State Health Reform Assistance Network
Charting the Road to Coverage

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Medicaid Expansion: Framing and Planning a Financial Impact Analysis

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The Supreme Court's decision in *NFIB v. Sebelius* did not change the underlying Medicaid expansion provisions of the Patient Protection and Affordable Care Act (ACA), but it did remove the ACA's enforcement authority for states choosing not to expand.[1] States have generally viewed the decision as providing the option whether to expand Medicaid for adults up to 133 percent of the federal poverty level (FPL), though the newly eligible remain a mandatory population in the underlying statute. As a result, states are facing an unexpected and difficult implementation decision regarding this expansion. The availability of 100 percent federal match for this population from 2014 through 2016, along with federal match ratcheting down to 90 percent in the later years, is, for many states, a strong incentive to expand Medicaid. Regardless of that incentive, most states are taking a measured and analytical approach in determining the fiscal impact of this choice before making a final decision.

The following worksheet and considerations table serve as a guide for states conducting their own Medicaid expansion analysis. The documents are the result of collaboration between the State Network experts at State Health Access Data Assistance Center (SHADAC), Center for Health Care Strategies (CHCS), and Manatt Health Solutions. The worksheet and considerations also take into account analyses that have already been released by other states and organizations.[2] This analysis approach, however, is limited to financial considerations related to a state's decision to expand and therefore excludes many important financial aspects related to the ACA as a whole (e.g. remaining mandatory provisions).

State specific Medicaid expansion analysis should take into account existing program structure, available data sources (both state and national), and realistic assumptions about enrollment and costs. States should also note within the analysis whether costs are directly related to Medicaid expansion or if they are likely to occur despite expansion (e.g., the woodwork effect for individuals eligible but not currently enrolled). Not every state will need cost or savings projects for every possible row of the analysis outlined here, but there are six main areas of financial analysis that all states should consider:

1. Cost of Newly Eligibles
2. Cost of Currently Eligible but Not Enrolled
3. Administrative Costs
4. Savings from Transitioning Current Medicaid Populations to Newly Eligible Group
5. Savings from Reduction in State Programs for the Uninsured
6. Other Revenue Gains and Savings

There are a number of other financial impacts states may wish to consider that do not have an easily measurable or direct impact on state budgets. These impacts include: large disproportionate share hospital (DSH) payments to facilities currently serving the uninsured; local funding for indigent care; general economic effects from the increase in health spending on the newly insured (jobs, income taxes, etc.); potential tax penalties for employers if (in the absence of Medicaid expansion) employees qualify for premium tax credits; and crowd-out of existing private insurance into newly expanded public programs

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1 Letter from Secretary of Health And Human Services Kathleen Sebelius to Governors, US Department of Health and Human Services, July 10, 2012. http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf

2 A number of states have completed some level of Medicaid expansion fiscal analysis. Some national organizations have and will in the near future be offering additional analyses that will include state level breakdowns using national data sets. Analyses and useful documents identified to date include: Arkansas analysis and summary; Florida analysis (slide presentation); Idaho report on Newly Eligibles; Indiana analysis; Iowa Report; Maryland broader reform simulation (including Medicaid expansion); Maryland Medicaid Director Health Affairs Blog explaining expansion decision; Nebraska analysis (University policy center, not state funded); Ohio analysis; South Carolina analysis (slide presentation); and, Urban Institute Expansion Considerations Brief.

