IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

APPENDIX OF EXHIBITS IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

VOLUME II

(Exhibits 10-14)

Plaintiffs hereby submit Volume II of their Appendix of Exhibits in Support of their Motion for Summary Judgment.

Respectfully submitted,
BILL MCCOLLUM
ATTORNEY GENERAL OF FLORIDA

/s/ Blaine H. Winship
Blaine H. Winship (Fla. Bar No. 0356913)
Special Counsel
Joseph W. Jacquot (Fla. Bar No. 189715)
Deputy Attorney General
Scott D. Makar (Fla. Bar No. 709697)
Solicitor General
Louis F. Hubener (Fla. Bar No. 0140084)
Timothy D. Osterhaus (Fla. Bar No. 0133728)
Deputy Solicitors General
Office of the Attorney General of Florida
The Capitol, Suite PL-01
Tallahassee, Florida 32399-1050
Telephone: (850) 414-3300
Facsimile: (850) 488-4872
Email: blaine.winship@myfloridalegal.com
Attorneys for Plaintiff States

David B. Rivkin (D.C. Bar No. 394446)
Lee A. Casey (D.C. Bar No. 447443)
Baker & Hostetler LLP
1050 Connecticut Avenue, N.W., Ste. 1100
Washington, DC 20036
Telephone: (202) 861-1731
Facsimile: (202) 861-1783
Attorneys for Plaintiff States, National Federation of Independent Business, Mary Brown, and Kaj Ahlburg

Katherine J. Spohn
Special Counsel to the Attorney General
Office of the Attorney General of Nebraska
2115 State Capitol Building
Lincoln, Nebraska 68508
Telephone: (402) 471-2834
Facsimile: (402) 471-1929
Email: katie.spohn@nebraska.gov

Attorneys for Plaintiff the State of Nebraska

Karen R. Harned
Executive Director
National Federation of Independent Business
Small Business Legal Center
1201 F Street, N.W., Suite 200
Washington, DC 20004
Telephone: (202) 314-2061
Facsimile: (202) 554-5572
Of counsel for Plaintiff National Federation of Independent Business

Bill Cobb
Deputy Attorney General for Civil Litigation
Office of the Attorney General of Texas
P.O. Box 12548, Capitol Station
Austin, Texas 78711-2548
Telephone: (512) 475-0131
Facsimile: (512) 936-0545
Email: bill.cobb@oag.state.tx.us
Attorneys for Plaintiff the State of Texas

CERTIFICATE OF SERVICE

I hereby certify that, on this 4th day of November, 2010, a copy of the foregoing Volume II of Appendix of Exhibits in Support of Plaintiffs' Motion for Summary Judgment was served on counsel of record for all Defendants through the Court's Notice of Electronic Filing system.

/s/ Blaine H. Winship
Blaine H. Winship
Special Counsel

TABLE OF EXHIBITS

Exhibit No.

18 ___Bowman Declaration

19 ___Zinter Declaration

20 ___Millwee Declaration

21 ___Dial Declaration

22 ___Kukla Declaration

23 ___Gooch Declaration

24 ___Sundwall Declaration

25 ___Brown Declaration

26 ___Ahlburg Declaration

27 ___Danner Declaration

28 ___Grimes Declaration

29 ___Klemencic Declaration

30 ___McClain Declaration

31 ___Thompson Declaration

32 ___CMS Letter from Acting Director Barbara K. Richards to Monica Curry, AZ Off. of Intergovernmental Relations, April 1, 2010

33 ___Second CMS Letter from Acting Director Barbara K. Richards to Monica Curry, AZ Off. of Intergovernmental Relations, June 24, 2010

34 ___Chairman Ben S. Bernanke, Bd. of Governors of the Federal Reserve System, Challenges for the Economy and State Governments, Aug. 2, 2010

35 ___Policies for Increasing Economic Growth and Employment in 2010 and 2011, Cong. Budget Off., Jan. 2010

36 ___Variation in Analyses of PPACA's Fiscal Impact on States, Cong. Res.Serv., Sept. 8, 2010

37 ___State and Local Governments' Fiscal Outlook (GAO-10-358), Gov't Accountability Off, March 2010

38 ___State and Local Governments: Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs (GAO-10-899), Gov't Accountability Off., July 2010

39____Richard S. Foster, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," Centers for Medicare & Medicaid Service, April 22, 2010

40____Dubberly Declaration

Exhibit 10

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF PAT CASANOVA

Pursuant to 28 U.S.C. § 1746, I, Pat Casanova, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law:

1. I am the Director of Medicaid within the Indiana Family and Social Services Administration ("FSSA").

2. I have been the Director since March 2009 and, prior to that, I served as a director of Agency Coordination, Integration and Policy for the Office of Medicaid Policy and Planning ("OMPP") and in various other state governmental capacities for sixteen years.

3. The OMPP is responsible for setting policy within the FSSA for Medicaid and CHIP eligibility, rate-setting and reimbursement, and types of coverage/benefits for the citizens of Indiana. The OMPP also manages large contracts, such as those for claims processing and other business processes.

4. I have personal knowledge of the Medicaid program in Indiana.

5. Based in part on analyses competently and knowledgeably prepared by Milliman, Inc., the State's actuary, and attached as Exhibit A, I have knowledge of the impact of the Patient Protection and Affordable Care Act (the "Act") on the State's Medicaid program.

The Act's Injurious Impact on the Federal-State Healthcare Partnership

6. Indiana has always had, and has effectively utilized, the ability to control its costs by defining eligibility and benefits under its Medicaid program. The Act limits this flexibility.

7. While the Act does include 100% Federal funding to increase primary care physician reimbursement to 100% of Medicare for certain primary and preventative care services, the funding is only available for 2013 and 2014 and no Federal funding is available for other physician specialists or the full set of physician services. Thus, it appears that Indiana may be required to fund a substantial portion of the increase, estimated to be approximately $600 million for the period from January 1, 2014 through June 30, 2020, to ensure access to health care services for the current and newly eligible populations.

8. According to actuarial analysis, it is estimated that expanding Medicaid coverage to include all individuals under age 65 with incomes up to 138 percent of the federal poverty level will increase eligibility in Indiana by 413,000 parents and adults. In addition to the parents and adults, an additional 109,000 currently eligible children may enroll in Medicaid. This dramatic increase will lead to nearly 25% of Hoosiers being eligible for Medicaid.

9. By requiring that Indiana be responsible for providing healthcare services to Medicaid enrollees (as distinguished from providing healthcare funding), the Act may expose the State to increased costs and litigation risks. Neither the Medicaid Act nor State law gives the OMPP the authority to compel physicians to provide services to Medicaid patients.

The Act's Injurious Impact on Indiana

10. Based on 2008 Census Bureau statistics, Indiana has 744,600 uninsured persons living there. Of those, 274,000 are below 138 percent of the federal poverty line and must be added to the State's Medicaid rolls under the Act.

11. Medicaid outlays for Indiana consume almost 13% percent of the State's budget. For FY 2010-2011, Indiana will spend approximately $1.9 billion on Medicaid Assistance, servicing more than 1,000,000 persons.

12. It is not now feasible for Indiana to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program prior to the Act taking effect.

13. The added costs incurred by Indiana under the Act would not be offset by increased federal contributions under the Act. Indeed, the total fiscal impact to Indiana's budget during the next ten years is estimated by the State's actuary to be between $2.6 billion and $3.1 billion.

14. The Act requires that State agencies begin to immediately devote funds and human resources to implement the mandated changes, such as enforcing immediately-effective provisions of the Act; determining gaps between current State resources and resources that are projected to be needed to comply with the Act; evaluating current State infrastructure to determine how to implement new programs and to expand existing programs to comply with the Act; developing a strategic plan and coordinating the plan across various affected State agencies; initiating legislative and regulatory processes to comply with the Act; being familiar and dealing with federal regulatory processes to protect State interests; deciding whether to participate in optional programs under the Act; and developing communications to disseminate information regarding changes brought about by the Act to affected persons or entities in Indiana.

Indiana Cannot Avoid the Act's Requirements and Effects

15. No State has ever dropped out of Medicaid.

16. Indiana has no other parallel Medicaid-like program that can substitute or provide Medicaid-like benefits should Indiana's Medicaid Program be terminated.

17. If Indiana were to end its participation in Medicaid, it would likely leave many of its citizens and residents without access to the healthcare services they have depended on for years under Indiana's Medicaid Program.

Qualifying Attached Exhibits Prepared by Outside Firm

18. Indiana Code § 12-8-1-7 gives the secretary of FSSA the power to employ experts and consultants to carry out the duties of the secretary and the offices. Under this power, the Secretary of FSSA hired Milliman, Inc. to provide consulting services related to the financial review of the Act as it relates to the provisions impacting the State's Medicaid program and budget.

19. It is the OMPP's duty to make assessments and projections as the need arises and it is the agency's regular practice to do so. Milliman was asked to create Exhibit A pursuant to that practice, by persons with knowledge, and contemporaneously with the obtaining of the reported information. The OMPP provided information for the report, has reviewed it, and is satisfied that it is reliable and trustworthy. The Exhibit was not created in anticipation of litigation.

20. The assessments and projections stated herein are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision (a) as additional data are generated over time and (b) as the Act is amended or as regulations pursuant to the Act are announced and implemented by federal agencies.

21. I hereby certify to authenticity of the Exhibit.

22. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 3rd day of November, 2010.

P Casanova

Pat Casanova, Director of Medicaid, 302 West Washington Street, Indianapolis, Indiana 46204

Milliman

Chase Center/Circle
111 Monument Circle
Suite 601
Indianapolis, IN 46204-5128
USA

Tel +1 317 639 1000
Fax +1 317 639 1001

milliman.com

October 18, 2010

Ms. Anne W. Murphy
Secretary
State of Indiana
Family and Social Services Administration
402 W. Washington Street
Indianapolis, IN 46204

RE: AFFORDABLE CARE ACT (ACA) – FINANCIAL ANALYSIS UPDATE

Dear Secretary Murphy:

Milliman, Inc. (Milliman) has been retained by the State of Indiana, Family and Social Services Administration to provide consulting services related to the financial review of the Affordable Care Act (ACA) as it relates to the provisions impacting the State's Medicaid program and budget. Milliman had provided several prior analyses, with the most recent version dated May 21, 2010. This letter reflects an update to our analysis reflecting the instructions for the Federal offset of Medicaid prescription drug rebates, as outlined in the September 28, 2010 letter from Department of Health and Human Services October 2010 update to State Medicaid Directors.

SUMMARY OF RESULTS

Milliman has developed an estimate of the enrollment and fiscal impact associated with the Medicaid expansion and other related provisions of the Affordable Care Act.

Enclosures 1 and 2 provide the fiscal impact projection results of the Medicaid Assistance expansion under an alternate participation scenario (Enclosure 1) and a full participation scenario (Enclosure 2). Table 1 illustrates the anticipated expenditure impacts to the State of Indiana budget for the period of SFY 2012 through SFY 2020.

EXHIBIT
tabbies
A

Table 1

State of Indiana
Family and Social Services Administration

State Budget Fiscal Impact – SFY 2012 through SFY 2020
{values shown in millions}

	Alternate Participation	Full Participation
	SFY 2014 – SFY 2020	SFY 2014 – SFY 2020
Medicaid Assistance Expansion to 138%		
• Uninsured – Children	$199.7	$235.0
• Uninsured – Parents / Adults	286.0	351.0
• Insured – Children	339.4	452.6
• Insured – Parents / Adults	126.5	278.1
Impact of Reduced FMAP on HIP Eligibles	482.5	482.5
Spend-down and SSI Eligible	568.4	568.4
Pharmacy Rebate Loss	0.0	0.0
Physician Fee Schedule Increase to 80% Medicare	592.6	675.8
Foster Children – Expansion to Age 26	14.8	14.8
Administrative Expenses – 2014+	192.5	262.5
CHIP Program – Enhanced FMAP	(195.2)	(195.2)
Breast and Cervical Cancer Program	(14.2)	(14.2)
Pregnant Women > 138% FPL	(46.2)	(46.2)
Sub-Total	2,546.8	3,065.0
Administrative Expenses – Pre-2014	40.0	40.0
Sub-Total	2,586.8	3,105.0

The results shown in Table 1 and the enclosures vary from our May 21, 2010 letter based on the following assumption changes:

- Pharmacy rebate loss has been removed based on recent guidance from CMS
- Administrative expenses for SFY 2012 and SFY 2013 have been shown separately
- The Federal Medicaid Assistance Percentage (FMAP) is updated and published on an annual basis. Since the release of the May 21, 2010 letter, a new estimate of the FMAP for FFY 2012 was published. This letter has been updated for the new FMAP.
- Populations have been further delineated

The results of our analysis are highlighted below, as well as additional detail information regarding enrollment and other key assumptions.

Current Medicaid and CHIP Enrollment – Projected SFY 2010 Average Monthly Enrollment

• Medicaid	930,000
• CHIP	79,000
• Healthy Indiana Plan	56,000
• Total	1,065,000

Estimated Medicaid Enrollment under Patient Protection and Affordable Care Act

The following values reflect enrollment as of SFY 2010 for comparison with current Medicaid enrollment.

- Alternate Participation Scenario - Increase in Medicaid enrollment reflecting 138% FPL limit:
  - 302,000 Adults: This reflects 195,000 Parents and Childless Adults that are uninsured and 107,000 that are currently insured through employer or other insurance.
  - 86,000 Children: This reflects 32,000 Children that are currently uninsured and 54,000 with insurance coverage.

- Full Participation Scenario - Increase in Medicaid enrollment reflecting 138% FPL limit:
  - 413,000 Adults: This reflects 237,000 Parents and Childless Adults that are uninsured and 176,000 that are currently insured through employer or other insurance.
  - 109,000 Children: This reflects 37,000 Children that are currently uninsured and 72,000 with insurance coverage.

The alternate participation scenario includes participation assumptions as noted below.

- Milliman assumed the following participation rates:
  - 75% for Insured Parents and Children
  - 85% for Uninsured Parents and Children
  - 50% for Insured Adults
  - 80% for Uninsured Adults

Participation rates for the uninsured are consistent with other independent analyses performed of the Medicaid Health Care Reform legislation. The participation rates for the insured were based on a review of the Children population participation and Parent and Childless Adult applications submitted for the Healthy Indiana Plan.

Additionally, the participation rates were reviewed for consistency with participation in the Medicare program which exceeds 95% and the Medicaid/CHIP programs for children which exceeds 85%. Actual participation in the Medicaid program after the expansion may exceed the participation rates noted in these other programs, since there will be an individual mandate for health insurance coverage under federal health care reform legislation.

- Increase Medicaid enrollment for the SSI eligible that are not currently eligible for Indiana Medicaid program by approximately 23,100 lives
- Move 56,000 Healthy Indiana Plan enrollees to Medicaid (included in Adult assumptions identified above)
- Total Medicaid enrollment would increase to 1,420,100 under the alternate participation scenario or 1,554,100 under the full participation scenario

Percentage increase in Medicaid in relation to the total number of Hoosiers

- Calendar Year 2008 Indiana Census Estimate 6,377,000
- Increase would be approximately 5.6% (alternate participation) or 7.7% (full participation) more Hoosiers on Medicaid
- Increase from 16.7% to 22.3% (alternate participation) or 24.4% (full participation) - or nearly 1 in 4 Hoosiers
- Note, Milliman utilized population statistics prior to the full impact of the recession in the State of Indiana. While we have allowed for long-term growth rates in the population below the 138% FPL eligibility threshold, the actual population that will qualify due to the income threshold may be greater in 2014 depending on the impact of the economic recovery.

Table 2 illustrates the average monthly enrollment for the current Medicaid program, as well as projected enrollment under the Medicaid expansion. We have shown values in 5 year intervals. The projected enrollment has been trended at a long-term enrollment growth rate of 2.0% per year.

Table 2

State of Indiana
Family and Social Services Administration

Enrollment Projections

Population	SFY 2010	SFY 2014	SFY 2019	SFY 2024
Current Programs				
Medicaid	930,000	1,007,000	1,112,000	1,228,000
CHIP	79,000	86,000	95,000	105,000
Healthy Indiana Plan	56,000	0	0	0
Total	1,065,000	1,093,000	1,207,000	1,333,000
After Expansion – Alternate Participation				
Expansion Population				
Parents / Childless Adults		211,000	233,000	257,000
Currently Insured Population (Crowd-out)				
Children		58,000	64,000	71,000
Parents / Childless Adults		116,000	128,000	141,000
Currently Uninsured (Eligible but Unenrolled)				
Children		35,000	39,000	43,000
SSI Disabled Eligible		25,000	28,000	31,000
Total Medicaid Population After Expansion		1,538,000	1,699,000	1,876,000
After Expansion – Full Participation				
Expansion Population				
Parents / Childless Adults		257,000	284,000	314,000
Currently Insured Population (Crowd-out)				
Children		78,000	86,000	95,000
Parents / Childless Adults		191,000	211,000	233,000
Currently Uninsured (Eligible but Unenrolled)				
Children		40,000	44,000	49,000
SSI Disabled Eligible		25,000	28,000	31,000
Total Medicaid Population After Expansion		1,684,000	1,860,000	2,055,000

The remainder of this letter outlines the assumptions and methodologies used to develop the projections shown in the enclosures, as well as throughout the letter.

a. Medicaid Assistance Expansion to 138% FPL

The fiscal impact associated the Parent and Adult expansion to 138% includes both currently insured and uninsured individuals below the 138% FPL amount and children not currently covered under Medicaid, who are also below the 138% FPL. The 138% FPL reflects the 133% FPL indicated in the Act with the additional 5% allowance. The analysis presented in this report reflects modified participation assumptions.

Note, in prior analysis, the estimated fiscal impact reflected an offsetting savings associated with the current costs of the Healthy Indiana Plan. Under the scenario presented in this letter, the fiscal impact assumes that the Healthy Indiana Plan (HIP) will be terminated on December 31, 2012. Therefore, there are no savings associated with the termination of HIP.

The Act reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

We have also illustrated the additional impact of the reduced FMAP on HIP eligibles. Although Indiana is not an early expansion state, CMS has informally indicated that the standard FMAP will apply to the first 36,500 expansion enrollees.

Milliman has not included any fiscal impact associated with the potential for some children to move from the higher enhanced federal match rate under CHIP to the standard federal match rate under Medicaid. Due to the new coverage provisions, movement between these populations may occur. This has not been included in our fiscal analysis.

b. Spend-down and SSI Eligible Populations

Currently, the State of Indiana performs the disability eligibility determination. In addition to the disability determination, Indiana provides eligibility on a spend-down basis. It is anticipated that Indiana would need to modify the eligibility provision for the disabled population and convert to SSI eligibility standards. Milliman has estimated an additional 23,100 lives would be enrolled in the program with this expansion. Additionally, approximately 75% of individuals currently classified as spend-down would convert to full Medicaid eligibility due to the increase to 138% FPL standard. The expenditures associated with the modification reflect an offset due to savings associated with the current spend-down eligible above 138% FPL.

c. Pharmacy Rebate Modifications

The Act includes increasing the brand name and generic rebates. The Act indicates that the impact will be accrued 100% to the Federal government. Based on instructions regarding the Pharmacy Rebate offset from Department of Health and Human Services to the state Medicaid Directors dated September 28, 2010, we have estimated that no impact will occur to the rebates currently accruing to the state budget.

d. Increase Physician Fee Schedule to 80% of Medicare Physician Fee Schedule

The current Indiana Medicaid fee schedule reimburses at approximately 60% to 65% of the Medicare fee schedule. It would be anticipated that OMPP would need to increase the physician fee schedule to assure access to physician care. We have estimated that the minimum increase for physicians would be to 80% of the current Medicare fee schedule. The Affordable Care Act includes 100% Federal funding to increase primary care physician reimbursement to 100% of Medicare for a limited set of primary and preventive care services. However, the 100% Federal funding is only available for 2013 and 2014. No additional funding is available for other physician specialists or the full set of physician services.

