



## Ten Powerful Reasons Why Illinois Should Enact HB 6253 and Provide Medicaid Coverage to All People Made Eligible By Federal Law

### I. Introduction

Current Medicaid Program – Efficient Program with a Big Gap: Not all low-income Illinoisans are currently eligible for Medicaid. Instead, to qualify for Medicaid, a low-income person must fit into a category: age 65 or over, totally and permanently disabled, pregnant, a child under age 19, or a parent or caretaker relative living with a child under age 19. If you are a non-disabled adult not living with a child, you do not qualify for Medicaid no matter how poor you are.

The current Medicaid program is efficiently run. Nationally, the per-enrollee cost growth in Medicaid (6.1%) is lower than the per-enrollee cost growth in comparable coverage under Medicare (6.9%), private health insurance (10.6%), and monthly premiums for employer-sponsored coverage (12.6%).<sup>1</sup> Illinois' average annual growth in Medicaid spending for FY 2007-FY 2010 was 6.6%.<sup>2</sup>

Affordable Care Act Fills This Gap in the Medicaid Program: The Affordable Care Act (ACA) closes Medicaid's current gap in coverage by providing insurance to low-income adults with household income less than 138% of the federal poverty level (FPL).

No means-tested public program has ever achieved a 100% participation rate (not even Medicare—which has a participation rate of 96 percent). Evidence suggests it is reasonable to assume that of the uninsured individuals who will be newly eligible for Medicaid, 57-75% will sign up for coverage.<sup>3</sup> It will likely take a number of years of intense outreach, education, and

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<sup>1</sup> Kaiser Family Foundation Ten Myths About Medicaid (# 7306), available at:

<sup>2</sup> Kaiser State Health Facts, available at:

<http://http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=4&rgn=15&ind=181&sub=47>

<sup>3</sup> “Guidance on Analyzing and Estimating the Cost of Expanding Medicaid,” Center for Budget and Policy Priorities (October 11, 2012), citing “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL,” The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, May 2010, available at:

<http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>.



simplification of the enrollment process to maximize participation among the newly eligible.<sup>4</sup> A reasonable estimate of Medicaid costs should assume relatively modest participation initially, increasing over time, but never to 100%. The Urban Institute’s analysis does this and found that by 2019, Illinois is expected to have 429,258 enrolled from the newly eligible group.<sup>5</sup>

The Urban Institute’s projected demographics of this newly eligible population in Illinois include:<sup>6</sup>

- Age distribution:
  - 27% are age 19-24
  - 27% are age 25-34
  - 32% are age 35-54
  - 14% are age 55-64
- Sex: 58% are male; 42% are female
- Race/ethnicity:
  - 51% are white
  - 16% are Hispanic
  - 28% are Black
  - 6% are other race
- By citizenship status: 96% are U.S. citizens; 4% are legal immigrants in the U.S. at least 5 years.

U.S. Supreme Court’s Ruling: In June 2012, the U. S. Supreme Court ruled that while the ACA’s provision filling in the Medicaid gap is constitutional, it also ruled that it would be unconstitutional to withdraw all Medicaid funding, including funding for the current Medicaid program, from states that do not implement the new Medicaid provision. The ruling technically leaves intact both the mandatory nature of the new Medicaid provision and the other lesser remedies that the federal Medicaid authorities might use to enforce it.<sup>7</sup> As a practical matter, though, the ruling made the adoption of the provision closing the Medicaid gap an option for states.

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<sup>4</sup> “Guidance on Analyzing and Estimating the Cost of Expanding Medicaid,” Center for Budget and Policy Priorities (October 11, 2012), citing “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL,” The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, May 2010, available at: <http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>.

<sup>5</sup> “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL,” The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, May 2010, available at: <http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>.

<sup>6</sup> “Opting into the Medicaid Expansion under the ACA: Who are the Uninsured Adults who Could Gain Health Insurance Coverage?” Timely Analysis of Immediate Health Policy Issues, August 2012.

<sup>7</sup> Nat. Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012). See also 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

In Illinois, as in any other state, the ACA's new eligibility category would close the current coverage gap in the state's Medicaid program in 2014. Illinois should provide Medicaid coverage to all people made eligible under federal law. Below are ten powerful reasons why it is both the smart and right thing for Illinois to do.

