

Medicaid Expansion: Just the Facts

1. MEDICAID EXPANSION HAS A POSITIVE IMPACT ON STATE AND LOCAL BUDGETS. The evidence from states that have expanded consistently shows that it generates savings and revenue which can be used to finance other priorities or offset much, if not all, of the state costs of expansion.

- Thirty states, plus Washington DC, have already expanded Medicaid, and most are already seeing substantial savings in their state budgets. Data from Kentucky and Arkansas show more than \$1 billion in savings from those two states alone.^{i, ii, iii}
- States cite three sources of expansion savings/revenue: (1) as low-income residents gain Medicaid coverage, federal Medicaid funding can replace entirely state-funded services for the uninsured; (2) some people who have been eligible for Medicaid but whose coverage qualified only for the “regular” federal match rate — including many with high costs, such as the “medically needy” — now qualify for the “enhanced” match rate; (3) revenues from pre-expansion provider taxes and assessments increase because the base upon which they are calculated grows when more people are covered. These direct budget savings are *in addition to* any economic boost flowing from more federal revenues and growth in jobs.^{iv}
- States’ shares of Medicaid spending grew more slowly in states that expanded. In FY 2015, states’ shares of general fund spending on Medicaid in expansion states declined relative to the previous year, and it was half as much as it was in non-expansion states (3.4% compared to 6.9%).^v

2. MEDICAID EXPANSION BOLSTERS STATE ECONOMIES. Medicaid expansion brings in hundreds of millions of federal dollars annually, which ripples through the state economies, creates jobs, and allows savings in other areas.

- Medicaid expansion states see more jobs in the health sector. On average, the states that expanded Medicaid in January 2014 saw jobs grow by 2.4% during 2014, while jobs in states that did not expand grew by only 1.8% in the same year.^{vi}
- The Bureau of Labor Statistics projects health care and social assistance jobs will grow to nearly 22 million by 2022 due to Medicaid expansion.^{vii}
- In 2014, Kentucky’s expanded Medicaid created 12,000 new jobs and it is estimated by 2021 that expansion will be responsible for the employment of 40,000 Kentuckians annually.^{viii}

3. STATES CAN COUNT ON CONTINUED FEDERAL FINANCIAL SUPPORT FOR EXPANSION. The Federal “enhanced” match covers the vast majority of expansion costs and is in federal law. It cannot be changed without Congressional and Presidential approval.

- Federal law requires the federal government to pick up 100% of the expansion’s costs through 2016; it drops to 95% in 2017 but never goes below 90%. This means that when the 10% state share is in effect (in 2020), the federal government will pay \$90 for every \$100 in health care costs for the newly eligible people.^{ix, x}
- The federal share of the expansion will average roughly 95% from 2016 to 2025, according to the Congressional Budget Office (CBO). The CBO estimates total state spending on Medicaid and CHIP will increase by only 1.6% over the same time period.^{xi}
- New federal law would be required to change federal funding commitment, and history shows no evidence that this is likely. Congress has only modified Medicaid’s overall matching rate three times over the last three and a half decades. President Reagan and Congress enacted a temporary cut in 1981, but the most recent changes involved temporary *increases* to aid states during the last two economic downturns.^{xii}
- In the event that the match rate changes — or for any other reason — states can drop their Medicaid expansion. Several states have included sunset provisions in their authorizing legislation.^{xiii}

4. MEDICAID EXPANSION PROTECTS AND STRENGTHENS STRUGGLING AND RURAL HOSPITALS. Medicaid expansion significantly reduces hospitals’ uncompensated care costs and helps stabilize rural hospitals.

- Hospital financial reporting suggests that coverage expansions are contributing to a national reduction in hospital uncompensated care costs. Hospitals’ uncompensated care costs are estimated to have been \$7.4 billion (21%) less in 2014 than they would have been in the absence of coverage expansions.^{xiv}
- Ascension Health, which has hospitals in expansion and non-expansion states, found that, in 2014, hospitals in expansion states saw a 63.2% reduction in uncompensated care compared to a 2.6% increase in non-expansion states.^{xv, xvi}
- In New Mexico, uncompensated care reimbursements for the state’s Safety Net Care Pool (SNCP) have dropped by 30% as a result of Medicaid expansion. Additionally, for all hospitals within the state, uncompensated care as a share of hospital expenses dropped by 12.5%, and net revenue increased by more than 40% in 2014 compared to 2013.^{xvii}
- As of September 2015, the percentage of rural hospitals at risk of closure has nearly doubled in non-expansion states in comparison to expansion states (based on measures of financial strength, quality and outcomes, inpatient/outpatient share, and population risk). For FY 2013, vulnerable hospitals reported operating profit

margins were 131% lower than the national median, and cash flow margins were 76% lower than the national median.^{xviii}

- In states that have chosen not to expand the program, rural hospitals are struggling with the fallout. In many rural counties, these hospitals are the largest employers, but many say they're now facing layoffs, even closure.^{xix}
- According to the National Rural Health Association, 300 rural hospitals across the U.S. are on the verge of closing due to financial issues. The major cause for these issues is the states opting out of Medicaid expansion. In addition to compromising the health of rural people, a hospital closure causes lost jobs, lost economic activity, and lost community vibrancy in rural communities. A small-town hospital closure costs about \$1,000 in per capita income.^{xx}

5. MEDICAID EXPANSION IS AFFORDABLE INSURANCE FOR LOW-INCOME, WORKING ADULTS. Most people eligible for Medicaid expansion are in working families, many caring for children.

