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RESEARCH SUMMARY

THE ACA'S OPTIONAL MEDICAID EXPANSION: Considerations Facing State Governments

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In the wake of a 2012 Supreme Court ruling, states face complex decisions concerning whether to expand Medicaid coverage to the full extent envisioned in the Affordable Care Act (ACA, commonly referred to as Obamacare). With the federal government no longer able to coerce expansion, states must base their decisions on value judgments that incorporate each state's unique budgetary circumstances, the needs of its uninsured population, and the incentives established by interactions among the ACA's provisions.

In a new study published by the Mercatus Center at George Mason University, senior research fellow Charles Blahous analyzes the myriad factors states must weigh in their decisions whether to expand Medicaid coverage. The study concludes that for most states the decision will be complex and finely balanced, resulting in different states making different choices and some states finding it prudent to defer their decisions until the federal fiscal picture is further clarified.

Below is a brief summary of Blahous's paper. To read the study in its entirety and learn more about the author, see "The Affordable Care Act's Optional Medicaid Expansion: Considerations Facing State Governments."

KEY FACTS AND FINDINGS

- **Medicaid Expansion.** The ACA intended to expand health insurance coverage for the previously uninsured poor through the pre-existing Medicaid program. The new law mandated that state Medicaid plans expand to cover childless adults with incomes effectively up to 138 percent of the Federal Poverty Level (FPL). The law also provided states the financial inducement of an enhanced Federal Medical Assistance Percentage (FMAP), covering 100 percent of the costs for the newly eligible population for the first three years and gradually declining to 90 percent thereafter. Historically, the federal government has picked up 57 percent of Medicaid costs on average.

- **The Legal Challenge.** The Supreme Court struck down the ACA's Medicaid expansion mandate but left the rest of the law largely intact. While this took away the federal government's Medicaid expansion "stick," it left in place its generous FMAP "carrot."

- **The Question before the States.** States now face the complex decision of whether to expand Medicaid coverage—a decision that requires a careful balancing of powerful, conflicting considerations.

- **Weighing the Costs.** In particular, states must weigh the burden of higher state Medicaid expenditures under expansion against the benefit of maximizing externally financed health benefits for their citizens. These conflicting considerations are both very powerful, and responsible elected officials can be expected to weigh them differently according to their state's unique circumstances.

State Budget Concerns. States already face substantial near-term Medicaid cost increases irrespective of coverage expansion decisions. As a result, any new costs to states associated with Medicaid expansion must be budgeted for on top of preexisting cost increases.

- In 2011, Medicaid accounted for nearly 24 percent of state budget expenditures—despite the temporary FMAP increase provided under the 2009 stimulus law.

- States' Medicaid costs are projected to rise by more than 150 percent over the next decade. Much of the projected cost increase reflects growth in Medicaid caseloads and of per-enrollee Medicaid costs; some of the increase derives from the expiration of temporary emergency assistance provided to states during 2009–11 in federal stimulus legislation.

- Even with the generous FMAP rate provided under the ACA, states will need to shoulder not only higher costs in the future but a higher *percentage* of total Medicaid costs than they were responsible for financing during 2009–2011.

Federal Budget Context. States must also factor in the strong likelihood the federal government will reduce its scheduled Medicaid payments in the future.

- While the amount of resultant cost-shifting to states is unknown, it is reasonably likely that states will need to assume additional costs above and beyond current law of roughly the same magnitude as those they will face if they participate in the ACA's Medicaid expansion.

• **Changing Incentives and Fiscal Outcomes.** By removing the mandate, the court's decision also changed the interactions between the ACA's provisions; the Medicaid expansion and new health exchanges no longer work together as originally envisioned. This changes the incentives facing states and creates significant potential for unanticipated fiscal outcomes.

Adults with Incomes between 100 and 138 Percent of FPL. States now face one common, powerful incentive: to *decline* Medicaid coverage to childless adults with incomes between 100 and 138 percent of the FPL.

- By declining Medicaid coverage to this population, states can minimize their own budgetary exposure while leaving these individuals eligible for the ACA's new health insurance exchanges—and shifting the *full costs of their health coverage subsidies to the federal government*.

- This policy also would likely maximize potential health benefits for the individuals in this income range; government subsidies and insurance value are projected to be greater for such individuals in the ACA's health exchanges than they would be under Medicaid.

- Reducing states' incentives to have this population covered through the health exchanges rather than Medicaid would likely require substantial reductions in the ACA's health exchange subsidies.

Adults with Incomes below 100 Percent of FPL. States' decisions whether to cover childless adults with incomes below the poverty level are far more complicated, though a recent Department of Health and Human Services (HHS) announcement weakens their incentive to do so.

