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Top Five Myths and Facts about the Cost of the ACA's Adult Medicaid Expansion

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The Affordable Care Act (ACA) requires states to expand their Medicaid programs to cover non-disabled, non-pregnant adults under age 65 with incomes below 138% of the federal poverty level (FPL). However, the Supreme Court held that the federal government cannot force states to implement the expansion using the threat to terminate the federal funds going to the existing Medicaid program, in effect allowing states to opt out of the Medicaid expansion.[1] Currently, about 52.6 million people are enrolled in Medicaid, and about 17 million more would receive coverage if all states adopt the Medicaid expansion – a 32% increase.[2]

As state officials consider whether to implement the expansion, one key factor remains the cost. Many states are conducting fiscal analyses to assess the costs and savings from the Medicaid expansion, often contracting with outside consultants like Milliman and The Lewin Group.

NHeLP has reviewed more than a dozen state fiscal analyses, most of which are posted in our Medicaid Expansion Toolbox. Some of these reports greatly exaggerate the cost of the Medicaid expansion. For a more information on how to evaluate these analyses, please see NHeLP's *Resource Guide for Evaluating Fiscal Analyses of Medicaid Expansion* (Jan. 2013).

The following are some of the most common myths about the costs of the Medicaid expansion, along with some suggested counter-points:

Myth 1 – *Medicaid is already taking up a huge percentage of state budgets and the Medicaid expansion will only increase it.*

> **Fact – When stating its Medicaid budget, the state must acknowledge the generous federal matching funds it receives and that the federal government will pay for nearly all the costs of the expansion.**

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[1] *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012).
[2] *See* Henry J. Kaiser Family Foundation, *Medicaid Enrollment: June 2011 Data Snapshot* (June 2012), available at http://www.kff.org/medicaid/upload/8050-05.pdf; Congressional Budget Office, *Analysis of the Major Health Care Legislation Enacted in March 2010* (Mar. 30, 2011), available at http://www.cbo.gov/publication/22077.

Often, states report the total amount spent on Medicaid as a dollar figure or percentage of the state's budget.[3] This is misleading if, as many states do, it includes both the federal and state contributions to Medicaid. States only pay 26-50% of the costs of Medicaid; the federal match for state Medicaid expenditures ranges from 50% to as high as 74.18%.[4] Moreover, under the ACA, the federal government will provide 100% funding for the Medicaid expansion from 2014-2016, gradually lowering to 90% thereafter.

For purposes of the Medicaid expansion, the accurate estimate is the annual state contribution to the Medicaid expansion using state-appropriated dollars. This can be expressed as a dollar amount. However, showing the expenditure as a percentage of the overall state budget can better provide context and proportionality. Reasonable analyses estimate an average increase of 1.1% to 2.8% in a state's share of Medicaid spending due to the expansion through 2019.[5]

Myth 2 – The *Medicaid expansion will grow the program too big, too fast.*

> **Fact – While enrollment stands to increase significantly as a result of Medicaid expansion, it is unrealistic to assume 100% participation and it is inaccurate to include ineligible populations. These actions artificially inflate the projected cost.**

Some reports project the number of newly eligible beneficiaries based on the total number of adults living below 138% FPL.[6] These estimates fail to exclude those who are currently enrolled under an existing eligibility category, those who are currently eligible but not enrolled, and those who have already have insurance or are otherwise ineligible. None of these individuals should be included in the costs of the adult Medicaid expansion.

The so-called "woodwork" or "welcome-mat" effect, whereby currently eligible individuals will enroll in Medicaid due to publicity around health reform implementation, will occur whether or not a state implements the Medicaid expansion. In addition, some fiscal analyses include the cost of extending Medicaid to children between ages 6-19 who live below 138% FPL, as well as individuals aging out of foster care. However, these populations are not part of the adult Medicaid expansion. States must expand

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[3] Hon. Robert F. McDonnell, Governor of the Commonwealth of Virginia, Remarks to the Joint Meeting of the Senate Finance, House Appropriations and House Finance Committees (Dec. 17, 2012), at 7, available at http://www.governor.virginia.gov/utility/docs/Dec12JMC.pdf.

[4] *See* http://aspe.hhs.gov/health/fmap.htm.The statutory maximum for FMAP is 83%.

[5] January Angeles, Center for Budget and Policy Priorities, *How Health Reform's Medicaid Expansion Will Impact State Budgets*, (July 2012) available at http://www.cbpp.org/cms/?fa=view&id=3801.

[6] *See* Milliman, *South Carolina Dept. of Health and Human Services, Affordable Care Act – Financial Impact SFY 2014 Through SFY 2020* (April 2006) at 5, available at http://www.scstatehouse.gov/CommitteeInfo/Ways&MeansHealthcareBudgetSubcommittee/July272012/ACA%20-%20Financial%20Impact%20SFY2014_2020%20v%206.pdf.

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Medicaid to these populations regardless of whether they implement the adult expansion.

Further, many of the analyses that find huge costs in Medicaid expansion assume a 100% participation rate beginning on day one of implementation.[7] More accurate participation rates begin at around 25-50% in the first year and gradually increase over time (but never reach 100%). Analyses should also base enrollment trends on long-term historic data and not on the upsurge in Medicaid enrollment during the historic 2008-2010 recession. (Medicaid is known as a counter-cyclical program meaning that enrollment goes up with economic downturns.)

