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THE IMPACT OF HEALTH INSURANCE REFORM ON STATE AND LOCAL GOVERNMENTS

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CONTENTS

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OVERVIEW

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. As part of the proposed increases in health insurance coverage, the House Tri-Committee legislation calls for an expansion in Medicaid to all individuals under 133 percent of the federal poverty line (FPL).[1] Understandably, there has been some concern in state capitals surrounding this proposal given the possible increase in state Medicaid expenditures that could result.

However, state and local governments are already spending billions of dollars each year providing coverage to the uninsured – costs that could be significantly reduced as a result of the currently proposed reforms. Additionally, state and local governments employ more than 19 million individuals, and their total spending on health insurance premiums for this group in 2007 was approximately $95 billion.[2] This group currently pays a "hidden tax" in the form of higher health insurance premiums that helps to cover expenses incurred by the uninsured. This burden would be greatly reduced as a result of expansions in insurance coverage resulting from health insurance reform, which would generate significant savings for state and local governments.

A June report by the Council of Economic Advisers (CEA) demonstrated the health and overall economic benefits of health insurance reform (CEA, 2009a). A subsequent study produced by the CEA in July showed the significant benefits to small businesses and their employees from health insurance reform. This report, the third in the CEA series, illustrates the potential benefits of health insurance reform for state and local government budgets through a detailed analysis of current spending levels. Focusing on a sample of sixteen diverse states, we provide detailed case studies of the multitude of ways that state and local governments spend billions of dollars on uncompensated care. These estimates, combined with estimates of possible state expenditures associated with reform, indicate that the move to greater insurance coverage would likely result in substantial savings for state and local governments. Rather than harming the budget situation of the states, health insurance reform would improve it.

A. Scope and Methodology of the Study

Determining what states spend on uncompensated care is difficult. This information is not collected in one place or in a consistent form across states. To gather this information, we examined publicly available information from each state government and in many cases from county and city governments. We supplemented this with information from federal agencies,

[1] The Senate HELP Committee does not have jurisdiction over Medicaid and we therefore focus on the House Tri-Committee legislation in this document.

[2] State spending on employee health premiums totaled $19.5 billion in 2003 (NASBO, 2005). Taking the ratio of national health care spending in 2007 to spending in 2003, we estimate this increased to $25 billion by 2007. However, this reflects only the cost of providing health insurance to the approximately 5 million state employees in 2007. Assuming that the average cost per employee of health insurance is the same for the 14 million employees of local governments, we estimate $95 billion in premium costs to state and local governments.

non-profit research organizations, and other sources, all of which we list in the references that are included at the end of each state summary.

Because of the inherent difficulty in locating comprehensive information on all government spending on the uninsured, the state and local government programs that we highlight are in no way meant to be an exhaustive list. Our estimates should be considered a plausible lower bound on the potential cost savings to state and local governments.

It is precisely because of the difficulty involved in gathering the information that we begin with a sample of states. The sixteen states that we examine are Arkansas, California, Florida, Idaho, Indiana, Iowa, Maine, Michigan, Minnesota, Montana, Nebraska, North Carolina, Oregon, Pennsylvania, Vermont, and Wyoming. While not a random sample, this group covers a range of geographic, economic, and demographic features. These states also run the gamut from low to high uncompensated care expenditures. For this reason we feel they are largely representative of the experience of the states we have not yet analyzed.

In addition to gathering uncompensated care expenditure data from a multitude of sources, we also provide estimates of how much states pay in higher health care premiums for state employees because of uncompensated care. Though not as large as some of the direct expenditures, this hidden tax is substantial, especially for larger states. The technical appendix provides details on the methodology that we use to do this calculation.

To estimate the possible cost to state governments of health insurance reform, we use detailed statistics for each state from the March 2008 Current Population Survey to estimate the number of uninsured citizens at various income levels. We combine these estimates with information on Medicaid expenditures by state and details from the proposed legislation on the share to be paid for by the states. Details of how we conduct this analysis are also included in the Appendix.

B. State Spending on Uncompensated Care

Our analysis reveals that states spend billions on uncompensated care in a wide variety of ways. Most obviously, there are state programs to cover low-income uninsured patients. Consider the following three examples.

- In California, counties are the "providers of last resort" for health services to low-income uninsured people with no other sources of care. In 2004-2005, 24 California counties spent $1.61 billion providing care to the uninsured through their Medically Indigent Services Programs. The remaining 34 (primarily rural) counties spent $283 million on care to the uninsured through their County Medical Services Programs during the 2008 fiscal year. Between both programs, California spent $1.90 billion.

- In Minnesota, the state-funded General Assistance Medical Care program provides full health coverage to uninsured adults up to 75 percent of the FPL who are not eligible for federal benefits. In FY 2007, the state spent $281 million in payments to providers for GAMC services.

- In Miami-Dade County, Florida, funding for uncompensated care through its public health facilities comes from a 0.5 percent sales tax. In FY 2007-2008, revenue from this tax amounted to $187 million.

Under current draft legislation, low-income uninsured citizens and legal residents would be covered by Medicaid, which would be primarily federally-funded, greatly reducing the need for such expenditures by state and local governments.

Many states fund programs which cover residents who earn above 133 percent of the federal poverty level. Consider the following three examples.

- In Maine**,** Dirigo Health subsidizes health insurance for certain individuals up to 300 percent of the FPL. These subsidies are financed by an earmarked assessment on health insurance and self-insured companies and drawing on the state treasury's cash pool. In 2008, Dirigo had subsidy costs of $41.5 million and operating costs of $2.8 million.

- In Pennsylvania, the adultBasic program provides subsidized basic health insurance to legal residents with incomes up to 200 percent of the FPL. In 2008, the program cost $172 million. Due to high demand and budget constraints, the program is limited in size and there is a substantial waiting list for the subsidized coverage.

- In Vermont**,** uninsured citizens who are not eligible for Medicaid or other state programs and do not have reliable access to an employer-sponsored plan can enroll in a "Catamount Health" plan, and may receive state-funded premium assistance if they meet certain qualifications. In state fiscal year 2008, Vermont paid a net amount of $10.2 million in state funds for Catamount Health enrollees.

Under current proposals for reform, these individuals would be eligible for subsidized health insurance through the national health insurance exchange, at no cost to the state.

Finally, providing uncompensated care to the uninsured imposes a "hidden tax" on health insurance premiums for the insured. This tax increases premiums for all employers, including state and local governments and their 19.4 million employees (16.5 million as measured by "full-time equivalents"). By greatly reducing uncompensated care, health insurance reform would reduce this hidden tax.[3]

Table 1 shows our estimates of the amount spent in each of our sixteen states on uncompensated care and the hidden tax on the health insurance provided to state employees each year. There is substantial variation across states, most obviously because states vary greatly in size and thus in the number of uninsured. But importantly, in each case, the estimates are large. Summing the sixteen states together, we estimate that they spend at least $4.2 billion on uncompensated care per year.

[3] It is possible that part of the savings from lower employer contributions to health insurance premiums would be passed on to workers in the form of higher wages. This would to some extent offset the estimated savings to state and local governments, though it would improve the economic well-being of their employees.

As described above, it is simply impossible to track down every state and local program that contributes to covering the uninsured. As a result, true expenditures on uncompensated care are surely substantially larger than our estimates. Therefore, health insurance reform that greatly reduces uncompensated care would reduce costs to the states by more than the amount that we identify. This is true even taking into account the fact that some uncompensated care would remain following reform.

Table 1: Summary of Detailed Analyses of Net Health Insurance Reform Savings in 16 States ($ millions)

State	Spending on Existing Programs	Cost of Hidden Tax on State Employee Health Premiums	Lower Bound Estimate of Uncompensated Care Spending	Cost of Medicaid Expansion with 90% FMAP	Net Budget Impact with 90% FMAP	Net Budget Impact with 100% FMAP
Arkansas	$6.2	$17.2	$23.4	-$20.4	$3.0	$23.4
California	$1,934.0	$210.0	$2,144.0	-$195.0	$1,949.0	$2,144.0
Florida	$275.3	$102.0	$377.3	-$251.6	$125.7	$377.3
Idaho	$38.9	$8.3	$47.2	-$25.8	$21.4	$47.2
Indiana	$308.0	$29.5	$337.5	-$62.3	$275.2	$337.5
Iowa	$33.6	$11.2	$44.8	-$20.0	$24.8	$44.8
Maine	$45.7	$5.1	$50.8	-$15.3	$35.5	$50.8
Michigan	$168.4	$43.5	$211.9	-$68.1	$143.8	$211.9
Minnesota	$281.0	$13.6	$294.6	-$31.7	$262.9	$294.6
Montana	$22.8	$7.0	$29.8	-$20.8	$9.0	$29.8
Nebraska	$27.0	$8.6	$35.6	-$17.8	$17.8	$35.6
North Carolina	$150.7	$58.6	$209.3	-$188.3	$21.0	$209.3
Oregon	$116.0	$22.3	$138.3	-$59.3	$79.0	$138.3
Pennsylvania	$171.8	$43.1	$214.9	-$149.7	$65.2	$214.9
Vermont	$17.5	$3.3	$20.8	-$6.8	$14.0	$20.8
Wyoming	$6.9	$4.5	$11.4	-$10.6	$0.8	$11.4
Total	$3,603.8	$587.8	$4,191.6	-$1,143.5	$3,048.1	$4,191.6

One way to quantify the degree to which our state-by-state estimates of uncompensated care could be too low is to compare it to estimates using different approaches. Hadley et al. (2008) use individual-level data from the Medical Expenditure Panel Survey to form an estimate of uncompensated care for the United States as a whole. They estimate that state and local governments spent $15.9 billion on care for the uninsured during the 2008 calendar year. We estimate that the hidden tax on the insurance policies provided to state employees adds another $1.6 billion to costs for state and local governments for the country as a whole.[4] Thus, these estimates suggest that state and local governments spend a total of $17.5 billion nationally on uncompensated care.

[4] See appendix for details of this calculation.

Our estimate based on detailed analysis of state programs is $4.2 billion for sixteen states. These sixteen states include 38.1 percent of the total population of the United States. If one scaled up our estimate to be an estimate for the entire country (by multiplying by 100/38.1), the resulting number is $11.0 billion. This suggests that our direct identification of expenditures on uncompensated care is indeed a lower bound by a significant margin.

C. Bottom Line for State Governments

Table 1 also shows our estimates of the costs to the states of expanding coverage. For uninsured citizens and legal permanent residents above 133 percent of the federal poverty level, current proposals call for the creation of an insurance exchange with a sliding-scale subsidy. These subsidies would be paid for entirely by the federal government. Therefore, they would add nothing to state expenditures.

Current proposals call for uninsured citizens with incomes less than 133 percent of the federal poverty level to be covered by Medicaid. Under existing proposals, the federal government would pay 100 percent of the cost of this addition to Medicaid for the first three years and State governments would pay none. After that, the federal government would pay 90 percent and the State governments would pay 10 percent. As with the current Medicaid program, only citizens and legal permanent residents would be covered.

Table 1 shows our estimate of the cost of increased Medicaid coverage for each of the states we analyze and for the sum of the sixteen. Again, the estimated cost varies substantially across states because both the number of people who would be covered and the Medicaid costs per person vary substantially across states. The total cost of coverage expansion in the sixteen states we analyze is $11.4 billion (in 2007 dollars).[5] In current versions of the draft legislation, states would be required to pay zero under the 100 percent federal matching rates for the first three years. Under the 90 percent matching rate after three years, the amount would be $1.1 billion per year.[6]

For the sixteen states we analyze taken together, the total net saving is $4.2 billion per year for each of the first three years when the federal government is paying for all of the expansion of Medicaid. Importantly, even when the federal matching rate is reduced to 90 percent, the saving to state governments from health insurance reform is substantial. We estimate that the sixteen states we analyze would save $3.0 billion per year with the 90 percent match, with the savings more than offsetting the additional Medicaid costs in every one of the sixteen states. Thus, health insurance reform, far from harming state budgets, would likely improve them substantially.

In addition, further savings may come from the Children's Health Insurance Program (CHIP). In FY 2008, the sixteen states that we analyze spent $1.3 billion on CHIP coverage for low-income children, with the federal government paying an additional $2.7 billion on CHIP in these same

[5] Projections for Medicaid spending cited here and elsewhere in the document are in 2007 dollars to facilitate comparisons with existing spending by state and local governments on care for the uninsured and on their employees' health insurance premiums.

[6] If instead of a 90 percent FMAP, the sixteen states' existing FMAPs were in effect, their share of the $11.4 billion in total Medicaid costs would be $4.8 billion.

states (Kaiser Family Foundation, 2009). Under the current draft legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing states to save a considerable amount of the costs of this program.[7] However, CEA does not include savings on CHIP in the bottom line calculations of net savings from health insurance reform detailed below, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

Our study has only focused on sixteen states so far. However, there is every reason to believe that the findings for these states would generalize to others. Thus, health insurance reform is likely to be widely beneficial to state and local governments in the U.S.

