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Charting the Road to Coverage

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Tools and Policy Considerations for State Medicaid Expansion Analyses

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Introduction

The Supreme Court ruling in NFIB v Sebelius effectively made the Medicaid expansion created by the Affordable Care Act (ACA) optional for states.[1] As written, the ACA would have denied all federal Medicaid matching funds to states that did not expand their Medicaid programs to cover all individuals below 138 percent of the federal poverty level (FPL). The Supreme Court ruling disallows this penalty as unconstitutionally coercive. Thus, states that choose not to take up a Medicaid expansion will continue to receive federal matching funds for the populations they do cover.

The ACA provides enhanced matching funds for the Medicaid expansion population. The federal government will pay a 100 percent matching rate in 2014 through 2016; after that, the matching rate phases down to 90 percent. Since the Supreme Court's ruling, the Centers for Medicare & Medicaid Services (CMS) has clarified that the enhanced matching funds provided for expansion populations through the ACA are available only in states that take up an expansion to 138 percent FPL.[2] Partial expansions will not receive an enhanced match. There is no deadline for states to decide whether to expand their Medicaid programs.[3] A state that takes up the expansion may later drop the expansion.[4]

Through various financing mechanisms, including the implementation of the Children's Health Insurance Program (CHIP), Medicaid waivers and the use of nonfederal funds, states have implemented coverage expansions in the past. Many of these coverage expansions have been carefully evaluated and found to improve health outcomes for participants.[5,6] As of early July 2013, 24 states, including the District of Columbia, had made decisions to expand Medicaid to all individuals with incomes below 138 percent FPL. Additional states are discussing with CMS alternatives to traditional Medicaid coverage, such as premium assistance, that would leverage Marketplace health plans to provide coverage to Medicaid expansion populations.

The potential for the ACA's Medicaid expansion to increase coverage is strong, and the federal subsidy is generous and appealing to states. But, in order to make responsible decisions, states are considering long-term costs as part of their expansion decisions. Estimating these costs is complex, as many factors interact. Relevant parameters differ across states. The assumptions states make about a potential expansion influence the cost estimates for that expansion. Thus, it is

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

ABOUT NASHP
The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers dedicated to helping states achieve excellence in health policy and practice. A non-profit and nonpartisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues. NASHP funders include both public and private organizations that contract for its services. For more information, visit *www.nashp.org*.

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critical to make assumptions clearly and, where available, with state-specific data.[7] The worksheet and considerations table contained in the tool Medicaid Expansion: Framing and Planning a Financial Impact Analysis can serve as a guide for states conducting their own Medicaid expansion analyses.[8]

The major factors states have examined in order to inform their expansion decisions are:

- Who will enroll in Medicaid with or without a Medicaid expansion?
- How do the alternatives afforded by Medicaid's Alternative Benefit Plans and Medicaid waivers affect expansion considerations?
- How are health care institutions, state agencies, and a state's broader economy affected by a state's decision regarding Medicaid expansion?

This brief lays out the major factors that states have considered in estimating the cost of a potential Medicaid expansion, provides examples of state fiscal impact analyses, and highlights the tools created through the State Health Reform Assistance Network (*State Network*) that additional states can use to inform their fiscal analyses as they consider the Medicaid expansion decision.

1. Who will enroll in Medicaid with or without Medicaid expansion?

The composition of Medicaid populations under ACA may change due to the uneven impact of Medicaid expansion in states that expand Medicaid eligibility to all individuals with incomes up to 138 percent FPL. Since current eligibility levels for children and pregnant women are higher than eligibility levels for parents and childless adults, the latter two groups will make up a larger proportion of the newly eligible. States have conducted research to assess the composition and health needs of the existing and newly eligible Medicaid populations, and have employed various methods to estimate the number of individuals who will enroll in Medicaid in 2014. The size and demographic characteristics of the population eligible for Medicaid in 2014 have a direct impact on the Medicaid program's total costs. A multitude of resources are available to states as they conduct this important analysis. A State Health Reform Data Assistance Center (SHADAC) primer identifies state-level data available from seven federal surveys.[9] States likely have their own data. (For examples, see Appendix 2 for data sources states have relied on to estimate Medicaid enrollment).