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MEDICAID EXPANSION FINANCIAL IMPACT | DECISION-FRAMING AND PLANNING WORKSHEET

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	2014	2015	2016	2017	2018	2019	2020	Cumulative
1. Cost of Newly Eligibles States will be responsible for a portion of the cost of the newly eligible starting in 2017. States may want to consider cumulative costs for shorter windows (e.g., 2014-2016) given the flexibility to opt-in or out of Medicaid expansion at any time.								
Total Number of Newly Eligibles								
Take Up Rate (Percentage)								
Newly Eligibles Who Enroll								
PMPY Cost								
Total Cost								
FMAP	100%	100%	100%	95%	94%	93%	90%	
Subtotal - State Cost								
2. Cost of Currently Eligible but Not Enrolled In addition to the newly eligible, it is likely that states will see increases in Medicaid enrollment by currently eligible individuals due in large part to the new coverage paradigm that includes the individual mandate and insurance Exchanges. In addition, outreach and enrollment simplifications will increase the visibility of Medicaid and make it easier to enroll. For these reasons, we expect an increased enrollment of currently eligible, but not enrolled regardless of a state's decision to expand Medicaid.								
Currently Eligible but Not Enrolled								
Take Up Rate (Percentage)								
Currently Eligible Who Enroll (Not Previously Enrolled)								
PMPY Cost								
Total Cost								
FMAP								
Subtotal - State Cost								
3. Administrative Costs With increased enrollment, administrative costs are likely to increase. This will be partially offset by enhanced FMAP for certain categories of spending (e.g., 90% match for eligibility system build, 75% match for eligibility system operation and 50% match for non-admin system costs).								
PMPM Administrative Costs								
Subtotal - State Cost								
TOTAL - STATE COST								
4. Savings from Transitioning Current Medicaid Populations to Newly Eligible Group Many states currently cover individuals in Medicaid who may transition to the newly eligible group under an expanded Medicaid program. The savings is generated by replacing the state's regular FMAP with the enhanced FMAP (no state share until 2017) for current Medicaid populations that move into the newly eligible group. It should be noted that CMS has not yet finalized the methods needed to account for disability and assets in determining who qualifies as newly eligible.								
Adults Enrolled Through Waivers (Select Groups e.g., Limited Benefits)								
Disease Specific Coverage (e.g., Breast and Cervical Cancer Treatment Program)								
Family Planning Services								
Medically Needy Spend-Down								
Other?								
Subtotal - State Savings								

	2014	2015	2016	2017	2018	2019	2020	Cumulative
5. Savings from Reduction in State Programs for Uninsured Many states underwrite 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 and providers will enroll in Medicaid, thus reducing the uncompensated care costs required to be subsidized by the state. The savings represent the reduction in the amount of state funds used to support these programs.								
State-Only Funded Coverage Programs								
Uncompensated Care Pool/Fund (e.g., Support for Public Hospitals)								
State Mental Health Spending								
State Substance Abuse Spending								
State High-Risk Pool Spending								
State Spending on Public Health Services								
State Spending on Hospital Inpatient Costs of Prisoners								
Other (e.g., Unique State Specific Programs/Spending)								
Subtotal - State Savings								
6. Other Revenue Gains and Savings Many states collect revenue related to the provision of health care services or insurance. By expanding Medicaid, provider and payer revenue will increase thereby increasing the revenue generated by the applicable assessments and taxes.								
Provider Taxes/Assessments								
Insurer Taxes/Assessments								
General Business Taxes								
Other Tax Impacts								
Subtotal - State Gains/Savings								
TOTAL - STATE SAVINGS/REVENUE GAINS								
NET of TOTAL STATE SAVINGS/REVENUE GAINS & TOTAL STATE COST								

