

The Cost to States of Not Expanding Medicaid

Stan Dorn and Matthew Buettgens

Timely Analysis of Immediate Health Policy Issues

AUGUST 2016

In-Brief

Nineteen states have not expanded Medicaid eligibility under the Affordable Care Act (ACA). We estimate that from 2017 to 2026, expansion in these states would increase nominal state costs and federal spending by \$54.1 billion and \$404.4 billion, respectively, if enrollment is moderate and by \$56.4 billion and \$462.1 billion if enrollment is high. Each state dollar would thus draw down between \$7 and \$8 in net federal funding (Tables 1 and 2).

More specifically,

- higher caseloads would increase state Medicaid spending by \$75.9 billion to \$83.5 billion,
- caseload growth would increase federal Medicaid funding by \$568.5 billion to \$634.5 billion,
- federal subsidies in health insurance marketplaces would fall by \$129.1 billion, and
- reductions in uncompensated care would save states \$21.8 billion to \$27.1 billion while lowering federal spending by \$34.9 billion to \$43.3 billion.

We were not able to estimate offsetting state revenue gains and state cost savings, aside from uncompensated care reductions. Every broad fiscal review conducted in expansion states has found that such offsets have exceeded state cost increases, so expansion has improved state budget balances. Most such reviews forecast that state budget gains from expansion will continue into the indefinite future.

Expanding Medicaid Makes Economic Sense for States



For every dollar states spend on Medicaid Expansion



Expansion States report net budget savings.

They'll receive \$7 to \$8 in federal funding

Introduction

Nineteen states have not expanded Medicaid eligibility to adults with incomes at or below 138 percent of the federal poverty level (FPL) as provided by the Affordable Care Act (ACA). If those states chose to expand, the number of uninsured is estimated to fall by an additional 4.1 million to 5.0 million, depending on enrollment success.¹

Before Medicaid expansion was first implemented in January 2014, research estimated some of the fiscal and economic effects of states' decisions to not expand eligibility.² Here, we update and broaden that work, examining the following questions:

- How would the caseload increases that result from expansion affect state Medicaid costs and federal Medicaid funding in states that have not yet expanded coverage?
- With expansion, most adults with incomes between 100 percent and 138 percent of FPL would no longer qualify for premium tax credits and cost-sharing reductions (i.e., subsidies) in health insurance marketplaces. How much in federal subsidies would states lose if they expanded Medicaid?
- Expansion would reduce the number of uninsured. How would that affect uncompensated care costs? What

would the resulting savings equal for the federal government and states?

- Before Medicaid expansions began in 2014, net state budget gains were projected by every state-specific comprehensive analysis—that is, every analysis that examined increased state costs from higher caseloads, reduced non-Medicaid spending on health care for the uninsured poor, higher federal matching rates for some beneficiaries who would have participated in Medicaid without expansion, and revenue increases. Now that expansion has gone into effect, what state fiscal effects have been observed?

Table 1. Projected State and Federal Fiscal Effects of Medicaid Expansion, Moderate Enrollment: 2017-26 (\$ Billions)

	State effects			Federal effects				Net federal dollars gained for each estimated new state dollar
	Higher caseload costs	Uncompensated care savings	Net estimated costs	Spending on higher caseload	Reduced marketplace subsidies	Uncompensated care savings	Net increase in federal funding	
Alabama	1.6	(1.0)	0.5	11.4	(4.9)	(1.7)	4.9	\$9.17
Florida	12.3	(3.5)	8.8	100.8	(30.0)	(5.6)	65.2	\$7.42
Georgia	7.2	(1.9)	5.2	60.8	(12.3)	(3.1)	45.4	\$8.68
Idaho	1.5	(0.3)	1.2	13.4	(1.6)	(0.5)	11.3	\$9.73
Kansas	1.5	(0.7)	0.8	10.3	(1.9)	(1.1)	7.3	\$8.95
Maine	0.3	(0.2)	0.1	1.9	(1.5)	(0.3)	0.1	\$0.97
Mississippi	1.8	(1.0)	0.8	15.7	(3.0)	(1.6)	11.1	\$13.31
Missouri	3.7	(1.4)	2.3	24.2	(6.5)	(2.3)	15.5	\$6.81
Nebraska	1.0	(0.4)	0.6	6.9	(1.6)	(0.7)	4.7	\$7.99
N. Carolina	6.2	(1.3)	4.9	52.4	(14.2)	(2.1)	36.1	\$7.42
Oklahoma	2.5	(1.2)	1.3	16.3	(2.9)	(1.9)	11.5	\$8.77
S. Carolina	2.9	(0.9)	2.0	20.9	(5.2)	(1.5)	14.2	\$7.26
S. Dakota	0.6	(0.3)	0.3	3.9	(0.5)	(0.4)	3.0	\$8.87
Tennessee	3.8	(1.2)	2.6	32.5	(4.4)	(2.0)	26.1	\$10.03
Texas	21.0	(3.9)	17.1	145.7	(25.2)	(6.2)	114.2	\$6.67
Utah	1.5	(0.4)	1.1	9.6	(1.7)	(0.6)	7.4	\$6.56
Virginia	4.9	(1.3)	3.6	32.6	(7.7)	(2.1)	22.8	\$6.42
Wisconsin	1.2	(0.6)	0.6	6.6	(3.2)	(0.9)	2.5	\$3.86
Wyoming	0.4	(0.2)	0.2	2.5	(0.9)	(0.3)	1.3	\$5.51
Total	75.9	(21.8)	54.1	568.5	(129.1)	(34.9)	404.4	\$7.48