Demographics of the Newly Eligible

Demographic data helps paint a picture of those who could be newly eligible for Medicaid in 2014. Understanding racial, ethnic, employment, and health characteristics can help project how these individuals might utilize the health care system and the associated costs. Individuals who could be newly eligible for Medicaid—uninsured, nonelderly adults—are a diverse group in terms of age, race and ethnicity, with great variation from state to state.[10] Among uninsured adults under 138 percent FPL who will be Medicaid-eligible in 2014, parents comprise roughly 35 percent, disabled adults comprise 10-15 percent, and childless adults make up the remaining 50-55 percent of the population.[11]

A study of California's newly eligible Medicaid population finds the group is mostly healthy, even though they now have limited access to care.[12] In contrast, an analysis of the newly eligible in Idaho found that this population is likely to have significant and chronic health conditions as well as prevalent mental health issues.[13] A toolkit developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) provides states and other payers with information on the prevalence and use of behavioral health services for individuals who may be newly eligible for health coverage in 2014. The toolkit gives states step-by-step instructions on how to generate projections of utilization under insurance expansions and outlines factors to consider when deciding the appropriate mix of behavioral health benefits, services, and providers to meet the

Getting Started: Framing and Planning a Financial Impact Analysis

This worksheet and considerations table serve as a guide for states conducting their own Medicaid expansion analysis. State-specific Medicaid expansion analysis should take into account existing program structure, available data sources (both state and national), and realistic assumptions about enrollment and costs. States should also note within the analysis whether costs are directly related to Medicaid expansion or if they are likely to occur despite expansion (e.g., the woodwork effect for individuals eligible but not currently enrolled). Not every state will need cost or savings projections for every possible row of the analysis outlined here, but there are six main areas of financial analysis that all states should consider:

1. Cost of Newly Eligible
2. Cost of Currently Eligible but Not Enrolled
3. Administrative Costs
4. Savings from Transitioning Current Medicaid Populations to Newly Eligible Group
5. Savings from Reduction in State Programs for the Uninsured
6. Other Revenue Gains and Savings

This tool is the result of collaboration between the State Health Reform Assistance Network (State Network) experts at State Health Access Data Assistance Center (SHADAC), Center for Health Care Strategies (CHCS), and Manatt Health Solutions.

needs of newly eligible populations. This type of demographic information will help states determine the cost of covering behavioral health services to the newly eligible.

A comprehensive analysis in Colorado, using data from the 2011 Colorado Health Access survey, compared the newly eligible to the general state population. The analysis found that the newly eligible are younger, less educated, in worse health, and twice as likely to be currently uninsured compared with the general state population. In addition, Hispanics are disproportionately represented compared to the state's population. The study also compared the newly eligible to current Medicaid enrollees and determined that among the newly eligible there are more males than current Medicaid clients, especially among adults without dependent children. These comparisons among demographic groups will assist Colorado in predicting the usage of and cost of health services to prepare them to expand eligibility.

Ultimately, each state's analysis of the newly eligible population will be different depending on the state's current Medicaid rules. Determining the number of newly eligible in each state begins with a comparison to the state's current eligibility level for childless adults.[14] Existing state medically needy programs, high-risk pools, and public health programs may affect how the newly eligible population's health compares to the health of current Medicaid enrollees. States will want to keep these factors in mind while conducting demographic research and analyses to estimate the number of individuals who might enroll in Medicaid in 2014, their health needs, and the cost of providing them with needed health services.

Estimating Enrollment

The Congressional Budget Office (CBO) estimates 12 million individuals will gain coverage through Medicaid expansion by 2022.[15] Multiple factors play an important role in projecting the size of the Medicaid-enrolled population. Among these are: the baseline data set chosen for analysis, estimates of the size and income distribution of the uninsured population, economic trends, population growth, and assumed take-up rates. Various models treat these factors differently; the State Health Access Data Assistance Center (SHADAC) compares five major public and private models.[16]

