Guidance on Analyzing and Estimating the Cost of Expanding Medicaid

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Over the coming months, most states will be examining the impact of expanding Medicaid on their state budgets. This analysis will be a critical component of the debate at the state level on whether to move ahead with the Medicaid expansion.

State fiscal and health groups will want to be fully engaged in these debates. To support these efforts, this memo reviews the key elements that would comprise a reasonable estimate of the state cost of expanding Medicaid including appropriate assumptions for participation rates and the cost of coverage, appropriate costs to include (and exclude), and potential savings that would reduce state spending in other areas of the budget and offset the costs of the Medicaid expansion.

We encourage you to use this information to critically evaluate estimates produced by your state, and/or to help you develop your own state-specific estimates.

Key Elements of the Analysis that Have the Greatest Impact on Costs

In some states, estimates of the cost of expanding Medicaid vary greatly. These state-specific estimates are influenced in large part by the assumptions used in five key areas, which we describe below.

- **What participation rates does the analysis use?** Some estimates assume that 100 percent of the people who will be eligible for Medicaid — including those who are currently eligible but not enrolled as well as those who will be newly eligible — will immediately sign up on January 1, 2014. This is a highly unrealistic assumption. No means-tested public program has ever achieved a 100 percent participation rate. Even Medicare, a popular universal program has a participation rate of 96 percent. More credible estimates prepared by the Urban Institute assume that of the uninsured individuals who will be eligible for Medicaid, *10-40 percent* of those who are currently eligible but not enrolled and *57-75 percent* of those who will be newly eligible, will sign up for coverage.[1]

  In addition, while strong participation is a goal for successful implementation of the ACA, it will likely take a number of years of intense outreach, education, and simplification of the enrollment process to maximize participation among parents and childless adults. A reasonable estimate of Medicaid costs should assume relatively modest participation initially, ramping up over time to a higher level, but never to 100 percent. The Urban Institute report, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results," provides state-by-state estimates that you can compare with your own state's estimates of how many people will enroll in Medicaid as a result of the expansion.

[1] John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, May 2010.

In examining participation rates, it is also important to make sure that the state's estimate of the number of people who would be eligible for the expansion is reasonable. Some analyses simply use the number of non-elderly, non-disabled adults with incomes below 138 percent of the poverty line. This would be inappropriate because some of these individuals already have insurance and it includes some individuals who will not be eligible for Medicaid even if their incomes are below the income eligibility threshold (e.g., legal immigrants who have been in the U.S. for less than five years).

- **What does the analysis assume about the rate of "crowd-out," or enrollment among people who are already insured?** Some estimates assume that all or a substantial share of low-income people who become newly eligible for Medicaid (as well as those who are currently eligible) will drop their existing private coverage and enroll in Medicaid instead. These rates of "crowd-out" are highly unrealistic and not in line with historical experience. Studies that have looked at whether Medicaid crowds out private health insurance, focusing primarily on state expansions of CHIP, show only modest crowd-out — only between *10 percent and 20 percent* of new Medicaid enrollees previously had private coverage.

  Crowd-out is not likely to be a significant factor in the Medicaid expansion because the vast majority of low-income individuals who will become eligible for Medicaid under health reform *do not* have access to affordable private health insurance coverage. Many low-income workers are employed in small firms and service industries where health insurance is typically not offered as a benefit. The Center on Budget and Policy Priorities paper, "Medicaid Expansion in Health Reform Not Likely to 'Crowd Out' Private Insurance," provides a more detailed look at the research on crowd-out and why it is unlikely there will be substantial crowd-out under the Medicaid expansion.

- **What is the estimated per-enrollee cost of covering people who will newly enroll in Medicaid? How was this per-enrollee cost derived?** Since many states do not have experience covering childless adults, they do not have historical data on the per-enrollee cost of covering this population. Some analyses assume that the new enrollees will be sicker and more expensive to cover and use the cost of covering people with disabilities as a benchmark. Research conducted by the Urban Institute, however, show that new Medicaid enrollees are not likely to be significantly different from parents who are currently on Medicaid, and in fact, on average, those who will be newly covered are likely to be somewhat healthier and less costly than those who are currently enrolled.[2] Therefore, it is not appropriate to use the cost of covering people with disabilities in a state's Medicaid program as a benchmark for the cost of covering those who will newly enroll, as some state estimates have done. The cost of new enrollees is likely to be closer to the cost of covering parents in the state's Medicaid program today.

