THE ECONOMIC AND FISCAL IMPACT OF MEDICAID EXPANSION IN PENNSYLVANIA

Pennsylvania Economy League, Inc.
Econsult Solutions, Inc.

Commissioned by the PA Health Funders Collaborative
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CONTENTS

TABLE OF FIGURES

BACKGROUND

Pennsylvania lawmakers face an important decision – whether or not to expand Medicaid to hundreds of thousands of low-to moderate-income Pennsylvanians. The expansion would bring:

- new federal funding to subsidize the expanded coverage;
- new state costs for that coverage (particularly as the federal subsidies decline to 90% over time);
- state savings for current state programs whose recipients would now be eligible for Medicaid; and
- economic and tax revenue impacts resulting from new federal funds being spent throughout the Pennsylvania economy.

This report is intended to provide Pennsylvania lawmakers with the information they need to decide whether to accept federal support of an expanded Medicaid program. As such, the report details: projected changes in coverage for the over five hundred thousand low- and moderate-income Pennsylvanians who would qualify for federal Medicaid coverage under expanded Medicaid; budgetary impacts, taking into account both new state savings and new costs; and the impact on the state budget, considering savings, costs and potential new revenues.

Given that the extensive costs associated with the ACA will occur regardless of whether Pennsylvania chooses to expand Medicaid coverage, this report does *not* attempt to analyze the total impact of the Affordable Care Act in the Commonwealth. Instead, this analysis focuses only the *incremental* economic and fiscal changes that would result from the decision to expand Medicaid. To avoid misstating any of the impacts, this research approach is conservative and only includes effects that are clearly identifiable and defensible as being caused by Medicaid expansion.

ABOUT THE REPORT PARTNERS

The Economic and Fiscal Impact of Medicaid Expansion in Pennsylvania was commissioned by the PA Health Funders Collaborative (PHFC). PHFC is an association of health foundations that work with their communities to promote better health care outcomes and healthy lifestyles. PHFC's goal in commissioning the analysis was to provide information to inform pending decisions by the Commonwealth on whether to accept the expanded Medicaid funding being offered under the Affordable Care Act. For more about PHFC, see Appendix D.

PHFC's research partner, the Pennsylvania Economy League, Inc. (PEL), has been a force for positive change since 1936. It is the leading, regionally based, statewide public policy organization providing independent research and insight on emerging issues with the goal of stimulating public and private action to make Pennsylvania a better place to live, work, and do business. The economic modeling and analysis was conducted by the Pennsylvania Economy League of Greater Pittsburgh, an affiliate of the Allegheny Conference on Community Development.

For more about the 3 regional offices of the Pennsylvania Economy League, visit www.economyleague.org; www.pelcentral.org; and http://www.alleghenyconference.org/PennsylvaniaEconomyLeague/.

PEL engaged Econsult Solutions, Inc. (ESI), a private economic consulting firm, as its economic research partner. ESI provides businesses and public policy makers with economic consulting services in urban economics, real estate economics, transportation, public infrastructure, development, public policy and finance, community and neighborhood development, planning, as well as expert witness services for litigation support. ESI's team was responsible for leading the economic impact and fiscal analysis research and calculations. For more about Econsult Solutions, visit http://www.econsultsolutions.com/.

ESTIMATING NEW COVERAGE, NEW SPENDING, AND SAVINGS

To begin the analysis, PEL and ESI needed to identify the number of Pennsylvanians who would become Medicaid recipients under the expansion, including both insured and uninsured individuals. The team used data from the Kaiser Family Foundation's (Kaiser) *Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*[1]*,* as this report has been used by numerous analysts of Medicaid expansion and serves as the best regarded non-partisan source of information on the new law.

The Kaiser estimates take three key factors into account:

1.) *The federal reimbursement rate*. The Affordable Care Act provides that the federal government will pay 100 percent of the costs of those made newly eligible for the program for 2014 through 2016. The federal match rate decreases to 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019. The 90 percent federal match rate for new eligibles in 2020 is carried forward into subsequent years.

2.) *The take-up rate for the expanded Medicaid coverage.* Kaiser estimates that, on a national level, "11.4 percent of those who receive employer-sponsored coverage[2], 85.0 percent of those with non-group coverage, and 74.0 percent of those who are uninsured will enroll. Overall, the take-up rate among new eligibles is 60.5 percent."[3]

3.) *Administrative costs.* While the bulk of state administrative cost increases will occur because of the ACA (regardless of the decision to expand Medicaid), per-person enrollment costs due to expansion are also expected to change due to the remodeling of Medicaid administrative and IT systems. Additionally, the impact on administrative burden due to the reduction of other State-funded programs is likely to have a sizeable positive effect. At present, there is no clear consensus on what this will mean for the overall magnitude and allocation of administrative costs associated with Medicaid and other healthcare services. As such, our analysis focuses primarily on non-administrative costs, and does not attempt to consider either the administrative benefits or costs mentioned above.

Using the estimates, the research team also calculated three inputs necessary to conduct the economic impact modeling[4]:

[1] http://www.kff.org/medicaid/upload/8384.pdf

[2] Under Pennsylvania's HIPP program, those with employer-based coverage who are eligible for Medicaid can continue to keep their employer-based coverage with Medicaid helping to pay some of the employee premiums and providing wrap around coverage.

[3] Kaiser notes that "this is about 10 percentage points below the projected participation rate among current eligibles. This is because new eligibles are more likely to be male, are less likely to be children, and are more likely to be white – all factors that are associated with lower participation rates. They are also far more likely to be located in the South, states with lower participation rates in general."

[4] The Kaiser analysis uses the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to "simulate the decisions of businesses and individuals in response to policy changes such as Medicaid expansion but also new health insurance options, subsidies for the purchase of health insurance and insurance market reforms." In calculating enrollment and Medicaid participation, the Kaiser Family Foundation incorporates estimates for woodwork effects throughout its model of Medicaid expansion. We adopt their assumptions regarding woodwork and enrollment incentive throughout our report.

1. *New state savings*, resulting from reductions in state-only spending on programs that provide health care services to people who will now be covered by Medicaid;
2. *New household savings,* resulting from individuals who were previously covered by private insurance opting into Medicaid; and
3. *New spending* on healthcare for uninsured residents who meet the expanded eligibility requirements.

With these data in hand, the research team used IMPLAN, an industry standard economic modeling software, to calculate the increase in jobs, economic activity, GDP, earnings and resulting state taxes.

With this analysis, the team produced an estimate of the impact on the state budget due to program savings, program costs and new tax revenues.

All of the analyses focus on three time periods:

1. 2016, the last year of 100% federal funding and the expected full enrollment date;
2. 2022, a date at which the federal funding match is expected to be at its final, and lowest, level (90%); and
3. 2013 to 2022, a cumulative ten-year time period.

Expanded Coverage

Kaiser estimates that about 542,000 additional Pennsylvanians will receive Medicaid coverage under the Medicaid expansion.

- 229,000 would already have some form of insurance that will be replaced or supplemented by Medicaid, whether that is from an employer, purchased themselves or with their family, or through a state government program.
- 313,000 uninsured Pennsylvanians, or about 25% of the current total, would receive Medicaid coverage as a result of the Medicaid expansion.

