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The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States

As enacted, the Affordable Care Act (ACA) broadened Medicaid's role, making it the foundation of coverage for nearly all low-income Americans with incomes up to 138 percent of the federal poverty level (FPL) ($16,242 per year for an individual in 2015). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. For those that expand, the federal government will pay 100 percent of Medicaid costs of those newly eligible for Medicaid from 2014 to 2016. The federal share gradually phases down to 90 percent in 2020, where it remains well above traditional federal medical assistance percentage (FMAP) rates. As of March 2015, 29 states (including the District of Columbia) adopted the Medicaid expansion, though debate continues in other states. In deciding whether to implement the Medicaid expansion, the effect on state budgets has been a key issue for policy makers. However, isolating the full effects of the Medicaid expansion across all parts of the state budget has proven challenging. State-specific estimates of the Medicaid expansion were created with varying degrees of completeness; those that were complete found net fiscal gains, with state savings and revenues exceeding increased state costs.[1]

This brief looks beyond the estimates and examines the early budget effects of expansion in three states: Connecticut, New Mexico, and Washington State. The study was conducted during the Fall of 2014; budgets had been enacted for state fiscal year 2015, the first full state fiscal year with the Medicaid expansion in effect. Budget officials were also in the process of closing the books on SFY 2014, the latter half of which included the first 6 months of the Medicaid expansion in each of these states. These findings are based on interviews conducted with budget officials and staff in each of the three states; the interviews focused on their state's experiences in this early period, when the costs of those newly eligible are fully financed with federal dollars. Specifically, budget officials were asked about assumptions and early experiences with state savings and costs from the expansion across state budgets (within and outside of Medicaid) as well as the expansion's impact on state revenue. (See the Methodology section for more details on how the study was conducted.) Findings from a separate report commissioned by Kentucky are also included. Key findings include:

- **Overall Finding**. Early evidence from interviews with budget officials in these case study states shows state savings and revenue gains with limited costs resulting from expansion, even as some potential fiscal gains have not yet been tracked.
- **Medicaid Enrollment and State Costs.** Enrollment of those newly eligible exceeded expectations; however, these individuals are fully financed with federal dollars through December 31, 2016, presenting no costs to states during this period. While enrollment among those previously eligible but not enrolled (which is financed at the state's regular matching rate) increased in each of the study states, the majority of this enrollment growth was driven by other changes in the ACA rather than just the Medicaid expansion.

- **Savings within Medicaid budgets.** Savings were reported within Medicaid programs in all study states as beneficiaries who otherwise would have qualified for pre-ACA Medicaid categories at the state's regular match instead enrolled in the new expansion group and were eligible for the higher ACA enhanced match rate (and therefore reduced state costs.)
- **Savings outside of Medicaid budgets.** All study states experienced savings in other areas of the state budget beyond Medicaid, such as state-funded behavioral health services and corrections. Some savings were captured for state general funds and others were reinvested, often to compensate for earlier cutbacks.
- **Revenue effects.** The impact on state revenue, as monitored by budget officials, was primarily reflected in increased provider and premium taxes. Only one study state (New Mexico) accounted for the increased economic activity resulting from expansion in general revenue forecasts. A separate study found the Medicaid expansion in Kentucky led to increases in jobs and tax revenues for the state and localities.
- **Long-term estimates of full effects.** Disentangling the revenue and budgetary impact of the Medicaid expansion from other ACA effects as well as other factors shaping health care costs, state economies and state budgets is a tremendous challenge that is generally not part of state budget processes. The one study state that produced net estimates, Washington, projected that state savings from expansion would exceed costs, resulting in net fiscal gains. During the current fiscal year (2015), net gains of expansion are estimated to equal 1.7 percent of total General Fund spending.[2] Net savings through 2021 due to the expansion were also found in a separate report examining the impact of the Medicaid expansion in the Kentucky. Both states projected net state savings in future years when the federal share of spending on newly eligible adults will fall to 90 percent.

Summary Table

The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States			
	Connecticut	New Mexico	Washington
Enrollment			
Newly Eligible Enrollment	Higher than projected; no state costs.	Higher than projected; no state costs.	Higher than projected; no state costs.
Previously Eligible but not Enrolled	Higher than projected; mostly children.	Higher than expected; mostly adults but also some children.[3]	Lower than expected; mostly children.
Savings within Medicaid			
Limited Medicaid programs for low-income adults	Savings from conversion of early expansion state plan group.	Substantial source of one-time savings from conversion of SCI waiver.	Substantial source of one-time savings from conversion of Bridge to Reform waiver.
Medically Needy Spend-Down	Enrollment decline noted; not included in budget.	N/A	Moderate savings noted.
Breast and Cervical Cancer Treatment	No change in enrollment.	Not noted or tracked (limited program to begin with.)	Limited savings noted from enrollment declines.
Family Planning	Limited savings noted from declining enrollment.	Not noted or tracked (limited program to begin with.)	Limited savings noted from declining enrollment.
Pregnancy Related Enrollment	Not noted or tracked.	Not noted or tracked.	Not included in budget, but enrollment decline noted (due mostly to the expansion.) Planning to take limited savings.
Savings outside of Medicaid			
Mental Health and Substance Abuse	Substantial savings included in budget.	Moderate savings noted, most funds reprogrammed within agency.	Moderate savings included in budget.
Uncompensated Care	Significant savings included in budget.	N/A – mostly county responsibility.	N/A – programs had mostly been eliminated by the state in earlier years.
State Funded Indigent Care**	N/A	N/A	N/A
High Risk Pools	N/A	Moderate savings included in budget; savings are slower than expected.	N/A
Inpatient Care for Prisoners	Not explicitly accounted for in budget. Many of those eligible under the expansion enrolled in the state's early expansion.	Not included in budget; anticipated to be small savings for counties and state.	Limited savings included in budget.
Public Health Services	Limited savings included in budget.	Exploring potential savings.	Limited savings included in budget.
Other Health Care Programs for Vulnerable Populations			Limited savings included in budget.
Revenues			
Taxes or Fees on Providers	No additional revenue included in budget.	Additional revenue included in budget.	Additional revenue included in budget.
General Revenue due to increased economic activity	Did not include in economic and revenue estimates at this time.	Included in economic and revenue estimates.	Did not include in economic and revenue estimates at this time.