- **What is the expected increase in administrative costs?** Administrative costs for Medicaid generally fall in a range of 3 percent to 8 percent of medical costs. It is important to ensure that only Medicaid administrative costs are included in state estimates. Some analyses have included the cost of administering the exchanges in a state, which is inappropriate as this is unrelated to

[2] John Holahan, Genevieve Kenney and Jennifer Pelletier, "The Health Status of New Medicaid Enrollees under Health Reform," Urban Institute, August 2010.

the Medicaid expansion. Also, because administrative costs are generally calculated as a percentage of total medical costs, a state's assumptions around participation and the per-person cost of coverage will affect this estimate. If those two factors are inflated, then administrative costs will be inflated as well.

- **What timeframe does the cost estimate cover?** The timeframes covered by different cost estimates vary significantly. When comparing various estimates for your state, it is important to use the same timeframes to ensure an apples-to-apples comparison. Also note that the longer the time period covered by the estimate, the higher the estimate of costs will be.

Other Factors that Will Also Affect the Medicaid Cost Estimate

In addition to the five issues discussed above, there are other factors that will affect the estimate of the Medicaid expansion's fiscal impact on a state, some of which will depend on policy decisions that a state will make should it decide to expand. In reviewing state-specific estimates of the Medicaid expansion, we have often seen incorrect assumptions about these costs. Below, we highlight these key factors and indicate what the appropriate assumptions around the cost of these items should be.

- **Does the estimate appropriately attribute increased enrollment among the currently eligible to the mandate and additional outreach, rather than to the expansion?** Most of the cost estimates that have been released to date were developed before the Supreme Court decision. Thus, the estimates analyzed what would happen with the ACA and without the ACA. However, even if a state chooses not to expand Medicaid, the rest of the ACA remains intact. This means that there will still be a requirement for people to have health insurance, and there will be significant outreach around the premium credits that will be available through the exchanges along with simplification of the eligibility process. Thus, we expect that some of the people who are eligible under current rules in a particular state will seek coverage and newly enroll into Medicaid anyway, regardless of that state's choice to expand the program. According to one of the nation's leading health economists, Jonathan Gruber of MIT, most of the expected increase in enrollment among people who are currently eligible but unenrolled will be due to the individual responsibility requirement and the overall "ethos" of health reform, irrespective of whether states take up the Medicaid expansion. As a result, only a small portion of the cost of increased enrollment among the currently eligible should be included in the cost to the state of the Medicaid expansion.

- **What does the estimate assume about the cost of increasing primary care provider rates?** To help ensure that there are enough providers to deal with the increased Medicaid enrollment, the ACA requires states to increase the rate at which they pay providers for certain primary care services to match Medicare rates. States have to pay these higher rates in 2013 and 2014, but the additional costs associated with this requirement are fully paid for by the federal government. Some states have assumed retention of these higher payment rates beyond 2014. States may feel this is necessary to ensure continued participation of providers. However, if a state chooses to maintain the rates beyond 2014, these costs should not be cited as an ACA requirement or a necessary component of the Medicaid expansion. In addition, some states have gone farther and assumed that payment rates for other services, including specialty care,

would also increase. Again, it will be important to point out that this is not required by the expansion or the ACA. Advocates should also question assumed increases in Medicaid payment rates that are higher than Medicare rates.

- **What matching rate is assumed for children enrolled in CHIP who move to Medicaid?** States that currently cover children from ages six to 19 with family incomes between 100 percent and 133 percent of the poverty line through CHIP will have to transition these children to Medicaid starting January 1, 2014. In estimating the cost of covering these children, some states assume that those children will be subject to the lower Medicaid match rate. However, CMS has indicated in guidance that states will be able to continue to secure the higher CHIP match rate for the cost of covering these children even after they move to Medicaid. Specifically, the CHIP statute allows CHIP-funded Medicaid coverage to be matched at the higher CHIP rate so long as the children would not have been eligible for Medicaid before CHIP was enacted in 1997.