## II. Ten Powerful Reasons Why Illinois Should Close the Medicaid Gap

1. **Covering newly eligible people will be paid for entirely with federal funds for three years and minimal state funds thereafter.**<sup>8</sup> The ACA provides that the Federal Medical Assistance Percentage (FMAP) rates for the newly eligible individuals are 100% for calendar years 2014 through 2016. Federal support will then phase down slightly over the following several years (95% in 2017, 94% in 2018, and 93% in 2019). By 2020 and for all subsequent years, the federal government will pay 90% of the costs of covering these individuals. In Illinois in 2020, the state will pay just 10% of the cost of care for this new population, estimated at \$135 million.<sup>9</sup> (This is 10% of the current cost per adult beneficiary in Illinois, \$3,157, times 429,258 new beneficiaries). But the billions in federal funds injected into the Illinois economy will produce enhanced employment and tax revenues for the state. There will also be savings to the state from efficiencies in eligibility and enrollment for Medicaid paid for by the federal government.<sup>10</sup> The new coverage will also stabilize the health of the newly eligible population, causing a decrease in expensive emergency room care and long-term hospitalizations.<sup>11</sup> Finally, there will also be a reduction in state health care costs through care coordination initiatives promoted in the ACA, especially for persons with chronic conditions and for dual eligibles (persons eligible for both Medicaid and Medicare). The Lewin Group estimates that the ACA will increase Illinois's

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<sup>8</sup> <http://www.urban.org/UploadedPDF/412361-consider-savings.pdf>

<sup>9</sup> FY2009 Spending per adult non-disabled Medicaid enrollee including both state and federal payments, available at:

<http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=4&rgn=15&ind=183&sub=47>. The Center for Budget and Policy Priorities states, "Research conducted by the Urban Institute, however, show that new Medicaid enrollees are not likely to be significantly different from parents who are currently on Medicaid, and in fact, on average, those who will be newly covered are likely to be somewhat healthier and less costly than those who are currently enrolled." Citing John Holahan, Genevieve Kenney and Jennifer Pelletier, —The Health Status of New Medicaid Enrollees under Health Reform, Urban Institute, August 2010.

<sup>10</sup> See: <http://insurance.illinois.gov/hirc/resources/EVE-Needs-Assessment.pdf>.

<http://insurance.illinois.gov/hirc/resources/ReformCouncil101411.pdf>.

<http://insurance.illinois.gov/hirc/resources/EVE-Needs-Assessment.pdf>

<sup>11</sup> <http://www.cookcountyhhs.org/patient-services/county-care/>

Medicaid spending by just 2.8% between 2014 and 2019,<sup>12</sup> while the Congressional Budget Office (CBO) has estimated that the ACA would impose less than a 1% increase in state Medicaid costs. These estimates reflect the increased state costs for Medicaid but not the offsetting savings states will also secure in uncompensated care and other health services.

Moreover, these high federal matching rates are highly likely to stay. In Medicaid's close to 50-year history, Congress has never decreased FMAP levels in Medicaid other than to allow the expiration of temporary FMAP increases enacted as parts of stimulus packages in recessions. The more states that adopt the "newly eligibles" expansion, the greater the number of members of Congress who will resist any reduction below 90% down the line. In fact, with sufficient support, Congress could amend the matching rate, keeping it at 100% indefinitely. In the current "fiscal cliff" negotiations, the Obama Administration has taken all significant Medicaid cuts off the table and, bolstered by the recent election, has promised that states can trust the federal matching rates for the ACA newly eligible group.<sup>13</sup>

**2. Covering newly eligible people creates jobs and generates revenue.** Adding the new eligibility category to Illinois' Medicaid program will bring in a large amount of federal funds, which will result in more economic growth and jobs. In Illinois, the total amount of federal Medicaid funding anticipated to accompany the expansion is over \$21 billion dollars from 2013 to 2022,<sup>14</sup> which could finance hundreds of thousands of new healthcare jobs. And we know from our recent past that an increased federal matching rate in the Medicaid program has an enormously significant economic impact—called a multiplier effect—throughout the economy and positively impacts jobs.<sup>15</sup> When Congress included an increase in the federal Medicaid matching rate in the American Recovery and Reinvestment Act (the "stimulus") from 50% to 61.88% from October 2008 through December 2010, \$1.2 billion per year for that period flowed

