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FEDERAL GOVERNMENT WILL PICK UP NEARLY ALL COSTS OF HEALTH REFORM'S MEDICAID EXPANSION

By January Angeles and Matthew Broaddus

Health reform's critics argue that states will bear a significant share of the costs of the new law's Medicaid expansion, placing an unaffordable financial burden on states. The argument does not withstand scrutiny. In its first five years, the Medicaid expansion will add just 1.25 percent to what states were projected to spend on Medicaid over that period in the absence of health reform, while providing health coverage to 16 million more low-income adults and children.

The health reform law requires all states to expand Medicaid to all non-elderly individuals with incomes up to 133 percent of the poverty line, or about \$29,000 for a family of four. The Medicaid expansion and new premium credits for people with incomes too high to qualify for Medicaid will, together, reduce the number of uninsured people by 32 million by 2019, according to the Congressional Budget Office (CBO).

The Medicaid expansion in health reform is a good deal for states.

- The additional cost to the states represents only a 1.25 percent increase in what states would have spent on Medicaid from 2014 to 2019 in the absence of health reform.
- The federal government will assume 96 percent of the costs of the Medicaid expansion over the next ten years, according to an analysis of CBO estimates.
- And having more people covered as a result of the Medicaid expansion and other provisions in the health reform law will reduce state and local governments' current spending on other services for the uninsured, such as mental health services.

In sum, the Medicaid expansion will significantly increase coverage at a modest cost to the states and will help reduce states' costs for providing care to the uninsured through a variety of state programs outside of Medicaid.

This analysis also examines critical statements by officials in several states who have cited higher costs to their states. It finds their estimates to be flawed because they overstated the cost of the

Medicaid expansion to the state, left out (or underestimated) the savings that state and local governments will realize in other health services programs, or both.

Medicaid Expansion Plays Critical Role in Health Reform

The expansion of Medicaid is critical to the success of health reform. Medicaid is the most cost-effective way to provide comprehensive and affordable coverage to people with very low incomes and thereby ensure that the low-income uninsured gain coverage. Medicaid beneficiaries generally do not pay premiums and pay only modest co-payments. The program covers a broad array of services and supports that are well-suited to the needs of low-income people (especially children and people with disabilities), who are more likely than people with higher incomes to be in fair or poor health. Medicaid is also significantly less costly, on a per-beneficiary basis, than private insurance (after adjusting for health status), largely due to its lower provider rates and administrative costs.

Currently, Medicaid covers many low-income individuals but leaves many others out. It generally does not cover childless adults unless they are pregnant, over age 65, or have serious disabilities.¹ It also leaves out many low-income parents. While the median income eligibility limit for children under Medicaid and the Children's Health Insurance Program (CHIP) is 235 percent of the poverty line in the median state, the median income eligibility limit for working parents under Medicaid is just 64 percent of the poverty line.²

Starting on January 1, 2014, the new health reform law will expand Medicaid eligibility to 133 percent of the poverty line for all non-elderly individuals who are lawfully residing in the United States and are not eligible for Medicare. Millions of low-income parents and people with disabilities, and millions of non-disabled low-income adults who do not have dependent children, will become eligible for the program. CBO estimates that by 2019, 16 million more individuals — most of whom are now uninsured — will have health insurance through Medicaid and CHIP.³

Federal Government Will Assume Vast Majority of Medicaid Expansion Costs

Since its inception, Medicaid has been jointly financed by the federal government and the states, with the federal government currently paying 57 percent of the cost, on average. The new health reform law takes a different approach. To minimize the financial burden on states of the Medicaid expansion, the federal government will pay *96 percent* of the cost of expanding Medicaid over the next ten years.