** Connecticut and Washington State had state-funded indigent care programs before the ACA; both states transitioned these programs to Medicaid financing before the Medicaid expansion went into effect. See Appendix A for more details.

Introduction

As enacted, the Affordable Care Act (ACA) broadened Medicaid's role, making it the foundation of coverage for nearly all low-income Americans with incomes up to 138 percent of the federal poverty level (FPL) ($16,242 per year for an individual in 2015). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. For states that expand Medicaid, the federal government will pay 100 percent of Medicaid costs of those newly eligible for Medicaid for up to three calendar years from 2014 to 2016. The federal share gradually phases down to 90 percent in 2020, where it remains well above traditional federal medical assistance percentage (FMAP) rates in every state. As of March 2015, 29 states (including the District of Columbia) have adopted the Medicaid expansion though debate continues in other states. A key issue for policy makers at the state level has been the state budget effects of the Medicaid expansion on states' budgets.

This brief presents findings from a study of the early budget effects of the Medicaid expansion in three states: Connecticut, New Mexico, and Washington State. These interviews took place in the Fall of 2014, as executive-branch officials had begun preparing executive budget proposals for the 2015 legislative sessions. (See the Methodology section for more details on how the study was conducted.) Also included are findings from a separate study commissioned by Kentucky officials that examined the impact of that state's decision to expand. The findings provide a limited and early insight into the effect of the Medicaid expansion on state budgets, both within and outside of the Medicaid programs. Key findings are summarized below, first looking at effects within the Medicaid budget, then turning to the effects on other parts of the state budget as well as revenues. A summary of the findings is also presented in the Summary Table. This study focused primarily on budget factors that may apply elsewhere, but one should be careful in generalizing, as each state's budget situation is unique.

Medicaid Enrollment and State Costs

While enrollment among those previously eligible but not enrolled (which is financed at the state's regular match rate) increased in each of the study states, the majority of this enrollment growth was driven by other changes in the ACA rather than just the Medicaid expansion. All states anticipated increased enrollment resulting from the Medicaid expansion, both for newly eligible adults and among those who were previously eligible but not enrolled. In each state, newly eligible enrollment exceeded expectations. Under the ACA, these costs are fully funded with federal dollars through December 31, 2016, so this did not increase state costs in SFYs 2014 or 2015. The extent to which states saw increased enrollment among those previously eligible but not enrolled varied across the study states. In Connecticut and New Mexico, the enrollment increase was above projections, but it was below projections in Washington State. A separate study commissioned by the Kentucky officials also found enrollment of those previously eligible but not enrolled was well above projections.[4] However, the enrollment growth among those previously eligible but not enrolled in each of these states was primarily driven by other ACA changes, such as the streamlining and simplifying of Medicaid enrollment processes that occurred in all states regardless of expansion decisions as well as broader outreach efforts. Washington State officials, for example, estimated that nearly three-quarters of such enrollment growth resulted from features of the ACA that would have been present with or without expanded eligibility.

While study states saw some increased Medicaid administrative costs, these costs were relatively small. Medicaid administrative costs in general represent only five percent of total Medicaid spending nationally.[5] Additionally, most of these administrative costs would have been incurred with or without the Medicaid expansion due to other aspects of the ACA. Officials expect these effects to be ameliorated by the ACA's shift to a more data-driven and less labor-intensive approach to eligibility determination. The transition to this new approach is supported by 90 percent federal funding for necessary investments in information technology, along with 75 percent federal funding for operating expenses.[6]

Savings within Medicaid budgets

All study states reported savings within their Medicaid programs as some beneficiaries for whom states would have received standard FMAP instead qualified as low-income adults eligible for the ACA's enhanced match rate.[7] Conversion of limited Medicaid programs for low-income adults in each of the study states provided a source of immediate, significant savings within Medicaid programs. For two of these states, Connecticut and Washington, these limited Medicaid programs for low-income adults had started as state-funded indigent care programs that were converted to Medicaid financed programs (at the state's regular matching rate) ahead of the ACA expansion. (More details on these programs are provided in Appendix A.)

