THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT

THE COST OF NOT EXPANDING MEDICAID

July 2013

PREPARED BY

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The Urban Institute

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

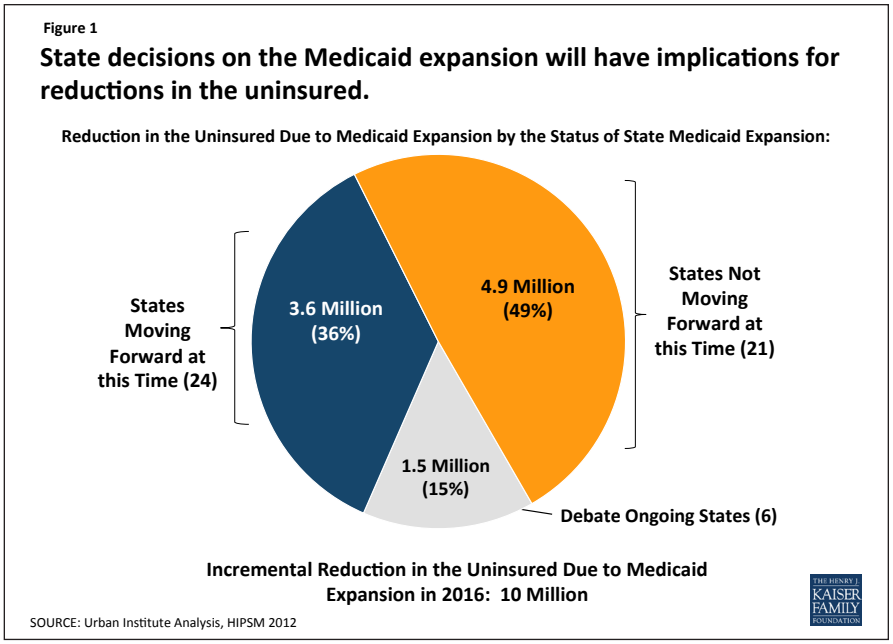
Executive Summary

As states wrap up legislative sessions and make decisions about whether to implement the Medicaid expansion included in the Affordable Care Act (ACA), this new analysis highlights the implications of these decisions for coverage, state finances and providers. As of July 2013, 24 states were moving forward with the Medicaid expansion, 21 states were not moving forward with the expansion and debate was on-going in the remaining 6 states. The decisions by as many as 27 states not to adopt the Medicaid expansion will leave a major hole in the health reform effort. Key finding from this analysis include:

- There would be fewer people enrolled in Medicaid and many more uninsured. Nearly two-thirds of those who were originally expected to be covered by the Medicaid expansion are in these 27 states. As many as 6.4 million uninsured will not be covered if all 27 states do not adopt the Medicaid expansion. Texas, Florida and Georgia account for half of the uninsured in the states not moving forward. (Figure 1)

Figure 1

State decisions on the Medicaid expansion will have implications for reductions in the uninsured.



SOURCE: Urban Institute Analysis, HIPSM 2012

- The 21 states that are not expanding Medicaid would forgo $35 billion in federal funds in 2016 and $345.9 over the 2013 to 2022 period while the 6 states still currently debating would forgo $15.2 in 2016 and $151 billion over the 2013 to 2022 period. These states would have experienced larger percentage increases in federal funds relative to the states moving forward with the expansion.
- For states that move forward with the expansion, reductions in uncompensated care costs help to mitigate increases in state costs or increase estimated savings. There are also many other state specific offsetting savings due to the expansion that could result in net benefits. These vary state to state and cannot be included in this analysis which uses national data sets.
- For states that move forward with the expansion, increases in federal funding will greatly outweigh any potential increases in state expenditures and will have positive economic effects, increasing employment and state general revenues.
- The decision not to adopt the Medicaid expansion will create inequities in coverage. Those with incomes below 100 percent will not be eligible for subsidies in exchanges or for Medicaid coverage beyond current eligibility levels. This leaves considerable gaps in coverage and will also result in substantially less revenue for hospitals. Under the ACA, hospitals in these states will still face cutbacks in Medicare and Medicaid disproportionate share hospital payments as well as lower Medicare payment rates independent of whether or not a state adopts the Medicaid expansion. And they will still be faced with serving a large uninsured population. Based on this analysis we conclude that the economic case for Medicaid expansion for state officials is extremely strong.

Introduction

A central goal of the Patient Protection and Affordable Care Act (ACA) is to significantly reduce the number of uninsured by providing affordable coverage options through Medicaid and new Health Insurance Exchanges or Marketplaces. Following the June 2012 Supreme Court decision, states have been faced with a decision about whether to adopt the Medicaid expansion. These decisions will have enormous consequences for health coverage for the low-income population.

In November 2012, the Kaiser Commission on Medicaid and the Uninsured released a report prepared by the Urban Institute, showing the cost and coverage implications the ACA Medicaid expansion.[1] The analyses used the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to provide national and state-by-state estimates (see Appendix A for more details about the report methods). The analysis showed that the impact of the ACA Medicaid expansion will vary across states based on current coverage levels and the number of uninsured, but implementing the Medicaid expansion along with other provisions of the ACA would significantly reduce the number of uninsured. Some states would see relatively modest state costs tied to implementing the Medicaid expansion compared to increases in federal funds, and many states are likely to see net budget gains. Changes in coverage and costs were measured in two parts:

- ACA With No States Expanding: Changes that would occur regardless if states implement the Medicaid expansion (i.e. states would experience increases in enrollment and costs tied to increased participation among those currently eligible for Medicaid as a result of enrollment simplification, outreach and coordination with the new marketplaces)
- ACA With All States Expanding: Changes tied to the decision to implement the Medicaid expansion or the incremental effect of the expansion.

The incremental savings are increased and costs mitigated by savings tied to reductions in uncompensated care costs. However, this analysis did not capture many sources of state fiscal gains from expansion because these vary state to state and cannot be measured with national data. Many state-level analyses that have considered the full range of costs, savings, and revenue effects have found that Medicaid expansion would create positive state budget effects throughout a multi-year period.[2]

As states wrap up legislative sessions and make decisions about whether to implement the Medicaid expansion for January 2014, this new analysis builds on the prior work using HIPSM to show more clearly how these decisions will affect the incremental changes related to Medicaid enrollment, reductions in the number of uninsured, and federal and state expenditures. Since a number of states are not moving forward with the expansion and some are still debating this issue, the number of uninsured will remain much higher than intended by the law and state and federal and state expenditures will be lower.

This paper classifies states into three groups: not moving forward with the expansion at this time; states where debate is on-going, and states moving forward with the expansion at this time. Taking into account both the Executive and Legislative branches of state government, the Kaiser Family Foundation found that, as of July 15, 2013, 24 states were moving forward with the Medicaid expansion at this time, 21 states were not moving forward and debate was on-going in the remaining 6 states. (Figure 2) This recent classification is a more updated assessment of the status of states' decisions regarding the expansion than accounted for in a recent *Health Affairs* article that projected that in 2016, 14 states would not implement the Medicaid expansion.[3] That analysis illustrated the direction of effects, but significantly understated their magnitude. The status of state decisions affect the estimated coverage (increase in Medicaid and reduction in the uninsured) as well as estimates of aggregate state and federal fiscal implications of the expansion.

Figure 2: State Decisions to Expand Medicaid, July 2013

NOT MOVING FORWARD	DEBATE ONGOING	MOVING FORWARD
Alabama	Indiana	Arkansas
Alaska	Michigan	Arizona
Florida	New Hampshire	California
Georgia	Ohio	Colorado
Idaho	Pennsylvania	Connecticut
Kansas	Tennessee	Delaware
Louisiana		District of Columbia
Maine		Hawaii
Mississippi		Illinois
Missouri		Iowa
Montana		Kentucky
Nebraska		Maryland
North Carolina		Massachusetts
Oklahoma		Minnesota
South Carolina		Nevada
South Dakota		New Jersey
Texas		New Mexico
Utah		New York
Virginia		North Dakota
Wisconsin		Oregon
Wyoming		Rhode Island
		Vermont
		Washington
		West Virginia

RESULTS

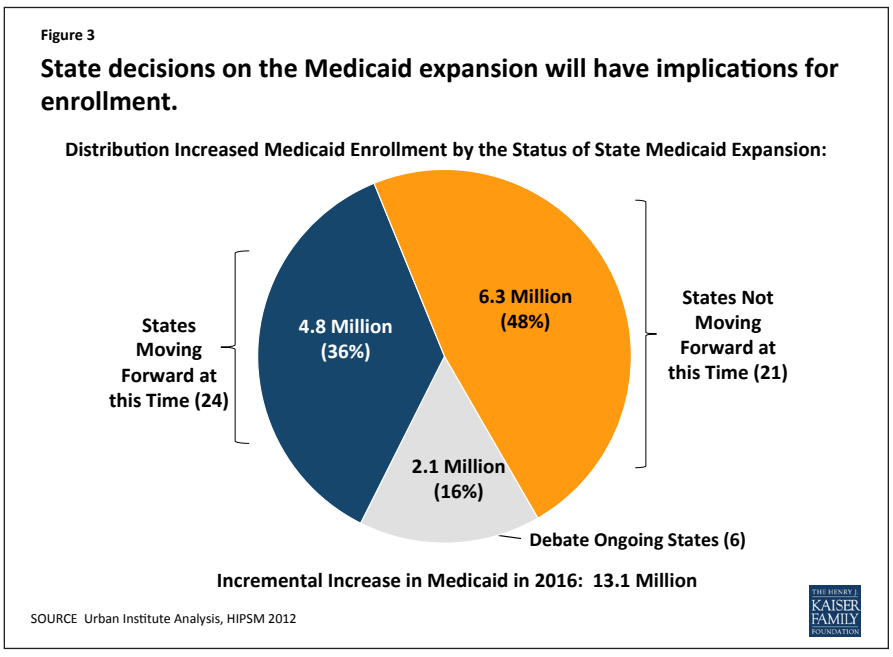
These results build on the November 2012 analysis to look at changes in coverage and financing given the current status of state decisions regarding the ACA Medicaid expansion.

