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Estimated State Budget Impact of an Oklahoma SoonerCare Expansion

Prepared by Manatt Health for the Oklahoma Hospital Association

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Estimated State Budget Impact of an Oklahoma SoonerCare Expansion

In 2012, the United States Supreme Court ruled that the Medicaid expansion authorized by the Affordable Care Act (ACA) was optional. That is, each state could decide whether or not to use its Medicaid program to cover all adults with incomes below 138% of the Federal Poverty Level (FPL). States that opt to cover the new adult group receive an enhanced federal matching rate, starting at 100% in 2014 through 2016 and then declining annually and leveling off at 90% in 2020 and beyond. To date, 31 states plus the District of Columbia have expanded.

This report examines the budget implications of using SoonerCare (Oklahoma's Medicaid program) to cover adults with incomes up to 138% of the FPL beginning in 2017. Were the State to take up this option, it is projected that 272,000 individuals would gain coverage in the new adult group on average during 2019 (the first calendar year of full enrollment after a ramp-up period). Prior to the application of any savings or revenue offsets, the five-year total costs associated with extending coverage to the new adult group are an estimated $8.3 billion, of which the federal government would finance $7.5 billion and Oklahoma would cover $739 million.

However, it is anticipated that the State would be able to offset a considerable portion of its costs by accessing enhanced federal match for some current SoonerCare populations and by replacing State general fund spending on healthcare programs for uninsured populations with federal Medicaid funds. In addition, as hospitals' revenues increase with the number of people covered, Oklahoma could expect to see higher State revenues from its existing hospital assessment. Enrollee premium contributions could also provide a source of revenue. From 2017 through 2021, it is projected that Oklahoma could see $491 million in savings and $52 million in new revenues, bringing the net State costs of covering the new adult group to $196 million during this five-year period. Not included in these figures are potential State savings under a recent change in federal policy that could provide tens of millions in additional federal matching funds annually for individuals served by Indian Health Service and Tribal facilities, which could help to offset the cost of covering the new adult group.

A variety of sources were examined to develop our estimates. These include data from the Oklahoma Health Care Authority (OHCA) on current SoonerCare enrollment and spending, estimates of State-only spending on low-income uninsured adults previously developed for OHCA, earlier estimates of SoonerCare costs and savings for the new adult group, and findings from states that have already expanded Medicaid. Detailed data and methods can be found in the Appendix.

The discussion throughout this report focuses on the period 2017–2021, during which new adult group costs and savings are expected to grow and then stabilize. We also provide 10-year estimates in the Appendix. Although our estimates are based on the best information currently available, the longer-term projections—of both new adult group and existing program costs—are inherently less certain and should be viewed with caution.

Not analyzed in this report are the broader economic impacts Oklahoma will realize through new spending that generates jobs, income, and tax revenues in the State. Impacts on healthcare providers via reductions in uncompensated care costs for the uninsured also are not addressed. Both of these gains are important additional areas of analysis for Oklahoma as it contemplates coverage for the new adult group.

I. Background

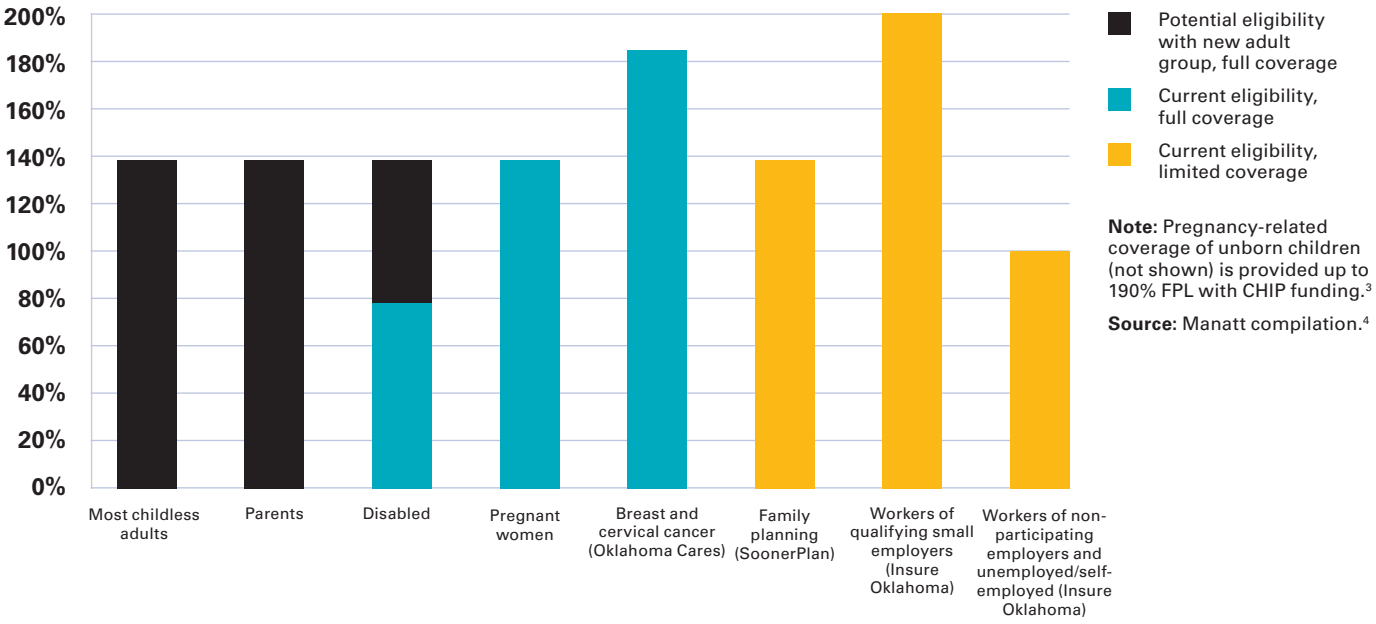
To provide context for the analysis in this report, a summary of Oklahoma's current SoonerCare eligibility and financing is provided here, along with information on key federal provisions related to coverage of the new adult group.

SoonerCare Eligibility

More than 1 million Oklahomans were enrolled in coverage funded by Medicaid and the State Children's Health Insurance Program (CHIP) for some portion of state fiscal year (SFY) 2015, at a total cost of $5.1 billion.[1] This figure includes about 370,000 adults ages 19 to 64.[2] As shown in Figure 1, Oklahoma's current coverage of adults extends to 46% FPL for parents, 79% FPL for individuals eligible based on a disability, 138% FPL for pregnant women, and 185% FPL for certain women with breast or cervical cancer. The State also has limited coverage for other adults under a Section 1115 waiver and a family planning-only benefit.

Under the ACA, states may opt to provide Medicaid coverage to childless adults and parents above state eligibility levels that were in place as of December 1, 2009, up to 138% FPL. If Oklahoma were to cover the new adult group under SoonerCare, the State would not only extend coverage to a new population of individuals but also provide access to a full benefit package for those whose current coverage is more limited in scope.

Figure 1. SoonerCare Eligibility Levels for Adults as a Percentage of the FPL



Note: Pregnancy-related coverage of unborn children (not shown) is provided up to 190% FPL with CHIP funding.[3]

Source: Manatt compilation.[4]

State and Federal Financing

Under the ACA, the federal government is obligated to pay 100% of the 2014–2016 costs of individuals in the new adult group who meet the statutory definition of newly eligible,[5] phasing down to 90% in 2020 and beyond (Table 1). Today, the federal medical assistance percentage (FMAP) that applies to most Medicaid spending in Oklahoma is approximately 61%. Certain expenditures receive a higher federal share, including services for women eligible for coverage based on their need for breast or cervical cancer treatment at 73%; family planning services and supplies at 90%; and services delivered through Indian Health Service and Tribal facilities at 100% (see Box 1).

Table 1. Federal Share of Spending for Oklahoma Medicaid Populations and Services

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020+
Newly eligible adults	100%	100%	100%	95%	94%	93%	90%
	FY 2014	**FY 2015**	**FY 2016**	**FY 2017**			
Most other populations	64.02%	62.30%	60.99%	59.94%			
CHIP	74.81%	73.61%	72.69%	71.96%			
					All years		
Family planning services					90%		
Services through Indian Health Service and Tribal facilities					100%		

Note: CY is calendar year; FY is federal fiscal year. The CHIP federal share applies to Medicaid spending for women eligible based on their need for breast or cervical cancer treatment (a higher CHIP match is available for children).

