manatt

Memorandum

To: Maine Health Access Foundation

From: Manatt Health

Subject: Estimated Budget Impacts of Expanding MaineCare

Date: February 27, 2018

In November 2017, Maine voters approved a referendum to implement expansion of MaineCare under the Affordable Care Act (ACA) to adults with incomes up to 138 percent of the federal poverty level (FPL). As Maine's legislature begins implementation planning, the Maine Health Access Foundation (MeHAF) asked Manatt to update and refine an analysis prepared by Manatt for MeHAF in April 2015 that examined the estimated budget impacts of a MaineCare expansion.[1] This update is intended to contribute objective and nonpartisan information to policymakers and other stakeholders on the budget impacts of expansion. It reflects more recent data, the experiences of other states, and the applicable federal matching rates for the years under review. In this memorandum, we describe the data and assumptions used by Manatt to produce estimates of MaineCare expansion costs and savings for state fiscal years (SFYs) 2019 through 2021, which are summarized below (Exhibit 1).

Other than estimating hospital tax revenues that could result from expansion, the analysis does not address the potential economic impacts—via jobs, income, and tax revenues—of new and largely federal spending in Maine; nor does it address impacts on healthcare providers (e.g., reductions in uncompensated care costs for the uninsured).[2] In addition, the analysis does not reflect the potential impact of provisions proposed in a Section 1115 waiver for the State's current MaineCare program (e.g., premium and cost-sharing requirements for certain enrollees), which could affect both enrollment and costs if they were applied to the expansion population.

Under expansion, we estimate that approximately 71,500 individuals will gain coverage by SFY 2021, including 62,000 expansion group adults and 9,500 currently eligible but not enrolled parents and children. Prior to the application of any savings or revenue offsets, the SFY 2021 cost of expansion is an estimated $576.9 million, with $489.5 million financed by the federal government and $87.4 million financed by the State of Maine. However, it is anticipated that the State would be able to offset a considerable portion of its costs by accessing enhanced federal match for some current MaineCare populations and by replacing State general fund spending on certain healthcare services with federal Medicaid funds. In addition, as hospitals' revenues increase with the number of people covered, the State may see increased hospital tax revenues. By SFY 2021, State savings and revenues are estimated at $25.5 million, for a net State cost of expansion at $61.9 million.[3] State costs would be lower in the years leading up to

SFY 2021, in part because enrollment is expected to ramp up over time (see discussion of this issue in "Estimated Costs" section below).

Exhibit 1. Summary of MaineCare Expansion Estimated Costs and Savings, SFYs 2019-2021

	SFY 2019	SFY 2020	SFY 2021
Number of new enrollees	**50,038**	**67,908**	**71,483**
Expansion group	43,400	58,900	62,000
Expansion childless adults up to 138% FPL	33,525	45,498	47,893
Expansion parents from 101% to 138% FPL	9,875	13,402	14,107
Currently eligible but not enrolled	6,638	9,008	9,483
Parents	2,564	3,479	3,663
Children	4,074	5,529	5,820
Total costs by funding source	**$362,228,285**	**$517,803,984**	**$576,898,368**
Federal	$316,582,335	$445,322,596	$489,542,332
State	$45,645,950	$72,481,389	$87,356,036
Total costs by category	**$362,228,285**	**$517,803,984**	**$576,898,368**
Expansion childless adults up to 138% FPL	$283,319,775	$407,576,544	$454,772,771
Expansion parents from 101% to 138% FPL	$40,562,550	$58,353,380	$65,108,319
Currently eligible but not enrolled parents	$10,531,886	$15,147,844	$16,905,917
Currently eligible but not enrolled children	$20,320,786	$29,232,929	$32,618,074
Administrative	$7,493,287	$7,493,287	$7,493,287
State savings and revenues	**$(15,113,497)**	**$(23,891,598)**	**$(25,453,938)**
Existing Medicaid populations*	$(3,694,111)	$(7,552,543)	$(8,809,862)
Pregnant women	$(1,854,384)	$(3,488,203)	$(3,741,350)
Breast and cervical cancer	$(63,761)	$(96,742)	$(93,133)
Poverty level disabled	$(542,622)	$(1,537,130)	$(2,542,317)
Medically needy	$(769,466)	$(1,516,335)	$(1,517,954)
HIV waiver	$(463,878)	$(914,132)	$(915,108)
Non-Medicaid programs*	$(10,040,291)	$(13,978,812)	$(13,951,713)
Corrections	$(2,750,516)	$(3,423,819)	$(3,569,752)
Mental health and substance abuse	$(6,793,245)	$(9,971,902)	$(9,808,428)
General Assistance	$(315,339)	$(370,313)	$(364,242)
Low Cost Drugs for the Elderly and Disabled	$(181,192)	$(212,779)	$(209,291)
Hospital tax revenues	$(1,379,095)	$(2,360,242)	$(2,692,362)
Net change in State costs	**$30,532,453**	**$48,589,791**	**$61,902,098**

Note: Sums of components may not equal totals due to rounding. Savings and revenues in parentheses are an offset to costs.

* In cases where the SFY 2021 savings estimate drops slightly or remains flat, it is due to the federal matching rate decreasing and leveling out at 90 percent. All savings figures thereafter would increase with normal cost growth or remain flat. See discussion of each savings category in this memorandum for details.

Background

Under the ACA, states may opt to expand Medicaid to childless adults and parents above state eligibility levels that were in place as of December 1, 2009, up to 138 percent FPL. The federal

government paid 100 percent of the cost of newly eligible adults through 2016, and the federal matching rate for this population phases down to 90 percent in 2020 and beyond (Exhibit 2).

Exhibit 2. Federal Share of Spending for MaineCare Populations and Services

	CY 2018	CY 2019	CY 2020+
Newly eligible adults in expansion group	94%	93%	90%
	FFY 2018	**FFY 2019**	**FFY 2020+**
Most other MaineCare populations	64.34%	64.52%	Not yet available
Breast and cervical cancer group	75.04%	75.16%	
Children in the income range for CHIP*	98.04%	98.16%	

Note: CY is calendar year; FFY is federal fiscal year.[4]
* The current federal share for these children reflects a time-limited "bump" of 23 percentage points added to the level shown for the breast and cervical cancer group. The bump will be phased down to 11.5 points in FFY 2020 and zero in FFY 2021 and beyond, but the federal share for CHIP will remain higher than for regular Medicaid.

As of February 2017, approximately 267,000 low-income Maine residents were covered by MaineCare.[5] Eligibility pre-expansion for non-disabled adults age 19 to 64 is limited to certain groups and generally excludes those without dependent children (Exhibit 3). Under the expansion adopted by Maine voters, MaineCare will cover adults—parents as well as those not living with dependent children—with incomes up to 138 percent FPL,[6] or $16,753 per year for a single individual in 2018 (Exhibit 4).