Changes in Medicaid

State decisions to implement the Medicaid expansion will have significant implications for Medicaid enrollment as well as reductions in the uninsured. If all 50 states adopted the Medicaid expansion, an estimated 13.1 million would newly enroll in 2016 as a result of expansion. Of the 13.1 million potential new enrollees, 4.8 million are in states that have decided to move forward with the expansion (with 1.6 million in California alone). Nearly two thirds (64 percent) of all consumers who were originally slated to receive coverage under Medicaid expansion live in states that are not moving forward or are still debating the expansion – 6.3 million and 2.1 million, respectively. (Table 1) Texas, Florida and Georgia account for half of the enrollees in the states not moving forward. (Figure 3)

Figure 3

State decisions on the Medicaid expansion will have implications for enrollment.



SOURCE Urban Institute Analysis, HIPSM 2012

TABLE 1. MEDICAID ENROLLMENT WITH NO ACA AND UNDER THE ACA WITH FULL MEDICAID EXPANSION[1] AND NO MEDICAID EXPANSION, 2016 (THOUSANDS)

	TOTAL MEDICAID ENROLLMENT			
State	**ACA Without Expansion**	**ACA With Expansion[1]**	**Incremental Impact of Medicaid Expansion**	**Percentage Increase in Medicaid Relative to ACA without expansion**
US TOTAL	**55,778**	**68,910**	**13,132**	**23.5%**
Not Moving Forward at This Time	**18,581**	**24,870**	**6,290**	**33.9%**
Alabama	835	1,096	260	31.1%
Alaska	117	148	31	26.2%
Florida	2,709	3,789	1,080	39.9%
Georgia	1,618	2,206	588	36.3%
Idaho	209	283	75	35.7%
Kansas	357	501	144	40.4%
Louisiana	1,016	1,353	336	33.1%
Maine	300	338	38	12.7%
Mississippi	701	894	194	27.6%
Missouri	980	1,302	322	32.9%
Montana	122	177	54	44.5%
Nebraska	228	303	75	32.8%
North Carolina	1,586	2,064	478	30.1%
Oklahoma	663	835	172	25.9%
South Carolina	839	1,101	262	31.2%
South Dakota	113	150	37	33.1%
Texas	4,108	5,621	1,513	36.8%
Utah	316	467	151	47.9%
Virginia	815	1,091	276	33.9%
Wisconsin	872	1,053	181	20.8%
Wyoming	76	99	23	30.2%
Debate Ongoing	**8,344**	**10,418**	**2,075**	**24.9%**
Indiana	980	1,379	399	40.7%
Michigan	1,851	2,139	289	15.6%
New Hampshire	134	170	36	26.7%
Ohio	2,025	2,603	578	28.6%
Pennsylvania	2,007	2,472	465	23.2%
Tennessee	1,347	1,655	307	22.8%
Moving Forward At This Time	**28,854**	**33,621**	**4,768**	**16.5%**
Arkansas	644	838	194	30.2%
Arizona	1,354	1,553	199	14.7%
California	9,929	11,509	1,580	15.9%
Colorado	554	746	192	34.7%
Connecticut	495	616	120	24.3%
Delaware	184	198	14	7.6%
District of Columbia	153	175	23	14.9%
Hawaii	203	254	52	25.5%
Illinois	2,245	2,733	488	21.7%
Iowa	454	513	58	12.9%
Kentucky	774	998	224	28.9%
Maryland	793	914	122	15.4%
Massachusetts	1,371	1,383	13	0.9%
Minnesota	754	844	91	12.0%
Nevada	267	384	116	43.5%
New Jersey	923	1,169	246	26.6%
New Mexico	485	653	168	34.5%
New York	4,880	5,149	269	5.5%
North Dakota	68	95	27	40.1%
Oregon	514	834	320	62.3%
Rhode Island	176	210	34	19.2%
Vermont	144	147	3	1.8%
Washington	1,128	1,245	117	10.4%
West Virginia	364	461	97	26.6%

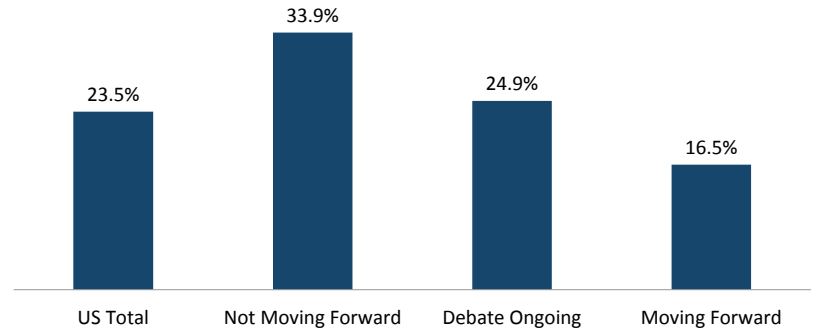
Source: Urban Institute Analysis, HIPSM 2012

[1] Includes enrollment increases that would have occurred without the Medicaid expansion

Overall, 13.1 million new enrollees represents an increase of 23.5 percent over a baseline where no states were implementing the expansion. Because many of the states that are not moving forward with the expansion at this time have low Medicaid eligibility levels and high low-income uninsured populations, the biggest expansion of Medicaid would have been in these states – a 33.9 percent increase in enrollment. In the states where debate continues, the Medicaid expansion would result in an average 24.9 percent increase. In the states that are moving forward, the expansion will result in just a 16.5 percent increase in enrollment. Most of the states that are expanding their Medicaid programs already have high levels of eligibility. As a result, they would not see, in percentage terms, the large increase that would occur in the two other groups of states. As illustrated in Table 1, the decisions of large states and states with large uninsured populations have disproportionate implications in the overall numbers.

Figure 4

States not moving forward with the Medicaid expansion would have experienced the largest increases in Medicaid enrollment.



SOURCE Urban Institute Analysis, HIPSM 2012

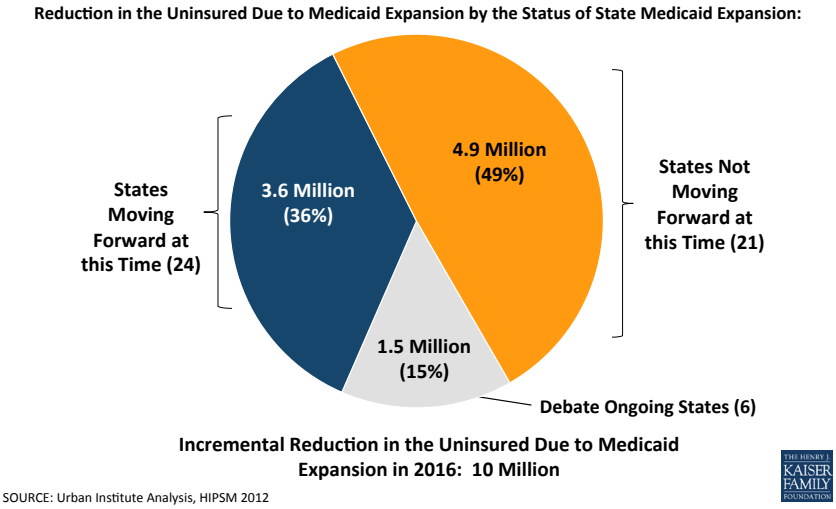
Given the current status of state decision making, the *Medicaid expansion would have more than twice the effect on enrollment in the states that are not moving forward, compared to the states that have decided to expand.* (Figure 4)

Changes in the Uninsured

States that are not expanding will leave large numbers of people uninsured. Even if states do not implement the Medicaid expansion there will be reductions in the uninsured stemming from other provisions of the ACA (including subsidies in health insurance exchanges, the requirement to purchase insurance and increased participation among those currently eligible for Medicaid). If no states implemented the expansion, we would expect a 14.7 million reduction in the uninsured. The incremental effect of the Medicaid expansion could reduce the uninsured by another 10 million in 2016. (Table 2) Of the 10 million potential incremental reduction in the uninsured 3.6 million are in states that have decided to move forward with the expansion (with 1.4 million in California alone). Nearly two thirds of the potential reduction in the uninsured live in states that are not moving forward or are still debating the expansion – 4.9 million and 1.5 million, respectively. (Figure 5) Texas, Florida and Georgia account for half of the enrollees in the states not moving forward.

Figure 5

State decisions on the Medicaid expansion will have implications for reductions in the uninsured.



