

ACA Implementation—Monitoring and Tracking

Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs

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With support from the Robert Wood Johnson Foundation, the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

INTRODUCTION AND SUMMARY

As originally enacted, the Patient Protection and Affordable Care Act (ACA) required each state to expand Medicaid eligibility to 138 percent of the federal poverty level (FPL).¹ According to the Congressional Budget Office, Medicaid was expected to account for roughly half of all new coverage of the uninsured.² However, in June 2012, the U.S. Supreme Court's decision in *National Federation of Independent Business v. Sebelius*³ effectively converted this mandatory step into a state option. Since then, one of the central questions facing ACA implementation has involved state-level choices about whether to expand Medicaid.

This brief explores how state officials and stakeholders are analyzing the fiscal and macroeconomic implications of this choice. We focus on 10 of the 11 states that are participating in the Robert Wood Johnson Foundation's (RWJF) health reform monitoring and tracking project. The discussion is divided into four sections:

- The legal and policy context in which states are deciding whether to expand Medicaid;
- The status of decision-making around Medicaid expansion in our 10 RWJF states;
- How the fiscal effects of Medicaid expansion are being analyzed; and
- How the macroeconomic effects of Medicaid expansion are being analyzed.

Based on interviews with officials and key stakeholders in these 10 states, as well as a review of relevant documents, we conclude that:

- Recent analyses of Medicaid expansion have avoided the analytic errors that characterized some early calculations;
- Many (but not all) of these states have benefited from multi-faceted fiscal estimates that include the cost of increased enrollment, savings both within and outside Medicaid, and revenue effects that are expected to result from expansion;
- Both macroeconomic and net fiscal gains from Medicaid expansion are projected for each state that received comprehensive analyses; but
- The states we reviewed did not consider certain fiscal effects of expansion. These consisted primarily (but not exclusively) of additional opportunities for state budget savings.

An important motivation for this report is to help inform future examination of Medicaid expansion's fiscal and macroeconomic effects at the state level. Information about what their counterparts have done could be helpful to other states that are either still deciding whether to expand eligibility or made an initial decision for 2014 but may reexamine their choice.

THE LEGAL AND POLICY CONTEXT OF MEDICAID EXPANSION

If a state expands Medicaid, the federal government will pay 100 percent of the cost of newly eligible enrollees during calendar years 2014–16. After that, the federal share will gradually decline to 90 percent in 2020 and thereafter. (The percentage of funding paid by the federal government is often called the “federal medical

assistance percentage,” or FMAP.) By contrast, for other Medicaid beneficiaries, the federal government pays an average of 57 percent of health care costs.⁴ To obtain this special FMAP for newly eligible adults before 2017, a state must expand eligibility to 138 percent FPL.⁵

A state's decision about Medicaid expansion influences eligibility for subsidies in health insurance exchanges (HIXes), which are sometimes called "marketplaces." Without Medicaid expansion, HIX subsidies cover citizens and lawfully present immigrants with incomes between 100 and 400 percent FPL who are not offered employer-sponsored insurance (ESI) that the ACA defines as "affordable."⁶ If a state expands Medicaid to 138 percent FPL, the lower income threshold for HIX subsidy eligibility rises to 138 percent FPL.⁷

In most states, the decision not to expand Medicaid eligibility would leave a large gap in adult eligibility for assistance. In the median state—

- Children are covered up to 235 percent FPL through Medicaid and the Children's Health Insurance Program (CHIP);
- Medicaid coverage of parents ends at 61 and 37 percent FPL for workers and the unemployed, respectively; and
- Medicaid flatly denies coverage to childless adults and empty nesters, no matter how poor, unless they are pregnant, severely disabled, or over age 65.

Altogether, an estimated 11.5 million uninsured adults with incomes below poverty will be ineligible for assistance if their states do not expand Medicaid, even though millions of uninsured adults in those states with incomes above poverty will qualify for HIX subsidies.⁸

DECISION-MAKING AROUND MEDICAID EXPANSION IN THE 10 RWJF STATES

In the 10 states we examined that are being monitored by the Robert Wood Johnson Foundation, five have already decided to implement the Medicaid expansion; two

appear likely to do so; and in three, expansion appears unlikely to occur by January 2014 (Table 1).

TABLE 1: Status of Medicaid Expansion in 10 RWJF States

State	Governor	Legislature	Outcome
Alabama	Opposed expansion to Medicaid in its current form.	Discussion focused primarily on reforming Medicaid's structure, rather than expanded eligibility.	Serious obstacles to expansion by January 2014.
Colorado	Proposed expansion.	Approved expansion.	Expansion approved.
Maryland	Proposed expansion.	Approved expansion.	Expansion approved.
Michigan	Proposed expansion.	Approval uncertain.	Serious obstacles to expansion by January 2014.
Minnesota	Proposed expansion.	Approved expansion.	Expansion approved.
New Mexico	Approved expansion.	Action not required, as a practical matter.	Expansion approved.
New York	Proposed expansion.	Approved expansion.	Expansion approved.
Oregon	Proposed expansion.	Expansion appears likely.	Likely expansion.
Rhode Island	Proposed expansion.	Expansion appears likely.	Likely expansion.
Virginia	Opposed expansion.	Compromise approved. Medicaid reforms required before expansion.	Serious obstacles to expansion by January 2014.

NOTE: Green font indicates expansion approved; blue indicates likely expansion; and red indicates serious obstacles to expansion by January 2014.

FISCAL ANALYSIS OF EXPANSION

In many of the 10 states we examined, the costs and benefits of Medicaid expansion were analyzed by some combination of the executive and legislative branches of government, academics or other researchers, and private interest groups. Here, we combine all of these estimates to catalog the range of findings about the impact of the expansion. These state-level experts could achieve a level of precision in developing comprehensive estimates of costs, savings, and revenue effects that, by themselves, national researchers cannot attain.

Increased State Medicaid Costs

During 2013, both executive branch and legislative fiscal analyses have made estimates of the increased state Medicaid cost that would result from expanded eligibility that are generally consistent with the published literature. These analyses avoided some of the pitfalls that sometimes characterized earlier calculations released soon after the Supreme Court's decision, including some in our 10 states.⁹ For example, a number of such early analyses¹⁰—

- Made unrealistically high assumptions about participation among newly eligible adults—including, in some cases, 100 percent participation—anticipating take-up levels never before achieved by any need-based benefit program;¹¹
- Assumed that newly eligible adults would have average costs typical of relatively unhealthy current beneficiary groups, despite research showing that, on average, newly eligible adults have fewer health care needs, hence lower expected costs than current Medicaid adults;¹²
- Assumed that the elderly (including nursing home residents) would increase their enrollment into Medicaid, despite the absence of such effects observed during earlier coverage expansions focused exclusively on the non-elderly;¹³ or
- Attributed to Medicaid expansion significant enrollment increases among currently eligible populations that are likely to result under the ACA, even without Medicaid expansion. Such “welcome mat” or “woodwork” effects are expected because of the ACA's individual coverage requirement, the availability of new subsidies in the exchange, the automatic routing of subsidy applications from exchanges to Medicaid programs, streamlined enrollment procedures for Medicaid, and other ACA provisions that will go into effect, with or without expansion.