- Projections indicate that even if the ACA's high FMAP rates were provided for a partial Medicaid expansion, covering newly eligible individuals as well as increased numbers of those previously eligible (but yet uncovered) would add substantially to state budget costs.

- Effective FMAP rates associated with expansion will be lower than those expressly provided for in the ACA because of the "woodwork effect" of previously eligible individuals being brought under Medicaid at pre-ACA FMAP rates.

- HHS's recent announcement that the ACA's enhanced FMAP rate will *not* apply to a partial expansion further reduces state incentives to expand Medicaid at all.

- For some states to find it attractive to expand Medicaid coverage to 100 percent of the FPL would likely require the federal government to deem such an expansion as compliant with Medicaid law; to grant the requisite waivers; or to find another regulatory path to partial-expansion states receiving the ACA's enhanced FMAP rate.

- **Diverse Responses.** In contrast with statements made by both supporters and opponents of the ACA, the complexities of states' decisions to expand Medicaid suggest states will make a wide variety of policy choices.

- **Deferred Responses.** Some states will probably find it prudent to defer their decisions for as long as possible, seeking to maximize clarification of federal fiscal policies before they make further long-term commitments.

BACKGROUND

Medicaid before the Affordable Care Act

Medicaid is a complex partnership in which states receive federal funding support, along with a complicated set of federal stipulations and requirements. These include minimum standards for Medicaid insurance coverage, as well as certain individual participant eligibility criteria. Medicaid law has also long mandated that participating states cover specific needy and vulnerable populations, while expressly giving states the option of extending coverage to others. While state participation is technically optional, all states participate in the Medicaid program.

The secretary of the federal Department of Health and Human Services (HHS) is charged with determining whether a state is in compliance with Medicaid benefit and eligibility standards. The federal government has provided financing for compliant state Medicaid plans according to a statutory formula known as the Federal Medical Assistance Percentage (FMAP).

The FMAP varies by state and is a function of average individual income levels within each one; the lower the per capita income within the state, the greater the proportion of federal assistance. Historically, the federal government has picked up 57 percent of Medicaid costs on average, with states financing the remaining 43 percent. The federal share was temporarily increased in 2009 stimulus legislation that provided substantial short-term federal assistance to the states.

Despite the general applicability of federal law's basic Medicaid eligibility criteria, coverage levels have varied significantly from state to state. This is because of each state's statutory flexibility to cover those in "optional" coverage categories, as well as other aspects of Medicaid law that allow states to somewhat tailor their degree of coverage to their policy preferences. Many states have thus negotiated with the federal government to allow them to cover other populations beyond those specified in Medicaid law while still receiving the majority of their financing from the federal government.

SUMMARY

Expansion of Medicaid under the Affordable Care Act

One of the primary objectives of the ACA was to considerably expand US health insurance coverage, using federal funds to subsidize that expansion. Federal lawmakers chose the preexisting Medicaid program as the ACA's main vehicle for expanding both coverage and subsidies for the previously uninsured poor.

The ACA added a large category to the population that states' Medicaid programs must cover: essentially all previously ineligible individuals with incomes below 133 percent of the FPL were to be covered under Medicaid beginning January 1, 2014. The law also provides for an income exclusion equal to 5 percent of the FPL; thus, the ACA effectively expanded Medicaid eligibility to those with an income lower than 138 percent of the FPL.

In combination with the provision of law that empowers the HHS secretary to withhold further Medicaid payments to noncompliant states, the ACA threatened states with the loss of their existing federal Medicaid funding

if they did not proceed to cover all those with incomes below 138 percent of the FPL. At the same time, the ACA sought to provide the states, whose participation in Medicaid remained technically voluntary, with a powerful financial inducement to expand coverage.

The ACA specified that the FMAP for "newly eligible" individuals would be 100 percent for the years 2014–16, then gradually decline to 90 percent in 2020 and thereafter. This language effectively stipulates that the federal government will pick up most but not all of the costs of the ACA's intended Medicaid expansion.

The 2012 Supreme Court Decision

In June 2012, the Supreme Court ruled on the constitutionality of the ACA. While most of the law was upheld, the court concluded that it would be unconstitutional to apply a provision of law that would have permitted the federal government to take away states' existing Medicaid funding if they chose not to participate in the ACA's Medicaid expansion.

The Court's ruling took away the federal government's stick: it could not force states to expand Medicaid by denying their existing Medicaid funding if they declined, nor could it force states that chose to expand to do so according to the ACA's expansion schedule. The decision, however, left the federal government's carrot; the generous FMAP for the ACA's planned Medicaid coverage expansion.

