

Economic Impacts of Federal Health Insurance Reform (PPACA) for Alaska

CHARTBOOK with NOTES

Prepared for: State of Alaska, Dept. of Health &
Social Services, Alaska Health Care Commission

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in collaboration with Scott Goldsmith, UAA ISER,

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Caveats/Limitations of Preliminary Analysis

- The analysis presented here have been independently developed and does not necessarily reflect the view of any MAFA or ISER clients
- These are *preliminary* *reconnaissance-level* estimates based on readily available public data and analysis, including the Center for Medicare/Medicaid Services (CMS) Office of the Actuary, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) and cross checked against other public estimates, e.g., RAND, that have been scaled to Alaska and adjusted to reflect Alaska market considerations.
- The federal health reform package involves a large change in health insurance and health care sectors over the course of the next decade. These **preliminary estimates** of impacts on Alaska contain *significant uncertainty*, but nonetheless reflect current reconnaissance-level estimates for magnitude and direction of the economic impact of reform for Alaska.
- Mr. Foster would like to express his appreciation for Scott Goldsmith's advice, counsel and collaboration on issues concerning the Alaska economy and Katherine Jackstadt's excellent assistance with data research and compilation under ambitious time frames.
- Mark Foster is the principal author of this analysis and remains responsible for any errors. Please send any questions, comments or concerns to mafa@alaska.net

Chartbook Outline

- Outline of Key Provisions of Federal Health Insurance Reform
 - Notes on Key Differences between Alaska & U.S.
- Changes in Health Coverage
 - U.S., Alaska, Key differences
- Summary of Financial Impact
- Change in Overall Health Care Spending
- Change in Spending by Utilization and Price Drivers
- Change in Federal Revenues To/From Alaska
- Federal Taxes and Fees from Alaskans
- Federal Exchange Subsidies to Alaskans
- Alaska Competitive Outlook (key industries)
- Supplemental Schedules
 - Changes in Medicare
 - Health Insurance Expansion implications for Medicare Beneficiaries
 - Federally funded Medicaid bump up to Medicare (2013-2014)

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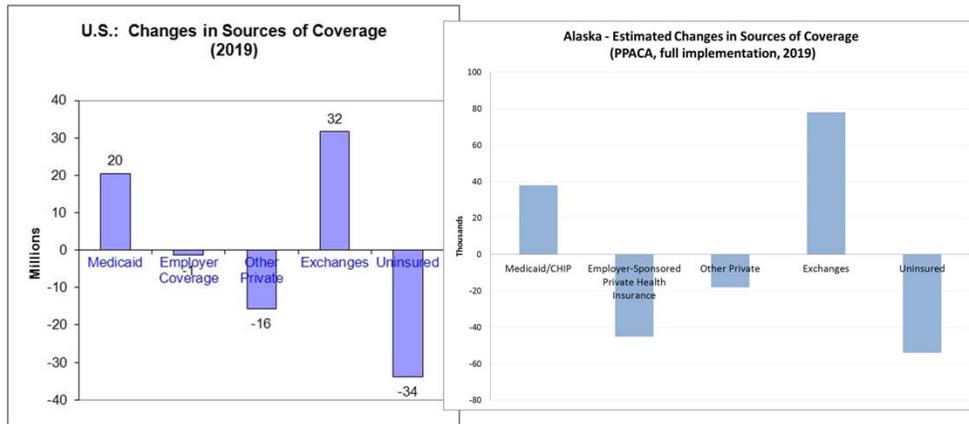
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PPACA – Key Provisions

PPACA – Key Provisions	Considerations: U.S. & Alaska
Individual mandate to obtain minimum health insurance coverage; those without coverage pay a tax penalty up to \$695 per year or up to a max of three times that per family or 2.5% of income	Exemptions from individual mandate, including financial hardship, religious objections, American Indian/Alaska Native, undocumented immigrants, low income households who do not have to file income tax returns, and households where the cost of insurance exceeds 8 percent of income, may be higher in Alaska
Business (>50 employees) mandate to provide minimum health insurance coverage; \$2000 fee per full time employee not covered by business, but receiving federal premium support	Relatively higher proportion of smaller businesses in Alaska means larger number of businesses will be exempt from business mandate
Creation of health insurance “Exchange”; federal subsidies available for individuals up to 400% of Federal Poverty Level (FPL)	Alaska FPL is 125% of continental U.S. – Federal premium subsidy eligibility extends to higher incomes in Alaska and yields more federal subsidy per income bracket; provides marginal benefit to Alaska compared to other states <i>as Alaska incomes trend toward U.S.</i>
Medicaid Expansion to cover up to 138% of Federal Poverty Level (FPL)	Alaska FPL is 125% of continental U.S. – Federal Medicaid support subsidy eligibility extends to higher incomes in Alaska and yields more federal subsidy per income bracket; provides marginal benefit to Alaska compared to other states <i>as Alaska incomes trend toward U.S.</i>
Tax Changes: <ol style="list-style-type: none"> 40% Excise tax on high cost insurance above thresholds (\$10,200/\$27,500 in 2018) Medicare hospital insurance tax increase of 0.9% on incomes above \$200/\$250K and 3.8% tax on unearned income for \$200/250K Annual excise taxes and fees on pharma, health insurance, medical devices, indoor tanning services, 	<ol style="list-style-type: none"> 40% excise tax on high cost plans likely to touch around half of Alaskan health plans vs. 10-15% of U.S. in first year resulting in relatively high federal tax burden vs. other states Medicare tax increases on incomes above \$200/\$250K appear to touch roughly 4% of Alaskans vs. 2-3% of U.S. Taxes and fees assessed on a percentage basis; higher costs in Alaska may result in higher taxes and fees
Cost Containment: <ol style="list-style-type: none"> Restructure payments to Medicare Advantage plans Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice, and other Medicare providers, and adjust for productivity Reduce Medicare & Medicaid disproportionate share hospital (DSH) payments Establish Independent Payment Advisory Board 	<ol style="list-style-type: none"> Medicare advantage plans are de minimis in Alaska; smaller payments to MA will reduce federal spending in other States more than AK Reduced updates and productivity adjustments roughly comparable in Anchorage MSA; rural and near rural markets have some insulation DSH payment reductions roughly comparable in Anchorage MSA; API Medicaid DSH payment reductions are material Potential IPAB reductions in Medicare Part A & B may reduce access in Anchorage MSA more acutely than other MSA’s due to already low rates

