FIEC

Provide Medicaid Coverage to Eligible Low-Income Adults

18-16

2019

Financial Impact Estimating Conference

Provide Medicaid Coverage to Eligible Low-Income Adults
Serial Number 18-16

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Tab 1

Authorization

FLORIDA DEPARTMENT of STATE

RON DESANTIS
Governor

LAUREL M. LEE
Secretary of State

May 28, 2019

Financial Impact Estimating Conference
c/o Amy Baker, Coordinator
Office of Economic and Demographic Research
111 West Madison Street, Ste. 574
Tallahassee, Florida 32399-6588

Dear Ms. Baker:

Section 15.21, Florida Statutes, provides that the Secretary of State shall submit an initiative petition to the Financial Impact Estimating Conference when a sponsoring political committee has met the registration, petition form submission and signature criteria set forth in that section.

The criteria in section 15.21, Florida Statutes, has now been met for the initiative petition titled **Provide Medicaid Coverage to Eligible Low-Income Adults**, Serial Number **18-16**. Therefore, I am submitting the proposed constitutional amendment petition form, along with a status update for the initiative petition, and a chart that provides a statewide signature count and count by congressional districts.

Sincerely,

Laurel M. Lee
Secretary of State

LL/am/ljr

pc: Whitney Untiedt, Chairperson, Florida Decides Healthcare, Inc.

Enclosures

CONSTITUTIONAL AMENDMENT PETITION FORM

Note:

- *All information on this form, including your signature, becomes a public record upon receipt by the Supervisor of Elections.*
- *Under Florida law, it is a first degree misdemeanor, punishable as provided in s. 775.082 or s. 775.08, Florida Statutes, to knowingly sign more than one petition for an issue. [Section 104.185, Florida Statutes]*
- *If all requested information on this form is not completed, the form will not be valid.*

Your name: _____

Please Print Name ***as it appears on your Voter Information Card***

Your address:

_____

City _____ **Zip**_____ **County**_____

☐ Please change my legal residence address on my voter registration record to the above residence address (check box, if applicable).

Voter Registration Number _____ **or Date of Birth** _____

I am a registered voter of Florida and hereby petition the Secretary of State to place the following proposed amendment to the Florida Constitution on the ballot in the general election:

BALLOT TITLE: Provide Medicaid Coverage to Eligible Low-Income Adults.

BALLOT SUMMARY: Requires State to provide Medicaid coverage to individuals over age 18 and under age 65 whose incomes are at or below 138 percent of the federal poverty level and meet other nonfinancial eligibility requirements, with no greater burdens placed on eligibility, enrollment, or benefits for these newly eligible individuals compared to other Medicaid beneficiaries. Directs Agency for Health Care Administration to implement the initiative by maximizing federal financial participation for newly eligible individuals.

ARTICLE AND SECTION BEING CREATED OR AMENDED: Creates New Section 33 in Article X.

FULL TEXT OF THE PROPOSED CONSTITUTIONAL AMENDMENT:

A new Section 33 is added to Article X of the State Constitution, as follows:

SECTION 33. Provide Medicaid Coverage to Eligible Low-Income Adults.–

(a) MEDICAID COVERAGE FOR LOW-INCOME ADULTS. The State shall provide Medicaid benefits to Low Income Adults over age 18 and under age 65 whose income is one-hundred thirty-eight percent (138%) of the federal poverty level or below, and who meet other nonfinancial eligibility requirements of the federal Medicaid statute. The State shall not impose on Low Income Adults any greater or additional burdens or restrictions on eligibility, enrollment, or benefits than on any other population eligible for medical assistance.

(Continues on back)

(Continued from front)

(b) DEFINITIONS. For the purposes of this section, the following words and terms shall have the stated meanings:

(1) "Low Income Adults" refers to those individuals over age 18 and under age 65, whose income is one-hundred thirty-eight percent (138%) of the federal poverty level or below, as described by and using the income methodology provided for by the federal Medicaid statute at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), and who meet applicable non-financial eligibility conditions for Medicaid under 42 CFR Part 435, Subpart E.

(2) "Agency for Health Care Administration" or "Agency" refers to the single State agency responsible for administering Florida's Medicaid plan pursuant to 42 U.S.C. § 1396a(a)(5) and § 409.902, Fla. Stat.

(3) "State Plan Amendment" refers to the document(s) the State submits to the Centers for Medicare and Medicaid Services (CMS) for review and approval before making a change to its program policies, including setting forth the groups of individuals to be covered.

(4) "Centers for Medicare and Medicaid Services" refers to the agency responsible for administering the Medicaid program at the federal level, including review and approval of State Plan Amendments.

(c) IMPLEMENTATION.

(1) Within 90 days of voter approval of this Section, in order to implement the provision of Medicaid coverage to Low Income Adults and obtain Federal Medical Assistance Percentage funds for the cost of their coverage, the Agency for Health Care Administration shall submit a State Plan Amendment and all other necessary documents, as well as take any additional necessary steps to seek required approvals from the Centers for Medicare and Medicaid Services to include Low Income Adults as a coverage group in Florida's Medicaid program.

(2) Nothing in this Section shall limit the Legislature from enacting laws consistent with this Section. Specifically, it is consistent with this section to add a new subsection (section (9) below) to Fla. Stat. 409.903 Mandatory payments for eligible persons.—

(9) A person over age 18 and under age 65 whose income is 138 percent of the poverty level or below.

_____ X_____

DATE OF SIGNATURE **SIGNATURE OF REGISTERED VOTER**

Initiative petition sponsored by Florida Decides Healthcare, Inc., P.O. Box 15415, Coral Gables, FL 33114-5415.

Return signed form to:
Florida Decides Healthcare, Inc.
P.O. Box 15415
Coral Gables, FL 33114-5415

If paid petition circulator is used:

Circulator's name_____

Circulator's address_____

_____

For Official Use Only:

Serial Number: 18-16

Date Approved: 12/12/2018

FLORIDA DEPARTMENT OF STATE
DIVISION OF ELECTIONS

SUMMARY OF PETITION SIGNATURES

Political Committee: **Florida Decides Healthcare, Inc.**

Amendment Title: **Provide Medicaid Coverage to Eligible Low-Income Adults**

Congressional District	Voting Electors in 2016 Presidential Election	For Review 10% of 8% Required By Section 15 21 Florida Statutes	For Ballot 8% Required By Article XI, Section 3 Florida Constitution	Signatures Certified	
FIRST	386,504	3,093	30,921	872	
SECOND	360,098	2,881	28,808	1,240	
THIRD	356,715	2,854	28,538	3,467	***
FOURTH	428,190	3,426	34,256	1,731	
FIFTH	316,115	2,529	25,290	3,509	***
SIXTH	385,918	3,088	30,874	1,544	
SEVENTH	370,466	2,964	29,638	3,206	***
EIGHTH	409,569	3,277	32,766	4,955	***
NINTH	362,593	2,901	29,008	7,347	***
TENTH	320,548	2,565	25,644	3,975	***
ELEVENTH	417,253	3,339	33,381	1,996	
TWELFTH	386,775	3,095	30,942	795	
THIRTEENTH	367,818	2,943	29,426	4,761	***
FOURTEENTH	336,289	2,691	26,904	4,116	***
FIFTEENTH	340,331	2,723	27,227	2,812	***
SIXTEENTH	403,805	3,231	32,305	2,825	
SEVENTEENTH	360,061	2,881	28,805	3,296	***
EIGHTEENTH	388,772	3,111	31,102	1,888	
NINETEENTH	389,415	3,116	31,154	3,519	***
TWENTIETH	291,984	2,336	23,359	5,714	***
TWENTY-FIRST	355,842	2,847	28,468	2,504	
TWENTY-SECOND	361,305	2,891	28,905	2,229	
TWENTY-THIRD	342,784	2,743	27,423	2,486	
TWENTY-FOURTH	269,446	2,156	21,556	5,872	***
TWENTY-FIFTH	269,983	2,160	21,599	936	
TWENTY-SIXTH	294,742	2,358	23,580	1,994	
TWENTY-SEVENTH	304,012	2,433	24,321	1,992	
TOTAL:	**9,577,333**	**76,632**	**766,200**	**81,581**	

Date: 5/30/2019 3.28 53 PM

Attachment for Initiative Petition

Provide Medicaid Coverage to Eligible Low-Income Adults
Serial Number 18-16

1. **Name and address of the sponsor of the initiative petition:**
   Whitney Untiedt, Chairperson
   Florida Decides Healthcare, Inc.
   2 South Biscayne Boulevard
   Suite 3100
   Miami, Florida 33131

2. **Name and address of the sponsor's attorney, if the sponsor is represented:** Unknown

3. **A statement as to whether the sponsor has obtained the requisite number of signatures on the initiative petition to have the proposed amendment put on the ballot:** As of May 28, 2019, the sponsor has not obtained the requisite number of signatures to have the proposed amendment placed on the ballot. A total of 766,200 valid signatures are required for placement on the 2020 general election ballot.

4. **If the sponsor has not obtained the requisite number of signatures on the initiative petition to have the proposed amendment put on the ballot, the current status of the signature-collection process:** As of May 28, 2019, Supervisors of Elections have certified a total of 81,581 valid petition signatures to the Division of Elections for this initiative petition. This number represents more than 10% of the total number of valid signatures needed from electors statewide and in at least one-fourth of the congressional districts in order to have the initiative placed on the 2020 general election ballot.

5. **The date of the election during which the sponsor is planning to submit the proposed amendment to the voters:** Unknown. The earliest date of election that this proposed amendment can be placed on the ballot is November 3, 2020, provided the sponsor successfully obtains the requisite number of valid signatures by February 1, 2020.

6. **The last possible date that the ballot for the target election can be printed in order to be ready for the election:** Unknown

7. **A statement identifying the date by which the Financial Impact Statement will be filed, if the Financial Impact Statement is not filed concurrently with the request:** The Secretary of State forwarded a letter to the Financial Impact Estimating Conference in the care of the coordinator on May 28, 2019.

8. **The names and complete mailing addresses of all of the parties who are to be served:** This information is unknown at this time.

Tab 2

Current Law

(14) Income determined using modified adjusted gross income.-

(A) In general.-Notwithstanding subsection (r) or any other provision of this subchapter, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on March 23, 2010. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this subchapter and subchapter XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(B) No income or expense disregards.-Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

(C) No assets test.-A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D) Exceptions.-

(i) Individuals eligible because of other aid or assistance, elderly individuals, medically needy individuals, and individuals eligible for medicare cost-sharing.-Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under subchapter XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

(II) Individuals who have attained age 65.

(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of paragraph (3).

(IV) Individuals described in subsection (a)(10)(C).

(V) Individuals described in any clause of subsection (a)(10)(E).

(ii) Express lane agency findings.-In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane

agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

(iii) Medicare prescription drug subsidies determinations.-Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1395w–114 of this title made by the State pursuant to section 1396u–5(a)(2) of this title.

(iv) Long-term care.-Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1396n of this title or a waiver under section 1315 of this title, and services described in section 1396p(c)(1)(C)(ii) of this title.

(v) Grandfather of current enrollees until date of next regular redetermination.-An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified adjusted gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

(E) Transition planning and oversight.-Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on March 23, 2010. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, no longer being eligible for such assistance.

(F) Limitation on secretarial authority.-The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1396n(h)(2)(B) of this title) under the State plan or under a waiver of the plan and under subchapter XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

(G) Definitions of modified adjusted gross income and household income.-In this paragraph, the terms "modified adjusted gross income" and "household income" have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

(H) Continued application of medicaid rules regarding point-in-time income and sources of income.-The requirement under this paragraph for States to use modified adjusted gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of-

(i) the requirement under this subchapter and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

(ii) any rules established under this subchapter or under the State plan or a waiver of the plan regarding sources of countable income.

(I) Treatment of portion of modified adjusted gross income.-For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall-

(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and

(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.

(J) Exclusion of parent mentor compensation from income determination.-Any nominal amount received by an individual as compensation, including a stipend, for participation as a parent mentor (as defined in paragraph (5) of section 1397mm(f) of this title) in an activity or program funded through a grant under such section shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

(K) Treatment of certain lottery winnings and income received as a lump sum.-

(i) In general.-In the case of an individual who is the recipient of qualified lottery winnings (pursuant to lotteries occurring on or after January 1, 2018) or qualified lump sum income (received on or after such date) and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall, in determining such eligibility, include such winnings or income (as applicable) as income received-

(I) in the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than $80,000;

(II) over a period of 2 months if the amount of such winnings or income (as applicable) is greater than or equal to $80,000 but less than $90,000;

(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to $90,000 but less than $100,000; and

(IV) over a period of 3 months plus 1 additional month for each increment of $10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of $1,260,000 or more), if the amount of such winnings or income is greater than or equal to $100,000.

(ii) Counting in equal installments.-For purposes of subclauses (II), (III), and (IV) of clause (i), winnings or income to which such subclause applies shall be counted in equal monthly installments over the period of months specified under such subclause.

(iii) Hardship exemption.-An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, shall continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State (in accordance with standards specified by the

Secretary), that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

(iv) Notifications and assistance required in case of loss of eligibility.-A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i)-

(I) before the date on which the individual loses such eligibility, inform the individual-

(aa) of the individual's opportunity to enroll in a qualified health plan offered through an Exchange established under title I of the Patient Protection and Affordable Care Act during the special enrollment period specified in section 9801(f)(3) of title 26 (relating to loss of Medicaid or CHIP coverage); and

(bb) of the date on which the individual would no longer be considered ineligible by reason of clause (i) to receive medical assistance under the State plan or under any waiver of such plan and be eligible to reapply to receive such medical assistance; and

(II) provide technical assistance to the individual seeking to enroll in such a qualified health plan.

(v) Qualified lottery winnings defined.-In this subparagraph, the term "qualified lottery winnings" means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of title 26 or a lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

(vi) Qualified lump sum income defined.-In this subparagraph, the term "qualified lump sum income" means income that is received as a lump sum from monetary winnings from gambling (as defined by the Secretary and including gambling activities described in section 1955(b)(4) of title 18).

42 USC 1396a: State plans for medical assistance Text contains those laws in effect on June 6, 2019
From Title 42-THE PUBLIC HEALTH AND WELFARECHAPTER 7-SOCIAL SECURITYSUBCHAPTER XIX-GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS
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§1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must-

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor, and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under chapter 21 of title 41 to persons described in section 2102(a)(3) of title 41;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of

subchapter IV if the State is not eligible to participate in the State plan program established under subchapter XVI;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide-

(A) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with-

(i) the administration of the plan; and

(ii) the exchange of information necessary to certify or verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 [42 U.S.C. 1771 et seq.] and free or reduced price lunches under the Richard B. Russell National School Lunch Act [42 U.S.C. 1751 et seq.], in accordance with section 9(b) of that Act [42 U.S.C. 1758(b)], using data standards and formats established by the State agency; and

(B) that, notwithstanding the Express Lane option under subsection (e)(13), the State may enter into an agreement with the State agency administering the school lunch program established under the Richard B. Russell National School Lunch Act under which the State shall establish procedures to ensure that-

(i) a child receiving medical assistance under the State plan under this subchapter whose family income does not exceed 133 percent of the poverty line (as defined in section 9902(2) of this title, including any revision required by such section), as determined without regard to any expense, block, or other income disregard, applicable to a family of the size involved, may be certified as eligible for free lunches under the Richard B. Russell National School Lunch Act and free breakfasts under the Child Nutrition Act of 1966 without further application; and

(ii) the State agencies responsible for administering the State plan under this subchapter, and for carrying out the school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the school breakfast program established by section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773), cooperate in carrying out paragraphs (3)(F) and (15) of section 9(b) of that Act [42 U.S.C. 1758(b)];

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide-

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions,

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) of section 1395x(s) of

this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title, and

(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;

(10) provide-

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), (28), and (29) of section 1396d(a) of this title, to-

(i) all individuals-

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A or part E of subchapter IV (including individuals eligible under this subchapter by reason of section 602(a)(37),[1] 606(h),[1] or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6)[1] of this title),

(II)(aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1396d(q) of this title), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI if subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase "the first day of the month following",

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family; [2]

(V) who are qualified family members as defined in section 1396d(m)(1) of this title,

(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family,

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family; [2]

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved, subject to subsection (k); [2] or

Subpart E—General Eligibility Requirements

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§435.400 Scope.

This subpart prescribes general requirements for determining the eligibility of both categorically and medically needy individuals specified in subparts B, C, and D of this part.

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§435.401 General rules.

(a) A Medicaid agency may not impose any eligibility requirement that is prohibited under Title XIX of the Act.

(b) The agency must base any optional group covered under subparts B and C of this part on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals and groups and that are consistent with the objectives of Title XIX.

(c) The agency must not use requirements for determining eligibility for optional coverage groups that are—

(1) [Reserved]

(2) For aged, blind, and disabled individuals, more restrictive than those used under SSI, except for individuals receiving an optional State supplement as specified in §435.230 or individuals in categories specified by the agency under §435.121.

[43 FR 45204, Sept. 29, 1978, as amended at 81 FR 86454, Nov. 30, 2016]

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§435.402 [Reserved]

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§435.403 State residence.

(a) *Requirement.* The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in §431.52 of this chapter.

(b) *Definition.* For purposes of this section—*Institution* has the same meaning as *Institution* and *Medical institution,* as defined in §435.1010. For purposes of State placement, the term also includes *foster care homes,* licensed as set forth in 45 CFR 1355.20, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

(c) *Incapability of indicating intent.* For purposes of this section, an individual is considered incapable of indicating intent if the individual—

(1) Has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the Intellectual Disability agency in the State:

(2) Is judged legally incompetent; or

(3) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the State in the field of intellectual disability.

(d) *Who is a State resident.* A resident of a State is any individual who:

(1) Meets the conditions in paragraphs (e) through (i) of this section; or

(2) Meets the criteria specified in an interstate agreement under paragraph (k) of this section.

(e) *Placement by a State in an out-of-State institution*—(1) *General rule.* Any agency of the State, including an entity recognized under State law as being under contract with the State for such purposes, that arranges for an individual to be placed in an institution located in another State, is recognized as acting on behalf of the State in making a placement. The State arranging or actually making the placement is considered as the individual's State of residence.

(2) Any action beyond providing information to the individual and the individual's family would constitute arranging or making a State placement. However, the following actions do not constitute State placement:

(i) Providing basic information to individuals about another State's Medicaid program, and information about the availability of health care services and facilities in another State.

(ii) Assisting an individual in locating an institution in another State, provided the individual is capable of indicating intent and independently decides to move.

(3) When a competent individual leaves the facility in which the individual is placed by a State, that individual's State of residence for Medicaid purposes is the State where the individual is physically located.

(4) Where a placement is initiated by a State because the State lacks a sufficient number of appropriate facilities to provide services to its residents, the State making the placement is the individual's State of residence for Medicaid purposes.

(f) *Individuals receiving a State supplementary payment (SSP).* For individuals of any age who are receiving an SSP, the State of residence is the State paying the SSP.

(g) *Individuals receiving Title IV-E payments.* For individuals of any age who are receiving Federal payments for foster care and adoption assistance under title IV-E of the Social

Security Act, the State of residence is the State where the child lives.

(h) *Individuals age 21 and over.* Except as provided in paragraph (f) of this section, with respect to individuals age 21 and over —

(1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence is the State where the individual is living and—

(i) Intends to reside, including without a fixed address; or

(ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed).

(2) For an individual not residing in an institution as defined in paragraph (b) of this section who is not capable of stating intent, the State of residency is the State where the individual is living.

(3) For any institutionalized individual who became incapable of indicating intent before age 21, the State of residence is—

(i) That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate States (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's);

(ii) The parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or

(iii) The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that State (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's).

(iv) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

(4) For any institutionalized individual who became incapable of indicating intent at or after age 21, the State of residence is the State in which the individual is physically present, except where another State makes a placement.

(5) For any other institutionalized individual, the State of residence is the State where the individual is living and intends to reside.

(i) *Individuals under age 21.* For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under title IV-E of the Act, as addressed in paragraph (g) of this section, and is not receiving a State supplementary payment, as addressed in paragraph (f) of this section, the State of residence is as follows:

(1) For an individual who is capable of indicating intent and who is emancipated from his or her parent or who is married, the State of residence is determined in accordance with paragraph (h)(1) of this section.

(2) For an individual not described in paragraph (i)(1) of this section, not living in an institution as defined in paragraph (b) of this section and not eligible for Medicaid based on receipt of assistance under title IV-E of the Act, as addressed in paragraph (g) of this section, and is not receiving a State supplementary payment, as addressed in paragraph (f) of this section, the State of residence is:

(i) The State where the individual resides, including without a fixed address; or

(ii) The State of residency of the parent or caretaker, in accordance with paragraph (h)(1) of this section, with whom the individual resides.

(3) For any institutionalized individual who is neither married nor emancipated, the State of residence is—

(i) The parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or

(ii) The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that State (if a legal guardian has been appointed and parental rights are terminated, the State or residence of the guardian is used instead of the parent's).

(iii) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

(j) *Specific prohibitions.* (1) The agency may not deny Medicaid eligibility because an individual has not resided in the State for a specified period.

(2) The agency may not deny Medicaid eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in the State before entering the institution.

(3) The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.

(k) *Interstate agreements.* A State may have a written agreement with another State setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in paragraphs (c) through (i) of this section, but must not include criteria that result in loss of residency in both States or that are prohibited by paragraph (j) of this section. The agreements must contain a procedure for providing

Medicaid to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of title IV-E individuals when the child and his or her adoptive parent(s) move into another State.

(l) *Continued Medicaid for institutionalized beneficiaries.* If an agency is providing Medicaid to an institutionalized beneficiary who, as a result of this section, would be considered a resident of a different State—

(1) The agency must continue to provide Medicaid to that beneficiary from June 24, 1983 until July 5, 1984, unless it makes arrangements with another State of residence to provide Medicaid at an earlier date: and

(2) Those arrangements must not include provisions prohibited by paragraph (i) of this section.

(m) *Cases of disputed residency.* Where two or more States cannot resolve which State is the State of residence, the State where the individual is physically located is the State of residence.

[49 FR 13531, Apr. 5, 1984, as amended at 55 FR 48609, Nov. 21, 1990; 71 FR 39222, July 12, 2006; 77 FR 17206, Mar. 23, 2012]

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§435.404 Applicant's choice of category.

The agency must allow an individual who would be eligible under more than one category to have his eligibility determined for the category he selects.

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§435.406 Citizenship and non-citizen eligibility.

(a) The agency must provide Medicaid to otherwise eligible individuals who are—

(1) Citizens and nationals of the United States, provided that—

(i) The individual has made a declaration of United States citizenship, as defined in §435.4, or an individual described in paragraph (a)(3) of this section has made such declaration on the individual's behalf, and such status is verified in accordance with paragraph (c) of this section; and

(ii) For purposes of the declaration and citizenship verification requirements discussed in paragraphs (a)(1)(i) of this section, an individual includes applicants under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in its expenditures.

(iii) The following groups of individuals are exempt from the requirement to provide documentation to verify citizenship in paragraph (c) of this section:

(A) Individuals receiving SSI benefits under title XVI of the Act.

(B) Individuals entitled to or enrolled in any part of Medicare.

(C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).

(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV-E of the Act.

(E)(*1*) Individuals who are or were deemed eligible for Medicaid in the State under §435.117 or §457.360 of this chapter on or after July 1, 2006, based on being born to a pregnant woman eligible under the State's Medicaid or CHIP state plan or waiver of such plan;

(*2*) At State option, individuals who were deemed eligible for coverage under §435.117 or §457.360 of this chapter in another State on or after July 1, 2006, provided that the agency verifies such deemed eligibility.

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified non-citizens), qualified non-citizens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified non-citizens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Non-Citizen status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an non-citizen in a satisfactory immigration status.

(ii) The eligibility of qualified non-citizens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(3) For purposes of paragraphs (a)(1) and (2), of this section, a declaration of citizenship or satisfactory immigration status may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative, as defined in §435.923, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.

(b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified non-citizens subject to the 5-year bar or who are non-qualified non-citizens who meet all Medicaid eligibility criteria, except non-qualified non-citizens need not present a social security number or document immigration status.

(c) The agency must verify the declaration of citizenship or satisfactory immigration status under paragraph (a)(1) or (2) of this section in accordance with §435.956.

[55 FR 36819, Sept. 7, 1990, as amended at 56 FR 10807, Mar. 14, 1991; 71 FR 39222, July 12, 2006; 72 FR 38691, July 13, 2007; 81 FR 86454, Nov. 30, 2016]

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§435.407 Types of acceptable documentary evidence of citizenship.

(a) *Stand-alone evidence of citizenship.* The following must be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of U.S. Citizenship.

(4) A valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship, or obtains and verifies a SSN from the applicant who is a citizen before issuing such license.

(5)(i) Documentary evidence issued by a Federally recognized Indian Tribe identified in the FEDERAL REGISTER by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including Tribes located in a State that has an international border, which—

(A) Identifies the Federally recognized Indian Tribe that issued the document;

(B) Identifies the individual by name; and

(C) Confirms the individual's membership, enrollment, or affiliation with the Tribe.

(ii) Documents described in paragraph (a)(5)(i) of this section include, but are not limited to:

(A) A Tribal enrollment card;

(B) A Certificate of Degree of Indian Blood;

(C) A Tribal census document;

(D) Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official, that meet the requirements of paragraph (a)(5)(i) of this section.

(6) A data match with the Social Security Administration.

(b) *Evidence of citizenship.* If an applicant does not provide documentary evidence from the list in paragraph (a) of this section, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in paragraph (c) of this section—

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Guam, American Samoa, Swain's Island, Puerto Rico (if born on or after January 13, 1941), the Virgin Islands of the U.S. or the CNMI (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the Northern Mariana Islands before the applicable date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) *Puerto Rico:* Evidence of birth in Puerto Rico and the applicant's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941.

(ii) *Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):*

(A) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986, (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);

(B) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975, and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);

(C) Evidence of continuous domicile in the NMI since before January 1, 1974, and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time). Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) At State option, a cross match with a State vital statistics agency documenting a record of birth.

(3) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(4) A Report of Birth Abroad of a U.S. Citizen.

(5) A Certification of birth in the United States.

(6) A U.S. Citizen I.D. card.

(7) A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency).

(8) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth.

(9) Evidence of U.S. Civil Service employment before June 1, 1976.

(10) U.S. Military Record showing a U.S. place of birth.

(11) A data match with the SAVE Program or any other process established by DHS to verify that an individual is a citizen.

(12) Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 as amended (8 U.S.C. 1431).

(13) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(14) Life, health, or other insurance record that indicates a U.S. place of birth.

(15) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(16) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth.

(17) Federal or State census record showing U.S. citizenship or a U.S. place of birth.

(18) If the applicant does not have one of the documents listed in paragraphs (a) or (b)(1) through (17) of this section, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(c) *Evidence of identity.* (1) The agency must accept the following as proof of identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(i) Identity documents listed at 8 CFR 274a.2 (b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(ii) Driver's license issued by a State or Territory.

(iii) School identification card.

(iv) U.S. military card or draft record.

(v) Identification card issued by the Federal, State, or local government.

(vi) Military dependent's identification card.

(vii) U.S. Coast Guard Merchant Mariner card.

(viii) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(ix) A finding of identity from an Express Lane agency, as defined in section 1902(e)(13)(F) of the Act.

(x) Two other documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards; high school, high school equivalency and college diplomas; marriage certificates; divorce decrees; and property deeds or titles.

(2) Finding of identity from a Federal or State governmental agency. The agency may accept as proof of identity a finding of identity from a Federal agency or another State agency (not described in paragraph (c)(1)(ix) of this section), including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(3) If the applicant does not have any document specified in paragraph (c)(1) of this section and identity is not verified under paragraph (c)(2) of this section, the agency must accept an affidavit signed, under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described in paragraph (c)(1) of this section. The affidavit does not have to be notarized.

(d) *Verification of citizenship by a Federal agency or another State.* The agency may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a Federal agency or another State agency, if such verification was done on or after July 1, 2006.

(e) *Assistance with obtaining documentation.* States must provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

(f) *Documentary evidence.* A photocopy, facsimile, scanned or other copy of a document must be accepted to the same extent as an original document under this section, unless information on the copy submitted is inconsistent with other information available to the agency or the agency otherwise has reason to question the validity of, or the information in, the document.

[81 FR 86455, Nov. 30, 2016]

The 2018 Florida Statutes

Title XXX - SOCIAL WELFARE

Chapter 409 - SOCIAL AND ECONOMIC ASSISTANCE

409.915 County contributions to Medicaid.—Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, the state shall charge the counties an annual contribution in order to acquire a certain portion of these funds.

(1) As used in this section, the term "state Medicaid expenditures" means those expenditures used as matching funds for the federal Medicaid program.

(2)(a) For the 2013-2014 state fiscal year, the total amount of the counties' annual contribution is $269.6 million.

(b) For the 2014-2015 state fiscal year, the total amount of the counties' annual contribution is $277 million.

(c) By March 15, 2015, and each year thereafter, the Social Services Estimating Conference shall determine the percentage change in state Medicaid expenditures by comparing expenditures for the 2 most recent completed state fiscal years.

(d) For the 2015-2016 state fiscal year through the 2019-2020 state fiscal year, the total amount of the counties' annual contribution shall be the total contribution for the prior fiscal year adjusted by 50 percent of the percentage change in the state Medicaid expenditures as determined by the Social Services Estimating Conference.

(e) For each fiscal year after the 2019-2020 state fiscal year, the total amount of the counties' annual contribution shall be the total contribution for the prior fiscal year adjusted by the percentage change in the state Medicaid expenditures as determined by the Social Services Estimating Conference.

(3)(a)1. The amount of each county's annual contribution is equal to the product of the amount determined under subsection (2) multiplied by the sum of the percentages calculated in sub-subparagraphs a. and b.:

a. The enrollment weight provided in subparagraph 2. is multiplied by a fraction, the numerator of which is the number of the county's Medicaid enrollees as of March 1 of each year, and the denominator of which is the number of all counties' Medicaid enrollees as of March 1 of each year. The agency shall calculate this amount for each county and provide the information to the Department of Revenue by May 15 of each year.

b. The payment weight provided in subparagraph 2. is multiplied by the percentage share of payments provided in subparagraph 3. for each county.

2. The weights for each fiscal year are equal to:

WEIGHTS

FISCAL YEAR	ENROLLMENT	PAYMENT
2013-14	0%	100%
2014-15	0%	100%
2015-16	20%	80%
2016-17	40%	60%
2017-18	60%	40%
2018-19	80%	20%
2019-20+	100%	0%

3. The percentage share of payments for each county is:

COUNTY	SHARE OF PAYMENTS
Alachua	1.278%
Baker	0.116%
Bay	0.607%
Bradford	0.179%
Brevard	2.471%
Broward	9.228%
Calhoun	0.084%
Charlotte	0.578%
Citrus	0.663%
Clay	0.635%
Collier	1.161%
Columbia	0.557%
Dade (Miami-Dade)	18.853%
Desoto	0.167%
Dixie	0.098%
Duval	5.337%
Escambia	1.615%
Flagler	0.397%
Franklin	0.091%
Gadsden	0.239%
Gilchrist	0.078%
Glades	0.055%
Gulf	0.076%
Hamilton	0.075%
Hardee	0.110%
Hendry	0.163%
Hernando	0.862%
Highlands	0.468%
Hillsborough	6.953%
Holmes	0.101%
Indian River	0.397%
Jackson	0.219%
Jefferson	0.083%

Lafayette	0.014%
Lake	1.525%
Lee	2.512%
Leon	0.929%
Levy	0.256%
Liberty	0.050%
Madison	0.086%
Manatee	1.623%
Marion	1.630%
Martin	0.353%
Monroe	0.262%
Nassau	0.240%
Okaloosa	0.567%
Okeechobee	0.235%
Orange	6.682%
Osceola	1.613%
Palm Beach	5.899%
Pasco	2.392%
Pinellas	6.645%
Polk	3.643%
Putnam	0.417%
Saint Johns	0.459%
Saint Lucie	1.155%
Santa Rosa	0.462%
Sarasota	1.230%
Seminole	1.740%
Sumter	0.218%
Suwannee	0.252%
Taylor	0.103%
Union	0.075%
Volusia	2.298%
Wakulla	0.103%
Walton	0.229%
Washington	0.114%

(b)1. The Legislature intends to replace the county percentage share provided in subparagraph (a)3. with percentage shares based upon each county's proportion of the total statewide amount of county billings made

under this section from April 1, 2012, through March 31, 2013, for which the state ultimately receives payment.
2. By February 1 of each year and continuing until a certification is made under sub-subparagraph b., the agency shall report to the President of the Senate and the Speaker of the House of Representatives the status of the county billings made under this section from April 1, 2012, through March 31, 2013, by county, including:
a. The amounts billed to each county which remain unpaid, if any; and
b. A certification from the agency of a final accounting of the amount of funds received by the state from such billings, by county, upon the expiration of all appeal rights that counties may have to contest such billings.
3. By March 15 of the state fiscal year in which the state receives the certification provided for in sub-subparagraph 2.b., the Social Services Estimating Conference shall calculate each county's percentage share of the total statewide amount of county billings made under this section from April 1, 2012, through March 31, 2013, for which the state ultimately receives payment.
4. Beginning in the state fiscal year following the receipt by the state of the certification provided in sub-subparagraph 2.b., each county's percentage share under subparagraph (a)3. shall be replaced by the percentage calculated under subparagraph 3.
5. If the court invalidates the replacement of each county's share as provided in this paragraph, the county share set forth in subparagraph (a)3. shall continue to apply.
(4) By June 1 of each year, the Department of Revenue shall notify each county of its required annual contribution. Each county shall pay its contribution, by check or electronic transfer, in equal monthly installments to the department by the 5th day of each month. If a county fails to remit the payment by the 5th day of the month, the department shall reduce the monthly distribution of that county pursuant to s. 218.61 and, if necessary, by the amount of the monthly installment pursuant to s. 218.26. The payments and the amounts by which the distributions are reduced shall be transferred to the General Revenue Fund.
(5) In any county in which a special taxing district or authority is located which benefits from the Medicaid program, the board of county commissioners may divide the county's financial responsibility for this purpose proportionately, and each such district or authority must furnish its share to the board of county commissioners in time for the board to comply with subsection (4). Any appeal of the proration made by the board of county commissioners must be made to the Department of Financial Services, which shall set the proportionate share for each party.
(6)(a) By August 1, 2012, the agency shall certify to each county the amount of such county's billings from November 1, 2001, through April 30, 2012, which remain unpaid. A county may contest the amount certified by filing a petition under the applicable provisions of chapter 120 on or before September 1, 2012. This procedure is the exclusive method to challenge the amount certified. In order to successfully challenge the amount certified, a county must show, by a preponderance of the evidence, that a recipient was not an eligible recipient of that county or that the amount certified was otherwise in error.
(b) By September 15, 2012, the agency shall certify to the Department of Revenue:
1. For each county that files a petition on or before September 1, 2012, the amount certified under paragraph (a); and
2. For each county that does not file a petition on or before September 1, 2012, an amount equal to 85 percent of the amount certified under paragraph (a).
(c) The filing of a petition under paragraph (a) does not stay or stop the Department of Revenue from reducing distributions in accordance with paragraph (b) and subsection (7). If a county that files a petition under paragraph (a) is able to demonstrate that the amount certified should be reduced, the agency shall notify the Department of Revenue of the amount of the reduction. The Department of Revenue shall adjust all future monthly distribution reductions under subsection (7) in a manner that results in the remaining total distribution reduction being applied in equal monthly amounts.
(7)(a) Beginning with the October 2012 distribution, the Department of Revenue shall reduce each county's distributions pursuant to s. 218.26 by one thirty-sixth of the amount certified by the agency under subsection (6) for that county, minus any amount required under paragraph (b). Beginning with the October 2013 distribution, the Department of Revenue shall reduce each county's distributions pursuant to s. 218.26 by one forty-eighth of two-thirds of the amount certified by the agency under subsection (6) for that county, minus

any amount required under paragraph (b). However, the amount of the reduction may not exceed 50 percent of each county's distribution. If, after 60 months, the reductions for any county do not equal the total amount initially certified by the agency, the Department of Revenue shall continue to reduce such county's distribution by up to 50 percent until the total amount certified is reached. The amounts by which the distributions are reduced shall be transferred to the General Revenue Fund.

(b) As an assurance to holders of bonds issued before the effective date of this act to which distributions made pursuant to s. 218.26 are pledged, or bonds issued to refund such bonds which mature no later than the bonds they refunded and which result in a reduction of debt service payable in each fiscal year, the amount available for distribution to a county shall remain as provided by law and continue to be subject to any lien or claim on behalf of the bondholders. The Department of Revenue must ensure, based on information provided by an affected county, that any reduction in amounts distributed pursuant to paragraph (a) does not reduce the amount of distribution to a county below the amount necessary for the timely payment of principal and interest when due on the bonds and the amount necessary to comply with any covenant under the bond resolution or other documents relating to the issuance of the bonds. If a reduction to a county's monthly distribution must be decreased in order to comply with this paragraph, the Department of Revenue must notify the agency of the amount of the decrease and the agency must send a bill for payment of such amount to the affected county.

(8) Beginning in the 2013-2014 fiscal year and each year thereafter through the 2020-2021 fiscal year, the Chief Financial Officer shall transfer from the General Revenue Fund to the Lawton Chiles Endowment Fund an amount equal to the amounts transferred to the General Revenue Fund in the previous fiscal year pursuant to subsections (4) and (7) which are in excess of the official estimate for medical hospital fees for such previous fiscal year adopted by the Revenue Estimating Conference on January 12, 2012, as reflected in the conference's workpapers. By July 20 of each year, the Office of Economic and Demographic Research shall certify the amount to be transferred to the Chief Financial Officer. Such transfers must be made before July 31 of each year until the total transfers for all years equal $350 million. If such transfers do not total $350 million by July 1, 2021, the Legislature shall provide for the transfer of amounts necessary to total $350 million. The Office of Economic and Demographic Research shall publish the official estimates reflected in the conference's workpapers on its website.

(9) The agency may adopt rules to administer this section.

History.—s. 46, ch. 91-282; s. 8, ch. 96-417; s. 190, ch. 99-8; s. 26, ch. 2000-171; s. 11, ch. 2001-104; s. 3, ch. 2002-35; s. 452, ch. 2003-261; s. 3, ch. 2007-82; s. 12, ch. 2012-33; s. 10, ch. 2013-48.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SHO # 16-007

RE: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities

April 28, 2016

Dear State Health Official:

The purpose of this letter and its attachment is to provide guidance on facilitating access to covered Medicaid services for eligible individuals prior to and after a stay in a correctional institution. This State Health Official Letter with attached Questions and Answers (Qs & As) describes how states can better facilitate access to Medicaid services for individuals transitioning from incarceration to their communities.

As a result of changes states are adopting in their Medicaid programs, individuals in many states who were previously uninsured now are eligible for Medicaid coverage, including a significant numbers of justice-involved individuals. While the Medicaid statute limits payment for services for individuals while residing in correctional institutions, Medicaid coverage can be crucial to ensuring a successful transition following incarceration. Many individuals in the justice-involved population have a high prevalence of long-untreated, chronic health care conditions as well as a high incidence of substance use and mental health disorders. Facilitating enrollment in Medicaid and supporting access to services following incarceration has the potential to make a significant difference in the health of this population and in eligible individuals' ability to obtain health services that can promote their well-being. Such enrollment will also help individuals with disabilities obtain critical community services to avoid crises and unnecessary institutionalization.

As states consider eligibility and coverage issues, many have asked questions about the longstanding provision of the Medicaid statute that excludes Medicaid payment for services provided to inmates of public institutions, including correctional institutions, except for services provided as "a patient in a medical institution". We address them in the following Qs & As. The Centers for Medicare & Medicaid Services (CMS) Center for Medicaid and CHIP Services (CMCS) welcomes the opportunity to work closely with states to identify ways to improve access to needed health care for individuals returning to the community following incarceration.

If you have any questions regarding the information in the Qs & As, please send questions to CMCSMedicaidQAInmates@cms.hhs.gov.

