An Analysis of Medicaid Expansion Spending Projections, State Funding Offsets, and an Additional Financing Mechanism Offered by Oklahoma's Indian Health Care Providers

MEDICAID EXPANSION IN OKLAHOMA

OPPORTUNITY FOR SUBSTANTIAL ECONOMIC, FISCAL, AND HEALTH STATUS BENEFITS

EXECUTIVE SUMMARY

Federal law offers states the option of expanding their Medicaid programs to cover parents and other adults with a household income at or less than 138% of the federal poverty level (FPL), with the federal government covering 90% of health services expenditures.

In 2016, Oklahoma's citizenry engaged with elected officials to consider options available to the State to broaden access to health insurance coverage under the State's Medicaid program. Two comprehensive reports were prepared to inform the discussions: (1) spending projections and funding offsets prepared by Manatt Health and (2) analysis of the economic impact on the State and State residents—including additional tax revenues generated from accessing substantial federal funds—prepared by health economists at Oklahoma State University.[1] Both reports were commissioned by the Oklahoma Hospital Association.

Oklahoma did not exercise its option to expand Medicaid, but Oklahoma citizens now have re-engaged on this issue—in significant part driven by the understanding that *the State is forgoing nearly $2 billion per year in critically needed federal funding as a result of this inaction.*

To help advance consideration—and hoped-for adoption—of the expansion of Medicaid eligibility, this analysis:

- Brings together the spending projections and the revenue and funding offsets identified in the two earlier reports;
- Updates the spending and offset projections that assumed a State fiscal year (SFY) 2017 implementation with an SFY 2020 implementation target; and
- Incorporates into the projections an additional financing mechanism offered by Oklahoma's Indian health care providers (IHCPs).

Updated 5-year projections indicate that the Medicaid expansion would result in no *net* costs to the State.

- $1.924 billion in average annual program spending would be funded through $1.718 billion in federal revenues and $206 million in direct State funding.
- The federal revenues would subsequently generate an estimated $246 million in annual State spending and revenue offsets—including $19 million in average annual savings resulting from the IHCP-sponsored initiative—resulting in no net costs to the State budget.
- Savings under the IHCP-sponsored initiative ($95.2 million over 5 years) are generated as the State is able to claim 100% federal contribution for a greater share of the health service expenditures for Indian Health Service (IHS)-eligible individuals (either provided by or "received through" IHCPs) for current and Medicaid expansion enrollees.

Oklahoma's IHCPs offer to partner with the State and other health care providers to advance this initiative.

With implementation of the Medicaid expansion, 275,000 newly eligible Oklahomans, including 44,000 American Indians, are anticipated to enroll, resulting in (1) significant improvements in the physical health of residents; (2) reduced uncompensated care costs at rural and urban hospitals across the State; (3) relief for small employers and low-wage workers least able to afford health insurance coverage; (4) $1.9 billion in average annual federal revenues to the State; and (5) an estimated 17,662 new, permanent jobs for residents once fully implemented—all at no net cost to the State.

FINANCING EXPANSION OF MEDICAID ELIGIBILITY TO LOW-INCOME PARENTS AND OTHER ADULTS

A. Beginning in calendar year 2020 and for each subsequent year, the federal government will fund 90% of health services expenditures (referred to as the federal medical assistance percentage, or FMAP) and about 62% of administrative costs[2] under the Medicaid expansion, with the State covering the remaining share, for the roughly 275,000 Oklahoma residents[3]—including about 44,000 American Indians and Alaska Natives (AI/ANs)[4]—anticipated to enroll in Medicaid by SFY 2024 if the State adopts the expansion.

B. Preliminary estimates (shown in Table 1 below) derived from a Manatt Health report[5] indicate that, for the 5-year period studied, a direct State investment of approximately $206.4 million per year will secure an average of $1.72 billion in annual federal revenues, a ratio of more than $8 in federal revenues for each $1 in direct State funding.