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<sup>12</sup> "Managing the Medicaid Enrollment Surge Starts Today: Strategies for Success by 2014," The Lewin Group, (2011), available at: [http://www.lewin.com/~media/lewin/site\\_sections/publications/optuminsight\\_lewingroup\\_mging\\_medicaid\\_surge\\_wp\\_6-13-11.pdf](http://www.lewin.com/~media/lewin/site_sections/publications/optuminsight_lewingroup_mging_medicaid_surge_wp_6-13-11.pdf)

<sup>13</sup> In fact, as recently as December 10, 2012, the Department of Health & Human Services' (HHS) guidance states that HHS does not support a blended match rate, but rather "continue[s] to seek efficiencies and identify opportunities to reduce waste, fraud and abuse in Medicaid, and we want to work with Congress, states, and stakeholders to achieve those goals while expanding access to affordable health care. The Supreme Court decision has made the higher matching rates available in the Affordable Care Act for the new groups covered even more important to incentivize states to expand Medicaid coverage. The Administration is focused on implementing the Affordable Care Act and providing assistance to states in their efforts to expand Medicaid coverage to these new groups." "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid," HHS, Centers for Medicaid and Medicaid Services, Dec. 10, 2012, available at: <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>.

<sup>14</sup> "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," Kaiser Commission on Medicaid and the Uninsured, (November 2012), Table ES-2 available at: <http://www.kff.org/medicaid/upload/8384.pdf>.

<sup>15</sup> "Medicaid Plays A Critical Role in Illinois' Economy," CTBA, (December 2009), available at: [http://www.ctbaonline.org/New\\_Folder/Health\\_Care/Medicaid\\_Economic\\_Impact\\_Analysis\\_Final.pdf](http://www.ctbaonline.org/New_Folder/Health_Care/Medicaid_Economic_Impact_Analysis_Final.pdf)

into Illinois. For FY 2009, one estimate places the value of the wages generated from the Medicaid program that included the enhanced match as high as \$15.8 billion, supporting as many as 385,742 jobs.<sup>16</sup> And a 2004 study estimated that this “multiplier effect” creates \$3.35 worth of economic activity per dollar spent.<sup>17</sup> The job growth and wages generated are likely to be much more substantial under the ACA’s Medicaid expansion, since the federal matching rate under the ACA is 100% from 2014 through 2016 and an additional roughly 429,000 newly eligible Medicaid patients are expected to enroll.<sup>18</sup> State and local revenue increases when Illinois residents pay income, sales, and other taxes generated by the federal funding for the Medicaid expansion.

**3. Covering newly eligible people will help stabilize the state budget.**<sup>19</sup> The Illinois budget depends heavily on federal Medicaid funding.<sup>20</sup> The Illinois Medicaid program is by far the largest source of federal revenues to the state. In addition to the Department of Health Care and Family Services, federal Medicaid funds also support the Department of Human Services, Department on Aging, Department of Children and Family Services, local public health departments, Cook County Health and Hospitals Systems, Illinois’s state universities, and local school districts’ special education programs, among others.<sup>21</sup> Filling the Medicaid gap will provide crucial federal funds across the state and local governments to support programs now being delivered to the newly eligible population with no federal funds, or being withheld from that population due to lack of funds. In fact, a recent study from the Urban Institute estimated that, between 2014 and 2019, states would save between \$92 and \$129 billion under the ACA.<sup>22</sup> A recent Kaiser study found that, “The Medicaid expansion will yield [] state fiscal gains in three areas: increasing federal matching payments for consumers who would qualify for Medicaid even without the expansion; reducing states’ non-Medicaid health care spending on poor, uninsured residents who would receive Medicaid under the expansion; and increasing state revenues due to heightened economic activity or taxes on insurance premiums or health-industry-specific transactions. These factors could outweigh the net cost increases that we estimate for many states, and they would raise the

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<sup>16</sup> “Medicaid Plays A Critical Role in Illinois’ Economy,” CTBA, (December 2009), available at: [http://www.ctbaonline.org/New\\_Folder/Health\\_Care/Medicaid\\_Economic\\_Impact\\_Analysis\\_Final.pdf](http://www.ctbaonline.org/New_Folder/Health_Care/Medicaid_Economic_Impact_Analysis_Final.pdf)

<sup>17</sup> “Medicaid: Good Medicine for State Economies,” Families U.S.A., 2004. See also Univ. of Arkansas Sam M. Walton College of Business, The Economic Impact of Medicaid Spending in Arkansas (May 2010); Christopher Dumas, PhD, et al., The Economic Impacts of Medicaid in North Carolina, 69 N.C. Med. J. 78 (Mar./Apr. 2008). See also Kaiser Family Found., The Role of Medicaid in State Economies: A Look at the Research (Jan. 2009).