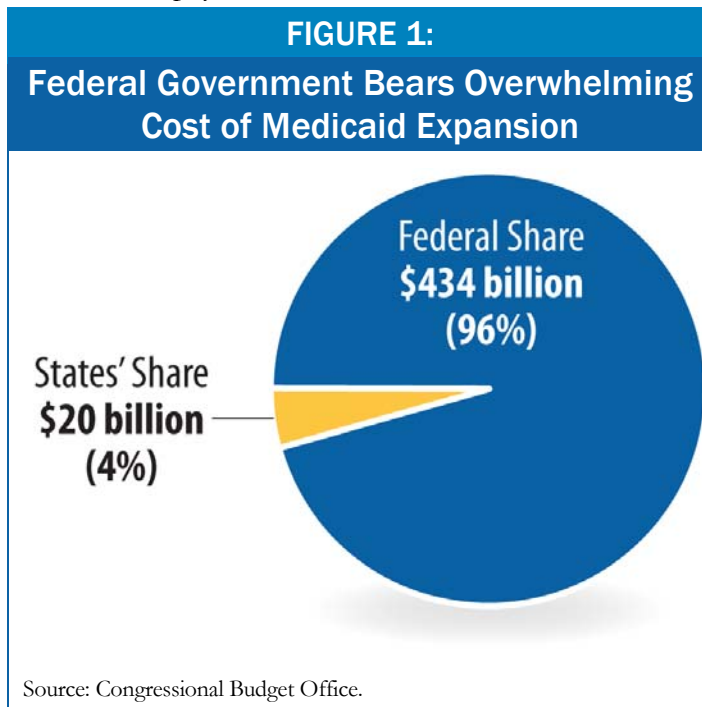
¹ Some states have expanded Medicaid to cover low-income childless adults through Section 1115 waivers.

² Median income eligibility for non-working parents is 38 percent of the poverty line. See Donna Cohen Ross, Marian Jarlenski, Samantha Artiga, and Caryn Marks, "A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009," Kaiser Commission on Medicaid and the Uninsured, December 2009.

³ In addition to the Medicaid expansion, individuals and families who do not qualify for Medicaid and have incomes below 400 percent of the poverty line will be eligible for fully federally funded subsidies (on a sliding scale) to help purchase private coverage through the new health care exchanges. CBO estimates that by 2019, 24 million individuals will have coverage through the exchanges, nearly 80 percent of whom will be eligible for subsidies.

Specifically, the federal government will assume 100 percent of the Medicaid costs of covering newly eligible individuals for the first three years (2014-2016).⁴ Federal support will phase down slightly over the following several years, so that for 2020 and all subsequent years, the federal government is responsible for 90 percent of the costs of covering these individuals. According to CBO, over the next ten years, the federal government will pay \$434 billion of the cost of the Medicaid expansion, while the states will pay roughly \$20 billion (see Figure 1).⁵ Had states been required to pay 43 percent of the cost of the Medicaid expansion (their usual share of Medicaid costs), the expansion would have cost states roughly \$195 billion.

Throughout the health reform debate, federal lawmakers have been mindful of the need to limit the costs of the Medicaid expansion to states. The bill that the Senate Finance Committee approved in October 2009 would have increased state spending on Medicaid and CHIP by \$33 billion over ten years.⁶ The bill that the House and Senate approved and President Obama signed in March 2010 slightly reduced states' obligations to \$30 billion.⁷ And the health reconciliation measure Congress subsequently enacted reduced states' costs further to \$20 billion over ten years, by increasing the federal matching rate for the costs of serving people whom the law makes newly eligible for Medicaid and childless adults whom some states already cover through Medicaid waivers.⁸



⁴ States that expanded Medicaid coverage for childless adults (as well as to parents) up to 100 percent of the poverty line in advance of health care reform will receive an increase in the federal match for covering those childless adults. The federal match will phase up to 90 percent in 2020 and subsequent years.

⁵ CBO's estimate of \$20 billion in state costs assumes that some states will reduce benefits for some of their currently eligible populations, as was already permitted under prior law. CBO's estimate also includes increased CHIP spending by states due primarily to expected increases in state contributions as a result of the significant increase the health reform law provides in national CHIP allotments in 2014 and 2015. Based on our preliminary analysis, the vast majority of the additional state spending will be in Medicaid.