Table 1: Estimated Federal and State Funding of Total Expenditures for Oklahoma Medicaid Expansion Population; SFYs 2020-2024

	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	All Years
Total Expenditures						
Total Funding	$1,234,641,026	$1,820,890,909	$2,071,898,182	$2,183,491,227	$2,309,461,875	$9,620,383,219
Federal Funding	$1,102,194,139	$1,625,567,273	$1,849,649,455	$1,949,272,118	$2,061,730,125	$8,588,413,110
Direct State Funding	**$132,446,886**	**$195,323,636**	**$222,248,727**	**$234,219,109**	**$247,731,750**	**$1,031,970,109**
Effective FMAP	*89.3%*	*89.3%*	*89.3%*	*89.3%*	*89.3%*	*89.3%*

C. And as shown in Table 2a below (and in Table 2b in Attachment A), the $1.03 billion in total direct State funding required to fund the Medicaid expansion over the SFY 2020-2024 period is anticipated to be fully countered by a series of offsets.

1. Current State-supported spending in other components of the State's budget will be replaced with federal revenues generated by the Medicaid expansion, including:
   - Medicaid program offsets (from converting federal funding from the standard FMAP—of approximately 65%—to 90% FMAP for some current Medicaid-eligible individuals); and
   - Other State program offsets (from replacing 100% State funding with 90% federal funding).
2. Heightened tax revenues will be generated from expanded economic activity in the State.
3. Health services furnished to AI/ANs have the potential to become increasingly subject to 100% FMAP as a result of a combination of:
   - Expanded IHCP capacity to serve AI/ANs; and
   - Increased claiming for services "received through" IHCPs at non-IHCPs.

D. Each of the three offset categories has occurred in other Medicaid expansion states, and the third offset category has already proven to be doable in Oklahoma—even prior to implementation of the Medicaid expansion—as a pilot effort involving a partnership among the State, IHCPs, and non-IHCPs has generated savings to the State.

As indicated by the preliminary estimates in Table 2a below, over the SFY 2020-2024 period, $1.03 billion in direct State funding is required for the Medicaid expansion, but this spending is countered fully by $1.23 billion in estimated offsets, of which a total of $95.2 million in offsets is derived from the additional 100% FMAP claiming for services to IHS-eligible individuals. On an annual basis, the estimates show that $206.4 million in average annual direct State funding for the Medicaid expansion over the SFY 2020-2024 period is countered by a combined $245.7 million in average annual offsets, leaving no annual net State costs.[6] Of the total average annual offsets, $226.6 million is projected to result in increased revenues to the State, as well as savings to

Table 2a: Oklahoma Medicaid Expansion Option -- Summary of State Spending and Offsets: SFYs 2020-2024
(Dollars in millions; "( )" indicates estimated offsets to Oklahoma General Revenue Fund (GRF)) spending

	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	Totals (SFY 2020-SFY 2024)	Average Annual Impact
EXPENDITURES							
Direct State spending	$132.4	$195.3	$222.2	$234.2	$247.7	**$1,032.0**	**$206.4**
OFFSETS TO STATE GRF							
Offsets to State spending (Manatt and OSU reports)	($152.2)	($213.4)	($241.6)	($255.0)	($271.0)	**($1,133.2)**	**($226.6)**
Additional offsets: Indian Health Care Providers	($5.7)	($11.7)	($18.3)	($25.6)	($33.8)	**($95.2)**	**($19.0)**
TOTAL OFFSETS:	**($157.9)**	**($225.1)**	**($259.9)**	**($280.7)**	**($304.8)**	**($1,228.4)**	**($245.7)**
NET ANNUAL COSTS TO STATE GRF:	**($25.5)**	**($29.7)**	**($37.7)**	**($46.5)**	**($57.0)**	**($196.4)**	**($39.3)**

Medicaid and other State programs, and $19.0 million is projected to result from recently realized or projected additional 100% FMAP claiming for Medicaid services provided to certain AI/ANs.[7]

As a result of these combined offsets, adoption of the Medicaid expansion is shown to require zero net direct spending by the State—and possibly to achieve net *savings* to the State—yet return substantial benefits to low-income parents and other adults, to health care providers, to small businesses, and to the overall State economy.

A full accounting of projected Medicaid expansion expenditures and associated offsets for the SFY 2020-2024 period appears in Table 2b in Attachment A. Additional details on the offset estimates and the anticipated benefits of implementing the Medicaid expansion also are discussed below.

Offsets to State Spending: As discussed above, by adopting the Medicaid expansion, Oklahoma could accrue significant offsets to State spending that would fully counter the direct State spending needed to fund the program. A summary of each of these offsets, with the amount of projected savings over the SFY 2020-2024 period shown in parentheses, appears below.