Preliminary Estimate of Coverage Changes

U.S. & Alaska



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1. Medicaid Expansion enrollment = function of (eligibility, benefits, enrollment incentives and rate, provider acceptance)
2. Exchange enrollment = function of (federal subsidies, mandate penalties, eligibility, benefits, enrollment incentives, rates, provider acceptance)
3. Employer coverage = function of (labor markets, wage/benefit mix, penalties, subsidies, new Exchange and Medicaid opportunities, mandated expansion of coverage to children up to age 26)
4. Other private coverage = function of (transfer of individual, non-group market to new Exchange)
5. Reduction in uninsured = movement to Medicaid, subsidized Exchange, new employer sponsored health insurance

Medicaid Expansion U.S. & Alaska

U.S.	Alaska
The PPACA expands Medicaid to cover all adults with incomes below 138% of the federal poverty level (FPL), including both parents and non-aged childless adults. Estimated increase in eligibility of roughly 6% of U.S. population.	Estimated increase in Medicaid eligibility amounts to roughly 8% of the Alaska population. Slightly larger percentage than U.S. due to 25% higher federal poverty level determination for Alaska and slightly larger low income tail in Alaska.
Enrollment rate among newly eligible may be roughly ¾ vs. 2/3 among current program due to anticipated changes in outreach efforts and easier enrollment through new Exchanges. Estimated increase in enrollment from the newly eligible of roughly 4.7% of the U.S. population.	Enrollment rate from among the newly eligible is estimated to lag U.S. due to combination of remote rural, relatively transient populations and larger safety net provided by Tribal Health and Dept. of Defense. Estimated increase in enrollment from the newly eligible amounting to roughly 4.4% of the Alaska population.
Enrollment increase among <i>previously eligible</i> of around 0.6% of the U.S. population	Enrollment rate from among the previously eligible is estimated to lag the U.S. due to relative success of prior Alaska enrollment efforts considering Alaska's challenging circumstances. Enrollment increase among <i>previously eligible</i> of roughly 0.5% of the Alaska population.
Net new enrollment in Medicaid estimated at 18 million (5.2% of population); including 15.5 million newly eligible and 2 million previously eligible	Net new enrollment in Medicaid estimated at 38 thousand (4.9% of population); including 34 thousand newly eligible and 4 thousand previously eligible

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In contrast to Alaska, with a net enrollment gain on the order of 38 thousand (4.9% of the population) and State spending increases expected on the order of \$112 million as a result of the PPACA (2014-2019), the net new enrollment in Medicaid for New York state, where the state had previously expanded eligibility – but kept provider payment rates low, is estimated at 180 thousand (0.9% of population); including 120 thousand newly eligible and 60 thousand previously eligible. When combined with other shifts in coverage and spending and CHIP cost shifting effects, New York is expected to spend around \$11 billion *less* on Medicaid as a result of the PPACA (2014-2019).

New Health Insurance Exchange(s)