Exhibit 3. MaineCare Non-Disabled Adult Eligibility and Enrollment

Group	Eligibility limit as a % of FPL	SFY 2016 enrollment
Parents of dependent children	105%	42,433
Individuals age 19 or 20	161%	5,976
Pregnant women	214%	3,213
Women with breast or cervical cancer	250%	189
Former Maine foster care children under age 26	None	Not available
Individuals in need of family planning services (limited benefits)	214%	0*
Individuals with HIV (limited benefits)	250%	461
Other non-disabled adults age 19-64	138% under expansion	0**

Note: MaineCare coverage provides full benefits unless noted otherwise.[7]
* Coverage for this group was implemented in SFY 2017.
** Expansion was approved by a ballot initiative in November 2017, but coverage has not yet been implemented.

Exhibit 4. 2018 Annual Income Amounts Corresponding with Selected MaineCare Eligibility Limits

Family size	105% FPL	138% FPL	161% FPL	214% FPL	250% FPL
Individual	$12,747	$16,753	$19,545	$25,980	$30,350
2	$17,283	$22,715	$26,501	$35,224	$41,150
3	$21,819	$28,676	$33,456	$44,469	$51,950
4	$26,355	$34,638	$40,411	$53,714	$62,750

Note: FPL is federal poverty level.[8]

Maine previously covered parents up to 200 percent FPL and some childless adults up to 100 percent FPL, but dropped this coverage in 2013 and 2014, respectively.[9] Because Maine covered all parents and all individuals age 19-20 up to 138 percent FPL with a full benefit package as of December 1, 2009, these individuals are not considered newly eligible under the ACA and their coverage will be at the State's regular federal matching rate of approximately 64 percent. (As indicated later in this memorandum, those age 19-20 and parents with incomes from 101 to 105 percent FPL are currently covered under MaineCare and will simply shift their eligibility to the expansion adult group; as such, they are not a new cost to the program.[10]) Coverage for other adults without dependent children (referred to as childless adults throughout this memorandum) who enroll through the expansion group will receive the newly eligible federal matching rate (94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond).[11]

Estimated Costs

Below we describe the data and assumptions used to estimate the costs associated with increased MaineCare enrollment under expansion, broken into the following categories:

- coverage for expansion group childless adults from 0 to 138 percent FPL;
- coverage for expansion group parents from 101 to 138 percent FPL;
- coverage for currently eligible but not enrolled parents from 0 to 100 percent FPL;
- coverage for currently eligible but not enrolled children; and
- administrative costs.

For all estimates, we assume the following:

- Coverage begins July 2, 2018, which is one day after the start of Maine's SFY 2019.

- Based on 2016 American Community Survey (ACS) data, an average of approximately 112,700 Maine adults age 19-64 with incomes up to 138 percent FPL are potentially eligible for MaineCare coverage.[12] This reflects both uninsured individuals and those with some form of private coverage,[13] including through the Marketplace.[14]

- When full-take up is realized, MaineCare expansion group enrollment reflects approximately 55 percent of all potentially eligible adults, including 90 percent of these adults who are uninsured.[15] This reflects a midpoint value for states that have recently expanded. In Alaska, Louisiana, and Montana (the three most recent states to expand after 2014), actual expansion group enrollment as a share of all potentially eligible adults ranges from approximately 40 to 70 percent. In neighboring New Hampshire, the figure is less than 45 percent.[16]

  The assumptions used for Maine in our analysis result in an estimated 62,000 expansion group adults gaining coverage.[17] This figure is lower than estimates produced by the Maine Department of Health and Human Services (DHHS) and the Maine State Legislature's Office of Fiscal and Program Review (OFPR), which assume larger numbers of childless adult enrollees.[18] However, it is higher than estimates produced by a microsimulation model maintained by the Urban Institute.[19]

  It is important to note that it is possible for expansion group enrollment to exceed the net increase in Medicaid enrollment that occurs under expansion, which can lead to an overstatement of expansion impacts when this population is viewed in isolation. For example, prior to expanding in August 2014, New Hampshire had an estimated 123,000 potentially eligible adults (i.e., age 19-64 with incomes up to 138 percent FPL who were uninsured or privately insured), slightly higher than Maine's figure of 112,700. Throughout 2017, enrollment in New Hampshire's expansion group remained steady at no more than 53,200. However, as of December 2017, their increase in total Medicaid enrollment relative to July 2014 (prior to expansion) was only 45,800, which likely reflects some previously enrolled individuals shifting to the expansion group (see "Estimated Savings" section below).

- Using a midpoint of other states' experiences, full take-up of coverage (i.e., the 55 percent described above) is not realized until SFY 2021, with a ramp-up period where approximately 58 percent of the number ultimately expected to enroll do so in the first six months of expansion, 70 percent do so during SFY 2019, and 95 percent do so during SFY 2020. Based on the experience of Louisiana, Montana, and New Hampshire, enrollment growth is likely to level off after approximately 18 months. Using the highest expansion group enrollment figures to date as an estimate of full take-up for these states, between approximately 45 and 70 percent were covered on average during the first six months of expansion, between approximately 60 and 80 percent were covered on average during the first year, and close to 90 percent or more were covered on average during the second year.[20] OFPR assumes no ramp-up of enrollment, and DHHS assumes a one-month lag in claims due to eligibility determination of applications.

- Eligibility group-specific per member per month (PMPM) estimates from DHHS are used as the base for spending per enrollee estimates. Previous expansion estimates from OFPR contain lower PMPMs that were based on older DHHS data. Unlike states in which there was little experience upon which to base PMPMs for expansion enrollees, Maine's

previous coverage of childless adults and higher income parents provides a solid foundation for such estimates. DHHS applies an annual growth rate of 6 percent to PMPMs, including a factor for both medical prices (4 percent) and utilization (2 percent). Six percent is higher than national estimates of growth produced by the Congressional Budget Office and the Centers for Medicare & Medicaid Services.[21] Because there is little publicly available data on MaineCare PMPMs,[22] we rely on DHHS estimates.

- Federal matching rates applied for a given SFY are a blend of calendar year and federal fiscal year (FFY) values. The FFY runs from October to September, while Maine's SFY runs from July to June. Regular federal matching rates for Medicaid and CHIP are not yet available beyond FFY 2019 (Exhibit 2), so we assume the FFY 2019 values for future years.

