Expanding Utah's Health Insurance Options

An Economic Analysis of Benefits, Costs and Risks

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Executive Summary

Tens of thousands of low-income Utahns currently fall into a health insurance coverage gap, and tens of thousands more people risk falling into that gap should their economic situation worsen. This coverage gap places lives in jeopardy, puts families in economic peril, imposes costs on the health care industry and the economy, and strains state and county budgets.

Two primary options are currently being considered by the state: 1) The ***Healthy Utah*** plan, which significantly expands private insurance for low-income individuals using almost entirely federal funds during its pilot period, and 2), the ***Utah Cares*** plan, which partially expands Medicaid and offers primary care, but not specialty care or hospitalization, to those in poverty using a mix of federal and state funds.

Using forecasts of program enrollments, the predicted costs and benefits with the *Healthy Utah* and *Utah Cares* plans are summarized in the following table:

Benefits & Costs	Healthy Utah	Utah Cares
Economic Benefit	$ 911,634,885	$ 344,832,332
Cost to State	$ 37,438,154	$ 84,202,079
Net Benefit	$ 874,196,731	$ 260,630,253
Return on Investment	24.4	4.1
> Both projects are evaluated on the two-year period 7/1/2015-6/30/2017		
> Healthy Utah costs and benefits are only for those in 0-100% FPL group		

Both programs bring in significant new federal funds into the state and extend valuable benefits to low-income residents. However, the *Healthy Utah* plan not only brings in three times the benefits to the state, it does so at significantly lower costs. *Put another way, Healthy Utah provides approximately 6 times more value per dollar than Utah Cares.*

Opponents of *Healthy Utah* have criticized the plan as tying the state to a risky federal program for which costs would spiral out of control and imperil the state budget. A careful analysis of these risks suggests the opposite:

- *Healthy Utah* effectively closes the insurance coverage gap. *Utah Cares* does not close the gap, and leaves tens of thousands of individuals with no more than basic primary care services, which is only a small fraction of their health care needs.
- As a pilot program, *Healthy Utah* is funded 100% by the federal government through the end of 2016 and at 95% in 2017. In contrast, 30% of *Utah Cares* (an estimated $32 million annually) must be paid from state funds.
- Downside risks such as economic downturns, increasing insurance and health care costs, and errors in government forecasting are borne by the federal government under *Healthy Utah*. Under *Utah Cares*, these risks are shared by the state and may result in drastic cutbacks in enrollment, putting many Utahns back in the coverage gap.
- After the pilot program ends, *Healthy Utah* can be continued with the state paying only 5-10% of the costs. The state's bill for *Utah Cares* continues at 30%.
- *Both* programs are associated with "woodwork" effects, which will cause traditional Medicaid costs to rise. Woodwork costs come about when people previously eligible for Medicaid "come out of the woodwork" as they apply for a new program. Thes eare somewhat higher under *Healthy Utah*, but less than $30 million annually.
- A long-term commitment to *Healthy Utah* would necessitate a dedicated revenue source, but the inflow of federal money into the state's economy increases state revenues and reduces costs in a variety of other areas.
- The long-term cost of continuing *Healthy Utah* beyond the pilot phase would be a tiny portion of state outlays, even under pessimistic risk scenarios. The benefits are many multiples of those outlays.

Even in the most pessimistic scenarios, in which the estimated benefits are far lower than expected and the expected costs are far higher, the *Healthy Utah* plan is significantly better than *Utah Cares* in terms of economic and social benefits and in terms of risk management.

Utah Cares handles risk by allowing the program to contract (or expand) the population covered according to program cost and the state budget. Once the increased demand (or limited budget) is known, the program can be reduced. Thus, cost overruns should be only temporary before adjustment. Such an adjustment would reduce the benefit of the program by pulling back coverage and returning Utahns to the gap.

Healthy Utah mitigates risk by shifting the funding burden to the federal government. If enrollment or costs increase, then the federal government pays for most of it. The state pays 5% of costs starting in 2017, and increases annually to 10% in 2020, where it will stay. By paying for additional enrollment, the state provides for more low-income citizens' health care.

In the pilot phase, the state will gain close to one billion dollars in benefits by laying claim to the federal funds already being sent to Washington by Utah taxpayers. In aggregate, there is essentially no meaningful downside risk to the state from implementing the *Healthy Utah* plan.

Over the next several months, the state can continue to monitor costs and benefits and learn from the experience of other states. It can also continue to have discussions with the federal government about modifications to the program. And starting in 2017, all states have the opportunity, under the ACA, to significantly restructure their entire Medicaid program.

If we face a different set of options in the next few years that makes *Healthy Utah* obsolete or undesirable in some way, then the state can change direction, just as it has changed its Medicaid policies many times in the past.

Finally, in no way does the *Utah Cares* option constitute a safer or more conservative approach for the state to take in this uncertain period. Simply put, both plans significantly improve the lot of low-income people, but the *Utah Cares* plan provides fewer services to fewer people at greater cost than *Healthy Utah*.

Research sponsored by AARP Utah, Voices for Utah's Children and the Utah Health Policy Project by Notalys, LLC. Project leader is Sven E. Wilson, PhD, Chief Economist for Notalys.

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1. Utah's Policy Options

The Problem: Utah's Coverage Gap

The Patient Protection and Affordable Care Act (ACA, also known as Obamacare) has increased insurance coverage across the country through two mechanisms: access to subsidies for insurance in the new insurance exchanges, and Medicaid expansion. Utah chose not to expand Medicaid, and the subsidies under the ACA are available only to those making 100% of Federal Poverty Level (FPL) or more.

This outcome is a combination of the way the ACA was written, the Supreme Court ruling on expansion, Utah's indecision on Medicaid expansion, and the state's minimal coverage rules, which all work together to leave a significant number of Utahns in a coverage gap. These include two groups of people:

- Childless adults earning less than 100% of FPL
- Adults with children earning between 45% and 100% of FPL

Estimates of the number of uninsured in the coverage gap vary somewhat, but all indicate well over 50,000 persons. In a previous analysis reported in 2014, our consulting group estimated that the number of persons in the gap who lacked insurance was approximately 66,000.[1]

There are also tens of thousands of Utahns who are at risk of falling into the gap. Those who make more than the poverty level can now qualify for subsidies that pay for all or most of the cost of health insurance. But if their income should slip below the poverty line, they would lose their subsidies and in most cases could not afford health insurance. And adults with children who are very poor would lose their Medicaid benefits if their income rose above 45% of the poverty line.

In sum, the current policy environment provides new access to the near-poor and the middle class, but leaves many of those who are in truly desperate need without options. Finding a way to cover those people is the challenge facing Utah policy makers at this point.

Important Policy Realities

Under federal law and regulation, states such as Utah have limited options for health insurance expansion. A full Medicaid expansion is not on the table politically, though recent research (see below) indicates that states who have expanded Medicaid are experiencing significant economic savings.

[1] Notalys, 2014a, *Utah Medicaid Gap Analysis,* Consulting Report.

Governor Herbert's team has negotiated with Centers for Medicare & Medicaid Services (CMS) on the options available to the state to use federal funds to cover low income people in the gap. The *Healthy Utah* plan is the result of those discussions. Before addressing the plan's features, we note four important policy realities:

- *Taxes being levied on Utah to fund the ACA can only be recovered through a program that gains approval from CMS.*

Medicaid expansion began nationally at the beginning of 2014. Since that time, Utah has been paying taxes to fund the ACA. To date, Utah has taken no actions to recover the maximum amount of funding available to the state (though Utahns above the poverty line are collecting hundreds of millions of dollars in the federally-subsidized exchange).

- *To achieve a full match of 100% federal funding for new enrollees, program benefits must approximate the benefits offered under traditional Medicaid.*

A reasonable argument could be made that Utah should be allowed to use the federal funds to create an insurance program with a different benefit structure and different premiums and co-pays. But such an option does not currently exist.

- *Medicaid expansion to a level lower than 138% of FPL is not allowed.*

Another reasonable approach to policy would be to expand Medicaid for those under the poverty level and let those above the line buy subsidized insurance on the exchange. CMS has indicated they do not believe they have the authority to lower that threshold for Medicaid expansion. Thus a fully-funded "partial expansion," whether based on income or eligibility category, is not an option at the moment.

- *The state can withdraw from its health insurance expansion at any time.*

Unfortunately there is a lot of political rhetoric that new plans to expand health insurance, either through *Healthy Utah* or the *Utah Cares* option, cannot be ended as the state faces long term risk from expanding insurance. *These claims have no basis in fact*. The state can withdraw at any time and, indeed, the legislature can essentially limit the length of the insurance expansion as a time-limited pilot project.

Comparing Program Features

In this section we compare the basics of the two primary alternatives that were the result of the 2015 legislative session and form the starting point for ongoing discussions by the Governor and legislative leadership. The first, the *Healthy Utah* plan, is a comprehensive insurance approach funded 100% by federal ACA dollars through 2016 and at 95% in 2017. The second is

the *Utah Cares* program, which expands existing Medicaid-funded programs using federal Medicaid and state dollars.