U.S. & Alaska

U.S.	Alaska
<p>Roughly 31 million (9.3%) would be enrolled in the new Health Benefit Exchange (16 million with net new health coverage, 15 million switching health coverage to an Exchange plan). Roughly 63% of those eligible for the Exchange would enroll – principal incentive being level of premium assistance available.</p>	<p>Roughly 78 thousand (6.5%) would be enrolled in the new health benefit exchange (22 thousand with new health coverage, 56 thousand switching health coverage from individual/group to an Exchange plan). Share of uninsured population is smaller due to large proportion of population already covered by Indian Health Service and Department of Defense, offset by larger portion of businesses who may drop coverage.</p>
<p>Individuals/families would not be subject to penalty for failing to enroll in an Exchange plan if the bronze premium would exceed 8 percent of income – this provision is estimated to exempt individuals and families with incomes between 400% and 542% of FPL, representing around 16% of the non-aged population. Roughly 15 percentage points in this income group would still retain coverage.</p>	<p>Combination of higher cost of insurance, 25% higher federal poverty level calculation, and projected Alaska income growth moderation relative to U.S. results in roughly similar proportion of non-aged population being exempt due to lack of affordable premiums (<8% of income). <i>Estimates subject to substantial uncertainty.</i></p>
<p>Smaller employers and companies with lower average wages may end their coverage, allowing workers to qualify for heavily subsidized coverage through the Exchanges.</p>	<p>Larger portion of small employers, relatively high cost of insurance relative to compensation, and 25% higher federal poverty level may lead to higher proportion of employers dropping coverage to allow workers to qualify for the heavily subsidized coverage through the Exchanges.</p>

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Changes in Employer Sponsored Coverage U.S. & Alaska

U.S.	Alaska
Roughly 13 million (3.9%) would become newly covered as a result of additional employers offering health coverage, a greater proportion of workers enrolling in employer plans, and an extension of dependent coverage up to age 26.	Roughly 24 thousand (3.1%) would become newly covered. Smaller shift in Alaska due to smaller proportion of employers (>50 employees) subject to mandate offset by extension of dependent coverage up to age 26, especially among government and large employers
Roughly 14 million (4.2%) would lose employer-sponsored health coverage as a result of shifts to expanded Medicaid and subsidized coverage through the Exchange.	Roughly 70 thousand (9%) would lose employer-sponsored health coverage. Larger shift in Alaska due to higher cost of insurance and higher price sensitivity outside of government and large employers combined with relatively attractive federal subsidies.
Net result is an estimated loss of roughly 1 million (0.3%) from employer-sponsored health coverage.	Net result is an estimated loss of roughly 45 thousand (5.8%) from employer-sponsored health coverage. <i>Estimates subject to substantial uncertainty.</i>

Changes in Uninsured U.S. & Alaska

U.S.	Alaska
<p>Roughly 23 million (6.9%) would remain uninsured. 5 million (1.5%) are undocumented aliens who would not be eligible for Medicaid or Exchange subsidies. 8 million (2.5%) would choose not to be insured and to pay the penalty associated with the individual mandate. For the most part these would be individuals with relatively low health care expenses for whom the individual or family premium would be significantly in excess of any penalty and their anticipated health benefit value.</p> <p>3.5 million (1.1%) would chose not to be insured and not pay the penalty because they are below the threshold to file income tax.</p> <p>3.5 million (1.1%) would chose not to be insured and would not pay the penalty because premiums were over 8% of income</p> <p>1.5 million (0.5%) would chose not to be insured and would not pay the penalty because they were uninsured less than 3 months.</p>	<p>Roughly 54 thousand (7%) would remain uninsured.</p> <p>We do not have sufficient data to be able to develop an estimate comparable in detail to CMS regarding who remains uninsured.</p> <p>In aggregate, we would not be surprised if the proportion of the population exempt from the individual mandate (and not subject to penalties) may be larger than the U.S. due to relatively high portion of the population covered by the Indian Health Service and Department of Defense and a relatively long low income tail in Alaska associated with highly seasonal employment sectors, low proportion who file income tax, and potential for undocumented aliens to represent a portion of the highly seasonal employment.</p>

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Summary of basic financial impact - Alaska, 2019

Health Insurance Coverage Expansion	Medicaid Expansion + Individual Mandate + Business Mandate (>50 employees) may result in an increase of roughly 54,000 insured individuals in Alaska; reducing uninsured by almost 50%
Increase in Overall Health Care Spending in Alaska	Net increase in overall spending of ~2-3% (~\$289M); consisting of ~4% (~\$500M) increase in utilization from newly insured & upgrades to new mandates, potentially offset by ~2% reduction in Medicare and ~1% reduction in utilization as the 40% excise tax on health benefits creates an incentive to shift compensation from insurance back toward income for those with high cost health plans (\$10,200 single/\$27,500 family)
Health Provider Considerations	Hospitals – Gross revenue increase; <i>net</i> revenue may be negative if rate of Medicare and Medicaid reductions exceed efficiency gains over time Physicians – Gross revenue increase; <i>net</i> revenue may be positive if exposure to low reimbursement insurance, e.g., Medicare, is minimized
Who pays for the increase <i>First point of payment</i>	Federal expenditures on Medicaid Expansion + Exchange subsidies to those ≤400% of poverty ~\$693M; Net <i>reductions</i> in Medicare ~\$60M; Penalties on households ~\$25M; Penalties on business ~\$36M that will be passed onto households; new taxes and fees from Alaska ~\$448M; net new federal contribution \$123M; Internal reallocation of State spending to support Medicaid expansion (~\$41M) and *aggregate* household reallocation of spending to cover increased utilization associated with expanded coverage (~\$124M) not covered by federal or state resources
Household Impacts	~\$693M from outside federal subsidies and cost support [Exchange + Medicaid]; Internal reallocations: ~\$180M to new premiums for new or expanded insurance; \$120M from reductions in out of pocket (co-pays, deductibles), \$61M to penalties for not having coverage; ~\$448M to new taxes and fees; net increase from household budgets ~\$124M; net shift from high income to mid/low income, healthy to less healthy, young to old
Business Impacts	Increased costs to cover adult children up to age 26, “pay or play” coverage mandates which get passed back to households in the form of changes in total compensation and changes in prices depending upon labor and product/service market conditions

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Review after spreadsheets and charts have been updated.