This conclusion is strengthened by the fact that this analysis has only focused on the savings to state and local governments from reduced expenditures on uncompensated care. Health insurance reform is like to reduce their health care expenditures in a number of other ways. For example, cost savings from Medicaid reform and increased efficiency of health care utilization would reduce state Medicaid expenses and reduce the cost of providing health insurance for government employees. Similarly, increased health insurance coverage would imply more continuous care received by the millions of individuals who transition in and out of Medicaid eligibility in a typical year. To the extent that this greater continuity leads to improvements in health for Medicaid recipients, program expenditures would decline. Thus, there is every reason to expect health insurance reform to be even more beneficial to state budgets than our estimates suggest.

[7] In current draft legislation, CHIP would expire after 2013 and thus state governments would realize savings from this as these children would then be financed through the federally-financed exchange.

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APPENDIX ON METHODOLOGY

In each of the sixteen state reports that follow, we utilize data from several different sources to estimate the effects of health insurance reform on state and local governments. Two important components of these effects are the reduction in employee health insurance premiums that would result from an elimination of the "hidden tax" on state and local government employees' health insurance premiums and the cost of the Medicaid expansion to individuals with incomes of less than 133 percent of the FPL. In this section, we discuss our methodology for estimating the impact of both of these components and also describe our key data sources.

A. Estimating the Savings to State and Local Governments from Reduction of the "Hidden Tax"

Individuals without health insurance receive a significant amount of uncompensated care from hospitals and from other health care providers. Much of the cost of this care is then passed on to those with private health insurance in the form of higher prices for health care services, with this ultimately translating into higher health insurance premiums. Because state and local governments provide health insurance to most of their 19.4 million employees, this "hidden tax" results in higher costs for state and local governments. By extending health insurance to the uninsured, health insurance reform would lower these costs to state and local governments.

To estimate the magnitude of this effect for each state, we begin with the results from recent research by Hadley et al (2008), which indicates that $14.1 billion of this uncompensated care for the uninsured was not funded through government sources and thus would plausibly lead to higher premiums for individuals with private health insurance. We then divide this number by the 45.7 million uninsured U.S. residents[8] to obtain an average of $309 in uncompensated care costs per uninsured person. We then multiply this cost by our estimate of the number of non-elderly uninsured U.S. citizens and legal residents in each state.[9] Finally, we multiply this estimate of total uncompensated care costs in each state by the share of employment accounted for by state and local government workers to estimate the total savings to state and local governments from reduced health insurance premiums.[10]

B. Estimating the Costs of the Medicaid Expansion

Health insurance reform as currently proposed in draft legislation would expand Medicaid to uninsured individuals with incomes of less than 133 percent of the federal poverty line (FPL). To estimate the number of uninsured individuals who would become eligible for Medicaid in each state, we utilized data from the March 2008 Current Population Survey, which contains individual-level data on income, poverty, and health insurance coverage for a large sample of U.S. residents.

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[8] New data from the Census indicate that the number of uninsured individuals increased to 46.3 million in 2008.

[9] We exclude undocumented immigrants from this calculation as they would not be eligible to obtain health insurance through Medicaid or through the exchange as a result of reform.

[10] Our 2007 employment data for state and local governments comes from the U.S. Census Bureau. Raw data is located at: http://www.census.gov/govs/apes/index.html. To calculate the share of employment accounted for by state and local employees, we divide the number of employees working for state and local governments by the total number of employees, taken from the March 2008 CPS.

We define individuals in the survey as uninsured if they do not report coverage from either private or public (e.g. Medicare, Medicaid, or military health care) health insurance. We combine these data with information on the ratio of each survey respondent's family income to the FPL to estimate the number who are both uninsured and who are in families with incomes of less than 133 percent of the FPL.[11] It is this group that would be potentially eligible for Medicaid as a result of health insurance reform. Uninsured individuals with family incomes above 133 percent of the FPL would be eligible for health insurance through the exchange.

In Table 1 of each state's report, we provide detailed information on the health insurance coverage of children (defined as ages 0 through 18 inclusive) and non-elderly adults residing in the state. We differentiate between those with high and low incomes (above and below 133 percent of the FPL, respectively) and place each individual into one of four mutually exclusive insurance categories: uninsured, privately insured, Medicaid, and Medicare / VA / TRICARE.[12]

In Table 2 of each state's report, in which we summarize our estimates of the cost of the Medicaid expansion, we list the estimated number of low-income uninsured adults and children residing in each state who are U.S. citizens or legal residents. We exclude undocumented immigrants because they would not be eligible for Medicaid as a result of health insurance reform.[13]

We next combine this estimate with data from the Centers for Medicare and Medicaid Services (CMS) regarding average Medicaid spending per recipient in each state. More specifically, we use the data that is available from the CMS Medicaid Statistical Information State Summary Datamart (http://msis.cms.hhs.gov/). We consider Medicaid spending for recipients who are not disabled, not dually eligible for Medicare, and who have a basis of eligibility (BOE) as either children (ages 0 to 18) or non-elderly adults (ages 19 to 64). We use the default settings of all other variables. Most states have data from 2007, although some states have data only for 2006 or (in one case) 2004. We adjust all numbers to a 2007 baseline using the average annual rate of Medicaid expenditure growth of 7.2 percent from 2006 to 2007.[14]

[11] The categorical variable "povll" in the March 2008 CPS takes on one of fourteen values depending on the ratio of the family's income to the poverty line. Those in one of the four lowest categories (0 to 49 percent up to 100 to 124 percent) are defined as being below 133 percent of the FPL. One of the categories for this variable is 125 to 149 percent of the FPL. For this group, we divide their reported family income by the state-specific (the value for Alsaska and Hawaii is different from other states) poverty guidelines that pertain to their family size and structure from http://aspe.hhs.gov/poverty/08fedreg.htm to determine whether they are below 133 percent of the FPL.

[12] Some individuals report multiple sources of health insurance coverage. If a person reports Medicare, VA, or TRICARE, then we place him or her in that category. If the person does not report coverage from any of these sources but reports that they were covered by Medicaid, he or she is placed in the Medicaid category. Individuals are placed into the private health insurance category if they report private health insurance coverage but do not report public health insurance coverage. Uninsured individuals are those who do not report coverage from any private or public source.

[13] We rely on estimates from Jeffrey Passel at the Pew Hispanic Center regarding the number of undocumented immigrants in each state. See Passel and Cohn's "A Portrait of Undocumented Immigrants in the U.S." at http://pewresearch.org/pubs/1190/portrait-unauthorized-immigrants-states for a description of their methodology, which accounts for under-sampling of undocumented immigrants in the CPS.

[14] See http://www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf.

We then multiply these values for average Medicaid spending in each state by 1.20 to account for the fact that disabled individuals typically have higher health care costs than the non-disabled. For example, disabled Medicaid recipients have average program expenditures that are approximately five times greater than similarly aged non-disabled Medicaid recipients. Furthermore, approximately five percent of uninsured individuals report in the March 2008 CPS that they are disabled. If the same five-to-one spending ratio would hold for disabled and non-disabled uninsured individuals when they became eligible for Medicaid, then on average costs would be twenty percent greater than implied by the average for the non-disabled.[15]

We then multiply the estimated state-specific number of low-income, uninsured U.S. citizens and legal residents in each age group by the corresponding state-specific average Medicaid spending to estimate the average costs of the Medicaid expansion. The key assumption of this approach is that average Medicaid spending per uninsured individual would be equal to average Medicaid spending for current recipients. It also assumes that only the uninsured would enroll, and thus that the expansion would not "crowd out" health insurance from other sources.

[15] It is perhaps most useful to explain this with an example. Suppose that, on average, annual Medicaid spending for non-disabled adults in a state was $2,000 per year and for disabled adults in the same state it was $10,000 per year. If five percent of individuals were disabled, then average annual costs would be $2,400, which is twenty percent greater than the non-disabled average of $2,000 per year.

ARKANSAS

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Arkansas and its local governments.

Arkansas subsidizes small businesses to offer their employees health insurance and both the state and local governments provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Arkansas and its local governments currently spend at least **$23 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Arkansas' **143,713** low-income uninsured individuals would be $204 million (in 2007 dollars).[16] After initially sharing none of that cost, Arkansas' share with a 90 percent FMAP would be **$20 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Arkansas and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Arkansas would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs and would have additional financial benefits for Arkansas' private hospitals and other health care providers, which bear heavy costs for providing care to Arkansas' residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Arkansas.

The following is a summary of *some* of the savings that Arkansas and its local governments could expect from health insurance reform.

- **ARHealthnet**: ARHealthnet is a group health insurance program for small to medium businesses (two to 500 employees) that have not offered insurance for 12 months (Arkansas Department of Human Services, 2009). Benefits are limited and premiums are subsidized for employees under 200 percent of the FPL (RWJF, 2009). In 2007, the first year of operations, the state spent **$781,000** on the program. Costs are expected to grow significantly as the program expands (Arkansas Tobacco Settlement Commission, 2008). It is reasonable to assume that under health insurance reform Arkansas would recover a substantial amount of what they currently spend on ARHealthnet. Under current reform proposals, small businesses

[16] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

would be offered tax credits as an incentive to offer health insurance to their employees. Additionally, individuals now enrolled in ARHealthnet with incomes below 133 percent of the FPL would become eligible for Medicaid, with the vast majority of this cost funded by the federal government. Individuals with incomes above 133 percent would be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **Hospital Indigent Care**: The University of Arkansas Medical Sciences (UAMS) provides services to the indigent. In 2009, the state allocated **$5.4 million** to UAMS for covering these costs (Arkansas Funded Operating Budget, FY 2008). Much of what Arkansas currently allocates for indigent care at UAMS would be saved under health insurance reform. All individuals below 133 percent would qualify for Medicaid and those above that threshold would be eligible to obtain subsidized insurance through the exchange, at no cost to the state.

- **Hidden Tax**: Arkansas' hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care. Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Arkansas because the state and its local governments help pay for health insurance for many of their 165,666 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Arkansas and its local governments **$17.2 million** a year in the form of higher employee health insurance premiums.[17]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Arkansas currently spends **$26.3 million** on CHIP coverage (Kaiser Family Foundation, 2009) for children in families with incomes up to 200 percent of the FPL (RWJF, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Arkansas would see at least

[17] CEA calculates the hidden tax for Arkansas and for all subsequent states in the following way. We use the estimate of $14.1 billion in uncompensated care that was not funded by other government sources from Hadley et al (2008). We then divide this by the 45.7 million uninsured to obtain an estimate of $309 per uninsured person. We then multiply this by the number of non-elderly non-illegal uninsured in the state to arrive at $118.9 million for the state of Arkansas. Finally, we multiply this by the share of employment accounted for by state and local employees (14.5 percent in Arkansas in 2007) to arrive at $17.2 million.

$23 million in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Arkansas

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Arkansas' non-elderly residents during the 2007 calendar year, broken down by poverty status and by age groups. These estimates suggest that there are roughly 135,000 uninsured adults and 23,000 uninsured children in Arkansas with family incomes below 133 percent of the FPL.

As the table shows, the majority of uninsured individuals (62 percent) in Arkansas has incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Arkansas would not be responsible for any of the financing for this group.

Table 1: Total Estimated Non-Elderly Population of Arkansas

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	228,576	1,043,576	30,143	102,349
	< 133% FPL	134,719	71,579	43,674	34,535
Children (0-18)	≥ 133% FPL	24,433	339,906	161,297	18,521
	< 133% FPL	22,667	29,508	153,069	7,342

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Arkansas: 1,241.

C. Estimated Costs to the State of Arkansas from the Medicaid Expansions

Table 2 lists the estimated number of legal, non-elderly residents in Arkansas with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion would be $204 million per year. With an FMAP of 90 percent, the annual cost to the state would be **$20 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Arkansas

	Number of Legal Uninsured Below 133% FPL	Cost of Medicaid Expansion ($ millions)	Cost per New Enrollee	State Population	Cost to State with 90% FMAP ($ millions)
Adults (19-64)	124,771	$165	$1,321	2,834,797	$20
Children (18 and under)	18,942	$40	$2,091		

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.

D. Bottom Line for Arkansas

Table 3 shows the net impact for the Arkansas state budget of health insurance reform. It shows the likely cost of the Medicaid expansion under three FMAP matching rates – current, 90 percent and 100 percent. It then shows the identifiable savings from reducing uncompensated care. As the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. And these other savings would offset 42 percent of the cost even if the current FMAP of 72.78 percent was used.[18]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Arkansas ($ millions)

Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-55.6	-20.4	0.0
AR Health Net	+0.8	+0.8	+0.8
U of Arkansas	+5.4	+5.4	+5.4
Hidden Tax	+17.2	+17.2	+17.2
Net Effect for Arkansas	-32.2	+3.0	+23.4

This table likely understates the benefits to the state of Arkansas and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[18] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that the programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Arkansas can expect to see from health insurance reform.

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CALIFORNIA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of California and its local governments.