SOURCE: Urban Institute Analysis, HIPSM 2012

TABLE 2. UNINSURANCE[1] WITH NO ACA AND UNDER THE ACA WITH NO MEDICAID EXPANSION AND FULL MEDICAID EXPANSION,[2] 2016

	NO ACA	ACA WITH NO MEDICAID EXPANSION		INCREMENTAL IMPACT OF MEDICAID EXPANSION	ACA WITH FULL MEDICAID EXPANSION[2]	
State (thousands)	Total Uninsured	Reduction in the Uninsured	% Reduction in Uninsured	Incremental Reduction in Uninsured	Reduction in the Uninsured	% Reduction in Uninsured
US TOTAL	**52,005**	**14,732**	**28.3%**	**10,010**	**24,742**	**47.6%**
Not Moving Forward at This Time	**22,754**	**7,062**	**31.0%**	**4,889**	11,951	52.5%
Alabama	694	212	30.5%	235	446	64.3%
Alaska	133	43	32.6%	26	70	52.4%
Florida	4,082	1,217	29.8%	848	2,065	50.6%
Georgia	2,057	578	28.1%	478	1,056	51.3%
Idaho	245	68	27.5%	55	122	49.9%
Kansas	374	78	20.9%	100	178	47.6%
Louisiana	856	250	29.1%	265	515	60.1%
Maine	143	44	30.8%	28	72	50.6%
Mississippi	549	154	28.1%	165	319	58.2%
Missouri	786	229	29.2%	253	482	61.3%
Montana	179	58	32.4%	38	96	53.6%
Nebraska	233	63	27.1%	48	111	47.6%
North Carolina	1,612	398	24.7%	377	776	48.1%
Oklahoma	631	220	34.9%	123	343	54.4%
South Carolina	757	232	30.6%	198	429	56.7%
South Dakota	113	31	27.7%	26	57	50.5%
Texas	7,180	2,493	34.7%	1,208	3,701	51.6%
Utah	431	159	36.9%	74	233	54.0%
Virginia	1,045	331	31.7%	210	541	51.7%
Wisconsin	567	173	30.5%	120	293	51.7%
Wyoming	87	29	33.8%	16	45	51.8%
Debate Ongoing	**6,229**	**1,887**	**30.3%**	**1,486**	**3,373**	**54.1%**
Indiana	846	213	25.2%	262	475	56.2%
Michigan	1,339	405	30.2%	212	617	46.1%
New Hampshire	135	38	27.9%	26	63	47.0%
Ohio	1,588	521	32.8%	446	967	60.9%
Pennsylvania	1,325	383	28.9%	305	689	52.0%
Tennessee	996	327	32.9%	234	561	56.4%
Moving Forward at This Time	**23,023**	**5,783**	**25.1%**	**3,636**	**9,418**	**40.9%**
Arkansas	560	178	31.8%	143	321	57.3%
Arizona	1,386	377	27.2%	51	428	30.9%
California	7,869	1,689	21.5%	1,390	3,079	39.1%
Colorado	848	238	28.1%	154	392	46.3%
Connecticut	395	92	23.3%	84	176	44.6%
Delaware	117	39	33.7%	7	46	39.5%
District of Columbia	68	5	7.8%	19	24	35.8%
Hawaii	112	17	14.8%	39	56	49.9%
Illinois	1,816	478	26.3%	398	876	48.3%
Iowa	292	53	18.1%	20	72	24.8%
Kentucky	722	222	30.7%	177	399	55.2%
Maryland	762	185	24.2%	135	320	42.0%
Massachusetts	219	37	16.9%	2	39	17.8%
Minnesota	456	131	28.8%	42	173	38.0%
Nevada	572	151	26.4%	105	257	44.8%
New Jersey	1,381	349	25.3%	227	576	41.7%
New Mexico	543	178	32.7%	96	273	50.4%
New York	2,883	893	31.0%	167	1,060	36.8%
North Dakota	78	14	17.5%	21	35	44.5%
Oregon	674	159	23.6%	186	345	51.2%
Rhode Island	123	27	21.8%	26	53	43.1%
Vermont	60	17	28.8%	4	21	35.1%
Washington	820	153	18.7%	64	217	26.5%
West Virginia	266	100	37.5%	80	179	67.4%

Source: Urban Institute Analysis, HIPSM 2012

[1] Note that uninsurance depends not only on new Medicaid enrollment, but also other coverage transitions such as movement into the exchanges or ESI takeup.

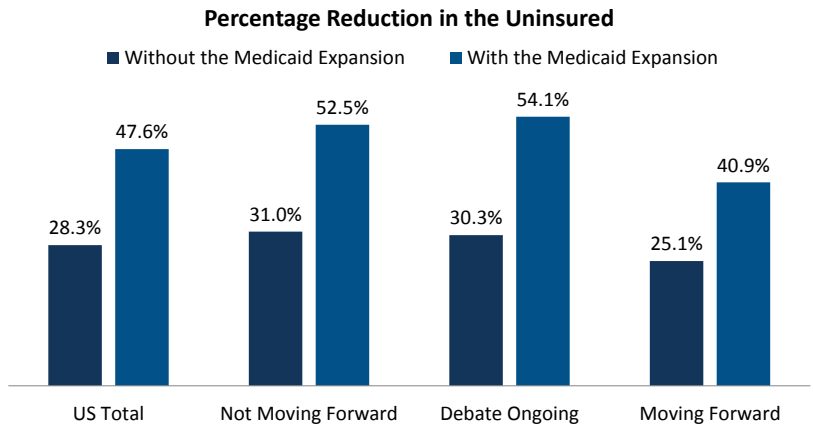
[2] Estimates include enrollment changes that would have occurred without the Medicaid expansion

Without the Medicaid expansion, the ACA's other provisions would lower the number of uninsured by 14.7 million or 28.3 percent (31.0 percent in the states not moving forward states, 30.3 percent reduction in the states with debate-ongoing states, and a 25.1 percent reduction in the states moving forward states).[4]

If all states expanded Medicaid, the number of uninsured would fall by another 10 million. Adding Medicaid expansion to the remainder of the ACA would further lower the number of uninsured, compared to pre-ACA levels, by 47.6 percent nationally (52.5 percent in the states that have decided to expand, by 54.1 percent in those that are still undecided, and 40.9 percent in those that are not moving forward). (Figure 6)

Figure 6

States not moving forward with the Medicaid expansion would have experienced the largest reduction in the uninsured.



SOURCE: Urban Institute Analysis, HIPSM 2012

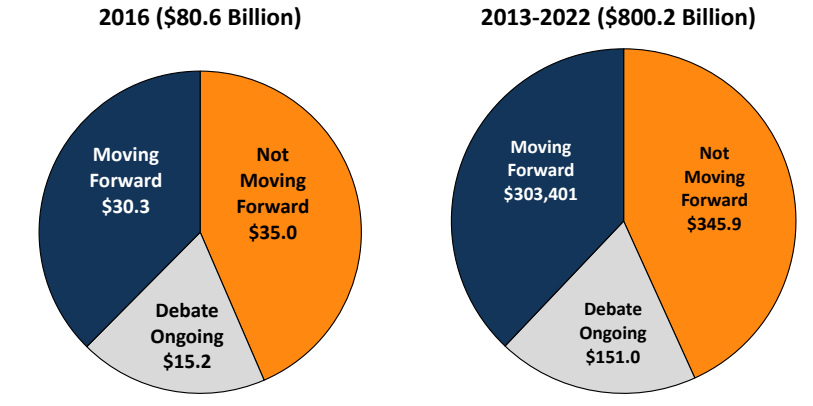
Accordingly, the states that would see the greatest reductions in uninsurance resulting from the Medicaid expansion tend to be the states that are not currently planning to expand eligibility.

Federal Funding

The Medicaid expansion could significantly increase federal funds to states. If all states expanded Medicaid, there would be an increase of $80.6 billion in federal funds in 2016 and of $800.2 over the 2013-2022 period. (Table 3) States that do not expand stand to forego a large amount of federal dollars. In 2016, states that are not moving forward would turn down $35.0 billion and states with debate ongoing could forego $15.2 billion. These amounts increase to $345.9 billion and $151.0 billion over the 2013-2022 period. The states that are moving forward would see increases in federal funds. (Figure 7)

Figure 7

States not moving forward with the Medicaid expansion would have experienced the largest increases in federal funds.



SOURCE: Urban Institute Analysis, HIPSM 2012

There is considerable variation within each group of states in the increase in federal funding. States like Massachusetts, Minnesota, New York, and Vermont, are expected to see lower percentage increases in federal funding because they already cover a large share of the expansion populations.

TABLE 3. TOTAL FEDERAL EXPENDITURES[1] UNDER THE ACA WITH FULL MEDICAID EXPANSION[2] COMPARED TO ACA WITH NO MEDICAID EXPANSION, MILLIONS

	FEDERAL EXPENDITURES, 2016				FEDERAL EXPENDITURES, 2013 TO 2022			
	ACA Without Expansion	ACA With Expansion	Change	Change	ACA Without Expansion	ACA With Expansion	Change	Change
State	($)	($)	($)	(%)	($)	($)	($)	(%)
US TOTAL	**341,920**	**422,481**	**80,561**	**23.6%**	**3,811,219**	**4,611,463**	**800,244**	**21.0%**
Not Moving Forward at This Time	**110,924**	**145,972**	**35,048**	**31.6%**	1,234,921	1,580,790	345,868	28.0%
Alabama	4,787	6,237	1,450	30.3%	53,150	67,521	14,371	27.0%
Alaska	1,056	1,203	147	13.9%	11,777	13,236	1,458	12.4%
Florida	13,769	20,472	6,703	48.7%	154,153	220,266	66,113	42.9%
Georgia	7,964	11,379	3,414	42.9%	88,442	122,153	33,711	38.1%
Idaho	1,583	1,916	333	21.1%	17,688	20,967	3,280	18.5%
Kansas	2,630	3,167	537	20.4%	29,312	34,582	5,270	18.0%
Louisiana	5,811	7,405	1,594	27.4%	63,921	79,708	15,786	24.7%
Maine	2,436	2,749	313	12.8%	27,307	30,432	3,124	11.4%
Mississippi	4,362	5,825	1,463	33.5%	48,689	63,188	14,499	29.8%
Missouri	7,126	8,934	1,807	25.4%	78,815	96,610	17,795	22.6%
Montana	1,012	1,226	215	21.2%	11,282	13,370	2,088	18.5%
Nebraska	1,797	2,110	313	17.4%	20,099	23,162	3,063	15.2%
North Carolina	11,862	15,877	4,015	33.8%	132,358	171,996	39,638	29.9%
Oklahoma	3,995	4,861	866	21.7%	44,782	53,344	8,561	19.1%
South Carolina	4,908	6,508	1,599	32.6%	54,403	70,230	15,827	29.1%
South Dakota	829	1,044	214	25.9%	9,260	11,370	2,110	22.8%
Texas	21,626	28,267	6,641	30.7%	239,646	305,266	65,619	27.4%
Utah	2,136	2,671	535	25.1%	23,722	28,996	5,274	22.2%
Virginia	4,821	6,302	1,481	30.7%	53,969	68,633	14,665	27.2%
Wisconsin	5,843	7,113	1,270	21.7%	65,794	78,057	12,263	18.6%
Wyoming	571	707	137	24.0%	6,352	7,705	1,353	21.3%
Debate Ongoing	**57,207**	**72,455**	**15,248**	**26.7%**	**639,370**	**790,345**	**150,975**	**23.6%**
Indiana	6,385	8,136	1,751	27.4%	71,375	88,698	17,322	24.3%
Michigan	10,145	11,911	1,765	17.4%	113,147	130,659	17,512	15.5%
New Hampshire	1,213	1,459	246	20.3%	13,320	15,736	2,417	18.1%
Ohio	15,226	20,609	5,383	35.4%	170,401	223,742	53,341	31.3%
Pennsylvania	15,473	19,318	3,845	24.8%	173,018	210,859	37,842	21.9%
Tennessee	8,765	11,022	2,257	25.8%	98,109	120,650	22,541	23.0%
Moving Forward at This Time	**173,789**	**204,053**	**30,265**	**17.4%**	**1,936,928**	**2,240,329**	**303,401**	**15.7%**
Arkansas	3,849	5,102	1,253	32.6%	43,215	55,681	12,465	28.8%
Arizona	7,173	8,261	1,088	15.2%	79,852	90,554	10,701	13.4%
California	35,549	42,535	6,987	19.7%	395,266	464,016	68,750	17.4%
Colorado	2,946	3,991	1,045	35.5%	32,778	43,086	10,308	31.4%
Connecticut	4,289	5,123	834	19.4%	47,796	55,954	8,159	17.1%
Delaware	1,191	1,374	183	15.4%	13,301	15,228	1,927	14.5%
District of Columbia	1,790	1,877	87	4.9%	19,984	20,836	852	4.3%
Hawaii	1,127	1,454	327	29.0%	12,623	15,917	3,294	26.1%
Illinois	12,108	14,328	2,220	18.3%	134,865	156,621	21,756	16.1%
Iowa	3,207	3,609	401	12.5%	35,813	39,722	3,909	10.9%
Kentucky	5,751	7,542	1,791	31.1%	64,341	82,173	17,832	27.7%
Maryland	5,067	6,328	1,261	24.9%	56,811	69,064	12,253	21.6%
Massachusetts	9,280	9,933	653	7.0%	104,329	111,599	7,270	7.0%
Minnesota	6,696	7,267	572	8.5%	75,092	80,688	5,597	7.5%
Nevada	1,436	2,009	573	39.9%	15,905	21,525	5,620	35.3%
New Jersey	8,337	9,927	1,590	19.1%	91,973	107,339	15,366	16.7%
New Mexico	3,468	3,967	499	14.4%	38,832	43,758	4,926	12.7%
New York	44,630	49,862	5,231	11.7%	496,885	552,992	56,107	11.3%
North Dakota	744	984	241	32.3%	8,285	10,642	2,357	28.4%
Oregon	3,606	4,901	1,295	35.9%	40,185	53,027	12,842	32.0%
Rhode Island	1,756	2,054	297	16.9%	19,592	22,527	2,935	15.0%
Vermont	1,102	1,198	95	8.7%	12,333	13,359	1,026	8.3%
Washington	5,641	6,501	860	15.2%	62,820	71,226	8,406	13.4%
West Virginia	3,044	3,925	882	29.0%	34,054	42,798	8,744	25.7%