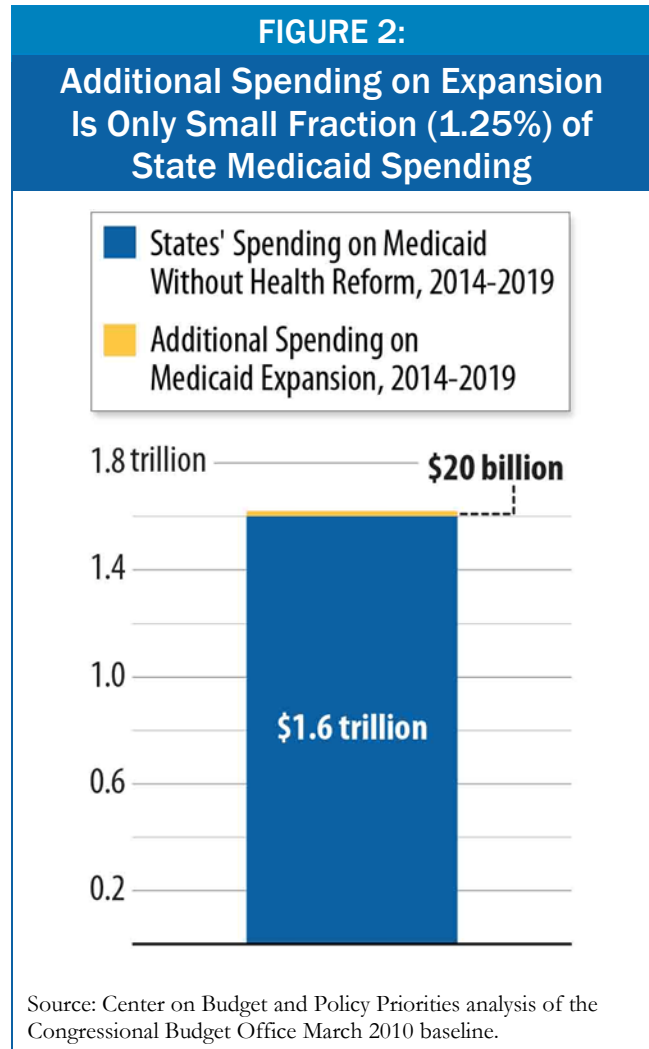
⁶ Congressional Budget Office, "Letter to the Honorable Max Baucus Providing a Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended," October 7, 2009.

⁷ Congressional Budget Office, "Letter to the Honorable Harry Reid Providing an Estimate of the Direct Spending and Revenue Effects of H.R. 3590, the Patient Protection and Affordable Care Act (PPACA) as Passed by the Senate on December 24, 2009," March 11, 2010.

⁸ Congressional Budget Office, "Letter to the Honorable Nancy Pelosi Providing an Estimate of the Direct Spending and Revenue Effects of an Amendment in the Nature of a Substitute to H.R. 4872, the Reconciliation Act of 2010 (Final Health Care Legislation)," March 20, 2010.

Health reform will likely increase participation among individuals who currently are eligible for Medicaid but are not enrolled. States will receive the regular federal matching rate for covering these people. However, the \$20 billion that CBO estimates will be the net increase in state costs under the Medicaid expansion *includes* the cost of covering individuals who already are eligible for Medicaid, currently are uninsured, and are expected to enroll when the expansion is implemented. CBO has informed congressional staff that the cost of covering the newly eligible populations is much larger and accounts for most of the Medicaid expansion costs.

To put the states' share of the Medicaid expansion cost in perspective, \$20 billion represents a 1.25 percent increase over the \$1.6 trillion that states were projected to spend on Medicaid over the same time frame in the absence of health reform (see Figure 2). When combined with the federal government picking up 96 percent share of the cost, that \$20 billion will enable states to cover 16 million more children and adults at a very modest cost to the states.



Health Reform Will Reduce Other State Costs Related to the Uninsured

Many individuals who will become newly eligible for Medicaid already receive some state-funded health services, such as mental health treatment or hospital treatment. Under the new law, Medicaid will now cover many of those services, so the federal government will pick up half or more of the cost of services (depending on a state's matching rate) for which the state is now bearing all of the cost. For example:

- The law will immediately allow states that cover low-income childless adults through state-funded programs (such as Connecticut and Minnesota) to cover them through Medicaid instead, thereby reducing state expenditures.

Massachusetts Shows That Expanding Coverage Reduces Other Costs

Massachusetts' experience with its reform efforts offers evidence that expanding coverage under a comprehensive health reform plan can lead to sizeable reductions in state costs for uncompensated care.

In 2006, Massachusetts enacted legislation to provide nearly universal health care coverage. The legislation combined a Medicaid expansion with subsidies to help low- and moderate-income residents purchase insurance, an employer responsibility requirement, and a requirement for individuals to obtain coverage — all core elements of the new national health reform legislation.

