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NHeLP's Guide for Evaluating Fiscal Analyses of the ACA's Adult Medicaid Expansion

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Introduction

Over a dozen states have conducted fiscal analyses of the projected impact on the state budget due to the Affordable Care Act's Medicaid expansion for adults up to 138% of the Federal Poverty Level (FPL). Advocates, policy analysts, and academics have also been releasing their own studies. This guide will help advocates understand the major elements that comprise a robust fiscal estimate of a state-specific Medicaid expansion and highlights potential areas of concern when assessing already released fiscal reports. We have linked to a number of resources that will help advocates identify and counter inflated estimates of costs and/or develop their own estimates. This guide's companion piece, Five Myths and Facts about the Costs of Medicaid Expansion, offers a condensed version of key themes that come out of this collection of fiscal analyses.

I. Enrollment rates

A key question for state officials considering the potential costs of the Medicaid expansion is – how many people are expected to enroll? Numerous resources quantify how many individuals would be eligible under the expansion, as well as historic data on reasonable take up and participation rates. However, enrollment predictions can vary widely, with some fiscal analyses projecting unrealistically high participation rates that, in turn, inflate the estimated cost of expansion.

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Eligible Adult Population up to 138% FPL	Some reports project the number of newly eligible based on the *total* number of adults living below 138% FPL. They fail to exclude those who are already enrolled or who are otherwise ineligible. The Current Population Survey (CPS), on which many states base their analyses, typically undercounts current Medicaid participation (see Kaiser	**How to:** The Urban Institute's analysis, Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?, provides useful tables with the number of adults under 138% FPL by state, citizenship status, race/ethnicity, age and

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	Family Foundation (KFF) report on Affordable Care Act's (ACA) costs, at 18). For example, some Medicaid enrollees mistakenly report having private insurance or no insurance at all (~20%), see Health Services Research article. So fiscal analyses should account for this underreporting. A properly conducted fiscal analysis also discounts adults who are not Medicaid eligible, such as lawful immigrants subject to a 5-year Medicaid bar and "inmates in a public institution."	gender. This 2012 study is based on adjusted data from the American Community Survey and accounts for Medicaid underreporting as well as institutionalization. (See n9 at pg. 5 in the report for details). **Examples:** • University of Maryland-Baltimore County's Hilltop Institute fiscal analysis of health reform gives a detailed methodology of how they estimated this population using unemployment projections and CPS data (at 6-7). • For a detailed methodology of how researchers modeled Medicaid eligible populations in Washington state, see: The ACA Medicaid Expansion in Washington (Urban Institute).
Total Participation Rate	Many fiscal studies find huge costs by assuming that nearly everyone eligible for the expansion will enroll. In the long history of public programs, including previous Medicaid expansions, predictions of participation rates of 95 to 100% have proven to be unrealistic. For an overview of historical participation rates see the 2012 Assistant Secretary for Planning & Evaluation (ASPE) Literature review. CMS Office of the Actuary offers an eventual 87% take up (2011 report at 32; cited by ASPE, n35), which is much higher than historical trends. CMS acknowledges that this number is unreliable: "The actual number of people who will become eligible for and enroll in Medicaid in 2014 is unknown, as are their health care costs; accordingly, these estimates should be considered more uncertain than other projections of Medicaid enrollment and expenditures under current eligibility criteria due to the lack of experience and program data to inform them." (2011 Report at 7). A University Research Center analysis (Mississippi) (at 9) incorrectly claims that CMS projects a 95% participation rate. In the CMS report, that projection only applies to people who have been uninsured for at least a year.	**How To:** For rough estimates of state-by-state average participation, see KFF's The Coverage and Cost Impacts of Expanding Medicaid, 2009 (at 36-37). **Example:** • For a detailed methodology of how researchers modeled Medicaid participation in Washington state, see: The ACA Medicaid Expansion in Washington (The Urban Institute).