Various national estimates project that Medicaid take-up under the ACA will range from 57 percent to 95 percent.[17] Take-up rates will vary by state, based on factors including outreach, education, and historical program enrollment. New coverage paradigms under the ACA including the individual mandate and Health Insurance Marketplaces, coupled with outreach and enrollment simplifications, will increase the visibility of Medicaid and make enrollment easier. Due to these ACA-related changes, every state should anticipate an increase in enrollment in Medicaid for individuals currently eligible but not enrolled, known as the "welcome mat" effect.[18] Thus, regardless of a state's decision to expand Medicaid eligibility to 138 percent FPL, estimated enrollment increases need to be incorporated in cost estimates. A tool from experts at the *State Network*, *Medicaid Expansion: Framing and Planning a Financial Impact Analysis*, explicitly includes the costs of currently eligible, but not enrolled, Medicaid beneficiaries in its financial analysis.[19]

State officials can estimate the number of people who will enroll in Medicaid in 2014 using a variety of methods, ranging from spreadsheets to intricate microsimulation models. Each approach has positives and negatives in terms of cost, time, complexity and adaptability for ongoing state analysis needs.[20] SHADAC has developed a spreadsheet model incorporating complex formulas, the SHADAC Projection Model, to predict coverage impacts of state-level policy changes and take-up rates of newly eligible Medicaid populations under the ACA. This tool allows states to conduct analyses that are timely, state-specific, and relatively inexpensive while giving them the flexibility to update baseline data or test different assumptions.

In Oregon, a report from the *State Network* used the SHADAC Projection Model to make a coverage projection of 95 percent. The high take-up rate assumed in this analysis was developed in consultation with state officials and is supported by the state's experience of high participation among Oregon children who are eligible for Medicaid and the Children's Health Insurance Program (CHIP). The assumed participation rate results in 95 percent of Oregonians having some type of insurance coverage through Medicaid, CHIP, or the Marketplace. This projection includes providing coverage to 240,000 newly eligible individuals, in addition to 20,000 who are estimated to gain coverage through the "welcome mat" effect.

One popular microsimulation model is the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), which can be utilized for quick analysis and estimation of cost and coverage effects of proposed health care policy options.[21] This model is flexible and can be easily adapted to analyze various scenarios and can describe the effects of a policy option at different points in time. States can use HIPSM to predict Medicaid participation rates among newly and currently eligible people and to obtain detailed demographic, economic, and health care cost information for those enrolled in public and private insurance markets, as well as the uninsured.[22]

Researchers have used New York-specific data to construct the New York version of HIPSM (HIPSM-NY), which utilizes the Current Population Survey's Annual Social and Economic Supplement matched with several other national datasets. HIPSM-NY used detailed information on state eligibility rules to simulate Medicaid eligibility and enrollment and used detailed

enrollment and cost data from the Department of Health to calibrate the model's pre-ACA baseline for state-funded programs.[23] The model found that under the ACA, Medicaid enrollment increases by about 513,000 in total, 76,000 of whom are newly eligible enrollees. The number of newly eligible due to the ACA's eligibility expansion is relatively low in New York because the state had already expanded Medicaid eligibility criteria prior to the ACA.

The Maryland Health Care Reform Simulation Model consists of four major component models that determine the impact of implementing the ACA on Maryland's health care expenditures and economy: the population, employment, health care expenditure, and economic impact models. The population model uses population projection data from the Maryland Department of Planning, as well as estimates of the number of uninsured individuals, by age group and FPL, derived from the U.S. Census Bureau's 2011 Current Population Survey. Using projections of Maryland's total population by age group, and the number of uninsured individuals by age group and FPL, the population model estimates the number of people who will be eligible in a Medicaid expansion scenario, the number of individuals who are likely to enroll due to the "welcome mat" effect, and the number of uninsured people who are candidates for coverage through the Health Insurance Marketplace.

The three different projection models, used in three different states, each used state-specific estimated take-up rates for their analyses ranging from 70 to 95 percent. Even with this variation, the models predict that overall insurance coverage rates in the each of the states will be 90 percent or higher. See Table 1.

Table 1: State-specific take-up rates used in projections

State	Model	Estimated Take-up Rate	Resulting Coverage Rate
Oregon	SHADAC Projection Model	NA[a]	95%[b]
New York	HIPSM	73%[c]	90%
Maryland	Maryland Health Care Reform Simulation Model	70%-90% based on FPL[d]	90%-94% (increases over time)

[a] Due to artifacts of the data, how the model is constructed, and the fact that people will gain and lose access to Employer-Sponsored Insurance as well as having offers of public coverage, a specific take-up could not be generated.