California and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that California and its local governments currently spend at least **$2.14 billion** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to California's **1,717,309** low-income uninsured individuals would be $1.95 billion (in 2007 dollars).[19] After initially sharing none of that cost, California's share with a 90 percent FMAP would be **$195 million**. Thus health insurance reform would provide a substantial financial benefit to the state of California and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of California would benefit fiscally from health insurance reform because they currently spend money helping individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for California's private hospitals and other health care providers, which bear heavy costs for providing care to California's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in California.

The following is a summary of *some* of the savings that California and its local governments could expect from health insurance reform.

- **Medically Indigent Services Programs (MISP):** This program provides insurance coverage to low-income adults in 24 California mostly large, urban counties. Under California law, counties are the "providers of last resort" for health services to low-income uninsured people with no other sources of care. These programs vary in their eligibility requirements and coverage. Most programs provide care free of charge to adults under some income threshold (100 percent of the FPL to 300 percent of the FPL) and care with some measure of cost sharing to those earning above the threshold (California Health Care Foundation, 2006). In

[19] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

2004-2005, the most recent year for which data are available, counties spent **$1.613 billion** on this program (California Department of Public Health, 2008).

- **County Medical Services Program (CMSP):** This program provides health insurance coverage to low-income adults in 34 primarily rural California counties. Enrollees must be legal citizens with incomes below 200 percent of the FPL (California Health Care Foundation, 2006). In 2008-09, the program had a budget of **$283 million** (County Medical Services Program, 2009). It is reasonable to assume that under health insurance reform California would recover a substantial amount of what they currently spend on the MISP and CMSP programs. Under current reform proposals, legal residents now enrolled in MISP or CMSP with incomes below 133 percent of the FPL would become eligible for Medicaid, with virtually all of this cost financed by the federal government. Individuals currently enrolled in MISP or CMSP with incomes above 133 percent of the FPL would be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **California's Major Risk Medical Insurance Program (MRMIP):** This program provides California residents with subsidized insurance if they cannot otherwise obtain affordable insurance (California Managed Risk Medical Insurance Board, 2009). Enrollees must have been rejected for private insurance, involuntarily dropped from insurance, or been offered insurance only at a premium higher than the MRMIP rate. Due to budget constraints, there is often a waiting list for this program (National Conference of State Legislatures, 2009). In 2008-09, MRMIP's budget was **$37.7 million** (California Managed Risk Medical Insurance Board, 2008). California should save virtually all of the costs of this program under health insurance reform, since the national health insurance exchange would offer reasonably-price health insurance to all enrollees, regardless of pre-existing conditions.

- **Hidden Tax:** California's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care. Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to California because the state and its local governments help pay for health insurance for many of their 1,835,452 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of California and its local governments **$210 million** a year in the form of higher employee health insurance premiums.[20]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of California currently spends **$707 million** on CHIP coverage for children in families with incomes up to 250 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net

[20] Based on calculation that 13.3 percent of California's employment is in state and local government.

state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that California would see at least **$2.14 billion** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of California

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of California's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 1.84 million uninsured adults and 454,000 uninsured children in California with family incomes below 133 percent of the FPL.

Table 1: Total Estimated Non-Elderly Population of California

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	3,482,926	13,583,882	895,274	564,625
	< 133% FPL	1,836,675	825,016	925,098	241,776
Children (0-18)	≥ 133% FPL	706,707	5,048,759	1,235,885	146,040
	< 133% FPL	454,028	492,895	1,837,020	47,342

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for California: 10,049.

As the table also shows, the majority (65 percent) of the uninsured in California has incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of California would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of California from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in California with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion would be approximately $1.950 billion per year. With a 90 percent FMAP, the annual cost to the state would be **$195 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of California					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	1,332,828	$1,391	$1,044	36,553,215	$195
Children (18 and under)	384,481	$559	$1,454		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for California

Table 3 shows the net impact for the California state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. As the following table shows, those savings would more than offset the cost of the Medicaid expansion described even if the current FMAP of 50 percent was used.[21]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in California ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-975	-195	-0
MISP	+1,613	+1,613	+1,613
CMSP	+283	+283	+283
MRMIP	+38	+38	+38
Hidden Tax	+210	+210	+210
Net Effect for California	+1,169	+1,949	+2,144

This table understates the benefits to the state of California and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[21] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that the programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings California can expect to see from health insurance reform.

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FLORIDA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Florida and its local governments.

Florida and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Florida and its local governments currently spend at least **$377 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Florida's **933,638** low-income uninsured individuals would be $2.52 billion (in 2007 dollars).[22] After initially sharing none of that cost, Florida's share with a 90 percent FMAP would be **$252 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Florida and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Florida would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Florida's private hospitals and other health care providers, which bear heavy costs for providing care to Florida's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Florida.

The following is a summary of *some* of the savings that Florida's state government and its local governments could expect from health insurance reform.

- **Florida's Health Flex**: This program allows private health insurers, as well as non-profits or local governments, to offer basic health insurance plans to individuals with income under 300 percent of the FPL. The plans offered through Health Flex do not have to meet Florida's regular criteria for licensed insurance companies. The Health Flex program has little cost to the state (Florida Agency for Health Care Administration, 2009). However, since coverage in the Health Flex program is often very basic, individuals who switch from Health Flex plans to the exchange would likely benefit from having more comprehensive coverage. In addition,

[22] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

local governments that fund health coverage through Health Flex would see savings (see JaxCare, below.)

- **The Health Care Responsibility Act**: This requires counties to reimburse hospitals in other counties for providing uncompensated care to their residents. Some counties also provide reimbursement to their own hospitals. Hospitals are not eligible to get reimbursement until their uncompensated care costs exceed 2 percent of their total operations. In FY 2006-2007, counties spent **$5.6 million** reimbursing hospitals (Florida Agency for Health Care Administration, 2008).

- **Hidden Tax**: Florida's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[23] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Florida because the state and its local governments help pay for health insurance for many of their 890,834 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Florida and its local governments **$102 million** a year in the form of higher employee health insurance premiums.[24]

Some counties have their own programs to provide health care or health insurance to low income residents. Examples of such programs:

- **Hillsborough County Health Care**: This program provides comprehensive managed health care for low-income individuals who are not eligible for Medicaid or Medicare. It is funded with a local sales tax. In FY 2007-2008, the program had expenses of **$82 million** for its Direct Health Care Services program (Hillsborough County, 2008).

- **Miami-Dade County**: This county, which has a high number of uninsured residents, funds its public health facilities, including Jackson Memorial Hospital, with a 0.5 percent sales tax. In FY 2007-2008, revenue from this tax in just this one county amounted to **$187 million** (Miami-Dade County, 2008).

- **Duval County's JaxCare**: This program provides health coverage in Duval County through the state Health Flex program. JaxCare provides subsidized coverage to individuals with incomes under 200 percent of the FPL, through the individual's employers. JaxCare is funded through premiums, donations, federal grants, and by the city of Jacksonville. In 2006, projected costs of the program were $2.6 million, **$660,000** of which was funded by the city of Jacksonville (Jacksonville Community Forums on Health Care and the Uninsured, 2006).

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Florida currently spends **$117.7 million** on CHIP coverage for children in families with

[23] Hospitals in Florida incurred $1.561 billion in uncompensated care costs in 2003 (U.S. Government Accountability Office, 2005).
[24] Based on calculation that 11.8 percent of Florida's employment is in state and local government.

incomes up to 200 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Florida would see at least **$377 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Florida

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Florida's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 818,000 uninsured adults and 360,000 uninsured children in Florida with family incomes below 133 percent of the FPL.

Table 1: Total Estimated Non-Elderly Population of Florida

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	1,777,668	6,253,888	232,548	751,172
	< 133% FPL	817,593	425,288	215,899	162,284
Children (18 and under)	≥ 133% FPL	425,341	2,075,165	448,184	137,771
	< 133% FPL	359,619	262,755	543,485	49,620

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Florida: 4,226.

As the table also shows, the majority (65 percent) of the uninsured in Florida have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Florida would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Florida from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Florida with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Florida					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	618,769	$1,987	$3,211	18,251,243	$252
Children (18 and under)	314,869	$529	$1,682		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

These estimates suggest that the total cost of this expansion would be approximately $2.516 billion per year. With an FMAP of 90 percent, the cost to the state would be **$252 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

D. Bottom Line for Florida

Table 3 shows the net impact for the Florida state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. Moreover, these other savings would offset one-third of the cost even if the current FMAP of 54.98 percent was used.[25]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Florida ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-1,132.9	-251.6	-0.0
Miami-Dade hospital sales tax	+187	+187	+187
Health Care Responsibility Act	+5.6	+5.6	+5.6
Hillsborough County Health Care	+82	+82	+82
JaxCare	+0.7	+0.7	+0.7
Hidden Tax	+102.0	+102.0	+102.0
Net Effect for Florida	-755.6	+125.7	+377.3

This table understates the benefits to the state of Florida and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second,

[25] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that the programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Florida can expect to see from health insurance reform.

it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

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IDAHO

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Idaho and its local governments.

Idaho and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Idaho and its local governments currently spend at least **$47 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Idaho's **66,798** low-income uninsured individuals would be $258 million (in 2007 dollars).[26] After initially sharing none of that cost, Idaho's share with a 90 percent FMAP would be **$26 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Idaho and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Idaho would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Idaho's private hospitals and other health care providers, which bear heavy costs for providing care to Idaho's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Idaho.

The following is a summary of *some* of the savings that Idaho and its local governments could expect from health insurance reform.

- **The Idaho Individual High Risk Reinsurance Pool**: The pool provides insurance to individuals who have been turned down by private insurers. All Idaho insurance companies must provide high risk plans; the state reinsurance program covers losses past a certain point for a single event. In 2006, state expenditures for this program were **$2.4 million** (SHADAC, 2007a). Under the bill, the individuals covered in the high risk pool could obtain insurance through the exchange instead.

[26] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

- **County Governments**: Idaho's counties have traditionally been responsible for covering health care expenses for residents who have no other source of care, through the County Medical Indigency Program. In 2006, county expenditures under this program totaled **$16.1 million** (SHADAC, 2007a). These costs could be reduced substantially if the individuals using uncompensated care in Idaho were insured through the exchange.

- **The State Catastrophic Health Care Cost Program**: This program assists counties in covering uncompensated care costing more than $10,000 for a single incident. State expenditures under the Catastrophic Health Care Cost Program were **$20.4 million** in 2006 (SHADAC, 2007a). These costs could be reduced substantially if the individuals using uncompensated care in Idaho were insured through the exchange.

- **Hidden Tax**: Idaho's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[27] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Idaho because the state and its local governments help pay for health insurance for many of their 80,585 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Idaho and its local governments **$8.3 million** a year in the form of higher employee health insurance premiums.[28]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Idaho currently spends **$9.4 million** on CHIP coverage for children in families with incomes up to 185 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Idaho would see at least **$47 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

[27] Idaho hospitals incurred $42.7 million in uncompensated care costs in 2005 (SHADAC, 2007b).
[28] Based on calculation that 14.5 percent of Idaho's employment is in state and local government.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Idaho

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Idaho's non-elderly residents, broken down by poverty status and by age groups.

Table 1: Total Estimated Non-Elderly Population of Idaho					
	Poverty Status	**Uninsured**	**Private Insurance**	**Medicaid**	**Medicare, VA, or TRICARE**
Adults (19-64)	≥ 133% FPL	95,056	587,667	15,130	31,386
	< 133% FPL	55,028	35,292	21,431	11,484
Children (18 and under)	≥ 133% FPL	34,623	261,130	40,933	11,366
	< 133% FPL	21,617	23,733	43,678	7,995
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Idaho: 1,352.					

These estimates suggest that there are roughly 55,000 uninsured adults and 22,000 uninsured children in Idaho with family incomes below 133 percent of the FPL.

As the table also shows, the majority (63 percent) of the uninsured in Idaho have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Idaho would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Idaho from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Idaho with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion is approximately $258 million per year. With an FMAP of 90 percent, the cost to the state would be **$26 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Idaho					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	46,547	$217	$4,654	1,499,402	$26
Children (18 and under)	20,251	$41	$2,048		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Idaho

Table 3 shows the net impact for the Idaho state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. Moreover, these other savings would offset nearly 60 percent of the cost even if the current FMAP of 69.4 percent was used.[29]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Idaho ($ millions)

Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-79.0	-25.8	-0.0
Idaho Individual High Risk Reinsurance Pool	+2.4	+2.4	+2.4
County Governments	+16.1	+16.1	+16.1
Catastrophic Care Program	+20.4	+20.4	+20.4
Hidden Tax	+8.3	+8.3	+8.3
Net Effect for Idaho	-31.8	+21.4	+47.2

This table understates the benefits to the state of Idaho and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[29] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Idaho can expect to see from health insurance reform.

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INDIANA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Indiana and its local governments.

Indiana and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Indian and its local governments currently spend at least **$338 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Indiana's **220,939** low-income uninsured individuals would be $623 million (in 2007 dollars).[30] After initially sharing none of that cost, Indiana's share with a 90 percent FMAP would be **$62 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Indiana and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Indiana would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Indiana's private hospitals and other health care providers, which bear heavy costs for providing care to Indiana's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Indiana.