In addition, some of the study states observed enrollment declines in optional Medicaid eligibility categories without reducing eligibility. For example, some study states saw declines in the enrollment of lower cost programs such as family planning (Connecticut and Washington) and breast and cervical cancer treatment programs (Washington). These two states also saw declining enrollment in higher-cost eligibility categories, such as medically needy spend-down programs for adults; Washington State also saw declining enrollment in an optional eligibility pathway that provides coverage for those awaiting an SSI disability determination. Adults who would have enrolled under these optional eligibility pathways were instead enrolling under the new Medicaid expansion group, qualifying for a higher matching rate.[8] (See Appendix B for more on these pathways.) Similar declines in enrollment among optional groups were also seen in Kentucky; according to this separate report, the Commonwealth saw savings of over $38 million in SFYs 2014 and 2015 from beneficiaries qualifying under the newly eligible group instead of other optional pathways such as breast and cervical cancer treatment program and spend-down groups among others.[9]

Officials in Washington state also observed unexpected declines among pregnant women that had not been included in enacted budgets. Officials in Washington noted that much of the decline was due to more women qualifying under the Medicaid expansion group. Medicaid programs have long been required to cover pregnant women at levels at or above the Medicaid expansion. This requirement continues under the ACA; their coverage is reimbursed at the state's regular match rate. However, women enrolled in the new adult expansion group who become pregnant are not required to move to the pregnancy-related eligibility group outside of their regular renewal period. Budget officials also noted that the availability or coverage in the Marketplace as well as improving economic conditions could also have caused some of this decline.

Savings Outside of Medicaid Budgets

All study states experienced savings in other areas of the state budget beyond Medicaid.[10] Expanded Medicaid coverage helped to reduce some of the need for state-funded programs to serve this population, such as behavioral health and corrections. Savings either benefited the state general fund or were reinvested within the program area, often restoring cuts made during the economic downturn.

All three study states experienced savings in behavioral health programs. Behavioral health programs across the country saw substantial state funding cuts during the economic downturn; many remain underfunded.[11] States that have implemented the Medicaid expansion may use the federal dollars from the Medicaid expansion either to substitute for state funds spent on mental health services, help restore funding cuts implemented during the economic downturn, or reduce general fund spending (e.g. "book" savings.) Connecticut and Washington State "booked" these savings for their general funds, while New Mexico reprogrammed the majority of savings within the behavioral health agency's budget.

While the study states noted savings and efficiencies in their behavioral health programs due to the expansion, there were some challenges and delays in transitioning behavioral health care providers to billing for their clients' claims (rather than relying on grant funding) and enrolling beneficiaries of behavioral health programs (a generally hard-to-reach population) into Medicaid. These challenges necessitated adjustments to original budget assumptions, but state officials were confident both that expansion was already yielding savings and that the magnitude of savings would likely grow as these transitions progressed.[12] General Fund savings were also found for Kentucky as Medicaid beneficiaries – those newly eligible as well as those previously enrolled – received mental health treatment and substance use disorder services through community mental health centers reimbursed with Medicaid funds instead of general fund dollars.[13] Coinciding with the Medicaid expansion, the Commonwealth of Kentucky had expanded the types of behavioral health providers that were eligible for Medicaid reimbursement, both for the traditional Medicaid program as well as for the Medicaid expansion, increasing access to such services.[14]

Two of the study states also experienced budget savings or offsets for corrections. Many inmates historically could not qualify for Medicaid since they did not fit into one of the traditional eligibility categories. Even for inmates who did meet the income and categorical eligibility requirements to qualify for Medicaid, federal law prohibits Medicaid payment for services provided in jails or prisons under a policy known as the "inmate exclusion."[15] However, Medicaid reimbursement is available for care provided to eligible individuals who are admitted to an inpatient facility off jail or prison grounds, such as a hospital, for at least 24 hours. Prior to the ACA, few states had pursued Medicaid reimbursement for these services given the limited share of the incarcerated population that could qualify for Medicaid.[16] However, the Medicaid expansion offers greater potential savings to states from reimbursement for inpatient services provided to incarcerated individuals, since a larger share of the incarcerated population may qualify for Medicaid under the Medicaid expansion and the federal government is providing states an enhanced federal matching rate for newly eligible adults.[17]

Washington State included limited state budget savings in its enacted corrections budget for SFYs 2014 and 2015. Connecticut officials noted that while they hadn't quantified savings from the Medicaid expansion, the state's Department of Correction had been able to weather notable budget reductions in their inmate medical account since the state implemented the early expansion in 2010. New Mexico's Medicaid program was working to realize savings in this area, but officials also noted that many corrections responsibilities are vested locally.[18] General Fund savings from the Medicaid expansion in the state's corrections department were also noted in a separate report commissioned by Kentucky.[19]

Some study states also reported savings in other areas, including uncompensated care payments and high risk pools. In addition to federal funding for uncompensated care costs through Medicare and Medicaid Disproportionate Share Hospital (DSH) programs, states and localities generally fund roughly 40 percent of uncompensated care costs.[20] When the previously uninsured gain coverage that pays for their care, previously uncompensated costs decline. Among our three study states, only Connecticut had a state-level uncompensated care program in place before the ACA; Washington state did not have an uncompensated care pool and counties bear much of the responsibility for financing hospital uncompensated care in New Mexico. When it converted its pre-ACA state indigent care program into an early Medicaid expansion, Connecticut was able to significantly reduce their uncompensated care payments to hospitals as well as make some reductions in uncompensated care for community health and mental health centers. Reductions in state and local expenditures for uncompensated care were also noted through SFY 2016 in a separate report examining the expansion's impacts on Kentucky; this same report also noted general fund savings in later years from the scheduled reductions in DSH funds.[21] Early evidence from that state's expansion also saw declines in uncompensated care charges as well as increased revenues for providers.[22]

Case study states noted additional areas of moderate or limited budget savings outside of Medicaid. For example, New Mexico, which was the only study state that operated a state-funded high-risk pool, saw moderate savings as enrollees transitioned to other coverage options. Like the movement of behavioral health program beneficiaries into Medicaid, this transition moved more slowly than expected, resulting in fewer short-term savings than originally projected. Connecticut and Washington also reported savings from state-funded public health programs; similar savings were also found in Kentucky as services provided through local health departments to Medicaid enrollees were now reimbursed by Medicaid.[23] Washington reported savings from a state-funded program that provided long-term services for adults with developmental disabilities.