To be clear, adding Medicaid expansion to the remainder of the ACA should further increase the enrollment of populations who currently qualify for Medicaid, for whom states receive only their standard share of federal matching funds. But most of the “welcome mat” or “woodwork” effect is likely to result from the ACA's other provisions, even without expansion.

One possible point of comparison for these state cost estimates is the Urban Institute (UI) analysis that used the Health Insurance Policy Simulation Model (HIPSM) to project Medicaid expenditures and take-up under expansion for all 50 states and DC.¹⁴ The authors are not aware of any other estimates, rooted in the health economics literature, that include all 10 of the states we examine here. HIPSM's key features include the following:

- It does not apply uniform participation rates across the population. Rather than assumptions, HIPSM's take-up rates are results that are based on the characteristics of affected individuals. These results emerge from econometric models that analyze the impact on participation of factors such as income, education, and previous coverage.¹⁵
- HIPSM projects the impact of health policy changes on the labor market, including offers of ESI. These projections are based on published research about crowd-out effects of earlier coverage expansions, as well as empirical observations.
- The model estimates costs per enrollee based on individual characteristics, including age, gender, and health status, and takes into account health care expenditure data from the Medical Expenditure Panel Survey.

Many of the states we studied used very different assumptions and methods but reached conclusions in the same general range as the UI estimates. Such convergence reinforces the plausibility of both sets of projections. For example:

- Applying a spreadsheet model rather than a microsimulation, Colorado used take-up assumptions for newly eligible adults similar to those that resulted from the UI model. However, the state decided not to model any crowd-out effects specifically. Also, the state projected a greater impact of expanded eligibility on participation levels by previously eligible consumers, compared to HIPSM. These two differences largely offset each other, resulting in enrollment levels much

like those estimated by UI. Along similar lines, Colorado estimated somewhat higher average costs of new enrollees but somewhat lower annual health care cost growth rates, compared to the UI model, resulting in comparable overall expenditure projections.

- Maryland's Hilltop Institute used a microsimulation model. Differences between the Hilltop and UI approaches included how to model take-up rates, the inputs that affect crowd-out levels, assumptions about the state's CHIP program, and estimates about whether the state's adult waiver population and per capita costs will rise after ACA implementation. Despite those differences, the "bottom line" expenditure and enrollment projections from the Hilltop model and HIPSM are similar.
- The New Mexico Human Services Department (HSD) did not assume any crowd-out. The resulting reduction in projected enrollment was more than offset by an anticipated take-up rate among new eligibles of 80 percent by 2020, significantly exceeding the participation level found by HIPSM. In addition, HSD based its per capita cost estimate for new eligibles on the state's current waiver population. By contrast, HIPSM's per capita cost estimate reflected the demographic characteristics of newly eligible adults in New Mexico, including age, gender, and health status, as well as health care costs. These factors led New Mexico HSD to cost estimates that were slightly higher than UI's.
- New York had UI conduct additional, independent analyses using HIPSM, which modified the underlying HIPSM model to incorporate a large amount of state-specific data. This increased the level of estimated savings that would result from higher FMAP for the state's pre-ACA expanded eligibility group of childless adults.

State Medicaid Savings

Most states anticipated that expanding eligibility would allow savings because they could substitute 90 to 100 percent FMAP for standard FMAP furnished to certain current beneficiaries. We focus here on beneficiary groups that may be relevant to other states as well.¹⁶

Limited benefit Medicaid programs. Beneficiaries who received less than full-scope Medicaid before the ACA can qualify for enhanced FMAP as newly eligible adults. Several states projected savings in this category, including Michigan for its "adult benefit waiver" program limited to ambulatory care coverage for very low-income childless adults;¹⁷ New Mexico's "State Coverage Initiative" program;¹⁸ and Maryland's Primary Adult Care program.¹⁹

Pre-ACA coverage of all poor adults. States that, before the ACA, extended Medicaid to all poor adults, including childless adults and "empty nesters," can receive special enhanced FMAP for such adults without children. This enhanced FMAP gradually increases above current levels until it reaches 93 percent in 2019 and 90 percent in 2020 and thereafter. Among our states, New York qualifies for this kind of enhanced match, which reduced projected state expenditures for current beneficiaries.²⁰

Medically needy coverage. Currently, many states extend so-called "medically needy spend-down" coverage to people with incomes too high for ordinary Medicaid eligibility. Such consumers qualify for Medicaid by incurring medical bills large enough to reduce their disposable incomes below applicable thresholds. After such bills have been incurred, during the remainder of the relevant period chosen by the state—one month or six months, for example—the consumer's health care costs are covered by Medicaid, with FMAP at standard levels.

If a state expands Medicaid eligibility, its medically needy spend-down adults with incomes at or below 138 percent FPL will qualify as newly eligible adults, without incurring any health care costs. Because they will not meet pre-ACA spend-down requirements, they will not fall within this pre-ACA eligibility category and so can receive FMAP reserved for newly eligible adults.²¹ 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. In Maryland, the legislative fiscal note projected substantial net savings from this shift.²²

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 that covers all adults up to 138 percent FPL, financially eligible women will receive Medicaid without visiting such clinics or obtaining that diagnosis. Further, states are not required to track newly eligible adults by diagnosis; rather, FMAP claims are to be submitted based on income thresholds.²³ Accordingly, expanding Medicaid eligibility allows women with breast and cervical cancer to be covered as newly eligible adults, resulting in higher FMAP levels.²⁴ A number of states, including Oregon and Virginia, estimated savings in this area.²⁵

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 all adults up to 138 percent FPL, spending on these services could be greatly reduced, in favor of largely federal Medicaid funding, without cutting consumers' care or increasing their costs.

Programs to fund uncompensated care at hospitals and other safety net providers. Virginia and Maryland quantified reductions in funding for hospital uncompensated care that could take place if Medicaid were expanded.²⁶ Virginia's savings took place in the context of Medicaid's disproportionate share hospital (DSH) funding, which is not limited to Medicaid beneficiaries.