The following is a summary of *some* of the savings that Indiana and its local governments could expect from health insurance reform.

- **The Healthy Indiana Plan (HIP)**: This program covers individuals up to 200 percent of the FPL who are ineligible for Medicaid. The HIP program provides a high deductible health plan and a health savings account. HIP provides $500 in "first-dollar" preventive benefits. Members make monthly contributions to their health savings account based on income level (RWJF, 2009). Funding for HIP comes from $50 million in disproportionate share hospital (DSH) payments and through a 44 cent per pack tax on cigarettes. The money is allocated to a special fund that maintains reserves (State University of New York, 2009). In 2009, Indiana

[30] The estimated number of low-income uninsured individuals excludes undocumented immigrants, who would not be eligible for Medicaid as a result of health insurance reform.

allocated **$154.8 million** to the fund for HIP, of which $11 million is reserved for childhood immunization programs (Indiana Legislative Services Agency, 2007).

It is reasonable to assume that under health insurance reform Indiana would recover a substantial amount of what they currently spend on the HIP program. Under current reform proposals, individuals now enrolled in HIP with incomes below 133 percent of the FPL would become eligible for Medicaid, likely at no additional cost to the state. Individuals currently enrolled in HIP with incomes above 133 percent of the FPL would be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **The Indiana Comprehensive Health Insurance Association (ICHIA)**: The ICHIA, the state's high-risk pool, provides coverage for individuals who cannot obtain it through Medicaid or private insurers as well as to those who have federal eligibility through HIPAA or TAA. The program offers premium subsidies for those with incomes up to 350 percent of the FPL. The program is funded by premiums, state general funds and insurance carrier assessments (National Conference of State Legislatures, 2009). In 2008, the state spent **$15 million** on the program (Indiana Comprehensive Health Insurance Association, 2008). Indiana would save the costs of this program under health insurance reform, since the federal government would take responsibility for providing a larger, more efficient subsidized pool for low-income uninsured individuals in the form of a national health insurance exchange.

- **Tax Credit**: Indiana's tax credit incentive for businesses to offer health insurance provides the lesser of $50 per employee or $2,500 for two years if the employer establishes a Section 125 plan. In 2009, Indiana spent **$12.2 million** on this program (Indiana Legislative Services Agency, 2007). Indiana would much of the cost of this program under health insurance reform, since the federal government would take responsibility for offering small businesses tax credits as an incentive to offer health insurance to their employees.

- **Hospital Uncompensated Care for the Indigent Program (HCIP)**: HCIP is available to patients who receive emergency medical care and meet other program criteria. As of January 2009, funding for the HCIP predominantly comes from state funding streams (Community Catalyst, 2009). In 2009, the governor recommended allocating **$126 million** to the HCI fund in the FY 2010-11 state budget (Indiana State Budget Agency, 2009). Much of what Indiana currently allocates for hospital indigent care would be saved under health insurance reform. All individuals below 133 percent of the FPL would qualify for Medicaid and those above that threshold would be eligible to obtain subsidized insurance through the exchange, at no cost to the state.

- **Hidden Tax**: Indiana's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[31] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals

[31] Hospitals in Indiana incurred $342 million in uncompensated care costs in 2003 (U.S. Government Accountability Office, 2005).

with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Indiana because the state and its local governments help pay for health insurance for many of their 339,787 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Indiana and its local governments **$29.5 million** a year in the form of higher employee health insurance premiums.[32]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Indiana currently spends **$36.2 million** on CHIP coverage (Kaiser Family Foundation, 2009) for children in families with incomes up to 200 percent of the FPL (RWJF, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Indiana would see at least **$338 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Indiana

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Indiana's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 211,000 uninsured adults and 34,000 uninsured children in Indiana with family incomes below 133 percent of the FPL.

Table 1: Total Estimated Non-Elderly Population of Indiana

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	443,780	2,700,676	50,330	152,716
	< 133% FPL	210,607	113,573	117,548	45,474
Children (18 and under)	≥ 133% FPL	75,810	1,036,075	156,813	20,878
	< 133% FPL	33,777	76,753	258,794	14,217

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Indiana: 1,783.

As the table also shows, the majority (68 percent) of the uninsured in Indiana have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the

[32] Based on calculation that 13.4 percent of Indiana's employment is in state and local government.

exchange rather than through Medicaid. The state of Indiana would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Indiana from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Indiana with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion is approximately $623 million per year. With an FMAP of 90 percent, the cost to the state would be **$62 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Indiana

	Number of Legal Uninsured Below 133% FPL	Cost of Medicaid Expansion ($ millions)	Cost per New Enrollee	State Population	Cost to State with 90% FMAP ($ millions)
Adults (19-64)	189,296	$563	$2,974	6,345,389	$62
Children (18 and under)	31,643	$60	$1,898		

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.

D. Bottom Line for Indiana

Table 3 shows the net impact for the Indiana state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid expansion described above even if the current FMAP of 65.93 percent was used.[33]

[33] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Indiana can expect to see from health insurance reform.

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Indiana ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-212.3	-62.3	-0.0
Healthy Indiana Plan	+154.8	+154.8	+154.8
ICHIA	+15	+15	+15
Tax Credit	+12.2	+12.2	+12.2
HCIP	+126	+126	+126
Hidden Tax	+29.5	+29.5	+29.5
Net Effect for Indiana	+125.2	+275.2	+337.5

This table understates the benefits to the state of Indiana and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

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IOWA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Iowa and its local governments.

Iowa and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Iowa and its local governments currently spend at least **$45 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Iowa's **90,745** low-income uninsured individuals would be $200 million (in 2007 dollars).[34] After initially sharing none of that cost, Iowa's share with a 90 percent FMAP would be **$20 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Iowa and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Iowa would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Iowa's private hospitals and other health care providers, which bear heavy costs for providing care to Iowa's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Iowa.

The following is a summary of *some* of the savings that Iowa and its local governments could expect from health insurance reform.

- **IowaCare**: IowaCare is a Medicaid expansion program created with a Section 1115 waiver. The program provides a limited set of Medicaid benefits to uninsured adults ages 19 through 64 with incomes up to 200 percent of the FPL (RWJF, 2009). In 2010, it is estimated that state funding for IowaCare will total **$33.6 million** (Iowa Department of Human Services, 2009). It is reasonable to assume that under health insurance reform Iowa would recover a substantial amount of what they currently spend on the IowaCare program. For example, individuals currently enrolled in IowaCare with incomes above 133 percent of the FPL would

[34] The estimated number of low-income uninsured individuals excludes undocumented immigrants, who would not be eligible for Medicaid as a result of health insurance reform.

be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **Hidden Tax**: Iowa's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[35] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Iowa because the state and its local governments help pay for health insurance for many of their 182,356 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Iowa and its local governments **$11.2 million** a year in the form of higher employee health insurance premiums.[36]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Iowa currently spends **$20.2 million** on CHIP coverage (Kaiser Family Foundation, 2009) for children in families with incomes up to 300 percent of the FPL (RWJF, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Iowa would see at least **$45 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Iowa

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Iowa's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 95,000 uninsured adults and 11,000 uninsured children in Iowa with family incomes below 133 percent of the FPL.

[35] Iowa's hospitals incurred $465 million in uncompensated care costs in 2005 (Iowa Hospital Association, 2005).
[36] Based on calculation that 15.0 percent of Iowa's employment is in state and local government

Table 1: Total Estimated Non-Elderly Population of Iowa					
	Poverty Status	**Uninsured**	**Private Insurance**	**Medicaid**	**Medicare, VA, or TRICARE**
Adults (19-64)	≥ 133% FPL	141,802	1,340,990	49,661	70,152
	< 133% FPL	94,539	53,758	52,969	18,589
Children (18 and under)	≥ 133% FPL	17,191	475,417	92,127	13,025
	< 133% FPL	10,744	14,955	115,217	6,477
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Iowa: 2,202.					

As the table also shows, the majority (60 percent) of the uninsured in Iowa have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Iowa would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Iowa from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Iowa with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion is approximately $200 million per year. With an FMAP of 90 percent, the cost to the state would be **$20 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Iowa					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	81,075	$184	$2,264	2,988,046	$20
Children (18 and under)	9,670	$17	$1,736		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Iowa

Table 3 shows the net impact for the Iowa state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. As the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation.

Moreover, these other savings would offset more than 60 percent of the cost even if the current FMAP of 63.51 percent was used.[37]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Iowa ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-73.1	-20.0	-0.0
IowaCare	+33.6	+33.6	+33.6
Hidden Tax	+11.2	+11.2	+11.2
Net Effect for Iowa	-28.3	+24.8	+44.8

This table understates the benefits to the state of Iowa and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[37] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Iowa can expect to see from health insurance reform.

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MAINE

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Maine and its local governments.

The state government in Maine subsidizes individuals to obtain health insurance and provides direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL), which may increase state expenditures on this program.

Our findings, which we summarize below, indicate that Maine and its local governments currently spend at least **$51 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Maine's **24,322** low-income uninsured individuals would be $153 million (in 2007 dollars).[38] After initially sharing none of that cost, Maine's share with a 90 percent FMAP would be **$15 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Maine and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Maine would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Maine's private hospitals and other health care providers, which bear heavy costs for providing care to Maine's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Maine.

The following is a summary of *some* of the savings that Maine and its local governments could expect from health insurance reform.

- **Maine's Dirigo Health Agency**: Dirigo Health subsidizes health insurance for individuals who are self-employed, work in small businesses, are unemployed, work less than 20 hours per week for any particular employer, or are early retirees and whose incomes are less than 300 percent of the FPL. Dirigo had subsidy costs of **$41.5 million** and operating costs of **$2.8 million** in 2008. These state subsidies are funded by an assessment on health insurance and self-insured companies that operate in the state, and drawing on the state treasury's cash pool. In 2008, Dirigo was projected to draw $9.0 million from the state's cash pool, in addition to collecting earmarked assessments totaling $40.1 million to pay for subsidy and

[38] The estimated number of low-income uninsured individuals excludes undocumented immigrants, who would not be eligible for Medicaid as a result of health insurance reform.

operating expenses. Moreover, the state is trying to move to an alternative funding source to the assessment on health insurance companies, such as taxes on beer, wine, and soda. (Dirigo Health Agency, 2009). While some of the individuals insured by Dirigo may move to Medicaid under the bill, those with incomes of more than 133 percent of the FPL would receive federally-subsidized coverage in the exchange. The money that the state would save from the resulting decline in Dirigo Health subsidy and operating expenses would provide a sizeable offset to any additional Medicaid costs as the program would draw less spending from the state treasury's cash pool, and other sources of state funds.[39]

- **Municipalities**: Some of Maine's municipalities have programs that pay for health care for the uninsured. For example, the city of Portland pays **$1.4 million** a year to run a free clinic program (Portland Department of Health and Human Services, 2009). In addition, the Knox County Health Clinic was received funding from the Maine Department of Health and Human Services (Knox County Health Clinic, 2009). The Leavitt's Mill Free Health Center, located in Bar Mills, receives municipal support for its coverage of the uninsured (Leavitt's Mill Free Health Center, 2008). Additional coverage through Medicaid and through the exchange would reduce the need for locally financed programs such as these.

- **Hidden Tax**: Maine's hospitals also shoulder much of the burden of the state's uncompensated care. All Maine hospitals must provide free care to uninsured individuals with incomes of less than 150 percent of the FPL, and many provide care to individuals with higher incomes.[40] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Maine because the state and its local governments help pay for health insurance for many of their 76,382 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Maine and its local governments **$5.1 million** a year in the form of higher employee health insurance premiums.[41]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Maine currently spends **$11.5 million** on CHIP coverage for children in families with incomes up to 200 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to

[39] There are also many privately financed charity care programs. For example, CarePartners provides free medical care to uninsured individuals with incomes of less than 175 percent of the federal poverty line in Cumberland, Kennebec, and Lincoln counties, and the Franklin Health Access Project provides free medical care to uninsured individuals living in Franklin County, Livermore, Livermore Falls, and Vienna.

[40] Recent data indicate that hospitals and other health care providers in Maine incurred $138 million in uncompensated care costs in 2005. (Maine Health Access Foundation, 2007).

[41] Based on calculation that 13.0 percent of Maine's employment is in state and local government.

equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

According to one recent study of Maine's health care system, "large numbers of uninsured persons and their inevitable need to receive health care has resulted in a complex mosaic of government programs and private initiatives (Maine Health Access Foundation, 2007)."

The discussion above has highlighted some of the most important examples of this, though the list is not intended to be comprehensive. Instead, it clearly demonstrates that the state of Maine and its local governments would realize substantial savings from health insurance reform that would more than offset the costs of the Medicaid expansion to the state government as shown in the following table. Added together, we estimate that Maine would see at least **$51 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Maine

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Maine's non-elderly residents during the 2007 calendar year, broken down by poverty status and by age groups. These estimates suggest that there are roughly 23,000 uninsured adults and 1,500 uninsured children in Maine with family incomes below 133 percent of the federal poverty line.