*Key Features of the **Healthy Utah** plan:*

- Uses federal funds to purchase *private insurance* for those under 138% of FPL who are not currently eligible for Medicaid.
- Benefits are commensurate with Medicaid benefits.
- Purchases qualified employer plans, where available.
- Keeps families together in same plans.
- Encourages work through work-search benefits.
- People over the poverty level pay premiums and higher co-pays.
- "Medically frail" individuals have the option of participating in Medicaid.
- Estimated enrollment during 2016: 130,000 Utahns.
- Enrollment and cost overruns are absorbed by the federal government because of the 100% match.
- Proposed as a 2-year pilot program that is 100% funded by the federal government.
- Federal contributions drop to 95% in 2017 and decline gradually to remain at 90% in 2020 and beyond.

*Key Features of the **Utah Cares** plan:*

- Uses federal (70%) and state (30%) funds to expand two Medicaid programs.
    - Expansion of Medicaid for childless adults from 0-33% FPL.
    - Expansion of Medicaid for adults with children from 45-65% FPL.
    - Expansion of the cap on the number of people allowed to enroll in the Primary Care Network (PCN, the Medicaid waiver program), which covers people up to 100% FPL.
- Estimated enrollment during first year: 18,000 in Medicaid and 35,000 in PCN.
- Enrollment and cost overruns result either in higher expenses to the state or to a reduction in enrollment and benefits to program participants.
- PCN covers only primary care and some prescription drugs.
- No protection from catastrophic costs.
- Those in the PCN receive only a small fraction of the benefits available to those with insurance.
- Individuals who are in the 100-138% FPL continue to receive federal subsidies to use on healthcare.gov (this occurs whether or not *Utah Cares* is passed).

Healthy Utah provides full private insurance for low-income adults to purchase health care in the same way that other individuals use their health insurance. The insurance is purchased

from companies offering other policies in the state. Thus, from the enrollee and provider perspective, *Healthy Utah* is predominantly thought of as a *private insurance expansion.*

Conversely, *Utah Cares* works through partially expanding the state's Medicaid programs. People at the lowest income levels will have access to traditional Medicaid that was not available to them before. Additionally, the expansion of the Primary Care Network (which is funded through a waiver using a mix of federal and state Medicaid funds) is a valuable service to those without other options, but this program in no way approximates an insurance expansion, since the primary value of insurance to people, whether rich or poor, is through protection against serious events—the sort of critical events that require high cost specialty care and, especially, in-patient hospital care and are not covered for those in the Primary Care Network.

2. New Evidence

Debates about Medicaid expansion alternatives focus on several questions about the effects of increasing health care in Utah. Proponents of *Healthy Utah* and *Utah Cares* are making conflicting claims about the likely impacts of the proposed programs, but these impacts can be difficult to predict in advance. Still, scholarly research and the experiences of states that have enacted similar expansions can both provide some picture of what might happen in Utah.

Financial Effects

The Oregon Health Insurance Experiment (OHIE) highlights some of the possible health and financial effects for individuals under Utah's proposed expansion plans. In 2008, Oregon extended Medicaid coverage to adults under the FPL, but the state allocated spots through a lottery system since the program budget was not large enough to cover everyone who wanted to join. This randomization allowed researchers to compare new enrollees to their less-lucky counterparts to determine the effect of Medicaid coverage on their health and employment outcomes. The Oregon enrollees were uninsured, low-income adults – similar to most of the Utahns who could gain insurance in an expansion.

One of the primary purposes of health insurance is economic security, and key findings from the OHIE indicate that expanding insurance coverage may improve the well-being of many households by reducing the financial burden of health care costs. The OHIE "nearly eliminated catastrophic out-of-pocket medical expenditures" among enrollees and reduced medical debt and out-of-pocket spending.[2] Based on Oregon's experience and other findings, researchers

[2] K Baicker, et al., 2013, Effects of Medicaid on Clinical Outcomes, 1713.

estimate that extending health care coverage would shield 4.4% of the newly-insured from catastrophic out-of-pocket medical costs (30% or more of income) in a typical year. Expanding coverage would also protect 16% of the newly-insured who would otherwise have to borrow money or skip other payments in order to pay their medical bills.[3]

Additionally, expanding Medicaid coverage did not cause a decline in enrollees' employment or earnings.[4] Although some other research links public health insurance coverage to decreased employment for childless adults, it suggests that this was likely caused by new enrollees quitting their jobs when they no longer relied on their employer for insurance.[5] Unlike the subjects of those studies, the Oregon enrollees were unlikely to have the option of private insurance through their employers. In sum, because Utahns in the coverage gap are more like Oregonians in the OHIE than the wealthier or previously-insured subjects of the other studies, the results in Utah would likely be more similar to Oregon's.

Health Outcomes

Research from across the nation shows that expanding health care coverage increases access to health care. In the OHIE, the newly-insured were more likely to have a usual source of health care and receive important preventive care, raising the rates of detection and management for prevalent diseases such as diabetes.[6] Findings from other states link increased health care access to reduced mortality, especially among non-white and lower-income groups. Researchers who evaluated Medicaid expansions in New York, Maine, and Arizona in the mid-2000s found that these programs "were significantly associated with reduced mortality [a 6.1% decrease] as well as improved coverage, access to care, and self-reported health."[7]

Substantial health gains were also associated with other programs that expanded health insurance. The Massachusetts health reform instituted under Governor Mitt Romney in 2006 was associated with a 2.9% decline in the overall mortality rate compared to similar counties outside the state.[8] While there was no significant change in deaths from homicides, car crashes, etc., deaths caused by cancer, infections, and disease were down. This means that the improvement was likely due to health services associated with expanded insurance coverage, rather than to some unrelated factor. Similar to the other expansions previously discussed, Massachusetts' program has improved health across the board.

[3] White House Council of Economic Advisers, 2015, 28.
[4] K Baicker, et al., 2013, Impact of Medicaid on Labor Force Activity and Program Participation.
[5] C Garthwaite, T Gross & MJ Notowidigdo, 2013; L Dague, T DeLeire & L Leininger, 2014.
[6] K Baicker, et al., 2013, Effects of Medicaid on Clinical Outcomes.
[7] BD Sommers, K Baicker, & AM Epstein, 2012, 1025.
[8] BD Sommers, SK Long & K Baicker, 2014.

Early Evidence from Other States

To date, 30 states (including the District of Columbia) have already opted for Medicaid expansions or robust alternatives. Their results can give us some idea of the possible effects of an expansion in Utah; major benefits fall into three categories:

- Access to federal matching funds to provide Medicaid benefits for several groups.
- Replacing general funds with Medicaid funds for state programs for the uninsured.
- Additional state revenues from increasing health plan revenues. [9]

Recent reports show that several of the states that expanded Medicaid in 2014 have seen many more new enrollees than they anticipated, but it is not yet clear how these higher enrollment rates will affect overall budgets. Enrollment surges may increase program expenditures but also yield greater health outcomes and economic activity.[10] An analysis of Kentucky's expansion reported that higher-than-anticipated enrollments actually corresponded with large financial gains for the state budget and local economies. Just over twice as many Kentuckians enrolled in Medicaid as the state had projected (approximately 300,000 instead of 150,000), but in addition to the health improvements from increased screenings and preventive care, the state health care system and overall economy also gained about $1.16 billion, largely driven by federal payments.[11]

Additionally, Kentucky hospitals saw a decrease of $1.15 billion in uncompensated care in the first three quarters of 2014 compared with the previous year. Other states that expanded Medicaid also saw significant decreases in uncompensated care. The Iowa Hospital Association reported that in the first half of 2014, 45.7% fewer people were hospitalized without insurance, overall admissions dropped 4.4%, and charity care losses fell by 18.5% compared to 2013.[12] The New Hampshire Hospital Association similarly reported decreases in uninsured emergency department visits and hospital admissions of 22% and 28%, respectively, with a 1% reduction in overall admissions.[13] This experience and other scholarly research show that state and local governments in non-expansion states are missing out on recovering part of the bill they end up footing for uncompensated care.[14]

Several states have pursued "private option" alternatives to traditional Medicaid expansion. In states such as Arkansas, governors and legislators cooperated to develop innovative ways to make health care accessible to their citizens in the coverage gap. Arkansas' program extends

[9] D Bachrach, P Boozang & D Glanz, 2015.
[10] R Pradhan, 2015.
[11] Deloitte, 2015.
[12] Iowa Hospital Association, 2014.
[13] Associated Press, 2015.
[14] TA Coughlin et al., 2014; White House Council of Economic Advisers, 2015.

private health coverage to the poor by purchasing insurance on the health exchange with federal funds.[15] The thinking behind the plan is that private insurers will manage patients' health with greater efficiency and less cost than state Medicaid systems, hospitals and doctors will see higher reimbursement rates, and insurance companies receive more business. Iowa, New Hampshire, and other states have enacted similar plans that, like *Healthy Utah*, close the coverage gap by making some new populations eligible for Medicaid and covering others with private insurance purchased from the health exchange.

What about Non-Expansion States?