The increased cost would be an additional $300 to $350 million per year for the current Medicaid program and expansion populations. The increased cost would be estimated at $2.2 billion (State and Federal) or $0.6 billion (State only) for the period beginning on January 1, 2014.

e. Foster Children Expansion to Age 26

Indiana currently provides Medicaid eligibility coverage to Foster Children to age 21. The Affordable Care Act includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. The annual cost has been estimated at $6.5 million per year (State and Federal) or $2.3 million per year (State only).

f. Administrative Expenditures

In addition to the expenditures associated with providing medical services, the State of Indiana will incur additional administrative expenditures. The expenditures for the initial modifications to the current administrative systems, as well as integration of Medicaid eligibility with an Exchange, are estimated to be $80 million (State and Federal) or $40 million (State only). On-going costs for the coverage of the additional 388,000 enrollees are estimated to be $55 million per year (State and Federal) or $27.5 million per year (State only). The on-going costs were developed assuming approximately $150 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenses would be anticipated to be incurred in 2012 and 2013 for the initial administrative expenditures and in 2014 forward for the on-going expenditures. The administrative expenses include, but are not limited to, the following items: changes to the MMIS system, additional staffing, integration with the Exchange, upgrades to the eligibility systems, claims and eligibility processing, and contracting. The administration expenses were assumed to be matched at 50%.

g. CHIP Program Enhanced FMAP

Under the Act, the CHIP program provides additional Federal matching rate of 23% beginning on October 1, 2015 and ending September 30, 2019. The additional 23% FMAP will increase the total FMAP for the CHIP program to approximately 99.57%. The enhanced FMAP will decrease expenditures for Indiana and increase expenditures for the Federal share.

h. Breast and Cervical Cancer Program

The State of Indiana currently provides eligibility under the Breast and Cervical Cancer program. The total annual expenditures under the program are approximately $7.0 million (State and Federal) or $1.7 million (State only). It is not anticipated that this program will be required to be continued with the expansion requirements below 138% FPL and insurance reforms for individuals above 138% FPL. Therefore, we have estimated that this program may be terminated beginning on January 1, 2014; although, some of these individuals will become eligible under the new Medicaid eligibility requirements.

i. Pregnant Women above 138% FPL

The State of Indiana currently provides eligibility for pregnant women up to 200% FPL. As with the Breast and Cervical Cancer Program, it would be anticipated that the pregnant women between 138% FPL and 200% FPL will have access to care through the insurance exchange. We have estimated that 9.5% of the current expenditures for the pregnant women population will no longer be incurred by the Indiana Medicaid program. We have estimated the annual savings to be approximately $18.5 million (State and Federal) per year or $6.2 million (State only) per year beginning on January 1, 2014.

j. Premium Assistance Program

The fiscal analysis did not consider the implementation of a premium assistance program which is required under Affordable Care Act. The implementation of a premium assistance program may be expected to increase the fiscal analysis results presented in this report.

KEY ASSUMPTIONS

- Medicaid Expansion up to 138% FPL including Adults, Parents, Children, and Disabled.
- Implementation of expansion on January 1, 2014.
- Assumed that Indiana would cover all individuals eligible for SSI disability at the standard FMAP.
- Healthy Indiana Plan would be discontinued on January 1, 2013.
- Assumed that the current spend-down population for the Aged, Blind and Disabled eligibility categories below 138% FPL would be converted to full benefit Medicaid. Assumed that the spend-down population above 138% FPL would be transferred to the insurance exchange.

LIMITATIONS

The information contained in this correspondence, including any enclosures, has been prepared for the State of Indiana, Family and Social Services Administration, related Divisions, and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for FSSA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by FSSA and its vendors. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Indiana Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.

If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

Milliman

ENCLOSURE 1

(Values in Millions)

EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2014 - SFY2020	SFY 2021 - SFY2024
Medicaid													
Total (State and Federal)	$7,674.2	$8,025.0	$8,394.5	$8,783.7	$9,193.9	$9,626.2	$10,082.1	$10,562.8	$11,069.9	$11,604.9	$12,169.6	$61,779.7	$45,407.1
Federal Funds	$5,138.7	$5,373.6	$5,621.0	$5,881.6	$6,156.2	$6,445.7	$6,750.9	$7,072.8	$7,412.4	$7,770.6	$8,148.8	$41,367.7	$30,404.6
State Funds	$2,535.6	$2,651.5	$2,773.5	$2,902.1	$3,037.7	$3,180.5	$3,331.1	$3,489.9	$3,657.5	$3,834.3	$4,020.8	$20,412.0	$15,002.5
CHIP													
Total (State and Federal)	$170.1	$180.3	$191.1	$202.6	$214.8	$227.7	$241.3	$255.8	$271.1	$287.4	$304.6	$1,427.9	$1,119.0
Federal Funds	$130.3	$138.1	$146.4	$155.1	$164.4	$174.3	$184.8	$195.9	$207.6	$220.1	$233.3	$1,093.3	$856.8
State Funds	$39.9	$42.2	$44.8	$47.5	$50.3	$53.3	$56.5	$59.9	$63.5	$67.3	$71.4	$334.6	$262.2
Healthy Indiana Plan													
Total (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
All Programs													
Total (State and Federal)	$7,844.4	$8,205.4	$8,585.6	$8,986.3	$9,408.7	$9,853.9	$10,323.4	$10,818.6	$11,341.0	$11,892.3	$12,474.2	$63,207.6	$46,526.1
Federal Funds	$5,268.9	$5,511.6	$5,767.3	$6,036.7	$6,320.7	$6,620.0	$6,935.7	$7,268.7	$7,620.0	$7,990.7	$8,382.0	$42,461.1	$31,261.4
State Funds	$2,575.4	$2,693.7	$2,818.3	$2,949.6	$3,088.0	$3,233.8	$3,387.7	$3,549.9	$3,721.0	$3,901.6	$4,092.2	$20,746.6	$15,264.7
Parents / Adults / Children (< 138% FPL)													
Uninsured (State and Federal)													
Children	$38.3	$81.2	$86.0	$91.2	$96.7	$102.5	$108.6	$115.1	$122.1	$129.4	$137.1	$604.5	$503.7
Parents / Adults	$473.9	$1,004.8	$1,065.1	$1,129.0	$1,196.7	$1,268.5	$1,344.6	$1,425.3	$1,510.8	$1,601.4	$1,697.5	$7,482.5	$6,235.1
Insured (State and Federal)													
Children	$65.1	$138.0	$146.2	$155.0	$164.3	$174.2	$184.6	$195.7	$207.4	$219.9	$233.1	$1,027.4	$856.1
Parents / Adults	$270.4	$573.3	$607.7	$644.2	$682.9	$723.8	$767.3	$813.3	$862.1	$913.8	$968.6	$4,269.7	$3,557.8
Uninsured (Federal)													
Children	$25.6	$54.4	$57.6	$61.1	$64.7	$68.6	$72.7	$77.1	$81.7	$86.6	$91.8	$404.8	$337.3
Parents / Adults	$454.7	$963.9	$1,021.7	$1,059.4	$1,091.3	$1,145.6	$1,190.7	$1,243.3	$1,317.9	$1,397.0	$1,480.8	$6,927.3	$5,439.2
Insured (Federal)													
Children	$43.6	$92.4	$97.9	$103.8	$110.0	$116.6	$123.6	$131.0	$138.9	$147.2	$156.1	$687.9	$573.2
Parents / Adults	$255.2	$540.9	$573.4	$604.5	$622.7	$653.7	$679.4	$709.5	$752.0	$797.2	$845.0	$3,929.9	$3,103.7
Uninsured (State)													
Children	$12.7	$26.8	$28.4	$30.1	$31.9	$33.9	$35.9	$38.0	$40.3	$42.7	$45.3	$199.7	$166.4
Parents / Adults	$0.0	$0.0	$0.0	$27.1	$64.7	$81.2	$113.1	$141.3	$149.7	$158.7	$168.2	$286.0	$617.9
Insured (State)													
Children	$21.5	$45.6	$48.3	$51.2	$54.3	$57.5	$61.0	$64.7	$68.5	$72.6	$77.0	$339.4	$282.9
Parents / Adults	$0.0	$0.0	$0.0	$6.0	$27.9	$37.1	$55.5	$71.6	$75.9	$80.4	$85.3	$126.5	$313.2
State Funds - Reduced FMAP on HIP Eligible	$34.6	$73.3	$77.7	$76.2	$73.0	$74.6	$73.2	$72.9	$77.3	$81.9	$86.8	$482.5	$319.0
Spend-down and SSI Eligible													
Total (State and Federal)	$107.2	$228.4	$243.2	$259.0	$275.8	$293.8	$312.9	$333.2	$354.9	$377.9	$402.5	$1,720.3	$1,468.5
Federal Funds	$71.8	$152.9	$162.9	$173.4	$184.7	$196.7	$209.5	$223.1	$237.6	$253.1	$269.5	$1,151.9	$983.3
State Funds	$35.4	$75.5	$80.4	$85.6	$91.1	$97.1	$103.4	$110.1	$117.2	$124.9	$133.0	$568.4	$485.2

(Values in Millions)

EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2014 - SFY2020	SFY 2021 - SFY2024
CHIP Program (Enhanced FMAP)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$33.0	$46.6	$49.4	$52.4	$13.9	$0.0	$0.0	$0.0	$0.0	$195.2	$0.0
State Funds	$0.0	$0.0	($33.0)	($46.6)	($49.4)	($52.4)	($13.9)	$0.0	$0.0	$0.0	$0.0	($195.2)	$0.0
Breast & Cervical Cancer	($4.0)	($8.4)	($8.8)	($9.2)	($9.6)	($10.1)	($10.6)	($11.1)	($11.6)	($12.2)	($12.8)	($60.8)	($47.7)
Federal Funds	($3.1)	($6.4)	($6.7)	($7.1)	($7.4)	($7.7)	($8.1)	($8.5)	($8.9)	($9.3)	($9.8)	($46.6)	($36.5)
State Funds	($0.9)	($2.0)	($2.1)	($2.2)	($2.3)	($2.4)	($2.5)	($2.6)	($2.7)	($2.9)	($3.0)	($14.2)	($11.2)
Pregnant Women (>138%)	($9.3)	($19.4)	($20.3)	($21.2)	($22.2)	($23.2)	($24.3)	($25.5)	($26.7)	($28.0)	($29.4)	($139.8)	($109.6)
Federal Funds	($6.2)	($13.0)	($13.6)	($14.2)	($14.9)	($15.6)	($16.3)	($17.1)	($17.9)	($18.8)	($19.7)	($93.6)	($73.4)
State Funds	($3.1)	($6.4)	($6.7)	($7.0)	($7.3)	($7.7)	($8.0)	($8.4)	($8.8)	($9.3)	($9.7)	($46.2)	($36.2)
Phys Fee Schedule Inc (80% Medicare)	$144.3	$301.8	$315.7	$330.4	$345.8	$362.0	$379.2	$397.3	$416.3	$436.5	$457.7	$2,179.3	$1,707.8
Federal Funds	$106.2	$222.0	$232.3	$241.4	$250.6	$261.6	$272.5	$284.3	$298.0	$312.4	$327.6	$1,586.6	$1,222.2
State Funds	$38.1	$79.8	$83.5	$89.0	$95.2	$100.4	$106.7	$113.0	$118.4	$124.1	$130.1	$592.6	$485.6
Foster Children Increase	$3.3	$6.5	$6.5	$6.5	$6.5	$6.5	$6.5	$6.5	$6.5	$6.5	$6.5	$42.3	$26.0
Federal Funds	$2.1	$4.2	$4.2	$4.2	$4.2	$4.2	$4.2	$4.2	$4.2	$4.2	$4.2	$27.5	$16.9
State Funds	$1.1	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$14.8	$9.1
Administrative Expenses	$55.0	$55.0	$55.0	$55.0	$55.0	$55.0	$55.0	$55.0	$55.0	$55.0	$55.0	$385.0	$220.0
Federal Funds	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$192.5	$110.0
State Funds	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$192.5	$110.0
All Programs - After Expansion													
Total (State and Federal)	$8,988.6	$10,566.5	$11,082.1	$11,626.2	$12,200.5	$12,806.9	$13,447.1	$14,123.4	$14,837.8	$15,592.5	$16,390.2	$80,717.9	$60,943.9
Federal Funds	$6,246.2	$7,550.4	$7,957.5	$8,337.3	$8,703.7	$9,123.8	$9,505.5	$9,943.3	$10,451.1	$10,987.9	$11,555.1	$57,424.4	$42,937.4
State Funds	$2,742.4	$3,016.1	$3,124.6	$3,288.8	$3,496.8	$3,683.0	$3,941.7	$4,180.1	$4,386.6	$4,604.7	$4,835.1	$23,293.4	$18,006.5
All Programs - Fiscal Impact													
Total (State and Federal)	$1,144.2	$2,361.1	$2,496.4	$2,639.8	$2,791.8	$2,953.0	$3,123.8	$3,304.8	$3,496.8	$3,700.2	$3,916.0	$17,510.2	$14,417.8
Federal Funds	$977.3	$2,038.8	$2,190.1	$2,300.6	$2,383.0	$2,503.8	$2,569.7	$2,674.6	$2,831.2	$2,997.1	$3,173.1	$14,963.4	$11,676.0
State Funds	$166.9	$322.3	$306.3	$339.2	$408.9	$449.2	$554.0	$630.3	$665.6	$703.1	$742.9	$2,546.8	$2,741.8

Milliman

ENCLOSURE 2

STATE OF INDIANA
Family and Social Services Administration
Health Care Reform Projection - Affordable Care Act
Full Participation Scenario
(Values in Millions)

EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2014 - SFY2020
Medicaid								
Total (State and Federal)	$7,674.2	$8,025.0	$8,394.5	$8,783.7	$9,193.9	$9,626.2	$10,082.1	$61,779.7
Federal Funds	$5,138.7	$5,373.6	$5,621.0	$5,881.6	$6,156.2	$6,445.7	$6,750.9	$41,367.7
State Funds	$2,535.6	$2,651.5	$2,773.5	$2,902.1	$3,037.7	$3,180.5	$3,331.1	$20,412.0
CHIP								
Total (State and Federal)	$170.1	$180.3	$191.1	$202.6	$214.8	$227.7	$241.3	$1,427.9
Federal Funds	$130.3	$138.1	$146.4	$155.1	$164.4	$174.3	$184.8	$1,093.3
State Funds	$39.9	$42.2	$44.8	$47.5	$50.3	$53.3	$56.5	$334.6
Healthy Indiana Plan								
Total (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
All Programs								
Total (State and Federal)	$7,844.4	$8,205.4	$8,585.6	$8,986.3	$9,408.7	$9,853.9	$10,323.4	$63,207.6
Federal Funds	$5,268.9	$5,511.6	$5,767.3	$6,036.7	$6,320.7	$6,620.0	$6,935.7	$42,461.1
State Funds	$2,575.4	$2,693.7	$2,818.3	$2,949.6	$3,088.0	$3,233.8	$3,387.7	$20,746.6
Parents / Adults / Children (< 138% FPL)								
Uninsured (State and Federal)								
Children	$45.0	$95.5	$101.2	$107.3	$113.7	$120.6	$127.8	$711.2
Parents / Adults	$576.4	$1,221.9	$1,295.2	$1,372.9	$1,455.3	$1,542.6	$1,635.1	$9,099.2
Insured (State and Federal)								
Children	$86.8	$183.9	$195.0	$206.7	$219.1	$232.2	$246.2	$1,369.8
Parents / Adults	$456.7	$968.1	$1,026.2	$1,087.8	$1,153.0	$1,222.2	$1,295.5	$7,209.5
Uninsured (Federal)								
Children	$30.2	$63.9	$67.8	$71.8	$76.2	$80.7	$85.6	$476.2
Parents / Adults	$557.1	$1,181.0	$1,251.8	$1,296.6	$1,335.1	$1,401.4	$1,456.0	$8,479.0
Insured (Federal)								
Children	$58.1	$123.2	$130.6	$138.4	$146.7	$155.5	$164.8	$917.2
Parents / Adults	$441.4	$935.7	$991.8	$1,027.3	$1,057.9	$1,110.3	$1,153.6	$6,718.1
Uninsured (State)								
Children	$14.9	$31.6	$33.4	$35.5	$37.6	$39.8	$42.2	$235.0
Parents / Adults	$0.0	$0.0	$0.0	$33.7	$79.4	$99.6	$138.3	$351.0
Insured (State)								
Children	$28.7	$60.8	$64.4	$68.3	$72.4	$76.7	$81.3	$452.6
Parents / Adults	$0.0	$0.0	$0.0	$26.7	$62.9	$78.9	$109.6	$278.1
State Funds - Reduced FMAP on HIP Eligible	$34.6	$73.3	$77.7	$76.2	$73.0	$74.6	$73.2	$482.5

STATE OF INDIANA
Family and Social Services Administration
Health Care Reform Projection - Affordable Care Act
Full Participation Scenario
(Values in Millions)

EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2014 - SFY2020
Spend-down and SSI Eligible								
Total (State and Federal)	$107.2	$228.4	$243.2	$259.0	$275.8	$293.8	$312.9	$1,720.3
Federal Funds	$71.8	$152.9	$162.9	$173.4	$184.7	$196.7	$209.5	$1,151.9
State Funds	$35.4	$75.5	$80.4	$85.6	$91.1	$97.1	$103.4	$568.4
CHIP Program (Enhanced FMAP)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$33.0	$46.6	$49.4	$52.4	$13.9	$195.2
State Funds	$0.0	$0.0	($33.0)	($46.6)	($49.4)	($52.4)	($13.9)	($195.2)
Breast & Cervical Cancer	($4.0)	($8.4)	($8.8)	($9.2)	($9.6)	($10.1)	($10.6)	($60.8)
Federal Funds	($3.1)	($6.4)	($6.7)	($7.1)	($7.4)	($7.7)	($8.1)	($46.6)
State Funds	($0.9)	($2.0)	($2.1)	($2.2)	($2.3)	($2.4)	($2.5)	($14.2)
Pregnant Women (>138%)	($9.3)	($19.4)	($20.3)	($21.2)	($22.2)	($23.2)	($24.3)	($139.8)
Federal Funds	($6.2)	($13.0)	($13.6)	($14.2)	($14.9)	($15.6)	($16.3)	($93.6)
State Funds	($3.1)	($6.4)	($6.7)	($7.0)	($7.3)	($7.7)	($8.0)	($46.2)
Phys Fee Schedule Inc (80% Medicare)	$164.6	$344.2	$360.0	$376.7	$394.3	$412.9	$432.4	$2,485.1
Federal Funds	$121.1	$253.2	$264.9	$275.3	$285.8	$298.4	$310.8	$1,809.3
State Funds	$43.5	$91.0	$95.2	$101.5	$108.6	$114.5	$121.6	$675.8
Foster Children Increase	$3.3	$6.5	$6.5	$6.5	$6.5	$6.5	$6.5	$42.3
Federal Funds	$2.1	$4.2	$4.2	$4.2	$4.2	$4.2	$4.2	$27.5
State Funds	$1.1	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$14.8
Administrative Expenses	$75.0	$75.0	$75.0	$75.0	$75.0	$75.0	$75.0	$525.0
Federal Funds	$37.5	$37.5	$37.5	$37.5	$37.5	$37.5	$37.5	$262.5
State Funds	$37.5	$37.5	$37.5	$37.5	$37.5	$37.5	$37.5	$262.5
All Programs - After Expansion								
Total (State and Federal)	$9,345.9	$11,301.0	$11,858.9	$12,447.8	$13,069.6	$13,726.3	$14,419.9	$86,169.4
Federal Funds	$6,578.8	$8,243.9	$8,691.4	$9,086.7	$9,475.9	$9,933.8	$10,347.2	$62,357.8
State Funds	$2,767.1	$3,057.2	$3,167.5	$3,361.1	$3,593.7	$3,792.4	$4,072.6	$23,811.6
All Programs - Fiscal Impact								
Total (State and Federal)	$1,501.6	$3,095.7	$3,273.2	$3,461.5	$3,660.9	$3,872.4	$4,096.5	$22,961.7
Federal Funds	$1,309.9	$2,732.2	$2,924.1	$3,050.0	$3,155.2	$3,313.8	$3,411.5	$19,896.7
State Funds	$191.7	$363.5	$349.1	$411.5	$505.7	$558.6	$685.0	$3,065.0

Exhibit 11

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF ROBERT M. DAMLER

Pursuant to 28 U.S.C. § 1746, I, Robert M. Damler, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law:

1. I am a Principal and Consulting Actuary with Milliman, Inc.

2. I hereby certify to the authenticity of Exhibit A, a letter dated October 18, 2010, as attached to the Affidavit of Pat Casanova.