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	Additionally, a 2012 Health Affairs article explores some of the reasons for variation in participation rates and indicates that take-up for childless adults is generally lower than for other eligibility categories. **Reasonable Estimates:** KFF developed a participation range of 57-75% (2010 KFF report on ACA costs, at 36) using simulation scenarios based on an analysis of historic data from previous expansions, but it does not account for phase-in (see "Phase-in of enrollment" below).	
Privately insured who switch to Medicaid (Crowd out)	"Crowd out" refers to the number of people with Employer Sponsored Insurance (ESI) who will switch to Medicaid after 2014. Milliman's Nebraska and South Carolina (PPT, at 7) analyses of proposed Medicaid expansion assumed a 50-75% crowd out rate. Milliman does not explain the basis for this estimate. In contrast, Massachusetts's 2006 health reform, a model similar to the ACA, , found no evidence of crowd out and instead found that employer sponsored insurance increased (see Health Reform in Massachusetts: An Update as of Fall 2009, at 11). Most estimates find that a relatively low percentage of individuals will switch from ESI coverage. **Reasonable Estimates:** Realistic "crowd out" estimates range from 10-25%. (KFF report on ACA costs, at 8)	**How to:** See KFF report on ACA costs (at 8).
Phase-in of enrollment	Some studies – including Milliman's fiscal analyses for Indiana, Nebraska, South Carolina, and Mississippi – project costs based on 100% participation on Day 1. Studies should gradually phase-in to the projected total enrollment. **Reasonable Estimates:** Between 25-50% of total projected enrollment in the first year, such as CHRT's Michigan analysis.	**Example:** • The Center for Healthcare Research & Transformation's (CHRT) Michigan Medicaid expansion analysis estimates that up to half of potential newly eligible individuals will enroll in the first year.
Base data for enrollment growth projections	If a fiscal analysis bases its projections on enrollment figures from 2008-2010, the projections will likely be inflated due to the countercyclical effect of increasing Medicaid enrollment during economic crisis. Projected enrollment increases should draw from averages over a longer period of time.	**Example:** • Milliman's 2012 South Carolina analysis (at 2) updates an earlier projection and adjusts the estimates for enrollment citing distortions in the baseline due to the recession.

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Time frame	Fiscal analyses often use different time frames, which can make side-by-side cost comparisons difficult. The degree of uncertainty in any projection compounds over time (see, e.g., CMS' Office of the Actuary report cited in "Total Participation Rate" above). Because Medicaid expansion *begins* with high uncertainty and most state expenditures fall in the out years (2019 and beyond), reports that include projections beyond 2020 deserve extra scrutiny.	**Example:** • Mississippi's University Research Center Medicaid expansion analysis projects costs through 2025.

II. Enrollee Costs Related to the Adult Expansion

The cost of providing care to newly eligible enrollees is perhaps the most critical, yet most difficult, figure to accurately estimate. Most analyses estimate the costs based upon expenditures for current Medicaid populations. However, no hard data exactly matches the newly eligible populations. Some analyses fail to adequately consider differences in health status and utilization rates between existing and newly eligible enrollees. Other factors, such as growth and inflation rates, also vary and can greatly influence the outcome of enrollee cost projections.

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Predicting Per Member Per Year (PMPY) costs: comparison with existing groups	Due to uncertainty in how to estimate these costs, it may be best to present these figures as a range rather than a single figure, similar to the enrollment estimates. We have yet to encounter a fiscal analysis that does so. Also, few estimates adequately describe or justify their assumptions for estimates. CMS' Office of the Actuary (at 18-19) nicely outlines the various sources of uncertainty in fiscal projections relating to the ACA. In their 2011 report (at 26), CMS estimates that benefit expenditures for expansion adults will be roughly 40% lower than the PMPY for existing adult beneficiaries, in line with PMPY costs for Medicaid children. They attribute this to the current tendency for adults to become Medicaid eligible due to loss of income due to an illness and to the expected increase in participation of healthy, low-expense adults in Medicaid expansion (at 28). The Office of the Actuary's PMPY estimate for expansion adults in 2014 is $3,700.	**How to:** State-specific estimates are important because costs vary greatly, but some state-by-state resources can serve as a jumping off point for developing a reasonable projection and growth rate (see below). Be careful to note *who* and *what* are included in a given eligibility category. For example, the "adult" group used as a basis for estimating PMPY costs in many analyses includes pregnant women, who will not be eligible for the adult expansion unless they are enrolled prior to their pregnancy (e.g. in MACPAC data). Also, be sure to factor in that states with higher