With the expansion of affordable health insurance options and the institution of an individual mandate, Massachusetts enjoyed an immediate and significant decrease in spending on uncompensated care. As part of its health reform effort, the state replaced its Uncompensated Care Pool (also known as “Free Care”) with the Health Safety Net, which provides financial support to public hospitals and community health centers that serve low-income residents who are uninsured, underinsured, or have significant medical needs. In 2008, the first full year of health reform implementation, Health Safety Net payments were *\$252 million (38 percent) less* than the previous year's Uncompensated Care Pool payments.^a

This reduction in uncompensated care costs coincided with a decline in the share of residents who are uninsured. Only 2.7 percent of residents were uninsured in 2009, compared to 5.7 percent in 2007.^b

^a Massachusetts Division of Health Care Finance and Policy, “2009 Annual Report – Health Safety Net,” December 2009.

^b Massachusetts Division of Health Care Finance and Policy, “Access to Health Care in Massachusetts: Results from the 2008 and 2009 Massachusetts Health Insurance Survey,” November 2009.

- The law will dramatically reduce the number of people with no health insurance over time, so state obligations to fund hospital care for the uninsured will necessarily decline.⁹ In 2008, state and local governments shouldered \$10.6 billion, or nearly 20 percent, of the cost of caring for uninsured people in hospitals, according to Urban Institute research.¹⁰
- By reducing the percentage of people who are uninsured, the new law also will reduce another major state cost: providing mental health services to the uninsured. State and local governments provide 47 percent of the funding for state mental health agencies, amounting to \$14.7 billion in 2006.¹¹

Thus, a portion of the \$20 billion that CBO describes as additional state Medicaid spending under the new law will be offset by state savings in other areas as a result of having more people covered.¹²

⁹ The federal health reform law would reduce federal assistance to hospitals that disproportionately serve the uninsured provided through the Medicaid Disproportionate Share Hospital (DSH) program on the assumption that hospitals would be providing less uncompensated care.

¹⁰ Jack Hadley, *et al.*, “Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs,” *Health Affairs*, August 25, 2008.

¹¹ National Association of State Mental Health Program Directors Research Institute, Inc., “SMHA-Controlled Mental Health Revenues, By Revenue Source and by State, FY 2006,” accessed April 6, 2010 at <http://www.nri-inc.org>.

¹² States are also expected to receive a portion of the savings from applying the rebates that drug manufacturers pay the Medicaid program for prescriptions provided through Medicaid managed care plans, though some states may receive

In other words, some of the additional state spending on Medicaid will in fact be substituting for existing state spending, except that now such spending will qualify for federal Medicaid matching funds.

Moreover, there is strong reason to believe that the savings states will realize from a reduction in the number of uninsured people will grow rapidly in the coming years. Experts at the Urban Institute note that in the *absence* of health reform, states' share of Medicaid costs would have grown rapidly not only because of rising health care costs but because state Medicaid programs would have had to pick up some of the slack as employer-sponsored insurance continued to erode and more people became Medicaid eligible. The amount of uncompensated care would also have grown substantially as the ranks of the uninsured continued to expand.¹³ State and local governments likely would have borne a large share of these costs.¹⁴ As a result, by shrinking the number of the uninsured and having the federal government pick up the overwhelming share of the tab, health reform will ease pressures on states to bear a significant portion of the cost of covering more of the uninsured as their numbers grew, decrease state and local spending on uncompensated hospital care, and lower the cost of state-supported mental health and other health services.

Health reform will also bring other, broader benefits to states. Not only will millions of uninsured low- and middle-income residents gain coverage, but market reforms will improve access to health insurance for people at all income levels. In addition, the infusion of federal funds for the Medicaid expansion and the subsidies for people to purchase private coverage will help protect newly insured state residents from preventable illnesses and should result in a healthier workforce.

Some State Estimates Substantially Overstate Costs

Some critics of the health reform legislation have exaggerated the cost of the Medicaid expansion for particular states. Their estimates use flawed assumptions that result in substantial overstatement of the number of people who will enroll in Medicaid.