- **Do estimates include savings from Medicaid drug rebates?** Under federal law drug manufacturers are required to pay rebates to the federal and state governments for outpatient prescription drugs that Medicaid dispenses to beneficiaries. This was a condition of Medicaid covering their products. Prior to the ACA, drugs prescribed to Medicaid managed care beneficiaries were exempt from this requirement. Congress based this exception on the assumption that managed care plans could negotiate discounted drug prices as favorable as those required under the Medicaid drug rebate. However, evidence shows that this has not been the case. Starting in 2010, the ACA now requires manufacturers to pay rebates for drugs provided through managed care plans, ensuring that Medicaid is obtaining the best prices for all the drugs it covers, which results in state savings. These changes to the Medicaid drug rebate remain in place regardless of a state's decision on the Medicaid expansion and therefore are not an area of savings that result from the expansion itself. Nevertheless, these savings should be incorporated into the underlying projections of state spending on Medicaid with and without the expansion.

Other Potential Medicaid Offsets in States that Cover Childless Adults and Parents at Higher Income Levels

There are a few other areas of potential Medicaid savings that should be incorporated into an expansion cost estimate, although whether a particular state will be able to take advantage of these savings depends on what it has done in the past to expand coverage for parents and childless adults.

- **Increased match for states that already cover poor childless adults and parents.** For states taking up the Medicaid expansion that had already covered parents and childless adults up to the federal poverty line prior to the ACA, currently eligible childless adults will qualify for a higher Medicaid matching rate starting in 2014. By 2019, the rate will reach 93 percent and then starting in 2020, remain at 90 percent on a permanent basis, the same matching rate available for newly eligible individuals.

- **Enhanced match for states that took up the early expansion for childless adults.** The ACA allows states to cover childless adults immediately and receive federal funding for this

population using the state's regular Medicaid matching rate. A few states have taken up this option and others have used waivers to expand coverage in advance of 2014. These states include California, Connecticut, Colorado, Minnesota, Missouri, New Jersey, Washington, and the District of Columbia. If these states expand Medicaid, they would receive the enhanced match for these childless adults that they are currently covering.

- **Higher match for states that offer limited benefit coverage through waivers.** Some states currently offer limited benefit coverage for parents and childless adults through waivers. In these states, individuals who are enrolled in these limited benefit programs would be considered newly eligible for Medicaid, and the state can get the higher federal matching rate for covering them.

- **Subsidized exchange coverage for adults in states that offer coverage at higher income levels.** Some states like Connecticut and New York currently offer parent coverage at higher income levels. For example, Connecticut covers non-working parents up to 185 percent of the poverty level, and New York covers these parents up to 150 percent of poverty of the poverty level. When the coverage expansions take effect in 2014, these states can scale back Medicaid coverage of these parents and shift them to subsidized exchange coverage, which is fully federally funded. It should be noted that shifting coverage of these populations from Medicaid to exchange subsidies does raise some concerns around the affordability of premiums and cost-sharing under subsidized exchange plans. Some states contemplating this shift are also examining ways to mitigate the impact on beneficiaries, including providing additional assistance with premiums and cost-sharing.

Potential Offsets Elsewhere in the State and Local Budgets

In assessing the overall fiscal impact of the Medicaid expansion, it will be important to go beyond the Medicaid budget and also consider potential offsets in other areas of state spending. A state that expands Medicaid will cover more people who would otherwise be uninsured, and states (and localities) pay for a lot of health services for the uninsured now. It would, therefore, make sense to see savings in state spending in care provided to the uninsured.

Each state's budget is unique in terms of how it classifies and categorizes areas of spending, so a careful analysis of potential offsets will require delving deeper into each state's budget documents. A complete examination would also likely require analysis of expenditures by county and local governments that are funded (in part) by the state. In some cases, some services for the uninsured are funded in large part by counties so it would also make sense to look at potential savings at the county level.