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	A 2010 Urban Institute study compares health status of different groups of low-income adults and also shows that newly eligible will likely cost less than currently eligible adults because the uninsured and privately insured across income categories report better overall health. Unlike the CMS' Actuary, however, the authors project that PMPY for newly eligible adults will be roughly in line with currently enrolled non-disabled adults (at 9). The Urban study identifies a range of roughly $4,200-$6,000 PMPY for different non-disabled adult eligibility groups. A Center for Healthcare Strategies (CHCS) brief examined the actual costs of newly eligible childless adults in state waiver programs, but this is expected to differ from expansion adults due to different eligibility thresholds, different benefit structures, and adverse selection in current adult programs. Moreover, prior expansion states' costs vary widely. For example, Arizona's program, which covers adults to 100% FPL, has a PMPY of $7,361. Maine, with the same eligibility standard, had a lower PMPY of $4,872 in 2008 (this is artificially high to the inclusion of funds associated with prior hospital settlements). Expansion to 138% FPL would likely lower 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%) generally have fewer health risks; and 3) the Expansion will likely enroll a higher proportion of healthy adults than current childless adult demonstration programs. **Reasonable Estimates:** While estimates will depend on particularities of state data, credible projections of PMPY for expansion adults should be roughly in line with currently enrolled non-disabled adults. Advocates that give more weight to CMS' Office of the Actuary projections may estimate PMPY between the rate for children and the rate for non-disabled adults.	expansion take-up rates will experience *lower* PMPY costs because they will include more of the healthiest individuals in a population, who are often the last to enroll but have lower costs. **Examples:** • Congressional Budget Office (CBO) estimates on Per Person Costs, 2012. (Note: this includes only federal share of spending.) • The Medicaid & CHIP Payment and Access Commission (MACPAC) gives estimates for 2009 adult enrollee Medicaid payments on a state-by-state level (at 110). Note that PMPY for adults may not accurately approximate the expansion adult population. • KFF has similar 2009 estimates at statehealthfacts.org.
Pent-up demand	Experts agree that much of the new adult population has a history of being uninsured and a higher risk of chronic disease. To offset these issues, Milliman's 2011 Ohio analysis (at 14) increases the average PMPY by 5% for the first year of coverage for newly eligible enrollees, but does not explain how it arrived at that number.	**Examples:** • According to the CHCS analysis, Indiana found that PMPY costs for its childless adult waiver coverage dropped after the first six months in most categories (see also the Milliman analysis).

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	In the first years of expansion, expenditures may well increase due to the pent up demand. However, the Federal government will cover the full costs of expansion from 2014 to 2016. Thus, pent up demand actually supports states expanding Medicaid quickly, as the federal government will cover 100% of expenditures to absorb the impact of pent-up demand.	• If a fiscal analysis includes an increase for pent-up demand, it may have to adjust PMPY growth rates downward in subsequent years.
Administration costs	Some fiscal analyses predict significant administrative cost increases under Medicaid expansion. While the volume of applicants will increase, the cost of enrolling a single applicant should decline significantly as states streamline and largely automate eligibility systems. Overall, administration as a percent of total health expenditures should go down after 2014. Notably, states receive an increased FMAP of 90% for the design, development and implementation of upgraded eligibility systems until 2015, and a 75% FMAP for the maintenance and operation of enhanced systems (with no time limit). Some fiscal analyses, like Milliman's 2010 Nebraska report (at 5), lump Exchange administration and Medicaid eligibility system overhauls into this category, which is inappropriate for an analysis of Medicaid expansion. All states must redesign their eligibility systems, regardless of the Expansion. **Reasonable Estimates:** A Center on Budget & Policy Priorities (CBPP) issue brief (at 2) estimates administration costs at 3 to 8% of expenditures. Milliman's 2010 Nebraska report (at 5) is in line with CBPP, citing a range of 3.5 to 6%. Administrative costs are usually derived as a percentage of total medical costs and thus depend on an accurate PMPY estimate.	**Examples:** • UMBC's Hilltop Institute uses 5.5% of total health expenditures, and $100 million for upgrading eligibility systems. • A Kaiser Family Foundation brief, State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts (at v), includes a table with a few states' reported estimates of their Medicaid administrative costs.
Annual cost inflation	Annual cost inflation introduces significant uncertainty into the model, especially if the model projects over a long time frame, such as 10 years. This is especially critical for the Medicaid expansion projections because most of a state's costs arise in later years. A number of fiscal analyses project medical expenditure growth at around 3% per year (e.g. Milliman's 2010 Nebraska report (at 4), CHRT's Michigan analysis (at 6)). Other analyses (Milliman 2011 Ohio (at 15), University of New Mexico (at 9)) use a 5% annual growth rate. To illustrate the difference:	**How to:** The Bureau of Labor Statistics publishes the Consumer Price Index (CPI) which includes data on medical services and goods. **Example:** • CHRT's Michigan analysis based its 3% projection on the state Department of Community Health's HMO Actuarial Rate Certification.