Additional data and assumptions are detailed below. Unless noted otherwise, historical MaineCare enrollment data are from DHHS and reflect SFY 2016, the most recent complete year of information available to Manatt when we began our work on updated expansion estimates for MeHAF.[23]

Expansion group childless adults from 0 to 138 percent FPL.[24] To determine the number of enrollees in this group, we first apply separate take-up rates to the uninsured and privately insured populations of potentially eligible adults in Maine. As described above, this results in expansion group enrollment (including both childless adults and parents) that reflects approximately 55 percent of all potentially eligible adults. From this figure, we subtract estimated expansion group parent enrollment (see below) to arrive at the estimated number of expansion group childless adults. As previously noted, some adults (e.g., those age 19-20) will simply be shifting their eligibility category under expansion. We do not estimate these individuals as a new cost to MaineCare, and for some groups (e.g., pregnant women, people with disabilities) estimate that they will generate savings as described later in this memorandum.

Expansion group parents from 101 to 138 percent FPL.[25] In SFY 2012, prior to subsequent reductions in eligibility, approximately 21,400 parents with incomes between 101 and 150 percent FPL were enrolled in MaineCare. Under an assumption that these individuals were evenly distributed by income, we estimate that 14,107 were between 106 and 138 percent FPL. This figure reflects our estimate of new expansion group parents,[26] and is conservative given that Maine's total population of adults age 19-64 with incomes at or below 138 percent FPL decreased by 9 percent between 2012 and 2016.[27] As previously noted, some adults (e.g., parents from 101 to 105 percent FPL) will simply be shifting their eligibility category under expansion. We do not estimate these individuals as a new cost to MaineCare, and some may generate savings.

Currently eligible but not enrolled parents from 0 to 100 percent FPL. Between SFYs 2012 and 2016, the number of MaineCare parent enrollees in this income range fell by 7,300 (15 percent). While a falling number of eligible low-income adults (noted above) likely played a

role, some portion may have been attributable to programmatic changes that influenced enrollment (e.g., elimination of coverage for higher income parents leading to uncertainty about eligibility among those with lower incomes). Under a future expansion, we assume that a so-called "woodwork" or "welcome mat" effect leads to an enrollment increase equal to half of what was lost between 2012 and 2016. However, given that the ACA would already have been responsible for a woodwork effect beginning with 2014 (e.g., due to enrollment simplifications, increased public awareness of coverage options, etc.), this may be an overestimate of the potential woodwork effect associated with a current MaineCare expansion.

Currently eligible but not enrolled children. Between SFYs 2012 and 2016, the number of MaineCare child enrollees fell by 11,600 (10 percent). Slightly more than half of these children had Medicaid-funded coverage, and the remainder had CHIP-funded coverage for which there is a higher federal matching rate (Exhibit 2).[28] As with parents, we assume that some portion of the drop in enrollment was due to a falling number of eligible individuals (e.g., the number of children age 0-18 with incomes at or below 138 percent FPL residing in Maine fell by 11 percent between 2012 and 2016), and that some was attributable to programmatic changes (e.g., reductions in parent eligibility) that influenced enrollment. Similarly, under a future expansion, we assume that a woodwork effect leads to an enrollment increase equal to half of what was lost between 2012 and 2016. However, given that child enrollment fell at approximately the same rate as Maine's number of low-income children (i.e., that much of the enrollment decrease could be explained by population changes) and that the ACA would already have had some impact (see above), this may be an overestimate of the potential woodwork effect associated with a current MaineCare expansion.

With regard to the federal matching rate for children gaining coverage under a woodwork effect, we assume that half would be in the income range for the Medicaid rate and that half would be in the range for the higher CHIP rate. This differs from DHHS and OFPR estimates, which apply the CHIP federal matching rate to the cost of coverage for all currently eligible but not enrolled children.

Administrative costs. DHHS and OFPR estimate the total administrative costs of expansion (primarily associated with hiring additional caseworkers) at approximately $8.6 million per year. Given that these costs vary based on the number of new enrollees, we prorate this figure down to $7.5 million to account for our proportionately lower enrollment.[29] We use the most recent estimate from DHHS that appears to assume a federal share of approximately 61 percent (with no specific breakout of costs that would be at 75 percent versus 50 percent),[30] but note that the earlier OFPR estimate appears to use a higher blended rate of 70 percent. The administrative cost figure accounts for approximately 2 percent or less of total expansion spending in each year, and is in line with the experience of other expansion states.

While we do not provide estimates in this memorandum, it should be noted that there may be opportunities for Maine to further reduce the administrative costs of eligibility determinations for both current and expansion MaineCare populations. For example, many states use automated matches with state wage and unemployment data to verify income, and are able to

make real-time or overnight determinations of eligibility by checking against electronic data sources. Maine does not yet have real-time determination capability.[31] With regard to expansion, some states accomplished a significant portion of their coverage gains through direct enrollment into Medicaid based on enrollment in other programs, which is permitted under certain circumstances. Finally, a number of states, perhaps most notably Louisiana, relied on community partners (e.g., health centers) and outstationed workers (e.g., on site at hospitals and other locations) to facilitate the expansion enrollment process by helping individuals submit applications that were as complete and fully documented as possible. All of these strategies could be considered to reduce the MaineCare administrative workload, and ultimately the number of staff required to run the program.

If Maine took advantage of these permissible ways to streamline enrollment, administrative costs could be lower than what DHHS and OFPR have estimated. For example, there are parent Supplemental Nutrition Assistance Program (SNAP) participants in Maine with incomes above 105 percent FPL who are currently ineligible for MaineCare but will qualify for coverage under the expansion group. If Maine were to implement a fast-track enrollment process that relies on existing SNAP information to determine Medicaid eligibility for these individuals, it would require less caseworker involvement in processing applications and could result in lower administrative costs for the State.[32]

Estimated Savings

Based on the experience of states that have already opted to cover the expansion adult group under Medicaid, Maine can expect savings in two categories: accessing enhanced federal matching funds for some current MaineCare enrollees, and replacing State funds with federal Medicaid funds for healthcare services provided to low-income adults. Savings in each category below are presented as annual savings per SFY.

MaineCare pregnant women group. An average of 3,213 women with incomes up to 214 percent FPL were enrolled in MaineCare through a pregnancy-related eligibility pathway in SFY 2016, with an average PMPM of $981.[33] Under an assumption that these individuals were evenly distributed by income, we estimate that 2,072 had incomes between 0 and 138 percent FPL. This is a conservative estimate given that the women who enroll in MaineCare are likely to be skewed at the lower end of the income range. Using the midpoint of other states' percentage reductions in enrollment as a guide (see below), an estimated 932 of these women shift from the pregnancy group to the expansion group in Maine by SFY 2021. Coverage for these women draws a higher federal match, thereby generating State savings estimated at $3.7 million by SFY 2021.