Most of these savings will occur in three areas:

- **Uncompensated care.** By reducing the number of people without health insurance, the Medicaid expansion will reduce state and local costs for uncompensated hospital care for the uninsured. In 2008, state and local governments shouldered $10.6 billion, or nearly 20 percent,

of the cost of caring for uninsured people in hospitals.[3] Some items you may want to explore to get a sense of your state's savings on uncompensated care include: How much uncompensated care spending occurs in the state? How does the state finance uncompensated care — through general funds, county taxes, provider taxes, or some other means? What is your state's Medicaid disproportionate share hospital (DSH) allotment? How does your state distribute its DSH payments? Does the state have other uncompensated care or indigent care programs? What are the income levels of the uninsured people that receive uncompensated care? Would these individuals qualify for the Medicaid expansion? (In some states, the hospital association, counties, or other groups might be able to share these data with you, or they may be publicly available.) How much of the uncompensated care savings would accrue to the state? How much would accrue to local governments and other payers?

- **Mental health and substance abuse treatment services.** The Medicaid expansion will also push down state costs in providing mental health and substance abuse treatment services to the uninsured. State and local governments provided 44 percent of the funding for state mental health agencies in 2009, amounting to $17 billion.[4] The Medicaid expansion would enable states to replace state and local dollars spent on mental health and substance abuse treatment services with federal Medicaid funds. To determine the potential savings in a particular state, advocates should try to identify the following: Who are the people served by state-funded mental health and substance abuse programs? Would they qualify for the Medicaid expansion? What types of services do they receive? What portion of these services is funded through state general funds? What portion is funded through local funds? Could these services be covered through Medicaid? (Keep in mind that some savings may need to stay in the mental health system given the overall inadequacy of funding for mental health and substance abuse services.)

- **Public health services.** Some states' budget for public health includes funding for preventive care provided in public clinics, such as immunizations. Some of these services could be covered through Medicaid. Some questions you can ask to determine savings in this area include: What health services are included in your state's public health budget? Are any of these considered Medicaid-covered services? Could the people who use these public health services be eligible for Medicaid under the expansion? (Similar savings may accrue to county and local health department budgets that often cover these services.)

As you explore these issues further, you may discover that it is not possible to quantify the impact of expanding Medicaid on these services. However, it may be possible to work with health care providers and others to profile a particular program or service and show the impact of expanding Medicaid. A mental health provider, for example, may have information on how many people receiving services are uninsured and would be covered if the state expanded Medicaid. Local chapters of the American Cancer Society, the American Heart Association and other similar groups may be able to provide examples of people who are uninsured and explain how their care is provided and paid for. County health departments can provide information about immunizations,

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[3] Jack Hadley, *et al.,* "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs,* August 25, 2008.

[4] National Association of State Mental Health Program Directors Research Institute, Inc., "FY 2009 State Mental Health Revenue and Expenditure Study Results," September 2011.

public health nursing and other services they provide to uninsured people. Information like this may be helpful as a supplement to estimates of the federal and state costs of the expansion.

Estimating the Revenue and Broader Economic Effects of the Additional Federal Dollars Brought in by the Medicaid Expansion

We have received many requests for help in quantifying the positive impact that the Medicaid expansion would have on a state's economy, jobs, and revenues. The ACA as a whole, and the Medicaid expansion, is clearly good for a state's and the nation's economy, but quantifying its impact is quite difficult because of the many moving pieces involved. In addition, the economic models (input-output models) that are being proposed to estimate job creation are not appropriate for measuring impacts on the state economy as a whole. This is particularly true for estimating "multiplier effects," or the spillover effects on other parts of the economy from increased federal health spending. Any quantitative estimates will be speculative and highly uncertain.

