

The Impact of Medicaid Expansion on State Budgets

States' experience shows that Medicaid expansion generates budget savings—sometimes substantial—from reduced costs in state-funded health care programs, savings in a state's traditional Medicaid program and correctional health costs, and other areas described below. Depending on the state, these savings can offset or exceed the 10 percent state share of expansion costs that states will pick up in 2020.

Any assessments of the potential budget impact of Medicaid expansion should carefully consider the areas where expansion can reduce other state costs.

Areas where states routinely see savings are outlined below, along with a closer look at savings reported by six expansion states. The bottom line:

- » Across the board, states that have expanded Medicaid have seen savings—often substantial—in health care costs they would otherwise incur.
- » Some of those savings have been in non-Medicaid budget areas, such as correctional health costs.
- » A significant number of states find that expansion pays for itself, and they project it will continue to do so even when the state share increases.
- » The state share cannot be considered just an added cost. Many potential savings need to be factored into a full analysis of budget impact.

Areas of Savings

Below we describe some areas where states see savings as a result of the decision to expand Medicaid. Such savings greatly reduce or even eliminate the net state cost of expansion.

For some of the savings areas noted below, we used expansion states' experience in 2015–2016 to estimate the degree to which we can expect savings to offset expansion costs when the state share fully phases in at 10 percent in 2020.

Increased Matching Rate for Existing Medicaid Enrollees

Some enrollees in a state's traditional Medicaid program may be eligible for expansion coverage, through which the federal government will pay a greater share of the costs. Areas states should consider when evaluating the potential for enrollee transitions are described below.

- » **Pregnant women.** *Approximate savings offset: 10 percent of 2020 state share.* All states must provide Medicaid coverage to pregnant

women with incomes up to 138 percent of poverty. In non-expansion states, pregnant women are covered through the traditional Medicaid program at that program’s regular federal matching rate. In expansion states, if a woman becomes pregnant while enrolled in the expansion, she can stay enrolled in the expansion during her pregnancy; she is not required to move to traditional Medicaid. This means that many pregnancies that would have been covered at the traditional match rate can be covered at the higher, enhanced match. (Note: In an expansion state, a woman who is pregnant when she enrolls in Medicaid is placed in traditional Medicaid until she no longer qualifies under the “pregnant women” category.)

Savings depend on birth rates and the parents’ income levels. Arkansas, for example, has experienced savings by shifting pregnant women into the enhanced match, offsetting 1.1 percent of total expansion costs (or 11 percent of its state share) when that share reaches 10 percent of total expansion costs. Maryland, a wealthier state with lower birth rates, experienced savings of about half that level.¹

Based on the experience of expansion states, the projection of offsetting savings for current non-expansion states is 10 percent of the 2020 state share.

- » **Medically needy program enrollees.** *Approximate savings offset: 5–10 percent of state share.* In states with medically needy programs for adults, many medically needy beneficiaries will qualify for coverage under the Medicaid expansion. Savings levels depend largely on how many adults were covered as

medically needy before expansion. Kentucky has experienced savings equivalent to about 5 percent of its 2020 state share, while Arkansas estimated savings equivalent to cover 10 percent of its 2020 state share.²

- » **Reduced state medical costs for state correctional facilities.** *Approximate savings offset: 10 percent of state share.* For Medicaid-enrolled inmates, Medicaid will pay for care provided in an inpatient facility outside the correctional institution, as long as the inmate is admitted for at least 24 hours. For eligible inmates who are not enrolled in Medicaid at the time of admission, states can obtain retroactive coverage as long as the individual applies for Medicaid within three months of the date of service.³ In expansion states, more inmates are eligible for Medicaid coverage, meaning that Medicaid will pay for the qualifying hospitalizations of more inmates. All the states we looked at in detail reported substantial savings in corrections costs (see below). Our estimate is based on an average of these states’ offsetting savings. Michigan experienced even higher savings, offsetting the equivalent of almost 15 percent of its 2020 state share.⁴
- » **Other “pre-expansion” adult eligibility categories.** *Approximate savings offset varies by state pre-expansion coverage.* These categories include disease-specific coverage programs, such as breast and cervical cancer eligibility or limited coverage programs that may be available to adults under a waiver. Transitioning those Medicaid enrollees into the Medicaid expansion will enable the state to receive a higher matching rate for their care. Savings will depend on how many such waiver programs exist in a state and waiver enrollment levels.