A. Medicaid program offsets (from converting federal funding from the standard FMAP to 90% FMAP for some current Medicaid-eligible individuals), as follows[8]:

- **Coverage of women during pregnancy ($150.9 million)**: Women who become pregnant while enrolled in the Medicaid expansion can stay enrolled in the expansion during their pregnancy (until they undergo an eligibility redetermination), rather than enroll in traditional Medicaid, which has a lower FMAP.
- **Breast and cervical cancer patients ($13.9 million)**: The State can transition individuals previously eligible for the Breast and Cervical Cancer Program (BCCP) to full Medicaid coverage under the Medicaid expansion and claim the enhanced FMAP, rather than the regular FMAP, for health services for this population.
- **Insure Oklahoma enrollees ($97.5 million)**: The State can transition individuals previously eligible for Insure Oklahoma—a section 1115 waiver program that (1) provides premium assistance for employer-sponsored health insurance to individuals who have an income at or less than 200% FPL and work for qualified employers and (2) provides subsidized coverage to individuals who have an income at or less than 100% FPL and do not work for qualified employers—to the Medicaid expansion and claim the enhanced FMAP, rather than the standard FMAP, for health services for this population.
- **Individuals eligible for Medicaid based on disabled status ($88.2 million)**: A number of low-income individuals who previously would have needed to secure a disability determination to qualify for Medicaid are anticipated to opt out of this process because, under the expansion, they can enroll in

Medicaid based on income alone. As a result, to the extent that these individuals enroll in Medicaid under the expansion (rather than through the disabled category), the State can achieve savings by claiming the enhanced FMAP, rather than the standard FMAP, for health services for this population. In addition, the State can achieve savings through reduced administrative costs associated with the disability determination process.

B. Other State program offsets (from replacing 100% State funding with 90% federal funding), as follows[9]:

- **Department of Mental Health and Substance Abuse Services ($176.4 million)**: Many uninsured, low-income adults for whom the State currently fully funds mental health and substance use disorder services could newly enroll in Medicaid under the expansion, allowing the State to claim the enhanced FMAP for these services.
- **Department of Corrections ($27.9 million)**: Most prison inmates could newly enroll in Medicaid under the expansion, under which the federal government would assume most of the cost of their inpatient hospital services (whereas the State otherwise would have covered this cost).
- **Department of Health ($18.6 million)**: Many uninsured, low-income adults for whom the State currently fully funds immunizations and other public health services, including services provided at county health department clinics, could newly enroll in Medicaid under the expansion, allowing the State to claim the enhanced FMAP for these services.

C. Heightened tax revenues generated from expanded economic activity in the State, as follows[10]:

- **Hospital assessment ($59.2 million)**: The amount of funding collected by the State under its current 3% assessment on hospital revenues would increase because of greater utilization of hospital services (and revenues) resulting from more individuals having health insurance coverage under the Medicaid expansion.
- **Taxes on corporations ($16.4 million)**: As a result of increased economic activity generated by the Medicaid expansion, corporations will have higher revenues, resulting in the payment of more in State/local taxes on the dividends and profits.
- **Taxes on households ($148.3 million)**: As a result of billions of dollars in increased economic activity generated by the Medicaid expansion, households will have higher earnings and will pay more in State/local taxes on income and property.
- **Taxes on production/imports ($323.3 million)**: As a result of increased economic activity generated by the Medicaid expansion, the State and localities will collect more revenues from sales tax, property tax, and other sources (*i.e.*, motor vehicle licenses, severance tax, other taxes, and State and local fines/fees).
- **Social insurance taxes ($12.7 million)**: As a result of increased economic activity generated by the Medicaid expansion, employees will have higher compensation, leading to employees and employers having to contribute more in taxes for social insurance programs.

D. Health services furnished to AI/ANs becoming increasingly subject to 100% FMAP, as follows:

- **Increase in non-expansion/expansion services furnished by IHCPs ($42.2 million/$3.6 million)**[11]: Revenues generated by the Medicaid expansion could allow IHCPs to expand their capacity to provide health services to AI/ANs (and others), a development that would result in savings to the State, as Medicaid services furnished by IHCPs to IHS-eligible enrollees qualify for 100% FMAP, rather than the standard FMAP (see Table 3 below).