However, recognizing that these are important arguments in many states, we provide the following guidance on how to approach these issues:

- **The impact of the Medicaid expansion on a state's economy.** A state's decision to take the Medicaid expansion option will clearly benefit its economy. The influx of new federal dollars that would pay for most of the expansion would have a positive effect on the state's economy in the next few years as the overall economy remains weak. The impact, however, would tend to diminish in future years as the economy recovers, but remain positive for some time. (Note that we are *not* saying that the increased *state* spending on Medicaid would have a positive effect, for the same reason that we are not saying that the reduced state/local spending on uncompensated care would have a negative effect: either way, the state impact of higher or lower state spending would be largely offset by changes in other state and local taxes or spending.) This impact occurs because: (a) some of those federal dollars pay for care that otherwise wouldn't have been provided; and (b) the rest of those federal dollars pay for care that otherwise would have been provided at state, local, private or individual expense, thereby freeing up dollars for other uses.

- **The impact of the Medicaid expansion on jobs.** The effects of the Medicaid expansion on a state's economy and on jobs are two sides of the same coin. A state that moves forward with the expansion will bring in a large amount of federal funds, which in the current economy operating below its potential will result in more economic growth and jobs. However, for the reasons just noted, it is not possible to estimate precisely how many jobs would be created as a result. One suggestion we can make for connecting the increased federal funding that would result from the Medicaid expansion to jobs is to take the total amount of federal funding anticipated to accompany the expansion and translate it into the number of jobs it could finance. For example, in a state where the Medicaid expansion is expected to bring in $100 million per year in additional federal dollars, one could make the statement that "$100 million is enough money to pay the salaries of about 1,600 health workers at an average salary of $61,000." Discussing the federal dollars that would flow to the state in this context could be useful. This calculation can be done by looking up at the Bureau of Labor Statistics' website

what the average salary is for jobs in the health care sector and dividing the federal dollars flowing into the state over that figure.

- **Revenues resulting from the additional federal dollars spent on Medicaid in the state.** Some states have included in their estimates revenue increases that would result from expanding Medicaid. For example, Arkansas assumes that the additional federal dollars that would flow into the state and the resulting greater economic activity would be subject to state taxes and therefore bring in additional revenue. While this approach increases the estimated financial benefits to the state, we caution advocates against making such claims. Including such economic feedbacks in revenue estimates is unwise as a matter of overall budget policy.[5] Moreover, advocates can make a strong financial case for the Medicaid expansion without counting such revenue impacts. Indeed, the Arkansas analysis shows that the state would still save money on the expansion even if it did not include revenues from taxes on the federal Medicaid dollars.

[5] Paul N. Van de Water, "Budget Plans Should Not Rely on 'Dynamic Scoring,'" Center on Budget and Policy Priorities, June 21, 2012, http://www.cbpp.org/cms/index.cfm?fa=view&id=3598.

Additional Resources

John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, The Urban Institute/Kaiser Family Foundation, May 2010.

Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), the authors estimate each state's additional Medicaid enrollment and expenditures under the ACA Medicaid expansion. National enrollment is projected to increase between 16 million and 23 million individuals, with states financing only between 5 percent and 7.5 percent of the costs of the expansion. State spending would increase 1.4 percent to 2.9 percent above what they otherwise would spend in the absence of the ACA. Estimates are presented under two participation rate scenarios – a standard scenario aligning enrollment and spending with the original ACA Congressional Budget Office estimates, and an enhanced outreach scenario. A methodology section is included with a brief explanation of the HIPSM, and details on participation rate and per beneficiary cost assumptions. Estimates include only adults and do not include children.

The following data are estimated for every state:

- Increase in Medicaid enrollment in 2019 and the share who previously were uninsured
- Federal and state Medicaid expenditures from 2014 through 2019
- Medicaid enrollment and expenditures relative to the Medicaid baseline in the absence of the ACA
- Medicaid expenditures for those newly eligible for Medicaid who enroll and for those currently eligible who newly enroll

Genevieve Kenney et. al., *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid*, The Urban Institute, July 5, 2012.

This brief estimates the number of uninsured who would be newly eligible under the ACA's Medicaid expansion, including those with incomes below the poverty line. It also estimates the number who are currently eligible for Medicaid but uninsured. More than 3 of every 4 of all Medicaid-eligible uninsured with incomes below 138 percent of the poverty line are newly eligible under the expansion. These estimates include only adults. These data do not make any assumption about the share likely to enroll in the program.

