State Health Reform Assistance Network
Charting the Road to Coverage
A Robert Wood Johnson Foundation program

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Assessment Tool: State Budget Impact of Medicaid Expansion

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States that have expanded Medicaid received over $60 billion in federal funds in 2015[1] and covered approximately 11 million newly eligible people. Among other things, these federal funds have generated state savings and new revenues, which states have used to finance spending priorities and to offset state Medicaid costs. The positive budget impacts of expansion fall into three major categories: savings from accessing enhanced federal matching funds for some previously eligible Medicaid populations, savings from replacing state general funds with Medicaid funds, and revenue gains from provider or health plan assessments or taxes.

This tool was designed to help states document the impacts of Medicaid expansion on state budgets, including revenue generation and reductions to state general fund spending on Medicaid and other health related programs and services. As the Trump administration and new Congress develop proposals to repeal the Affordable Care Act (ACA), potentially including the Medicaid expansion, state policymakers and other stakeholders can use this tool to evaluate the budgetary implications of repeal. While the impacts of expansion reversal will vary by state, all states can use this tool as a guide and checklist to gather data and assess impacts to state budgets of the potential loss of federal expansion funding.

The tool is a starting point for states to evaluate the implications of reversing expansion, primarily because those implications will be highly influenced by state policy decisions related to filling the coverage gaps created by elimination of expansion. For example, if a state decides that it will no longer cover any of the newly eligible adults, it will no longer have to expend state dollars on the state share. But, the state will have to make decisions regarding allocation of state dollars to services for uninsured residents (such as mental health and substance use disorder services) and to uninsured populations such as prisoners and pregnant women. States like New York, New Jersey, Arizona, and Massachusetts that previously covered some expansion adults will have to decide whether to again provide coverage to this population with less or perhaps no federal dollars. In short, the tool provides a roadmap to the numbers; how they play out will depend on the final repeal legislation and the choices states make. An accompanying index provides detailed explanations of expansion related costs, savings, and revenue sources outlined in this tool.

[1] This figure reflects funding for newly eligible enrollees only, and does not include federal funding for expansions in Louisiana, Montana, and Alaska, as these states expanded in late 2015 or in 2016.

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org.*

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State costs

COSTS RELATED TO NEWLY ELIGIBLE ADULTS

This category should capture state budget costs of newly eligible adults (non-elderly, non-disabled adults with incomes above the state's pre-expansion Medicaid adult eligibility level and up to 138 percent of the federal poverty level). The figures included in these fields should consider the total eligible population by year, and account for the take up rate of this eligible population.

Relevant Data Points for Analysis	Calendar Year ________
Total Number of Newly Eligible Adult Enrollees	
PMPY Cost	
Total Cost	
Newly Eligible FMAP[2]	
State Cost (applying newly eligible FMAP)	

COSTS RELATED TO PREVIOUSLY ELIGIBLE BUT UNENROLLED (WOODWORK OR WELCOME MAT EFFECT ENROLLEES)

In addition to the newly eligible adults, it is likely that states have seen increases in Medicaid enrollment by previously eligible but unenrolled individuals—the so-called "Woodwork" or "Welcome Mat" effect. The figures included in these fields should consider the total previously eligible but uninsured population by year, and account for the take up rate of this population.

Relevant Data Points for Analysis	Calendar Year ________
Total Number of Previously Eligible but Unenrolled Adult Enrollees	
PMPY Cost	
Total Cost	
Regular FMAP[3]	
State Cost (applying regular FMAP)	

ADMINISTRATIVE COSTS

With increased eligibility and enrollment, administrative costs are likely to increase. This increase will have been partially offset by enhanced FMAP for certain categories of spending or by administrative efficiencies related to new eligibility and enrollment systems, ex parte renewal, economies of scale, etc. These fields should include available data on net administrative cost increases related to ACA implementation, but should exclude costs related to IT development and operations (which states incur regardless of expansion).