Under expansion, the number of women in the pregnancy group is expected to decrease as many would already be enrolled in the expansion group when they become pregnant. Women who become pregnant while in the expansion group can remain there and states receive an enhanced match for these women until their next eligibility redetermination, at which point they revert to pregnancy-related eligibility at the regular matching rate. In New Hampshire, for

example, enrollment in the pregnancy group (which covers women up to 201 percent FPL) had generally been trending upward and averaged 2,805 in the 12 months prior to expansion; relative to this level, enrollment in the pregnancy group fell by 8 percent in the first year of expansion, by 20 percent in the second year, and by 24 percent in the third year. Under a reasonable assumption that these coverage reductions occurred among the subset of women from 0 to 138 percent FPL, this translates to a reduction of 35 percent for those in the expansion group income range. In Louisiana, enrollment in the pregnancy group (which covers women up to 138 percent FPL) fell by 33 percent in the first year of expansion, and by 55 percent after 18 months.[34]

Maine's own experience also suggests a relationship between pregnancy group and expansion group enrollment. In SFYs 2012 and 2013, approximately 1,800 women were enrolled in the pregnancy group. By SFY 2015, when Maine eliminated coverage for parents above 100 percent FPL and childless adults, pregnancy group enrollment grew to more than 3,000 women (an increase of nearly 70 percent), approximately where it remains today. This is particularly notable given that Maine's number of low-income adults was decreasing during this time period (noted above).

MaineCare breast and cervical cancer group. An average of 189 women with incomes up to 250 percent FPL were enrolled in MaineCare through a breast and cervical cancer eligibility pathway in SFY 2016. Under a conservative assumption that these individuals were evenly distributed by income, we estimate that 104 were between 0 and 138 percent FPL. Using the midpoint of other states' percentage reductions in enrollment as a guide (see below), an estimated 49 of these women shift from the breast and cervical cancer group to the expansion group in Maine by SFY 2020. Coverage for these women under expansion draws a higher federal match,[35] thereby generating State savings estimated at $0.1 million each year.[36]

As with the pregnancy group, the number of women in the breast and cervical cancer group is expected to decrease as many would already be enrolled in the expansion group when they are diagnosed. In New Hampshire, for example, enrollment in the breast and cervical cancer group had been steady and averaged 204 in the 12 months prior to expansion; relative to this level, enrollment in the breast and cervical cancer group fell by 10 percent in the first year of expansion, by 26 percent in the second year, and remained at a 26 percent reduction in the third year. In Louisiana, enrollment in the breast and cervical cancer group has decreased each month, falling by more than half after 18 months of expansion. In Montana, enrollment in this group has fallen as well, with a 21 percent reduction in total spending after 6 months of expansion, and a 50 percent reduction after 18 months.[37]

MaineCare poverty level disabled group. In general, states are required to provide Medicaid coverage for people with a disability determination who receive Supplemental Security Income (SSI), which has an income limit of approximately 74 percent FPL. In Maine, the State also provides MaineCare coverage to individuals with a disability determination whose income is above the SSI level, up to 100 percent FPL (i.e., the poverty level group). In FFY 2009, the State enrolled approximately 5,300 of these individuals who could potentially qualify under the

expansion group, for whom MaineCare spending totaled $39 million and spending per enrollee was approximately 65 percent of the average for all disabled enrollees in Maine.[38] While figures on the annual number of new entrants to the poverty level disabled group (i.e., the number of individuals who could forgo a disability determination for MaineCare purposes in light of expansion group coverage) are not readily available, we assume that approximately 4.5 percent of individuals in this group are new enrollees each year and that they will instead enroll through the expansion group in the future.[39] Current PMPMs are used to estimate costs for this population.[40] Coverage for these individuals under expansion draws a higher federal match, thereby generating State savings estimated at $2.5 million by SFY 2021.

MaineCare medically needy group. In Maine, people who could otherwise qualify for MaineCare under an existing category (e.g., individuals age 65 or older, younger people with a disability determination, parents, children) but whose income exceeds the allowable limit can become eligible for medically needy coverage by incurring medical expenses and "spending down" their income to a required level. In 2012, Maine enrolled approximately 5,800 medically needy individuals for whom MaineCare spending totaled $78 million.[41] Of these individuals, an estimated $3.6 million in spending was for adults who could shift to the expansion group.[42] After applying a 6 percent annual growth figure to the $3.6 million, SFY 2019 total spending is estimated at $5.3 million. With a higher federal matching rate applied to this spending, State savings are estimated at $1.5 million by SFY 2020.[43]

Such a reduction in medically needy spending is consistent with findings in a variety of other states.[44] In Montana, for example, total medically needy spending decreased by approximately 30 percent after expansion was implemented, resulting in State savings of at least $3.8 million after 18 months.[45]

MaineCare HIV waiver group. MaineCare currently covers certain adults with HIV up to 250 percent FPL under a waiver that provides a more limited benefit package than regular MaineCare. During the first three quarters of 2017, an average of 444 individuals who are otherwise ineligible for MaineCare were enrolled under the waiver.[46] DHHS estimates that 60 percent of these individuals would qualify for enrollment as expansion group adults.[47] After applying a 6 percent annual growth figure, SFY 2019 total spending for these individuals is estimated at $5.3 million. With a higher federal match rate applied to 30 percent of this spending in the first year and 60 percent thereafter, State savings are estimated at $0.9 million by SFY 2020.

State-only corrections. Federal funding for Medicaid coverage of inmates of a public institution is prohibited by federal law, with the exception of spending for inmates receiving inpatient hospital care, provided the inmate would be eligible for Medicaid coverage but for the fact that he or she is incarcerated. In expansion states, the vast majority of inmates meet this standard,[48] and states realize savings as the federal government picks up the majority of their inpatient hospitalization costs.[49] In SFY 2015, Maine spent $15.5 million on inmate health care,[50] and an estimated $3.1 million of this amount was for inpatient hospitalizations.[51] After applying a 6 percent annual growth figure to the $3.1 million, SFY 2019 total spending on inmate

hospitalizations is estimated at $3.9 million. With a higher federal matching rate applied to 75 percent of this spending in the first year and 90 percent thereafter (under an assumption that not all individuals will be able to enroll in coverage due to paperwork or other constraints but that the State will have a financial incentive to maximize participation), State savings are estimated at $3.6 million by SFY 2020.