Alaska Implications – Health Care Expenditures

	Impact on Alaska	Impact on Alaska relative to Other States/International Competitors
Total Health Care Expenditures [Slides 14,15]	Health expenditures to increase 2-3% over baseline in 2019; largely driven by increased utilization by the newly insured which is offset by imposed/negotiated price reductions, reductions in Medicare reimbursement updates, and 40% excise tax on high cost plans	Overall health expenditures increase from 68% (baseline) to 70% (w/reform) of oil wellhead value; reform appears to bend cost curve upward through 2020, raises questions concerning sustainability of expenditures
Health Care Expenditures by Source [Slides 24, 25]	Medicare – increase in taxes on high income and cuts in reimbursements; lower reimbursement levels have the potential to exacerbate Anchorage area access problems if reimbursements drop faster than efficiency gains	Tribal Health support sustained (\$ 1790); incremental opportunities for grants, demonstration projects
Health Care Expenditures by Category [Slide 16]	Hospitals – increase in utilization offset by lower reimbursement updates for Medicare, risk of lower margins relative to baseline Physicians – increase in revenue and margins in the aggregate; those with high Medicare exposure face continued risk of volatile reimbursements and low or negative margins	Physicians – AK, WY, ID, ND, OK fall behind in 2013/2014 due to federally funded increment to raise Medicaid to Medicare rates for primary care providers. NY, NJ, CA, FL, IL see gains.

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Alaska Impact – Households & Business

	Impact on Alaska	Impact on Alaska relative to Other States/International Competitors
Households	Increase in taxes for high income families and increase in fees across all families are offset by subsidies/cost sharing for low to moderate income families (<400% FPL); Medicare update <i>reductions</i> increase risk of access problems (hospitals, nursing facilities, long-term care, hospice); Insurance mandates shift costs from 55-64 age group to younger demographic (27-44 yrs)	Net effect of taxes/fees on high wage structure and high health care cost structure plus mandated coverage costs are offset by additional support for AI/AN and higher subsidy levels associated with AK Poverty Guidelines (1.25X Federal Poverty Guidelines)
Private Sector Businesses	Relatively small proportion of pay/play penalties due to relatively high pct of firms w/>50 employees already offer coverage (93%); High income (\$200,000+) sole-proprietors exposed to potentially large increases due to combined effect of cap on deductibles, premium increases and new taxes	Upward trend in high cost structure; potentially offset by increase in overall labor mobility. Lower wage states in line to receive higher share of small business subsidies. Potential reduction in labor market supply due to spouse's dropping out to become eligible for federally subsidies in Exchange
Key economic sector competitiveness	Upward trend in health benefit costs, especially cost shift to younger demographic, shifts resource/tourism/fishing sector compensation from wages to benefits under mandate; increased labor mobility may increase overall labor supply, <i>but Western States and Canadian labor cost advantage over Alaska is exacerbated for most segments with possible exception of 55-64 year olds in firms with less than 50 employees</i>	

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Review after spreadsheets and charts have been updated.

Basic Methodology - Alaska Health Care Expenditure Outlook through 2019

- Develop baseline projection for total health care expenditures in Alaska for 2010-2019 for all payers/providers; enable comparisons to National Health Care expenditure projections by Center for Medicare and Medicaid (CMS) and Congressional Budget Office (CBO)
- Review key cost growth factors including basic inflation, medical inflation, utilization, population, demographics (age) for Alaska; develop Alaska to U.S. cost per capita and cost growth differentials
- Develop preliminary estimate for the *changes* associated with Federal Health Reform (P.L. 111-148, P.L. 111-152) based on CMS, Joint Committee on Taxation (JCT), CBO
- Compare federal reform to baseline for Alaska
 - Total Health Care Expenditures in Alaska (nominal \$; consistent with CBO, CMS, JCT)
 - Total Health Care Expenditures as a Percentage of Oil Wellhead Value (In absence of widely disclosed state GDP projections, use THCE as Pet of OWV as proxy measure to illustrate health care expenditures as a percentage of the primary economic value driver in the Alaska economy)
 - Summarize principal factors driving cost growth and cost containment
 - Compare Alaska & U.S. Changes (Use CMS OCA April 22, 2010 as baseline)