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	• At 3% growth, a baseline $5,000 PMPY in 2014 would lead to a $6,523 PMPY in 2023 (30.5% increase); • At 5% growth, the same $5,000 baseline would lead to a $7,756 PMPY in 2023 (55.1% increase). Studies show that Medicaid costs increase at a slower rate than private insurance (see the Urban Institute's paper Medicare, Medicaid, and the Deficit Debate). **Reasonable estimates:** While it may vary from state to state, CHRT's Michigan report is one of the few that cites a source for their assumption, and they use 3%.	
Provider rates	Some Milliman studies (Mississippi, Indiana) predict substantial increases in provider rates will be necessary to meet increased demand under the expansion. The ACA enacted a primary care provider payment boost for FY 2014-2015 to partially address this issue. Medicaid payment rates and network adequacy are problems for some provider types, but assumptions that states will need to increase rates to match Medicare are speculative. .	**How to:** The ACA includes measures that address the need to expand provider capacity. Some programs have been underfunded. However, participation in the National Health Service Corps has nearly reached 10,000 clinicians in 2012, an increase from 3,600 in 2008. The NHSC repays medical student loans if clinicians agree to work in medically underserved areas. Funding for infrastructure and capacity building for Federally Qualified Health Centers and other essential community providers also helps to build capacity to handle future enrollment increases.

III. Conflating the Adult Expansion with Other ACA Enrollment Expansions

A number of analyses combine the costs of the adult Expansion with other ACA reforms that will impact Medicaid enrollment. To accurately account for the impacts of a state's decision on the adult Expansion, fiscal analyses must separate the cost of the adult expansion from the costs of the mandatory expansion of children to 133% FPL and the impact of increased enrollment of currently eligible individuals due to publicity around health reform, changes in the application process, and the individual mandate.

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"Woodwork" or "welcome mat" effect	Some fiscal analyses include the number of currently eligible but not enrolled individuals when projecting enrollment and cost under the adult Medicaid expansion (e.g. Milliman 2011 Ohio, which includes those currently eligible in its estimate of the PMPY rate for those newly eligible). This overinflates the cost to states contemplating whether to adopt the adult expansion. In 2014, many currently eligible but unenrolled individuals will enroll in Medicaid regardless of whether a state implements the adult Expansion. The ACA requires all states to develop a single-streamlined application for their publicly supported health insurance coverage and to improve coordination across these insurance programs (e.g., Medicaid, CHIP and Exchanges). Publicity around the launch of the Exchanges, the mandatory child expansion and the requirement that individuals have coverage or pay a penalty (a.k.a. the individual mandate) will also encourage enrollment despite a state's decision on the adult Expansion. That said, many experts acknowledge that states that refuse to expand Medicaid may have a slightly lower boost in current enrollment due to less publicity and active outreach. **Reasonable Estimates:** Credible sources estimate the difference at 10% to 25% of the general welcome mat effect. See KFF report on ACA costs (at 8).	**How to:** See KFF's The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. Fiscal analyses should exclude the costs for the "woodwork" effect,
Foster Children Mandatory expansion	The ACA requires states to extend Medicaid to children aging out of foster care until age 26. Some analyses include this population when estimating the cost of the adult expansion. However, the extension of coverage for former foster children provision is separate from the ACA's adult Medicaid expansion and remains mandatory for all states. It therefore should not be included in cost/benefit estimates of the adult expansion.	**How to:** State Medicaid agencies and child welfare agencies should have data available on the number of children expected to age out of foster care. Fiscal analyses should exclude the costs for these individuals when estimating the cost of the adult expansion. See Child Welfare and the Affordable Care Act: Key Provisions for Foster Care Children and Youth from Community Catalyst and the Center for Children and Families.