Table 1: Total Estimated Non-Elderly Population of Maine

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	72,426	511,964	44,934	59,761
	< 133% FPL	23,051	23,667	53,834	11,858
Children (18 and under)	≥ 133% FPL	12,412	161,790	46,261	11,515
	< 133% FPL	1,530	7,689	56,146	2,661

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Maine: 2,087.

As the table also shows, the vast majority (78 percent) of the uninsured in Maine have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Maine would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Maine from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Maine with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion would be approximately $153 million per year. With an FMAP of 90 percent, the cost to the state would be $15 million. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Maine					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	22,792	$145	$6,352	1,317,207	$15
Children (18 and under)	1,530	$8	$5,075		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Maine

Table 3 shows the net impact for the Maine state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. As the following table shows, those savings would offset more than 95 percent of the cost of the Medicaid expansion described above even if the current FMAP of 64.99 percent was used.[42]

Table 3: The Impact of Health Insurance Reform on State and Local Governments in Maine ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-53.4	-15.3	-0.0
Dirigo Health	+44.3	+44.3	+44.3
Portland Free Clinics	+1.4	+1.4	+1.4
Hidden Tax	+5.1	+5.1	+5.1
Net Effect for Maine	-2.6	+35.5	+50.8

This table understates the benefits to the state of Maine and its local governments for a number of reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[42] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Maine can expect to see from health insurance reform.

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MICHIGAN

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Michigan and its local governments.

Michigan and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Michigan and its local governments currently spend at least **$212 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Michigan's **291,180** low-income uninsured individuals would be $681 million (in 2007 dollars).[43] After initially sharing none of that cost, Michigan's share with a 90 percent FMAP would be **$68 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Michigan and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Michigan would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Michigan's private hospitals and other health care providers, which bear heavy costs for providing care to Michigan's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Michigan.

The following is a summary of *some* of the savings that Michigan and its local governments could expect from health insurance reform.

Michigan County Health Plans

Much of Michigan's indigent care is provided through County Health Plans. These programs, which operate in 72 of Michigan's 83 counties, provide access to organized systems of health care for approximately 150,000 indigent uninsured and low income state residents (Michigan County Health Plan Association, 2009). Some County Health Plans, such as the Medical Access Program, which is administered by the Medical Care Access Coalition for all 15 counties in the Upper Peninsula, cover wide geographic areas. Others operate in only one county. Where they

[43] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

exist, County Health Plans oversee both state and local indigent care programs. These programs are referred to as Plan A, Plan B, and Plan C (Health Management Associates, 2005).

- **Plan A**: The Adult Medical Program (AMP) provides basic medical care to childless adults below 35 percent of the FPL who do not qualify for Medicaid. The program is limited in that it excludes inpatient coverage, but it does provide pharmaceutical benefits. Areas with County Health Plans provide AMP coverage through those programs, while in other areas benefits are provided through fee for service (Michigan Department of Community Health, 2009). The coverage is funded by state general funds and an increased utilization of Michigan's CHIP allocation to cover uninsured childless adults. Enrollment in this program is currently capped at 62,000, and as a result of the cap, enrollment has been closed much of the time since July 1, 2004 (Michigan League for Human Services, 2009). In 2008, the state spent **$30.8 million** on the program, while local governments spent **$6.7 million**. Starting on October 1, 2009, the program would include a hospital benefit at an additional estimated cost of $23,673,400 to the state (Michigan House Fiscal Agency, 2009b).

  While Michigan may not recover a substantial amount of what it currently spends on the AMP program under health insurance reform, the state and its low-income residents still stand to gain. Under reform, AMP beneficiaries would become eligible for Medicaid. Since the federal government matches state Medicaid spending, Michigan may end up spending less to provide care to current AMP beneficiaries through the Medicaid program than they spent to provide a more limited benefit under AMP.

- **Plan B**: Plan B programs provide basic medical care to uninsured adults up to 200 percent of the FPL who are not eligible for Medicaid or other public programs. Each County Health Plan administers its own program, so health benefits and eligibility specifics are determined locally. There are currently 49 counties in Michigan with Plan B programs, and as of December 2005, estimated enrollment was between 50,000 to 52,000 Michigan residents. Due to both budget constraints as well as unprecedented demand, many Plan B programs have stopped accepting new enrollees. Plan B programs are funded from special Medicaid DSH payments that are comprised of state, local, and federal dollars (Michigan Department of Community Health, 2006). In 2008, Michigan appropriated **$88.5 million** for the three-share program (see below) and county indigent care in general, which includes Plan B programs (Michigan House Fiscal Agency, 2009a). However, due to the mechanism by which Plan B programs are funded, it is difficult to estimate the exact proportion of this number which is actually state and local general fund spending, and which is federal Medicaid DSH payment program pass-throughs.

  It is reasonable to assume that under health insurance reform Michigan would recover a substantial amount of what it currently spends on Plan B programs. Under current reform proposals, individuals now enrolled in Plan B plans with incomes below 133 percent of the FPL would become eligible for Medicaid, likely at no additional cost to the state. Individuals currently enrolled in Plan B plans with incomes above 133 percent of the FPL would be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **Plan C**: Third-Share Programs are comprehensive insurance programs for low-income employees of small employers. Under a third-share program, the employee, his or her employer, and community funding share the premium in three equal or similar parts. Third-share programs are administered by County Health Plans, and thus employer and employee eligibility for the program is determined locally. As of 2006, approximately 5,000 individuals were enrolled in a Third-Share program in Michigan (Health Management Associates, 2005). Like Plan B programs, Third-Share programs are largely funded by federal Medicaid DSH funds. Counties transfer employer contributions to the state, which it then considers a DSH payment to county hospitals, thereby qualifying the funds for a federal match. The money is then used to fund the counties' share of the program (Fronstin and Lee, 2005). In 2008, Michigan appropriated **$88.5 million** for the three-share program and county indigent care in general. However, as discussed above, it is difficult to estimate the exact proportion of this number which is actually state and local general fund spending, and which is federal Medicaid DSH payment program pass-throughs.

  It is reasonable to assume that under health insurance reform Michigan would recover a substantial amount of what it currently spends on Third-Share programs. There would be no need for local governments to offer incentives for small businesses to offer health insurance to their employees, since under reform small businesses would receive federal tax credits for offering insurance. Furthermore, under current reform proposals, individuals now enrolled in Third-Share plans with incomes below 133 percent of the FPL would become eligible for Medicaid, likely at no additional cost to the state. Individuals currently enrolled in Third-Share plans with incomes above 133 percent of the FPL would be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **Maternity Outpatient Medical Services (MOMS)**: MOMS provides pregnancy-related services to women up to 185 percent of the FPL who are pregnant or were recently pregnant and do not qualify for Medicaid or whose Medicaid application is pending (Michigan Surgeon General, 2009). State funding for this program was **$1.6 million** in FY 2008-09 (Michigan House Fiscal Agency, 2008). It is reasonable to assume that under health insurance reform Michigan would recover a substantial amount of what it currently spends on the MOMS program. Under current reform proposals, individuals now enrolled in MOMS with incomes below 133 percent of the FPL would become eligible for Medicaid, likely at no additional cost to the state. Individuals currently enrolled in MOMS with incomes above 133 percent of the FPL would be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **Local Health Administration and Grants**: In Michigan the costs of providing safety net care are shared between the state and local governments (Michigan Department of Community Health, 2006). In 2008, state appropriations for local public health departments for state-local cost-shared public health services totaled **$35.7 million**. Local spending was **$5.1 million** (Michigan House Fiscal Agency, 2009a). Much of what Michigan currently spends on safety net care through local health departments would be saved under health insurance reform. All individuals below 133 percent of the FPL would qualify for Medicaid

and those above that threshold would be eligible to obtain subsidized insurance through the exchange, at no cost to the state.

- **Hidden Tax**: Michigan's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[44] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Michigan because the state and its local governments help pay for health insurance for many of their 493,466 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Michigan and its local governments **$43.5 million** a year in the form of higher employee health insurance premiums.[45]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Michigan currently spends **$71.9 million** on CHIP coverage for children in families with incomes up to 200 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Michigan would see at least **$212 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Michigan

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Michigan's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 269,000 uninsured adults and 37,000 uninsured children in Michigan with family incomes below 133 percent of the FPL.

[44] Michigan hospitals incurred more than $2 billion in uncompensated care costs in 2007 (Michigan Health and Hospital Association, 2009).
[45] Based on calculation that 13.7 percent of Michigan's employment is in state and local government.

Table 1: Total Estimated Non-Elderly Population of Michigan					
	Poverty Status	**Uninsured**	**Private Insurance**	**Medicaid**	**Medicare, VA, or TRICARE**
Adults (19-64)	≥ 133% FPL	658,523	4,106,360	156,123	290,620
	< 133% FPL	268,954	190,277	249,642	93,935
Children (18 and under)	≥ 133% FPL	106,549	1,535,117	261,738	55,006
	< 133% FPL	37,124	118,898	420,360	16,947
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Michigan: 2,723.					

As the table also shows, the vast majority (71 percent) of the uninsured in Michigan have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Michigan would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Michigan from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Michigan with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion would be approximately $681 million per year. With an FMAP of 90 percent, the cost to the state would be **$68 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Michigan					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	255,356	$629	$2,463	10,071,822	$68
Children (18 and under)	35,824	$52	$1,458		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Michigan

Table 3 shows the net impact for the Michigan state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. As shown in the table, the savings would much more than offset the cost if a 90 percent FMAP was

in effect and would offset nearly 85 percent of the cost even if the current FMAP of 63.19 percent was used.[46]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Michigan ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-250.7	-68.1	-0.0
Plan A	+37.5	+37.5	+37.5
Plan B, Plan C and Indigent care	+88.5	+88.5	+88.5
MOMS	+1.6	+1.6	+1.6
Local Health Admin and Grants	+40.8	+40.8	+40.8
Hidden Tax	+43.5	+43.5	+43.5
Net Effect for Michigan	-38.8	+143.8	+211.9

This table understates the benefits to the state of Michigan and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[46] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Michigan can expect to see from health insurance reform.

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MINNESOTA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Minnesota and its local governments.

Minnesota and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Minnesota and its local governments currently spend at least **$295 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Minnesota's **91,627** low-income uninsured individuals would be $317 million (in 2007 dollars).[47] After initially sharing none of that cost, Minnesota's share with a 90 percent FMAP would be **$32 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Minnesota and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Minnesota would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Minnesota's private hospitals and other health care providers, which bear heavy costs for providing care to Minnesota's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Minnesota. The following is a summary of *some* of the savings that Minnesota and its local governments could expect from health insurance reform.

- **General Assistance Medical Care (GAMC)**: GAMC is a state-funded program which covers adults who are not eligible for federal programs. Full medical benefits are provided for individuals at or below 75 percent of the FPL, while limited hospital coverage is provided to those at or below 175 percent of the FPL. All enrollees must pay co-pays, and individuals with incomes above 175 percent of the FPL have a $1,000 hospital deductible (Minnesota Department of Human Services, 2009). In fiscal year 2007, the state spent **$281 million** in payments to health care providers for GAMC services (Minnesota House of Representatives, 2008). It is reasonable to assume that under health insurance reform Minnesota would recover a substantial amount of what they currently spend on the GAMC program. Under

[47] The estimated number of low-income uninsured individuals excludes undocumented immigrants, who would not be eligible for Medicaid as a result of health insurance reform.

current reform proposals, individuals now enrolled in GAMC with incomes below 133 percent of the FPL would become eligible for Medicaid, likely at no additional cost to the state. Individuals currently enrolled in GAMC with incomes above 133 percent of the FPL would be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **Hidden Tax:** Minnesota's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[48] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Minnesota because the state and its local governments help pay for health insurance for many of their 280,783 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Minnesota and its local governments **$13.6 million** a year in the form of higher employee health insurance premiums.[49]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Minnesota currently spends **$38.4 million** on CHIP coverage (Kaiser Family Foundation, 2009) for children in families with incomes up to 275 percent of the FPL (National Conference of State Legislatures, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Minnesota would see at least **$295 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Minnesota

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Minnesota's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 91,000 uninsured adults and 29,000 uninsured children in Minnesota with family incomes below 133 percent of the FPL.

[48] Hospitals in Minnesota incurred $244 million in uncompensated care costs in 2007 (State Health Access Data Assistance Center, 2009).
[49] Based on calculation that 13.5 percent of Minnesota's employment is in state and local government.

Table 1: Total Estimated Non-Elderly Population of Minnesota					
	Poverty Status	**Uninsured**	**Private Insurance**	**Medicaid**	**Medicare, VA, or TRICARE**
Adults (19-64)	≥ 133% FPL	220,025	2,409,884	127,643	121,670
	< 133% FPL	91,037	103,563	119,101	41,019
Children (18 and under)	≥ 133% FPL	38,269	897,050	126,871	18,807
	< 133% FPL	28,801	52,639	150,831	10,087
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Minnesota: 2751.					