Sincerely,

/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures

Enclosure:

Questions & Answers

Section 1: Inmate Definition

Inmates of a public institution who are held involuntarily may be enrolled in Medicaid, but may not receive Medicaid covered services. The inmate coverage exclusion applies to Medicaid services to inmates, except as inpatients in a medical institution as provided in statute and described in Section 3 of this document.

Q1. Inmate Defined: ***Who is an inmate of a public institution?***

A1. Medicaid regulations at 42 Code of Federal Regulations (CFR) 435.1010 define an inmate of a public institution as "a person living in a public institution" and define a public institution as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control." A public institution includes a correctional institution. There are separate definitions for "child care institutions" and "publicly operated community residences," and we interpret such institutions to be in a separate category and therefore not included as public institutions for the purposes of identifying who is in an inmate in this guidance.

CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution, other than a child care institution, publicly operated community residence that serves no more than 16 residents, or a public educational or vocational training institution for purposes of securing educational or vocational training. Correctional institutions include facilities operated by, or under contract with, the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held involuntarily in lawful custody through operation of law enforcement authorities. Correctional institutions include state or federal prisons, local jails, detention facilities, or other penal settings (e.g., boot camps, wilderness camps). While correctional institutions may provide medical and related services, they are organized for the primary purpose of involuntary confinement. Thus, correctional institutions are never considered to be medical institutions (which are defined in 42 CFR 435.1010 to be organized to provide medical care).

We recognize that federal, state, local, and tribal authorities attach different names, conditions, and requirements to individuals in various custody arrangements. Regardless of the label attached to any particular custody status, an important consideration of whether an individual is an "inmate" is his or her legal ability to exercise personal freedom.

Q2. **Individuals on Parole or Probation**: ***Is Federal Financial Participation (FFP) available for eligible individuals who are in the community on parole or probation, or have been released to the community pending trial (including those under pre-trial supervision)?***

A2. Yes. Individuals who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision) are not considered inmates, and thus are not subject to the prohibition on providing Medicaid covered services to inmates. If they are otherwise eligible for Medicaid, FFP is available for covered services provided to such individuals.

Q3. **Residence in a Halfway House:** ***When is FFP available for Medicaid-covered services to individuals residing in state or local private or publicly operated corrections-related "supervised community residential facilities"?***

A3. FFP is available for covered services for Medicaid-eligible individuals living in state or local corrections-related supervised community residential facilities (whether operated by a governmental entity or a private entity) unless the individual does not have freedom of movement and association while residing at the facility. In order for FFP to be available for covered services for Medicaid-eligible individuals living in such a facility, the facility would have to operate in such a way as to ensure that individuals living there have freedom of movement and association according to the following tenets: (1) residents are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision; (2) residents can use community resources (libraries, grocery stores, recreation, education, etc.) at will; and (3) residents can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state. For this purpose, "at will" includes and is consistent with requirements related to operational "house rules" where, for example, the residence may be closed or locked during certain hours or where residents are required to report during certain times and sign in and out. Similarly, an individual's supervisory requirements may restrict travelling to or frequenting certain locations that may be associated with high criminal activity. To claim FFP for Medicaid-covered services furnished to Medicaid-eligible individuals while they are living in a supervised community residential facility, the state Medicaid agency must ensure that the facility meets the requirements described above.

Q4. **Residential Reentry Centers:** ***Is FFP available for Medicaid-covered services to individuals residing in federal "Residential Reentry Centers"?***

A4. No. The Department of Justice, Bureau of Prisons (BOP) retains responsibility for payment of health care services rendered to individuals in Residential Re-entry Centers (RRCs). RRC residents previously enrolled in their state Medicaid program would have benefits suspended while serving a duly adjudicated term of incarceration in a federal facility or RRC.

RRC residents not previously enrolled in their state Medicaid program would be able to apply to their intended release state of residency for eligibility determination while incarcerated, but would not be eligible to receive Medicaid benefits until their status changed to home confinement, parole, probation, or full-term release.

Q5. Free Choice of Provider: ***Must individuals in transitional or supervisory arrangements have the ability to freely choose their Medicaid providers, as required in Federal law at Section 1902 (a)(23) of the Act?***

A5. Yes. Eligible individuals who are not inmates but rather who are in transitional or supervisory arrangements, as beneficiaries of the Medicaid program, have the same ability to choose their providers of health care services as afforded to other Medicaid beneficiaries in their states.

Q6. Individuals on Home Confinement: ***Is FFP available if an individual is on home confinement?***

A6. Yes. An individual's private place of residence generally would not meet the definition of a "public institution", which is a component of the coverage exclusion, despite the involuntary nature of the home confinement scenario. FFP is available for expenditures under the approved state plan for covered Medicaid benefits furnished to eligible individuals living at home under home confinement.

Q7. Voluntary and Temporary Residence in a Public Institution: ***Is an individual considered an inmate of a public institution if residing there voluntarily for a temporary period?***

A7. No. An individual is not considered an inmate when residing in a public institution voluntarily and the coverage exclusion does not apply. For example, FFP is available for services when an individual (if eligible and enrolled in Medicaid) is living voluntarily in a detention center for a temporary period of time after his case has been adjudicated and arrangements are being made for his transfer to a community residence. The voluntary nature of the residence is critical; an individual would be considered an inmate during temporary involuntary residence in a public institution imposed by the justice system (for example when confined pending trial) but not when the individual is free to leave, but is "residing in a public institution for a temporary period pending other arrangements appropriate to his needs" consistent with 42 CFR 435.1010.

Q8. Residence in Facilities for Treating Mental Health and Substance Use Disorders: ***Is FFP available for mental health or substance use disorder services, furnished exclusively to inmates, in a residential treatment facility?***

A8. No. FFP is not available for services in a residential treatment facility for inmates who are involuntarily residing in the facility by operation of law enforcement authorities, since this facility would be a correctional institution (even if it were operated by a private entity under contract).

In addition to the inmate exclusion, the Medicaid statute also includes a coverage exclusion related to services for patients in Institutions for Mental Diseases (IMDs), which include residential treatment facilities of over sixteen beds that are primarily engaged in the diagnosis, treatment, or care of persons with mental diseases.[1]

Q9. Applicability of other Medicaid Requirements: ***Will services provided to individuals who have been released to the community be subject to any other requirements before being qualified for Medicaid reimbursement?***

A9. Yes. All Medicaid rules apply in determining the circumstances in which reimbursement is available, including the coverage exclusion for services provided to individuals who are in an IMD and the Home and Community Based Services (HCBS) requirements relating to the provision of services authorized under 1915(c) HCBS waivers, 1915(i) HCBS state plan options, and 1915(k) Community First Choice programs.[2]

Section 2: Eligibility and Enrollment

Q10. Medicaid Eligibility While Incarcerated: ***Does being incarcerated prevent an inmate from being determined eligible for or maintaining eligibility for Medicaid?***

A10. No. The inmate exclusion is a general coverage exclusion; it is not an eligibility exclusion. Incarceration does not preclude an inmate from being determined Medicaid-eligible. The state Medicaid agency must accept applications from inmates to enroll in Medicaid or renew Medicaid enrollment during the time of their incarceration. If the individual meets all applicable Medicaid eligibility requirements, the state must enroll or renew the enrollment of the individual effective before, during, and after the period of time spent in the correctional facility. Once enrolled, however, the state may place the inmate in a suspended eligibility status during the period of incarceration, or it may suspend coverage by establishing markers and edits in the claims processing system to deny claims for excluded services, as discussed below.

It should be noted that, due to Medicaid retroactive eligibility provisions at section 1902(a)(34) of the Social Security Act, FFP is available for Medicaid-covered inpatient services provided in

[1] The exclusion for services provided to individuals who are in an Institution for Mental Disease can be found at section 1905(a)(29)(B) of the Act.

[2] The exclusion for services provided to individuals who are in an Institution for Mental Disease can be found at section 1905(a)(29)(B) of the Act; qualities of a home and community based setting are outlined in 42 CFR 441.301(c)(4).

a medical institution to an inmate in the 3-month period prior to application, if the individual would have been Medicaid-eligible.

We strongly encourage correctional institutions and other state, local, or tribal agencies to take an active role in preparing inmates for release by assisting or facilitating the application process prior to release. Individuals can apply for Medicaid online at www.HealthCare.gov or through their state Medicaid agency or state-based Marketplace. If restrictions on internet access make it impossible or impractical for an inmate to file an online application, then a paper application may be used. A telephone application is another option; individuals may call the Marketplace call center at 1-800-318-2596 to apply 24 hours a day, 7 days a week. Correctional institutions and other entities should coordinate with their state Medicaid agencies in order to receive paper copies of forms. In accordance with federal regulations governing Medicaid applications at 42 CFR 435.907, state Medicaid agencies must accept applications that are submitted online, through the mail, or by phone.

We also support correctional institutions' efforts to transfer medical records to new primary care, mental health providers, substance use treatment providers, other specialists, and other providers to ensure continuity of care, including electronic means of maintaining and transferring such records. Various types of financial match are available for states to support these activities. In addition, federal Medicaid matching funds are available for application assistance and eligibility determination, assuming all other qualifications are met.

Q11. Financial Eligibility: ***How does incarceration affect a Medicaid-enrolled individual's household income?***

A11. The effect of incarceration on an individual's financial eligibility for Medicaid depends on the individual's circumstances. For most individuals, financial eligibility is determined using modified adjusted gross income (MAGI), which is generally based on tax filing relationships and taxable income. There are no special rules or exceptions for incarcerated individuals. If the incarcerated individual does not expect to file taxes, then Medicaid financial eligibility would be based solely on the income of the individual.

Q12. Suspended Status: ***How should states handle the situation when a Medicaid-enrolled individual is or becomes incarcerated?***

A12. To ensure that FFP is only claimed for Medicaid-covered inpatient services delivered to inmates in a medical institution, states should consider placing the eligibility of a Medicaid-enrolled inmate in a suspended status upon incarceration and/or setting up claims processing markers and edits to ensure that services are limited to only inpatient services. Other methods may also be used to accomplish the same result (suspending coverage instead of eligibility). A temporary suspension process maintains the individual's eligibility for Medicaid and provides for continuity of care so that the individual can immediately access Medicaid-covered services

upon release from the facility. Whatever approach is used, the suspension must be promptly lifted when the inmate exclusion no longer applies (e.g., upon release, or when the individual is admitted as a patient for inpatient treatment in a medical institution). Establishing proactive communication processes between the state Medicaid agency and state and local correctional facilities can help to ensure prompt notification of release and timely access to coverage.

Q13. Feasibility of Suspended Status: ***Is it feasible for states' eligibility determination systems to accommodate a suspension process when a Medicaid-eligible individual is incarcerated? Are there resources available to support modernizing states' eligibility systems, to allow for suspended enrollment status?***

A13. Yes for both. While some states have a history of suspending eligibility for incarcerated individuals, others have faced challenges with their legacy eligibility and enrollment systems when placing Medicaid-eligible inmates in a suspended status. Addressing these challenges should be possible with the availability of enhanced federal funding for new or improved eligibility systems, as specified in the final rule, codified at 42 CFR 433.112, "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, FR 2011-09340," published in April 2011.

Q14. Promoting Enrollment to Ensure Continuity of Care: ***What can states do in order to promote enrollment for Medicaid-eligible individuals who are incarcerated?***

A14. State Medicaid agencies can work with their local departments of corrections, prisons, and jails to assist incarcerated individuals, who may not have been enrolled in Medicaid at the time of their incarceration, to apply and receive an eligibility determination for Medicaid. Once enrolled, states may employ various approaches to suspend eligibility, such as implementing a claims processing edit, instead of terminating the Medicaid eligibility of an incarcerated individual. Suspension of eligibility or claims processing edits allow for individuals to retain eligibility for Medicaid-covered inpatient services provided in a medical institution while incarcerated. States and local jurisdictions, or their contractors, need to be proactive in notifying the state Medicaid agency of an inmate's release, to ensure timely removal of suspension or claims processing edits. This will ensure active Medicaid coverage at re-entry and timely access to the full array of Medicaid-covered services upon release. To further assist individuals exiting incarceration, states can encourage or require their Medicaid managed care entities to work with state and local correctional agencies to connect such individuals to needed health services upon release.

Q15. Eligibility and Transfers to Another State: ***When an inmate is involuntarily transferred to a correctional institution out of the individual's home state, how does that affect the individual's eligibility for Medicaid and a state's ability to maintain, suspend, or terminate existing coverage?***

A15. If the inmate was incarcerated by a home state but sent to an out-of-state institution meeting the definition of "a public institution" under 42 CFR 435.1010, for any reason, including the home state not having capacity to house the individual, the home state remains the state of residence (see 42 CFR 435.403(b) and(e)). Therefore, in this scenario, the inmate would retain residency for purposes of Medicaid eligibility in the home state. The inmate would have Medicaid coverage from the home state for incurred costs for inpatient services provided within the exception to the inmate exclusion, even if such services were provided outside the home state.

Individuals who have committed a crime outside of their home state and are placed in a correctional institution in and by the state in which the crime was committed would be considered to be residents of that state while incarcerated, as provided at 42 CFR 435.403(h)(5). In these circumstances, it is, therefore, the responsibility of the state in which the individual is incarcerated to determine how eligibility is established and how inpatient costs incurred for the inmate would be reimbursed (e.g., claimed by the Medicaid agency under the exception to the coverage exclusion, if the individual is eligible for Medicaid in that state, or borne by the Department of Corrections in that state).

Q16. **Home Addresses:** ***Can an individual incarcerated in a correctional institution be determined eligible for Medicaid in the state of incarceration using the correctional institution as the home address?***

A16. Yes. The correctional institution could be used as the home address for establishing residency for purposes of Medicaid eligibility, except in the scenario described in the preceding question, when the individual is placed in an out-of-state facility by their home state.

Q17. **Avoiding Simultaneous Eligibility:** ***If an inmate is enrolled in Medicaid in the state in which he/she is incarcerated, does that Medicaid coverage need to be terminated before he/she can begin the process of enrolling in Medicaid in the home state to which he/she will be returning upon release from the correctional institution?***

A17. There should not be simultaneous Medicaid coverage in multiple states. However, it would be possible to initiate an application for benefits in a second state prior to termination in the first state. In this situation, there should be communication between the respective state agencies to ensure there are no overlapping coverage periods.

Q18. **Applying for Medicaid in a Different State:** ***Prior to release, can an individual incarcerated in a correctional institution apply for Medicaid in a different state in which the individual intends to reside upon release?***

A18. Yes. States can process applications of incarcerated individuals prior to the individual's release, regardless of whether the individual intends to reside in the same state or a different

state upon release. In the case of individuals who intend to reside in a different state, the address where the individual being released intends to live or the address of a probation or parole office or community residential facility may be used. We note that, in accordance with 1902(b)(2) of the Act and 42 CFR 435.403(h) and (i), Medicaid does not require an individual to have a fixed or home address in the state, but in that situation an address through which the state can contact the individual after release is needed. The effective date of eligibility would be the date the individual arrives in their new state of residence. Alternatively, if, for operational reasons, a state preferred to make eligibility effective prior to the date of release or arrival, the state could cover these individuals as non-residents, if these individuals otherwise meet the eligibility criteria in the state.

Q19. Filing an Application for a Different State: ***How does the application process work for an individual who is incarcerated and is preparing for release, but is not yet living in the state to which he or she is applying and intending to reside?***

A19. Individuals who are incarcerated are permitted to file applications through modalities generally available to applicants in accordance with §435.907– i.e., online, by telephone and by mail. However, as a practical matter, states may need to employ a variety of approaches to assist with the determinations of eligibility and enrollment for individuals in this situation, depending on the systems' capability and operations in the state. We encourage states to work cooperatively with corrections facilities operated in their own and other states, as well as with the Federal Bureau of Prisons, to achieve as coordinated and seamless a process for these individuals as possible. CMS is available for technical assistance.

Q20. Agreements with Medicaid Managed Care Plans: ***How can states that use Medicaid managed care plans prevent capitated payments from being made on behalf of individuals who are incarcerated?***

A20. States should establish agreements with their Medicaid managed care plans to ensure timely reporting in order to prevent capitated payments being made on behalf of individuals who are incarcerated. Contracts should exclude individuals who are incarcerated from the managed care plan, or provide for disenrollment from the plan when an enrollee becomes incarcerated. States should establish in their contracts that the state will recoup a capitated payment made on behalf of an enrollee who is incarcerated or a portion of a capitation payment for an individual who becomes incarcerated mid-month.

Q21. Eligibility under Alternative Benefit Plans: ***Is FFP available for inmates eligible under the new adult group for inpatient services covered under Medicaid Alternative Benefit Plans (ABPs)?***

A21. The coverage exclusion applies generally to medical assistance, whether provided through an ABP or other coverage. FFP is available for services received during an inpatient

stay only pursuant to the inmate payment exclusion exception provided in statute and described in Section 3 of this document. States are not eligible for federal payments for services inconsistent with the exclusion.

Section 3: Services Covered Under the Exception to the General Coverage

Exclusion for Inmates

Q22. Services, Settings, and Conditions: ***For which services and settings is FFP generally available under the inpatient exception to the general coverage exclusion for inmates?***

A22. To qualify for the inpatient exception, services must be covered under the state's Medicaid Plan, delivered in a prescribed setting in a way that is consistent with other terms of the state's Medicaid Plan, and provided by a certified or enrolled provider that maintains compliance with federal requirements. In this document, we use the term "federal requirements" to refer to all federal requirements, including the CMS Conditions of Participation (CoPs).

Under the law at section 1905(a)(29)(A) of the Act, FFP is only available for inpatient services furnished to patients in a medical institution (including services furnished by such providers during the inpatient stay, which is defined in CFR 435.1010 as a stay of 24 hours or more in which there is an admission of the individual to the facility as an inpatient on the orders of the practitioner responsible for the care of the patient).

Additional information about federal requirements for medical institutions is available through the Center for Clinical Standards and Quality, Survey & Certification Group and CMS interpretive guidelines for surveyors at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

Q23. Services Not Available to Others: ***Is FFP available for inpatient services to inmates for conditions that Medicaid would otherwise not reimburse in an inpatient setting?***

A23. No. Covered Medicaid inpatient services are the same for all Medicaid eligible individuals, including individuals who are in a medical institution but who would otherwise be in a correctional institution. FFP is not available for services that are not otherwise covered under the state plan in that setting.

Q24. Third Party Resource: ***Do state, local, and correctional entities meet the definition of a third party resource, for purposes of inpatient care provided to inmates of public institutions?***

A24. We do not require states to treat state, local, and tribal correctional entities as legally liable third parties, and Medicaid may pay primary to such entities for covered inpatient

services, unless the state has elected under state law to consider these entities as legally liable third parties.

CMS maintains its policy that state and local correctional entities are considered a source of third party coverage for purposes of the hospital-specific limit on disproportionate share hospital (DSH) payments when they, in fact, are obligated to pay for the services because Medicaid payment is not available. To the extent that services are under the exception to the inmate coverage exclusion, and Medicaid pays primary, uncompensated costs not paid by state and local correctional entities would be part of the Medicaid shortfall and could support DSH payments.

Q25. Outpatient Services: ***Is FFP available, under the inmate coverage exclusion exception, for outpatient services furnished by or in a local hospital emergency department, an urgent care center, a clinic, or a Federally Qualified Health Center/Rural Health Clinic?***

A25. No. FFP is not available for outpatient services for inmates, including but not limited to services in a local hospital emergency department, an urgent care center, a clinic, or a Federally Qualified Health Center/Rural Health Clinic.

Q26. Contracts with Health Care Management Entities: ***Some state and local correctional entities contract with a health care management entity to provide medical services to inmates. Is FFP available for services to inmates provided by the health care management entity?***

A26. No. FFP is not available for services furnished in a correctional institution to an inmate regardless of whether those services are provided through a health care management entity under contract with a correctional institution or between the health care management entity and the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe. FFP is available for inpatient services in a medical institution furnished by qualified providers with a provider agreement with the State Medicaid Agency under the circumstances described above. To the extent that state or local entities contract with a health care management entity to provide medical services to inmates, that health care management entity would be a liable third party for services under its contract. To the extent that services furnished during an inpatient stay in a medical institution affiliated with a health care management entity under contract with state or local entities are not included in the contract, the Medicaid program can pay for such services when within the scope of Medicaid coverage and provided to eligible individuals by a provider meeting federal and state requirements and Conditions of Participation.

Q27. Correctional Hospitals or Nursing Facilities: ***Can hospitals or nursing homes that exclusively serve inmates qualify for FFP?***

A27. No. Hospitals, nursing facilities, or other medical institutions operated primarily or exclusively to serve inmates are considered correctional institutions and FFP would not be available for services. Nursing facilities and all medical institutions under this exception to the general exclusion must be operated as medical institutions generally available to the public, organized primarily for the provision of medical care, meet federal requirements discussed in A21, and meet the additional requirements of the definition of medical institution at 42 CFR 435.1010.

Q28. <u>Additional Considerations</u>: ***In addition to the considerations included under the previous Qs & As, what other criteria must be applied when determining whether FFP would be available for costs of inpatient care provided to individuals otherwise in a correctional institution?***

A28. FFP is available for such inpatient care when the other factors identified in federal guidance are met and when:

- The overall nature of the medical institution is one of community interaction such that members of the general public may be admitted to receive services and admission into the medical institution or into specific beds within the institution is not limited to individuals under the responsibility of the correctional facility.
    - For nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID, the same staff (i.e., physicians, nurses, aides) are generally available between any unit or wing and the remainder of the medical institution (Note: this does not preclude the deployment of staff with specialized expertise or experience working with individuals under the jurisdiction of the correctional system);
    - For nursing facilities and ICFs/IID, the same services are provided between the units, departments or other locations and the remainder of the medical institution;
    - For hospitals, the individuals are admitted to specific medical units based not on their status as inmates of a correctional institution, but rather based on their treatment needs and plan of care and generally are placed in units also serving other individuals with similar treatment needs and plans of care; and
- Allowable medical services are those provided under the state Medicaid Plan, at approved rates, as would be the case for any other similarly situated Medicaid beneficiary.

Q29. Hospital Conditions of Participation: ***What requirements pertain to hospitals and other medical institutions serving inpatients who otherwise would be in correctional institutions? To which Conditions of Participation should hospitals pay special attention?***

A29. Hospitals and other medical institutions must meet all Medicaid requirements when serving patients who would otherwise be in correctional institutions as described above. This will be discussed in more detail in an upcoming companion CMS Survey and Certification memorandum.

Q30. Compliance: ***Will states be able to take time to bring their claiming into compliance based on this guidance?***

A30. This guidance is intended to provide further clarification of policy. States that find that they are out of compliance with this guidance should contact their regional offices, including Medicaid Survey and Certification contacts, as soon as they are aware so that agreement can be reached on a path forward.

133⅓ percent limitation (under the authority of section 4106 of Public Law 100–230).

(d) For purposes of paragraph (b)(1) of this section, a State that as of June 1, 1989, has in its State plan (as defined in section 2373(c)(5) of Public Law 98–369 as amended by section 9 of Public Law 100–93) an amount for individuals that was reasonably related to 133⅓ percent of the highest amount of AFDC which would ordinarily be paid to a family of two without income or resources may use an amount based upon a reasonable relationship to such an AFDC standard for a family of two.

(e) FFP is not available in expenditures for services provided to categorically needy and medically needy recipients subject to the FFP limits if their annual income, after the cash assistance income deductions and any income disregards in the State plan authorized under section 1902(r)(2) of the Act are applied, exceeds the 133⅓ percent limitation described under paragraphs (b), (c), and (d) of this section.

(f) A State may use the less restrictive income methodologies included under its State plan as authorized under § 435.601 in determining whether a family's income exceeds the limitation described in paragraph (b) of this section.

[58 FR 4933, Jan. 19, 1993, as amended at 66 FR 2321, 2667, Jan. 11, 2001]

§ 435.1008 FFP in expenditures for medical assistance for individuals who have declared United States citizenship or nationality under section 1137(d) of the Act and with respect to whom the State has not documented citizenship and identity.

Except for individuals described in § 435.406(a)(1)(v), FFP will not be available to a State with respect to expenditures for medical assistance furnished to individuals unless the State has obtained satisfactory documentary evidence of citizenship or national status, as described in § 435.407 that complies with the requirements of section 1903(x) of the Act.

[72 FR 38694, July 13, 2007]

§ 435.1009 Institutionalized individuals.

(a) FFP is not available in expenditures for services provided to—

(1) Individuals who are inmates of public institutions as defined in § 435.1010; or

(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.

(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

[43 FR 45204, Sept. 29, 1978, as amended at 50 FR 13199, Apr. 3, 1985; 50 FR 38811, Sept. 25, 1985. Redesignated and amended at 71 FR 39225, July 12, 2006]

§ 435.1010 Definitions relating to institutional status.

For purposes of FFP, the following definitions apply:

Active treatment in intermediate care facilities for the mentally retarded means treatment that meets the requirements specified in the standard concerning active treatment for intermediate care facilities for persons with mental retardation under § 483.440(a) of this subchapter.

Child-care institution means a nonprofit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the State in which it is situated, or has been approved by the agency of the State responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term does not include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

In an institution refers to an individual who is admitted to live there and receive treatment or services provided there that are appropriate to his requirements.

Inmate of a public institution means a person who is living in a public institution. An individual is not considered an inmate if—

(a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or

(b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who—

(1) Receives room, board and professional services in the institution for a 24 hour period or longer, or

(2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

Institution means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that—

(a) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and

(b) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

Institution for tuberculosis means an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis, including medical attention, nursing care, and related services. Whether an institution is an institution for tuberculosis is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of tuberculosis, whether or not it is licensed as such.

Medical institution means an institution that—

(a) Is organized to provide medical care, including nursing and convalescent care;

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;

(c) Is authorized under State law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

Outpatient means a patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive, and who does receive, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a

bed is used or whether or not the patient remains in the facility past midnight.

Patient means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to—

(1) Cerebral palsy or epilepsy; or

(2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care.

(2) Understanding and use of language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

Public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does not include—

(a) A medical institution as defined in this section;

(b) An intermediate care facility as defined in §§ 440.140 and 440.150 of this chapter;

(c) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or

(d) A child-care institution as defined in this section with respect to—

(1) Children for whom foster care maintenance payments are made under title IV-E of the Act; and

(2) Children receiving AFDC—foster care under title IV-A of the Act.

Publicly operated community residence that serves no more than 16 residents is defined in 20 CFR 416.231(b)(6)(i). A summary of that definition is repeated here for the information of readers.

(a) In general, a publicly operated community residence means—

(1) It is publicly operated as defined in 20 CFR 416.231(b)(2).

(2) It is designed or has been changed to serve no more than 16 residents and it is serving no more than 16; and

(3) It provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided as defined in 45 CFR 228.1; and

(b) A publicly operated community residence does not include the following facilities, even though they accommodate 16 or fewer residents:

(1) Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.

(2) Educational or vocational training institutions that primarily provide an approved, accredited, or recognized program to individuals residing there.

(3) Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

(4) Hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

[43 FR 45204, Sept. 29, 1978, as amended at 47 FR 28655, July 1, 1982; 47 FR 31532, July 20, 1982; 51 FR 19181, May 28, 1986; 52 FR 47934, Dec. 17, 1987; 53 FR 657, Jan. 11, 1988; 53 FR 20495, June 3, 1988; 56 FR 8854, Mar. 1, 1991; 56 FR 23022, May 20, 1991; 59 FR 56233, Nov. 10, 1994. Redesignated at 71 FR 39225, July 12, 2006]

REQUIREMENTS FOR STATE SUPPLEMENTS

§ 435.1011 Requirement for mandatory State supplements.

(a) Except as specified in paragraph (b) of this section, FFP is not available in Medicaid expenditures in any quarter in which the State does not have in

that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act [42 U.S.C. 1396b] for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) Health care-acquired condition

In this section.[1] the term "health care-acquired condition" means a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) Medicare provisions

In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

(Pub. L. 111–148, title II, §2702, Mar. 23, 2010, 124 Stat. 318.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XIX of the Act is classified generally to this subchapter. Title XVIII of the Act is classified generally to subchapter XVIII (§1395 et seq.) of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

§ 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title XIX, §1904, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 351.)

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1)[1] of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not

[1] So in original. The period probably should be a comma.

[1] See References in Text note below.

eligible to participate in the State plan program established under subchapter XVI of this chapter,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1396r–6 of this title,

(x) individuals described in section 1396a(u)(1) of this title,

(xi) individuals described in section 1396a(z)(1) of this title,

(xii) employed individuals with a medically improved disability (as defined in subsection (v) of this section),

(xiii) individuals described in section 1396a(aa) of this title,

(xiv) individuals described in section 1396a(a)(10)(A)(i)(VIII) or 1396a(a)(10)(A)(i)(IX) of this title,

(xv) individuals described in section 1396a(a)(10)(A)(ii)(XX) of this title,

(xvi) individuals described in section 1396a(ii) of this title, or

(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (*l*)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (*l*)(1) of this section) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (*l*)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));

(5)(A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in section 1395x(gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (*o*) of this section);

(19) case management services (as defined in section 1396n(g)(2) of this title) and TB-related services described in section 1396a(z)(2)(F) of this title;

(20) respiratory care services (as defined in section 1396a(e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t) of this section);

(26) services furnished under a PACE program under section 1396u–4 of this title to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x) of this section, primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

(28) freestanding birth center services (as defined in subsection (*l*)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (*l*)(3)(B)) and that are otherwise included in the plan; and

(29) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary,

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to subsections (y), (z), and (aa) and section 1396u–3(d) of this title, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of title 25). Not-

withstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures (other than expenditures under section 1396r–4 of this title) described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 1397dd of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title.

(c) Nursing facility

For definition of the term "nursing facility", see section 1396r(a) of this title.

(d) Intermediate care facility for mentally retarded

The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this subchapter is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this subchapter, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this subchapter.

(e) Physicians' services

In the case of any State the State plan of which (as approved under this subchapter)—

(1) does not provide for the payment of services (other than services covered under section 1396a(a)(12) of this title) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term "physicians' services" (as used in subsection (a)(5) of this section) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) Nursing facility services

For purposes of this subchapter, the term "nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) Chiropractors' services

If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1395x(r)(5) of this title; and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h) Inpatient psychiatric hospital services for individuals under age 21

(1) For purposes of paragraph (16) of subsection (a) of this section, the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1395x(f) of this title or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) Institution for mental diseases

The term "institution for mental diseases" means a hospital, nursing facility, or other in-

stitution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) State supplementary payment

The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under subchapter XVI of this chapter or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under subchapter XVI of this chapter, or would but for his income be payable under that subchapter.

(k) Supplemental security income benefits

Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93–66 shall not be considered supplemental security income benefits payable under subchapter XVI of this chapter.

***(l)* Rural health clinics**

(1) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1395x(aa) of this title, except that (A) clause (ii) of section 1395x(aa)(2) of this title shall not apply to such terms, and (B) the physician arrangement required under section 1395x(aa)(2)(B) of this title shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term "Federally-qualified health center services" means services of the type described in subparagraphs (A) through (C) of section 1395x(aa)(1) of this title when furnished to an individual as an[2] patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1395x(aa)(2)(B) of this title is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means an entity which—

(i) is receiving a grant under section 254b of this title,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 254b of this title,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of subchapter XVIII of this chapter, as a comprehensive Federally funded health center as of January 1, 1990;

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638) [25 U.S.C. 450f et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.] for the provision of primary health services. In applying clause (ii),[3] the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(3)(A) The term "freestanding birth center services" means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

(B) The term "freestanding birth center" means a health facility—

(i) that is not a hospital;

(ii) where childbirth is planned to occur away from the pregnant woman's residence;

(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term "birth attendant" means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.

(m) Qualified family member

(1) Subject to paragraph (2), the term "qualified family member" means an individual (other than a qualified pregnant woman or child, as defined in subsection (n) of this section) who is a member of a family that would be receiving aid under the State plan under part A of subchapter IV of this chapter pursuant to section 607[1] of this title if the State had not exercised the option under section 607(b)(2)(B)(i)[1] of this title.

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) "Qualified pregnant woman or child" defined

The term "qualified pregnant woman or child" means—

[2] So in original. Probably should be "a".

[3] So in original. Probably should be clause "(iii),". See References in Text note below.

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of subchapter IV of this chapter (or would be eligible for such aid if coverage under the State plan under part A of subchapter IV of this chapter included aid to families with dependent children of unemployed parents pursuant to section 607 of this title) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of subchapter IV of this chapter pursuant to section 607 of this title if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of subchapter IV of this chapter; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of subchapter IV of this chapter.

(*o*) Optional hospice benefits

(1)(A) Subject to subparagraphs (B) and (C), the term "hospice care" means the care described in section 1395x(dd)(1) of this title furnished by a hospice program (as defined in section 1395x(dd)(2) of this title) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1395d(d)(2)(A) of this title and for which payment may otherwise be made under subchapter XVIII of this chapter and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this subchapter, with respect to the definition of hospice program under section 1395x(dd)(2) of this title, the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this subchapter for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

(2) An individual's voluntary election under this subsection—

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1395d(d)(2) of this title;

(B) shall be for such a period or periods (which need not be the same periods described in section 1395d(d)(1) of this title) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of subchapter XVIII of this chapter and has elected, under section 1395d(d) of this title, to receive hospice care under such part, and

(C) with respect to whom the hospice program under such subchapter and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1396a(a)(13)(B) of this title and, if the individual is an individual described in section 1396a(a)(10)(A) of this title, shall provide for payment of any coinsurance amounts imposed under section 1395e(a)(4) of this title.

(p) Qualified medicare beneficiary; medicare cost-sharing

(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395i–2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i–2a of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1395w–114(a)(3) of this title (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent

provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 85 percent,
(ii) January 1, 1990, is 90 percent, and
(iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1396a(f) of this title and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under subchapter XVI of this chapter, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 80 percent,
(ii) January 1, 1990, is 85 percent,
(iii) January 1, 1991, is 95 percent, and
(iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under subchapter II of this chapter for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such subchapter which have occurred pursuant to section 415(i) of this title for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term "medicare cost-sharing" means (subject to section 1396a(n)(2) of this title) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395i–2 or 1395i–2a of this title, and

(ii) premiums under section 1395r of this title,[4]

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e of this title and section 1395*l*(b) of this title).

(D) The difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

(4) Notwithstanding any other provision of this subchapter, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1396a(a)(10)(E) of this title shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B)[5] or[6] 1396a(a)(10)(E)(iii) of this title of such paragraph[5] any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this subchapter in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally. The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 426 or 426–1 of this title and shall make the translated forms available to the States and to the Commissioner of Social Security.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1320b–14 of this title.

(q) Qualified severely impaired individual

The term "qualified severely impaired individual" means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

(A) received (i) a payment of supplemental security income benefits under section 1382(b) of this title on the basis of blindness or disability, (ii) a supplementary payment under section 1382e of this title or under section 212 of Public Law 93–66 on such basis, (iii) a payment of monthly benefits under section 1382h(a) of this title, or (iv) a supplementary payment under section 1382e(c)(3), and

(B) was eligible for medical assistance under the State plan approved under this subchapter; and

(2) with respect to whom the Commissioner of Social Security determines that—

[4] So in original. The comma probably should be a period.

[5] So in original. The words "of such paragraph" probably should follow "subparagraph (B)".

[6] So in original. Probably should be "or section".

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under subchapter XVI of this chapter,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382(b) of this title (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this subchapter would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under subchapter XVI of this chapter (including any federally administered State supplementary payments), this subchapter, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1382h(b) of this title in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) Early and periodic screening, diagnostic, and treatment services

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

(s) Qualified disabled and working individual

The term "qualified disabled and working individual" means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of subchapter XVIII of this chapter under section 1395i–2a of this title;

(2) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved;

(3) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under subchapter XVI of this chapter; and

(4) who is not otherwise eligible for medical assistance under this subchapter.

(t) Primary care case management services; primary care case manager; primary care case management contract; and primary care

(1) The term "primary care case management services" means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term "primary care case manager" means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

(i) a nurse practitioner (as described in subsection (a)(21) of this section);

(ii) a certified nurse-midwife (as defined in section 1395x(gg) of this title); or

(iii) a physician assistant (as defined in section 1395x(aa)(5) of this title).

(3) The term "primary care case management contract" means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this subchapter;

(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1396u–2(a)(4) of this title; and

(F) complies with the other applicable provisions of section 1396u–2 of this title.

(4) For purposes of this subsection, the term "primary care" includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u) Conditions for State plans

(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 1397ee(d)(1) of this title.

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b) of this section.

(2)(A) For purposes of subsection (b) of this section, the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term "optional targeted low-income child" means a targeted low-income child as defined in section 1397jj(b)(1) of this title (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this subchapter) who would not qualify for medical assistance under the State plan under this subchapter as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1396a(*l*)(1)(D) of this title). Such term excludes any child eligible for medical assistance only by reason of section 1396a(a)(10)(A)(ii)(XIX) of this title.

(3) For purposes of subsection (b) of this section, the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1396a(*l*)(1)(D) of this title if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this subchapter based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under subsections (f) and (g) of section 1308 of this title shall not apply to Federal payments made under section 1396b(a)(1) of this title based on an enhanced FMAP described in section 1397ee(b) of this title.

(v) Employed individual with a medically improved disability

(1) The term "employed individual with a medically improved disability" means an individual who—

(A) is at least 16, but less than 65, years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under section 1396a(a)(10)(A)(ii)(XV) of this title because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 423(d) or 1382c(a)(3) of this title; and

(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

(2) For purposes of paragraph (1), an individual is considered to be "employed" if the individual—

(A) is earning at least the applicable minimum wage requirement under section 206 of title 29 and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.

(w) Independent foster care adolescent

(1) For purposes of this subchapter, the term "independent foster care adolescent" means an individual—

(A) who is under 21 years of age;

(B) who, on the individual's 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1396u–1(b) of this title.

(3) A State may limit the eligibility of independent foster care adolescents under section 1396a(a)(10)(A)(ii)(XVII) of this title to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of subchapter IV of this chapter before the date the individuals attained 18 years of age.

(x) Strategies, treatment, and services

For purposes of subsection (a)(27) of this section, the strategies, treatment, and services described in that subsection include the following:

(1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.

(2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.

(3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.

(y) Increased FMAP for medical assistance for newly eligible mandatory individuals

(1) Amount of increase

Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be equal to—

(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

(D) 93 percent for calendar quarters in 2019; and

(E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) Definitions

In this subsection:

(A) Newly eligible

The term "newly eligible" means, with respect to an individual described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u–7(b)(1) of this title or benchmark equivalent coverage described in section 1396u–7(b)(2) of this title that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u–7(b)(1) of this title, or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

(B) Full benefits

The term "full benefits" means, with respect to an individual, medical assistance for all services covered under the State plan under this subchapter that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1396a(a)(10)(A)(i) of this title.

(z) Equitable support for certain States

(1)(A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not

newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title.

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

(i) is an expansion State described in paragraph (3);

(ii) the Secretary determines will not receive any payments under this subchapter on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.[7]

(2)(A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to medical assistance for individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1396u–7 of this title shall be equal to the percent specified in subparagraph (B)(i) for such year.

(B)(i) The percent specified in this subparagraph for a State for a year is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to the transition percentage (specified in clause (ii) for the year) of the number of percentage points by which—

(I) such Federal medical assistance percentage for the State, is less than

(II) the percent specified in subsection (y)(1) for the year.

(ii) The transition percentage specified in this clause for—

(I) 2014 is 50 percent;

(II) 2015 is 60 percent;

(III) 2016 is 70 percent;

(IV) 2017 is 80 percent;

(V) 2018 is 90 percent; and

(VI) 2019 and each subsequent year is 100 percent.

(3) A State is an expansion State if, on March 23, 2010, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1396u–8 of this title. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

[7] So in original.

(aa) Special adjustment to FMAP determination for certain States recovering from a major disaster

(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5.

(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

(2) In this subsection, the term "disaster-recovery FMAP adjustment State" means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act [42 U.S.C. 5170] and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act [42 U.S.C. 5121 et seq.] and for which—

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to

the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this subchapter (other than with respect to disproportionate share hospital payments described in section 1396r–4 of this title and payments under this subchapter that are based on the enhanced FMAP described in 1397ee(b)[8] of this title) and shall not apply with respect to payments under subchapter IV (other than under part E of subchapter IV) or payments under subchapter XXI.