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Children age 6-18 Mandatory expansion	Some fiscal reports include the costs of expanding Medicaid to children age 6-19 to 133% FPL. These costs should be separated from cost of the Medicaid expansion since this is an independent requirement regardless of whether a state expands Medicaid to all adults. 42 U.S.C. § 1396a(l). Note that expansion children are not entitled to the 100% adult FMAP. They may be eligible for enhanced CHIP matching rates.	**How to:** See KFF State Health Facts or your state Medicaid/CHIP agency for current enrollment numbers. Fiscal analyses should exclude the costs for these individuals when estimating the cost of the adult expansion

IV. State Budget Savings Due to the Adult Expansion

States implementing the expansion will realize substantial budget savings because they will receive enhanced federal Medicaid match for many services previously paid for using state dollars. However, some fiscal analyses fail to mention these potential offsets when predicting the impact of the Medicaid expansion on state budgets. Also, states that refuse to implement the expansion will see greater budget pressures due to the continued numbers of uninsured individuals, uncompensated care and reductions in federal subsidies to help pay for those costs.

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Medically Needy	Milliman's 2010 Nebraska analysis estimates that the cost of the medically needy group ("MN") will increase because the eligibility standard will increase from 43% to 138% FPL. In fact, eligibility limits for the MN will not change absent a state plan amendment. Milliman's 2011 Ohio analysis (at 18) also discusses additional costs due to the MN, though these costs were not included in their total estimate. In contrast, the Arkansas Department of Health and Human Services finds huge savings from the MN in its fiscal analysis, probably due to the expectation that many enrollees currently eligible as the MN will fold into the new adult group (or the state exchange) over time. Going forward, states will not be required to evaluate new applicants as potentially medically needy as long as they are otherwise eligible. Those with incomes below 138% will likely qualify for enhanced FMAP (and thus offset current state expenditures). However, CMS has not issued specific guidance on how it will calculate FMAP for this group.	**How to:** Investigate the eligibility criteria for MN in your state (if applicable) to see whether currently enrolled MN adults might qualify under the adult expansion criteria. Potential savings will be easier to estimate after HHS issues more guidance on the methodology for determining FMAP. State-by-state MN enrollment and annual costs is available on the CMS website (here).

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Family Planning	In states that expand Medicaid, eligible individuals with incomes below 138% FPL currently enrolled in a state's family planning expansion program will shift to benchmark Medicaid coverage at the enhanced FMAP. Family planning services, supplies and related services will still be covered. Some fiscal analyses point to potential budget savings due to this switch. However, because Medicaid already reimburses family planning services and supplies with a 90% FMAP, the savings would be minimal and time limited. 42 USC § 1396b(a)(5). Potential savings associated with family planning enrollees above 138% FPL would likewise be minimal and are not germane to the adult Medicaid expansion. Advocates may also consider that continuing existing Medicaid family planning expansion programs for individuals with incomes over 138% of FPL avoids problems with access to contraceptives due to churn (switching between Medicaid and Exchange coverage). More consistent access could yield significant savings by reducing a state's Medicaid-funded pregnancies and births.	**How to:** For more information on the potential cost-savings of family planning services in Medicaid, see: • NHeLP's 2011 fact sheet: Medicaid Family Planning Services Save Money; • A Guttmacher Institute study on how family planning reduces unwanted pregnancies and government expenses; • A 2011 New England Journal of Medicine article (Cleland et al).
Breast and Cervical Cancer Treatment Program (BCCTP)	BCCTP beneficiaries under 133% FPL currently receive full scope Medicaid. Some fiscal analysts claim that if a state ends its BCCTP program, currently eligible women may fold into the new adult category and receive enhanced match. Some states, like California, provide state funds to cover men with breast cancer or people diagnosed outside the CDC system since, with limited exceptions, only CDC-screened individuals are eligible for BCCTP coverage. These state-funded add-ons would be unnecessary if the state implements the adult Medicaid expansion. Until CMS provides more guidance on the determination of FMAP, NHeLP does not recommend assuming enhanced match for this population.	**How to:** State-by-state 2009 annual enrollment in BCCTP program is available on this CMS' MSIS table. MSIS data for total 2009 Medicaid payments for BCCTP beneficiaries are here (includes both the federal and state share). More recent MSIS data may be available for your state on the CMS website (here). **Example:** • California has a detailed 2011 report of state enrollment for this program.
Currently operating programs for childless adults	Some states already cover childless adults and parents to at least 100% FPL with full Medicaid benefits (or substantially equivalent coverage). These states will receive a transitional FMAP boost for currently eligible adults when they expand coverage. This transitional FMAP will rise to 93% in 2019 and thereafter stay at 90%. This is perhaps the greatest source of Medicaid budget relief for these states.	**How to:** Review your state budget and state demonstration waiver (these populations will previously have been covered through a "section 1115 waiver" because they did not qualify under a state Medicaid plan. If your state