State-only behavioral health. In SFY 2015, Maine spent an estimated $34.5 million in State general funds on non-Medicaid mental health and substance abuse services for adults.[52] While data on the number and characteristics of individuals served with these funds are not publicly available, a conservative assumption based on the income distribution of uninsured adults age 19-64 in Maine would suggest that at least $14.5 million (42 percent) of this amount is used to serve individuals with incomes from 0 to 138 percent FPL.[53] Given that many of these individuals will now be eligible for comprehensive behavioral health services under MaineCare, a substantial portion of individuals will have their State general fund spending replaced with federal Medicaid dollars, estimated at 50 percent in the first year and 75 percent thereafter (under an assumption that not all individuals will be able to enroll in coverage due to paperwork or other constraints), for a State savings of $9.8 million by SFY 2021.[54]

The State general funds that are freed up in this process could be used to offset the costs of Medicaid expansion, but they could also be reinvested to serve more of the uninsured and underinsured individuals who remain ineligible for MaineCare coverage.[55] In addition, Maine will need to consider its maintenance of effort (MOE) obligations for federal mental health and substance abuse block grant funds, which require State expenditures for mental health and substance abuse to remain at or above the average level in the 2-year period preceding the current block grant year. Under a conservative assumption that 10 percent of MaineCare expenditures (including the State share) for new enrollees under expansion will be for mental health and substance abuse services,[56] we estimate that at least $8.4 million in annual MOE funds—and likely more—would be generated by SFY 2021 by counting the State's share of these service.[57]

State-only General Assistance (GA). In SFY 2016, Maine spent $642,000 on prescriptions and other medical care under its GA program, 70 percent of which was paid with State funds.[58] Given that many of the individuals who receive GA will now be eligible for comprehensive health services under MaineCare and that there is a statutory requirement for individuals to make an effort to secure resources from programs other than GA,[59] a substantial portion of this spending could be replaced with federal Medicaid dollars, estimated at 75 percent in the first year and 90 percent thereafter (under an assumption that not all individuals will be able to enroll in coverage due to paperwork or other constraints). State savings are estimated at approximately $0.4 million by SFY 2021.[60]

State-only Low Cost Drugs for the Elderly and Disabled (DEL). DEL is a State-funded program that helps pay for prescription and over-the-counter drugs in Maine for certain individuals with incomes below 175 percent FPL, including those who are age 62 or older, or who are age 19 to 61 and meet federal disability criteria. SFY 2016 general fund appropriations for the program

totaled $4.4 million, and an additional $6.2 million was provided from the Fund for a Healthy Maine.[61] Based on SFY 2010 data, approximately 15 percent of DEL spending was for individuals not otherwise eligible for MaineCare (i.e., "DEL only" individuals).[62] In the absence of publicly available data, we assume that those age 62-64 and younger adults with a disability determination account for half of general fund spending for DEL only individuals, given that most individuals age 65 or older would have Medicare Part D coverage that pays for a substantial portion of their prescription drug costs. After further accounting for the fact that DEL serves individuals up to 175 percent FPL and assuming that most DEL individuals up to 138 percent FPL who could enroll in MaineCare under expansion would be motivated to do so in light of their ongoing need for assistance with drug costs (75 percent the first year and 90 percent thereafter), State general fund savings are estimated at approximately $0.2 million annually.[63]

Estimated Revenues

In Maine, Medicaid expansion could generate additional State revenues because it increases the base to which the existing hospital tax can be applied. However, legislative action would be required to re-base this amount, which was most recently updated to reflect calendar year 2014 hospital revenues.[64] To estimate the increase in hospital revenues that could result under expansion, we applied a methodology that accounts for an increase in Medicaid revenues for the expansion population and is offset by a decrease in revenues for the population of individuals who shift from Marketplace coverage.[65] The methodology results in an estimated hospital revenue increase of $120.7 million by SFY 2021, and applying the current tax rate of 2.23 percent to this amount results in State revenues of $2.7 million.

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[1] Deborah Bachrach et al., *Estimated State Budget Impact of a MaineCare Expansion in 2016*, Prepared by Manatt Health for MeHAF (Apr. 2015), http://www.mehaf.org/content/uploaded/images/reports-research/Estimated%20State%20Budget%20Impact%20MaineCare%20Expansion_May%202015.pdf.

[2] For a summary of findings from other states, see Larisa Antoinesse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, Kaiser Family Foundation (Sep. 25, 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/.

[3] Sums of components may not equal totals due to rounding, as noted in Exhibit 1.

[4] Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, *Federal Medical Assistance Percentages*, https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures.

Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2017 Through September 30, 2018, 81 Fed. Reg. 80078 (Nov. 15, 2016), https://www.federalregister.gov/documents/2016/11/15/2016-27424/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for.

Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2018 Through September 30, 2019, 82 Fed. Reg. 55383 (Nov. 21, 2017), https://www.federalregister.gov/documents/2017/11/21/2017-24953/federal-matching-shares-for-medicaid-the-childrens-health-insurance-program-and-aid-to-needy-aged.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, *Medicaid Program; Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010*, 78 Fed. Reg. 19918 (Apr. 2, 2013), https://www.gpo.gov/fdsys/pkg/FR-2013-04-02/pdf/2013-07599.pdf.
Tricia Brooks et al., *Medicaid and CHIP Eligibility, January 2017 Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey*, Kaiser Family Foundation (Jan. 2017), http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017.

[5] Manatt and MeHAF, *MaineCare: What Everyone Should Know About Maine's Medicaid Program*, Fact Sheet (October 2017), http://www.mehaf.org/learning-resources/reports-research/.

[6] Individuals who are pregnant at the time of application or enrolled in Medicare are not eligible for coverage in the expansion group.

[7] Maine DHHS, *MaineCare Eligibility Manual* (Sep. 2017), http://www.maine.gov/dhhs/oms/member/index.shtml.
Maine DHHS, *MaineCare Caseload*, Excel file (May 2017).

[8] Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, *HHS Poverty Guidelines for 2018* (Jan. 13, 2018), https://aspe.hhs.gov/poverty-guidelines.

[9] Kaiser Family Foundation, *Medicaid Income Eligibility Limits for Parents, 2002-2017*, State Health Facts, https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents.
Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, *MaineCare for Childless Adults section 1115(a) Demonstration: Fact Sheet* (Feb. 2014), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/me/me-childless-adults-fs.pdf.

[10] For details, see the description and endnotes for these groups in the "Estimated Costs" section.

[11] Deloitte, *MaineCare Actuarial Value Benefit Assessment – MaineCare for Childless Adults* (Jan. 2, 2014), http://www.mehaf.org/content/uploaded/images/reports-research/MaineCare_Actuarial_Value_Benefit_Assessment.pdf.