High-risk pool. New Mexico estimated that significant savings would result from shifting poor and near-poor enrollees out of the state-funded high-risk pool and into an expanded Medicaid program.²⁷ Maryland acknowledged the possibility of similar savings but did not quantify them.²⁸

State-funded indigent care. Minnesota estimated significant savings from converting its pre-ACA state-funded coverage of childless adults and empty nesters into largely federally funded Medicaid coverage of newly eligible adults.²⁹ The state had already realized savings by implementing an early expansion that allowed it to obtain standard FMAP for this previously state-funded coverage, but standard FMAP will become "newly eligible adult" FMAP, beginning in 2014.³⁰ Colorado likewise anticipated savings from converting state-funded indigent care into federally funded Medicaid.³¹

State-funded mental health and substance abuse treatment for the poor and near-poor uninsured. Many states estimated significant savings in this area, including Colorado, Michigan, Oregon, and Virginia.³² Not all mental health and substance abuse services can qualify for Medicaid reimbursement, however. For example, institutions for the treatment of adults with mental illness are generally prohibited from receiving Medicaid payments. Also, some residential treatment of substance abuse is outside the scope of traditional Medicaid coverage. That said, a substantial volume of state-funded care can be reimbursed by mostly federally funded Medicaid coverage of newly eligible adults, according to analysts in many of the states we examined.

Inpatient care for state prisoners. As a general rule, federal Medicaid funds may not pay for services furnished to inmates. However, there is an exception for inpatient and institutional care furnished off prison grounds for at least 24 hours. Accordingly, Colorado, Michigan, and Virginia projected general fund savings on inpatient health care for prisoners that would result from expanding Medicaid coverage.³³

Public health expenditures. None of the states we examined quantified potential savings in public health services furnished to uninsured residents that could be eliminated in favor of new Medicaid coverage. Such services might include, for example, screenings and immunizations. However, Maryland mentioned the possibility of such savings without quantifying them.³⁴

Public employee and retiree coverage. This final category of non-Medicaid savings is qualitatively different from those described above. Colorado, Maryland, New Mexico, Oregon, and Virginia anticipated that Medicaid expansion would lower the cost of providing health coverage to public employees and retirees. Expansion would mean fewer uninsured, according to these analyses, which would reduce hospital uncompensated care. In turn, hospitals would shift fewer unreimbursed costs to private insurers, who would reduce the premiums they charge, including to public employers.³⁵ In one striking example, Oregon took a very conservative approach to estimating such savings, which still resulted in non-trivial fiscal gains, given the significant budgetary commitment the state has made to covering public employees and retirees.³⁶

Revenue Effects

States estimated several types of revenue gains that would result from Medicaid expansion.

General revenues. As the later discussion of macroeconomic effects explains, Medicaid expansion will cause a significant influx of new federal Medicaid funds buying health care within a state's borders, which in turn leads to the purchase of other goods and services. Colorado, Maryland, New Mexico, Oregon, and Virginia each projected a rise in general revenue resulting from this increased economic activity.³⁷

Premium taxes. Several states, including Maryland and New Mexico, have premium taxes that apply to Medicaid managed care capitated payments. These states projected that Medicaid expansion would increase

Medicaid managed care enrollment, thus raising revenue from these sector-specific taxes.³⁸

Note that the Medicaid program pays these taxes, which are included in the capitated payment charged by the managed care organization. The state's share of capitated payments is thus a wash; one part of state government, in effect, pays a different part of state government. 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 thus comes from the federal government.

Provider taxes and fees. Colorado, Michigan, and New Mexico estimated that increased Medicaid enrollment would boost the state's receipt of provider taxes or fees, since providers would obtain increased Medicaid revenue.³⁹ As with premium taxes that apply to Medicaid managed care premiums, the state's net increase in revenue depends on the portion of provider taxes and fees paid by the federal government, which, in the case of newly eligible adults, is considerable.

Prescription drug rebates. Counting it effectively as revenue offsetting other Medicaid costs, Minnesota included the prescription drug rebates that would follow from increased Medicaid enrollment based on differential levels of prescription drug use among affected populations.⁴⁰

Overall Conclusion of Fiscal Analyses

Virginia exemplifies a state where public officials and private stakeholders have carefully analyzed multiple effects of Medicaid expansion. Table 2 shows the factors included in the state's analysis of both increased Medicaid costs resulting from expansion, as well as offsetting savings. Particularly noteworthy are both the care with which state analysts distinguished expanded eligibility from other ACA provisions (including separate "welcome mat" or "woodwork" effects resulting from the ACA, with and without expanded eligibility) and the range of potential cost savings taken into account.

State officials concluded that Medicaid expansion would yield net state budget gains for state fiscal years 2014–20 (data not shown), even though, over the entire 2014–22

period, the expansion was projected to result in a small net state cost increase. Building on these estimates and the Chmura Group's analysis of macroeconomic effects,⁴¹ the Commonwealth Institute for Fiscal Analysis found that Medicaid expansion would produce state budget gains for entire 2014–22 period. This analysis took into account the state's estimated Medicaid cost effects, the Chmura group's general revenue projections, and anticipated savings on health coverage costs for public employees and retirees.⁴²

In each state where relatively comprehensive analyses of costs and fiscal gains were conducted, the net result showed that, on balance, Medicaid expansion would yield state fiscal advantages. In a number of states, key informants reported that these analyses were critically important in obtaining support for expansion from state policy-makers. In Colorado, Maryland, New Mexico, Oregon and Virginia, calendar year 2020 and beyond—the years in which federal support for expansion fell to 90 percent FMAP—involved net state costs that modestly exceeded state budget benefits of expansion. However, inherent uncertainty attaches to projections of costs, savings, and revenue many years in the future; and these analyses did not take into account the potential sources of savings described below.

Not all of our 10 states saw the completion of comprehensive analyses. In some states, like New York and Minnesota, preliminary analyses were sufficient to demonstrate significant net savings, lessening the need for further investigation. In Rhode Island and Alabama, the general outcome of the expansion discussion during the legislative session seemed unlikely to be influenced by the public release of any comprehensive fiscal analysis. Leaders in the former state were firmly committed to expansion; and those in the latter were equally clear that expansion would not take place as long as Alabama's Medicaid program remained in its current form. Given finite resources, policy-makers and outside stakeholders in each state have made careful judgments about how much to invest in estimating not just the cost of expansion but also the magnitude of potential state budget savings and revenue offsets.