Source: ASPE and CMS.[6]

Box 1. Expanded Access to 100% Federal Share for Indian Health Service and Tribal Facility Services

Recently released guidance from the federal Centers for Medicare & Medicaid Services (CMS) expands the circumstances under which 100% federal funding is available for individuals who receive Medicaid services through Indian Health Service and Tribal facilities.[7] This change could lower the cost of Oklahoma's existing SoonerCare program by tens of millions of dollars each year. It could also lower the State's cost of covering the new adult group, as individuals receiving services through Indian Health providers continue to be eligible for 100% federal funding, while the rate for newly eligible adults decreases to 90%. Oklahoma currently spends about $111 million

in State funds for individuals who receive care from both Indian and non-Indian Health providers.[8] Even if the State obtained 100% federal funding for only 10% of this amount in 2017, it would realize savings of $11 million.

Under the new CMS guidance, states may claim 100% federal funding for services rendered by non-Indian Health providers if an individual remains in the care of an Indian Health provider under a written care coordination agreement and a number of other conditions are met. To the extent that such agreements are implemented, spending for enrollees who currently use a mix of services from Indian and non-Indian Health providers will be eligible for increased federal funding. This change would affect current SoonerCare enrollees, as well as new adult group enrollees if the State were to cover them. As noted in the Appendix, estimates for the new adult group in this report reflect current State claiming practices for Indian Health. However, if Oklahoma were to increase its claiming of 100% federal funding in light of the recent CMS guidance, State costs for the new adult group would be lower.

II. Costs

In estimating the costs of providing SoonerCare coverage to the new adult group beginning in 2017, we factor in service costs for the new adult group, service costs associated with the so-called woodwork or welcome-mat population, and administrative costs. The estimates are discussed below, and additional details regarding data and methods can be found in the Appendix.

Service Costs for the New Adult Group

If the State were to take up the ACA option, SoonerCare could cover adults with incomes up to 138% FPL in Oklahoma, including parents with incomes from 47% to 138% FPL. As shown in Table 2, an estimated 272,000 individuals would gain coverage in the new adult group on average during 2019, the first calendar year of full enrollment after a ramp-up period of 18 months. Estimated costs to the State of providing services to the new adult group are $48 million in 2017 and total $595 million through 2021 prior to the application of any savings or offsets.

To obtain the number of individuals who would potentially enroll in the new adult group, we estimate the size of the eligible population using a combination of survey and administrative data. In particular, we determine the number of uninsured and privately insured adults below 138% FPL by examining American Community Survey (ACS) data that have been grouped into health insurance units (HIUs). HIUs reflect the people whose income would be counted together for Medicaid eligibility purposes, and they result in a higher estimate of eligible individuals relative to ACS tables published by the Census Bureau that use a family definition of income.[9] We then apply assumptions regarding the percentage of the eligible population that would enroll. For uninsured individuals, we generally assume that 75% will take up coverage when the program has fully ramped up; for those with private coverage, we

generally assume that 10% will choose to participate.[10]

To estimate the service costs associated with individuals who would enroll, we use OHCA information on per-enrollee spending for current Insure Oklahoma Individual Plan enrollees below 100% FPL who receive State-sponsored coverage. This amount is trended forward using cost growth assumptions described in the Appendix. Given that spending per enrollee increased when the State reduced eligibility from 200% to 100% FPL in January 2014, current Individual Plan experience may overstate the costs of a population with coverage up to 138% FPL. However, given the possibility of pent-up demand for services among currently uninsured individuals and a desire to err on the side of a conservative estimate, we use the current experience as our starting point.

Service Costs for the Woodwork Population

In addition to covering those who were previously ineligible for SoonerCare, extending coverage to the new adult group may encourage currently eligible but unenrolled individuals to take up coverage, a phenomenon referred to as the woodwork or welcome-mat effect. Although estimates of the size of this effect vary, even a non-expansion state such as Oklahoma would already have experienced it to some degree in connection with the opening of the Marketplace, the simplification of the Medicaid application process, and general publicity surrounding health reform as of 2014. As shown in Table 2, State costs of services associated with a woodwork effect are estimated at $13 million in 2017 and $74 million through 2021.

Administrative Costs

Oklahoma should expect to see increased administrative costs as the size of the SoonerCare program grows. Costs related to eligibility and enrollment infrastructure are matched by the federal government at an enhanced rate (75% for personnel and 90% for systems),[11] while the State would receive the standard 50% federal match for other administrative expenses. Administrative costs to the State associated with extending SoonerCare coverage to the new adult group are estimated at $9 million in 2017 and $70 million through 2021.

Table 2. Estimated Costs of Extending SoonerCare Coverage to the New Adult Group, Prior to Application of Savings and Revenue Offsets, CYs 2017 – 2021 (millions)

	2017	2018	2019	2020	2021	2017 – 2021
Number potentially eligible for new adult group	534,000	538,000	542,000	546,000	550,000	–
Uninsured	266,000	268,000	270,000	272,000	274,000	–
Privately insured	268,000	270,000	272,000	274,000	276,000	–
Number estimated to gain coverage in new adult group	179,000	251,000	272,000	273,000	275,000	–
Uninsured	140,000	195,000	212,000	213,000	215,000	–
Privately insured	40,000	55,000	60,000	60,000	61,000	–

Table 2. Estimated Costs of Extending SoonerCare Coverage to the New Adult Group, Prior to Application of Savings and Revenue Offsets, CYs 2017 – 2021 (millions), continued

	2017	2018	2019	2020	2021	2017 – 2021
Total costs for new adult and woodwork enrollees	$1,073	$1,562	$1,776	$1,882	$1,995	$8,288
Federal	$1,003	$1,450	$1,634	$1,681	$1,781	$7,549
State	$70	$112	$142	$202	$214	$739
Components of total:						
Service costs for new adult group	*$1,011*	*$1,487*	*$1,694*	*$1,795*	*$1,902*	*$7,889*
Federal	*$963*	*$1,402*	*$1,582*	*$1,625*	*$1,722*	*$7,294*
State	*$48*	*$85*	*$112*	*$170*	*$180*	*$595*
Service costs for woodwork group	*$38*	*$40*	*$42*	*$45*	*$48*	*$212*
Federal	*$25*	*$26*	*$28*	*$29*	*$31*	*$138*
State	*$13*	*$14*	*$15*	*$16*	*$17*	*$74*
Administrative costs for new enrollees	*$24*	*$35*	*$40*	*$42*	*$45*	*$186*
Federal	*$15*	*$22*	*$25*	*$26*	*$28*	*$116*
State	*$9*	*$13*	*$15*	*$16*	*$17*	*$70*

Note: Components may not sum to totals because of rounding.

Source: Manatt analysis; see Appendix for details.

III. Savings

Based on the experience of states that have already opted to cover the new adult group under Medicaid, Oklahoma can expect savings in two categories: savings from accessing enhanced federal matching funds for some current enrollees, and savings from replacing State funds with federal Medicaid funds for healthcare programs for uninsured low-income adults. Additional details regarding the data and methods used to arrive at savings estimates can be found in the Appendix.

State Savings Opportunities: Accessing Enhanced Federal Matching Funds for Existing SoonerCare Populations

Oklahoma can expect to see savings as certain currently eligible SoonerCare populations

move from eligibility categories with a regular federal matching rate to the new adult group, for which the State may draw down an enhanced match. These populations include:

- **Pregnant women.** If the State opts to extend coverage, women in Oklahoma who become pregnant while enrolled in the new adult group (reflecting those who are first-time parents and parents with incomes above 46% of the FPL) will remain in that group at least until their next eligibility renewal. While in the new adult group, the State will be able to claim enhanced federal match for the costs of all services they receive. Previously, these women would have been covered only with a regular federal match, resulting in State savings from covering the new adult group. Arkansas, for example, saw spending on its pregnant women group drop by 50% after it expanded Medicaid;[12] additional states have reported a range of savings estimates.[13] Oklahoma would likewise save money in this category. State savings associated with extending coverage to the new adult group under SoonerCare are estimated at $129 million for the pregnant women group during the period 2017–2021.
- **Individuals with disabilities.** With the availability of coverage under the new adult group, some low-income individuals who previously would have had to secure a disability determination to qualify for Medicaid are able to enroll based on income alone. As a result, expansion states are reporting drops in the number of individuals seeking disability determinations. In the near term, states may see savings from reduced administrative costs, and in the long term, from fewer individuals enrolling in the disability category. For example, Oregon has seen a decrease in the number of people seeking disability determinations and Arkansas has seen spending for its Supplemental Security Income (SSI) population flatten.[14] Other research examining pre-ACA Medicaid expansions finds that on average, introducing Medicaid coverage for childless adults decreases SSI participation for this population by 7%.[15] In Oklahoma, receipt of SSI cash assistance is the primary pathway to SoonerCare coverage based on a disability. When individuals are covered in the disability category, Oklahoma receives a regular federal match; if they are covered in the new adult category, the State will receive an enhanced match. State savings associated with extending coverage to the new adult group under SoonerCare are estimated at $75 million for the disabled adult group during the period 2017–2021.