[12] While this ACS-based "potentially eligible" figure reflects a substantial number of people who would enroll through the expansion group, there are some people in this age and income range who are already eligible for MaineCare coverage. This includes, for example, people age 19 or 20 and parents with incomes from 101 to 105 percent FPL (Exhibit 2). As a result, when we apply a take-up rate to the "potentially eligible" figure, it will include these pre-expansion eligibles; however, our take-up rate is designed to result in a number of expansion group enrollees that reflects the experience of other states. As described in this memorandum, we have a separate methodology for estimating the number of currently eligible but not enrolled individuals who would gain coverage as a result of expansion.

[13] Manatt analysis of ACS data tabulated by State Health Access Data Assistance Center (SHADAC), http://statehealthcompare.shadac.org. The potentially eligible figure includes 37,200 uninsured and 75,500 with some form of private coverage. Family income is counted using a health insurance unit (HIU) definition, based on individuals who would likely be considered a family unit in determining eligibility for either private or public coverage. The number of potentially eligible individuals excludes those who are currently enrolled in Medicare (who do not qualify for ACA expansion coverage) or Medicaid. In addition, figures reflect the *average* number of potentially eligible adults during the year, but the number who are *ever* eligible during the year would be larger. For example, while 11.7 percent of U.S. adults age 19-64 reported being uninsured at the time of a survey interview in 2016, 16.1 percent were uninsured for at least one month during the past year. The larger number of "ever uninsured" may partly explain why most studies have found little or no decrease in private coverage in Medicaid expansion states. See:
Medicaid and CHIP Payment and Access Commission (MACPAC), *MACStats: Medicaid and CHIP Data Book* (Dec. 2017), Exhibit 43, https://www.macpac.gov/macstats/.
Larisa Antoinesse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, Kaiser Family Foundation (Sep. 25, 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/.

[14] Marketplace enrollees with incomes between 100 and 138 percent FPL will transition to MaineCare coverage, and the estimated number of affected individuals is approximately 17,100. This is based on Manatt analysis of administrative data on Maine's most recent Marketplace enrollment total (2018) and most recent Marketplace

enrollment with an income breakout at 138 percent FPL (2016), which indicates that approximately 23 percent of enrollees with non-missing income data were between 100 and 138 percent FPL.
Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, *Final Weekly Enrollment Snapshot For 2018 Open Enrollment Period* (Dec. 28, 2017), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-28.html.
Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, *2016 Qualifying Health Plan Selections by Household Income as a Percent of the Federal Poverty Level and County, as of February 1, 2016* (Mar. 29, 2017), https://data.cms.gov/Marketplace-Qualified-Health-Plan-QHP-/2016-Qualifying-Health-Plan-Selections-by-Househol/n4mh-474r.

[15] The Urban Institute estimates that many expansion states had uninsured take-up rates of approximately 70 percent, but that some (including California, Kentucky, and Rhode Island) had rates closer to 90 percent. Stan Dorn and Matt Buettgens, *The Cost to States of Not Expanding Medicaid* (Aug. 2016), https://www.urban.org/sites/default/files/publication/83301/2000886-The-Cost-to-States-of-Not-Expanding-Medicaid.pdf.

[16] Manatt analysis of pre-expansion ACS data on uninsured and privately insured adults age 19-64 with incomes up to 138 percent FPL, and administrative data on enrollment from the following sources:
ACS data tabulated by SHADAC, http://statehealthcompare.shadac.org.
Alaska Department of Health and Social Services, http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx.
Louisiana Department of Health and Human Services, http://new.dhh.louisiana.gov/index.cfm/page/1275.
Montana Department of Public Health and Human Services, https://dphhs.mt.gov/Portals/85/Statistics/documents/20171204_Monthly_Charting.pdf.
New Hampshire Department of Health and Human Services, https://www.dhhs.nh.gov/ombp/medicaid/enrollment-data.htm.
Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/enrollment-mbes/index.html.

[17] This consists of 47,900 childless adults and 14,100 parents in the expansion group; an additional 3,700 parents and 5,800 children who were currently eligible are also estimated to enroll (Exhibit 1).

[18] The DHHS estimate for childless adults and parents (excluding "woodwork" enrollees) is 73,152. Ricker Hamilton, Commissioner, Maine DHHS, *Medicaid Expansion Fiscal Note and Related Information*, memorandum to Senator James Hamper and Representative Drew Gattine (Jan. 3, 2018), http://legislature.maine.gov/uploads/originals/20180202111632348.pdf.
The comparable OFPR estimate is 80,113. Maine State Legislature, OFPR, *Initiated Bill to Enhance Access to Affordable Health Care: Fiscal Note*, 128th Maine Legislature (also see data table accompanying the fiscal note).

[19] The Urban Institute analysis estimates that under a high take-up scenario, 55,300 non-elderly individuals (including expansion group and currently eligible but not enrolled individuals) would newly enroll in MaineCare. See Stan Dorn and Matt Buettgens, *The Cost of Not Expanding Medicaid: An Updated Analysis* (Apr. 2017), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf436919.

[20] See data sources cited above. Alaska's enrollment, which is estimated at approximately 40 percent of all potentially eligible adults, has ramped up more slowly but has continued to grow in part because the state is experiencing a recession.

[21] For non-disabled, non-elderly, non-expansion adults and children, both CBO and CMS have projected growth rates averaging around 5 percent. For expansion adults at the national level, CMS estimated that spending per enrollee would initially be high as a result of individuals with the greatest health needs enrolling first and previously uninsured individuals demonstrating pent-up demand for services, and that average spending would fall as healthier individuals enrolled and service use stabilized. See Office of the Actuary, CMS, U.S. Department of Health and Human Services, *2016 Actuarial Report on the Financial Outlook for Medicaid* (Jan. 2017), https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf.
One recent report, which did not examine state variation and is unclear on the extent to which findings are generalizable, indicates continued growth in expansion enrollee PMPMs over time. See Avalere Health, *Profile of*

the Medicaid Expansion Population: Demographics, Enrollment, and Utilization (Jan. 2018), http://go.avalere.com/acton/attachment/12909/f-0517/1/-/-/-/-/Avalere%20Medicaid%20Expansion%20Analysis.pdf.

In practice, experience has varied and there is no single data source available that allows for a consistent examination of trends in spending per expansion enrollee. Based on Manatt's communication with a variety of states, most of which enroll expansion adults in managed care, some initially set their expansion capitation rates high and subsequently dropped them; others have been fairly steady, particularly where the state already had a substantial adult population prior to expansion; and at least one has provided retroactive increases as rates were initially set too low. As indicated, we believe Maine's previous experience with coverage for childless adults and higher income parents provides a solid basis for estimating future expansion adult group PMPMs.