TABLE 2: Virginia State Government's Analysis of ACA Fiscal Effects

	SFY 2010 – SFY 2022		
	State Funds	Federal Funds	Total Funds
Coverage for Eligible but Unenrolled “Woodwork” including Foster Care Alumni	539,207,001	806,189,744	1,345,396,745
Administrative Costs for Additional Enrollment	7,395,317	14,355,616	21,750,934
Federal Primary Care Physician Rate Increase (CY13-CY14)	-	145,085,077	145,085,077
ACA Insurance Tax (Current Medicaid Program & Initial Woodwork)	255,668,590	258,943,782	514,612,371
Restoration of Lost DSH Funds ²	215,000,000	(215,000,000)	-
Subtotal: Costs due to ACA Provisions	1,017,270,908	1,009,574,218	2,026,845,127
Changes in Medicaid Drug Rebate Program	(528,533,173)	(528,533,173)	(1,057,066,346)
Reductions in DSH Allotments ²	(215,000,000)	215,000,000	-
Increase in Title XXI FMAP	(322,334,595)	322,334,595	-
Elimination of Public Coverage Programs ³	(60,060,606)	(137,728,846)	(197,789,452)
Indigent Care Savings (133-200% FPL)	(33,548,028)	(33,548,028)	(67,096,056)
Subtotal: Savings accrued from ACA Provisions	(1,159,476,402)	(162,475,452)	(1,321,951,854)
Net Estimate of ACA Provisions	(142,205,494)	847,098,766	704,893,272
Coverage of Newly Eligible Adults to 138% FPL – Medicaid Package	1,339,261,205	21,990,580,445	23,329,841,650
Coverage for Additional Eligible but Unenrolled “Woodwork”	85,066,259	60,795,100	145,861,359
Administrative Cost for Additional Enrollment	161,438,748	313,381,099	474,819,847
ACA Insurance Tax (Additional Woodwork & Newly Eligible)	17,127,567	264,426,744	281,554,310
Subtotal: Costs due to Optional ACA Expansion	1,602,893,778	22,629,183,387	24,232,077,166
Elimination of Public Coverage Programs ³ and Coverage of Current Populations as Newly Eligible ⁴	(103,981,438)	80,032,478	(23,948,960)
Coverage of Inpatient Hospital Care for Incarcerated Populations	(289,781,538)	274,234,497	(15,547,041)
Reductions in State-Only Funded Community Behavioral Health Services for Expansion Population	(292,026,917)	-	(292,026,917)
Indigent Care Savings (0-133% FPL)	(637,412,533)	(637,412,533)	(1,274,825,066)
Subtotal: Savings accrued from Optional ACA Expansion	(1,323,202,426)	(283,145,559)	(1,606,347,984)
Net Estimate of Optional ACA Expansion	279,691,353	22,346,037,829	22,625,729,181
Net Estimate of ACA Provisions with Optional Expansion	137,485,859	23,193,136,595	23,330,622,454

SOURCES: Virginia Department of Medical Assistance Services, December 7, 2012

NOTES:

1. Costs and savings assume a 69 percent ACA expansion take-up rate.

2. Line 5 and Line 8 contain entries that cancel each other out. One line reflects the ACA-mandated federal DSH reduction and the corresponding reduction in state DSH spending. The other reflects the likelihood that Virginia will restore the DSH reduction by increasing hospital payments in a non-DSH payment stream, increasing both federal and state expenditures by an amount equal to the DSH reduction. Both lines were included to make all assumptions explicit. As a result, if policymakers choose not to restore the DSH reduction, the cost estimates can easily be revised to reflect that decision.

3. Public coverage programs in Virginia include “FAMIS MOMS” which covers pregnant women 133–200 percent FPL; and “Plan First”, a program covering family planning services only, serving consumers up to 200 percent FPL. Under the Mandated ACA Provisions (Line 10) Virginia proposed to eliminate FAMIS MOMS and coverage of Plan First for individuals 133 percent FPL and above as these individuals not offered ESI will have access to subsidized health care coverage through the Health Insurance Exchange. Under the Optional ACA Expansion, Virginia proposed to eliminate the remaining Plan First program (0–133 percent FPL).

4. Breast and Cervical Cancer program and state-funded Temporary Detention Orders.

FACTORS NOT INCLUDED IN STATE FISCAL ANALYSES

Several factors were addressed incompletely, not clearly, or not at all in the analyses we reviewed.

Additional Savings that Could Result from Expansion

None of the states we reviewed considered the following savings possibilities, in significant part because many are based on regulations that CMS issued after we completed the bulk of our interviews. These regulations clarify how states can claim enhanced FMAP for newly eligible adults.⁴³

Low-income adults with disabilities. In a state that expands Medicaid, some adults with incomes at or below 138 percent FPL who would otherwise have been covered based on disabilities, with the state receiving standard FMAP, will instead be covered as newly eligible adults, with the state receiving FMAP between 90 and 100 percent, depending on the year.

After submitting a Medicaid application, it typically takes several months to obtain a disability determination. In a state that expands eligibility, health care provided during that period to adults with incomes at or below 138 percent FPL is classified as furnished to newly eligible adults and qualifies for 90 to 100 percent FMAP. Only after an applicant is found disabled does FMAP return to standard levels. Without a Medicaid expansion, by contrast, standard FMAP applies to all services for adults who ultimately qualify, including those furnished before the disability determination.

Further, only adults who receive actual disability determinations are classified within pre-ACA Medicaid eligibility groups that are based on disability. Unless newly eligible adults ask to be reclassified as eligible based on disability, they cannot be forced to undergo time-consuming and potentially invasive disability determinations for the purpose of determining applicable FMAP.

Even in a state that expands Medicaid eligibility, many people with disabilities will continue to seek disability determinations, notwithstanding the associated inconvenience. In some cases, such determinations let consumers obtain cash assistance. In other cases, consumers will seek disability determinations to obtain more generous Medicaid coverage; these consumers live

in states that will provide more limited Medicaid benefits to newly eligible adults than for people with disabilities. Nevertheless, some people with disabilities who, in the past, would have sought a disability determination in order to obtain Medicaid will no longer do so in a state that expands Medicaid eligibility. States will receive much more generous FMAP for their care.

Retroactive eligibility. Medicaid programs cover not just services obtained after an eligible person submits an application, but also services received during the 90 days before the application was filed. Such “retroactive coverage” is likely to become less common in a state that extends coverage continuously from 0 to 138 percent FPL. In such a state, subsidies from Medicaid, the HIX, or employers will be available for all citizens and lawfully present immigrants across the income spectrum, from 0 to 400 percent FPL. Such continuous subsidies should lessen gaps in coverage. As a result, Medicaid programs will incur fewer costs for retroactive services, because there will be many fewer periods of uninsurance that precede initial applications for Medicaid coverage. Put differently, Medicaid programs that today assume a certain average level of retroactive cost per beneficiary are likely to lower that average if they expand eligibility.⁴⁴ The resulting savings will include currently eligible beneficiaries, for whom states receive standard FMAP.