  On a related note, although most individuals who have had a disability determination would not qualify for the new adult group, individuals with substantial needs and disabling conditions who do not have an official determination may still do so.[16] If the State chose, it could provide them with additional targeted services and receive enhanced match, potentially benefitting at least some individuals who are currently on a waiting list for home and community-based waiver services (see Box 2). The estimates in this report do not reflect the cost of providing these additional services, up to 10% of which would be financed by the State.

Box 2. Home and Community-Based Services

Today, Oklahomans who require certain home and community-based services (HCBS) may only access them through the State's waiver programs, some of which have long waiting lists as the State has limited the number of waiver slots.[17] Were the State to extend coverage to the new adult group, it could include waiver-like HCBS under Section 1915(i) of the Social Security Act as part of the "alternative benefit plan" applicable to the new adult group.[18] This would enable some individuals on the waiting list (adults under age 65 who are not eligible for Medicare, not pregnant, not otherwise eligible for SoonerCare, and have incomes below 138% of the FPL) to immediately secure the HCBS they need. In addition, in the future some of the individuals who need HCBS could likewise receive them through the new adult group. The result: fewer people would require HCBS waiver services; the waiver waiting list would be reduced; and the State could claim enhanced federal match for the HCBS services provided as part of the alternative benefit plan.

- **Section 1115 waiver coverage that does not provide full Medicaid benefits.** States may claim enhanced FMAP for individuals in the new adult group who were previously eligible for limited benefits under a Section 1115 Medicaid waiver.[19] Under the Insure Oklahoma waiver, individuals who work for a qualifying small employer may receive premium assistance under the Insure Oklahoma Employer-Sponsored Insurance program. Workers of non-participating small employers, as well as self-employed and unemployed workers, may receive State-sponsored coverage under the Insure Oklahoma Individual Plan. In both cases, the coverage under Insure Oklahoma is more limited than under SoonerCare. If the State extends coverage to the new adult group, Insure Oklahoma enrollees should qualify as newly eligible adults and the State is projected to save an estimated $84 million during the period 2017–2021 by obtaining enhanced FMAP for these individuals.
- **Breast and cervical cancer group.** Today, women under age 65 who are otherwise ineligible for SoonerCare may be covered if they receive a Centers for Disease Control and Prevention Breast and Cervical Cancer Treatment Program screening and are referred for treatment. Oklahoma's federal match for this eligibility group is approximately 73%. If the State were to extend SoonerCare coverage, some women who previously would have gained eligibility under this group will instead be enrolled in the new adult group and the State will be able to claim a higher federal match for the services they receive. If Oklahoma extends coverage to the new adult group, State savings are estimated at $11 million for these women during the period 2017–2021.
- **Family planning group.** States receive an enhanced federal share of 90% for family planning services and regular federal match for family planning-related services such as treatment for sexually transmitted diseases.[20] Individuals with incomes below 138% FPL who previously qualified

for family planning-only coverage in Oklahoma could enroll in the new adult group if the State were to extend SoonerCare coverage. Savings would accrue in years prior to 2020, when the enhanced federal matching rate for new adults exceeds the 90% currently available for family planning services. If Oklahoma extends coverage to the new adult group, State savings are estimated at $1 million for these individuals during the period 2017–2021.

Table 3. Estimated State Savings from Extending SoonerCare Coverage to the New Adult Group by Replacing Regular Federal Match with Enhanced Match, CYs 2017-2021 (millions)

	2017	2018	2019	2020	2021	2017 – 2021
Total state savings for existing SoonerCare populations	$42	$54	$62	$67	$76	$301
Pregnant women group	$20	$25	$27	$28	$30	$129
Individuals eligible based on disability	$5	$10	$15	$20	$26	$75
Insure Oklahoma Employer-Sponsored	$7	$7	$8	$7	$8	$37
Insure Oklahoma Individual Plan	$9	$9	$10	$9	$10	$47
Breast and cervical cancer group	$1	$2	$3	$3	$3	$11
Family planning group	*	*	*	$0	$0	$1

Note: Components may not sum to totals because of rounding. State savings shown are the result of accessing enhanced FMAP for individuals in existing SoonerCare populations who become eligible under the new adult group.

*Savings are less than $0.5 million

Source: Manatt analysis; see Appendix for details.

Savings from Replacing State General Funds with Federal Medicaid Funds

Oklahoma currently uses State-only funds to support health services for the uninsured, including behavioral health programs, immunizations and other public health services, and inpatient hospital care for State prison inmates. If Oklahoma opts to cover the new adult group under SoonerCare, many of the individuals receiving these services would be able to enroll, permitting the State to shift some current general fund spending to SoonerCare. As a result of this shift, the availability of federal match would significantly reduce the amount of State-only spending required to provide existing services (because the State would be funding no more than 10% of the cost where previously it had been funding 100% of the cost). State savings are estimated at $24 million in 2017 and $190 million through 2021 (Table 4). Details regarding these estimates are provided in the Appendix.

- **Mental health and substance abuse.** Like other states, Oklahoma appropriates funds to support mental health and substance abuse treatment for uninsured individuals. In

states that expand Medicaid, many of the previously uninsured individuals who were recipients of these state-funded behavioral health services are now eligible for full benefits under the new adult group and their Medicaid-covered services are eligible for enhanced federal match. Oklahoma spends an estimated $46 million in State-only dollars on mental health and substance abuse services for uninsured low-income adults identified by the State as potentially matchable under SoonerCare. It is estimated that the State will be able to reduce this spending by 40% in 2017, increasing to 80% in 2020 and beyond as eligible individuals are enrolled in SoonerCare, resulting in State savings of $151 million through 2021. The dollars saved could be used to support coverage of the new adult group or be reinvested in the behavioral health delivery system, or a combination thereof.

- **Public health.** Oklahoma also provides State-only funding for a wide range of public health activities, including services at county health department clinics located throughout most of the State. Oklahoma spends an estimated $4 million on public health services identified as potentially matchable if SoonerCare coverage is extended to the new adult group. It is estimated that the State will be able to reduce this spending by 40% in 2017, increasing to 80% in 2020 and beyond, resulting in State savings of $15 million through 2021. As with State-only savings for behavioral health, these dollars could be used to support coverage of the new adult group or be reinvested in public health.
- **Corrections.** Federal funding for Medicaid coverage of inmates of a public institution is prohibited by federal law, with one exception: Medicaid will cover the inpatient costs of inmates receiving care in a community hospital, provided the inmate would be eligible for Medicaid coverage but for the fact that he or she is incarcerated.[21] In expansion states, the vast majority of inmates meet this standard and states are able to reduce their general fund spending accordingly. In 2015, Oklahoma spent $5 million on inpatient hospital admissions for inmates who do not currently qualify for SoonerCare. It is estimated that the State will be able to reduce this spending by 80% in 2017, increasing to 90% in 2018 and beyond, resulting in State savings of $24 million through 2021.

Although not estimated in this report, counties and other local governments may realize additional savings if they use their own funds to cover similar services for low-income uninsured individuals. For example, county jails may incur costs for inmate hospital admissions in a manner similar to State prisons; as a result, they may realize savings from SoonerCare coverage of the new adult group.[22]

Table 4. Estimated Savings from Extending SoonerCare Coverage to the New Adult Group by Replacing State General Fund Spending with SoonerCare Funding, CYs 2017–2021 (millions)

	2017	2018	2019	2020	2021	2017 – 2021
Total state savings for other state programs	$24	$35	$40	$45	$45	$190
Oklahoma Department of Mental Health and Substance Abuse Services	$18	$28	$32	$37	$37	$151
Oklahoma State Department of Health	$2	$3	$3	$4	$4	$15
Oklahoma Department of Corrections	$4	$5	$5	$5	$5	$24

Note: Components may not sum to total because of rounding. State savings shown are the result of accessing federal match for services previously provided with State-only dollars to uninsured individuals who become eligible for SoonerCare under the new adult group.

