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# Considerations in Assessing State-Specific Fiscal Effects of the ACA's Medicaid Expansion

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## Summary

Following the Supreme Court's recent decision about the Patient Protection and Affordable Care Act (ACA), states are deciding whether to implement the ACA's expansion of Medicaid to adults with incomes up to 138 percent of the Federal Poverty Level (FPL). That expansion would increase state Medicaid costs for two groups:

- Newly-eligible adults, for whom states must begin paying a small percentage of health care expenses starting in 2017.
- Currently eligible adults, for whom states must pay their standard share of Medicaid costs. Whether or not a state implements the Medicaid expansion, some currently eligible adults will sign-up because of the ACA's individual mandate and new enrollment mechanisms and subsidies in health insurance exchanges (HIX). But this "welcome mat" or "woodwork" effect will probably be more pronounced in a state that also expands Medicaid eligibility.

On the other hand, state budgets would experience several gains from expanding Medicaid:

- The federal government would pay a much higher percentage of health care costs for certain currently eligible adults. This is especially true if the adults now receive less than full-scope Medicaid and if the state designs the expansion so that all adults receive the same benefits.
- The state could cut its non-Medicaid spending on health care for poor and near-poor uninsured adults, who would receive federally-funded Medicaid under the expansion. Examples include mental health services and payments to hospitals for uncompensated care.
- State income and sales tax revenue would increase, since the state would receive more federal Medicaid dollars, which would increase total economic activity. A state with insurance premium taxes might gain additional revenue.

The balance of costs and gains will depend on each state's situation.

## Introduction

In its ruling on the ACA,[1] the U.S. Supreme Court held that, if a state does not expand Medicaid to all residents with incomes up to 138 percent of FPL,[2] the U.S. Department of Health and Human Services (HHS) may not terminate federal funding for the state's entire Medicaid program. As a result, state officials in much of the country are now deciding whether to implement the expansion.

For many states, fiscal issues are critically important to this decision. Years of rising Medicaid costs have left state officials understandably nervous about the financial risks of any increase to Medicaid eligibility. But this particular expansion has unusual features. Some factors would raise state costs, others would lessen state budget deficits, and still others could cut either way.

Prior work has used national survey data to estimate the ACA's fiscal effects on all states.[3] Such analyses provide an important starting point, but a state seeking to develop a comprehensive fiscal analysis must go

beyond the factors that can be evaluated using 50-state data. Further, the most reliable sources of information often require an intimate acquaintance with the details of state budgets. Put simply, developing a definitive fiscal analysis for a particular state requires analyzing unique, state-specific information sources. The goal of this brief paper is aid those efforts by flagging issues for consideration by state-level analysts. And unlike earlier work that considered the full range of ACA fiscal effects, this analysis is limited to the implications of the Medicaid expansion.[4]

The paper explores potential effects in four areas: state costs, state savings, state administration, and state revenue. Items are presented in logical rather than priority order. In most states, certain items are likely to have particularly large fiscal effects,[5] but major interstate differences require each state to make its own assessment.

Two preliminary comments are important. First, some observers question whether the federal government might respond to its own budget problems by reducing federal payments below the levels promised under the ACA. Historically, while policymakers in both parties have often **proposed** cuts to federal matching payments for health coverage, the policies that were **actually implemented** have generally increased rather than lowered such levels.[6] If federal policymakers depart from this pattern and reduce federal funding levels for the ACA's Medicaid expansion, a state could respond by revoking that expansion. Such revocation is easier said than done, of course. But it is far from impossible, especially if the state's leaders lay the appropriate groundwork as expansion is being debated.

Second, this paper identifies potential state fiscal implications, but non-financial considerations are also important to policymakers. Nonetheless, money matters—hence this analysis.

## Factors that could raise state costs

Two separate factors could increase Medicaid health coverage costs.

### 1. If we implement the Medicaid expansion, how much will our state spend on newly-eligible adults starting in 2017?

Beginning in 2017, states must pay a small share of such adults' costs. Officials could estimate the number of newly-eligible adults who would receive coverage under the expansion, project their total costs, then calculate the state's share of such costs starting in 2017 as federal funding gradually falls to 90 percent in 2020 and beyond.