» **Savings in state-funded uncompensated care programs.** *Approximate savings offset varies by state pre-expansion funding levels.* Most states offer hospitals some support for uncompensated care, including care for uninsured people. Because hospitals in expansion states see decreases in uncompensated care, states can reduce their spending on this support. Arkansas's offsetting savings from reduced state uncompensated care funding in 2015 were equivalent to over 12 percent of its 2020 state share.⁵ Similarly, states that have expanded Medicaid have been able to reduce spending on state-funded health programs for the uninsured, such as state mental health and substance use treatment programs.

Details on States' Experiences

Examples of states' reported budget savings are outlined below. Some states reported both direct savings (i.e., costs that states would incur if the expansion were not in place) and others reported savings and offsets to expansion costs. Savings are noted as states reported them.

Reported offsets include drug rebates, which lower state prescription drug costs for expansion enrollees, and reduced supplemental payments to hospitals' upper payment limit (UPL) payments. UPL payments are supplemental payments that states can make to hospitals, nursing homes, and intermediate care facilities to provide financial stability to providers that serve a large number of Medicaid or uninsured patients. Federal law limits payment amounts.⁶

Some states reported reduced disproportionate share (DSH) payments as savings. States must make DSH payments to hospitals serving a large number

of Medicaid or low-income uninsured patients, and payments are set by federal law.

Both DSH and UPL payments are funded jointly by states and the federal government.

Although the reported level of detail differs across states, in all states examined, we found that Medicaid expansion has produced savings in multiple budget areas.

Colorado

In the first year of Colorado's Medicaid expansion, the Department of Corrections reported \$10 million in savings on inpatient hospitalizations.⁷ Other savings areas identified included state-funded mental health and substance use disorder treatment programs and the state's Old Age Pension Health and Medical Care Program.⁸

In an assessment of the Medicaid expansion's budget impact, the Colorado Health Foundation stated, "Colorado currently is and will be able to insure the expansion populations with no negative impact to the state's General Fund."⁹

Louisiana

In the 2017 calendar year, Medicaid expansion saved Louisiana \$199 million. For 2018, savings were projected to be \$350 million,¹⁰ attributable to:

- » Additional revenue from a premium tax on managed care organizations.
- » Enrollees transferred from traditional Medicaid to the expansion, with a higher federal match.
- » Decreased disproportionate share payments to hospitals that are providing less uncompensated care.

- » Hospital supplemental payments funded at a higher matching rate (lower state costs).
- » Automatic Medicaid enrollment for newly released state inmates, resulting in inpatient cost savings by reducing recidivism.¹¹

Michigan

The House Fiscal Agency's January 2018 budget briefing on Medical Services and Behavioral Health reported that the Healthy Michigan program, the state's Medicaid expansion, had:

- » Produced \$235 million in budget savings in FY 2016/2017 and was projected to continue to achieve that level of savings through 2020.
- » Produced additional revenue through a Health Insurance Claims Assessment and a Use Tax on Medicaid managed care plans.

In FY 2016/2017, combined revenue and savings attributable to Healthy Michigan were \$306 million.¹²

Overall, Healthy Michigan was a net positive to the state budget in FY 2016/2017, producing savings of \$284 million. The agency projected that the program would continue to be net positive through 2020, even though the provider tax is scheduled to sunset and the state share will increase to 10 percent. In 2020, net savings are projected to be \$11 million.

The 2016/2017 direct savings attributed to Healthy Michigan include:

- » Reduction in Medicaid mental health funding: \$168 million.
- » Reduction in costs for an Adult Benefit Waiver program: \$47 million.

- » Reduction in prisoner health care costs for the Department of Corrections: \$19 million.
- » Reduction in Costs for smaller health care programs (unspecified): \$1 million.

Montana

Savings in Montana's traditional Medicaid program, corrections costs, and mental health and substance use treatment costs are attributable to its Medicaid expansion. These savings include:

- » Reduction in traditional Medicaid costs of \$40 million in the first two years of expansion (individuals who would have been eligible for Medicaid pre-expansion transitioned into the expansion program at the higher matching rate).¹³
- » Savings to the Department of Corrections of \$7.66 million in FY 2017.¹⁴
- » Reduced state spending on mental health and substance use programs projected at \$3 million per year for 2018 and 2019.¹⁵