Revenue Effects

The impact on state revenue, as monitored by budget officials, was primarily reflected in increased provider and premium taxes and fees. Washington and New Mexico projected increased revenue from provider taxes and fees as a result of expansion in their budgets. Both states have premium taxes on insurers; revenues collected from these taxes and fees increased as more Medicaid members joined managed care plans and more Medicaid patients saw providers. Connecticut experienced no increase in revenues as a result of expansion. The state's Medicaid enrollment has grown substantially as a result of the expansion and hospital revenues increased as care shifted from uncompensated to Medicaid-reimbursed. While Connecticut has Medicaid provider taxes and fees, they have not been rebased since 2009 and therefore have not increased due to Medicaid expansion. Further, as a state with very high rates of health insurance

coverage prior to the expansion, insurance company premium taxes have not appreciably increased following expansion. As a final complicating factor, a state program that allows for the purchase of tax credits to reduce tax liability has been utilized by some providers subject to the Medicaid provider tax, and this has resulted in a reduction in revenue from this source.

Expansion is expected to increase overall economic activity,[24] and thus state general revenue, due to the significant influx of federal Medicaid dollars used to purchase health care within such states. However, only one study state (New Mexico) specifically noted this effect in its overall economic and revenue projections for the first years of implementation. The other states' economic forecasts did not include such detail in their underlying assumptions at this point. It will be difficult to isolate the expansion's effects on work force and economic growth until more detailed data become available. However, a separate analysis conducted by the Urban Studies Institute at the University of Louisville estimated that the Medicaid expansion in Kentucky led to an increase of 12,000 jobs in SFY 2014 alone and over 40,000 additional jobs through 2021. The analysis estimates that this increase in jobs will result in additional tax revenue for the state an localities through SFY 2021.[25]

Conclusion

Disentangling the fiscal impact of expanded Medicaid eligibility from other ACA effects as well as other factors shaping health care costs can be a tremendous challenge. Policy and budget decisions are not made in a vacuum; isolating the budgetary effects of one policy decision from other policy decisions as well as from larger demographic and economic trends is inherently difficult. In this particular case, other changes resulting from the ACA, such as requirements that all states implement new policies to streamline and simplify Medicaid enrollment, the individual coverage requirement, and new coverage options available through the Marketplace make isolating the effects of the Medicaid expansion particularly difficult.

State budget offices are not set up to estimate the net budget impact of a single policy, such as the Medicaid expansion. Such offices, unlike the Congressional Budget Office, do not typically maintain alternative budget scenarios that estimate costs and revenues in the absence of a particular policy (such as the Medicaid expansion.) They rarely have good reason to spend resources analyzing the effects of past decisions, like expansion. Moreover, the fiscal effects of the Medicaid expansion are hard to analyze comprehensively because they are experienced across budget categories; cost implications fall within and outside Medicaid, and both general and special revenue sources can be affected. Among the three states examined, only Washington was in a position to assess the overall budgetary impact of expansion; at the time of our interviews, the state was in the final months of maintaining an alternative budget scenario that estimated state costs in the absence of Medicaid expansion. Based on that scenario, state savings from higher federal matching rates for newly eligible enrollees and from reduced spending on some (but not all) pre-ACA, state-funded programs could be analyzed. Without taking into account any revenue gains resulting from expansion, those savings exceeded increased state costs attributable to expansion in both SFY 2014 and 2015 (Appendix C); in fact, the state noted net Medicaid budget savings for each budget period throughout the 2013-2021, including the period during which the FMAP for low-income adults reaches its final 90 percent level. During SFY 2015, the net savings from expansion was projected to equal 1.7 percent of the state's entire General Fund for SFY 2013.[26] Kentucky commissioned Deloitte to examine the fiscal and economic impact of the Medicaid expansion decision on Kentucky; this independent analysis, which examined the impact of the expansion across the state's budget and

at the broader economic effects among other factors, estimates Kentucky will see a net positive fiscal impact of $919.1 million over the SFY 2014 through 2021 period compared to what the state would have spent in the absence of the Medicaid expansion.[27]

Early evidence from these case study states shows that expansion yields state savings and state revenues while causing limited increases in state costs. Both newly eligible consumers and those who qualified under pre-ACA categories can be expected to enroll in large numbers, although much of the latter enrollment will occur with or without expansion. States can experience notable savings both within Medicaid and outside Medicaid budgets, though savings in parts of the budget outside of Medicaid may be slower to materialize than anticipated, and policymakers may choose to reinvest savings to increase the provision of non-Medicaid services rather than reduce General Fund commitments. Two of the study states projected increased revenue from provider taxes and fees; states are expected to also realize revenue gains from increased economic activity as evidenced by the findings of the expansion's impact on Kentucky. In sum, our analysis of early experiences in three states suggests that expansion creates both state budget savings and some limited initial costs for states in these early years of the expansion, when the cost of the newly eligible is fully financed with federal dollars.