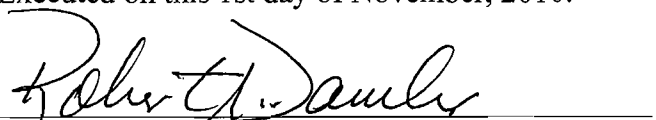
3. The report was prepared in cooperation with and based on information provided by the State.

4. The facts and data set forth in the report are reliable and of the type reasonably relied on by experts preparing such a report.

5. The methodology I used to prepare the Exhibit is described in the document itself.

6. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 1st day of November, 2010.



Robert M. Damler, FSA, MAAA, Principal and Consulting Actuary, Milliman, Inc.,
111 Monument Circle, Suite 601, Indianapolis, Indiana 46204

Exhibit 12

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF JERRY L. PHILLIPS

Pursuant to 28 U.S.C. § 1746, I, Jerry L. Phillips, declare the following:

1. I am the Undersecretary of the Louisiana Department of Health and Hospitals ("DHH"), which includes Louisiana's single State Medicaid agency.

2. As Undersecretary, I direct the Office of Management and Fiance (OM&F). The OM&F manages DHH's budget and oversees the Louisiana Medicaid program, as well as the administrative divisions with departmental responsibilities for budget preparation, financial forecasting, reasearch and planning, purchasing, personnel, training, contracting, program evaluation, quality assurance, payment management, accounting, data processing, and strategic and operational planning. Additionally, I assist the Secretary and Deputy Secretary of the Department in the planning and execution of all major departmental efforts and initiatives.

3. Before becoming Undersecretary earlier this year, I worked in the Louisiana Medicaid program for ten years, first as Deputy Director and then as Director. Prior to that, I was a member of DHH's legal staff for eleven years, during which I worked closely with the Medicaid program.

4. I have personal knowledge of the Medicaid program in Louisiana and the impact of the Patient Protection and Affordable Care Act (the "Act") on Louisiana's Medicaid program.

5. The sections that follow provide further information on the Act's injurious impact on Louisiana Medicaid and, if called to testify as a witness, I could explain that impact competently.

A. Louisiana's Medicaid Program Prior to the Act

1. Louisiana's Medicaid program began in 1966.
2. It is my understanding that when Louisiana entered into the Medicaid Program, the State understood it to be a state/federal partnership that allowed state flexibility and control over a variety of aspects of the program. This allowed states to specifically construct a Medicaid Program that is (a) tailored to meet the needs of its citizenry and (b) within its budgetary means.

3. It is my understanding that Louisiana entered into the Medicaid Program with the expectation that the federal government's role in the program would be one of partnership with the States, not one of coercion. Louisiana fully anticipated that any expansions of Medicaid eligibility for particular coverage groups would remain optional at the discretion of the States, rather than being required by mandates from the federal government, so that the States would not be forced to expand eligibility for enrollment beyond their ability to fund their participation in the program.

4. Moreover, the Act has expanded the definition of "medical assistance" for Medicaid purposes to include, for the first time, the actual provision of health care services. Since the original definition encompassed only the payment for health care services, this represents a significant departure from Louisiana's previous understanding of what the States are required to do under the Medicaid Program.

B. The Act's Injurious Impact on the Federal-State Healthcare Partnership

1. The Act eliminates Louisiana's flexibility with respect to eligibility. The states used to have flexibility to carve a Medicaid program that the state felt was best suited to caring for its most vulnerable and still fell within state budgetary constraints. Defining eligibility was a key part of that flexibility that was completely eliminated by the Act. Louisiana is now locked into a program that is covering over 102,000 childless adults, over 283,000 parents in an optional category and several other optional populations. Louisiana has exercised the option to allow persons with an institutional level of need to participate in the program up to 300 percent of the Federal Benefit Rate. It has also elected a parental income disregard for children with an institutional level of need. The State also provides coverage under the Breast and Cervical Cancer Treatment Program and the Medicaid Purchase Plan. These are examples of options the State has elected that now have become mandated. These are also examples of options that, during this major recession, the State simply cannot afford, but the Act has forced Louisiana to retain them in the program.

2. The Act essentially requires the State to make cost-saving adjustments to the Medicaid Program on the backs of its providers. Medicaid funding is a three-legged stool, in essence – eligibility, provider reimbursement and benefits. The Act prohibits states from adjusting eligibility. Thus, states can make changes to benefits and provider rates. Changes to benefits may save money in the short term but often are more costly in the long term because managing a member's care is more effective than paying for emergency care. Meanwhile, the real dollar savings comes from reducing rates. Provider reimbursement is critical to maintaining access to care and an adequate provider network that will meet the needs of the Medicaid members. The states cannot so damage their relationships with providers by reducing reimbursement to a point where providers are no longer willing to accept Medicaid patients. Providers should be reimbursed fairly and adequately for the care they provide. The Act disregards this issue and forces states to reduce provider rates.

3. The Act increases Medicaid rates for primary care physicians, and a substantial portion of that increase must be funded by the States. Louisiana estimates that this will increase its costs by approximately $186 million in State Matching Funds. In addition, the higher rates for primary care physicians may increase provider participation in the Medicaid program and broaden enrollee access to primary care services. A portion of the enrollee health care needs that are identified by primary care providers will require follow-up with specialty physician services, and increases in physician fees for those specialty services may be needed to meet related demand. This will likely cost Louisiana Medicaid an additional $38.5 million or more in State Matching Funds from 2014 to 2023.

4. Louisiana is currently undergoing review as to whether the State will operate its own Exchange. Regardless of the outcome of that policy decision, Louisiana Medicaid will have to upgrade its eligibility systems in order to be interoperable with the Exchange such that it can screen for Medicaid/CHIP. The State will also need to acquire resources and expert staffing in order to address Exchange requirements relating to instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes.

5. The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Louisiana's costs, less so in the early years but more so after 2016. Louisiana estimates that the mandated expansion will result in the enrollment of approximately 617,000 parents and childless adults at a cost to the State of approximately $701 million in State Matching Funds from 2014 to 2023.

6. In addition, many of the individuals who are added to the Medicaid rolls as a result of this expansion will be children who are currently covered under Louisiana's Children's Health Insurance Program (LaCHIP). Because the Federal Medicaid Assistance Percentage (FMAP) rate for Medicaid is lower than the FMAP rate for LaCHIP, the federal government will pay a smaller share of the total cost of Medicaid services to children with household incomes between 101 and 133 percent of the federal poverty level, and consequently more State General Funds will be required to maintain coverage

of this population. Louisiana estimates that this will cost it approximately $291 million in State Matching Funds from 2014 to 2023.

7. Louisiana anticipates that the Act's individual mandate to obtain health insurance coverage will result in the Medicaid enrollment of more than 27,000 Louisiana parents with incomes below 11 percent of the federal poverty level who are currently eligible but unenrolled, at a cost to the State of approximately $701 million in State Matching Funds from 2014 to 2023.
8. The Act's requirement that Louisiana be responsible for providing healthcare services to Medicaid enrollees (as distinguished from providing healthcare funding) will almost certainly expose the State to increased costs and litigation risks. Neither the Medicaid Act nor state law gives the State Medicaid agency any authority to compel providers to render care to Medicaid patients. The only way to encourage provider participation is to raise payment rates, which is not feasible at this time.

C. The Act's Injurious Impact on Louisiana

1. Based on U.S. Census Bureau statistics for 2008, Louisiana has more than 800,000 uninsured individuals living in the State. Of those, according to data contained in the DHH eligibility system, the U.S. Census Bureau Current Population Survey (CPS) data from 2004-2008, and the 2007 Louisiana Household Insurance Survey, there are more than 400,000 adults between the age of 19 and 64 whose income is below 133 percent of the federal poverty level, and therefore must be added to Louisiana's Medicaid rolls as required by the Act.

2. Medicaid outlays for Louisiana consume approximately 22 percent of the State's budget. For FY 2009-2010, Louisiana spent nearly $7 billion (State Matching Funds) on Medicaid, servicing approximately 1.31 million persons.

3. It is not now feasible for Louisiana to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program. The Medicaid program accounts for nearly $7 billion (State Matching Funds) in health care spending annually for the State of Louisiana. Moreover, Louisiana Medicaid members are integrated within the overall Louisiana health care delivery system. That means that Medicaid members rely on the very same providers from whom all Louisianans receive care. Eliminating Medicaid would mean that hospital uncompensated care would skyrocket, hospitals would have to close certain departments, stop expansion projects, and physicians would see a loss in revenue. In addition, community health centers would see a severe decline in their insured patient mix. The hit to Louisiana's health care system would be devastating.

4. The added costs to Louisiana under the Act would not be offset by increased federal contributions under the Act. In fact, Louisiana believes that overall, the Act will potentially cost the State approximately an additional $7 billion in State Matching Funds from 2010 to 2023.

5. DHH estimates that more than 233,000 parents, children and childless adults with incomes up to 133 percent of the federal poverty level who are now covered by employer sponsored health insurance will drop that coverage and enroll in Medicaid, at a cost to the State of approximately $1.2 billion in State Matching Funds from 2014 to 2023.

6. The health care system as a whole is financed by a mix of public and private payer sources. Public programs, such as Medicare and Medicaid, often compensate health care providers below the cost of service while private insurers compensate at or above cost. In effect, private health insurance payments underwrite the cost of uncompensated care resulting from public program payments. To offset uncompensated costs, some hospitals receive Disproportionate Share (DSH) payments. Medicaid DSH payments pay for either the difference between Medicaid rates and actual cost ("Medicaid shortfall") and/or the actual cost of care to the uninsured. With the expansion of Medicaid to adults with income below 133 percent of the federal poverty level, the health care system as a whole will depend more on the Medicaid program as a payer source at the same time as DSH allocations, including those that pay for the Medicaid shortfall, to states are reduced. The result may be an increase in uncompensated cost for hospital services provided to Medicaid enrollees. Assuming that Medicaid rates for inpatient and outpatient hospital services will have to increase to 90 percent of cost to prevent or moderate increases in hospital uncompensated cost from Medicaid shortfall, Louisiana estimates that this will cost it approximately $1.8 billion in State Matching Funds.

7. One of the most difficult aspects of the Act is allocating scarce resources in order to implement the Act's requirements. There are numerous provisions directly impacting the Medicaid program. Then there are a variety of other provisions that will require action on the part of State Medicaid programs, like the Exchange. The Louisiana Medicaid Administration has made reductions and streamlined administrative functions wherever possible. Currently, all staff is focused on only critical core Medicaid functions. The Act has disrupted this focus and mandated how the State allocates scarce resources. Almost overnight, Louisiana Medicaid has had to devote funds and human resources to implement changes such as enforcing immediately-effective provisions of the Act; determining gaps between current State resources and resources that are projected to be needed to comply with the Act; evaluating current State infrastructure to determine how to implement new programs and to expand existing programs to comply with the Act; developing a strategic plan and coordinating the plan across various affected State agencies; initiating legislative and regulatory processes to comply with the Act; being familiar and dealing with federal regulatory processes to protect State interests; deciding whether to participate in optional programs under the Act; developing communications to disseminate information regarding changes brought about by the Act to affected persons or entities in Louisiana. In fact, the State has been required to add an entire new section to its Medicaid staff which is dedicated solely to ensure compliance with the Act, at an annual cost of almost $750,000 in State Fiscal year 2011 alone.

8. These added costs under the Act will have a significant effect on Louisiana's fiscal condition, decreasing its discretion to fund other critical needs such as education, corrections, law enforcement and more.

D. Louisiana Cannot Avoid the Act's Requirements and Effects

1. If Louisiana terminates its participation in Medicaid, 1.31 million of its most vulnerable citizens would be left without access to the healthcare services they have depended on for years under the Louisiana Medicaid program. Such an occurrence is unfathomable.
2. As partly noted above, ending Louisiana's participation in Medicaid would devastate the overall health care system upon which all Louisianans rely. Medicaid funding has been a significant part of Louisiana's hospitals' ability to gain a payor source for what was previously uncompensated care. Louisiana's safety net hospitals would be completely devastated and would have to shut down beds and close down entire areas. Community Health Centers would also be hurt by the elimination of Medicaid. Since they serve as a critical safety net, having Medicaid as a payor is tremendously important. There also are so many Louisiana physicians who are dedicated to caring for Louisiana's most vulnerable citizens. These physicians would not be able to continue their mission without Medicaid as a payor. Of particular concern would be the impact to nursing facilities, intermediate care facilities for the developmentally disabled, home and community based services providers, and behavioral health providers, all of whom are largely dependent on Medicaid. Finally, the impact to ancillary services, such as labs, transportation companies, etc., that support the health care community cannot be underestimated. These are important businesses in Louisiana. Combined, the termination of Medicaid would not only harm health care but impact the State's economy and increase job losses.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

Executed this 10th day of September, 2010, at Baton Rouge, Louisiana.

Jerry L. Phillips
Undersecretary, Louisiana Department of Health and Hospitals
628 N. Fourth St.
Baton Rouge, Louisiana 70802

Exhibit 13

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

State of Florida by and through Bill McCollum et al.,	)	
Plaintiff,	)	
vs.	)	
United States Department of Health and Human Services, et al.,	)	**Case No. 3:10-cv-91-RV/EMT**
Defendants.	)	

AFFIDAVIT OF MAGGIE ANDERSON

STATE OF NORTH DAKOTA)
) ss.
COUNTY OF BURLEIGH)

Maggie Anderson states as follows:

1. I swear and affirm under penalty of perjury that the statements made in this affidavit are true and correct and made based on my own knowledge, except for the statements in this Affidavit stated on information and belief, and, as to those, I believe them to be true and correct.

2. I am the Director of the Medical Services Division of the North Dakota Department of Human Services (NDDHS), which manages and oversees the North Dakota Medicaid program. My duties consist of directing the

operations of the Medicaid, Children's Health Insurance, and state-funded Home and Community-Based Services Programs.

3. The Patient Protection and Affordable Care Act restricts North Dakota's ability to define health care eligibility and attributes under North Dakota's Medicaid Program to a degree that significantly limits North Dakota's discretionary authority.

4. Based on 2008 Census Bureau statistics (Current Population Survey: Health Insurance Coverage Status by State for All People: 2008), North Dakota has approximately 74,000 uninsured persons living in the state. As of July 2010, the North Dakota Medicaid enrollment was 62,486. According to projections from the Kaiser Commission on Medicaid and the Uninsured, due to the Patient Protection and Affordable Care Act, the enrollment in the North Dakota Medicaid program is estimated to increase by 44% by 2019. See Ex. A at 10.

5. Medicaid outlays for North Dakota consume 12.6% of North Dakota's 2009-2011 state budget. These outlays come from the State's general fund. For State Fiscal Years 2010 and 2011, North Dakota estimates spending $408.7 million of state general funds on Medicaid. For State Fiscal Year 2009, the unduplicated count of Medicaid recipients was 77,637.

6. In my view, as Director of the state's Medicaid program, it would not be feasible for North Dakota to operate a traditional Medicaid-like program in the absence of federal funding.

7. The added costs to North Dakota under the Patient Protection and Affordable Care Act would not be offset by increased federal contributions under the Act. See Ex. B. Over the next 10 years it is estimated the net additional state Medicaid expenditures (state general funds) required under the Act will exceed $105 million. See id. at 1.

8. North Dakota, through the NDDHS Medical Services Division, the state's designated Medicaid agency, estimates some individuals who now have some form of health care insurance but fall below 133% of the federal poverty level will drop their coverage and enroll in Medicaid. Based on estimates from the US Census Bureau (Current Population Survey Annual Social and Economic Supplement (2006-2009)), there are approximately 27,679 individuals at or below 133% of the poverty level in North Dakota between the ages of 21 and 64 with insurance. If 33% of the 27,679 drop their insurance and enroll in Medicaid in 2014, it is estimated it will cost the state of North Dakota $11.1 million (calculated from estimated enrollment and cost increases shown in figures 5 and 6 of the Lewin Group report, October 2009) for the period of 2014 through 2019. See Ex. C at 6. If 50% of the 27,679 drop their insurance and enroll in Medicaid in 2014,

it is estimated it will cost the state of North Dakota $13.9 million (calculated from estimated enrollment and cost increases shown in figures 5 and 6 of the Lewin Group report, October 2009) for the period of 2014 through 2019. Id.

9. The Patient Protection and Affordable Care Act requires that NDDHS immediately begin to devote funds and human resources to implement changes necessary to comply with the Act.

10. Exhibit B contains assessments and projections relating to particular aspects of the Patient Protection and Affordable Care Act and the Act's impact on North Dakota's Medicaid program. Each layer of information within the exhibit has been collected, analyzed, and reported by agency personnel having knowledge, expertise, and experience for performing such tasks.

11. Exhibit B was prepared by Affiant with the assistance of Brenda Weisz, Chief Financial Officer of the NDDHS, immediately prior to the May 27, 2010 Legislative hearing at which it was presented. We regularly prepare reports on Medicaid expenditures. See, e.g., NDDHS 2007-2009 Biennial Report (Nov. 2009), available at www.nd.gov/dhs/info/pubs/docs/2007-2009-dhs-biennial-report.pdf.

12. Exhibit B was not created in anticipation of litigation, but pursuant to statutory requirements or authorizations. Under N.D.C.C. § 54-06-04, NDDHS is required to prepare a biennial report that includes a detailed review of Medicaid

expenditures. NDDHS regularly reviews and develops recommendations regarding various healthcare services provided to Medicaid recipients similar to the assessments and projections set forth in Exhibit B.

13. I certify that Exhibit B is an official public record. Exhibits A and C are market reports that contain published compilations of Medicaid enrollment and expenditures and projections of enrollment and expenditures generally used and relied upon by the public and government officials responsible for Medicaid programs.

14. The assessments and projections stated in this Affidavit are complete and accurate to the best of Affiant's knowledge as of the date of this Affidavit, and are subject to revision (a) as additional data is generated over time, (b) as the Patient Protection and Affordable Care Act is amended or as regulations pursuant to the Act are announced and implemented by federal agencies, and (c) as NDDHS receives policy guidance from the Centers for Medicare and Medicaid Services.