Table 3: Potential Oklahoma Spending Reductions Through Increased Federal Revenues Resulting from (1) Expanded IHCP Capacity and (2) Increased "Received Through" Claiming
(non-Medicaid expansion health services expenditures,[1] in millions; SFY 2024)

	Current	Estimated	
		(1) With 5 percentage point increase in IHCP capacity (*i.e.*, services provided to AI/ANs by IHCPs)	(& 2) With 5 percentage point increase in "received through" claiming
Share of expenditures receiving 100% FMAP	44.4%	49.4%	54.4%
Projected combined reduction in State spending	--	**($15.1)**	**($30.3)**

- **Current & increase in non-expansion/expansion services "received through" IHCPs ($3.6 million[12] & $42.2 million/$3.6 million[13])**: The opportunity exists to access additional federal revenues by taking advantage of a recent change in federal policy under which services for IHS-eligible enrollees "received through" non-IHCPs under care coordination agreements with IHCPs can qualify for reimbursement at 100% FMAP (see Table 3 above). A pilot initiative in Oklahoma to capture "received through" revenues is reported to have generated savings to the State ($151,878 in the most recent fiscal quarter), demonstrating the potential and ability to capture substantially greater savings to the State.

To achieve the savings potential that can result from 100% FMAP claiming—and make a significant contribution to funding the Medicaid expansion—a renewed and expanded partnership involving the State and IHCPs is required in order to (a) expand IHCP capacity to provide health services to AI/ANs and (b) document "received through" services.

IMPACT OF EXTENDING MEDICAID ELIGIBILITY TO ADDITIONAL PARENTS AND OTHER LOW-WAGE WORKERS

Implementing the Medicaid expansion would have significant positive economic, social, fiscal, and health status benefits, particularly to Oklahoma families, small businesses, and the State economy. See a discussion of these benefits below.

Expanded Access to Coverage:

- The Medicaid expansion would provide an opportunity for low-wage Oklahoma residents to gain timely access to a wide range of needed health services, with about 275,000 newly eligible individuals, including 44,000 AI/ANs, anticipated to enroll in Medicaid by SFY 2024 if the State adopts the expansion.
- The Medicaid expansion would benefit low-wage workers in Oklahoma; to qualify for Medicaid under the expansion, an individual in a single-person household could work full time at $8.29 per hour, a couple—with one full-time worker—could earn as much as $11.22 per hour, and a parent in a 4-person, single-income household who works full time could earn as much as $17.08 per hour.[14]

Support to Small Employers with Low-Wage Workers:

- The Medicaid expansion would relieve health insurance costs for low-wage workers and their employers.
- For example, currently, a parent in a 4-person, single-income household who works full time and earns the State minimum wage ($7.25 per hour) would have to spend 30% of his or her income on the premium for "self-only" coverage and be liable for up to an additional $7,900 in out-of-pocket costs.[15]
- And for small employers, even providing a high-deductible health insurance plan adds a significant cost—more than $2 per hour for a full-time worker—a 30% increase in employee compensation for a minimum-wage worker.

Return on Investment—Economic, Social, and Health Status Factors:

- The Medicaid expansion would have a positive impact on the Oklahoma economy, injecting an average of $1.72 billion per year in new federal revenues, with these funds serving as a multiplier for an even larger increase in annual economic activity in the State.
- The Medicaid expansion would support a projected 17,662 new jobs by SFY 2024, generate an average of $1.03 billion in annual labor income over the SFY 2020-2024 period, and contribute to increased business sales.[16]
- In addition, based on published findings from other states, expanding Medicaid for low-wage workers has the potential to (1) decrease medical debt, prevent bankruptcies, and improve credit terms for borrowers[17]; (2) curb crime in the State[18]; and (3) result in significant improvements in the physical health of residents, including improvements in mortality rates.[19]
- Research from Montana and Ohio also indicates that implementing the Medicaid expansion can make it easier for residents to seek or maintain employment and can contribute to increased labor force participation.[20]

Increasing Access to Critically Needed Health Services:

- Oklahoma, like many states, is experiencing significant challenges from opioid use, leading to a greater need for substance use disorder services, as well as associated inpatient and pharmaceutical services; the benefit package under the Medicaid (health insurance) expansion would enable increased resources to be made available, as necessary, for these and other critically needed services.