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

Savings Opportunities that Expansion Would Preclude

None of the states we reviewed considered that expansion would eliminate the possibility of shifting Medicaid adults with incomes between 100 and 138 percent FPL into subsidized exchange coverage. Such adults typically include pregnant women, women with breast and cervical cancer diagnoses, and others. This coverage shift could reduce state costs without eliminating subsidies; rather, the affected consumers would transition from Medicaid subsidies to either ESI

or purely federal subsidies in the exchange. But with expansion, HIX subsidies would no longer be available between 100 and 138 percent FPL.⁴⁵ Whether or not a state expands eligibility, states can shift Medicaid adults above 138 percent FPL into subsidized HIX coverage, thereby achieving savings. Without an expansion, however, states can expand this shift to include additional Medicaid adults.

Of course, not all states would shift near-poor Medicaid beneficiaries into the HIX. Compared to Medicaid, subsidized HIX coverage would likely impose higher premium and out-of-pocket costs and expose consumers to the risk of incurring tax debts if annual income turns out to exceed projected levels. Further, some former Medicaid beneficiaries with access to ESI would be ineligible for HIX subsidies. That said, this opportunity for potential savings would be foreclosed in a state that expanded eligibility.

Administrative costs and savings. Among the states we reviewed, some did not estimate administrative costs. Others, like Virginia, assumed that administrative costs would rise in proportion to the Medicaid program's total growth under expansion.

In fact, the impact of expansion on state administrative costs is much more complex. A critically important change involves shifting eligibility determination from manual procedures towards data-matching, whenever possible. This change can result in significant operational savings, but it requires up-front investments in information technology (IT).⁴⁶ The federal government will pay 90 percent of necessary IT investment costs and 75 percent of later operating costs for automated eligibility determination. By contrast, before the ACA, all costs related to eligibility determination, whether involving investments or operations, qualified for only 50 percent FMAP. As a result, states are likely to experience significant administrative cost advantages through moving to the ACA's new, more data-driven eligibility system, both because the total operational cost of eligibility determination should decline when manual intervention becomes less common, but also because the federal government's share of costs will rise substantially. All of this will occur with or without Medicaid expansion, but this major change reshapes the context for analyzing the administrative cost effects of expansion.⁴⁷

If a state adds Medicaid expansion to the remainder of the ACA, it will experience increased administrative

costs in the following categories, which will vary between a 25 and 50 percent state share:⁴⁸ another increment of additional applications would presumably be filed, in addition to those that would result from ACA implementation without an expansion; more people will be enrolled, so more people will need to have their eligibility redetermined; to the extent the state operates fee-for-service Medicaid, it will need to process more fee-for-service claims; to the extent the state provides Medicaid managed care, the related administrative services⁴⁹ that it provides on a "per beneficiary" basis will increase in volume; and more beneficiaries will enroll, so more are likely to request fair hearings on service denials.

On the other hand, Medicaid expansion will lower state administrative costs in the following categories, each of which involves a 50 percent state share of cost: fewer beneficiaries will need to have medically needy eligibility evaluated, since those with incomes at or below 138 percent FPL will qualify as newly eligible adults;⁵⁰ fewer applicants will request disability determinations, since many will qualify based simply on income; by increasing continuity of subsidized coverage, Medicaid expansion will lessen "churning" on and off the program, thus cutting the time spent redetermining eligibility for "returning alumni;" Medicaid expansion may reduce the number of fair hearings that result from challenges to eligibility denials, since fewer applicants will be found ineligible;⁵¹ and Medicaid expansion will consolidate and simplify Medicaid eligibility categories, allowing at least some savings in caseworker training, management, and quality control. Without further analysis of these specifics, it is impossible to tell whether expanding eligibility would increase or lower net state administrative costs.

Limiting Estimated Revenue Gains Based on Offsetting Losses of Exchange Subsidies

Several states foresaw higher general revenues based on the macroeconomic effects of increased federal Medicaid dollars, as explained earlier. It is not clear whether they took into account that Medicaid expansion would eliminate federal subsidies in the exchange for consumers with incomes between 100 and 138 percent FPL. Despite this offsetting effect on HIX subsidies, Medicaid expansion would still yield a net infusion of significant new federal resources, by a significant margin.⁵² As a result, expansion would increase economic activity, hence general revenues. Nevertheless, calculating the precise level of such gains requires considering not just the amount of increased federal Medicaid dollars, but also the offsetting loss in federal exchange subsidies. Colorado's analysis explicitly

made this subtraction, but it is not clear whether it took place in our other states.

Along similar lines, several states projected that, as a result of Medicaid expansion, premium tax revenue would rise because of more enrollees in Medicaid managed care. It is not clear whether those states also considered the offsetting loss of premium tax revenue resulting from fewer enrollees in exchange coverage. Medicaid expansion would increase the total amount of premium payments in a state that fully implements Medicaid managed care, but calculating the size of the net rise requires taking into account both HIX effects and Medicaid effects.

Gain-Sharing Arrangements

None of our states analyzed in any great detail the possibility of new arrangements through which interest

groups that benefit financially from expansion—typically hospitals or localities—could share part of their gains with the state to help fund the state’s share of expansion costs. Such arrangements have been discussed elsewhere. For example, Arizona’s Governor Brewer proposed increasing hospital taxes to pay for that state’s expansion;⁵³ and California’s Governor Jerry Brown wants that state’s counties to pay a significant portion of expansion costs.⁵⁴ The former proposal enjoys the support of Arizona’s hospitals, but the latter is being resisted by California’s counties.

That said, our states did analyze the effect of existing provider taxes and fees in helping pay expansion costs, thus lessening the need to create new gain-sharing mechanisms.

MACROECONOMIC ANALYSIS OF EXPANSION

In several states, either public agencies, academic researchers, foundations, or other non-governmental organizations analyzed the effect of Medicaid expansion on the state’s economy as a whole. In each of these states—Alabama, Colorado, Maryland, New Mexico, Oregon, and Virginia—analysts conclude that Medicaid expansion would cause a significant increase in the

state’s receipt of federal Medicaid funds purchasing health care within the state’s borders, thereby increasing overall levels of economic activity, with resulting employment gains and increased earnings by state residents.⁵⁵ Table 3 shows some of the conclusions reached by these studies.