For example, Florida's Agency for Health Care Administration (AHCA) estimates that the law will increase the state's Medicaid spending by \$5.1 billion.¹⁵ The AHCA estimate assumes, however, that *100 percent* of the people whom the law would make eligible for Medicaid and *100 percent* of those who are currently eligible but not enrolled (1.8 million people) will sign up for the program by the third year of the coverage expansion. *No* means-tested public program has ever achieved a 100 percent participation rate. Even Medicare, a universal social insurance program, enjoys a participation rate of only 96 percent, and a variety of other means-tested programs have

lower supplemental rebates (on top of those provided under the federal Medicaid drug rebate program) that they have negotiated directly with drug manufacturers.

¹³ Bowen Garrett, John Holahan, Lan Doan, and Irene Headen, "The Cost of Failure to Enact Health Reform: Implications for States," Robert Wood Johnson Foundation, September 2009.

¹⁴ This includes tax appropriations by state and local governments for hospitals and state public assistance programs. Jack Hadley *et al.*, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs*, August 2008.

¹⁵ Agency for Health Care Administration, "Estimated Fiscal Impact to Florida's Medicaid Program Under Public Law 111-148 and Public Law 111-152," April 1, 2010.

Attorneys General Lawsuit Exaggerates Fiscal Impact on States

On the day the health reform legislation was enacted, 13 state attorneys general filed a lawsuit seeking to invalidate the new law. One of their claims is that the law would force the states to spend large sums to expand Medicaid. The lawsuit greatly exaggerates the impact of health reform on the states by erroneously describing how states will be reimbursed for newly eligible Medicaid beneficiaries.

The lawsuit states (without citing evidence) that the vast majority of people with other health coverage will drop their coverage when they become eligible for Medicaid and then claims that “the federal government does not offer any funding for these persons, because they qualified for insurance other than Medicaid prior to passage of the Act.” This is simply incorrect. For any individuals who were not previously eligible for Medicaid, the state will receive full federal funding to cover them in Medicaid for the first three years. The federal contribution will then scale down to 90 percent by 2020 and thereafter.

participation rates of 43 percent to 86 percent.¹⁶ While a mandate to have health insurance and the publicity and outreach efforts surrounding the expansion should substantially increase enrollment, the evidence is overwhelming that the participation rate will not be 100 percent.¹⁷

Indiana also commissioned an analysis of the state’s spending under health reform (albeit for an earlier version of the Senate health reform bill) that is based on faulty assumptions. The analysis asserts that Medicaid enrollment will increase by 495,000 as a result of health reform.¹⁸ Yet, according to Census data, only 264,000 uninsured people in the state have incomes below 133 percent of the poverty line and thus would potentially qualify for Medicaid.¹⁹ The analysis also wrongly assumes that low-income adults now covered under the Healthy Indiana Plan would be covered by Medicaid under the *regular* Medicaid matching rate. In fact, the federal government would cover nearly the entire cost of covering these individuals under the Medicaid expansion because they would be considered newly eligible for Medicaid.²⁰

Moreover, the Florida and Indiana estimates — as well as others that health reform critics have produced — do not account for all of the benefits likely to accrue to state budgets as a result of reducing the number of uninsured.

¹⁶ Dahlia Remler and Sherry Glied, “What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs,” *American Journal of Public Health*, January 2003.

¹⁷ Sherry Glied, Jacob Hartz, and Genessa Giorgi, “Consider It Done? The Likely Efficacy of Mandates for Health Insurance,” *Health Affairs*, November/December 2007.

¹⁸ Milliman, “Financial Review of Patient Protection and Affordable Care Act,” December 3, 2009.

¹⁹ Center on Budget and Policy Priorities analysis of the Annual Social and Economic Characteristics’ supplements to the 2007, 2008, and 2009 Current Population Survey.

²⁰ The Healthy Indiana Plan is a Medicaid waiver. However, participants in the program will be treated as individuals newly eligible for Medicaid because of limits in the Healthy Indiana benefit package. As noted, states will receive greatly enhanced federal funds for newly eligible beneficiaries.

Conclusion

Contrary to claims made by health reform critics, the Medicaid expansion does not pose substantial financial burdens on states. The additional state spending that will result from the expansion is only 1.25 percent of what states would have spent in the absence of health reform, but it will cover 16 million more people, which will help reduce states' costs for other programs and bring numerous other benefits to the states. The federal government will pick up most of the costs of the Medicaid expansion, overall making it a good deal for the states.