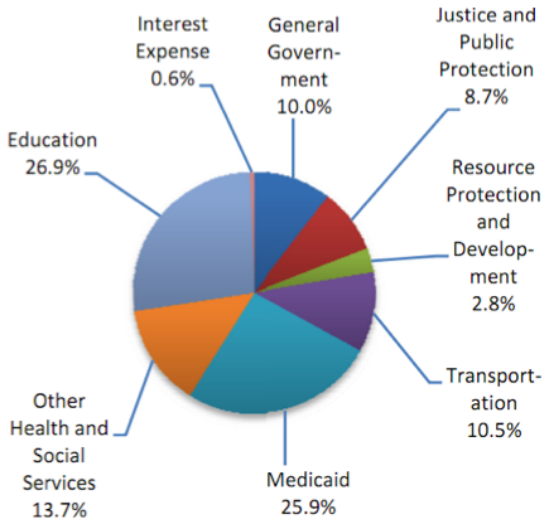

Figure 2 – New Hampshire total State Budget Usage

Figure 3 – The break down of expenses of the $5.5 billion New Hampshire budget, for State Fiscal Year 2010.

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The Medicaid budget of $1.4 billion is currently funded approximately 50 percent by the federal government, making the federal contribution to the program over $700 million. **Figure 3** shows the main sources of funding for the Medicaid program in New Hampshire and how much each source contributes to the program. Not included in this

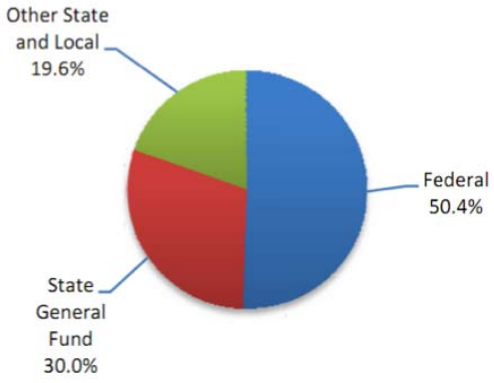

Figure 3 – Sources of Funding for NH Medicaid

Figure 2 – Sources of funding for New Hampshire Medicaid, which together adds up to $1.4 billion. The federal government thus contributes over $700 million to the Medicaid program in New Hampshire, which would be lost if New Hampshire opted out of Medicaid.

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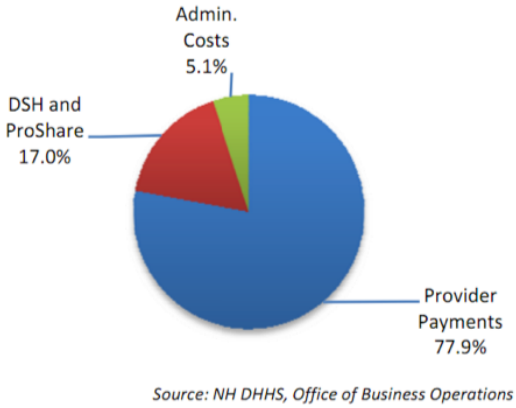
figure is the additional $124.1 million in federal funds appropriated in SFY 2010 due to FMAP increases under the ARRA.



Source: NH DHHS, Office of Business Operations

Figure 4 – Breakdown of Medicaid Spending

Figure 4 – Medicaid spending by percentage breakdown. Total Medicaid spending is $1.4 billion.

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The budget is distributed as shown in **Figure 4**, with the great majority of the spending going toward provider payments. Medicaid payments are usually determined in one of two ways: fee for service at a specific rate per unit basis or a single payment for a bundle of services, like inpatient hospital stays. **Figure 5** shows the Medicaid payments by type of service, the two most expensive services categories being home and community based care and nursing home care. In 2011, the Department of Health and Human Services started an investigation to analyze the possibility of shifting the entire Medicaid population of the state from a fee for service system to a managed care system. The current fee for service system relies on a fee schedule and reimburses patients for each procedure on the schedule at a given rate. Managed care, on the other hand, focuses on creating incentives for lower errors, evidence-based care, lower cost venues and bonuses for doctors or systems that meet cost targets.

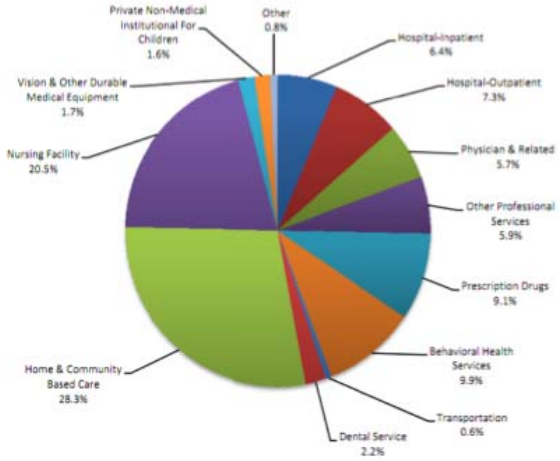

Figure 5- Distribution of NH Medicaid Payments by Types of Service, SFY 2010

Also noteworthy, in New Hampshire, services for the developmentally disabled are provided through 10 area non-profit institutions that are contracted by the Department of Health and Human Services.