Source: Urban Institute Analysis, HIPSM 2012

[1] Includes all Medicaid spending in baseline including aged, long term care, DSH, etc.

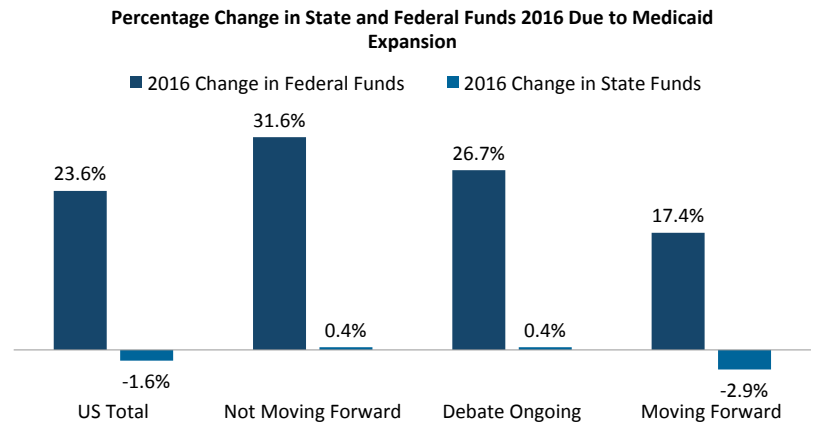
[2] Includes expenditure increases that would have occurred without the Medicaid expansion

State Expenditures

Table 4 provides information on the increase (or reduction) in state expenditures from expansion. Estimated increases in state costs have been a major factor in state decisions to implement the Medicaid expansion. Overall, states would save $3.8 billion in 2016 if all expanded Medicaid (-1.6 percent relative to not expanding). The states that are not moving forward would have had new expenditures of $254 million (.4 percent increase) due to a small incremental increase in participation among current eligibles relative to not expanding. In the debate ongoing states, there would be an estimated an increase of $129.0 million (.4 percent increase). The states that are moving forward are expected to save money – $4.2 billion (2.9 percent). These savings are driven by some states that will receive enhanced federal matching funds for adults that are currently covered with the regular match rate. There are many additional state specific fiscal offsets that could not be included in this analysis that are discussed in the following section.

Figure 8

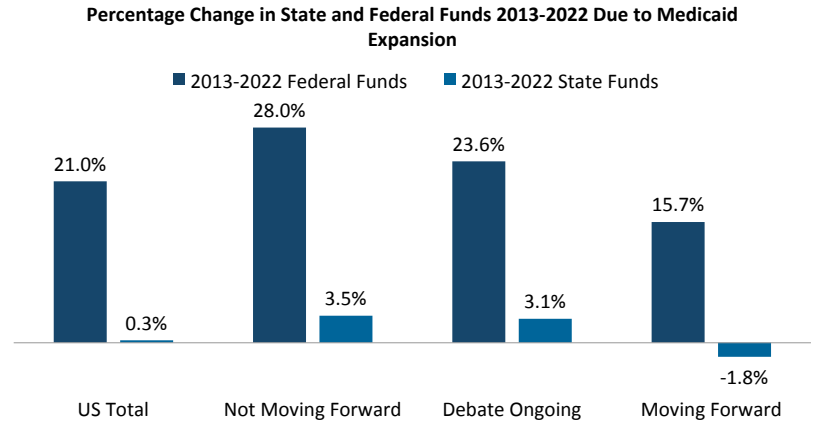
States not moving forward with the Medicaid expansion would have experienced the largest increases in federal funds.



SOURCE: Urban Institute Analysis, HIPSM 2012

Figure 9

States not moving forward with the Medicaid expansion would have experienced the largest increases in federal funds.



SOURCE: Urban Institute Analysis, HIPSM 2012

It is important to consider changes in state costs relative to increases in federal funds. In 2016, states that are not moving forward would have modest increases in state spending, but the largest percentage increases in federal funding. (Figure 8)

A very similar story plays out over the 2013—2022 period. The overall increase in state expenditures if all states expanded Medicaid would be $8.2 billion, or 0.3 percent. (Table 4) This total can be misleading, however; it averages quite disparate results experienced by different states. Among states that are not moving forward at this time, the expansion would raise their Medicaid costs during this period by $25.9 billion, representing a 3.5 percent increase relative to the baseline. In the debate ongoing states, there would have been an increase in expenditures of $11.5 billion, 3.1 percent increase over the baseline. In sharp contrast, those states that are moving forward would save $29.2 billion, or 1.8 percent (largely driven by savings in New York). Over the period, states that are not moving forward would have increases in state spending, but the largest percentage increases in federal funding. (Figure 9)

TABLE 4. TOTAL STATE EXPENDITURES[1] UNDER THE ACA WITH FULL MEDICAID EXPANSION[2] COMPARED TO ACA WITH NO MEDICAID EXPANSION, MILLIONS