<sup>18</sup> “Medicaid 101,” Illinois Department of Healthcare and Family Services,” available at: <http://www2.illinois.gov/hfs/agency/Documents/Medicaid101.pdf>

<sup>19</sup> “Net Effects of the Affordable Care Act on State Budgets,” Stan Dorn, and Matthew Buettgens, The Urban Institute, (December 2010), available at: <http://www.urban.org/UploadedPDF/1001480-Affordable-Care-Act.pdf>

<sup>20</sup> “Medicaid Cuts Will Hurt Illinois’ Economy,” CBHC and Families U.S.A., (April 2012), available at: <http://familiesusa2.org/assets/pdfs/Illinois-Medicaid-Cuts-2012.pdf>

<sup>21</sup> “Medicaid 101,” Illinois Department of Healthcare and Family Services,” available at: <http://www2.illinois.gov/hfs/agency/Documents/Medicaid101.pdf>

<sup>22</sup> “Consider Savings As Well As Costs,” The Urban Institute (July 2011), available at: <http://www.urban.org/UploadedPDF/412361-consider-savings.pdf>

total savings experienced by states collectively above the estimated \$10.1 billion for 2013-2022.”<sup>23</sup>

**4. Covering newly eligible people will save taxpayers money.** Insured people and taxpayers already pay for uncompensated care – they have been filling the Medicaid gap.<sup>24</sup> A Kaiser and Urban Institute report on state spending under the ACA found that if Illinois fills the Medicaid gap, by 2019 Illinois would have reduced its number of uninsured adults in this newly eligible population by over 42% with the federal government paying for over 94% of the cost.<sup>25</sup> This translates into a decrease in Illinois’s uncompensated care spending of as much as \$1.5 billion.<sup>26</sup> Working Illinoisans in low-wage jobs without insurance still get sick, still get injured.<sup>27</sup> But without the federal dollars from filling the Medicaid gap, other Illinoisans with insurance will still have to pick up the cost of their care, to the tune of \$1,000 per year in increased annual premiums.<sup>28</sup> And local property taxes are strained to support the township medical assistance programs and safety net health systems that provide care for low-income uninsured people now. In fact, currently over \$400 million in services for uncompensated care is being provided annually by just one hospital: Cook County’s Stroger Hospital.<sup>29</sup> If Illinois does not take advantage of the federal 100%/90% funding for filling the Medicaid gap, the Illinois federal taxpayers’ portion of federal funds will support Medicaid coverage for newly eligible adults in other states but leave Illinois low-income adults out.

**5. Covering newly eligible people is the linchpin for the big picture reforms that will deliver both better health outcomes and lower costs.**<sup>30</sup> Health coverage requires an investment (which the federal government virtually entirely funds under the ACA). But the

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<sup>23</sup> “The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis,” Kaiser Commission on Medicaid and the Uninsured, (November 2012), available at: <http://www.kff.org/medicaid/upload/8384.pdf>

<sup>24</sup> “Net Effects of the Affordable Care Act on State Budgets,” Stan Dorn, and Matthew Buettgens, The Urban Institute, (December 2010), available at: <http://www.urban.org/UploadedPDF/1001480-Affordable-Care-Act.pdf>

<sup>25</sup> “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL,” The Urban Institute and the Kaiser Family Foundation, (May 2010), available at: <http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>

<sup>26</sup> “State Progress Toward Health Reform Implementation: Slower Moving States Have Much To Gain,” RWJ Foundation and The Urban Institute (January 2012), available at: <http://www.urban.org/UploadedPDF/412485-state-progress-report.pdf>

<sup>27</sup> “Dying for Coverage: The Deadly Consequences of Being Uninsured,” Families U.S.A., (June 2012) available at: <http://familiesusa2.org/assets/pdfs/Dying-for-Coverage.pdf>