Table 1: Distribution of Medicaid Expansion Enrollment by Insured Status

Program/Enrollment Category	Insured	Uninsured	Total
Pre-ACA Pennsylvania	9,146,000	1,254,000	10,400,000
New Enrollees, by Previous Insurance Status	229,000	313,000	542,000

Source: US Census Small Area Health Insurance Estimates (Pre-ACA Pennsylvania), Kaiser Family Foundation (New Enrollees)

New Spending on Expanded Medicaid

Based on these assumptions and models, Kaiser estimates that Pennsylvania would receive almost $38 billion in federal funds to fund expanded Medicaid, with the state being required to contribute another $2.8 billion (7.3%), for a total of over $40 billion in government spending on expanded Medicaid between 2013 and 2022. On an annual basis, Kaiser estimates $3.8 billion in federal funding in 2016 and

$5.5 billion in 2022 would be required to fund the expanded coverage; the state would be required to spend $29 million in 2016, growing to $645 million by 2022.

Table 2: Federal and State Spending on Medicaid Expansion in Pennsylvania (in millions)

Spending Category	2016	2022	2013-2022
Total Federal Spending on Expansion	$3,845	$5,505	$37,842
Total State Spending on Expansion	$29	$645	$2,842
Total Government Spending on Expansion	**$3,874**	**$6,150**	**$40,684**

Source: Kaiser Family Foundation

STATE HEALTH CARE SAVINGS

As a result of the expanded coverage of both previously uninsured individuals and individuals who were either covered under a state program or by private employers, there will be reductions in state spending. To estimate these budgetary savings, the research team analyzed existing state-funded (either partially or wholly) programs to determine the cost savings that should result from Medicaid expansion. While identifying such programs, and quantifying the extent to which they will be reduced, is an involved and imprecise task, the research team assessed the state's Medicaid-expansion projections and interviewed experts, professionals, and local authorities to produce the projections below.

- **General Assistance** is a state-funded "Medicaid look-alike" program, which provides a basic level of coverage to enrollees, below what would be provided to the Medicaid expansion group. As such, almost all of its 70,000 participants are projected to participate in Medicaid expansion at the 100% federal match.
- In contrast, a variety of specialized programs that serve highly targeted populations (e.g., **Medically Needy, SelectPlan for Women, Mental/Behavioral Health and Drug/Alcohol Abuse,** and) will likely be only "moderately reduced" under Medicaid expansion, even though some participants would be eligible for a 100% federal match. Many services provided by these programs are outside the scope of Medicaid coverage, and so Medicaid will not always be an adequate substitute for many people in these programs. However, particularly in the case of Mental/Behavioral Health and Drug/Alcohol Abuse programs, the participants who use the less intensive or specific services in these programs will likely be better served by the scope and scale of Medicaid, which does offer some services comparable to those in the programs mentioned above. Because of the specialized nature of services provided by these programs, we assume a sizeable portion of participants will either chose not to move to Medicaid or be unable to due to income or other categorical restrictions.[5]

[5] To estimate potential savings from these programs, the research team first applied a reduction in proportion to the total estimated decrease in uninsured persons due to Medicaid expansion (25%) to the total budget value for each program. This highly conservative approach only captures 20% of the initial calculated savings for this program; the reduction reported here represents only 5% of the total budget for the Mental/Behavioral Health project budget.

- Under expansion, **state prisoners** who meet Medicaid's income requirements will qualify for Medicaid coverage when receiving inpatient hospital services that takes them out of the prison for more than 24 hours. Due to the low income levels of prisoners, We assume that a large majority of prisoners will qualify after the expansion in addition to those already covered through Act 22.
- **Disproportionate Share Hospital Payments** (DSH), federal funds dedicated to easing the burden of uncompensated care costs on hospitals, will be reduced as a result of the ACA—regardless of the Commonwealth's decision to expand Medicaid. However, choosing to expand would result in a reduction in the number of uninsured individuals in the state, lessening the burden of uncompensated care on hospitals and reducing the portion of uncompensated care that the state decides to cover.

Based on these program changes, the following table shows the expected fiscal savings in reduced state health care costs. The Commonwealth can expect to save a total of $413 million in 2016; $595 million in 2022; and more than $4.4 billion over the ten-year period between 2013 and 2022. (For a complete description these programs and the methodology used for determining savings, please see Appendix A.)

Table 3: State Healthcare Savings (in millions)

Savings Category	2016	2022	2013-2022
Reduction in General Assistance Spending	$277.5	$401.8	$2,973.5
Reduction in Medically Needy State Spending	$36.2	$52.4	$387.8
Reduction in SelectPlan for Women State Spending	$0.3	$0.3	$2.6
Reduction in Mental/Behavioral Health Spending	$42.5	$61.5	$454.8
Reduction in Drug/Alcohol Abuse State Spending	$2.2	$2.7	$22.4
Reduction in Prison/Incarcerated State Spending	$5.2	$6.2	$52.5
Reductions in State Uncompensated Care	$48.6	$70.3	$520.4
Total State Healthcare Savings	**$412.5**	**$595.2**	**$4,414.0**

Source: Pennsylvania Health Law Project, Pennsylvania Department of Public Welfare, Pennsylvania Department of Corrections, Econsult Solutions

After factoring in the estimated costs of expanded Medicaid to the state as well as the reductions in state-funded health care spending, the research team expect the state's healthcare spending will be reduced by almost $400 million in 2016; by more than $200 million in 2022 as the federal match declines; and by $2.7 billion over the ten-year period between 2013 to 2022.

Table 4: Net New State Healthcare Spending (Savings) on Expansion (in millions)

Spending Category	2016	2022	2013-2022
New State Spending on Previously Uninsured	$17	$372	$1,641
State Healthcare Savings	($413)	($595)	($4,414)
Net New State Healthcare Spending (Savings) on Expansion	**($396)**	**($223)**	**($2,773)**

Source: Kaiser Family Foundation, Pennsylvania Health Law Project, Pennsylvania Department of Public Welfare, Pennsylvania Department of Corrections, Econsult Solutions

State Fiscal Savings

We then calculated the total state fiscal savings by combining the total state spending on Medicaid expansion with the expected state health care savings. In 2016, Pennsylvania would realize a net savings of about $384 million. By 2022, after the federal subsidy is reduced to 90%, the changes would result in a net increase in state spending of $50 million.

Table 5: State Fiscal Savings due to Medicaid Expansion (in millions)

Spending Category	2016	2022	2013-2022
Total State Spending on Expansion	($29)	($645)	($2,842)
State Healthcare Savings	$413	$595	$4,414
State Fiscal Savings (Costs)	**$384**	**($50)**	**$1,572**

Source: Kaiser Family Foundation, Pennsylvania Health Law Project, Pennsylvania Department of Public Welfare, Pennsylvania Department of Corrections, Econsult Solutions

New Spending in the PA Economy

Using the estimates of the insurance distribution of Medicaid expansion and the total spending required to provide coverage, the research team then used the number of newly covered uninsured as a share of the newly covered individuals (which includes the uninsured and those who were insured prior to being covered by Medicaid) to estimate two types of spending for both the federal and state governments: net new healthcare spending and net new spending on previously insured individuals. Without Medicaid expansion, the federal government would still provide healthcare spending to certain individuals through Exchange subsidies. Some individuals that would receive an Exchange subsidy will instead receive Medicaid coverage with Medicaid expansion. This portion of spending is not considered new, and so spending on previously insured individuals is reduced by the estimated value of these subsidies.