Preliminary Data on State Attitudes and Incentives for Medicaid Coverage Expansion

The Supreme Court's ruling brought into focus a critical question: would all of the states expand Medicaid per the terms of the ACA now that it was no longer compulsory? For states, this decision is extremely complex, involving circumstances and value judgments that will vary from state to state.

After the Supreme Court decision, the Congressional Budget Office (CBO) lowered its estimate of individuals who would gain Medicaid coverage by 2022 under the ACA expansion from 17 million to 11 million. Of the 6 million CBO cut from its earlier estimates, it assumed 3 million would be insured under the law's newly established health exchanges, with the other 3 million remaining uninsured. CBO also projected that this partial expansion would reduce the "woodwork effect" of enrollment by previously eligible (but uncovered) individuals by roughly one-fifth.

While CBO recognized the ACA's substantial financial inducements were a strong incentive for states to participate in the Medicaid expansion, it also warned of the significant budgetary risks states choosing to expand Medicaid would face:

> ...[T]here are significant disincentives for states to expand Medicaid eligibility. One is that states would ultimately have to bear some costs for an expansion of Medicaid coverage during a period when their budgets are already under pressure, in part from the rising costs of the existing Medicaid program. ...although the 10 percent share of the costs of newly eligible people that states would ultimately bear would be a small share of total additional Medicaid spending, it would nevertheless represent a large extra cost for some states. In addition, CBO estimates, and states expect, that expanding the Medicaid-eligible population would lead to an increase in enrollment among those who would have been eligible under prior law and would not qualify for the higher federal matching rates, resulting in additional costs for participating states. States may also fear that the federal government, which faces its own severe budgetary pressures, will ultimately reduce the federal matching rate and that if it did so, rolling back expansions already in place would be difficult.

In addition to revising its expectation to only partial participation, CBO projected that expansions would be somewhat delayed as states were no longer bound by the ACA's timeline: instead of occurring by 2014 as originally required by the ACA, one-third would occur in 2014, one-third in 2015, and one-third in 2016 or later.

Expanding Medicaid: Weighing Conflicting Value Judgments

States' primary consideration competing with the benefits of expanded coverage is increased state Medicaid expenditures. The National Association of State Budget Officers reports that in 2011 Medicaid accounted for nearly 24 percent of state budget expenditures—despite the temporary FMAP increase provided under the 2009 stimulus law. A bipartisan State Budget Crisis Task Force reported in July 2012 that "Medicaid spending growth is crowding out other needs."

Further, irrespective of states' expansion decisions, Medicaid expenditures are projected to grow dramatically in the coming years. The Centers for Medicare and Medicaid Services (CMS) projected states' Medicaid expenditures to increase by more than 150 percent over the next decade. Much of this projected increase reflects caseload and the growth of per-enrollee Medicaid costs, though some of it also derives from the expiration of temporary emergency assistance provided to states during 2009–11 in federal stimulus legislation.

CMS projected that if state participation in the Medicaid expansion is universal, it will add a total of $64 billion in new state costs, equaling about 3 percent of total state Medicaid expenditures, through 2020. Using the assumptions from CBO's March 2012 estimates, this increase might be as much as $85 billion, or roughly 4 percent of total state Medicaid expenditures, through 2020.

While either increase would be small relative to the increase in federal costs and to states' total projected Medicaid budgets, it would be an incremental push in the wrong fiscal direction at a time when many states are already struggling to lower Medicaid expenditures.

Incentives for States to Limit Medicaid Coverage to 100 Percent of the Federal Poverty Level

When combined with the interactions of various ACA provisions, the Supreme Court's decision created a strong *disincentive* for states to expand Medicaid coverage to childless adults with incomes above 100 percent of the FPL.

By declining to cover this population under Medicaid, states can minimize their budgetary exposure while at the same time providing these individuals access to potentially more generous health insurance coverage through the ACA's health exchanges. Subsidies for participation in these exchanges are only available to individuals with incomes between 100 and 400 percent of the FPL who are not eligible for Medicaid.

Under the ACA, states that choose to cover these individuals under Medicaid will have to pay 10 percent of the associated costs by 2020. If instead these individuals remain uninsured by Medicaid and receive their health insurance through exchanges, the full cost of their subsidy support will be provided by the federal government.

It is likely individuals in the exchanges would receive better quality health insurance coverage than they would through Medicaid. For individuals in this income range, CBO estimates the annual value of the federal subsidy per exchange participant at about $9,000 by 2022, whereas the total value of Medicaid coverage would be well less than $7,000.

Expanding Medicaid to Cover Childless Adults with Incomes below 100 Percent of the FPL

States also face conflicting incentives and must make important subjective value judgments in determining coverage for those living in poverty. States must weigh any positive value associated with covering these individuals under Medicaid against the additional costs to the state of doing so. Historically, states have made a wide variety of choices reflecting substantially different weightings of these conflicting considerations.