Source: Manatt analysis; see Appendix for details.

IV. Revenue Gains

We identify two areas in which extending SoonerCare coverage to the new adult group could generate additional revenues. First, we assume that Oklahoma would maintain its current 3% assessment on hospital revenues; as hospitals' revenues increase with the number of people covered, so would the amount generated by the assessment. Second, based on the State's decision to impose premiums on individuals participating in its Insure Oklahoma waiver, we assume that the State will seek a waiver to obligate individuals with incomes above 100% FPL to pay premiums equal to 2% of their household income. We estimate $7 million in new State revenues from the hospital assessment in 2017 and $51 million through 2021 (Table 5). Enrollee premiums are estimated to generate $2 million in State revenues through 2021; this amount is relatively small given that most of the premiums will be credited to the federal government, as they are covering at least 90% of the costs of coverage for this population. Details regarding these estimates are provided in the Appendix.

Table 5. Estimated Revenues from Extending SoonerCare Coverage to the New Adult Group, CYs 2017–2021 (millions)

	2017	2018	2019	2020	2021	2017 – 2021
Total revenues from hospital assessment and enrollee premiums	$14	$20	$23	$24	$25	$105
Federal	$7	$10	$12	$12	$12	$53
State	$6	$10	$11	$12	$13	$52
State revenues from hospital assessment	$7	$10	$11	$11	$12	$51
Enrollee premium revenues	$7	$11	$12	$12	$13	$54
Federal	$7	$10	$12	$12	$12	$53
State	*	*	*	*	$1	$2

Note: Components may not sum to totals because of rounding.

* Revenues are less than $0.5 million.

Source: Manatt analysis; see Appendix for details.

V. Conclusion

Table 6 shows estimates of the number of people who would gain coverage if Oklahoma were to extend SoonerCare to the new adult group, the costs to the State and the federal government, and the savings and new revenues that would be generated. Over the five-year period from 2017 through 2021, net State costs of extending coverage to the new adult group are estimated at $196 million. If an additional offset is included to reflect the increased availability of 100% federal funding for current enrollees who receive SoonerCare services through Indian Health providers, the five-year net cost is an estimated $95 million. State savings are projected to exceed State costs in 2017; in 2020, when the enhanced federal match for newly eligible individuals levels off at 90%, net State costs are an estimated $77 million (or $55 million with an Indian Health offset assumption). During this same five-year period, it is estimated that the State will bring in an additional $7.8 billion in federal dollars.[23]

Although the focus of this report is on the State budget impacts of extending SoonerCare coverage to the new adult group, Oklahoma will also realize broader economic impacts. Studies from states that have expanded Medicaid have found that it creates jobs, brings in new federal dollars that spur the economy, and increases state and local tax revenue.[24] Impacts on healthcare providers via reductions in uncompensated care costs for the uninsured also are not addressed in this report.[25] Both of these gains

are important additional areas of analysis for Oklahoma as it contemplates extending SoonerCare coverage to the new adult group.

Table 6. Estimated State and Federal Budget Impacts of Extending SoonerCare Coverage to the New Adult Group, CYs 2017–2021 (millions)

	2017	2018	2019	2020	2021	2017 – 2021
Number estimated to gain coverage in new adult group	179,000	251,000	272,000	273,000	275,000	–
Net federal costs*	**$1,037**	**$1,493**	**$1,685**	**$1,737**	**$1,846**	**$7,797**
Federal costs for new adult group and woodwork enrollees	$1,003	$1,450	$1,634	$1,681	$1,781	$7,549
Federal costs for existing SoonerCare populations	$42	$54	$62	$67	$76	$301
Federal share of revenues from enrollee premiums	$7	$10	$12	$12	$12	$53
Net state costs*	**-$3**	**$13**	**$29**	**$77**	**$79**	**$196**
State costs for new adult group and woodwork enrollees	$70	$112	$142	$202	$214	$739
State savings for existing SoonerCare populations	$42	$54	$62	$67	$76	$301
State savings for other state programs	$24	$35	$40	$45	$45	$190
State revenues from hospital assessment and enrollee premiums	$6	$10	$11	$12	$13	$52
Potential for additional offset:						
State savings if a portion of current spending related to Indian Health is converted to federal funds*	*$11*	*$22*	*$22*	*$22*	*$22*	*$100*
Net state costs with Indian Health offset to current spending*	***-$14***	***-$9***	***$7***	***$55***	***$57***	***$95***

Note: Components may not sum to totals because of rounding.

* Savings and revenues are subtracted from costs to determine the net amount. Figures here assume that savings and revenues are available to offset costs associated with coverage for the new adult group; however, the State may choose to reinvest these amounts or use them for other purposes.

** As discussed in the background section of this report, recent CMS guidance expands the availability of 100% federal funding for individuals who receive SoonerCare services through Indian Health Service and Tribal facilities. Oklahoma currently spends about $111 million in State funds for these individuals; figures here assume no cost growth trend and show the impact of obtaining 100% federal funding for 10% of the $111 million in 2017 and 20% in later years. In addition, estimates for the new adult group in this report reflect current State claiming practices for Indian Health. State costs for the new adult group would be lower if Oklahoma were to increase its claiming of 100% federal funding.

Source: Manatt analysis; see Appendix for details.

Appendix

Detailed Data and Methods for Estimating Costs, Savings, and Revenues

Service Costs for the New Adult Group

On average during 2014, American Community Survey data from the Census Bureau indicate that there were approximately 685,000 adults age 19 to 64 with incomes below 138% FPL in Oklahoma. About 269,000 of these individuals were uninsured, about 253,000 had private coverage, and the remainder had only Medicare, Medicaid, or some other type of coverage. As noted earlier, we examine ACS data that have been grouped into health insurance units.[26] HIUs reflect the people whose income would be counted together for Medicaid eligibility purposes, and result in a higher estimate of eligible individuals relative to ACS tables published by the Census Bureau that use a family definition of income.[27] In order to estimate the population of individuals who would potentially enroll in SoonerCare if coverage were extended to the new adult group beginning in 2017, we use the following data and methods:[28]

- ACS uninsured and privately insured estimates for 2014 were trended forward using an average annual growth rate of 0.73%, which reflects State projections of overall population growth in Oklahoma.[29] An additional adjustment was made to reflect increased Marketplace enrollment as of 2016. After subtracting Marketplace and family planning-only enrollees from the ACS totals (these individuals are treated separately as described below),[30] we apply a 75% take-up rate among uninsured individuals and a 10% participation rate among insured individuals.[31] We assume that enrollment will ramp up over a period of 18 months, such that 2019 is the first calendar year where average enrollment reflects full take-up and participation rates.
- An estimated number of Oklahomans between 100% and 138% FPL enrolled in Marketplace coverage (36,000 in 2016) was derived from federal administrative data and trended forward using the standard 0.73% population growth rate.[32] In light of the fact that these individuals were motivated to obtain coverage, we assume 100% take-up for this group.[33]
- The number of family planning-only enrollees with SoonerPlan coverage up to 138% FPL (42,000 as of June 2015) was obtained from OHCA data and trended forward using the standard 0.73% population growth rate.[34] Given that these individuals are currently known to the State and could be converted to full-benefit coverage with relative ease, we assume 100% take-up for this group.

Per-member per-month (PMPM) claims costs for current Insure Oklahoma Individual Plan (IP) enrollees below 100% FPL who receive State-sponsored coverage were $470 in SFY 2015.[35] We assume this amount remains flat in 2016 and 2017 to reflect recently enacted provider rate cuts in Oklahoma and a sizable proposal for further cuts,[36] resulting in a per-member per-year (PMPY) cost of approximately $5,600 in 2017. For 2018 forward, we assume 5.2% average annual per-enrollee cost growth.[37]

To estimate the State share of benefit costs for new adult group enrollees, we determine total spending (number of enrollees multiplied by PMPY costs) and apply an appropriate federal matching rate:

- In SFY 2015, 5.2% of the State's total spending on member benefits for OHCA programs reflected services provided to enrollees through Indian Health Service and Tribal facilities that are eligible for 100% federal funding. We assume that new adult group enrollees have a similar percentage of Indian Health spending and apply a 100% federal matching rate to 5.2% of total spending for the entire 2017–2026 period. As noted earlier, if Oklahoma were to increase its claiming of 100% federal funding in light of recent CMS guidance, State costs for the new adult group would be smaller than what we have estimated.
- For the remaining amount of benefit spending, we apply newly eligible federal matching rates that range from 95% in 2017 to 90% in 2020 and beyond.