This brief provides insight into the early experiences in only three states along with findings from a separate study commissioned by Kentucky. Each state and its budget are unique. The findings of this brief are likely to illustrate important general trends, but ultimately the effect of Medicaid expansion on state budgets must be assessed in terms of the particular circumstances of each state. In states that have already chosen to expand eligibility, the implications of that decision on state budgets and revenues will continue to be monitored as implementation continues and more data become available.

This brief was prepared by Stan Dorn and Norton Francis of the Urban Institute and Robin Rudowitz and Laura Snyder from the Kaiser Family Foundation.

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Methods

This study analyzes the state budgetary effects that have been identified thus far in three geographically diverse states that began implementing the full expansion on January 1, 2014: Connecticut, New Mexico, and Washington State. Researchers from the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute interviewed state budget staff and officials and reviewed state budget documents during August through November, 2014, before the start of the 2015 open enrollment period. These interviews were based on semi-structured protocols, and key topic areas were shared in advance with state officials.

The interviews took place as executive-branch officials had begun preparing executive budget proposals for forthcoming legislative sessions. Of the three states included in this study, two (Connecticut and Washington state) operate on a biennial budget cycle while New Mexico operates on an annual budget cycle. All three states were in the process of developing new budgets for the next budget window, which would cover SFY 2016 as well as SFY 2017 in Connecticut and Washington. All three study states adopted the Medicaid expansion as of January 1, 2014, halfway through their SFY 2014 budgets. Because of the timing of this study, states were asked about the budget effects for SFY 2014 and SFY 2015. While SFY 2014 had ended, states were still finalizing actual figures for SFY 2014. Therefore, state officials were basing responses off of what was included in SFY 2014 and SFY 2015 budgets as enacted; for SFY 2014, officials commented where they could on what had been observed (e.g. if savings originally included in budgets were in line with original assumptions.)

Washington State was able to provide cost and savings estimates for a number areas affected by the state's decision to implement the Medicaid expansion due to the fact the state has maintained an alternative budget scenario that estimated state costs in the absence of Medicaid expansion, a process the state is expected to stop in the near future. Budget officials in Connecticut and New Mexico reported cost and savings estimates where possible, but all states reported more broadly about the scope of changes that had been considered to date. Each of these states reviewed the findings; their feedback has been incorporated.

Additional findings of the expansion's impact on Kentucky published in a separate report commissioned by that state have also been included.

This study focused primarily on budget factors that may apply elsewhere, but one should be careful in generalizing, as each state's budget situation is unique.

APPENDIX A: COVERAGE INITIATIVES PRIOR TO THE ACA

Prior to the ACA, coverage for adults was limited. Parent eligibility in many states was below the poverty level. Adults without dependent children were ineligible for Medicaid regardless of their income; states could only cover adults without dependent children through waivers. As of January 2013, nine states provided coverage for low-income adults comparable to full Medicaid benefits; an additional 16 states provided such adults with limited benefit coverage under Medicaid.[28] Provided below is a summary of coverage initiatives the case study states had in place prior to the Medicaid expansion; individuals in each of these programs were transitioned to the new coverage group and eligible for full federal financing under the Medicaid expansion.

Connecticut: Prior to the ACA, Connecticut provided medical assistance under the State Administered General Assistance (SAGA) program, which is state-funded.[29] Under provisions in the ACA, states were given the option to implement the Medicaid expansion ahead of January 1, 2014 at the state's regular matching rate. Connecticut was the first state to take up this option, implementing a state plan amendment to cover non-elderly, non-disabled adults up to 56 percent FPL without an asset test (there was a $1000 asset test under the SAGA program.) The state experienced significantly higher enrollment than expected. Even though the federal government was paying half of the cost, the state's 50 percent share of expenditures for the new, low-income adult program exceeded the cost for medical assistance under the original SAGA program as enrollment grew substantially above projections. In January 2014, the state implemented the full Medicaid expansion, increasing income eligibility up to 138 percent FPL; the federal share for these expenditures increased to 100 percent.[30]

New Mexico: New Mexico implemented its 1115 waiver to cover uninsured adults up to 200 percent FPL in 2002 under the State Coverage Initiative. The coverage provided was more limited than Medicaid, cost-sharing and premiums were above Medicaid-allowable levels, and enrollment into the program was closed in 2008 due to budget constraints. The waiver program, originally approved as a HIFA waiver, was first financed with CHIP funding and then converted to Medicaid funding. In January 2014, the state ended the SCI program, transitioning two-thirds of those served by the program to the new Medicaid expansion group, under which the federal match increased from approximately 75 percent to 100 percent. The other one-third of SCI enrollees had incomes above 138 percent FPL and qualified for subsidies to purchase coverage in the Marketplace.

Washington: Washington had for decades provided coverage for low-income uninsured adults through its Basic Health Program, which was funded with state-only dollars. During the economic downturn, the state faced notable budget shortfalls. After the ACA was passed, Washington was able to obtain federal matching funds under a Section 1115 waiver program to act as a bridge to the Medicaid expansion. This conversion to a Medicaid waiver allowed the state to collect federal dollars at the state's regular matching rate for the program (as well as the Disability Lifeline program and the Alcohol and Drug Abuse Treatment and Support Act or ADATSA program, both of which were also previously state-funded.) In January 2014, the state transitioned these adults to the Medicaid expansion group, where the federal match increased from 50 to 100 percent.