<sup>28</sup> “Hidden Health Tax: Americans Pay a Premium,” Families U.S.A., (May 2009), available at: <http://www.familiesusa.org/resources/publications/reports/hidden-health-tax.html>

<sup>29</sup> “Cook County Health and Hospital System’s Care Coordination Enhancements and Bridge to the ACA,” Medicaid 115 Waiver Proposal, Illinois Department of Healthcare and Family Services and CCHHS, (January 2012), available at: <http://www2.illinois.gov/hfs/PublicInvolvement/PublicNotices/Documents/030712pna1.pdf>

<sup>30</sup> “The Oregon Health Study,” available at: <http://www.oregonhealthstudy.org/en/home.php>

investment will yield returns. Insurance coverage makes possible an ongoing relationship with a regular doctor, often for the first time.<sup>31</sup> That, in turn, facilitates preventive care, wellness advice, early detection of conditions, maintenance care (avoiding acute care), a platform for the full use of health information technology that avoids duplication and mistakes and spreads best practices, and care coordination. For instance, a randomized study in Oregon showed that Medicaid enrollees were 70% more likely to report having a regular place of care, and 55% more likely to report having a usual doctor than those who were uninsured.<sup>32</sup> Medicaid enrollees were also 40% less likely to have to borrow money or skip other payments because of medical bills. The Medicaid enrollees were 25% more likely to indicate they are in good, very good, or excellent health. And a recent study in the *New England Journal of Medicine* shows that states that expanded Medicaid saw a reduction in their mortality rate, as well as improved access to care, and better self-reported health among the expansion population.<sup>33</sup> In contrast, lack of coverage means disruptions in care and coordination—the exact triggers that increase health costs. Coverage thus addresses the cost of health care by improving health outcomes across the system. This overall downward bending of the cost curve helps all of us, not just the newly insured.

**6. Covering newly eligible people will pay hospitals and healthcare providers for their work.** Illinois hospitals would gain over \$11 billion in payments from 2013 to 2022 if Illinois fills the Medicaid gap—an increase in payments of over 12% if Illinois and other states fill the Medicaid gap.<sup>34</sup> Additionally, Illinois hospitals need the Medicaid payments to offset reductions in federal funds in other areas. Targeted hospital subsidies, known as disproportionate share hospital (DSH) payments, will decline under the Affordable Care Act.<sup>35</sup> The reduction was justified on the theory that filling the Medicaid gap will eliminate the need for DSH subsidies by greatly reducing the burden of uncompensated care. If hospitals lose DSH payments, and the loss is not made up by filling the Medicaid gap, it will devastate not only hospitals, but entire communities. In

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<sup>31</sup> “Health Reform: Moving Ahead,” RWJ Foundation, available at:

<http://www.rwjf.org/qualityequality/product.jsp?id=68929>.

<sup>32</sup> Baicker, Katherine, Ph.D., and Finkelstein, Amy, Ph.D. “The Effects of Medicaid Coverage — Learning from the Oregon Experiment” <http://www.nejm.org/doi/pdf/10.1056/NEJMp1108222>.

<sup>33</sup> Sommers, Benjamin D. M.D., Ph.D., Baicker, Katherine Ph.D., and Epstein, Arnold M. M.D. “Mortality and Access to Care among Adults after State Medicaid Expansions” <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202099>.

<sup>34</sup> “The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis,” Kaiser Commission on Medicaid and the Uninsured, (November 2012), available at: <http://www.kff.org/medicaid/upload/8384.pdf>. The budget window used was from 2013 to 2022, in accordance with CBO analysis per CBO’s “Updated Estimates for the Increasing Coverage Provision of the Affordable Care Act,” (March 2012).

<sup>35</sup> <http://www.healthcare.gov/law/resources/authorities/section/1202-payments-to-primary-care-physicians.pdf>

FY 2011, Illinois received over \$215 million dollars in federal DSH allotments.<sup>36</sup> Many Illinois hospitals, especially in rural areas, simply are not viable if their DSH subsidies decline without being replaced by the filling the Medicaid gap. Hospitals are among the largest employers in their communities. When a hospital closes, the community not only loses a major employer, but other providers leave too, and then the community loses its appeal to other businesses. Additionally, filling the Medicaid gap will ensure that Illinois's hospitals and doctors will have the financial support to offset Medicare payment reductions contained in the ACA. Moreover, federally funded health centers, the main source of primary care for medically underserved populations, would benefit. With the Medicaid gap filled, these centers will be able to expand capacity to serve the uninsured as well as those newly covered by Medicaid. Health centers would be enabled to reach approximately 19.8 million new patients. If the gap is not filled, however, health centers' new patient care capacity will be reduced by nearly 27%, a 5.3 million drop in new patients.<sup>37</sup>