Table 6: New Federal and State Spending on Medicaid Expansion (in millions)

Spending Category	2016	2022	2013-2022
Net New Federal Healthcare Spending for Previously Uninsured	$2,220	$3,179	$21,853
Federal Spending on Expansion for Previously Insured	$1,625	$2,326	$15,989
Less Federal Exchange Subsidy Covered by Medicaid Expansion	($549)	($785)	($5,406)
Total New Federal Spending on Expansion	**$3,296**	**$4,719**	**$32,436**
Net New State Healthcare Spending for Previously Uninsured	$17	$372	$1,641
State Spending on Expansion for Previously Insured	$12	$273	$1,201
Total New State Spending on Expansion	**$29**	**$645**	**$2,842**

Source: Kaiser Family Foundation, Econsult Solutions

New Household Spending

We then used those figures to calculate the change in household spending as a result of replacing previously obtained insurance with Medicaid due to expansion. To arrive at this impact, we used the National Health Expenditure Projections estimates for out-of-pocket healthcare spending to project the

amount of spending by uninsured persons displaced by Medicaid expansion. It is assumed that the savings by households on healthcare expenses or insurance premiums, and the spending by the state on healthcare programs, will relocate to another aspect of the economy.

Table 7: New Household Spending due to Medicaid Expansion (in millions)

Spending Category	2016	2022	2013-2022
Savings for Previously Insured [a]	$1,088	$1,812	$11,783
Out-of-Pocket Health Care Savings[b]	$51	$72	573
Net New Household Spending	**$1,139**	**$1,884**	**$12,357**

Source: Kaiser Family Foundation, Pennsylvania Health Law Project, Pennsylvania Department of Public Welfare, Econsult Solutions

[a] This figure is drawn from the state ($12 million in 2016) and federal ($1,625 million in 2016) spending on expansion for the previously insured, less the federal Exchange subsidies ($549 million in 2016) Pennsylvania would have received without Medicaid expansion, in Table 6.

[b] This figure represents money flowing to Pennsylvania residents who had been purchasing private insurance, but would be eligible for Medicaid under expansion.

Net New Healthcare Spending

To arrive at an estimate of the net total new healthcare spending in Pennsylvania as a result of expansion, the research team subtracted the *new state savings (*resulting from reductions in spending on programs that provide health care services to people who will now be covered by Medicaid) and the *new household savings* (resulting from individuals who were previously covered by private insurance opting into Medicaid) from the *new federal spending* (on healthcare for uninsured residents who meet the expanded requirements).

Table 8: New Healthcare Spending due to Expansion (in millions)

Spending Category	2016	2022	2013-2022
New Federal Healthcare Spending	$2,220	$3,179	$21,853
New State Healthcare Savings	($396)	($223)	($2,773)
Out-of-Pocket Health Care Savings	($51)	($72)	($573)
New Healthcare Spending on Expansion	**$1,773**	**$2,885**	**$18,507**

Source: Kaiser Family Foundation, Pennsylvania Health Law Project, Pennsylvania Department of Public Welfare, Pennsylvania Department of Corrections, Econsult Solutions

Total New Spending

Combining the three categories of spending –new healthcare spending, new household spending, and net state fiscal savings (or costs) – the research team estimates that expansion will result in $1.8 billion in new spending in 2016; $2.9 billion in new spending in 2022; and $18.5 billion in total new spending over the ten-year period between 2013 to 2022.

Table 9: Total New Spending due to Expansion (in millions)

Spending Category	2016	2022	2013-2022
State Fiscal Savings (costs)	$384	($50)	$1,572
New Household Spending	$1,139	$1,884	$12,357
New Healthcare Spending	$1,773	$2,885	$18,507
Total New Spending	**$3,296**	**$4,719**	**$32,436**

Source: Kaiser Family Foundation, Pennsylvania Health Law Project, Pennsylvania Department of Public Welfare, Pennsylvania Department of Corrections, Econsult Solutions

We note that the ACA Medicaid expansion funding mechanism does not depend on whether a state participates in Medicaid expansion, so the residents of Pennsylvania will be paying their federal taxes to support the ACA's planned Medicaid expansion and the amount of federal taxes will not change based on Pennsylvania's expansion decision. Thus Pennsylvanians will be paying for Medicaid expansion whether or not they enjoy the benefits of it.

ECONOMIC AND FISCAL IMPACT

We used the new spending estimates to calculate the economic and fiscal impacts resulting from Medicaid expansion. The analysis considers three primary impact categories:

- Economic impacts due to increased spending within the state (including increased business activity, increased personal wealth, and increased employment);
- Increases in state tax revenue generated by new economic activity; and
- Budgetary spending and savings resulting from the incremental increase in coverage through Medicaid expansion.

Each of the impacts is considered over the ten-year period between 2013 to 2022. Tax and budgetary impacts are calculated at the state level; only state-level taxes are quantified in the analysis, and only state funds are considered for budgetary spending or savings.

Identifying the coverage and spending implications of Medicaid expansion provides the foundation for all three of the impact categories mentioned above. The change in the number of individuals who are Medicaid insured, privately insured, and uninsured, as well as the federal and state spending supporting those changes, defines the shape and size of the economic impact, the scope of budgetary changes available or required, and the change in tax revenues resulting from the economic impacts. It is worth noting, however, that any spending on previously insured individuals (covered either by private insurance or state programs) is not considered a new healthcare impact, as the healthcare spending is already occurring.

To fully understand the economic impact of Medicaid expansion, it is critical to recognize that the spending from households on healthcare expenses or insurance premiums and the spending from the state on healthcare programs will be freed up to be spent elsewhere in the economy. We accounted for this in their analysis in the following ways:

- Household savings from out-of-pocket healthcare expenditures and insurance premiums[6] were treated as household savings and spent on other goods, and
- State fiscal savings generated by reducing state-funded programs were reallocated into general government services/expenditures.

ECONOMIC IMPACT ANALYSIS

Impacts from spending in healthcare industries, government services, and increased household savings were modeled using IMPLAN. The resulting impacts constitute the full economic impact, which is expressed in terms of new employment, economic activity, GDP and earnings. (For full economic impact methodology, please see Appendix B).

[6] We used the National Health Expenditure Projections estimates for out-of-pocket healthcare spending to calculate the amount of spending by uninsured persons that would be displaced by Medicaid expansion.

Table 10: Statewide Spending due to Medicaid Expansion, by IMPLAN Sector (in millions)

IMPLAN Sector	2016	2022	2013-2022
Hospitals	$656	$1,067	$6,843
Offices of Physicians, Dentists, and other Health Practitioners	$508	$827	$5,304
Home Health Care Services	$39	$63	$403
Pharmaceutical Preparation Manufacturing	$255	$415	$2,664
Medicinal and Botanical Manufacturing	$23	$37	$237
Nursing and Residential Care Facilities	$161	$261	$1,675
Medical and Diagnostic Labs/Outpatient and Other Ambulatory Care	$132	$215	$1,380
Total Healthcare	$1,773	$2,885	$18,507
State Government Savings	**$384**	**($50)**	**$1,572**
Household Spending	$1,139	$1,884	$12,357
Total Spending	**$3,296**	**$4,719**	**$32,436**

Source: IMPLAN, Centers for Medicare and Medicaid Services, Kaiser Family Foundation, Econsult Solutions

[a] Growth rates for future medical expenses were projected using the National Health Expenditures Projections from Centers for Medicare and Medicaid Services. Where more conservative growth rates are merited, a 3% inflation rate was used.

