The Colorado Health Foundation™

Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015-16 through FY 2034-35
Frequently Asked Questions

BACKGROUND

What did this study do?
"Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015-16 through FY 2034-35," is an independent, nonpartisan analysis of the economic and budgetary impact of the Medicaid expansion in Colorado. The report was commissioned by the Colorado Health Foundation and completed by the Colorado Futures Center at Colorado State University. It serves as an update to the 2013 study, "Medicaid Expansion: Examining the Impact on Colorado's Economy," that was commissioned by the Colorado Health Foundation and completed by Charles Brown Consulting, Inc.

Why did the Colorado Health Foundation commission this study?
The Colorado Health Foundation is committed to making Colorado the healthiest state in the nation. We work toward this vision by ensuring that all Colorado kids are fit and healthy and that all Coloradans achieve stable, affordable and adequate health coverage to improve their health with support from a network of primary health care and community services. While we know that Colorado's decision to opt into Medicaid expansion has contributed to increasing the rate of Coloradans with health insurance coverage, we were interested in examining the broader impact that Medicaid expansion has had on Colorado's economy and state budget.

How is this study different than the 2013 analysis?
The 2013 study was completed before Colorado opted to expand Medicaid. It made calculated projections to forecast the future state of Colorado's economy under two scenarios: with Medicaid expansion and without Medicaid expansion. With the passage of Senate Bill (SB) 13-200, many of the unknowns in the previous analysis are now known, including the rate at which Coloradans would enroll in Medicaid and the source of funding for the state match. This new study looks at the actual results to date and calculates updated forecasts for the economic and budgetary impacts of Colorado's Medicaid expansion out to fiscal year (FY) 2034-35.

What are the key findings?
Colorado's Medicaid expansion, largely funded by the federal government, is already having and will continue to have a significant positive impact on the state's economy. The combination of federal funding for expansion, the use of the Hospital Provider Fee (HPF) as the source of revenue for the state's share of expansion costs, increased tax revenues due to a larger post-Medicaid expansion economy, and modest savings in other state programs has and will allow Colorado to support Medicaid expansion at no cost to the state's General Fund. Key impacts are illustrated in the table below and in this infographic.

Economic and Budgetary Impacts for Colorado	Impact to Date (FY 2015-16)	Projected Future Impact (FY 2034-2035)
New Jobs Created	31,074	43,018
Increase in State GDP	$3.82 billion (1.14%)	$8.53 billion (1.38%)
Increase in Average Annual Household Earnings	$643	$1,033
Increase in General Fund Revenues	$102.4 million	$248.3 million

Why does Medicaid expansion have an economic impact?
Economic impacts occur when a policy change results in a change in patterns and/or levels of spending within an economy. In the case of Medicaid expansion, both levels and patterns of spending changed with a decision to opt into expansion. Levels changed largely because of the infusion of federal dollars into

Colorado to support expansion populations. Spending patterns change as the state and households, through their respective budgets, rededicate spending in response to the requirements and incentives provided by Medicaid expansion.

