FLORIDA CENTER FOR FISCAL AND ECONOMIC POLICY

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Political Rhetoric - Not Fiscal Reality – Drives Up Estimates of Medicaid Expansion Cost

Summary:

Florida's elected leadership is currently wrestling with the question of whether or not to increase the Medicaid income eligibility limit for most adults to 138 percent of the federal poverty level ($26,344 for a family of three in 2012). Often referred to as Medicaid expansion, this extension of health coverage to more than a million uninsured Floridians created by the Affordable Care Act remains on the books and will become effective January 2014. As a result of the U.S. Supreme Court's June decision, however, Medicaid expansion has effectively become optional for states.

The primary claim of those opposed to Medicaid expansion is that the cost to the state would be prohibitive. This brief examines six 10-year cost estimates circulated during the past year and the underlying assumptions used to generate them. First and foremost, one estimate – produced last month by Florida's Agency for Health Care Administration ($2.1 billion per year) – is three times higher than its *own* estimate from earlier in the year and four times higher than any of the other estimates. F or reasons explained in this brief, that estimate must be dismissed outright. Other state-generated estimates ($741 million, $482 million) are less unreasonable, but still deliberately incorporate assumptions that significantly inflate the cost. Furthermore, a well-researched estimate ($536 million) prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured is nevertheless problematic because it assumes excessive per person costs that do not remotely track with Florida's experience.

Florida's elected leaders have consistently voiced their opposition to Medicaid expansion since the ACA was enacted in 2010. However, growing recognition of the benefits the expansion would provide to Florida's low-wage workers, service sector employers, and economy as a whole has begun to prompt serious consideration by decision-makers regarding how much Florida stands to gain from its participation.

Adjusting the unrealistic assumptions in those over-estimates would bring them in line with lower per-year estimates by Georgetown University's Health Policy Institute (less than $310 million, inferred) and FCFEP ($214 million). However, FCFEP's estimate incorporates some secondary assumptions that should be updated; doing so would increase the estimate to $270 million. Even at $270 million, however, Medicaid expansion would still increase the state's share of the total Medicaid budget by only 2 percent over the 10-year period. After factoring in the savings to the state associated with reductions in uncompensated care, the net (true) cost to the state may very well be *negative*. Thus, despite efforts to make the burden of Medicaid expansion seem onerous and unsustainable, in fact the opposite is true.

Background:

After surviving the most intense of legal and political attacks in 2012, the Affordable Care Act (ACA) remains the law of the land, and its most significant provisions will come on-line in 2014. Despite the fact that the law is fully in effect, Florida leaders must nevertheless decide whether or not to implement a key ACA provision that would make more than a million low-income, uninsured Florida adults[1] eligible for Medicaid coverage. Specifically, the ACA increases the income limit for Medicaid eligibility for most adults to 138 percent of the federal poverty level ($15,414 for an individual or $26,344 for a family of three in 2012). Although the U.S. Supreme Court's June decision affirming the constitutionality of the ACA left this Medicaid expansion intact, the court also ruled that federal officials cannot withhold funding from states' existing Medicaid programs if they decline to expand. This in effect made Medicaid expansion for adults a state option.

In estimates released this month, AHCA sought to portray Medicaid expansion as an entirely untenable option for Florida, estimating the state's share of "the total additional tax payer cost over 10 years" at "$25,840,082,587…[o]r even higher." Although almost $5 billion of that total pertains to costs unrelated to Medicaid expansion, the remaining $21.1 billion is still almost triple the amount produced by the same agency earlier in the year.

Florida's elected leaders have consistently voiced their opposition to Medicaid expansion since the ACA was enacted in 2010. However, growing recognition of the benefits the expansion would provide to Florida's low-wage workers, service sector employers, and economy as a whole[2] has begun to prompt serious consideration by decision-makers regarding how much Florida stands to gain from its participation. Criticism of expansion has been muted in recent months, and has been focused almost exclusively on the supposedly prohibitive price tag of expansion, with the most extreme such claims generated by Florida's Agency for Health Care Administration (AHCA), the state Medicaid agency.