As the table also shows, the majority (68 percent) of the uninsured in Minnesota have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Minnesota would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Minnesota from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Minnesota with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion is approximately $317 million per year. With an FMAP of 90 percent, the cost to the state would be **$32 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Minnesota					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	70,447	$252	$3,582	5,197,621	$32
Children (18 and under)	21,180	$65	$3,057		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Minnesota

Table 3 shows the net impact for the Minnesota state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid expansion described above even if the current FMAP of 50 percent was used.[50]

[50] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Minnesota ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-158.5	-31.7	-0.0
GAMC	+281	+281	+281
Hidden Tax	+13.6	+13.6	+13.6
Net Effect for Minnesota	+136.1	+262.9	+294.6

This table understates the benefits to the state of Minnesota and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Minnesota can expect to see from health insurance reform.

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MONTANA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Montana and its local governments.

Montana and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Montana and its local governments currently spend at least **$30 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Montana's **56,790** low-income uninsured individuals would be $208 million (in 2007 dollars).[51] After initially sharing none of that cost, Montana's share with a 90 percent FMAP would be **$21 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Montana and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Montana would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Montana's private hospitals and other health care providers, which bear heavy costs for providing care to Montana's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Montana.

The following is a summary of *some* of the savings that Montana and its local governments could expect from health insurance reform.

- **The Montana Comprehensive Health Association (MCHA)**: MCHA offers policies to individuals who cannot obtain insurance due to medical conditions. There is a limited-enrollment premium assistance program for low income individuals. The program is funded through state funds from Tobacco Settlement monies and by assessments on insurance companies operating in Montana. In FY 2007-2008, state funding was **$960,000**, while assessments totaled $7.4 million (Montana Comprehensive Health Association, 2008). Under the proposed legislation, many of the individuals insured through the high risk pool would be

[51] The estimated number of low-income uninsured individuals excludes undocumented immigrants, who would not be eligible for Medicaid as a result of health insurance reform.

able to obtain insurance through the exchange. This would provide some offsetting cost savings for the state of Montana.

- **The Insure Montana Purchasing Pool**: The pool provides premium assistance aimed at encouraging small businesses to provide health insurance for their employees. For qualified businesses with 2-9 employees, the program subsidizes both the employer's and employee's portion of the monthly premium for a policy in the pool. Enrollment in the pool is currently capped due to funding constraints (Montana State Auditor's Office, 2009a). In 2007, the Montana state legislature allocated **$13.1 million** in tobacco tax revenue to fund this program (Montana Legislative Fiscal Division, 2008). Under health insurance reform, the cost of the purchasing pool would be saved.

- **Small Business Tax Credit:** The Insure Montana Tax Credit provides a tax credit to small businesses that provide health insurance to their employers through private insurance. The number of businesses that can receive this credit is capped due to funding constraints (Montana State Auditor's Office, 2009b). In 2007, the Montana state legislature allocated **$8.7 million** in tobacco tax revenue to fund this program (Montana Legislative Fiscal Division, 2008). Under health insurance reform, the cost of the tax credit would be saved, since there would be a national small business tax credit.

- **Hidden Tax:** Montana's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[52] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Montana because the state and its local governments help pay for health insurance for many of their 55,982 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Montana and its local governments **$7.0 million** a year in the form of higher employee health insurance premiums.[53]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Montana currently spends **$7.0 million** on CHIP coverage for children in families with incomes up to 175 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

[52] Montana's hospitals incurred $43.7 million in uncompensated care costs in 2008 (Montana Office of Consumer Protection, 2008).
[53] Based on calculation that 14.8 percent of Montana's employment is in state and local government.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Montana would see at least **$30 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Montana

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Montana's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 44,000 uninsured adults and 13,000 uninsured children in Montana with family incomes below 133 percent of the FPL.

Table 1: Total Estimated Non-Elderly Population of Montana

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	76,373	358,505	7,861	37,361
	< 133% FPL	43,756	27,658	25,008	18,520
Children (18 and under)	≥ 133% FPL	20,811	105,834	22,019	1,861
	< 133% FPL	13,034	8,292	46,353	6,207

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Montana: 1,111.

As the table also shows, the majority (63 percent) of the uninsured in Montana have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Montana would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Montana from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Montana with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion is approximately $208 million per year. With an FMAP of 90 percent, the cost to the state would be **$21 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Montana					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	42,992	$177	$4,124	957,861	$21
Children (18 and under)	13,034	$31	$2,368		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Montana

Table 3 shows the net impact for the Montana state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care, which would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. Moreover, these savings would offset nearly half of the cost even if the current FMAP of 67.42 percent was used.[54]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Montana ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-67.8	-20.8	-0.0
MCHA	+1.0	+1.0	+1.0
Insure Montana Purchasing Pool	+13.1	+13.1	+13.1
Small Business Tax Credit	+8.7	+8.7	+8.7
Hidden Tax	+7.0	+7.0	+7.0
Net Effect for Montana	-38.0	+9.0	+29.8

This table understates the benefits to the state of Montana and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[54] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Montana can expect to see from health insurance reform.

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NEBRASKA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Nebraska and its local governments.

Nebraska and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Nebraska and its local governments currently spend at least **$36 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Nebraska's **55,345** low-income uninsured individuals would be $178 million (in 2007 dollars).[55] After initially sharing none of that cost, Nebraska's share with a 90 percent FMAP would be **$18 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Nebraska and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Nebraska would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Nebraska's private hospitals and other health care providers, which bear heavy costs for providing care to Nebraska's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Nebraska.

The following is a summary of *some* of the savings that Nebraska and its local governments could expect from health insurance reform.

- **Nebraska's Comprehensive Health Insurance Pool**: The pool provides health insurance coverage for high risk individuals that have been turned down for private coverage (National Conference of State Legislatures, 2009). The program is funded partially through premiums and cost **$27 million** in 2008 (Nebraska Comprehensive Health Insurance Pool, 2008). Under the health insurance reform bill, the individuals insured in the high risk pool could be insured through the exchange, and Nebraska would no longer have to fund the pool. These cost savings would provide a moderate offset against the additional Medicaid costs.

[55] The estimated number of low-income uninsured individuals excludes undocumented immigrants, who would not be eligible for Medicaid as a result of health insurance reform.

- **Hidden Tax:** Nebraska's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care. Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Nebraska because the state and its local governments help pay for health insurance for many of their 113,600 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Nebraska and its local governments **$8.6 million** a year in the form of higher employee health insurance premiums.[56]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Nebraska currently spends **$14.8 million** on CHIP coverage (Kaiser Family Foundation, 2009) for children in families with incomes up to 200 percent of the FPL (National Conference of State Legislatures, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Nebraska would see at least **$36 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Nebraska

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Nebraska's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 52,000 uninsured adults and 15,000 uninsured children in Nebraska with family incomes below 133 percent of the FPL.

[56] Based on calculation that 15.2 percent of Nebraska's employment is in state and local government.

Table 1: Total Estimated Non-Elderly Population of Nebraska					
	Poverty Status	**Uninsured**	**Private Insurance**	**Medicaid**	**Medicare, VA, or TRICARE**
Adults (19-64)	≥ 133% FPL	118,018	757,477	10,945	56,271
	< 133% FPL	52,049	48,384	29,602	11,411
Children (18 and under)	≥ 133% FPL	21,670	296,418	48,339	9,832
	< 133% FPL	15,062	27,236	49,485	741
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in CPS for Nebraska: 1,730.					

As the table also shows, the majority (68 percent) of the uninsured in Nebraska have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Nebraska would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Nebraska from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Nebraska with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion is approximately $178 million per year. With an FMAP of 90 percent, the cost to the state would be **$18 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Nebraska					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	42,694	$149	$3,489	1,774,571	$18
Children (18 and under)	12,651	$29	$2,261		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Nebraska

Table 3 shows the net impact for the Nebraska state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft

legislation. Moreover, these other savings would offset half of the cost even if the current FMAP of 60.56 percent was used.[57]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Nebraska ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-70.0	-17.8	-0.0
Comprehensive HI Pool	+27	+27	+27
Hidden Tax	+8.6	+8.6	+8.6
Net Effect for Nebraska	-34.4	+17.8	+35.6

This table understates the benefits to the state of Nebraska and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[57]CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Nebraska can expect to see from health insurance reform.

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NORTH CAROLINA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of North Carolina and its local governments.

North Carolina and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that North Carolina and its local governments currently spend at least **$209 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to North Carolina's **547,747** low-income uninsured individuals would be $1.88 billion (in 2007 dollars).[58] After initially sharing none of that cost, North Carolina's share with a 90 percent FMAP would be **$188 million**. Thus health insurance reform would provide a substantial financial benefit to the state of North Carolina and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of North Carolina would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for North Carolina's private hospitals and other health care providers, which bear heavy costs for providing care to North Carolina's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in North Carolina. The following is a summary of *some* of the savings that North Carolina and its local governments could expect from health insurance reform.

- **NC HealthNet**: This program builds upon existing county indigent care programs, using state funding to coordinate free and low-cost health care services and indigent care programs. For 2009, the state allocated **$2.8 million** recurring and **$0.95 million** non-recurring funds to sustain indigent care networks and support new collaborations through HealthNet (North Carolina Institute of Medicine, 2008). Much of what North Carolina currently allocates for indigent care would be saved under health insurance reform. All individuals below 133 percent of the FPL would qualify for Medicaid and those above that threshold would be eligible to obtain subsidized insurance through the exchange, at no cost to the state.

[58] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

- **Medication Assistance Program**: This program assists indigent individuals in obtaining access to the pharmaceutical manufacturers' free drug program. In 2009, the state appropriated **$2.7 million** to this program (North Carolina Office of State Budget and Management, 2009a). The state would likely save most of the costs of this program, since indigent individuals would obtain prescriptions either through the expanded Medicaid program, or through subsidized insurance in the national exchange.

- **Inclusive Health [also known as North Carolina Health Insurance Risk Pool (NCHIRP)]**: The state's high-risk pool offers coverage to individuals with a qualifying medical condition, those who have been denied coverage, offered coverage with restrictions, offered coverage at higher rates than the Inclusive Health rate, or have federal eligibility under HIPAA or TAA (National Conference of State Legislatures, 2009). Benefits are similar to those available in the non-group market, and have annual deductibles starting at $1,000 and a lifetime maximum of $1,000,000. Premiums are set at 175 percent of the average premium that a person with a standard health risk would pay for similar coverage. Premiums vary by age, gender, and smoker status (North Carolina Institute of Medicine, 2009). Inclusive Health is funded both by premiums and state funding sources. In 2008, Inclusive Health received **$22.9 million** from the state in the form of grants and revenue from premium taxes (North Carolina Health Insurance Risk Pool, 2008). North Carolina would save the costs of this program under health insurance reform, since the federal government would take responsibility for providing a larger, more efficient subsidized pool for low-income uninsured individuals in the form of a national health insurance exchange.

- **Area Health Education Centers (AHEC) Program**: The AHEC program works to meet the state's health and health workforce needs by providing educational programs for healthcare professionals in partnership with academic institutions, health care agencies, and other organizations. As part of this mission, AHEC supports residency programs in family medicine, rural family medicine, internal medicine, obstetrics/gynecology, pediatrics, and surgery. These residency programs provide a significant amount of services to the uninsured. In 2003-2004, AHEC residency programs provided outpatient services to an estimated 35,427 uninsured patients (North Carolina Institute of Medicine, 2005). The 2009 state budget allocates **$50.3 million** for this program (North Carolina Office of State Budget and Management, 2009b). The state may save some of the costs of this program under health insurance reform, since there would be less of a demand for indigent care from these residency programs.

- **County Indigent Care Spending**: Several counties in North Carolina appropriate funds for indigent care. In 2009, Charlotte-Mecklenburg County appropriated **$20.5 million** for indigent care (Charlotte-Mecklenburg County North Carolina, 2009). Additionally, in FY 2006-07 Beaufort County spent **$1.6 million** funding care for the indigent through the Medically Indigent Assistant Act as well as Beaufort-Jasper Comprehensive Health, a provider for the underserved in South Carolina (Beaufort County North Carolina, 2006).

- **Project Access**: The program is a partnership between county government, county physicians, county service agencies, hospitals and pharmacists, though which physicians provide care to individuals free of charge. Buncombe County appropriated **$420,000** to the

program in 2005, while Durham County appropriated **$451,000** in 2008 (Buncombe County North Carolina, 2005) (Durham County North Carolina, 2008).

- **Hospital Indigent Care**: State and local governments in North Carolina provide funding for indigent care at hospitals. The University of North Carolina (UNC) health care system provides substantial levels of primary care and other vital clinical services to the uninsured. In 2008, the state allocated **$47.4 million** to the UNC health care system to help cover operating expenses, including those associated with indigent care services (University of North Carolina Health Care System, 2008). In addition, Beaufort County allocated **$635,000** in FY 2006-07 to Beaufort Memorial Hospital (Beaufort County North Carolina, 2006). Much of what North Carolina currently allocates for indigent care provided by the UNC health care system would be saved under health insurance reform. All individuals below 133 percent of the FPL would qualify for Medicaid and those above that threshold would be eligible to obtain subsidized health insurance through the exchange, at no cost to the state.