(bb) Counseling and pharmacotherapy for cessation of tobacco use by pregnant women

(1) For purposes of this subchapter, the term "counseling and pharmacotherapy for cessation of tobacco use by pregnant women" means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

(A) by or under the supervision of a physician; or

(B) by any other health care professional who—

(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(ii) is authorized to receive payment for other services under this subchapter or is designated by the Secretary for this purpose.

(2) Subject to paragraph (3), such term is limited to—

(A) services recommended with respect to pregnant women in "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline", published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this subchapter.

(cc) Requirement for certain States

Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1396a(a)(2) of this title, the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1396r–4 of this title, than the respective percentages that would have been required by the State under the State plan under this subchapter, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this subchapter or to the non-Federal share of payments under section 1396r–4 of this title, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this subchapter, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.

(dd) Increased FMAP for additional expenditures for primary care services

Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1396a(a)(13)(C) of this title furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1396u–2(f) of this title) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence.

(Aug. 14, 1935, ch. 531, title XIX, § 1905, as added Pub. L. 89–97, title I, § 121(a), July 30, 1965, 79 Stat. 351; amended Pub. L. 90–248, title II, §§ 230, 233, 241(f)(6), 248(e), title III, § 302(a), Jan. 2, 1968, 81 Stat. 905, 917, 919, 929; Pub. L. 92–223, § 4(a), Dec. 28, 1971, 85 Stat. 809; Pub. L. 92–603, title II, §§ 212(a), 247(b), 275(a), 278(a)(21)–(23), 280, 297(a), 299, 299B, 299E(b), 299L, Oct. 30, 1972, 86 Stat. 1384, 1425, 1452–1454, 1459–1462, 1464; Pub. L. 93–233, §§ 13(a)(13)–(88), 18(w), (x)(7)–(10), (y)(2), Dec. 31, 1973, 87 Stat. 963, 964, 972, 973; Pub. L. 94–437, title IV, § 402(e), Sept. 30, 1976, 90 Stat. 1410; Pub. L. 95–210, § 2(a), (b), Dec. 13, 1977, 91 Stat. 1488; Pub. L. 95–292, § 8(a), (b), June 13, 1978, 92 Stat. 316; Pub. L. 96–473, § 6(k), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 96–499, title IX, § 965(a), Dec. 5, 1980, 94 Stat. 2651; Pub. L. 97–35, title XXI, §§ 2162(a)(2), 2172(b), Aug. 13, 1981, 95 Stat. 806, 808; Pub. L. 97–248, title I, §§ 136(c), 137(b)(17), (18), (f), Sept. 3, 1982, 96 Stat. 376, 379, 381; Pub. L. 98–369, div. B,

[8] So in original. Probably should be preceded by "section".

title III, §§2335(f), 2340(b), 2361(b), 2371(a), 2373(b)(15)–(20), July 18, 1984, 98 Stat. 1091, 1093, 1104, 1110, 1112; Pub. L. 99–272, title IX, §§9501(a), 9505(a), 9511(a), Apr. 7, 1986, 100 Stat. 201, 208, 212; Pub. L. 99–509, title IX, §§9403(b), (d), (g)(3), 9404(b), 9408(c)(1), 9435(b)(2), Oct. 21, 1986, 100 Stat. 2053, 2054, 2056, 2061, 2070; Pub. L. 99–514, title XVIII, §1895(c)(3)(A), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 100–203, title IV, §§4073(d), 4101(c)(1), 4103(a), 4105(a), 4114, 4118(p)(8), 4211(e), (f), (h)(6), Dec. 22, 1987, 101 Stat. 1330–119, 1330–141, 1330–146, 1330–147, 1330–152, 1330–159, 1330–204 to 1330–206; Pub. L. 100–360, title III, §301(a)(2)–(d), (g)(2), title IV, §411(h)(4)(E), (k)(4), (8), (14)(A), July 1, 1988, 102 Stat. 748–750, 787, 791, 794, 798; Pub. L. 100–485, title III, §303(b)(2), title IV, §401(d)(2), title VI, §608(d)(14)(A)–(G), (J), (f)(3), Oct. 13, 1988, 102 Stat. 2392, 2396, 2415, 2416, 2424; Pub. L. 100–647, title VIII, §8434(a), (b)(3), (4), Nov. 10, 1988, 102 Stat. 3805; Pub. L. 101–234, title II, §201(b), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6402(c)(1), 6403(a), (c), (d)(2), 6404(a), (b), 6405(a), 6408(d)(2), (4)(A), (B), Dec. 19, 1989, 103 Stat. 2261–2265, 2268, 2269; Pub. L. 101–508, title IV, §§4402(d)(2), 4501(a), (c), (e)(1), 4601(a)(2), 4704(c), (d), (e)(1), 4705(a), 4711(a), 4712(a), 4713(b), 4717, 4719(a), 4721(a), 4722, 4755(a)(1)(A), Nov. 5, 1990, 104 Stat. 1388–163 to 1388–166, 1388–172, 1388–174, 1388–187, 1388–191, 1388–193, 1388–194, 1388–209; Pub. L. 103–66, title XIII, §§13601(a), 13603(e), 13605(a), 13606(a), 13631(f)(2), (g)(1), Aug. 10, 1993, 107 Stat. 612, 620, 621, 644, 645; Pub. L. 103–296, title I, §108(d)(2), (3), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 104–299, §4(b)(2), Oct. 11, 1996, 110 Stat. 3645; Pub. L. 105–33, title IV, §§4702(a), 4711(c)(1), 4712(d)(1), 4714(a)(2), 4725(b)(1), 4732(b), 4802(a)(1), 4911(a), Aug. 5, 1997, 111 Stat. 494, 508–510, 518, 520, 538, 570; Pub. L. 105–100, title I, §162(1), (2), Nov. 19, 1997, 111 Stat. 2188; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §§605(a), 608(*l*), (m), (aa)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396 to 1501A–398; Pub. L. 106–169, title I, §121(a)(2), (c)(5), Dec. 14, 1999, 113 Stat. 1829, 1830; Pub. L. 106–170, title II, §201(a)(2)(B), (C), Dec. 17, 1999, 113 Stat. 1892; Pub. L. 106–354, §2(a)(4), (c), Oct. 24, 2000, 114 Stat. 1382, 1384; Pub. L. 106–554, §1(a)(6) [title VII, §709(a), title VIII, §802(d)(1), (2), title IX, §911(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–578, 2763A–581, 2763A–584; Pub. L. 108–357, title VII, §712(a)(1), Oct. 22, 2004, 118 Stat. 1558; Pub. L. 109–171, title VI, §6062(c)(2), Feb. 8, 2006, 120 Stat. 98; Pub. L. 110–275, title I, §§112, 118(a), July 15, 2008, 122 Stat. 2503, 2507; Pub. L. 111–148, title II, §§2001(a)(3), (5)(C), (e)(2)(A), 2005(c)(1), 2006, 2301(a), 2302(a), 2303(a)(4)(A), 2304, 2402(d)(2)(B), title IV, §§4106(a), (b), 4107(a), title X, §10201(c), Mar. 23, 2010, 124 Stat. 272, 275, 279, 284, 292–294, 296, 304, 559, 560, 918; Pub. L. 111–152, title I, §§1201, 1202(b), Mar. 30, 2010, 124 Stat. 1051, 1053.)

AMENDMENT OF SUBSECTION (a)(13)

Pub. L. 111–148, title IV, §4106(a), (c), Mar. 23, 2010, 124 Stat. 559, 560, provided that, effective Jan. 1, 2013, subsection (a)(13) of this section is amended to read as follows:

(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

AMENDMENT OF SUBSECTION (b)

Pub. L. 111–148, title II, §2005(c), Mar. 23, 2010, 124 Stat. 284, as amended by Pub. L. 111–152, title I, §1204(b)(2)(B), Mar. 30, 2010, 124 Stat. 1056, provided that, effective July 1, 2011, subsection (b) of this section is amended by striking "shall be 50 per centum" and inserting "shall be 55 percent".

Pub. L. 111–148, title IV, §4106(b), (c), Mar. 23, 2010, 124 Stat. 559, 560, provided that, effective Jan. 1, 2013, subsection (b) of this section is amended in the first sentence—

(1) by striking ", and (4)" and inserting ", (4)"; and

(2) by inserting before the period the following: ", and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D)".

REFERENCES IN TEXT

Part A of subchapter IV of this chapter, referred to in subsecs. (a), (m)(1), and (n), is classified to section 601 et seq. of this title.

Parts A and B of subchapter XVIII of this chapter, referred to in subsecs. (a), (*l*)(2)(B)(iv), (o)(3)(B), (p)(1)(A), and (s)(1), are classified to sections 1395c et seq. and 1395j et seq., respectively, of this title.

Section 606 of this title, referred to in subsec. (a)(ii), was repealed and a new section 606 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (b)(1).

Section 211 of Pub. L. 93–66, referred to in subsec. (k), is section 211 of Pub. L. 93–66, July 9, 1973, 87 Stat. 152, which is set out as a note under section 1382 of this title.

The Indian Self-Determination Act, referred to in subsec. (*l*)(2)(B), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to part A (§450f et seq.) of subchapter II of chapter 14 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 450 of Title 25 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (*l*)(2)(B), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

Clause (ii), referred to in subsec. (*l*)(2)(B), was redesignated as cl. (iii) by Pub. L. 101–508, title IV, § 4704(c)(3), Nov. 5, 1990, 104 Stat. 1388–172.

Section 607 of this title, referred to in subsec. (m)(1), was repealed and a new section 607 enacted by Pub. L. 104–193, title I, § 103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (b)(2)(B)(i).

Section 212 of Public Law 93–66, referred to in subsec. (q)(1)(A), is section 212 of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

Section 5001 of Public Law 111–5, referred to in subsec. (aa)(1)(A), (2)(A), is set out as a note under this section.

Section 10202 of the Patient Protection and Affordable Care Act, referred to in subsec. (aa)(1), (2), is section 10202 of Pub. L. 111–148, which is set out as a note under this section.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, referred to in subsec. (aa)(2), is Pub. L. 93–288, May 22, 1974, 88 Stat. 143, which is classified principally to chapter 68 (§ 5121 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5121 of this title and Tables.

Section 5001 of the American Recovery and Reinvestment Act of 2009, referred to in subsec. (cc), is section 5001 of Pub. L. 111–5, which is set out as a note under this section.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, § 2304, inserted "or the care and services themselves, or both" before "(if provided in or after" in introductory provisions.

Subsec. (a)(xiv). Pub. L. 111–148, § 10201(c)(1), inserted "or 1396a(a)(10)(A)(i)(IX)" after "section 1396a(a)(10)(A)(i)(VIII)".

Pub. L. 111–148, § 2001(a)(5)(C), added cl. (xiv).

Subsec. (a)(xv). Pub. L. 111–148, § 2001(e)(2)(A), added cl. (xv).

Subsec. (a)(xvi). Pub. L. 111–148, § 2303(a)(4)(A), added cl. (xvi).

Subsec. (a)(xvii). Pub. L. 111–148, § 2402(d)(2)(B), added cl. (xvii).

Subsec. (a)(4). Pub. L. 111–148, § 4107(a)(1), added subpar. (D).

Subsec. (a)(28), (29). Pub. L. 111–148, § 2301(a)(1), added par. (28) and redesignated former par. (28) as (29).

Subsec. (b). Pub. L. 111–148, § 10201(c)(2), inserted ", (z)," before "and (aa)" in first sentence.

Pub. L. 111–148, § 2006(1), substituted "subsections (y) and (aa)" for "subsection (y)" in first sentence.

Pub. L. 111–148, § 2001(a)(3)(A), inserted "subsection (y) and" before "section 1396u–3(d) of this title" in first sentence.

Subsec. (*l*)(3). Pub. L. 111–148, § 2301(a)(2), added par. (3).

Subsec. (*o*)(1)(A). Pub. L. 111–148, § 2302(a)(1), substituted "subparagraphs (B) and (C)" for "subparagraph (B)".

Subsec. (*o*)(1)(C). Pub. L. 111–148, § 2302(a)(2), added subpar. (C).

Subsec. (y). Pub. L. 111–148, § 2001(a)(3)(B), added subsec. (y).

Subsec. (y)(1). Pub. L. 111–152, § 1201(1)(B), added par. (1) and struck out former par. (1). Prior to amendment, par. (1) related to the amount of increase for the Federal medical assistance percentage.

Subsec. (y)(1)(B)(ii)(II). Pub. L. 111–152, § 1201(1)(A), redesignated subcl. (II) as par. (5) of subsec. (z).

Pub. L. 111–148, § 10201(c)(3)(A), inserted "includes inpatient hospital services," after "100 percent of the poverty line, that".

Subsec. (y)(2)(A). Pub. L. 111–148, § 10201(c)(3)(B), substituted "as of December 1, 2009" for "on March 23, 2010".

Subsec. (z). Pub. L. 111–148, § 10201(c)(4), added subsec. (z).

Subsec. (z)(1)(A). Pub. L. 111–152, § 1201(2)(A), substituted "December 31, 2015" for "September 30, 2019".

Subsec. (z)(1)(B)(i). Pub. L. 111–152, § 1201(2)(A), substituted "paragraph (3)" for "subsection (y)(1)(B)(ii)(II)".

Subsec. (z)(2). Pub. L. 111–152, § 1201(2)(B), added par. (2) and struck out former par. (2), which read as follows:

"(A) During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year occurring during that period shall be increased by .5 percentage point for a State described in subparagraph (B) for amounts expended for medical assistance under the State plan under this subchapter or under a waiver of that plan during that period.

"(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

"(i) is described in clauses (i) and (ii) of paragraph (1)(B); and

"(ii) is the State with the highest percentage of its population insured during 2008, based on the Current Population Survey."

Subsec. (z)(3). Pub. L. 111–152, § 1201(2)(C), redesignated par. (5) as (3), struck out heading, and substituted "A State is" for "For purposes of the table in subclause (I), a State is".

Pub. L. 111–152, § 1201(2)(B), struck out par. (3), which read as follows: "Notwithstanding subsection (b) and paragraphs (1) and (2) of this subsection, the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year that begins on or after January 1, 2017, for the State of Nebraska, with respect to amounts expended for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be determined as provided for under subsection (y)(1)(A) (notwithstanding the period provided for in such paragraph)."

Subsec. (z)(4). Pub. L. 111–152, § 1201(2)(B), struck out par. (4) which read as follows: "The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this subchapter and shall not apply with respect to—

"(A) disproportionate share hospital payments described in section 1396r–4 of this title;

"(B) payments under subchapter IV;

"(C) payments under subchapter XXI; and

"(D) payments under this subchapter that are based on the enhanced FMAP described in section 1397ee(b) of this title."

Subsec. (z)(5). Pub. L. 111–152, § 1201(2)(C), redesignated par. (5) as (3).

Pub. L. 111–152, § 1201(1)(A), redesignated subsec. (y)(1)(B)(ii)(II) as subsec. (z)(5) and realigned margins.

Subsec. (aa). Pub. L. 111–148, § 2006(2), added subsec. (aa).

Subsec. (aa)(1), (2). Pub. L. 111–148, § 10201(c)(5), substituted "without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act" for "without regard to this subsection and subsection (y)" wherever appearing.

Subsec. (bb). Pub. L. 111–148, § 4107(a)(2), added subsec. (bb).

Subsec. (cc). Pub. L. 111–148, § 10201(c)(6), added subsec. (cc).

Subsec. (dd). Pub. L. 111–152, § 1202(b), added subsec. (dd).

2008—Subsec. (p)(1)(C). Pub. L. 110–275, § 112, inserted "or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1395w–114(a)(3) of this title (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be)" before period at end.

Subsec. (p)(5)(A). Pub. L. 110–275, § 118(a), inserted at end "The Secretary shall provide for the translation of

such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 426 or 426–1 of this title and shall make the translated forms available to the States and to the Commissioner of Social Security."

2006—Subsec. (u)(2)(B). Pub. L. 109–171 inserted at end "Such term excludes any child eligible for medical assistance only by reason of section 1396a(a)(10)(A)(ii)(XIX) of this title."

2004—Subsec. (a)(27), (28). Pub. L. 108–357, §712(a)(1)(A), added par. (27) and redesignated former par. (27) as (28).

Subsec. (x). Pub. L. 108–357, §712(a)(1)(B), added subsec. (x).

2000—Subsec. (a)(xiii). Pub. L. 106–354, §2(a)(4), added cl. (xiii).

Subsec. (b). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(1)], in last sentence, substituted "the State's available allotment under section 1397dd of this title" for "the State's allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allotment for such fiscal year".

Pub. L. 106–354, §2(c), in first sentence, struck out "and" before "(3)" and inserted before period at end ", and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title".

Subsec. (p)(5). Pub. L. 106–554, §1(a)(6) [title VII, §709(a)], added par. (5).

Subsec. (p)(6). Pub. L. 106–554, §1(a)(6) [title IX, §911(a)(2)], added par. (6).

Subsec. (u)(1)(B). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(2)], struck out "and section 1397dd(d) of this title" before period at end.

1999—Subsec. (a)(xii). Pub. L. 106–170, §201(a)(2)(C), added cl. (xii).

Subsec. (a)(15). Pub. L. 106–113, §1000(a)(6) [title VI, §608(aa)(3)], substituted "1396a(a)(31) of this title" for "1396a(a)(31)(A) of this title".

Subsec. (b). Pub. L. 106–113, §1000(a)(6) [title VI, §605(a)], inserted "(other than expenditures under section 1396r–4 of this title)" after "with respect to expenditures" in last sentence.

Subsec. (b)(1). Pub. L. 106–113, §1000(a)(6) [title VI, §608(*l*)], substituted "83 per centum," for "83 per centum,,".

Subsec. (*l*)(2)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(m)], substituted "an entity" for "a entity" in introductory provisions.

Subsec. (v). Pub. L. 106–169, §121(c)(5)(A), redesignated subsec. (v), related to independent foster care adolescent, as (w).

Pub. L. 106–169, §121(a)(2), added subsec. (v), related to independent foster care adolescent.

Pub. L. 106–170, §201(a)(2)(B), added subsec. (v).

Subsec. (w). Pub. L. 106–169, §121(c)(5), redesignated subsec. (v) as (w) and substituted "1396a(a)(10)(A)(ii)(XVII)" for "1396a(a)(10)(A)(ii)(XV)".

1997—Subsec. (a)(25). Pub. L. 105–33, §4702(a)(1), added par. (25). Former par. (25) redesignated (26).

Subsec. (a)(26). Pub. L. 105–33, §4802(a)(1), added par. (26). Former par. (26) redesignated (27).

Pub. L. 105–33, §4702(a)(1)(B), redesignated par. (25) as (26) and substituted comma for period at end.

Subsec. (a)(27). Pub. L. 105–33, §4802(a)(1)(B), redesignated par. (26) as (27).

Subsec. (b). Pub. L. 105–100, §162(1), inserted "for the State for a fiscal year, and that do not exceed the amount of the State's allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allotment for such fiscal year," after "subsection (u)(3) of this section".

Pub. L. 105–33, §4911(a)(1), inserted at end "Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title."

Pub. L. 105–33, §4732(b), substituted "Subject to section 1396u–3(d) of this title, the term" for "The term".

Pub. L. 105–33, §4725(b)(1), in first sentence, substituted ", (2)" for "and (2)" and inserted before period ", and (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent".

Subsec. (*l*)(2)(B)(iii). Pub. L. 105–33, §4712(d)(1), inserted "including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity," after "such a grant,".

Subsec. (*o*)(3). Pub. L. 105–33, §4711(c)(1), substituted "amount determined in section 1396a(a)(13)(B) of this title" for "amount described in section 1396a(a)(13)(D) of this title" in concluding provisions.

Subsec. (p)(3). Pub. L. 105–33, §4714(a)(2), inserted "(subject to section 1396a(n)(2) of this title)" after "means" in introductory provisions.

Subsec. (t). Pub. L. 105–33, §4702(a)(2), added subsec. (t).

Subsec. (u). Pub. L. 105–33, §4911(a)(2), added subsec. (u).

Subsec. (u)(1)(B). Pub. L. 105–100, §162(2)(A), substituted "the fourth sentence of subsection (b) of this section" for "paragraph (2)".

Subsec. (u)(2)(A). Pub. L. 105–100, §162(2)(B), substituted "subparagraph (B)" for "subparagraph (C), but not in excess, for a State for a fiscal year, of the amount described in subparagraph (B) for the State and fiscal year".

Subsec. (u)(2)(B), (C). Pub. L. 105–100, §162(2)(C), added subpar. (B) and struck out former subpars. (B) and (C) which read as follows:

"(B) The amount described in this subparagraph, for a State for a fiscal year, is the amount of the State's allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allotment for such fiscal year.

"(C) For purposes of this paragraph, the term 'optional targeted low-income child' means a targeted low-income child as defined in section 1397jj(b)(1) of this title who would not qualify for medical assistance under the State plan under this subchapter based on such plan as in effect on April 15, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1396a(*l*)(2)(D) of this title)."

Subsec. (u)(3). Pub. L. 105–100, §162(2)(D), substituted "described in this paragraph" for "described in this subparagraph" and "March 31, 1997" for "April 15, 1997".

Subsec. (u)(4). Pub. L. 105–100, §162(2)(E), added par. (4).

1996—Subsec. (*l*)(2)(B)(i), (ii)(II). Pub. L. 104–299 substituted "section 254b of this title" for "section 254b, 254c, 256, or 256a of this title".

1994—Subsecs. (j), (q)(2). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary".

1993—Subsec. (a)(xi). Pub. L. 103–66, §13603(e)(1)–(3), added cl. (xi).

Subsec. (a)(7). Pub. L. 103–66, §13601(a)(1), struck out "including personal care services (A) prescribed by a physician for an individual in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, (C) supervised by a registered nurse, and (D) furnished in a home or other lo-

cation; but not including such services furnished to an inpatient or resident of a nursing facility" after "services".

Subsec. (a)(17). Pub. L. 103–66, § 13605(a), inserted before semicolon at end ", and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle".

Subsec. (a)(19). Pub. L. 103–66, § 13603(e)(4), amended par. (19) generally, inserting reference to TB-related services described in section 1396a(z)(2)(F) of this title.

Subsec. (a)(21). Pub. L. 103–66, § 13601(a)(2), struck out "and" at end.

Subsec. (a)(22). Pub. L. 103–66, § 13601(a)(4), redesignated par. (23) as (22). Former par. (22) redesignated (25).

Subsec. (a)(23). Pub. L. 103–66, § 13601(a)(4), redesignated par. (24) as (23). Former par. (23) redesignated (22).

Subsec. (a)(24). Pub. L. 103–66, § 13601(a)(5), added par. (24). Former par. (24) redesignated (23).

Pub. L. 103–66, § 13601(a)(3), which directed amendment of par. (24) by substituting semicolon for comma at end, was executed by substituting semicolon for period at end to reflect the probable intent of Congress.

Subsec. (a)(25). Pub. L. 103–66, § 13601(a)(4), redesignated par. (22) as (25), transferred such par. to appear after par. (23), and substituted period for semicolon at end.

Subsec. (*l*)(2)(B). Pub. L. 103–66, § 13631(f)(2)(B), in concluding provisions, inserted "or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services" before ". In applying clause".

Subsec. (*l*)(2)(B)(i). Pub. L. 103–66, § 13631(f)(2)(A), substituted "256, or 256a" for "or 256".

Pub. L. 103–66, § 13606(a)(1), struck out "or" at end.

Subsec. (*l*)(2)(B)(ii). Pub. L. 103–66, § 13631(f)(2)(A), substituted "256, or 256a" for "or 256" in subcl. (II).

Pub. L. 103–66, § 13606(a)(2), (3), realigned margin and substituted a comma for semicolon at end.

Subsec. (*l*)(2)(B)(iv). Pub. L. 103–66, § 13606(a)(4), (5), added cl. (iv).

Subsec. (r)(1)(A)(i). Pub. L. 103–66, § 13631(g)(1)(A), inserted "and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines" after "child health care".

Subsec. (r)(1)(B)(iii). Pub. L. 103–66, § 13631(g)(1)(B), inserted "(according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines)" after "appropriate immunizations".

1990—Subsec. (a). Pub. L. 101–508, § 4722, inserted at end "No service (including counseling) shall be excluded from the definition of 'medical assistance' solely because it is provided as a treatment service for alcoholism or drug dependency."

Pub. L. 101–508, § 4402(d)(2), inserted at end "The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof."

Subsec. (a)(x). Pub. L. 101–508, § 4713(b), added cl. (x).

Subsec. (a)(2)(C). Pub. L. 101–508, § 4704(e)(1), repealed Pub. L. 101–239, § 6402(c)(1). See 1989 Amendment note below.

Subsec. (a)(7). Pub. L. 101–508, § 4721(a), substituted "services including personal care services" for "services" and added subpars. (A) to (D).

Subsec. (a)(13). Pub. L. 101–508, § 4719(a), inserted before semicolon at end ", including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level".

Subsec. (a)(22). Pub. L. 101–508, § 4711(a)(1), which directed amendment of par. (22) by striking "and" at end, could not be executed because the word did not appear.

Subsec. (a)(23). Pub. L. 101–508, § 4712(a)(1), inserted "and" after semicolon at end.

Pub. L. 101–508, § 4711(a)(2), (3), which directed amendment of subsec. (a) by redesignating par. (23) as (24) and adding a new par. (23), was executed by adding the new par. (23), there being no former par. (23).

Subsec. (a)(24). Pub. L. 101–508, § 4712(a)(2), (3), which directed amendment of subsec. (a) by redesignating par. (24) as (25) and adding a new par. (24), was executed by adding the new par. (24), there being no former par. (24).

Subsec. (h)(1)(A). Pub. L. 101–508, § 4755(a)(1)(A), inserted "or in another inpatient setting that the Secretary has specified in regulations" after "section 1395x(f) of this title".

Subsec. (*l*)(2)(A). Pub. L. 101–508, § 4704(c)(1), substituted "patient" for "outpatient".

Subsec. (*l*)(2)(B). Pub. L. 101–508, § 4704(d)(2), which directed amendment of subpar. (B) by inserting "and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638)." after and below cl. (ii), was executed by inserting the new language after cl. (iii) to reflect the probable intent of Congress and the intervening redesignation of former cl. (ii) as (iii) by Pub. L. 101–508, § 4704(c)(3). See below.

Pub. L. 101–508, § 4704(c)(2), substituted "entity" for "facility" in introductory provisions.

Subsec. (*l*)(2)(B)(ii), (iii). Pub. L. 101–508, § 4704(c)(3), (d)(1), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted comma for period at end of cl. (iii).

Subsec. (n)(2). Pub. L. 101–508, § 4601(a)(2), substituted "age of 19" for "age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)".

Subsec. (*o*)(1)(A). Pub. L. 101–508, § 4717, inserted "and for which payment may otherwise be made under subchapter XVIII of this chapter" after "section 1395d(d)(2)(A) of this title".

Subsec. (*o*)(3). Pub. L. 101–508, § 4705(a)(1), struck out "a State which elects not to provide medical assistance for hospice care, but provides medical assistance for skilled nursing or intermediate care facility services with respect to" after "In the case of" in introductory provisions.

Pub. L. 101–508, § 4705(a)(3), (4), in concluding provisions, substituted "the additional amount described in section 1396a(a)(13)(D) of this title" for "the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1396a(a)(13) of this title," and struck out at end "For purposes of this paragraph and section 1396a(a)(13)(D) of this title, the term 'room and board' includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies."

Subsec. (*o*)(3)(A), (C). Pub. L. 101–508, § 4705(a)(2), substituted "nursing facility or intermediate care facility for the mentally retarded" for "skilled nursing or intermediate care facility".

Subsec. (p)(1)(B). Pub. L. 101–508, § 4501(e)(1)(A), which directed amendment of subpar. (B) by inserting

", except as provided in paragraph (2)(D)" after "supplementary social security income program", was executed by inserting the new language after "supplemental security income program" to reflect the probable intent of Congress.

Subsec. (p)(2)(B). Pub. L. 101–508, §4501(a)(1), inserted "and" at end of cl. (ii), substituted "100 percent." for "95 percent, and" in cl. (iii), and struck out cl. (iv) which read as follows: "January 1, 1992, is 100 percent."

Subsec. (p)(2)(C). Pub. L. 101–508, §4501(a)(2), substituted "95 percent, and" for "90 percent," in cl. (iii) and "100 percent." for "95 percent, and" in cl. (iv) and struck out cl. (v) which read as follows: "January 1, 1993, is 100 percent."

Subsec. (p)(2)(D). Pub. L. 101–508, §4501(e)(1)(B), added subpar. (D).

Subsec. (p)(4). Pub. L. 101–508, §4501(c)(2), inserted at end "In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter."

Subsec. (p)(4)(B). Pub. L. 101–508, §4501(c)(1), inserted "or 1396a(a)(10)(E)(iii) of this title" after "subparagraph (B)".

1989—Subsec. (a)(2)(B). Pub. L. 101–239, §6404(a)(2), substituted "subsection (*l*)(1)" for "subsection (*l*)" in two places.

Subsec. (a)(2)(C). Pub. L. 101–239, §6404(a)(3), added cl. (C) relating to Federally-qualified health center services.

Pub. L. 101–239, §6402(c)(1), which directed addition of cl. (C) relating to ambulatory services, was repealed by Pub. L. 101–508, §4704(e)(1).

Subsec. (a)(4)(B). Pub. L. 101–239, §6403(d)(2), amended cl. (B) generally. Prior to amendment, cl. (B) read as follows: "effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and".

Subsec. (a)(21), (22). Pub. L. 101–239, §6405(a), added par. (21) and redesignated former par. (21) as (22).

Subsec. (*l*). Pub. L. 101–239, §6404(b), designated existing provisions as par. (1), redesignated former cls. (1) and (2) as (A) and (B), respectively, and added par. (2).

Subsec. (p)(1)(A). Pub. L. 101–239, §6408(d)(4)(B), inserted ", but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i–2a of this title" after "section 1395i–2 of this title".

Subsec. (p)(3)(A). Pub. L. 101–239, §6408(d)(4)(A)(i), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "Premiums under subchapter XVIII of this chapter (including under part B and, if applicable, under section 1395i–2 of this title)."

Subsec. (p)(3)(A)(i). Pub. L. 101–239, §6408(d)(4)(A)(ii), substituted "section 1395i–2 or 1395i–2a" for "section 1395i–2".

Subsec. (p)(3)(C). Pub. L. 101–234, §201(b)(1), substituted "Deductibles" for "Subject to paragraph (4), deductibles" and "section 1395e of this title and section 1395*l*(b) of this title)" for "section 1395e of this title, section 1395*l*(b) of this title, and section 1395m(c)(1) of this title".

Subsec. (p)(4), (5). Pub. L. 101–234, §201(b)(2), redesignated par. (5) as (4) and struck out former par. (4) which read as follows: "In a State which provides medical assistance for prescribed drugs under subsection (a)(12) of this section, instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1395m(c)(1) of this title, the State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in section 1396a(a)(10)(A)(i) of this title."

Subsec. (r). Pub. L. 101–239, §6403(c), inserted at end "The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services."

Pub. L. 101–239, §6403(a), added subsec. (r).

Subsec. (s). Pub. L. 101–239, §6408(d)(2), added subsec. (s).

1988—Subsec. (a). Pub. L. 100–647, §8434(b)(3), substituted "in the case of medicare cost-sharing with respect to a qualified medicare beneficiary" for "in the case of a qualified medicare beneficiary" in introductory provisions.

Subsec. (a)(ix). Pub. L. 100–485, §303(b)(2), added cl. (ix).

Subsec. (a)(5)(B). Pub. L. 100–360, §411(k)(4), substituted "described in clause (A) if" for "described in subparagraph (A) if".

Subsec. (a)(17). Pub. L. 100–360, §411(h)(4)(E), amended Pub. L. 100–203, §4073(d)(1), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100–360, §411(k)(14)(A), added subsec. (i).

Subsec. (m). Pub. L. 100–485, §401(d)(2), added subsec. (m).

Subsec. (*o*)(1). Pub. L. 100–360, §411(k)(8)(A), made clarifying amendment to directory language of Pub. L. 100–203, §4114, see 1987 Amendment note below.

Subsec. (*o*)(1)(B). Pub. L. 100–360, §411(k)(8)(B), struck out "only" after "For purposes of this subchapter" and substituted "immune deficiency syndrome (AIDS)" for "immunodeficiency syndrome".

Subsec. (*o*)(3). Pub. L. 100–485, §608(f)(3), realigned the margin of par. (3).

Subsec. (p)(1). Pub. L. 100–647, §8434(a), redesignated subpars. (C) and (D) as (B) and (C), respectively, and struck out former subpar. (B) which read: "who, but for section 1396a(a)(10)(E) of this title, is not eligible for medical assistance under the plan,".

Subsec. (p)(1)(B). Pub. L. 100–360, §301(a)(2), struck out "and the election of the State" after "1396a(a)(10)(E) of this title".

Subsec. (p)(1)(C). Pub. L. 100–360, §301(c)(1), as amended by Pub. L. 100–485, §608(d)(14)(E)(i), substituted "paragraph (2)" for "paragraph (2)(A)".

Subsec. (p)(1)(D). Pub. L. 100–360, §301(c)(2), as amended by Pub. L. 100–485, §608(d)(14)(E)(ii), substituted "twice" for "(except as provided in paragraph (2)(B))".

Subsec. (p)(2)(A). Pub. L. 100–647, §8434(b)(4), substituted "paragraph (1)(B)" for "paragraph (1)(C)".

Pub. L. 100–360, §301(b)(1), as amended by Pub. L. 100–485, §608(d)(14)(A), substituted "shall be at least the percent provided under subparagraph (B) (but not more than 100 percent)" for "may not exceed a percentage (not more than 100 percent)".

Pub. L. 100–360, §301(c)(3)(A), which directed amendment of subpar. (A) by striking "(2)(A)" and inserting "(2)", was repealed by Pub. L. 100–485, §608(d)(14)(E)(iii).

Pub. L. 100–360, §301(b)(2), which directed amendment of subpar. (A) by inserting "(i)" after "(2)(A)", was repealed by Pub. L. 100–485, §608(d)(14)(B).

Subsec. (p)(2)(B). Pub. L. 100–360, §301(b)(2), formerly §301(b)(3), as renumbered and amended by Pub. L. 100–485, §608(d)(14)(B)–(D)(ii), added subpar. (B) and struck out former subpar. (B) which read as follows: "In the case of a State that provides medical assistance to individuals not described in section 1396a(a)(10)(A) of this title and at the State's option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1396a(a)(10)(A) of this title."

Pub. L. 100–360, §301(c)(3)(B), which directed amendment of par. (2) by striking subpar. (B), was repealed by Pub. L. 100–485, §608(d)(14)(E)(iii).

Subsec. (p)(2)(C). Pub. L. 100–360, §301(b)(2), formerly §301(b)(3), as renumbered and amended by Pub. L. 100–485, §608(d)(14)(B), (C), (D)(i), (iii), added subpar. (C).

Subsec. (p)(3). Pub. L. 100–360, §301(d)(1), as added by Pub. L. 100–485, §608(d)(14)(G)(ii), inserted "without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan" after "qualified medicare beneficiary" in introductory provisions.

Subsec. (p)(3)(A). Pub. L. 100–360, §301(d)(2), formerly §301(d)(1), as renumbered by Pub. L. 100–485, §608(d)(14)(G)(i), substituted "under subchapter XVIII of this chapter (including under part B and, if applicable, under section 1395i–2 of this title)" for "under part B and (if applicable) under section 1395i–2 of this title".

Subsec. (p)(3)(B). Pub. L. 100–360, §301(d)(3), formerly §301(d)(2), as renumbered by Pub. L. 100–485, §608(d)(14)(G)(i), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "Deductibles and coinsurance described in section 1395e of this title."

Subsec. (p)(3)(C). Pub. L. 100–360, §301(d)(3), formerly §301(d)(2), as renumbered and amended by Pub. L. 100–485, §608(d)(14)(F), (G)(i), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "The annual deductible described in section 1395*l*(b) of this title."

Subsec. (p)(4). Pub. L. 100–360, §301(d)(4), formerly §301(d)(3), as renumbered by Pub. L. 100–485, §618(d)(14)(G)(i), added par. (4).

Subsec. (p)(5). Pub. L. 100–360, §301(g)(2), as amended by Pub. L. 100–485, §608(d)(14)(J), added par. (5).

1987—Subsec. (a)(4)(A). Pub. L. 100–203, §4211(f), struck out "skilled" before "nursing".

Subsec. (a)(5). Pub. L. 100–203, §4211(h)(6)(A), struck out "skilled" before "nursing" in cl. (A).

Pub. L. 100–203, §4103(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (a)(9). Pub. L. 100–203, §4105(a), inserted provision including services furnished to an eligible individual who does not reside in a permanent dwelling or have a fixed home or mailing address.

Subsec. (a)(14). Pub. L. 100–203, §4211(h)(6)(B), substituted "and nursing facility services" for ", skilled nursing facility services, and intermediate care facility services".

Subsec. (a)(15). Pub. L. 100–203, §4211(h)(6)(C), substituted "services in an intermediate care facility for the mentally retarded (other than" for "intermediate care facility services (other than such services".

Subsec. (a)(17). Pub. L. 100–203, §4073(d)(1), as amended by Pub. L. 100–360, §411(h)(4)(E), substituted "(as defined in section 1395x(gg) of this title)" for "(as defined in subsection (m) of this section)".

Subsec. (c). Pub. L. 100–203, §4211(e)(1), amended subsec. (c) generally. Prior to amendment, subsec. (c) defined "intermediate care facility".

Subsec. (d). Pub. L. 100–203, §4211(e)(2), substituted "intermediate care facility for the mentally retarded" for "intermediate care facility" and "means an" for "may include services in a public", and in par. (3) inserted "in the case of a public institution" after "(3)".

Subsec. (f). Pub. L. 100–203, §4211(e)(3), struck out "skilled" before "nursing" in four places and before "rehabilitation".

Subsec. (i). Pub. L. 100–203, §4211(e)(4), struck out subsec. (i) which provided that for purposes of this subchapter "skilled nursing facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as being a qualified skilled nursing facility by meeting the requirements of section 1395x(j) of this title.

Subsec. (m). Pub. L. 100–203, §4073(d)(2), struck out subsec. (m) which defined "nurse-midwife". See section 1395x(gg) of this title.

Subsec. (n)(2). Pub. L. 100–203, §4101(c)(1), substituted "has not attained the age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)" for "is under 5 years of age".

Subsec. (*o*)(1). Pub. L. 100–203, §4114, as amended by Pub. L. 100–360, §411(k)(8)(A), designated existing provisions as subpar. (A), substituted "Subject to subparagraph (B), the" for "The", and added subpar. (B).

Subsec. (p)(2)(A). Pub. L. 100–203, §4118(p)(8), struck out "nonfarm" before "official".

1986—Subsec. (a). Pub. L. 99–509, §9403(g)(3), inserted "or, in the case of a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary" after "makes application for assistance".

Subsec. (a)(18). Pub. L. 99–272, §9505(a)(1), added par. (18). Former par. (18) redesignated (19).

Subsec. (a)(19). Pub. L. 99–514, §1895(c)(3)(A), added par. (19). Former par. (19) redesignated (20).

Pub. L. 99–272, §9505(a)(1)(B), redesignated former par. (18) as (19).

Subsec. (a)(20). Pub. L. 99–509, §9408(c)(1), added par. (20). Former par. (20) redesignated (21).

Pub. L. 99–514, §1895(c)(3)(A)(ii), redesignated former par. (19) as (20).

Subsec. (a)(21). Pub. L. 99–509, §9408(c)(1)(B), redesignated former par. (20) as (21).

Subsec. (n)(1)(C). Pub. L. 99–272, §9501(a), added subpar. (C).

Subsec. (n)(2). Pub. L. 99–272, §9511(a), inserted "(or such earlier date as the State may designate)" after "September 30, 1983".