TABLE 3: Estimated Macroeconomic Effects of Medicaid Expansion

State	Estimator	State Fiscal Year	State G.D.P. (millions)	Earnings by State Residents	Employment	State General Revenue (millions)
Alabama	University of Alabama at Birmingham	2014–20	\$19,837	-	-	\$1.706
Colorado	Charles Brown Consulting	2025–26	\$4,400	\$608 per household	22,388	\$128
Maryland	Hilltop Institute	2020	\$3,283	-	26,970	\$237 (includes local revenue and premium taxes)
New Mexico	University of New Mexico	2020	\$729.5	\$298.4 million (statewide)	6,001	\$6
Oregon	SHADAC, OHSU, Manatt	2020	\$3,782	\$1,584 million (statewide)	29,100	\$60.6
Virginia	Chmura Economics & Analytics	Annual average, 2014–19	\$3,032	-	23,898	\$29.9

NOTE: Maryland estimates were for the ACA as a whole, not limited to the effects of the Medicaid expansion. Estimates with multiple scenarios, assuming various take-up levels, are shown with mid-level take-up; if only high and low levels are available (as with New Mexico), this table shows the low level. For the Hilltop, University of New Mexico, and SHADAC, et al., studies, this table displays all results for the final estimated year, even though the studies also include multi-year estimates for state GDP, earnings, and state general revenue.

Key to these analyses is that each state's contribution to expansion costs is not affected by whether it expands Medicaid. No matter what choices its leaders make, a state will experience the ACA's cuts to hospital reimbursement, increased Medicare payroll taxes, medical device taxes, health insurance fees, taxes on high-cost insurance premiums starting in 2017, and other measures. The only macroeconomic factor within the state's control is whether the state also receives its allotted share of federal Medicaid funds, with resulting economic activity.

Ordinarily, a coverage expansion does not generate significant net economic growth, because the increased demand generated by higher health care spending is offset by the reduced demand resulting from funding the expansion. In this case, however, the funding mechanisms are fixed in stone. The only question

facing each state is whether it will also experience the accompanying increase in demand that results from higher health care spending. Accordingly, the incremental impact of adding Medicaid expansion to the remainder of the ACA, as it operates within a state, is to boost economic activity and employment.

Analysts used different models to estimate effects in both the health care industry and, as health care providers purchase other goods and services, economic sectors going beyond health care. Analysts took into account that some of the increased activity would take place outside the state.⁵⁶ As noted earlier, it is not clear whether all of our states' macroeconomic projections took into account the offsetting losses in federal HIX subsidies, not just the increased federal Medicaid funding that would result from expansion.

CONCLUSION

The Medicaid and non-Medicaid health programs that our 10 states operated before the ACA's enactment are quite diverse, as are the states' underlying economic and demographic conditions. The fiscal and macroeconomic analyses that have taken place in these states are, for the most part, quite comprehensive. They illustrate that, under a broad range of state conditions, Medicaid expansion can result in economic growth, increased employment and earnings for state residents, and net state budget gains. Future fiscal analyses will no doubt be stronger

still, based on new CMS guidance, as well as states learning from each other how best to implement the ACA and manage the resulting effects. Our hope is that, by describing the analysis that has taken place in these 10 states and suggesting some additional areas for new work, we can facilitate the further development of solid fiscal and economic analysis to illuminate the consequences of key Medicaid decisions that face state policy-makers.