Service Costs for the Woodwork Group

Our estimate of costs associated with a woodwork or welcome-mat effect is primarily based on a recent analysis of ACS data indicating that expansion states had roughly double the percentage decrease in uninsured children compared to non-expansion states in 2014.[38] Given that Oklahoma had a 13.5% (13,000) reduction in uninsured children in 2014 without expansion, one could reasonably expect another 13,000 to gain coverage under expansion. Part of this effect could be attributed to parents gaining coverage in the new adult group, as studies and state experiences have consistently shown that covering parents improves their children's coverage rates.[39]

On a base of approximately 500,000 non-disabled children currently covered by SoonerCare,[40] 13,000 new enrollees would be a 2.6% increase. A baseline estimate of spending for the current SoonerCare program is determined by taking SFY 2015 total spending on non-disabled children ($1.4 billion[41]) and trending it forward by overall population and per-enrollee growth assumptions noted earlier. Beginning in 2017, the baseline is increased by 2.6% to reflect a woodwork effect, and the State's regular federal matching rates for Medicaid and CHIP are applied to determine new State costs.

Administrative Costs

Based on OHCA's current administrative spending as a share of the SoonerCare total,[42] this report assumes that new administrative spending would equal 2.3% of total benefit spending for the new adult and woodwork groups.[43] A blended federal match of 62.5% is applied to determine State costs.[44]

Savings from Accessing Enhanced Federal Matching Funds for Current SoonerCare Populations

Except where noted below, baseline total costs for each of the populations were determined by trending current spending forward by the overall population and per-enrollee growth assumptions noted earlier. Regular and enhanced federal matching rates were then applied to determine State savings.

Pregnant women. About 49,000 women with incomes up to 138% FPL were enrolled in the State's pregnancy-related eligibility group in SFY 2015, with $194 million in total spending.[45] If the State opts to extend SoonerCare coverage, the number of women in this pregnancy group would decrease as many would already be enrolled in the new adult group when they become pregnant. Women who become pregnant while in the new adult group would remain there and the State would receive an enhanced match until their next eligibility redetermination, at which point they would revert to pregnancy-related eligibility at the regular matching rate. State savings estimates assume a 25% reduction in baseline spending on the pregnancy-related eligibility group in 2017 and 30% in 2018 and beyond.[46]

Adults with disabilities. In Oklahoma, receipt of SSI cash assistance is the primary pathway to SoonerCare coverage based on a disability. If the State opts to extend SoonerCare coverage to the new adult group, individuals who previously would have pursued a disability determination for the sole purpose of obtaining coverage could now enroll without the need for such a determination. To account for this shift, we assume that the number of adults with disability-related coverage in Oklahoma is 1% lower than it would have been under the baseline SoonerCare program in 2017, ramping up to 5% in 2021 and beyond. These individuals would instead enroll through the new adult group with an enhanced federal match, and savings would accrue to the State. This estimate is informed by research indicating that on average, introducing Medicaid coverage for childless adults decreases SSI participation for this population by 7%.[47]

Insure Oklahoma. Insure Oklahoma Employer-Sponsored Insurance (ESI) currently serves about 15,000 individuals, while Insure Oklahoma IP serves about 4,000.[48] Total spending on the programs was $67 million in SFY 2015.[49] If SoonerCare were extended to the new adult group, we assume that Insure Oklahoma ESI would continue largely as it exists today, but that adjustments would be made to conform with alternative benefit plan requirements that apply to the new adult group (e.g., the addition of a wrap-around benefit for non-emergency transportation).[50, 51] For Insure Oklahoma IP, which provides State-sponsored coverage that resembles SoonerCare, we assume that current enrollees would be rolled in with the new adult group.

As discussed earlier, the State's current Insure Oklahoma coverage does not provide full benefits that are equivalent to those available to SoonerCare enrollees. As a result, it is likely that Insure Oklahoma enrollees up to 138% FPL would be considered newly eligible and therefore qualify for enhanced federal match. State savings estimates are due to moving from the 61% federal match currently available for this population.

Breast and cervical cancer group. The Oklahoma Cares program currently provides SoonerCare coverage to about 1,000 women with incomes up to 185% FPL who have been referred for breast or cervical cancer treatment through a Centers for Disease Control and Prevention screening, with total spending of $14 million in SFY 2015.[52] About 80% of these women have incomes below 138% FPL.[53] If the State opts to extend SoonerCare coverage, some of the women who previously would have gained eligibility under this group will instead be enrolled in the new adult group and the State will be able to claim a higher federal match for the services they receive. Our State savings estimates assume a 25% reduction in spending on the breast and cervical cancer group in 2017, increasing to 75% in 2019 and beyond.

Family planning enrollees. Oklahoma's SoonerPlan program currently provides family planning-only coverage to about 36,000 individuals up to 138% FPL,[54] with total spending of $5 million in SFY 2015.[55] If the State opts to extend SoonerCare coverage, these enrollees would shift to the new adult group. State savings would accrue in years prior to 2020, when the enhanced federal matching rate for new adults exceeds the 90% currently available for family planning services.

Savings from Replacing State General Funds with Federal Medicaid Funds

Oklahoma currently uses State-only funds to support health services for the uninsured, including behavioral and public health programs and inpatient

hospital care for State prison inmates. Many of the individuals receiving these services would be able to secure coverage in the new adult group, permitting the State to shift some current State-only spending to SoonerCare. Potential State savings associated with these programs are largely based on amounts that were identified in a study commissioned by OHCA in 2010:[56]

- The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) spent $45.9 million in State-only dollars during SFY 2010 for services provided to uninsured adults below 133% FPL identified by the State as potentially matchable under SoonerCare.
- The Oklahoma State Department of Health (OSDH) budgeted $4.8 million in SFY 2010 for State-funded services at county health departments identified as potentially matchable under SoonerCare, a high percentage of which is believed to fund immunizations for uninsured adults below 150% FPL. Assuming a proportional distribution, this translates to $4.4 million in spending for those below 138% FPL.
- The Oklahoma State Department of Corrections (ODOC) provided updated data to Manatt indicating that the State paid $5.4 million in 2015 for 762 inpatient hospital admissions for inmates who do not currently qualify for SoonerCare.[57]

OHCA indicates that these figures reflect the best available estimates of current State-only spending on health services for uninsured adults who could potentially enroll in SoonerCare. If coverage is extended to the new adult group, we conservatively estimate future State savings without any trend factor (that is, we assume no increase in appropriations by the State). For ODMHSAS and OSDH spending, we assume that 60% continues in 2017 as individuals begin to enroll in coverage, ramping down to 20% in 2020 and beyond, reflecting the fact that some adults seeking services will continue to be uninsured (for example, because they are ineligible for SoonerCare based on immigration status or are eligible but do not complete the paperwork to enroll). For ODOC spending on inpatient admissions, we assume that 20% continues in 2017 and that 10% continues thereafter. This reflects the fact that ODOC should be able to begin immediate enrollment of inmates in the new adult group, consistent with its current practice of identifying those who qualify for SoonerCare upon hospitalization (such as pregnant women) and enrolling them for the duration of their hospitalization.[58]

Revenues

Hospital assessment. Oklahoma currently imposes a 3% assessment on hospital revenues referred to as the Supplemental Hospital Offset Payment Program (SHOPP).[59] In order to determine increased State revenues from SHOPP, we first estimated the total service costs associated with newly insured individuals.[60] We then applied an assumption that inpatient and outpatient hospital spending accounts for about 32% percent of the total, reflecting the current experience among Insure Oklahoma IP enrollees. Finally, we applied 3% to the hospital revenue total and reduced the resulting amount by 17% to account for the fact that some Oklahoma hospitals are exempt from the SHOPP assessment.[61]

Enrollee premiums. For Insure Oklahoma, enrollee premium and cost-sharing contributions are capped at 5% of household income. The premium portion may be up to 3% (ESI coverage) or 4% (IP coverage) of household income. Most ESI enrollees would be paying a premium given that they are obtaining

employer coverage that typically requires an employee contribution, and OHCA data indicate that about 60% of IP enrollees pay a premium each month.[62] As noted earlier, we assume that Insure Oklahoma ESI would continue largely as it exists today, and that Insure Oklahoma IP enrollees would be rolled in with the new adult group.