Reduction in Uncompensated Care:

- As indicated by experiences in other states, the Medicaid expansion has the potential to provide a significant reduction in uncompensated care costs, which health care providers otherwise must absorb or shift to other payers.
- Decreased uncompensated care costs can lead to improved operating margins for hospitals, strengthening their ability to remain vital providers of critically needed health services and of local employment, as well as lessen the pressure for State and/or local subsidies to maintain operations at these facilities.

For questions about this document, contact Doneg McDonough, Technical Advisor, Tribal Self-Governance Advisory Committee to IHS, at DonegMcD@outlook.com.

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[1] This brief relies primarily on prior projections from two reports— the Manatt Health report titled "Estimated State Budget Impact of an Oklahoma SoonerCare Expansion" and the Oklahoma State University (OSU) report titled "The Economic Impact of the Proposed Oklahoma SoonerCare Expansion, CYs 2017-2026," both dated April 2016—with these projections adjusted to reflect a Medicaid expansion start date of SFY 2020, rather than SFY 2017.

[2] Figure was calculated based on Medicaid expansion administrative expenditure projections included in the Manatt Health report.

[3] Figure was taken from the Manatt Health report.

[4] Figure assumes that AI/ANs will comprise 16% of the Medicaid expansion population, based on current Medicaid enrollment patterns. See the Oklahoma Health Care Authority (OHCA) report titled "American Indian Fast Facts, March 2019" and dated April 17, 2019.

[5] Figures were derived from estimates included in the Manatt Health report (see page 8), with adjustments made to funding for SFYs 2020 and 2021 to reflect a Medicaid expansion start date of SFY 2020, rather than SFY 2017, and with projections made for years beyond SFY 2021 based on assumptions of annual per capita spending growth of 5%.

[6] See Attachment A for footnotes to Table 2. With access to additional source data, it is expected that some estimates of savings will increase and others will decline. In addition, some of the offsets to spending identified will accrue to other levels of government, in addition to the State government.

[7] This estimated savings is predicated on a continued and expanded partnership between the State, IHCPs, and non-IHCPs.

[8] Offset figures in this subsection were derived from the Manatt Health report.

[9] Ibid.

[10] Offset figure for hospital assessment was derived from the Manatt Health report. All other figures in this subsection were derived from the Oklahoma State University (OSU) report titled "The Economic Impact of the Proposed Oklahoma SoonerCare Expansion, CYs 2017-2026" and dated April 2016. Some of the offsets identified in this subsection that are generated from increased revenues will accrue to other levels of government, in addition to the State government.

[11] In estimating the amount of savings, a baseline of 11.7% was assumed for the percentage of total Medicaid expenditures for health services provided to AI/AN enrollees, with services furnished by IHCPs accounting for 44.4% of these expenditures (based on figures for SFY 2015 taken from the Manatt Health report). The percentage of services furnished to AI/AN enrollees by IHCPs then was assumed to increase by 1 percentage point annually over the SFY 2020-2024 period for both the non-expansion and expansion populations. The total amount of Medicaid expenditures for health services for the non-expansion population for the SFY 2020-2024 period was generated by inflating expenditures for SFY 2015 (the most recent data available), using assumptions of annual enrollment growth of 1% and per capita spending growth of 5%.

[12] Offset figures for current non-expansion services "received through" IHCPs were derived from a reported figure of $151,878 for the most recent fiscal quarter. Offset figures for the SFY 2020-2024 period were calculated by inflating the estimated current (SFY 2019) savings ($151,878 times 4 quarters), using assumptions of annual enrollment growth of 1% and per capita spending growth of 5%.

[13] See footnote 11.

[14] Individuals with earnings just above these levels and without an offer of employer-provided health insurance coverage could qualify for federal premium assistance through the Health Insurance Marketplace.

[15] Figures are for a 40-year-old non-smoker who lives in Tulsa and purchases the lowest-cost bronze plan available on the Oklahoma Marketplace in 2019. Figures assume no eligibility for premium tax credits.

[16] Figures were derived from estimates included in the OSU report (see page 5), with adjustments made to reflect higher new revenues associated with the Medicaid expansion as a result of assuming a start date of SFY 2020, rather than SFY 2017.

[17] See pages 5-6 of the National Bureau of Economic Research report titled "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing" and dated April 2016 , pages 39-41 of the Ohio Department of Medicaid report titled "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly" and dated January 2017, and page 19 of the University of Montana Bureau of Business and Economic Research (BBER) report titled "The Economic Impact of Medicaid Expansion in Montana: Updated Findings" and dated January 2019.