	STATE EXPENDITURES, 2016				STATE EXPENDITURES, 2013 TO 2022			
	ACA - No Expansion	ACA - Expansion	Change	Change	ACA - No Expansion	ACA - Expansion	Change	Change
State	($)	($)	($)	(%)	($)	($)	($)	(%)
US TOTAL	**245,267**	**241,465**	**-3,802**	**-1.6%**	**2,748,031**	**2,756,269**	**8,238**	**0.3%**
Not Moving Forward at This Time	**66,052**	**66,306**	**254**	**0.4%**	738,808	764,757	25,949	3.5%
Alabama	2,063	2,073	10	0.5%	22,990	24,071	1,081	4.7%
Alaska	868	872	5	0.5%	9,736	9,883	147	1.5%
Florida	10,283	10,370	87	0.8%	115,485	120,849	5,364	4.6%
Georgia	3,743	3,769	26	0.7%	41,972	44,512	2,541	6.1%
Idaho	590	593	3	0.5%	6,654	6,901	246	3.7%
Kansas	1,799	1,816	17	1.0%	20,209	20,734	525	2.6%
Louisiana	3,566	3,583	17	0.5%	39,271	40,515	1,244	3.2%
Maine	1,318	1,248	-70	-5.3%	14,815	14,246	-570	-3.8%
Mississippi	1,417	1,424	6	0.4%	15,901	16,949	1,048	6.6%
Missouri	3,904	3,943	39	1.0%	43,333	44,906	1,573	3.6%
Montana	438	444	6	1.3%	4,936	5,130	194	3.9%
Nebraska	1,274	1,278	4	0.3%	14,272	14,522	250	1.8%
North Carolina	6,079	6,118	39	0.6%	68,011	71,086	3,075	4.5%
Oklahoma	2,168	2,178	11	0.5%	24,321	25,010	689	2.8%
South Carolina	1,989	1,996	8	0.4%	22,087	23,242	1,155	5.2%
South Dakota	485	486	1	0.3%	5,451	5,608	157	2.9%
Texas	14,604	14,729	125	0.9%	162,914	168,582	5,669	3.5%
Utah	768	769	1	0.1%	8,638	9,002	364	4.2%
Virginia	4,574	4,606	32	0.7%	51,356	52,682	1,326	2.6%
Wisconsin	3,678	3,563	-116	-3.1%	41,444	41,196	-248	-0.6%
Wyoming	446	448	3	0.6%	5,012	5,131	118	2.4%
Debate Ongoing	**33,220**	**33,349**	**129**	**0.4%**	**373,056**	**384,578**	**11,522**	**3.1%**
Indiana	2,975	2,966	-9	-0.3%	33,416	34,515	1,099	3.3%
Michigan	4,788	4,837	49	1.0%	53,922	55,583	1,661	3.1%
New Hampshire	1,069	1,072	2	0.2%	11,785	11,972	188	1.6%
Ohio	8,315	8,356	40	0.5%	93,082	97,100	4,017	4.3%
Pennsylvania	11,858	11,887	29	0.2%	133,437	136,278	2,842	2.1%
Tennessee	4,215	4,232	17	0.4%	47,415	49,130	1,715	3.6%
Moving Forward at This Time	**145,996**	**141,811**	**-4,185**	**-2.9%**	**1,636,167**	**1,606,933**	**-29,233**	**-1.8%**
Arkansas	1,524	1,531	7	0.5%	17,123	18,046	922	5.4%
Arizona	3,344	3,317	-27	-0.8%	37,381	37,848	467	1.2%
California	33,480	33,643	163	0.5%	374,496	380,810	6,314	1.7%
Colorado	2,708	2,724	16	0.6%	30,296	31,154	858	2.8%
Connecticut	3,952	3,766	-186	-4.7%	44,318	43,068	-1,251	-2.8%
Delaware	893	790	-104	-11.6%	10,029	8,928	-1,100	-11.0%
District of Columbia	711	712	1	0.1%	7,952	8,019	67	0.8%
Hawaii	987	940	-48	-4.8%	11,098	10,758	-340	-3.1%
Illinois	11,329	11,404	75	0.7%	127,067	129,279	2,213	1.7%
Iowa	1,848	1,762	-86	-4.6%	20,869	20,335	-534	-2.6%
Kentucky	2,241	2,249	8	0.3%	25,108	26,404	1,297	5.2%
Maryland	4,896	4,629	-267	-5.4%	54,937	53,187	-1,751	-3.2%
Massachusetts	8,743	8,149	-593	-6.8%	98,826	92,209	-6,617	-6.7%
Minnesota	6,486	6,495	9	0.1%	72,783	73,255	472	0.6%
Nevada	1,010	1,024	14	1.4%	11,232	11,745	513	4.6%
New Jersey	7,725	7,773	47	0.6%	85,807	87,299	1,492	1.7%
New Mexico	1,465	1,457	-8	-0.5%	16,420	16,688	268	1.6%
New York	41,602	38,552	-3,050	-7.3%	466,654	433,308	-33,345	-7.1%
North Dakota	477	483	5	1.1%	5,388	5,598	211	3.9%
Oregon	1,917	1,877	-40	-2.1%	21,580	22,087	506	2.3%
Rhode Island	1,495	1,500	5	0.3%	16,707	16,957	250	1.5%
Vermont	721	639	-82	-11.4%	8,100	7,214	-886	-10.9%
Washington	5,382	5,336	-46	-0.9%	60,085	60,206	121	0.2%
West Virginia	1,058	1,060	2	0.2%	11,912	12,531	619	5.2%

Source: Urban Institute Analysis, HIPSM 2012

[1] Includes all Medicaid spending in baseline including aged, long term care, DSH, etc.

[2] Includes expenditure increases that would have occurred without the Medicaid expansion

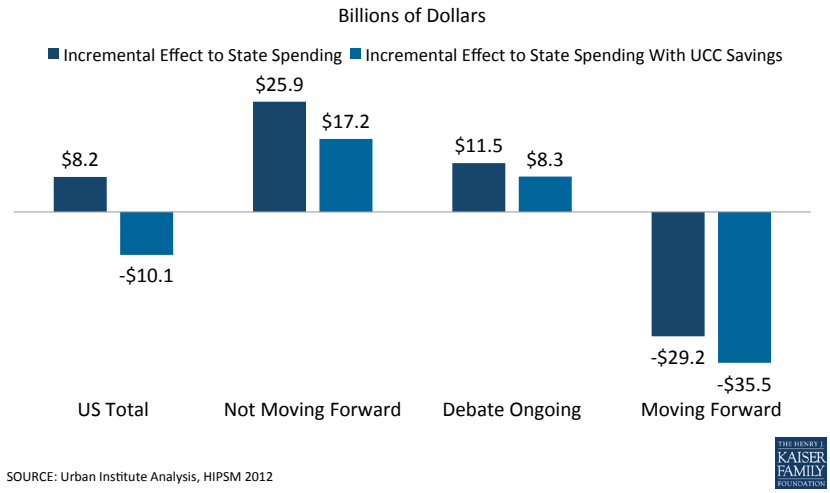
Uncompensated Care and State Expenditures

In Table 5 we further examine the increase in state expenditures. On balance, between the combination of savings and new revenues, many states should experience savings, but, many of these offsets cannot be assessed using national data and are therefore not included in this analysis. The HIPSM analysis does account for savings on uncompensated care. With increases in coverage there will be fewer uninsured individuals and therefore less uncompensated care. An estimated 30 percent of uncompensated care expenditures are paid for by state and local governments. We assumed that states would save one-third of this by reducing payments to hospitals and clinics that provide charity care to the uninsured. We assumed less than 100 percent savings because there is still less than full coverage and because of the political difficulty of ending programs that support this care.

Nationally we find uncompensated care savings of $18.3 billion over the ten year period (or $10.1 billion in net savings). These savings add to the savings in states that are moving forward. In states not moving forward or debate on-going these savings mitigate costs but do not result in savings. In the not moving forward states, uncompensated care savings would reduce state costs from $25.9 billion to $17.2 billion. This would represent a 2.3 percent increase in spending relative to the baseline. In the debate on-going states, state costs are reduced from $11.5 billion to $8.3 billion, a 2.2 percent increase relative to the baseline. (Figure 10)

Figure 10

Savings from uncompensated care costs help to mitigate state costs or increase savings.



SOURCE: Urban Institute Analysis, HIPSM 2012

New expenditures would still be quite small as a percentage of general revenue expenditures. For example, in the states not moving forward at this time, the increase in net state expenditures, after considering uncompensated care savings, relative to general revenue expenditures would be 0.6 percent. In the debate ongoing states, the increase would be 0.7 percent of general fund expenditures.

Hospital Payments

Finally, we examine the impact of the Medicaid expansion on federal and state payments to hospitals over the 2013—2022 period. Hospitals have a considerable stake in the state decision not to expand Medicaid coverage. Under the ACA, hospitals face reductions in Medicaid and Medicare payments for disproportionate share hospitals ($22 billion and $34 billion respectively over the next 10 years), as well as the legislation's much larger reductions in future Medicare fee-for-service rate increases ($260 billion). Reductions in uncompensated care, half of which were expected to result from Medicaid expansion were expected to temper these reductions.[5] If states do not expand coverage, hospitals will experience the full measure of these reimbursement reductions, but they will not obtain the offsetting revenue increase originally intended by the ACA.

TABLE 5. STATE MEDICAID AND UNCOMPENSATED CARE EXPENDITURES, UNDER THE ACA WITH NO MEDICAID EXPANSION AND FULL MEDICAID EXPANSION,[1] 2013-2022 (MILLIONS)