2.3 Enrollment

2.3.1 Current Enrollment and Trends in Enrollment

As of 2010, there were about 145,000 New Hampshire residents enrolled in the state's Medicaid program. Percentages of the total population of New Hampshire enrolled in Medicaid ranges from 6 percent in Derry to 19 percent in Claremont, while the Nashua, Manchester and Concord areas compose about 41 percent of the total Medicaid enrollment in New Hampshire. Enrollment varies significantly by age category. Children 0-18 years of age make up approximately 60 percent of New Hampshire's Medicaid enrollment, adults age 19-64 make up approximately 30 percent, and those 65 and over make up the remaining 10 percent.

The state's policy covers all infants whose household has an income of up to 300 percent of the FPL, and all children 1-18 years old with a household income up to 185 percent of the FPL. This accounts for the high proportion of this age group as compared to the older age groups enrolled in Medicaid. Although they make up about sixty percent of total enrollment, children on Medicaid account for only 22 percent of program expenditures, while the elderly (65+) account for 24 percent of expenditures. **Table 1** breaks down the enrollment categories for Medicaid as well as the percentage of total expenses made by each category.

Eligibility Category†	Enrolled at any time during SFY 2010	Percent Enrolled	Medicaid Expenditures	Percent of Cost
Low-income Child	96,035	58.0%	$224,341,503	22.1%
Low-income Adult	26,139	15.8%	$81,500,086	8.0%
Severely Disabled Child	1,816	1.1%	$37,997,947	3.7%
Adults with Physical Disabilities	10,649	6.4%	$201,241,500	19.8%
Adults with Mental Illness Disabilities	13,382	8.1%	$219,639,929	21.6%
Elderly	11,682	7.1%	$246,343,546	24.2%
QMB/SLMB Only	11,335	6.8%	$5,512,028	0.5%
Unique Total	**165,609****		**$1,016,708,930§**	

**The sum of the enrollment rows does not equal the unique total since some individuals were in multiple eligibility categories during the year.

§Difference from $1.42 Billion due to provider spending for services with dates of services (7/1/2009-6/30/2010); does not reflect administrative, cost settlements, rebates or other off-claim payments. Additionally, rows do not sum to the total amount due to $132,391 with missing eligibility information.

Table 1 – Medicaid Enrollment and Medical Provider Expenditures, 2010

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2.3.2 Per-Patient Spending

The population of New Hampshire grew by approximately 6.5 percent between the 2000 and 2010 census. This growth is significantly smaller than the one experienced between 1990 and 2000 of approximately 11.9 percent. The percentage of population growth per year shows a negative trend, suggesting that population growth is not a major concern for Medicaid in New Hampshire. Trends show a steady yearly increase in patient enrollment from 2004 to 2008, and a steeper increase in enrollment between 2008 and 2009, and a less substantial increase from 2009 to 2010 (**Figure 7**).

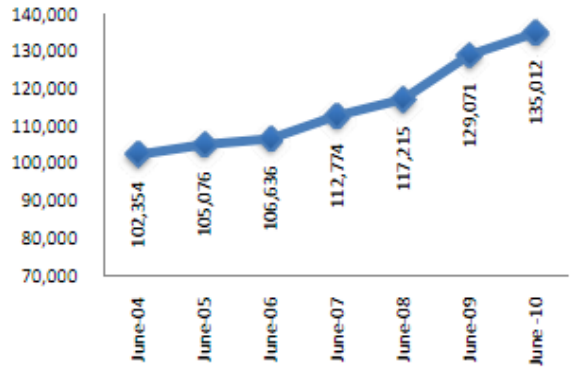


Figure 7: NH Medicaid Enrollment for Month of June Over Time, SFY 2004 - 2010
Note: Includes retroactive and partial month enrollment

New Hampshire's per capita Medicaid spending is $653 less than, or , 47 percent below the New England regional average. **Figure 8** shows the amount of spending per patient in relation to the patients enrolled in Medicaid. While the graph shows an increase in patient enrollment over the years, as shown above, spending per patient actually shows a downward trend for the past three fiscal years.