Subsec. (*o*). Pub. L. 99–272, §9505(a)(2), added subsec. (*o*).

Subsec. (*o*)(3). Pub. L. 99–509, §9435(b)(2), added par. (3).

Subsec. (p). Pub. L. 99–509, §9403(b), (d), added subsec. (p).

Subsec. (q). Pub. L. 99–509, §9404(b), added subsec. (q).

1984—Subsec. (a). Pub. L. 98–369, §2335(f), substituted "mental diseases" for "tuberculosis or mental diseases" in subd. (B) following par. (18).

Pub. L. 98–369, §2373(b)(17), substituted "clause (vi)" for "clauses (vi)" and "well-being" for "well being" in last sentence.

Subsec. (a)(1). Pub. L. 98–369, §2335(f), substituted "mental diseases" for "tuberculosis or mental diseases".

Subsec. (a)(4). Pub. L. 98–369, §2335(f), substituted "mental diseases" for "tuberculosis or mental diseases".

Pub. L. 98–369, §2373(b)(15), inserted a semicolon before "(B)".

Subsec. (a)(9). Pub. L. 98–369, §2371(a), amended par. (9) generally, inserting "furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician".

Subsec. (a)(14), (15). Pub. L. 98–369, §2335(f), substituted "mental diseases" for "tuberculosis or mental diseases".

Subsec. (a)(17). Pub. L. 98–369, §2373(b)(16), substituted "the nurse-midwife" for "he" in two places.

Subsec. (b). Pub. L. 98–369, §2373(b)(18), substituted "section 1301(a)(8)(B) of this title" for "subparagraph (B) of section 1301(a)(8) of this title".

Subsec. (d)(1). Pub. L. 98–369, §2373(b)(19), substituted "the institution meets" for "which meet".

Subsec. (h)(1)(A). Pub. L. 98–369, §2340(b), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "inpatient services which are provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;".

Subsec. (m). Pub. L. 98–369, §2373(b)(20), substituted "the nurse" for "he" in two places.

Subsec. (n). Pub. L. 98–369, §2361(b), added subsec. (n).

1982—Subsec. (a)(i). Pub. L. 97–248, §137(b)(17), struck out "or any reasonable category of such individuals," after "as the State may choose,".

Subsec. (a)(viii). Pub. L. 97–248, §137(b)(18), added cl. (viii).

Subsec. (b)(2). Pub. L. 97–248, § 136(c), substituted "the Northern Mariana Islands, and American Samoa" for "and the Northern Mariana Islands".

Subsec. (h)(1)(C). Pub. L. 97–248, § 137(f), redesignated cls. (i) and (ii) as subcls. (I) and (II), respectively, and redesignated cls. (A) and (B) as cls. (i) and (ii), respectively.

1981—Subsec. (a). Pub. L. 97–35, § 2172(b), in cl. (i), inserted "or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, or any reasonable category of such individuals," and in cl. (ii), struck out reference to section 606(a)(2) of this title.

Subsec. (b). Pub. L. 97–35, § 2162(a)(2), inserted reference to Northern Mariana Islands.

1980—Subsec. (a)(17), (18). Pub. L. 96–499, § 965(a)(1)(B), (C), added par. (17) and redesignated former par. (17) as (18).

Subsec. (c). Pub. L. 96–473 substituted "clause (1)" for "clauses (1)".

Subsec. (m). Pub. L. 96–499, § 965(a)(2), added subsec. (m).

1978—Subsec. (c). Pub. L. 95–292 added cl. (4) to first sentence relating to a requirement that intermediate care facilities meet section 1395x(j)(14) of this title with respect to protection of patients' personal funds, and inserted reference to that cl. (4) in provisions covering intermediate care facilities on Indian reservations.

1977—Subsec. (a)(2). Pub. L. 95–210, § 2(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (*l*). Pub. L. 95–210, § 2(b), added subsec. (*l*).

1976—Subsec. (b). Pub. L. 94–437 inserted provision requiring that the Federal medical assistance percentage be 100 per centum for services received through an Indian Health Service facility.

1973—Subsec. (a). Pub. L. 93–233, § 13(a)(13), substituted in introductory text "individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter" for "individuals not receiving aid or assistance under the State's plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter".

Subsec. (a)(iv). Pub. L. 93–233, § 13(a)(14), inserted "with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter," after "blind,".

Subsec. (a)(v). Pub. L. 93–233, § 13(a)(15), substituted "with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter," for "or".

Subsec. (a)(vi). Pub. L. 93–233, § 13(a)(16), inserted "or" at end of text.

Subsec. (a)(vii). Pub. L. 93–233, § 13(a)(17), added cl. (vii).

Subsec. (a)(16). Pub. L. 93–233, § 18(x)(7), substituted "under age 21, as defined in subsection (h) of this section; and" for "under 21, as defined in subsection (e) of this section;".

Subsec. (b). Pub. L. 93–233, § 18(y)(2), struck out "; except that the Secretary shall promulgate such percentage as soon as possible after July 30, 1965, which promulgation shall be conclusive for each of the six quarters in the period beginning January 1, 1966, and ending with the close of June 30, 1966" after "section 1301(a)(8) of this title".

Subsec. (c). Pub. L. 93–233, § 18(x)(8), substituted "skilled nursing facility" for "skilled nursing home" wherever appearing.

Subsec. (h)(1)(B). Pub. L. 93–233, § 18(w), substituted "(i) involve active treatment" for ", involves active treatment (i)"; struck out "pursuant to subchapter XVIII of this chapter" after "may be prescribed"; and substituted "(ii)" for "(ii) which", respectively.

Subsec. (h)(2). Pub. L. 93–233, § 18(x)(10), substituted "paragraph (1)" for "paragraph (e)(1)".

Subsec. (i). Pub. L. 93–233, § 18(x)(9), redesignated subsec. (h) as added by Pub. L. 92–603, § 299L(b), as subsec. (i).

Subsecs. (j), (k). Pub. L. 93–233, § 13(a)(18), added subsecs. (j) and (k).

1972—Subsec. (a). Pub. L. 92–603, § 299B(c), in text following redesignated subsec. (a)(17) substituted "as otherwise provided in paragraph (16)," for "that".

Subsec. (a)(4). Pub. L. 92–603, §§ 278(a)(21), 299E(b), substituted "skilled nursing facility" for "skilled nursing home" and added cl. (C).

Subsec. (a)(5). Pub. L. 92–603, §§ 278(a)(22), 280, substituted "skilled nursing facility" for "skilled nursing home" and inserted "furnished by a physician (as defined in section 1395x(r)(1) of this title) after "physicians' services".

Subsec. (a)(14). Pub. L. 92–603, §§ 278(a)(23), 297(a), substituted "skilled nursing facility" for "skilled nursing home" and inserted reference to intermediate care facility services.

Subsec. (a)(15) to (17). Pub. L. 92–603, § 299B(a), added par. (16) and redesignated existing pars. (15) and (16) as (17) and (15), respectively.

Subsec. (c). Pub. L. 92–603, § 299L(a), inserted provision defining "intermediate care facility" with respect to any institution located in a State on an Indian reservation.

Subsec. (d)(3). Pub. L. 92–603, § 299, inserted provisions relating to reduction of non-Federal expenditures in any calendar quarter prior to January 1, 1975.

Subsec. (e). Pub. L. 92–603, § 212(a), added subsec. (e).

Subsec. (f). Pub. L. 92–603, § 247(b), added subsec. (f).

Subsec. (g). Pub. L. 92–603, § 275(a), added subsec. (g).

Subsec. (h). Pub. L. 92–603, § 299B(b), added subsec. (h).

Subsec. (i). Pub. L. 92–603, § 299L(b), added subsec. (i).

1971—Subsec. (a)(16). Pub. L. 92–223, § 4(a)(1)(C), added cl. (16).

Subsecs. (c), (d). Pub. L. 92–223, § 4(a)(2), added subsecs. (c) and (d).

1968—Subsec. (a). Pub. L. 90–248, § 230, inserted ", and with respect to physicians' or dentists' services, at the option of the State, to individuals not receiving aid or assistance under the State's plan approved under subchapter I, X, XIV, XVI of this chapter, or part A of subchapter IV of this chapter" after "for individuals" in text preceding cl. (i).

Pub. L. 90–248, § 233(b), inserted provision deeming, for purposes of cl. (vi) of the preceding sentence, a person as essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XV of this chapter, and such person is determined, under such a State plan, to be essential to the well being of such individual.

Subsec. (a)(ii). Pub. L. 90–248, § 241(f)(6), inserted "part A of" before "subchapter IV".

Subsec. (a)(vi). Pub. L. 90–248, § 233(a), added cl. (vi).

Subsec. (a)(4). Pub. L. 90–248, § 302(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (b). Pub. L. 90–248, § 248(e), substituted in cl. (2) of first sentence "50" for "55".

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, § 2005(c)(2), Mar. 23, 2010, 124 Stat. 284, as amended by Pub. L. 111–152, title I, § 1204(b)(2)(B), Mar. 30, 2010, 124 Stat. 1056, provided that: "The amendment made by paragraph (1) [amending this section] takes effect on July 1, 2011."

Amendment by section 2301(a) of Pub. L. 111–148 effective Mar. 23, 2010, and applicable to services furnished on or after such date, with certain exceptions, see section 2301(c) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2303(a)(4)(A) of Pub. L. 111–148 effective Mar. 23, 2010, and applicable to items and services furnished on or after such date, see section 2303(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2402(d)(2)(B) of Pub. L. 111–148 effective on the first day of the first fiscal year quarter that begins after Mar. 23, 2010, see section 2402(g) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Pub. L. 111–148, title IV, § 4106(c), Mar. 23, 2010, 124 Stat. 560, provided that: "The amendments made under this section [amending this section] shall take effect on January 1, 2013."

Pub. L. 111–148, title IV, § 4107(d), Mar. 23, 2010, 124 Stat. 561, provided that: "The amendments made by this section [amending this section and sections 1396*o*, 1396*o*–1, and 1396r–8 of this title] shall take effect on October 1, 2010."

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, § 118(b), July 15, 2008, 122 Stat. 2508, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2010."

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 applicable to medical assistance for items and services furnished on or after Jan. 1, 2007, see section 6062(d) of Pub. L. 109–171, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–357 effective Oct. 22, 2004, and applicable to medical assistance and services provided under this subchapter on or after that date, see section 712(d) of Pub. L. 108–357, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 2000 AMENDMENTS

Pub. L. 106–554, § 1(a)(6) [title VII, § 709(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–578, provided that: "The amendment made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Dec. 21, 2000], regardless of whether regulations have been promulgated to carry out such amendment by such date. The Secretary of Health and Human Services shall develop the uniform application form under such amendment by not later than 9 months after the date of the enactment of this Act."

Pub. L. 106–554, § 1(a)(6) [title VIII, § 802(f)], Dec. 21, 2000, 114 Stat. 2763, 2763A–582, provided that: "The amendments made by this section [amending this section and sections 1397dd, 1397ee, and 1397jj of this title] shall be effective as if included in the enactment of section 4901 of the BBA [Pub. L. 105–33] (111 Stat. 552)."

Amendment by section 1(a)(6) [title IX, § 911(a)(2)] of Pub. L. 106–554 effective one year after Dec. 21, 2000, see section 1(a)(6) [title IX, § 911(c)] of Pub. L. 106–554, set out as an Effective Date note under section 1320b–14 of this title.

Amendment by Pub. L. 106–354 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date, see section 2(d) of Pub. L. 106–354, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENTS

Amendment by Pub. L. 106–170 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, see section 201(d) of Pub. L. 106–170, set out as a note under section 1396a of this title.

Amendment by section 121(a)(2) of Pub. L. 106–169 applicable to medical assistance for items and services furnished on or after Oct. 1, 1999, see section 121(b) of Pub. L. 106–169, set out as a note under section 1396a of this title.

Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 605(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, provided that: "The amendment made by subsection (a) [amending this section] takes effect on October 1, 1999, and applies to expenditures made on or after such date."

Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 608(aa)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398, provided that the amendment made by section 1000(a)(6) [title VI, § 608(aa)(3)] is effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

Amendment by section 1000(a)(6) [title VI, § 608(*l*), (m)] of Pub. L. 106–113 effective Nov. 29, 1999, see section 1000(a)(6) [title VI, § 608(bb)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENTS

Section 162 of Pub. L. 105–100 provided that the amendment made by that section is effective as if included in the enactment of subtitle J (§§ 4901–4923) of title IV of the Balanced Budget Act of 1997, Pub. L. 105–33.

Amendment by section 4702(a) of Pub. L. 105–33 applicable to primary care case management services furnished on or after Oct. 1, 1997, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, see section 4710(b)(1) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Amendment by section 4711(c)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to payment for items and services furnished on or after Oct. 1, 1997, see section 4711(d) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Section 4712(d)(2) of Pub. L. 105–33 provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Aug. 5, 1997]."

Amendment by section 4714(a)(2) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, and to payment by a State for items and services furnished before such date if such payment is subject of lawsuit that is based on subsection (p) of this section and section 1396a(n) of this title and that is pending as of, or is initiated after Aug. 5, 1997, see section 4714(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Section 4725(b)(2) of Pub. L. 105–33 provided that: "The amendments made by paragraph (1) [amending this section] shall apply to—

"(A) items and services furnished on or after October 1, 1997;

"(B) payments made on a capitation or other risk-basis for coverage occurring on or after such date; and

"(C) payments attributable to DSH allotments for such States determined under section 1923(f) of such Act (42 U.S.C. 1396r–4(f)) for fiscal years beginning with fiscal year 1998."

Amendment by section 4911(a) of Pub. L. 105–33 applicable to medical assistance for items and services furnished on or after Oct. 1, 1997, see section 4911(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–299 effective Oct. 1, 1996, see section 5 of Pub. L. 104–299, as amended, set out as a note under section 233 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13601(a) of Pub. L. 103–66 effective as if included in enactment of section 4721(a) of the

Omnibus Budget Reconciliation Act of 1990, Pub. L. 101–508, see section 13601(c) of Pub. L. 103–66, set out as a note under section 1396a of this title.

Amendment by section 13603(e) of Pub. L. 103–66 applicable to medical assistance furnished on or after Jan. 1, 1994, without regard to whether or not final regulations to carry out the amendments by section 13603 of Pub. L. 103–66 have been promulgated by such date, see section 13603(f) of Pub. L. 103–66, set out as a note under section 1396a of this title.

Section 13605(b) of Pub. L. 103–66 provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after October 1, 1993."

Section 13606(b) of Pub. L. 103–66 provided that: "The amendments made by subsection (a) [amending this section] shall apply to calendar quarters beginning on or after July 1, 1993."

Amendment by section 13631(f)(2) of Pub. L. 103–66 applicable, except as otherwise provided, to calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not final regulations to carry out the amendments by section 13631(f) of Pub. L. 103–66 have been promulgated by such date, see section 13631(f)(3) of Pub. L. 103–66, set out as a note under section 1396a of this title.

Section 13631(g)(2) of Pub. L. 103–66 provided that: "The amendments made by subparagraphs (A) and (B) of paragraph (1) [amending this section] shall first apply 90 days after the date the schedule referred to in subparagraphs (A)(i) and subparagraph (B)(iii) of section 1905(r)(1) of the Social Security Act [subsec. (r)(1)(B)(iii) of this section] (as amended by such respective subparagraphs) is first established."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4402(d)(2) of Pub. L. 101–508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4402 of Pub. L. 101–508 have been promulgated by such date, see section 4402(e) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4501(a), (c), (e)(1) of Pub. L. 101–508 applicable to calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not regulations to implement the amendments by section 4501 of Pub. L. 101–508 are promulgated by such date, except that amendment by section 4501(e)(1) of Pub. L. 101–508 is applicable to determinations of income for months beginning with January 1991, see section 4501(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4601(a)(2) of Pub. L. 101–508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4601 of Pub. L. 101–508 have been promulgated by such date, see section 4601(b) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4704(c), (d), (e)(1) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239, see section 4704(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Section 4705(b) of Pub. L. 101–508 provided that: "The amendments made by subsection (a) [amending this section] shall be effective as if included in the amendments made by section 6408(c)(1) of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239, amending section 1396a of this title]."

Amendment by section 4711(a) of Pub. L. 101–508 applicable to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4711 of Pub. L. 101–508 have been promulgated by such date, see section 4711(e) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4712(a) of Pub. L. 101–508 applicable to community supported living arrangements services furnished on or after the later of July 1, 1991, or 30 days after the publication of regulations setting forth interim requirements under section 1396u(h) of this title without regard to whether or not final regulations to carry out the amendments by section 4712 of Pub. L. 101–508 have been promulgated by such date, see section 4712(c) of Pub. L. 101–508, set out as an Effective Date note under section 1396u of this title.

Amendment by section 4713(b) of Pub. L. 101–508 applicable to medical assistance furnished on or after Jan. 1, 1991, see section 4713(c) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Section 4719(b) of Pub. L. 101–508 provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

Section 4721(b) of Pub. L. 101–508 provided that: "The amendment made by this section [amending this section] shall become effective with respect to personal care services provided on or after October 1, 1994."

Section 4755(a)(1)(B) of Pub. L. 101–508 provided that: "The amendment made by subparagraph (A) [amending this section] shall be effective as if included in the enactment of the Deficit Reduction Act of 1984 [Pub. L. 98–369]."

EFFECTIVE DATE OF 1989 AMENDMENTS

Amendment by section 6403(a), (c), (d)(2) of Pub. L. 101–239 effective Apr. 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6403 of Pub. L. 101–239 have been promulgated by such date, see section 6403(e) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by section 6404(a), (b) of Pub. L. 101–239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6404 of Pub. L. 101–239 have been promulgated by such date, see section 6404(d) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by section 6405(a) of Pub. L. 101–239 effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990, see section 6405(c) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by section 6408(d)(2), (4)(A), (B) of Pub. L. 101–239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6408(d) of Pub. L. 101–239 have been promulgated by such date, see section 6408(d)(5) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–647 effective as if included in the enactment of section 301 of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 8434(c) of Pub. L. 100–647, set out as a note under section 1396a of this title.

Amendment by section 303(b)(2) of Pub. L. 100–485 applicable to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990 (or, in the case of the Commonwealth of Kentucky, Oct. 1, 1990) (without regard to whether regulations to implement such amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter on or after that date, see section 303(f)(1) of Pub. L. 100–485, set out as a note under section 1396a of this title.

Amendment by section 401(d)(2) of Pub. L. 100–485 effective Oct. 1, 1990, except as provided in subsec. (m)(2) of this section and not effective for Puerto Rico, Guam, American Samoa, and the Virgin Islands, until the date of repeal of limitations contained in section 1308(a) of this title on payments to such jurisdictions for purposes of making maintenance payments under this part and part E of this subchapter, see section 401(g) of Pub. L. 100–485, as amended, set out as a note under section 1396a of this title.

Amendment by section 608(d)(14)(A)–(G), (J) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 608(f)(3) of Pub. L. 100–485 effective Oct. 13, 1988, see section 608(g)(2) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 301(a)(2)–(d) of Pub. L. 100–360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1989, without regard to whether or not final regulations to carry out such amendment have been promulgated by that date, with respect to medical assistance for monthly premiums under subchapter XVIII of this chapter for months beginning with January 1989, and items and services furnished on and after Jan. 1, 1989, see section 301(h) of Pub. L. 100–360, set out as a note under section 1396a of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(h)(4)(E), (k)(4), (8) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Section 411(k)(14)(B) of Pub. L. 100–360 provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4073(d) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4073(e) of Pub. L. 100–203, set out as a note under section 1395k of this title.

Section 4101(c)(3) of Pub. L. 100–203 provided that:

"(A) The amendments made by this subsection [amending this section and section 1396a of this title] shall apply to medical assistance furnished on or after October 1, 1988.

"(B) For purposes of section 1905(n)(2) of the Social Security Act [section 1396d(n)(2) of this title] (as amended by subsection (a) [probably means "subsection (c)"]) for medical assistance furnished during fiscal year 1989, any reference to 'age of 7' is deemed to be a reference to 'age of 6'."

Section 4103(b) of Pub. L. 100–203 provided that:

"(1) The amendment made by subsection (a) [amending this section] applies (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after January 1, 1988, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Dec. 22, 1987]."

Section 4105(b) of Pub. L. 100–203 provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1988, without regard to whether regulations to implement such amendment are promulgated by such date."

Amendments by section 4211(e), (f), (h)(6) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1986 AMENDMENTS

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 9403(b), (d), (g)(3) of Pub. L. 99–509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9403(h) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9404(b) of Pub. L. 99–509 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement such amendments are promulgated by such date, see section 9404(c) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9408(c)(1) of Pub. L. 99–509 applicable to services furnished on or after Oct. 21, 1986, see section 9408(d) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Section 9501(d)(1) of Pub. L. 99–272 provided that:

"(A) The amendments made by subsection (a) [amending this section] apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after the [sic] July 1, 1986, without regard to whether or not final regulations to carry out the amendments have been promulgated by that date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Apr. 7, 1986]."

Amendment by section 9505(a) of Pub. L. 99–272 applicable to medical assistance provided for hospice care furnished on or after Apr. 7, 1986, see section 9505(e) of Pub. L. 99–272, set out as a note under section 1396a of this title.

Section 9511(b) of Pub. L. 99–272, as amended by Pub. L. 99–509, title IX, § 9435(d)(2), Oct. 21, 1986, 100 Stat. 2070, provided that: "The amendment made by this section [amending this section] shall apply to services furnished on or after April 1, 1986, without regard to whether or not regulations to carry out the amendment have been promulgated by that date."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2335(f) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 2340(b) of Pub. L. 98–369 effective July 18, 1984, see section 2340(c) of Pub. L. 98–369, set out as a note under section 1395x of this title.

Amendment by section 2361(b) of Pub. L. 98–369 applicable to calendar quarters beginning on or after Oct. 1, 1984, without regard to whether or not final regulations to carry out the amendment have been promulgated by such date, except as otherwise provided, see section 2361(d) of Pub. L. 98–369, set out as a note under section 1396a of this title.

Section 2371(b) of Pub. L. 98–369 provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [July 18, 1984]."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 136(c) of Pub. L. 97–248 effective Oct. 1, 1982, see section 136(e) of Pub. L. 97–248, set out as a note under section 1301 of this title.

Amendment by section 137(b)(17), (18) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2172(b) of Pub. L. 97–35 effective Aug. 13, 1981, see section 2172(c) of Pub. L. 97–35, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

For effective date of amendment by Pub. L. 96–499, see section 965(c) of Pub. L. 96–499, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Section 8(d)(1) of Pub. L. 95–292 provided that: "The amendments made by subsections (a) and (b) [amending this section] shall become effective on July 1, 1978."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to medical assistance provided, under a State plan approved under subchapter XIX of this chapter, on and after the first day of the first calendar quarter that begins more than six months after Dec. 13, 1977, with exception for plans requiring State legislation, see section 2(f) of Pub. L. 95–210, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by section 13(a)(13)–(18) of Pub. L. 93–233 effective with respect to payments under section 1396b of this title for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93–233, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Section 212(b) of Pub. L. 92–603 provided that: "The provisions of subsection (e) of section 1905 of the Social Security Act [subsec. (e) of this section] (as added by subsection (a) of this section) shall be applicable in the case of services performed on or after the date of enactment of this Act [Oct. 30, 1972]."

Amendment by section 247(b) of Pub. L. 92–603 effective with respect to services furnished after Dec. 31, 1972, see section 247(c) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Section 275(b) of Pub. L. 92–603 provided that: "The amendment made by this section [amending this section] shall be effective with respect to services furnished after June 30, 1973."

Section 297(b) of Pub. L. 92–603 provided that: "The amendment made by this section [amending this section] shall apply with respect to services furnished after December 31, 1972."

EFFECTIVE DATE OF 1971 AMENDMENT

Amendment by Pub. L. 92–223 effective Jan. 1, 1972, see section 4(d) of Pub. L. 92–223, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Section 248(e) of Pub. L. 90–248 provided that the amendment made by that section is effective with respect to quarters after 1967.

CONSTRUCTION OF 2004 AMENDMENT

Pub. L. 108–357, title VII, § 712(a)(2), Oct. 22, 2004, 118 Stat. 1558, provided that: "Nothing in subsections (a)(27) or (x) of section 1905 of the Social Security Act (42 U.S.C. 1396d), as added by paragraph (1), shall be construed as implying that a State medicaid program under title XIX of such Act [this subchapter] could not have treated, prior to the date of enactment of this Act [Oct. 22, 2004], any of the primary and secondary medical strategies and treatment and services described in such subsections as medical assistance under such program, including as early and periodic screening, diagnostic, and treatment services under section 1905(r) of such Act [subsec. (r) of this section]."

CONSTRUCTION OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 to be executed as if Pub. L. 106–169 had been enacted after the enactment of Pub. L. 106–170, see section 121(c)(1) of Pub. L. 106–169, set out as a note under section 1396a of this title.

INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES

Pub. L. 111–148, title X, § 10202, Mar. 23, 2010, 124 Stat. 923, provided that:

"(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (z) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

"(b) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

"(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f))(1)) [sic] are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

"(2) that submits an application and meets the conditions described in subsection (c); and

"(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

"(c) CONDITIONS.—The conditions described in this subsection are the following:

"(1) APPLICATION.—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

"(A) a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a 'no wrong door—single entry

point system', optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

"(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)], at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).

"(2) TARGET SPENDING PERCENTAGES.—

"(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

"(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

"(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

"(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

"(5) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

"(A) 'NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM'.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

"(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

"(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

"(6) DATA COLLECTION.—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

"(A) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

"(B) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

"(C) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

"(i) measures of beneficiary and family caregiver experience with providers;

"(ii) measures of beneficiary and family caregiver satisfaction with services; and

"(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

"(d) APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.—The applicable percentage points increase is—

"(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and

"(2) in the case of any other balancing incentive payment State, 2 percentage points.

"(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

"(1) IN GENERAL.—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.

"(2) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed $3,000,000,000.

"(f) DEFINITIONS.—In this section:

"(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term 'long-term services and supports' has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):

"(A) Institutionally-based long-term services and supports.—Services provided in an institution, including the following:

"(i) Nursing facility services.

"(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act [42 U.S.C. 1396d(a)(15)].

"(B) Non-institutionally-based long-term services and supports.—Services not provided in an institution, including the following:

"(i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act [42 U.S.C. 1396n(c), (d), (i)] or under a waiver under section 1115 of such Act [42 U.S.C. 1315].

"(ii) Home health care services.

"(iii) Personal care services.

"(iv) Services described in subsection (a)(26) of section 1905 of such Act [42 U.S.C. 1396d(a)(26)] (relating to PACE program services).

"(v) Self-directed personal assistance services described in section 1915(j) of such Act [42 U.S.C. 1396n(j)].

"(2) BALANCING INCENTIVE PERIOD.—The term 'balancing incentive period' means the period that begins on October 1, 2011, and ends on September 30, 2015.

"(3) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

"(4) STATE MEDICAID PROGRAM.—The term 'State Medicaid program' means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and under any waiver approved with respect to such State plan."

TEMPORARY INCREASE OF MEDICAID FMAP

Pub. L. 111–5, div. B, title V, §5001, Feb. 17, 2009, 123 Stat. 496, as amended by Pub. L. 111–226, title II, §201, Aug. 10, 2010, 124 Stat. 2393, provided that:

"(a) PERMITTING MAINTENANCE OF FMAP.—Subject to subsections (e), (f), and (g), if the FMAP determined without regard to this section for a State for—

"(1) fiscal year 2009 is less than the FMAP as so determined for fiscal year 2008, the FMAP for the State for fiscal year 2008 shall be substituted for the State's FMAP for fiscal year 2009, before the application of this section;

"(2) fiscal year 2010 is less than the FMAP as so determined for fiscal year 2008 or fiscal year 2009 (after the application of paragraph (1)), the greater of such FMAP for the State for fiscal year 2008 or fiscal year 2009 shall be substituted for the State's FMAP for fiscal year 2010, before the application of this section; and

"(3) fiscal year 2011 is less than the FMAP as so determined for fiscal year 2008, fiscal year 2009 (after the application of paragraph (1)), or fiscal year 2010 (after the application of paragraph (2)), the greatest of such FMAP for the State for fiscal year 2008, fiscal year 2009, or fiscal year 2010 shall be substituted for the State's FMAP for fiscal year 2011, before the application of this section, but only for the first 3 calendar quarters in fiscal year 2011.

"(b) GENERAL 6.2 PERCENTAGE POINT INCREASE.—

"(1) IN GENERAL.—Subject to subsections (e), (f), and (g) and paragraphs (2) and (3), for each State for calendar quarters during the recession adjustment period (as defined in subsection (h)(3)), the FMAP (after the application of subsection (a)) shall be increased (without regard to any limitation otherwise specified in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))) by 6.2 percentage points.

"(2) SPECIAL ELECTION FOR TERRITORIES.—In the case of a State that is not one of the 50 States or the District of Columbia, paragraph (1) shall only apply if the State makes a one-time election, in a form and manner specified by the Secretary and for the entire recession adjustment period, to apply the increase in FMAP under paragraph (1) and a 15 percent increase under subsection (d) instead of applying a 30 percent increase under subsection (d).

"(3) PHASE-DOWN OF GENERAL INCREASE.—

"(A) SECOND QUARTER OF FISCAL YEAR 2011.—For each State, for the second quarter of fiscal year 2011, the FMAP percentage increase for the State under paragraph (1) or (2) (as applicable) shall be 3.2 percentage points.

"(B) THIRD QUARTER OF FISCAL YEAR 2011.—For each State, for the third quarter of fiscal year 2011, the FMAP percentage increase for the State under paragraph (1) or (2) (as applicable) shall be 1.2 percentage points.

"(c) ADDITIONAL RELIEF BASED ON INCREASE IN UNEMPLOYMENT.—

"(1) IN GENERAL.—Subject to subsections (e), (f), and (g), if a State is a qualifying State under paragraph (2) for a calendar quarter occurring during the recession adjustment period, the FMAP for the State shall be further increased by the number of percentage points equal to the product of—

"(A) the State percentage applicable for the State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) after the application of subsection (a) and after the application of ½ of the increase under subsection (b); and

"(B) the applicable percent determined in paragraph (3) for the calendar quarter (or, if greater, for a previous such calendar quarter).

"(2) QUALIFYING CRITERIA.—

"(A) IN GENERAL.—For purposes of paragraph (1), a State qualifies for additional relief under this subsection for a calendar quarter occurring during the recession adjustment period if the State is 1 of the 50 States or the District of Columbia and the State satisfies any of the following criteria for the quarter:

"(i) The State unemployment increase percentage (as defined in paragraph (4)) for the quarter is at least 1.5 percentage points but less than 2.5 percentage points.

"(ii) The State unemployment increase percentage for the quarter is at least 2.5 percentage points but less than 3.5 percentage points.

"(iii) The State unemployment increase percentage for the quarter is at least 3.5 percentage points.

"(B) MAINTENANCE OF STATUS.—If a State qualifies for additional relief under this subsection for a calendar quarter, it shall be deemed to have qualified for such relief for each subsequent calendar quarter ending before January 1, 2011.

"(3) APPLICABLE PERCENT.—

"(A) IN GENERAL.—For purposes of paragraph (1), subject to subparagraph (B), the applicable percent is—

"(i) 5.5 percent, if the State satisfies the criteria described in paragraph (2)(A)(i) for the calendar quarter;

"(ii) 8.5 percent if the State satisfies the criteria described in paragraph (2)(A)(ii) for the calendar quarter; and

"(iii) 11.5 percent if the State satisfies the criteria described in paragraph (2)(A)(iii) for the calendar quarter.

"(B) MAINTENANCE OF HIGHER APPLICABLE PERCENT.—

"(i) HOLD HARMLESS PERIOD.—If the percent applied to a State under subparagraph (A) for any calendar quarter in the recession adjustment period beginning on or after January 1, 2009, and ending before January 1, 2011, [sic] (determined without regard to this subparagraph) is less than the percent applied for the preceding quarter (as so determined), the higher applicable percent shall continue in effect for each subsequent calendar quarter ending before January 1, 2011.

"(ii) NOTICE OF LOWER APPLICABLE PERCENT.—The Secretary shall notify a State at least 60 days prior to applying any lower applicable percent to the State under this paragraph.

"(4) COMPUTATION OF STATE UNEMPLOYMENT INCREASE PERCENTAGE.—

"(A) IN GENERAL.—In this subsection, the 'State unemployment increase percentage' for a State for a calendar quarter is equal to the number of percentage points (if any) by which—

"(i) the average monthly unemployment rate for the State for months in the most recent previous 3-consecutive-month period for which data are available, subject to subparagraph (C); exceeds

"(ii) the lowest average monthly unemployment rate for the State for any 3-consecutive-month period preceding the period described in clause (i) and beginning on or after January 1, 2006.

"(B) AVERAGE MONTHLY UNEMPLOYMENT RATE DEFINED.—In this paragraph, the term 'average monthly unemployment rate' means the average of the monthly number unemployed, divided by the average of the monthly civilian labor force, seasonally adjusted, as determined based on the most recent monthly publications of the Bureau of Labor Statistics of the Department of Labor.

"(C) SPECIAL RULE.—With respect to—

"(i) the first 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in subparagraph (A)(i) shall be the 3-consecutive-month period beginning with October 2008; and

"(ii) the last 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in such subparagraph shall be the 3-consecutive-month period beginning with December 2009, or, if it results in a higher applicable percent under paragraph (3), any 3-consecutive-month period that begins after December 2009 and ends before January 2011.

"(d) INCREASE IN CAP ON MEDICAID PAYMENTS TO TERRITORIES.—Subject to subsections (f) and (g), with respect to entire fiscal years occurring during the recession adjustment period and with respect to fiscal years only a portion of which occurs during such period (and in proportion to the portion of the fiscal year that occurs during such period), the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsections (f) and (g) of section 1108 of the Social Security Act (42 6 [42] U.S.C. 1308) shall each be increased by 30 percent (or, in the case of an election under subsection (b)(2), 15 percent). In the case of such an election by a territory, subsection (a)(1) of such section shall be applied without regard to any increase in payment made to the territory under part E of title IV of such Act [part E of subchapter IV of this chapter] that is attributable to the increase in FMAP effected under subsection (b) for the territory.

"(e) SCOPE OF APPLICATION.—The increases in the FMAP for a State under this section shall apply for purposes of title XIX of the Social Security Act [this subchapter] and shall not apply with respect to—

"(1) disproportionate share hospital payments described in section 1923 of such Act (42 U.S.C. 1396r–4);

"(2) payments under title IV of such Act (42 U.S.C. 601 et seq.) (except that the increases under subsections (a) and (b) shall apply to payments under part E of title IV of such Act (42 U.S.C. 670 et seq.) and, for purposes of the application of this section to the District of Columbia, payments under such part shall be deemed to be made on the basis of the FMAP applied with respect to such District for purposes of title XIX [this subchapter] and as increased under subsection (b));

"(3) payments under title XXI of such Act (42 U.S.C. 1397aa et seq.);

"(4) any payments under title XIX of such Act [this subchapter] that are based on the enhanced FMAP described in section 2105(b) of such Act (42 U.S.C. 1397ee(b)); or

"(5) any payments under title XIX of such Act [this subchapter] that are attributable to expenditures for medical assistance provided to individuals made eligible under a State plan under title XIX of the Social Security Act (including under any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) because of income standards (expressed as a percentage of the poverty line) for eligibility for medical assistance that are higher than the income standards (as so expressed) for such eligibility as in effect on July 1, 2008, [sic] (including as such standards were proposed to be in effect under a State law enacted but not effective as of such date or a State plan amendment or waiver request under title XIX of such Act that was pending approval on such date).

Notwithstanding paragraph (5), effective for payments made on or after January 1, 2010, the increases in the FMAP for a State under this section shall apply to payments under title XIX of such Act [42 U.S.C. 1396 et seq.] that are attributable to expenditures for medical assistance provided to nonpregnant childless adults made eligible under a State plan under such title (including under any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) who would have been eligible for child health assistance or other health benefits under eligibility standards in effect as of December 31, 2009, of a waiver of the State child health plan under the [sic] title XXI of such Act [42 U.S.C. 1397aa et seq.].

"(f) STATE INELIGIBILITY; LIMITATION; SPECIAL RULES.—

"(1) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a State is not eligible for an increase in its FMAP under subsection (a), (b), or (c), or an increase in a cap amount under subsection (d), if eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act [this subchapter] (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

"(B) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—Subject to subparagraph (C), a State that has restricted eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act [this subchapter] (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) after July 1, 2008, is no longer ineligible under subparagraph (A) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

"(C) SPECIAL RULES.—A State shall not be ineligible under subparagraph (A)—

"(i) for the calendar quarters before July 1, 2009, on the basis of a restriction that was applied after July 1, 2008, and before the date of the enactment of this Act [Feb. 17, 2009], if the State prior to July 1, 2009, has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008; or

"(ii) on the basis of a restriction that was directed to be made under State law as in effect on July 1, 2008, and would have been in effect as of such date, but for a delay in the effective date of a waiver under section 1115 of such Act [42 U.S.C. 1315] with respect to such restriction.

"(2) COMPLIANCE WITH PROMPT PAY REQUIREMENTS.—

"(A) APPLICATION TO PRACTITIONERS.—

"(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, no State shall be eligible for an increased FMAP rate as provided under this section for any claim received by a State from a practitioner subject to the terms of section 1902(a)(37)(A) of the Social Security Act (42 U.S.C. 1396a(a)(37)(A)) for such days during any period in which that State has failed to pay claims in accordance with such section as applied under title XIX of such Act [this subchapter].

"(ii) REPORTING REQUIREMENT.—Each State shall report to the Secretary, on a quarterly basis, its compliance with the requirements of clause (i) as such requirements pertain to claims made for covered services during each month of the preceding quarter.

"(iii) WAIVER AUTHORITY.—The Secretary may waive the application of clause (i) to a State, or the reporting requirement imposed under clause (ii), during any period in which there are exigent

circumstances, including natural disasters, that prevent the timely processing of claims or the submission of such a report.

"(iv) APPLICATION TO CLAIMS.—Clauses (i) and (ii) shall only apply to claims made for covered services after the date of enactment of this Act [Feb. 17, 2009].

"(B) APPLICATION TO NURSING FACILITIES AND HOSPITALS.—

"(i) IN GENERAL.—Subject to clause (ii), the provisions of subparagraph (A) shall apply with respect to a nursing facility or hospital, insofar as it is paid under title XIX of the Social Security Act [this subchapter] on the basis of submission of claims, in the same or similar manner (but within the same timeframe) as such provisions apply to practitioners described in such subparagraph.

"(ii) GRACE PERIOD.—Notwithstanding clause (i), no period of ineligibility shall be imposed against a State prior to June 1, 2009, on the basis of the State failing to pay a claim in accordance with such clause.

"(3) STATE'S APPLICATION TOWARD RAINY DAY FUND.—A State is not eligible for an increase in its FMAP under subsection (b) or (c), or an increase in a cap amount under subsection (d), if any amounts attributable (directly or indirectly) to such increase are deposited or credited into any reserve or rainy day fund of the State.

"(4) NO WAIVER AUTHORITY.—Except as provided in paragraph (2)(A)(iii), the Secretary may not waive the application of this subsection or subsection (g) under section 1115 of the Social Security Act [42 U.S.C. 1315] or otherwise.

"(5) LIMITATION OF FMAP TO 100 PERCENT.—In no case shall an increase in FMAP under this section result in an FMAP that exceeds 100 percent.

"(6) TREATMENT OF CERTAIN EXPENDITURES.—With respect to expenditures described in section 2105(a)(1)(B) of the Social Security Act (42 U.S.C. 1397ee(a)(1)(B)), as in effect before April 1, 2009, that are made during the period beginning on October 1, 2008, and ending on March 31, 2009, any additional Federal funds that are paid to a State as a result of this section that are attributable to such expenditures shall not be counted against any allotment under section 2104 of such Act (42 U.S.C. 1397dd).

"(g) REQUIREMENTS.—

"(1) STATE REPORTS.—Each State that is paid additional Federal funds as a result of this section shall, not later than March 31, 2012, submit a report to the Secretary, in such form and such manner as the Secretary shall determine, regarding how the additional Federal funds were expended.