Relevant Data Points for Analysis	Calendar Year ________
New Vendor or Contractor Costs Related to E&E Operations	
Costs from New FTE Hires Related to E&E Operations	
Other Administrative Costs Related to Expansion	

State savings

STATE SAVINGS FROM ACCESSING ENHANCED FEDERAL MATCHING FUNDS

Many states previously covered individuals in Medicaid who transitioned to the newly eligible group under expansion. These fields should document savings generated when the state replaces regular FMAP with the enhanced FMAP (no state share until 2017) for current Medicaid populations that moved into the newly eligible group.

State savings are estimated by taking the difference between nonfederal share that would have been paid for the population using regular FMAP versus newly eligible FMAP for a given year.

[2] The federal matching rate (FMAP) for newly eligible adults is: 100% in CY 2014 - 2016; 95% in CY 2017, 94% in CY 2018, 93% in CY 2019, and 90% thereafter. Note that FMAP is tied to the calendar year. State Fiscal Years may cover more than one calendar year, which would have implications for FMAP.

[3] Note that FMAP is tied to the calendar year. State Fiscal Years may cover more than one calendar year, which would have implications for FMAP.

Example: Adults Previously Enrolled Through Waivers

In State A, 3,000 adults were previously enrolled in a partial benefit waiver. With expansion, all of these adults transitioned to the new adult group and the state receives enhanced FMAP for this population. The state has a regular FMAP of 50 percent, and would have spent a state share of $10 million to cover this population in 2017 had they not expanded. With expansion in place in 2017, however, the state will receive 95 percent FMAP for this group, and will pay only $1 million (5 percent of the total costs of $20 million). So, the state will save $9 million on this waiver group in 2017 should expansion remain in place.

Example: Medically Needy

State B previously covered 5,000 non-elderly adults in the medically needy coverage category. After expansion, some of these adults with incomes below 138 percent FPL transitioned to the new adult group and the state received enhanced FMAP for this population. The state has a regular FMAP of 50 percent, and would have spent a state share of $50 million for this population (50 percent of the total costs of $100 million) in 2017 had they not expanded. The state observed that 50 percent of the medically needy adults had incomes below 138 percent FPL and became eligible for the new adult group with expansion, where they are eligible for 95 percent FMAP in 2017. State savings are calculated by subtracting the regular FMAP from the newly eligible FMAP (95% - 50% = 45%) and applying this difference to the new adult transitioning population (half of medically needy enrollees with total costs of $50 million). The state will save $22.5 million on medically needy enrollees in 2017 should expansion remain in place.

Example: Pregnant Women

With expansion, women who are enrolled in the new adult group and become pregnant remain in the new adult group and are eligible for enhanced federal match until such time that they report their pregnancy. The state has a regular FMAP of 50 percent, and would have spent $100 million in state share on pregnant women (50 percent of the total costs of $200 million) in 2017, absent expansion. With expansion, based on experience to date, the state estimates that in 2017 50 percent of the women who otherwise would have enrolled in the pregnant women group will instead remain in the new adult group where they are eligible for 95 percent FMAP. Therefore, state costs for the pregnant women group are expected to be $50 million (half of the pre-expansion state costs of $100 million). State savings are calculated by subtracting the regular FMAP from the newly eligible FMAP (95% - 50% = 45%) and applying this difference to the new adult population (half of pregnant women enrollees with total costs of $100 million). The state will save $45 million on pregnant women in 2017 should expansion remain in place.