In light of the State's current enrollee contribution structure and based on premiums that CMS has approved for expansion states, we assume that a 2% premium would be charged for new adult group enrollees between 100% and 138% FPL. Although CMS has approved premium amounts for individuals with lower incomes, coverage cannot be denied for nonpayment, and states' experience in collecting those amounts has varied.[63] Based on the income distribution of currently uninsured individuals in Oklahoma, we estimate that about 75,000 new adult group enrollees would be subject to a premium contribution in 2019 (when program enrollment has fully ramped up). The average premium would be about $300 per year, and we assume that about 60% of enrollees would pay (consistent with the current IP program).[64] As with program costs paid for enrollees, premium revenues received from enrollees are shared between the State and the federal government. Due to the high federal matching rate for the new adult group, the State share of their premiums is 10% or less. As a final step in estimating premium revenues, we net out the baseline estimate of premiums paid by Insure Oklahoma IP members below 100% FPL, which are not assumed to continue.

Previous Estimate of Costs, Savings, and Revenues Developed for OHCA

In considering whether to cover the new adult group under Medicaid, numerous states have engaged in modeling efforts to determine potential costs, savings, and revenues. This includes Oklahoma, which in 2013 contracted with Leavitt Partners to evaluate its SoonerCare program and to make recommendations on how to optimize access and quality of health care in the State.[65] In its work for the State, Leavitt Partners estimated the number of and costs associated with individuals who might enroll under the new adult group; savings from existing SoonerCare populations and other State programs; and economic effects that would generate State tax revenue. While our methods for estimating costs of the new adult group are broadly similar,[66] we examine different time periods with varying federal matching rates (2014–2023 versus 2017–2026), apply different savings assumptions,[67] and estimate hospital assessment and enrollee premium revenues rather than overall State tax revenues. In addition, the analysis in this report benefits from drawing on the actual experience of states that have expanded Medicaid and provided evidence of both savings and revenue effects.[68] For example, the ability to claim enhanced federal match for women in the new adult group who become pregnant was uncertain in 2013; today, it is clear that states may do so and are seeing substantial savings as a result.

Table 7. Estimated Budget Impacts of Extending SoonerCare Coverage to the New Adult Group, CYs 2017–2026 (millions)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2021	2017–2026
Number estimated to gain coverage in new adult group	179,000	251,000	272,000	273,000	275,000	278,000	280,000	282,000	284,000	286,000	–	–
New adult and woodwork enrollees												
Total costs	$1,073	$1,562	$1,776	$1,882	$1,995	$2,114	$2,240	$2,374	$2,515	$2,665	$8,288	$20,196
Federal	$1,003	$1,450	$1,634	$1,681	$1,781	$1,887	$2,000	$2,119	$2,246	$2,380	$7,549	$18,181
State	$70	$112	$142	$202	$214	$226	$240	$254	$269	$286	$739	$2,015
Existing SoonerCare populations												
Total savings	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Federal	-$42	-$54	-$62	-$67	-$76	-$81	-$86	-$91	-$96	-$102	-$301	-$758
State	$42	$54	$62	$67	$76	$81	$86	$91	$96	$102	$301	$758
Other state programs												
Total state savings	$24	$35	$40	$45	$45	$45	$45	$45	$45	$45	$190	$416
Revenues from hospital assessment and enrollee premiums												
Total revenues	$14	$20	$23	$24	$25	$26	$27	$28	$30	$31	$105	$247
Federal	$7	$10	$12	$12	$12	$12	$13	$13	$13	$14	$53	$118
State	$6	$10	$11	$12	$13	$14	$14	$15	$16	$17	$52	$129
Net cost*												
Total	$1,035	$1,507	$1,714	$1,814	$1,925	$2,043	$2,168	$2,300	$2,440	$2,589	$7,993	$19,533
Federal	$1,037	$1,493	$1,685	$1,737	$1,846	$1,956	$2,073	$2,197	$2,329	$2,468	$7,797	$18,821
State	-$3	$13	$29	$77	$79	$87	$94	$103	$112	$121	$196	$712

Note: Components may not sum to totals because of rounding.
* Savings and revenues are subtracted from costs to determine the net amount.

Source: Manatt analysis; see Appendix for details.

[1] OHCA, *SFY2015 OHCA Annual Report*, Figure 10, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180.

[2] Includes approximately 54,000 pregnant women; 111,000 parents; 1,000 women with breast and cervical cancer; 72,000 family planning-only enrollees; 40,000 workers and dependents with Insure Oklahoma coverage under the State's Section 1115 waiver; and 92,000 other adults, primarily those qualifying based on a disability. The number of individuals enrolled in an average month is lower than these ever-enrolled counts; for example, total enrollment was about 814,000 in January 2016. Manatt analysis of unpublished data from OHCA (all SFY 2015 figures except Insure Oklahoma); OHCA, *SFY2015 OHCA Annual Report*, Table VI, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180 (for SFY 2015 Insure Oklahoma); and OHCA, SoonerCare Fast Facts, January 2016, http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18782&libID=17764 (for January 2016 total enrollment).

[3] Additional notes on Figure 1:
- Current eligibility reflects Medicaid-funded coverage under the State plan and Oklahoma's Section 1115 waiver.
- Parent eligibility is specified by the state as a dollar amount and may vary slightly by family size when converted to a percentage of the federal poverty level.
- Under SoonerPlan, enrollees receive family planning-only coverage.
- Under the Insure Oklahoma Employer-Sponsored Insurance program, individuals who work for a qualifying small employer receive premium assistance.
- Under the Insure Oklahoma Individual Plan, workers of non-participating small employers, as well as self-employed and unemployed workers, receive State-sponsored coverage that is more limited than SoonerCare coverage.

[4] OHCA, *SoonerCare Qualification Guidelines*, https://www.okhca.org/individuals.aspx?id=124; Oklahoma Department of Human Services, *Maximum Income, Resource, and Payment Standards*, http://www.okdhs.org/okdhs%20form%20library/C-1.pdf; Centers for Medicare & Medicaid Services, Section 1115 waiver special terms and conditions, September 17, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/ok-soonercare-ca.pdf ; Pasternik-Ikard, R., *SoonerCare Coverage for Pregnant Women*, 2014, http://www.nashpcloud.org/2014-presentations/public/SESSION.20.PASTERNIK-IKARD.R.pdf; and Brooks, T. et al., *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, http://files.kff.org/attachment/report-medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey.

[5] Under Section 1905(y)(2) of the Social Security Act, a newly eligible adult is one who meets the expansion group criteria (under age 65, not pregnant, not eligible for Medicare, not eligible under another mandatory Medicaid eligibility group, and has income at or below 13% FPL) and "…who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage…or benchmark equivalent coverage…or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full…The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in [one of the mandatory Medicaid eligibility groups]."

[6] Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, *Federal Medical Assistance Percentages*, https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures; and Centers for Medicare & Medicaid Services (CMS), *Medicaid Program; Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010*, 78 FR 19918, April 2, 2013, https://www.gpo.gov/fdsys/pkg/FR-2013-04-02/pdf/2013-07599.pdf.

[7] Centers for Medicare & Medicaid Services, *Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives*, SHO#16-002, February 26, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf; Bachrach, D., Boozang, P., and Polaris, J., *Medicaid and the Indian Health Service*: *New Guidance Explains How States May Secure Additional Federal Funds*, March 2016, http://statenetwork.org/wp-content/uploads/2016/03/State-Network-Manatt-Medicaid-and-the-Indian-Health-Service-March-2016.pdf.

[8] Medicaid services provided to enrollees through Indian Health Service and Tribal facilities accounted for $228 million, or 5.2% of Oklahoma's $4.4 billion total spending on member benefits for OHCA programs in SFY 2015. Enrollees receiving care from Indian Health providers also had $286 million in spending for non-Indian Health providers. Based on the state's current FMAP (about 61%), Oklahoma's share of the non-Indian Health spending for these individuals is about $111 million (39%). Estimates are based on Manatt analysis of OHCA, *American Indian Health Fast Facts, SFY 2015: Members with paid Indian Health and non-Indian Health Provider Claims,* unpublished data; and OHCA, *SFY2015 OHCA Annual Report*, Table VII, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180.