15. The furnishing of the official statements in this Affidavit and in Exhibit B is within Affiant's official duty.

16. Attached as Exhibit A is a true and correct copy of Appendix F to the May 27, 2010 Minutes of the Industry Business and Labor Interim Committee, Kaiser Commission on Medicaid and the Uninsured, Medicaid Coverage and

Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL [federal poverty level], Urban Institute, May 2010, attached to NDDHS/Anderson testimony, May 27, 2010 interim committee hearing; attached as Exhibit B is a true and correct copy of Appendix E to the May 27, 2010 Minutes of the Industry Business and Labor Interim Committee, NDDHS White House/Congressional Leadership Reconciliation Bill Preliminary Estimate of Health Care Reform Impacts on ND Medicaid May 27, 2010, and attached as Exhibit C is a true and correct copy of the Memorandum from John Sheils and Randy Haught of The Lewin Group, to the National Governors Association on Cost and Coverage Estimates for the Medicaid Expansion Provision of the Senate Finance Health Reform Proposal in North Dakota (Oct. 5, 2009).

Dated this 11th day of October, 2010.

Maggie Anderson

Subscribed and sworn to before me
this 11th day of October, 2010.

Notary Public

e:\bann\briefs\constitution br\healthcare\anderson_afficavit11.doc

MARY LOU THOMPSON
Notary Public
State of North Dakota
My Commission Expires June 28, 2014

kaiser commission on medicaid and the uninsured

Medicaid Coverage and Spending in Health Reform:
National and State-by-State Results for Adults at or Below 133% FPL

Prepared by:
John Holahan and Irene Headen
Urban Institute

May 2010

THE HENRY J. KAISER FAMILY FOUNDATION

kaiser commission on medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

Executive Summary

The Patient Protection and Affordable Care Act (PPACA) expands Medicaid to nearly all individuals under age 65 with incomes up to 133 percent of the federal poverty line (FPL) which will extend coverage to large numbers of the nation's uninsured population, especially adults. However, the ultimate reach of the program will depend heavily on both federal and state actions to implement the new law. The Congressional Budget Office (CBO) has provided national estimates of the impacts of health reform, but does not provide state-by-state estimates. We know that the impact of health reform will vary across states based on coverage levels in states today. This analysis provides national and state-by-state estimates of the increases in coverage and the associated costs compared to a baseline scenario without the Medicaid expansions in health reform. Nationally and across states, this analysis shows that:

- ***Medicaid expansions will significantly increase coverage and reduce the number of uninsured***
- ***The federal government will pay a very high share of new Medicaid costs in all states***
- ***Increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted***

Today there is a great deal of variation across states in terms of Medicaid coverage, the uninsured, state fiscal capacity, leadership and priorities. These variations make it impossible to know how each state individually will respond to the new health reform law. There are a range of implementation scenarios that will impact the number of people who participate or sign up for coverage and these participation rates are directly related to the estimates of coverage and cost for health reform. Since it is impossible to predict the behavior of each state, this analysis examines two participation rate scenarios that are applied uniformly across states; however, we recognize that some states may implement reform to achieve coverage levels above expectations and others may be slower to implement reform or face implementation barriers that result in lower coverage levels. The two modeled scenarios are:

1. ***Standard Participation Scenario.*** This scenario attempts to approximate participation rates used by the CBO to estimate the national impact of the Medicaid expansion and then examines the results by state. These results assume moderate levels of participation similar to current experience among those made newly eligible for coverage and little additional participation among those currently eligible. This scenario assumes 57 percent participation among the newly eligible uninsured and lower participation across other coverage groups.

2. ***Enhanced Outreach Scenario.*** This scenario examines the impact and reach of Medicaid assuming a more aggressive outreach and enrollment campaign by federal and state governments as well as key stakeholders including community based organizations and providers that would promote more robust participation among those newly eligible (75 percent participation among the newly eligible that are currently uninsured and lower participation across other coverage groups) and higher participation among those currently eligible for coverage than in the standard scenario.

Even in a scenario with higher participation, we did not assume that there will be full or 100 percent participation. We did not model a participation rate lower than the standard, but this scenario might result in coverage levels that are not a substantial improvement over what would have occurred in the absence of reform (or baseline levels).

This analysis estimates the impact of the coverage provisions for adults in health reform between 2014 and 2019 but does not account for other Medicaid changes in the law. For a more detailed description of the methods used in the analysis for this brief and a description of how the changes in the Medicaid match rates are applied to different populations, see the full text of the report and boxes 1 and 2 at the end of the executive summary.

Standard Participation Scenario

This scenario assumes that states will implement health reform and achieve levels of participation similar to current enrollment in Medicaid among those made newly eligible for coverage; however, this scenario assumes little additional participation among those currently eligible. These results attempt to approximate participation rates used by the CBO.

National Results

Medicaid expansions will significantly increase coverage and reduce the number of uninsured. Medicaid enrollment is projected to increase by 15.9 million by 2019. This new coverage would result in a reduction of uninsured adults under 133 percent of poverty of 11.2 million, a 45 percent reduction in 2019 (Figure 1). States with more limited coverage and higher uninsured rates pre-reform (like Texas) will see larger decreases in the uninsured compared to states with broader coverage and fewer uninsured pre-reform (like Massachusetts).

The federal government will pay a very high share of new Medicaid costs in all states. In this scenario, federal spending would increase by $443.5 billion and state spending would increase by $21.1 billion between 2014-2019 (Figure 2). Thus about 95 percent of all new spending would be by the federal government. Spending in 2014 is expected to be relatively small, particularly for states because enrollment is being phased-in and the federal matching rate for new eligibles is 100 percent. Overall and state spending increases by 2019 as coverage is phased in to full implementation levels and federal matching rates for new eligibles fall to 93 percent from 100 percent.

Figure 1

Standard Scenario: Changes in Coverage from Medicaid Expansion in PPACA in 2019 (in millions)

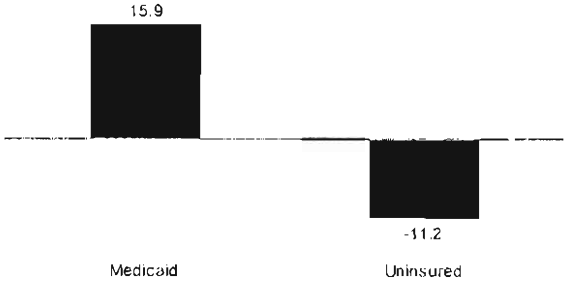


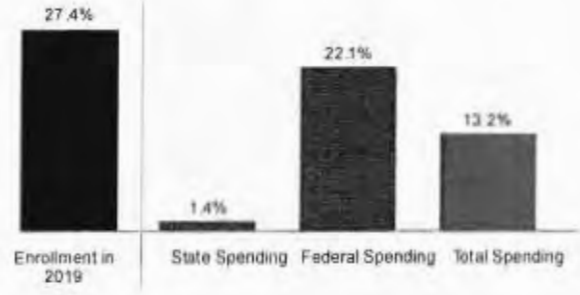
Figure 2

Standard Scenario: Changes in Costs from Medicaid Expansion in PPACA 2014-2019 (in billions)

Increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted (baseline). Nationally, enrollment is expected to increase by 27.4 percent compared to baseline. This increase in enrollment far exceeds increases in state spending relative to baseline of 1.4 percent. Due to the large increase in federal matching rates, the federal increases in Medicaid spending compared to baseline are expected to be 22.1 percent with overall spending increases of 13.2 percent. (Figure 3) The federal matching rates pre-reform and pre-ARRA average 57.1 percent. The federal matching rate after reform is the combination of current matching rates on current eligibles, expansion state match rate for certain childless adults, and the higher federal matching rates on new eligibles. The aggregate match rates for Medicaid or the share of total Medicaid spending financed by the federal government is expected to increase from 57.1 percent (under current law) to 61.6 percent; however, states that have had large increases in the number of new eligibles will see the greatest increases in matching rates.

Figure 3

Standard Scenario: Enrollment and Spending Increases Over Baseline 2014-2019



State-by-State Results

The impact of the Medicaid expansions under health reform will vary across states based on current levels of coverage and current match rates for states. The next section reviews the variation in the impact of costs and coverage across states. For state-by-state results of the standard scenario see Table 1. For purposes of this discussion we group the results into the experience in three types of states. For each group we will use the results from two states as illustrative of the experience for other states in that group:

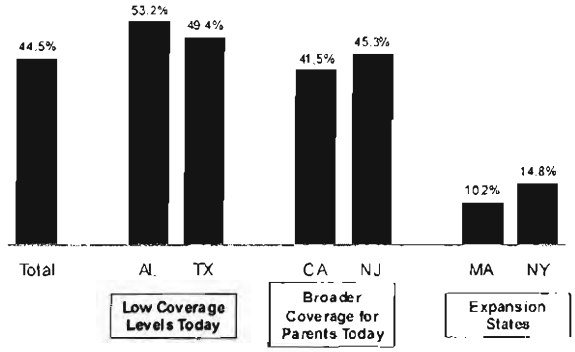
- States with low Medicaid eligibility for adults today (Alabama and Texas)
- States that have broader coverage today for parents but have no Medicaid coverage for childless adults (California and New Jersey), and
- Expansion states that cover both parents and childless adults in Medicaid today (Massachusetts and New York).[1]

[1] For this analysis we assume that there are seven "expansion states" which include: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

The Medicaid expansion will result in large reductions in the uninsured across states, but especially in states that have higher levels of uninsured today. Overall, the Medicaid expansion is expected to result in a decrease in the number of uninsured of 11.2 million people, or 45 percent of the uninsured adults below 133 percent of poverty. States with low coverage levels and higher uninsured rates today will see larger reductions (Alabama 53.2 percent and Texas 49.4). States with broader coverage levels for parents today, no coverage for childless adults and high uninsured rates will also see large reductions in the uninsured (California 41.5 percent and New Jersey 45.3 percent). States with lower uninsured rates today will see smaller reductions (Massachusetts 10.2 percent reduction and New York 14.8 percent). (Figure 4) Overall, Texas and California could each see a reduction in the uninsured of about 1.4 million compared to baseline in 2019.

Figure 4

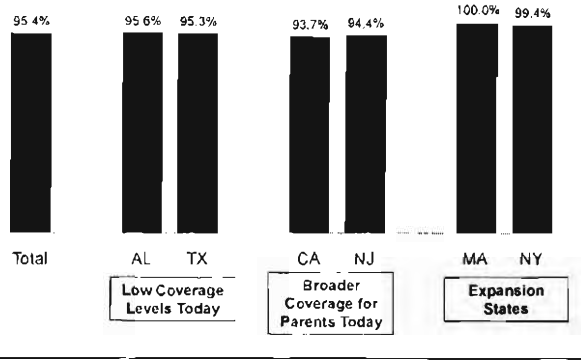
Standard Scenario: Percent Reduction in Uninsured Adults < 133% FPL Due to Medicaid Expansion in 2019



The actual federal share of the costs of the Medicaid expansion varies based on state coverage levels today, but it is always very high. States with low coverage levels today will see the vast majority of the costs of new enrollment financed by the federal government over the 2014 to 2019 period because most of their increased enrollment is from individuals made eligible by health reform who qualify for the high newly eligible match rate (for Alabama, 96 percent and Texas, 95 percent). States with broader coverage of parents today have the majority of costs financed by the federal government, but at slightly lower levels because they experience a higher participation of those currently eligible whose coverage is reimbursed at the states' regular match rates (California, 94 percent and New Jersey 94 percent). For expansion states, the level of federal financing varies with the proportion of current eligibles to newly eligible or those eligible for the expansion match rate. Massachusetts, a state with no new eligibles, will actually achieve some savings because the benefit of the expansion match rate for current and new coverage of childless adults outweighs any new state costs related to increases in participation for parents at the regular Medicaid match rate. States with state funded coverage programs for adults benefit because these adults will be considered newly eligible for Medicaid and qualify for the newly eligible match rate. Generally, states will benefit from a large influx of federal dollars and new coverage is likely to reduce the need for state payments for uncompensated care. (Figure 5)

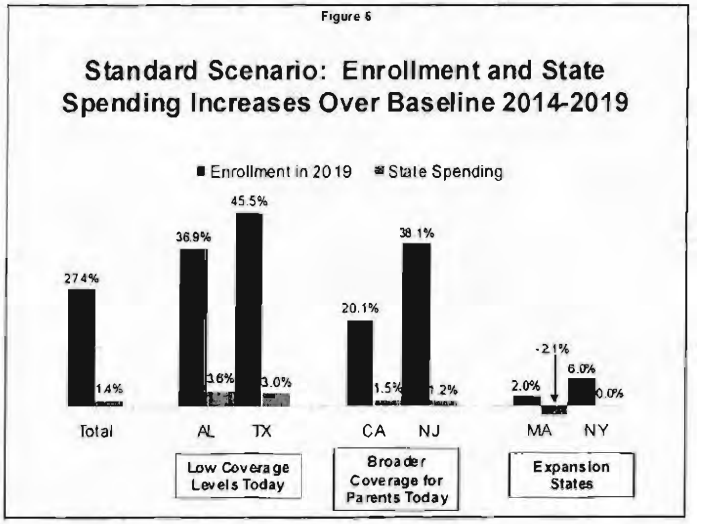
Figure 5

Standard Scenario: Federal Share of Costs of the Medicaid Expansion 2014-2019



Compared to projected enrollment without health reform, increases in new enrollment and coverage will far exceed new state costs, but these increases vary based on current levels of coverage across states. States with more modest coverage today are expected to see large increases in enrollment compared to projections without health reform. Increases in enrollment will be lower in states that have already covered a large share of these populations. Increases in enrollment far exceed increases in state spending relative to baseline estimates and this differential is biggest in states with low coverage today. For example, Texas could see an increase in enrollment of 46 percent but an increase in state spending of about 3 percent. Federal spending in Texas is expected to increase by 39 percent compared to baseline. States with low coverage today are expected to see large increases in federal spending relative to baseline both because of the very favorable matching rate on new eligibles and because these states also have a high regular Medicaid match rate for current eligibles. Increases in coverage and spending will be lower in states that have already covered a large share of these populations. (Figure 6)

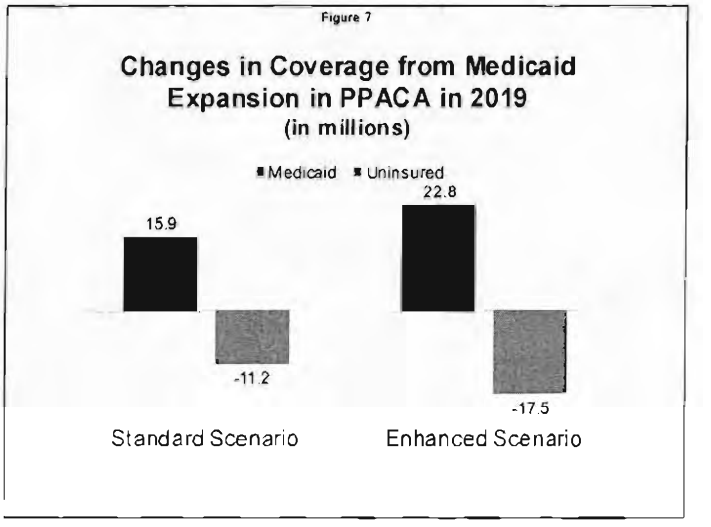
Figure 6



Enhanced Outreach Scenario

This scenario examines the impact on Medicaid and the uninsured assuming a more aggressive outreach and enrollment campaign at both the federal and state levels that would promote more robust participation in Medicaid and further reduce the number of uninsured in this low-income population compared to the standard scenario. The enhanced scenario also assumes that individuals respond favorably to the new mandate for coverage. Even though the large majority of those eligible for Medicaid will be exempt from the penalties for failure to comply with the mandate, a new culture of coverage along with outreach efforts are likely to yield more participation. These factors would increase participation of both those made newly eligible for coverage under health reform and eligible for coverage prior to changes in reform.

Figure 7

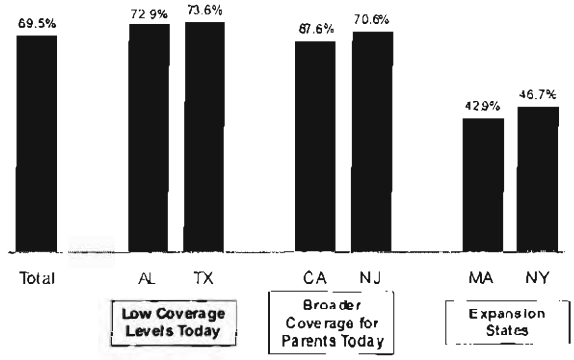


Under the enhanced outreach scenario applied uniformly across states, Medicaid enrollment could increase by 22.8 million by 2019 resulting in a 17.5 million reduction in uninsured adults under 133 percent of poverty (a 70 percent reduction). (Figure 7)

Compared to the standard scenario, states will see larger reductions in the uninsured. Similar to the standard scenario, states with low coverage levels today will see larger reductions (Alabama 73 percent and Texas 74 percent). States with broader coverage levels for parents but no coverage for childless adults and high uninsured rates will also see large reductions in the uninsured (California 68 percent and New Jersey 71 percent). States with lower uninsured rates today will see smaller reductions (Massachusetts 43 percent reduction and New York 47 percent). (Figure 8) In this scenario, California could see a reduction in the uninsured of 2.3 million and Texas could see a 2.1 million reduction compared to baseline projections in 2019. See Table 2 for the state-by-state results of the enhanced participation scenario.

Figure 8

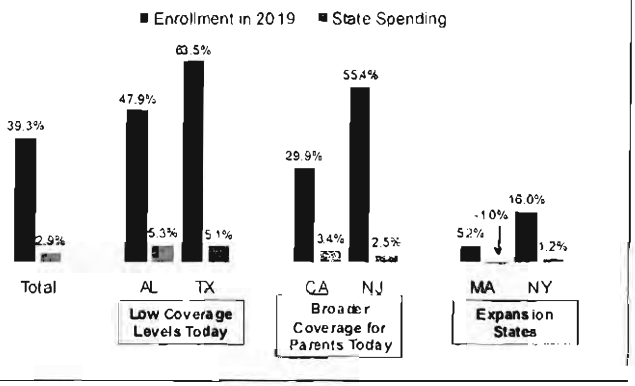
Enhanced Scenario: Percent Reduction in Uninsured Adults < 133% FPL Due to Medicaid Expansion in 2019



Under these higher participation assumptions, new spending for Medicaid would continue to be mostly federal (92.5 percent) over the 2014 to 2019 period. State spending could increase by $43 billion while federal spending could increase by $532 billion. The share of spending borne by the federal government will be somewhat lower under the higher participation assumptions, primarily due to higher take-up among those who are eligible under pre-PPACA rules. Since the states will receive lower federal matching rates for those previously eligible, states will be responsible for a higher share of their costs. Relative to baseline spending, Medicaid enrollment could increase by 39 percent, significantly higher than state spending increases of 2.9 percent. Federal spending nationally in this scenario could be about 27 percent higher than baseline projections. (Figure 9) . In this scenario, the aggregate match rates for Medicaid or the share of total Medicaid spending financed by the federal government is expected to increase from 57.1 percent (under current law) to 62.1 percent; however, states with large increases in the number of new eligibles will see the greatest increases in matching rates.