Source: Urban Institute, Health Insurance Policy Simulation Model, 2016

Notes: State cost estimates do not show savings offsets for reduced spending on state-only programs for the uninsured poor (other than for uncompensated care), higher federal matching rates for beneficiaries projected to enroll without expansion, or revenue effects of expansion. Assumed enrollment is comparable to most expansion states.

Methods

State and federal cost effects of caseload increases

We used the Health Insurance Policy Simulation Model (HIPSM) to estimate the federal and state cost effects of Medicaid expansion. Our methodology was the same as that used in our recent report that analyzed the effect of all states expanding Medicaid eligibility on enrollment, and the number of uninsured.³ As explained in that report, we simulated Medicaid enrollment under two assumptions about expansion: (1) moderate new enrollment based on previous HIPSM projections, which are generally consistent with observations

in most expansion states, and (2) high enrollment, reflecting participation in states like California, Rhode Island, and Kentucky. These two scenarios involved approximately 70 percent and 88 percent, respectively, of the eligible uninsured enrolling in coverage.

Uncompensated care

Uncompensated care for the uninsured is estimated in our model based on data from the Medical Expenditure Panel Survey—Household Component adjusted to the results of a detailed analysis of uncompensated care in 2013.⁴ The authors of that analysis found that the uninsured pay for about 30 percent of their health care out-of-

pocket, with the remainder becoming uncompensated care. About 45 percent of uncompensated care is funded by the federal government through programs such as Medicaid Disproportionate Share Hospital (DSH) funding, Medicare DSH, and the Veterans Administration. About 24 percent is funded through state and local governments. The remainder is funded by health care providers themselves.

Federal subsidies for marketplace coverage

We calibrated our model to reproduce the latest available data on marketplace enrollment and second-lowest silver plan premiums in each state. As

Table 2. Projected State and Federal Fiscal Effects of Medicaid Expansion, High Enrollment: 2017-26 (\$ Billions)