Eighteen of twenty-two non-expansion states in 2014, including Utah, saw increases in Medicaid enrollment as previously-eligible adults signed up during the nationwide media focus on the ACA.[16] Because of these "woodwork" enrollees, non-expansion states realized many of the costs and none of the benefits of Medicaid expansion, outside of the benefits of having more citizens insured.

3. Benefit Analysis

Critics of public programs are quick to point out their costs, but public health spending also brings several types of benefits to the state. These benefits can be large, and they play a crucial role in the health and well-being of the state's citizens.

Benefits from the *Healthy Utah* plan and the *Utah Cares* plan are varied and differ significantly. We examine here the various categories of benefits and how they stack up across the two plans.

The Fiscal Benefit: Returning Tax Dollars to the State

Direct Economic Benefits

Recent actuarial estimates suggest that *Healthy Utah* will bring more than $500 million in federal money to the state on an annual basis. This is a small proportion (much less than 1%) of Utah's economy, which has an output approaching $150 billion annually, but the total still amounts to roughly $1,000 for each Utah family each year.

[15] M Williams, 2015.
[16] A Boothe & C Ryan, 2014.

Obviously this money is not "free," so where does it come from? It comes from taxes that Utahns and other Americans are currently paying to fund the implementation of the ACA. *The most important economic fact about the Healthy Utah plan is that it returns hard-earned dollars to Utah taxpayers.* Polls show that Obamacare is very unpopular in Utah and a lot of other states. But that does not prevent the federal government from collecting taxes to fund it. This taxation is already happening, and tax collections are flowing from Utah to Washington, DC.

For the past year and half, tens of billions of federal dollars have been flowing back to states like California, New York, Illinois, and neighbors such as Colorado and Arizona through Medicaid expansion, but Utah has not received its due because it has failed to pass and implement a plan to use those funds. Though hundreds of millions of dollars have already been lost by the state through inaction, the *Healthy Utah* plan would allow the state to receive its full share of the federal dollars available in the future.

Economic Stimulus

When taxes are implemented in an economy, the economic burden of those taxes is greater than the amount of the tax. Economists refer to this as deadweight loss or the marginal excess tax burden. For example, if the tax bill of citizens goes up by $500 million, an additional amount is lost through further economic contraction due to the way taxation distorts markets. The amount is highly uncertain, but $200 million is a reasonable estimate. Thus, the total economic effect of government taxation is, in this example, $700 million (government accounting reports usually ignore the economic inefficiency caused by taxation).

When government spends money, a different but related process happens in reverse. Spending by government causes some additional spending through what is called a spending multiplier. The amount of this stimulus is hard to determine and controversial among economists. And when government spends in markets that are otherwise working well, spending by government can "crowd out" some spending in the private market, limiting further the effect of the multiplier.

On balance, however, when tax dollars are returned to Utah, the economic benefit exceeds the amount of the spending. Even a very small multiplier will generate hundreds of million annually. Multipliers are also stronger when the economy is depressed. Thus in economically distressed regions or during economic downturns, the stimulus effect grows.

Some analysts have estimated that implementing the *Healthy Utah* Plan will support over 3,000 new healthcare sector jobs and could lead to billions in newly generated economic impact. Research by experts in other states have indicated large economic benefits due to the Medicaid expansion. In Kentucky, Deloitte estimated that the expansion created 12,000 jobs during the

2014 fiscal year, along with $1.16 billion in new revenues going to the health care providers of the state.[17]

Whereas the *Healthy Utah* option brings the full measure of federal dollars back to the state (over $300 million), the *Utah Cares* option would bring a much smaller amount, around $82 million annually beginning in fiscal year 2016.[18] (Under *Utah Cares*, low-income families with incomes 100-138% of FPL can still gain insurance subsidies from the federal government, but those subsidies occur whether or not the state adopts *Utah Cares*.) These new federal dollars work much the same way the federal dollars work under *Healthy Utah,* though they are channeled through the Medicaid program and the PCN program, not the private insurance market. Moreover, each dollar that the state spends through *Utah Cares* will cost 30 cents to Utah taxpayers (plus an additional deadweight loss associated with taxation to pay for that expense).

It is crucial to note that this economic analysis does *not* assume that Obamacare itself is fiscally beneficial to the state or the nation. The overall effects to the state of the ACA may be positive or negative, but this analysis does not address that question because it is already the law of the land.

Uncompensated Care

As noted above, states around the country that expanded Medicaid are seeing significant reductions in uncompensated care costs. The Utah health care industry's support for *Healthy Utah* suggests that our providers here anticipate a similar benefit. A Public Consulting Group (PCG) report estimated a benefit to the state's industry of over $800 million over the time period studied.[19]

Utah Cares would have a much smaller impact on uncompensated care. The industry would benefit from new Medicaid patients, though because of Medicaid reimbursement rates, providers much prefer treating patients on private insurance. But hospitals would face little benefit beyond the new Medicaid patients because the PCN does not cover specialty medicine or hospital care.

Utah has a rich tradition of charity care that will not go away with the addition of either the *Healthy Utah* or *Utah Cares* plan. Utah will still have many thousands of uninsured people, some of whom will rely on charitable services. Reducing the amount of uncompensated care

[17] Deloitte, 2015.
[18] Utah Office of Legislative Research and General Counsel, 2015.
[19] Public Consulting Group, 2013.

that results from treating uninsured patients also gives the industry flexibility to provide more charitable services to the community.

Additional State and Local Revenues

For lawmakers concerned with balancing the state budget, *Healthy Utah* has an additional advantage: some of those federal dollars and the resulting economic stimulus will end up as taxable income to state residents and spent on goods and services that are subject to sales taxes. Thus the state (as well as counties and municipalities) will, thereby, increase revenues.

The amount of revenue depends on the size of the economic expansion. Based on analysis found in the 2013 PCG report, we estimate that tax revenues over the initial two-year period would be $14 million. These revenues, by themselves, would finance a significant portion of the estimated state costs of the *Healthy Utah* plan. A larger stimulus that some analysts estimate would result in even greater state revenues.

The *Utah Cares* option would also bring in federal money that would generate some taxes. Note, however, that the state would have to use tax revenue to finance the 30% portion of the program.

Benefit Category: Direct Fiscal Effects

Policy Option	Consequences for Utahns	Budgetary Impact
Option 1: Do Nothing	Health care industry continues to absorb costs of uncompensated care and pass them on to consumers.	Minimal health care options for the poor continue to put strain on budgets, particularly at county level.
Option 2: *Utah Cares*	Access to primary care spreads. Expansion of Medicaid helps poorest of the poor. Creates work disincentive for poorest adults through eligibility limits.	State pays 30% of all costs. $32 million in immediate annual costs plus significant woodwork costs.
Option 3: *Healthy Utah*	Over $500 million annually in direct benefits to the poor. Significant benefits to insurance and health care industries. Stimulus effects are highest in economically depressed areas. Encourages work and creates no disincentives.	Short term costs include only the woodwork effect. Long-term costs grow gradually if state continues program, but program costs are significantly offset (perhaps even exceeded) by increased revenues and decreased burden on other social service programs.

The Economic and Social Value of Insurance

Value of Insurance for the Poor

The most important benefit from the *Healthy Utah* plan is simple: *it provides access to health insurance to tens of thousands of uninsured Utahns.* A good chunk of those benefits are captured by the hundreds of millions in program expenditures, but the value of insurance in a society far exceeds what it costs.

Polling indicates that Utahns across the political spectrum want to ensure that the poor have access to health insurance, and research shows that they see government as an important tool to meet that goal.[20] The ACA reforms and Supreme Court decisions have left approximately 66,000 people in the coverage gap where they have no access to Medicaid or to subsidies.

How much is insurance worth? The primary measuring stick in economic analysis for something's value is the amount that people are willing to pay (WTP) for it in the market. But in economics, *willingness* to pay is a function of *ability* to pay. Thus the WTP metric has serious problems in assessing societal economic value in this case.

Previous research has tried to determine how much the poor would be willing to pay out of their limited income for a comprehensive health insurance plan if they had access to it. The answer was about $2,000.[21] A new working paper by the lead researchers on the Oregon Health Insurance Experiment found that the poor would be willing to pay between 20-40% of the cost of coverage to have Medicaid. The remaining costs of the program are attributable to transfers to those who provide care, including uncompensated care by hospitals and providers, extended family members, and churches and other charitable organizations.[22]

It is a mistake, however, to assume that low willingness to pay means low economic value to society. The research suggests that if given the choice between a cash benefit of, say, $2,500 and a Medicaid policy, most low-income people would take the cash—even though the dollar cost of Medicaid is nearly twice the amount of the cash. However, this is not because insurance is not valuable, but because additional income for the poor is so valuable.[23]

The annual cost per enrollee of providing insurance under *Healthy Utah* is, according to Milliman, $4,833 in 2016. This expenditure is what is captured in the "direct" costs discussed above. But the typical Utahn's value from insurance far exceeds that amount. The average person pays (either directly or indirectly through an employer plan) over $5,000 per year. More

[20] Notalys, 2014b, *The Healthy Utah Poll: Initial Findings*
[21] AK Krueger & I Kuziemko, 2013.
[22] A Finkelstein, N Hendren & EFP Luttmer, 2015, The Value of Medicaid: Interpreting Results from the Health Insurance Experiment.
[23] In economic terms, at low levels of income, the marginal utility of income is very high.

importantly, a good many people would be willing to spend (and, indeed, often do spend) much, much more than that to gain the economic security that insurance provides.