Appendix B: Optional Medicaid Eligibility Pathways

Prior to the ACA, some states had adopted Medicaid eligibility pathways that provided limited coverage (meaning that the coverage provided limited benefits or the coverage offered full Medicaid benefits but limited eligibility to those that either had a specific condition or those that met spend-down requirements.) The availability of subsidized Marketplace coverage and expanded Medicaid coverage (in 28 states) provides new options for states to reconsider some of these coverage options, such as:

- **Family Planning.** Family planning waivers and state plan amendments allow for states to provide limited Medicaid coverage to US citizens otherwise ineligible for Medicaid (largely adults.) Coverage is limited to family planning services only and is reimbursed at 90 percent federal match. Washington State had an existing family planning waivers; Connecticut and New Mexico had previously adopted the family planning state plan option. None of the case study states had elected to eliminate this coverage, though across the country, eight states reported plans to end family-planning only coverage.[31]
- **Breast and Cervical Cancer Treatment (BCCT).** In 2000, Congress gave states the option to extend Medicaid coverage to low-income uninsured or underinsured women under age 65 that had been screened and diagnosed with breast and cervical cancer through state screening programs funded by the CDC. All states had adopted this option; coverage for these individuals is reimbursed at the state's CHIP matching rate. None of the case study states had elected to eliminate this coverage, though across the country, three states reported plans to end BCCT coverage.[32]
- **Medically Needy Spend-Down.** Another optional Medicaid eligibility pathway that some states considered eliminating in light of new coverage options was medically-needy spend-down programs for adults. Under this coverage group, people can qualify for Medicaid by incurring medical bills that "spend down" their income to lower levels. None of the case study states had elected to eliminate this coverage, though across the country, five states reported plans to reduce or end medically needy spend-down coverage for adults.[33]

APPENDIX C: WASHINGTON STATE BUDGET IMPACTS OF THE MEDICAID EXPANSION

The figures included below were provided by Washington State budget officials and reflect estimates used when the state enacted its FY 2013-2015 state budget. These figures were derived from an alternative budget scenario that estimates the state costs in the absence of the Medicaid expansion maintained by state officials. States often do not maintain alternative budget scenarios of what would have happened had the state not implemented a specific policy over time; Washington state officials noted that they do not plan to continue this process going forward.

Washington State Budget Effects of Medicaid Expansion, SFYs 2014 and 2015		
Budget Areas	SFY 2014	SFY 2015
Increased Enrollment among those previously eligible but not enrolled*	$22.8 million	$59.9 million
State Administrative Costs*	$4.0 million	$3.5 million
State Administrative Savings*	-$0.3 million	-$1.6 million
Savings within Medicaid from pre-ACA eligibility transitions:		
1115 Waiver Transition	-$34.0 million	-$69.1 million
Medically Needy Spend-Down Adults	-$11.5 million	-$35.0 million
Breast and Cervical Cancer Program	-$0.7 million	-$3.6 million
Family Planning	-$0.5 million	-$1.0 million
Presumptive SSI***	-$38.1 million	-$109.8 million
Savings outside of Medicaid:		
Mental Health and Substance Abuse	-$13.4 million	-$51.2 million
Inpatient Care for Prisoners	-$0.7 million	-$1.4 million
Public Health Services	-$2.6 million	-$5.8 million
Other health care programs for vulnerable populations**	-$4.0 million	-$9.7 million
Increased Revenues:		
Premium tax revenue *		$33.9 million
Fiscal Benefit (Net Savings and New Revenues):	$79.0 million	$258.7 million
Total State General Fund Spending in SFY 2013	$15.5 billion	$15.5 billion
Fiscal Benefit from Medicaid Expansion as a Share of Total State General Fund Spending in SFY 2013	0.5%	1.7%

NOTES: *The cost and savings figures included here reflect the total impact of the ACA and are not isolated to the Medicaid expansion.**This included savings for programs related to long term care, developmental disability and labor and industries programs outside of Medicaid. ***Washington State also noted savings from the transition of adults who were previously eligible for their presumptive SSI category. This is an optional Medicaid eligibility category that provides Medicaid coverage while adults await a disability determination for SSI coverage. It is unclear how many states offer Medicaid coverage for such individuals. While expenses for those that qualified under this pre-ACA eligibility pathway were not reimbursed at the 100 percent federal match rate, the state did receive a higher matching rate for these individuals (equivalent to the early adopter matching rates.)

SOURCE: Based on estimates from the state's Forecast Model as well as from the 2013-2015 budget as originally enacted by the legislature in Washington State and discussions with Washington state budget officials. Figures may differ from more recent updates to budget analyses. The calculations of savings compared to SFY General Fund Spending are those of the authors based on savings figures provided by state officials compared to the state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in their State Expenditure Report: Examining Fiscal 2012-2014.