- **Hidden Tax**: North Carolina's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[59] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to North Carolina because the state and its local governments help pay for health insurance for many of their 542,180 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of North Carolina and its local governments **$58.6 million** a year in the form of higher employee health insurance premiums.[60]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of North Carolina currently spends **$89.8 million** on CHIP coverage for children in families with incomes up to 200 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that North Carolina would see at

[59] North Carolina's hospitals incurred $850 million in uncompensated care costs in 2007 (North Carolina Institute of Medicine, 2009).
[60] Based on calculation that 15.2 percent of North Carolina's employment is in state and local government.

least **$209 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of North Carolina

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of North Carolina's non-elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 473,000 uninsured adults and 191,000 uninsured children in North Carolina with family incomes below 133 percent of the FPL.

As the table also shows, the majority (55 percent) of the uninsured in North Carolina have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of North Carolina would not be responsible for any of the financing for this group.

Table 1: Total Estimated Non-Elderly Population of North Carolina

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	658,987	3,199,308	119,298	323,583
	< 133% FPL	472,858	300,827	207,156	133,161
Children (18 and under)	≥ 133% FPL	167,875	1,199,882	207,762	99,644
	< 133% FPL	191,029	139,767	383,813	17,056

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for North Carolina: 2,243.

C. Estimated Costs to the State of North Carolina from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in North Carolina with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest the total cost of this expansion is approximately $1883 million per year. With an FMAP of 90 percent, the cost to the state would be **$188 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of North Carolina					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	385,447	$1,476	$3,829	9,061,032	$188
Children (18 and under)	162,300	$408	$2,512		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for North Carolina

Table 3 shows the net impact for the North Carolina state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. Moreover, these other savings would offset almost one-third of the cost even if the current FMAP of 65.13 percent was used.[61]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in North Carolina ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-656.8	-188.3	-0.0
NC HealthNet	+3.8	+3.8	+3.8
Medication Assistance	+2.7	+2.7	+2.7
NCHIRP	+22.9	+22.9	+22.9
AHEC	+50.3	+50.3	+50.3
County Indigent Care	+22.1	+22.1	+22.1
Project Access	+0.9	+0.9	+0.9
Hospital Indigent Care	+48.0	+48.0	+48.0
Hidden Tax	+58.6	+58.6	+58.6
Net Effect for North Carolina	-447.5	+21.0	+209.3

This table understates the benefits to the state of North Carolina and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not

[61] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings North Carolina can expect to see from health insurance reform.

include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

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OREGON

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Oregon and its local governments.

Oregon and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Oregon and its local governments currently spend at least **$138 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Oregon's **174,531** low-income uninsured individuals would be $593 million (in 2007 dollars).[62] After initially sharing none of that cost, Oregon's share with a 90 percent FMAP would be **$59 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Oregon and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Oregon would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Oregon's private hospitals and other health care providers, which bear heavy costs for providing care to Oregon's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Oregon. The following is a summary of *some* of the savings that Oregon and its local governments could expect from health insurance reform.

In addition to the portion of the costs that would be covered by the federal government, Oregon's state government and local governments would see large offsetting cost savings from state insurance programs and local spending on health care.

- **The Family Health Insurance Assistance Program (FHIAP)**: This program provides subsidies for adults and children up to 185 percent of the FPL to buy insurance in the private market (National Conference of State Legislatures, 2009). Enrollment in the program is severely limited; only 6,356 individuals are currently in the program, while 64,638 individuals are on the waiting list (Oregon Office of Private Health Partnerships, 2009b). The

[62] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

subsidies are funded through general funds, and taxes on health providers (such as hospitals). Funding for the program, excluding federal funds, is currently about **$24 million** per year (Oregon Office of Private Health Partnerships, 2009a). Under the proposed legislation, the individuals in this program could obtain coverage through Medicaid or subsidized coverage through the exchange. The state would see offsetting cost savings from the latter group. In addition, the exchange would provide subsidized coverage to many of the over 60,000 individuals on the waiting list for this program, at no extra cost to the state.

- **The Oregon Medical Insurance Pool**: The pool provides health insurance for individuals who have been denied private health insurance or who have moved jobs and lack portability of coverage. The pool is funded by premiums and assessments on insurers operating in the state of Oregon (Oregon Department of Consumer and Business Services, 2009). In 2008, these assessments amounted to **$79 million** (Oregon Department of Consumer and Business Services, 2008). Under the proposed legislation, the individuals in the pool could obtain insurance through the exchange; in many cases, the insurance would be subsidized. This would result in sizeable offsetting cost savings to the state of Oregon.

- **Health Districts**: Oregon Health Districts provide funding for local clinics and hospitals in Oregon. There are 25 health districts in the state. In FY2006-2007, these districts collected **$13 million** in tax revenues (McGinnis et al., 2007). Reducing the number of patients without insurance is likely to have large savings for these local health districts, providing moderate offsetting cost savings for the state of Oregon.

- **Hidden Tax:** Oregon's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[63] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Oregon because the state and its local governments help pay for health insurance for many of their 190,197 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Oregon and its local governments **$22.3 million** a year in the form of higher employee health insurance premiums.[64]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Oregon currently spends **$25 million** on CHIP coverage for children in families with incomes up to 185 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net

[63] Oregon's hospitals incurred $722 million in uncompensated care costs in 2006 (Office for Oregon Health Policy and Research).
[64] Based on calculation that 13.6 percent of Oregon's employment is in state and local government.

state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Oregon would see at least **$138 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Oregon

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Oregon's non-elderly residents, broken down by poverty status and by age groups.[65] These estimates suggest that there are roughly 169,000 uninsured adults and 60,000 uninsured children in Oregon with family incomes below 133 percent of the FPL.

Table 1: Total Estimated Non-Elderly Population of Oregon

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	344,672	1,496,088	65,624	77,988
	< 133% FPL	168,512	96,179	85,309	31,713
Children (18 and under)	≥ 133% FPL	74,055	514,424	98,941	13,260
	< 133% FPL	59,827	45,183	90,887	0

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Oregon: 1,592.

As the table also shows, the majority (65 percent) of the uninsured in Oregon have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Oregon would not be responsible for any of the financing for this group.

C. Estimated Costs to the State of Oregon from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Oregon with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion is approximately $593 million per year. With an FMAP of 90 percent, the cost to the state would be **$59 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

[65] This table indicates that there were 0 children in Oregon with incomes of less than 133 percent of poverty in the Medicare, VA, or TRICARE category. This presumably reflects sampling error, whereby there were no children in the March 2008 CPS sample selected from Oregon with these characteristics.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Oregon					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	123,570	$504	$4,076	3,747,455	$59
Children (18 and under)	50,961	$90	$1,762		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Oregon

Table 3 shows the net impact for the Oregon state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. Moreover, these other savings would offset more than 60 percent of the cost even if the current FMAP of 62.74 percent was used.[66]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Oregon ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-221.1	-59.3	-0.0
FHIAP	+24	+24	+24
Medical Insurance Pool	+79	+79	+79
Health Districts	+13	+13	+13
Hidden Tax	+22.3	+22.3	+22.3
Net Effect for Oregon	-82.8	+79.0	+138.3

This table understates the benefits to the state of Oregon and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[66]CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Oregon can expect to see from health insurance reform.

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PENNSYLVANIA

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Pennsylvania and its local governments.

Pennsylvania and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Pennsylvania and its local governments currently spend at least **$215 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Pennsylvania's **422,659** low-income uninsured individuals would be $1.50 billion (in 2007 dollars).[67] After initially sharing none of that cost, Pennsylvania's share with a 90 percent FMAP would be **$150 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Pennsylvania and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Pennsylvania would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Pennsylvania's private hospitals and other health care providers, which bear heavy costs for providing care to Pennsylvania's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Pennsylvania.

The following is a summary of *some* of the savings that Pennsylvania and its local governments could expect from health insurance reform.

- **adultBasic**: This program provides subsidized basic health insurance coverage to uninsured legal resident adults with incomes up to 200 percent of the FPL. Although coverage is subsidized, there are premium and co-payment requirements for the program. adultBasic is funded partially through proceeds from the state's tobacco settlement, as well as a funding agreement with charitable Blue Cross/Blue Shield health insurers. In 2008, the program cost **$171.8 million** (Pennsylvania Insurance Department, 2008). Due to budget constraints, the program is limited in size. Enrollees can purchase unsubsidized coverage through the program while on the wait list for subsidized coverage (National Conference of State

[67] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

Legislatures, 2009). Currently, over 44,000 individuals are enrolled in the program, and there are an additional 289,000 on the wait list (Pennsylvania Insurance Department, 2009). It is reasonable to assume that under health insurance reform Pennsylvania would recover a substantial amount of what it currently spends on the adultBasic program. Under current reform proposals, individuals now enrolled in adultBasic with incomes below 133 percent of the FPL would become eligible for Medicaid, likely at no additional cost to the state. Individuals currently enrolled in adultBasic with incomes above 133 percent of the FPL would be eligible for subsidized health insurance through the national health insurance exchange. It would cost the state nothing to insure these individuals.

- **Hidden Tax**: Pennsylvania's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[68] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Pennsylvania because the state and its local governments help pay for health insurance for many of their 594,225 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Pennsylvania and its local governments **$43.1 million** a year in the form of higher employee health insurance premiums.[69]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Pennsylvania currently spends **$96.8 million** on CHIP coverage for children in families with incomes up to 300 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Pennsylvania would see at least **$215 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

[68] Pennsylvania's hospitals incurred $678 million in uncompensated care costs in 2007 (Pennsylvania Health Care Cost Containment Council, 2008).
[69] Based on calculation that 12.2 percent of Pennsylvania's employment is in state and local government.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Pennsylvania

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Pennsylvania's non-elderly residents, broken down by poverty status and by age groups.[70] These estimates suggest that there are roughly 312,000 uninsured adults and 140,000 uninsured children in Pennsylvania with family incomes below 133 percent of the FPL.

As the table also shows, the majority (62 percent) of the uninsured in Pennsylvania have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Pennsylvania would not be responsible for any of the financing for this group.

Table 1: Total Estimated Non-Elderly Population of Pennsylvania

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	629,206	5,330,566	273,863	260,649
	< 133% FPL	312,157	238,593	327,965	84,686
Children (18 and under)	≥ 133% FPL	117,613	1,800,210	340,108	22,288
	< 133% FPL	140,411	106,649	396,939	0

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Pennsylvania: 3,488.

C. Estimated Costs to the State of Pennsylvania from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Pennsylvania with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest the total cost of this expansion is approximately $1,497 million per year. With an FMAP of 90 percent, the cost to the state would be **$150 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

[70] This table indicates that there were 0 children in Pennsylvania with incomes of less than 133 percent of poverty in the Medicare, VA, or TRICARE category. This presumably reflects sampling error, whereby there were no children in the March 2008 CPS sample selected from Pennsylvania with these characteristics.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Pennsylvania					
	Number of Legal Uninsured Below 133% FPL	**Cost of Medicaid Expansion ($ millions)**	**Cost per New Enrollee**	**State Population**	**Cost to State with 90% FMAP ($ millions)**
Adults (19-64)	288,463	$1,122	$3,889	12,432,792	$150
Children (18 and under)	134,196	$375	$2,794		
Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.					

D. Bottom Line for Pennsylvania

Table 3 shows the net impact for the Pennsylvania state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. Moreover, these other savings would offset almost one-third of the cost even if the current FMAP of 54.81 percent was used.[71]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Pennsylvania ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-676.3	-149.7	-0.0
adultBasic	+171.8	+171.8	+171.8
Hidden Tax	+43.1	+43.1	+43.1
Net Effect for Pennsylvania	-461.4	+65.2	+214.9

This table understates the benefits to the state of Pennsylvania and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[71] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Pennsylvania can expect to see from health insurance reform.

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VERMONT

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Vermont and its local governments.

Vermont offers uninsured state residents who would not otherwise be eligible for Medicaid a combination of subsidized insurance and assistance in paying employer-sponsored health insurance premiums. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Vermont and its local governments currently spend at least **$20.8 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Vermont's **22,258** low-income uninsured individuals would be $68 million (in 2007 dollars).[72] After initially sharing none of that cost, Vermont's share with a 90 percent FMAP would be **$6.8 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Vermont and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Vermont would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs and would have additional financial benefits for Vermont's private hospitals and other health care providers, which bear heavy costs for providing care to Vermont's residents who are not insured. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Vermont.

The following is a summary of *some* of the savings that Vermont and its local governments could expect from health insurance reform.

- **Catamount Health**: Catamount Health is a health insurance plan, offered in cooperation with the state of Vermont, by Blue Cross Blue Shield of Vermont and MVP Health Care. Uninsured Vermonters who are not eligible for Medicaid or other state programs and do not have reliable access to an employer-sponsored plan can enroll in Catamount Health, and may receive state-funded premium assistance if they meet certain qualifications. In state fiscal year 2008, Vermont paid a net amount **$10.2 million** in state funds for Catamount Health

[72] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

enrollees, which would be saved after individuals in Catamount Health transitioned to federally-funded coverage through the national health insurance exchange.