The Oregon health insurance study has shown that the short term health benefits of Medicaid coverage (in terms of outcomes such as hypertension or diabetes) are quite small.[24] We would likely find similar effects for people on private insurance. Evidence does show that health insurance save lives and promotes health,[25] but the primary purpose is economic security—the ability to avoid catastrophic costs that can cripple the present and future lives of our fellow citizens and their families.

If federal regulations allowed it, a plan that had higher individual premiums and higher co-pays, requiring more "skin in the game" for the poor, would be superior on economic efficiency grounds (though perhaps not on fairness grounds). But mandated federal benefits do not allow that option. The *Healthy Utah* plan will be used to buy insurance on the private market, but that amount (which varies across people) is much less than average Utahns would be willing to pay for insurance if they had to.

So what is the state being asked to pay for the ability to extend insurance benefits to the poor under *Healthy Utah*? Initially, the state pays nothing, since the federal government picks up the full cost. Over time the state contribution rises to as high as 10% if the state decides to keep the program for several years. With today's prices that means about $400 per enrollee.

The Problem of Overspending

One complication with determining the value of health insurance is that insurance can contribute to the problem of wasteful care. We have known since the RAND Health Insurance Experience 20 years ago that as the out-of-pocket costs for health care go down, people consume more of it.[26] These incentives contribute to a lot of waste in health care spending. A recent study found that about 30% of total health care spending is wasteful when it comes to promoting health.[27]

When people obtain health insurance, evidence shows that their utilization of health care will go up. Some of that increased utilization will not be cost-effective (just as some of the health care spending from other people with insurance is wasteful). Utah's Medicaid program has recently undergone reforms that are reducing wasteful spending by creating better incentives for patients and providers.[28] Private health insurance companies are engaging in similar

[24] K Baicker, et al., 2013, Effects of Medicaid on Clinical Outcomes.
[25] BD Sommers, K Baicker & AM Epstein, 2012; BD Sommers, SK Long & K Baicker, 2014.
[26] JP Newhouse, 1996.
[27] Institute of Medicine, 2013.
[28] D Liljenquist, 2014; Executive Appropriations Committee meeting report, 2015.

efforts. Nonetheless, the overall benefits of insurance needs to be discounted somewhat to account for these inefficiencies in how we deliver care.

A big part of the value of insurance, however, is that when faced with potentially life-threatening events, people value the ability to spend those extra dollars that are not cost-effective. In such situations, individuals tend to be very risk-averse. The measures of waste and overspending look at the *average* effectiveness of care. The peace of mind that comes from being able to take that extra measure of care has economic value that explains both the high cost of insurance and the willingness of people to pay for it. Health insurance expansion extends the same piece of mind to low-income citizens.

Other Economic and Social Benefits

The value of insurance extends far beyond the covered individuals. When people have insurance, greater economic security is realized by immediate and extended family members as well. Economic strain among low income people results in worse health, stressed and broken families, and economic hardship for adults and children. Trying to put a dollar value on such a benefit would be very hard to do, but such benefits may be very significant—perhaps approaching the value to the insured individuals.

Benefit Category: Value of Insurance

Policy Option	Consequences for Utahns	Budgetary Impact
Option 1: Do Nothing	Uninsured Utahns continue to face severe economic stress. Health care is fragmented. Broken families and social problems such as crime and substance abuse continue.	Poor physical and mental health care leads to long term consequences for counties and states.
Option 2: *Utah Cares*	Some insurance is provided with full benefits through Medicaid. PCN provides modest assistance but is not an insurance program and does not, therefore, bring the economic and social benefits of insurance.	Better primary care helps families and modestly reduces long term impacts on counties and states.
Option 3: *Healthy Utah*	All the benefits of insurance are realized by covered persons, their families and communities.	Full insurance promotes the entire range of economic and social benefits that result from access to health care.

A variety of social services are affected by insurance access as well. County governments have supported *Healthy Utah* because of the strain that the uninsured put on their services and budgets; they bear a large portion of the mental health and criminal justice expenditures associated with people who have incomplete and intermittent access to health insurance.

4. Risk Analysis

Any effort to expand the reach of health insurance to include more needy individuals faces uncertainties that policy makers must be mindful of. The rapidly changing landscape for health care and insurance imposes a number of risks that need to be considered carefully by decision makers.

The wide range of uncertain variables related to health insurance expansion can be daunting. In this section we divide the various risks into categories that can be carefully examined, and we evaluate the competing policy alternatives with respect to each type of risk. The questions to be addressed include what level of confidence we have that current projections are solid and, more importantly, what the consequences would be if things were to go badly in the future? In other words, can we reap the benefits of insurance expansion and at the same time manage the risks we face?

Economic Downturns

In the past decade the world endured the greatest economic downturn since the Great Depression. Economic output contracted, unemployment soared, home foreclosures increased, and bankruptcies abounded. The impact of a major macroeconomic event also has a large impact on government finances.

The state of Utah must balance its budget annually, so economic downturns can force difficult choices as tax revenues fall and the cost of welfare programs increase. For instance, at the end of FY 2008 (June), there were 164,229 persons enrolled in the state Medicaid program. Two years later at the end of FY 2010, enrollment had increased to 221,954. *This is an increase of 35% in just two years.*

There was no expansion of Medicaid eligibility driving this increase. The rapid increase was due primarily to economic contraction. During this time, Utah's unemployment rate increased from 3.3% to 7.9%. At the same time, state tax revenues were contracting. The federal government can borrow to pay its portion of the Medicaid cost, but that option is not available to the state.

Economic downturns have devastating consequences for families who lose their jobs. And job losses in a recession are particularly damaging on the health insurance front because they tend to be concentrated among those people who are most likely to fall into the coverage gap if they lose their job. In the "Do Nothing" case, citizens will experience the same hardships that they have faced during past recessions, only now health care costs are even more expensive and harder to manage without insurance than they were in the past.

The *Utah Cares* option allows people who enroll in the program to obtain access to primary care providers. This can be helpful, though for temporary loss of insurance, primary care is the least important type of coverage. Primary care is important over the long term, but what people most need during a temporary downturn is coverage for catastrophic health care costs.

Enrollment increases under *Utah Cares* can only be financed with federal funds at the 70% match rate that is used in traditional Medicaid. Thus the budgetary cost disadvantage of *Utah Cares* grows even more in the event of a downturn. The *Utah Cares* proposal authorizes that enrollments in the program can be trimmed if costs rise. Thus, under *Utah Cares,* the state would have to either find more money or cut back on eligibility and put Utahns back into the coverage gap.

Risk Category: Economic Downturns

Policy Option	Consequences for Utahns	Budgetary Impact
Option 1: Do Nothing	Newly uninsured fall into the coverage gap and cannot obtain insurance.	Existing Medicaid program faces increased costs and lower revenues. No protection for ineligible Utahns.
Option 2: *Utah Cares*	Many newly uninsured lose access to all care except primary care. Cost overruns reduce coverage levels, putting people back in the coverage gap.	Enrollment limits do not cover increased need unless state allocates more funds.
Option 3: *Healthy Utah*	People who lose jobs still have access to private insurance.	Enrollment increases provide more coverage for needy individuals, but costs do not rise significantly because of the enhanced federal match.

History suggests that in the coming years we are very unlikely to experience a recession as large as the recent one, but economic contraction is a regular occurrence in our economy. Far-sighted decision makers will weigh the eventuality of the next recession in their calculations.

Program Cost Overruns Due to Mandated Federal Benefits

Insurance plans offered under *Healthy Utah* will be tightly regulated and must offer benefits that are commensurate with traditional Medicaid benefits. CMS has been offering some limited flexibility to states on issues such as premiums and co-pays, but the state has little flexibility in terms of benefits.

One of the big unanswered questions about premium assistance programs is whether they can provide Medicaid-style benefits at the same cost. CMS requires that programs receiving waivers are budget neutral. The fundamental accounting problem with these programs is that private insurance pays higher reimbursement rates to providers than Medicaid does. Indeed, one of the central problems with traditional Medicaid is that reimbursement rates are so low that many providers resist treating Medicaid patients.

Therefore, can *Healthy Utah* offer a program with mandated benefits and higher reimbursement rates at the same cost as Medicaid expansion, which has lower reimbursement rates? Under *Healthy Utah*, there will be small premiums for those in the 100-138% range, but these will be limited to 2% of income, which mirrors what they'd pay on the marketplace and which constitutes only a small portion of the overall cost of insurance.

Reasonable arguments for how this might be possible rely on the fact that individuals and providers will make better decisions regarding health care utilization when they are using private insurance rather than they would under Medicaid, thereby lowering costs. If their health improves and their health utilization is more efficient (relative to participation in Medicaid), program costs will fall.

Will this theory work in practice? A very important piece of evidence comes from the state of Arkansas, which has a "Private Option" program that is very similar in design to *Healthy Utah*. In the first few months of the Arkansas experience, costs per enrollee were increasing sharply. But within a few months, they levelled off. Since then the costs have been under the budget neutrality cap and have been gradually declining. The cumulative cost of the program will be budget neutral by Fall 2015.