"(2) ADDITIONAL REQUIREMENT FOR CERTAIN STATES.—In the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures under the State Medicaid plan required under section 1902(a)(2) of the Social Security Act (42 U.S.C. 1396a(a)(2)), the State is not eligible for an increase in its FMAP under subsection (b) or (c), or an increase in a cap amount under subsection (d), if it requires that such political subdivisions pay for quarters during the recession adjustment period a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923 of such Act [42 U.S.C. 1396r–4], than the respective percentage that would have been required by the State under such plan on September 30, 2008, prior to application of this section.

"(3) CERTIFICATION BY CHIEF EXECUTIVE OFFICER.—No additional Federal funds shall be paid to a State as a result of this section with respect to a calendar quarter occurring during the period beginning on January 1, 2011, and ending on June 30, 2011, unless, not later than 45 days after the date of enactment of this paragraph, the chief executive officer of the State certifies that the State will request and use such additional Federal funds.

"(h) DEFINITIONS.—In this section, except as otherwise provided:

"(1) FMAP.—The term 'FMAP' means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as determined without regard to this section except as otherwise specified.

"(2) POVERTY LINE.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

"(3) RECESSION ADJUSTMENT PERIOD.—The term 'recession adjustment period' means the period beginning on October 1, 2008, and ending on June 30, 2011.

"(4) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(5) STATE.—The term 'State' has the meaning given such term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

"(i) SUNSET.—This section shall not apply to items and services furnished after the end of the recession adjustment period.

"(j) LIMITATION ON FMAP CHANGE.—The increase in FMAP effected under section 614 of the Children's Health Insurance Program Reauthorization Act of 2009 [section 614 of Pub. L. 111–3, set out below] shall not apply in the computation of the enhanced FMAP under title XXI or XIX of the Social Security Act [subchapters XXI or XIX of this chapter] for any period (notwithstanding subsection (i))."

STATE AUTHORITY UNDER MEDICAID

Pub. L. 111–3, title I, §115, Feb. 4, 2009, 123 Stat. 35, provided that: "Notwithstanding any other provision of law, including the fourth sentence of subsection (b) of section 1905 of the Social Security Act (42 U.S.C. 1396d) or subsection (u) of such section, at State option, the Secretary shall provide the State with the Federal medical assistance percentage determined for the State for Medicaid with respect to expenditures described in section 1905(u)(2)(A) of such Act or otherwise made to provide medical assistance under Medicaid to a child who could be covered by the State under CHIP."

[For definitions of "CHIP", "Medicaid", and "Secretary", see section 1(c) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

ADJUSTMENT IN COMPUTATION OF FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION

Pub. L. 111–3, title VI, §614, Feb. 4, 2009, 123 Stat. 101, provided that:

"(a) IN GENERAL.—Only for purposes of computing the FMAP (as defined in subsection (e)) for a State for a fiscal year (beginning with fiscal year 2006) and applying the FMAP under title XIX of the Social Security Act [this subchapter], any significantly disproportionate employer pension or insurance fund contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

"(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION AND INSURANCE FUND CONTRIBUTION.—

"(1) IN GENERAL.—For purposes of this section, a significantly disproportionate employer pension and insurance fund contribution described in this subsection with respect to a State is any identifiable employer contribution towards pension or other employee insurance funds that is estimated to accrue to residents of such State for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25 percent of the total increase in personal income in that State for the year involved.

"(2) DATA TO BE USED.—For estimating and adjustment a FMAP already calculated as of the date of the enactment of this Act [Feb. 4, 2009] for a State with

a significantly disproportionate employer pension and insurance fund contribution, the Secretary shall use the personal income data set originally used in calculating such FMAP.

"(3) SPECIAL ADJUSTMENT FOR NEGATIVE GROWTH.—If in any calendar year the total personal income growth in a State is negative, an employer pension and insurance fund contribution for the purposes of calculating the State's FMAP for a calendar year shall not exceed 125 percent of the amount of such contribution for the previous calendar year for the State.

"(c) HOLD HARMLESS.—No State shall have its FMAP for a fiscal year reduced as a result of the application of this section.

"(d) REPORT.—Not later than May 15, 2009, the Secretary shall submit to the Congress a report on the problems presented by the current treatment of pension and insurance fund contributions in the use of Bureau of Economic Affairs calculations for the FMAP and for Medicaid and on possible alternative methodologies to mitigate such problems.

"(e) FMAP DEFINED.—For purposes of this section, the term 'FMAP' means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396(d) [1396d[b]])."

[For definitions of "Medicaid" and "Secretary", see section 1(c) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

TEMPORARY STATE FISCAL RELIEF

Pub. L. 108–27, title IV, § 401(a), May 28, 2003, 117 Stat. 764, as amended by Pub. L. 108–74, § 2(a), Aug. 15, 2003, 117 Stat. 896, which authorized $10,000,000,000 for an increase of the Medicaid Federal medical assistance percentage (FMAP) for the last 2 calendar quarters of fiscal year 2003 and the first 3 quarters of fiscal year 2004 and set forth State eligibility requirements, and was repealed effective Oct. 1, 2004, by Pub. L. 108–27, title IV, § 401(a)(9), May 28, 2003, 117 Stat. 766.

ALASKA FMAPS

Pub. L. 106–554, § 1(a)(6) [title VII, § 706], Dec. 21, 2000, 114 Stat. 2763, 2763A–577, provided that: "Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), only with respect to each of fiscal years 2001 through 2005, for purposes of titles XIX and XXI of the Social Security Act [this subchapter and subchapter XXI of this chapter], the State percentage used to determine the Federal medical assistance percentage for Alaska shall be that percentage which bears the same ratio to 45 percent as the square of the adjusted per capita income of Alaska (determined by dividing the State's 3-year average per capita income by 1.05) bears to the square of the per capita income of the 50 States."

Section 4725(a) of Pub. L. 105–33 provided that: "Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), the Federal medical assistance percentage determined under such sentence for Alaska shall be 59.8 percent but only with respect to—

"(1) items and services furnished under a State plan under title XIX [this subchapter] or under a State child health plan under title XXI of such Act [subchapter XXI of this chapter] during fiscal years 1998, 1999, and 2000;

"(2) payments made on a capitation or other risk-basis under such titles for coverage occurring during such period; and

"(3) payments under title XIX of such Act attributable to DSH allotments for such State determined under section 1923(f) of such Act (42 U.S.C. 1396r–4(f)) for such fiscal years."

EPSDT BENEFIT STUDY AND REPORT

Section 4744 of Pub. L. 105–33 provided that:

"(a) STUDY.—

"(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with Governors, directors of State medicaid programs, the American Academy of Actuaries, and representatives of appropriate provider and beneficiary organizations, shall conduct a study of the provision of early and periodic screening, diagnostic, and treatment services under the medicaid program under title XIX of the Social Security Act [this subchapter] in accordance with the requirements of section 1905(r) of such Act (42 U.S.C. 1396d(r)).

"(2) REQUIRED CONTENTS.—The study conducted under paragraph (1) shall include examination of the actuarial value of the provision of such services under the medicaid program and an examination of the portions of such actuarial value that are attributable to paragraph (5) of section 1905(r) of such Act and to the second sentence of such section.

"(b) REPORT.—Not later than 12 months after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit a report to Congress on the results of the study conducted under subsection (a)."

REFERENCES TO PROVISIONS OF PART A OF SUBCHAPTER IV CONSIDERED REFERENCES TO SUCH PROVISIONS AS IN EFFECT JULY 16, 1996

For provisions that certain references to provisions of part A (§ 601 et seq.) of subchapter IV of this chapter be considered references to such provisions of part A as in effect July 16, 1996, see section 1396u–1(a) of this title.

LIMITATION ON DISALLOWANCES OR DEFERRAL OF FEDERAL FINANCIAL PARTICIPATION FOR CERTAIN INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR INDIVIDUALS UNDER AGE 21

Section 4706 of Pub. L. 101–508 provided that:

"(a) IN GENERAL.—(1) If the Secretary of Health and Human Services makes a determination that a psychiatric facility has failed to comply with certification of need requirements for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(h) of the Social Security Act [subsec. (h) of this section], and such determination has not been subject to a final judicial decision, any disallowance or deferral of Federal financial participation under such Act [this chapter] based on such determination shall only apply to the period of time beginning with the first day of noncompliance and ending with the date by which the psychiatric facility develops documentation (using plan of care or utilization review procedures) of the need for inpatient care with respect to such individuals.

"(2) Any disallowance of Federal financial participation under title XIX of the Social Security Act [this subchapter] relating to the failure of a psychiatric facility to comply with certification of need requirements—

"(A) shall not exceed 25 percent of the amount of Federal financial participation for the period described in paragraph (1); and

"(B) shall not apply to any fiscal year before the fiscal year that is 3 years before the fiscal year in which the determination of noncompliance described in paragraph (1) is made.

"(b) EFFECTIVE DATE.—Subsection (a) shall apply to disallowance actions and deferrals of Federal financial participation with respect to services provided before the date of enactment of this Act [Nov. 5, 1990]."

INTERMEDIATE CARE FACILITY; ACCESS AND VISITATION RIGHTS

Section 411(*l*)(3)(C)(i), formerly § 411(*l*)(3)(C), of Pub. L. 100–360, as redesignated by Pub. L. 100–485, title VI, § 608(d)(27)(E), Oct. 13, 1988, 102 Stat. 2423, provided that: "Effective as of the date of the enactment of this Act [July 1, 1988] and until the effective date of section 1919(c) of such Act [section 1396r(c) of this title, see Effective Date note set out under section 1396r of this title], section 1905(c) of the Social Security Act [subsec.

(c) of this section] is deemed to include the requirement described in section 1919(c)(3)(A) of such Act (as inserted by section 4211(a)(3) of OBRA)."

REGULATIONS FOR INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED

Section 9514 of Pub. L. 99-272 provided that: "The Secretary of Health and Human Services shall promulgate proposed regulations revising standards for intermediate care facilities for the mentally retarded under title XIX of the Social Security Act [this subchapter] within 60 days after the date of the enactment of this Act [Apr. 7, 1986]."

LIFE SAFETY CODE RECOGNITION

Section 9515 of Pub. L. 99-272 provided that: "For purposes of section 1905(c) of the Social Security Act [subsec. (c) of this section], an intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) which meets the requirements of the relevant sections of the 1985 edition of the Life Safety Code of the National Fire Protection Association shall be deemed to meet the fire safety requirements for intermediate care facilities for the mentally retarded until such time as the Secretary specifies a later edition of the Life Safety Code for purposes of such section, or the Secretary determines that more stringent standards are necessary to protect the safety of residents of such facilities."

STUDY OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE FORMULA AND OF ADJUSTMENTS OF TARGET AMOUNTS FOR FEDERAL MEDICAID EXPENDITURES; REPORT TO CONGRESS

Section 2165 of Pub. L. 97-35 directed the Comptroller General, in consultation with the Advisory Committee for Intergovernmental Relations, to study the Federal medical assistance percentage formula as applicable to distribution of Federal funds to States, with a view to revising the medicaid matching formula so as to take into account factors which might result in a more equitable distribution of Federal funds to States under this chapter, and to report to Congress on such study not later than Oct. 1, 1982.

COSTS CHARGED TO PERSONAL FUNDS OF PATIENTS IN INTERMEDIATE CARE FACILITIES; COSTS INCLUDED IN CHARGES FOR SERVICES; REGULATIONS

Section 8(c), (d)(2) of Pub. L. 95-292 required the Secretary of Health, Education, and Welfare to issue regulations, within 90 days after enactment of Pub. L. 95-292 but not later than July 1, 1978, defining those costs that may be charged to the personal funds of patients in intermediate care facilities who are individuals receiving medical assistance under a State plan approved under title XIX of the Social Security Act, and those costs that are to be included in the reasonable cost or reasonable charge for intermediate care facility services. See section 1302 of this title.

§ 1396e. Enrollment of individuals under group health plans

(a) Requirements of each State plan; guidelines

Each State plan—

(1) may implement guidelines established by the Secretary, consistent with subsection (b) of this section, to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this subchapter in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2) of this section);

(2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this subchapter and subject to subsection (b)(2) of this section, notwithstanding any other provision of this subchapter, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

(3) in the case of such enrollment (except as provided in subsection (c)(1)(B) of this section), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under section 1396*o* of this title), and shall treat coverage under the group health plan as a third party liability (under section 1396a(a)(25) of this title).

(b) Timing of enrollment; failure to enroll

(1) In establishing guidelines under subsection (a)(1) of this section, the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2) of this section, such failure shall not affect the child's eligibility for benefits under this subchapter.

(c) Premiums considered payments for medical assistance; eligibility

(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1396b(a) of this title, to be payments for medical assistance.

(B) If all members of a family are not eligible for medical assistance under this subchapter and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1396a(a)(25) of this title provides that payment for such benefits shall first be made by such plan.

(d) Repealed. Pub. L. 105-33, title IV, § 4741(b)(2), Aug. 5, 1997, 111 Stat. 523

(e) Definitions

In this section:

(1) The term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, and includes the provision of continuation coverage

Tab 3

Prior State Reports for Reference

Impact of Medicaid Expansion 2015
Part 1: Simple Expansion

(does not address the specifics of any proposed legislation)

March 25, 2015

Presented by:

The Florida Legislature
Office of Economic and
Demographic Research
850.487.1402
http://edr.state.fl.us

Medicaid Base Population...

Total Population	2009-11 ACS PUMS	2011-13 ACS PUMS
Florida Resident		
Population	18,849,600	19,319,031
Insured	14,808,869	15,326,577
Medicaid, etc.**	2,947,715	3,342,015
Other health insurance	11,861,154	11,984,562
Uninsured	4,040,731	3,992,454
Florida Resident Citizens*		
Population	16,986,587	17,493,281
Insured	13,977,342	14,493,194
Medicaid, etc.**	2,770,954	3,139,393
Other health insurance	11,206,388	11,353,801
Uninsured	3,009,245	3,000,087

* Excludes individuals who are not a citizen of the US, inclusive of legal and illegal residents

**Medicaid, etc. = Medicaid, medical assistance, or any kind of government-assistance plan for those with low incomes or a disability

Source: US Census Bureau, American Community Survey, Public Use Microdata Sample (ACS PUMS)

While the 2011-13 ACS PUMS data represents a later period than the earlier EDR analysis, it would still reflect coverage prior to the Affordable Care Act (ACA) Exchange activities.

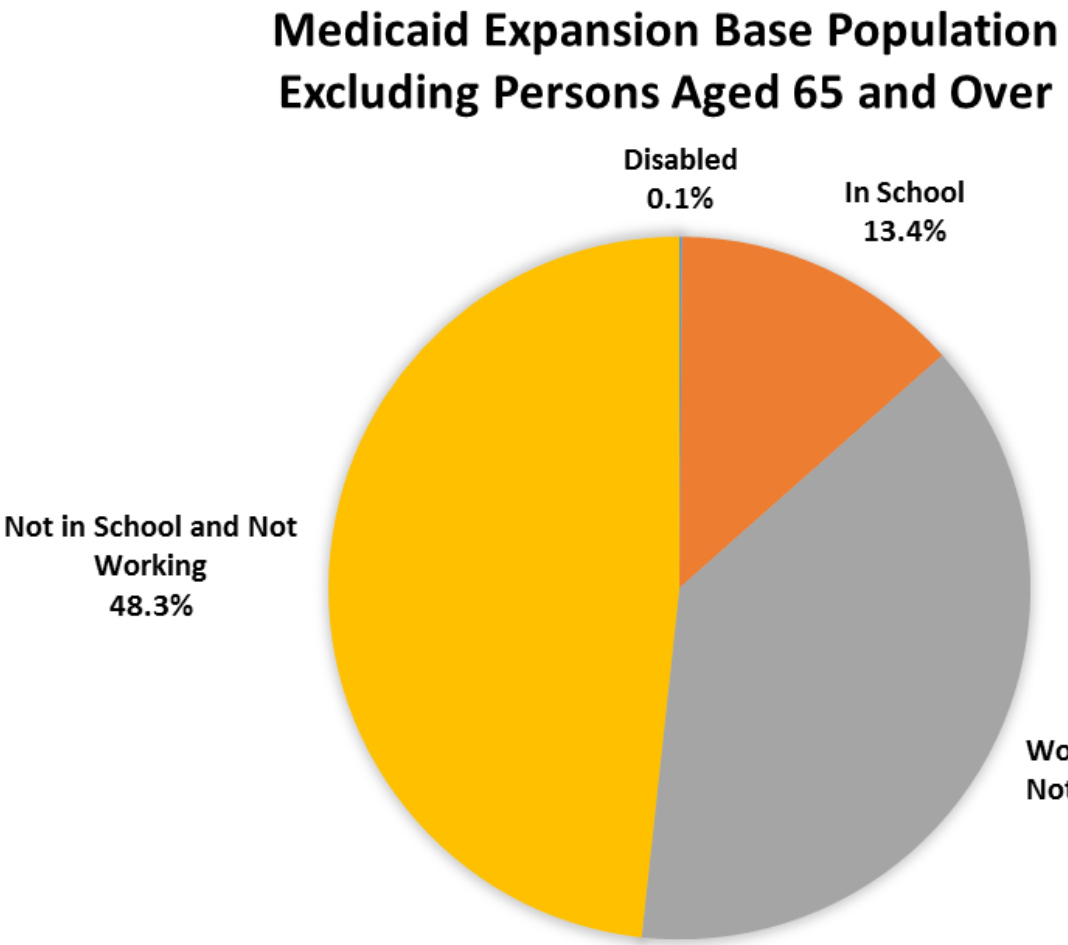
Medicaid Expansion Base Population...

Medicaid Expansion Base Population	Using Same Assumptions as EDR's March 4, 2013 Analysis		Difference between 2011-13 and 2009-2011 ACS PUMS using EDR's March 4, 2013 Assumptions	Using New Thresholds	Difference between 2011-13 ACS PUMS using both the New Thresholds and EDR's March 4, 2013 Assumptions
Group	2009-11 ACS PUMS (A)	2011-13 ACS PUMS (B)	(C)=(B)-(A)	2011-13 ACS PUMS (D)	(E)=(D)-(B)
Infants	0	0	0	Already Covered	0
Children Aged 1-5	2,546	1,807	-739		-1,807
Children Aged 6-18	56,254	68,278	12,024		-68,278
Aged 19-20	50,717	49,892	-825	48,269	-1,623
Pregnant Women	0	0	0	0	0
SSI	901	1,000	99	968	-32
Parents	193,206	187,972	-5,234	179,297	-8,675
Childless Adults	574,795	631,490	56,695	608,022	-23,468
Total	**878,419**	**940,439**	**62,020**	**836,556**	**-103,883**

Assumptions	EDR March 4, 2013 Analysis	EDR March 24, 2015 Analysis
Expansion Level	Less than 138% FPL	Less than 133% FPL
Ages 19-20	Less than 22% FPL	Less than 18% FPL
Parents	Less than 22% FPL	Less than 18% FPL

The 2011-13 Medicaid Expansion base population of 836,556 was further screened to exclude persons aged 65 or older, resulting in a new base population of 829,802.

Characteristics of the Expansion Base Population...



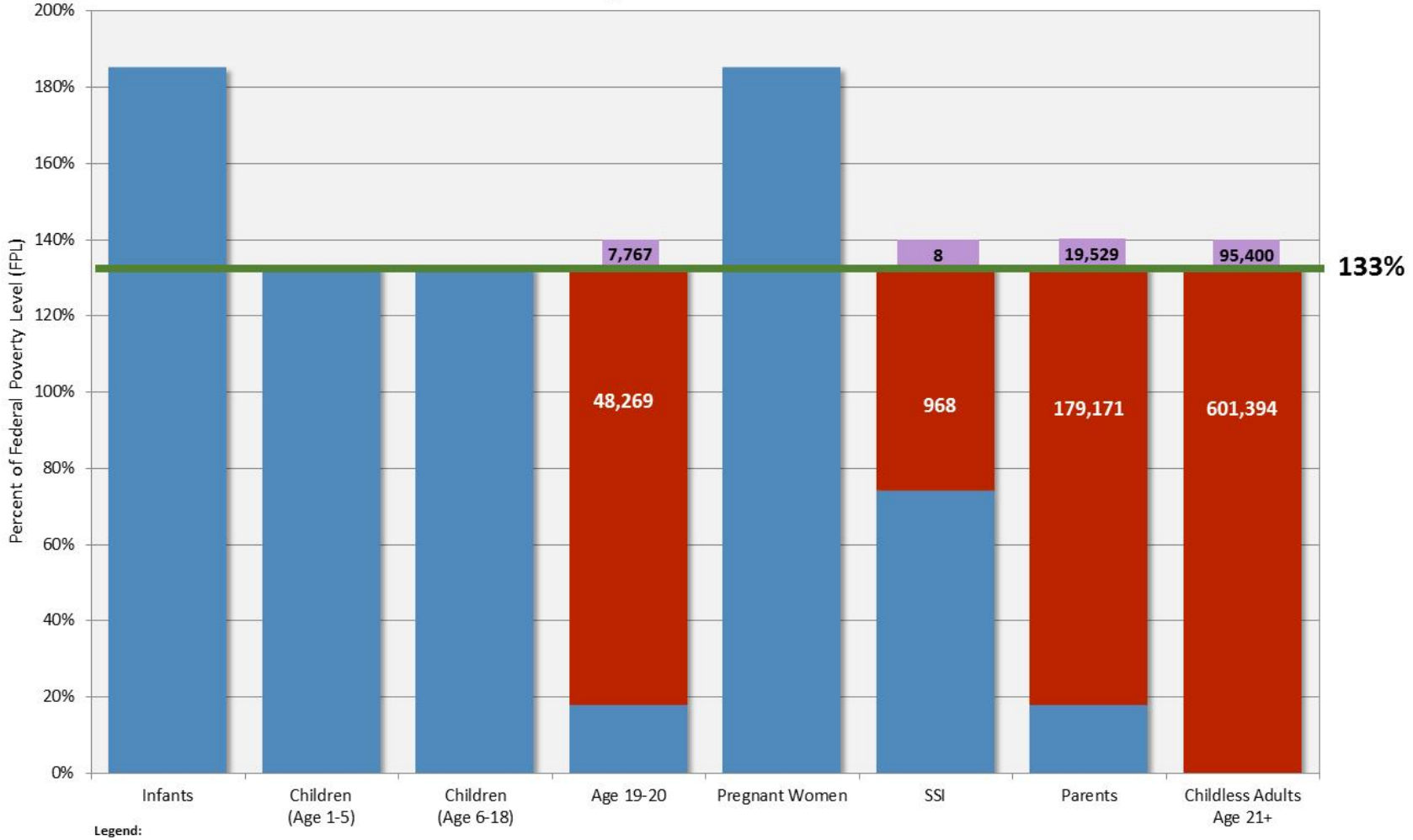
Population of 829,802

Crowd Out Population...

- The crowd out population is individuals who are only paying for private health insurance today and who would qualify for Medicaid coverage under expansion.

- Using the 2011-13 ACS PUMS data, there were 122,704 individuals who would be classified as crowd out population.

Medicaid Expansion Base Population
Excluding those Aged 65 and Over
Including Crowd Out



Legend:

Blue Bars: Medicaid enrolled
Red Bars with White Labels: Newly eligible
Purple Box with Black Labels: Crowd Out related to expansion
Green Line: 133% Federal Poverty Level

Source: U.S. Census Bureau, 2011-13 3-year American Community Survey Public Use Microdata Sample

Medicaid Base Expansion Population and Likely Presenters...

- Crowd out Population:
  - The analysis assumes that 100% of the crowd out population would present because they have insurance today.
- Medicaid Expansion Base Population:
  - A take-up rate of 85.8% was applied to the Medicaid Expansion population, derived from the health insurance participation rate of today's Medicaid eligible population.
- The total number of likely presenters is 834,674. This number is subsequently adjusted for population growth.

	2009-11 ACS PUMS		2011-13 ACS PUMS		2011-13 ACS PUMS Excluding Persons Aged 65 and Over	
Medicaid Expansion Base Population	878,419		836,556		829,802	
Likely Presenters	**Population**	**Take-up Rate**	**Population**	**Take-up Rate**	**Population**	**Take-up Rate**
CHIP "Woodworking Shift"	14,700	25.0%	**Already Covered**		**Already Covered**	
Uninsured Presenters	653,236	79.7%	717,765	85.8%	711,970	85.8%
Crowd Out	131,791	100.0%	125,225	100.0%	122,704	100.0%
Total	799,727		842,990		834,674	

2009-11 analysis shows CHIP "Woodworking Shift" which is only applicable to Children Aged 1-5 and 6-18

Expansion Expenditures with Caseload... (New Participants in Medicaid)

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY19-20
Uninsured Presenters	742,677	753,446	764,167	774,835	785,423
Total expenditures	$2,872,367,920	$3,004,377,283	$3,132,873,391	$3,266,016,165	$3,403,809,912
Crowd Out	122,704	122,704	122,704	122,704	122,704
Total expenditures	$472,569,192	$487,221,758	$500,933,418	$515,030,960	$529,525,241
Total	865,381	876,150	886,871	897,539	908,127
Total expenditures	$3,344,937,112	$3,491,599,041	$3,633,806,809	$3,781,047,125	$3,933,335,153
Expansion FMAP	100%	97.50%	94.50%	93.50%	91.50%
Federal Expenditures	$3,344,937,112	$3,404,309,065	$3,433,947,435	$3,535,279,062	$3,599,001,665
State Expenditures	**$0**	**$87,289,976**	**$199,859,374**	**$245,768,063**	**$334,333,488**

Medically Needy…

- Non-pregnant adults aged 19-64 under 133% FPL would automatically transition from the Medically Needy Program to Medicaid Expansion.
- Because this is a shift from one Medicaid Program to another, there would be no change to the overall Medicaid caseload.
- Transition of these individuals would result in state savings due to the different federal participation matching rates.

Medically Needy Expenditures and Savings with Caseload...

	FY15-16	FY16-17	FY17-18	FY18-19	FY19-20
Caseload	25,964	25,886	25,808	25,731	25,653
Per Capita Expenditures	$23,157	$23,273	$23,389	$23,506	$23,624
Total Expenditures	$601,244,252	$602,437,722	$603,633,560	$604,831,773	$606,032,364
Non-expansion Medically Needy FMAP	60.51%	61.17%	61.33%	61.50%	61.74%
Non-expansion Federal Expenditures	$363,812,897	$368,511,154	$370,208,463	$371,971,540	$374,164,382
Non-expansion State Expenditures	$237,431,355	$233,926,568	$233,425,097	$232,860,233	$231,867,982
Expansion FMAP	100.0%	97.5%	94.5%	93.5%	91.5%
Expansion Federal Expenditures	$601,244,252	$587,376,779	$570,433,715	$565,517,708	$554,519,613
Expansion State Expenditures	$0	$15,060,943	$33,199,845	$39,314,065	$51,512,751
Expansion State Savings	**$237,431,355**	**$218,865,625**	**$200,225,252**	**$193,546,168**	**$180,355,231**

Substance Abuse and Mental Health Treatment from DCF...

- Non-pregnant clients aged 19-64 under 133% FPL would automatically transition from state supported substance abuse and mental health program services to eligible Medicaid services under Medicaid Expansion.

- Much of the Department of Children and Families' behavioral health funding comes from the federal government in the form of block grants. For FY 2013-14:
  - The Substance Abuse Prevention and Treatment block grant represented approximately $100 million.
  - The Community Mental Health block grant was approximately $29 million.

- These grants require maintenance of effort (MOE) funding from the state based on a rolling two-year average.

Substance Abuse and Mental Health MOE...

- Community Mental Health Block Grant:
  - For FY 2014-15 the state MOE is $73 million.
  - State dollars spent at other agencies can count towards DCF's MOE for the block grant.

- Substance Abuse Prevention and Treatment Block Grant:
  - For FY 2014-15 the state MOE is $96 million.
  - State dollars spent at other agencies cannot count towards DCF's MOE for the block grant. Only dollars that flow through DCF can count.
  - For the past several years the Department has fallen short of the MOE ($4-14 Million). The Department has had to request a waiver from the federal government in order to keep the block grant.

- Freed MOE dollars will have to be used for wraparound services not covered by Medicaid and new or additional services not offered by the state today. For the purposes of this analysis, no state savings are assumed.

Agency for Persons with Disabilities...

- Non-pregnant adults aged 19-64 under 133% FPL would automatically transition from the waitlist for the Developmental Disabilities Home and Community-Based Services Waiver to Medicaid Expansion.

- The Agency for Persons with Disabilities (APD) does not have current income information on waitlist clients. When a waiver slot becomes available, individuals on the waitlist go through a determination process to confirm eligibility for the waiver. At that time, income information is obtained.

- In a preliminary analysis, APD compiled data on FY 2012-13 expenditures for Individual and Family Supports (IFS) services provided to waitlist members, and classified those services as those that are covered under the Medicaid State Plan and those that are not. Services that were classified as potentially Medicaid covered include transportation, supplies and equipment, and home assistance.

- An analysis prepared several years ago was based on an assumption of Medicaid coverage up to 138% FPL.

Agency for Persons with Disabilities...

(A) Current Law and Current Administration

SFY 2012-2013	Unique IFS Service Users[1]	Total IFS Expenditures	Medicaid Covered[2]	Not Medicaid Covered	Annual Expenditure per User Covered	Annual Expenditure per User Not Covered
Under Age 21	878	$1,022,223	$483,755	$538,468	$550.97	$613.29
Ages 21 - 64	1,341	$4,480,695	$1,172,418	$3,308,277	$874.29	$2,467.02
Ages 65 and Older	45	$314,854	$33,981	$280,872	$755.14	$6,241.61
Total	**2,264**	**$5,817,772**	**$1,690,154**	**$4,127,618**	**$746.53**	**$1,823.15**

[1]Data consists of non-waiver clients who are currently not Medicaid eligible

[2]Determination based on high-level review only. More definitive results would require more extensive analysis of specific services and provider types.

(B) Expand Medicaid to 138% FPL and Provide Services through Medicaid

	Low (50%)	High (75%)	Upper Bound (100%)
Population Shifting to Medicaid	1,110	1,664	2,219
Annual Expenditure per Client	$746.36	$746.36	$746.36
Expenditures shifting to Medicaid	$828,086	$1,242,130	$1,656,173

For the purposes of this analysis, no state savings are assumed.

Department of Corrections...

- The state inmate population is not included in the Medicaid Expansion population because their inclusion would require additional actions by the Legislature and federal approval.

- Currently, inmate health care services under the Department of Corrections are paid for with state General Revenue Funds.

- While there is federal authorization for Medicaid to cover inpatient hospital services provided to eligible inmates in non-correctional inpatient hospital settings, the federal option has not been exercised in Florida.

- Implementation of this issue would require administrative issues to be addressed:
  - Overlay with current contracts for privatized health care services for the DOC population, and
  - Administrative process for eligibility determination among AHCA, DOC, DCF, and the private companies involved in inmate health care.

- An analysis prepared several years ago was based on an assumption of Medicaid coverage up to 138% FPL.

Department of Corrections...

(A) Current Law and Current Administration

	October 2013 Caseload	Assumed Income Distribution* Below 138%FPL	Above 138%FPL		Annual Inpatient & Related Physician Expenditures (5 year average)	
Non Pregnant adults < 21	2,979	2,830	149		General Revenue	**$65,084,627**
Non Pregnant adults 21-64	95,758	90,970	4,788		Annual Days	15,808
Pregnant Women	29	28	1		Cost per Day	$4,117
Adults 65+	2,358	2,240	118		Annual Exp per Inmate	$644
Total	**101,124**	**96,068**	**5,056**			

Potentially Eligible for Medicaid Expansion

*The Department of Corrections does not have information on inmate income status prior to incarceration. For purposes of this cost savings analysis, DOC has made the assumption that 95% of the inmate population meets the 138% FPL eligibility requirement.

(B) Expand Medicaid to 138% FPL and Provide Inmate Hospital Inpatient Services through Medicaid

Population Shifting to Medicaid	93,828	
Annual Expenditure per Inmate	$643.61	
DOC Expenditures shifting to Medicaid	$60,388,640	General Revenue

Medicaid Expansion Cost Summary...

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY19-20
Total caseload	**891,345**	**902,036**	**912,679**	**923,270**	**933,780**
Uninsured Presenters and Crowd Out	865,381	876,150	886,871	897,539	908,127
Medically Needy	25,964	25,886	25,808	25,731	25,653
Total expenditures (millions)	**$3,946.1**	**$4,094.0**	**$4,237.4**	**$4,385.8**	**$4,539.3**
Uninsured Presenters and Crowd Out	$3,344.9	$3,491.6	$3,633.8	$3,781.0	$3,933.3
Medically Needy	$601.2	$602.4	$603.6	$604.8	$606.0
State Expenditures (millions)	**$0**	**$102.4**	**$233.1**	**$285.1**	**$385.8**
State Expenditures per capita (dollars)	**$0**	**$113**	**$255**	**$309**	**$413**

This chart reflects the costs (state and federal) directly associated with the Expansion Program and does not include the savings generated from the Medically Needy Program.

Insurance Premium Tax: Affordable Care Act Adjustment...

- The current revenue forecast assumes 1.44 million individuals are induced by the Affordable Care Act to obtain private insurance that is subject to the Insurance Premium Tax in the 2015 calendar year.

- This analysis assumes that 234,284 of the 1.44 million individuals would qualify for and move to Medicaid under Expansion in lieu of seeking private insurance. This number grows and is included within the uninsured presenters.

- By enacting Medicaid Expansion, the premiums and tax collections from the underlying Insurance Premium Tax forecast associated with these individuals would be removed.

Insurance Premium Tax: Crowd Out Adjustment...

- 122,704 persons currently have private individual insurance and would qualify for Medicaid under Expansion.

- This analysis assumes this cohort of 122,704 would forgo private insurance for Medicaid, removing them from the current pool of privately insured.

- By enacting Medicaid Expansion, the premiums and tax collections from the underlying Insurance Premium Tax forecast associated with the 122,704 would be removed.

Medicaid Expansion Revenue Summary: Insurance Premium Tax...

Insurance Premium Tax Collections

	2015-16	2016-17	2017-18	2018-19	2019-20
March 2015 GR Estimating Conference					
Insurance Premium Tax ACA Baseline	$55,236,517	$46,126,417	$50,153,552	$52,159,694	$54,246,081
Newly Insured Impact	($7,226,394)	($6,187,003)	($6,570,490)	($6,807,356)	($7,108,618)
Existing Insured Crowd Out Impact	($1,722,352)	($1,777,489)	($1,831,001)	($1,885,844)	($1,942,432)
Total Cash Impact	($8,948,746)	($7,964,492)	($8,401,492)	($8,693,199)	($9,051,049)
New Insurance Premium Tax ACA Baseline	$46,287,771	$38,161,925	$41,752,060	$43,466,495	$45,195,032

Overall Fiscal Impact...

Expansion Program	2015-16		2016-17		2017-18		2018-19		2019-20	
	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$
*Uninsured Presenters (new)**	742,677	-	753,446	(75.1)	764,167	(172.3)	774,835	(212.3)	785,423	(289.3)
Crowd-Out (new)	122,704	-	122,704	(12.2)	122,704	(27.6)	122,704	(33.5)	122,704	(45.0)
*Medically Needy Shift (net)***	-	237.4	-	218.9	-	200.2	-	193.5	-	180.4
Medicaid Subtotal	865,381	237.4	876,150	131.6	886,871	0.3	897,539	-52.3	908,127	-153.9
Insurance Premium Revenue Adj.	-	(8.9)	-	(8.0)	-	(8.4)	-	(8.7)	-	(9.1)
Total	865,381	228.5	876,150	123.6	886,871	(8.1)	897,539	(61.0)	908,127	(163.0)

Note: Dollars in Millions; Positive Total = Surplus; Negative Total = Shortfall

*Includes qualifying persons on the waitlist for the APD Developmental Services Waiver and service recipients in the DCF Substance Abuse and Mental Health Program.
**Assumes approximately 26,000 non-pregnant adults aged 19-64 shift from the Medically Needy Program to the Expansion Program, with no other changes.

Shifted Medically Needy	25,964	25,886	25,808	25,731	25,653
Expansion Program Count	891,345	902,036	912,679	923,270	933,780

Impact of Medicaid Expansion 2015
Part 2: Phase 1 & Phase 2

(reflects the impact of SB 2512 First Engrossed in FY 2015-16)

Phase 1 – Simple Expansion
Phase 2 – FHIX

April 6, 2015

Presented by:

The Florida Legislature
Office of Economic and Demographic Research
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Phase 1 – Simple Expansion Assumptions…

July 1, 2015 to no later than April 1, 2016

- Simple expansion with the exception that the Crowd Out population has a new decision framework that causes them not to present during Phase 1.
  - Underlying Expansion Population...
    - Uninsured Presenters have a take-up rate of 85.8%.
    - 50% present July 1, 2015; the remainder are split evenly to present on August 1, 2015; September 1, 2015; October 1, 2015.
  - Crowd Out...
    - Since this group already has insurance, they will wait for the FHIX options to become known and then make a decision at the beginning of Phase 2.
  - Medically Needy...
    - Splits into three groups:
      - Group 1 – Children under the age of 19 and Pregnant Women who do not otherwise qualify for Medicaid are enrolled until October 1, 2019.
      - Group 2 – Persons aged 19-64 above 133% FPL and Seniors at all income levels are disenrolled on October 1, 2015.
      - Group 3 – Persons aged 19-64 below 133% FPL move to Phase 1 – Simple Expansion on July 1, 2015 with a take-up rate 100% (shift population).

Phase 1 – Simple Expansion Enrollees…

Expansion Population in Phase 1 - Simple Expansion	**Assumptions**	**FY 2015-16**
Eligible Universe		865,591
Take-Up Rate (85.8%)	85.8%	742,677
Phase 1 - Uninsured Presenters (100.0%) present July-October 2015	100.0%	742,677

Crowd Out in Phase 1 - Simple Expansion	**Assumptions**	**FY 2015-16**
Eligible Universe		122,704
Take-Up Rate (0.0%)	0.0%	-
Phase 1 - Crowd Out Enrollees (100.0%)	100.0%	-

Medically Needy in Phase 1 - Simple Expansion	**Assumptions**	**FY 2015-16**
Shift Population		25,964
Take-Up Rate (100.0%)	100.0%	25,964
Phase 1 - Medically Needy Enrollees (100.0%) present July 1, 2015	100.0%	25,964

Phase 1 - Simple Expansion Total Enrollees	768,641

Phase 2 – FHIX Assumptions…

Beginning January 1, 2016

- Phase 2 Expansion Enrollees - Uninsured Presenters from Phase 1 are:
  - Reduced for Constraints (64.4% remain).
    - School
    - Employment by hours for parents and others
    - Job Seekers
    - Disabled
  - Increased for Caregivers (estimated to be 6,857 in the base population).
  - Further reduced for attrition between Phase 1 and Phase 2 (70.0% remain).
  - Participants present evenly during the months of January through March 2016
    - Some Phase 1 Uninsured Presenters disenroll, while others transition to FHIX.
- Crowd Out...
  - The Eligible Universe was screened to determine those most likely to stay with private insurance (approximately 67% based on school status, youth, and probability of constraint failure).
  - The remaining population was reduced again by 50% to reflect those making a case by case decision based on specific FHIX offerings.
  - This population presents evenly during the months of January through March 2016.
- Medically Needy...
  - Group 3 transitions from Phase 1 to Phase 2 during the months of January through March 2016 (33.33% each month).

Phase 2 – FHIX Assumptions…

Beginning January 1, 2016

- Assumptions (continued):
  - It is unclear what the insurance coverage options will be for those enrolled in Phase 1 who do not transition to Phase 2. At least Phase 1 will be deemed a Medicaid program; the status of Phase 2 is unknown until federal approval is given. If Phase 2 is also deemed to be a Medicaid program, potential enrollees may no longer be eligible for subsidies through the Exchange.
  - All Phase 2 participants continue to pay premiums in a timely manner.
  - Premiums are deducted from total expenses before application of Federal/State split, mirroring the Healthy Kids program.
  - Phase 2 continues for the duration of this analysis.