	State effects			Federal effects				Net federal dollars gained for each estimated new state dollar
	Higher caseload costs	Uncompensated care savings	Net estimated costs	Spending on higher caseload	Reduced marketplace subsidies	Uncompensated care savings	Net increase in federal funding	
Alabama	1.7	(1.3)	0.4	12.7	(4.9)	(2.1)	5.7	\$13.80
Florida	13.5	(4.4)	9.1	112.1	(30.0)	(7.0)	75.1	\$8.23
Georgia	7.9	(2.4)	5.5	67.8	(12.3)	(3.9)	51.6	\$9.42
Idaho	1.6	(0.4)	1.2	14.7	(1.6)	(0.7)	12.3	\$10.61
Kansas	1.6	(0.8)	0.9	11.4	(1.9)	(1.2)	8.3	\$9.43
Maine	0.3	(0.2)	0.1	2.1	(1.5)	(0.3)	0.2	\$2.56
Mississippi	2.0	(1.2)	0.9	17.7	(3.0)	(1.9)	12.8	\$14.97
Missouri	4.1	(1.8)	2.3	27.2	(6.5)	(2.8)	17.9	\$7.80
Nebraska	1.1	(0.5)	0.6	7.5	(1.6)	(0.7)	5.2	\$8.52
N. Carolina	6.8	(1.7)	5.2	58.1	(14.2)	(2.7)	41.3	\$7.99
Oklahoma	2.8	(1.4)	1.3	18.3	(2.9)	(2.3)	13.2	\$9.89
S. Carolina	3.2	(1.2)	2.0	23.8	(5.2)	(1.9)	16.7	\$8.24
S. Dakota	0.7	(0.3)	0.4	4.5	(0.5)	(0.5)	3.6	\$9.93
Tennessee	4.3	(1.5)	2.8	36.9	(4.4)	(2.4)	30.0	\$10.91
Texas	23.1	(5.0)	18.1	162.8	(25.2)	(8.0)	129.5	\$7.15
Utah	1.6	(0.5)	1.1	10.7	(1.7)	(0.9)	8.2	\$7.58
Virginia	5.3	(1.6)	3.7	36.4	(7.7)	(2.6)	26.2	\$7.01
Wisconsin	1.3	(0.6)	0.7	6.8	(3.2)	(1.0)	2.7	\$3.85
Wyoming	0.5	(0.2)	0.2	2.9	(0.9)	(0.3)	1.6	\$6.47
Total	83.5	(27.1)	56.4	634.5	(129.1)	(43.3)	462.1	\$8.19

Source: Urban Institute, Health Insurance Policy Simulation Model, 2016

Notes: State cost estimates do not show savings offsets for reduced spending on state-only programs for the uninsured poor (other than for uncompensated care), higher federal matching rates for beneficiaries projected to enroll without expansion, or revenue effects of expansion. Assumed enrollment is comparable to the expansion states with the highest take-up.

in earlier work,⁵ we assumed that marketplace enrollment would not increase notably after 2016. However, marketplace enrollment in our model changes over time because of changes in the population and the availability of employer coverage.

Effect of expansion on state budgets

For this portion of the analysis, we synthesized all known analyses of state fiscal effects since expansion was implemented in particular states. We included only analyses that estimated both (1) state cost increases caused by higher caseloads and, in some cases, higher administrative costs; and (2)

state fiscal gains from expansion, from higher federal matching percentages within Medicaid, reduced spending on non-Medicaid health care programs that serve the uninsured poor, and state revenue effects of expansion.

Results

Estimated fiscal effects of expansion

As shown in Tables 1 and 2, states that expand Medicaid will make a small investment of state dollars, drawing down a much larger volume of federal dollars. Several factors cause this.

First, most additional enrollees under

expansion are newly eligible adults, for whom the federal government pays 90 percent or more of all health care costs. Expansion would thus cause an 11 percent to 12 percent increase in state spending on Medicaid beneficiaries under age 65 along with a 45 percent to 51 percent increase in federal dollars (Table 3). The difference between state and federal spending increases is greater than it first appears because the federal government is now paying nearly two-thirds of Medicaid costs (64 percent) in nonexpansion states.

Second, both the federal and state governments save money on payments

Table 3. Projected Federal and State Fiscal Effects of Medicaid Expansion, Relative to Current-Law Projections: 2017-26

	Current law			Increased federal spending (%)		Increased estimated state costs (%)	
	Federal (\$ millions)	State (\$ millions)	Overall federal share (%)	Moderate enrollment	High enrollment	Moderate enrollment	High enrollment
Alabama	\$42,837	\$18,332	70	27	30	9	9
Florida	\$169,520	\$105,683	62	59	66	12	13
Georgia	\$93,240	\$43,014	68	65	73	17	18
Idaho	\$23,722	\$8,415	74	57	62	17	19
Kansas	\$22,071	\$15,071	59	46	52	10	11
Maine	\$15,943	\$9,102	64	12	13	3	3
Mississippi	\$40,308	\$13,881	74	39	44	13	15
Missouri	\$74,134	\$42,090	64	33	37	9	10
Nebraska	\$13,501	\$10,858	55	51	56	9	10
N. Carolina	\$134,972	\$63,614	68	39	43	10	11
Oklahoma	\$44,154	\$24,106	65	37	41	10	11
S. Carolina	\$49,314	\$20,191	71	42	48	14	16
S. Dakota	\$7,622	\$6,224	55	51	59	10	11
Tennessee	\$91,038	\$42,723	68	36	40	9	10
Texas	\$297,881	\$193,069	61	49	55	11	12
Utah	\$29,796	\$11,714	72	32	36	13	14
Virginia	\$52,510	\$47,822	52	62	69	10	11
Wisconsin	\$47,519	\$27,447	63	14	14	4	5
Wyoming	\$4,210	\$3,959	52	60	68	11	11
Total	\$1,254,293	\$707,315	64	45	51	11	12