	TOTAL STATE MEDICAID EXPENDITURES				STATE UNCOMPENSATED CARE	NET STATE EXPENDITURE (RELATIVE TO BASELINE)		NET STATE EXPENDITURE (RELATIVE TO GENERAL FUND EXPENDITURES
	(2013-2022)				(2013-2022)	(2013-2022)		(2013-2022)
	ACA with No Medicaid Expansion[2]	ACA with Full Medicaid Expansion[1,2]	Incremental Impact of Medicaid Expansion		Incremental State Savings with Medicaid Expansion[3]	Incremental Impact of Medicaid Expansion		Incremental Impact of Medicaid Expansion
State	($)	($)	Δ ($)	Δ (%)	($)	Δ ($)	Δ (%)	Δ (%)
US TOTAL	**2,748,031**	**2,756,269**	**8,238**	**0.3%**	**-18,310**	**-10,072**	**-0.4%**	**-0.1%**
Not Moving Forward at this Time	**738,808**	**764,757**	**25,949**	**3.5%**	-8,775	17,174	2.3%	0.6%
Alabama	22,990	24,071	1,081	4.7%	-512	569	2.5%	0.6%
Alaska	9,736	9,883	147	1.5%	-38	109	1.1%	0.1%
Florida	115,485	120,849	5,364	4.6%	-1,254	4,109	3.6%	1.3%
Georgia	41,972	44,512	2,541	6.1%	-726	1,814	4.3%	0.8%
Idaho	6,654	6,901	246	3.7%	-97	149	2.2%	0.4%
Kansas	20,209	20,734	525	2.6%	-149	375	1.9%	0.5%
Louisiana	39,271	40,515	1,244	3.2%	-267	977	2.5%	0.9%
Maine	14,815	14,246	-570	-3.8%	-120	-690	-4.7%	-1.8%
Mississippi	15,901	16,949	1,048	6.6%	-400	649	4.1%	1.0%
Missouri	43,333	44,906	1,573	3.6%	-385	1,188	2.7%	1.1%
Montana	4,936	5,130	194	3.9%	-56	138	2.8%	0.6%
Nebraska	14,272	14,522	250	1.8%	-97	153	1.1%	0.3%
North Carolina	68,011	71,086	3,075	4.5%	-1,350	1,725	2.5%	0.7%
Oklahoma	24,321	25,010	689	2.8%	-205	485	2.0%	0.7%
South Carolina	22,087	23,242	1,155	5.2%	-543	612	2.8%	0.9%
South Dakota	5,451	5,608	157	2.9%	-62	95	1.7%	0.6%
Texas	162,914	168,582	5,669	3.5%	-1,712	3,956	2.4%	0.7%
Utah	8,638	9,002	364	4.2%	-101	263	3.0%	0.4%
Virginia	51,356	52,682	1,326	2.6%	-424	902	1.8%	0.4%
Wisconsin	41,444	41,196	-248	-0.6%	-247	-494	-1.2%	-0.3%
Wyoming	5,012	5,131	118	2.4%	-28	90	1.8%	0.4%
Debate Ongoing	**373,056**	**384,578**	**11,522**	**3.1%**	**-3,223**	**8,299**	**2.2%**	**0.7%**
Indiana	33,416	34,515	1,099	3.3%	-562	537	1.6%	0.3%
Michigan	53,922	55,583	1,661	3.1%	-351	1,310	2.4%	1.2%
New Hampshire	11,785	11,972	188	1.6%	-62	126	1.1%	0.7%
Ohio	93,082	97,100	4,017	4.3%	-876	3,142	3.4%	0.8%
Pennsylvania	133,437	136,278	2,842	2.1%	-878	1,964	1.5%	0.5%
Tennessee	47,415	49,130	1,715	3.6%	-494	1,220	2.6%	0.9%
Moving Forward at this Time	**1,636,167**	**1,606,933**	**-29,233**	**-1.8%**	**-6,312**	**-35,545**	**-2.2%**	**-0.7%**
Arkansas	17,123	18,046	922	5.4%	-257	665	3.9%	0.6%
Arizona	37,381	37,848	467	1.2%	-50	417	1.1%	0.7%
California	374,496	380,810	6,314	1.7%	-1,901	4,413	1.2%	0.4%
Colorado	30,296	31,154	858	2.8%	-277	581	1.9%	0.6%
Connecticut	44,318	43,068	-1,251	-2.8%	-222	-1,473	-3.3%	-0.6%
Delaware	10,029	8,928	-1,100	-11.0%	-18	-1,118	-11.2%	-2.5%
District of Columbia	7,952	8,019	67	0.8%	-18	49	0.6%	N/A
Hawaii	11,098	10,758	-340	-3.1%	-101	-441	-4.0%	-0.6%
Illinois	127,067	129,279	2,213	1.7%	-953	1,260	1.0%	0.3%
Iowa	20,869	20,335	-534	-2.6%	-13	-546	-2.6%	-0.7%
Kentucky	25,108	26,404	1,297	5.2%	-451	845	3.4%	0.7%
Maryland	54,937	53,187	-1,751	-3.2%	-178	-1,929	-3.5%	-1.1%
Massachusetts	98,826	92,209	-6,617	-6.7%	1	-6,616	-6.7%	-1.5%
Minnesota	72,783	73,255	472	0.6%	-49	424	0.6%	0.2%
Nevada	11,232	11,745	513	4.6%	-210	303	2.7%	0.6%
New Jersey	85,807	87,299	1,492	1.7%	-296	1,196	1.4%	0.3%
New Mexico	16,420	16,688	268	1.6%	-104	164	1.0%	0.2%
New York	466,654	433,308	-33,345	-7.1%	-426	-33,772	-7.2%	-4.5%
North Dakota	5,388	5,598	211	3.9%	-52	159	3.0%	0.7%
Oregon	21,580	22,087	506	2.3%	-280	226	1.0%	0.3%
Rhode Island	16,707	16,957	250	1.5%	-51	199	1.2%	0.5%
Vermont	8,100	7,214	-886	-10.9%	-5	-891	-11.0%	-5.6%
Washington	60,085	60,206	121	0.2%	-119	2	0.0%	0.0%
West Virginia	11,912	12,531	619	5.2%	-281	338	2.8%	0.7%

Source: Urban Institute Analysis, HIPSM 2012

[1] Estimates include expenditure increases that would have occurred without the Medicaid expansion

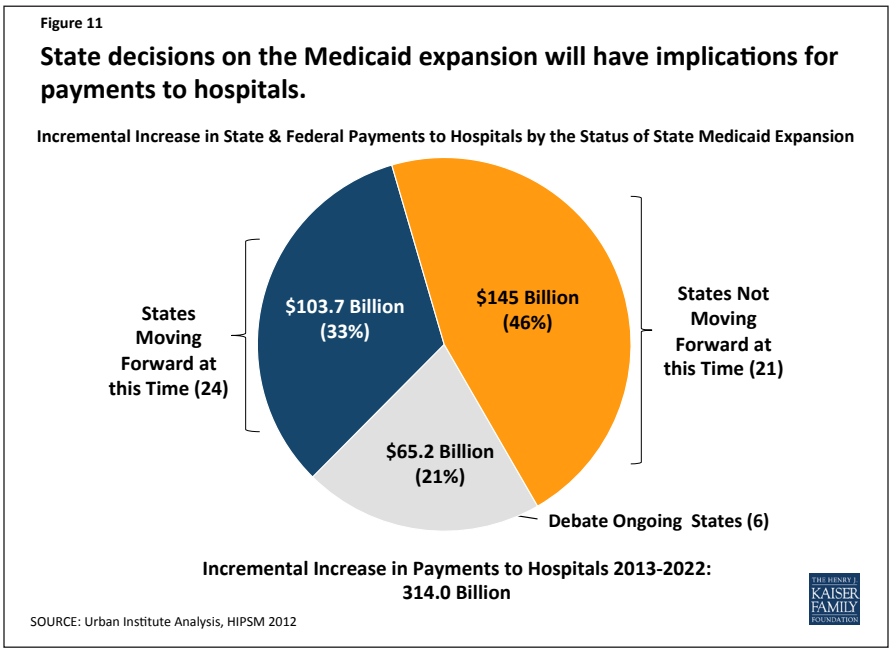
[2] Includes all Medicaid spending in baseline including aged, long term care, DSH, etc.

[3] We estimate uncompensated care as the cost of care used by the uninsured but not paid for by the uninsured. We assume that states and localities pay for 30% of uncompensated care. We further assume that states and localities will be able to achieve only 33% of the decrease in uncompensated care as savings.

We estimate that there would be an increase of $314 billion, or a 17.8 percent increase in Medicaid reimbursement, to US hospitals if all states adopted the Medicaid expansion.[6] (Table 6) In the states that are moving forward, there would be an increase of $103.7 billion, or 11.8 percent, in hospital payments. In the not moving forward states, hospital will receive $145.0 billion less than they would have with the expansion, or 24.8 percent less than they otherwise would have received. In the debate ongoing states, hospitals in these states will receive $65.2 billion less, or 21.6 percent less than they otherwise would have received. (Figures 11 and 12)

Figure 11

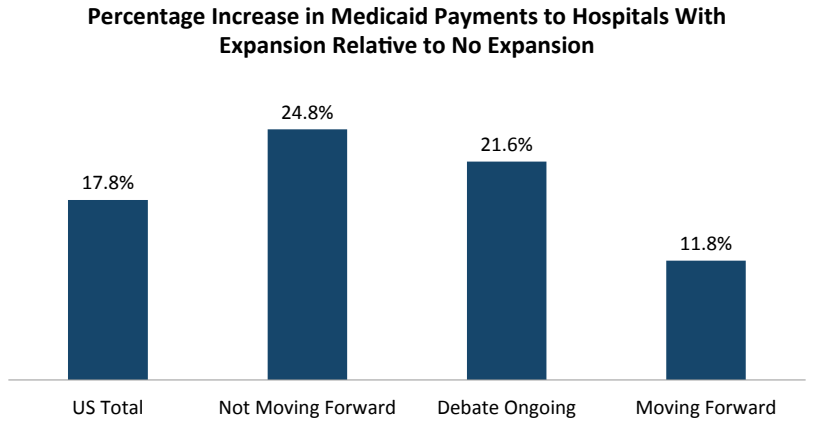
State decisions on the Medicaid expansion will have implications for payments to hospitals.



SOURCE: Urban Institute Analysis, HIPSM 2012

Figure 12

States not moving forward with the Medicaid expansion would have experienced larger increases in Medicaid payments to hospitals.



SOURCE: Urban Institute Analysis, HIPSM 2012

TABLE 6. INCREMENTAL IMPACT OF MEDICAID EXPANSION ON FEDERAL AND STATE MEDICAID PAYMENTS TO HOSPITALS,[1] 2013-2022 (MILLIONS)

State	Medicaid Payments to Hospitals Under ACA with Full Medicaid Expansion[2]	Medicaid Payments to Hospitals Under ACA with No Medicaid Expansion	Incremental Impact of Medicaid Expansion on Payments to Hospitals	
State	($)	($)	Δ ($)	Δ (%)
US TOTAL	**1,764,376**	**1,450,409**	**313,967**	**17.8%**
Not Moving Forward At This Time	**585,873**	**440,859**	**145,014**	**24.8%**
Alabama	9,791	7,093	2,697	27.6%
Alaska	5,000	4,439	561	11.2%
Florida	107,808	74,239	33,569	31.1%
Georgia	59,569	41,966	17,604	29.6%
Idaho	5,965	4,765	1,200	20.1%
Kansas	12,983	10,654	2,329	17.9%
Louisiana	28,997	22,256	6,740	23.2%
Maine	3,359	3,011	348	10.4%
Mississippi	22,664	15,823	6,841	30.2%
Missouri	35,966	28,301	7,666	21.3%
Montana	3,394	2,672	722	21.3%
Nebraska	7,908	6,650	1,258	15.9%
North Carolina	52,648	39,269	13,379	25.4%
Oklahoma	19,648	16,008	3,640	18.5%
South Carolina	25,547	18,819	6,728	26.3%
South Dakota	4,103	3,154	949	23.1%
Texas	111,713	86,890	24,822	22.2%
Utah	12,249	9,684	2,565	20.9%
Virginia	28,523	22,385	6,137	21.5%
Wisconsin	24,943	20,352	4,592	18.4%
Wyoming	3,096	2,428	668	21.6%
Debate Ongoing	**301,625**	**236,412**	**65,212**	**21.6%**
Indiana	27,570	21,177	6,393	23.2%
Michigan	55,528	47,303	8,226	14.8%
New Hampshire	3,351	2,722	629	18.8%
Ohio	80,567	57,448	23,119	28.7%
Pennsylvania	88,779	71,269	17,510	19.7%
Tennessee	45,829	36,494	9,335	20.4%
Moving Forward At This Time	**876,878**	**773,137**	**103,741**	**11.8%**
Arkansas	13,522	9,632	3,890	28.8%
Arizona	N/A	N/A	N/A	N/A
California	181,882	153,586	28,296	15.6%
Colorado	18,029	13,480	4,549	25.2%
Connecticut	17,866	15,326	2,540	14.2%
Delaware	5,182	4,897	285	5.5%
District of Columbia	7,168	6,799	369	5.1%
Hawaii	6,814	5,605	1,209	17.7%
Illinois	95,045	83,553	11,492	12.1%
Iowa	12,365	11,099	1,266	10.2%
Kentucky	28,233	21,101	7,131	25.3%
Maryland	36,098	31,168	4,930	13.7%
Massachusetts	42,023	41,791	232	0.6%
Minnesota	32,353	29,940	2,412	7.5%
Nevada	7,150	5,182	1,968	27.5%
New Jersey	39,938	33,353	6,585	16.5%
New Mexico	19,267	16,785	2,482	12.9%
New York	237,091	227,035	10,055	4.2%
North Dakota	3,088	2,135	953	30.9%
Oregon	20,275	14,538	5,737	28.3%
Rhode Island	7,440	6,454	986	13.3%
Vermont	2,541	2,506	35	1.4%
Washington	33,220	29,575	3,645	11.0%
West Virginia	10,290	7,595	2,695	26.2%

