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## *In Health Care Policy*

### MEDICAID EXPANSION: WHAT'S AT STAKE FOR 2014 AND BEYOND?

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The June 2012 Supreme Court decision permitting states to opt out of the ACA's planned expansion of Medicaid sent most states scrambling to determine their best course of action. As of early April 2013, governors of 27 states and the mayor of the District of Columbia have announced their support for expansion, 19 governors are opposed, and four remain undecided. Governors who are opposed to or undecided about expansion most often cite the potential high cost to their states and their opposition to expanding a "broken" program that can be better managed by allowing states more flexibility. Governors supporting expansion point to the potential to reduce the number of uninsured and bolster other state health improvement efforts, net state budget savings and other economic benefits.<sup>1</sup>

In this essay, we examine expansion from the perspectives of states and other stakeholders and present estimates of how these various stakeholders may be affected. The weight of the evidence indicates that the generous federal match rate will make it financially advantageous for virtually all states to participate during the first three years of the program, and that a broad range of other savings and new revenues can yield significant net financial gains for states even when their Medicaid outlays increase in later years. Non-expansion also will leave millions of low-income individuals without health insurance and may have large negative consequences for hospitals, employers and those with private insurance.

<sup>i</sup> The authors previously served as Medicaid Directors in Colorado and Indiana, respectively.

#### NEW STATE BUDGET COSTS

States are understandably anxious about expanding Medicaid, already the largest single category in most state budgets. While an expansion will entail additional administrative costs inherent to running a larger program, states are most concerned about the medical costs for new enrollees. The state cost of covering those newly eligible under the expansion will be zero through 2016 due to the 100 percent federal match rate for the first three years. States will then begin picking up a portion of these costs as the federal match rate gradually declines to 90 percent for 2020 and beyond. A few states that had previously expanded coverage to childless adults (known as "expansion states") will see their match rates for this population increase in the early years until reaching the 90 percent threshold in 2020 – actually yielding savings for these states.

States also expect more people who are currently eligible for Medicaid to enroll in the program in 2014 – the so-called "woodwork effect." They will receive only the regular Medicaid match rate for this group. Higher enrollment of currently eligible individuals is likely to result from simplified eligibility screening and enrollment in the new exchanges and from increased outreach and publicity about the need to have health insurance. Thus, a state will see a woodwork effect even if it does not expand Medicaid, although experts believe this effect will be somewhat larger in states that choose to expand.

#### NEW STATE BUDGET BENEFITS

Virtually all states will have offsetting savings in other state programs. To begin, many states will be able to convert some existing Medicaid populations, such as individuals eligible via family planning waivers or medically needy criteria, to the newly eligible group and receive the enhanced match. The most significant savings will accrue to states that previously used waiver authority to provide a limited benefit to childless adults or parents (as opposed to comprehensive benefits provided by expansion states). States can eliminate these waivers and move the enrollees to the newly eligible group at the 100 percent match rate.

A second category of savings will come from state-funded programs that are able to reduce their spending due to the new Medicaid coverage. Such savings can be expected in programs that provide or finance care for indigent populations, behavioral health and substance abuse programs, state high-risk pools, and correctional health spending for inpatient care provided outside of the correctional system.

Finally, states will likely see direct and indirect revenue benefits from an expansion. For example, a state that imposes a Medicaid-related provider tax or premium assessment could expect increased collections largely funded by the federal government. The large infusion of federal funds – derived in some cases from taxpayers beyond state borders – would also boost economic activity in the state, leading to more jobs and higher state income and sales tax revenues.

## ADDING UP THE STATE IMPACTS

States and other stakeholder groups have been busy conducting analyses to quantify these costs and benefits. While the studies vary broadly in the methods and data used, those that adopt a comprehensive framework are generally computing substantial net financial benefits to states from expansion even after 2016. For example, the Michigan House Fiscal Agency estimated net state savings of \$1.1 billion over the first 10 years of the expansion, with more than \$2.4 billion saved on mental health services and the adult benefits waiver.<sup>2</sup> Preliminary estimates for Ohio suggest a net gain of as much as \$1.8 billion from 2014 to 2022, including \$273 million in correctional health savings, at least \$1.6 billion in new revenues from Medicaid taxes and more than \$800 million in new general state revenues.<sup>3</sup>