[b] This projection includes providing coverage to 240,000 newly eligible individuals, in addition to 20,000 who will gain coverage through the "welcome mat" effect. The assumed participation rate results in 95 percent of Oregonians having some type of insurance coverage.

[c] 513,000 will be newly eligible for Medicaid and CHIP under a "standard implementation" scenario: Standard Implementation of the ACA; Merged small group and nongroup markets; small group ≤ 100 workers; no maintenance of effort for FHP parents; no BHP.

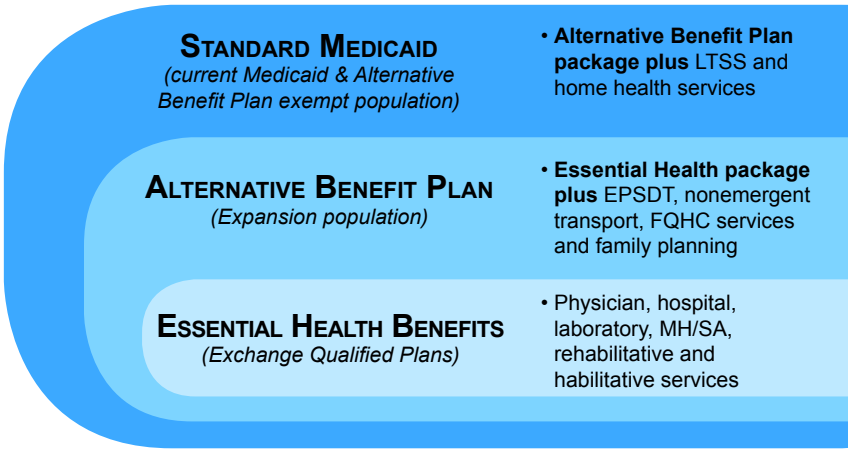
[d] Take-up rate was assumed to be 90 percent for people with incomes under 50 percent FPL and 70 percent for people with incomes between 50 and 133 percent FPL.

2. How do the alternatives afforded by Medicaid's Alternative Benefit Plans and Medicaid waivers affect expansion considerations?

States that choose to expand Medicaid have flexibility in determining the benefits that will be offered to the newly eligible population, a decision that has a direct impact on the overall cost of expanding the state's Medicaid eligibility. The set of benefits offered to the new adult group is known as an "Alternative Benefit Plan" (ABP). States can choose a different ABP for different groups of newly eligible individuals, or the same plan for multiple groups. These benefits can differ from those offered in traditional Medicaid, and may be more robust than benefit packages offered by qualified health plans (QHPs) sold in Health Insurance Marketplaces because of the requirement to include certain traditional Medicaid services. Each state will have to determine what set of benefits is appropriate based on population demographics and the state budget. (See Figure 1)

Figure 1:

Benefit Packages in the Affordable Care Act



Alternative Benefit Plans (ABPs) must be benchmarked to particular health insurance plans in the state. The benchmark options for Medicaid overlap with–but are not the same as–those used to determine essential health benefits (EHB) for Marketplace qualified health plans. Based on the proposed rule from CMS, the options for Medicaid benchmark plans are:

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefits program.
- State employee coverage that is offered and generally available to state employees.
- The largest commercial, non-Medicaid HMO in the state.
- Secretary-approved coverage, which can include the Medicaid state plan benefit package offered in that state.[24]

States also have a fifth option, known as Medicaid "benchmark-equivalent" coverage, which means that the benefits include certain specified services, which are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages.[25]

ABPs must cover all ten required EHB services. The ABPs must also include mental health parity, nonemergency transportation, prescription drugs, and family planning benefits even when these are not covered by a state's existing Medicaid benchmark packages. In addition, for children under age 21, states must ensure Early and Periodic Screening, Diagnostic, and Treatment services are included. Similar to its decision to flexibly define habilitative services for private market EHBs, CMS is giving states flexibility to define habilitative services for Medicaid, and states are still discussing how best to define habilitative services in their ABPs.