ENDNOTES

1. This represents the maximum gross income level consistent with Medicaid eligibility under the ACA. However, in determining “net income,” 5 FPL percentage points are subtracted from household income. Accordingly, the net or nominal income threshold for expanded Medicaid is 133 percent FPL.
2. Congressional Budget Office, “Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act,” Washington, DC: Congressional Budget Office, 2012. <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-CoverageEstimates.pdf>.
3. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012).
4. Centers for Medicare and Medicaid Services, “Financing and Reimbursement,” undated, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html>. CMS, December 10, 2012. “Frequently asked questions on Exchanges, Market Reforms and Medicaid.” <http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/Governor-FAQs-12-10-12.pdf>.
5. After 2016, the Centers for Medicare and Medicaid Services (CMS) may entertain waivers providing enhanced funding to states that extend Medicaid eligibility to an income threshold below that level.
6. Under this definition, ESI is affordable if worker-only coverage costs no more than 9.5 percent of household income. Between 97.5 percent and 98.8 percent of all ESI offered to consumers with incomes between 138 percent and 400 percent FPL is classified as affordable under this standard. Authors’ calculations from table 1, Buettgens M, Dorn S, and Moody H. “Access to Employer-Sponsored Insurance and Subsidy Eligibility in Health Benefits Exchanges: Two Data-Based Approaches.” Washington, DC: Prepared by the Urban Institute for the California HealthCare Foundation, 2012. <http://www.urban.org/UploadedPDF/412721-Access-to-Employer-Sponsored-Insurance.pdf>.
7. There is one exception. Whether the lower income bound for HIX subsidy eligibility is 100 or 138 percent FPL, lawfully present immigrants with incomes below that threshold can qualify for HIX subsidies if they are ineligible for Medicaid only because of their immigration status—for example, because they have been lawfully present in the US for fewer than 5 years.
8. Kenney GM, Zuckerman S, Dubay L, Huntress M, Lynch V, Haley J and Anderson N. “Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?” Washington, DC: Prepared by the Urban Institute for the Robert Wood Johnson Foundation, 2012. <http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf>.
9. For example, 2012 newspaper articles cited estimates from the New Mexico Human Services Department (HSD) that expanding Medicaid would cost the state up to \$500 million (Quigley W. “N.M. Medicaid Expansion Price Tag Up to \$500M”. Albuquerque Journal: 2012. <http://www.abqjournal.com/main/120392/news/nm-medicaid-expansion-price.html>). However, this figure included expenditures on the “welcome mat” or “woodwork” population, which would have occurred with or without expansion. Besides this confusion, questions arose about several methodological choices behind the HSD numbers. First, HSD modeled the welcome mat or woodwork effect for the elderly, assuming that they had similar costs to those currently enrolled in the coordination of long-term services program. The per capita costs of this program are far higher than for other types of enrollees such as children and parents. Second, HSD assumed that 8 percent of newly eligible adults will have children and therefore move into the “parents” category of current eligibility and draw down a lower federal match. This analysis did not take account that, even without expansion, some of these parents would have enrolled in Medicaid upon becoming pregnant and then remained enrolled after their children were born. For more detail, see New Mexico LFC Hearing Brief, *Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility*, 2012. [http://www.nmlegis.gov/lcs/lfc/lfcdocs/LFC Hearing Brief, Implementation of Affordable Care Act - Costs and Benefits of Expansion of Medicaid Eligibility, September 2012.pdf](http://www.nmlegis.gov/lcs/lfc/lfcdocs/LFC%20Hearing%20Brief,%20Implementation%20of%20Affordable%20Care%20Act-%20Costs%20and%20Benefits%20of%20Expansion%20of%20Medicaid%20Eligibility,%20September%202012.pdf). Eventually, the University of New Mexico, in conjunction with the Bureau of Business and Economic Research, released a comprehensive report. Taking into account not only the cost of the Medicaid expansion, but also the increased revenues and economic impact, the UNM report found that expanding Medicaid would, on balance, save New Mexico \$500 million. (Reynis L. “Economic and Fiscal Impacts of the Proposed Medicaid Expansion in New Mexico.” University of New Mexico, Bureau of Business and Economic Research, 2012. http://bber.unm.edu/pubs/Medicaid_Expansion_10-12.pdf.)
10. For example, on December 17, 2012, the Agency for Health Care Administration (AHCA) shared a report with members of the Legislative Budget Committee that estimated the cost of the Medicaid expansion in Florida to be \$63 billion, with a state share of \$26 billion. (Estimates Related to Federal Affordable Care Act Title XIX (Medicaid) Program. 2012. http://www.fdhc.state.fl.us/medicaid/pdffiles/SSEC_ACA_12-17-12_Medicaid_Estimates.pdf) The next month, *Health News Florida* revealed that these initial estimates were flawed and likely overstated in part because AHCA had not taken the increased federal match rate for new eligibles into account. (Gentry, C. Legislative Analysts Told Scott His Medicaid Estimates Are Wrong (But He’s Using Them Anyway).” WUSF: 2013. <http://health.wusf.usf.edu/post/legislative-analysts-told-scott-his-medicaid-estimates-are-wrong-hes-using-them-anyway>).
11. For example, participation levels among Medicaid adults now average 67 percent, and the combination of Medicaid and CHIP reaches 86 percent of eligible children. Kenney GM, Lynch V, Huntress M, Haley K, and Anderson N. “*Medicaid/CHIP Participation Among Children and Parents*.” Washington, DC: prepared by the Urban Institute for the Robert Wood Johnson Foundation, 2012. Kenney GM, Lynch V, Haley J, and Huntress M. “Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act.” *Inquiry*. 49: 231–253. 2012. To furnish other examples, after extensive streamlining and modernization of program administration, the proportion of eligible individuals receiving benefits from the Supplemental Nutrition Assistance Program (formerly known as food stamps) rose from 54 percent in 2002 to 75 percent in 2010; and only 75 percent of eligible households received Earned Income Tax Credits in 2005, the most recent year for which participation estimates are available, including 56 percent of eligible childless adults. Rosenbaum D. “*SNAP Is Effective and Efficient*.” Washington, DC: Center on Budget and Policy Priorities. 2013; Plueger D. “The EITC Participation Rate for Tax Year 2005.” *Internal Revenue Service Bulletin*. 2009.
12. Holahan J, Kenney GM, and Pelletier J. “The Health Status of New Medicaid Enrollees Under Health Reform.” Washington, DC: The Urban Institute, 2010.
13. For an example of a state projection that a Medicaid expansion in coverage for the non-elderly would cause increased Medicaid enrollment by the elderly, including recipients of long-term care, see the analysis by the New Mexico Human Services Department, New Mexico LFC Hearing Brief, *Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility*, 2012. [http://www.nmlegis.gov/lcs/lfc/lfcdocs/LFC Hearing Brief, Implementation of Affordable Care Act - Costs and Benefits of Expansion of Medicaid Eligibility, September 2012.pdf](http://www.nmlegis.gov/lcs/lfc/lfcdocs/LFC%20Hearing%20Brief,%20Implementation%20of%20Affordable%20Care%20Act-%20Costs%20and%20Benefits%20of%20Expansion%20of%20Medicaid%20Eligibility,%20September%202012.pdf). For raw enrollment numbers that suggest the lack of strong relationship between coverage expansion for the non-elderly and Medicaid enrollment levels for the elderly and disabled in the three states that implemented significant state-based expansions over the past decade—namely, Maine, Massachusetts and Wisconsin—see Snyder L, Rudowitz R, Ellis E and Roberts D. “Medicaid Enrollment: June 2011 Data Snapshot.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, 2012; Ellis E, Roberts D, Rousseau DM, Schwartz T. “Medicaid Enrollment in 50 States: June 2008 Data Update.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, 2009.
14. Holahan J, Buettgens M, Carroll C, and Dorn S. “*The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*.” Washington, DC: Kaiser Commission for Medicaid and the Uninsured, 2012.
15. Previous HIPSM research found that average national take-up rates will average 60.5 percent among new eligibles and 23.4 percent among currently eligible but not enrolled individuals; these will vary among states depending on population characteristics. The participation rate among new eligibles averages 11.4 percent among those who previously had ESI, 85 percent among those who previously had nongroup coverage, and 74 percent among the currently uninsured. Since those who are currently eligible already had an opportunity to enroll, HIPSM finds a lower take-up rate for this population—only 39.5 percent among the currently uninsured, 4.9 percent among those with ESI, and 69.2 percent among those with nongroup coverage.
16. An important savings estimated by Oregon involves presumptive coverage of people with disabilities, for which analogous programs do not exist in most other states, as far as the authors are aware.
17. 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 expansion memo jul17.pdf](http://www.house.mi.gov/hfa/pdfs/medicaid%20expansion%20memo%20jul17.pdf).
18. Reynis L. *Economic and Fiscal Impacts of the Proposed Medicaid Expansion in New Mexico*, University of New Mexico, Bureau of Business and Economic Research, October 13, 2012. http://bber.unm.edu/pubs/Medicaid_Expansion_10-12.pdf.
19. UMBC and The Hilltop Institute. *Maryland Health Care Reform Simulation Model: Detailed Analysis and Methodology*, July 2012. <http://www.hilltopinstitute.org/publications/MarylandHealthCareReformSimulationModel-July2012.pdf>.