Relevant Data Points for Analysis	Calendar Year ________
Savings from Adults Currently Enrolled Through Certain Waivers	
Savings from Adults Currently Enrolled in the Breast and Cervical Cancer Treatment Program	
Savings from Adults Currently Enrolled in the Tuberculosis Program	
Savings from Adults Currently Enrolled in the HIV Program	
Savings from Adults Currently Enrolled in Other Disease-Specific Programs	
Savings from Adults Currently Enrolled in the Family Planning Program	
Savings from Adults Currently Enrolled in the Medically Needy Spend Down Program	
Savings from Pregnant Women	
Savings from Disabled Individuals	

State savings from replacing general funds with medicaid funds

Many states have historically underwritten the costs of programs and services for the uninsured. Under an expanded Medicaid program, some, perhaps most, of the individuals receiving care from these programs will enroll in Medicaid, thus reducing the uncompensated care costs that a state is required to subsidize. Savings in these categories come from reductions in the amount of state funds used to support these programs. To capture these savings, reductions in state budget appropriations and cooperation between Medicaid and other state agencies (e.g. Corrections) may be required.

Example: Corrections Savings

Before expansion, the State Corrections Department in State C spent $5 million per year on inpatient care for prisoners. Medicaid's "inmate exclusion" typically prohibits payment of care of services for any individual who is an inmate of a public institution. But when State C expanded, Medicaid began to cover services provided to an inmate during an inpatient stay of at least 24 hours in a medical institution such as an acute care facility.[4] Nearly all prisoners in State C became Medicaid-eligible with expansion and each year the state sees savings of $5 million to its State Corrections Department Budget due to expansion.

Example: Reductions in State Mental Health Spending

State D had previously allocated $10 million per year in state funding to support mental health and substance abuse treatment programs provided directly to uninsured individuals. After expansion, State D noted that these previously uninsured individuals who were recipients of the state-funded mental health and substance abuse services were eligible for full Medicaid coverage under the new adult group, and reduced their budget allocation for the state-funded services. State D sees annual savings to its State Mental Health Department Budget of $10 million under expansion.

Relevant Data Points for Analysis	Calendar Year ________
Corrections Savings	
Reductions in State Mental Health and Substance Abuse Spending	
Reductions in State High-Risk Pool Spending	
Reductions in State Public Health Spending	
Reductions in Other Targeted State-Only Funded Coverage Programs	
Reductions in State Uncompensated Care Spending	

State revenue gains

Many states collect revenue related to the provision of health care services or insurance. After expanding Medicaid, provider and payer revenue increases, thereby increasing the revenue generated by the applicable assessments and taxes. In addition, states that collect premium contributions will see an increase in those revenues.

Relevant Data Points for Analysis	Calendar Year ________
Gains in Provider Taxes/Assessments	
Gains in Insurer Taxes/Assessments	
Gains in General Business Taxes	
Enrollee Premium Contributions	

[4] 42 U.S.C. 1396a(a)(29)(A).

Index of savings and revenue opportunities identified in expansion states

STATE COSTS

- **Newly Eligible Adults.** States that expand Medicaid will see increased costs for coverage of new adult enrollees (non-elderly, non-disabled adults with incomes above the state's pre-expansion Medicaid adult eligibility level and up to 138% of the federal poverty level (FPL)). Costs depend on enrollment, the health care needs of the expansion population, and on the federal matching rate for the year for which the state is measuring or projecting expansion costs.[5] Enrollment estimates reflect the total eligible population for the year, and account for the observed or expected take up rate of this eligible population.

- **Previously Eligible but Unenrolled (Woodwork or Welcome Mat Effect Enrollees).** In addition to newly eligible adult enrollees, states expanding Medicaid will see some increase in enrollment by individuals previously eligible for Medicaid but unenrolled—the so-called "Woodwork" or "Welcome Mat" effect. For states that have expanded, this effect can be captured by measuring the increase in enrollment and costs related to growth in the low-income parents and children categories. For states that have not expanded, these costs can be estimated by projecting growth in these categories. However, in states that have not expanded, much of the "Woodwork" effect has already occurred as result of outreach and publicity around the marketplace and the more streamlined eligibility and enrollment process mandated by the ACA. These previously-eligible individuals are not considered newly eligible adults, and are eligible for the state's regular federal matching rate.