Appendix D: Estimates from Separate Report Commissioned by Kentucky

In February 2015, Kentucky released a report it had commissioned Deloitte to conduct and analysis of the impact of the first-year impact of the Medicaid expansion on Kentucky and to estimate the potential future impact. Using data from a number of sources, including the data from the Centers for Medicare & Medicaid Services (CMS), the Kentucky Cabinet for Health and Family Services (the state Medicaid agency), Aon Consulting (the state's Medicaid actuary), and the Urban Studies Institute at the University of Louisville, the study provided point-in-time analysis of the impact across multiple areas – including the impact on Medicaid enrollment, the state's uninsured rate, the state's economy, it's budget, the overall health care system and providers, and access to care for state residents. In terms of the effect on the state's budget and economy, the study estimated that the Medicaid expansion will have a significant positive cumulative impact of $30.1 billion on Kentucky's economy through SFY 2021; the net difference between expanding and not expanding Medicaid is estimated to be a positive $919.1 million from SFY 2014 through SFY 2021. The data below reflect the estimates for SFY 2014 and SFY 2015 and puts the fiscal effect in context of total state general fund spending.

Kentucky State Budget Effects of Medicaid Expansion, SFYs 2014 and 2015		
Budget Areas	SFY 2014	SFY 2015
Increased Enrollment among those previously eligible but not enrolled*	$15.7 million	$41.4 million
Additional benefits provided to those not in the expansion group**	$4.2 million	$9.6 million
State Administrative Costs*	-	-
Savings within Medicaid from pre-ACA eligibility transitions:		
Medically Needy Spend-Down Adults	-$2.4 million	-$14.0 million
Breast and Cervical Cancer Program	-$0.4 million	-$1.3 million
Kentucky Transitional Medical Assistance Program (K-TAP)	-$1.9 million	-$9.0 million
Nursing Facility (Adult Medicaid)***	-$1.7 million	-$7.9 million
Savings outside of Medicaid:		
Department of Behavioral Health, Developmental and Intellectual Disabilities	-$9.0 million	-$21.0 million
Department of Corrections	-$5.4 million	-$11.0 million
Department of Public Health	-$4.0 million	-$6.0 million
Uncompensated Care Contributions (QCCT Contributions)	-	-$13.8 million
Private Insurance for Foster Care Children****	-$1.0 million	-$1.1 million
Increased Revenues:		
State Income Taxes	$19.3 million	$56.3 million
State Sales Taxes	$18.1 million	$52.9 million
Fiscal Benefit (Net Savings and New Revenues):	$43.3 million	$143.3 million
Total State General Fund Spending in SFY 2013	$9.4 billion	$9.4 billion
Fiscal Benefit from Medicaid Expansion as a Share of Total State General Fund Spending in SFY 2013	0.5%	1.5%

NOTES: *The cost and savings figures included here reflect the total impact of the ACA and are not isolated to the Medicaid expansion. ** Kentucky elected to expand access to these substance use services to all of their Medicaid population, not just the newly eligible. The study commissioned by Kentucky noted that there would be increased general fund requirements for providing these additional substance abuse benefits to those previously eligible as well as those already enrolled in Medicaid. ***The study also noted savings from the transition of adults with disabilities from their Nursing Facility Medicaid group; according to the study, these are disabled adults that meet an administrative disability with assets below $2000. ****Kentucky previously provided health care coverage with state-only dollars to former foster care children up through age 25; this is a group now covered under Medicaid. In addition to the effects listed in the above table, the study also notes increased tax revenue for local occupational and payroll taxes.

SOURCE: *Report on Medicaid Expansion in 2014*. (Deloitte commissioned by Kentucky, February 2015.) http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf. The calculations of savings compared to SFY General Fund Spending are those of the authors based on savings figures provided by state officials compared to the state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in their State Expenditure Report: Examining Fiscal 2012-2014.

ENDNOTES

[1] Researchers found fiscal estimates of the Medicaid expansion in 16 states that were deemed "comprehensive" because they estimated increased state costs resulting from higher enrollment, state budget savings both inside and outside Medicaid programs, and state revenue effects. Stan Dorn, Megan McGrath, John Holahan. What Is the Result of States Not Expanding Medicaid? Urban Institute, August 2014. http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid.pdf.

[2] The calculations are those of the authors based on (1) savings figures provided by state officials (2) compared to state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in its State Expenditure Report: Examining Fiscal 2012-2014.

[3] New Mexico noted that the state costs for enrollment among those previously eligible but not enrolled were significant. However, as noted earlier, the enrollment growth among those previously eligible but not enrolled was primarily driven by other ACA changes, such as the streamlining and simplifying of Medicaid enrollment processes that occurred in all states, regardless of expansion decisions, as well as broader outreach efforts.

[4] *Report on Medicaid Expansion in 2014.* (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.) http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[5] Urban Institute estimates based on data from CMS (Form 64) (as of 9/16/13).

[6] The 90 percent FMAP for initial eligibility-related IT investments was initially set to expire at the end of 2015, but in October 2014, CMS announced plans to extend the higher federal match permanently.

[7] In addition to the areas of savings within Medicaid budgets mentioned in this section, states were asked about savings-related declines in applications for disability-based cash assistance and well as savings from health care services provided to adults with disabilities under 138 percent FPL during the months while they are waiting for their disability determinations. No states in this study tracked such savings.

[8] Washington State also noted savings from the transition of adults who were previously eligible for their presumptive SSI category. This is an optional Medicaid eligibility category that provides Medicaid coverage while adults await a disability determination for SSI coverage. It is unclear how many states offer Medicaid coverage for such individuals, although once a disability determination is obtained that qualifies an applicant for Medicaid, all states are legally required to retroactively pay all Medicaid-covered claims that were incurred up to 90 days before the date of application. While expenses for those who qualified under this pre-ACA eligibility pathway in Washington state were not reimbursed at the 100 percent federal match rate, the state did receive a higher matching rate for these individuals (equivalent to the early adopter matching rates.) As a general matter, CMS has ruled that, in a state that implements the Medicaid expansion, adults who qualify based on income generate federal matching rates at the level paid for newly eligible adults for claims incurred until the point of disability determination, after which normal FMAP applies. 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.