Cost considerations facing the states can be at least roughly estimated. Assuming all states fully participated in the coverage expansion, CBO estimates that roughly two-thirds of those who would be newly eligible for Medicaid coverage would have incomes below 100 percent of the FPL. While actual proportions would vary significantly from state to state, on average, states that expanded coverage for only these individuals would see their Medicaid costs increase by roughly 2–3 percent.

Some have suggested that expanding Medicaid coverage could actually save money for states by reducing their costs for treating the uninsured. While a total evaluation should indeed net such savings against the gross costs of expanding Medicaid coverage, current data indicate it is unlikely they would fully offset the new costs.

Findings in a recent Kaiser Foundation study suggests that for states to come out ahead fiscally by expanding Medicaid, the effective FMAP percentage associated with the coverage expansion would likely need to be extremely high—perhaps as high as 92 percent. If states face even 8 percent of Medicaid costs for new enrollees, their total expenditures are likely to increase.

Beginning in 2020, the ACA's specified FMAP for the expansion population is 90 percent. Even when assuming states receive this enhanced FMAP rate for all those newly eligible, state costs would likely increase significantly under a Medicaid expansion. Part of the reason is the "woodwork effect" of previously eligible (but uncovered) individuals with lower FMAP match rates being signed up for the first time under the ACA's outreach processes.

CBO estimates that of those who would receive new Medicaid coverage under the ACA:

- approximately 25 percent would be newly eligible enrollees with incomes between 100 and 138 percent of the FPL;
- approximately 50 percent would be newly eligible enrollees with incomes below 100 percent of the FPL; and
- approximately 25 percent would be previously eligible enrollees who had not already enrolled.

This distribution suggests that if states were to expand Medicaid and receive the ACA's enhanced FMAP rate, roughly two-thirds of the newly Medicaid-insured population with incomes below the FPL will be covered with a long-term FMAP rate of 90 percent, the remaining third being those previously eligible with an average FMAP rate of 57 percent. Under these assumptions, states could expect their average long-term contribution for covering this population to be roughly 21 percent—far higher than the estimated break-even level of 8 percent.

In December 2012, HHS Secretary Sebelius wrote to governors to indicate that the ACA's enhanced FMAP rate would not apply to a Medicaid expansion that is less than that envisioned under the ACA. The letter stated that waivers for partial expansions would be considered only "at the regular matching rate." This announcement is likely to considerably reduce state incentives to expand Medicaid even to 100 percent of the FPL.

Ultimately, state Medicaid coverage decisions may depend on whether states can obtain a waiver from the federal government for coverage only up to 100 percent of the FPL, or to a lower income level. It is therefore likely that some states will decline to undertake even a partial expansion unless certain favorable terms, including not only higher FMAP rates but also other new administrative flexibility, are extended.

Is Projected Federal Financing Support for Medicaid Reliable?

States must also factor in the near certainty the federal government will not provide the full level of Medicaid funding now scheduled under law.

Medicaid, CHIP, and the ACA's new health exchange subsidies are all leading contributors to the mounting federal fiscal problem. To return the federal budget to sustainable historical norms in the absence of any cuts in the growth of Medicaid and the new health exchanges would require all other noninterest spending to be cut by nearly one-quarter by 2037 relative to projected levels, and by roughly 15 percent relative to current levels in relation to GDP. This is probably unrealistic.

There also appears to be general bipartisan agreement that the current path of federal Medicaid spending is unsustainable and must be slowed. Constraints on Medicaid spending growth have been proposed in President Obama's submitted budgets, in the recommendations of the bipartisan Simpson–Bowles Commission, and in the budget resolution passed by the House of Representatives in 2012. The projected cost savings vary widely between

these proposals, but each would trim a minimum of $100 billion from the projected cost of Medicaid over the coming decade, though practical budgetary considerations suggest that substantially greater savings will be needed.

Though reductions in the growth of federal Medicaid spending are nearly certain, the extent to which they would result in increased state Medicaid costs cannot be precisely quantified. It is reasonable for states to expect, however, that these reductions could result in their carrying additional costs of the same order of magnitude as the ACA's Medicaid expansion.

Medicaid reforms that empower states to employ market forces to improve efficiency and reduce the growth of federal Medicaid spending could actually reduce total Medicaid spending growth, rather than simply shift costs between federal and state governments. A number of governors have publicly expressed support for such structural reforms as the keys to whether state governments will be able to handle projected caseload increases—including the Medicaid coverage expansion envisioned in the ACA.

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