Source: Urban Institute Analysis, HIPSM 2012

[1] Includes an estimate of those payments made by managed care plans

[2] Estimates include expenditure increases that would have occurred without the Medicaid expansion

Additional State-Specific Fiscal Effects of Expansion

This paper does not attempt to assess the overall impact of Medicaid expansion on state budgets. Our analysis is limited to effects that can be estimated on a 50-state basis. Medicaid expansion has many other, highly significant state fiscal consequences that cannot be quantified without state-specific information. If those factors were taken into account, the state budget effects of expansion would be much more favorable than what we show above. Numerous studies where a combination of public and private research has examined fiscal effects in all relevant categories—that is, state costs from increased Medicaid enrollment, state savings from increased federal match for current beneficiaries, state savings on non-Medicaid health care costs, and state revenue effects of expansion—the analysis has shown that, on balance, Medicaid expansion would help, not hurt state budgets over a multi-year period extending well beyond 2016. These state-specific factors are discussed below:

State savings from higher federal matching payments for existing Medicaid beneficiaries. States that expand Medicaid could receive a higher FMAP, which means that states spend less for their care.

Limited benefit Medicaid programs. Beneficiaries who received less than full-scope Medicaid before the ACA can qualify for enhanced FMAP as newly eligible adults.

Pre-ACA coverage of poor adults. States that, before the ACA, extended Medicaid to all poor adults, including childless adults, can receive special enhanced FMAP for the latter.

Medically needy coverage. Many states extend "medically needy spend-down" coverage to people with incomes too high for ordinary Medicaid eligibility. If a state expands Medicaid eligibility, its medically needy spend-down adults with incomes below 138 percent FPL will qualify as newly eligible adults without incurring any bills, receiving the higher FMAP.[7]

Breast and cervical cancer treatment. Almost all state Medicaid programs cover women whom CDC-affiliated clinics have diagnosed to have breast or cervical cancer. In a state adopts the Medicaid expansion, these women could qualify newly eligible adults, at higher FMAP levels.[8]

Low-income adults with disabilities. In a state that expands Medicaid, some adults with incomes below 138 percent FPL who would otherwise have been covered based on disabilities at the standard FMAP, will instead be covered as newly eligible adults. States can claim the enhanced FMAP for these individuals while a disability determination is in process and some individuals may skip the disability determination process and qualify for Medicaid based on income alone at the enhanced FMAP.

State savings on programs not for Medicaid beneficiaries. Most (but not all) savings in this general category involve state general fund expenditures on health care services for the poor and near-poor uninsured; if Medicaid covered adults up to 138 percent FPL, spending on these services could be greatly reduced, due to expanded Medicaid coverage and funding, without cutting consumers' care or increasing their costs.

Programs to fund uncompensated care at hospitals and other safety net providers. Medicaid expansion would reduce the number of uninsured, thereby reducing uncompensated care. This allows states and localities to reduce (but not eliminate) the amount they spend reimbursing safety net providers to cover uncompensated care costs. (These savings were accounted for in the HIPSM model)

High-risk pools. Some states fund high-risk pools for otherwise uninsured consumers with health problems who are ill-served by the individual market. Medicaid expansion can allow the lowest-income consumers in those pools to shift into Medicaid.[9]

State-funded indigent care. Some states have long supported indigent care programs outside Medicaid. With Medicaid expansion, formerly state-funded beneficiaries become newly eligible adults, qualifying for federal funding that replaces state dollars.[10]

State-funded mental health and substance abuse treatment. If poor and near-poor uninsured adults receive Medicaid coverage, states that expand Medicaid could greatly reduce spending on their mental health and substance abuse treatment.[11] Not all such services qualify for Medicaid, however. For example, institutions for the treatment of adults with mental illness are generally prohibited from receiving Medicaid payments.

Inpatient care for state prisoners. Generally, federal Medicaid funds may not pay for services furnished to inmates except for inpatient and institutional care furnished off prison grounds for at least 24 hours. States that expand Medicaid can thus save money on inpatient health care for prisoners, almost all of whom could be newly eligible adults.[12]

Public health expenditures. Expanded Medicaid could substitute for some public health services, such as screenings and immunizations, now provided to the poor uninsured.

Other federally-matched health care programs. States operate many federally-matched, non-Medicaid programs that serve the poor uninsured, including programs that serve people with AIDS, maternal and child health programs, and so forth. Medicaid expansion could let states reduce their contributions to such programs without reducing services.

Revenue. All states gain general revenue from expansion, but some will see other receipts rise as well.

General revenue. Medicaid expansion brings in many new federal Medicaid dollars buying health care, which leads to the purchase of other goods and services. The resulting economic activity generates state revenue (income taxes, sales taxes, etc.).[13]

Premium taxes. Some states have premium taxes or sales taxes that apply to Medicaid capitated payments. These taxes raise more revenue if a Medicaid expansion increases Medicaid managed care enrollment.[14] Medicaid pays the taxes, as part of capitated payments charged by managed care plans. The state's share of capitated payments is thus a wash. But the federal government's share of capitated payments goes directly to the state treasury. For newly eligible adults, the vast majority of increased premium tax revenue will thus come from the federal treasury.

Provider taxes and fees. States that impose taxes or fees on providers' revenue will receive more revenue from expansion, since providers' Medicaid revenue rises.[15] As with premium taxes that apply to Medicaid managed care premiums, the state's net revenue depends on the portion of provider fees paid by the federal government, which, for newly eligible adults, is considerable.

Prescription drug rebates. Manufacturers provide rebates on Medicaid purchases of prescription drugs. More Medicaid enrollment thus means increased rebate revenue.

Gain-sharing. If a state expands Medicaid, interest groups that benefit—typically hospitals or localities—can share part of their gains to help finance expansion costs.

Administrative savings. Expanding eligibility will increase some administrative costs (related to eligibility and claims processing, utilization review, case management, etc), but it will save others. Due to broader coverage rules, administrative savings may result from fewer medically needy determinations,[16] fewer disability determinations, less churning, fewer redeterminations, reductions in the number of fair hearings that result from challenges to eligibility denials,[17] and reductions in caseworker training, management, and quality control due to simplified eligibility rules.

Conclusions

The decisions by as many as 27 states not to adopt the Medicaid expansion will result in fewer people enrolled in Medicaid and many more uninsured. As many as 6.4 million uninsured will not be covered if all 27 states do not adopt the Medicaid expansion. This would result in lower federal and direct state expenditures.

The states that would benefit most from Medicaid expansion are generally the states that have decided against expansion or are still undecided. This applies when examining the impact of expansion on the uninsured, increases in federal Medicaid funding, or hospital Medicaid revenues.

Based on the factors we could estimate on a 50-state basis, most of the 27 states currently not moving forward or debating the Medicaid expansion would have seen small increases in Medicaid expenditures over the 2013-2022 period, if they had expanded, relative to not expanding due to the phase in of a some state share to finance the newly eligible after 2016 (up to 10 percent in 2020 and beyond). Reduced costs for uncompensated care would help to mitigate increases in state costs. The large amount of federal dollars that will come into the states will far exceed the increases in state expenditures. In addition, there are many offsetting savings such as the ability to cover many people who are receiving state support of some kind into Medicaid as new eligibles, reducing expenditures on mental health and substance abuse services, and savings on hospital care for incarcerated populations. States that expand eligibility will also experience increased revenue from many different sources. Increases in federal funding within states that expand will have positive economic effects, increasing employment and state general revenues. It has been noted by some governors that their state citizens will pay federal taxes to support these federal expenditures that will occur in other states.

The decision not to adopt the Medicaid expansion will create inequities in coverage within and between states. Those with incomes below 100 percent will not be eligible for subsidies in exchanges or for Medicaid coverage beyond current eligibility levels. This leaves considerable gaps in coverage and will also result in substantially less revenue for hospitals. Under the ACA, hospitals in these states will still face cutbacks in Medicare and Medicaid disproportionate share hospital payments as well as lower Medicare payment rates independent of whether or not a state adopts the Medicaid expansion. And they will still be faced with serving a large uninsured population. Based on this analysis we conclude that the economic case for Medicaid expansion for state officials is extremely strong.

Appendix A: Methods and Analytic Approach

This analysis uses the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) supported by the Robert Wood Johnson Foundation, the Kaiser Family Foundation and the Urban Institute, to provide national and state-by-state cost and coverage estimates of the ACA Medicaid expansion for the period 2013-2022. To assess the impact of the ACA Medicaid expansion, we compare three scenarios:

No ACA Baseline uses the Congressional Budget Office (CBO) March 2012 projections of current law and the impact of the ACA, as well as state-by-state Medicaid data, to estimate what Medicaid spending and coverage would be if the ACA had not been enacted.

ACA with All States Expanding Medicaid uses HIPSM to estimate what Medicaid spending and coverage would be if the ACA remains in place and all states implement the Medicaid expansion. Comparing these results to the "No ACA Baseline" provides estimates of the impact of the ACA if all states expand Medicaid.