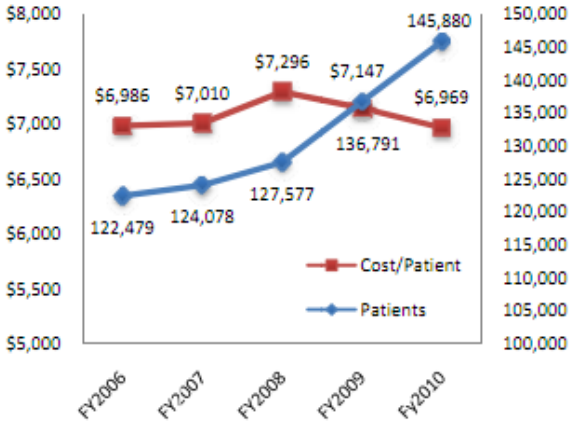


Figure 8: Per Patient Medicaid Spending vs. Number of Medicaid Recipients

Rise in enrollment is correlated with rise in unemployment, which almost doubled between December 2007 and June 2009. According to Jennifer Weiner of the New England Public Policy Center, State enrollment as a percentage of the total population is lower in NH than in any other state in New England, at 10.9 percent (compared to a range from Connecticut at 15.2 percent to Massachusetts at 26.6 percent). Weiner's analysis points to more stringent enrollment criteria for working and unemployed adults (with or without families) in New Hampshire than in any other state in New England as an important reason. New Hampshire's Medicaid program sets strict eligibility criteria compared to the rest of the New England states, capping eligibility for jobless parents at 46 percent of the Federal Poverty Level, while the caps of the neighboring states ranged

from 133 percent to 200 percent. Looking at the enrollment-to-poverty ratio in New Hampshire as compared to the regional result shows that the state's per capita Medicaid spending would rise by 36 percent if the government used the regional average eligibility criteria. Lower Medicaid enrollment expenditure need in New Hampshire accounts for about 52 percent of the gap in per capita spending between New Hampshire and the other states in the region. This is partially explained by the state having a less poor population than other states. In addition stricter enrollment criteria and lower participation. Costs to the Medicaid program per patient were also significantly reduced by capping Medicaid services at a maximum of 80 percent of Medicare rates (which are already lower than private sector rates). Testing by diagnostic labs is reimbursed at approximately 60 percent of Medicare rates. Another reason for lower per patient spending may be that due to the recession, healthier but now lower-income patients have been added to the pool of Medicaid recipients, lowering the overall average per-patient cost of the program.

3. THE LEGALITY OF OPTING-OUT OF MEDICAID

The Medicaid program is by nature a voluntary program with the purpose to "assist the poor, elderly, and disabled in obtaining medical care."[6] States can choose whether or not to opt into the jointly funded federal-state program, but once a state decides to participate it must comply with the federal regulations of Title XIX of the Social Security Act (also called the "Medicaid Act").[7] Given the original opt in nature of Medicaid legislation, prima facie, opting out should be constitutionally and legally feasible. The Medicaid Act requires states to submit proposals to the Center for Medicare and Medicaid Services (CMS) to ensure that the state programs meet federal requirements and provide sufficient resources to provide care for those whose "income and resources are insufficient to meet the costs of necessary medical services."[8] Despite the regulations and requirements imposed by the federal government once states decide to join the Medicaid program, states are not legally required to participate in the program.

As New Hampshire struggles with its budget, Medicaid reimbursement to New Hampshire hospitals has presented a challenge. Under Medicaid regulations hospitals should be reimbursed for service to low-income patients to prevent an incentive for hospitals to deny care to Medicaid patients. Earlier this year, Dartmouth Hitchcock and nine other hospitals filed a law suit against the New Hampshire Department of Health and Human Services (represented by Commissioner Nick Toumpas), claiming that cuts to reimbursement rates would make it impossible for hospitals to provide adequate care to low income patients. The plaintiff hospitals claim that in doing so, New Hampshire is violating Medicaid implementation regulations.[9] DHHS has set a motion to dismiss the case claiming that the federal government cannot regulate how states distribute their budget.[10] While a decision has yet to be reached, dismissing the case could provide legal precedent to dismiss federal regulation and authority in New Hampshire health programs for low-income residents in favor of state created and funded programs.

While opting out of the Medicaid program does not seem to be in direct violation of the Social Security Act, the implications of opting out of Medicaid must be analyzed in order to determine whether reducing or eliminating the Medicaid program will violate other laws, thus indirectly making a Medicaid opt-out illegal. Two current lawsuits provide a case study and perhaps will set a precedent arguing that a reduction or elimination of Medicaid will eliminate services to disabled citizens and violate the Americans with Disabilities Act (ADA). The first case, *The Gray Panthers of San Francisco et. al vs Arnold Schwarzenegger et al.* was filed in San Francisco on behalf of Medi-Cal beneficiaries who saw reduced benefits after California cut optional Medicaid programs to reduce the state deficit. The courts ruled in favor of the state and the plaintiffs dismissed their claims when injunction by the Circuit Court was denied.[11] The second case, also in California, *Oster, David et al vs John Wagner, Director of DSS, et al.* was filed on behalf of beneficiaries who would see coverage of In-Home Supportive Services denied by revisions in eligibility. This case asserts that new criteria for eligibility for these benefits denies access to enough people that it violates state and federal laws, potentially including the ADA.[12] Depending on the outcome, legal restraints may make the implementation of a state funded safety net more expensive than previously thought.