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Perceptions aside, meaningful evaluation of Medicaid expansion cost estimates requires examination of their underlying assumptions and how they are applied. This brief attempts to undertake such an evaluation by "looking under the hood" of the various estimates circulated during the past year. Table 1 below lists six[5] different estimates of the costs and related impacts of Medicaid expansion in Florida from 2012. These include the two sets of estimates issued by AHCA as well as one each from the Florida Legislature's Social Services Estimating Conference, the Urban Institute (for the Kaiser Commission on Medicaid and the Uninsured), the Health Policy Institute at Georgetown University, and FCFEP.

Each estimate includes (or implies) at least six distinct pieces of information of interest to decision-makers and stakeholders: 1) the total 10-year cost to the state, 2) the total amount of federal funds that would flow into Florida over the 10 years, 3) the average annual cost to the state, 4) the maximum cost to the state in any of the 10 years (i.e., in 2022-23), 5) the state share of the total 10-year cost, expressed as a percentage of the total

(equivalently, the amount of federal dollars leveraged for each state dollar invested[6]), and 6) the percent change in the amount the state would need to spend on Medicaid over the 10 years as a result of expansion. Two sources provide an additional and perhaps most important piece of information, namely the net percent change in the amount the state would need to spend on Medicaid under expansion (i.e., after deducting state savings associated with reduced uncompensated care.)

Although most of the estimates are grounded in similar assumptions, significant variation exists among other assumptions. The effect of that variation is compounded across hundreds of thousands of Medicaid recipients and over a ten-year period, ultimately resulting in significantly different estimates. For example, if one source assumes that 25 percent more Floridians will be eligible under expansion than another source, *and* that 25 percent more of those who are eligible will enroll, *and* that the per-person cost of care for those who enroll will be 25 percent higher, the resulting higher estimate would be almost double the lower estimate. As it turns out, the variation among these estimates of the average cost of Medicaid expansion to the state is even greater, as AHCA's most recent estimate of $2.1 billion is ten times more than FCFEP's estimate of $214 million.

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Table 1 - Comparison of Estimates of 10-Year Impact of Medicaid Expansion in Florida									
Source of Estimate	**Period Covered by Estimate**		**Total 10-Year Cost to State** (in billions)	**Total Federal Funds Drawn Down** (in billions)	**Average Cost to State Per Year** (in millions)	**Maximum Cost to State in Any Year** (in billions)	**% of Total Paid by State** Equivalently: [Federal Funds Received for Every State Dollar Spent]	**% Increase in State Medicaid Spending**	**Net % Increase in State Medicaid Spending** (factoring in state savings)
Florida Agency for Health Care Administration December 2012[7]	July 2013 – June 2023		$21.1B	$50.8B	**$2,106M**	$2,736M	41.4% [$2.41]	**17.6%**	Not provided
Florida Agency for Health Care Administration January 2012[8]	July 2013 – June 2023		$7.4B	57.3B$	**$741M**	$1,062M	12.9% [$7.74]	**6.8% (Derived)**	Not provided
Urban Institute November 2012[9]	January 2013-December 2022		$5.4B	$66.1B	**$536M**	$1,186M	7.5% [$12.33]	**4.6%**	3.6%
Florida Legislature: Social Services Estimating Conference August 2012[10]	July 2013-June 2023	MAX	$4.8B	$40.8B	**$482M**	$670M	10.6% [$9.47]	**4.3% (Derived)**	Not provided
		MIN	$1.7B	$27.8B	**$175M**	$338M	6.3% [$15.96]	**2.2% (Derived)**	Not provided
Inferred by FCFEP based on Georgetown University - Health Policy Institute November 2012[11]	July 2013 – June 2023		Less than $3.1B	More than $38.0B	**Less than $310M**	$400M	Less than 7.5% [$12.25+]	**4%**	-1%
Florida Center for Fiscal and Economic Policy March 2012[12]	July 2013-June 2023		$2.1B	$20.3B	**$214M**	$372M	10.5% [$9.51]	**1.8%**	Not provided

Reviewing the Individual Estimates:

In an effort to understand and assess the factors that contribute to this variation, we examined these estimates in detail. A summary of that examination is contained in Table 2 below.

Meaningful estimates of the cost of Medicaid expansion are a function of several different factors, and each factor is present at different levels, with each level pertaining to a different subgroup of Floridians affected by Medicaid expansion. For example, Floridians who are eligible for Medicaid under current rules but are not enrolled (referred to in this brief as the Already Eligible Group) are not expected to sign up for Medicaid at the same rate as those who only become eligible as a result of Medicaid expansion (referred to in this brief as the Expansion Group).