[22] Between 2000 and 2011, Maine experienced extremely low growth in Medicaid spending per enrollee for non-disabled, non-elderly children and adults. See Kaiser Family Foundation, *Average Growth in Annual Medicaid Spending from FY2000 to FY2011 for Full-Benefit Enrollees*, State Health Facts, https://www.kff.org/medicaid/state-indicator/average-growth-in-annual-medicaid-spending-from-fy2000-to-fy2011-for-full-benefit-enrollees.

We are not aware of publicly available data that would allow for a comprehensive examination of spending per enrollee growth after this period, which in particular would need to account for the changing mix of parent and childless adult enrollees in the program. While growth in aggregate MaineCare spending has been approximately 2 percent or less in most years since SFY 2012, enrollment has been decreasing. For SFYs 2017-2019, aggregate growth was projected by DHHS to range from 0.7 percent to 1.7 percent, but it is unclear whether enrollment was assumed to continue falling during this period—and therefore whether per enrollee growth would exceed the aggregate growth that was projected. See Stefanie Nadeau, Director, *An Introduction to the Office of MaineCare Services: Maine Department of Health and Human Services*, Prepared for the 128th Legislative Session (Jan. 2017).

[23] Maine DHHS, *MaineCare Caseload*, Excel file (May 2017).

[24] Pre-expansion MaineCare eligibility defines children to include individuals age 19 or 20 at State option and these individuals are currently covered by MaineCare. In the future, their existing coverage will shift to the expansion adult group, which takes precedence over optional eligibility categories. As with parents, the enhanced matching rate is not available for this population because they were eligible for Medicaid with a full benefit package as of December 1, 2009. See:

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, *Medicaid and the Affordable Care Act: FMAP Final Rule Frequently Asked Questions* (Aug. 29, 2013), https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/fmap-faqs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, *Medicaid and CHIP in 2014: Eligibility Final Rule Wrap Up* (May 10, 2012), https://www.medicaid.gov/state-resource-center/downloads/eligibilityandenrollment-wrapup-final.pdf.

[25] Although pre-expansion MaineCare eligibility for parents extends up to 105 percent FPL, existing coverage for those between 101 and 105 percent FPL will shift to the expansion group in the future. This is due to the treatment of a 5 percent income disregard, which is only applied when determining overall eligibility for Medicaid, rather than eligibility for specific groups. Under expansion, the parent group will end at 100 percent FPL (excluding the 5 percent disregard), and individuals with incomes above that level will be enrolled in the expansion group up to 138 percent FPL (with the 5 percent disregard applied at the top of the income range that determines their overall Medicaid eligibility). As noted earlier, Maine previously covered parents up to 138 percent FPL, so the enhanced newly eligible federal matching rate is not available for this population, regardless of whether they enroll through the expansion group. For information on treatment of the 5 percent disregard, see Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, *Medicaid and CHIP FAQs: MAGI Conversion* (Aug. 2013), https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-MAGI-Conversion-2013.pdf.

[26] As previously noted, parents from 101 to 105 percent FPL are currently covered but will shift to the expansion group. We base our estimates for *new* expansion group parents on those in the income range (106 to 138 percent FPL) not currently covered.

[27] Manatt analysis of ACS data tabulated by SHADAC, http://statehealthcompare.shadac.org.

[28] See Table 1 in Tricia Brooks et al., *Medicaid and CHIP Eligibility, January 2017 Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey*, Kaiser Family Foundation (Jan. 2017), http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017.

[29] Although enrollment is expected to ramp up over time, we conservatively estimate administrative costs based on the SFY 2021 full take-up level under an assumption that the State will staff up in advance of anticipated needs.

[30] For Medicaid eligibility in particular, some administrative activities receive 75 percent federal match while others are at 50 percent. See Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, *Medicaid and CHIP FAQs: Enhanced Funding for Medicaid Eligibility Systems* (Aug. 2013), https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/faqs-by-topic-75-25-eligibility-systems.pdf.

[31] Tricia Brooks et al., *Medicaid and CHIP Eligibility, January 2017 Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey, Kaiser Family Foundation* (Jan. 2017), http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017.

[32] Sanjay Kishore, Elizabeth Hagan, *Fast-Track Medicaid Enrollment Saves States Money*, Families USA (Jun. 2014), http://familiesusa.org/product/fast-track-medicaid-enrollment-saves-states-money.

[33] Manatt analysis of PMPM data provided by OFPR. *OMS - Traditional Eligibility - Total Spending/Members/PMPM by Month Jan 2015 - Jun 2016* (Feb. 17, 2017).

[34] See New Hampshire and Louisiana data sources cited above. In the case of Louisiana, enrollment in the 12 months leading up to expansion averaged 22,709 and had begun flattening, but had decreased by 14 percent relative to the prior year. Even if a portion of the post-expansion decrease in pregnancy group enrollment would have occurred without expansion, it would not fully account for drops in enrollment of the magnitude observed.

[35] As indicated in Exhibit 1, the regular match for these women is already at an enhanced rate, so the savings from the expansion group match is smaller than for other groups.

[36] Because we assume that the percentage of women shifting to the expansion group is flat after SFY 2020, the SFY 2021 savings estimate drops slightly (see Exhibit 1) as the federal matching rate decreases and levels out at 90 percent. Assumed savings would increase with normal cost growth (6 percent annually) thereafter.

[37] See New Hampshire and Louisiana data sources cited above. For Montana, figures are based on Manatt analysis of unpublished data provided by the Montana Department of Health and Human Services.

[38] Excludes individuals who are dually enrolled in Medicare and MaineCare, who cannot enroll in the expansion group. More recent figures on this group are not publicly available, but the FFY 2009 number may be conservative given that eligibility for non-disabled adults was higher in 2009 (offering an alternative to enrollment based on a disability) and that DHHS caseload data indicate growth in the overall number of individuals enrolled in MaineCare on the basis of a disability. Manatt analysis of Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Medicaid Statistical Information System (MSIS) data.

[39] Based on data from MACPAC for FFY 2013, the churn rate for MaineCare enrollees eligible based on a disability overall is approximately 9 percent. See Medicaid and CHIP Payment and Access Commission (MACPAC), *MACStats: Medicaid and CHIP Data Book* (Dec. 2017), Exhibits 14 and 15, https://www.macpac.gov/macstats/.
Since DHHS caseload data indicate that the number of disabled enrollees has remained fairly steady in recent years, a reasonable assumption is that half of the churn (4.5 percent) is attributable to individuals gaining coverage (the other half would be individuals losing coverage). We further assume that the individuals gaining coverage are spread evenly over the course of the year (i.e., that the full 4.5 percent is not realized until month 12), resulting in an average value of 2.4 percent for each new year of expansion plus 4.5 percent for each previous year.