METHODOLOGY

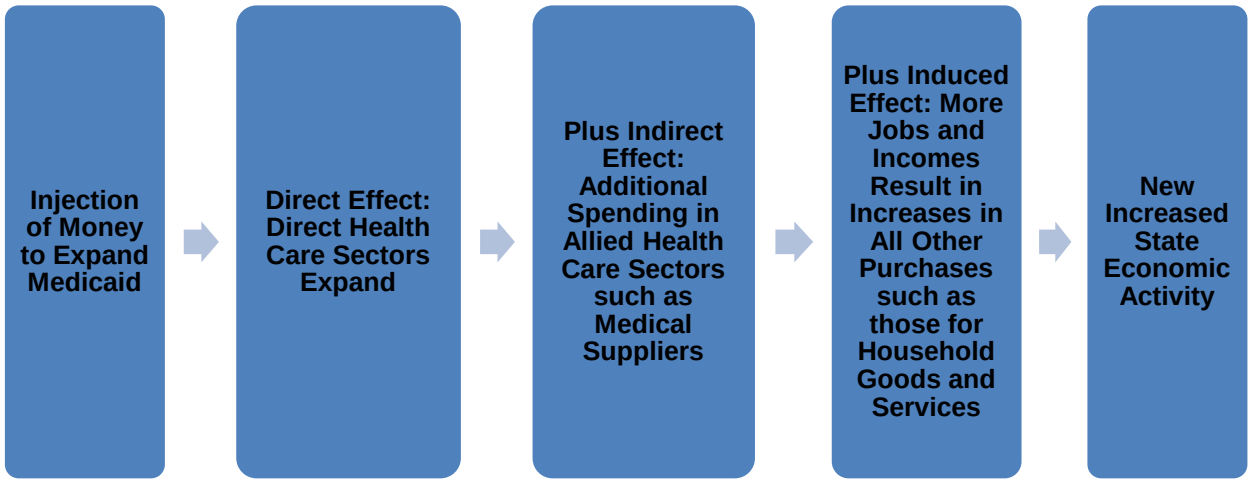
What general assumptions were made when developing the forecast model?
The current study builds on the methodology used in the 2013 analysis. When developing the model, a conservative approach was taken to ensure that any economic and budgetary impact of Medicaid expansion was not inflated. An advisory group made up of health policy, business and economic experts provided guidance, input and oversight on the original analysis.

Who were the members of the 2013 Advisory Committee?

- Bill Lindsay, president, Lockton Employee Benefits Group
- Rick Newsome, CFO, Kaiser Permanente Colorado
- Patty Silverstein, president, Development Research Partners
- Tamra Ward, former CEO, Colorado Concern
- Jennifer Webster, former senior VP of public affairs and communications, Denver Metro Chamber of Commerce

What is a Multiplier Analysis?
Multiplier analysis quantifies the direct, indirect and induced effects of an infusion or redirection of additional dollars into a state or regional economy. In the case of Medicaid expansion, the initial infusion is spent by health care providers and a direct spending effect is created. The impact on economic activity does not end, however, with the direct payment to health care providers. Instead, the increased demand for medical services also creates a demand for health supplies and other allied health care spending. This secondary health care spending is referred to as the indirect effect. In the case of direct and indirect health care spending, much of the spending is made within the state and local economy, resulting in higher employment levels and household incomes for those in the health care and allied health care sectors. When health care related workers spend additional income on household related purchases, they create an induced effect by creating demand for items such as restaurant meals, consumer goods and personal services. As a result, workers in those induced sectors have additional income and employment opportunities and the cycle continues. This process is referred to as the multiplier effect and the full quantification of that effect measures the economic impact of a policy decision such as Medicaid expansion. Figure A depicts this effect. In the case of Medicaid expansion in Colorado, much of the direct injection of spending into the economy is the result of additional federal funds flowing into the state.

Figure A: The Multiplier Effect from Public Investment



What specific tool was used to quantify the economic impact?
There are several different tools that combine the direct, indirect and induced effects to quantify the overall impact of public and private investments. For this analysis of the economic impact of Medicaid expansion in Colorado, the Regional Input-Output System II (RIMS II) created by the Bureau of Economic Analysis (BEA) of the United States Department of Commerce was used. This methodology has been widely used for approximately 40 years to assess economic impacts at the regional, state and local levels of government throughout the United States.

Does this study analyze the economic impact of just the Medicaid expansion, or the impact of the Affordable Care Act (ACA) more broadly?
This study focuses specifically on the economic and budgetary impacts attributable to Medicaid expansion in Colorado. The ACA contained numerous provisions that would have increased Medicaid enrollment regardless of whether or not Colorado had expanded Medicaid eligibility. Many state-level analyses of impacts of Medicaid expansion have failed to account for enrollment increases among those currently eligible that will take place regardless of a state's decision to expand eligibility, thus overstating costs attributable to the expansion decision. This analysis attributes only enrollment growth associated with the expansion decision to Medicaid expansion and not that enrollment increase induced by the ACA that would take place even without eligibility expansion.