[9] The use of estimates based on family income may partially explain findings from other analyses suggesting that Medicaid enrollment increases in some states have exceeded the number of eligible uninsured individuals. For example, see Census Bureau estimates cited in Deloitte, *Commonwealth of Kentucky: Medicaid Expansion Report 2014*, February 2015, http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[10] As described in the Appendix, take-up and participation rates are estimated to be higher for current family planning-only enrollees (who are assumed to be included in survey-based estimates of the uninsured population given the limited nature of their Medicaid benefits) and those with Marketplace coverage.

[11] Centers for Medicare & Medicaid Services, *Affordable Care Act: State Resources FAQ*, April 25, 2013, https://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf.

[12] Communication with Arkansas State official, October 20, 2015.

[13] Bachrach, D., Boozang, P., Herring, A., and Glanz, D., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, March 2016, http://statenetwork.org/wp-content/uploads/2016/03/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-March-2016.pdf.

[14] Bachrach, D., Boozang, P., Herring, A., and Glanz, D., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, March 2016, http://statenetwork.org/wp-content/uploads/2016/03/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-March-2016.pdf.

[15] Burns, M. and Dague, L., *The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation*, Working paper, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2753784.

[16] Centers for Medicare & Medicaid Services, *Medicaid and the Affordable Care Act: FMAP Final Rule Frequently Asked Questions*, August 29, 2013, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/fmap-faqs.pdf.

[17] As in many other states, Oklahoma has more individuals who need home and community-based waiver services than the number of waiver slots available, with more than 7,000 individuals on its waiting list for people with developmental disabilities as of February 2016; see Oklahoma Department of Human Services, *Developmental Disabilities Services: Waiting List Statistics, Number of individuals on the Waiver Request Waiting List as of 02/19/16*, http://www.okdhs.org/services/dd/pages/waiting.aspx. Although additional services for the new adult group could receive enhanced federal match, it should be noted that such targeting could lead new adult and existing Medicaid enrollees to be treated differently. For example, an individual with a disability determination who currently receives SSI and is eligible for Medicaid on that basis would continue to remain on the waiting list until a waiver slot opens up. In contrast, an adult with income just above the SSI level who does not currently qualify for Medicaid would be able to access waiver-like services immediately upon enrolling in the new adult group.

[18] Federal law specifically permits the creation of varying benefit packages (referred to as alternative benefit plans or ABPs) for subgroups of the adult expansion population. See Centers for Medicare & Medicaid Services, *Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Final Rule*, 78 FR 42160, July 15, 2013, https://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf.

[19] Centers for Medicare & Medicaid Services, *Medicaid Program; Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010*, 78 FR 19918, April 2, 2013, https://www.gpo.gov/fdsys/pkg/FR-2013-04-02/pdf/2013-07599.pdf; and Centers for Medicare & Medicaid Services, *Medicaid and CHIP FAQS: Newly Eligible and Expansion State FMAP*, February 2013, https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Expansion-State-FMAP-2013.pdf.

[20] Centers for Medicare and Medicaid Services, *Family Planning Services Option and New Benefit Rules for Benchmark Plans*, SMDL#10-013 ACA#4, July 2, 2010, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10013.pdf.

[21] U.S. Government Accountability Office, *Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services*, September 2014, http://www.gao.gov/assets/670/665552.pdf. Also see Guyer, J., Bachrach, D., and Shine, N., *Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States*, November 2015, http://statenetwork.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf.

[22] National Association of Counties, *County Jails and the Affordable Care Act: Community Services Division National Association of Counties Enrolling Eligible Individuals in Health Coverage*, March 2012, http://www.naco.org/sites/default/files/documents/County-Jails-HealthCare_WebVersion.pdf.

[23] Of this $7.8 billion, $7.5 billion is new spending for new adult group and woodwork enrollees; the remaining $301 million is existing spending that will be shifted from state to federal funding.

[24] Holahan, J., Buettgens, M., and Stan Dorn, *The Cost of Not Expanding Medicaid*, Kaiser Commission on Medicaid and the Uninsured, 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not- expanding-medicaid4.pdf; Ku, L. et al., *The Economic and Employment Costs of Not Expanding Medicaid in North Carolina: A County-Level Analysis*, Cone Health Foundation, December 1, 2014, http://www.conehealthfoundation.com/app/files/public/4202/The-Economic-and-Employment-Costs-of-Not-Expanding- Medicaid-in-North-Carolina.pdf; Beebe, M., *Governor Beebe's weekly column and radio address: Taking Advantage of Opportunity*, Arkansas Governor Mike Beebe, October 24, 2014, http://governor.arkansas.gov/newsroom/index.php?do:newsDetail=1&news_id=4690; Deloitte, *Commonwealth of Kentucky Medicaid Expansion Report 2014*, February 2015, http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[25] Center for Health Information and Data Analytics, *Colorado Hospital Association, Impact of Medicaid Expansion on Hospitals: Updated for Second Quarter 2014*, Colorado Hospital Association, September 2014, http://www.cha.com/Documents/CHA-Study/FINAL-CHA-Medicaid-Expansion-Study-Q2-Sept-2014.aspx; DeLeire, T., Joynt, K., and McDonald, R., *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014*, Office of the Assistant Secretary for Planning and Evaluation, September 24, 2014, http://aspe.hhs.gov/health/reports/2014/UncompensatedCare/ib_UncompensatedCare.pdf; Arkansas Center for Health Improvement, *AHA Report Measures Impact of Private Option on Arkansas Hospitals*, Arkansas Center for Health Improvement, October 31, 2014, http://www.achi.net/Pages/News/Article.aspx?ID=56; Arkansas Hospital Association and Arkansas Chapter of the Healthcare Financial Management Association, *Arkansas Private Option, Arkansas Center for Health Improvement*, October 31, 2014, http://www.achi.net/Docs/260/; Deloitte, *Commonwealth of Kentucky Medicaid Expansion Report 2014*, February 2015, http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[26] ACS estimates using HIU income were obtained from SHADAC, *Data Center*, http://datacenter.shadac.org/.

[27] SHADAC, *Defining "Family" for Studies of Health Insurance Coverage*, March 2012, http://shadac.org/sites/default/files/Old_files/shadac/publications/SHADAC_Brief27.pdf.

[28] The number of individuals estimated to enroll in the new adult group generally excludes enrollees who would shift from an existing SoonerCare eligibility category to the new adult group, because we separately account for their total costs in our baseline and savings estimates. Family planning-only enrollees are included in estimates for the new adult group, because their total costs would increase substantially relative to the baseline.

[29] Barker, S., *Oklahoma state and county population projections through 2075*, Oklahoma Department of Commerce, http://okcommerce.gov/wp-content/uploads/2015/06/Population_Projections_Report-2012.pdf.

[30] Family planning-only enrollees are assumed to be included in survey-based estimates of the uninsured population given the limited nature of their Medicaid benefits, and therefore are subtracted from the ACS uninsured total. The number of 2016 Marketplace enrollees who were insured or uninsured as of 2014 is estimated based on survey reports of prior coverage among individuals with Marketplace coverage, and subtracted accordingly from the 2014 ACS totals; see Hamel, L. et al., *Survey of Non-Group Health Insurance Enrollees*, Kaiser Family Foundation, June 2014, http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/.

[31] As noted earlier, findings from analyses suggesting that recent Medicaid enrollment increases in some states have exceeded the number of eligible uninsured individuals may partially be explained by the use of family income (which produces lower numbers of eligible individuals), rather than health insurance unit income (which produces higher numbers). In this report, we use HIU income and apply an uninsured take-up rate that is consistent with the high end of ranges estimated for pre-ACA Medicaid participation among adults; for example, see Sommers, B. et al., *Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act*, ASPE Issue Brief, March 2012, https://aspe.hhs.gov/sites/default/files/pdf/76411/ib.pdf. The privately insured participation rate applied in this report also results in estimates that are consistent with those in the literature, which measures "crowd-out" in various ways; for example, see Dague, L. et al., *Estimates of Crowd-Out from a Public Health Insurance Expansion Using Administrative Data*, NBER Working Paper No. 17009, May 2011, http://www.nber.org/papers/w17009.