For each subgroup of Floridians who will be eligible for Medicaid starting in 2014, the cost to the state is a function of: 1) the number eligible, 2) the participation rate, 3) the per-person cost of care, and 4) and the share of the total cost for which the state is responsible for paying (i.e., state match rate).

This brief focuses on four primary elements that are necessary to generate a complete estimate of the cost of Medicaid expansion. Specifically, for each subgroup of Floridians who will be eligible for Medicaid starting in 2014, the cost to the state is a function of: 1) the number eligible, 2) the participation rate, 3) the per-person cost of care, and 4) and the share of the total cost for which the state is responsible for paying (i.e., state match rate).

1. General Issues

Most importantly these estimates must be reviewed and assessed in context. Although 10-year cost estimates could provide helpful longer-term perspective, a 10-year total likely does not provide the most useful of frame of reference, as state costs are almost always evaluated on an annualized basis. Use of 10-year estimates may enable critics of expansion to make the fiscal impact seem more burdensome, but the average annual cost and, to some extent, the maximum single-year cost more relevant. Additionally, even annualized cost estimates only make sense in relative terms. Estimates of average annual cost to the state range from $214 million to $2.11 billion, but this range corresponds to a range of 1.8 percent to 17.6 percent (i.e., a small portion) of the total state Medicaid budget over that period. Finally, it should be noted that this brief emphasizes the gross costs of expansion. The fact is, however, expanding Medicaid will reduce the need for other state expenditures, and so the true cost is in fact a *net* cost; unfortunately, only two of the estimates take this into consideration.

2. Federal Match Rates

Turning to AHCA's most recent estimate, it appears highly suspect based on magnitude alone, as it is three times higher than their *own* estimate from earlier in the year and four times higher than any estimate yielded by any of the other sources. The assumption primarily responsible for driving this estimate to a level so much higher than other state-generated estimates is that the vastly higher federal match rate provided for the Expansion Group *in federal law* (100 percent through 2016, 95 percent to 93 percent from 2017 to 2019, and 90 percent in 2020 and beyond)[13] will simply not be forthcoming, even in 2014. Instead, AHCA baselessly ignores the law and assumes that the match rate for the Already Eligible Group (currently about 58.6 percent) will apply to all recipients. This inappropriate assumption has an extreme impact; all other things being equal, the cost to the state at the Already Eligible Group match rate will be more than seven times greater than at the aggregate Expansion Group match rate. Applying that one indefensible assumption is that AHCA's estimate of state costs is inappropriately inflated by more than a billion dollars per year.

Table 2 – Key Assumptions Underlying Estimates of Impact of Medicaid Expansion in Florida							
Source of Estimate	**Estimated Additional Enrollment - January 2023 (in millions)**		**Federal Match Rate for Expansion Group**	**Participation Among Already Eligible Group**	**Participation Among Expansion Group**	**Participation by Those Eligible Except with Private Insurance ("Crowd-Out" Population)**	**Total Cost Per Recipient (2013-14)**
Florida Agency for Health Care Administration December 2012	1.41		58.6% (from 2014 on)	100% enrollment, all by January 2014	100% of the Newly Eligible will enroll Of these, 90% will enroll by July 2014	~60% of those who would be Newly Eligible but buy private coverage will drop it Of these, 80% will enroll by July 2014	Newly Eligible: $306 Already Eligible: $254 (3.35%/year increase)
Florida Agency for Health Care Administration January 2012	1.85		100% from 2014 - 16 93-95% from 2017-19 90% in 2020 and beyond	20% of all uninsured under 133% FPL are Already Eligible 90% of these will enroll by Jan 2015	100% of Newly Eligible will enroll Of these, 90% will enroll by January 2015	80% of those who would be Newly Eligible but buy private coverage will drop it Of these, 90% will enroll by January 2015	Overall: $320
Urban Institute November 2012	1.28			39.5%	74.0%	Employer-sponsored: Already: 4%, Newly: 11% Purchase: Already: 69%, Newly: 85%	Overall: $453 (2016) $617 (2022)
Florida Legislature: Social Services Estimating Conference July 2012	MAX	1.47		100% enrollment, all by January 2014 ("maximum exposure")	79.7% of the Newly Eligible will enroll Of these, 90% will enroll by July 2014	~60% of those who would be Newly Eligible but buy private coverage will drop it Of these, 80% will enroll by July 2014	Newly Eligible: $315 Already Eligible: $257
	MIN	0.91		Enrollment rate unknown ("indeterminate")			
Florida Center for Fiscal and Economic Policy March 2012	1.02			40%	75%	Employer-sponsored: Already: 5%, Newly: 25% Purchase: Already: 10%, Newly: 60%	Newly Eligible: $248 Already Eligible: $156
Georgetown University November 2012	Between 0.82 and 1.27			Between 10% and 40%	Between 57% and 75%	Not considered separately	Refers to Social Services Estimating Conference