STATE SAVINGS FROM ACCESSING ENHANCED FEDERAL MATCHING FUNDS

- **Adults Enrolled Through Waivers.** Many states have used 1115 waivers to provide limited-benefit coverage to childless adults or parents who were not otherwise Medicaid-eligible. With expansion, adults in these waivers and with incomes below 138 percent of the FPL will be eligible for full Medicaid coverage in the new adult group. If these individuals did not qualify for full Medicaid benefits under pre-ACA rules, they are considered newly eligible, and the state is able to secure enhanced federal matching funds on their behalf.

- **Breast and Cervical Cancer Treatment Program.** States may cover individuals who are in need of treatment for breast or cervical cancer through the Breast and Cervical Cancer Treatment Program.[6] To be eligible, individuals must be under age 65 and uninsured or not otherwise eligible for Medicaid. Individuals enrolled in this program receive full Medicaid coverage during the period that they need cancer treatment. State expenditures are matched at the state's Children's Health Insurance Program (CHIP) enhanced federal match rate. In expansion states, individuals with incomes below 138 percent of the FPL who might previously have been found eligible through the Breast and Cervical Cancer Treatment Program, will now be able to enroll in coverage through the new adult group, and the state would receive enhanced match for their coverage.

- **Tuberculosis Program.** A state may opt to cover non-disabled individuals who are infected with tuberculosis (TB).[7] Eligible individuals may receive coverage limited to their TB treatment such as TB-related prescriptions, physician services, and outpatient hospital treatment. Very few individuals are currently receiving coverage under this Medicaid category. With expansion, individuals with incomes below 138 percent of the FPL who have TB will receive coverage under the new adult group.

- **HIV Program.** Many states offer special coverage for Medicaid enrollees with HIV or AIDS under a waiver. In expansion states, individuals with incomes below 138 percent of the FPL who have HIV or AIDS will receive comprehensive coverage under the new adult group.

- **Family Planning Services.** States may offer family planning services to individuals under the Family Planning optional eligibility category or under a waiver. To be eligible, individuals must not be pregnant and may have incomes up to the income eligibility limit for pregnant women. States receive an enhanced federal match of 90 percent for family planning services, and the state's regular federal match for family planning-related services such as treatment for sexually-transmitted diseases.[8] Under expansion, individuals with incomes below 138 percent of the FPL who might have previously qualified for Family Planning coverage now enroll in the new adult group with the enhanced federal matching rate.

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[5] The federal matching rate (FMAP) for newly eligible adults is: 100% in CY 2014–2016; 95% in CY 2017, 94% in CY 2018, 93% in CY 2019, and 90% thereafter.

[6] 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII); 1396a(aa).

[7] 42 U.S.C. 1395a(a)(10)(A(ii)(XII).

[8] Centers for Medicare and Medicaid Services, "Family Planning Services Option and New Benefit Rules for Benchmark Plans," SMDL#10-013, (July 2, 2010).

- **Medically Needy Spend Down Program.** States have the option of covering individuals through a medically needy program.[9] The medically needy are individuals who are eligible for an eligibility category such as the Aged, Blind, or Disabled but their incomes or resources exceed maximum allowable limits. Applicants may become Medicaid-eligible by "spending down" their income to the state's medically needy threshold and submitting incurred medical expenses to the state. States receive the regular federal match for medically needy programs. In expansion states, individuals with incomes above the medically needy threshold but below 138 percent of the FPL are eligible for the new adult group.

- **Pregnant Women.** Women who are enrolled in the new adult group and become pregnant remain in the new adult group and are eligible for enhanced federal match until such time that they report their pregnancy (generally at renewal). In addition, some states are evaluating whether to reduce income eligibility limits for pregnant women.

- **Disabled Individuals.** Prior to the expansion of Medicaid eligibility, individuals who were disabled were able to secure coverage under disability-based Medicaid categories. To be eligible under these categories, individuals are required to be low-income and to seek either a federal or state disability determination. States receive their regular federal matching rate for these eligibility groups. In expansion states, individuals with incomes up to 138 percent of the FPL are eligible for Medicaid under the new adult group without a disability determination. As a result, individuals who previously sought a disability determination solely to secure health coverage no longer need to do so, resulting in fewer individuals enrolled in the disabled category at the regular match rate.