[18] See page 19 of the University of Montana Bureau BBER report.

[19] See an *Annals of Thoracic Surgery* article titled "Impact of Medicaid Expansion on Cardiac Surgery Volume and Outcomes" and dated June 2017 and a *New England Journal of Medicine* article titled "Health Insurance Coverage and Health—What the Recent Evidence Tells Us" dated August 10, 2017.

[20] See pages 41-42 of the Ohio Department of Medicaid report and pages 19-21 of the University of Montana BBER report.

Attachment A

Table 2b: Preliminary Estimates of Oklahoma Spending on Medicaid Expansion (with Offsets): SFYs 2020-2024
(Dollars in millions; "( )" indicates estimated offsets to Oklahoma General Revenue Fund (GRF)) spending

	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	Totals (SFY 2020-SFY 2024)	Overall Impact on State Budget
EXPENDITURES[a]							
Health Services Expenditures							
Federal share	$1,085.1	$1,600.0	$1,820.6	$1,918.6	$2,029.3	$8,453.7	--
State share	$122.0	$179.8	$204.6	$215.6	$228.1	$950.0	$950.0
Subtotal	**$1,207.1**	**$1,779.8**	**$2,025.2**	**$2,134.2**	**$2,257.4**	**$9,403.7**	--
Administrative Expenditures							
Federal share	$17.0	$25.6	$29.1	$30.6	$32.4	$134.7	--
State share	$10.5	$15.5	$17.7	$18.6	$19.7	$81.9	$81.9
Subtotal	**$27.5**	**$41.1**	**$46.7**	**$49.3**	**$52.1**	**$216.7**	--
Total Expenditures (health services and administrative)							
Federal share	$1,102.2	$1,625.6	$1,849.6	$1,949.3	$2,061.7	$8,588.4	--
State share	$132.4	$195.3	$222.2	$234.2	$247.7	$1,032.0	$1,032.0
TOTAL	**$1,234.6**	**$1,820.9**	**$2,071.9**	**$2,183.5**	**$2,309.5**	**$9,620.4**	--
OFFSETS TO STATE GRF[b]							
A. Medicaid Program Offsets (increase from standard FMAP to 90% FMAP for health services)							
Coverage of women during pregnancy[c]	($23.0)	($29.1)	($31.5)	($32.5)	($34.7)	($150.9)	--
Breast and cervical cancer patients[d]	($1.2)	($2.3)	($3.5)	($3.5)	($3.5)	($13.9)	--
Insure Oklahoma enrollees[e]	($18.4)	($18.7)	($21.0)	($18.6)	($20.8)	($97.5)	--
Individuals eligible for Medicaid based on disabled status[f]	($5.8)	($11.7)	($17.5)	($23.2)	($30.1)	($88.2)	--
Subtotal	**($48.3)**	**($61.8)**	**($73.5)**	**($77.7)**	**($89.1)**	**($350.4)**	**($350.4)**
B. Other State Program Offsets (90% FMAP for previously 100% State-funded health services)							
Department of Mental Health and Substance Abuse Services[g]	($20.7)	($32.6)	($37.3)	($42.9)	($42.8)	($176.4)	--
Department of Corrections[h]	($4.6)	($5.8)	($5.8)	($5.8)	($5.8)	($27.9)	--
Department of Health[i]	($2.3)	($3.5)	($3.5)	($4.6)	($4.6)	($18.6)	--
Subtotal	**($27.6)**	**($42.0)**	**($46.7)**	**($53.3)**	**($53.3)**	**($222.8)**	**($222.8)**
C. Revenues							
Hospital assessment[j]	($8.1)	($11.7)	($12.8)	($12.8)	($13.9)	($59.2)	--
Taxes on corporations[k]	($2.2)	($3.2)	($3.6)	($3.6)	($3.8)	($16.4)	--
Taxes on households (income/property/other)[l]	($20.2)	($29.0)	($32.2)	($32.9)	($34.0)	($148.3)	--
Taxes on production/imports (sales/property/other)[m]	($44.0)	($63.3)	($70.1)	($71.8)	($74.1)	($323.3)	--
Social insurance taxes[n]	($1.7)	($2.5)	($2.8)	($2.8)	($2.9)	($12.7)	--
Subtotal	**($76.2)**	**($109.6)**	**($121.5)**	**($124.0)**	**($128.6)**	**($559.9)**	**($559.9)**
D. 100% FMAP for Medicaid Services for AI/ANs							
Increase in non-expansion services furnished by IHCPs (1 pct pt/year)[o]	($2.4)	($5.1)	($8.1)	($11.4)	($15.1)	($42.2)	--
Increase in expansion services furnished by IHCPs (1 pct pt/year)[o]	($0.1)	($0.4)	($0.7)	($1.0)	($1.3)	($3.6)	--
Current non-expansion services "received through" IHCPs[p]	($0.6)	($0.7)	($0.7)	($0.8)	($0.8)	($3.6)	--
Increase in non-expansion services "received through" IHCPs (1 pct pt/year)[p]	($2.4)	($5.1)	($8.1)	($11.4)	($15.1)	($42.2)	--
Increase in expansion services "received through" IHCPs (1 pct pt/year)[q]	($0.1)	($0.4)	($0.7)	($1.0)	($1.3)	($3.6)	--
Subtotal	**($5.7)**	**($11.7)**	**($18.3)**	**($25.6)**	**($33.8)**	**($95.2)**	**($95.2)**
Total Offsets	**($157.9)**	**($225.1)**	**($259.9)**	**($280.7)**	**($304.8)**	**($1,228.4)**	**($1,228.4)**
Net Annual Costs to State GRF	**($25.5)**	**($29.7)**	**($37.7)**	**($46.5)**	**($57.0)**	**($196.4)**	**($196.4)**