States are beginning to consider options for selecting ABPs and are conducting research and analyses to inform their choices. The Washington Health Care Authority released Medicaid expansion strawman proposals for the development of the ABP, which would be based on the standard Medicaid benefit package, and a proposed overview of potential Medicaid cost-sharing regulations. A report from New York examines four options for the state's Medicaid benchmark: 1) Medicaid; 2) Family Health Plus; 3) multiple benchmark plans; and 4) commercial insurance. Iowa is also considering options for the state's ABP. Finally, in Oregon, the state's Medicaid Advisory Committee recommended the Oregon Health Plan Plus as the state's Medicaid benchmark plan in order to minimize disruption for individuals who move among different benefit packages. Ultimately, the set of benefits chosen for inclusion in ABPs will have an effect on the cost of coverage offered to newly eligible individuals.

In addition to choosing an ABP, states must decide whether to maintain or discontinue existing Medicaid waivers. Some states offer more limited coverage than standard Medicaid benefits through a waiver, or offer tailored benefits to specific populations.[26] Cost is one of the main factors states evaluate when making this decision. States will want to consider the potential state savings associated with the enhanced Federal Medical Assistance Percentage (FMAP) provided for the newly eligible Medicaid expansion population compared to the traditional Medicaid FMAP for current waiver populations.[27] At the same time, states will want to consider the benefits offered through a waiver compared with those offered through an ABP to ensure enrollees receive the services they need.

Several states currently cover childless adults in Medicaid through a waiver.[28] Other states cover this population using state funds. According to a report from the Center for Health Care Strategies, Inc. (CHCS), Medicaid expansion to 138 percent FPL would likely lower per member per year (PMPY) costs relative to current childless adult programs because: 1) the Medicaid expansion population in most states would include a mix of parents (younger demographic) and childless adults; 2) higher income populations (to 138 percent FPL) generally have fewer health risks; and 3) the expansion will likely enroll a higher proportion of healthy adults than current childless adult demonstration programs.

Expert-designed tools are available to support states with decisions about transitioning populations from one form of coverage to another. One such tool, created by Manatt Health Solutions for the *State Network*, assists states in evaluating their options for transitioning certain Medicaid and state-funded populations and programs. The template presents populations and programs that may be eligible to transition into the new Medicaid adult group or the Marketplace. The tool helps states consider factors such as differences in covered benefits, consumer cost-sharing, the impact on state financing, and the administrative complexity of maintaining or eliminating various Medicaid options. The template outlines state choices: maintain the program for some or all consumers; transition some or all consumers to the Medicaid new adult group; or, transition some or all consumers to the Marketplace.[29,30]

Another toolkit, prepared by the National Academy for State Health Policy (NASHP) for the *State Network*, aims to assist states in systematically identifying issues and decisions they may face transitioning current Medicaid populations to MAGI-related categories. The report discusses decision points for states, including benefits offered to these populations who may or may not transition to new coverage groups. The tool includes blank matrices comparing the current eligibility groups to 2014 coverage options or requirements in terms of income eligibility, federal financial participation, and benefits. States can use the matrix to help calculate potential costs and savings from transitioning current Medicaid populations to the newly eligible group.[31]

3. How are health care institutions, state agencies, and the state's broader economy affected by a state's decision regarding Medicaid expansion?

A state's decision regarding Medicaid expansion will affect the institutions—hospitals and community health centers, as well as other safety net providers—that are likely to serve those individuals who would receive coverage through Medicaid expansion, as well as state agencies that provide health care services or coverage. The specific fiscal impacts of the Medicaid expansion decision on hospitals, community health centers, and state agencies will vary by state, depending on the existing organization and financing of the health care delivery system. A Medicaid expansion decision could also have a broader fiscal impact on a state's economy.

The Medicaid Expansion Decision and Hospitals

Hospitals' revenue streams will shift in 2014 as some patients move to new sources of insurance coverage. Medicaid expansion increases the number of patients for whom hospitals are paid. An analysis of the fiscal impact of these shifts finds that hospitals will benefit on net in states that take up the Medicaid expansion. These additional revenues come from both a larger insured population and the ability of hospitals to grant 'presumptive eligibility' to uninsured individuals with incomes below 138 percent FPL in Medicaid expansion states.[32]

Individual states have also analyzed the effects of Medicaid expansion decisions on hospital revenue. In Maryland, for example, the analysis found a $3.1 billion reduction in hospital costs due to reduced uncompensated care when the state expands Medicaid. And in Nebraska, the reduction in uncompensated care due to Medicaid expansion is estimated to help both hospitals and community health centers cross-subsidize their uninsured populations and thus hold down premium increases for individuals with insurance.