- **Vermont Health Access Plan (VHAP) Expansion Population**: Vermont's Section 1115 Medicaid waiver allows the state to cover an "expansion population" beyond federally-mandated and optional Medicaid eligibles such as low income families with children and certain pregnant women. For example, Vermont's VHAP expansion population includes adults with children with incomes between 150 and 185 percent of the FPL (Centers for Medicare and Medicaid Services, 2009). In 2008 more than 2,000 Vermont adults were not covered by Medicaid in this income bracket (U.S. Department of Commerce, 2009). Based on the reported $302 per-member-per-month cost of the VHAP program in 2008 (Office of Vermont Health Access), these individuals cost the state approximately **$7.3 million** to cover. After health insurance reform, the individuals in the expansion population would be covered by federally-subsidized insurance through the exchange, reducing the need for state spending on their care.

- **Hidden Tax**: Vermont's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care. Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Vermont because the state and its local governments help pay for health insurance for many of their 48,185 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Vermont and its local governments **$3.3 million** a year in the form of higher employee health insurance premiums.

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Vermont currently spends nearly **$700,000** on CHIP coverage for children in families with incomes up to 300 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Vermont would see at least **$20.8 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Vermont

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Vermont's non-elderly residents during the 2007 calendar year, broken down by poverty status and by age groups.[73] These estimates suggest that there are roughly 14,600 uninsured adults and 7,900 uninsured children in Vermont with family incomes below 133 percent of the FPL.

As the table shows, the majority of uninsured individuals (70 percent) in Vermont has incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Vermont would not be responsible for any of the financing for this group.

Table 1: Total Estimated Non-Elderly Population of Vermont

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	42,565	254,191	28,302	18,641
	< 133% FPL	14,587	13,631	16,942	6,784
Children (0-18)	≥ 133% FPL	9,621	69,679	25,387	5,147
	< 133% FPL	7,881	1,202	14,928	0

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Vermont: 1,556.

C. Estimated Costs to the State of Vermont from the Medicaid Expansions

Table 2 lists the estimated number of legal, non-elderly residents in Vermont with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion would be $68 million per year. With an FMAP of 90 percent, the annual cost to the state would be **$6.8 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Vermont

	Number of Legal Uninsured Below 133% FPL	Cost of Medicaid Expansion ($ millions)	Cost per New Enrollee	State Population	Cost to State with 90% FMAP ($ millions)
Adults (19-64)	14,514	49	$3,377	621,254	$6.8
Children (18 and under)	7,744	19	$2,487		

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.

[73] This table indicates that there were 0 children in Vermont with incomes of less than 133 percent of poverty in the Medicare, VA, or TRICARE category. This presumably reflects sampling error, whereby there were no children in the March 2008 CPS sample selected from Vermont with these characteristics.

D. Bottom Line for Vermont

Table 3 shows the net impact for the Vermont state budget of health insurance reform. It shows the likely cost of the Medicaid expansion under three FMAP matching rates – current, 90 percent and 100 percent. It then shows the identifiable savings from reducing uncompensated care. As the following table shows, those savings would more than offset the cost of the Medicaid expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. Moreover, these other savings would offset nearly 75 percent of the cost even if the current FMAP of 58.73 percent was used.[74]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Vermont ($ millions)

Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-28.1	-6.8	0.0
Catamount Health	+10.2	+10.2	+10.2
VHAP Expansion	+7.3	+7.3	+7.3
Hidden Tax	+3.3	+3.3	+3.3
Net Effect for Vermont	-7.3	+14.0	+20.8

This table likely understates the benefits to the state of Vermont and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[74] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that the programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Vermont can expect to see from health insurance reform.

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WYOMING

Health insurance reform as currently proposed in both the House Tri-Committee and in the Senate HELP Committee would ensure that virtually all Americans receive health insurance. This memo explores the likely effects of this reform on the budget of the state of Wyoming and its local governments.

Wyoming and its local governments subsidize individuals to obtain health insurance and provide direct services to the uninsured. In addition, the state and local governments indirectly pay for uncompensated care through higher insurance premiums for government employees. On each of these fronts, the reform would save money for the state and local governments. On the other hand, the reform calls for an expansion in Medicaid for all individuals under 133 percent of the federal poverty line (FPL).

Our findings, which we summarize below, indicate that Wyoming and its local governments currently spend at least **$11.4 million** on care for the uninsured. Because this is a lower bound of such expenditures, we estimate that at least that much would be saved by current reform proposals. We estimate that the total annual cost of the Medicaid expansion to Wyoming's **25,645** low-income uninsured individuals would be $106 million (in 2007 dollars).[75] After initially sharing none of that cost, Wyoming's share with a 90 percent FMAP would be **$10.6 million**. Thus health insurance reform would provide a substantial financial benefit to the state of Wyoming and its local governments.

A. Current State and Local Expenditures on Health Care for the Uninsured

The state and local governments of Wyoming would benefit fiscally from health insurance reform because they currently spend money encouraging individuals to become insured, treating the uninsured, and providing uncompensated care. Health insurance reform would reduce each of these costs, and would have additional financial benefits for Wyoming's private hospitals and other health care providers, which bear heavy costs for providing care to Wyoming's residents who are not insured. Since Wyoming does not spend large amounts on providing health care for the uninsured, the main benefits to the state would come through reducing hospital uncompensated care costs, which would lower health care costs generally and make it less expensive for the state to provide insurance for its employees. These and other uncompensated care costs are passed on to the privately insured, including the employees of state and local governments in Wyoming.

The following is a summary of *some* of the savings that Wyoming and its local governments could expect from health insurance reform.

- **The Wyoming Health Insurance Pool**: The pool provides insurance to individuals who have been turned down by private insurers. In 2009, the state contributed **$6 million** in revenue from its general fund to the pool. It is also funded through premiums and assessments against insurance companies that operate in Wyoming. In exchange for the

[75] The estimated number of low-income uninsured individuals excludes undocumented residents, who would not be eligible for Medicaid as a result of health insurance reform.

insurer assessments, the state grants the insurance companies tax credits. Under the bill, individuals could be covered through the exchange, saving Wyoming state general funds as well as tax revenue (Wyoming Insurance Department, 2009).

- **County Indigent Care**: Many of Wyoming's hospitals and other health facilities receive funding from county governments to finance uncompensated care. For example, in the 2007-08 fiscal year, Fremont County allocated **$242,000** for indigent care services and in the 2005-06 fiscal year, Sweetwater County allocated **$700,000** (Sweetwater County commissioner minutes, 2005, Freemont County Treasurer, 2007).

- **Hidden Tax**: Wyoming's hospitals and other health care providers also shoulder much of the burden of the state's uncompensated care.[76] Much of this cost is then shifted to those who have private health insurance in the form of higher prices for health care services. As a result of this uncompensated care, private health insurance premiums are higher than they otherwise would be. Health insurance reform would reduce this "hidden tax" that individuals with private health insurance pay for uncompensated care for the uninsured. This is of particular importance to Wyoming because the state and its local governments help pay for health insurance for many of their 48,050 full-time equivalent employees. We estimate that the hidden cost of uncompensated care costs the state of Wyoming and its local governments **$4.5 million** a year in the form of higher employee health insurance premiums.[77]

Additional savings may come from the Children's Health Insurance Program (CHIP). The state of Wyoming currently spends **$4.7 million** on CHIP coverage for children in families with incomes up to 200 percent of the FPL (Kaiser Family Foundation, 2009). Under the current draft of reform legislation, children in families with incomes above 133 percent of the FPL may transition to equivalent, federally-financed coverage through the national health insurance exchange, potentially allowing the state to save a considerable amount of the costs of this program. However, CEA does not include savings on CHIP in bottom line calculations of net state savings from health insurance reform, because transitioning children from CHIP to equivalent federal coverage would be subject to approval by the Secretary of Health and Human Services, and may not occur in all states.

The discussion above has highlighted some of the most important examples of state and local financing of care for the uninsured, though the list is by no means intended to be comprehensive. Instead, it is a lower bound on the savings that state and local governments would realize as a result of health insurance reform. Added together, we estimate that Wyoming would see at least **$11.4 million** in savings in existing programs and in reduced health insurance premiums for state and local employees as a result of health insurance reform.

B. A Snapshot of Health Insurance Coverage for Non-Elderly Residents of Wyoming

A brief snapshot of insurance coverage in the state helps illustrate the fiscal and coverage impact of national health insurance reform. Table 1 shows the insurance status of Wyoming's non-

[76] In 2007, Wyoming hospitals provided more than $125 million in uncompensated care (Wyoming Hospital Association, 2009).
[77] Based on calculation that 21.6 percent of Wyoming's employment is in state and local government.

elderly residents, broken down by poverty status and by age groups. These estimates suggest that there are roughly 23,000 uninsured adults and 5,000 uninsured children in Wyoming with family incomes below 133 percent of the FPL.

As the table also shows, the majority (61 percent) of the uninsured in Wyoming have incomes above 133 percent of the FPL, and would therefore qualify for health insurance through the exchange rather than through Medicaid. The state of Wyoming would not be responsible for any of the financing for this group.

Table 1: Total Estimated Non-Elderly Population of Wyoming

	Poverty Status	Uninsured	Private Insurance	Medicaid	Medicare, VA, or TRICARE
Adults (19-64)	≥ 133% FPL	34,587	216,340	2,837	17,799
	< 133% FPL	23,025	11,381	8,882	4,947
Children (18 and under)	≥ 133% FPL	9,854	81,504	12,212	8,077
	< 133% FPL	5,451	4,256	12,007	1,618

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. Number of observations in the CPS for Wyoming: 1,470.

C. Estimated Costs to the State of Wyoming from the Medicaid Expansion

Table 2 lists the estimated number of legal, non-elderly residents in Wyoming with incomes of less than 133 percent of the FPL who would become eligible for Medicaid under the proposed legislation. The table also presents the projected costs of extending Medicaid to these individuals. These estimates suggest that the total cost of this expansion is approximately $106 million per year. With an FMAP of 90 percent, the cost to the state would be **$10.6 million**. We consider a 90 percent FMAP because it is the one scheduled to take effect in 2017 in current draft legislation, though we recognize that this could change as the legislation moves forward.

Table 2: Uninsured, Low-Income, Legal, and Non-Elderly Population of Wyoming

	Number of Legal Uninsured Below 133% FPL	Cost of Medicaid Expansion ($ millions)	Cost per New Enrollee	State Population	Cost to State with 90% FMAP ($ millions)
Adults (19-64)	20,629	$94	$4,573	522,830	$10.6
Children (18 and under)	5,016	$11	$2,242		

Note: Data from the March 2008 CPS. Uninsured individuals report having no form of health insurance. See the technical appendix for a further discussion of the data used and CEA's methodology with respect to poverty and insurance status classification. These data exclude undocumented residents; estimates come from Passel and are described in the appendix.

D. Bottom Line for Wyoming

Table 3 shows the net impact for the Wyoming state budget of health insurance reform. It shows the likely cost of Medicaid expansion under three FMAP matching rates – current, 90 percent, and 100 percent. It then shows the identifiable savings from reducing uncompensated care. And as the following table shows, those savings would more than offset the cost of the Medicaid

expansion described above if a 90 percent FMAP were in effect, as is proposed in current draft legislation. Moreover, these other savings would offset 22 percent of the cost even if the current FMAP of 50 percent was used.[78]

Table 3: Financial Impact of Health Insurance Reform on State and Local Governments in Wyoming ($ millions)			
Component	Current FMAP	90% FMAP	100% FMAP
Medicaid Expansion	-52.8	-10.6	-0.0
Health Insurance Pool	+6	+6	+6
County Indigent Care	+0.9	+0.9	+0.9
Hidden Tax	+4.5	+4.5	+4.5
Net Effect for Wyoming	-41.4	+0.8	+11.4

This table understates the benefits to the state of Wyoming and its local governments for at least three additional reasons. First, it does not include savings that would result from reductions in other state and local programs not listed above that finance health care for the uninsured. Second, it ignores the increase in tax revenue that would result from reform-induced increases in the efficiency of the labor market, including a reduction in "job lock." And finally, it does not include the benefits of reductions in health care spending that would result from more coordinated care. At present, many individuals transition in and out of health insurance, leading to inefficient care delivery including more care in emergency rooms.

[78] CEA recognizes that not all of the costs from some of these programs will be saved under health insurance reform, and thus our calculations are not exact. State and local governments retain the discretion to offer subsidized care programs to their residents. Additionally, some of the individuals covered by these programs are undocumented immigrants who would not obtain health insurance as a result of reform. However, given that these programs analyzed here are not exhaustive of all uncompensated care spending in the state, this table is meant to be illustrative of a conservative estimate of the potential cost savings Wyoming can expect to see from health insurance reform.

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