The infusion of billions of dollars in new spending into the Commonwealth will have significant economic impacts. Our analysis shows that in 2016, the $3.3 billion in new spending will support:

- Over 34,000 jobs;
- $5.3 billion in economic activity;
- $3 billion in GDP; and
- $1.8 billion in employee earnings.

In 2022, the $4.7 billion in spending will support:

- Almost 43,000 jobs;
- $7.3 billion in economic activity;
- $4.4 billion in GDP; and
- $2.6 billion in employee earnings

Regional Economic Impact

In the interest of making economic impacts more relevant and relatable, Medicaid spending and the resulting economic impacts were also analyzed using county-defined HealthChoices coverage regions. Using county-level insurance coverage and income data from the Census Bureau's Small Area Health Insurance Estimates, spending was distributed by each region's share of total uninsured persons below 138% of the federal poverty level.

While this analysis does not calculate local tax impacts due to the vast array of taxing jurisdictions and rates, you can assume that new earnings will result in new local wage, sales and property tax revenues for local governments (depending on their tax mix).

Table 11: Total Economic Impact by Type and Region, 2016 Nominal Values ($ in millions)

Region	Jobs	Economic Activity	GDP	Employee Wages	Avg. Wage	Total Labor Earnings
Lehigh Central	8,080	$1,164	$649	$397	$49,090	$440
New East Region	4,932	$677	$360	$214	$43,408	$243
New West Region	2,077	$263	$140	$88	$42,269	$98
Southeast Region	10,368	$1,749	$1,029	$621	$59,936	$725
Southwest Region	7,535	$1,115	$628	$382	$50,637	$429
Statewide	**34,727**	**$**5,343	**$**3,024	**$1,822**	**$52,461**	**$ 2,070**

Source: IMPLAN, Centers for Medicare and Medicaid Services, Kaiser Family Foundation, Econsult Solutions

Table 12: Total Economic Impact by Type and Region, 2022 Nominal Values ($ in millions)

Region	Jobs	Economic Activity	GDP	Employee Wages	Avg. Wage	Total Labor Earnings
Lehigh Central	10,005	$1,587	$946	$566	$56,543	$630
New East Region	6,069	$918	$527	$306	$50,347	$348
New West Region	2,576	$352	$205	$125	$48,711	$140
Southeast Region	12,763	$2,388	$1,482	$874	$68,465	$1,027
Southwest Region	9,257	$1,508	$900	$537	$58,055	$604
Statewide	**42,780**	**$7,282**	**$4,366**	**$2,579**	**$60,277**	**$2,940**

Source: IMPLAN, Centers for Medicare and Medicaid Services, Kaiser Family Foundation, Econsult Solutions

Tax Revenue Analysis

The economic impacts provide the basis for the tax revenue aspect of the estimated fiscal impacts. The state would collect $292 million in new tax revenues in 2016, almost $420 million in 2022, and a total of $3.6 billion between 2013 and 2022. We estimate the tax revenues using the following methodologies:

- The effective sales and corporate income tax rates are generated by estimating the ratio of the total revenues for these taxes to Pennsylvania's GDP. This can then be applied to the total new value-added from the IMPLAN model.
- To estimate effective income tax rate, the ratio of Pennsylvania income tax revenues to total PA earnings is estimated. This is then applied to the new labor income from the IMPLAN model.
- We estimate the revenues from the gross receipts tax on Medicaid MCO health insurance by taking the 5.9% tax rate times the total amount of federal dollars spent on the previously uninsured.

Table 13: State Tax Revenue Impact (in millions)

	2016	2022
New Income Tax Revenue	$62.8	$89.2
New Insurance Gross Receipts Tax Revenue[7]	$131.0	$187.6
New Corporate Income Tax Revenue	$10.3	$14.9
New Sales Tax Revenue	$87.7	$126.6
Total Tax Revenue Impact	**$291.8**	**$418.3**

Source: IMPLAN, Centers for Medicare and Medicaid Services, Kaiser Family Foundation, Econsult Solutions

Fiscal Impact Analysis

In an era of tight budgets, the net fiscal impact of Medicaid expansion is an important consideration. Under the assumption that the federal government will fulfill all the promises of matching funds as detailed in the Affordable Care Act[8], the expansion will allow the state to realize some savings from existing programs and new tax revenues from economic activity as a result of the new federal spending. It will also require the state to spend more, particularly as the matching funds from the federal government begin to decline from 100% in 2016 to 90% by 2020.

To analyze the fiscal impact, We compared the expected total state healthcare savings (see **Table 3**), total tax revenue impact (see **Table 13**), and total state spending (see **Table 2**) for two years – 2016 and 2022 – and across the ten-year period between 2013 and 2022.

[7] There is some concern that a gross receipts tax will be disallowed by the federal government. As this federal decision is not finalized, we have included Gross Receipts Tax revenue to represent the potential impact from this tax. Our results should be considered with this potential disallowance in mind, although even without this revenue source the net fiscal impact for the State is positive.

[8] Pennsylvania can terminate the Medicaid expansion at any time and for any reason, including should the federal government reduce its contribution.

In 2016, with 100% funding, the fiscal impact is very positive, with a net budgetary impact of $675 million. Interestingly, even without the impact of new spending, the 2016 picture would be positive. By 2022, as the federal subsidy declines, the net fiscal impact is positive only because of the tax revenues that would be collected as a result of new spending for the program, with a net fiscal impact of $369 million. Over the ten-year period, it is expected that the cumulative fiscal impact would exceed $5 billion, with nearly $8 billion in combined savings and new revenues offsetting $2.8 billion in new state spending.

Table 14: State Net Fiscal Impact (in millions)

	2016	2022	2013-2022
Total State Healthcare Savings	$412.5	$595.2	$4,414.0
Total Tax Revenue Impact	$291.8	$418.3	$3,550.4
Total State Spending[9]	($29.0)	($645.0)	($2,842.0)
Net Fiscal Impact	**$675.3**	**$368.5**	**$5,122.4**

Source: IMPLAN, Centers for Medicare and Medicaid Services, Kaiser Family Foundation, Econsult Solutions

[9] There are many potential costs to the State that could arise depending on policy decisions and other changes to the healthcare landscape. For example, it is possible that the State may decide to incur the cost of paying higher premiums to doctors serving Medicaid populations in later years. This is a cost that will initially be carried by the federal government. If they stop funding this effort, it may be in Pennsylvania's best interest to continue funding for this effort. As this, and other similar issues, are speculative issues, dependent primarily on the State's policy decisions, we make no attempt to model them.