Which cohorts were counted as expansion cohorts in the model?
Medicaid expansion extended coverage to 138 percent of the federal poverty level (FPL). In Colorado, two cohorts were affected by this expansion: parents and adults without dependent children (AWDC). House Bill (HB) 09-1293 extended Medicaid to parents 60-100 percent FPL and to AWDC 0-100 percent FPL, but practically only AWDC to 10 percent were covered originally and that cohort was capped at 10,000. Just before the Medicaid expansion, the Colorado Department of Health Care Policy and Financing (HCPF) extended the cap beyond 10,000 but practically most AWDC remained uncovered.

For the purposes of this analysis, all the HB 09-1293 parent and AWDC cohorts were considered expansion populations even though a subset of them had coverage after HB 09-1293 passed. There are two reasons that these cohorts were fully considered expansion populations:

- First, they are considered by the federal government as expansion populations because they received coverage after the ACA passed. This makes them eligible for the enhanced federal match rates.
- And second, according to the fiscal note on SB 13-200, a portion of the savings from refinancing the existing HB 09-1293 populations to the enhanced federal match was appropriated to cover eligible but not enrolled (EBNE) populations that would present for coverage at the time of Medicaid expansion. Since the bill authorized spending the savings, this analysis fully counted the HB 09-1293 populations as ACA expansion populations without offsetting the economic impact for the funds that were otherwise spent to cover those populations prior to 2014.

What about the EBNE populations?
The consensus of Medicaid experts in Colorado is that the EBNE effect is attributable to the ACA overall and not specifically to the Medicaid expansion. That is, it is believed that the folks who presented for coverage would have done so even if Colorado had not extended Medicaid. The following reasons were given for this assumption:

- The outreach efforts of the Health Benefits Exchange and the outreach network were so far reaching that many Coloradans realized they were Medicaid eligible through the outreach efforts associated with the Exchange and its community partners. This network would have done this outreach effort even if Medicaid had not been expanded. Thus, the EBNE effect is one of the ACA generally and not of the Medicaid expansion specifically.
- The individual mandate in the ACA made some Coloradans more aware of the need to have health care. Once they explored options for coverage, they found they were Medicaid eligible.
- States that did not expand Medicaid also saw large increases in Medicaid enrollment. Therefore, the EBNE effect is of the ACA overall and not specific to Medicaid expansion.

Because of this, the EBNE effect was not attributed to Medicaid expansion in this model. The economic impacts and the finding that there was no expenditure effect on the General Fund from Medicaid expansion assume that the EBNE effect is not attributed to the Medicaid expansion.

What is the federal/state split for the spending on expansion?
The ACA provides for the following match rates for expansion populations:

Calendar Year	Federal Enhanced Match Rate
2014-2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

Since the model of economic impact was done on a fiscal year basis, the match rate used was the average of the two corresponding calendar years. Administrative costs had a 50/50 match rate in the model.

How was the total cost of the expansion forecast out to the year 2034-35?
There are two components to the total cost. The first is the caseload and the second is the average cost per caseload. The product of those two determines the cost of coverage. HCPF currently forecasts caseloads to 2017-18. This analysis used the HCPF forecasts through 2017-18. To forecast beyond 2018, the research team ran trend and structural forecasts econometrically, looked at the growth rates as well as the share of the underlying reference population, and ultimately developed a cohort forecast using the results of the modeling, judgement and feedback from Medicaid experts in Colorado.

HCPF also forecasts average cost per caseload, by cohort, for both medical and mental health services. Their current forecast goes to FY 2017-18. After that, the cost per caseload was grown by the forecast for Denver Boulder Greeley Consumer Price Index (CPI) plus an extra cost growth increment forecast by the Congressional Budget Office (CBO). CBO forecasts extra cost growth as the amount by which the cost of medical services is expected to grow above the rate of inflation in the general economy.