[9] Additionally, the report commissioned by the Commonwealth of Kentucky reported savings from beneficiaries qualifying for the newly eligible group instead of the Kentucky Temporary Assistance Program (K-TAP)and for a program referred to in that state as "nursing facility," which provided coverage to disabled adults in select circumstances. *Report on Medicaid Expansion in 2014.* (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.) http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[10] In addition to the areas of savings outside of Medicaid budgets listed in the text, states were asked about savings from reduced health insurance costs for public employees and retirees. While no state included in this study tracked such savings, some state-level projections estimated that, along with other employers, states would see premium increases decline slightly when reductions in hospital uncompensated care, caused by lower levels of uninsurance resulting from Medicaid expansion, reduce hospital cost-shifting to private insurers. The Oregon Health Authority, Estimated Financial Effects of Expanding Oregon's Medicaid Program Under the Affordable Care Act (2014–2020), February 2013, http://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/OR_Effect%20of%20ACA%20Medicaid%20Expansion_Feb2013_Final.pdf.

[11] *State Mental Health Legislation 2014 - Trends, Themes & Effective Practices*. National Alliance on Mental Illness, December 2014. http://www.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=172851

[12] Additionally, officials in Connecticut believed that the majority of the chronically mentally ill were picked up under the state's early expansion in April 2010, which included adults with income up to 56% FPL; the increase to 138% FPL in January 2014 therefore did not have a dramatic impact.

[13] *Report on Medicaid Expansion in 2014.* (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.) http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[14] Vernon Smith, et al. *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015.* (Kaiser Family Foundation, October 2014.) http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/.

Kentucky elected to expand access to these substance use services to all of their Medicaid population, not just the newly eligible. The study commissioned by the Commonwealth of Kentucky noted that there would be increased general fund requirements for providing these additional substance abuse benefits to those previously eligible as well as those already enrolled in Medicaid.

[15] Federal Medicaid law (Subparagraph (A) in the matter after section 1905(a)(29) of the Social Security Act) prohibits the payment of federal Medicaid matching funds for the cost of any services provided to an "inmate of a public institution," except when the individual is a "patient in a medical institution." This policy applies to both adults in jails or prisons as well as to youths involuntarily detained in a state or local juvenile facility. This policy does not prohibit individuals from being enrolled in Medicaid while incarcerated; however, even if they are enrolled, Medicaid will not cover the cost of their care, except for care received as an inpatient in a hospital or other medical institution. Because individuals may remain enrolled, states can suspend, rather than terminate, Medicaid coverage for inmates to accommodate the inmate exclusion. However, suspension and termination policies vary across states.

[16] *Managing Prison Health Care Spending,* (Washington DC: Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, October 2013),
http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf .

[17] *Managing Prison Health Care Spending,* (Washington DC: Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, October 2013),
http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf .

[18] Some state officials also noted that tracking state savings in this area can require costly reprogramming of Medicaid eligibility systems.

[19] *Report on Medicaid Expansion in 2014.* (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.)
http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[20] Teresa A. Coughlin, John Holahan, Kyle Caswell, and Megan McGrath. *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*. (Washington, DC: Urban Institute, May 2014.) http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/.

[21] *Report on Medicaid Expansion in 2014.* (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.)
http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[22] Ibid.

[23] Ibid.

[24] Council of Economic Advisers. Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid. July 2014, http://www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid.pdf.

[25] *Report on Medicaid Expansion in 2014.* (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.)
http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[26] The calculations are those of the authors based on (1) savings figures provided by state officials as (2) compared to state general fund spending across all budget categories for SFY 2013 as reported by the National Association of State Budget Officers in its *State Expenditure Report: Examining Fiscal 2012-2014.*

[27] *Report on Medicaid Expansion in 2014.* (Deloitte commissioned by the Commonwealth of Kentucky, February 2015.)
http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[28] Martha Heberlein, Tricia Brooks, Joan Alker, Samantha Artiga and Jessica Stephens. *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013.* (Kaiser Commission on Medicaid and the Uninsured, January 2013.) http://kff.org/medicaid/report/getting-into-gear-for-2014-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-2012-2013/.

[29] Connecticut's SAGA program included both cash and medical assistance; the cash assistance component remains.

[30] After projecting a $300 million surplus for FY 2015 twice, the state's Comptroller projected a $31 million deficit due in part to a shortfall in the Medicaid program resulting from federal reimbursement issues and hospital settlement payments that were above projections. http://www.osc.ct.gov/public/news/releases/20150102.html. The state has been working with CMS to finalize the methodology for obtaining the enhanced match.

[31] New Mexico had originally reported plans to eliminate its family planning program, but did not ultimately do so. Virginia also reduced eligibility for this group to 100 percent FPL in 2014 but plans to restore coverage to 200 percent FPL in 2015. Vern Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder. *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015.* (Washington, DC: Kaiser Commission on Medicaid and

the Uninsured,) October 2014. http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/.

[32] Vern Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder. *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) October 2014. http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/.

[33] Ibid.