APPENDIX A: METHODOLOGY FOR STATE SAVINGS ESTIMATES

To estimate State budgetary savings, we undertook intensive analysis of various State-funded (either partially or wholly) programs to determine which programs would likely be reduced or absolved as a result of Medicaid expansion. Identifying such programs, and quantifying the extent to which they will be reduced, is an involved and imprecise task. By assessing the State's projections on the topic of Medicaid expansion, in addition to our conversations with various experts, professionals, and local authorities in the topic of healthcare and Medicaid, we were able to identify programs that could be partially or wholly covered by Medicaid expansion, as listed below:

- The **General Assistance** program was projected to be almost completely absolved. This program is a state-funded "Medicaid look-alike" which provides a basic level of coverage to enrollees, below what would be provided in the Medicaid expansion group. Enrollees for this program must not be eligible for any Medicaid program, and have incomes below 50% FPL. As such, almost all participants are projected to be eligible for Medicaid expansion at the 100% FMAP. The Pennsylvania Health Law Project estimates a potential General Assistance savings of $230 million in 2013. This value is estimated by annualizing per-member-per-month costs for a General Assistance enrollee (as reported by HealthChoices) and multiplying by the number of enrollees assumed to move to the Medicaid expansion group. Some of these funds come from the State's use of Disproportional Share Hospital (DSH) Payments to "federalize" the General Assistance program. However, these funds are allocated to states though an assessment of the total amount of uncompensated care (services administered by hospitals to patients with no insurance and who do not reimburse the hospitals for those services) in the state, and the extent to which the state adequately and effectively administers the payments to the hospitals that need them most. If the State reduces its General Assistance program it will still receive the DSH funds that would otherwise be attributed to General Assistance, but could instead use those funds for other related programs, or to cover more of the uncompensated care burden, as much uncompensated care currently goes unreimbursed each year. As such, these funds are treated as State budgetary savings, and modeled as funds that will be spent on other government programs. For our analysis we take this value and apply relevant inflation rates to bring the value into future dollars. There are currently approximately 70,000 enrollees in General Assistance, and we estimate that the savings to the state from shifting people from General Assistance will be $227 million in 2016 (this amount does not include administrative savings).
- **Disproportionate Share Hospital Payments** (DSH), federal funds dedicated to easing the burden of uncompensated care costs on hospitals, will be reduced as a result of the ACA. Whether or not Pennsylvania participates in Medicaid expansion will have no effect on the reduction of federal funds allotted for DSH. Post-ACA, the State will have to either allot more funds to DSH or pass more of the uncompensated care burden onto hospitals. However, by expanding Medicaid, Pennsylvania will reduce the number of uninsured persons within the state, reducing the burden of uncompensated care on hospitals. This will effectively reduce the funds required to cover the portion of uncompensated care that the State decides to cover. As such, this effect

registers as a saving to the State as a result of Medicaid expansion. To calculate the magnitude of these savings to the State, we reduce the State's contribution to DSH payments by the percent decrease in Pennsylvania's uninsured population (25%). To keep our estimate conservative, we take suggestion from the Kaiser Family Foundation's report and further reduce this decrease by 33%, to account for political pressures and other rigidity that would prevent the State from reducing DSH funding.

- The **Mental/Behavioral Health** program is designed to cover a selective group of recipients with comparably specific health needs. While a number of the services provided by this program could be covered under Medicaid expansion, it is very likely that the coverage required for a number of participants could not be adequately covered by Medicaid expansion. As such, we only assume that participants who use the less intensive services in these programs would be likely to move to Medicaid, as those individuals would likely be better served by the broad scope of healthcare services provided by Medicaid, which they are ineligible for without Medicaid expansion. Generally, Medicaid provides coverage for psychiatric care, and care to those with mental or behavioral issues. These services are not as broad as those provided by the Mental/Behavioral Health program, but would provide enough similarity to accommodate those that have mental or behavioral issues, but would benefit from more general healthcare coverage instead of specific mental or behavioral health services. To estimate potential savings from the Mental/Behavioral Health program, we first applied a reduction in proportion to the total estimated decrease in uninsured persons due to Medicaid expansion (25%) to the total budget value for this program. Because of the specialized nature of this program, we assume a sizeable portion of participants will either chose not to move to Medicaid, or be unable to. To account for this, we only capture 20% of the initial calculated savings for this program. This is a highly conservative approach, as the reduction reported here represents only 5% of the total budget for the Mental/Behavioral Health project budget.
- Similarly, certain people currently participating in programs such as the **SelectPlan for Women** or **Medicaid Medically Needy** programs (which receive a reduced scope of coverage in PA) would be eligible for the Medicaid expansion group at the 100% FMAP, but many will not qualify due to income restrictions or other categorical restrictions. Consequently, these programs were only moderately reduced.
- The **Drug/Alcohol Abuse** program is greatly similar to the Mental/Behavioral Health program, for our considerations, as it is a highly specialized service program designed to serve a specific, generally uninsured population. Because of these similarities, the potential savings are calculated with the same method as used for the Mental/Behavioral Health program; we assume a 25% reduction as the total potential reduction (in line with the decrease in uninsured persons due to Medicaid expansion) and conservatively assume only 20% of those savings are actually realized by the State.
- **Healthcare services for incarcerated populations** were also projected to be partially coverable through Medicaid expansion. Pennsylvania state prisoners are able to qualify for Medicaid coverage when receiving inpatient hospital services that take them out of the prison for more than 24 hours and the prisoner meets Medicaid requirements. Approximately 50% of current

inpatient hospital spending is covered by Medicaid because many prisoners are eligible for Medicaid inpatient coverage due to disability. Due to the low income levels of prisoners we assume that a large majority of prisoners will qualify after the expansion. Currently, the State pays Medicaid rates to hospitals for all inpatient care due to Act 22, but the State only receives federal matching on about 50% of inpatient cases. The percent of inpatient cases not currently eligible for federal matching will decrease with Medicaid expansion. For this report, we only consider prisoners in state prisons. It is conservatively assumed Department of Corrections current inpatient hospital spending not covered by Medicaid will be reduced by 60%, for a savings of $5.2 million in 2016, and $6.2 million in 2022.

APPENDIX B: METHODOLOGY FOR ANALYZING THE ECONOMIC IMPACT OF THE OPTIONAL EXPANSION OF MEDICAID UNDER THE AFFORDABLE CARE ACT

An input-output model was used to estimate the economic impact of the expansion of Medicaid in Pennsylvania. There are several input-output models commonly used by economists to estimate multiplier effects. Because of the complexity of measuring multiplier effects, all of the models have limitations. Still, economists generally agree that the models can provide an approximate measure of the indirect and induced spending, total jobs and personal income generated by a given amount of direct spending in a particular geographic area. The Pennsylvania Economy League (PEL) employed the IMPLAN input-output model in developing the estimates of the impact on the economy of the proposed expansion of Medicaid in Pennsylvania.

The IMPLAN model organizes the economy into 440 separate industries and has comprehensive data on every geographic area of the United States, sourced from federal agencies such as the Bureau of Economic Analysis.[10] It was initially developed and used in 1984 by the U.S. Department of Agriculture, in conjunction with the University of Minnesota. In 1993, the technology was transferred to a new company, the Minnesota IMPLAN Group, Inc. (MIG, Inc.). Today, their tools are in use by more than 1,000 public and private institutions.

INDIRECT AND INDUCED ECONOMIC IMPACTS

The economic impact of the optional expansion of Medicaid would not be limited to the employment, compensation, and other economic activity directly related the additional healthcare services that would be provided. Through the supply chain, the optional expansion of Medicaid would create jobs in related industries, and some of these jobs would not exist without the expansion. Similarly, the wages paid to the employees of healthcare providers and to employees in the supply chain have an effect on the broader economy as employees use their compensation to buy goods and services.