**7. Covering newly eligible people will stabilize Illinois' insurance market, increase the certainty around the cost of covering people in Illinois, and decrease the risk of adverse selection for private insurers.** The Illinois insurance Exchange will begin operating in 2014 and will provide a pathway for many low and moderate income people to access federal subsidies for premiums and cost sharing for the purchase of private insurance plans offered in the Exchange. The ACA provides for premium subsidies to individuals purchasing coverage in an Exchange if they have income between 100% and 400% FPL and are neither eligible for Medicaid nor offered employer-sponsored coverage that meets minimum value and affordability requirements. If Illinois does not fill the Medicaid gap, then individuals 100% to 138% FPL who otherwise would have been eligible for Medicaid will have access to premium subsidies to buy private insurance on the Exchange. This population will be added to the overall risk pool of people in Illinois' Exchange, and if they have high healthcare needs they will drive up the cost of premiums for Exchange plans, which in turn, would discourage more young and healthy people from enrolling,

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<sup>36</sup> Kaiser State Health Facts, available at:

<http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=15>. The ACA reduces DSH allotments for FYs 2014-2020. The payments will be reduced by \$500 million in FY 2014, \$600 million in FYs 2015-2016, \$1.8 billion in FY 2017, \$5 billion in FY 2018, \$5.6 billion in FY 2019, and \$4 billion in FY 2020.

<sup>37</sup> Katherine J. Hayes, JD. et al., George Washington Univ. School of Public Health & Health Servs., How the Supreme Court's Medicaid Decision May Affect Health Centers: An Early Estimate (July 19, 2012), available at:

[http://sphhs.gwu.edu/departments/healthpolicy/dhp\\_publications/pub\\_uploads/dhpPublication\\_9BB1853A-5056-9D20-3D3DCBB99318306E.pdf](http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_9BB1853A-5056-9D20-3D3DCBB99318306E.pdf)

thus destabilizing Illinois' insurance market.<sup>38</sup> Additionally, the CBO has determined that the per capita cost of covering the 100-138% FPL population in the exchange will be \$5,926 in 2019, as compared with \$1,826 if covered by filling the Medicaid gap.<sup>39</sup> Using these numbers, a state leaving the 100-138% FPL group to Exchange coverage instead of the new Medicaid eligibility category would effectively be substantially increasing system costs.

Moreover, anyone under 100% FPL will be left without access to subsidized coverage. Of the newly eligible population in Illinois, an estimated 431,000 Illinoisans with household incomes less than 100% FPL will be left in the cold if Illinois does not fill the Medicaid gap.<sup>40</sup> The ACA envisioned that these individuals would qualify for Medicaid. That's why the federal subsidy to help pay for private insurance premiums starts at 100% FPL and goes to 400% FPL. If Illinois does not fill the Medicaid gap, the lowest income people will remain uninsured.

**8. Covering newly eligible people will pull down federal Medicaid dollars to pay for behavioral and mental health services for Medicaid enrollees.** In Illinois, in FY 2010, expenditures for community mental health services alone amounted to \$728 million; state psychiatric hospital inpatient care amounted to over \$279 million.<sup>41</sup> The portion of these are costs that are allocated to serving the Medicaid gap population are now being borne by state and local funds, or else the services are simply not being provided to this population, which increases costs in emergency rooms, state institutions and the criminal justice system and affects the overall quality of life in communities. Filling the Medicaid gap would enable Illinois to save the state and local dollars now spent on mental health and substance abuse treatment services for the Medicaid

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<sup>38</sup> Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." July 2012. Available at: <http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>. See also "Why a State's Health Insurers Should Support Expanding Medicaid," Center on Budget and Policy Priorities, (September 2012). See also, "Businesses will Push Perry to rethink Medicaid Expansion," Kaiser Health News, July 18, 2012, available at: <http://www.kaiserhealthnews.org/Stories/2012/July/18/Texas-Medicaid-expansion-business.aspx>

<sup>39</sup> Sara Rosenbaum, Medicaid and National Health Care Reform, 361 New Eng. J. Med. 2009, 2011 (2009).