The experience of Arkansas is still very new and very controversial. At the federal level, there is a dispute about how to measure budget neutrality. A 2014 report by the Government Accountability Office (GAO) claimed that the Arkansas program actually exceeded budget

neutrality by $758 million (a cost overrun of 24%) over the first three years.[29] The Department of Health and Human Services (HHS) disputes this claim.

But regardless of which federal agency is right on this issue, those potential overruns are born by the federal government, not the state. The same will be the case for the *Healthy Utah* plan. The agreement with CMS will cover 100% of the *actual* program costs through the end of 2016. Thus in the short term, the federal government is bearing the risk for this program. Utahns only pay for these cost overruns to the extent that they share the burdens that all US taxpayers face from federal budget outlays.

In the longer term, Utah's percentage of the costs will increase and, therefore, the state budget will have to absorb some of the impact of excess costs. It is also possible that the federal government will move to change the terms of the agreement with the state. In either case, the state can quickly remove itself and cancel participation in the program. This makes long term risks of cost overruns very manageable for the state.

The *Utah Cares* program may also face cost overruns. The difference is that funds for that program would only be matched at a 70% rate by the federal government. Thus the impact of cost overruns for *Utah Cares* is actually higher than *Healthy Utah*. But because *Utah Cares* is more limited in scope, this risk is constrained by the limited budget of the *Utah Cares* program. The long term risk for *Utah Cares* is essentially the same as the short term risk.

Risk Category: Program Cost Overruns

Policy Option	Consequences for Utahns	Budgetary Impact
Option 1: Do Nothing	N/A.	N/A.
Option 2: *Utah Cares*	Coverage is potentially scaled back due to cost overruns, putting Utahns back in the coverage gap.	70% of excess costs paid by federal government; 30% of excess costs paid by state.
Option 3: *Healthy Utah*	Overruns lead to even greater federal funds in the state, which has widespread benefits.	No short run effect. Federal government bears risk; budget impact rises over time if program continues.

[29] U.S. Government Accountability Office, 2014.

Increasing Insurance Costs

Healthy Utah's primary feature is the use of federal funds for low-income Utahns to purchase insurance from the private market. Insurance rates are regulated by the state, but they are subject to strong market pressures. *Therefore, one risk facing the Healthy Utah option is a sudden and unanticipated increase in the total cost of insurance*.

How likely is this risk, and what would be the impact on the state if it occurs?

Recent news reports have highlighted that in some areas of the country, insurance companies are requesting significant increases for the rates they are charging for individual policies in health exchanges. New reports indicate the same is happening in Utah, with several requested increases of 10% or more.[30]

These proposed increases, however, will not necessarily translate into higher rates under *Healthy Utah*. The primary reason is that, as a group, those qualifying for insurance under the *Healthy Utah* plan are healthier than average. People with unusually high health care needs—for instance, pregnant women, the disabled, and the elderly—often have access to insurance through other mechanisms such as Medicare or Medicaid.

People in the coverage gap are non-elderly, non-pregnant, non-disabled adults. As such, the insurance risks for providing insurance to this group are lower than for the adult population on average.

Furthermore, Utah has an advantage that many states do not have: a very healthy population. Recent health rankings named Utahns the 5th healthiest in America because of their healthy behavior patterns. Utah has the lowest rate of smoking and tobacco use, obesity and diabetes rates that are both among the lowest in the nation, and a low rate of preventable hospitalizations.[31] Thus the premium risks to the *Healthy Utah* program are held in check by the health of the population.

Of course *Healthy Utah* will also be required to match the benefit packages available under traditional Medicaid. Thus insurance companies cannot keep premiums down by offering lower benefits and high deductibles. This will put upward pressure on rates.

Another important data point from the Arkansas experience is that incoming premiums for 2016 in Arkansas are less than 5% above their 2015 levels. Utah is different in many ways from Arkansas, but its experience still provides evidence that premiums are likely to be manageable. This is especially true when considering the trend in Utah's private health insurance premiums in the past, the overall health of the population, and Utah's low per-capita

[30] L Radnofsky, 2015; ML Price, 2015.
[31] United Health Foundation, 2015.

health care costs. These factors point to modest premium increases in the future under *Healthy Utah*.

Most importantly, the agreement between the federal government and Utah allocates the risk of higher costs to the federal government, which agrees to pay their full share of the actual program costs, even if premiums turn out to be higher than projected.

Because it does not offer private health insurance, there is no premium risk for the *Utah Cares* option. A program that does not offer insurance does not have to worry about the price of insurance going up.

Risk Category: Cost of Insurance

Policy Option	Consequences for Utahns	Budgetary Impact
Option 1: Do Nothing	Rising insurance costs cause more people to lose insurance, especially the working poor.	N/A.
Option 2: *Utah Cares*	Same as Do Nothing option.	N/A (program does not provide insurance other than Medicaid).
Option 3: *Healthy Utah*	Covered individuals shielded from cost increases.	No short run effect. Budget impact rises over time if program continues.

Rising Health Care Costs

In the period between 2000 and 2007, inflation-adjusted health care expenditures in the US increased at an annual rate of almost 4%.[32] Over the past several decades, there have been several years where expenditures have grown between 6-8%. Thus the historical record indicates that health care costs can spike relatively rapidly, even in a single year.

When health care costs rise rapidly, insurers often face unanticipated losses which they seek to recoup through higher rates. Negotiated rates will protect the state budget from spikes in costs, but only for a very short time.

[32] White House Council of Economic Advisers, 2013.

Individuals who are uninsured or face co-pays and high deductibles feel the cost of rising health care immediately. Individuals with more generous insurance benefits are shielded from rising costs in the short run.

Are health care costs going to rise in the near future? The good news is that in recent years, the growth in costs has slowed significantly—in other words, the US cost curve appears to be bending downward (the reason why this is occurring is a hotly debated topic among economists). In 2007-2010, the annual growth rate in expenditures slowed to 1.8% and from 2010-2013 it slowed further to 1.3%. Since 2007, medical inflation (the Consumer Price Index (CPI) for medical care) has been at 3.5%. This is slightly higher than inflation in general, but much lower than our historical record. From 1965-2010, medical inflation averaged 6.3% in the US.

This slowdown in health care cost growth is good news all around, including in public programs. Nationally, per enrollee costs for Medicare and Medicaid have been flat or actually declining. If the recent pattern holds, the cost associated with both *Healthy Utah* and *Utah Cares* will hold steady.

Risk Category: Rising Health Care Costs

Policy Option	Consequences for Utahns	Budgetary Impact
Option 1: Do Nothing	Rising costs increase economic burdens on the uninsured.	Rising costs have wide impact on the budget.
Option 2: *Utah Cares*	Some primary care covered; other services are put further out of reach of the poor on the program. Rising costs lead to enrollment cuts.	30% of excess costs paid by state.
Option 3: *Healthy Utah*	Covered individuals shielded from cost increases.	No short run effect. Budget impact rises over time if program continues.

However, just as the economy can experience a downturn rapidly and with little warning, health care prices could potentially rise--quickly and without much warning. If this happens, rising costs will put upward pressure on premiums (see above). Under the *Healthy Utah* pilot program, enrollees are shielded from these cost increases. Under *Utah Cares*, those seeking to gain health services beyond basic primary care will face higher costs unless they are part of the

new enrollees in Medicaid. If the state does nothing, all low-income residents will face an additional burden of increased health care costs.

Errors in Enrollment Projections

Predicting enrollment in new government programs is a very difficult enterprise. Insurance expansions under the ACA are no different. Recent news articles have highlighted the large mistakes some states have made with respect to forecasting enrollments in their Medicaid expansion. For example, one-half year into the Medicaid expansion period in mid-2014, Kentucky had nearly 311,000 new people in Medicaid, which was more than double than the state's forecasts. By the end of 2014, Illinois had enrolled more than 2.7 times the projected number of persons.[33]

It is tempting to see these reports and think that enrollment projections for *Healthy Utah* could be off by a similar ratio and that the results of such an error will be disastrous.

Could the projections for Utah be way off the mark? It is possible. Two professional actuarial consulting groups, PCG and Milliman, have done independent analyses for Utah and come up with similar enrollment forecasts.[34] These estimates rely on assumptions about how many eligible people will actually enroll for the program. Those assumptions could be off considerably, just as other states have made large errors in projecting enrollment.

The key variable in these projections is the percent of eligible people who actually enroll. Census data is used to predict the number of eligible people, but it is very hard to forecast enrollment. The recent Milliman estimates assume a rate of just under 50% when averaged across different groups. This is about the same uptake rate assumed by Illinois in their projections for their Medicaid expansions, despite multiple warnings from other analyses that predicted much higher uptake. The actual uptake rate was much higher than 50%.

It is quite possible that the enrollment projections for Utah are off. Total program costs could swell significantly if this occurs. But in the agreement Utah will make with CMS under *Healthy Utah*, these enrollment overruns will be covered by the federal government and compensation will be based on actual costs, not projected costs. Thus, there is a measure of protection in the short run.