MEDICAID EXPANSION FINANCIAL IMPACT | ESTIMATE GUIDANCE AND CONSIDERATIONS

	Key Considerations	Available Data/Research
1. Cost of Newly Eligibles States will want to make estimates about the number of newly eligibles and how quickly they will sign up under Medicaid expansion. This analysis should include reasonable annual indexing factors for growth in the number of beneficiaries and cost per beneficiary given historic population and Medicaid cost growth.		
Number of Newly Eligibles	To estimate the number of newly eligibles, states will need to start by converting current eligibility levels for parents and childless adults (if state provides any level of coverage). CMS has provided preliminary guidance on MAGI income conversions. States will generally receive enhanced federal matching dollars (FMAP) for adults between current eligibility levels (MAGI converted) up to 133% of the FPL.	State-specific estimates are available from several sources (SHADAC and Urban Institute).[i,ii] In addition, in-state estimates may have been developed. Estimates can differ based on underlying assumptions (e.g., treatment of immigrants, crowd out, additional employer sponsored insurance due to employer responsibility).
Take-up Rate of Newly Eligibles	States will want to estimate a percentage of newly eligibles that will actually enroll in coverage. Historically, means tested programs have not achieved 100 percent enrollment. Estimates for take-up of the newly eligible population range from 57% to 75%. In addition, states can assume that take up will occur over several years, potentially as follows: 25% in year one; 50% in year two; 75% in year three; 90% in year four; and 100% thereafter. These are all conservative estimates that can be increased with effective outreach and education.	Urban Institute analysis uses internal assumptions and assumptions by the CBO that range between 57% and 75%.[iii] States have also developed their own internal take-up assumptions. See individual state analyses listed in introduction for more information.
PMPY Cost	The cost of newly eligibles is expected to be similar to the cost of currently enrolled parents. States should be careful not to apply current cost figures to the extent they reflect significant numbers of adults in the aged, blind, and disabled (ABD) category.[iv] States may also want to consider likely Medicaid benchmark benefits that will be offered to newly eligibles if those benefits differ substantially from currently enrolled parents.	State data is best. Average 2009 state-specific estimates are available from Medicaid and CHIP Payment and Access Commission (MACPAC).[v]
FMAP	Phase down from 100% in 2014-2016 to 90% by 2020. Expansion states – those that expanded their Medicaid eligibility levels for both parents and childless adults to 100% before 2010 – will receive enhanced FMAP for all childless adults phasing up to 90% in 2020.	
2. Cost of Currently Eligible but Not Enrolled For purposes of understanding the fiscal impact of the ACA, states will want to analyze the expected take-up rate of individuals who are currently eligible for Medicaid but are not enrolled, often referred to as the woodwork or welcome mat effect. In considering the fiscal impact of the woodwork effect, it is important to note that most of the new enrollment and related costs will occur regardless of whether the state pursues Medicaid expansion as a result of the Exchange, simplified eligibility process, and ACA-related outreach and education.		
Number Currently Eligible but not Enrolled	Estimates using national data sources are available for each state, but states may want to consider using their own estimates using those data sources (fully understanding those included and excluded from the analysis) or using state specific data sources to assess the number of currently eligible but not enrolled.	SHADAC can produce state-level estimates for kids and adults. The Urban Institute has also developed state level estimates for adults and regional estimates for kids.[vi,vii]
Take-up of Individuals Currently Eligible but Not Enrolled	May differ for kids, parents and childless adults. Depends on outreach intensity, efforts to streamline and simplify enrollment processes, and currently eligibility levels. As noted above, a substantial portion of this take up will occur regardless of the state's decision on Medicaid expansion. States may want to consider take-up both with and without Medicaid expansion.	Urban Institute analysis uses internal assumptions and assumptions by the CBO that range between 10% and 40%.[vii] States have also developed their own internal take-up assumptions for currently eligible but not enrolled individuals. See individual state analyses listed in introduction for more information.
PMPY Cost	Costs are likely to be different for different subsets of the currently eligible but not enrolled population. For example, costs will be greater if currently eligible but not enrolled are adults as opposed to kids.	State data is best. Average 2009 state-specific estimates for current enrollees are available from Medicaid and CHIP Payment and Access Commission (MACPAC).[ix]
FMAP (regular)	No enhanced match for currently eligible but not enrolled. CHIP match increases 23 percentage points on October 1, 2015. CHIP kids transitioning to Medicaid (ages 1-5 with incomes between 100-133% FPL who were not eligible prior to 1997) will receive enhanced CHIP match.	States should use their specific FMAPs for different eligibility categories when estimating costs for the currently eligible but not enrolled.