Finally, the decision to opt out is contingent on the assumption that the individual mandate clause of the Affordable Care Act is repealed or deemed unconstitutional. The individual mandate, to be implemented in 2014, requires all US citizens to have some form of health insurance (private, employer-based, or government subsidized) or face a tax penalty. Supporters of the mandate cite the Commerce Clause (Article 1, Section 8, Clause 3) of the US Constitution as justification of the constitutionality of the mandate. Supporters claim that the Commerce Clause gives the federal government the right to monitor interstate commerce within the fifty states, in this case by levying a tax on those who do not have health insurance. Opponents of the mandate view the tax as a fine for not purchasing a service, and believe this is an overexertion of government authority not grounded in the Constitution.[13] Three federal cases have questioned the constitutionality of the mandate but with no unanimous conclusion: one case deemed the mandate constitutional, one deemed it unconstitutional, and one dismissed the case. This question is currently being brought to the Supreme Court.

The Commonwealth of Massachusetts has already implemented an individual mandate within the state, potentially setting a precedent for the implementation of an individual mandate on the federal level. Importantly, in Massachusetts, the penalty for not having insurance is a forfeiture of tax exemption rather than an additional tax or fine.[14] If the individual mandate is not repealed, New Hampshire's uninsured citizens would face a tax penalty. A summary of the tax penalty in the ACA is presented below:

> Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of

taxable income in 2016. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples)."[15]

Opting out of Medicaid would create a large group of uninsured individuals, thus making the decision economically burdensome to individuals without insurance.

4. NEW ESTIMATED ENROLLMENT, COSTS AND SAVINGS UNDER THE AFFORDABLE CARE ACT

The Office of Medicaid Business and Policy issued a report in March of 2010 entitled "Estimating the NH Medicaid Impact for Health Reform under the House Passed Reconciliation of the PPACA." According to an interview with Andrew Chalsma, Chief of the Bureau of Data and Systems Management for the NH DHHS Office of Medicaid Business and Policy, there is a great degree of uncertainty in the estimates calculated by the OMBP, limiting the strength of conclusions from the data. On a national scale, U.S. Census data provides a large enough sample size to draw several statistically significant conclusions on a variety of socioeconomic factors. However, given that the New Hampshire population represents approximately one-third of one percent of the total U.S. population, the few thousand responses collected from the entire state of NH in the census data provides a small sample size of the percentage of the poor in the State as a percentage of the Federal Poverty Level. A state level survey would have been very useful in increasing the accuracy of this estimate. The CPS estimate is the least precise factor in the model, and because the estimate is used as a basis for estimating both the new adult populations and subsequent annual State Fund costs and annual State Fund savings in existing coverage areas, any conclusions from this data are limited by their substantial statistical uncertainty.[16]

This uncertainty in estimates is indicated by the great variation in the 90 percent confidence interval for the three age groups (19-34, 35-49, and 50-64) of the new adult population likely to come into Medicaid (the currently uninsured) under the new legislation (**Figure 9**).

Figure 9- Current Uninsured Population Estimate in New Hampshire by Age Category

2006-2008 Current Population Survey Uninsured <133% FPL (Interpolated)

Age Group	Mid-Point Estimate	90% Confidence Interval	
19 to 34	15,857	7,104	24,610
35 to 49	8,251	1,935	14,567
50 to 64	6,816	525	11,150

The data are broken down into three age categories in order to account for increased mean cost and decreased enrollment probability as age increases. Of the adult new eligibles under federal legislation, it is estimated that under State pressure rapid enrollment of 90 percent of new eligibles will occur by 2016, since that is the last year before the Federal Medical Assistance Percentage (FMAP) rate drops from 100 percent (**Figure 10**).[17]

Figure 10- NH Medicaid Uptake Percentage from 2014-2020

Program Uptake for New Adult <133%FPL Eligibles						
2014	2015	2016	2017	2018	2019	2020
45%	80%	90%	90%	90%	90%	90%

Figure 11 shows the FMAP rates from 2014-2020 (after 2020 the FMAP rates remain at 2020 levels indefinitely) for mandated new adult eligibles, existing mandatory coverage groups, and for the Children's Health Insurance Program (CHIP), which sees a maintained increase in matching percentage from 65 percent to 88 percent starting in 2016. Currently, CHIP eligibility for Children 1-18 under current New Hampshire Medicaid is set at 185 percent of the FPL.