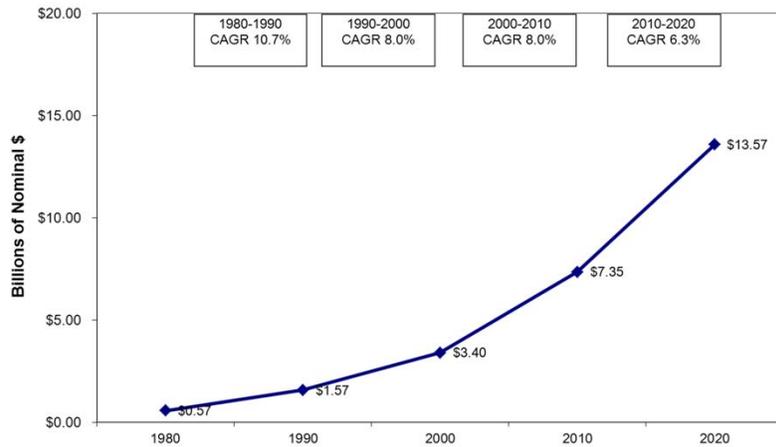
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Add bullet to describe GDP projection methodology

Projected Cost of Health Care in Alaska Nominal \$

Alaska Health Care Expenditures History & Outlook



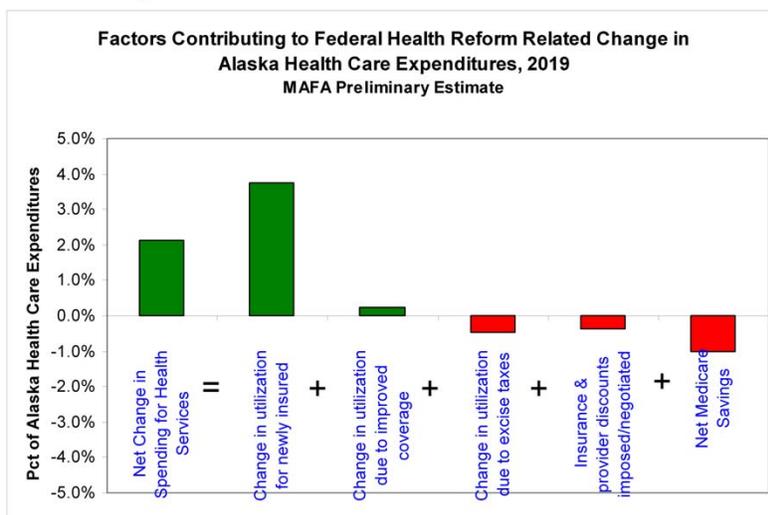
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June 2011 Update:

1. Revise 2010 estimate to reflect Personal Health Care Expenditures – does not include administrative overhead
2. Revise 2010-2020 growth rates to reflect most recent CMS projections which include reductions in growth rate associated with 2009-2011 economic slow down

Factors Contributing to the Net Increase in Health Expenditures in Alaska under Federal Reform

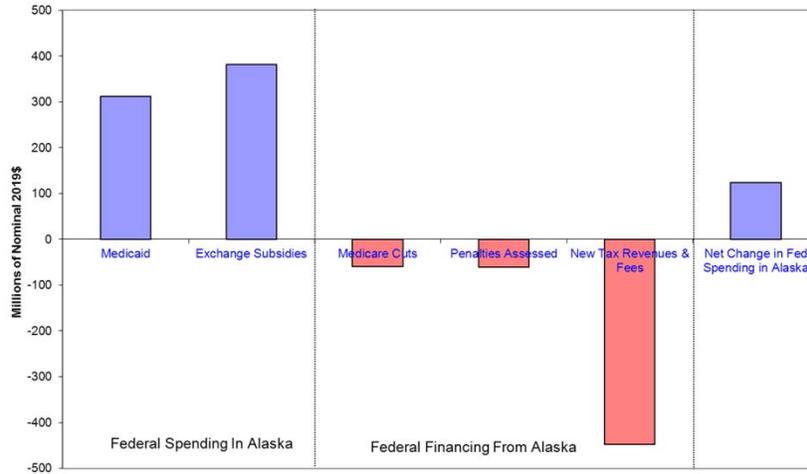


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Changes in Federal Spending in & Revenues From Alaska under Reform (2019)

Figure 3. Change in Federal Spending in & Revenues from Alaska, 2019



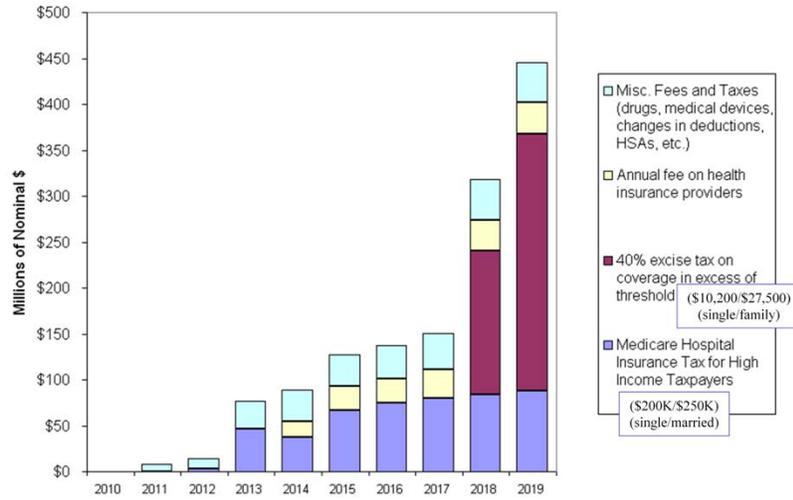
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Update