Figure 9

Enhanced Scenario: Enrollment and State Spending Increases Over Baseline 2014-2019



Limited Outreach Scenario

Right now, states are still in the midst of a major economic downturn facing historic declines in revenues and increased demand for public programs. The impact of the downturn varies across states and the economic recovery will vary across states as well. Heading into health reform, some states will move quickly to promote coverage with efforts that may begin in 2010, while others may move more slowly. Some are challenging and opposing health reform through amendments to their state statutes and constitutions, ballot initiatives and court challenges. Continuing an approach to Medicaid that dates back to its enactment in 1965, health reform revises the standards with which states that choose to participate in the program must comply. Because

Medicaid is voluntary, states may choose to not to participate and thereby forego the federal Medicaid funding to which participating states are entitled. States that elect not to implement these new requirements in effect would be making the choice not to participate.

The outcome of state actions will affect the extent to which implementation of health reform reaches its fullest potential. If states fall short of implementation expectations, fewer individuals will be covered and more individuals will remain uninsured. Under this scenario, states would also forgo large sums of federal funding tied to the coverage of those made newly eligible under reform. Even though states would have higher numbers of uninsured in this scenario, they will also face a reduction in the federal dollars to support uncompensated care since the new law calls for reductions in disproportionate share hospital payments (DSH) of $14 billion over the 2014 to 2019 period.

Conclusion

The changes to the Medicaid program under the Patient Protection and Affordability Care Act (PPACA) significantly expand Medicaid coverage for adults. There will be large increases in coverage and federal funding in exchange for a small increase in state spending. States with low coverage levels and high uninsured rates will see the largest increases in coverage and federal funding. Higher levels of coverage will allow states to reduce payments they make to support uncompensated care costs.

The impact of health reform will vary across states based on coverage levels in states today, state decisions about implementation and ultimately the number of individuals who sign up for coverage. It is impossible to know how individual states will respond, so this analysis looked at a range of participation assumptions that are applied uniformly across states, but in reality this will vary. Some states may not aggressively implement health reform and therefore not see significant reductions in the uninsured while other states will have higher levels of participation because of effective outreach and enrollment strategies and see greater reductions in the number of uninsured.

Box 1: Methods Summary

The Model Database. We use the 2007 and 2008 Current Population Survey (CPS) as our baseline data set (which provides data for 2006 and 2007). It is generally accepted that the CPS has an undercount of the Medicaid population. We adjust for the undercount with a partial adjustment to state administrative data. We then generate a 2009 dataset by growing the population to 2009. We account for the impact of unemployment on coverage which has the effect of reducing employer coverage, increasing Medicaid enrollment, and increasing the number of uninsured. We also benchmark to 2009 CPS total population estimates by state and estimate population growth to 2019 using growth rates based on Census population projections.

Eligibility Simulation. To estimate the impact of health reform on states, we use a model developed at the Urban Institute's Health Policy Center (Health Insurance Policy Simulation Model or HIPSM). The model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility pathways and applies them to person- and family-level data from the Annual Social and Economic Supplement to the CPS to simulate the eligibility determination process. The model identifies eligibility for Section 1115 waiver programs which is critical for determining match rates for coverage in seven states: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

Participation Rates. Once we have identified individuals who are newly eligible for Medicaid, we then assess the likelihood that they will participate in Medicaid under reform. The uninsured are likely to participate at relatively higher rates post-reform because they currently lack coverage but not all new participation will come from the ranks of the uninsured. Participation rates are also likely to increase for those who are currently eligible but not participating in Medicaid. Under the standard scenario, we use a set of participation rates that attempt to approximate those used by CBO (57% participation from the uninsured and lower rates for other coverage groups). The actual participation rates assumed in the CBO estimates are not publicly available. We also look at the impact of a scenario with aggressive broader outreach and enrollment efforts and stronger response to the individual mandate (even though the Medicaid population is largely exempt from these requirements). In this scenario we assume 75% participation of the uninsured and lower rates for other coverage groups.

Baseline Coverage	Standard Scenario	Enhanced Scenario
Current Eligibles		
ESI	3%	5%
Non-group	7%	10%
Uninsured	10%	40%
New Eligibles		
ESI	25%	25%
Non-group	54%	60%
Uninsured	57%	75%

Cost per Person. We make estimates on the costs per enrollee using data from HIPSM. These estimates are based on the Medical Expenditure Panel Survey (MEPS) but calibrated to reflect differences in health status of Medicaid eligibles who are currently uninsured, have non-group coverage, or employer-sponsored insurance. Estimates from MEPS are adjusted to be consistent with targets from the Medicaid Statistical Information System (MSIS). Cost per enrollee is then grown to 2019 using growth rates taken from the CBO March 2009 baseline.

The Baseline. We use estimates of state and federal Medicaid spending in the baseline, i.e. what would have happened without reform if current law continued, to assess the impact of reform. Baseline enrollment and national spending totals for the years 2009-2019 were calculated using published CBO estimates from March 2009 to grow data from the 2007 Medicaid Statistical Information Statistics (MSIS) and CMS Form-64 Medicaid Financial Report (CMS-64). Using published Federal Medical Assistance Percentages (FMAP) from the Department of Health and Human Services, we calculated the federal and state share of spending for each state. These 2007 federal spending counts were grown to match 2009 spending from the CBO by enrollment group at the national level. Then these same growth rates were applied to each state. Published 2009 FMAP rates were then used to calculate the state and total spending amounts in 2009. This process was repeated for each year, 2010 through 2019, using CBO estimates and the most recent FMAP rates for each year, without the adjustments made by the American Recovery and Reinvestment Act (ARRA).

Other Assumptions. These estimates do not account for: increased participation for states with current Medicaid coverage levels above 133% FPL because after 2014 states are unlikely to continue to cover these individuals on Medicaid; costs associated with the increase in physician payment rates for primary care; the effects of reform for children; or the fiscal implications of the reductions of disproportionate share hospital payments. Finally, the analysis also does not account for any changes in Medicaid between 2010 and 2014. States are permitted to extend coverage to childless adults and receive their regular federal medical assistance percentages (FMAP) until 2014.

Box 2: Medicaid Match Rates for Coverage in Health Reform Summary

The health reform law establishes a new, minimum standard for Medicaid coverage that is uniform across the country and fills the biggest gaps in coverage for low-income people. Specifically, the PPACA requires states by January 1, 2014, to extend Medicaid eligibility to all groups of people under age 65 with income up to 133 percent of the FPL who are not otherwise eligible for Medicaid.[2] For most states, this will mean providing Medicaid to adults without children for the first time, as well as increasing their income eligibility threshold for parents to 133 percent of the federal poverty line. The law specifies different match rates for individuals eligible for coverage as of December 1, 2009; those made newly eligible for coverage under health reform and for certain expansion states.

- **Regular Medicaid Matching Rate**: The regular Medicaid matching rate is determined by a formula that has been in place since the program was enacted in 1965. It ranges from 50 percent to 76 percent, and is designed to provide more federal support to states with lower per capita incomes. In 2014, it will continue to be used for "already-eligible" individuals (people who qualify for Medicaid under the rules in effect on December 1, 2009).

- **Newly-Eligible Matching Rate**: The newly-eligible matching rate assures that the federal government finances much of the cost of the Medicaid expansion to 133 percent of the FPL included in the health reform legislation. It is set at 100 percent in FY2014 through FY2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. Beginning in 2014, it is available for non-elderly adults with income up to 133 percent of the FPL who are not eligible for Medicaid under the rules that a state had in place on December 1, 2009.

- **"Expansion" States Matching Rate**: The transition-matching rate is designed to provide some additional federal help to "expansion" states (states that expanded coverage for adults to at least 100 percent of the FPL prior to enactment of health reform). These states can receive a phased-in increase in their federal matching rate for adults without children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults. This analysis assumes that there are seven states that fall into this category: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York, and Vermont.

Enhanced Matching Rates for Parents and Childless Adults, 2014 and Beyond

Year	Newly-Eligible Parents & Childless Adults (up to 133% FPL)	Medicaid-Eligible Childless Adults in "Expansion" States Only		
		Transition Percentage used to Calculate Enhanced Match	Example: State with 50% Original FMAP *Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]*	Example: State with 60% Original FMAP *Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]*
2014	100%	50%	75%	80%
2015	100%	60%	80%	84%
2016	100%	70%	85%	88%
2017	95%	80%	86%	88%
2018	94%	90%	89.6%	90.6%
2019	93%	100%	93%	93%
2020 on	90%	100%	90%	90%

[2]To promote coordination, the gross income standard that will be used for the premium tax credits available in the Exchanges also will apply to most existing Medicaid eligibility groups. A standard five percent of income disregard will be built into the gross income test for Medicaid to compensate for the loss of other, existing Medicaid disregards. In addition, states will no longer be able to impose asset tests on most Medicaid populations.

Table 1: Standard Participation Scenario

	Coverage in 2019			Spending in 2014-2019 (in millions)				Change From Baseline 2014-2019			
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Reduction in Uninsured Adults < 133% FPL	State Spending	Federal Spending	Total Spending	% Federal Spending	Enrollment in 2019	State Spending	Federal Spending	Total Spending
Northeast											
Connecticut	114,083	75,864	48.0%	$263	$4,686	$4,949	94.7%	20.1%	1.2%	21.0%	11.1%
Maine	43,468	27,877	47.4%	-$118	$1,857	$1,738	100%*	11.8%	-1.5%	12.9%	7.7%
Massachusetts**	29,921	10,401	10.2%	-$1,274	$2,137	$864	100%*	2.0%	-2.1%	3.5%	0.7%
New Hampshire	55,918	34,625	48.7%	$63	$1,204	$1,267	95.0%	38.8%	1.1%	21.3%	11.2%
New Jersey	390,490	292,489	45.3%	$533	$9,030	$9,563	94.4%	38.1%	1.2%	20.9%	11.1%
New York	305,945	223,175	14.8%	$50	$8,049	$8,099	99.4%	6.0%	0.0%	3.3%	1.7%
Pennsylvania	482,366	282,014	41.4%	$1,054	$17,086	$18,140	94.2%	21.7%	1.4%	17.7%	10.5%
Rhode Island	41,185	29,147	50.6%	$70	$1,559	$1,629	95.7%	20.0%	0.7%	14.6%	8.1%
Vermont	4,484	3,214	10.2%	-$26	$112	$86	100%*	2.8%	-0.6%	1.9%	0.9%
Midwest											
Illinois	631,024	429,258	42.5%	$1,202	$19,259	$20,461	94.1%	25.8%	1.6%	25.9%	13.8%
Indiana	297,737	215,803	44.2%	$478	$8,535	$9,013	94.7%	29.4%	2.5%	22.9%	16.1%
Iowa	114,691	74,498	44.1%	$147	$2,800	$2,947	95.0%	25.3%	1.4%	15.7%	10.3%
Kansas	143,445	89,265	50.9%	$166	$3,477	$3,643	95.4%	42.0%	1.7%	24.0%	14.8%
Michigan	589,965	430,744	50.6%	$686	$14,252	$14,938	95.4%	30.2%	2.0%	21.5%	14.8%
Minnesota	251,783	132,511	44.2%	$421	$7,836	$8,257	94.9%	32.9%	1.2%	22.0%	11.6%
Missouri	307,872	207,678	45.5%	$431	$8,395	$8,826	95.1%	29.8%	1.7%	19.5%	13.0%
Nebraska	83,898	50,364	53.9%	$106	$2,345	$2,451	95.7%	36.2%	1.5%	23.5%	14.4%
North Dakota	28,864	17,198	45.1%	$32	$595	$627	94.9%	44.0%	1.4%	16.9%	10.8%
Ohio	667,376	462,024	50.0%	$830	$17,130	$17,960	95.4%	31.9%	1.6%	19.2%	12.8%
South Dakota	31,317	18,594	51.9%	$32	$717	$748	95.8%	25.9%	1.1%	16.4%	10.5%
Wisconsin	205,987	127,862	50.6%	$205	$4,252	$4,457	95.4%	20.8%	0.9%	12.7%	8.0%
South											
Alabama	351,567	244,804	53.2%	$470	$10,305	$10,776	95.6%	36.9%	3.6%	35.9%	25.7%
Arkansas	200,690	154,836	47.6%	$455	$9,401	$9,856	95.4%	27.9%	4.7%	38.9%	29.1%
Delaware	12,081	7,916	15.9%	$3	$387	$390	99.2%	6.7%	0.1%	6.2%	3.3%
District of Columbia	28,900	15,308	49.1%	$42	$902	$944	95.6%	16.1%	0.9%	8.3%	6.1%
Florida	951,622	683,477	44.4%	$1,233	$20,050	$21,283	94.2%	34.7%	1.9%	24.3%	14.3%
Georgia	646,557	479,138	49.4%	$714	$14,551	$15,265	95.3%	40.4%	2.7%	28.9%	19.8%
Kentucky	329,000	250,704	57.1%	$515	$11,878	$12,393	95.8%	37.3%	3.5%	32.2%	24.0%
Louisiana	366,318	277,746	50.7%	$337	$7,273	$7,610	95.6%	32.4%	1.7%	21.6%	14.4%
Maryland	245,996	174,484	46.2%	$533	$9,112	$9,645	94.5%	32.4%	1.7%	29.6%	15.6%
Mississippi	320,748	256,920	54.9%	$429	$9,865	$10,294	95.8%	41.2%	4.8%	37.0%	28.9%
North Carolina	633,485	429,272	46.6%	$1,029	$20,712	$21,741	95.3%	38.2%	2.6%	29.0%	19.7%
Oklahoma	357,150	261,157	53.1%	$549	$12,179	$12,728	95.7%	51.2%	4.0%	48.2%	32.7%
South Carolina	344,109	247,478	56.4%	$470	$10,919	$11,389	95.9%	38.4%	3.6%	36.0%	26.3%
Tennessee	330,932	245,691	43.3%	$716	$11,072	$11,788	93.9%	20.9%	2.5%	20.4%	14.3%
Texas	1,798,314	1,379,713	49.4%	$2,619	$52,537	$55,156	95.3%	45.5%	3.0%	38.9%	24.7%
Virginia	372,470	245,840	50.6%	$498	$9,629	$10,127	95.1%	41.8%	1.8%	35.1%	18.4%
West Virginia	121,635	95,675	56.7%	$164	$3,781	$3,945	95.9%	29.5%	2.4%	20.4%	15.6%
West											
Alaska	42,794	33,106	48.4%	$117	$2,046	$2,163	94.6%	38.5%	2.1%	36.9%	19.5%
Arizona	105,428	81,095	13.6%	$56	$2,091	$2,147	97.4%	7.7%	0.2%	4.2%	2.9%
California	2,008,796	1,406,101	41.5%	$2,982	$44,694	$47,676	93.7%	20.1%	1.5%	23.0%	12.3%
Colorado	245,730	166,471	50.0%	$286	$5,917	$6,203	95.4%	47.7%	1.8%	37.1%	19.4%
Hawaii	84,130	42,381	50.0%	-$28	$2,999	$2,971	100%*	38.0%	-0.5%	46.8%	24.0%
Idaho	85,883	59,078	53.9%	$101	$2,402	$2,502	96.0%	39.4%	2.5%	27.1%	19.4%
Montana	57,356	37,978	49.6%	$100	$2,178	$2,278	95.6%	54.5%	3.7%	40.0%	27.9%
Nevada	136,563	100,813	47.0%	$188	$3,445	$3,633	94.8%	61.7%	2.9%	49.8%	27.1%
New Mexico	145,024	111,279	52.6%	$194	$4,510	$4,704	95.9%	28.3%	2.1%	21.3%	15.5%
Oregon	294,600	211,542	56.7%	$438	$10,302	$10,739	95.9%	60.6%	3.6%	50.6%	33.1%
Utah	138,918	78,284	52.5%	$174	$4,129	$4,304	96.0%	56.1%	3.7%	35.3%	26.2%
Washington	295,662	189,463	52.2%	$380	$8,271	$8,651	95.6%	25.2%	1.2%	26.0%	13.6%
Wyoming	29,899	19,099	53.0%	$32	$683	$715	95.6%	40.0%	1.2%	26.8%	14.0%
Total	**15,904,173**	**11,221,455**	**44.5%**	**$21,148**	**$443,530**	**$464,678**	**95.4%**	**27.4%**	**1.4%**	**22.1%**	**13.2%**

*Includes newly enrolled 1115 waiver eligible population.

**Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Note: These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in the exchanges or state or federal savings from reduced uncompensated care or the transition of individuals from state-funded programs to Medicaid in 2014.