20. Blavin F, Blumberg L, Buettgens M, and Roth J. "The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State." Washington, DC: Urban Institute, 2012.
 21. These adults might qualify for 90 to 100 percent FMAP for a second reason as well. Spend-down requirements may place medically needy coverage in the category of limited benefit eligibility.
 22. Maryland HB 228, Fiscal and Policy Note, *Maryland Health Progress Act of 2013*, 2013 Session, http://mgaleg.maryland.gov/2013RS/notes/bil_0008/hb0228.pdf.
 23. CMS. "Medicaid Program; Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010," *Federal Register*, April 2, 2013, Vol. 78, No. 63, 19918-19947 (April 2 FMAP Regulations).
 24. 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.
 25. The Oregon Health Authority. *Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014–2020)*, 2013. <http://www.statelibrary.org/resource/estimated-financial-effects-of-expanding-oregons-medicaid-program-under-the-affordable-care-act-2014-2020/>.
 26. E.g., Maryland HB 228. 2013. *Maryland Health Progress Act of 2013*.
 27. New Mexico LFC Hearing Brief. *Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility*. 2012.
 28. Maryland HB 228. 2013. *Maryland Health Progress Act of 2013*.
 29. Before enactment of the ACA, some categories of MinnesotaCare were federally matched and others were not.
 30. Minnesota Bill S0005-6A (R), Shernan K, *MA Eligibility Expansion*, February 12, 2013, http://www.mmb.state.mn.us/bis/fnts_leg/2013-14/S0005_6A.pdf.
 31. 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>.
 32. Charles Brown Consulting. 2013. *Medicaid Expansion: Examining the Impact on Colorado's Economy*; Michigan House Fiscal Agency, *Medicaid Expansion—Affordable Care Act*, Memo to House Appropriations Committee, 2012. The Oregon Health Authority, 2013. *Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014–2020)*.
 33. Charles Brown Consulting. 2013. *Medicaid Expansion: Examining the Impact on Colorado's Economy*; Michigan House Fiscal Agency, 2012. *Medicaid Expansion—Affordable Care Act*.
 34. Maryland HB 228. 2013. *Maryland Health Progress Act of 2013*.
 35. Hadley J, Holahan J, Coughlin T, and Miller D. "Costs Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs*, 27, no. 5: w399-w415, 2008.
 36. Oregon's analysis began with the finding by Urban Institute researchers that only 1.6 percent of private premiums results from cost-shifting due to uninsurance. Oregon's researchers calculated the amount of state employee and retiree health costs comprising that 1.6 percent and then applied the proportionate reduction that would result from the decline in uninsurance projected to result from Medicaid expansion.
 37. Charles Brown Consulting. 2013. *Medicaid Expansion: Examining the Impact on Colorado's Economy*; UMBC, The Hilltop Institute, *Maryland Health Care Reform Simulation Model: Detailed Analysis and Methodology*, 2012. The Oregon Health Authority. 2013. *Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014–2020)*.
 38. Maryland HB 228. 2013. *Maryland Health Progress Act of 2013*; New Mexico LFC Hearing Brief. *Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility*, 2012.
 39. Udow-Phillips M, Fangmeier J, Buchmueller T, and Levy H. "The ACA's Medicaid Expansion: Michigan Impact." Center for Healthcare Research & Transformation. Ann Arbor, MI: 2012. <http://www.chrt.org/publications/price-of-care/aca-medicaid-expansion-michigan-impact/>; New Mexico LFC Hearing Brief, *Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility*, September 27, 2012.
 40. MN Department of Human Services, *February 2013 Forecast*, 2013. http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs16_174967.pdf.
 41. Chmura Economics and Analytics. *The Economic Impact of the Medicaid Expansion on Virginia's Economy*, prepared for the Virginia Hospital & Healthcare Association, 2012.
 42. Commonwealth Institute for Fiscal Analysis. *Revised: Medicaid Expansion Still Saves Money in Virginia's Budget*, January 16, 2013. This analysis is also the source of our statement in the text that the state's cost analysis found that the incremental effects of Medicaid expansion would result in net state budget savings for 2014–20. Other year-by-year estimates produced by the state do not distinguish between Medicaid expansion effects and other net budget results of the ACA.
 43. CMS. April 2 FMAP Regulations.
 44. ACA implementation without Medicaid expansion will also reduce retroactive costs, since currently eligible adults will be more likely to enroll. However, this reduction will be larger in magnitude if a state expands eligibility. The authors thank Dr. William Hayes of Ohio State University for these insights, including the basic insight that retroactive eligibility costs will be affected by Medicaid expansion and other features of ACA implementation.
 45. See Haislmaier EF and Gonshorowski D. *State Lawmaker's Guide to Evaluating Medicaid Expansion Projections*. Washington, D.C.: The Heritage Foundation, 2012.
 46. See, for example, the analysis of administrative costs and savings involved in Louisiana's implementation of Express Lane Eligibility in Hoag S, et al., "Final Report," *CHIPRA Mandated Evaluation of Express Lane Eligibility: First Year Findings*, prepared by Mathematica, Inc., and The Urban Institute for the US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2012.
 47. Other important changes to Medicaid eligibility that will take place, regardless of expansion, include the use of modified adjusted gross income; the requirement to base verification on data-matches, rather than documentation from consumers, whenever possible; and the requirement to coordinate eligibility determination with exchanges, using "no wrong door" strategies. All of these measures require a substantial initial investment in information technology, even if they promise eventual operational savings in less labor-intensive processing of applications and redetermining eligibility.
- Another contextually important administrative cost effect that will result from ACA, with or without expansion, is a significant increase in the number of Medicaid applications. Even without expansion, many new people are likely to submit applications for health coverage, prompted by publicity about health reform as well as the availability of new subsidies in the exchange. For consumers with incomes too low for exchanges subsidies, their applications will often be forwarded to the Medicaid agency, which will need to process them.
48. The first three categories involve a mix of staff time and automated costs, the latter of which involves a much smaller, 25 percent state share. The last two categories involve staff time, for which the state must likely pay 50 percent of all administrative costs.
 49. This category includes enrollment broker services, call center services, and processing disenrollment and change requests.
 50. 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).
- The authors thank Dr. Hayes for many of the insights in this area of the paper, including not just expansion's reduction in the need for spend-down eligibility determinations and the significant cost of such determinations, but also the reduced level of churning and the general simplification of eligibility categories that would result from expansion.
51. 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.
 52. Holahan, et al., 2012. *Cost and Coverage Implications*.
 53. Christie B. Associated Press, *USA Today*, "Arizona to tax hospitals to pay for Medicaid," January 20, 2013. <http://www.usatoday.com/story/news/nation/2013/01/20/arizona-tax-hospitals-for-medicaid/1849395/>; Office of the Arizona Governor, *Difficult Choice: Expanding Adult Medicaid Coverage*, January 2013. http://azgovernor.gov/dms/upload/PR_011413_MedicaidBudgetMessage.pdf.

54. Scott D. *Governing*, "Brown Proposes County-Level Medicaid Expansion." 2013. <http://www.governing.com/news/state/gov-brown-proposes-county-level-medicaid-expansion-in-california.html>.

55. UMBC, The Hilltop Institute, *Maryland Health Care Reform Simulation Model: Detailed Analysis and Methodology*, 2012. Charles Brown Consulting. 2013. *Medicaid Expansion: Examining the Impact on Colorado's Economy*; Chmura Economics and Analytics. *The Economic Impact of the Medicaid Expansion on Virginia's Economy*, 2012, prepared for the Virginia Hospital & Healthcare Association; The Oregon Health Authority. 2013. *Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014–2020)*; Reynis. 2012. "Economic and Fiscal Impacts of the Proposed Medicaid Expansion in New Mexico."

56. See, for example, Charles Brown Consulting, Colorado Health Foundation, Medicaid Expansion: *Examining the Impact on Colorado's Economy*, 2013, <http://www.coloradohealth.org/studies.aspx>; The Oregon Health Authority. 2013. *Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014–2020)*.

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