Alaska Households – Taxes & Fees

New Taxes & Fees for Alaska Households under Federal Health Reform



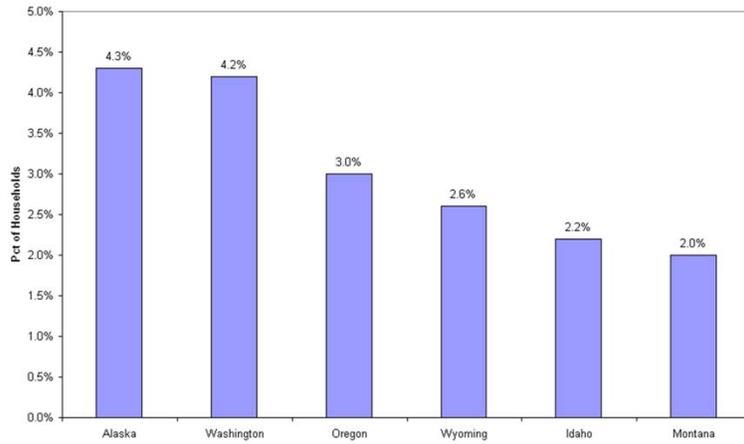
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Alaska Households – Taxes & Fees:

Medicare Hospital Tax on income and investment income lands disproportionately on AK & WA due to higher proportion of household incomes > \$200K/year

Households with Incomes >\$200,000
(American Community Survey, 2006-2008)



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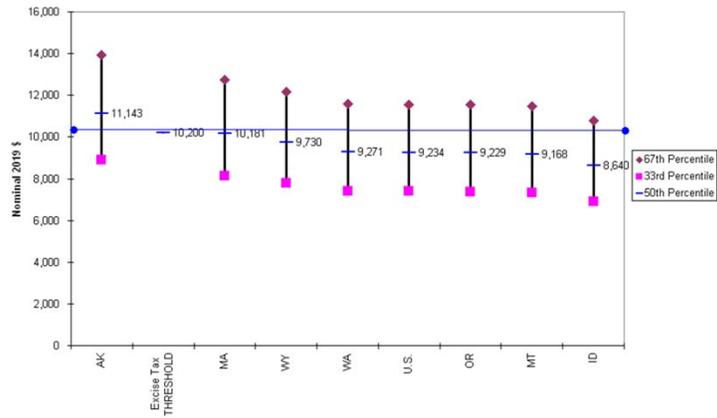
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Double check American Community Survey for updates

Alaska Household Taxes & Fees:

40% excise tax on health insurance amounts above excise tax thresholds hits Alaskan households disproportionately due to **higher cost of health care and health insurance**

Estimate of Single Premiums in Selected Western States/U.S. in 2019
Source: MEPS, 2008; Projected to 2019

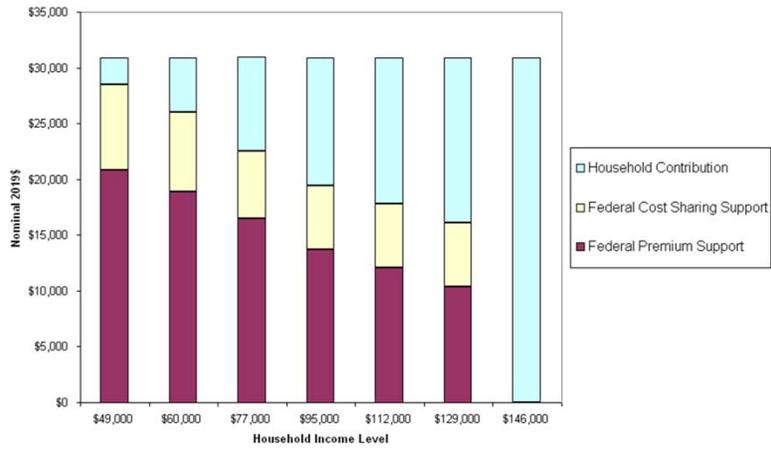


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Alaska Households – Potential Federal Subsidies & Household Costs

Estimated Exchange Subsidies and Enrollee Payments in Alaska, 2019
Family of Four, by Income Level
[Source: MAFA June 2010 Estimates, Apply PPACA provisions to Alaska Projections]