A higher than anticipated enrollment brings more money into the state and reflects that the need for insurance was even greater than anticipated. These are good things. But as the

[33] R Pradhan, 2015.
[34] Public Consulting Group, 2013; BJ Diederich, AS Wright & LF Kartchner, 2014.

federal match declines, the state budget has to pick up these higher costs if the state continues the *Healthy Utah* program beyond its pilot phase.

Higher than anticipated enrollment would require the state to make a choice concerning whether or not the higher benefits were worth the higher costs. If the state citizens do not want to bear these higher costs, the state could withdraw from the program.

It is also possible that enrollment projections for *Utah Cares* will exceed the actual numbers. As is the case with *Healthy Utah*, these higher than expected enrollments have benefits—both to enrollees and to the state. Because the cost is capped, higher than anticipated enrollments in a given period would require that the state either expand the program or cut people from it.

Risk Category: Errors in Enrollment Projections

Policy Option	Consequences for Utahns	Budgetary Impact
Option 1: Do Nothing	Indicates greater need than anticipated.	N/A.
Option 2: *Utah Cares*	In short run, more people received benefits, but enrollments are then cut to keep costs down.	Immediate cost impact is considerable and proportional to the size of the estimation error (30% of unanticipated costs).
Option 3: *Healthy Utah*	More people receive benefits of plan.	No short run effect. Budget impact rises over time if program continues (eventually 10% of unanticipated costs).

Woodwork Effects

If the state adopts *Healthy Utah*, some of those seeking coverage will be found to be eligible for traditional Medicaid and will therefore be put in that program. The same holds true for the *Utah Cares* program. Because the state bears 30% of the Medicaid cost for individuals who are already eligible for Medicaid, both programs are subject to these "woodwork" effects, named for those new enrollees who "come out of the woodwork" to enroll in programs that they were already eligible for.

How should we treat those who take advantage of a program that they are currently eligible for but either do not know it or choose not to participate? (Utah spends very minimal resources to

do outreach for new enrollees, in contrast to many other states which actively conduct public outreach campaigns.)

On the benefit side, new enrollees receive significant value from health insurance that they are currently not receiving. The new enrollees would also bring additional federal dollars into the state economy and the health care industry would benefit by having to provide less uncompensated care.

On the cost side, the state has to pay for 30% of the costs of these enrollees. According to the recent Milliman study, the annual costs to the state due to woodwork effects from *Healthy Utah* will rise to almost $28 million annually.[35] These costs are permanent and will not go away if Utah withdraws from *Healthy Utah*.

It is also possible that these projections are lower than what would actually happen because of the same type of projection error discussed above. It is not impossible that they could rise to $50 million or more annually if the current projections are far off base. Because of historically low participation rates in Medicaid and CHIP, Utah has a higher percentage of unenrolled persons who might come into the program because of the woodwork effect.

Risk Category: Woodwork Effects

Policy Option	Consequences for Utahns	Budgetary Impact
Option 1: Do Nothing	N/A.	N/A.
Option 2: *Utah Cares*	Access to both primary care and Medicaid increases.	Unknown, but permanent. Lower projected woodwork costs than *Healthy Utah.*
Option 3: *Healthy Utah*	Woodwork enrollees covered under Medicaid, which is less preferred than private insurance. Overall insured rate increases.	Both short term and permanent costs, estimated to rise to $28 million annually by 2018. Woodwork effect is permanent but likely declines over time.

The *Utah Cares* program will also generate a permanent woodwork effect. Because the number of applicants is likely to be much higher for *Healthy Utah* than *Utah Cares*, the

[35] BJ Diederich, AS Wright & LF Kartchner. 2014.

magnitude of the *Utah Cares* woodwork costs will be smaller, though no actuarial estimates have been made of this effect to our knowledge.

For both programs, the woodwork effect represents uninsured people moving to insurance programs (Medicaid and CHIP) *for which they were already eligible by state law.* The budget must account for this result, but it does not represent an expansion of Medicaid eligibility.

Other Risks

Health System Strain

As the results of expansion programs in other states show, increased health care coverage leads to greater access to health care services. In addition to a higher number of visits to primary care physicians, this could also result in increasing use of other health services as newly-insured patients receive care they had previously foregone. However, some research indicates that this initial surge may be temporary.

For example, in the first 18 months of the Oregon experiment in 2009, new Medicaid patients used the emergency department 40% more often than the control group.[36] However, the latest update reported a 21% decrease in emergency department visits from 2011 to 2014.[37] A review of other studies of emergency room use concluded that the gradual decrease after an initial spike, combined with higher reimbursement rates that are higher for Medicaid patients than self-pay patients, would reduce the potential initial strain on emergency departments associated with an increase in Medicaid.[38] As previously mentioned, both charity care cases and overall hospital admissions decreased in Iowa and New Hampshire after their plans went into effect, so it appears the strain to the healthcare system would come largely in primary care.

One recent estimate suggests Utahns would make 184,000 additional physician visits annually under some type of Medicaid expansion.[39] These estimates, as well as the capacity of the state's health care system to handle these increases, are uncertain. What is certain is that it is more efficient and less costly to help patients through preventive primary care than to treat them for major health disasters later. Inaction will not save the state from the inevitable strains of aging Utahns and a growing population that does not receive recommended preventive care. Additionally, the success of Utah's Accountable Care Organizations (ACO) reform points to the

[36] SL Taubman, et al., 2014.
[37] Oregon Health Authority, 2015.
[38] LN Medford-Davis, et al., 2015.
[39] White House Council of Economic Advisers, 2015, 19.

capacity of the state health care system to address new challenges by adapting and improving delivery of health services.

Potential Crowd-out of Employer Plans

Under *Healthy Utah*, the first option for working participants is for the state to assist in the purchase of employer-sponsored plans as long as they are affordable and provide sufficient benefits. Some have argued that employers will see this as an opportunity to stop offering such plans.

There are compelling reasons why few employers will choose such an option.

- Employers face strong tax incentives for offering insurance.
- Insurers prefer the large group plans that they sell to employers rather than bearing the risks in the individual market, thus insurers will try to make the employer- sponsored plans more desirable.
- Employers use insurance as a means of competing for employees.
- Employers see the benefits of having a healthy workforce who enjoy their health plans.
- Many employers will face fines under the ACA if they fail to offer insurance.

Of course these employer-side incentives are largely irrelevant for many of the potential enrollees under *Healthy Utah*. This is because many of those plans are too expensive for the working poor to afford. And from a budgetary perspective, it makes no difference to the state whether the plan they purchase is an employer-sponsored plan or an individual plan, as long as the prices are comparable.

What *Healthy Utah* does is put millions of dollars into the private insurance market. Many employers would like to offer health insurance but they cannot afford to offer plans that their employees can afford. As *Healthy Utah* makes those plans more affordable, it is possible that some employers will actually be *more* likely to offer a plan that they would not have otherwise.

5. Weighing Benefits, Costs and Risks

Qualitative Summary

In this section, we bring together the major features of the different plans for comparison. To do so, we identify the three alternatives' primary benefits, costs, and risks from the preceding sections. These features are assembled in the table below.

While different perspectives may emphasize different benefits, costs, and risks, the largest one or two items in each category are included in the table. The primary benefit of both the *Utah Cares* plan and the *Healthy Utah* plan is that more individuals will be covered by health insurance, with *Healthy Utah* more amply covering catastrophic and specialty care. Because *Healthy Utah* covers more people than *Utah Cares*, from a pure health perspective, this is reason enough to adopt *Healthy Utah*. As noted above, covering more people with health insurance will improve health outcomes and economic security.

Health is not the only priority in public policy. Legislators and other government decision-makers must also consider the cost of these programs. *Utah Cares* is an expansion of existing Medicaid and PCN programs, and follows the same funding structure as those programs: 70% from the federal government and 30% from state government. Thus, one benefit is that the federal government will subsidize 70% of the proposed expansion, whose overall cost is over $100 million. And similarly, a primary cost is that the state government will pay 30% of the proposed *Utah Cares* expansion, estimated to be about $32 million by the legislature's fiscal analyst.[40]

In contrast, *Healthy Utah* brings over $500 million annually from the federal government. For the first year, the state government pays nothing for the expansion, but will eventually pay 10% if the state chooses to extend the program. As noted above, the funding for the program will be collected from taxes nationally, including Utah, whether Utah participates or not in receiving the benefits.

There is also the option to adopt neither program, which is what Utah has done for the past year and a half as other states have expanded their coverage. The benefits and costs of doing nothing have already been discussed extensively elsewhere: for example, a coverage gap among those not able to afford insurance, and inefficient health care provided through emergency rooms (and funded through increased premiums to those who have insurance).

[40] Utah Office of Legislative Research and General Counsel, 2015.