Table 2: Enhanced Outreach Scenario

	Coverage in 2019			Spending in 2014-2019 (in millions)				Change From Baseline 2014-2019			
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Reduction in Uninsured Adults < 133% FPL	State Spending	Federal Spending	Total Spending	% Federal Spending	Enrollment in 2019	State Spending	Federal Spending	Total Spending
Northeast											
Connecticut	154,664	113,876	72.1%	$440	$5,048	$5,488	92.0%	27.3%	2.0%	22.6%	12.3%
Maine	59,502	41,858	71.1%	-$65	$2,105	$2,040	100%*	16.2%	-0.8%	14.7%	9.1%
Massachusetts**	75,569	43,508	42.9%	-$628	$2,783	$2,155	100%*	5.2%	-1.0%	4.5%	1.8%
New Hampshire	76,744	52,146	73.4%	$117	$1,470	$1,586	92.6%	53.3%	2.1%	26.0%	14.0%
New Jersey	567,852	455,627	70.6%	$1,078	$11,129	$12,207	91.2%	55.4%	2.5%	25.7%	14.1%
New York	820,623	706,575	46.7%	$2,859	$17,170	$20,030	85.7%	16.0%	1.2%	7.1%	4.1%
Pennsylvania	682,880	458,200	67.2%	$2,041	$19,489	$21,530	90.5%	30.8%	2.7%	20.2%	12.4%
Rhode Island	53,841	40,850	70.9%	$100	$1,768	$1,868	94.6%	26.2%	1.1%	16.5%	9.2%
Vermont	15,509	13,443	42.9%	$8	$283	$291	97.4%	9.7%	0.2%	4.9%	2.9%
Midwest											
Illinois	911,830	694,012	68.8%	$2,468	$22,109	$24,577	90.0%	37.2%	3.3%	29.7%	16.6%
Indiana	427,311	337,987	69.1%	$899	$10,112	$11,010	91.8%	42.2%	4.8%	27.1%	19.6%
Iowa	163,264	117,621	69.6%	$257	$3,298	$3,555	92.8%	36.1%	2.4%	18.4%	12.4%
Kansas	192,006	131,528	75.1%	$260	$4,033	$4,293	93.9%	56.2%	2.6%	27.8%	17.5%
Michigan	812,818	635,231	74.6%	$1,096	$16,944	$18,040	93.9%	41.6%	3.2%	25.6%	17.9%
Minnesota	348,684	211,781	70.7%	$745	$9,116	$9,861	92.4%	45.6%	2.1%	25.6%	13.9%
Missouri	437,735	324,276	71.0%	$773	$10,228	$11,001	93.0%	42.4%	3.1%	23.8%	16.2%
Nebraska	110,820	71,053	76.0%	$155	$2,732	$2,886	94.6%	47.8%	2.2%	27.4%	16.9%
North Dakota	40,017	26,457	69.4%	$57	$709	$766	92.5%	61.0%	2.5%	20.2%	13.2%
Ohio	901,023	670,992	72.6%	$1,335	$19,578	$20,913	93.6%	43.1%	2.6%	22.0%	14.9%
South Dakota	41,847	27,160	75.8%	$46	$844	$890	94.9%	34.6%	1.6%	19.3%	12.5%
Wisconsin	277,116	188,043	74.3%	$314	$4,912	$5,226	94.0%	28.0%	1.4%	14.7%	9.4%
South											
Alabama	455,952	335,547	72.9%	$693	$11,404	$12,097	94.3%	47.9%	5.3%	39.7%	28.9%
Arkansas	286,347	234,695	72.1%	$761	$11,523	$12,284	93.8%	39.9%	7.9%	47.7%	36.3%
Delaware	28,839	23,317	46.9%	$90	$686	$776	88.4%	15.9%	1.6%	11.0%	6.6%
District of Columbia	38,763	22,891	73.4%	$62	$1,068	$1,129	94.5%	21.5%	1.3%	9.9%	7.3%
Florida	1,376,753	1,073,391	69.7%	$2,537	$24,260	$26,797	90.5%	50.2%	3.8%	29.4%	18.0%
Georgia	907,203	721,558	74.4%	$1,233	$17,916	$19,149	93.6%	56.7%	4.6%	35.6%	24.9%
Kentucky	423,757	337,987	77.0%	$695	$13,220	$13,915	95.0%	48.1%	4.7%	35.8%	26.9%
Louisiana	507,952	409,869	74.8%	$536	$8,937	$9,472	94.3%	44.9%	2.8%	26.5%	17.9%
Maryland	348,140	267,555	70.8%	$1,060	$10,881	$11,941	91.1%	45.9%	3.4%	35.3%	19.4%
Mississippi	419,571	350,091	74.8%	$581	$10,959	$11,539	95.0%	53.9%	6.4%	41.1%	32.4%
North Carolina	887,560	661,292	71.8%	$1,791	$24,720	$26,511	93.2%	53.5%	4.6%	34.6%	24.0%
Oklahoma	470,358	367,541	74.8%	$789	$13,436	$14,225	94.5%	67.4%	5.8%	53.2%	36.6%
South Carolina	443,020	334,296	76.2%	$615	$12,109	$12,724	95.2%	49.4%	4.7%	39.9%	29.4%
Tennessee	474,240	372,894	65.7%	$1,523	$13,128	$14,651	89.6%	29.9%	5.4%	24.2%	17.8%
Texas	2,513,355	2,055,888	73.6%	$4,514	$62,056	$66,570	93.2%	63.5%	5.1%	45.9%	29.8%
Virginia	504,466	365,514	75.2%	$863	$11,129	$11,992	92.8%	56.7%	3.1%	40.5%	21.8%
West Virginia	156,582	129,185	76.5%	$217	$4,182	$4,399	95.1%	37.9%	3.2%	22.6%	17.4%
West											
Alaska	59,914	49,061	71.7%	$219	$2,379	$2,598	91.6%	53.9%	3.9%	42.9%	23.4%
Arizona	305,634	273,008	45.6%	$739	$4,861	$5,600	86.8%	22.4%	2.9%	9.9%	7.5%
California	2,986,362	2,291,221	67.6%	$6,544	$54,936	$61,481	89.4%	29.9%	3.4%	28.3%	15.8%
Colorado	337,706	249,208	74.8%	$470	$6,925	$7,395	93.6%	65.6%	2.9%	43.4%	23.2%
Hawaii	110,203	64,167	75.7%	$30	$3,414	$3,444	99.1%	49.7%	0.5%	53.3%	27.8%
Idaho	115,730	85,523	78.1%	$133	$2,896	$3,028	95.6%	53.1%	3.3%	32.7%	23.5%
Montana	78,840	56,889	74.3%	$155	$2,558	$2,713	94.3%	75.0%	5.7%	47.0%	33.3%
Nevada	196,168	156,025	72.7%	$338	$4,100	$4,438	92.4%	88.6%	5.2%	59.3%	33.1%
New Mexico	201,855	163,105	77.1%	$278	$5,608	$5,885	95.3%	39.4%	3.0%	26.5%	19.4%
Oregon	386,845	292,651	78.4%	$555	$11,723	$12,279	95.5%	79.6%	4.6%	57.6%	37.9%
Utah	180,478	113,872	76.3%	$227	$4,695	$4,921	95.4%	72.8%	4.8%	40.2%	30.0%
Washington	395,577	276,096	76.1%	$567	$9,573	$10,139	94.4%	33.6%	1.8%	30.1%	15.9%
Wyoming	40,041	27,488	76.2%	$49	$818	$867	94.3%	53.6%	1.9%	32.0%	17.0%
Total	22,809,862	17,524,046	69.5%	$43,218	$531,958	$575,176	92.5%	39.3%	2.9%	26.5%	16.4%

*Includes newly enrolled 1115 waiver eligible population.

**Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Note: These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in the exchanges or state or federal savings from reduced uncompensated care or the transition of individuals from state-funded programs to Medicaid in 2014.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

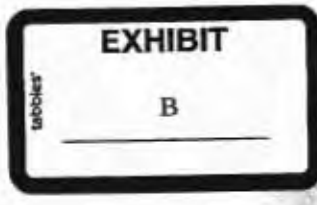
This publication (#8076) is available on the Kaiser Family Foundation's website at www.kff.org.

ND Department of Human Services
White House / Congressional Leadership Reconciliation Bill
Preliminary Estimate of Health Care Reform Impacts on ND Medicaid
May 27, 2010

Estimates should be used with caution, as amounts will change when additional guidance and policy decisions are made at the federal level.

	Estimated "STATE" Costs										
	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	Total
Administrative Costs:											
Salary/Benefits and Related Operating Costs											
Medical Services Division (18 FTEs) Coding Specialist, Provider Relations/Utilization Review (2), Claims Processing (2), Pharmacy Technician, Nurse (2), Program Integrity (2), Children's Health/Dental, Support Staff (2), Managed Care, Eligibility Policy (2), Medicaid Expansion Implementation Manager, Medical Services Mailroom Staff	14,295	100,830	165,762	536,229	589,004	589,004	589,004	589,004	589,004	589,004	4,351,140
Economic Assistance Policy (3 FTEs) Quality Assurance, Help Desk, Trainer				59,623	104,672	104,672	104,672	104,672	104,672	104,672	687,655
Administration & Technology Support (9 FTEs) Accountant (2), Account Tech, Fiscal Mailroom Staff, Data Entry (3), Attorney, Technology Business Analyst	40,248	50,920	50,920	178,795	296,696	296,696	296,696	296,696	296,696	296,696	2,101,059
Vendor Contracts & Mailing Costs Medical, Dental and Optometry Consultants, Health Care Review, Health Information Design, Medicaid Identification Cards, Postage and Printing					327,916	327,916	327,916	327,916	327,916	327,916	1,967,496
One Time Technology Costs											
New Eligibility System Development			6,137,500	6,137,500							12,275,000
Implementation of New Business Rules in MMIS				1,375,000							1,375,000
Total Overall Administrative One Time Costs and Annual Ongoing Costs thru CY 2019	54,543	151,750	6,354,182	8,287,147	1,318,288	1,318,288	1,318,288	1,318,288	1,318,288	1,318,288	22,757,350
Grant Costs:											
Newly Eligible - Medicaid Expansion								9,100,000	11,600,000	14,600,000	35,300,000
Costs Associated with Other Provisions	671,399	846,884	869,172	869,172	5,276,800	7,090,357	7,603,913	7,917,469	8,231,026	8,544,582	47,920,774
Total Grant Costs	671,399	846,884	869,172	869,172	5,276,800	7,090,357	7,603,913	17,017,469	19,831,026	23,144,582	83,220,774
OVERALL ESTIMATE OF ADMINISTRATIVE AND GRANT COSTS (STATE SHARE) THROUGH CY 2019	725,942	998,634	7,223,354	9,156,319	6,595,088	8,408,645	8,922,201	18,335,757	21,149,314	24,462,870	105,978,124

NOTES:
This estimate only includes 6 years of state costs because benefits do not start until 2014.
The estimate does not include the 5% income disregard.



ND Department of Human Services
White House / Congressional Leadership Reconciliation Bill
Preliminary Estimate of Health Care Reform Impacts on ND Medicaid
May 27, 2010

Estimates should be used with caution, as amounts will change when additional guidance and policy decisions are made at the federal level.

	Estimated "TOTAL" Costs										
	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	Total
Administrative Costs:											
Salary/Benefits and Related Operating Costs											
Medical Services Division (18 FTEs) Coding Specialist, Provider Relations/Utilization Review (2), Claims Processing (2), Pharmacy Technician, Nurse (2), Program Integrity (2), Children's Health/Dental, Support Staff (2), Managed Care, Eligibility Policy (2), Medicaid Expansion Implementation Manager, Medical Services Mailroom Staff	28,590	201,660	331,524	1,072,458	1,178,008	1,178,008	1,178,008	1,178,008	1,178,008	1,178,008	8,702,280
Economic Assistance Policy (3 FTEs) Quality Assurance, Help Desk, Trainer				119,246	209,344	209,344	209,344	209,344	209,344	209,344	1,375,310
Administration & Technology Support (9 FTEs) Accountant (2), Account Tech, Fiscal Mailroom Staff, Data Entry (3), Attorney, Technology Business Analyst	80,496	101,840	101,840	357,590	593,392	593,392	593,392	593,392	593,392	593,392	4,202,118
Vendor Contracts & Mailing Costs					655,832	655,832	655,832	655,832	655,832	655,832	3,934,992
Medical, Dental and Optometry Consultants, Health Care Review, Health Information Design, Medicaid Identification Cards, Postage and Printing											
One Time Technology Costs											
New Eligibility System Development			12,275,000	12,275,000							24,550,000
Implementation of New Business Rules in MMIS				5,500,000							5,500,000
Total Overall Administrative One Time Costs and Annual Ongoing Costs thru CY 2019	109,086	303,500	12,708,364	19,324,294	2,636,576	2,636,576	2,636,576	2,636,576	2,636,576	2,636,576	48,264,700
Grant Costs:											
Newly Eligible - Medicaid Expansion								182,000,000	193,300,000	208,600,000	583,900,000
Costs Associated with Other Provisions	2,234,268	2,135,904	2,192,112	2,192,112	12,594,014	17,224,040	18,609,947	19,184,824	20,030,044	20,875,264	117,272,529
Total Grant Costs	2,234,268	2,135,904	2,192,112	2,192,112	12,594,014	17,224,040	18,609,947	201,184,824	213,330,044	229,475,264	701,172,529
OVERALL ESTIMATE OF ADMINISTRATIVE AND GRANT COSTS THROUGH CY 2019	2,343,354	2,439,404	14,900,476	21,516,406	15,230,590	19,860,616	21,246,523	203,821,400	215,966,620	232,111,840	749,437,229

NOTES:
This estimate only includes 6 years of state costs because benefits do not start until 2014.
The estimate does not include the 5% income disregard.

The LEWIN GROUP®

3130 Fairview Park Drive, Suite 800 | Falls Church, VA 22042 | phone: (703) 269-5500 | fax: (703) 269-5501 | www.lewin.com

memorandum

October 5, 2009

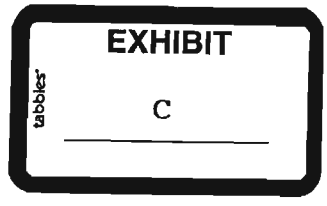
To: National Governors Association

From: John Sheils, Randy Haught

Subject: Cost and Coverage Estimates for the Medicaid Expansion Provision of the Senate Finance Health Reform Proposal in North Dakota

In this memo, we present an analysis for the North Dakota of the impact of the Medicaid expansion provisions of the Senate Finance Committee Chairman's Mark, which does not reflect the amendments made during markup. The key features of these provisions include the following:

- In 2011 states would have the option to expand coverage for parents and childless adults at their regular Federal medical assistance percentage (FMAP);
- Beginning in 2014, all states would be required to expand Medicaid coverage to all people at or below 133 percent of the federal poverty level (FPL), which includes children, parents and childless adults;
- Children covered by CHIP who are below 133% of the FPL will be moved to Medicaid;
- The newly eligible adults would be eligible only for the benchmark benefit packages;
- Individuals between 100 and 133 percent of the FPL would have the option of enrolling in Medicaid or subsidized coverage through the exchange;
- Medicaid eligibility would be based on modified adjusted gross income (MAGI) and income disregards would be eliminated;
- People below 133 percent of FPL are exempt from the requirement to have coverage and are not required to pay the penalty if uninsured;
- All states would receive an enhanced match to assist them in covering the newly eligible population. States would be reimbursed for currently eligible but not enrolled individuals at the state's regular FMAP.
- Beginning in 2014, the level of additional federal assistance for the new population would vary based on the state's income eligibility policy (as of the date of enactment). At the end of the 10 year budget window, all states would receive the same percentage increase in their regular FMAP for the newly eligible population.



  - The 13 early expansion states are: AZ, DE, DC, HI, ME, MD, MA, MN, NY, PA, VT, WA, WI would start with a 27.3 percentage increase in their regular FMAP, which would increase by one percentage point each year through and including 2019.
  - All other states, would receive at 37.3 percentage increase in their regular FMAP, which would decrease by one percentage point each year through and including 2019.
- The enhanced FMAP for the expansion population would be capped at 95 percent for each year. Michigan, Nevada, Oregon and Rhode Island will receive 100% matching rates from 2014 to 2018;
- States that currently provide coverage to childless adults using state only funds, provide only a limited benefits package or have a capped program will be eligible for the enhanced matching funds; and
- The proposal contains a number of provisions that effect Medicaid drugs prices. These include increased rebates for brand name and generic prescription drugs, requirements that drugs manufactures pay rebates to the states for prescription drugs purchased by beneficiaries enrolled in managed care plans and other provisions.

The state-level enrollment estimates were developed using the Lewin Group Health Benefits Simulation Model (HBSM) which used pooled Current Population Survey data for 2006-2008. State level spending estimates per enrollee were estimated using data for currently enrolled non-disabled adults and children from the Medicaid Statistical Information System (MSIS) for 2006, which is the most recent complete year of data. We adjusted the per-person spending amounts for newly enrolled people using HBSM to reflect utilization and costs for the specific groups of people who would enroll in the expansion which includes low-income parents and childless adults.

The key assumptions we made to produce these estimates are as follows:

- We assume that no states will opt to expand coverage before 2014. For illustrative purposes, we present program enrollment in 2019;
- Since people below 133 percent of FPL are exempt from the requirement to pay the penalty if uninsured, we assume enrollment rates under the expansion will be similar to enrollment rates under the current Medicaid program. We assume that some currently eligible but uninsured adults will enroll in the program due to the bill requiring presumptive eligibility for all Medicaid groups at certain hospitals and the public awareness of the mandate for health insurance. We also assume that currently eligible but uninsured children of newly enrolled parents will be enrolled in Medicaid;
- We assume that individuals between 100 and 133 percent of the FPL would enroll in Medicaid instead of opting for subsidized coverage through the exchange;

- We also assume that states would not reduce their Medicaid eligibility levels for groups where eligibility currently exceeds 133% of FPL and continue to provide coverage to this group at current federal matching rates;
- The newly eligible adults would be eligible only for the benchmark benefit packages, which we assume would equal about 90 percent of the cost of an average Medicaid benefits package;
- We assume that undocumented immigrants and legal immigrants that have been in the country for less than 5 years will not be eligible for the Medicaid expansions;
- We did not assume a change in Medicaid provider payment rates for the newly eligible groups;
- CHIP children below 133% of the FPL will be moved to Medicaid [1]. This will primarily include children ages 6 through 18 in families between 100% and 133% of the FPL. However, states whose regular Medicaid program extends to children at or above 133% of FPL will not be affected. These include states who had higher eligibility levels for children than was federal mandated prior to SCHIP. These children would receive a more comprehensive Medicaid benefits package, in states that have separate CHIP program, and state spending would be matched at the regular Medicaid matching rate instead of the enhanced CHIP matching rate. This leads to an increased cost to states and a savings to the Federal government; and
- These estimates reflect only the Medicaid expansion provisions included in the Senate Finance Committee Chairman's Mark and are not modeled in conjunction with other provisions including the insurance market reforms, tax credits and the employer play-or-pay.

Our detailed estimates of the impact of the Medicaid provisions on coverage and costs by state are presented in the following figures.

- *Figure 1*: Shows our projected Medicaid and CHIP enrollment under current law for 2019. The 2008 enrollment is based on monthly enrollment data from the Kaiser Family Foundation StateHealthFacts for June 2008 and the projected 2019 enrollment assumes CBO average annual enrollment growth rates from 2009 through 2019 [2];
- *Figure 2:* Shows estimated enrollment for newly eligible adults under the proposal in 2019;
- *Figure 3:* Presents estimated enrollment for previously eligible groups who become newly enrolled under the proposal;
- *Figure 4*: Shows disposition of CHIP under the proposal, which includes CHIP children below 133% of FPL moved to Medicaid;
- *Figure 5*: Presents the net impact on Medicaid enrollment under the proposal in 2019;

[1] HHS Secretary will need to certify that the coverage offered in the Exchange is at least as sufficient as the existing state CHIP benefit package. For this analysis we assume that all states offer coverage in the exchange that meets these criteria.
[2] CBO estimates that average annual Medicaid enrollment will grow at 1.0% per year and CHIP enrollment will grow at 5% per year.

- *Figure 6:* Shows the estimated increase in state Medicaid spending for newly eligible groups and people previously eligible but uninsured that become newly covered under the proposal for 2014-2019. Due to lags in public awareness about the program, we assume that the program will reach 40 percent of its ultimate enrollment in 2014, 90 percent in 2015 and full enrollment in 2016. The table also presents the estimated change in state CHIP spending and the impact of all provisions on state Medicaid and CHIP spending for 2014-2019, including the prescription drug provisions. Finally, the table shows the state's Federal Matching Percentage (FMAP) as proposed under the bill;
- *Figure 7:* Shows the impact of the Medicaid prescription drug rebate provisions on state Medicaid spending under the proposal for 2011-2019.

We also present a sensitivity analysis of the estimates of the Medicaid expansion provisions of the Senate Finance Health Reform Proposal assuming that 60 percent of people currently eligible for Medicaid but uninsured will enroll in the program due to presumptive eligibility, simplified application processes and expanded outreach. Our original estimate assumes that 40 percent would enroll.

- *Figure 8*: Presents the net impact on Medicaid enrollment under the sensitivity analysis in 2019; and
- *Figure 9*: Shows the estimated increase in state Medicaid spending for newly eligible groups and people previously eligible but uninsured that become newly covered under the sensitivity analysis for 2014-2019. Due to lags in public awareness about the program, we assume that the program will reach 40 percent of its ultimate enrollment in 2014, 90 percent in 2015 and full enrollment in 2016. The table also presents the estimated change in state CHIP spending and impact of all the provisions on state Medicaid and CHIP spending for 2014-2019, including the prescription drug provisions. Finally, the table shows the state's Federal Matching Percentage (FMAP) as proposed under the bill.

Please call if you have any questions at (703) 269-5610.

Sincerely;

John Sheils
Senior Vice President

Figure 1: Baseline Medicaid and CHIP Enrollment by State in 2008 and 2019 (projected)				
North Dakota				
Average Monthly Medicaid Enrollment		Average Monthly CHIP Enrollment		Total Medicaid and CHIP Enrollment in 2019
2008	2019	2008	2019	
51,890	58,065	5,785	9,950	68,015

2008 enrollment based on Kaiser Family Foundation Statehealthfacts monthly enrollment June 2008.
Projected 2009 estimates assume CBO average annual enrollment growth rates from 2009 through 2019

Figure 2: Number of People Newly Eligible and Newly Enrolled under the Senate Finance Committee Chairman's Mark in 2019					
North Dakota					
Newly Eligible			Newly Eligible and Newly Enrolled		
Parents	Childless Adults	Total	Parents	Childless Adults	Total
12,406	47,594	60,001	6,105	28,980	35,085

Source: Lewin Group Estimates using the Health Benefits Simulation Model HBSM.