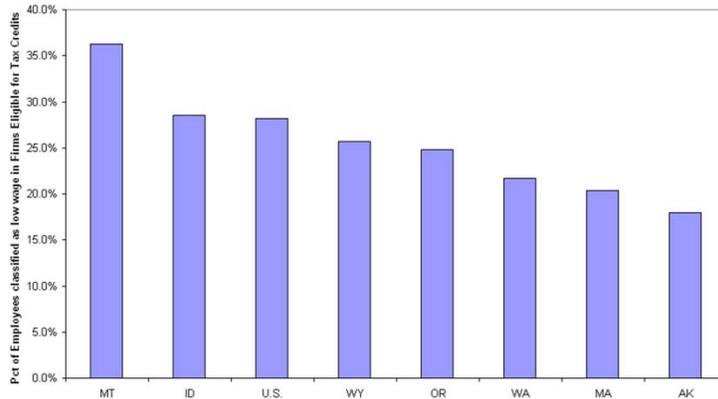
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Review and revise to match updated spreadsheet calculations

Alaska Business Implications: Other states have higher proportion of low wage employees; those states are in line to receive proportionately more small business tax credits due to lower wages

Pct of Low Wage Employees in Firms Eligible for Small Business Health Care Tax Credits Under Health Reform
(MEPS Low Wage & Firm Size Data, 2008)



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Check for MEPS data updates

Consider adding a slide to show how the small business tax credits and insurance costs compare between AK and MT, circa 2011-2013, for two or three illustrative small businesses.

Alaska Competitive Outlook

Industry/Sector	Large Firms	Small Firms
Oil & Gas	More high cost insurance subject to 40% excise tax; firms may shift more compensation to wages and shift more health insurance cost to employees depending upon need to attract/retain based on benefits/wage mix	More high cost insurance subject to 40% excise tax; firms may shift more health insurance cost to employees depending upon need to attract/retain based on benefits/wage mix
Fishing	Fish processors may be faced with "pay or play" costs associated with full time seasonal employees who buy mandated insurance from Exchange	Small firms with low wage employees may be eligible for tax credits; Net effect of individual mandate is likely to shift income from wages toward relatively high cost health insurance
Tourism	Tourism firms may be faced with "pay or play" costs associated with full time seasonal employees who buy mandated insurance from Exchange	Small firms with low wage employees may be eligible for tax credits; Net effect of individual mandate is to likely shift income from wages toward relatively high cost health insurance
Mining	Mining firms may be faced with "pay or play" costs associated with employees who buy mandated insurance from Exchange	More high cost insurance subject to 40% excise tax; firms may shift more health insurance cost to employees depending upon need to attract/retain based on benefits/wage mix

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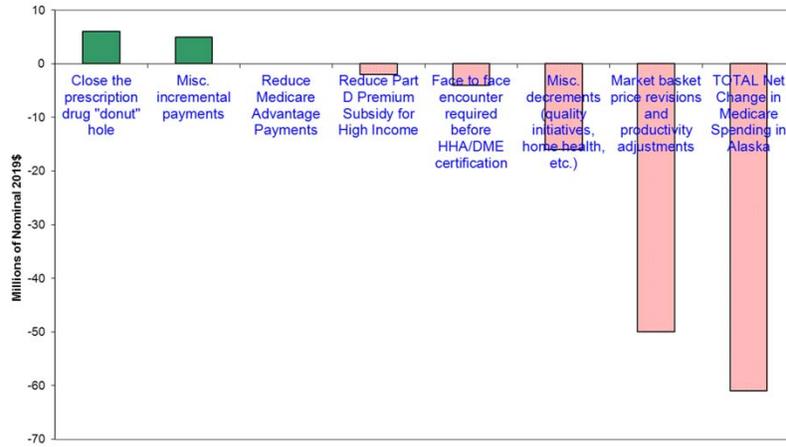
Supplemental Schedules

- Medicare Changes in Alaska (2019)
 - Changes in Medicare Spending in Alaska Associated with the PPACA, 2019
 - Changes in Medicare Spending in Alaska Associated with
 - Net impact on overall health spending in Alaska if Medicare reductions are postponed
- Health Insurance Expansion – Potential Impacts on Seniors in Alaska
- Medicaid bump up to Medicare (2013-2014)

Changes in Medicare Payments in Alaska (2019)

Changes in Medicare in Alaska - PPACA Full Implementation in 2019

Source: CMS April 22, 2010 PPACA Impacts, adjusted for Alaska demographics & PPACA exemptions



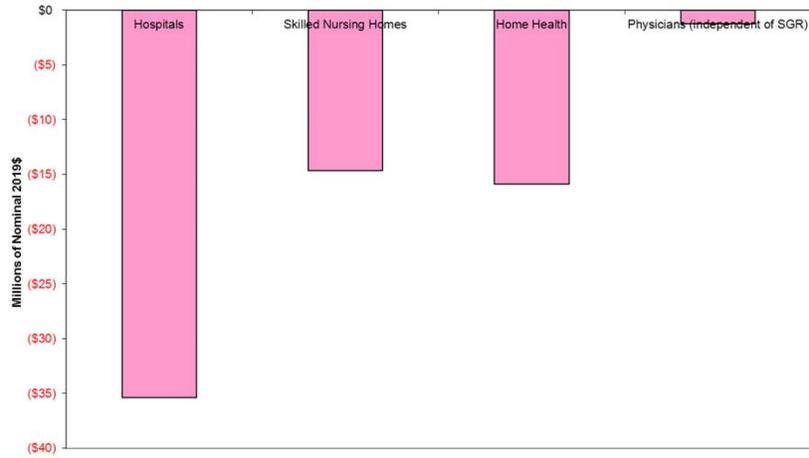
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Reductions in Payments for Medicare in Alaska, 2019

Changes in Medicare Provider Payments - PPACA Full Implementation, 2019

Source: CMS April 22, 2010 PPACA Impacts, adjusted for Alaska demographics & PPACA exemptions



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Please note that rural and some near rural hospitals have exemptions and transitional support which mitigates the potential depth of the reductions in the Medicare provider payment updates.