In making this calculation, states need to consider the likely proportion of newly-eligible adults who will enroll. Some prior cost estimates have suffered from the unrealistic assumption that every eligible person will sign up. A starting point for more realistic estimates may be the state's current proportion of eligible adults who participate. One recent study found that, during 2005-2010, Medicaid enrolled 62.6 percent of eligible adults ages 19-64 who lacked private insurance. Participation varied considerably by state, ranging from 43.0 percent in Arkansas and Louisiana to 82.8 percent in Massachusetts.[7] As explained later, several aspects of the ACA should increase overall Medicaid enrollment above previous levels; but childless adults, who represent the majority of newly-eligible people, have typically been less likely than other beneficiaries to join.[8]

States also need to consider the average health care costs of newly-eligible adults. Prior research shows that newly-eligible adults as a whole are healthier and less costly than current Medicaid beneficiaries. Although the least healthy members of this group are the most likely to enroll immediately, federal funds will cover all costs during the initial "post-launch" period, when such adverse selection and any effects of "pent-up demand" will probably be experienced.[9] Moreover, average costs will be high for the newly eligible only if healthy adults do not enroll in large numbers, in which case participation levels and total costs will be low.

Another factor affecting coverage costs is the generosity of benefits that newly-eligible adults receive. The ACA provides that newly-eligible adults qualify for "benchmark benefits." Guidance from the Centers for Medicare and Medicaid Services (CMS) specifies that such benefits can either be the same as what other

Medicaid adults receive or include fewer benefits (although the benchmark package must meet certain minimum requirements, including coverage of all essential benefits).[10] Of course, the primary consideration in selecting covered benefits involves the needs of affected beneficiaries. That said, fiscal consequences also matter, and a state would lower projected coverage costs by providing fewer benefits to newly-eligible adults than to previously eligible adults.[11] On the other hand, differentiating adult benefits would:

- *Increase administrative costs.* A state offering differential benefits must: (a) distinguish between newly-eligible and other adults; and (b) assess whether adults found to be "newly eligible" have health care needs that, under federal law, forbid states from limiting them to benchmark benefits. For example, someone who is "medically frail or otherwise an individual with special medical needs"[12] must receive standard benefits. Unlike coverage costs for newly-eligible adults, most of which will be federally funded, states are generally responsible for paying 50 percent of Medicaid administrative expenses.
- *Limit a state's ability to claim enhanced federal funding*. As explained below, a broader benefits package could increase the number of current, high-cost beneficiaries for whom the state can receive enhanced federal funding as "newly-eligible adults."[13]

**States would save nothing by limiting benefits for newly-eligible adults from 2014 through 2016, when the federal government will pay all their costs. States would thus realize net savings, during these first three years, if the newly eligible receive the same benefits as other Medicaid adults.** This early experience could then inform a state's assessment of the longer-term costs and benefits of limiting newly-eligible adult coverage starting in 2017.

### 2. If we implement the Medicaid expansion, how much will our state spend on currently eligible people who did not previously enroll?

Whether or not a state implements the Medicaid expansion, states will see increased enrollment among currently eligible people, most of whom were previously uninsured. States will be required to pay their standard share of Medicaid costs to cover this group. Among other factors, the ACA's individual coverage requirement and the "welcome mat" or "woodwork" effect of creating new subsidies and enrollment mechanisms in HIXes will cause a spike in participation.[14] Nevertheless, a state without the Medicaid expansion is likely to experience a smaller spike, as noted by the Congressional Budget Office.[15] In calculating the resulting cost effects, officials should consider that currently eligible people who have not yet signed up have less need for health care, on average, than those who have already done the work needed to enroll.[16]

## Factors that could reduce state costs

A state that expands Medicaid may be able to achieve several types of cost savings.

### 3. If we implement the Medicaid expansion, how much money can we save by increasing the federal matching percentage for beneficiaries who otherwise would receive standard match?

**A. What do we spend, in state dollars, on beneficiaries who: (i) now receive Medicaid that covers less than full or benchmark benefits; and (ii) are citizens or qualified immigrants under age 65 with income at or below 138 percent of FPL? These adults could qualify as "newly-eligible" if we implement the Medicaid expansion. Such beneficiaries may include—**

- **i. Adults covered under an 1115 waiver that provides less than full-scope Medicaid;**
- **ii. People who are covered through a Medicaid eligibility category limited to treatment of certain diseases (such as breast or cervical cancer);**
- **iii. People who are covered through a Medicaid eligibility category that is limited to specific services (such as through a family planning waiver);**
- **iv. So-called "medically needy" beneficiaries, who now qualify for Medicaid only after incurring medical costs that "spend down" their income to certain levels, but who could receive ongoing coverage as newly-eligible adults if we implemented the expansion;**
- **v. Anyone else?**[17]

The ACA lets states cover as "newly-eligible adults" people who qualify for a type of Medicaid under current law that provides less than full or benchmark Medicaid benefits.[18] Today, the federal government pays a standard share of their costs. But if they were instead covered as newly-eligible adults under an ACA Medicaid expansion, they would qualify for very generous federal matching percentages—100 percent in 2014-2016, gradually declining to 90 percent in 2020 and thereafter.