Figure 11- FMAP rates from 2014-2020 for Medicaid coverage groups

	2014	2015	2016	2017	2018	2019	2020
New Adult Mandatory Group	100%	100%	100%	95%	94%	93%	90%
Existing Mandatory Groups	50%	50%	50%	50%	50%	50%	50%
CHIP (Medicaid and CHIP)*	65%	65%	88%	88%	88%	88%	-

The estimates in **Figure 11** assume that CHIP funding by the state will be maintained at 185 percent until 2019, as mandated by the maintenance of eligibility (MOE) provisions of the Affordable Care Act. The MOE provision stipulates that states cannot impose more restrictive eligibility requirements than those that were in place at the time the ACA was enacted (March 2010), and is intended to engender stability in coverage until the health exchanges fully roll out and coverage is expanded under reform. Therefore, states that do not comply with MOE requirements for Medicaid (until 2014) and CHIP (until 2019) risk losing all federal Medicaid matching funds.[18]

MOE requirements in the ACA have become a large source of contention for policy makers, even given the enhanced matching percentages from the Federal government, as they put an additional pressure on already financially strained state budgets. If passed, H.R. 1683, The State Flexibility Act, would repeal MOE requirements in the ACA, and is estimated to reduce federal budget deficits by $2.1 billion from 2012 to 2021. The CBO

estimates that repeal of MOE requirements would cause fifty-percent of states to drop their CHIP programs in 2016, moving the previously covered populations into the exchange (although a percentage of children would remain uninsured—data for NH not known). The OMBP report estimates that approximately $16 million more in NH State General Funds could be saved from 2016-2019 if this were the case. If the state maintains current FPL standards for children at 185 percent through 2019 under the MOE, it still saves a substantial amount of money due to enhanced FMAP from 65 percent to 88 percent.

Trending forward the 2007 Current Population Survey Estimate by the uptake percent for each year from 2014-2020, the OMBP estimated the new adult population covered in each age category using the CPS mid-point and upper 90 percent confidence interval estimates, as shown below in **Figure 12**.

Figure 12- Estimate of New Adult Population Enrollment 2014-2020

Using CPS Upper 90% Confidence Interval									
Age Group	2007	...	2014	2015	2016	2017	2018	2019	2020
19 to 34	24,610	...	13,164	23,988	27,661	28,352	29,061	29,788	30,532
35 to 49	14,567	...	7,792	14,198	16,372	16,782	17,201	17,631	18,072
50 to 64	11,150	...	5,964	10,869	12,533	12,846	13,167	13,496	13,834
Total	**52,334**	**...**	**26,920**	**49,054**	**56,566**	**57,980**	**59,430**	**60,915**	**62,438**
Using CPS Mid-Point									
19 to 34	15,857	...	8,482	15,456	17,822	18,268	18,725	19,193	19,673
35 to 49	8,251	...	4,413	8,042	9,274	9,506	9,743	9,987	10,236
50 to 64	6,816	...	3,646	6,644	7,661	7,853	8,049	8,250	8,456
Total	**32,930**	**...**	**16,541**	**30,142**	**34,757**	**35,626**	**36,517**	**37,430**	**38,365**

On the basis of these annual enrollment estimates, the OMBP calculated the mean cost per new enrollee per month and the State General Fund share of that cost, as shown in **Figure 13**, using real costs of Temporary Assistance to Needy Families and FPL eligible adults from 2008 and trending them forward.

Figure 13- Mean Total and State General Fund Share of Cost Per Enrollee Per Month

Medicaid Total Fund Cost									
Age Group	2008	...	2014	2015	2016	2017	2018	2019	2020
19 to 34	$319	...	$362	$373	$384	$396	$407	$420	$432
35 to 49	$459	...	$521	$536	$552	$569	$586	$604	$622
50 to 64	$605	...	$686	$707	$728	$750	$772	$796	$819
State General Fund Share									
19 to 34		...	$0	$0	$0	$20	$24	$29	$43
35 to 49		...	$0	$0	$0	$28	$35	$42	$62
50 to 64		...	$0	$0	$0	$37	$46	$56	$82

Converting the per member per month mean costs to cost per annum, multiplying by the projected estimates of the new adult population and then multiplying by the State share of the payment (100 percent minus the FMAP rate for each year) gives the estimated cost to the State General Fund from 2014-2020 according to the CPS upper 90 percent confidence interval and the CPS mid-point estimate. This data is shown below in **Figure 14**.

Figure 14- Annual State Fund Costs of New Adults (in millions of dollars)

Using CPS Upper 90% Confidence Interval							
Age Group	2014	2015	2016	2017	2018	2019	2020
19 to 34	$0	$0	$0	$7	$9	$11	$16
35 to 49	$0	$0	$0	$6	$7	$9	$13
50 to 64	$0	$0	$0	$6	$7	$9	$14
Total Cost	**$0**	**$0**	**$0**	**$18**	**$23**	**$28**	**$43**
Using CPS Mid-Point							
19 to 34	$0	$0	$0	$4	$5	$7	$10
35 to 49	$0	$0	$0	$3	$4	$5	$8
50 to 64	$0	$0	$0	$4	$4	$6	$8
Total Cost	**$0**	**$0**	**$0**	**$11**	**$14**	**$17**	**$26**

The additional State General Fund share of Medicaid costs from the new legislation begin in 2017 (technically the costs to the State due to the mandate, discussed below, begin in 2014), the first year the FMAP rate for new eligible adults is reduced from 100 percent, and increase each year up to 2020 consistent with the decrease in the FMAP rate and projected increases in new adult eligible enrollment.