Notes to Table 2b:

[a] Expenditure figures were derived from estimates included in the Manatt Health report titled "Estimated State Budget Impact of an Oklahoma SoonerCare Expansion" and dated April 2016, with adjustments made to estimated expenditures for SFYs 2020 and 2021 to reflect a Medicaid expansion start date of SFY 2020, rather than SFY 2017, and with estimates made for years beyond SFY 2021 using per capita spending growth of 5%.

[b] Reported offset figures were adjusted to reflect a Medicaid expansion start date of SFY 2020, rather than SFY 2017.

[c] Offset figures for coverage of women during pregnancy were determined based on the premise that women who become pregnant while enrolled in the Medicaid expansion can stay enrolled in the expansion during their pregnancy (until they undergo an eligibility redetermination), rather than enroll in traditional Medicaid, which has a lower FMAP. Figures were derived from the Manatt Health report.

[d] Offset figures for breast and cervical cancer patients were determined based on the premise that the state can transition individuals previously eligible for the Breast and Cervical Cancer Program (BCCP) to full Medicaid coverage under the Medicaid expansion and claim the enhanced FMAP, rather than the regular FMAP, for health services for this population. Figures were derived from the Manatt Health report.

[e] Offset figures for Insure Oklahoma enrollees were determined based on the premise that the state can transition individuals previously eligible for Insure Oklahoma—a section 1115 waiver program that 1) provides premium assistance for employer-sponsored health insurance to individuals who have an income at or less than 200% of the federal poverty level (FPL) and work for qualified employers and 2) provides subsidized coverage to individuals who have an income at or less than 100% FPL and do not work for qualified employers—to the Medicaid expansion and claim the enhanced FMAP, rather than the standard FMAP, for health services for this population. Figures were derived from the Manatt Health report.

[f] Offset figures for individuals eligible for Medicaid based on disabled status were determined based on the premise that a number of low-income individuals who previously would have needed to secure a disability determination to qualify for Medicaid are anticipated to opt out of this process because, under the expansion, they can enroll in Medicaid based on income alone. As a result, the state can achieve savings through reduced administrative costs associated with the disability determination process. In addition, to the extent that these individuals enroll in Medicaid under the expansion (rather than through the disabled category), the state can achieve savings by claiming the enhanced FMAP, rather than the standard FMAP, for health services for this population. Figures were derived from the Manatt Health report.

[g] Offset figures for Department of Mental Health and Substance Abuse Services were determined based on the premise that many uninsured, low-income adults for whom the state currently fully funds mental health and substance use disorder (SUD) services could newly enroll in Medicaid under the expansion, allowing the state to claim the enhanced FMAP for these services. Figures were derived from the Manatt Health report.

[h] Offset figures for Department of Corrections were determined based on the premise that most prison inmates could newly enroll in Medicaid under the expansion, under which the federal government would assume most of the cost of their inpatient hospital services (whereas the state otherwise would have covered this cost). Figures were derived from the Manatt Health report.