Source: Urban Institute, Health Insurance Policy Simulation Model, 2016

Notes: Estimates are for Medicaid spending on acute care for the nonelderly. State cost estimates do not show savings offsets for reduced spending on state-only programs for the uninsured poor (other than for uncompensated care), higher federal matching rates for beneficiaries projected to enroll without expansion, or revenue effects of expansion. Moderate take-up is comparable to those in most expansion states. High-take up estimates assume participation like that in the expansion states with the highest enrollment.

for uncompensated care. However, because the federal government's current share of such costs exceeds the state share, federal savings are higher.

Third, Medicaid expansion ends most eligibility for federal marketplace subsidies among consumers with incomes between 100 and 138 percent of FPL. The resulting reduction in federal subsidy dollars offsets between 20.3 and 22.7 percent of the increased federal Medicaid funding that results from expansion (calculations from Tables 1 and 2).

These state fiscal effects do not represent the full state budgetary impact of Medicaid expansion because we were unable to estimate certain factors for each state. The next section discusses those factors.

State budget effects of Medicaid expansion

Only a few expansion states have comprehensively analyzed the overall fiscal effects of expansion. We classify state fiscal estimates as comprehensive if they consider not only increased state costs resulting from higher caseload, but also one or more of the following:

- increased revenue, through special revenue sources (such as taxes and fees on premiums or provider revenue) or general revenue sources (resulting from increased economic activity attributable to increased federal Medicaid dollars buying additional health care within the state);
- reduced spending on non-Medicaid programs for the uninsured poor;
- higher federal matching rates for beneficiaries who, without expansion, would have been covered through pre-ACA eligibility categories.

Our research found such analyses for 14 states, all of which concluded that, on balance, expansion has yielded net state budget gains: Arkansas,⁶ Alaska,⁷ California,⁸ Colorado,⁹ the District of Columbia,¹⁰ Kentucky,¹¹ Maryland,¹² Michigan,¹³ New Jersey,¹⁴ New Mexico,¹⁵ Oregon,¹⁶ Pennsylvania,¹⁷ Washington State,¹⁸ and West Virginia.¹⁹

Ten of these results were or can be projected forward to calendar year 2020 and beyond, when federal Medicaid funding for expansion reaches its final 90 percent level. For eight expansion states, positive fiscal results appeared likely throughout this period:

- Arkansas, Kentucky, and Washington projected net state budget gains during that future period.
- Even without factoring in general revenue effects, short-term estimates for California, Colorado,²⁰ the District of Columbia, Maryland, and Michigan show state fiscal gains that exceed 10 percent of total expansion costs, the state share of Medicaid spending starting in calendar year 2020.

On the other hand:

- New Mexico projects net state budget gains until state fiscal year 2020–2021, at which point a small net adverse budget impact is anticipated. The author of the New Mexico analysis notes that his revenue estimates are conservative, so state budget effects of expansion may turn out to be positive, on balance.
- In Alaska, net state budget losses are forecast starting in federal fiscal year 2017. Alaska does not have sales or individual income taxes, from which the analysis concluded that state general revenue will not be affected

by expansion-generated economic activity. Every other state collects sales taxes, individual income taxes, or both,²¹ so these fiscal conditions in Alaska do not apply to remaining nonexpansion states.

The above single-state analyses are consistent with national data. Even though 2015 saw total federal plus state Medicaid spending increase much more rapidly in expansion than in nonexpansion states—17.7 percent versus 6.1 percent—expansion states experienced less than half the growth in state Medicaid costs incurred by nonexpansion states: 3.4 percent compared to 6.9 percent.²² This suggests that even without accounting for increased revenue and state savings on non-Medicaid health care for the poor uninsured, expansion's first year proved fiscally advantageous for expansion states as a whole.

Conclusion

In the 19 states that have not yet expanded Medicaid eligibility, a small investment of state dollars would yield much larger infusions of federal resources, even taking into account offsetting reductions in federal marketplace subsidies and uncompensated care savings.