- Nationally, 61% of those eligible for Medicaid expansion are in working families. More than half (55%) work in either the service industry or agriculture, and most work in firms with less than 100 employees, the types of firms that are less likely to offer affordable insurance. One out of four are caring for children, some have medical issues that limit their ability to work (one out of five report poor health), and 17% are over age 55.^{xxi}
- Among the uninsured non-elderly adults (19-64) with incomes below 138% FPL — people eligible under the expansion and those already eligible but unenrolled — 72% report working full time.^{xxii}
- Medicaid expansion encourages work and job advancement among low-income parents. In the median states that have not expanded, a parent is “over income” for Medicaid if she earns \$8,840 for a family of three. If she gets a better job, a raise, or more hours, she is likely to fall within the coverage gap — her income is too high for Medicaid and too low for the Marketplace subsidies. By contrast, in states that expand, low-income parents can earn more without losing their health insurance.

6. STATE SPECIFIC SOLUTIONS ARE WORKING. States have crafted programs that address their unique health care and cultural landscapes, giving them control.

- Medicaid gives states flexibility to design their own programs. States can design their benefit packages for the new adult group based on a commercial benchmark that they select, and states have the flexibility to impose copayments at nominal levels for those under poverty and a higher level for those with incomes at or above the poverty level.^{xxiii}
- States can make additional changes through Section 1115 waivers. Six states that have expanded Medicaid have done so using an alternative to traditional expansion: Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire.^{xxiv} These waiver-based expansions include policies such as premiums, health savings accounts,

incentives for healthy behaviors, referrals to work programs, and initiatives to use Medicaid funds to purchase private insurance policies offered by employers or through the Marketplace.

7. ENROLLMENT GROWTH IN EXPANSION STATES IS STRONG, DRIVING DOWN THE UNINSURED RATE TO RECORD LOWS.

- Overall, the nation's current uninsured rate is the lowest it's been in the last 60 years. In one year, Arkansas and Kentucky cut their uninsured rate in half.^{xxv}
- Nine of the ten states with the largest reductions in uninsured rates expanded Medicaid.^{xxvi}
- In 17 of the 29 states that expanded in 2015, enrollment grew faster than the state projected. At the same time, the costs per enrollee were as or lower than expected. States project the rate of growth leveling off over the next year.^{xxvii}
- Despite higher than expected expansion enrollment, Ohio's actual FY 2014 Medicaid spending was \$2 billion below estimates because of a number of program reforms.^{xxviii}

8. MEDICAID EXPANSION IS GOOD FOR PATIENTS AND PUBLIC HEALTH. Expansion increases access to primary and preventive care and increases continuity of coverage, which improves health and ultimately reduces costs.

- Women in Medicaid expansion states are far more likely to get screened for breast cancer. In 2008 — before states could expand Medicaid — low-income women in states that would go on to expand Medicaid were equally likely to be screened for breast cancer as low-income women in states that would remain un-expanded. In 2012, however, low-income women in expansion states were 25% more likely to get screened for breast cancer than those in non-expansion states.^{xxix}
- Medicaid expansion enables states to offer new adult services for mental health and substance abuse with an enhanced match^{xxx} — particularly critical service needs in light of the alarming growth in opioid abuse.^{xxxi}
- Expansion enables states to connect ex-inmates to health coverage, address their mental health or substance use disorder needs, and reduce recidivism rates.^{xxxii}
- *Michigan*: Expansion is increasing access to primary care — as of February 2015, more than half of expansion enrollees had visited a primary care physician, and enrollees were participating in the expansion program's voluntary health risk assessment program at more than twice the rate of enrollees in private health insurance plans.^{xxxiii}
- *Oregon*: A landmark study of Oregon's Medicaid program found that, compared with similar people without coverage, people with Medicaid were 40% less likely to have suffered a decline in their health in the previous six months. They were also more likely to use preventive care (such as cholesterol screenings), to have a regular

office or clinic where they could receive primary care, and to receive a diagnosis of and treatment for depression and diabetes. People with Medicaid in Oregon were also 40% less likely than those without insurance to go into medical debt or to leave other bills unpaid in order to cover medical expenses. In fact, the latest research from Oregon found that Medicaid coverage “nearly eliminated catastrophic out-of-pocket medical expenditures.”^{xxxiv}

- *Arizona, Maine, and New York*: Research published in the *New England Journal of Medicine* reported that expansions of Medicaid coverage for low-income adults in Arizona, Maine, and New York reduced mortality by 6.1%.^{xxxv}

9. MEDICAID IS COST EFFICIENT AND IS MOVING FORWARD WITH CARE AND PAYMENT IMPROVEMENTS.

- Medicaid’s costs per beneficiary are lower than those for private insurance and national health expenditure per capita costs between fiscal years 2000 and 2011.^{xxxvi}
- Access to care for Medicaid enrollees is generally as good as it is in the private sector.^{xxxvii}
- Six states participate in the Center for Medicare and Medicaid Services (CMS) DSRIP program — California, Kansas, Massachusetts, New Jersey, New York, and Texas. Each state’s implementation varies in terms of the number of participating provider organizations, funding, and projects. Kennedy Health System in New Jersey has had success with the DSRIP program, resulting in better care for individuals, better health for their patients, and lower costs by transitioning hospital funding to a model in which payment is tied to achieving health improvement goals.^{xxxviii}

December 2015

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