

Medicaid Expansion and 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, savings in correctional health costs, and other areas described below. Depending on the state, these savings can offset or exceed the 10% state share of expansion costs that states will eventually be picking up in 2020.

Any assessments of Medicaid expansion's potential budget impact 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:

- States that have expanded Medicaid have, across the board, seen savings in health care costs they would otherwise incur—often substantial.
- Some of those savings have been in non-Medicaid budget areas, such as correctional health costs.
- A significant proportion of states are finding that expansion pays for itself and project it will continue to do so even when the state share increases.
- The state share can't be looked at as just an added cost. There are lots of potential savings that need to be factored into a full analysis of the budget impact.

Areas of savings

These are areas where states are seeing savings as a result of the decision to expand Medicaid. These savings greatly reduce or eliminate the net state cost of expansion.

For some of the savings areas noted below, we used expansion states' experience in 2015-2016 to provide an estimate of the degree to which savings could be expected to offset expansion costs when the state share fully phases in at 10 percent in 2020.

1. Increased matching rate for existing Medicaid enrollees. Some enrollees in a state's traditional Medicaid program might be eligible for expansion coverage, where the federal government will pay for a greater share of the costs. Below are some areas states should look at when evaluating the potential for enrollee transitions.

- **Pregnant women.** Approximate savings offset—10% of 2020 state share. All states have to 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 does not have to move to traditional Medicaid. That 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, if a woman is pregnant at the point she enrolls in Medicaid, she is placed into traditional Medicaid until she no longer qualifies under the “pregnant women” category.)

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

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

- **Medically needy program enrollees.** Approximate savings offset—5-10% 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 before expansion as medically needy. Kentucky experienced savings equivalent to about 5% of its 2020 state share, while Arkansas estimated savings equivalent to over 10% of 2020 state share.²
- **Reduced state medical costs for state correctional facilities.** Approximate Savings Offset—10% of state share. For Medicaid enrolled inmates, Medicaid will pay for care provided in an inpatient facility outside of the correctional institution, as long as the person is admitted for 24 hours or more. 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 more inmates' qualifying hospitalizations. All of the states we looked at in detail

¹ Deborah Bachrach. Et al., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains: Early Data Shows Consistent Economic Benefit Across Expansion States* (Princeton, New Jersey: Robert Wood Johnson Foundation, March 2016) online at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwif419097; CMS Medicaid Budget and Expenditure System data, data for the new adult group, online at <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/enrollment-mbes/index.html>.

² Deborah Bachrach, *op cit*.

³ PEW Charitable Trust, “How and When Medicaid Covers People Under Correctional Supervision,” August 2016 online at <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 the inmate falls into would affect a state's ability to recover costs under this rule.

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 of offsetting the equivalent of almost 15% of 2020 state share.⁴

- **Other “pre-expansion” adult eligibility categories.** Approximate savings offset—varies by state pre-expansion coverage. These 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 allow the state to receive a higher matching rate for their care. Savings will depend on how many such waiver programs there are 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 a decrease 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% of 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 states would incur if the expansion were not in place) and other reported both savings and off-sets to expansion costs. Savings are noted as states reported them.

Off-sets reported 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 states can make to hospitals, nursing homes, 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 high number of Medicaid or low-income uninsured patients and payments are set by federal law.

⁴ Deborah Bachrach, *op cit*.

⁵ Deborah Bachrach, *op cit*

⁶ Cindy Mann, et al., *Integrating Medicaid Supplemental Payments into Value Based Purchasing* (New York, New York: Commonwealth Fund, November 2016 online at <https://www.commonwealthfund.org/publications/fund-reports/2016/nov/integrating-medicaid-supplemental-payments-value-based>).

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

Although the level of detail reported differs across states, all state examined 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 CY 2017, Medicaid expansion saved the state \$199 million. For 2018, savings were projected to be \$350 million.¹⁰ Savings were attributed to:

- Additional revenue from a premium tax on managed care organizations;
- Transferring enrollees from traditional Medicaid to the expansion, with a higher federal match;
- Decreased disproportionate share payments to hospitals that are incurring less uncompensated care;
- Hospital supplemental payments funded at a higher matching rate (lower state costs);
- Automatic Medicaid enrollment for newly released state prisoners, which has resulted in inpatient cost savings by reducing recidivism.¹¹

Michigan

⁷ Charles Brown, *Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015-16 through FY 2034-35* (Colorado Health Foundation, June 2016) online at https://coloradoheates/default/files/documents/2017-01/Medicaid_Expansion_Full_ONLINE_.PDF.