Thus far, expansion states have found that state cost increases resulting from higher caseloads are outweighed by state cost savings and revenue growth that result from expansion. For most states with relevant analyses, net fiscal gains are expected for the foreseeable future, even after states begin paying 10 percent of expansion costs.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Stan Dorn is a senior fellow and Matthew Buettgens is a senior research associate in the Urban Institute's Health Policy Center. The authors appreciate the comments and suggestions of John Holahan.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information specific to the Urban Institute's Health Policy Center, its staff, and its recent research, visit <http://www.urban.org/policy-centers/health-policy-center>.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

- 1 Buettgens M and Kenney GM. "What If More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured." Washington, DC: Urban Institute, 2016, <http://www.urban.org/research/publication/what-if-more-states-expanded-medicaid-2017-changes-eligibility-enrollment-and-uninsured>.
- 2 Dorn S, McGrath M and Holahan J. "What Is the Result of States Not Expanding Medicaid?" Washington, DC: Urban Institute, 2014, www.urban.org/sites/default/files/alfresco/publication-pdfs/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid-PDF.
- 3 Buettgens and Kenney.
- 4 Coughlin TA, Holahan J, Caswell KJ, et al. "Uncompensated Care for the Uninsured in 2013: A Detailed Examination." Washington, DC: Urban Institute, 2014, www.urban.org/research/publication/uncompensated-care-uninsured-2013.
- 5 Buettgens M, Blumberg LJ, Holahan J, et al. "The Cost of ACA Repeal." Washington, DC: Urban Institute, 2016, www.urban.org/sites/default/files/alfresco/publication-pdfs/2000806-The-Cost-of-the-ACA-Repeal.pdf.
- 6 Bachrach D, Boozang P, Herring A, et al. "States Expanding Medicaid See Significant Budget Savings and Revenue Gains." New York: Manatt Health, 2016, www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.
- 7 Evans A, Folkemr J, Menges J, et al. "Assessment of Medicaid Expansion and Reform: Initial Analysis." Prepared for Alaska Legislative Budget and Audit Committee, 2016. Arlington, VA: Menges Group, www.akleg.gov/basis/get_documents.asp?session=29&docid=29735.
- 8 Bachrach et al.
- 9 Brown C, Fisher SB and Resnick P. "Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015–16 through FY 2034–35." Denver: Colorado Health Foundation, 2016, www.coloradohealth.org/WorkArea/DownloadAsset.aspx?id=8353.
- 10 Bachrach et al.
- 11 Deloitte Development L.L.C. "Commonwealth of Kentucky: Medicaid Expansion Report, 2014." Oakland, CA: Deloitte Development L.L.C., 2015, www.jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.
- 12 Bachrach et al.
- 13 Bachrach et al.
- 14 This analysis found net reductions in state spending, due to expansion; it did not consider revenue effects. New Jersey Department of Human Services "Discussion Points, FY 2016–2017." Trenton: New Jersey Department of Human Services, 2016, www.njleg.state.nj.us/legislativepub/budget_2017/DHS_response.pdf.
- 15 Reynis LA. "Economic and Fiscal Impacts of Medicaid Expansion in New Mexico." Albuquerque, NM: University of New Mexico, Bureau of Business and Economic Research, 2016, http://bber.unm.edu/media/publications/Medicaid_Expansion_Final2116R.pdf.
- 16 Bachrach et al.
- 17 Bachrach et al.
- 18 Dorn S, Francis N, Rudowitz R, et al. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." Menlo Park, CA, and Washington, DC: Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, 2015, <http://files.kff.org/attachment/issue-brief-the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states>.
- 19 Bachrach et al.
- 20 For Colorado, this analysis comes from Bachrach et al.
- 21 Lee C, Pome E, Beleacov M, et al. "State Government Tax Collections Summary Report, 2014: Economy-Wide Statistics Brief—Public Sector." Washington, DC: U.S. Census Bureau, 2015, www2.census.gov/govs/statetax/G14-STC-Final.pdf. Even Alaska collects corporate income tax; the above-described Alaska analysis did not estimate the impact of expansion on such tax revenues.
- 22 Rudowitz R, Snyder L and Smith VK. "Medicaid Enrollment & Spending Growth: FY 2015 & 2016." Menlo Park, CA, and Naples, FL: Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, 2015, <http://files.kff.org/attachment/issue-brief-medicaid-enrollment-spending-growth-fy-2015-2016>.