In addition to costs from the enrollment of adult new eligibles in the Medicaid program, there are additional factors under new federal legislation that will increase the cost burden to the state. **Figure 15** lists three factors of the ACA that will add relatively stable annual costs to state funds, including the cost estimates of the woodwork effect, of covering former foster care children through age 24, and of increasing the primary care reimbursement fee to 100 percent of Medicare rates. One of the largest areas of cost savings for the Medicaid program from SFY 2008 to SFY 2010 was capping of provider reimbursement rates at 80 percent of Medicare.

Figure 15- Additional Annual Costs to State General Funds (in millions of dollars)

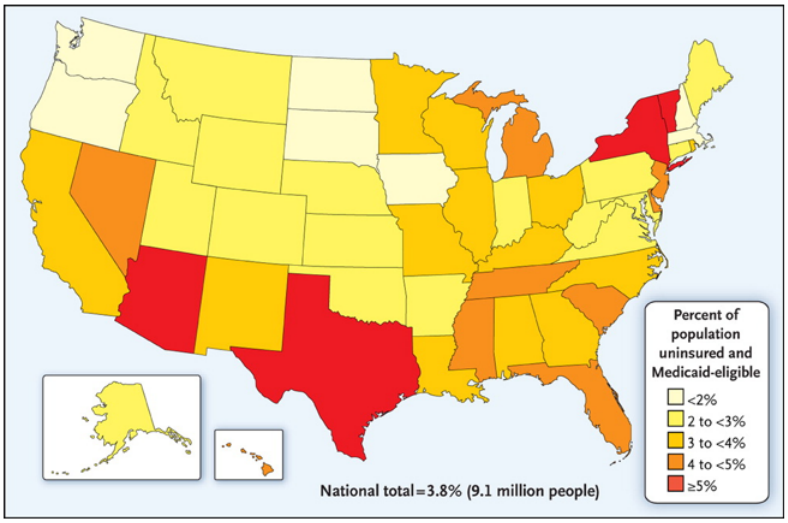
	2014	2015	2016	2017	2018	2019	2020
Cost Estimate of Woodwork Effect	$3	$3	$3	$3	$3	$3	$3
Cost Estimate of Covering Former Foster Care Children Through Age 24	$2	$2	$2	$2	$2	$2	$2
Cost Estimate of Primary Care Fee Increase to 100% Medicare Rates*	$0	$3	$3	$4	$4	$5	$5

Also important, the increase of the primary care fee to 100 percent of Medicare rates is only mandated until 2014, and could be reduced starting in 2015. Increased access to primary care has been shown by a large body of studies to result in healthier patient populations, increased use of preventive services, greater patient satisfaction, reduction in medical errors, and decreases in healthcare costs.[19] Many physicians do not accept Medicaid patients as a result of low reimbursement rates, so the decision to reduce the rates of reimbursement to primary care providers covering Medicaid patients should be approached with caution, since the Medicare reimbursement rates help ensure valuable access to the new patient population. On the other hand, the required rate increase for primary care services represents a 38 percent increase from current rates, and according to the OMBP analysis will cost NH an additional $22 million from 2016-2020.[xxii]

The woodwork effect noted in **Figure 15** is the idea that there are many low-income Americans that qualify for Medicaid but do not participate in the program due to enrollment barriers, poor retention, or lack of information. According to Drs. Epstein and Sommers of the Harvard School of Public Health, many of these currently eligible uninsured will "come out of the woodwork" and enroll in Medicaid due to large amounts of media coverage, the streamlining of enrollment procedures under the ACA, and most significantly the individual mandate to obtain health insurance.[20] As shown in **Figure 16**, New Hampshire will not be affected by this effect as much as most other states, since according to the 2010 CPS survey under two percent of the eligible Medicaid population is currently uninsured, compared to a national average of 3.8 percent. Nonetheless,

because New Hampshire will receive the current FMAP rate for currently eligible but uninsured constituents that newly enroll in Medicaid due to the woodwork effect, enrollment of this population will come at a 40-50 percent higher per patient cost than enrollment of adult new eligibles starting in 2014.

Figure 16- Percent of Population Uninsured and Medicaid Eligible[xxi]



While there are significant new costs under the Affordable Care Act, there are also sizeable savings to be found in existing coverage areas that could potentially balance the increase in costs to the State. The OMBP report considers several areas where savings to existing coverage areas will be realized, as shown in **Figure 17**. The 23 percent increase in federal matching funds for the Children's Health Insurance Program is one of the largest drivers in these savings, although as stated earlier in the report, by dropping coverage to 133 percent of the FPL for CHIP patients (conditional on passage of the State Flexibility Act), the State would save an estimated $16 million more from 2016-2019, since most of that population would be covered under the federally subsidized exchange and a portion would go uninsured.