In conjunction with increased reimbursement from Medicaid-insured patients, hospitals will experience cuts to Disproportionate Share Hospital (DSH) payments. The DSH program provides funds to safety net hospitals to help defray the costs of providing uncompensated care to low-income patients. DSH reductions are based on the premise that more individuals will gain insurance coverage, and the DSH provisions of the ACA were not altered by the Supreme Court's decision making Medicaid expansion optional for states.[33] The ACA requires that DSH funds be reduced beginning in 2014.[34] Additional reductions to DSH were made in the American Taxpayer Relief Act of 2012.[35]

In a proposed rule, CMS has laid out a methodology to implement the annual DSH reductions in 2014 and 2015.[36] CMS plans to refine the methodology before larger reductions begin in 2017.[37] The proposed rule takes into account a number of factors in allocating the DSH reductions among states:

- Larger reductions will be made in states with the lowest percentage of uninsured individuals.
- Larger reductions will be made in states that do not target their DSH payments to hospitals with high Medicaid volumes and hospitals with high uncompensated care costs.
- Smaller reductions will be made in states that have historically had low DSH expenditures.
- Smaller reductions will be made to account for portions of a state's DSH allotment that are used to support coverage expansions in approved §1115 waivers.

Thus, annual DSH reductions will vary based on underlying state circumstances. A state that does not take up the Medicaid expansion, and therefore retains a larger percentage of uninsured individuals, may see a relatively lower DSH reduction. States that effectively target their DSH payments to hospitals with high Medicaid volume and high uncompensated care costs will also see relatively lower DSH reductions. However, all states can expect to see reductions in their total DSH allotments.

The Medicaid Expansion Decision and Community Health Centers

The ACA authorized additional funding of $11 billion directly to Community Health Centers (CHCs) in order to build new health centers, modernize existing buildings, and expand capacity. The National Association of Community Health Centers (NACHC) estimates that by 2015, health centers will serve 40 million mostly low-income patients; twice the current capacity.[38] These health center expansions could save the health care system—hospitals, emergency rooms, and the Medicaid program—millions of dollars in reduced avoidable care.[39]

However, CHC capacity to serve both insured and uninsured patients will be diminished in states that do not take up the Medicaid expansion. Because the financial effects of Medicaid expansion account for roughly one quarter of the additional patient care capacity that health centers are projected to develop, states that do not take up Medicaid expansion will see a

corresponding decrease in CHC capacity.[40] Health centers in states that do not take up Medicaid expansion would have to divert growth funds to finance care for uninsured patients who were otherwise expected to gain Medicaid coverage.[41]

The Virginia Senate Finance Committee reports that CHCs served approximately 108,000 uninsured individuals in 2011, and estimates that 70 percent of these individuals would be eligible for Medicaid under an expansion. Thus, CHCs in Virginia would likely gain significant revenue from Medicaid expansion.

The Medicaid Expansion Decision and State Agencies

Medicaid expansion is projected to incur both costs and savings for state agencies. Most of the costs will accrue to the Medicaid agency, while savings will accrue more broadly across multiple state agencies and programs.

Apart from actual Medicaid program costs for health services provided, the administrative costs for a state Medicaid agency may increase under Medicaid expansion due to increases in enrollment. Federal matching funds are available to help states offset these increases:[42]

- 90 percent match for design, development and implementation of Medicaid eligibility and other IT systems through 2015.
- 75 percent match for maintenance and operation of Medicaid eligibility and other IT systems, activities related to applications, ongoing case maintenance, and customer service.
- 50 percent match for administrative costs.[43]

It is important to note that the matching funds to improve eligibility systems are available to all states, regardless of a state's decision regarding Medicaid expansion. CMS has committed that the 75 percent matching rate for maintenance and operations is available indefinitely.[44]

States may also experience savings as a result of Medicaid expansion. First, many individuals who currently receive health coverage through state-funded programs will be able to transition to Medicaid, where costs are shared with the federal government. Second, state health agencies other than the Medicaid agency—for example, state mental health agencies, public health agencies, or prescription drug assistance programs—may see savings when some of the services they currently provide can instead be reimbursed through Medicaid.