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.

¹⁰ Louisiana Department of Health, *Medicaid Expansion Annual Report 2016/2017*, June 2017, online at http://ldh.la.gov/assets/HealthyLa/Resources/MdcdExpnAnnRprt_2017_WEB.pdf. For an assessment of cents saved per Medicaid dollar from enrollee transfers for discrete programs in Louisiana Medicaid and supplemental payment savings, see James Richardson, et al, *Medicaid Expansion and the Louisiana Economy* (Baton Rouge, LA; Louisiana State University, March 2018), funded by the Louisiana Department of Health, online at <http://gov.louisiana.gov/assets/MedicaidExpansion/MedicaidExpansionStudy.pdf>.

¹¹ *Ibid*; and, Louisiana Department of Health Press Release, "Department of Health and Department of Corrections team up to provide health care coverage for newly released offenders," March 1, 2017 online at <http://ldh.la.gov/index.cfm/newsroom/detail/4170>.

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

- **Produced \$235 million in budget savings** in FY 2016/2017 and was projected to continue producing 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 Health 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 a 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 were:

- 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

Montana has seen savings in its traditional Medicaid program, corrections costs, and mental health and substance use treatment costs attributable to its Medicaid expansion.

- 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
- Department of Corrections savings of \$7.66 million in FY 2017;¹⁴
- Reduced state spending on mental health and substance use programs projected at \$3 million/year for 2018 and 2019.¹⁵

¹²Kevin Koorstra, "Budget Briefing: HHS-Medical Services and Behavioral Health," January 2018 online at https://www.house.mi.gov/hfa/PDF/Briefings/DHHS_Medicaid_BudgetBriefing_fy17-18.pdf

¹³ Bureau of Business and Economic Research, *The Economic Impact of Medicaid Expansion in Montana* (Missoula, MT: University of Montana, April 2018) online at https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf.

¹⁴ *Ibid.*

¹⁵ April Grady, et al., *Medicaid's Role in the Delivery and Payment of Substance Use Disorder Services in Montana* (Washington, DC: Manatt, 2017) online at <https://www.manatt.com/getattachment/5c943485-16d3-48aa-9d20-8a47368b3c88/attachment.aspx>.

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 off-sets that would reduce the state’s net match in 2021 from 10 percent to 3.2 percent. Off-sets projected for 2021, based on the state’s expansion experience, included the following¹⁹:

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

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

Estimating Medicaid expansion savings

¹⁶ Deborah Bachrach, “Repealing the Medicaid Expansion: Implications for Montana,” Manatt, March 16, 2017 online at <https://www.manatt.com/Insights/Newsletters/Medicaid-Update/Repealing-the-Medicaid-Expansion-Implications-for>.

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,” online at <http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html>.

¹⁸ Barbara Sears, *Ohio Medicaid Expansion Assessment*, Ohio Department of Medicaid, August 21, 2018 online at <https://medicaid.ohio.gov/Portals/0/Resources/Reports/MedicaidExpansion.pdf> (summary report) and *Ohio Department of Medicaid 2018 Group VIII Assessment*, August 2018 online at <https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf> (full report).

¹⁹ Ohio expanded Medicaid in January 2014.

Virginia, a state that has not yet implemented its expansion but that has recently gone through an expansion budget projection process, provides a good example of the areas that states should consider in budget planning. Virginia's expansion was a net budget saver in its biennial budget passed by bipartisan majorities in 2018, so that passing expansion freed up state funds for other budget priorities.

In setting its expansion budget, Virginia considered savings from the following areas:

- Reduced costs for the state indigent care pool (retroactive Medicaid coverage for hospital stays for expansion eligible individuals).
- Pregnant women covered 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);
- Savings from community behavioral health clinics funded through general funds (formerly uninsured patients covered through the expansion, saving state dollars);
- Department of Corrections savings (inmate hospitalization costs previously covered through the general fund covered by Medicaid expansion's federal share);
- 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);
- The state funded program for individuals with temporary detention orders (patients covered through the program covered by Medicaid);
- 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 in the process of expansion budgeting, or considering expansion, can look at the areas where states have seen savings, or that new expansion states like Virginia are considering savings sources, as they estimate expansion costs.

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

²⁰ http://sfc.virginia.gov/pdf/health/2018/010818_No1_Jones_DMAS%20Budget%20Briefing.pdf;
https://www.richmond.com/news/virginia/government-politics/general-assembly/virginia-house-and-senate-budget-plans-are-more-than-million/article_5aa40b75-8943-5c13-b90f-da5c49724199.html.