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	States that currently offer *limited* coverage for adults will be able to fold their current adult enrollees into the Medicaid expansion at the newly eligible FMAP (100% for 2014-2016). 42 U.S.C. 1396d(y)(2).	offers coverage to childless adults but provides less than full Medicaid benefits, all current participants would qualify as newly eligible at enhanced federal match rates. If it provides full Medicaid benefits, it will still receive additional federal funds that should be included in analyses. A KFF brief (at 2) includes the eligibility limits for low-income adults and parents and a map of states that offer less than full scope Medicaid. However, some states have special health programs for childless adults funded with state-only dollars. Many of these enrollees will become eligible for the Medicaid expansion. Prior expansion states that would qualify for a transitional FMAP include: NY, AZ, HI, DE, VT and possibly ME.
Mental Health Programs	Expanding Medicaid will reduce state and local costs associated with providing mental health services to people who are uninsured. CBPP estimates that in 2009, state and local governments spent approximately $17 billion on funding for state mental health agencies. A KFF brief, Medicaid Policy Options for Meeting the Needs of Adults with Mental Illness under the Affordable Care Act, examines the potential of Medicaid expansion to address largely unmet mental health needs. Many state and local mental health services were dramatically cut during the recession. The National Alliance on Mental Illness (NAMI) has issued a report detailing cuts to state Medicaid budgets between 2009-2012. Medicaid expansion is a mechanism to restore some of that funding as opposed to offsetting other budget expenses. The National Association of State Mental Health Program Directors describes significant state budget gains in its December 2012 report, The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States.	**How to:** State-by-state information on expenditures is available at State Mental Health Agency Systems U*Profiles. State expenditures on State Mental Health Agencies, 2009, and the National Survey on Drug Use and Health's state estimates of adult mental illness may also help to identify state general funds expenses, but they will require interpretation by a state budget expert. **Examples:** • CHRT Michigan Medicaid expansion analysis (at 8) found $150-$175 million savings in Community Mental Health in 2014 alone. • CHRT's study found non-Medicaid expenses in the Community Health budget appropriation (at 7). • Useful data on behavioral health and Medicaid financing can be found in Health Affairs 2006.

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		• A study by the Urban Institute, Ohio State University, REMI and the Health Policy Institute of Ohio estimates Ohio would save $389 million on mental health through 2022 (at 17).
Substance Abuse Treatment	The Medicaid expansion population will have high rates of substance abuse, according to a study in Washington State, which predicted substantial savings in state funding for treatment programs. A report by The National Association of State Alcohol and Drug Abuse Directors (NASADAD) examined health reform and substance abuse and found increased access to treatment services and increased capacity under Medicaid expansions - The Effects of Health Care Reform on Access to, and Funding of, Substance Abuse Services in Maine, Massachusetts, and Vermont.	**How to:** NASADAD provides state-by-state data on substance abuse treatment, including information on federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, state spending, and unmet need in the state.
Services for Homeless Individuals	A recent study by CHCS shows that providing Medicaid case management can lead to reduced costs for homeless individuals with complex health needs, including savings on incarceration and ED visits. **Reasonable Estimates:** Projected savings based upon economic models may be difficult to replicate in a more generalized fiscal analysis.	**How to:** State and local advocates for housing and homelessness can provide information on existing programs. Some jurisdictions may conduct needs assessments and population surveys.
Public Health	Many fiscal analyses fail to include savings to state-funded public health programs, such as immunizations and STD screenings, that now will be covered under the adult Medicaid expansion (see Medicaid Expansion and Public Health) **Reasonable estimates:** State and local health department budgets provide program-specific spending levels and distinguish between federal grants and locally appropriated dollars.	**How to:** Advocates should talk with health officials about public health services that could be reimbursable by Medicaid. However, savings may be limited if these programs have already been cut at the state level.