Myth 3 – *We cannot afford expansion because previously uninsured adults will have expensive health needs.*

> **Fact – Newly eligible adults will have lower health care costs than most current Medicaid enrollees.**

Some fiscal analyses estimate high per-member, per-year (PMPY) costs for expansion adults without explaining the basis for their assumptions.[8] Other studies factor in the costs for individuals who are currently eligible but not enrolled, which may include high-utilization populations such as people with disabilities.[9] Data from states that adopted the Medicaid expansion early suggest that the costs for newly eligible adults will be closer to those for currently enrolled parents, which are significantly lower than those for other adult Medicaid populations.[10] CMS' Office of the Actuary projects expansion adults to cost 40% less than currently eligible adults – also in line with costs for Medicaid children.[11]

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[7] *See* Milliman, *Indiana Family and Social Services Administration, Affordable Care Act - Medicaid Financial Impact Analysis Update* (Sept. 18, 2012), available at http://www.in.gov/aca/files/ACA_Fiscal_Impact_Update_9.2012.pdf.

[8] Bob Neal, Ph.D., *The Fiscal and Economic Impacts of Medicaid Expansion in Mississippi, 2014-2025,* University Research Center Mississippi Institutions of Higher Learning State Economist (Oct. 2012) at 9, available at http://www.mississippi.edu/urc/downloads/medicaid-oct-16.pdf.

[9] *See* Milliman, *Ohio Department of Job and Family Services, Patient Protection and Affordable Care Act (ACA) Fiscal Estimates for Ohio Medicaid SFY 2014 to SFY 2019* (June 30, 2011) at 12, available at http://www.statereforum.org/sites/default/files/ohio_fiscal_analysis_-_2014_to_2019_medicaid_expenditures_v2_1.pdf.

[10] Stephen A. Somers, et al., Center for Health Care Strategies, Inc., *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States* (Aug. 2010) available at http://www.chcs.org/usr_doc/Medicaid_Expansion_Brief.pdf.

[11] Office of the Actuary, Centers for Medicare & Medicaid Services, U.S. Dept. of Health & Human Services, *2011 Actuarial Report on the Financial Outlook for Medicaid* (Mar. 2012) at 26, available at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2011.pdf.

Policy experts agree that some previously uninsured adults will have "pent up demand" for health care, resulting in higher costs at the onset. However, the federal government will cover 100% of the costs from 2014-2016. Also, states with higher take-up rates will experience lower PMPY costs because it means they will be enrolling the healthiest individuals who will have fewer expenditures (and are otherwise least likely to enroll).

Myth 4 – *The Medicaid expansion will drain the state treasury.*

> **Fact – States implementing the expansion will realize substantial budget savings because they will receive the enhanced federal Medicaid reimbursement for many services currently paid for using state dollars. These savings will, in some cases, exceed the state's share of adult expansion costs.**

Some fiscal analyses omit budget savings and offsets that will result from using federal Medicaid dollars to pay for services currently paid by states, counties, and municipalities. State and local dollars often fund health care programs and uncompensated care for low-income, uninsured individuals who do not qualify for Medicaid. The vast majority of these individuals would shift to Medicaid if a state expands, with the federal government paying 100% of the costs from 2014-2016 for newly eligible individuals.

Other areas of state budget savings and revenue opportunities include: mental and behavioral health services, substance abuse treatment, certain services for homeless individuals, inpatient health care for inmates in public institutions, and individuals incarcerated pending disposition of charges, provider taxes, income taxes, and enhanced economic activity.

Myth 5 – *It's a waste of money to put more people into a broken Medicaid program.*

> **Fact – Medicaid is a highly successful program and implementing the expansion will save lives.**

Some politicians claim that Medicaid does a poor job serving the health care needs of low income residents. In reality, Medicaid is a success story, serving as a lifeline for millions of low income men, women and children.[12] A recent study published in the *New England Journal of Medicine* concludes that in states that have already expanded Medicaid, mortality rates declined significantly compared to states that did not expand Medicaid.[13]

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[12] Leighton Ku and Christine Ferguson, Dept. of Health Policy School of Public Health and Health Services, George Washington University, *Medicaid Works: A Review of How Public Insurance Protects the Health and Finances of Children and Other Vulnerable Populations* (June 2011) available at http://www.firstfocus.net/sites/default/files/MedicaidWorks.pdf.

[13] Benjamin D. Sommers, M.D., Ph.D., Katherine Baicker, Ph.D., and Arnold M. Epstein, M.D., *Mortality and Access to Care among Adults after State Medicaid Expansions*, N. ENGL. J. MED.,

Some fiscal analyses predict that provider rates will rise substantially to meet the demands of expanded enrollment and encourage more providers to participate. Provider rates and network adequacy are ongoing issues in Medicaid, but assumptions that rates will need to be drastically boosted are speculative. Further, the ACA contains numerous provisions to help increase provider capacity, including higher rates for certain primary care providers in 2013 and 2014 and direct funding for expanding capacity at community health centers.

Conclusion

A number of organizations are conducting or commissioning fiscal analyses of Medicaid expansion. Before analyses are conducted, advocates should provide input about the scope and assist in selecting neutral consultants to conduct the studies. One option is to work with state budget experts or local academics to ensure valid results. If a state or other entity publishes a flawed analysis, advocates should use every opportunity to identify and expose the erroneous assumptions and inflated costs. When correctly undertaken, financial analyses are consistently proving to be a strong tool in support of states' Medicaid expansion.

367:1025-1034 (Sept. 13, 2012), available at http://www.nejm.org/doi/full/10.1056/NEJMsa1202099; see also Finkelstein, et al., Natl. Bureau of Economic Research, *The Oregon Health Insurance Experiment: Evidence from the First Year*, July 2011, available at http://www.nber.org/papers/w17190.pdf?new_window=1.