For example, Wyoming finds that some of those who will be newly eligible for Medicaid starting in 2014 would have otherwise been eligible for other state-funded programs such as prescription drug assistance programs or behavioral health services. The state estimates that a Medicaid expansion would result in reduced enrollment and cost for those programs. The report also notes significant reductions in state costs for uncompensated care. Similarly, Montana determined that most clients of its Mental Health Services Plan (MHSP), currently entirely state-funded, will be eligible for Medicaid under an expansion. The MHSP, which covers outpatient mental health treatment and medication for adults with severe disabling mental illness, currently expends about $8 million per year on mental health services. Savings of roughly $4 million to $5 million per year are anticipated by shifting the MHSP population to Medicaid.

The Medicaid Expansion Decision and the Broader Economy

The economic effect of Medicaid expansion can be far-reaching as Medicaid spending flows through a state's economy. Economic impacts of Medicaid payments occur in three categories:

- Direct health care spending to health care service providers, which supports the jobs, income and purchases associated with the delivery of health care services.
- Indirect health care spending to other businesses and industries that support health care delivery.
- Household spending and related tax collections enabled by direct and indirect spending.

Various economic models have found that Medicaid spending generates economic activity, including jobs, income, and state tax revenue. Medicaid's economic impact at the state level is intensified because of federal matching dollars. The magnitude of the impact is dependent on state Medicaid spending, a state's matching rate, and the economic conditions in the state.[45]

States are using economic models to project the broader economic impacts of a Medicaid expansion decision. For example, Ohio's estimates indicate that Medicaid expansion would increase sales tax revenues and bring jobs to the state. Virginia's analysis found that federal Medicaid matching funds accompanying an expansion would increase health care employment and general fund revenues.

4. How have states considered the three elements above in their fiscal analyses of the Medicaid expansion option?

The cost for states to expand Medicaid eligibility to 138 percent FPL may ultimately be the deciding factor for many states considering the expansion. Indeed, in a number of states participating in the Robert Wood Johnson Foundation's (RWJF) health reform monitoring and tracking project, key informants reported that these analyses were critically important in obtaining support for expansion from state policy-makers.[46] Overall, Medicaid expansion, in addition to other provisions of the ACA, would increase state Medicaid spending by $76 billion between 2013 and 2022 (an increase of less than three percent), while federal Medicaid spending would increase by $952 billion (a 26 percent increase).[47] State-by-state estimates, however, vary. Thus, states will want to conduct robust and tailored fiscal analyses.

Sample Fiscal Analyses

Many states have conducted fiscal analyses to inform their Medicaid expansion decisions and have included a variety of elements in these reports. The major elements are described in earlier sections of this paper. States are also utilizing various economic models and formulas to calculate costs associated with a Medicaid expansion.

One fiscal analysis from Nebraska utilizes the IMPLAN economic Input-Output Model to estimate the economic and employment impact of federal spending on Medicaid expansion in Nebraska from 2014 to 2020. The analysis also employs HIPSM, the Milliman model and methods from the Center for Health Policy at the University of Nebraska Medical Center to compare estimated number of new enrollees in Medicaid under the ACA expansion in Nebraska. Finally, the analysis measures other economic benefits of Medicaid expansion, such as employment gains.[48]

In Alabama, researchers estimated health spending for the expansion population using the Medical Expenditure Panel Survey (MEPS) from 2008 to 2010.[49] They calculated per capita health expenditures for the newly eligible population of adults under 138 percent FPL by current insurance status and assumed newly insured individuals would have expenditures similar to those of the currently privately insured. The study found expenditures of the privately insured are between those of the uninsured and the publicly insured. The analysis focuses on five key areas: Medicaid enrollment of newly eligible individuals, state and Federal spending on the expansion population, aggregate economic impact of the expansion, state budgetary impact of the expansion, and potential health effects of the expansion.[50]