Figure 17- Annual State Fund Savings in Existing Coverage Areas (in millions of dollars)

	2013	2014	2015	2016	2017	2018	2019	2020
Enhancement to 88% FMAP for CHIP Kids 185-300% FPL (assume CHIP funding through 2019)*				$7	$7	$8	$9	$15
Enhancement to 88% FMAP for CHIP Medicaid Kids >=133%FPL				$11	$12	$13	$13	$21
Implementation of Family Planning program in 2011**	$1	$2	$2	$2	$2	$2	$2	$2
Eliminate Medicaid Eligibility for >=133%***		$5	$5	$6	$6	$6	$7	$7
Total Savings	**$1**	**$7**	**$7**	**$26**	**$27**	**$29**	**$31**	**$45**

*Assumes CHIP appropriation for 2016-2019 will be made; in 2020 they go to Exchange
**Based on prior Family Planning Budget Neutrality waiver calculations
***Eligible for coverage through Exchange instead

Based on the estimated costs and savings to the Medicaid program under the ACA, the OMBP tabulated estimates of the net state fund cost from 2013-2020, as shown in **Figure 18**. It is important to keep in mind that the substantial uncertainty in the cost estimates make it difficult to draw any strong conclusions on how taxing net state fund costs will be for New Hampshire throughout this decade.

Figure 18- Net State Fund Cost Estimates (in millions of dollars)

	2013	2014	2015	2016	2017	2018	2019	2020
Upper-End Estimate	-$1	-$3	$0	-$18	$0	$3	$7	$8
Mid-Point Estimate	-$1	-$3	$0	-$18	-$8	-$6	-$4	-$9

What is qualitatively clear from the OMBP report is that while the Federal Government has placed an increased burden on states to provide Medicaid coverage to a larger base of their constituency, the government has also absorbed a very large percentage of the upfront costs of doing so. Whether or not total state Medicaid costs will increase under the Affordable Care Act remains to be seen. According to the upper-end estimate from 2013 to 2020, NH will realize a net savings of $4 million dollars; according to the mid-point estimate NH will realize a net savings of $49 million dollars (**Figure 18**).

Overall, the net savings according to the NH OMBP are consistent with findings from the non-partisan Washington D.C.-based Urban Institute, which conducted a federal level analysis of the net effects on state budgets from the implementation of the Affordable Care Act. Their analysis contrasts increased costs from further enrollment with estimated savings from the following three categories:

- Eliminating optional Medicaid coverage for adults over 133 percent of FPL and shifting them to the federally subsidized exchange can save states and localities between $21.3 billion and $28.2 billion.
- Replacing state and local spending on indigent and uncompensated care with federal Medicaid dollars can save states and localities between $42.6 billion and $85.1 billion.
- Replacing state and local spending on mental health services with federal Medicaid dollars can save states and localities between $19.9 billion and $39.7 billion.[21]

The net savings for state budgets are displayed below in **Figure 19** under a best-case scenario, in which participation levels track historical averages (anticipated by the Congressional Budget Office) and under a worst-case scenario, in which participation levels significantly exceed historical levels (e.g., strong woodwork effect).

Figure 19- Net State Fiscal Gains Under Worst and Best Case Enrollment Scenarios (in billions of dollars)

	Worst-case scenario	Best-case scenario
Medicaid cost increases for low-income adults	$43.2	$21.1
Total state savings	$83.8	$153.0
Savings from shifting Medicaid adults to the exchange	$21.3	$28.2
Uncompensated care savings	$42.6	$85.1
Mental health savings	$19.9	$39.7
Net state fiscal gains:	$40.6	$131.9

While states will collectively gain under the ACA, some may lose out. Whether or not this is the case depends not only on the state's population demographics but on their policy choices, including how aggressively they pursue substituting state and local funds with federal ones, how difficult they make it for individuals to obtain/retain coverage, and how they choose to manage their overall Medicaid programs.

The Mental health savings noted in the Urban Institute report, but not considered in the OMBP analysis are also very important to consider. Long term care for the physically/mentally disabled and elderly represents the largest plurality of expenses by the NH Medicaid program. The decision to opt-out of the Medicaid program would not relieve the state from its obligation to serve these constituencies, and would likely be considered a violation of the ADA if the State Funded Safety Net did not cover these individuals. By contrast, the currently uninsured in community mental health centers, whose expenses are at the moment absorbed entirely on the state, will be shifting to

Medicaid under the new legislation at a FMAP rate phased down from 100 percent to 90 percent from 2014-2020. Following 2020, the FMAP rate for this population remains at 90 percent, meaning the State of NH will only be paying 10 percent of the costs for the services it currently fully pays for.[22]

One of the unaccounted for but possibly significant increases in costs under the ACA is the reduction in allotment for Disproportionate Share Hospital (DSH) spending, which currently accounts for 17 percent of NH Medicaid expenditures. DSH allotments are given to certain general and NH hospitals to account for the fact that they care for a higher than average share of the Medicaid and uninsured population. The ACA provides for the gradual reduction in a state's DSH allotment, because more coverage under health care reform should reduce the incidence of uncompensated care. Reductions in DSH allotments will be based on a formula that weighs heavier for states with a lower proportion of uninsured patients or those that do not target their DSH payments appropriately. Further research is necessary to calculate the estimated magnitude of this gradual reduction over the following decade.