Overall Benefits, Costs, and Risks

Plan	Primary Benefits	Primary Costs	Primary Risks
Do Nothing	Fewer federal entanglements.	Coverage gap and its associated problems persist for families and the state.	Economic downturn, increasing insurance and health care costs exacerbate problems with the current system.
Utah Cares	18,000 more persons have Medicaid. 35,000 more have primary care access through PCN More than $80 million annually from Washington; Those in the exchange continue receiving subsidies. Long-run cost avoidance, which also reduces coverage.	$33 million annually from state budget. Cost increases could lead to scaling back of benefits.	Costs can rise in the short run. Permanent (but declining) woodwork effects. Overruns can lead to sharp curtailment in number of participants.
Healthy Utah	Coverage gap is eliminated through private insurance. More than $500 million annually from DC. Economy and health care industry see large benefits. State and county revenues increase. Families strengthened through economic stability provided by full insurance.	Initially, $0. Costs rise over long term, but capped at 10% annually.	Permanent (but declining) woodwork effects. Long term costs persist, but are manageable.

Note: The benefits and costs of each plan are relative to each other.

Quantitative Projections

The tables above describe the benefits and risks of different options in largely qualitative terms. Here we use projections based on existing actuarial work to provide a quantitative summary of costs and benefits for both programs.

For both *Healthy Utah* and *Utah Cares*, *only expenditures for those under 100% FPL are used in the calculations*. *Healthy Utah* covers people up to 138% FPL, but those persons are currently eligible for highly subsidized insurance on healthcare.gov. Similarly, the people in the 100-138% FPL range continue to receive subsidies whether or not *Utah Cares* is adopted. Thus people in this income category may switch their insurer, but neither program is assumed to generate new direct benefits for persons in the 100-138% category.

The method for projecting each category of costs and benefits is described below. Except where otherwise noted, enrollment and cost figures are based upon the values estimated in December, 2014 by Milliman.

Direct Economic Benefit (new federal expenditures): This is the amount of new money coming into the state from federal sources. Program expenditures benefit recipients and the health care industry. Even spending that is "wasteful" in terms of medical need still has an economic benefit (of course spending the money more effectively would further increase the benefit).

The direct benefits calculated here, however, do not include any additional health or insurance values that might be attributable to providing low-income persons with insurance. In an analysis that valued the health and lives of beneficiaries *to the same degree as average citizens* would have large additional benefits because the average Utahn would be willing to spend considerably more for insurance benefits than the cost of Medicaid.

Economic Stimulus: The analysis of Medicaid expansion options completed by PCG in 2013 included an estimate of additional economic activity due to the inflow of federal funds. They used a highly respected software package (IMPLAN) to estimate the effect of federal spending that is based on widely used regional input-output models in economics.

Economic multipliers can be controversial and the full extent of the multiplier only occurs in practice if the economy faces no resource constraints and can costlessly expand to accommodate the new spending in a way that does not raise prices and crowd out other spending in the market. We thus treated the PCG multiplier estimates as a high-end estimate of economic stimulus.

To arrive at a low-end value, we took the pessimistic assumption that the most expansion that could occur is a portion of the lost economic inefficiency that results from the taxes used to finance the federal expenditures in the first place. A common value for the tax burden of federal programs funded through income tax is 40%.[41] To be conservative, we assumed that only half that value could be regained through government spending, thus arriving at a low-end value of 20% of expenditure. The number reported here is the midpoint between those two values.

Using this method, our estimate of the economic stimulus over the two-year period is $353 million, with $113 million as a low end value and $594 million as the high-end value. We also calculated an economic stimulus for the *Utah Cares* program of $103 million using the same multiplier estimate applied to the lower new expenditures associated with the *Utah Cares* program.

Economic stimulus is also associated with increased tax values. Using the same percentages found in the PCG analysis, we calculate the revenues gained by the state due to taxing the increased economic activity.

County-Level Savings: The PCG analysis also provided estimates for benefits to counties and county budgets. These amounts are included in the direct benefits rather than the state costs since they are separate from the state budget.

Cost of Woodwork Effects: The Milliman estimates for woodwork are used and adjusted to cover the 2-year pilot period for *Healthy Utah*. For *Healthy Utah*, the full woodwork effect is used, but the cost for *Healthy Utah* is scaled to incorporate that only those under 100% FPL are eligible to apply for the program. The scaling factor is proportional to the total percent of enrollment in *Healthy Utah* that comes from the 0-100% group (65.8%).

Marginal Excess Tax Burden: When state taxes are used to fund a program, it is appropriate subtract from the economic stimulus a portion that is lost due to the economic inefficiency of taxation, sometimes called the "marginal excess tax burden." A common value used in studies where program expenditures come predominantly from sales taxes is 25%.[42] Thus amount of the stimulus was reduced by multiplying .25 times the amount of state taxes used to fund the program. For *Healthy Utah* this amounts to a small amount since only 5% of expenditures in the first half of 2017 are financed through state taxes. For *Utah Cares*, 30% of all expenditures are funded through taxes.

[41] Bohanon, Howoritz & McClure (2014) survey a large number of studies and the median estimate (including compliance costs) is .4. Slemrod (2005) suggests a similar value.

[42] AE Boardman, DH Greenberg, AR Vining & DL Weimer, 2006, Cost-Benefit Analysis: Concepts and Practice, 3rd Edition.

Tax burdens are calculated both for taxes used to fund the program plus taxes resulting from funding the woodwork effect.

The table below summarizes costs and benefits for both the *Healthy Utah* and *Utah Cares* plans.

Cost-Benefit Analysis

Benefits & Costs		Healthy Utah	Utah Cares
Benefits			
	Direct Benefit (Program Expenditures)	$ 565,608,686	$ 229,292,100
	Economic Stimulus (net of new taxes)	$ 339,733,724	$ 137,724,650
	Marginal Excess Tax Burden	$ (6,188,199)	$ (25,831,132)
	County-Level Benefits	$ 12,480,674	$ 3,646,713
	Total:	***$ 911,634,885***	***$ 344,832,331***
Costs to State			
	State Expenditures	$ 11,857,744	$ 64,027,600
	Woodwork Effects (state portion)	$ 39,551,761	$ 25,838,324
	Taxes on Stimulus	$ (13,971,350)	$ (5,663,846)
	Total:	**$ 37,438,155**	**$ 84,202,078**
Net Benefit		**$ 874,196,730**	**$ 260,630,253**
Return on Investment (benefit/dollar)		**24.4**	**4.1**
> Both projects are evaluated on the two-year period 7/1/2015-6/30/2017			
> Healthy Utah costs and benefits are only for those in 0-100% FPL group			

Sensitivity Analysis

A variety of alternate projection scenarios can be generated that will alter the results across the cost and benefit categories in the table above. However, the differences between the two programs are so stark that no credible alternative scenario (such as the low-end stimulus estimate discussed above) undermines the conclusion that *Healthy Utah* provides greater benefits at lower costs than does *Utah Cares* and much greater than the status quo of doing nothing.

To illustrate, the table below gives the net benefits (benefits-costs) for both programs under the hi-end and low-end scenarios for economic stimulus. Recall that the hi-end stimulus is actually derived from the PCG analysis midpoint estimates for stimulus, meaning that some analysts would put the high end of benefits much higher than shown below.

Sensitivity Analysis of Net Benefits

Net Benefit	Healthy Utah	Utah Cares
With Low-End Stimulus	$ 633,613,394	$ 163,100,176
With High-End Stimulus	$ 1,114,780,040	$ 358,160,319

In general, even though there is considerable uncertainty about factors such as economic multipliers, the basic conclusions hold under a wide range of alternative scenarios.

Finally, given the difficult, imprecise nature of making projections, it is useful to think about what a worst-case scenario (a catastrophic situation where everything goes wrong). Suppose, for instance, that health care markets are extremely rigid and any influx of federal spending crowds out significant spending in the private market (in this case, new patients and additional care result in pushing out care from existing patients).[43] In this case, it is possible to actually have a negative stimulus, meaning that the new spending pushes out a lot of existing health-care spending that would happen otherwise and there are no positive multiplier effects in the economy. In this scenario, one-third of the federal spending is crowded out of the market. Assume, as well, that the woodwork costs to the state are *twice* their estimated value and that that one-third of the direct benefits from expenditures are actually wasted and contribute no value to anyone in the state.

What would happen in this highly pessimistic scenario? Our simulation shows that in this case the net benefits to the state under *Healthy Utah* are still $167 million and that the total benefits ($265 million) are still 2.7 times the costs ($98 million) to the state. In other words, the worst-case is still a good deal for Utah.

Utah Cares does not fare as well under this pessimistic scenario: total benefits are $98 million but total state costs are $118 billion. Thus there would be a small net cost to the state under Utah Cares in the worst-case scenario.

[43] Some commentators have profoundly misunderstood the economics of crowding-out and have assumed that the existence of crowding-out implies that Healthy Utah would actually harm the economy (See Moody, 2014, for an example). Such a mistake is founded in ignoring that the federal taxes to fund Healthy Utah are sunk costs and not relevant for the analysis of deciding whether or not to undertake the program. Even if there is extreme crowding-out resulting in net benefits being much lower than the amount of federal spending on the program, the net benefits are still *positive*. There is simply no credible economic theory (or empirical evidence) under which the crowding-out is so severe that the program actually does harm to the economy.

6. Conclusions

At the heart of both the *Healthy Utah* and *Utah Cares* plans is a desire to do something about the desperate economic situation of those in the coverage gap—people (most of whom work), who make too little to qualify for federal subsidies but do not qualify for traditional Medicaid.