3. Participation Rates

Removing the assumption that the federal law will be ignored would bring AHCA's recent estimate more in line with the other estimates generated within state government. Even so, these estimates are still several hundred million dollars per year higher than those generated by FCFEP or inferred from the report issued by Georgetown University's Health Policy Institute.

The most significant problem with the state-generated estimates is the set of assumed participation rates for the various subgroups of the Medicaid-eligible population. Specifically, the estimation process requires that assumptions be made about participation among the Already Eligible Group, the Expansion Group, and among those who have private health insurance coverage but are otherwise eligible. Among those in the latter group who drop private coverage to enroll in Medicaid (the so-called "Crowd Out" population), a few may fall into the Already Eligible Group, though most will be in the Expansion Group. Within each of those two subgroups, a few may have employment-based coverage, though most will be covered through directly purchased insurance. Given the differences in demographics and coverage take-up behavior among those groups and subgroups, at least six different participation rates must be assumed.

AHCA's most recent estimate appears highly suspect based on magnitude alone, as it is three times higher than their own estimate from earlier in the year and four times higher than any estimate yielded by any of the other sources. The assumption primarily responsible for driving this estimate to a level so much higher than other state-generated estimates is that the vastly higher federal match rate provided for the Expansion Group in federal law (100 percent through 2016, 95 percent to 93 percent from 2017 to 2019, and 90 percent in 2020 and beyond) will simply not be forthcoming, even in 2014.

With respect to the Already Eligible Group, both the older and newer AHCA estimates not only assume that, although not enrolled now nor subject to financial penalty[14] for not having coverage, every single such individual will not only enroll, but will be enrolled as of the very first day of Medicaid expansion. Even a far lower participation rate would be unprecedented in U.S. history, and the assumption of instantaneously full enrollment is simply beyond all reason.

The Social Services Estimating Conference of the Office of Economic and Demographic Research of the Florida Legislature is the entity responsible for generating official state forecasts of Medicaid caseloads and expenditures. The conference includes representatives from the House, Senate, and Office of the Governor. Although AHCA informed these estimates, the Estimating Conference recognized that assuming 100 percent participation among the Already Eligible Group was extremely problematic. In fact, their baseline estimate did not include any amount associated with the Already Eligible Group at all, describing those costs as "indeterminate" and omitting them from the forecast entirely. That omission of course does not reflect the state's actual position, as clearly some portion of the Already Eligible Group will enroll. Thus, for informational purposes, the conference also generated an additional set of estimates incorporating AHCA's assumption of 100 percent participation by the Already Eligible Group.

With respect to the Expansion Group, AHCA's recent estimates also grossly overstate reality, assuming 100 percent participation, with 90 percent enrolling within 12 months (by January 2015). By contrast, the Estimating Conference applied what they calculated as a 79.7 percent participation rate for the *current* Medicaid program as the estimated participation rate for the Expansion Group as well. That value is a bit higher than the 75 percent participation rate used by the Urban Institute in an earlier (2010) analysis,[15] which in turn was cited by FCFEP and Georgetown University. More accurately, the Urban Institute analysis presented two participation scenarios: one with higher participation rates based on more state engagement and aggressive outreach and education, the other with lower participation. Although the lower participation rate is likely far more realistic for Florida, FCFEP assumed that the higher participation rates apply in order to produce conservative (in this case, higher) estimates.