Figure 3: Number of People Previously Eligible and Newly Enrolled under the Senate Finance Committee Chairman's Mark in 2019		
North Dakota		
Previously Eligible and Previously Not Enrolled (under age 65)	Previously Eligible and Uninsured (under age 65)	Previously Eligible and Newly Enrolled
15,634	8,507	3,411

Source: Lewin Group Estimates using the Health Benefits Simulation Model HBSM.

Figure 4: Disposition of CHIP Enrollees under the Senate Finance Committee Chairman's Mark in 2019	
North Dakota	
Total CHIP Enrollment in 2019	CHIP Children below 133% FPL moved to Medicaid
9,950	8,425

Source: Lewin Group Estimates using the Health Benefits Simulation Model HBSM.

Figure 5: Impact on Medicaid Enrollment under the Senate Finance Committee Chairman's Mark in 2019					
North Dakota					
Baseline Medicaid Enrollment 2019	Newly Eligible and Newly Enrolled	Previously Eligible and Newly Enrolled	CHIP Children below 133% FPL moved to Medicaid	Total Medicaid Enrollment in 2019	Percent Change in Enrollment
58,065	35,085	3,411	8,425	104,986	81%

Source: Lewin Group Estimates using the Health Benefits Simulation Model HBSM.

Figure 6: Impact on State Medicaid and CHIP Spending under the Senate Finance Committee Chairman's Mark 2014-2019 (in millions)						
North Dakota						
2014	2015	2016	2017	2018	2019	2014-2019
Gross Cost for Newly Eligible Adults under the Medicaid Expansion Provisions						
$2.9	$7.1	$8.4	$9.1	$9.7	$10.4	$47.6
Gross Cost for Previously Eligible and Newly Enrolled under the Medicaid Expansion Provisions						
$1.1	$2.8	$3.3	$3.5	$3.8	$4.1	$18.5
Cost for CHIP Children below 133% FPL Moved to Medicaid [a/]						
$4.1	$4.4	$4.7	$5.0	$5.4	$5.8	$29.4
Gross Cost for All Medicaid Provisions (includes impact on drug rebates)						
$7.2	$13.2	$15.4	$16.6	$16.9	$18.2	$87.5
FMAP for Newly Eligible						
95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	n/a

a/ Includes the cost of covering these children under Medicaid at regular FMAP less the cost of covering them under CHIP with the enhanced FMAP

Source: Lewin Group Estimates using the Health Benefits Simulation Model HBSM.

Figure 7: Net State Savings for the Medicaid Prescription Drug Provisions Under the Senate Finance Proposal 2014-2019 (in millions)										
North Dakota										
2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Cumulative
$0	$1	$2	$2	$1	$1	$1	$1	$2	$2	$13

Source: Urban Institute estimates.

Figure 8: Impact on Medicaid Enrollment under the Senate Finance Committee Chairman's Mark in 2019 (Sensitivity Analysis)					
North Dakota					
Baseline Medicaid Enrollment 2019	Newly Eligible and Newly Enrolled	Previously Eligible and Newly Enrolled	CHIP Children below 133% FPL moved to Medicaid	Total Medicaid Enrollment in 2019	Percent Change in Enrollment
58,065	35,085	5,104	8,425	106,679	84%

Assumes that 60% of currently Medicaid eligible but uninsured will enroll under the proposal.

Source: Lewin Group Estimates using the Health Benefits Simulation Model HBSM.

Figure 9: Impact on State Medicaid and CHIP Spending under the Senate Finance Committee Chairman's Mark 2014-2019 (Sensitivity Analysis) (in millions)						
North Dakota						
2014	2015	2016	2017	2018	2019	2014-2019
Gross Cost for Newly Eligible Adults under the Medicaid Expansion Provisions						
$2.9	$7.1	$8.4	$9.1	$9.7	$10.4	$47.6
Gross Cost for Previously Eligible and Newly Enrolled under the Medicaid Expansion Provisions						
$1.8	$4.4	$5.2	$5.6	$6.0	$6.5	$29.5
Cost for CHIP Children below 133% FPL Moved to Medicaid [a/]						
$4.1	$4.4	$4.7	$5.0	$5.4	$5.8	$29.4
Gross Cost for All Medicaid Provisions (includes impact on drug rebates)						
$7.9	$14.9	$17.4	$18.7	$19.1	$20.6	$98.5
FMAP for Newly Eligible						
95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	n/a

a/ Includes the cost of covering these children under Medicaid at regular FMAP less the cost of covering them under CHIP with the enhanced FMAP

Assumes that 60% of currently Medicaid eligible but uninsured will enroll under the proposal.

Source: Lewin Group Estimates using the Health Benefits Simulation Model HBSM.

Exhibit 14

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

I, Vivianne M. Chaumont, being first duly sworn, hereby depose and state as follows:

1. I am competent to testify to the matters in this Affidavit.
2. This Affidavit is based on my personal knowledge and is offered in support of Plaintiffs' Motion for Summary Judgment.
3. I am the Director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services (Nebraska DHHS). My responsibilities include the administration of the Medicaid program which is subject to requirements of state and federal regulatory and statutory authority. Neb. Rev. Stat. § 68-904 to 956; Titles XIX, 42 USC §1396a, et seq.

4. The Nebraska Medicaid program is a medical assistance program, created under Title XIX of the federal Social Security Act, for individuals who fit within federally defined eligibility categories.

5. Nebraska statute requires that the State of Nebraska accept and assent to all applicable provisions of Title XIX of the federal Social Security Act. Neb. Rev. Stat. § 68-906.

6. The State of Nebraska is required to have a State Plan, which is reviewed and approved by the federal Department of Health & Human Services Centers for Medicare and Medicaid Services (CMS). The Medicaid State Plan is the "comprehensive written document, developed and amended by [Nebraska DHHS] and approved by CMS, which describes the nature and scope of the medical assistance program and provides assurances that [Nebraska DHHS] will administer the program in compliance with federal requirements." Neb. Rev. Stat. 68-907(4).

7. As Medicaid Director, I am required to ensure that the Medicaid program is administered in compliance with federal law.

8. In order to receive federal financial participation (FFP), the State of Nebraska must comply with all federal requirements of the Medicaid program. FFP accounts for nearly 60% of the funds which pay for the Medicaid program, and amounts to over $1 billion annually.

9. As Director, I am generally aware of changes in federal law, including the Patient Protection and Affordable Care Act, PL 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, PL 111-152 (hereinafter, the Act) and it is part of my duties to consider what impact changes in federal law may have on Nebraska's Medicaid program.

10. Because the Act would add large new populations to Nebraska's Medicaid program, Nebraska DHHS retained the services of Milliman, Inc., an actuarial firm, to review the Act and submit a written analysis of the impact of that Act as it pertains to DHHS and the State's Medicaid program.

11. Milliman conducted its review and analysis and provided a report to Nebraska DHHS, a true and correct copy of which is attached and marked as Exhibit A.

12. Nebraska passed legislation to implement the Medicaid program in 1965.

13. The original Nebraska Medicaid program was established under the premise that Nebraska would be required to cover specified limited populations, including needy children and their caretaker relatives, needy disabled and needy elderly.

14. Prior to the Act, expansion of eligibles has been at the discretion of the State of Nebraska, taking into account state resources. The Act,

which would greatly expand eligibility beyond that originally contemplated by the Medicaid statute, regardless of the availability of state resources, was not contemplated.

15. The State of Nebraska has had the flexibility to stop coverage of any category of eligibles that was not mandatory. The Act takes that flexibility away from Nebraska. Not only is the federal government adding large new populations, it is restricting the state's ability to manage its resources by not allowing Nebraska to drop optional coverage of eligibles.

16. In addition, the State of Nebraska's discretion to change eligibility criteria has been taken away, as well as the State's ability to increase or implement new premiums and other tools needed to manage resources.

17. The Act increases rebate percentages for covered outpatient drugs provided to Medicaid clients. However, the Act provides that the impact of these increased rebate percentages will accrue to the federal government. The Milliman report estimates that this could reduce Nebraska's drug rebates between 20.7% to 22.6% beginning in January 2010, for a total negative impact of between $68.1 and $74.4 million dollars from state fiscal years 2011 through 2020. Please see Exhibit A.

18. The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 138% (based on the 5% disregard in the statute) of the federal poverty level will increase the State of Nebraska's share of expenses relating to Medicaid, with the costs increasing on an accelerated basis after 2016.

19. Prior to the Act, the statute and case law have been clear that states have to pay for services, but are not responsible for providing services. The Act's requirement that Nebraska be responsible for providing health care services to Medicaid enrollees is an expansion of Nebraska's responsibility, which could easily add to litigation against the State by leading to increased costs and litigation risks.

20. Based on 2008 census bureau statistics, the State of Nebraska has 210,674 uninsured persons living in the state. Of those, 85,031 are below 138% of the federal poverty level and must be added to the State of Nebraska's Medicaid rolls under the Act.

21. Medicaid outlays for the State of Nebraska consume 19% of the state's budget. For fiscal year 2009-2010, Nebraska spent approximately $1.5 billion dollars in total funds on Medicaid, servicing approximately 201,000 persons.

22. It would not be feasible for the State of Nebraska to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program prior to the Act taking effect.

23. The added cost to the State of Nebraska under the Act will not be offset by increased federal contributions under the Act.

24. The State of Nebraska estimated that 50 to 100% of persons who now have some form of health care insurance but fall below 138% of the federal poverty level will drop their coverage and enroll in Medicaid. These persons represent a significant cost to the State of Nebraska.

25. In order to implement the Act in 2014, there are numerous administrative changes, including system changes, which need to take place prior to 2014. No additional administrative funding has been provided to the states at a time when state resources, including the State of Nebraska's resources, are shrinking. The Milliman report estimates administrative costs at $82.4 to $106.8 million dollars for state fiscal years 2011 through 2020. Please see Exhibit A.

26. The State of Nebraska established the Medicaid program by adopting a statute authorizing establishment of the program. State legislation would be required to cease the program.

Further affiant sayeth not.

Vivianne M. Chaumont
Director, Division of Medicaid and Long-Term Care
Department of Health and Human Services

Subscribed and sworn to before me this 14th day of September, 2010.

NOTARY

GENERAL NOTARY - State of Nebraska
KELLY J. OSTRANDER
My Comm. Exp. June 21, 2011

Kelly J. Ostrander
September 14, 2010

Milliman

Chase Center/Circle
111 Monument Circle
Suite 601
Indianapolis, IN 46204-5128
USA

Tel +1 317 639 1000
Fax +1 317 639 1001

milliman.com

August 16, 2010

Ms. Vivianne Chaumont, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services
State of Nebraska
P.O. Box 95026
Lincoln, NE 68509-5026

RE: PATIENT PROTECTION AND AFFORDABLE CARE ACT WITH HOUSE RECONCILIATION – FINANCIAL ANALYSIS

Dear Vivianne:

Milliman, Inc. (Milliman) has been retained by the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (DHHS) to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (Affordable Care Act) as they relate to the provisions impacting the State's Medicaid program and budget. This correspondence documents the results of our analysis.

SUMMARY OF RESULTS

Milliman has developed two estimates of the enrollment and fiscal impact associated with the Medicaid expansion and other related provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. We have developed (1) a mid-range participation scenario adnd (2) a full participation scenario. We have prepared our fiscal analysis to reflect the state impact for state fiscal years 2011 through 2020. We have adjusted all data to reflect the three month offset between the federal fiscal year and the state fiscal year as appropriate.

Enclosures 1 and 2 provide the fiscal impact results of the Affordable Care Act under a mid-range participation scenario (Enclosure 1) and a full participation scenario (Enclosure 2). The total fiscal impact to the Nebraska Medicaid budget during the next 10 years would be estimated to be in the range of approximately $526.3 million to $765.9 million based upon the assumptions outlined in this document. Table 1 illustrates the anticipated expenditure impacts to the Nebraska Medicaid budget for the period of SFY 2011 through SFY 2020 under each scenario.

Table 1

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

State Budget Fiscal Impact – SFY 2011 through SFY 2020
(Values Illustrated in Millions)

Component	Estimated Fiscal Impact – State Only	
	Mid-Range Participation Scenario	Full Participation Scenario
Adults/Parents/Children Expansion to 138% FPL	$465.1	$617.3
Administration	82.4	106.8
Pharmacy Rebate Loss for Nebraska	68.1	74.4
Physician Fee Schedule Increase to Medicare Rates	0.0	56.8
Foster Children Coverage to Age 26	15.1	15.1
Medically Needy Expansion to 138% FPL	5.6	5.6
DSH Reduction	(18.8)	(18.8)
CHIP Enrollment Shift and FMAP Increase	(30.9)	(30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL	(60.5)	(60.5)
Total	**$526.3**	**$765.9**

Note: Values have rounded

Estimated Medicaid Enrollment Impact

Table 2 illustrates the projected increase in Medicaid enrollment reflecting a 138% Federal Poverty Level (FPL) limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The values in Table 2 were derived from the 2009 Current Population Survey (2009 CPS) data from the U.S. Census Bureau collected in 2009 (representing 2008 insurance and income data) as well as Medicaid enrollment data provided by DHHS. Children were defined as ages 0 through 19. The Adult and Parent populations were defined as ages 20 through 64.

Table 2

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

State Budget Enrollment Impact – 2009 CPS Census Data

Population	FPL Range	Enrollment Full Participation Scenario	Mid-Range Participation Assumption	Enrollment Mid-Range Participation Scenario
Uninsured Adults	0% - 138%	36,779	80%	29,423
Newly Eligible Parents	50% - 138%	20,510	85%	17,433
Woodwork Parents	< 50%	4,623	70%	3,236
Woodwork Children	<138%	23,119	80%	18,496
Insured Switchers – Adults	0% - 138%	23,916	50%	11,958
Insured Switchers – Parents	0% - 138%	21,429	75%	16,071
Insured Switchers – Children	0% - 138%	14,538	75%	10,903
State Disability (1)	0% - 138%	154	DHHS 133% FPL Assumption+ 5%	154
Medically Needy (2)	43% - 138%	229	DHHS 133% FPL Assumption +5%	229
Sub-total		145,297		107,903

Notes: (1) State Disability currently covered with state funds to 100% FPL. Enrollment reflects shift to Medicaid and FPL expansion estimated as of 2014.
(2) Enrollment reflects FPL expansion estimated as of 2014.

The mid-range participation rates in Table 2 were reviewed for consistency with participation in the Medicare program which exceeds 95% and the Medicaid/CHIP programs for children which exceeds 85%. Actual participation in the Medicaid program after the expansion may exceed the participation rates noted in these other programs, since there will be an individual mandate for health insurance coverage under federal health care reform legislation.

Percentage increase in Medicaid in relation to the total number of Nebraskans

- Calendar Year 2008 Nebraska Census Estimate 1,783,000
- Increase would be approximately 6.1% to 8.2% more Nebraska residents on Medicaid
- Increase from 11.6% to range of 17.7% - 19.8% - or nearly 1 in 5 Nebraskans

The remainder of this letter discusses each of the Medicaid components of health care reform as listed in Table 1.

a. Adults/Parents/Children Expansion to 138% FPL

The fiscal impact associated with the Adults, Parents, and Children expansion to 138% FPL includes both currently insured and uninsured individuals below the 138% FPL amount and children not currently covered under Medicaid, who are also below the 138% FPL limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The analysis presented in this report reflects full participation (full participation scenario) as well as an alternate participation assumption (mid-range participation scenario). The participation assumptions by population are presented in Table 2. The assumed average annual cost per enrollee by population as of State fiscal year 2009 is provided in Table 3.

Table 3

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

Average Cost per Enrollee as of SFY 2009

Population	Average Annual Cost
Uninsured Adults	$5,467
Newly Eligible Parents	$4,881
Woodwork Parents	$4,881
Woodwork Children	$2,654
Insured Switchers – Adults	$5,900
Insured Switchers – Parents	$5,268
Insured Switchers – Children	$2,950
State Disability (1)	$78,107
Medically Needy – Disabled (1)	$85,390
Medically Needy – Long-Term (1)	$109,932

Notes: (1) State Disability and Medically Needy costs provided by DHHS for FFY 2014.

The cost estimates for the State Disability and Medically Needy populations were obtained from the health care reform projection provided by DHHS. All other annual cost estimates were developed from SFY 2009 enrollment and expenditures provided in the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 with appropriate adjustments. The values in Table 3 reflect the age/gender mix of each population based upon the 2009 CPS census data. For example, the insured switcher adult population does not have the same age distribution as the uninsured adult population which impacts expected average cost. Milliman additionally used internally available data from other Medicaid expansion analyses to develop the cost relationship between adults and parents. Milliman assumed a composite annual trend of 3.0% to project the claim cost for the expansion population into future years. The 3.0% trend reflects the impact of enrollment growth as well as projected trend for utilization and intensity of services.

The Affordable Care Act reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

Milliman assumed that the projected FFY 2012 FMAP rate of 57.64% for Medicaid and 70.35% for CHIP would continue through 2020 for non-expansion populations.

b. Administration

In addition to the expenditures associated with providing medical services, Nebraska will incur additional administrative expenditures. The expenditures for the initial modifications to the current administrative systems, as well as establishment of an Exchange, are estimated to be $25 million (State and Federal) or $12.5 million (State only). On-going costs for the coverage of the additional 108,000 to 145,000 Medicaid enrollees are estimated to be $21.5 to $29.0 million per year (State and Federal) or $10.8 to $14.5 million per year (State only). The on-going costs were developed assuming approximately $200 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenses would be anticipated to be incurred in calendar years 2012 and 2013 for the initial administrative expenditures and in calendar year 2014 forward for the on-going expenditures.

c. Pharmacy Rebate Loss for Nebraska

The Affordable Care Act includes increased rebate percentages for covered outpatient drugs provided to Medicaid patients. The minimum rebate percentage is increased from 15.1% to 23.1% for most brand name drugs and from 11% to 13% for generic drugs effective January 1, 2010. However, the Affordable Care Act indicates that the impact will be accrued 100% to the Federal government. Milliman has modeled that this could reduce Nebraska's rebates by 20.7% to 22.6% or more beginning on January 1, 2010. The 20.7% assumption used for the mid-range participation scenario corresponds to a 75%/25% distribution of brand-name/generic pharmacy expenditures. An 8% reduction for brand-name drugs and a 2% reduction for generic drugs equates to an average 6.5% reduction under the 75%/25% assumption. The 6.5% reduction is approximately 20.7% of the current 31.5% assumed rebate level. The 22.6% assumption used for the full participation scenario corresponds to an 85%/15% distribution of brand-name/generic pharmacy expenditures.

d. Physician Fee Schedule Increase to Medicare Rates

According to an April 2009 report by the Urban Institute's Health Policy Center, the current Nebraska Medicaid fee schedule reimburses at approximately 82% of the Medicare fee schedule for primary care services. The Affordable Care Act requires an increase in the Medicaid physician fee schedule for a

limited set of primary and preventive care services to 100% of the Medicare physician fee schedule. 100% Federal funding is available for calendar years 2013 and 2014. No additional funding is available for other physician services.

Full Participation Scenario –

The full participation scenario assumes that DHHS will increase the fee schedule for the required services for both primary care and specialty care providers and will continue the increased fee schedule after calendar year 2014 to assure continued access to physician care. In addition to increasing the expected cost of corresponding existing expenditures by approximately 22%, the analysis reflects an additional $120 per year for the dual eligible population since Medicare only pays 80% of the fee schedule for Part B services.