Phase 2 – FHIX Enrollees…

Expansion Population in Phase 2 - FHIX	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2017-18**	**FY 2018-19**
Eligibile Universe	865,591	878,142	890,637	903,071	915,411
Take-Up Rate (85.8%)	742,677	753,446	764,167	774,835	785,423
Meet School and Working Constraints (64.4%)	478,284	485,219	492,124	498,994	505,812
Add-in Adjustment for Caregivers	7,153	7,257	7,360	7,463	7,565
Subtotal	485,437	492,476	499,484	506,457	513,377
Phase 2 - Expansion Enrollees (70.0%)	339,806	344,733	349,639	354,520	359,364

Crowd Out Population in Phase 2 - FHIX	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2017-18**	**FY 2018-19**
Eligibile Universe	122,704	122,704	122,704	122,704	122,704
Take-Up Rate (100.0%)	122,704	122,704	122,704	122,704	122,704
Adjustment to Account for Initial Screening (approximately 32.6%)	40,062	40,062	40,062	40,062	40,062
Phase 2 - Crowd Out Enrollees (50.0%)	20,031	20,031	20,031	20,031	20,031

Medically Needy in Phase 2 - FHIX	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2017-18**	**FY 2018-19**
Shift Population (Group 3)	25,964	25,886	25,808	25,731	25,653
Take-Up Rate (100.0%)	25,964	25,886	25,808	25,731	25,653
Phase 2 - Medically Needy Enrollees (100.0%)	25,964	25,886	25,808	25,731	25,653

Phase 2 - FHIX Total Enrollees	385,801	390,650	395,478	400,282	405,048

Note: FY 2015-16 figures represent enrollment on June 30, 2016.

Phase 1 & Phase 2 – FY 2015-16 Worksheet…

FY 2015-16 Expenditures

	Total	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Phase 1 Expansion Enrollees[1]	**742,677**	371,339	495,366	619,393	742,677	742,677	742,677	495,143	247,609	0	0	0	0
Phase-in pattern		*50%*	*16.7%*	*16.7%*	*16.6%*	*0%*	*0%*						
Phase-out pattern								*-33.3%*	*-33.3%*	*-33.3%*	*0%*	*0%*	*0%*
Phase 1 Crowd out Enrollees[2]	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Phase 1 Medically Needy Enrollees[3]	**25,964**	25,964	25,964	25,964	25,964	25,964	25,964	17,310	8,656	0	0	0	0
Phase-in pattern		*100.0%*	*0.0%*	*0.0%*	*0.0%*	*0%*	*0%*						
Phase-out pattern								*-33.3%*	*-33.3%*	*-33.3%*	*0%*	*0%*	*0%*
Monthly per capita Expansion and Crowd out		$320.86	$320.86	$320.86	$320.86	$320.86	$320.86	$320.86	$320.86				
Monthly per capita Medically Needy		$1,929.76	$1,929.76	$1,929.76	$1,929.76	$1,929.76	$1,929.76	$1,929.76	$1,929.76				
Total Expenditures Phase 1 Expansion	$1,430,038,245	$119,148,115	$158,943,513	$198,738,912	$238,295,910	$238,295,910	$238,295,910	$158,871,962	$79,448,013	$0	$0	$0	$0
Total Expenditures Phase 1 Crowd out	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Expenditures Phase 1 Medically Needy	$350,730,824	$50,103,688	$50,103,688	$50,103,688	$50,103,688	$50,103,688	$50,103,688	$33,404,129	$16,704,569	$0	$0	$0	$0
Total Expenditures Phase 1	**$1,780,769,069**	$169,251,803	$209,047,201	$248,842,599	$288,399,598	$288,399,598	$288,399,598	$192,276,090	$96,152,582	$0	$0	$0	$0
Phase 2 Expansion Enrollees[1]	**339,806**							113,257	226,514	339,806	339,806	339,806	339,806
Phase-in pattern								*33.3%*	*33.3%*	*33.3%*	*0%*	*0%*	*0%*
Phase 2 Crowd out Enrollees[2]	**20,031**							6,676	13,352	20,031	20,031	20,031	20,031
Phase-in pattern								*33.3%*	*33.3%*	*33.3%*	*0%*	*0%*	*0%*
Phase 2 Medically Needy Enrollees[3]	**25,964**							8,654	17,307	25,964	25,964	25,964	25,964
Phase-in pattern								*33.3%*	*33.3%*	*33.3%*	*0%*	*0%*	*0%*
Monthly per capita Expansion and Crowd out								$320.86	$320.86	$320.86	$320.86	$320.86	$320.86
Monthly per capita Medically Needy								$1,929.76	$1,929.76	$1,929.76	$1,929.76	$1,929.76	$1,929.76
Total Expenditures Phase 2 Expansion	$545,140,835	$0	$0	$0	$0	$0	$0	$36,339,728	$72,679,455	$109,030,413	$109,030,413	$109,030,413	$109,030,413
Total Expenditures Phase 2 Crowd out	$32,134,847	$0	$0	$0	$0	$0	$0	$2,142,066	$4,284,133	$6,427,162	$6,427,162	$6,427,162	$6,427,162
Total Expenditures Phase 2 Medically Needy	$250,513,428	$0	$0	$0	$0	$0	$0	$16,699,559	$33,399,118	$50,103,688	$50,103,688	$50,103,688	$50,103,688
Total Expenditures Phase 2	**$827,789,110**	$0	$0	$0	$0	$0	$0	$55,181,353	$110,362,706	$165,561,263	$165,561,263	$165,561,263	$165,561,263
Expansion Enrollee Premium Revenue	$28,422,827	$0	$0	$0	$0	$0	$0	$1,894,699	$3,789,398	$5,684,683	$5,684,683	$5,684,683	$5,684,683
Crowd out Enrollee Premium Revenue	$1,494,588	$0	$0	$0	$0	$0	$0	$99,627	$199,255	$298,927	$298,927	$298,927	$298,927
Medically Needy Enrollee Premium Revenue	$2,171,711	$0	$0	$0	$0	$0	$0	$144,769	$289,538	$434,351	$434,351	$434,351	$434,351
Total Enrollee Premium Revenue Phase 2	**$32,089,126**	$0	$0	$0	$0	$0	$0	$2,139,095	$4,278,191	$6,417,960	$6,417,960	$6,417,960	$6,417,960

[1]Half of the Expansion enrollees enroll July 1, 2015; one-sixth enroll on the 1st of each of the subsequent 3 months. One-third of Expansion enrollees disenroll from Phase 1 in each of the first three months: January 1, February 1, and March 1, 2016. Of each one-third group that disenrolls, those who meet the FHIX criteria (46%) enroll in Phase 2 at that time. Those who do not meet the criteria (54%) cannot enter Phase 2 and may no longer be able to obtain insurance coverage through the Exchange.

[2]None of the Crowd out enrollees enroll in Phase 1. One-third of Crowd out enrollees enroll in Phase 2 in each of the first three months: January 1, February 1, and March 1, 2016.

[3]All of the current Medicaid Medically Needy who meet the simple Medicaid Expansion criteria are assumed to move from traditional Medicaid to FHIX Phase 1 on July 1, 2016. One-third of Medically Needy enrollees disenroll from Phase 1 in each of the first three months: January 1, February 1, and March 1, 2016. Of each one-third group that disenrolls, those who meet the FHIX criteria (100%) enroll in Phase 2 at that time.

Expenditures have to be calculated month-by-month to reflect movements into and out of Phase 1 and into Phase 2.

Phase 1 & Phase 2 – Annual Expenditures…

Phase 1 and 2 - Annual Expenditures	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Expansion Enrollees					
Total	See FY 2015-16 Worksheet	344,733	349,639	354,520	359,364
Per capita expenditures		$3,969.71	$4,081.43	$4,196.29	$4,314.39
Expenditures	$1,975,179,080	$1,368,491,130	$1,427,027,454	$1,487,669,744	$1,550,435,449
Per capita weighted annual premium	$200.75	$200.75	$200.75	$200.75	$200.75
Premium Revenue	$28,422,827	$69,205,288	$70,190,169	$71,170,032	$72,142,467
Net Expenditures (Premium Revenue subtracted)	$1,946,756,252	$1,299,285,842	$1,356,837,285	$1,416,499,712	$1,478,292,982
Crowd out Enrollees					
Caseload	See FY 2015-16 Worksheet	20,031	20,031	20,031	20,031
Per capita expenditures		$3,969.71	$4,081.43	$4,196.29	$4,314.39
Expenditures	$32,134,847	$79,517,324	$81,755,144	$84,055,942	$86,421,490
Per capita weighted annual premium	$179.08	$179.08	$179.08	$179.08	$179.08
Premium Revenue	$1,494,588	$3,587,119	$3,587,119	$3,587,119	$3,587,119
Net Expenditures (Premium Revenue subtracted)	$30,640,259	$75,930,205	$78,168,025	$80,468,823	$82,834,371
Medically Needy Enrollees					
Total	See FY 2015-16 Worksheet	25,886	25,808	25,731	25,653
Per capita expenditures		$23,272.96	$23,389.32	$23,506.27	$23,623.80
Expenditures	$601,244,252	$602,437,722	$603,633,560	$604,831,773	$606,032,364
Per capita weighted annual premium	$200.75	$200.75	$200.75	$200.75	$200.75
Premium Revenue	$2,171,711	$5,196,573	$5,180,983	$5,165,440	$5,149,944
Net Expenditures (Premium Revenue subtracted)	$599,072,541	$597,241,149	$598,452,577	$599,666,333	$600,882,420
Total Enrollees	See FY 2015-16 Worksheet	390,650	395,478	400,282	405,048
Total Expenditures	$2,608,558,179	$2,050,446,176	$2,112,416,159	$2,176,557,459	$2,242,889,303
Total Enrollee Premium Revenue	$32,089,126	$77,988,980	$78,958,272	$79,922,591	$80,879,530
Total Net Expenditures (Premium Revenue subtracted)	$2,576,469,053	$1,972,457,196	$2,033,457,887	$2,096,634,868	$2,162,009,773
Expansion FMAP	100.00%	97.50%	94.50%	93.50%	91.50%
Federal Expenditures	**$2,576,469,053**	**$1,923,145,766**	**$1,921,617,703**	**$1,960,353,601**	**$1,978,238,943**
State Expenditures	**$0**	**$49,311,430**	**$111,840,184**	**$136,281,266**	**$183,770,831**

Medically Needy Savings from Shift…

Non Pregnant adults 19-64 Below 133%	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Caseload Growth Rate for MN from SSEC[1]		-0.67%	-0.30%	-0.30%	-0.30%	-0.30%
Non Pregnant adults 19-64 Caseload Below 133%	26,139	25,964	25,886	25,808	25,731	25,653
Expenditures Growth Rate[2]		0.5%	0.5%	0.5%	0.5%	0.5%
Non Pregnant adults 19-64 Per Capita Expenditures Below 133%	$23,042	$23,157	$23,273	$23,389	$23,506	$23,624
Non Pregnant adults 19-64 Below 133% Total Expenditures[3]		**$601,244,252**	**$602,437,722**	**$603,633,560**	**$604,831,773**	**$606,032,364**
Medically Needy FMAP		60.51%	61.17%	61.33%	61.50%	61.74%
Federal Expenditures w/o SB 2512		$363,812,897	$368,511,154	$370,208,463	$371,971,540	$374,164,382
State Expenditures w/o SB 2512[4]		$237,431,355	$233,926,568	$233,425,097	$232,860,233	$231,867,982
Expansion FMAP		100.00%	97.50%	94.50%	93.50%	91.50%
Medically Needy Enrollees FHIX Net Expenditures (lower due to FHIX premium revenue)		$599,072,541	$597,241,149	$598,452,577	$599,666,333	$600,882,420
Federal Expenditures under SB 2512		$599,072,541	$582,310,120	$565,537,686	$560,688,021	$549,807,415
State Expenditures under SB 2512[4]		$0	$14,931,029	$32,914,892	$38,978,312	$51,075,006
State Impact - Medically Needy Non Pregnant adults 19-64 Under 133%		**($237,431,355)**	**($218,995,539)**	**($200,510,206)**	**($193,881,921)**	**($180,792,976)**

Note: The 25,964 below 133% move to Phase 1 on July 1, 2015 (Phase 1 and 2 net expenditures computed on Annual Expenditures table).

Footnotes:

[1]Last two years Caseload Growth Rate held at FY 2017-18 rate

[2]SSEC growth rate of Hospital Inpatient Services unit cost, which is the largest expenditure category for Medically Needy, of 0.5% annually

[3]Total Expenditure lines computed as under current law

[4]State Expenditures include GR, GDTF, and PMATF

Positive Total = Additional Cost; Negative Total = Savings

Medically Needy Savings from Population Reduction…

Non Pregnant adults Above 133% and Seniors at all income levels

Non Pregnant adults 19-64 Above 133%	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Caseload Growth Rate for MN from SSEC[1]		-0.67%	-0.30%	-0.30%	-0.30%	-0.30%
Non Pregnant adults 19-64 Caseload						
133-400%	3,134	3,113	3,104	3,094	3,085	3,076
Over 400%	100	99	99	99	98	98
Expenditures Growth Rate[2]		0.5%	0.5%	0.5%	0.5%	0.5%
Non Pregnant adults 19-64 Per Capita Expenditures						
133-400%	$23,042	$23,158	$23,273	$23,390	$23,507	$23,624
Over 400%	$23,051	$23,166	$23,282	$23,398	$23,515	$23,633
Non Pregnant adults 19-64 Above 133%						
Total Expenditures[3]		**$74,390,916.13**	**$74,538,582.10**	**$74,686,541.19**	**$74,834,793.97**	**$74,983,341.04**
Medically Needy FMAP		60.51%	61.17%	61.33%	61.50%	61.74%
Federal Expenditures w/o SB 2512		$45,013,943	$45,595,251	$45,805,256	$46,023,398	$46,294,715
State Expenditures w/o SB 2512[4]		$29,376,973	$28,943,331	$28,881,285	$28,811,396	$28,688,626
Federal Expenditures under SB 2512		$11,253,486	$0	$0	$0	$0
State Expenditures under SB 2512[4]		$7,344,243	$0	$0	$0	$0
SB 2512 State Impact - Medically Needy						
Non Pregnant adults 19-64 Above 133%		**($22,032,730)**	**($28,943,331)**	**($28,881,285)**	**($28,811,396)**	**($28,688,626)**

Note: Under SB 2512, the 133-400% and Over 400% groups are in Medicaid until the Medically Needy program ends for all except children and pregnant women on October 1, 2015.

Adults 65+ - All Income Levels	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Caseload Growth Rate for MN from SSEC[1]		-0.67%	-0.30%	-0.30%	-0.30%	-0.30%
Adults 65+ Caseload						
Below 133%	1,576	1,565	1,561	1,556	1,551	1,547
133-400%	334	332	331	330	329	328
Over 400%	5	5	5	5	5	5
Expenditures Growth Rate[2]		0.5%	0.5%	0.5%	0.5%	0.5%
Adults 65+ Per Capita Expenditures						
Below 133%	$20,487	$20,589	$20,692	$20,796	$20,900	$21,004
133-400%	$20,504	$20,606	$20,709	$20,813	$20,917	$21,022
Over 400%	$20,818	$20,922	$21,026	$21,131	$21,237	$21,343
Adults 65+ Total Expenditures[3]		**$39,171,935**	**$39,249,691**	**$39,327,602**	**$39,405,667**	**$39,483,887**
Medically Needy FMAP		60.51%	61.17%	61.33%	61.50%	61.74%
Federal Expenditures w/o SB 2512		$23,702,938	$24,009,036	$24,119,618	$24,234,485	$24,377,352
State Expenditures w/o SB 2512[4]		$15,468,997	$15,240,655	$15,207,984	$15,171,182	$15,106,535
Federal Expenditures under SB 2512		$5,925,734	$0	$0	$0	$0
State Expenditures under SB 2512[4]		$3,867,249	$0	$0	$0	$0
SB 2512 State Impact - Medically Needy						
Adults 65+		**($11,601,748)**	**($15,240,655)**	**($15,207,984)**	**($15,171,182)**	**($15,106,535)**

Note: Under SB 2512, individuals 65+ are in Medicaid until the Medically Needy program ends for all except children and pregnant women on October 1, 2015.

Positive Total = Additional Cost; Negative Total = Savings

Medically Needy Savings from Final Program Sunset…

Children and Pregnant Women

Children and Pregnant Women	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Caseload Growth Rate for MN from SSEC[1]		-0.67%	-0.30%	-0.30%	-0.30%	-0.30%
Children Caseload						
Below 133%	0	0	0	0	0	0
133-400%	839	833	831	828	826	823
Over 400%	4	4	4	4	4	4
Pregnant Women Caseload						
Below 133%	0	0	0	0	0	0
133-400%	100	99	99	99	98	98
Over 400%	0	0	0	0	0	0
Expenditures Growth Rate[2]		0.5%	0.5%	0.5%	0.5%	0.5%
Children Per Capita Expenditures						
Below 133%	$11,514	$11,571	$11,629	$11,687	$11,746	$11,804
133-400%	$11,518	$11,575	$11,633	$11,691	$11,750	$11,809
Over 400%	$11,664	$11,723	$11,781	$11,840	$11,899	$11,959
Pregnant Women Per Capita Expenditures						
Below 133%	$15,668	$15,746	$15,825	$15,904	$15,983	$16,063
133-400%	$15,926	$16,006	$16,086	$16,166	$16,247	$16,328
Over 400%	$0	$0	$0	$0	$0	$0
Children and Pregnant Women Total Expenditures[3]		**$11,283,106**	**$11,305,503**	**$11,327,944**	**$11,350,430**	**$11,372,961**
Medically Needy FMAP		60.51%	61.17%	61.33%	61.50%	61.74%
Federal Expenditures w/o SB 2512		$6,827,407	$6,915,576	$6,947,428	$6,980,514	$7,021,666
State Expenditures w/o SB 2512[4]		$4,455,699	$4,389,927	$4,380,516	$4,369,916	$4,351,295
Federal Expenditures under SB 2512		$6,827,407	$6,915,576	$6,947,428	$6,980,514	$1,755,417
State Expenditures under SB 2512[4]		$4,455,699	$4,389,927	$4,380,516	$4,369,916	$1,087,824
SB 2512 State Impact - Medically Needy Children and Pregnant Women		**$0**	**$0**	**$0**	**$0**	**($3,263,471)**

Note: Under SB 2512, children and pregnant women remain covered by Medicaid until the Medically Needy program ends on October 1, 2019.

Positive Total = Additional Cost; Negative Total = Savings

Medically Needy Total Savings…

Total State Impact	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Medically Needy Total Expenditures[3]		**$651,699,292**	**$652,992,915**	**$654,289,106**	**$655,587,870**	**$656,889,212**
Medically Needy FMAP		60.51%	61.17%	61.33%	61.50%	61.74%
Federal Expenditures w/o SB 2512		$439,357,185	$445,031,017	$447,080,765	$449,209,937	$451,858,115
State Expenditures w/o SB 2512[4]		$286,733,023	$282,500,480	$281,894,882	$281,212,727	$280,014,438
Federal Expenditures under SB 2512		$623,079,168	$589,225,696	$572,485,114	$567,668,535	$551,562,831
State Expenditures under SB 2512[4]		$15,667,191	$19,320,955	$37,295,408	$43,348,228	$52,162,829
SB 2512 State Impact - Medically Needy		**($271,065,833)**	**($263,179,525)**	**($244,599,475)**	**($237,864,499)**	**($227,851,609)**

Positive Total = Additional Cost; Negative Total = Savings

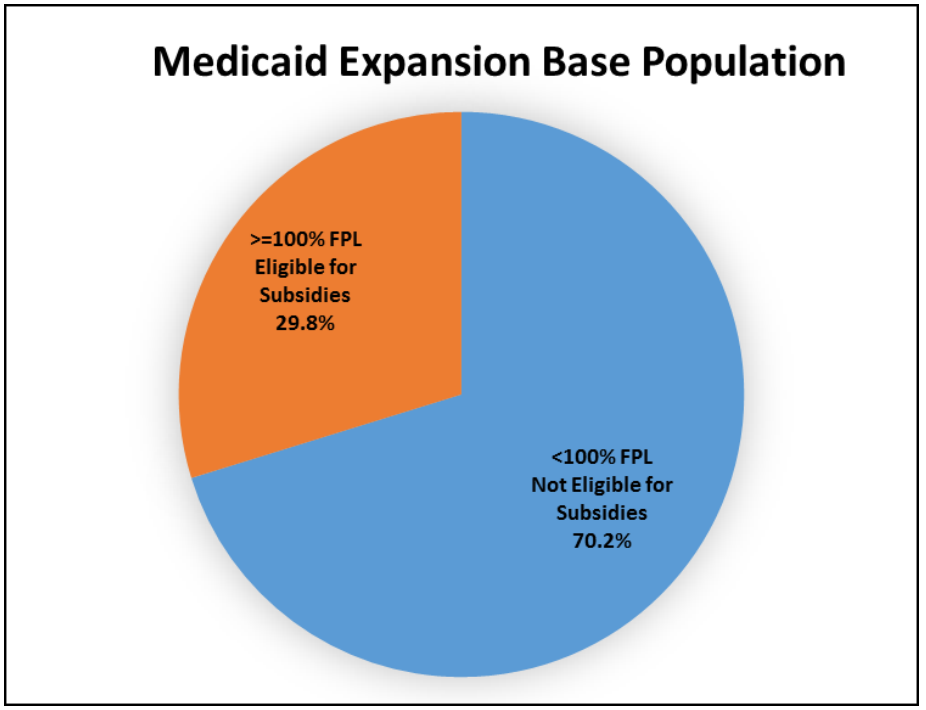
Phase 1 & Phase 2 – Medicaid Coverage…

Phase 1 and 2 Medicaid Coverage Summary	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Medicaid Expansion Population	742,677	753,446	764,167	774,835	785,423
FHIX Phase 1 Enrolled	742,677				
FHIX Phase 2 Enrolled	339,806	344,733	349,639	354,520	359,364
FHIX Phase 2 Disenrolled/Not Enrolled	402,871	408,713	414,528	420,315	426,059
Percent of Population Not Enrolled	***54.2%***	***54.2%***	***54.2%***	***54.2%***	***54.2%***
Crowd out Population	20,031	20,031	20,031	20,031	20,031
FHIX Phase 1 Enrolled	0				
FHIX Phase 2 Enrolled	20,031	20,031	20,031	20,031	20,031
FHIX Phase 2 Disenrolled/Not Enrolled	0	0	0	0	0
Percent of Population Not Enrolled	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
Medically Needy Shift	25,964	25,886	25,808	25,731	25,653
FHIX Phase 1 Enrolled	25,964				
FHIX Phase 2 Enrolled	25,964	25,886	25,808	25,731	25,653
FHIX Phase 2 Disenrolled/Not Enrolled	0	0	0	0	0
Percent of Population Not Enrolled	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
Medically Needy Children and Pregnant Women Population	937	934	931	928	925
Medically Needy Medicaid Enrolled	937	934	931	928	0
Medically Needy Medicaid Disenrolled/Not Enrolled[1]	0	0	0	0	925
Percent of Population Not Enrolled	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***
Medically Needy Non Pregnant Adults 19-64 above 133%	3,212	3,203	3,193	3,184	3,174
Medically Needy Medicaid Enrolled	0	0	0	0	0
Medically Needy Medicaid Disenrolled/Not Enrolled	3,212	3,203	3,193	3,184	3,174
Percent of Population Not Enrolled	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
Medically Needy Adults 65+ All Income Levels	1,902	1,896	1,891	1,885	1,879
Medically Needy Medicaid Enrolled	0	0	0	0	0
Medically Needy Medicaid Disenrolled/Not Enrolled	1,902	1,896	1,891	1,885	1,879
Percent of Population Not Enrolled	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
Total all groups	794,723	805,396	816,021	826,594	837,086
Total Enrolled	386,737	391,584	396,409	401,210	405,048
Total Disenrolled/Not Enrolled	407,986	413,812	419,612	425,384	432,038
Percent of Population Not Enrolled	***51.3%***	***51.4%***	***51.4%***	***51.5%***	***51.6%***

[1]Children and pregnant women are disenrolled from the Medically Needy program when it ends on October 1, 2019.

Disenrollees and the Exchange…

- Subsidies (health insurance premium tax credits) are only available to persons between 100% to 400% FPL selecting insurance coverage through the Exchange.
- Florida's Medicaid Expansion base population has 70.2% who are not eligible for subsidies today, and the remaining 29.8% are eligible for subsidies.
- EDR assumes that the disenrolled population would mirror Florida's Medicaid Expansion base population and therefore at least 70.2% would continue to be ineligible for subsidies on the Exchange.
- It is currently unknown whether the remaining 29.8% that are between 100% and 133% FPL would be allowed to receive subsidies for private insurance coverage purchased on the Exchange.



Insurance Premium Tax: Crowd Out Adjustment...

- 40,062 persons currently have private individual insurance and would qualify for FHIX.

- This analysis assumes that 20,031 would forgo private insurance for FHIX, removing them from the current pool of privately insured.

- In Phase 2, the premiums and tax collections from the underlying Insurance Premium Tax forecast associated with the 20,031 would be removed.

Insurance Premium Tax: ACA Induced...

- The current revenue forecast assumes 1.44 million individuals are induced by the Affordable Care Act to obtain private insurance that is subject to the Insurance Premium Tax in the 2015 calendar year.

- This analysis assumes that 234,284 of the 1.44 million individuals would qualify for and move to Medicaid under Phase 1 - Simple Expansion in lieu of seeking private insurance. This number grows and is included within the uninsured presenters.

- The premiums and tax collections from the underlying Insurance Premium Tax forecast associated with these individuals are removed during the entire forecast.

- Some of the Phase 1 participants would be disenrolled during the transition to Phase 2; however, their remaining insurance options are unclear and the disenrollee feedback to the Insurance Premium Tax forecast is indeterminate.

Insurance Premium Tax: FHIX Plan Selections...

- The ultimate mix of insurance offerings on FHIX are currently unknown.

- Among other options, FHIX can offer "...a managed care plan contracted with the Agency for Health Care Administration under the managed medical assistance program under part IV of Chapter 409." Today, these plans (Medicaid MMA) are not subject to the Insurance Premium Tax. The Insurance Premium Tax status of **Medicaid MMA *through FHIX*** is unclear.

- For these reasons, the impact of FHIX selections on Insurance Premium Tax collections is indeterminate.

Phase 1 & Phase 2 – Insurance Premium Tax...

Insurance Premium Tax

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Phase 1 - Impact of Simple Expansion	($7,226,394)	($6,187,003)	($6,570,490)	($6,807,356)	($7,108,618)
Phase 2 - Impact of Crowd Out leaving private insurance	$0	($403,304)	($311,722)	($307,841)	($317,198)
Phase 2 - Impact of FHIX plan selection	$0	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Impact of Disenrolled	$0	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Total Cash Impact on Insurance Premium Tax	($7,226,394)	($6,590,307)	($6,882,212)	($7,115,197)	($7,425,816)

Overall Fiscal Impacts...

Expansion Program	FY 2015-16		FY 2016-17		FY 2017-18		FY 2018-19		FY 2019-20	
	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$
*Uninsured Presenters (new)**	742,677	-	753,446	(75.1)	764,167	(172.3)	774,835	(212.3)	785,423	(289.3)
Crowd-Out (new)	122,704	-	122,704	(12.2)	122,704	(27.6)	122,704	(33.5)	122,704	(45.0)
*Medically Needy Shift (net)***	-	237.4	-	218.9	-	200.2	-	193.5	-	180.4
Medicaid Subtotal	865,381	237.4	876,150	131.6	886,871	0.3	897,539	-52.3	908,127	-153.9
Insurance Premium Revenue Adj.	-	(8.9)	-	(8.0)	-	(8.4)	-	(8.7)	-	(9.1)
Total	865,381	228.5	876,150	123.6	886,871	(8.1)	897,539	(61.0)	908,127	(163.0)

Note: Dollars in Millions; Positive Total = Surplus; Negative Total = Shortfall

*Includes qualifying persons on the waitlist for the APD Developmental Services Waiver and service recipients in the DCF Substance Abuse and Mental Health Program.

**Assumes approximately 26,000 non-pregnant adults aged 19-64 shift from the Medically Needy Program to the Expansion Program, with no other changes.

SB 2512 Phases 1 and 2	FY 2015-16		FY 2016-17		FY 2017-18		FY 2018-19		FY 2019-20	
	Caseload*	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$
*Uninsured Presenters (new)***	339,806	-	344,733	(32.5)	349,639	(75.0)	354,520	(92.1)	359,364	(125.7)
Crowd-Out (new)	20,301	-	20,031	(1.9)	20,031	(4.3)	20,031	(5.2)	20,031	(7.0)
*Medically Needy Shift (net)****	-	237.4	-	219.0	-	200.5	-	193.9	-	180.8
*Medically Needy Sunset*****	N/A	33.6	N/A	44.2	N/A	44.1	N/A	44.0	N/A	47.1
Phase 1 and 2 Subtotal	360,107	271.0	364,764	228.8	369,670	165.3	374,551	140.6	379,395	95.2
Insurance Premium Revenue Adj.	-	(7.2)	-	(6.6)	-	(6.9)	-	(7.1)	-	(7.4)
Total	360,107	263.8	364,764	222.2	369,670	158.4	374,551	133.5	379,395	87.8

Note: Dollars in Millions; Positive Total = Surplus; Negative Total = Shortfall

* The caseload figures for FY 2015-16 represent the number enrolled at the end of the fiscal year.

** Includes qualifying persons on the waitlist for the APD Developmental Services Waiver and service recipients in the DCF Substance Abuse and Mental Health Program.

*** Assumes approximately 26,000 non-pregnant adults aged 19-64 under 133% FPL shift from the Medically Needy Program to Phase 1 and 2. State savings result from the higher federal match rate for Phase 1 and 2 expenditures and from enrollee premium payments, which are exclusive to Phase 2.

**** Caseload in this row is not shown because individuals are included in current Medicaid program enrollment numbers. Non-pregnant adults ages 19-64 above 133% FPL and adults ages 65+ at all income levels (about 5,100 individuals in total) will be disenrolled from the program October 1, 2015. Children and pregnant women (about 930 individuals in total) will be disenrolled when the program is terminated on October 1, 2019. State savings in this row result from the disenrollment of these individuals at these points in time.

Expansion Program vs. SB 2512 Phases 1 and 2	FY 2015-16		FY 2016-17		FY 2017-18		FY 2018-19		FY 2019-20	
	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$
	-505,274	+35.3	-511,386	+98.6	-517,201	+166.5	-522,988	+194.5	-528,732	+250.8

Impact of Medicaid Expansion 2015
Part 3: Phases 1, 2, and 3

(Impact: SB 2512 First Engrossed, All years)

Phase 1: Simple Expansion

Phase 2: FHIX

Phase 3: Healthy Kids Transition

April 9, 2015

Presented by:

The Florida Legislature
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Phase 3 – Healthy Kids Assumptions…

- Phase 3 is interpreted to have two independent and simultaneously occurring components:
  - The continuation of Phase Two without further changes.
  - The transition of Florida Healthy Kids Title XXI to the FHIX marketplace.
- This analysis assumes that each of the three eligibility requirements for the FHIX Program [(1)(a); (1)(b); and (1)(c)] provided in s. 409.723, Florida Statutes, stands alone and should be evaluated in that manner. The following is from Section 5 of the bill:

  409.723 Participation.—

  (1) ELIGIBILITY.—In order to participate in FHIX, an individual must be a resident and must meet the following requirements, as applicable:

  (a) Qualify as a newly eligible enrollee, who must be an individual as described in s. 1902(a)(10)(A)(i)(VIII) of the Social Security Act or s. 2001 of the Affordable Care Act and as may be further defined by federal regulation.

  (b) Meet and maintain the responsibilities under subsection(4).

  (c) Qualify as a participant in the Florida Healthy Kids program under s. 624.91, subject to the implementation of Phase Three under s. 409.727.

Phase 3 – Healthy Kids Assumptions…

- For Phase 3, the bill language states:
  - (4)(b) Eligibility during this phase is based on meeting the requirements of Phase Two and s. 409.723(1)(c).
- This analysis assumes that Phase 3 eligibility for adults aged 19-64 is contingent upon meeting the requirements outlined in s. 409.723 (1)(a) and (1)(b), while eligibility for Florida Healthy Kids children aged 5-18 eligibility is contingent upon meeting the requirements of s. 409.723 (1)(c), Florida Statutes. As these are distinct qualifying populations, the analysis effectively treats the "and" used in the bill language as an "or".
- This assumption is further supported by the distinction between the terms enrollee and Healthy Kids enrollee.
  - Proposed sections 409.727(4)(c), (e), and (f) of the Florida Statutes concern all enrollees, while the language in sections 409.727(4)(a), (d), and (g) only addresses Florida Healthy Kids enrollees.

Phase 3 – Healthy Kids Assumptions…

- The eligibility requirements are assumed to correspond with the three phases of the program as follows:

Eligibility Requirements	Phase 1	Phase 2	Phase 3
Adults Aged 19-64	(a)	(a) & (b)	(a) & (b)
Florida Healthy Kids Children Aged 5-18			(c)

- This analysis further assumes that the Healthy Kids children (current and new) will be exempt from the "Participant Responsibilities" listed below:
  - Annually provide evidence of participation in one of the following activities:
    - Proof of employment.
    - On-the-job training or job placement activities.
    - Pursuit of educational opportunities.

Phase 3 – Healthy Kids Transition…

- Current Healthy Kids Title XXI (133% - 200% FPL):
  - Current enrollees will transition to FHIX on July 1, August 1, and September 1 2016 (one-third each month).
  - The monthly premium amount for these children will be the maximum $25 because all have family incomes above 100% FPL (the current average monthly premium is $12.48; the shift to FHIX will reduce costs to the state due to the increase in premiums).
- Current Healthy Kids Full Pay (above 200% FPL):
  - This analysis assumes Healthy Kids Full Pay enrollees will not be eligible for the FHIX marketplace (today, these families pay 100% of their insurance costs; if they transition to FHIX, they would receive heavily subsidized insurance).
  - Instead of moving to FHIX, Full Pay enrollees will shift to private insurance coverage on July 1, 2016.
  - The private insurance coverage that this population selects will be subject to the Insurance Premium Tax, thereby increasing state Insurance Premium Tax collections.

Phase 3 – Healthy Kids Assumptions…

- All Phase 3 participants will pay premiums in a timely manner.
- The relative shares of Federal and State expenditures for Healthy Kids in FHIX will be determined by the Enhanced FMAP, which was estimated by the February 2015 Social Services Estimating Conference (SSEC) and is currently used by the Healthy Kids program.
- Premiums will be deducted from total expenses before application of the Federal/State split, mirroring the current Healthy Kids program.

Phase 3 – Healthy Kids Title XXI Fiscal Impact...

Phase 3 - Healthy Kids Title XXI	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Average Monthly Enrollees		158,837	162,305	164,740	167,211
Total Expenditures		$249,670,639	$265,319,749	$280,071,684	$295,643,500
Average FMAP		95.79%	95.93%	96.04%	78.96%
Healthy Kids Title XXI w/o SB 2512					
Monthly Family Premium Contribution		$12.48	$12.48	$12.48	$12.48
Total Enrollee Premium Revenue		$23,787,379	$24,306,797	$24,671,412	$25,041,469
Total Net Expenditures					
(Premium Revenue subtracted)	Phase 3 Not	$225,883,260	$241,012,952	$255,400,272	$270,602,030
Federal Expenditures	in Effect	$216,372,540	$231,198,830	$245,283,139	$213,078,298
State Expenditures		$9,510,720	$9,814,122	$10,117,133	$57,523,732
Healthy Kids Title XXI w/ SB 2512					
Monthly Family Premium Contribution		$25.00	$25.00	$25.00	$25.00
Total Enrollee Premium Revenue		$45,686,508	$48,691,500	$49,421,900	$50,163,200
Total Net Expenditures					
(Premium Revenue subtracted)		$203,984,131	$216,628,249	$230,649,784	$245,480,300
Federal Expenditures		$195,389,990	$207,807,178	$221,513,348	$193,251,430
State Expenditures		$8,594,141	$8,821,071	$9,136,436	$52,228,870
State Impact: Phase 3 - Healthy Kids Title XXI		**($916,578)**	**($993,051)**	**($980,697)**	**($5,294,863)**

Notes:

- Positive Impact = Additional Cost; Negative Impact = Savings
- Figures for Healthy Kids without SB 2512 are from the February 2015 SSEC.
- It is assumed that the Healthy Kids FMAP would apply to Phase 3 Expenditures as it is currently applied to Healthy Kids Expenditures.
- Expenditures were computed monthly and summarized on the table above; see Supplemental Materials for underlying monthly analysis.

Phase 3 – Healthy Kids Full Pay Fiscal Impact…

Phase 3 - Healthy Kids Full Pay	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Healthy Kids Full Pay w/o SB 2512					
Average Monthly Enrollees		37,607	37,607	37,607	37,607
Total Expenditures		$59,563,224	$59,563,224	$59,563,224	$59,563,224
Total Enrollee Premium Revenue		$59,563,224	$59,563,224	$59,563,224	$59,563,224
Total Net Expenditures					
(Premium Revenue subtracted)		$0	$0	$0	$0
Federal Expenditures		$0	$0	$0	$0
State Expenditures	Phase 3 Not	$0	$0	$0	$0
Healthy Kids Full Pay w/ SB 2512	in Effect				
Average Monthly Enrollees		0	0	0	0
Monthly Family Premium Contribution		$0	$0	$0	$0
Total Enrollee Premium Revenue		$0	$0	$0	$0
Total Net Expenditures					
(Premium Revenue subtracted)		$0	$0	$0	$0
Federal Expenditures		$0	$0	$0	$0
State Expenditures		$0	$0	$0	$0
State Impact: Phase 3 - Healthy Kids Full Pay		**$0**	**$0**	**$0**	**$0**

Notes:

- Figures for Healthy Kids without SB 2512 are from the February 2015 SSEC.
- Expenditures were computed monthly and summarized on the table above; see Supplemental Materials for underlying monthly analysis.