[32] Data were only available for the 100% to 150% FPL income range, and a proportional distribution of individuals was assumed to calculate the number between 100% and 138% FPL. See U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Plan Selections by County in the Health Insurance Marketplace: July 2015 (Updated)*, https://aspe.hhs.gov/report/plan-selections-county-health-insurance-marketplace-july-2015-updated.

[33] Individuals who are eligible for Medicaid are generally ineligible for Marketplace subsidies; as a result, these individuals will need to enroll in SoonerCare in order to retain coverage. See Searing, A., *Resolving Enrollment Conflicts as States Expand Medicaid*, Georgetown University Center for Children and Families, November 2014, http://ccf.georgetown.edu/wp-content/uploads/2014/12/Resolving-Enrollment-Conflicts-as-States-Expand-Medicaid.pdf.

[34] OHCA, *SoonerCare Fast Facts June 2015: Total Enrollment*, http://www.okhca.org/WorkArea/DownloadAsset.aspx?id=17509.

[35] Manatt analysis of unpublished data from OHCA. Although Insure Oklahoma IP does not provide the traditional SoonerCare benefit package, it would generally meet alternative benefit plan requirements applicable to the new adult group; see Centers for Medicare & Medicaid Services, Section 1115 waiver special terms and conditions, September 17, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/ok-soonercare-ca.pdf. In addition, given that IP serves a lower-income population (at or below 100% FPL), it likely provides a high estimate of costs for the new adult group with incomes up to 138% FPL. Evidence for an income-based cost differential is provided by changes in PMPM costs when IP eligibility was reduced from 200% FPL to 100% FPL in January 2014. During calendar year 2013 (before the eligibility change), the PMPM was $402; during the last six months of calendar year 2014 (after the eligibility change), the PMPM exceeded $500. However, given the possibility of pent-up demand for services among currently uninsured individuals and a desire to err on the side of a conservative estimate, we use current IP experience as our starting point.

[36] The State implemented a rate cut of 3% in December 2015. The recent proposal would reduce provider rates by 25%, and is subject to a public notification process of 60 days. Communication with OHCA, February 2016; OHCA, *OHCA board approves provider rate cut amidst difficult budget year*, News release, December 10, 2015, https://www.okhca.org/about.aspx?id=18283; and OHCA, *OHCA to propose provider rate cuts*, Press release, March 29, 2016, https://www.okhca.org/about.aspx?id=18904.

[37] This reflects a Centers for Medicare & Medicaid estimate of national growth in benefit costs per enrollee for adults (excluding newly eligible individuals whose inclusion depresses average growth rates) during the period 2014 to 2023, from the agency's most recent actuarial report on Medicaid. See Centers for Medicare & Medicaid Services, *2014 Actuarial Report on the Outlook for Medicaid*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf.

[38] Alker, J. and Chester, A., *Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements*, Georgetown University Health Policy Institute Center for Children and Families, October 2015, http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf.

[39] Heberlein, M. et al., *Medicaid Coverage for Parents under the Affordable Care Act*, Georgetown University Health Policy Institute Center for Children and Families, June 2012, http://ccf.georgetown.edu/wp-content/uploads/2012/08/Medicaid-Coverage-for-Parents.pdf.

[40] OHCA, *SoonerCare Children Fast Facts*, December 2015, http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18599&libID=17581.

[41] Manatt analysis of OHCA, *SFY2015 OHCA Annual Report*, Table VIII, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180.

[42] OHCA, *SFY2015 OHCA Annual Report*, Figure 17, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180.

[43] Although other agencies play a role in administering SoonerCare, no increase in costs is assumed because OHCA has primary responsibility for managing eligibility and benefits for non-disabled individuals. Communication with OHCA staff, February 2016.

[44] The blended rate assumes that half of spending receives 50% match and half receives 75% match.

[45] Unpublished data from OHCA.

[46] These estimates are informed by recent experience in Arkansas and other states, take-up rates assumed in our modeling, and the timing of pregnancies relative to eligibility renewals.

[47] Burns, M. and Dague, L., *The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation*, at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2753784.

[48] OHCA, *Insure Oklahoma Fast Facts*, February 2016, http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18774&libID=17756.

[49] OHCA, *SFY2015 OHCA Annual Report*, Table VI, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180.

[50] Bachrach, D., Guyer, J., and Osius, E., *Marketplace Premium Assistance: Creating Alignment Between Medicaid and Qualified Health Plans*, Manatt Health Medicaid Update, April 23, 2015, https://www.manatt.com/Marketplace-Premium-Assistance-Creating-Alignment-Between-Medicaid.aspx.

[51] PMPY capitation associated with non-emergency transportation for non-disabled SoonerCare enrollees was approximately $6 in SFY 2015; Manatt analysis of OHCA, *SFY2015 OHCA Annual Report*, Figure 4, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180.

[52] OHCA, SFY2015 *OHCA Annual Report*, Table VII, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180.

[53] Unpublished data from OHCA.

[54] OHCA, *SoonerPlan Fast Facts*, January 2016, http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18780&libID=17762.

[55] OHCA, *SFY2015 OHCA Annual Report*, Table VI, https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=18198&libID=17180.

[56] Pacific Health Policy Group, *Affordable Care Act Medicaid Expansion: Cost Benefit Analysis of Early Expansion Option & Coverage of Public Employees*, November 2010.

[57] The Pacific Health Policy Group report commissioned by OHCA in 2010 did not include a complete accounting of spending for inmates because it was assumed that admissions to the locked unit of a public hospital were ineligible for Medicaid funding. The public hospital in question now receives payment for Medicaid-eligible inmates, consistent with current federal policy.

[58] Current inpatient stays by inmates are billed by the hospital to OHCA, with ODOC providing state matching dollars to draw down federal funds; see Pacific Health Policy Group, *Affordable Care Act Medicaid Expansion: Cost Benefit Analysis of Early Expansion Option & Coverage of Public Employees*, November 2010.

[59] OHCA, *SHOPP Forms and Reports*, http://www.okhca.org/providers.aspx?id=13569.

[60] Costs for previously insured individuals are excluded because they would not be receiving new hospital benefits under expansion; these include individuals moving from Marketplace to SoonerCare coverage, as well as those shifting from one SoonerCare category to another (e.g., pregnant women moving to the new adult group). Woodwork enrollees are assumed to be previously uninsured.

[61] The 17% is an unpublished estimate developed by the Oklahoma Hospital Association based on the current distribution of Medicaid spending across exempt and non-exempt hospitals.

[62] Manatt analysis of unpublished data from OHCA.

[63] Dickson, V., *Medicaid cost-sharing demonstrations have netted little revenue so far*, Modern Healthcare, June 1, 2015, http://www.modernhealthcare.com/article/20150601/NEWS/150529869.

[64] We assume that average income reflects a single individual at 119% FPL (the midpoint between 100% and 138% FPL); in practice, the premium percentage would be applied to an income amount that includes additional individuals in the household. The dollar amount of the FPL is assumed to grow with projected increases in the Consumer Price Index published by the Congressional Budget Office; as a result, the dollar amount of premiums equal to 2% of income grows as well. The amount would be slightly lower than $300 in earlier years, and slightly higher in later years.

[65] Leavitt Partners, *Covering the Low-Income, Uninsured in Oklahoma Recommendations for a Medicaid Demonstration Proposal*, Prepared for the Oklahoma Health Care Authority, June 27, 2013, http://www.okhca.org/research.aspx?id=14943.

[66] For example, similar to Leavitt Partners, we use Insure Oklahoma per-member per-month costs as a key input and generally apply a 75% take-up rate to the uninsured population and a 10% participation rate to the privately insured population when estimating costs of the new adult group. However, we differ in that we estimate a woodwork or welcome-mat effect that reflects increased participation among individuals who are currently eligible but not enrolled, which does not appear to be part of the Leavitt Partners analysis.

[67] For example, Leavitt Partners estimated savings associated with rolling back Medicaid eligibility for pregnant women from 185% FPL to 138% FPL and allowing those with higher incomes to obtain Marketplace coverage; after the report was completed, the state did reduce Medicaid eligibility to 138% FPL but also provided pregnancy-related coverage of unborn children up to 190% FPL using CHIP funds with an enhanced federal match. In our analysis, we assume no change in CHIP-funded coverage.

[68] For example, see Bachrach, D., Boozang, P., Herring, A., and Glanz, D., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, March 2016, http://statenetwork.org/wp-content/uploads/2016/03/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-March-2016.pdf.

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