Additional Considerations

It will be important for states to estimate the cost of providing care to newly eligible enrollees, which is challenging yet critical. Historical data on Medicaid take-up and participation rates can help make realistic predictions for enrollment estimations, which in turn allow for accurate cost predictions.[51] There remains uncertainty in how to best estimate annual enrollee costs, so states may want to present these numbers as a range rather than a single figure.[52] In addition to costs to a Medicaid program, state fiscal analyses may incorporate calculations for other potential costs and savings to their state's budget. State fiscal analyses may also want to address the effects of a potential Medicaid expansion on state economies by including projected economic benefits, such as increased employment and improved workforce health.[53] Finally, states may want to consider fiscal analyses for various windows of time, given the flexibility to opt in or out of the Medicaid expansion at varying FMAP rates. This tool produced by Manatt Health Solutions, the Center for Health Care Strategies (CHCS), and the State Health Access Data Assistance Center (SHADAC) can help states map out the necessary components of a fiscal analysis.

States may also explore other Medicaid options if they opt not to expand their Medicaid programs in 2014. Guidance from CMS indicates the agency will entertain proposals to use premium assistance options that provide continuity of coverage for individuals. Premium assistance is subject to federal guidelines regarding wrap around benefits, cost-sharing, and cost effectiveness.[54] Additional demonstration opportunities will be available under State Innovation Waivers in 2017, with respect to Health Insurance Marketplaces, and may be coupled with Section 1115 Medicaid demonstrations. The Centers for Medicare & Medicaid Services (CMS) will consider Section 1115 Medicaid demonstrations, with enhanced FMAP, in the context of overall system demonstrations.

Conclusion

There are many questions states need to answer in deciding whether to expand Medicaid eligibility to the "new adult group," mostly adults without dependent children and parents below 138 percent FPL. As part of the fiscal analyses that many states have completed, states considered who would be served by the expansion, how the potential Medicaid expansion compares to benefits otherwise available to meet the needs of this population, and the downstream impacts on states' health care systems and broader economies.

The examples and tools in this brief will help states conduct or refine their own analyses of a possible Medicaid expansion. The interactions among the many components of the health insurance and health care delivery systems are complex, and so any

analyses will reflect uncertainties. By using state-specific information along with robust analysis, states can arrive at reasonable projections forthe fiscal effects of Medicaid expansion. This analysis can inform a state's decision about whether to take up the ACA's Medicaid expansion, now or in the future.

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APPENDIX 1:

SELECT TOOLS TO ASSIST WITH A FISCAL ANALYSIS DEVELOPED BY THE STATE HEALTH REFORM ASSISTANCE NETWORK *(STATE NETWORK)*

These resources have been produced by the State Network to support state fiscal analyses that can inform decisions around Medicaid expansion.

Manatt Health Solutions. *Assessment of Current Coverage Programs and Future Options.* (Princeton, NJ: *State Health Reform Assistance Network*, October 2012). http://www.statenetwork.org/resource/assessment-of-current-coverage-programs-and-future-options/

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APPENDIX 2:

DATA SOURCES FOR STATE AND SUB-STATE ESTIMATES

American Community Survey:
The American Community Survey (ACS) provides state and sub-state level estimates for the potentially eligible and information on demographic characteristics (e.g., age, race, sex, employment).

- Pros: Large sample size allows the state to drill down into sub-state detail for where these people are located and what they look like.
- Cons: Documented Medicaid undercount can make estimates inconsistent with administrative data. There is no information on health care utilization or health status.

Current Population Survey:
The Current Population Survey can give state-level estimates for the potentially eligible and information on demographics, Employer-Sponsored Insurance (ESI) offer and take-up, out-of-pocket spending and health status.

- Pros: Broader information relevant to health policy (e.g., employer offer rates, out-of-pocket spending and health status).
- Cons: Documented Medicaid undercount can make estimates inconsistent with administrative data; smaller sample size makes sub-state estimates more challenging (often need to combine years of data to produce stable estimates).

State Surveys:
State Surveys are usually the best source of information about the state. Typically, they can produce state and sub-state level estimates of the potentially eligible.

- Pros: More in-depth information that is policy relevant to the state. Often the "official" source of information on coverage and uninsurance rates used by the state.
- Cons: Depending on the sample size, there can be limitations in sub-state analysis (both geography and by differing characteristics), limiting the ability to compare to other states.