[40] An average PMPM of $1,028 for SFY 2016 reflects 65 percent of the average PMPM for all blind and disabled enrollees in Maine, and this figure is increased by a 6 percent annual growth rate. Manatt analysis of PMPM data provided by OFPR. *OMS - Traditional Eligibility - Total Spending/Members/PMPM by Month Jan 2015 - Jun 2016* (Feb. 17, 2017).

[41] Most of this enrollment and spending was for elderly individuals and people with disabilities dually eligible for Medicare, but 744 were non-elderly, non-dually eligible adults for whom spending totaled $6.8 million. Manatt analysis of Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, *Medicaid Analytic eXtract (MAX) Validation Reports*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MAX-Validation-Reports.html.

[42] Reflects individuals age 21-64 who were not dually eligible for Medicare and had incomes at or below 138 percent FPL. Manatt analysis of Maine DHHS, *Medically Needy Members*, data extract for Jan. 2012 – Jan. 2013.
[43] Given that medically needy eligibility must be renewed every six months, we assume that these individuals could rapidly transition to the expansion group (50 percent in the first year, 100 percent in the second year) as they are no longer required to spend down their income to enroll in MaineCare.
[44] Deborah Bachrach et al., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, State Health Reform Assistance Network, Robert Wood Johnson Foundation (Mar. 2016), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.
[45] Manatt analysis of unpublished data provided by the Montana Department of Health and Human Services.
[46] Manatt analysis of Maine DHHS, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/Individuals-with-HIV-AIDS/me-hiv-qtrly-rpt-jul-sep-2017.pdf.
[47] Maine DHHS, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-hiv-pa.pdf.
[48] U.S. Government Accountability Office, *Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services*, September 2014, http://www.gao.gov/assets/670/665552.pdf.
[49] Jocelyn Guyer et al., *Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States*, State Health Reform Assistance Network, Robert Wood Johnson Foundation (Nov. 2015), http://statenetwork.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf.
The Pew Charitable Trusts, *Prison Health Care: Costs and Quality* (Oct. 2017), http://www.pewtrusts.org/~/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf.
[50] The Pew Charitable Trusts, *Prison Health Care: Costs and Quality* (Oct. 2017), http://www.pewtrusts.org/~/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf.
[51] An estimated 20 percent of prison health care spending is for hospitalizations. The Pew Charitable Trusts and Catherine T. McArthur Foundation, *State Prison Health Care Spending* (Jul. 2014), http://www.pewtrusts.org/~/media/assets/2014/07/stateprisonhealthcarespendingreport.pdf.
[52] Data provided by OFPR. For our savings estimates, we assume that the program amount remains flat under current law. For a description of services and programs, see Maine DHHS, *An Introduction to the Office of Substance Abuse and Mental Health Services: Maine DHHS*, Legislative Orientation Prepared for the 128th Legislative Session (Jan. 2017), http://www.maine.gov/legis/opla/SAMHSOrientationPresentationJanuary2017.pdf.
[53] Manatt analysis of 2016 ACS data cited above indicates that 32 percent of uninsured adults in Maine have incomes from 139 to 250 percent FPL, 18 percent have incomes from 251 to 400 percent FPL, and 8 percent have incomes above 400 percent FPL.
[54] Because we do not assume behavioral health program spending growth under current law, the SFY 2021 savings estimate drops slightly (see Exhibit 1) as the federal matching rate decreases and levels out at 90 percent. Assumed savings would remain at the SFY 2021 level thereafter.
[55] Some services, including certain types of residential treatment in facilities that do not qualify for Medicaid funding, are likely to require continued State-only funding. Assumed savings would remain at the SFY 2021 level thereafter.
[56] Manatt analysis of unpublished data from West Virginia indicates that substance use disorder (SUD) treatment services (including drugs) accounted for 6 percent of Medicaid expansion population services in SFY 2017, and that mental health services (excluding drugs) accounted for 4 percent. Drugs, including those for mental health conditions, accounted for another 33 percent of spending.
Similarly, mental health and SUD treatment services (excluding drugs) have accounted for 9 percent of Montana's Medicaid expansion spending. Drugs, including those for SUD and mental health, have accounted for 21 percent. Montana DPHHS, *Medicaid Expansion Health Care Services Profile (corrected)*, Medicaid Expansion (HELP Act) Oversight Committee meeting (Sep. 27, 2017), http://dphhs.mt.gov/Portals/85/Documents/healthcare/MedicaidExpansionHealthCareServicesProfile.pdf.
[57] This reflects 10 percent of an estimated $84.4 million in State spending on MaineCare services for new enrollees under expansion in SFY 2021.

[58] Office of Family Independence, Maine DHHS, *An Introduction to the Office for Family Independence: Maine DHHS*, Legislative Orientation Prepared for the 128th Legislative Session (Jan. 2017), http://legislature.maine.gov/legis/opla/OFIOrientationPresentationJanuary2017.pdf. For our savings estimates, we assume that the program amount remains flat under current law.

[59] 22 Maine Revised Statutes § 4317, http://legislature.maine.gov/statutes/22/title22sec4317.html.

[60] Because we do not assume GA program spending growth under current law, the SFY 2021 savings estimate drops slightly (see Exhibit 1) as the federal matching rate decreases and levels out at 90 percent. Assumed savings would remain at the SFY 2021 level thereafter.

[61] The Fund for a Healthy Maine includes tobacco settlement funds; savings estimated here apply only to State general funds. For our savings estimates, we assume that the program amount remains flat under current law. See Maine State Legislature, OFPR, *Total Appropriations & Allocations All Funds: 2016-2017 Biennium*, Through the 127th Legislature, 2nd Regular Session (Jun. 15, 2016), http://legislature.maine.gov/uploads/originals/2016-2017-approp-allocations-127-r2-posted-version-2.pdf.

22 Maine Revised Statutes § 1511, http://www.mainelegislature.org/legis/statutes/22/title22sec1511.html.

[62] Maine DHHS, *In Focus Reference Book* (Dec. 2010), http://lldc.mainelegislature.org/Open/Rpts/hv98_m2m338_2010.pdf.

[63] Because we do not assume DEL spending growth under current law, the SFY 2021 savings estimate drops slightly (see Exhibit 1) as the federal matching rate decreases and levels out at 90 percent.

[64] 36 Maine Revised Statutes § 2891-2896, http://www.mainelegislature.org/legis/statutes/36/title36ch377sec0.html.

[65] Based on information provided by the Maine Hospital Association, rates paid by Medicaid are estimated to be on average about 45 percent of what is paid by Marketplace or other commercial plans.