<sup>40</sup> "Opting Out of the Medicaid Expansion Under the ACA: How Many Uninsured Adults Would Not be Eligible for Medicaid?," The Urban Institute, (July 2012), available at: <http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf>

<sup>41</sup> National Association of State Mental Health Program Directors Research Institute data from Illinois Division of Mental Health, Illinois Department of Human Services, available at: <http://www.nri-inc.org/projects/Profiles/Profiles12/ProfileReport/il2012.pdf>

gap population with federal Medicaid funds.<sup>42</sup> And it would allow more of the gap population to receive appropriate treatment.

**9. Covering newly eligible people will provide Medicaid coverage for Illinois' veterans.**<sup>43</sup>

Not all veterans are able to get care at a Veterans Affairs hospital. And, in fact, filling the Medicaid gap would bring health coverage to 1,800 of the new veterans in Illinois (military service members who have been deployed in 2001 or later) and 12,600 of all veterans.<sup>44</sup> Illinois needs to take care of veterans, and filling the Medicaid gap will do just that for many of them. And nationally, in 2014, nearly half of uninsured veterans will likely qualify for the new Medicaid coverage.<sup>45</sup>

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<sup>42</sup>“Consider Savings As Well As Costs,” The Urban Institute (July 2011) available at: <http://www.urban.org/UploadedPDF/412361-consider-savings.pdf> stating “In FY 2008, state mental health agencies spent an estimated \$36.8 billion. Of this amount, 45.4 percent, or \$16.7 billion, represented state and local costs outside Medicaid. Medicaid paid for 46 percent of state mental health services, or \$16.9 billion. Other funds were provided by Medicare, federal block grants and additional sources. The ACA’s expansion of Medicaid coverage to reach adults with incomes up to 138 percent of FPL will have a major impact on these state- administered systems of care. Among the adults served by state mental health agencies, 79 percent are either unemployed or outside the labor force. Nevertheless, 43 percent of consumers served by these agencies have no Medicaid coverage. When the ACA is fully implemented, Medicaid coverage is expected to increase from 12.4 to 23.3 percent of individuals with mental illness or substance abuse disorders, and Medicaid’s mental health spending is projected to rise by 49.7 percent. If the latter increase had applied to state mental health agencies in FY 2008, their Medicaid revenue would have grown by \$8.4 billion. Trended forward based on per capita changes in state and local health spending projected by the CMS Office of the Actuary, the increased Medicaid revenue would total \$82.7 billion for 2014-2019. Of this amount, \$79.4 billion would represent new federal dollars, based on the average federal matching percentage projected for newly eligible adults. ...[I]f we assume that between a quarter and half of increased Medicaid reimbursement will substitute for state and local spending, state and local savings in this area would range from \$13 billion to \$26 billion over the six years from 2014 to 2020.”

<sup>43</sup> The Sargent Shriver National Center on Poverty Law, available at: <http://www.theshriverbrief.org/2012/05/articles/health-care-justice/the-affordable-care-act-protecting-americas-protectors/>

<sup>44</sup> Data are based on the Social IMPACT Research Center’s calculations of the American Community Survey data, available at: <http://www.heartlandalliance.org/research/>.

<sup>45</sup> Healthcare.gov, available at: <http://www.healthcare.gov/using-insurance/low-cost-care/medicaid/>.

**10. Covering newly eligible people benefits Illinois employers by increasing the likelihood of a more productive workforce.**<sup>46</sup> Workers with a regular source of healthcare are healthier, thus more employable and more productive as employees. Filling the Medicaid gap will help ensure a healthier workforce for employers of low-wage workers, including child care and home health care workers. Improved health decreases absenteeism, which in turn increases productivity.<sup>47</sup> And the gap population itself will experience a dramatic improvement in both the quality of life and their chances for upward mobility.

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<sup>46</sup> “Implications of Medicaid Expansion Decisions on Private Coverage,” American Academy of Actuaries, September 2012.

<sup>47</sup> See Univ. of Arkansas Sam M. Walton College of Business, The Economic Impact of Medicaid Spending in Arkansas (May 2010) (citing Karasek & Thoerell (1999) and Marslen & Moriconi (2009)).