3. Administrative Costs After determining the anticipated enrollment and take-up of individuals currently eligible but not yet enrolled in existing programs, states will want to determine how to allocate administrative costs for enrolling these populations.		
Administrative Costs	Match rate is dependent on spending type: Eligibility system build (90% match), eligibility system operation (75% match), and non-admin system costs (50% match). State should specifically consider increased costs of administering claims due to increased enrollment in both the traditional and expansion populations. This can be done through a time study, cost per claim, or through a population distribution. States may also want to consider efficiencies gained for the traditional and expansion populations due to streamlined enrollment and renewals resulting from improved systems and reduction of renewals to once per year.	State data is best. Research on this topic suggests that Medicaid administrative spending ranges from 2% to 9%.[x]
4. Saving From Transitioning Current Medicaid Populations to Newly Eligible Group After calculating state costs related to Medicaid expansion, states will want to deduct from that number the state savings that can be achieved as a result of the expansion. As detailed below, certain populations who are now covered under a state's Medicaid program with regular FMAP can be moved to the newly eligible group. By transitioning beneficiaries into this new adult group, the state will be able access enhanced FMAP and will be able to replace state dollars with federal dollars. Examples follow, but each state will want to do its own analysis of Medicaid programs that can be eliminated and the enrollees moved into the newly eligible Medicaid group. ACA defined the newly eligible adults as those who would not be eligible under a state's Medicaid program as in effect on December 1, 2009, and this definition is applicable for purposes of enhanced FMAP. Factors that will determine who among the waiver enrollees, if any, would be considered newly eligible include whether the benefit package provided under the waiver meets certain ACA benchmark benefit standards and the degree to which the waiver had an enrollment cap.		
Adults Enrolled Through Waivers	Many states have used 1115 waivers to expand coverage for childless adults or parents. In some cases these waiver populations may be considered newly eligible (e.g. where the state does not provide comprehensive benefits or limits or caps enrollment), the waiver can be eliminated and the covered adults moved into the new adult group. In this case the state will receive enhanced FMAP, allowing the state to substitute federal dollars for the state dollars previously invested in coverage of this population.	State data on number of enrollees and associated PMPY cost is best.
Breast and Cervical Cancer Treatment Program (BCCTP)	Many states participate in the Centers for Disease Control (CDC) BCCTP and provide Medicaid coverage to women diagnosed with breast or cervical cancer by hospitals participating in the CDC Program. There is no upper income limit and women receive full Medicaid coverage while they are being treated for breast or cervical cancer. States may determine to eliminate this program in connection with Medicaid expansion. Women with incomes below 133% of the FPL will move into Medicaid (with an enhanced match); women with incomes above 133% FPL will be eligible for tax credits and cost-sharing reductions through the Exchange (where no state expenditures are required).	State data on number of enrollees and associated PMPY cost is best. Select state-level enrollment and total annual spending for 2006 are available in a GAO Report to Congress.[xi]
Family Planning	States may conclude to eliminate this program as individuals with incomes below 133% FPL currently participating will be eligible for full Medicaid coverage (as opposed to only family planning services) and women above 133% FPL will be eligible for tax credits and cost-sharing reductions. The current matching rate for family planning services under a waiver or SPA is 90%. If the program is eliminated the state will receive an enhanced FMAP for newly eligibles and will have no costs for individuals above 133% FPL who receive tax credits and cost-sharing reductions in the Exchange.	State data on number of enrollees and associated PMPY cost is best.
Medically Needy Spend Down	Some states have adopted the medically needy spend down option whereby individuals who are disabled may "spend down" to the ABD eligibility level and receive Medicaid. If the state eliminates the program, individuals who might otherwise have accessed Medicaid coverage through the ABD group with regular FMAP will stay in the new adult group and qualify for enhanced FMAP.	State data on number of enrollees and associated PMPY cost is best.
State Spending on Hospital Inpatient Costs of Prisoners	State corrections budgets may be reduced to the extent that Medicaid eligible prisoners are treated in an inpatient facility outside of the state correctional system.[xii]	States should consult with corrections departments to determine likely newly eligibles and scope of off-site inpatient services.
Other?	E.g. Whether former foster care children under age 26 will access Medicaid under the traditional program or as newly eligible adults. States may also want to consider in this analysis current Medicaid populations that may transition to the Exchange.	State data on existing costs is best.