For example, some women below 138 percent FPL receive Medicaid coverage limited to the treatment of breast cancer. The state pays its standard share of Medicaid costs. If the state implements the Medicaid expansion, these women would receive full Medicaid coverage as newly-eligible adults, with 100 percent federal funding through 2016. The state would not need to eliminate the special eligibility category for women with breast cancer; it would achieve savings simply because women under 138 percent FPL would receive general Medicaid for adults, without any need to access this special, limited coverage category.

Along similar lines, a state could reduce its spending on medically needy adults without changing the rules for medically needy coverage. Adults with incomes at or below 138 percent FPL who, without the expansion, would have "spent down" to qualify will instead receive full Medicaid coverage, without any need to incur health care charges. The state can claim highly enhanced federal matching funds, since they will be classified as newly-eligible adults, receiving full coverage for the first time.

**B. What do we spend on people with disabilities under age 65 who might instead receive coverage as newly-eligible adults if we implement the Medicaid expansion?**

CMS has specified that, in a state implementing the Medicaid expansion, disabled, non-elderly beneficiaries with incomes at or below 138 percent FPL have the right to choose whether they receive coverage as newly-eligible adults or based on disability.[19] All else equal, many beneficiaries would choose the former category to avoid the red-tape and inconvenience of demonstrating disability. If a state gives newly-eligible adults the same benefits that other adults receive, fewer newly-eligible adults will shift to eligibility categories based on disability. As a result, the state could receive enhanced match for more adults with serious health problems. A generous benefit package raises costs for all newly-eligible adults, but the vast majority of those costs will be federally funded. Moreover, many services that will be important to people with disabilities will probably be needed by and covered for other beneficiaries only sparingly. Once all these factors are evaluated, many states are likely to conclude that net state savings will result from a benefit package that makes coverage as newly-eligible adults appealing to non-elderly people with disabilities.[20]

Two final comments are important. First, this analysis could be affected by future CMS decisions about how states can claim enhanced federal matching funds for newly eligible adults. Second, recipients of Supplemental Security Income (SSI) cannot be covered as newly eligible. In most states, SSI based on disabilities automatically confers disability-linked Medicaid eligibility.

**C. If we are a state that, before the ACA, provided Medicaid to all poor parents and all poor childless adults, how much do we now spend on childless adults? How much would we save by implementing the ACA's Medicaid expansion, which would gradually raise the applicable federal matching percentage for childless adults to 93 percent in 2019 and 90 percent in 2020 and later years?**

As a general rule, enhanced match under the ACA is unavailable for adults who would have qualified under a state's 2010 Medicaid program. Applying that rule to states with unusually generous pre-ACA Medicaid coverage, however, would deny them federal funding comparable to what less generous states receive. To prevent states from being heavily penalized for their generosity, Congress extended enhanced match to childless adults, regardless of their status under prior state law, in states that covered all poor adults before the ACA. Matching payments for childless adults in these states rise gradually above current levels until, in 2019 and beyond, they reach the same percentage that applies to newly-eligible adults in other states.

**D. Without the expansion, how much will we spend on former foster care children, whose coverage the ACA requires through age 25? How many of these young adults could instead qualify for enhanced federal match if we implement the Medicaid expansion?**

CMS has made clear its view that, aside from the Medicaid expansion to all poor and near-poor adults, the

Supreme Court decision left undisturbed the remainder of the ACA as enacted by Congress.[21] This presumably includes the expansion of Medicaid to all former foster care recipients until their 26th birthdays, regardless of income, starting in 2014.[22] States will receive their usual Medicaid match for these young people, who must be given standard rather than benchmark benefits. If a state implements the Medicaid expansion, many if not most of them could instead qualify as newly eligible adults, since they typically earn low incomes. Like people with disabilities, former foster care children can choose the category of Medicaid coverage they receive; and they are more likely to remain in the low-income adult category, with the state obtaining enhanced federal match, if they receive the same benefits, regardless of which category they choose.