In our analysis, the ***Direct Spending*** related to the expansion of Medicaid on the Pennsylvania economy is made up of the total of the direct spending on payroll, goods and services. The money spent because of the optional expansion of Medicaid is spent again by the recipient employees and local businesses. These businesses in the supply chain make their own purchases and hire employees, who then spend their salaries and wages throughout the local, regional and state economies – termed ***Indirect Spending***. Employees of the healthcare providers and the companies in their supply chain use their salaries and wages to purchase goods and services from other businesses for personal consumption – termed ***Induced Spending***. A chain reaction of indirect and induced spending continues, with subsequent rounds of additional spending gradually diminished through savings, taxes and expenditures made outside the state. This economic ripple effect is measured by IMPLAN and other input-output economic

[10] IMPLAN's state and industry specific input-output multipliers are based on numerous data sources, including the Bureau of Economic Analysis (BEA) Covered Employment and Wages, BEA Regional Economic Information System Data, BEA Output data, National Income and Product Accounts, BEA current benchmark I-O Study, the Consumer Expenditure Survey among others. The IMPLAN model assembles all of the data into a consistent accounting framework following the definitions and conventions of the US input-output benchmark study and the US National Income and Product Accounts.

models, using a series of multipliers to provide estimates of the number of times each dollar of input, or direct spending, cycles through the economy in terms of indirect and induced output, or additional spending, personal income and employment.

To determine the impact of optional expansion of Medicaid, We first identified the geographic areas of study. The team then modeled the impact within Pennsylvania as a whole, and within the five HealthChoices coverage regions, which are defined at the county level. These sub-regions, and the counties they contain, are outlined in Table 15 below.

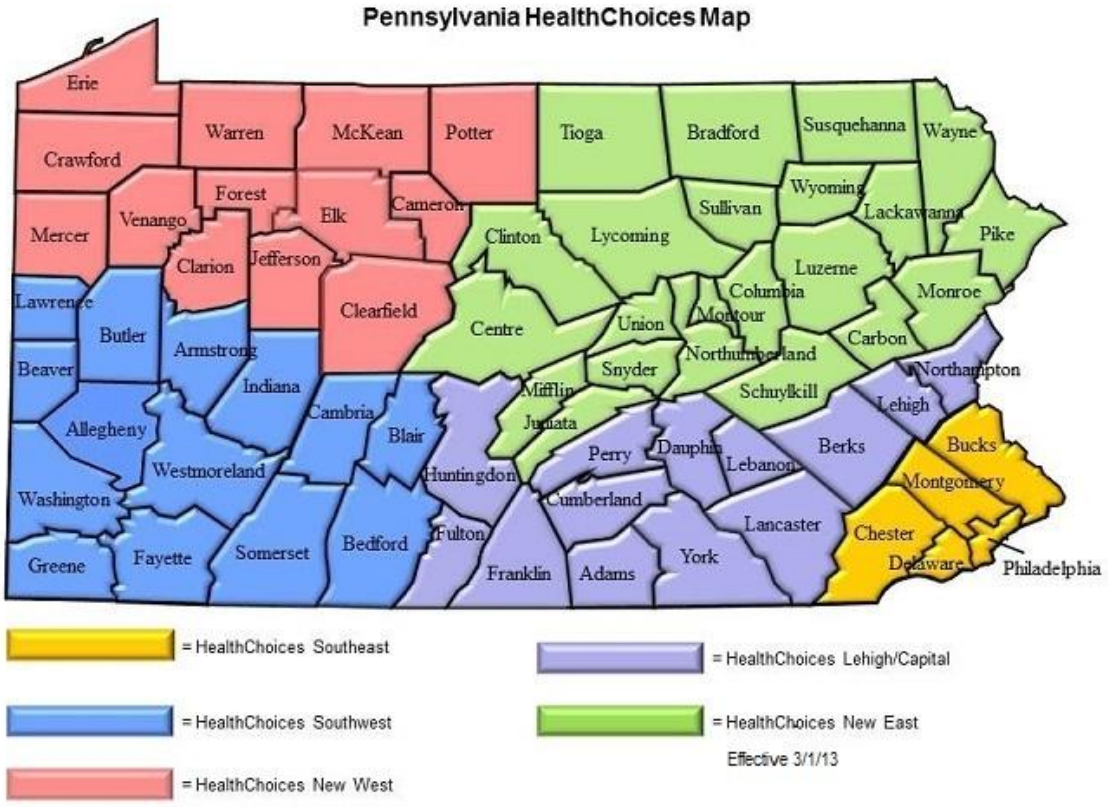


Table 15: HealthChoices zones used as regions in economic impact analysis

Northwest	Southwest	Lehigh / Capital	North East	Southeast
Cameron	Allegheny	Adams	Bradford	Bucks
Clarion	Armstrong	Berks	Carbon	Chester
Clearfield	Beaver	Cumberland	Centre	Delaware
Crawford	Bedford	Dauphin	Clinton	Montgomery
Elk	Blair	Franklin	Columbia	Philadelphia
Erie	Butler	Fulton	Juniata	
Forest	Cambria	Huntingdon	Lackawanna	
Jefferson	Fayette	Lancaster	Luzerne	
Mc Kean	Greene	Lebanon	Lycoming	
Mercer	Indiana	Lehigh	Mifflin	
Potter	Lawrence	Northampton	Monroe	
Venango	Somerset	Perry	Montour	
Warren	Washington	York	Northumberland	
	Westmoreland		Pike	
			Schuylkill	
			Snyder	
			Sullivan	
			Susquehanna	
			Tioga	
			Union	
			Wayne	
			Wyoming	

ANALYSIS 1: SPENDING

To model the economic impact of the optional expansion of Medicaid, we used State and Federal spending estimates from the Kaiser Family Foundation, along with State budget information and information from other sources, to construct a thorough estimate of incremental spending in the year 2016, the year 2022 and the period from 2013 through 2022 with the optional expansion of Medicaid in place (see **Table 16** below for statewide figures). The spending was allocated to the five regions according to each region's share of the total number of uninsured persons in Pennsylvania using the US Census's Small Area Health Insurance Estimates (SAHIE). In this analysis, the spending was allocated to the IMPLAN industry sectors as outlined in **Tables 16** through **21** below. In order to account for inflation over the period of analysis, the impacts for 2016 and 2022 were deflated to 2013 dollars using factors built into the IMPLAN model.

For each time period and each region, the direct, indirect and induced jobs and total economic value added were modeled using the IMPLAN software based on the change in spending that would result from the expansion of Medicaid.

Table 16: Statewide spending resulting from the expansion of Medicaid (in millions)

Spending Category	2016	2022	2013-2022
Total Healthcare	1,773	2,885	18,507
State Government Spending	384	(50)	1,572
Household Spending	1,139	1,884	12,357
Total Spending	**3,296**	**4,719**	**32,436**

Table 17: Northwest spending resulting from the expansion of Medicaid (in millions)

Spending Category	2016	2022	2013-2022
Total Healthcare	122	198	1,270
State Government Spending	26	(3)	108
Household Spending	78	129	848
Total Spending	**226**	**324**	**2,227**

Table 18: Southwest spending resulting from the expansion of Medicaid (in millions)

Spending Category	2016	2022	2013-2022
Total Healthcare	372	605	3,882
State Government Spending	80	(10)	330
Household Spending	239	395	2,592
Total Spending	**691**	**990**	**6,803**

Table 19: Lehigh /Central spending resulting from the expansion of Medicaid (in millions)

Spending Category	2016	2022	2013-2022
Total Healthcare	433	705	4,521
State Government Spending	94	(12)	384
Household Spending	278	460	3,019
Total Spending	**805**	**1,153**	**7,924**

Table 20: Northeast spending resulting from the expansion of Medicaid (in millions)

Spending Category	2016	2022	2013-2022
Total Healthcare	273	445	2,853
State Government Spending	59	(8)	242
Household Spending	176	290	1,905
Total Spending	**508**	**727**	**5,000**

Table 21: Southeast spending resulting from the expansion of Medicaid (in millions)

Spending Category	2016	2022	2013-2022
Total Healthcare	573	932	5,981
State Government Spending	124	(16)	508
Household Spending	368	609	3,994
Total Spending	**1,065**	**1,525**	**10,483**

ANALYSIS 2: PREVIOUSLY COVERED HEALTHCARE COSTS

For the analysis of the increased household spending due to reductions in paid private insurance premiums and out-of-pocket healthcare expenses, a different approach was used. Since the replacement of out-of-pocket expenditures and private insurance coverage by Medicaid does not represent new healthcare spending, only an increase in household disposable income, it would not have any direct effect on employment. Instead, the additional spending was modeled as additional labor income in the form of employee compensation.