Ample evidence exists that Utahns, including members of both political parties, want to do something to improve the health and economic security for those who have fallen into the coverage gap. Polling evidence indicates that even those identifying as "strongly conservative" in the state see the government playing a role in providing health care for the poor.[44]

Besides benefits and costs, policy makers and analysts must also consider that the future is uncertain, and weigh the risks of different plans. The primary risk to both plans is that the cost will be higher than expected, whether because of increased demand (higher enrollment because of economic downturns or mis-estimation of enrollment), or increased supply costs (health care or insurance costs).

Utah Cares mitigates this risk by allowing the program to contract (or expand) the population covered according to program cost and the state budget. Of course, such an adjustment would also reduce the benefit of the program by pulling back coverage and having more people fall into the gap (in addition to those not covered by *Utah Cares* in the first place).

Healthy Utah mitigates risk by shifting almost the entire funding burden to the federal government. If enrollment or costs increase, then the federal government pays for 100% of the costs through the end of 2015 and 95% in 2017. *Healthy Utah* allows the state to manage risks, especially the risk of more people not being able to find insurance coverage.

Aside from these risk issues, the net benefits of *Healthy Utah* are far more advantageous than the *Utah Cares* program, though both generate significant benefits for the state. Still, *Healthy Utah* generates far greater benefits at a much lower cost. Our quantitative projections suggest that over the next two years, *Healthy Utah* has an economic rate of return six times that of *Utah Cares*.

In sum, concerns about economic risks and failed projects are not a rational reason to reject the *Healthy Utah* option. Even in a cost-benefit analysis that gives no weight to the well-being of the poor, the simple economics of *Healthy Utah* make sense for the state to undertake. But

[44] Notalys, 2014b.

when a concern for the plight of the uninsured is factored into that analysis, the benefits of the *Healthy Utah* plan are overwhelming.

BIBLIOGRAPHY

Associated Press. 2015. New Hampshire hospitals say Medicaid expansion is working. *Washington Times (online edition).* May 24, 2015.

Bachrach, D, P Boozang & D Glanz. 2015. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains.* State Health Reform Assistance Network. April 2015.

Baicker, K. et al. 2013. *The Impact of Medicaid on Labor Force Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment*. National Bureau of Economic Research. Working Paper 19547.

Baicker K, et al. 2013. The Oregon Experiment—Effects of Medicaid on Clinical Outcomes. *New England Journal of Medicine* 368:1713-1722.

Blahous C. 2013. *The Affordable Care Act's Optional Medicaid Expansion: Considerations Facing State Governments.* Mercatus Center at George Mason University.

Boardman, AE, DH Greenberg, AR Vining, & DL Weimer. 2011. Cost-Benefit Analysis: Concepts and Practice. Upper Saddle River, NJ: Prentice Hall.

Bohanon, CE, JB Horowtiz & JE McClure. 2014. Saying Too Little, Too Late: Public Finance Textbooks and the Excess Burdens of Taxation. *Economic Journal Watch* 11:277-296.

Boothe, A & C Ryan. 2014. "The Woodwork Effect: Costing Non-Expansion States Up to $700 Million in 2014." American Action Forum. April 9, 2014. http://americanactionforum.org/insights/the-woodwork-effect-costing-non-expansion-states-up-to-700-million-in-2014.

Coughlin, TA, Holahan, J, Caswell, K & McGrath, M. 2014. *Uncompensated Care for Uninsured in 2013: A Detailed Examination.* The Kaiser Commission on Medicaid and the Uninsured.

Dague, L, T DeLeire & L Leininger. 2014. *The Effect of Public Insurance Coverage for Childless Adults on Labor Supply*. National Bureau of Economic Research. Working Paper 20111.

Deloitte Development, LLC. 2015. *The Commonwealth of Kentucky Report on Medicaid Expansion in 2014.* February.

Diederich, BJ, AS Wright, & LF Kartchner. 2014. *Healthy Utah Financial Analysis.* Milliman Client Report for Department of Health – State of Utah.

Finkelstein, A, H Hendren, & EFP Luttmer. 2015. The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment. Unpublished Working Paper, Massachusetts Institute of Technology.

Garthwaite, C, T Gross & MJ Notowidigdo. 2013. *Public Insurance, Labor Supply, and Employment Lock.* National Bureau of Economic Research. Working Paper 19220.

Gruber, J & Simon, K. 2008. Crowd-out 10 years later: Have recent public insurance expansions crowded out private health insurance? *Journal of Health Economics* 27:201-217.

"Impact of ACOs on Medicaid Costs." 2015. Report to the Executive Appropriations Committee meeting. May 19, 2015.

Iowa Hospital Association. 2014. Medicaid Expansion an Iowa Success Story. November 13, 2014.

The Kaiser Commission on Medicaid and the Uninsured. 2014. *The Utah Health Care Landscape.* September 10, 2014.

The Kaiser Commission on Medicaid and the Uninsured. 2015. *Medicaid Expansion, Health Coverage, and Spending: An Update for the 21 States that have not Expanded Eligibility.* April 2015.

Krueger, AK & I Kuziemko. 2013. The Demand for Health Insurance among Uninsured Americans: Results of a Survey Experiment and Implications for Policy. *Journal of Health Economics* 32:780-793.

Leavitt Partners & Notalys. 2013. *Utah State Innovation Model: Financial Analysis.* Consulting report prepared for the Utah Department of Health.

Liljenquest, D. 2014. Obamacare employer incentives could drive up Medicaid expansion costs. *Deseret News (online edition),* June 26, 2014.

Liljenquist, D. 2014. Utah's Medicaid reform has been a quiet success. *Deseret News (online edition)*, April 10, 2014.

Lo, N, Roby, DH, Padilla, J, Chen, Xiao, Salce, EN, Pourat, N, and GF Kominski. 2014. *Increased Service Use Following Medicaid Expansion is Mostly Temporary: Evidence from California's Low Income Health Program.* UCLA Center for Health Policy Research.

Medford-Davis, LN, et al. 2015. The Patient Protection and Affordable Care Act's Effect on Emergency Medicine: A Synthesis of the Data. *Annals of Emergency Medicine*.

Moody, JS. 2014. *Negative Impact of Medicaid Expansion on Utah's Families and Private Sector*. Federalism in Action. (http://www.federalisminaction.com/resources/studies/study-3/)

Newhouse, JP. 1996. *Free for All: Lessons from the RAND Health Insurance Experiment.* Harvard University Press.

Notalys. 2014a. *Utah Medicaid Gap Analysis.* Consulting report.

Notalys. 2014b. *Healthy Utah Poll: Initial Findings.* Consulting report.

Ollove, Michael. 2015. “States Strive to Keep Medicare Patients out of the Emergency Department.” Stateline, The Pew Charitable Trusts. February 24, 2015.

Oregon Health Authority. 2015. *Oregon’s Health System Transformation: 2014 Mid-Year Report.* January 14, 2015.

Pradhan, R. 2015. Skyrocketing Medicaid signups stir Obamacare fights. *Politico.* May 18.

Price, ML. 2015. Utah insurers request big rate hikes for 2016. *Salt Lake Tribune* (online edition), June 3, 2015.

Public Consulting Group. 2013. *State of Utah Medicaid Expansion Assessment: Impact Analysis: 2014-2023.*

Radnofsky, L. 2015. Health insurers seek hefty rate boosts. *Wall Street Journal* (online edition), May 21, 2015.

Slemrod, J. 2005. Options for Tax Reform: A Review of the 2005 Economic Report of the President’s Tax Chapter. *Journal of Economic Literature* 43: 816:822.

Sommers, BD, Baicker, K, and Epstein, AM. 2012. Mortality and Access to Care among Adults after State Medicaid Expansions. *New England Journal of Medicine* 367: 1025-1034.

Sommers, BD, Long, SK, & Baicker, K. 2014. Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study. *Annals of Internal Medicine* 160 (9): 585-594.

Taubman, SL., HL Allen, BJ Wright, K Baicker & Amy Finkelstien. 2014. Medicaid Increases Emergency-Department Use: Evidence from Oregon’s Health Insurance Experiment. *Science* 343:263-268.

United Health Foundation. 2015. *America’s Health Rankings – 2014.*

U.S. Government Accountability Office. 2014. *Medicaid Demonstrations: HHS’s Approval Process for Arkansas’s Medicaid Expansion Waiver Raises Cost Concerns.* GAO-14-689R.

Utah Office of Legislative Research and General Counsel. 2015. *H.B. 446 3rd Sub. (Cherry) Extension of Primary Care Network and Medicaid Benefits Under Existing 70/30 Federal/state Cost Sharing Amendments – Fiscal Note*. March 9, 2015.

White House Council of Economic Advisers. 2013. *Trends in Health Care Cost Growth and the Role of the Affordable Care Act.* November.

White House Council of Economic Advisers. 2015. *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid.* June.

Williams, M. 2015. Is Arkansas’ ‘Private Option’ Medicaid Expansion a Solution for Other Red States? *Kaiser Health News.* March 23, 2015.