Phases 1, 2, and 3 – Annual Expenditures…

Phases 1, 2, and 3 - Annual Expenditures	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Expansion, Crowd out, and Medically Needy					
Enrollees	Varies by Month	390,650	395,478	400,282	405,048
Expenditures	$2,608,558,179	$2,050,446,176	$2,112,416,159	$2,176,557,459	$2,242,889,303
Enrollee Premium Revenue	$32,089,126	$77,988,980	$78,958,272	$79,922,591	$80,879,530
Net Expenditures (Premium Revenue subtracted)	$2,576,469,053	$1,972,457,196	$2,033,457,887	$2,096,634,868	$2,162,009,773
Expansion FMAP	100.00%	97.50%	94.50%	93.50%	91.50%
Federal Expenditures w/o Phase 3 Healthy Kids	**$2,576,469,053**	**$1,923,145,766**	**$1,921,617,703**	**$1,960,353,601**	**$1,978,238,943**
State Expenditures w/o Phase 3 Healthy Kids	**$0**	**$49,311,430**	**$111,840,184**	**$136,281,266**	**$183,770,831**
Healthy Kids Title XXI					
Enrollees	Phase 3 Not in Effect	158,837	162,305	164,740	167,211
Expenditures		$249,670,639	$265,319,749	$280,071,684	$295,643,500
Enrollee Premium Revenue		$45,686,508	$48,691,500	$49,421,900	$50,163,200
Net Expenditures (Premium Revenue subtracted)		$203,984,131	$216,628,249	$230,649,784	$245,480,300
Expansion FMAP		95.79%	95.93%	96.04%	78.96%
Federal Expenditures Phase 3 Healthy Kids		**$195,389,990**	**$207,807,178**	**$221,513,348**	**$193,251,430**
State Expenditures Phase 3 Healthy Kids		**$8,594,141**	**$8,821,071**	**$9,136,436**	**$52,228,870**
Federal Expenditures Phases 1, 2, and 3	**$2,576,469,053**	**$2,118,535,756**	**$2,129,424,881**	**$2,181,866,949**	**$2,171,490,373**
State Expenditures Phases 1, 2, and 3	**$0**	**$57,905,571**	**$120,661,255**	**$145,417,703**	**$235,999,700**

Phases 1, 2, and 3 – Medicaid Coverage…

Phases 1, 2, and 3 Medicaid Coverage Summary	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Medicaid Expansion Population	742,677	753,446	764,167	774,835	785,423
FHIX Phase 1 Enrolled	742,677				
FHIX Phase 2 Enrolled	339,806	344,733	349,639	354,520	359,364
FHIX Phase 2 or 3 Disenrolled/Not Enrolled	402,871	408,713	414,528	420,315	426,059
Percent of Population Not Enrolled	***54.2%***	***54.2%***	***54.2%***	***54.2%***	***54.2%***
Crowd out Population	20,031	20,031	20,031	20,031	20,031
FHIX Phase 1 Enrolled	0				
FHIX Phase 2 Enrolled	20,031	20,031	20,031	20,031	20,031
FHIX Phase 2 or 3 Disenrolled/Not Enrolled	0	0	0	0	0
Percent of Population Not Enrolled	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
Medically Needy Shift	25,964	25,886	25,808	25,731	25,653
FHIX Phase 1 Enrolled	25,964				
FHIX Phase 2 Enrolled	25,964	25,886	25,808	25,731	25,653
FHIX Phase 2 or 3 Disenrolled/Not Enrolled	0	0	0	0	0
Percent of Population Not Enrolled	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
Medically Needy Children and Pregnant Women Population	937	934	931	928	925
Medically Needy Medicaid Enrolled	937	934	931	928	0
Medically Needy Medicaid Disenrolled/Not Enrolled[1]	0	0	0	0	925
Percent of Population Not Enrolled	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***
Medically Needy Non Pregnant Adults 19-64 above 133%	3,212	3,203	3,193	3,184	3,174
Medically Needy Medicaid Enrolled	0	0	0	0	0
Medically Needy Medicaid Disenrolled/Not Enrolled	3,212	3,203	3,193	3,184	3,174
Percent of Population Not Enrolled	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
Medically Needy Adults 65+ All Income Levels	1,902	1,896	1,891	1,885	1,879
Medically Needy Medicaid Enrolled	0	0	0	0	0
Medically Needy Medicaid Disenrolled/Not Enrolled	1,902	1,896	1,891	1,885	1,879
Percent of Population Not Enrolled	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
Healthy Kids Title XXI	Phase 3 not in effect	158,837	162,305	164,740	167,211
Healthy Kids or FHIX Enrolled		158,837	162,305	164,740	167,211
Healthy Kids or FHIX Disenrolled/Not Enrolled		0	0	0	0
Percent of Population Not Enrolled		***0.0%***	***0.0%***	***0.0%***	***0.0%***
Healthy Kids Full Pay		37,607	37,607	37,607	37,607
Healthy Kids or FHIX Enrolled		0	0	0	0
Healthy Kids or FHIX Disenrolled/Not Enrolled		37,607	37,607	37,607	37,607
Percent of Population Not Enrolled		***100.0%***	***100.0%***	***100.0%***	***100.0%***
Total all groups	794,723	1,001,839	1,015,933	1,028,940	1,041,904
Total Enrolled	386,737	550,420	558,714	565,950	572,259
Total Disenrolled/Not Enrolled	407,986	451,419	457,219	462,991	469,645
Percent of Population Not Enrolled	***51.3%***	***45.1%***	***45.0%***	***45.0%***	***45.1%***

Phase 3 Healthy Kids

[1]Children and pregnant women are disenrolled from the Medically Needy program when it ends on October 1, 2019.

Phases 1, 2, and 3 – Insurance Premium Tax...

	Insurance Premium Tax				
	FY 2015-16	FY 2016-17	FY2017-18	FY 2018-19	FY 2019-20
Phase 1 - Impact of Simple Expansion	($7,226,394)	($6,187,003)	($6,570,490)	($6,807,356)	($7,108,618)
Phase 2 - Impact of Crowd Out Leaving Private Insurance	$0	($403,304)	($311,722)	($307,841)	($317,198)
Phase 2 - Impact of FHIX Plan Selection	$0	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Impact of Disenrolled	$0	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Phase 3 - Impact of Healthy Kids Full Pay Purchasing Insurance	$0	$362,106	$629,801	$525,205	$548,440
Total Cash Impact of Insurance Premium Tax	($7,226,394)	($6,228,201)	($6,252,411)	($6,589,992)	($6,877,376)

Overall Fiscal Impacts...

Expansion Program	FY 2015-16		FY 2016-17		FY 2017-18		FY 2018-19		FY 2019-20	
	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$
*Uninsured Presenters (new)**	742,677	-	753,446	(75.1)	764,167	(172.3)	774,835	(212.3)	785,423	(289.3)
Crowd-Out (new)	122,704	-	122,704	(12.2)	122,704	(27.6)	122,704	(33.5)	122,704	(45.0)
*Medically Needy Shift (net)***	-	237.4	-	218.9	-	200.2	-	193.5	-	180.4
Medicaid Subtotal	865,381	237.4	876,150	131.6	886,871	0.3	897,539	(52.3)	908,127	(153.9)
Insurance Premium Revenue Adj.	-	(8.9)	0	(8.0)	0	(8.4)	0	(8.7)	0	(9.1)
Total	865,381	228.5	876,150	123.6	886,871	(8.1)	897,539	(61.0)	908,127	(163.0)

SB 2512 Phases 1 and 2	FY 2015-16		FY 2016-17		FY 2017-18		FY 2018-19		FY 2019-20	
	Caseload***	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$
*Uninsured Presenters (new)**	339,806	-	344,733	(32.5)	349,639	(75.0)	354,520	(92.1)	359,364	(125.7)
Crowd-Out (new)	20,301	-	20,031	(1.9)	20,031	(4.3)	20,031	(5.2)	20,031	(7.0)
Medically Needy Shift (net) †	-	237.4	-	219.0	-	200.5	-	193.9	-	180.8
Medically Needy Sunset‡	N/A	33.6	N/A	44.2	N/A	44.1	N/A	44.0	N/A	47.1
Phase 1 and 2 Subtotal	360,107	271.0	364,764	228.8	369,670	165.3	374,551	140.6	379,395	95.2
Insurance Premium Revenue Adj.	-	(7.2)	-	(6.6)	-	(6.9)	-	(7.1)	-	(7.4)
Total	360,107	263.8	364,764	222.2	369,670	158.4	374,551	133.5	379,395	87.8
Compared to Expansion Program	**-505,274**	**+35.3**	**-511,386**	**+98.6**	**-517,201**	**+166.5**	**-522,988**	**+194.5**	**-528,732**	**+250.8**

SB 2512 Phases 1, 2, and 3	FY 2015-16		FY 2016-17		FY 2017-18		FY 2018-19		FY 2019-20	
	Caseload***	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$	Caseload	State $$$
*Uninsured Presenters (new)**	339,806	-	344,733	(32.5)	349,639	(75.0)	354,520	(92.1)	359,364	(125.7)
Crowd-Out (new)	20,301	-	20,031	(1.9)	20,031	(4.3)	20,031	(5.2)	20,031	(7.0)
Medically Needy Shift (net) †	-	237.4	-	219.0	-	200.5	-	193.9	-	180.8
Medically Needy Sunset ††	N/A	33.6	N/A	44.2	N/A	44.1	N/A	44.0	N/A	47.1
Healthy Kids Title XXI ‡	N/A	N/A	-	0.9	-	1.0	-	1.0	-	5.3
Phase 1, 2, and 3 Subtotal	360,107	271.0	364,764	229.7	369,670	166.3	374,551	141.6	379,395	100.5
Insurance Premium Revenue Adj.	-	(7.2)	-	(6.2)	-	(6.3)	-	(6.6)	-	(6.9)
Total	360,107	263.8	364,764	223.5	369,670	160.0	374,551	135.0	379,395	93.6
Compared to Expansion Program	**-505,274**	**+35.3**	**-511,386**	**+99.9**	**-517,201**	**+168.1**	**-522,988**	**+196.0**	**-528,732**	**+256.6**
Compared to SB 2512 Phases 1 and 2	**0**	**0.0**	**0**	**+1.3**	**0**	**+1.6**	**0**	**+1.5**	**0**	**+5.8**

Note: Dollars in Millions; Positive Total = Surplus; Negative Total = Shortfall

Overall Fiscal Impacts Table Notes...

*Includes qualifying persons on the waitlist for the APD Developmental Services Waiver and service recipients in the DCF Substance Abuse and Mental Health Program.
**Assumes approximately 26,000 non-pregnant adults aged 19-64 shift from the Medically Needy Program to the Expansion Program, with no other changes.
*** The caseload figures for FY 2015-16 represent the number enrolled at the end of the fiscal year.
† Assumes approximately 26,000 non-pregnant adults aged 19-64 under 133% FPL shift from the Medically Needy Program to Phase 1 and 2. State savings result from the higher federal match rate for Phase 1 and 2 expenditures and from enrollee premium payments, which are exclusive to Phase 2.
†† Caseload in this row is not shown because individuals are included in current Medicaid program enrollment numbers. Non-pregnant adults ages 19-64 above 133% FPL and adults ages 65+ at all income levels (about 5,100 individuals in total) will be disenrolled from the program October 1, 2015. Children and pregnant women (about 930 individuals in total) will be disenrolled when the program is terminated on October 1, 2019. State savings in this row result from the disenrollment of these individuals at these points in time.
‡ State savings result from the increase in enrollee premium payments for Healthy Kids Title XXI from $12.48 per month (February 2015 SSEC) to $25.00 per month (cost sharing rate for those above 100% FPL). Assumes approximately 38,000 Healthy Kids Full Pay enrollees will transition to private insurance coverage on July 1, 2016 because they will not have a path to insurance through the FHIX marketplace.

Overall Coverage Status after Full Implementation...

Current Coverage Status	Coverage Status under SB 2512 (after Phase 3 full implementation)	Description	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Uninsured	FHIX	This group is currently uninsured and would qualify for the FHIX marketplace (school/work requirements and premium payment requirements).	344,733	349,639	354,520	359,364
Private Insurance	FHIX	This group currently has private insurance and would transition to the FHIX marketplace; they will meet all FHIX requirements and will opt for a FHIX plan over their current private insurance plan.	20,031	20,031	20,031	20,031
Medicaid Medically Needy	FHIX	This group is currently in Medicaid Medically Needy and would be transitioned to FHIX because they would meet all the requirements. This group, which has not paid premiums in Medicaid, would be subject to premium payments starting in Phase 2.	25,886	25,808	25,731	25,653
Healthy Kids Title XXI	FHIX	This group comprises the current Healthy Kids Title XXI population. They would be transitioned to FHIX in Phase 3; premiums would increase from the current average of $12.48 per month to $25.00 per month (all are above 100% FPL).	158,837	162,305	164,740	167,211
		FHIX Enrollment Subtotal	549,486	557,783	565,021	572,259
Medicaid Medically Needy	Medicaid Medically Needy	This group is children or pregnant women currently in Medicaid Medically Needy. They would remain in Medicaid until the Medically Needy program is terminated on October 1, 2019.	934	931	928	- 925
Medicaid Medically Needy	No longer with a state-sponsored program	This group includes the elderly at all income levels and the individuals with incomes above 133% FPL who are currently in Medicaid Medically Needy. This group would not meet income and/or age requirements for FHIX. They would be disenrolled from Medicaid on October 1, 2015.	- 5,099	- 5,084	- 5,069	- 5,053
Healthy Kids Full Pay	No longer with a state-sponsored program	This group comprises the Healthy Kids Full Pay population (all have incomes above 200% FPL). It is assumed that they would not have a path to insurance through the FHIX marketplace.	- 37,607	- 37,607	- 37,607	- 37,607
Uninsured	Not with a state-sponsored program	This group is currently uninsured and would not qualify for the FHIX marketplace (school/work requirements and/or premium payment requirements).	~ 408,713	~ 414,528	~ 420,315	~ 426,059

A negative sign (-) indicates individuals who are currently enrolled in a state-sponsored program but would be disenrolled under SB 2512.
A tilde (~) indicates individuals who are currently uninsured and would not become eligible for a state-sponsored program through SB 2512.

Supplemental Materials:

Economic Analysis of PPACA and Medicaid Expansion

Select Committees on Patient Protection and Affordable Care Act

March 4, 2013

Presented by:

The Florida Legislature
Office of Economic and Demographic Research
850.487.1402
http://edr.state.fl.us

Affordable Care Act Analysis: Assumptions

Background:

Leadership in the Florida Senate and House of Representatives requested that the Legislative Office of Economic and Demographic Research (EDR) conduct an in-depth analysis of the Affordable Care Act (Act) and the potential effects it will have on the Florida Economy. The analysis covers the mandatory provisions of the Act, as well as the optional Medicaid Expansion decision. The mandatory provisions will be in effect regardless of future legislative actions. The optional decision regarding Medicaid Expansion is under the direct control of the Legislature and Governor.

The evaluation was performed by using static estimates developed by EDR as inputs for the recently-deployed Statewide Model. The Statewide Model was used to generate the direct, indirect and induced economic effects for Florida suggested by the static inputs. Since all 50 states will be simultaneously undergoing major transformations caused by the Act, some of the Florida-specific results will be further altered by the national nature of the legislation and the ultimate interplay among states, as well as by feedback results that are beyond the scope of this analysis.

The analysis has been further hampered by the incomplete nature of the federal rules and regulations that will implement the Act. While EDR has made decisions and assumptions based on the information now available, some of the underlying premises are still in flux and could change the outcomes generated by the Statewide Model. For example, it is still not clear whether individual subsidies will be available in exchanges set up and run by the federal government; however, this analysis assumes they will be.

For these reasons, the Statewide Model results should be viewed not as specifics, but as suggestive of likely outcomes. Even the adjusted baseline described below should be regarded as a simulation.

Premise:

The current National and Florida Economic Outlooks have not fully taken account of the economic changes that will result from the implementation of the Act. This means that the baseline for the Statewide Model had to be adjusted to address the provisions that will be in effect regardless of future legislative actions prior to looking at policy changes that are dependent on state legislative action. All discrete adjustments to the baseline are documented and discussed, with the results compared to the starting or prior baseline. [Note: EDR has reviewed the assumptions made by IHS Global Insight for the control national forecast; largely their adjustments were directed at the new federally required taxes and fees.]

Among the more significant adjustments to the baseline were:

(1) Increased state budgetary costs and federal dollars associated with the mandatory portions of the Affordable Care Act.

a. Primary Care Practitioners Fee Increase to Medicare Rate—an increase in the state budget by the amount of anticipated federal dollars; the increase in state budget is then directed to providers in the ambulatory area without a commensurate increase in services.
    i. Level pulled from the AHCA 12/12 Response (with state costs converted to federal: $349.4 million in FY 2012-13; $698.8 million in 2013-14; and $349.4 million in FY 2014-15.
b. Health Insurance Tax Impact on Medicaid Managed Care—as the new tax effectively increases managed care rates within the existing Medicaid Program, the cost will be split between increased federal reimbursements and realignment within the state budget to provide the required match. The increased federal reimbursements will effectively offset a portion of the dollars leaving the state to pay the initial tax.
    i. Level pulled from the AHCA 12/12 Response (state costs range from $13.1 million in FY 2013-14 to $192.5 million in FY 2022-23.
c. The cost of implementing the Exchange and its effect on eligibility determinations are indeterminate.

(2) Increased insurance coverage associated with the mandatory portions of the Act resulting in a greater number of traditional insurance policies, self-insured programs and richer benefits, as well as the knock-on effects from overall increased demand for healthcare from the entire population of uninsured.
a. Increased demand for healthcare services resulting from uninsured becoming insured: Increased Demand = # of Uninsured x Policy Cost
    i. In the PUMS data, 1,442,014 persons will receive policy coverage and 727,972 persons will fall under a self-insured program for a total of 2,169,986 uninsured persons becoming insured. These numbers are translated into percentages of the population and then allowed to grow over time as part the overall population growth within those shares.
        1. Applied four-year ramp-up period: 40%, 60%, 80% and 100%.
        2. Included aliens and the potential Medicaid Expansion population.
        3. Made a 10% adjustment for the non-compliant portion of the tax base (referred to generally as “non-filers”) in any given year.
        4. Made discrete assumptions based on age, employment status, size and type of employer, and income.
    ii. For policy coverage, assumed new premium of $6,157 in base year (preliminary data from OIR). This assumption was developed by taking into account the following: 70% actuarial value of the silver plan; trend growth; reinsurance subsidy; guaranteed issue feature of the contract; new fees related to the Act; area factor average reduction; and essential health benefits requirement. In essence, the policy premiums initially increase

by 25% to comply with the new law and then grow at one-half the rate they otherwise would have in the baseline. This result reflects the dual effects from the upward pressure on policy premiums associated with the "richer" benefit package and the downward effects from better health outcomes.

iii. Applied a scalar to the premium cost to reflect non-direct healthcare expenditures retained by insurance companies (based on EDR research: 18% non-health; 82% health). This non-health portion does not increase final demand for health services.

iv. Recognized the out-of-pocket healthcare spending today by the uninsured that will convert to spending on copayments, deductibles and incidentals: $583 per uninsured person that becomes covered (Health Affairs spending table).

v. Downwardly adjusted increased demand by the amount of today's uncompensated care that will shift to the newly insured (whether through self-insurance programs or private coverage). Assumed $536 per newly insured person = $1.16 billion (Health Affairs spending table).
    1. Assumed Disproportionate Share reductions will be largely offset by the shift from uncompensated care to newly insured care, resulting in no overall loss in spending.
    2. Used "Estimated Total Uncompensated Care" as reported in the 2011 Florida Hospital Uniform Reporting System (FHURS): $2.6 billion. Insured care will reduce this amount by $1.2 billion, leaving a remaining level of uncompensated care of $1.4 billion and freeing the resources previously directed to the $1.2 billion.
    3. Florida's federal Disproportionate Share allocation has ranged from $188.3 million to $206.6 million.

vi. Developed separate estimates related to the treatment of federal "subsidies" for individuals and tax credits for small businesses.
    1. Assumed individual subsidies will be limited to the non-working population with incomes greater than 100% and less than 400%.
    2. Assumed business tax credits will be limited to entities with less than 25 employees—and that they will be further constrained by the amount of liability present within any given year.

vii. In regard to incidence, assumed that:
    1. Premium policy costs for non-working individuals are entirely absorbed by households.

2. Premium policy costs for employees initially hit businesses, but households absorb 100% of the cost in the long-run.
3. Self-insurance programs are a complete cost-shift from today's spending by households to businesses due to the lower requirements for self-insurance programs.

viii. There is also an increased demand for health services associated with the richer benefit packages required for existing policy-holders. Based on OIR preliminary data, a 25% mark-up is expected on the average policy premium costs today (from $5,177 to $6,465).
1. Some existing policy-holders are non-employed and pay for insurance out-of-pocket. A portion of this group is eligible for individual subsidies.
2. Some of the small firms providing insurance today are eligible for the tax credits.

ix. Woodworking (the entry of individuals who are currently eligible for the Medicaid or CHIP programs but not enrolled) is indeterminate as adopted by Social Services Estimating Conference (SSEC).

b. Insurance Premium Tax value is added to state revenues, which increases the size of the overall budget expenditure on the generic market basket of goods.
c. The business value associated with increased utility / productivity from better healthcare (reduced sick days, average workweek hours increased, and improved health) is indeterminate.
d. Effects from employers altering their practices regarding the provision of insurance (moving to self-funded pools to a greater extent than the historic trend, eliminating coverage altogether or reducing the scope of health benefits) are indeterminate and excluded from the baseline analysis. Similarly, the extent to which businesses scale back or eliminate coverage but increase wages is deemed indeterminate.

(3) The loss of Florida discretionary income and/or increases to business costs to pay increased federal taxes and fees required by the Affordable Care Act, as well as the dead-weight loss of penalties and the excise taxes on "Cadillac" insurance plans:
a. Individual penalties assumptions:
i. Medicaid Expansion population is exempt from penalties due to the blanket "hardship" exemption provided by HHS. In addition, the general threshold for the requirement to pay federal income taxes is within the Medicaid Expansion population group.
ii. The permanent penalties will be incurred only by the following:
1. Non-working adults—all of those 25 and younger, and 10% of those 26 and older (essentially the non-filers).

2. 10% of the self-employed (essentially the non-filers).
3. The children associated with the above groups (10% of all children).

Moreover, only 50% of the non-filers will be identified within any given year and have to pay the penalty (including any back penalties).

iii. Temporary or time-limited penalties are assigned to certain individuals during the ramp-up period (1 minus the ramp-up period percentages). They will become compliant over time.

b. Business penalties assumption—Indeterminate
   i. Large firms will have total compliance due to competitive pressures related to their brand images and recruitment needs.
   ii. Small firms are not subject to business penalties.
c. Existing policy-holders are assumed to have 100% compliance, meaning no penalties will apply.
d. Increased federal taxes and fees were adequately treated in the underlying National and Florida Economic Outlooks.
e. Changes associated with some plans being deemed "Cadillac" are indeterminate.

(4) The model endogenously handles the shifting between industry sectors from "all else" into healthcare, including the knock-on effects, to meet the new demand.

Scenarios (compared to adjusted baseline described above):
The adjusted baseline can be considered the standard approach to modeling the Affordable Care Act "shock", assuming everything works as designed without introducing atypical labor shortages, wage constraints or capacity issues. The alternative scenarios (#1 through #7) are provided to assess areas of potential risk or change and the impact they would have on the results; however, no attempt is made to gauge the likelihood of the alternative outcomes. [Note: In the presentation PowerPoint, the various scenarios are referred to as "risk simulations".]

1. ADJUSTED BASELINE SCENARIO #1: Difference from the adjusted baseline after incorporating a barrier on additional healthcare workers moving into the state to fill jobs. [key features: potentially constrained infusion of federal dollars; no job-related migration]

2. ADJUSTED BASELINE SCENARIO #2: Difference from the adjusted baseline after assuming the uninsured today from the small business, self-employed, and non-working populations remain uninsured—meaning that those individuals originally buying policies instead pay penalties, as well as a complete erosion of existing insurance provision among small employers (1-50 employees, excluding self-employed)—meaning those employees move to individual coverage and the employers lose their tax credits. [key features: increased penalties; reduced Insurance Premium Tax collections; reduced federal tax credits]

3. ADJUSTED BASELINE SCENARIO #3: Difference from the adjusted baseline after assuming 25% entry rate for Woodworking. Woodworking values came from EDR. [key features: infusion of federal dollars; redirected state dollars]

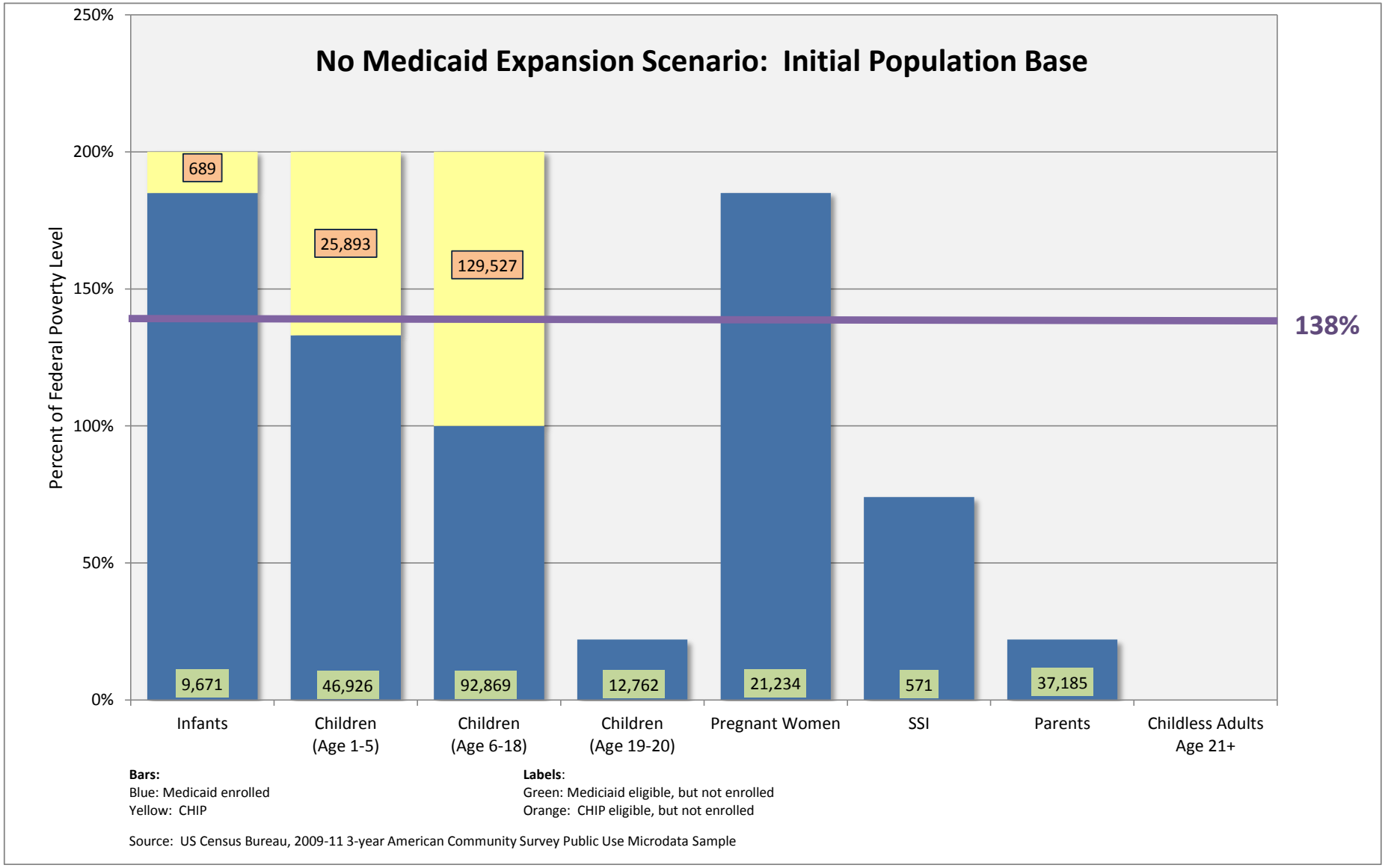
4. ADJUSTED BASELINE SCENARIO #4: Difference from the adjusted baseline after assuming that premium policy costs increase 50% from the existing blended level instead of the 25% assumed in the adjusted baseline, and that this higher level becomes the standard for all new policies. [key features: increased subsidies; increased Insurance Premium Tax]

5. ADJUSTED BASELINE SCENARIO #5 WITH MEDICAID EXPANSION: Difference from the adjusted baseline after incorporating the Medicaid Expansion coupled with an adjustment to assume 25% entry rate for Woodworking. Woodworking values came from EDR. The Medicaid Expansion values from the Social Services Estimating Conference have been updated to reflect new PUMS data and more recent "per member, per month" (PMPM) data. [key features: infusion of federal dollars; redirected state dollars; lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out populations]

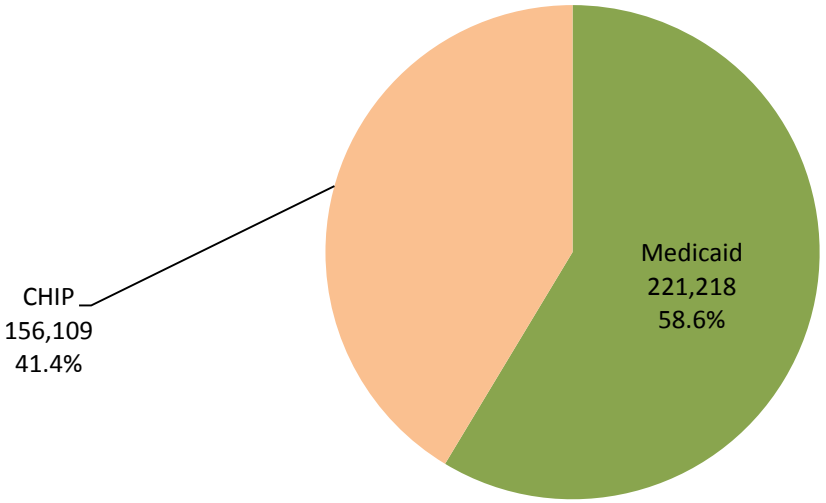
6. ADJUSTED BASELINE SCENARIO #6 WITH MEDICAID EXPANSION: Difference from the adjusted baseline after incorporating the Medicaid Expansion coupled with an adjustment to assume 25% entry rate for Woodworking and a barrier on additional healthcare workers moving into the state to fill jobs. Woodworking values came from EDR. The Medicaid Expansion values from the Social Services Estimating Conference have been updated to reflect new PUMS data and more recent PMPM data. [key features: infusion of federal dollars; redirected state dollars; lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out populations; no job-related migration]

7. ADJUSTED BASELINE SCENARIO #7 WITH MEDICAID EXPANSION: Difference from the adjusted baseline after incorporating the Medicaid Expansion coupled with an adjustment to assume 25% entry rate for Woodworking and a 60% increase in the annual costs implied by the PMPM rates for the Medicaid Expansion and Woodworking entrants. Woodworking and increased Medicaid Expansion values came from EDR. [key features: infusion of federal dollars; redirected state dollars; lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out populations]

8. BREAK-EVEN FUNDING ANALYSIS FOR MEDICAID EXPANSION: Incremental federal funding adjustments to the scenario which incorporates the Medicaid Expansion with no other alterations (Scenario #5) to determine at what point the additional economic benefits are driven to zero. Loss of federal funds are offset through an equal infusion of state funds with overall budget reductions elsewhere. The selected welfare variable to measure the economic benefits is Domestic Consumption by Households and Government.


No Medicaid Expansion Scenario: Initial Population Base
Percent of Federal Poverty Level
250%
200%
150%
100%
50%
0%
138%
689
25,893
129,527
9,671
46,926
92,869
12,762
21,234
571
37,185
Infants
Children (Age 1-5)
Children (Age 6-18)
Children (Age 19-20)
Pregnant Women
SSI
Parents
Childless Adults Age 21+
Bars:
Blue: Medicaid enrolled
Yellow: CHIP
Labels:
Green: Mediciaid eligible, but not enrolled
Orange: CHIP eligible, but not enrolled
Source: US Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample

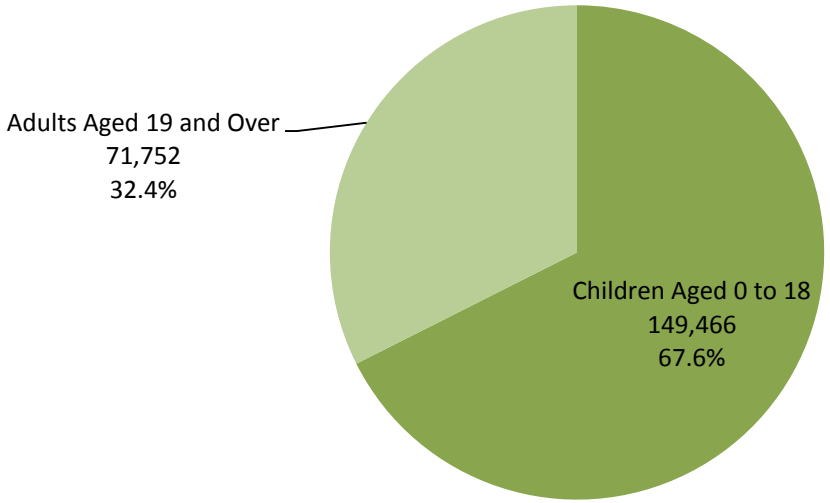
Eligible, but not Enrolled: No Expansion, Initial Population Base



Total: 377,327

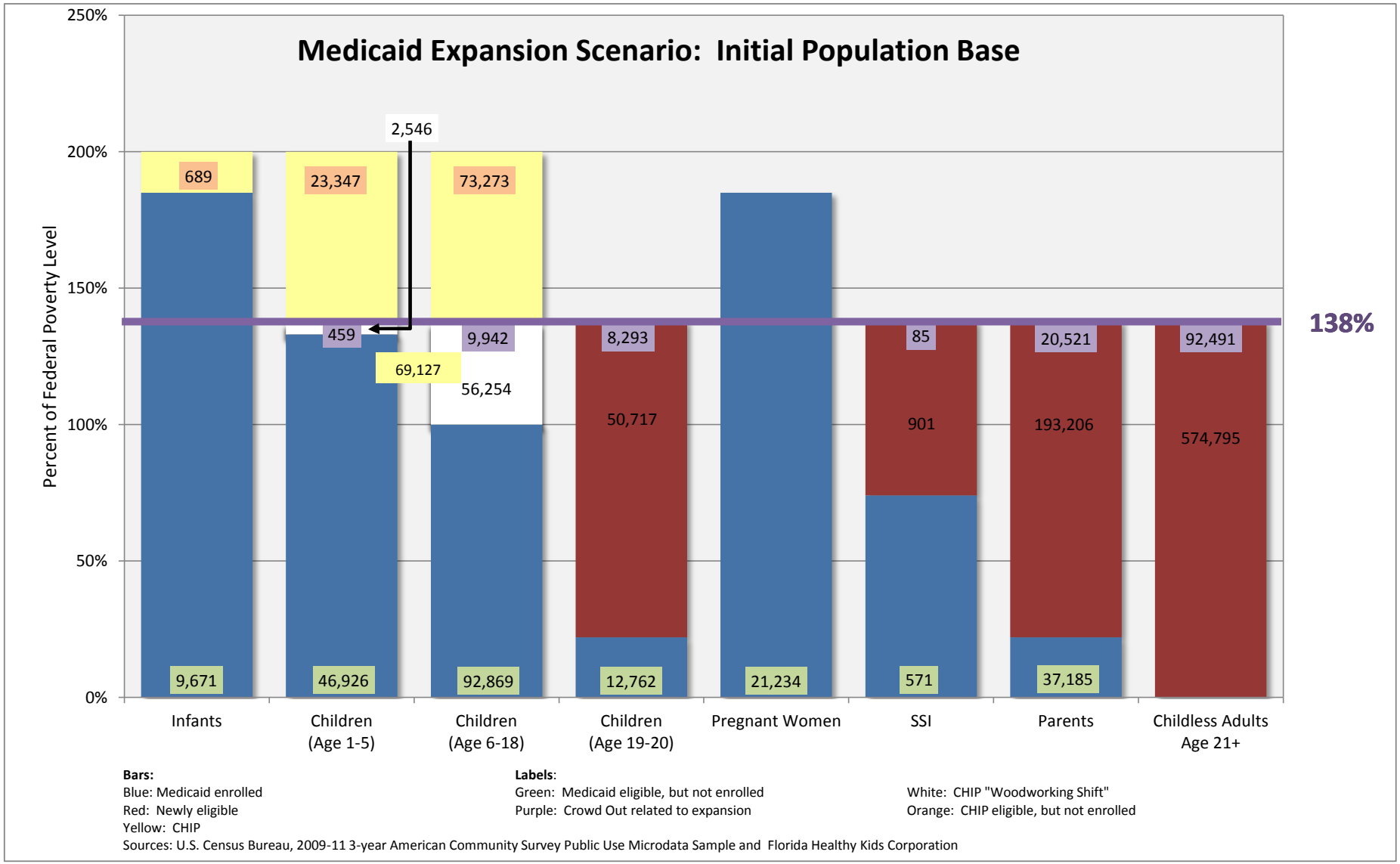
Source: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample

Eligible for Medicaid, but not Enrolled: Initial Population Base

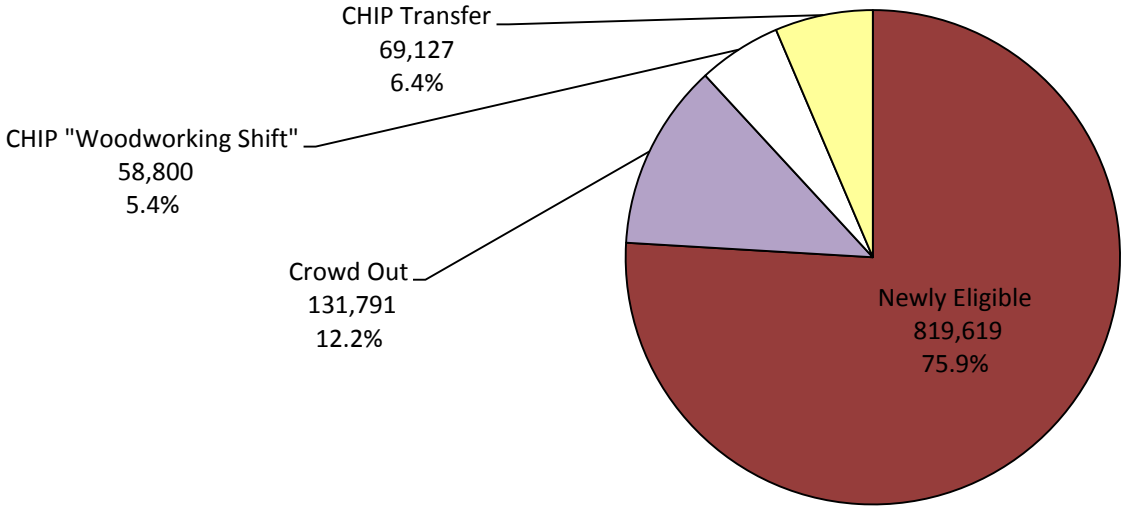


Total: 221,218

Source: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample


Medicaid Expansion Scenario: Initial Population Base
Percent of Federal Poverty Level
250%
200%
150%
100%
50%
0%
138%
2,546
689
23,347
73,273
459
9,942
69,127
56,254
8,293
50,717
85
901
20,521
193,206
92,491
574,795
9,671
46,926
92,869
12,762
21,234
571
37,185
Infants
Children (Age 1-5)
Children (Age 6-18)
Children (Age 19-20)
Pregnant Women
SSI
Parents
Childless Adults Age 21+
Bars:
Blue: Medicaid enrolled
Red: Newly eligible
Yellow: CHIP
Labels:
Green: Medicaid eligible, but not enrolled
Purple: Crowd Out related to expansion
White: CHIP "Woodworking Shift"
Orange: CHIP eligible, but not enrolled
Sources: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample and Florida Healthy Kids Corporation

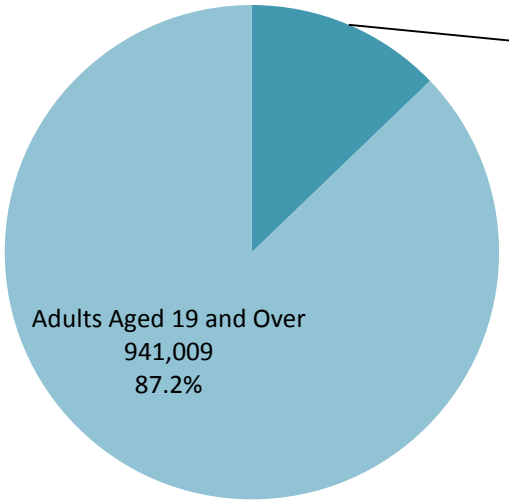
Medicaid Expansion Components: Initial Population Base



Total: 1,079,337

Sources: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample and Florida Healthy Kids Corporation

Medicaid Expansion Impact: Initial Population Base



Total: 1,079,337

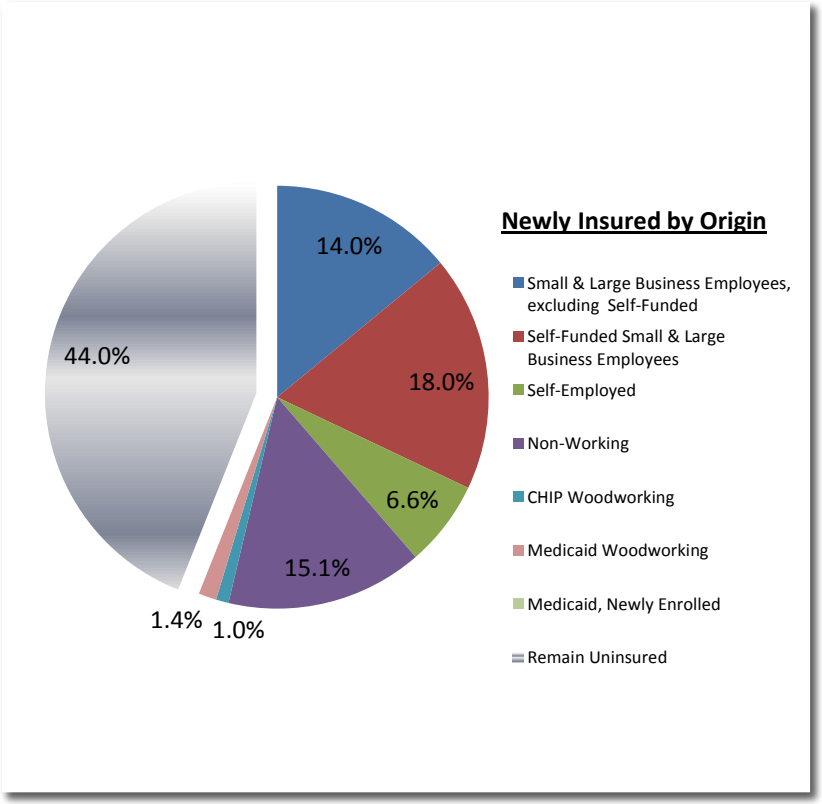
Note: 92.5% of Children Aged 0 to 18 are from CHIP (includes enrolled and those eligible, but not enrolled)

Sources: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample and Florida Healthy Kids Corporation

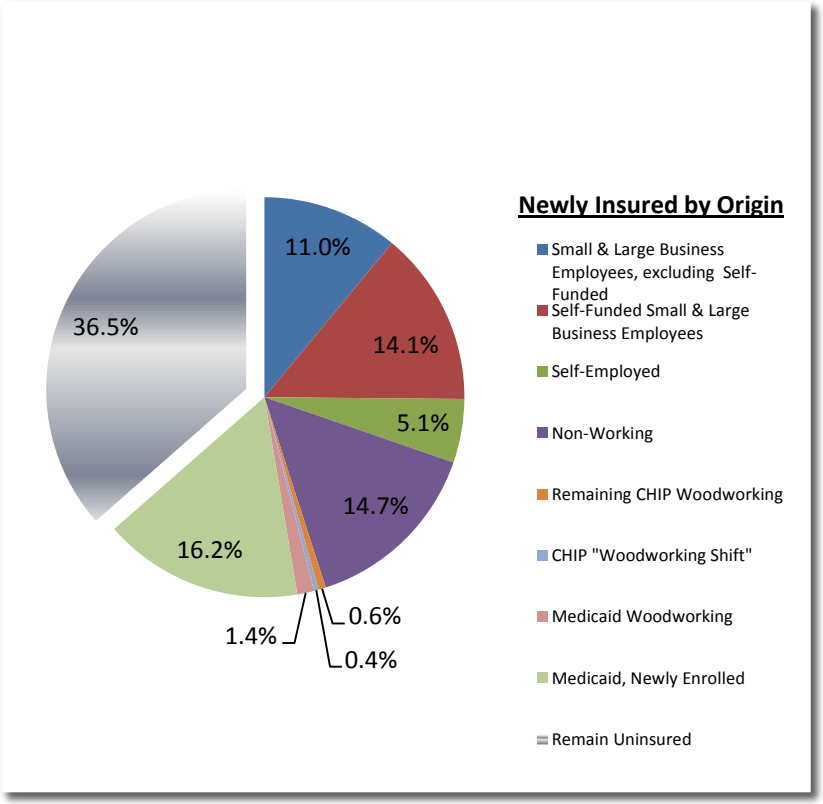
Newly Insured and Uninsured

Percent of Current Uninsured*

Adjusted Baseline with Woodworking**



Adjusted Baseline with Woodworking** and Medicaid Expansion



*4,040,731

** Woodworking are individuals that are currently eligible but not enrolled

Tab 4

Reports

Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies

by Adam Searing and Donna Cohen Ross

Key Findings

- New research shows states that expand Medicaid improve the health of women of childbearing age: increasing access to preventive care, reducing adverse health outcomes before, during and after pregnancies, and reducing maternal mortality rates.
- While more must be done, Medicaid expansion is an important means of addressing persistent racial disparities in maternal health and maternal mortality.
- Better health for women of childbearing age also means better health for their infants. States that have expanded Medicaid under the Affordable Care Act saw a 50 percent greater reduction in infant mortality than non-expansion states.
- The uninsured rate for women of childbearing age is nearly twice as high in states that have not expanded Medicaid compared to those that have expanded Medicaid (16 percent v. 9 percent). States with the highest uninsured rates for women of childbearing age are: Alabama, Alaska, Florida, Georgia, Idaho, Mississippi, Nevada, North Carolina, Oklahoma, South Carolina, Texas and Wyoming. Ten of these twelve states have not expanded Medicaid.