The values for previously privately insured or out-of-pocket healthcare expenditures are estimated through two primary analyses. First, healthcare spending that would be paid by private insurance, absent any coverage or subsidy, is estimated as the total Medicaid expansion spending multiplied by the percent of new enrollees who were previously insured, less the estimated value of out-of-pocket healthcare expenditures replaced by Medicaid coverage. The value of out-of-pocket healthcare expenditures was calculated using data from the CMS National Health Expenditure Projections.

Second, this value is further reduced by the amount of federal exchange subsidies expected to be replaced by Medicaid expansion coverage. Exchange subsidies are offered to certain low-income individuals to cover a portion of healthcare premiums or out-of-pocket expenditures deemed unaffordable to them. As such, the value of this subsidy cannot be considered a cost savings to households, as they would not pay this portion of healthcare costs with or without Medicaid expansion. Kaiser Family Foundation provides estimates for the value of Exchange subsidies that will be covered by Medicaid expansion by region (Table 11, The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis).

Using Pennsylvania's share of total Medicaid expansion spending in its region (the Middle Atlantic region), the value of these subsidies for Pennsylvania were calculated to be approximately one-seventh of federal spending on Medicaid expansion in Pennsylvania. The value of out-of-pocket healthcare expenditures was calculated using data from the CMS National Health Expenditure Projections. These values appear as "Household Spending" in Tables 2 – 7 above.

The economic impact effect of the increased employee compensation would have an effect on the broader economy as recipients use their compensation to buy goods and services. This is modeled as ***Induced Spending –*** where recipients of increased compensation from the expansion of Medicaid use some of the funds to purchase goods and services from other businesses for personal consumption.

Unlike in the modeling of the economic impact of the expansion of Medicaid, this analysis does not include either ***Direct Spending*** or ***Indirect Spending*** by the supply chain. This is because the behavior of households, not industries is being modeled.

ANALYSIS 3: ECONOMIC IMPACT MODEL

The two analyses were run together in the IMPLAN model to yield the overall economic impact estimates for the five regions and the Commonwealth, for three time periods (2016, 2022 and 2013 – 2022).

The IMPLAN model determines the impact that a change in spending has on the economy, including employment and total value added. These are defined as follows:

- ***Employment*** – Includes both full- and part-time workers
- ***Total Value Added (GDP)*** – The contribution of a change in spending to the economy

Total Value Added can be thought of as the share of Gross State Product (analogous to GDP at the national level) and is comprised of four components, defined as follows:

- ***Employee Compensation*** – Payroll costs for the industry, including salaries and benefits
- ***Proprietor's Income*** – Payments received by self-employed individuals as income, including income received by private business owners
- ***Other Investor and Property Owner Income*** – Payments for rents received on properties, royalties from contracts, dividends paid by corporations and corporate profits earned by corporations
- ***Indirect Business Taxes*** – Includes taxes on sales, property and production

Table 22: Summary Economic Impact, 2016 ($ in millions)

Region	Employment	Economic Activity	GDP	Labor Earnings	Employee Wages	Proprietors Income	Other Property Type Income	Indirect Business Taxes
Lehigh Central	8,080	$1,164	$649	$440	$397	$44	$175	$34
New East Region	4,932	$677	$360	$243	$214	$28	$99	$19
New West Region	2,077	$263	$140	$98	$88	$10	$35	$7
Southeast Region	10,368	$1,749	$1,029	$725	$621	$104	$257	$47
Southwest Region	7,535	$1,115	$628	$429	$382	$47	$165	$34
Statewide	**34,727**	**$5,343**	**$3,024**	**$2,070**	**$1,822**	**$248**	**$798**	**$156**

Table 23: Summary Economic Impact, 2022 ($ in millions)

Region	Employment	Economic Activity	GDP	Labor Earnings	Employee Wages	Proprietors Income	Other Property Type Income	Indirect Business Taxes
Lehigh Central	10,005	$1,587	$946	$630	$566	$64	$250	$66
New East Region	6,069	$918	$527	$348	$306	$42	$140	$39
New West Region	2,576	$352	$205	$140	$125	$15	$49	$15
Southeast Region	12,763	$2,388	$1,482	$1,027	$874	$153	$365	$90
Southwest Region	9,257	$1,508	$900	$604	$537	$67	$233	$63
Statewide	**42,780**	**$7,282**	**$4,366**	**$2,940**	**$2,579**	**$361**	**$1,132**	**$294**

APPENDIX C: DISCUSSION OF POTENTIAL ADDITIONAL IMPACTS NOT INCLUDED IN THIS ANALYSIS

Within comparable reports on Medicaid expansion in other states, a number of dynamics are modeled and quantified which are not represented in our approach.

It is important to note that most administrative costs are not considered in this report. There are many views circulating this issue now as to the nature of administrative cost changes. On one hand, the increase in persons enrolled in Medicaid should require more case workers, more processing, and altogether affect a greater administrative burden. However, if the State implements changes to its administrative/IT system in accordance with ACA guidelines, the actual burden should be greatly reduced. It may also be possible for the State to transfer some administrative burden onto the Exchange, which could further reduce administrative costs, In addition, the reductions in State-funded programs mentioned above should also alleviate administrative burden, much in the same way that the increase in Medicaid may raise that burden. Persuasive arguments by various organizations have claimed that either effect could be larger. It is possible that administrative systems in place will not downsize to the same extent that new administrative systems for Medicaid will increase, leading to an overall increase in administrative burden. However, it is also possible that the combined effects of a new and more efficient Medicaid administrative/IT system which will reduce the marginal enrollment costs associated with Medicaid, and full (programmatic as well as administrative) reductions in State programs to the extent they will be covered by Medicaid, will decrease the overall administrative burden on the State. However, the nature of these effects is very unclear. As such, we have conservatively excluded speculation on these impacts from our model and report.

The issue of impacts on private insurance premiums due to Medicaid expansion is discussed in many reports. However, many reports provide disparately different projections of this effect. One report asserts that the shifting of uncompensated care cost burdens onto Medicaid (due to the increase in coverage, and the consequent decrease in uninsured), will alleviate a burden that was previously being passed on to privately insured individuals in the form of higher premiums. Alternatively, other studies project that the effects of increased demand due to higher healthcare participation will cause insurance rates to rise. No definitive answer on this issue exists, and many assumptions regarding cost burden (e.g. will the state retain the savings from the decreased uncompensated care burden, or maintain funding to pass the savings on to hospitals) are necessary to give any estimation. In the interest of remaining conservative and concise in our approach, we do not attempt to quantify this effect.

Beyond private insurance premiums, there are many issues of widely varying natures beyond those covered in this study. Issues such as State hospital assessments, impacts to the quality of life and health, and economic leakage between states (e.g. being insured by a Pennsylvania provider, but receiving healthcare services in a bordering state) are some of the more prominent issues that could be explored and addressed. Each of these issues is heavily involved in the political environment of the Commonwealth, and cannot be reliably estimated for this economic and fiscal analysis while maintaining the clear and conservative nature of the analysis.