In 2017, savings to Montana's budget outweighed the costs of expansion.¹⁶

New Hampshire

With Medicaid expansion, the New Hampshire Department of Corrections reported a larger share of health care payments paid through the Medicaid program, as opposed to the general fund. In 2013, before the state's expansion, over 90 percent of inpatient hospital costs for incarcerated individuals were paid from the state's general fund. In 2017, post-Medicaid expansion, the general fund share had declined to roughly 68 percent, with the remainder paid by Medicaid.¹⁷

Ohio

In August 2018, Ohio’s Department of Medicaid issued a report on the state’s Medicaid expansion that concluded, “Medicaid expansion is manageable and affordable now and into the future.”¹⁸

The Department noted that the expansion produced a series of savings and offsets that would reduce the state’s net match in 2021 from 10 percent to 3.2 percent. Offsets projected for 2021, based on the state’s expansion experience, including the following:¹⁹

- » Health care cost savings for the Department of Corrections: \$18 million.
- » Drug rebates generated by expansion: \$60.4 million.
- » Expansion-generated managed care assessments per member per month: \$191.6 million.
- » Insurance tax from expansion premiums: \$48.6 million.
- » UPL costs allocated to the expansion program: \$35.5 million.

The report noted that net state cost was \$21 per expansion enrollee per month.

Estimating Medicaid Expansion Savings

Virginia had not yet implemented its expansion when it recently prepared an expansion budget projection. The state is a good example of areas that other states should consider in budget planning. Virginia’s expansion was a net budget saver in the biennial budget passed by bipartisan majorities in 2018. Passing expansion freed up state funds for other budget priorities.

In setting its expansion budget, Virginia considered the following:

- » Reducing costs for the state indigent care pool (retroactive Medicaid coverage for hospital stays for expansion-eligible individuals).
- » Covering pregnant women through the expansion instead of traditional Medicaid (higher match rate).
- » Ending the GAP Program, a Medicaid waiver program for uninsured adults with mental illness that had been funded at the traditional matching rate (enrollees transitioned to Medicaid expansion).
- » Realizing savings from community behavioral health clinics funded through general funds (formerly uninsured patients covered through the expansion, saving state dollars).
- » Reducing costs for the Department of Corrections (inmate hospitalization costs previously covered through the general fund, now covered by Medicaid expansion’s federal share).
- » Lowering costs for the state’s Medicaid breast and cervical cancer program (moving enrollees from traditional Medicaid to expansion coverage).
- » Moving some medically needy program enrollees into expansion coverage (enhanced match).
- » Reducing costs for the state-funded program for individuals with temporary detention orders (patients covered through the program covered by Medicaid).
- » Increasing savings in the state’s Medicaid family planning waiver (moving enrollees to expansion coverage).²⁰

Any evaluation of Medicaid expansion's budget impact should include a full assessment of potential savings.

States that are considering or budgeting for expansion can look at the areas where states have seen savings, or examine ways that new expansion states like Virginia are considering savings sources.

It is true that states will have to start paying 10 percent of expansion costs in 2020. However, when savings are considered, states that have expanded Medicaid project their actual costs to be much less—often fully covered or even a net positive to the state budget.

Endnotes

- ¹ Bachrach, D., et al., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains: Early Data Shows Consistent Economic Benefit Across Expansion States* (Princeton, N.J.: Robert Wood Johnson Foundation, March 2016), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097; CMS Medicaid Budget and Expenditure System data, data for the new adult group, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/enrollment-mbes/index.html>.
- ² Bachrach, *op cit*.
- ³ PEW Charitable Trust, “How and When Medicaid Covers People Under Correctional Supervision,” August 2016, <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision>. State waivers of retroactive eligibility for the eligibility group into which the inmate would affect a state’s ability to recover costs under this rule.
- ⁴ Bachrach, *op cit*.
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- ⁸ This Colorado program provides assistance to low-income residents over age 60.
- ⁹ This Colorado program provides assistance to low-income residents over age 60.
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- ¹⁴ *Ibid*.
- ¹⁵ Grady, A., et al., *Medicaid’s Role in the Delivery and Payment of Substance Use Disorder Services in Montana* (Washington, D.C.: Manatt, 2017), <https://www.manatt.com/getattachment/5c943485-16d3-48aa-9d20-8a47368b3c88/attachment.aspx>.
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- ¹⁷ Families USA estimates based on data presented in New Hampshire Fiscal Policy Institute, *Medicaid Expansion in New Hampshire and the State Senate’s Proposed Changes*, March 30, 2018, graphic “New Hampshire Department of Corrections Medicaid Expenses,” <http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html>.
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