4. Eligible Base Population

An even more basic ingredient than participation rates is needed for the estimation process. In particular, estimates of additional enrollment over a 10-year period ranged from Georgetown University's lower bound of 820,000 to AHCA's recent "100 percent participation" figure of 1.85 million. The breadth of this range is not only explained by variation among estimated participation rates, but also among estimates of the total number of Floridians who are Medicaid-eligible, including the number that fall into each of the constituent subgroups. It is these numbers to which participation rates are applied to produce estimated enrollment totals. Of particular concern is the fact that all of the state-generated estimates appear to ignore the reality that a significant number of Floridians who are income-eligible for Medicaid are nevertheless undocumented immigrants and so never Medicaid-eligible.[16] As another example, state estimates also appear to double-count those recipients in the Medically Needy program who will become eligible for full Medicaid in 2014.

More complex are a whole set of eligibility issues that only the Urban Institute meaningfully considered: conversion, for many eligibility groups, from the current method of calculating and counting income for eligibility determination purposes to a system based on Modified Adjusted Gross Income (MAGI) in 2014. The MAGI-based system, also a result of the Affordable Care Act, and the current system are to some degree "apples and oranges" and not easily compared. However, the conversion to a MAGI-based system is separate from and not linked to Medicaid expansion. Estimation of MAGI conversion-related impacts is therefore beyond the scope of this brief.

5. Cost Per Recipient

A final element needed to formulate estimates is the cost per recipient, which again varies by subgroup. AHCA and the Estimating Conference use similar numbers, and those are also accepted by Georgetown University. However, these numbers too are inflated.

The most recent state-generated estimate of the cost per person per month (PMPM) in the children and families (TANF) category, which serves as the primary component of an overall "blended" rate calculated as a weighted average of the PMPMs for several rate-specific subgroups, is $343. This amount appears overstated for several reasons. For one, AHCA reported the *actual* 2010-11 PMPMs for

the TANF category and the particularly relevant "Categorically Eligible" subgroup at $270 and $201, respectively.[17] For another, the median regional capitation rate paid to Medicaid HMOs for 2012-13 in the TANF category was $333 for adult women, but only $156 for adult men.[18] That distinction is significant; although the clear majority of adults in the Medicaid children subgroup are women, this is certainly not the case for the Expansion Group.

Specifically, the state's most recent estimate of the weighted PMPM for the Expansion Group is $315, while FCFEP's estimate is 17 percent lower at $261. The state's weighted PMPM for the Already Eligible is $257, but particularly because this group is mostly children, FCFEP estimated that PMPM at $144, a full 44 percent lower.

Although the Urban Institute (UI) incorporated more realistic assumptions about participation rates than the state, its cost estimates still come in significantly higher than even those issued by the Social Services Estimating Conference. This can be attributed to a few different factors, but by the far most impactful is that the PMPM estimates derived by UI are significantly higher than anything in the state's experience. For the Already Eligible Group, the UI estimate of $348 PMPM for 2016 is 35 percent higher than the Estimating Conference's $257. For the Expansion Group, UI's estimate of $505 PMPM for 2016 is fully 60 percent higher than the Estimating Conference's $315. Moreover, UI estimates that those PMPMs will increase to $493 and $677, respectively, by 2022. As discussed above, actual state PMPM-related data indicate that even the Estimating Conference's numbers seem too high, and given that UI agrees "that newly eligible adults are *less* costly on average than current adult enrollees", it seems advisable to set aside this element of UI's estimation method.

6. The Remaining Estimates

FCFEP estimates are significantly lower than those generated by the state, and they do not incorporate any of the assumptions discussed above that yield inflated estimates. However, a few issues warrant mention that seem to indicate the need for a limited upward adjustment from the March 2012 estimate of $214 million per year. In particular, FCFEP's estimation intentionally mirrored the methodology used by AHCA last January whenever defensible, and the latter estimates did not account for increases in PMPM or in Florida's total population as later state-generated estimates did. Also, the Urban Institute estimates cited in this brief improve on early placeholder participation rates (2010) that FCFEP used. Although most of these subgroup-specific rates are very similar to their predecessors, the current estimate of the crowd-out rate among those with purchased coverage is 69 percent, a six-fold increase over the placeholder estimate it replaced. Updating the assumptions in the FCFEP methodology produces a revised estimate of approximately $270 million per year, a 2 percent increase in the state's share of the Medicaid budget over 10 years.

