COMPARISON OF RELATIVE COSTS TO THE STATE AND FEDERAL GOVERNMENTS UNDER SENATE AND HOUSE VERSIONS OF SF 296

The Senate and House versions of Senate File 296 cover approximately the same number of adults under the new eligibility provisions in the Affordable Care Act—approximately 90,000 below the federal poverty level and approximately 60,000 between 100 percent and 138 percent of poverty.

There are slight differences in the benefits these adults would receive and the costs of administration, but the major difference in the House and Senate versions is in how the program is financed and what portion of the cost is the responsibility of the federal, versus state, government.

The Senate version extends Medicaid eligibility to 138 percent of the federal poverty level. Therefore, Iowa would be eligible for a special federal matching rate outlined in the ACA: 100 percent for the first three years, eventually going down to 90 percent. The House version only extends Medicaid eligibility to 100 percent of the federal poverty level. Therefore, Iowa would be eligible for federal matching for those adults at its regular FMAP rate (58 percent in FFY 2014 and 57 percent in FFY 2015). The state, through state or local financing, would be responsible for the remaining 42 percent of costs in FFY 2014 and 43 percent in FFY 2015.

Under the Senate plan, Iowa would receive the same special federal matching rate (100 percent declining to 90 percent) to cover adults between 100 and 138 percent of poverty as it would to cover adults below 100 percent of poverty.

Under the House plan, adults between 100 and 138 percent of poverty would be eligible for premium tax credits to obtain coverage through the health insurance exchange. The federal government assumes full responsibility for this funding.

Nationally, the annual cost of covering an adult under Medicaid is approximately $6,000. The cost of covering an adult under the health insurance exchange is higher, an estimated $9,000. (Medicaid costs are lower due to lower administrative costs and, lower provider reimbursement rates, although this varies by state.) Iowa's Medicaid coverage costs are lower, at about $4,000 per adult, as will be the expected costs under the exchange.

COMPARISON OF STATE-FEDERAL SHARE OF MEDICAID EXPANSION COSTS IN HOUSE AND SENATE VERSIONS OF SF 296, FFY 2015

	Under 100 Percent	**100 to 138 Percent**	**Total**
Number of adults	90,000	60,000	150,000
Total Cost	$366.0 M	$244-366 M*	$610-732 M
Senate Version (No Match)	$0	$0	$0
Senate Version (10 Percent)	$36.6 M	$24.4 M	$61.0 M
House Version (43 Percent)	$156.6 M	$ 0	$156.6 M

* This range is based on the difference between covering an adult under Medicaid and through the exchange (estimated at $4,000 and $6,000, respectively, for this table). Calculating the 10 percent match rate in the Senate version uses the $4,000 figure, as the Senate version expands Medicaid.

The table on the previous page provides broad estimates of federal and state costs under the Senate and House versions to cover the newly expanded population and what those figures would look like if the state share of participation under the Senate version were, in fact, fully phased in.

The House version provides for financing the state share of the $156.6 million through a combination of direct state funding and transfers, existing property tax levies that are directed to at least some of the services that now will be eligible for funding under the Medicaid expansion, and University of Iowa Hospitals and Clinics' funding that is directed to care for part of this population (those served under IowaCare).

While the total costs to Iowa and the federal government combined are similar, Iowa bears a much larger share of the costs under the House version. Iowans are also federal taxpayers and will contribute to these federal costs. Iowa's share of this responsibility is only about 1 percent of the estimated federal costs (for those under 100 percent of poverty, $3.6 million in the Senate version and $2.1 million in the House version). Clearly, Iowa taxpayers also will share in the federal costs of expansion for other states expanding Medicaid, but this will occur regardless of what Iowa does.

Two of the sources of funding in the House version are continuations of contributions made as part of the Section 1115 IowaCare demonstration – $42 million from Polk County property tax payers to Broadlawns and $12.6 million from the University of Iowa Hospitals and Clinics. In both instances, these institutions essentially agreed to transfer funds they previously had been receiving to provide indigent care because they would receive Medicaid funding for the patients now eligible for IowaCare, with those institutions being designated as the providers of care. Those funding agreements were reached prior to the ACA and essentially guaranteed both facilities a patient population of IowaCare Medicaid recipients. Under both House and Senate versions of the Medicaid expansion, however, adults will be able to choose their providers and there is no guarantee that the transferred funds from these accounts will, in fact, go back to these institutions.

A third source of funding is diverting 37.84 percent of the current county mental-health levy to the state. With Medicaid expansion, it is estimated that a share of county expenditures on mental-health services through this levy will be provided and covered under the Medicaid expansion or the Exchange. In its analysis of the Senate version, the Legislative Fiscal Bureau estimated that:

> [C]ounties could save between $55.0 and $60.0 million annually by covering individuals under Medicaid Expansion that are receiving mental health treatment and have no health insurance. Counties currently levy $122.2 million to fund mental health services. This change could also save the State from supplementing county mental health expenditures in the future. The Mental Health and Disability Services Interim Committee recommended an additional $29.8 million to supplement the county mental health system for FY 2014.

This is only an estimate. Currently, counties use their mental-health levy to fund a variety of services, including housing and other services that would not be eligible for Medicaid reimbursement. Some of the individuals they serve also do not meet eligibility criteria for Medicaid. Further, individual counties vary substantially in how they make use of the levy, and there may be very wide variations in the proportions of current county services provided under this levy that will be eligible for Medicaid funding.

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