5. Savings from Reduction in State Programs for Uninsured Many states underwrite the costs of health care programs and services for the uninsured. Under an expanded Medicaid program, some, perhaps most, of the individuals receiving care from these programs and providers will enroll in Medicaid, thus reducing the uncompensated care costs required to be subsidized by the state. The savings represent the reduction in the amount of state funds used to support these programs.		
State-Only Funded Coverage Programs	To the extent the state has any state-funded coverage programs, funding for these programs can be reduced significantly as most low-income adults will gain coverage under the expansion of Medicaid.	State data for these programs is best.
Uncompensated Care Pool/Fund (e.g., Support for Public Hospitals)	By expanding Medicaid to adults with incomes below 133% FPL, the state will be able to reduce any state expenditures for uncompensated care provided by hospitals and other health care providers.	State data is often collected by health departments or other entities running these pools. There are also national estimates of the total uncompensated care and the potential impacts of health reform on these costs produced by the Urban Institute.[xiii]
State Mental Health Spending	States will want to identify state and local funds now allocated to the support of public and private mental health clinics. Most of the uninsured adults relying on these facilities will be eligible for Medicaid. The state may be able to replace state and local spending with federal Medicaid funds. States will want to consider how much of the state mental health spending could/should be eliminated and over what period of time.	The National Association of State Mental Health Program Directors Research Institute releases total, per capita state-level estimates (include age breakdowns) for a variety of categories (most recent year available is 2009).[xiv]
State Substance Abuse Spending	Please see discussion above with respect to state and local spending on mental health services.	State share dollars that go to mental health facility services for Medicaid enrollees are available in the Medicaid Financial Management Reports through 2010. [xv]
State High-Risk Pool Spending	Some states have invested state dollars to subsidize the cost of coverage for individuals with pre-existing conditions who would either not have access to coverage or would be unable to afford coverage. Individuals with incomes below 133% FPL will be eligible for coverage under Medicaid expansion and here again the state will be able to substitute federal dollars for state dollars.	State data is often available from state budget offices or revenue departments. This information is also collected by the National Association of State Comprehensive Health Insurance Plans and available in a report available for purchase.[xvi]
Public Health Services	States often underwrite the cost of public health services, such as immunizations, for uninsured individuals. Some of these services and some of the individuals relying on these public programs will be able to access them through Medicaid expansion.	State-specific funding estimates are available from Trust for American's Health.[xvii]
Other (e.g., Unique State Specific Programs/ Spending)	Other programs might include state funds to local governments for indigent care, HIV/AIDS, homeless health services, etc. There may also be direct savings to local governments from reduced need for locally funded indigent care programs.	Historic state or local spending data for other programs is best.
6. Other Revenue Gains and Savings Many states assess or tax non-Medicare health care revenue of providers and insurers. By expanding Medicaid, the number of insured patients accessing services will increase and with it provider/payer revenue. Assessments and taxes will likewise increase as the provider/payer revenue base increases.		
Provider and Insurer Taxes/ Assessments	The state will want to estimate the additional revenue available to providers and payers as a result of Medicaid expansion and the additional tax/assessment revenue it will generate.	State data is best, often available from state budget offices or revenue departments. State provider taxes or fees affecting Medicaid and state budgets are available through the National Conference of State Legislatures.[xviii] New MLR reporting regulations under the ACA include reporting of state premium taxes paid by insurers (data is released in raw form and may require moderate/heavy analytic processing).[xix]
General Business Taxes	In some states, general business taxes apply to the services provided by (for profit) health care providers and payers. Again, the state will want to estimate the additional Medicaid revenue flowing to taxed entities and the additional tax revenue that will generate.	State data is best, often available from state budget offices or revenue departments.
Other Tax Impacts	The ACA imposes an excise tax on insurers of employer-sponsored health plans that exceed certain thresholds. To the extent state law links federal taxes through the state tax system, the impact of these taxes should be assessed for the purpose of this analysis. States may also want to consider broader tax impacts due to more macro-economic effects of increased health care spending.	State data is best, often available from state budget offices or revenue departments. Also see the Nebraska analysis (noted in the footnote of the intro section)[2] for an example of broader economic and tax impact analyses.
Reductions in Cost due to Simplified and Streamlined System	As states build integrated eligibility systems, the opportunity to develop new cost allocation methodologies to leverage federal funds between Medicaid and the future Health Insurance Exchanges could be used to substitute for existing state administrative funding.	States may have considered long-term cost allocation in developing their Advance Planning Documents, Exchange establishment grant proposals, or Exchange financial sustainability analyses.