With respect to the Georgetown University estimates, it should be noted that the authors' report is intended as a survey of issues related to Florida's Medicaid expansion decision and does not aim to provide fully developed estimates of the cost of Medicaid expansion. Nevertheless, estimates can be inferred from the information provided without additional assumptions.

Conclusion

The Affordable Care Act gives Florida's Governor and Legislature the opportunity to make more than a million uninsured Floridians, particularly low-wage workers and parents, eligible for health insurance by increasing the income limit for Medicaid starting in 2014. The potential benefit to Florida's families, businesses, and overall economy is compelling, but opponents insist that the price tag is prohibitive. In reality, however, higher cost estimates cited by critics are greatly inflated. A comparison of these estimates and their underlying assumptions shows that the true cost is low, increasing state spending for Medicaid only marginally, while reaping state savings in other programs that offset some or all of the new costs.

This brief was researched and written by Greg Mellowe.

Endnotes

[1] Medicaid expansion for adults is optional for states, but not expansion for children ages 6 through 18 with household incomes between 105 and 138 percent of the federal poverty level. The mandatory expansion for children was authorized via a different provision of the Affordable Care Act (ACA) and was not affected by the Supreme Court's decision.

[2] See, e.g., Hodges, Alan and Rahmani, Mohammad, Economic Impacts of the Patient Protection and Affordable Care Act in Florida, November 2012, and FCFEP, The Other Beneficiaries: Florida Employers Stand to Benefit Immensely, Disproportionately from Medicaid Expansion, November 2012

[3] The state-generated estimates are provided to the nearest dollar, although nowhere near this level of precision in estimation is between 105 and 138 percent of the federal poverty level. The mandatory expansion for children was authorized via a different provision of the Affordable Care Act (ACA) and was not affected by the Supreme Court's decision.

[3] The state-generated estimates are provided possible. The meaningless additional digits seem intended only to produce "sticker shock" for the reader.

[4] Costs incurred as a result of the ACA regardless of whether or not Medicaid expansion is implemented are not included in the cost estimates.

[5] In November 2012, the Florida Safety Net Hospital Alliance also released Medicaid expansion cost estimates, projecting that the cost of Medicaid expansion to the state would be about $170 million, lower than all other estimates. T hat report is not in circulation as of this writing. However, this estimate appears to exclude costs associated with enrollment by those who are already eligible under current rules (Already Eligible Group).

[6] The amount of federal dollars leveraged for each state dollar invested is the inverse of the federal percentage of Medicaid expansion costs paid by the state.

[7] Florida Agency for Health Care Administration (AHCA), Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) Program, December 2012

[8] AHCA, Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) Program, January 2012

[9] Kaiser Commission on Medicaid and the Uninsured, The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis, November 2012

[10] Florida Legislature, Office of Economic and Demographic Research, Social Services Estimating Conference, Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) Program, July 2012,

[11] Georgetown University Health Policy Institute, Jesse Ball du Pont Fund, and the Winter Park Health Foundation, Florida's Medicaid Choice: Understanding Implications of Supreme Court Ruling on Affordable Health Care Act, November 2012

[12] FCFEP, Overstated Burden: Why Florida's Claims Regarding Medicaid Expansion Are Vastly Inflated, Lacking in Merit, March 2012

[13] See Section 2001(a)(3) of the Affordable Care Act

[14] Few Medicaid-eligible recipients could be subject to any penalty for failing to obtain health coverage under the so-called "individual mandate". The vast majority have incomes below the income tax filing threshold, and it is likely that the remainder may be granted a hardship exemption under federal regulations.

[15] Kaiser Commission on Medicaid and the Uninsured, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, May 2010, p.8

[16] Medicaid can pay for care for undocumented immigrants only for the duration of a medical emergency.

[17] AHCA, Presentation to the Commission on Review of Taxpayer Funded Hospital Districts, *Florida Medicaid: Program Overview*, June 2011, slide 11

[18] AHCA, Estimated Health Plan Rates: September 1, 2012 – August 31, 2013 HMO Rates by Area, Age and Eligibility Category, p.1. (The rates cited include medical and mental health services.)