Under the full participation scenario, the increased cost would be an estimated $27 million (State and Federal) per year for the current Medicaid program and expansion populations. During calendar years 2013 and 2014, the state would have to pay the standard state portion of the increase for specialty providers for the existing Medicaid population. Therefore, the state share in these two calendar years would be approximately $2.8 million (State only) per year. In 2015, the State only cost for the fee schedule expansion would grow to an estimated $9 million (State only).

Mid-Range Participation Scenario –

The mid-range participation scenario assumes that DHHS will only increase the fee schedule for primary care providers, not specialty care providers. The mid-range participation scenario further assumes that the fee schedule increase will only continue through calendar year 2014 and will terminate when the Federal funding level decreases. The annual cost would be approximately $18 million and reflects 100% Federal funding for the calendar year 2013 and 2014 period.

e. Foster Children Coverage to Age 26

It is Milliman's understanding that Nebraska currently provides Medicaid eligibility coverage to Foster Children to age 19. The Affordable Care Act includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. Milliman has estimated the annual cost at $5.5 million per year (State and Federal) or approximately $2.3 million per year (State only).

f. Medically Needy Expansion to 138% FPL

The Medically Needy population is currently covered to 43% FPL. The population is limited to non-Dual eligibles under age 65. Effective January 1, 2014, the population will be covered to 138% FPL including the 5% income disregard allowance. Milliman has utilized the DHHS expenditure estimate for the Medically Needy population for fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

g. DSH Reduction

Based upon the aggregate Disproportionate Share Hospital (DSH) payment reductions indicated in the Affordable Care Act, Milliman developed average Federal fiscal year DSH reduction percentages. Milliman adjusted the Federal fiscal year percentages to a State fiscal year basis. The baseline DSH expenditures of $44.0 million provided by DHHS were ultimately reduced to two-thirds of the National reduction percentage. The reduction was reduced to two-thirds of the National percentage to reflect that Nebraska is a low DSH state.

Federal Fiscal Year	DSH Percentage Reduction	
	National Percentage	Nebraska Percentage
2014	4.4%	2.9%
2015	5.3%	3.5%
2016	5.3%	3.5%
2017	15.9%	10.6%
2018	44.1%	29.4%
2019	49.4%	32.9%
2020	35.3%	23.5%

Note: Nebraska percentage reduction was estimated at 2/3 of National percentage reduction since Nebraska is a low DSH state.

h. CHIP Enrollment Shift and FMAP Increase

Under the Affordable Care Act, the CHIP program is required to continue to 2019. However, the legislation provides an additional Federal matching rate of 23% beginning on October 1, 2015 and ending September 30, 2019. The additional 23% FMAP will increase the total FMAP for the CHIP program to approximately 93.35%. The enhanced FMAP will decrease expenditures for Nebraska and increase expenditures for the Federal share.

The projection additionally reflects that approximately 30% of current CHIP program enrollees will shift to Medicaid eligibility effective January 1, 2014. The 30% reflects CHIP enrollees <138% FPL.

i. State Disability Shift to Medicaid and Expansion to 138% FPL

Nebraska currently covers the State Disability population to 100% FPL with 100% state funds. Milliman has utilized the DHHS expenditure estimate for the State Disability population for Federal fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

OTHER CHANGES TO CURRENT PROGRAMS

Milliman anticipates potential savings from the following populations even if the programs are not discontinued. However, savings estimates have not been included in the total impact projection for either the full participation scenario or mid-range participation scenario.

Pregnant Women above 138% FPL

The State of Nebraska currently provides eligibility for pregnant women up to 185% FPL. It would be anticipated that the majority of pregnant women between 138% FPL and 185% FPL will receive care through the insurance exchange. We have estimated that approximately 10% of the current expenditures for the pregnant women population will no longer be incurred by the Nebraska Medicaid program. We have estimated the annual savings to be approximately $3.4 million (State and Federal) per year or $1.4 million (State only) per year beginning on January 1, 2014.

Breast and Cervical Cancer Program

The State of Nebraska currently provides eligibility under the Breast and Cervical Cancer program. The total annual expenditures under the program are approximately $5.0 million (State and Federal) or $1.5 million (State only). It is not anticipated that this program will be required to be continued with the expansion requirements below 138% FPL and insurance reforms for individuals above 138% FPL. Therefore, we have estimated that this program could be terminated beginning on January 1, 2014; although, some of these individuals will become eligible under the new Medicaid eligibility requirements.

LIMITATIONS

The information contained in this correspondence, including any enclosures, has been prepared for the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by DHHS as well as enrollment and expenditure data obtained from the Medicaid Statistical Information System (MSIS) State Summary Datamart and the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 as retrieved from the DHHS website. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Nebraska Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.

If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

Milliman

ENCLOSURE 1

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Participation Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Current Programs											
Medicaid											
Total (State and Federal)	$1,745.1	$1,792.5	$1,841.2	$1,891.3	$1,942.7	$1,995.5	$2,049.7	$2,105.4	$2,162.6	$2,221.4	$19,747.6
Federal Funds	$1,029.1	$1,036.8	$1,061.3	$1,090.1	$1,119.8	$1,150.2	$1,181.5	$1,213.6	$1,246.5	$1,280.4	$11,409.3
State Funds	$716.0	$755.7	$780.0	$801.2	$822.9	$845.3	$868.3	$891.9	$916.1	$941.0	$8,338.3
CHIP											
Total (State and Federal)	$63.2	$65.1	$67.0	$69.0	$71.1	$73.3	$75.4	$77.7	$80.0	$82.4	$724.4
Federal Funds	$45.0	$45.9	$47.2	$48.6	$50.0	$51.5	$53.1	$54.7	$56.3	$58.0	$510.3
State Funds	$18.1	$19.2	$19.9	$20.5	$21.1	$21.7	$22.4	$23.0	$23.7	$24.4	$214.1
State Disability											
Total (State and Federal)	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
All Programs											
Total (State and Federal)	$1,816.4	$1,866.0	$1,916.9	$1,969.2	$2,023.0	$2,078.2	$2,134.9	$2,193.2	$2,253.0	$2,314.4	$20,565.3
Federal Funds	$1,074.1	$1,082.7	$1,108.5	$1,138.7	$1,169.8	$1,201.7	$1,234.6	$1,268.2	$1,302.9	$1,338.4	$11,919.6
State Funds	$742.3	$783.3	$808.5	$830.5	$853.2	$876.5	$900.4	$924.9	$950.1	$976.0	$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Participation Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Health Care Reform											
Adults/Parents/Children - Expansion to 138% FPL											
Total (State and Federal) - Newly Eligible				$142.6	$293.7	$302.5	$311.6	$320.9	$330.5	$340.5	$2,042.2
Total (State and Federal) - Woodwork				$37.6	$77.5	$79.8	$82.2	$84.7	$87.2	$89.8	$538.7
Total (State and Federal) - Insured Switchers				$108.6	$223.8	$230.5	$237.4	$244.5	$251.8	$259.4	$1,556.0
Federal Funds				$265.0	$545.8	$562.2	$566.4	$567.6	$579.3	$585.6	$3,671.8
State Funds				$23.8	$49.1	$50.6	$64.8	$82.4	$90.3	$104.1	$465.1
Administrative Expenses											
Total (State and Federal)		$6.3	$12.5	$17.0	$21.5	$21.5	$21.5	$21.5	$21.5	$21.5	$164.8
Federal Funds		$3.1	$6.3	$8.5	$10.8	$10.8	$10.8	$10.8	$10.8	$10.8	$82.4
State Funds		$3.1	$6.3	$8.5	$10.8	$10.8	$10.8	$10.8	$10.8	$10.8	$82.4
Pharmacy Rebate Loss for Nebraska											
Total (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	($5.0)	($5.5)	($5.8)	($6.2)	($6.5)	($6.9)	($7.4)	($7.8)	($8.3)	($8.8)	($68.1)
State Funds	$5.0	$5.5	$5.8	$6.2	$6.5	$6.9	$7.4	$7.8	$8.3	$8.8	$68.1
Physician Fee Schedule Increase to Medicare Rates											
Total (State and Federal)			$7.2	$18.3	$9.4	$0.0	$0.0	$0.0	$0.0	$0.0	$34.9
Federal Funds			$7.2	$18.3	$9.4	$0.0	$0.0	$0.0	$0.0	$0.0	$34.9
State Funds			$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Foster Children Coverage to Age 26											
Total (State and Federal)				$2.8	$5.5	$5.5	$5.5	$5.5	$5.5	$5.5	$35.8
Federal Funds				$1.6	$3.2	$3.2	$3.2	$3.2	$3.2	$3.2	$20.6
State Funds				$1.2	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$15.1
Medically Needy Expansion to 138% FPL											
Total (State and Federal)				$10.6	$21.8	$22.5	$23.2	$23.9	$24.6	$25.3	$151.9
Federal Funds				$10.6	$21.8	$22.5	$22.6	$22.6	$23.0	$23.2	$146.2
State Funds				$0.0	$0.0	$0.0	$0.6	$1.3	$1.6	$2.2	$5.6
DSH Reduction											
Total (State and Federal)				($1.0)	($1.5)	($1.6)	($3.9)	($10.9)	($14.1)	($11.4)	($44.3)
Federal Funds				($0.6)	($0.9)	($0.9)	($2.2)	($6.3)	($8.1)	($6.6)	($25.5)
State Funds				($0.4)	($0.6)	($0.7)	($1.7)	($4.6)	($6.0)	($4.8)	($18.8)

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Participation Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
CHIP Enrollment Shift and FMAP Increase											
Total (State and Federal)				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds				($1.3)	($2.7)	$6.1	$9.3	$9.5	$9.8	$0.2	$30.9
State Funds				$1.3	$2.7	($6.1)	($9.3)	($9.5)	($9.8)	($0.2)	($30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL											
Total (State and Federal)				$1.6	$3.4	$3.5	$3.6	$3.7	$3.8	$3.9	$23.6
Federal Funds				$6.1	$12.6	$12.9	$13.0	$13.0	$13.2	$13.3	$84.0
State Funds				($4.4)	($9.2)	($9.4)	($9.4)	($9.3)	($9.4)	($9.4)	($60.5)
All Programs - After Expansion											
Total (State and Federal)	$1,816.4	$1,872.2	$1,936.6	$2,307.3	$2,678.0	$2,742.4	$2,815.9	$2,886.9	$2,963.9	$3,049.0	$25,068.7
Federal Funds	$1,069.1	$1,080.3	$1,116.1	$1,440.7	$1,763.2	$1,811.5	$1,850.1	$1,880.8	$1,925.7	$1,959.2	$15,896.7
State Funds	$747.3	$791.9	$820.5	$866.6	$914.8	$930.9	$965.8	$1,006.1	$1,038.2	$1,089.8	$9,172.0
All Programs - Fiscal Impact											
Total (State and Federal)	$0.0	$6.3	$19.7	$338.1	$655.0	$664.2	$681.0	$693.8	$710.9	$734.5	$4,503.4
Federal Funds	($5.0)	($2.3)	$7.6	$302.0	$593.4	$609.8	$615.5	$612.6	$622.8	$620.8	$3,977.1
State Funds	$5.0	$8.6	$12.1	$36.1	$61.6	$54.4	$65.5	$81.2	$88.0	$113.7	$526.3
Optional Changes to Current Programs											
Pregnant Women (133% - 185%)											
Total (State and Federal)				($1.6)	($3.3)	($3.4)	($3.5)	($3.6)	($3.7)	($3.8)	($22.8)
Federal Funds				($0.9)	($1.9)	($2.0)	($2.0)	($2.1)	($2.1)	($2.2)	($13.2)
State Funds				($0.7)	($1.4)	($1.4)	($1.5)	($1.5)	($1.6)	($1.6)	($9.7)
Breast & Cervical Cancer											
Total (State and Federal)				($2.4)	($5.0)	($5.2)	($5.3)	($5.5)	($5.6)	($5.8)	($34.8)
Federal Funds				($1.7)	($3.5)	($3.6)	($3.7)	($3.8)	($3.9)	($4.0)	($24.4)
State Funds				($0.7)	($1.5)	($1.5)	($1.6)	($1.6)	($1.7)	($1.7)	($10.3)

Milliman

ENCLOSURE 2

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Full Participation Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Current Programs											
Medicaid											
Total (State and Federal)	$1,745.1	$1,792.5	$1,841.2	$1,891.3	$1,942.7	$1,995.5	$2,049.7	$2,105.4	$2,162.6	$2,221.4	$19,747.6
Federal Funds	$1,029.1	$1,036.8	$1,061.3	$1,090.1	$1,119.8	$1,150.2	$1,181.5	$1,213.6	$1,246.5	$1,280.4	$11,409.3
State Funds	$716.0	$755.7	$780.0	$801.2	$822.9	$845.3	$868.3	$891.9	$916.1	$941.0	$8,338.3
CHIP											
Total (State and Federal)	$63.2	$65.1	$67.0	$69.0	$71.1	$73.3	$75.4	$77.7	$80.0	$82.4	$724.4
Federal Funds	$45.0	$45.9	$47.2	$48.6	$50.0	$51.5	$53.1	$54.7	$56.3	$58.0	$510.3
State Funds	$18.1	$19.2	$19.9	$20.5	$21.1	$21.7	$22.4	$23.0	$23.7	$24.4	$214.1
State Disability											
Total (State and Federal)	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
All Programs											
Total (State and Federal)	$1,816.4	$1,866.0	$1,916.9	$1,969.2	$2,023.0	$2,078.2	$2,134.9	$2,193.2	$2,253.0	$2,314.4	$20,565.3
Federal Funds	$1,074.1	$1,082.7	$1,108.5	$1,138.7	$1,169.8	$1,201.7	$1,234.6	$1,268.2	$1,302.9	$1,338.4	$11,919.6
State Funds	$742.3	$783.3	$808.5	$830.5	$853.2	$876.5	$900.4	$924.9	$950.1	$976.0	$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Full Participation Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Health Care Reform											
Adults/Parents/Children - Expansion to 138% FPL											
Total (State and Federal) - Newly Eligible				$174.6	$359.6	$370.4	$381.5	$393.0	$404.8	$416.9	$2,500.8
Total (State and Federal) - Woodwork				$48.6	$100.2	$103.2	$106.3	$109.5	$112.8	$116.2	$696.8
Total (State and Federal) - Insured Switchers				$172.1	$354.5	$365.1	$376.1	$387.4	$399.0	$411.0	$2,465.2
Federal Funds				$364.2	$750.2	$772.7	$778.3	$779.9	$795.9	$804.4	$5,045.5
State Funds				$31.1	$64.1	$66.1	$85.6	$109.9	$120.7	$139.7	$617.3
Administrative Expenses											
Total (State and Federal)		$6.3	$12.5	$20.8	$29.0	$29.0	$29.0	$29.0	$29.0	$29.0	$213.5
Federal Funds		$3.1	$6.3	$10.4	$14.5	$14.5	$14.5	$14.5	$14.5	$14.5	$106.8
State Funds		$3.1	$6.3	$10.4	$14.5	$14.5	$14.5	$14.5	$14.5	$14.5	$106.8
Pharmacy Rebate Loss for Nebraska											
Total (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	($5.5)	($6.0)	($6.4)	($6.7)	($7.1)	($7.6)	($8.0)	($8.5)	($9.0)	($9.6)	($74.4)
State Funds	$5.5	$6.0	$6.4	$6.7	$7.1	$7.6	$8.0	$8.5	$9.0	$9.6	$74.4
Physician Fee Schedule Increase to Medicare Rates											
Total (State and Federal)			$10.1	$27.3	$28.1	$28.9	$29.7	$30.5	$31.3	$32.2	$218.0
Federal Funds			$8.9	$24.5	$22.7	$20.3	$20.6	$20.9	$21.4	$21.8	$161.3
State Funds			$1.2	$2.8	$5.4	$8.6	$9.0	$9.5	$9.9	$10.4	$56.8
Foster Children Coverage to Age 26											
Total (State and Federal)				$2.8	$5.5	$5.5	$5.5	$5.5	$5.5	$5.5	$35.8
Federal Funds				$1.6	$3.2	$3.2	$3.2	$3.2	$3.2	$3.2	$20.6
State Funds				$1.2	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$15.1
Medically Needy Expansion to 138% FPL											
Total (State and Federal)				$10.6	$21.8	$22.5	$23.2	$23.9	$24.6	$25.3	$151.9
Federal Funds				$10.6	$21.8	$22.5	$22.6	$22.6	$23.0	$23.2	$146.2
State Funds				$0.0	$0.0	$0.0	$0.6	$1.3	$1.6	$2.2	$5.6
DSH Reduction											
Total (State and Federal)				($1.0)	($1.5)	($1.6)	($3.9)	($10.9)	($14.1)	($11.4)	($44.3)
Federal Funds				($0.6)	($0.9)	($0.9)	($2.2)	($6.3)	($8.1)	($6.6)	($25.5)
State Funds				($0.4)	($0.6)	($0.7)	($1.7)	($4.6)	($6.0)	($4.8)	($18.8)

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Full Participation Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
CHIP Enrollment Shift and FMAP Increase											
Total (State and Federal)				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds				($1.3)	($2.7)	$6.1	$9.3	$9.5	$9.8	$0.2	$30.9
State Funds				$1.3	$2.7	($6.1)	($9.3)	($9.5)	($9.8)	($0.2)	($30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL											
Total (State and Federal)				$1.6	$3.4	$3.5	$3.6	$3.7	$3.8	$3.9	$23.6
Federal Funds				$6.1	$12.6	$12.9	$13.0	$13.0	$13.2	$13.3	$84.0
State Funds				($4.4)	($9.2)	($9.4)	($9.4)	($9.3)	($9.4)	($9.4)	($60.5)
All Programs - After Expansion											
Total (State and Federal)	$1,816.4	$1,872.2	$1,939.5	$2,426.7	$2,923.6	$3,004.8	$3,085.9	$3,164.7	$3,249.7	$3,343.0	$26,826.5
Federal Funds	$1,068.6	$1,079.8	$1,117.2	$1,547.4	$1,984.1	$2,045.4	$2,085.7	$2,117.1	$2,166.7	$2,202.8	$17,414.9
State Funds	$747.8	$792.4	$822.3	$879.2	$939.6	$959.3	$1,000.1	$1,047.6	$1,083.0	$1,140.3	$9,411.6
All Programs - Fiscal Impact											
Total (State and Federal)	$0.0	$6.3	$22.6	$457.4	$900.7	$926.6	$951.0	$971.5	$996.7	$1,028.6	$6,261.2
Federal Funds	($5.5)	($2.8)	$8.8	$408.7	$814.3	$843.7	$851.2	$848.8	$863.8	$864.4	$5,495.3
State Funds	$5.5	$9.1	$13.8	$48.7	$86.4	$82.9	$99.8	$122.7	$132.8	$164.2	$765.9
Optional Changes to Current Programs											
Pregnant Women (133% - 185%)											
Total (State and Federal)				($1.6)	($3.3)	($3.4)	($3.5)	($3.6)	($3.7)	($3.8)	($22.8)
Federal Funds				($0.9)	($1.9)	($2.0)	($2.0)	($2.1)	($2.1)	($2.2)	($13.2)
State Funds				($0.7)	($1.4)	($1.4)	($1.5)	($1.5)	($1.6)	($1.6)	($9.7)
Breast & Cervical Cancer											
Total (State and Federal)				($2.4)	($5.0)	($5.2)	($5.3)	($5.5)	($5.6)	($5.8)	($34.8)
Federal Funds				($1.7)	($3.5)	($3.6)	($3.7)	($3.8)	($3.9)	($4.0)	($24.4)
State Funds				($0.7)	($1.5)	($1.5)	($1.6)	($1.6)	($1.7)	($1.7)	($10.3)