These reductions are concentrated in urban markets.

Health Reform Impacts on Seniors in Alaska

- Physician reimbursements for Medicaid in Alaska exceed Medicare by around 20%. Physician reimbursements for Employer Sponsored Insurance are around 20% higher than Medicaid.
- **If** this Private Insurance>Medicaid>Medicare reimbursement relationship holds, many physicians may be more inclined to treat the roughly 60,000 new enrollees in the new Exchange and Medicaid Expansion compared to Medicare, further exacerbating concerns with Senior access to primary care in Anchorage where less than 20% of primary care physicians are accepting new Medicare beneficiaries compared to around 60% in the U.S.

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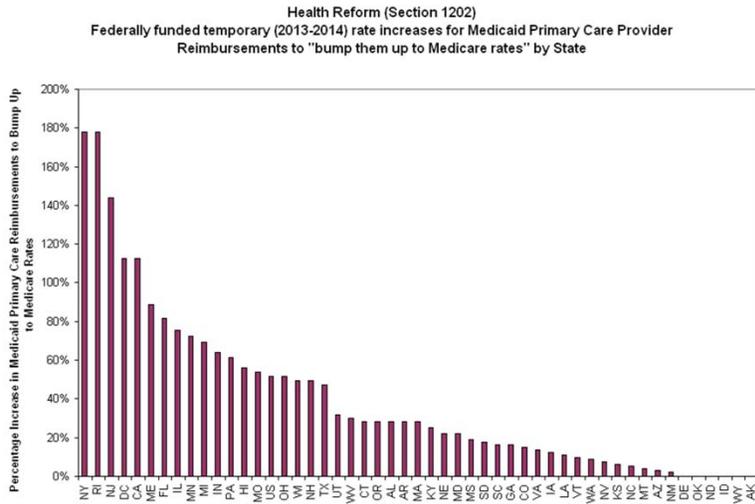
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For more details on concerns related to Senior Access please see UAA ISER Research Matters #48, Primary Care for Older Alaskans: Access and Options

Available at:

<http://www.iser.uaa.alaska.edu/Publications/Medicaresummaryfinal.pdf>

Alaska vs. Other States – Federally funded increase in Medicaid reimbursement to “bump up to Medicare” for primary care providers amount to around \$10 billion for physician services *in other states* in 2013-2014



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Section 1202 provides for two years (2013-2014) of federal funding to pay for bumping Medicaid rates up to Medicare rates for primary care providers.

The chart above illustrates the size of the potential Medicaid primary care rate increases based on Medicare/Medicaid reimbursement ratios for primary care data from the *Urban Institute 2008 Medicaid Physician Survey*.

Alaska, Wyoming, Idaho, North Dakota, Oklahoma, Delaware are not expected to receive material federal support under the Medicaid primary care provider “bump up to Medicare” provision since these states already provide Medicaid rates that roughly meet or, in the case of AK and WY, exceed Medicare rates.

Conversely, states with relatively low Medicaid reimbursement rates compared to Medicare are in line to receive significant increases in Medicaid reimbursements for primary care for 2013-2014. See for example NY, RI, NJ, CA, FL, IL, MN, MI, IN, and PA. In New York, the federally funded Medicaid to Medicare bump up on 2009 reimbursement rates for the most common procedures amounts to a bump up from \$150/hour to \$285/hour, an increase of \$135/hour for primary care physicians seeing Medicaid patients.

CBO estimates the Medicaid primary care provider “bump up to Medicare” provision (section 1202) will amount to \$8.3 Billion. CMS estimates the Medicaid primary care provider “bump up to Medicare” provision (section 1202) will amount to \$10.6 Billion.

The value of the bump up is roughly equivalent to 15,000 primary care provider FTE’s in each of the years 2013-2014 or roughly equivalent to the amount of physician FTE’s that would be required to cover the national Medicaid expansion slated to begin in 2014 based on national average FTE compensation and panel size.

To the extent that a practice group was looking to build their practice capacity in advance of the Medicaid expansion and Exchange (Individual Mandate + Business Pay or Play) scheduled for 2014, the income associated with the Medicaid bump up to Medicare reimbursement rates for primary care procedures provided by primary care providers might be reinvested in the practice to expand the facility, retain physicians/nurse practitioners, recruit new physicians/nurse practitioners. It would seem that those practices in large pct bump up (Medicaid to Medicare) States would have a head start on Alaska practices due to large increment in revenue that they could reinvest in the practice if they chose.