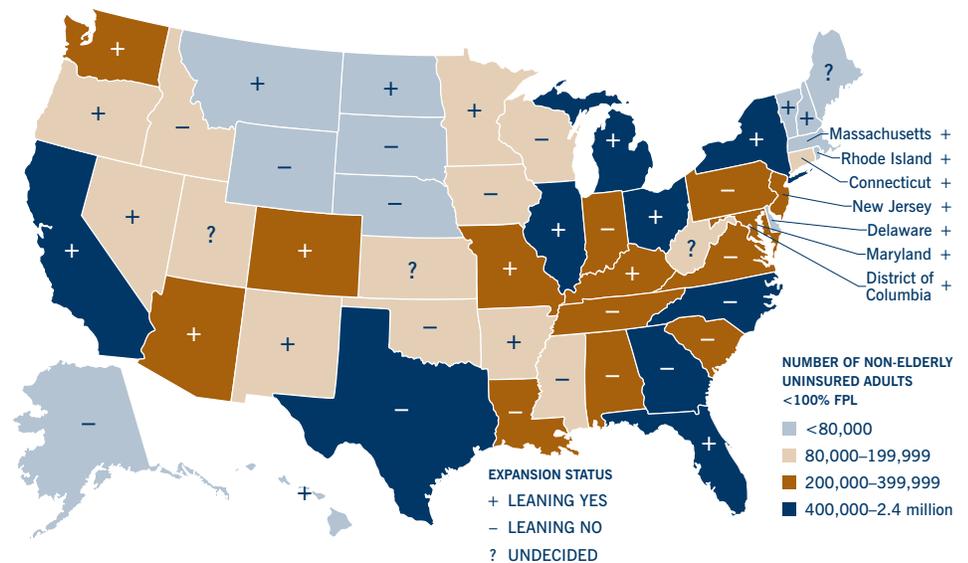
## BEYOND THE STATE PERSPECTIVE

Ideally, a state's fiscal impact analysis would also consider the impact on other stakeholders. Hospitals stand to gain considerably under expansion, with a recent study calculating an additional \$294 billion in Medicaid payments to hospitals through 2022 if all states participate.<sup>4</sup> This new revenue would be lost to facilities in states that do not expand Medicaid. At the same time, hospitals will be absorbing \$316 billion in cuts to disproportionate share (DSH) payments and other payment cuts under the ACA. Hospitals that rely heavily on DSH payments would be particularly stressed if they continue to serve large numbers of people left uninsured by the non-expansion decision.<sup>5</sup> For these reasons, hospital associations across the country have emerged as strong proponents of expansion.

Employers and those with private insurance would also be affected. Actuaries predict that individual premiums in the exchanges will be higher if people with incomes between 100 and 138 percent of poverty are covered through an exchange instead of through Medicaid,<sup>6</sup> and large numbers of low-income people without insurance will perpetuate higher prices for private coverage as providers try to recoup their uncompensated care losses. Large employers will also pay a penalty if any of their full-time workers in the 100-138 FPL segment receive subsidized coverage on the exchange.

Beyond the dollars, there is also a human side to consider. National modeling suggests that if no state expands Medicaid there will be 10 million more uninsured people in 2022 than would be the case under full expansion.<sup>7</sup> Most of those left without insurance will be adults without dependent children, and the

**FIGURE 1: POOR, NON-ELDERLY, UNINSURED ADULTS BY EXPANSION STATUS**



Sources: Expansion status based on governors' decisions as of April 5, 2013, as reflected in data compiled by The Advisory Board Company and State Reform. State demographic data from the Kaiser Family Foundation, StateHealthFacts.org

rest will be impoverished parents who have long been excluded from Medicaid coverage. Our own calculations indicate that nearly 6.4 million non-elderly adults are living in poverty and without health insurance in states whose governors are leaning against expansion or have yet to take a position (Figure 1).

## WHAT MIGHT THE FUTURE HOLD?

Since the November 2012 elections, states have been taking a much harder look at their options. Predicting when the dust will settle and what the world will look like when it does is a challenge. Despite governors' pronouncements, final resolution in many states still rests with the legislature. Further uncertainty has been introduced of late as a growing number of states have been seeking permission to use federal dollars to support private insurance for those eligible for expanded Medicaid coverage. The Arkansas legislature has just approved such a "private option," and the Department of Health and Human Services has indicated a willingness to move in this direction in a limited number of states. Many issues remain to be resolved, however, including how states might achieve cost-neutrality, provision of wrap-around benefits and other cost protections for enrollees, whether enrollment can be mandatory, whether a federal waiver will be required and how long that process might take.

With current legislative sessions drawing to a close in most states soon, the clock is ticking for this round. States that pass on expansion for 2014 may still opt in at a later

date, but will miss out on the full three years of the 100 percent match and may have to wait two additional years if they use biennial legislative sessions or biennial budgeting. Conversely, participating states may reverse their expansion decisions in the future, such as when the federal match rate declines. Indeed several governors have cited this protection and even called for re-evaluation of their expansion after 2016. In short, some uncertainty and fluidity is likely to persist well beyond 2014.

## ENDNOTES

- 1 Sommers BD, Epstein AM. "U.S. Governors and the Medicaid Expansion – No Quick Resolution in Sight." *The New England Journal of Medicine* 368(6)(February 7, 2013):496-9.
- 2 Stauff S. Medicaid Expansion – Affordable Care Act. Memorandum, Michigan House Fiscal Agency, July 2012, <http://tinyurl.com/d4722j8> (accessed March 28, 2013).
- 3 "Expanding Medicaid in Ohio: Preliminary Analysis of Likely Effects," Presentation, Partnership of Regional Economic Models, Inc., Urban Institute, The Ohio State University and Health Policy Institute of Ohio, revised February 26, 2013, <http://tinyurl.com/b2k7dvv> (accessed March 12, 2013).
- 4 Dorn S, Buettgens M, Holahan J, Carroll C. *The Financial Benefit to Hospitals from State Expansion of Medicaid*. Urban Institute Brief, March 2013.
- 5 Graves JA. "Medicaid Expansion Opt-Outs and Uncompensated Care." *The New England Journal of Medicine* 367(25)(December 20, 2012):2365-7.
- 6 American Academy of Actuaries. "Implications of Medicaid Expansion Decisions on Private Coverage." *Decision Brief*, September 2012.
- 7 "Holahan J, Buettgens M, Carroll C, Dorn S. *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*. Kaiser Family Foundation, November 2012.