ACA with No States Expanding Medicaid uses HIPSM to estimate what Medicaid spending and coverage would be if no states implement the Medicaid expansion, but other provisions of the ACA go into place (such as new requirements that most individuals must have coverage, no-wrong-door interface for Exchange and Medicaid/CHIP coverage, eligibility simplification, new subsidies in the Exchange, and other provisions of the ACA). Due to these provisions, we find some increased participation in Medicaid among those currently eligible for Medicaid or CHIP, even without the expansion. Comparing these results to the "ACA with All States Expanding Medicaid" provides estimates of the incremental impact of states implementing the Medicaid expansion.

Participation: 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. Take-up rates are modeling outcomes, not modeling assumptions. 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.

Costs: Like participation, we do 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 average costs per enrollee rise from $5,440 in 2016 to $7,399 in 2022. Average costs per enrollee are 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.

Financing: We split costs between the federal government and states for each state according to the federal medical assistance percentages (FMAP) stipulated under the ACA. If states do not expand Medicaid, states will receive their regular FMAP for new enrollment of current eligibles. If states do expand, they receive an enhanced FMAP for those newly eligible for Medicaid under the ACA (100% from 2014 to 2016 then phasing down to 90% in 2020 and beyond) and the regular FMAP for enrollees who are currently eligible for Medicaid. There are two exceptions to these match rates. First, states that have already enacted limited Medicaid benefits programs for adults or expanded coverage to childless adults after ACA enactment will receive the new eligible FMAP for these individuals as of 2014, provided their incomes are under 138% FPL.[18] Second, 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.[19] Last, we assume that the Children's Health Insurance Program (CHIP) will continue to be funded beyond the expiration of its current federal allotments in 2015. Beginning in 2016, the FMAP for CHIP will be raised by 23 percentage points, capped at 100%. The CHIP increase is not tied to the Medicaid expansion, so our estimates incorporate this increase even if states do not expand. Additional detail on the methods underlying this analysis can be found in the full report, available at http://www.kff.org/medicaid/8384.cfm

Endnotes

[1] Holahan, John, Matthew Buettgens, Caitlin Carroll, Stan Dorn, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis,* Washington, DC: The Urban Institute, 2012.

[2] Dorn, Stan, John Holahan, Caitlin Carroll, Megan McGrath, *Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs,* Washington, DC: The Urban Institute, 2013.

[3] Price, Carter C., Christine Eibner, "For States that Opt Out of Medicaid Expansion: 3.6 Million Fewer Insured And $8.4 Billion Less In Federal Payments," *Health Affairs,* 32(6):1030-36, June 2013.

[4] These estimates account for the provisions in the ACA that would allow individuals with incomes between 100 and 138 percent FPL to receive subsidies to participate in the new marketplaces.

[5] Dorn S, Buettgens M, Holahan J, Carroll . *The Financial Benefit to Hospitals from State Expansion of Medicaid.* Washington, DC: The Urban Institute, 2013.

[6] This is offset to some degree by the reductions in subsidized coverage in the exchange that would result from Medicaid expansion, but on balance, increased revenue from Medicaid would exceed lost revenue from exchanges by a factor of five. This earlier analysis assumed that subsidized coverage in the exchange would resemble traditional commercial coverage and so pay hospitals much more than Medicaid. If, instead, exchange coverage turns out to pay providers much less than expected, either because of pressure to keep premiums low or because insurers recruit consumers into "bronze" plans with extremely high out-of-pocket cost-sharing levels, Medicaid expansion becomes even more important financially to hospitals.]

[7] There are two reasons why the formerly medically needy will qualify as newly eligible adults. First, as newly eligible adults, they will not meet pre-ACA spend-down requirements, so they will not meet the requirements of this pre-ACA eligibility category. In addition, spend-down requirements may place medically needy coverage in the category of limited benefit eligibility. Although Medicaid will pay all of their costs, rather than only the costs incurred after spend-down requirements are met, the applicable FMAP will range between 90 and 100 percent, depending on the year, rather than the state's normal FMAP. States examining the issue have estimated that they would experience significant net savings as a result. See, e.g., Maryland HB 228, Fiscal and Policy Note, *Maryland Health Progress Act of 2013,* 2013 Session, http://mgaleg.maryland.gov/2013RS/fnotes/bil_0008/hb0228.pdf; Dorn, Stan, Matthew Buettgens, Caitlin Carroll, et al. *Expanding Medicaid in Ohio: Analysis of Likely Effects,* Health Policy Institute of Ohio, 2013.

[8] The increased FMAP for this particular category is less than for other categories. Coverage for women diagnosed with breast or cervical cancer receives CHIP-level of FMAP, which is higher than standard Medicaid FMAP, but lower than the FMAP that applies to newly eligible adults.

[9] New Mexico LFC Hearing Brief, Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility, September 27, 2012, http://www.nmlegis.gov/lcs/lfc/lfcdocs/LFC%20Hearing%20Brief,%20Implementation%20of%20Affordable%20Care%20Act%20-%20Costs%20and%20Benefits%20of%20Expansion%20of%20Medicaid%20Eligibility,%20September%202012.pdf. Maryland HB 228, Fiscal and Policy Note, Maryland Health Progress Act of 2013, 2013 Session, http://mgaleg.maryland.gov/2013RS/fnotes/bil_0008/hb0228.pdf.

[10] For examples, see Minnesota Bill S0005-6A (R), Kathleen Shernan, *MA Eligibility Expansion,* February 12, 2013, http://www.mmb.state.mn.us/bis/fnts_leg/2013-14/S0005_6A.pdf. Commonwealth Institute for Fiscal Analysis. *Revised: Medicaid Expansion Still Saves Money in Virginia's Budget,* January 16, 2013; Charles Brown Consulting, Colorado Health Foundation, *Medicaid Expansion: Examining the Impact on Colorado's Economy,* 2013, http://www.coloradohealth.org/studies.aspx.

[11] Charles Brown Consulting, Colorado Health Foundation, *Medicaid Expansion: Examining the Impact on Colorado's Economy,* 2013, http://www.coloradohealth.org/studies.aspx; Michigan House Fiscal Agency, *Medicaid Expansion—Affordable Care Act,* Memo to House Appropriations Committee, July 17, 2012, http://www.house.mi.gov/hfa/pdfs/medicaid%20expansion%20memo%20jul17.pdf; The Oregon Health Authority, *Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014-2020)*, February 2013, http://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/OR_Effect%20of%20ACA%20Medicaid%20Expansion_Feb2013_Final.pdf.

[12] Charles Brown Consulting, op cit.; Michigan House Fiscal Agency, *Medicaid Expansion – Affordable Care Act,* Memo to House Appropriations Committee, July 17, 2012, http://www.house.mi.gov/hfa/pdfs/medicaid%20expansion%20memo%20jul17.pdf

[13] Charles Brown Consulting, Colorado Health Foundation, *Medicaid Expansion: Examining the Impact on Colorado's Economy,* 2013, http://www.coloradohealth.org/studies.aspx; UMBC, The Hilltop Institute, *Maryland Health Care Reform Simulation Model: Detailed Analysis and Methodology*, July 2012, http://www.hilltopinstitute.org/publications/MarylandHealthCareReformSimulationModel-July2012.pdf. The Oregon Health Authority, Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014–2020), February 2013, http://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/OR_Effect%20of%20ACA%20Medicaid%20Expansion_Feb2013_Final.pdf. While this increase is offset, to some degree, by the loss of federal subsidies in the HIX, the net effect is nevertheless a significant increase. [cite earlier Holahan et al paper]

[14] Maryland HB 228, Fiscal and Policy Note, Maryland Health Progress Act of 2013, 2013 Session, http://mgaleg.maryland.gov/2013RS/fnotes/bil_0008/hb0228.pdf; New Mexico LFC Hearing Brief, *Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility*, September 27, 2012, http://www.nmlegis.gov/lcs/lfc/lfcdocs/LFC%20Hearing%20Brief,%20Implementation%20of%20Affordable%20Care%20Act%20-%20Costs%20and%20Benefits%20of%20Expansion%20of%20Medicaid%20Eligibility,%20September%202012.pdf.

[15] Udow-Phillips, Marianne, Fangmeier, Joshua, Buchmueller, Thomas, Levy, Helen, *The ACA's Medicaid Expansion: Michigan Impact,* October, 2012, Center for Healthcare Research & Transformation. Ann Arbor, MI. http://www.chrt.org/assets/price-of-care/CHRT-Issue-Brief-October-2012.pdf; New Mexico LFC Hearing Brief, *Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility,* September 27, 2012, http://www.nmlegis.gov/lcs/lfc/lfcdocs/LFC%20Hearing%20Brief,%20Implementation%20of%20Affordable%20Care%20Act%20-%20Costs%20and%20Benefits%20of%20Expansion%20of%20Medicaid%20Eligibility,%20September%202012.pdf.

[16] Per capita savings in this area will not be trivial. Spend-down determinations require the state to compare the amount of each beneficiary's medical bills to the beneficiary's individually calculated "spend-down amount" (i.e., the difference between income and the level down to which the beneficiary must spend before qualifying for Medicaid coverage).

[17] As noted earlier, applications that begin at the exchange will often be routed to Medicaid. States without an expansion will have large gaps in coverage, resulting in many cases of denied eligibility, each of which generates notices and a right of appeal. States that expand eligibility will lack such coverage gaps. Many fewer applicants will be denied coverage and receive denial notices that generate requests for fair hearings.

[18] This model accounts for 11 states that have extended limited Medicaid benefits to adults eligible through section 1115 waivers that will receive the higher federal matching rates applicable to new eligibles in 2014: Connecticut, Hawaii, Indiana, Iowa, Maryland, Minnesota, New Mexico, Oregon, Utah, Washington and Wisconsin. The model does not account for states in which limited benefits are available only through premium assistance, such as Arkansas, Idaho and Oklahoma, due to the difficulty of identifying premium assistance enrollees from survey data and the small enrollment in most such programs. We also did not model limited benefits programs that are not statewide, such as those in California and Missouri. See the full report for more information about how specific states were handled in the model.

[19] Seven states fall into this category: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York and Vermont.

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