States' per capita savings on this group could be considerable. Compared to their peers, former foster care children are more likely to have health problems, to be unemployed, to experience homelessness, to work in low-wage jobs, and to contract sexually-transmitted disease; many also report mental health problems and substance abuse.[23]

### 4. How much would the Medicaid expansion reduce the number of uninsured, compared to implementing the ACA without the Medicaid expansion? Would that let us cut back current state health spending on poor people whom the expansion would shift from uninsurance to Medicaid? In effect, can we substitute federal Medicaid dollars for current state or local spending in the following areas?

#### A. Direct state payments to hospitals and other safety-net providers to fund uncompensated care for the uninsured

The level of state savings will depend on officials' goals for the overall financial support that hospitals receive from all payors. Most states are likely to reduce their payments for uncompensated care by less than the hospitals' net increase in reimbursement from the Medicaid expansion. If states take such an approach, hospitals would receive more total funding than without the Medicaid expansion, and the state would still save money on its own uncompensated care costs. A state-specific cost estimate would need to assume a particular balance between gains realized by hospitals and costs saved by the state.

#### B. Indirect state payments for uncompensated care

In some states, General Fund dollars pay for health care received by very poor, uninsured, childless adults. Such coverage could be replaced by Medicaid, funded almost entirely with federal dollars, in a state implementing the ACA's Medicaid expansion. Even before 2014, with the federal government paying no more than its standard share of Medicaid costs, Minnesota saved General Fund dollars while improving access to care by converting its indigent care program into partially-federally-funded Medicaid.[24]

In other states, localities fund uncompensated care by operating public hospitals or "general relief"-type health programs. States typically help localities absorb these costs by providing local aid, granting localities revenue authority, or other mechanisms. If localities need fewer resources to fund indigent care, state support for localities could be reduced proportionately, so the state and its localities shared in the reduced cost of uncompensated care. A similar result could be accomplished through state legislation requiring each locality to pay the state a portion of its increased federal Medicaid revenue resulting from the expansion. Such legislation could be structured so that both the state and localities benefit, compared to a policy with neither the Medicaid expansion nor the local payments. A state-specific cost estimate would thus need to assume a particular balance between state and local gains.

#### C. Spending on behavioral health services for low-income residents

States typically devote significant resources providing mental health and substance abuse treatment to needy residents, including many uninsured, poor adults. On average, General Fund dollars pay for more than 40 percent of mental health spending controlled by state mental health agencies, according to the most recent available estimates.[25] If uninsured, poor adults received Medicaid coverage, many of their behavioral health care costs could be shifted from states to the federal government.

In calculating the resulting state savings, officials need to understand that some behavioral health services fall outside Medicaid's permitted scope. For example, Medicaid typically does not cover care furnished in

mental hospitals for adults, and some substance abuse treatment may fall outside Medicaid's purview. A state budget analysis could thus benefit from a conversation between state Medicaid officials and leaders within the state's mental health agencies. That said, states in the past have shifted significant behavioral health costs to Medicaid;[26] such shifts could be substantially larger if a state implements the ACA's Medicaid expansion.

As with uncompensated care payments, the level of savings will depend on whether policymakers want their state's mental health and substance abuse treatment system to receive additional resources. State officials must decide whether (a) to cut state spending, dollar for dollar, based on the amount of new federal Medicaid funds received for behavioral health services; or (b) to use some of the new federal dollars to strengthen behavioral health systems. Many such systems have experienced severe budget cuts in recent years;[27] some policymakers may want to use at least a portion of the new federal Medicaid dollars to restore the most harmful of those cutbacks.

**D. Public health services**

Some state- and locally-funded public health programs provide uninsured residents with preventive health care (including immunizations and screenings) that could instead be covered by Medicaid. A state implementing the Medicaid expansion would thus lessen the need for public health services, allowing the state to cut its funding without reducing the public's receipt of preventive care.

Alternatively, a state could cut its funding of public health by less than the amount of increased Medicaid payment for preventive care services, preserving some of the state's cost savings while allowing public health programs to share the gains that result from a new infusion of federal funds.