Are there any other elements to the economic impact model?
Other than the federal and state spending on medical and mental health services, there is administration which is estimated to be 2 percent of total cost. The only other element in the economic impact model is the accounting for the negative effect of having to pay the state share with the HPF. To account for this, a negative impact equal to the amount of HPF multiplied by the multiplier for hospital spending was included. The theory is that this fee, which is paid by hospitals, reduces hospital spending on other services and that reduction has a contractionary offsetting effect to the positive impact of the spending on expansion.

KEY FINDINGS

Your report indicates that Colorado's economy has grown by 1.14 percent with expansion. Is that a significant impact?
Annual expected growth in GDP is in the 3-4 percent range; an additional 1.14 percent is significant to the state's overall GDP.

How many of the 31,074 realized jobs are public vs. private? And can you describe what kinds of jobs these are?
While a specific breakdown is not available, it is assumed there is a mix of both, although primarily in the private sector. The new jobs are predominantly in health care and related industries, with some impact in other sectors. However, the report identifies positive impact on retail, accommodations and food service, personal and professional services, and other sectors directly affected by household spending.

Is the projected $643 in additional household income adjusted for inflation?
No, economic impacts are stated in non-inflation adjusted dollars (a.k.a. nominal dollars).

What about the economic impact of higher federal taxes to pay for the ACA? Doesn't that eliminate the benefits we see in Colorado?
Regardless of whether Colorado had opted to expand Medicaid eligibility, Coloradans are responsible for the increased taxes associated with the ACA. Given both that this tax liability is constant with respect to the Medicaid expansion decision and that the funds from the increased taxes pay for other programs such as marketplace subsidies in addition to expanded Medicaid, we attribute the increase in federal taxes to the ACA overall and not specifically to the decision to expand Medicaid in Colorado. As a result, in this study we do not model the contractionary effect of ACA taxes as a direct impact of Medicaid expansion.

Is the use of the HPF to fund Medicaid expansion responsible for Taxpayer Bill of Rights (TABOR) refunds?
TABOR refunds are triggered whenever total state revenue growth exceeds the population plus inflation growth limits of TABOR as modified by Referendum C (2005). Total state revenue subject to TABOR includes individual and corporate income taxes, sales and use taxes, transportation related taxes and fees, severance taxes, insurance taxes, and a variety of other fees and taxes imposed by the state, including the HPF. Recent state forecasts indicate that in fiscal year 2014-15, revenue subject to TABOR exceeded the TABOR limit by $156.5 million, triggering a TABOR refund. Of the various revenue sources covered by TABOR, the fiscal year 2014-15 hospital provider fee revenue actually ***declined*** by 6.7 percent below the level in the prior year, so the hospital provider fee did not contribute to the TABOR refund. In the following year, FY 2015-16, HPF revenue is expected to increase sharply by a little more than 50 percent, but the overall TABOR outlook for that year shows the TABOR limit growing faster than total TABOR revenue, so despite the increase in hospital provider fee revenue that year, no refund is expected. In fiscal year 2016-17, the state expects TABOR revenue growth to exceed the TABOR limit once again, triggering another TABOR refund, but in that year, hospital provider fee revenue is once again expected to decline by 6 percent, so it will not contribute to the TABOR refund in that year either. These dynamics show clearly that the hospital provider fee is not driving the state's TABOR refund.

GENERAL QUESTIONS

When can I expect the full report?
The full report is still under development and will be released in spring 2016. The primary findings released today will not differ from those in the full report. The full report will provide a more detailed discussion of the methodology and will address additional policy questions including the economic impact of Medicaid provider rates and a qualitative assessment of what would happen if Colorado's Medicaid expansion was retracted.

Who should I contact for more details on the methodology, findings, etc.?
Please contact Alexis Weightman, Colorado Health Foundation senior policy officer, at 303.953.3659 or aweightman@coloradohealth.org.

Who should I contact for media inquiries?
Please contact Taryn Fort, Colorado Health Foundation communications director, at 303.953.3666 or tfort@coloradohealth.org.