STATE SAVINGS FROM REPLACING GENERAL FUNDS WITH MEDICAID FUNDS

- **Corrections Savings.** Medicaid's "inmate exclusion" prohibits payment of care of services for any individual who is an inmate of a public institution. However, Medicaid will cover services provided to an inmate during an inpatient stay of at least 24 hours in a medical institution such as an acute care facility.[10] In expansion states, state correction budgets may be reduced to the extent that newly Medicaid-eligible prisoners are treated in an inpatient medical facility outside of the state correctional system. A State Network issue brief providing additional context on Medicaid expansion and the criminal justice-involved population is available online: *http://statenetwork.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf*.

- **State Mental Health and Substance Abuse Spending.** States have allocated state and local funding to support mental health and substance abuse treatment for uninsured individuals. In states that expand Medicaid, previously uninsured individuals who were recipients of these state funded mental health and substance abuse services are eligible for full coverage under the new adult group—reducing spending on state funded programs.

- **State High-Risk Pool Spending.** Prior to the Affordable Care Act, most states implemented a state-funded high-risk pool to provide health insurance for "uninsurable" individuals. After the Affordable Care Act was passed, most of these high-risk pools were discontinued. However, a handful of states still operate high-risk pool programs. In those states that operate such programs and expand Medicaid, many of the previously uninsured individuals who were recipients of state funded coverage are now eligible for full coverage under the new adult group.

- **State Public Health Spending.** States have allocated state and local funding to support public health services (such as family planning, tobacco cessation, or health and cancer screenings) to uninsured individuals. In states that expand Medicaid, previously uninsured individuals who were recipients of these state funded public health services are eligible for full coverage under the new adult group, freeing up state dollars previously spent on programs for the uninsured.

- **Other Targeted State-Only Funded Coverage Programs.** States may also allocate state and local funding to health coverage for other special populations, such as transient/homeless populations or hemophilia patients. In states that expand Medicaid, previously uninsured individuals who were recipients of these state funded services are eligible for full coverage under the new adult group.

- **Uncompensated Care Spending.** The expansion of Medicaid to adults with incomes up to 138 percent of the FPL has resulted in fewer patients who are unable to pay their medical bills because they are uninsured. As a result, expansion states are able to reduce or repurpose state expenditures for uncompensated care provided by hospitals and other health care providers. A State Network issue brief providing additional context on Medicaid expansion and uncompensated care costs is available online: *http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420741*.

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[9] 42 U.S.C. 1396a(a)(10)(C); 42 C.F.R. § 435.300-350.

[10] 42 U.S.C. 1396a(a)(29)(A).

STATE REVENUE GAINS

- **Provider Taxes/Assessments.** Many states raise revenue through taxes/assessments on providers such as hospitals and nursing homes. With expansion, provider revenues increase because the costs of providing care to some previously uninsured individuals become eligible for Medicaid reimbursement. As a result, existing taxes/assessments generate additional revenue for the state. Some states are imposing new or increased taxes/assessments to raise revenue to cover expansion-related costs.
- **Insurer Taxes/Assessments.** Similarly, many Medicaid managed care states raise revenue through taxes/assessments on plans. With expansion, revenues for plans increase as they gain new Medicaid enrollees. As a result, these existing taxes/assessments generate additional revenue for the state.
- **General Business Taxes.** States may also impose general business taxes, on entities including health care providers, plans, or other health care industry businesses. As revenues across the health care industry increase with expansion, state revenues from these business taxes will also increase.
- **Enrollee Premium Contributions.** Some expansion states choose to impose premiums on certain new adult enrollees (such as those with incomes above 100% of the FPL) under a waiver. These states will see small increased revenues from premium contributions by newly eligible adults enrolled through expansion.