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MEDICAID EXPANSION: STATE OF PLAY AND WHAT'S TO COME

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January 2016

Since the 2012 Supreme Court decision making it optional for states to implement the Affordable Care Act's expansion of Medicaid to cover non-elderly adults with incomes below 138 percent of the poverty line, 30 states and the District of Columbia have chosen to expand eligibility (Figure 1). In this essay I describe current data on the impact of these expansions and the alternative approaches adopted by some states and consider how the landscape may evolve in coming years.

THE IMPACT OF MEDICAID EXPANSION

The ACA coverage provisions are reducing uninsurance rates nationwide, with the biggest gains occurring in states that have expanded Medicaid. New data from the American Community Survey show that between 2013 and 2014 the overall uninsurance rate fell by 3.4 percentage points in expansion states vs. 2.3 percentage points in non-expansion states.¹ Likewise, the latest Health Reform Monitoring Survey pegs the declines in uninsurance rates for working age adults at 8.5 and 5.2 percentage points, respectively, for expansion vs. non-expansion states in the two years since the start of the 2013 open enrollment period.² With non-expansion states, as a group, starting off with higher uninsurance rates and seeing less improvement, their coverage disparity relative to expansion states has worsened.

Expansion states are also reporting positive budget impacts. States can reduce their Medicaid program costs when enrollees who had been receiving services under special targeted programs, such as medically needy beneficiaries, are moved to the expansion

program with its higher federal match. Expansion states have also been able to use federal Medicaid dollars instead of state general funds for uncompensated care programs and certain other services to the uninsured. And states that tax health plans or providers are seeing higher revenue as the Medicaid expansion increases plan and provider income.

These fiscal impacts are substantial, with one study estimating savings and revenue of \$1.8 billion by the end of 2015 across the eight expansion states it examined.³ Furthermore, in three states making such projections, these newfound gains are expected to more than offset new state expenditures associated with the expansion through at least 2021, after the federal match rate for the expansion population has declined to its long-term level of 90 percent.^{3,4} Numerous other studies are showing the large benefits to hospitals, which now have to provide much less uncompensated care, while others are documenting significant positive indirect impacts on state economies.^{5,6}

Early evidence on access to care for newly enrolled beneficiaries is also encouraging. In Michigan, despite a rapid influx of well over 600,000 newly insured people, Medicaid appointment availability improved significantly and new appointment wait times did not increase.⁷ Kentucky has reported dramatic gains in the number of its Medicaid beneficiaries receiving physical exams, cancer screenings and other preventive services.⁸ Nationally, 78 percent of new Medicaid enrollees who have obtained care said they would not have been able to afford or access this care prior to gaining Medicaid coverage.⁹

EXPANSION THROUGH WAIVERS

Five states—Arkansas, Indiana, Iowa, Michigan and New Hampshire—are currently operating their Medicaid expansions through an approved demonstration project or “waiver” authorized under section 1115 of the Social Security Act, and Montana is now enrolling people for 2016 coverage under its new waiver (Figure 1). Conversely, under a new governor, Pennsylvania reversed its approved waiver and is now proceeding with a traditional expansion.

Section 1115 waivers give states added flexibility in running their Medicaid program, but within limits. States must show that their demonstrations promote Medicaid's objectives of delivering health and long-term care services and other needed supports to vulnerable low-income populations. Some provisions of Medicaid law, most notably the rules limiting out-of-pocket costs such as copayments, cannot be waived under section 1115.

Arkansas broke new ground as the first state to receive an expansion waiver, gaining permission to use federal Medicaid funds to purchase private coverage on the health insurance exchange for most newly eligible adults. Since that time, Iowa and New Hampshire adopted this approach for some or all of their expansion populations, although Iowa now plans to transfer its enrollees to traditional Medicaid managed care plans. Other common features in approved expansion waivers include premiums, incentives for healthy behavior, and HSA-like accounts used to pay co-pays or deductibles.¹⁰

While section 1115 does not permit states to waive Medicaid's cost-sharing protections,