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People involved with the Justice System	Medicaid covers inpatient hospital expenses for people who are incarcerated. Many more of these individuals will become Medicaid eligible if a state expands. A report by the George Washington Dept. of Health Policy School of Public Health and Health Services examines the savings to states and counties for providing Medicaid coverage to persons incarcerated pending disposition. See also Community Oriented Correctional Health Services' issue brief, Increasing Access to Health Insurance Coverage for Pre-trial Detainees and Individuals Transitioning from Correctional Facilities Under the Patient Protection and Affordable Care Act.	**Examples:** • A 2010 study by the North Carolina Auditor found that the state lost $11.5 million in federal funds annually by failing to bill for Medicaid-eligible services. It predicted the annual savings would increase significantly when the state expands Medicaid coverage to childless adults. • A similar study released in Dec. 2012 by the NY Office of the Comptroller found that New York lost $20 million because it failed to bill Medicaid for healthcare services provided to inmates by outside providers for in-patient stays. These studies do not specifically project costs savings from Medicaid expansion.
Provider Assessments and Premium Taxes	Many states have instituted taxes on hospitals or insurance premiums to generate additional revenue. This can generate additional state matching funds for Medicaid. The Nation Conference of State Legislatures (NCSL) provides a summary of each state's current provider/premium tax structure. Additional enrollment from Medicaid expansion stands to increase revenue from provider taxes, which will offset some of the costs of expansion.	**How to:** See NCSL Provider Tax State summary. **Examples:** • Georgia's Dept. of Community Health estimates $70+ million in annual provider taxes after 2015, more than doubling current provider taxes. • A fiscal analysis from NM's Legislative Finance Committee (at 6) cites the 4% premium tax to offset state budget costs.
State and Local Income Taxes	Medicaid spending grows economic activity in the states, including by creating jobs and increasing income and state tax revenues. During economic downturns, Medicaid enrollment and spending increases, so cutting Medicaid adds to the decrease in income and economic activity as providers and other health care suppliers receive less financing. However, CBPP's report cautions that it is difficult to quantify expected state tax revenues flowing from increased federal Medicaid dollars ("Guidance on Analyzing and Estimating the Cost of Expanding Medicaid," at 8).	**How to:** Look closely at the state's budget, as well as at county and local budgets that draw on state funding to know where and how cost-savings might occur. The fiscal analysis from NM Legislative Finance Committee is fairly comprehensive on how all these taxes relate. While state specific, it is very detailed. In general, potential revenues can

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	A 2009 KFF literature review, Role of Medicaid in State Economies, discusses economic impact modeling for Medicaid. The review shows that regardless of the model used, all studies share a similar finding: *Medicaid spending has a positive impact on economic conditions in a state* (at 5).	include personal income taxes, gross receipt taxes, and premium taxes. **Example:** • See UNM Economic and Fiscal Impacts of the Proposed Medicaid.
Pharmacy Rebates	Medicaid law requires drug manufacturers who want their products covered by Medicaid to pay rebates each time one of their drugs is dispensed to an enrollee. 42 U.S.C. 1396r-8. Initial state offsets will be small because most of the rebates will accrue to the federal government, but as a state's share of expenses for the adult Medicaid expansion increases so will its share of pharmacy rebates related to this population. For more information on the Medicaid Drug Rebate program, see the Medicaid Drug Rebate Program.	**Examples:** • The Urban Institute, Ohio State University, REMI and the Health Policy Institute of Ohio produced a study that projects over $40 million annual savings after 2020 (at 23). • A 2013 Commonwealth Institute study of Virginia finds $293 million in rebate savings through 2021, though the methodology is not explained.
Medicaid DSH	The ACA calls for reductions in payments to states for uncompensated care in hospitals, also known as disproportionate share hospital funding, or DSH. These reductions are phased in to match the ramping up of enrollment in Medicaid and the new Exchanges, which will reduce uncompensated care overall. These reductions happen even if a state refuses the Medicaid expansion so that reduced DSH payments will squeeze budgets in hospitals with continuing high levels of uncompensated care. **Reasonable Estimates:** No state-by-state guidance exists on specific reductions, although three factors will contribute to relative reduction levels: • Number of uninsured in the state; • State's status as "low-DSH" recipient; and • Whether the state uses DSH funds for other purposes, such as waiver coverage. CMS has not indicated if it will consider whether a state expands or not in its calculation of continuing DSH payments.	**How to:** CMS annually publishes Disproportional Share allotments in the Federal Register. Current figures in statehealthfacts.org and an NHeLP Q&A provide an explanation and ACA citations on future reductions A December 2012 article in the New England Journal of Medicaid, Medicaid Expansion Opt-Outs and Uncompensated Care, provides an overview and state-specific data. See also KFF The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis.