The following data are estimated for every state:

- Number of uninsured under 138 percent of poverty newly eligible for Medicaid under the ACA
- Number of poor uninsured newly eligible for Medicaid under the ACA
- Number of uninsured under 138 percent of poverty currently eligible for Medicaid but uninsured

Genevieve Kenney et. al., *Making the Medicaid Expansion an ACA Option: How Many Low-income Americans Could Remain Uninsured*, The Urban Institute, June 29, 2012.

This brief estimates the number of uninsured who are newly or currently eligible for Medicaid coverage under the ACA. More than 22 million individuals fall into this group with nearly 18 million below the federal poverty line. The analysts use the most recent American Community Survey data and determine eligibility using state specific criteria. These estimates include both *adults and children* and account for citizenship status. It should be noted that the number who will newly enroll will be many fewer as the participation rate is expected to be between 50 percent and 70 percent.

The following data are estimated for every state:

- Number of poor uninsured individuals who are eligible for Medicaid under the ACA
- Number of uninsured individuals between 100 percent and 138 percent of the poverty line who are eligible for Medicaid under the ACA
- Total number of uninsured
- Share of total uninsured who are eligible for Medicaid under the ACA

Matthew Beuttgens, Stan Dorn and Caitlin Carroll, *Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014-2019*, The Urban Institute/Robert Wood Johnson Foundation, July 2011.

Using the HIPSM, the authors estimate for each state both additional Medicaid spending under the ACA and potential savings as a result of the ACA Medicaid expansion. States collectively are estimated to spend an additional $80 billion in ACA related Medicaid costs, but are expected to achieve net savings after accounting for several elements of savings (reduced uncompensated care spending, reduced state-only mental health care spending, increased federal matching funds for certain current Medicaid enrollees, and elimination of current Medicaid coverage for certain individuals who will be eligible for exchange coverage). The authors acknowledge there are other savings elements that they cannot include in their estimate (or estimates that they cannot provide on a state-by-state basis like savings in mental health costs). For the state-by-state estimates of uncompensated care savings, the authors estimate uncompensated care spending on a state-by-state basis but assume the same national percentage savings for state budgets due to the expansion. These estimates incorporate costs and savings related to both adults and children. Estimates are for the period from 2014 through 2019.

The state Medicaid costs before netting out savings are higher under this analysis than other HIPSM-based analyses (including the May 2010 estimates by Holahan and Headen) because the authors apparently do not align with CBO estimates and therefore assume higher participation rates and per beneficiary costs, particularly among those currently eligible for Medicaid coverage who are unenrolled. This increases the states' share of expansion costs considerably.

The following data are estimated for every state:

- Medicaid expenditures
- State savings due to increased federal match for certain currently eligible Medicaid beneficiaries

- State savings due to eliminating Medicaid coverage for certain currently eligible beneficiaries
- Federal spending on premium and cost-sharing subsidies
- State savings due to reduced uncompensated care
- Net state spending

Matthew Beuttgens, John Holahan and Caitlin Carroll, *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid,* The Urban Institute/Robert Wood Johnson Foundation, March 2011.

Applying the HIPSM in a slightly different manner, the authors estimate Medicaid enrollment and expenditures and exchange enrollment and expenditures for each state. More than 17 million are projected to enroll in Medicaid and nearly 24 million in non-group Exchanges. This analysis is slightly different than others in that it assumes full implementation immediately in 2011 and offers only single-year estimates. These estimates incorporate both adults and children and also include the effects on CHIP. The analysts assume a participation rate slightly higher than under the enhanced scenario of the Urban/Kaiser Family Foundation May 2010 report.

The following data are estimated for every state:

- Reduction in the number uninsured as a result of the expansion
- Number covered in individual exchanges by income
- Expenditures on premium credits and cost-sharing reductions by income
- Medicaid and CHIP enrollment by Medicaid eligibility status (currently or newly eligible)
- Medicaid expenditures for those newly eligible for Medicaid under the ACA