**E. Social services and mental health care for low-income parents**

States spend significant sums providing low-income parents with social services. These services include efforts to prevent or remedy child abuse and neglect. If Medicaid expanded to cover all poor and near-poor parents, some of these state-funded costs could be paid by federal Medicaid dollars. In quantifying potential state savings, however, officials need to identify current General Fund spending that occurs in the context of other federal programs; some such spending constitutes required "state match" for federal social welfare programs, which cannot be replaced by federal Medicaid dollars.

**F. Anything else?**[28]

## Cost effects that could cut either way

### 5. How will our administrative costs be affected by implementing the Medicaid expansion?[29]

**A. How many additional applications would we receive? How much would it cost to process those applications?**

As noted earlier, the ACA is likely to increase the number of applications that must be processed by Medicaid, whether or not the state implements the Medicaid expansion. But implementing the expansion should further raise that number.

In estimating the cost to process each additional application, officials need to consider several ACA policies. First, the ACA's more automated approach to eligibility determination would replace some caseworker time with computerized data exchange.[30] Second, future eligibility determination that involves automated systems developed with the aid of 90 percent federal funding can later receive 75 percent federal match for operational expenses, rather than the standard 50 percent match for Medicaid administration.[31] Third, some of the work required to process Medicaid applications may be done by the HIX or by an eligibility service that Medicaid and the HIX share, which could reduce the work required of the state Medicaid program. Fourth, if the state decides that a federally facilitated HIX will determine Medicaid eligibility, the HIX pays all administrative costs of such determinations[32] (although obviously this decision has implications that go far beyond administrative costs).

**B. If we implement the Medicaid expansion, how many fewer fair hearings would we conduct? How much would that save in state administrative costs?**

Without the Medicaid expansion, many consumers with incomes below 100 percent FPL will seek coverage at the HIX and ultimately be found ineligible for both HIX subsidies and Medicaid. The Medicaid program will need to send them notices of adverse action, including an explanation of their right to a fair hearing challenging the eligibility denial. Any resulting fair hearings will generate administrative costs, 50 percent of which will be paid by the state.

## Revenue effects

### 6. If we implement the Medicaid expansion, would the state's receipt of more federal Medicaid dollars generate economic activity that increased state revenue?

Primarily using new federal dollars, the Medicaid expansion would increase the volume of health care goods and services bought within the state. With more revenue, companies and individuals working in the health care sector would buy other goods and services, much of it within the state's borders.

This economic activity would increase employment and boost state revenue, either through state income taxes, sales taxes, or other general revenue mechanisms. For example, Arkansas officials estimate that, with the Medicaid expansion, Arkansas's receipt of new federal health care dollars under the ACA would increase state revenue by $254 million from 2014 through 2021.[33]

At the national level, the economic benefits of increased spending on health coverage are offset by the economic disadvantages of the mechanisms used to fund such spending. Just as new Medicaid spending and subsidies in the HIX increase demand for health care, so aggregate demand is reduced by ACA policies that slow Medicare spending growth, tax health care industries (such as insurers and device manufacturers), increase Medicare payroll taxes for families earning more than $250,000 a year, etc.

At the state level, the calculus is quite different. With or without a Medicaid expansion, a state's residents and businesses will experience the economic drag that results from funding coverage in other states. With a Medicaid expansion, however, the state's residents also receive the full economic and fiscal benefits of coverage expansions, financed by taxpayers elsewhere.

### 7. Do we have an insurance premium tax, a health care claims tax, or another industry-specific tax that would produce more revenue if additional residents received Medicaid coverage?

For example, some states apply insurance premium taxes to payments that certain health plans receive from Medicaid. If the Medicaid expansion boosts enrollment in such plans, premium tax revenues increase. Georgia's Department of Community Health estimates that, due to higher Medicaid and CHIP enrollment, full ACA implementation would raise the state's premium tax revenues by more than $70 million a year, once the law's effects are fully felt.[34]

From one vantage point, such premium taxes simply increase the amount that Medicaid must pay the affected health plans, some of which is taken from the state General Fund. But with the ACA's Medicaid expansion, the vast majority of such increased payments—hence the vast majority of new premium tax revenue—will come from the federal government.

## Conclusion

To fully analyze the fiscal consequences of implementing the ACA's Medicaid expansion in a particular state requires careful investigation. Not all cost and revenue factors are capable of decisive estimation, but comprehensive research and analysis can go a long way towards defining a range of likely costs, savings, and revenue effects. A thorough fiscal analysis that takes into account the factors listed here could help state officials make well-informed decisions about whether or not to implement the expansion.