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Medicare DSH	States may experience additional budget pressures as additional federal funding sources for uncompensated care dry up. The ACA calls for 75% reductions in Medicare DSH, but allows for providers with ongoing demand to apply for additional relief. Estimates of total reductions vary between 28% and 50% by 2020. In 2010, Medicare DSH totaled $10.8 billion nationwide (see John R. Jacob et al, The Medicare DSH Adjustment, at 4). Medicare DSH is delivered to hospitals as a percentage added to reimbursements. **Reasonable Estimates:** CBO estimates 50% reduction.	**How to:** Because it is based on reimbursements to individual hospitals, the aggregate state figure is difficult to obtain. The state hospital association may have both aggregated and disaggregated data.
State Employee Health Insurance	Insurance premiums are expected to increase in states that refuse to implement the expansion (see "Private Insurance" below). At least one fiscal analysis includes savings to the state employee health benefits that will result from the expansion.	**Example:** • CHRT's Michigan analysis predicts between $19 million and $24 million in savings for employee health benefits over 10 years (at 11).

V. Economic Benefits

Many fiscal analyses fail to address the collateral effects of the Medicaid expansion on state economies. However, some researchers have quantified anticipated economic benefits, such as increased employment and improved workforce health, resulting from the influx of federal funds. Others describe the impact on the private insurance market, predicting increases in premiums in states that refuse to implement the expansion.

Topics	Critical Points of Analysis	How to Locate Data in Your State
Multiplier effect	This type of analysis requires the use of an economic modeling program and is typically conducted by academic or research institutions. The methodologies and scope of these analyses vary widely. For more information, see: 2009 KFF literature review on Role of Medicaid in State Economies. See also this Families USA report from 2008 - Bad Medicine: The President's Medicaid Regulations Will Weaken State Economies and calculator Medicaid State Spending and Your State's Economy.	**Examples:** • Michigan, Maryland analyses are useful templates. • The Virginia Hospital & Healthcare Association commissioned a study, The Economic Impact of the Medicaid Expansion on Virginia's Economy, that projects direct and indirect employment and economic

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		benefits that could result from expansion. • The Louisiana Budget Projects examines the benefits to the workforce. • A University of Memphis study found increase employment, earnings, and overall state economic output. • The Urban Institute, Ohio State University, REMI and the Health Policy Institute of Ohio collaborated to produce a study that shows significant gains in employment opportunities, income for state residents, and sales and income tax revenue for the state and county governments. • A Texas fiscal analysis found that every state dollar spent on Medicaid expansion would generate $43 in economic activity in the state.
Private Insurance Market	The CBO predicts that private insurance premiums will rise by 2% nationwide if states reject the expansion because lower income, poorer health individuals will be buying coverage via the Exchange. The American Academy of Actuaries (AAA) came to a similar conclusion in its report Implications of Medicaid Expansion Decisions on Private Coverage. The AAA report also notes that Exchange premiums also may increase due to spreading fixed reinsurance subsidies over a larger enrollee population if states fail to implement the expansion. Families USA commissioned a study in 2009, Hidden Health Tax: Americans Pay a Premium, that estimated a $1,000/yr increase in private insurance premiums for a family of four due to offset hospitals' expenses associated with uncompensated care.	**How to:** There are no state-by-state estimates on the potential rise in insurance premiums due to states rejecting the adult expansion. However, advocates monitor proposed rate increases above 10% under an ACA provision that requires insurers to publicly disclose and justify rate increases. Advocates should check with their state Department of Insurance.