There are many competing theories regarding the impact of Medicaid coverage on the quality of life for recipients and until there is legislative clarity on the scope of coverage and other provisions in the ACA and Medicaid expansion, estimates put forward at this juncture will lack value or reliability.

Similarly, the assessment imposed on hospitals by the Commonwealth is subject to negotiation and agreement every three years; as the current political environment remains tense, political pressures will likely control these assessments, making economic quantification greatly unreliable.

Leakages beyond those incorporated in the IMPLAN modeling system will also be greatly dependent upon the decision of other states regarding Medicaid, and so are beyond the scope of the analysis conducted in this Pennsylvania-specific report. Further, Pennsylvania is likely more a destination for healthcare services for non-Pennsylvania residents than it is an 'exporter' of residents to neighboring states for healthcare services. However, as this position, or any position on the other issues mentioned here, is much less defensible that the rest of our analysis, we have decided not to quantify or estimate any impact from this effect.

APPENDIX D: PENNSYLVANIA HEALTH FUNDERS COLLABORATIVE

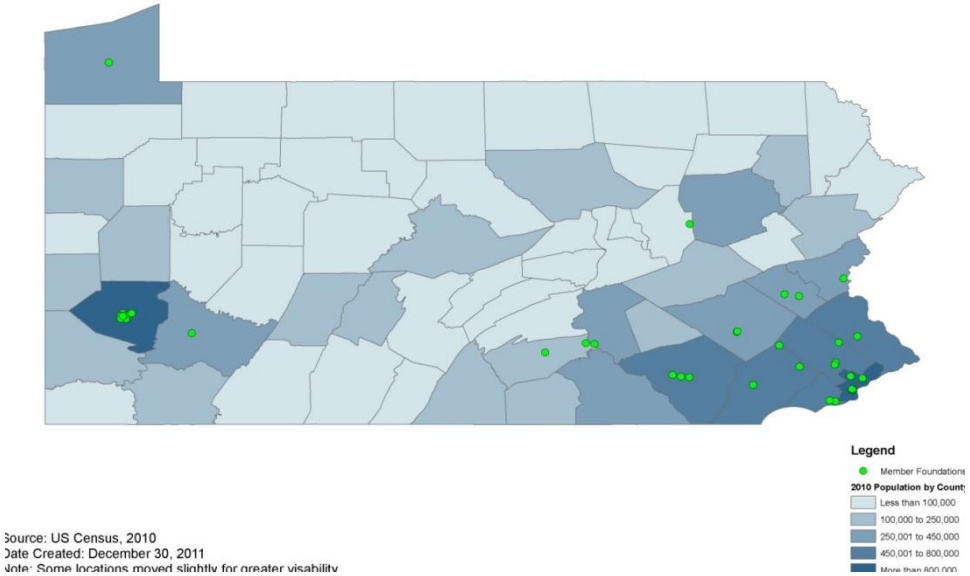
MISSION

The Pennsylvania Health Funders Collaborative (PHFC) strives to improve the effectiveness of health funders' initiatives by collaborating, networking, sharing best practices, and creating a unified voice among funders working in communities across Pennsylvania.

LEADERSHIP

- Karen Wolk Feinstein, PhD, President and CEO of the Jewish Healthcare Foundation, and Co-chair of PHFC
- Russell Johnson, President and CEO of the North Penn Community Health Foundation, and Co-chair of PHFC
- Ann S. Torregrossa, JD, Executive Director of PHFC

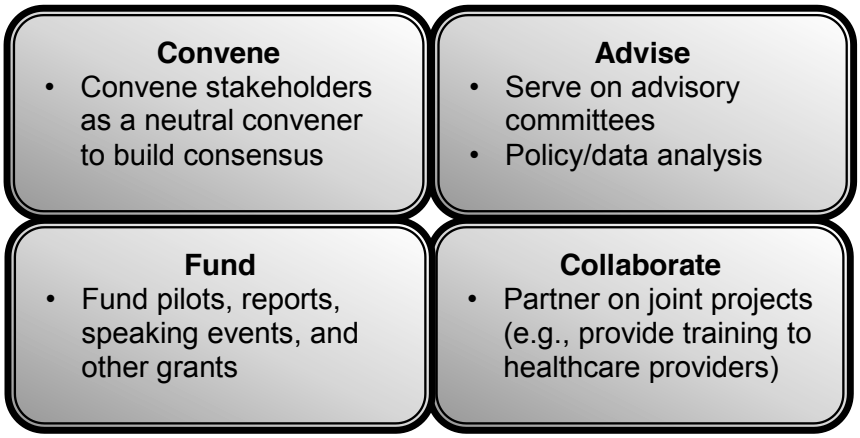
30 HEALTH FOUNDATIONS, SERVING 56 COUNTIES ACROSS PA



PHFC SEEKS TO:

- Build knowledge of current developments and intersections in health philanthropy and state health policy.
- Enhance awareness of funders' current grant initiatives and funding priorities to identify areas of convergence.
- Develop networks and explore opportunities for collaborative grantmaking.
- Leverage expertise and resources for greater impact.
- Establish or support opportunities for shared funding for specific projects.

PHFC is able to:



PHFC FOUNDATIONS

AmeriHealth Mercy Foundation	Berks County Community Foundation	Brandywine Health Foundation
Carlisle Area Health and Wellness Foundation	Central Susquehanna Community Foundation	CIGNA Foundation
Claneil Foundation	Claude Worthington Benedum Foundation	Community Foundation of Fayette County
Delaware Valley Grantmakers	Dorothy Rider Pool Health Foundation	Erie Community Foundation
First Hospital Foundation	FISA Foundation	Foundations Community Partnerships
Grantmakers in Western Pennsylvania	Green Tree Community Health Foundation	Highmark Foundation
Independence Blue Cross Foundation	Independence Foundation	Jewish Healthcare Foundation
McAuley Ministries	North Penn Community Health Foundation	Phoenixville Community Health Foundation
Pottstown Area Health and Wellness Foundation	Public Health Fund	St. Joseph Health Ministries
Staunton Farm Foundation	The Women and Girls Foundation of Southwest Pennsylvania	Thomas Scattergood Behavioral Health Foundation

APPENDIX E: SOURCE LIST

IRS, 2011 Data Book

The Lewin Group, *An Evaluation of the Impact of Medicaid Expansion in New Hampshire, Phase II Report*

Bureau of Economic Analysis, 2011

US Census, *State Government Tax Collections*

Pennsylvania Health Law Project, *Expanding Medicaid in PA: Consider the Savings*

CMS, 2011-2021 *National Health Expenditure Projections*

Pennsylvania Department of Corrections, 2010-2011 *Health Care Services Overview*

Pennsylvania Health Care Cost Containment Council (PHC4), 2011 *Annual Report on the Financial Health of Pennsylvania's Hospitals*

Kaiser Family Foundation, 2012 *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*

Kaiser Family Foundation, 2010 *Medicaid Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*

Department of Public Welfare, 2013 *Annual Budget*

Pennsylvania Budget Department, 2013-2014 Governor's *Executive Budget*

US Census, *Small Area Health Insurance Estimates (SAHIE)*

Interviews with PA corrections experts, PA Health Law Department, Hospital Alliance of Pennsylvania, and other sources