[i] Offset figures for Department of Health were determined based on the premise that many uninsured, low-income adults for whom the state currently fully funds immunizations and other public health services, including services provided at county health department clinics, could newly enroll in Medicaid under the expansion, allowing the state to claim the enhanced FMAP for these services. Figures were derived from the Manatt Health report.

[j] Offset figures for hospital assessment were determined based on the premise that the amount of funding collected by the state under its current 3% assessment on hospital revenues would increase because of greater utilization of hospital services (and revenues) resulting from more individuals having health insurance coverage under the Medicaid expansion. Figures were derived from the Manatt Health report.

Notes to Table 2b (cont.):

[k] Offset figures for taxes on corporations were determined based on the premise that, as a result of increased economic activity generated by the Medicaid expansion, corporations will have higher revenues and have to pay more in state/local taxes on dividends and profits. Figures were derived from the Oklahoma State University (OSU) report titled "The Economic Impact of the Proposed Oklahoma SoonerCare Expansion, CYs 2017-2026" and dated April 2016.

[l] Offset figures for taxes on households were determined based on the premise that, as a result of increased economic activity generated by the Medicaid expansion, households will have higher earnings and have to pay more in state/local taxes on income and property. Figures were derived from the OSU report.

[m] Offset figures for taxes on production/imports were determined based on the premise that, as a result of increased economic activity generated by the Medicaid expansion, the state and localities will collect more revenues from sales tax, property tax, and other sources (i.e., motor vehicle licenses, severance tax, other taxes, and state and local fines/fees). Figures were derived from the OSU report.

[n] Offset figures for social insurance taxes were determined based on the premise that, as a result of increased economic activity generated by the Medicaid expansion, employees will have higher compensation, leading to employees and employers having to contribute more in taxes for social insurance programs. Figures were derived from the OSU report.

[o] Offset figures for increase in services furnished by IHCPs were determined based on the premise that revenues generated by the Medicaid expansion could allow IHCPs to expand their capacity to provide health services to AI/ANs (and others), a development that would result in savings to the state, as Medicaid services furnished by IHCPs to AI/AN enrollees qualify for 100% FMAP, rather than the standard FMAP. In estimating the amount of savings, a baseline of 11.7% was assumed for the percentage of total Medicaid expenditures for health services provided to AI/AN enrollees, with services furnished by IHCPs accounting for 44.4% of these expenditures (based on figures for SFY 2015 taken from the Manatt Health report). The percentage of services furnished to AI/AN enrollees by IHCPs then was assumed to increase by 1 percentage point annually over the SFY 2020-2024 period for both the non-expansion and expansion populations. The amount total Medicaid expenditures for health services for the non-expansion population for the SFY 2020-2024 period was generated by inflating expenditures for SFY 2015 (the most recent data available), using assumptions of annual enrollment growth of 1% and per capita spending growth of 5%.

[p] Offset figures for current non-expansion services "received through" IHCPs were derived from a figure of $151,878 for the most recent fiscal quarter provided by a representative of the Chickasaw Nation. Offset figures for the SFY 2020-2024 period were calculated by inflating the estimated current (SFY 2019) savings ($151,878 times 4 quarters), using assumptions of annual enrollment growth of 1% and per capita spending growth of 5%.

[q] Offset figures for increase in non-expansion services "received through" IHCPs were determined based on the premise that the state can achieve savings through a recent change in federal policy under which services for AI/AN Medicaid enrollees "received through" non-IHCPs under care coordination agreements with IHCPs can qualify for 100% FMAP, rather than the standard FMAP. In estimating the amount of savings, a baseline of 11.7% was assumed for the percentage of total Medicaid expenditures for health services provided to AI/AN enrollees, with services furnished by IHCPs accounting for 44.4% of these expenditures (based on figures for SFY 2015 taken from the Manatt Health report). The percentage of services furnished to AI/AN enrollees by IHCPs then was assumed to increase by 1 percentage point annually over the SFY 2020-2024 period for both the non-expansion and expansion populations. The amount total Medicaid expenditures for health services for the non-expansion population for the SFY 2020-2024 period was generated by inflating expenditures for SFY 2015 (the most recent data available), using assumptions of annual enrollment growth of 1% and per capita spending growth of 5%.