## Notes

[1] National Federation of Independent Business, et al., vs. Sebelius, et al., 567 U.S._, 2012 WL 2427810 (U.S. June 28, 2012).

[2] Nominally, the Medicaid expansion, with enhanced federal matching funding, is limited to people with incomes at or below 133 percent FPL. However, 5 FPL percentage points are subtracted from gross income in determining eligibility. Accordingly, the gross income threshold for Medicaid eligibility under the expansion is 138 percent FPL.

[3] E.g., Buettgens, Matthew, Stan Dorn and Caitlin Carroll. July 2011. Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014 to 2019. Washington, DC: The Urban Institute.

[4] As a result, this analysis does not consider state administrative costs involved with changing Medicaid eligibility determination methods, converting income standards to Modified Adjusted Gross Income, using data-matches to replace consumer-produced documentation of eligibility, etc. Such changes will take place whether or not a state implements the ACA's Medicaid expansion. At the same time, we do not consider state savings potentially realizable from terminating Medicaid coverage of adults above 138 percent FPL and moving the affected beneficiaries into the exchange or the Basic Health Program (BHP). Such steps are made possible by subsidies in the exchange and BHP, not the ACA's Medicaid expansion.

[5] In many states, the following effects of a possible Medicaid expansion are likely to be most consequential: the cost of increased Medicaid enrollment, both among currently eligible and newly-eligible adults; the state revenue that results from increased economic activity due to additional federal Medicaid dollars purchasing health care within the state; increased federal matching payments for the medically needy and for non-elderly people with disabilities who do not receive Supplemental Security Income (SSI); and reduced state spending on uncompensated care and mental health services.

[6] For example, in 1997 the State Children's Health Insurance Program raised federal matching rates for newly eligible children above Medicaid levels to lower each state's share by 30 percent. When the program was reauthorized in 2009, these enhanced matching funds were extended to children who already qualified for Medicaid, so long as their incomes exceeded 133 percent FPL. In addition, the 2009 law added performance bonuses that had the effect of raising federal matching payments for significantly increased Medicaid enrollment among previously eligible children in states that implemented various "best practices" for enrollment and retention. One year later, in the ACA, lawmakers created an even higher federal matching percentage for newly-eligible adults, starting at 100 percent and gradually declining to 90 percent in 2020 and later years, as explained in the text. But ACA also included several less widely known policies that raised federal matching percentages above standard Medicaid levels. For example, it provided for time-limited enhanced match covering patient-centered medical homes; and a combination of time-limited and ongoing enhanced match for various policies to strengthen Medicaid coverage of home- and community-based long-term care.

[7] Sommers, Benjamin D., Meredith Roberts Tomasi, Katherine Swartz and Arnold M. Epstein. May 2012. "Reasons for the Wide Variation In Medicaid Participation Rates Among States Hold Lessons For Coverage Expansion In 2014." Health Affairs. 31(5):909-919. For a summary of earlier studies analyzing Medicaid participation, both under the current program and the ACA, see Sommers, Ben, Rick Kronick, Kenneth Finegold, Rosa Po, Karyn Schwartz, and Sherry Glied. March 16, 2012. Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, HHS.

[8] Davidoff, A, Yemane A, Adams E. 2005. Health Coverage for Low-Income Adults: Eligibility and Enrollment in Medicaid and State Programs, 2002. Kaiser Commission on Medicaid and the Uninsured. Sommers BD, Epstein AM. 2010. "Medicaid expansion: the soft underbelly of health care reform?" N Engl J Med; 363:2085-7.

[9] Holahan, John, Genevieve Kenney, and Jennifer Pelletier. August 2010. The Health Status of New Medicaid Enrollees Under Health Reform. Washington, DC: The Urban Institute.

[10] CMS. May 22, 2012. Medicaid/CHIP Affordable Care Act Implementation, Answers to Frequently Asked Questions: Benefits and Delivery Systems.

[11] This cost savings may be less than one might at first think. Even if a state limits benchmark benefits, many if not most newly eligible adults who need additional Medicaid services could access those services by demonstrating medical frailty or special need, as explained in the text below.

