kaiser commission on medicaid and the uninsured
DATA NOTE
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Understanding the 50-State Cost and Coverage Estimates of the ACA Medicaid Expansion: Why Do They Vary from State Specific Estimates?

A central goal of the Patient Protection and Affordable Care Act (ACA) is to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and new Health Insurance Exchanges. Following the June 2012 Supreme Court decision, states face a decision about whether to adopt the Medicaid expansion. These decisions will have substantial consequences for health coverage for the low-income population. The Kaiser Commission on Medicaid and the Uninsured (KCMU) released a report *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* in November 2012 prepared by the Urban Institute which provided national as well as state-by-state estimates of the impact of the ACA on federal and state Medicaid costs, Medicaid enrollment, and the number of uninsured.

The analysis primarily relies on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). The analysis showed that by implementing the Medicaid expansion with other provisions of the ACA, states could significantly reduce the number of uninsured and that the vast majority of the costs of the expansion would be borne by the federal government. The analysis also showed that impact of the ACA Medicaid expansion will vary across states based on current coverage levels and the number of uninsured.

The report aims to provide a national framework for cost and coverage estimates and then break down those estimates across the states. Many states and other groups are developing state specific estimates that are likely to be different from the Urban estimates for a variety of reasons including estimation approach, data sources, key assumptions (about future trends in population growth, employment and costs, participation and cost-per person), time period included, as well as additional savings or offsets that were not included in our analysis due to limitations on the availability of 50-state data. This data note highlights some key points of difference to look for across various analyses:

Estimation Approach. The analysis relies on the HIPSM model which model simulates the decisions of business and individuals in response to policy changes such as Medicaid expansion as well as new health insurance options, subsidies for the purchase of health insurance and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. HIPSM estimates of employer offers of coverage, employee take-up of offers, and participation rates in Medicaid are calibrated to the most recent research literature. States may not have access to complex micro-simulation models and would rely instead on data inputs and key assumptions such as expected uniform take-up rates and costs per person. More information on the HIPSM Model can be found in the HIPSM Methodology Documentation.

Data Sources. The HIPSM model uses national survey data. The model relies on the Current Population Survey (CPS) for survey years 2009 and 2010 for data on income, current coverage, and family characteristics inflated as described below. It incorporates data from the Medical Expenditure Panel Survey (MEPS) to obtain estimates of health care costs by personal characteristics such as health status, age, gender, etc. It also uses data from the 2007 Medicaid Statistical Information System (MSIS) to estimate baseline program growth. State specific estimates may rely on state data which may be more precise for existing enrollees in a specific state or more recent than what is available across the 50 states. These differences are particularly important for current enrollees that could be transitioned

from current programs to newly eligible Medicaid or exchange coverage. Other estimates may use different surveys, either Census surveys such as the American Community Survey or state-specific surveys where available and may have more recent data or larger sample sizes for sub-state groups.

Trend Assumptions. In the analysis, the national 2007 MSIS numbers for current enrollment in each eligibility group – children, adults, individuals with disabilities, and the elderly – were inflated to agree with CBO estimates of national spending by eligibility group. Each state was adjusted by the same national rate of increase. The data for each state is then inflated for 2013 to 2022 at the same rate as the CBO baseline without the ACA. So, each state would grow at the same rate over time but the differences in spending among states would be preserved. This is the baseline for estimating the effects of the Medicaid expansion with the HIPSM. HIPSM assumes population changes over this period based on Census projections; a decrease in the unemployment rate so that full employment is reached in 2015 and subsequent years, and that Medicaid enrollment reflects the phase-in of the ACA through 2017 and then a growth of about 2 percent per year. This is faster than population growth, but we assume a continuation of recent trends involving slow income growth among low-income populations and erosion in employer sponsored insurance for low-wage workers. We assume an annual growth in Medicaid spending of 5 percent.

Participation or Take-Up Assumptions. Not everyone who is eligible for Medicaid coverage enrolls in the program. HIPSM estimates take-up of Medicaid eligibility based on an individual's specific characteristics and current coverage, rather than applying a uniform participation rate across the population. Thus, Medicaid participation rates in HIPSM vary by a number of factors including race and ethnicity, income, and education, as well as previous coverage (receiving employer-sponsored insurance (ESI), non-group coverage, or uninsured) and whether an individual is currently eligible for Medicaid or newly eligible under the ACA expansion. The average take-up rates that result are 60.5% among new eligibles and 23.4% among currently eligible but not enrolled individuals. Among currently eligible individuals, the overall take-up rate increases from 64.0% without the ACA to 72.4% under the ACA with all states implementing the Medicaid expansion. The estimates account for increased participation among children as well as adults.

While specific state experience and assumptions may vary, these national participation rates as well as literature about participation can be a guide to assess state specific assumptions. For example, assumptions that 100% of those eligible would participate in the Medicaid expansion in not consistent with the HIPSM analysis or literature reviewing experience with Medicaid or other similar programs. Also, since the ACA expansion is primarily targeted to adults, some estimates may not include increased participation among children.

Cost Per Person Assumptions. Like participation, the HIPSM model does not apply a uniform cost per enrollee under Medicaid; rather, the cost of covering an individual newly-enrolled in Medicaid varies according to an individual's health status, previous coverage, and other characteristics. Costs per enrollee also vary by year, as prices for medical services change over time. The resulting national average costs per enrollee rise from $5,440 in 2016 to $7,399 in 2022. Average costs per enrollee are estimated to be lower among current eligibles than new eligibles because there are more children in the current eligible group, and children generally have lower costs than adults. However, newly eligible adults are less costly, on average, than current adult beneficiaries. While states may have more precise data about Medicaid costs, these results may be instructive in examining how the costs of new enrollees compares to costs of current enrollees.