[i] State-specific estimates are available from SHADAC upon request (Contact Elizabeth Lukanen at elukanen@umn.edu).

[ii] J. Holahan and L. Blumberg, "How Would States Be Affected By Health Reform?," The Urban Insisted, January 2010. http://www.urban.org/uploadedpdf/412015_affected_by_health_reform.pdf

[iii] J. Holahan and I. Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," The Kaiser Commission on Medicaid and the Uninsured, May 2010. http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf

[iv] J. Holahan, et al, "Health Status of New Medicaid Enrollees Under Health Reform," The Urban Institute, August 2010. http://www.urban.org/publications/412206.html

[v] Medicaid and CHIP Payment and Access Commission (MACPAC), "report to the Congress on Medicaid and CHIP," June, 2012. http://www.naph.org/Links/POL/6-15-2012-MACPAC-Report.aspx

[vi] G. Kenney et. al., "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid," The Urban Institute, July 5, 2012. http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf

[vii] G. Kenney et. al., "Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospect for Covering More Children, The Urban Institute, December, 2009. http://www.urban.org/uploadedpdf/411981_Progress_Enrolling_children_11_10.pdf

[viii] J. Holahan and I. Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," The Kaiser Commission on Medicaid and the Uninsured, May 2010. http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf

[ix] Medicaid and CHIP Payment and Access Commission (MACPAC), "Report to the Congress on Medicaid and CHIP," June, 2012. http://www.naph.org/Links/POL/6-15-2012-MACPAC-Report.aspx

[x] A. Schneider and V. Wachino. "The Medicaid Resource Book: Medicaid Administration," Kaiser Commission on Medicaid and the Uninsured, July, 2002. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14262

[xi] "Source of Screening Affects Women's Eligibility for Coverage of Breast and Cervical Cancer Treatment in Some States," GAO Report to Congress, May 2009. http://www.acscan.org/pdf/breastcancer/gao-report.pdf

[xii] "County Jails and the Affordable Care Act," National Association of Counties, March 2012. http://www.naco.org/research/pubs/documents/health,%20human%20services%20and%20justice/community%20services%20docs/webversion_pwfissuebrief.pdf

[xiii] J. Holahan and B Garrett. "The Cost of Uncompensated Care with and without Health Reform," The Urban Institute, March 2010. http://www.urban.org/UploadedPDF/412045_cost_of_uncompensated.pdf

[xiv] The National Association of State Mental Health Program Directors Research Institute runs a project called the State Mental Health Agency Systems U*Profiles) and Revenues Expenditures studies, which publishes a variety of state level estimates http://www.nri-inc.org/projects/Profiles/Prior_RE.cfm

[xv] http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/CMS-64-Quarterly-Expense-Report.html

[xvi] http://naschip.org/portal/index.php?option=com_content&view=article&id=246

[xvii] "Investing in America's Health," Issue Report, Trust for America's Health, March, 2012. http://healthyamericans.org/assets/files/Investing.pdf

[xviii] http://www.ncsl.org/issues-research/health/health-provider-and-industry-state-taxes-and-fees.aspx#Revenue

[xix] http://cciio.cms.gov/resources/data/mlr.html