[12] Social Security Act §1937(a)(2)(B)(vi), cross-referenced in §1902(k)(1). Other categories requiring standard benefits under §1937(a)(2)(B) include people who qualify for Medicaid on the basis of pregnancy, disability, Social Security Act Section 1931, participation in Medicaid's breast or cervical cancer programs, or institutionalization; people who are dually eligible for Medicare and Medicaid; terminally ill hospice patients; people who need long-term care (either in a nursing home or the community); and people whose coverage is limited to emergency services.

[13] The state's decision about Medicaid benefits will not limit its flexibility to set minimum requirements for private insurance. A state may choose a different benchmark benefits package for Medicaid than for coverage in the small group and individual markets. CMS 2012.

[14] Such an outcome would be consistent with past experience. In Massachusetts, the individual coverage requirement in the state's 2006 reform legislation increased participation among people who already qualified for Medicaid; even though they were exempt from the mandate, many did not fully understand the exemption. Dorn, Stan, Ian Hill, and Sara Hogan. November 2009. The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage. Washington, DC: The Urban Institute. Along similar lines, many (but not all) states found that initial implementation of the State Children's Health Insurance Program in 1997 increased participation among children who already qualified for Medicaid but had not previously enrolled. Government Accountability Office. Feb. 1, 2007. Children's Health Insurance: State Experiences in Implementing SCHIP and Considerations for Reauthorization. GAO-07-447T.

[15] Congressional Budget Office. July 2012. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. Washington, DC.

[16] Davidoff, Amy, Bowen Garrett, and Alshadye Yemane. October 2001. Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need? Washington, DC: Urban Institute.

[17] State savings may also be possible for another group—namely, pregnant women with incomes at or below 138 percent. Their situation is complex. On the one hand, the ACA limits newly eligible adults to people who are not pregnant. Social Security Act Section 1902(a)(10)(A)(i)(VIII), added by ACA Section 2001. A state can thus not receive enhanced federal funding for a woman who describes herself as pregnant when she applies for assistance or a woman who exercises her right to receive coverage based on pregnancy, rather than based on status as a low-income adult. On the other hand, states are not required to monitor the pregnancy status of each newly-eligible woman and change her eligibility category whenever pregnancy begins or ends. CMS. Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010. Final Regulations. Federal Register. Vol. 77, No. 57. Friday, March 23, 2012. 17144 (Final Medicaid regulations). CMS. May 22, 2012. Medicaid/CHIP Affordable Care Act Implementation. Answers to Frequently Asked Questions: Eligibility Policy (Medicaid eligibility guidance). In a state that implements the Medicaid expansion, many women who would otherwise have received pregnancy-related coverage instead will enroll and qualify as low-income adults before they become pregnant. Particularly if the state ensures that low-income adults get the same coverage of maternity care (including limits on out-of-pocket cost-sharing) that women receive who qualify based on pregnancy, women already enrolled as low-income adults will frequently stay in that category rather than request a change in their eligibility status after they become pregnant. Depending on how CMS policy unfolds, the state may wind up receiving enhanced match for many of these women, corresponding to such women's shift from episodic, pregnancy-based Medicaid to ongoing coverage as a low-income adult.

[18] Social Security Act §1905(y)(2)(A), added by ACA §2001(a)(3).

[19] Medicaid eligibility guidance. Final Medicaid regulations.

[20] Alternatively, a state could limit benefits for newly-eligible adults as a whole but, as required by statute, let them qualify for standard benefits on medical grounds—for example, by demonstrating medical frailty or other special health care needs short of disability, as mentioned earlier. However, someone making such a showing may have little reason to avoid the further work required to qualify as fully disabled, which might also allow receipt of cash aid. Moreover, if a showing of medical frailty gives a state evidence of potential disability, the state's ongoing ability to claim enhanced match could be impaired. In short, the safest route to qualifying people with health problems as newly-eligible adults may involve furnishing the same benefits to all adults.

[21] Mann, Cindy. Medicaid and CHIP: Today and Moving Forward. Presentation to National Conference of State Legislatures meeting, August 6, 2012. Washington, DC: Centers for Medicare and Medicaid Services.

[22] Social Security Act Section 1902(a)(10)(A)(i)(IX), added by ACA Section 2004.

[23] Courtney, Mark E., Amy Dworsky, Adam Brown, Colleen Cary, Kara Love, and Vanessa Vorhies. 2011. Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26. Chicago, IL: Chapin Hall at the University of Chicago. Macomber, Jennifer, et al. 2008. Coming of Age: Employment Outcomes for Youth Who Age Out of Foster Care Through Their Middle Twenties. Washington, DC: The Urban Institute.