State and Federal Cost Assumptions. The analysis distributes the costs of the expansion between the federal government and states according to the federal matching rates (FMAP) specified in the ACA. States will receive their regular matching rate for new enrollment of current eligibles. States receive an enhanced match rate for those newly eligible for Medicaid under the ACA (100% from 2014 to 2016 and phases down to 90% in 2020 and beyond). States that had expanded their Medicaid programs to include all adults with incomes up to 100% FPL as of ACA enactment will receive a phased-in increase of the FMAP for their childless adult population that will reach 93% in 2019 and 90% in 2020 and thereafter. Analysis that uses alternative federal match rates is based on the assumption that there would be a change in the law.

Offsets from Reduced State Spending on Uncompensated Care. The analysis also estimates savings for states and localities due reduced uncompensated care that would stem from increased coverage. Estimates of uncompensated care are based on the MEPS, adjusted for under-reporting based on other analyses and research. That earlier research found that states and localities finance 30% of the uncompensated care. The estimates assume that states would only be able to achieve savings equal to 33% of the reduction in their share of payments for uncompensated care, representing only 10 percent of the total reduction in uncompensated care as noted earlier. These savings help to mitigate the costs of implementing increased coverage under the expansion. Given the adjustments and assumptions required to include 50-state estimates on uncompensated care, state specific estimates of uncompensated care costs and potential savings may be more precise.

Elements Not Included in the Urban Estimates. Because the analysis is limited to data available for all 50 states and the District of Columbia, we were unable to estimate several areas of potential new costs and savings related to the Medicaid expansion.

- **Administrative Costs.** A number of state estimates account for increases in administrative costs associated with the ACA Medicaid expansion.

- **Savings From Transitioning Current Medicaid Coverage to Newly Eligible Coverage.** A number of states may be able to achieve savings under the ACA Medicaid expansion by transitioning current Medicaid coverage to a newly eligible population. This transition would allow states to increases federal funding by transitioning coverage from the state's regular match rate to the higher "newly eligible" match rate under the ACA. The Urban estimates account for savings in some states that would be able to shift coverage from limited benefit waiver programs to "newly eligible" coverage with the higher ACA match. However, states offering premium-assistance programs or programs that were not implemented state-wide were not accounted for, so these states could see additional offsets to expansion costs. In addition, prior to the ACA, states were able to provide targeted coverage to certain populations such as women served by the Breast and Cervical Cancer Treatment Program Coverage, individuals covered under limited family planning waivers, those enrolled in Medically Needy programs or Spend-down coverage. Transitioning coverage to a more simple income standard eliminates the need for targeted coverage of these specific groups. States that had provided coverage through these categories under the regular Medicaid match would be able to access the higher match if these populations newly qualify for coverage based on the new income standards.

- **Savings From Transitioning Current Medicaid Coverage to Exchange Coverage.** A number of states currently provide Medicaid coverage to adults above the new Medicaid eligibility

requirement of 138% FPL. These states could transition this coverage to coverage in new health insurance exchanges or to a Basic Health Plan to achieve savings.

- **Savings From Reduced Spending to Serve Indigent Populations.** The ACA provided states a new state plan option, effective April 2010, to receive federal Medicaid matching funds to cover adults with incomes up to 133% FPL to get an early start on the 2014 Medicaid expansion. In addition, subject to federal approval, states may still expand coverage to adults through a Section 1115 waiver. Under a waiver, states could cover adults above 133% FPL, provide a more limited benefit package than otherwise allowed, or cap enrollment, among other possibilities. Since April 2010, eight states (CA, CT, CO, DC, MN, MO, NJ, and WA) have received approval to expand Medicaid to low-income adults through the new ACA option and/or Section 1115 waiver authority. Nearly all of these states previously covered some low-income adults through state or county-funded programs. By moving this coverage to Medicaid, states were able to secure federal financing to help offset state spending for this coverage. In 2014, this coverage will still be eligible for the newly eligible match rates, so states that take up the Medicaid expansion will see additional state savings and additional federal funds for this coverage. States may also be able to reduce spending for other programs targeted provide services to individuals without coverage such as state-funded mental health services. Under the ACA, many or most of current clients for such services will become eligible for new Medicaid coverage or private insurance.

- **Savings and Revenue from Broader Economic Implications of the Medicaid Expansion.** Large increases in federal Medicaid revenues will have a positive effect on state economies. Medicaid spending generates economic activity including jobs, income and state tax revenues at the state level within the health care sector and beyond due to the multiplier effect of spending. The economic impact of Medicaid in health reform is intensified because small amounts of new state spending will result in significant federal matching dollars that will flow into the economy.

- **Broader Health Implications.** Beyond the costs and savings of the Medicaid expansion there are broader health implications to consider. The Medicaid expansion would make millions of currently uninsured adults newly eligible for the program. In the absence of a Medicaid expansion, adults in these states will be left without an affordable coverage option and continue to face the health and financial consequences of being uninsured. From research we know that health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. A seminal study of health insurance in Oregon found that newly insured Medicaid enrollees were more likely to receive care from a hospital or doctor than uninsured people. Being uninsured can also have devastating financial implications. Gaining Medicaid coverage was associated with approximately 35% increased likelihood of having an outpatient visit and a 15% increased likelihood of taking a prescription. New enrollees in Medicaid also reported improvements in physical and mental health status.

All projections of the future impact of a policy are estimates. The November 2012 estimates are based on available data and knowledge and aim to provide both national and 50-state comparisons. State-specific estimates may be able to build on this analysis to further enhance our understanding of the potential impact of the ACA in a given area.

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