5. OTHER CONSIDERATIONS

- If the State chose to opt out, citizens of New Hampshire would be contributing Federal Tax dollars to a program their constituents would never benefit from.
- Ethical Questions: Medicaid program is based on the premise that "entitlement to healthcare is a Statement that rejects the idea that sound health and treatment for sickness, disease and disabilities is reserved for those with the resources to pay for it." Opting-out could be considered a rejection of that premise to a degree, as it would inevitably lead to a higher rate of uninsured and decreased utilization of beneficial physical and mental health services by poor constituents.
- Data Gathering: Medicaid data is one of the only existing sources the State of NH has for providing information on health outcomes of constituents of low socioeconomic status.
- Several federal grants to states are contingent on the recipients providing mandated services to Medicaid eligible patients. If NH chose to opt- out, it would likely lose funding for Rural Health and Primary Care Initiatives, Safety and Quality Assurance programs, etc.
- Many economists tend to view the countercyclical nature of government spending as a good thing, since it protects household income and promotes consumption of goods, which are considered important for economic recovery. This is certainly up for substantial debate, although it appears implementation of the ACA follows this logic.
- There are costs associated with not providing services. Soumerai et al. demonstrate that limiting Medicaid drug reimbursement benefits for Schizophrenic patients increased the use of emergency mental health services and the rate of partial hospitalizations and psychiatric hospital admissions, at

increased cost to the state of New Hampshire (not to mention increased pain and suffering to low income mentally ill patients).[23]

- Hot-Spotting is a new concept that demonstrates there are significant cost-savings associated with actively targeting the highest-cost regions of the state with the largest incidence of chronic disease, alongside the health benefits[24]
- Reduction in payments to hospitals, clinics, practices, and providers serving the poor may force them to turn away patients. Public hospitals that are legally mandated to provide emergency medical coverage to uninsured would now have to fully shoulder costs. In contrast, increased enrollment in federally subsidized Medicaid and the exchange provide a larger base of insured patients, which can decrease the burden on public hospitals.
- The sheer impact to economy of turning down millions of federal dollars could be problematic. The Medicaid program is a large employer for the state, and according to the Kaiser Family Foundation the average Medicaid dollar circulates seven times per year.
- Increased administrative costs are a financial concern associated with implementing new State Funded Safety Net in absence of the federal Medicaid grant to cover additional administrative expenses under the Affordable Care Act.
- Options for Medicaid Reform— The NH DHHS surveyed a cohort of medical providers and key opinion leaders in the state on the multiple Managed Care Options for NH Medicaid and the cost savings associated with these options. These include Accountable Care Organizations, adopting the Medical Home Model, Primary Care Reimbursement Reform, Implementation of Administrative Service Organizations, Care Coordination and Pay for Performance Incentives, and more.[25]
- A study by Harvard economist David Cutler and Commonwealth Fund President Karen Davis attributes very large savings to overall health expenditures and to state budgets due to the more subjective, and less proven, measure of savings of healthcare modernization. The concept is that the correction of misaligned incentives, increases in efficiency, decreases in waste (shift from supply-sensitive to evidence based services), the enormous capacity for productivity improvement in the healthcare industry noted by business scholars (if reform drives healthcare to act like other industries), can save the industry billions. The estimate of savings due to healthcare modernization estimated by the Commonwealth fund was $406 billion from 2010-2019.[26]

6. CONCLUSION

Our analysis has only scratched the surface of an incredibly complex and multi-factorial decision to opt-out of one of the largest social service programs in the United States. New Hampshire, being one of the states that is likely to be less dramatically affected by the enactment of Medicaid eligibility requirements under new Federal Legislation, has substantial cost-saving alternatives at its disposal when considering whether or not to opt-

out of Medicaid. It is the opinion of the authors of this report that the negative effects of opting out of the Medicaid program are numerous and widespread, due to the breadth of the program's influence in almost all healthcare delivery institutions, while there are certain short term net cost savings and a lack of concrete future cost burdens according to available research. Additionally, states have at their disposal considerable flexibility in reforming their own Medicaid programs to find cost savings, several of which have been outlined. The decision to opt-out of Medicaid is a very serious one, with a scope of consequences that cannot be fully predicted. It is therefore the opinion of these authors that it would be one of last resort, but given the large financial investment from the Federal government we are optimistic that it is within the means of the nation's least poor state to figure out a way to make a highly valuable program sustainable.

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