[24] Courtot, Brigette, Stan Dorn, and Vicki Chen. July 2012. ACA Implementation – Monitoring and Tracking: Minnesota Site Visit Report. Washington, DC: Urban Institute.

[25] See Table 11, estimates for FY 2007. Substance Abuse and Mental Health Services Administration. 2011. Funding and Characteristics of State Mental Health Agencies, 2009. HHS Publication No. (SMA) 11-4655. Rockvie, MD: Substance Abuse and Mental Health Services Administration.

[26] Frank, Richard G. and Sherry Glied. 2006. "Changes In Mental Health Financing Since 1971: Implications For Policymakers And Patients," Health Affairs. May/June; 25(3):601-613.

[27] Lutterman, Ted. 2011 (updated). The Impact of the State Fiscal Crisis on State Mental Health Systems. http://www.nrinc.org/reports_pubs/2011ImpactOfStateFiscalCrisisOnMentalHealthSytems_Updated_12Feb11_NRI_Study.pdf.

[28] It might also be possible for states to shift some services now provided to the homeless from state General Fund resources to federal Medicaid dollars. See, e.g., Wilkins, Carol, Martha R. Burt, Danna Mauch. February 24, 2012. Medicaid Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities.

Prepared by Abt Associates for Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. States could also examine whether Medicaid coverage for previously uninsured, poor, HIV-positive adults might allow a reduction in state funding for Ryan White programs (including AIDS drug assistance programs, or ADAP), which serve people with HIV/AIDS. Policymakers would need to decide how much of the new federal funding should be devoted to serving people currently on the waiting list for services and how much would provide state fiscal relief. Burress, Jim. July 28, 2012. "New Funds Could Shorten AIDS Drug Waiting Lists." Kaiser Health News. Washington, DC: Kaiser Family Foundation. http://capsules.kaiserhealthnews.org/index.php/2012/07/newfunds-could-shorten-aids-drug-waiting-lists/ In addition, Medicaid could cover certain inpatient hospital services that are generally excluded from federal financial participation under 42 CFR § 435.1009(a)(1). See Memo from Robert A. Streimer, Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, to Associate Regional Administrators, Division for Medicaid and State Operations. Dec. 12, 1997. This document is available as Appendix A to Schwartz, Sonya and Melanie Glascock. June 2008. Improving Access to Health Coverage for Transitional Youth. Washington, DC: National Academy for State Health Policy.

[29] This section of the text focuses on eligibility-side administrative costs, but in some states, a Medicaid expansion would also increase service-side administrative expenses. In particular, Medicaid programs that provide fee-for-service coverage would need to pay more provider claims if more beneficiaries are covered. On the other hand, Medicaid managed care programs are unlikely to experience significant service-side increases in administrative costs. With an expansion, more beneficiaries would enroll in Medicaid plans, which would increase total payments to such plans, but it is not clear that state transaction costs would rise appreciably. There might even be efficiency or pricing gains resulting from a state's negotiation on behalf of more beneficiaries.

[30] Louisiana achieved significant savings when it qualified children for Medicaid based on data from the state's Supplemental Nutrition Assistance Program (SNAP), formerly known as, "Food Stamps." Dorn, Stan, Ian Hill, and Fiona Adams. 2012. Louisiana Breaks New Ground: The Nation's First Use of Automatic Enrollment through Express Lane Eligibility. Washington, DC: The Urban Institute. Using data matches from other sources to determine Medicaid eligibility may similarly yield administrative savings under the ACA, compared to more traditional methods of public program administration.

[31] Final Rule: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities. Published in the Federal Register on April 19, 2011 (Vol. 76, No. 76) at 21950.

[32] Center for Consumer Information and Insurance Oversight, CMS. May 16, 2012. General Guidance on Federally-facilitated Exchanges.

[33] Arkansas Department of Human Services. July 17, 2012. Estimated Medicaid-Related Impact of the Affordable Care Act with Medicaid Expansion.

[34] Georgia Dept. of Community Health. June 14, 2012. Medicaid Financial Update: Presentation to: DCH Board. http://dch.georgia.gov/vgn/images/portal/cit_1210/7/21/186139580Medicaid_Update_for_Board_June_2012.pdf. Downloaded 7/25/2012.

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