The authors would like to thank the American College of Obstetricians and Gynecologists and the March of Dimes for their contributions to this report.

Introduction

Disruptions in health coverage are associated with adverse health consequences.[1] This is especially true for women in their childbearing years, when a pregnancy means having health coverage is even more important. The stakes are high as the care a woman receives during pregnancy is critical to her own health, as well as to the health of her newborn. In the United States, maternal and infant mortality is higher than most other industrialized nations,[2] lending urgency to strategies to address the overall health of women.[3]

In this paper we review the substantial new research showing the significant improvements in access to health coverage for women of childbearing age achieved through the adoption of the Affordable Care Act's (ACA) Medicaid expansion. Better health coverage is important not just for women who are pregnant but also for women well before they become pregnant and well after childbirth. The American College of Obstetricians and Gynecologists (ACOG) recommends women have access to continuous health coverage in order to increase preventive care, reduce avoidable adverse obstetric and gynecologic health outcomes, increase early diagnosis of disease and reduce maternal mortality rates.[4] Research also finds that Medicaid expansion has an important role in reducing the significant and persistent racial disparities in maternal and infant health. And finally, new studies show that healthier mothers mean healthier infants—another benefit for states that expand Medicaid.

Pre-ACA Medicaid Expansions Focused on Pregnancy Status

Over the past four decades, in response to concerns about high rates of infant mortality and poor birth outcomes, states have increased Medicaid eligibility for pregnant women, making health care during pregnancy significantly more accessible for lower-income women.

While this has been a positive change for both mothers and children, it is only one part of a comprehensive strategy to improve maternal and child health. It has been established that the strong connection between the health of a mother and her baby begins well before pregnancy and continues long past the 60 days of post-partum coverage Medicaid typically provides.[5] This elevates the need for overall good health throughout a woman's childbearing years. Innovative efforts such as the University of North Carolina's 4th Trimester Project, in collaboration with groups like the March of Dimes, are highlighting how increasing coverage is a key part of a comprehensive strategy to improve the health of new mothers.[6]

The Effect of State Medicaid Expansions

Reviews of state data estimate the majority of pregnancy-related deaths are preventable.[7] Expanding access to health coverage is a key strategy for addressing this problem. A growing body of research demonstrates the ACA and implementation of state Medicaid expansions have had positive effects on the health of mothers and their infants. Recent studies show that state Medicaid expansions have helped to reduce the rates of both maternal deaths and infant mortality. Women are getting better health coverage before pregnancy, leading to improved prenatal nutrition and prenatal care. And postpartum coverage has improved for women, helping them get the care they need following the birth of their child. States that have expanded Medicaid also have decreased the likelihood that eligibility for coverage will fluctuate, resulting in losing and regaining coverage over a relatively short span of time, a phenomenon known as "churning." Breaks in health coverage can disrupt care and cause existing health conditions to become more serious and more difficult and expensive to treat.[8]

Pre-ACA Medicaid Expansions for Pregnant Women and Coverage Churn for Women of Childbearing Age

In the late 1980s, prompted by high infant mortality rates, many states expanded Medicaid coverage for pregnant women. The state median income eligibility for pregnant women rose to 185 percent of the federal poverty level (FPL) by 2013 and is now 200 percent FPL.[9] Low-income parents could also obtain Medicaid coverage but at a much lower income level, typically well below 100 percent of FPL. The ACA's coverage changes, and particularly its expansion of Medicaid to both parents and adults without children in the home with incomes below 138 percent FPL, have the potential to change this situation dramatically. But the Supreme Court's decision to make Medicaid expansion optional for states, coupled with ideological objections to Medicaid expansion, led to some states rejecting the option. This has resulted in significant differences across the country in access to health coverage for women of childbearing age. (See Appendix A.)

In non-expansion states, the median Medicaid eligibility level for parents is 40 percent FPL or $8,532 per year for a family of three in 2019. This compares to a minimum parental eligibility level of 138 percent FPL ($29,435 for a family of three) in states that have expanded Medicaid.[10] And women of childbearing age who do not have children under age 19 or are currently not pregnant fare much worse in non-expansion states—they are simply not eligible for Medicaid at all unless they have a serious disability.

Such limited coverage for low-income women means coverage churn is more common in non-expansion states. Research consistently shows women of childbearing age experience high rates of transition between being covered

by different insurance providers or being covered and then becoming uninsured.[11] **While Medicaid's relatively high eligibility levels for pregnant women mean a woman's delivery is often covered, these same lower-income women are at significant risk of being uninsured in the critical months before pregnancy and after delivery.** A recent national study found that half of women who were insured by Medicaid for their delivery were uninsured prior to pregnancy.[12] And of these new mothers, 55 percent experienced another coverage gap in the six months after giving birth. The authors also note that "[t]he well-being of infants can also be negatively affected by their mothers' lack of insurance after delivery. Poor management of maternal mental health adversely affects a child's cognitive, behavioral, and socioemotional development."[13]

Table 1 shows that Medicaid expansion decisions have had a direct impact on the ability of women of childbearing age to obtain health coverage. While the ACA reduced the uninsured rate among women of childbearing age across all states, women living in states refusing the Medicaid expansion have generally experienced much smaller reductions and are more likely to remain uninsured. **States with above average declines in their uninsured rate for women of childbearing age are mainly states that have expanded Medicaid.**

States that have not expanded Medicaid generally do not cover women of childbearing age who do not have a disability if they are not pregnant or are not parents of dependent children. These states generally have extremely low eligibility levels for parents to qualify for Medicaid. For example, in Texas an income of more than $302 a month disqualifies the parents in a family of three from enrolling in Medicaid. See Table 2.

Medicaid Expansion Provides Benefits that Confer Two-Generation Advantages

ACA Medicaid expansions provide women of childbearing age their state's full benefit package for adults. These services can benefit their children, as well. For example:

- Maternal Depression Screening and Treatment. Research estimates that more than half (55 percent) of all infants in families with incomes below the poverty level are being raised by mothers with some form of depression.[a] In addition to the toll depression takes on the mother herself, it also can disrupt the formation of a strong parent-child relationship, which compromises a child's early brain development, with implications for cognitive, social and emotional health. State Medicaid programs must make depression screening without cost-sharing available to women enrolled under Medicaid expansions, and refer women at risk of perinatal depression to counseling. Many states have adopted the option to allow pediatric care providers to conduct maternal depression screenings as part of the well-child visit and also to deliver "dyadic treatment" to mother and child together.[b] In Medicaid expansion states, mothers have access to additional treatments they may need, such as more intensive therapy or medication.
- Tobacco Use Cessation. Medicaid enrollees are about twice as likely as the general U.S. population to smoke tobacco: 32 percent of beneficiaries identify themselves as smokers.[c] The ACA requires that all state Medicaid programs offer comprehensive tobacco cessation benefits without cost-sharing for pregnant women and for populations made newly eligible under Medicaid expansion. Smoking cessation can not only reduce a woman's risk of cardiovascular and respiratory disease, cancer and other chronic conditions, it also decreases the chances of pregnancy-related complications, including preterm birth, low birth weight, and sudden infant death syndrome. When adults quit smoking, they also reduce the likelihood that their children will suffer from exposure to second-hand smoke, which can trigger more frequent and severe asthma attacks and is associated with ear infections and even tooth decay.

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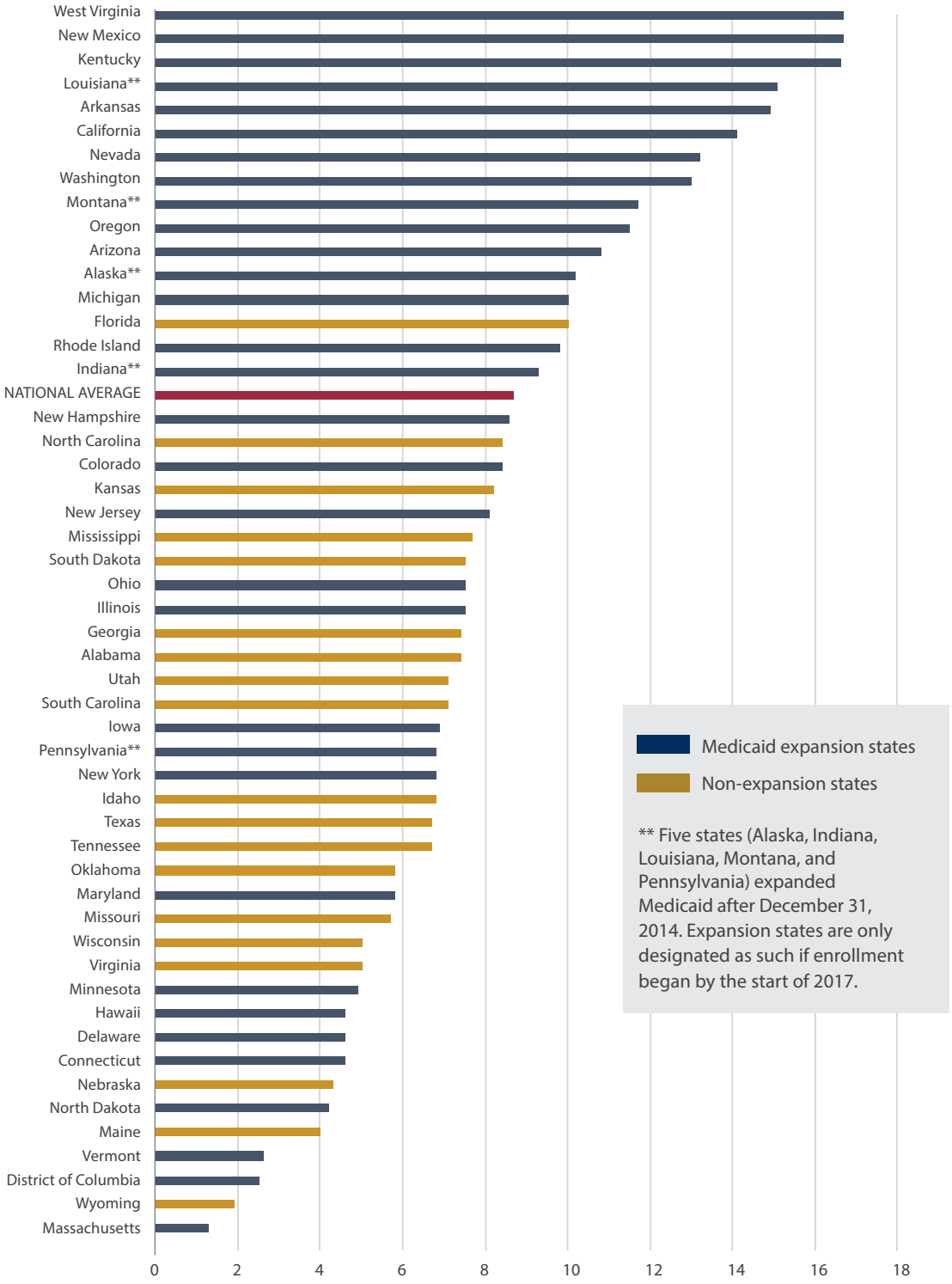
[a] Tracey Veriker, Jennifer Macomber, and Olivia Golden, "Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve," The Urban Institute. August 2010.

[b] "Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children," CMS Informational Bulletin, May 16, 2016.

[c] L. Ku, B. Bruen, S.Steinmetz, and T. Bysshe, "Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit," Health Affairs, Vol. 35, No. 1, January 2016.

Table 1. Percentage Point Decline in the Uninsured Rate for Women of Childbearing Age (18-44), 2013-2017



Source: Data is from a Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) data, 2013 and 2017 single year estimates from the Integrated Public Use Microdata Series (IPUMS).

Table 2. Medicaid Income Eligibility Limit in Non-Expansion States for Adults as a Percentage of the Federal Poverty Level, January 2019

State	Parent upper eligibility limit (in a family of three) – percent of FPL	Parent upper eligibility limit (in a family of three) – monthly dollar amount	Childless adult eligibility limit (for an individual)
Alabama	18%	$320	0%
Florida	32%	$569	0%
Georgia	35%	$622	0%
Idaho*	25%	$444	0%
Kansas	38%	$675	0%
Mississippi	26%	$462	0%
Missouri	21%	$373	0%
Nebraska*	63%	$1,120	0%
North Carolina	42%	$747	0%
Oklahoma	42%	$747	0%
South Carolina	67%	$1,191	0%
South Dakota	49%	$871	0%
Tennessee	95%	$1,689	0%
Texas	17%	$302	0%
Utah*	60%	$1,067	0%
Wisconsin	100%	$1,778	100%
Wyoming	54%	$960	0%

Source: Based on a national survey conducted by Kaiser Family Foundation with the Georgetown University Center for Children on Families, 2019. See here for more information on the survey and this table.

*Idaho and Nebraska voters approved Medicaid expansion but the expansions are not in effect and may be limited. Utah voters also approved a Medicaid expansion but Utah's legislature passed a law limiting the expansion to only some of those originally eligible and capping enrollment at the discretion of the state.

Note: Among reproductive-age women who remained uninsured in 2016, about 20 percent were likely eligible for comprehensive Medicaid or Children's Health Insurance Program (CHIP) coverage based on their income, indicating that outreach and enrollment efforts could help boost participation.[14]

States Rejecting Medicaid Expansion are Missing an Opportunity to Address Stark Racial Disparities in Maternal Health

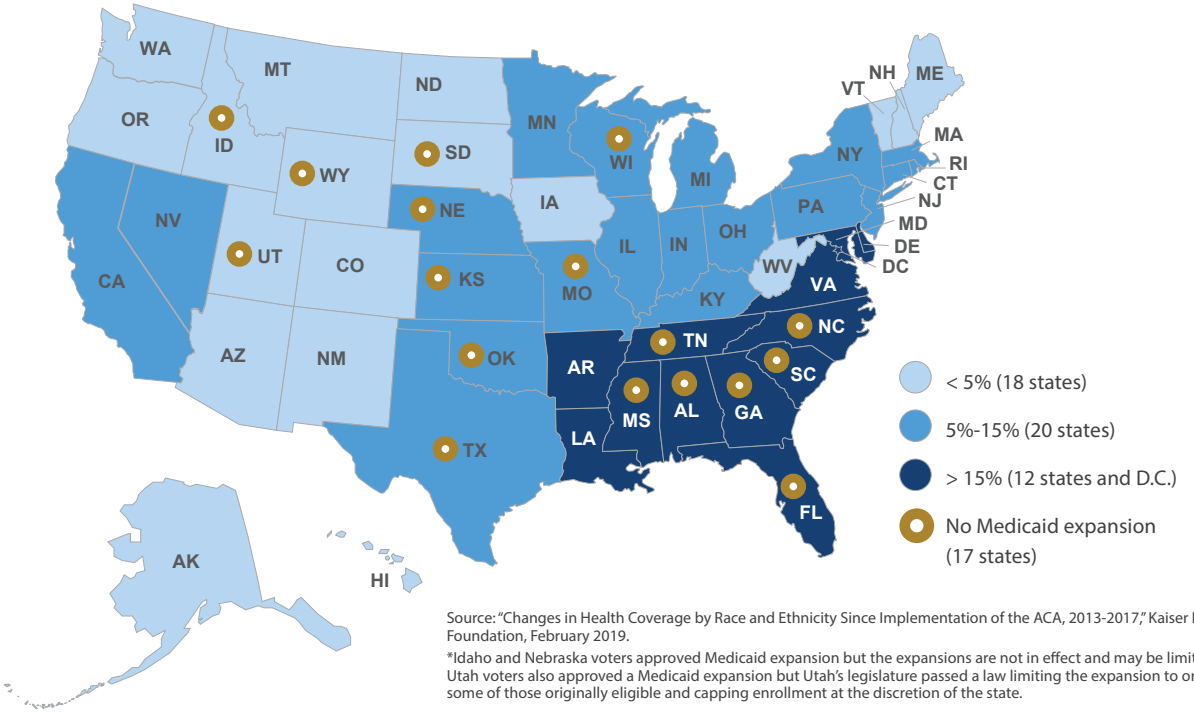
While strategies to increase women's health coverage have had positive effects, especially in states that have expanded Medicaid, stark racial disparities with respect to maternal mortality and maternal health persist. A recent commentary in the Journal of the American Medical Association noted that "African American women are nearly three times as likely to die of complications related to pregnancy and childbirth compared with white women . . . a gap that has not narrowed in decades."[15] The most recent comprehensive study on these disparities in the *American Journal of Obstetrics and Gynecology* found:

> "[B]lack women had a higher adjusted rate of severe maternal morbidity than white women. Our results confirm that the high risk of adverse outcomes faced by black women who give birth in comparison with white women in the United States and are similar to findings by others."[16]

Unsurprisingly, nonelderly adults are much more likely to be uninsured in states that have not expanded Medicaid.[17] Recent data specifically on women of childbearing age are not available, but overall this disparity in uninsured rates is magnified when race is taken into account. For example, the uninsured rate among nonelderly African Americans is 14 percent in states that haven't expanded Medicaid compared to 8 percent in expansion states. Nonelderly white children and adults (ages 0-64) experience lower overall rates of uninsurance: 10 percent in states that haven't expanded Medicaid compared to 6 percent in expansion states.[18] In Southern states, which make up the majority of those that have not expanded Medicaid, African Americans are disproportionately affected and experience higher uninsured rates. This is due in large part to the fact that the states that have not expanded Medicaid have larger shares of black residents.[19]

While multiple factors contribute to improving maternal health, new research is finding Medicaid coverage is a critical piece of the puzzle, especially for addressing racial inequities in access to affordable coverage and care.[20]

Share of Total Population that is Black by State and Current Medicaid Expansion Status



Source: "Changes in Health Coverage by Race and Ethnicity Since Implementation of the ACA, 2013-2017," Kaiser Family Foundation, February 2019.

*Idaho and Nebraska voters approved Medicaid expansion but the expansions are not in effect and may be limited. Utah voters also approved a Medicaid expansion but Utah's legislature passed a law limiting the expansion to only some of those originally eligible and capping enrollment at the discretion of the state.

Medicaid Expansion: Benefits for Women of Childbearing Age

When states decide to expand Medicaid, the resulting gains in coverage provide benefits that promote preventive health practices and can protect women and their children from serious health conditions and even death. Better coverage is the starting point for better care overall. In addition to the well-known advantages of being insured during pregnancy, coordination and quality of care during the pre-pregnancy period and during the postpartum period—sometimes called the "4th trimester"—are especially important.[21]

Several new studies provide insights into the impacts of Medicaid expansion for women of childbearing age including increased health coverage, earlier prenatal care, better overall care, lower rates of maternal mortality and a reduction in infant mortality.

1. Better health coverage for reproductive-age women

Overall, the ACA has had a major impact on increasing coverage for all women of reproductive age. This is due not only to Medicaid expansions but also other coverage changes like the expansion of dependent coverage to young adults up to age 26, the premium tax credit, elimination of pre-existing condition exclusions, and required coverage of maternity care. However, some low-income women are still at risk. Research published in the American Journal of Public Health reported "significant reductions in uninsurance and increases in nongroup private insurance and Medicaid among reproductive-aged women" in the first three years following the ACA's implementation. Across states, the authors identified the ACA as the cause of a 7.4 percentage-point decrease in the probability of uninsurance for reproductive age women. **Low-income women in non-expansion states were identified as a main group still at risk for lack of coverage.**[22]

2. Earlier initiation of prenatal care

The first long-term study examining the effect of pre-ACA Medicaid expansions on women of childbearing age found multiple positive effects. Medicaid expansions improved coverage prior to pregnancy and led to "earlier initiation and improved adequacy of prenatal care among pregnant mothers." Based on the findings, the author concluded that **"More recent state expansions in Medicaid under the ACA have the potential to impact even more women and children as they extend eligibility to all low-income women regardless of parental or pregnancy status."**[23]

3. Better care before women become pregnant

In Ohio, a 2018 study found that after the state's Medicaid expansion there was almost a 12 percentage-point increase in Medicaid enrollment for first-time mothers before they became pregnant. This improved access to proper prenatal care in the first 16 weeks after they became pregnant. **The researchers identified significant increases in the receipt of all recommended health screens and a nearly 14 percentage-point increase in receipt of prenatal vitamins for first-time mothers, compared with increases of 5 and 4 percentage points, respectively, for women with previous pregnancies.** Prenatal vitamins typically contain more iron and folic acid than standard adult multivitamins. They help prevent anemia during pregnancy and neural tube birth defects (such as spina bifida), which compromise a baby's brain and spinal cord development. While the authors caution the results also depend on other factors, including some unique to Ohio, the benefits for lower-income women in the state are clear after Medicaid expansion.[24]

4. Lower rates of maternal mortality

Findings from a study presented at the AcademyHealth National Health Policy Conference in February 2019 showed a link between implementation of Medicaid expansion under the ACA and lower rates of maternal mortality. An analysis of data from 1999 to 2016 from the National Center for Health Statistics compared maternal mortality rates in Medicaid expansion states with rates in states that did not expand. The study found that Medicaid expansion was associated with lower rates of maternal mortality, reflecting 1.6 fewer maternal deaths per 100,000 women. The researchers suggest that the reduction in maternal death rates is associated with women having increased access to Medicaid prior to pregnancy, which presented the opportunity to address pre-pregnancy risk factors such as obesity, diabetes and heart disease and also to begin prenatal care in a timely manner.[25]

5. Reductions in infant mortality

A study released in 2018 examined Medicaid expansions under the Affordable Care Act and their effect on the infant mortality rate in the United States. The researchers point out that since Medicaid covers a large proportion of maternal, infant, and child health care, as well as specific services related to pregnancy, maternity, pediatric care, chronic disease management, breastfeeding support, contraception, mental health and substance use disorder screening and treatment, and other behavioral health services; **"Medicaid expansion may be among the most important ways in which the ACA could improve maternal and child health indicators, such as the infant mortality rate."** Their analysis found that the infant mortality rate declined in both Medicaid expansion and non-expansion states between 2010 and 2016, however, **the decline in Medicaid expansion states was more than 50 percent greater than in non-expansion states.** The research also showed that the decline in infant mortality rates linked to Medicaid expansion were greatest among African American infants, which drove the overall decline and helped to substantially reduce the racial disparity in infant mortality rates.[26] And this improvement was not limited to overall infant mortality. Another recently released study examining the effect of state Medicaid expansions on overall birth outcomes found that while the rates of preterm birth and low birth weight did not show a change, there were significant improvements for African American infants relative to white infants. State Medicaid expansion was associated with "significant improvements in disparities for black infants relative to white infants for the four outcomes studied, including preterm birth, very preterm birth, low birth weight, and very low birth weight."[27]

Conclusion

Medicaid expansion under the Affordable Care Act offers affordable, comprehensive health coverage to women who would likely otherwise go without access to needed care. Most states have longstanding, generous Medicaid coverage for pregnant women, however, the pre-pregnancy coverage churn and post-partum (or "4th trimester") coverage gaps leave women without a full continuum of care. Prior to pregnancy, this can mean a significant missed opportunity to attend to health issues that pose high risks during pregnancy for mother and child. Similarly, a sudden plunge into uninsured status after the Medicaid post-partum period of 60 days can force women to abandon medication or other ongoing treatment they may need. And despite improved coverage during pregnancy, troubling racial maternal and infant health disparities persist, especially in Medicaid non-expansion states.

Recent studies show that Medicaid expansion has increased coverage rates for women during the childbearing years, has reduced the rate of women of childbearing age who are uninsured, and has improved health outcomes. Medicaid expansion has also played a role in reducing rates of maternal death, decreasing infant mortality rates, and improving the potential for optimal birth outcomes that can increase the prospects for a healthy childhood. Finally, it is clear if the remaining non-expansion states want to address significant racial disparities in maternal and infant health, expanding Medicaid is a critical first step.

Additional research could further illuminate the value of Medicaid expansion for women and their children. Many of the benefits Medicaid provides—smoking cessation treatment, treatment for substance use disorders, maternal depression screening and treatment, oral healthcare and other benefits—are likely to have positive two-generation impacts on women and their children.

Appendix A. Medicaid Income Eligibility Limit for Adults as a Percent of the FPL, January 2019

State	Parent upper eligibility limit (in a family of three) – percent of FPL	Parent upper eligibility limit (in a family of three) – monthly dollar amount	Childless adult eligibility limit (for an individual)
Alabama	18%	$320	0%
Alaska	138%	$3,066	138%
Arizona	138%	$2,453	138%
Arkansas	138%	$2,453	138%
California	138%	$2,453	138%
Colorado	138%	$2,453	138%
Connecticut	155%	$2,755	138%
Delaware	138%	$2,453	138%
District of Columbia	221%	$3,928	215%
Florida	32%	$569	0%
Georgia	35%	$622	0%
Hawaii	138%	$2,822	138%
Idaho*	25%	$444	0%
Illinois	138%	$2,453	138%
Indiana	139%	$2,471	139%
Iowa	138%	$2,453	138%
Kansas	38%	$675	0%
Kentucky	138%	$2,453	138%
Louisiana	138%	$2,453	138%
Maine**	138%	$2,453	138%
Maryland	138%	$2,453	138%
Massachusetts	138%	$2,453	138%
Michigan	138%	$2,453	138%
Minnesota	138%	$2,453	138%
Mississippi	26%	$462	0%
Missouri	21%	$373	0%
Montana	138%	$2,453	138%
Nebraska*	63%	$1,120	0%
Nevada	138%	$2,453	138%
New Hampshire	138%	$2,453	138%
New Jersey	138%	$2,453	138%
New Mexico	138%	$2,453	138%
New York	138%	$2,453	138%
North Carolina	42%	$747	0%
North Dakota	138%	$2,453	138%
Ohio	138%	$2,453	138%
Oklahoma	42%	$747	0%
Oregon	138%	$2,453	138%
Pennsylvania	138%	$2,453	138%
Rhode Island	138%	$2,453	138%
South Carolina	67%	$1,191	0%
South Dakota	49%	$871	0%
Tennessee	95%	$1,689	0%
Texas	17%	$302	0%
Utah*	60%	$1,067	0%
Vermont	138%	$2,453	138%
Virginia**	138%	$2,453	138%
Washington	138%	$2,453	138%
West Virginia	138%	$2,453	138%
Wisconsin	100%	$1,778	100%
Wyoming	54%	$960	0%

Non-expansion states

Source: Based on a national survey conducted by Kaiser Family Foundation with the Georgetown University Center for Children on Families, 2019. See here and here for more information on the survey and this table.

* Idaho and Nebraska voters approved Medicaid expansions but the expansions are not in effect and may be limited.

** Medicaid expansions in Maine and Virginia did not go into effect until 2019.

Appendix B. Uninsured Rates by State for Women of Child-Bearing Age (18-44), Comparing Rates for 2013 and 2017

Region	Uninsured Percent 2013 for Women Ages 18-44	Uninsured Percent 2017 for Women Ages 18-44	Percentage Point Change 2013-2017
US Total	21.0	12.3	-8.7
Alabama	23.0	15.6	-7.4
Alaska	25.5	15.3	-10.2
Arizona	24.2	13.4	-10.8
Arkansas	26.3	11.4	-14.9
California	23.4	9.3	-14.1
Colorado	18.6	10.2	-8.4
Connecticut	12.1	7.5	-4.6
Delaware	12.7	8.1	-4.6
District of Columbia	5.5	3.0	-2.5
Florida	29.0	19	-10.0
Georgia	27.5	20.1	-7.4
Hawaii	9.8	5.2	-4.6
Idaho	24.4	17.6	-6.8
Illinois	17.2	9.7	-7.5
Indiana	21.0	11.7	-9.3
Iowa	12.7	5.8	-6.9
Kansas	20.2	12.0	-8.2
Kentucky	24.0	7.4	-16.6
Louisiana	25.9	10.8	-15.1
Maine	15.8	11.8	-4.0
Maryland	13.9	8.1	-5.8
Massachusetts	4.6	3.3	-1.3
Michigan	16.4	6.4	-10.0
Minnesota	10.8	5.9	-4.9
Mississippi	26.2	18.5	-7.7
Missouri	19.6	13.9	-5.7
Montana	23.7	12.0	-11.7
Nebraska	16.8	12.5	-4.3
Nevada	29.0	15.8	-13.2
New Hampshire	16.5	7.9	-8.6
New Jersey	19.7	11.6	-8.1
New Mexico	29.8	13.1	-16.7
New York	14.2	7.4	-6.8
North Carolina	24.1	15.7	-8.4
North Dakota	14.4	10.2	-4.2
Ohio	15.1	7.6	-7.5
Oklahoma	27.2	21.4	-5.8
Oregon	20.8	9.3	-11.5
Pennsylvania	13.9	7.1	-6.8
Rhode Island	15.8	6.0	-9.8
South Carolina	23.9	16.8	-7.1
South Dakota	19.8	12.3	-7.5
Tennessee	18.9	12.2	-6.7
Texas	32.2	25.5	-6.7
Utah	18.3	11.2	-7.1
Vermont	8.0	5.4	-2.6
Virginia	17.4	12.4	-5.0
Washington	21.4	8.4	-13.0
West Virginia	24.6	7.9	-16.7
Wisconsin	11.8	6.8	-5.0
Wyoming	19.4	17.5	-1.9

Source: Data is from a Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) data, 2013 and 2017 single year estimates from the Integrated Public Use Microdata Series (IPUMS).

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Association of Medicaid Expansion With Cardiovascular Mortality

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IMPORTANCE Medicaid expansion under the Patient Protection and Affordable Care Act led to one of the largest gains in health insurance coverage for nonelderly adults in the United States. However, its association with cardiovascular mortality is unclear.

OBJECTIVE To investigate the association of Medicaid expansion with cardiovascular mortality rates in middle-aged adults.

DESIGN, SETTING, AND PARTICIPANTS This study used a longitudinal, observational design, using a difference-in-differences approach with county-level data from counties in 48 states (excluding Massachusetts and Wisconsin) and Washington, DC, from 2010 to 2016. Adults aged 45 to 64 years were included. Data were analyzed from November 2018 to January 2019.

EXPOSURES Residence in a Medicaid expansion state.

MAIN OUTCOMES AND MEASURES Difference-in-differences of annual, age-adjusted cardiovascular mortality rates from before Medicaid expansion to after expansion.

RESULTS As of 2016, 29 states and Washington, DC, had expanded Medicaid eligibility, while 19 states had not. Compared with counties in Medicaid nonexpansion states, counties in expansion states had a greater decrease in the percentage of uninsured residents at all income levels (mean [SD], 7.3% [3.2%] vs 5.6% [2.7%]; $P < .001$) and in low-income strata (19.8% [5.5%] vs 13.5% [3.9%]; $P < .001$) between 2010 and 2016. Counties in expansion states had a smaller change in cardiovascular mortality rates after expansion (146.5 [95% CI, 132.4-160.7] to 146.4 [95% CI, 131.9-161.0] deaths per 100 000 residents per year) than counties in nonexpansion states did (176.3 [95% CI, 154.2-198.5] to 180.9 [95% CI, 158.0-203.8] deaths per 100 000 residents per year). After accounting for demographic, clinical, and economic differences, counties in expansion states had 4.3 (95% CI, 1.8-6.9) fewer deaths per 100 000 residents per year from cardiovascular causes after Medicaid expansion than if they had followed the same trends as counties in nonexpansion states.

CONCLUSIONS AND RELEVANCE Counties in states that expanded Medicaid had a significantly smaller increase in cardiovascular mortality rates among middle-aged adults after expansion compared with counties in states that did not expand Medicaid. These findings suggest that recent Medicaid expansion was associated with lower cardiovascular mortality in middle-aged adults and may be of consideration as further expansion of Medicaid is debated.

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Supplemental content

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The Patient Protection and Affordable Care Act (ACA) led to the largest expansion of Medicaid coverage since the inception of the program.[1] Under the ACA, beginning in 2014, all nonelderly US citizens and permanent residents (with more than 5 years of residency) with an income up to 138% of the federal poverty level (FPL) became eligible for Medicaid. However, a number of states have not expanded eligibility for Medicaid, and there is continued debate regarding further changes in eligibility criteria.[2,3]

Observational studies have demonstrated that prior efforts to expand health insurance coverage in individual states were associated with improved health outcomes, including lower mortality rates.[4,5] However, a single-state randomized clinical trial of Medicaid expansion did not show conclusive evidence of improvements in several intermediate health measures.[6] In a recent analysis of patients with end-stage renal disease, Medicaid expansion was associated with lower all-cause mortality.[7]

Cardiovascular disease and its risk factors disproportionately affect individuals of lower socioeconomic status and those who are uninsured.[8,9] Since Medicaid expansion has been associated with improvements in the management of diabetes,[10] increased use of cardioprotective medications,[11] and access to preventive care,[12] expansion in health insurance coverage may have a potential association with cardiovascular disease and mortality. Medicaid expansion has also been associated with fewer cardiovascular hospitalizations without insurance.[13] However, studies of in-hospital cardiovascular outcomes have not shown a significant association with Medicaid expansion.[14,15] It is unclear whether Medicaid expansion has had an association with overall cardiovascular mortality rates in the population. The aim of this analysis was therefore to assess whether there have been differential changes in cardiovascular mortality rates in nonelderly adults living in states that expanded Medicaid eligibility compared with those in states that did not expand Medicaid eligibility between 2010 and 2016.

Key Points

Question Has the expansion of Medicaid eligibility under the Affordable Care Act been associated with any differences in cardiovascular mortality rates?

Findings In this difference-in-differences analysis, states that expanded eligibility for Medicaid had a significantly smaller increase in rates of cardiovascular mortality for middle-aged adults after expansion than states that did not expand Medicaid.

Meaning Medicaid expansion was associated with lower cardiovascular mortality and may be an important consideration for states debating expansion of Medicaid eligibility.

Methods

Data Sources

Because Medicaid coverage expansion has a greater outcome on individuals younger than 65 years and cardiovascular diseases are more prevalent in older adults,[16] we focused this study on cardiovascular mortality rates among adults 45 to 64 years of age. We obtained annual, county-level cardiovascular mortality rates, age-adjusted to the 2000 US population, from the Centers for Disease Control and Prevention's Wide-ranging Online Data for Epidemiologic Research mortality database from 2010 to 2016 for all 50 states and Washington, DC.[17] Causes of deaths were limited to diseases of the circulatory system (*International Classification of Diseases, 10th Revision* codes I00 to I99). Counties with fewer than 10 deaths per year are censored from the publicly visible version of the Wide-ranging Online Data for Epidemiologic Research database and were not included in this analysis. Because all the data analyzed are publicly available and aggregated at the county or state level, the project is considered exempt from institutional review board review based on guidelines from the University of Pennsylvania institutional review board. Informed consent was not obtained because of the aggregate and deidentified nature of the data.

Data on county-level percentages of residents who were female, black (non-Hispanic black, either alone or in combination with other races), Hispanic, living in poverty, and unemployed were obtained from the US Census Bureau and the Bureau of Labor Statistics.[18-20] Additionally, the median inflation-adjusted household income (in 2016 dollars) was obtained. Percentage of residents with health insurance was also obtained from the US Census Bureau and was aggregated for residents aged 40 to 64 years.[21] The number of primary care clinicians and cardiologists per 100 000 residents was obtained from the Health Resources and Services Administration Area Health Resource File.[22] Because data for cardiologists were only available for the years 2010, 2015, and 2016, the population density of cardiologists in 2010 was assigned to all years from 2010 to 2014. Diabetes, obesity, and smoking prevalence at baseline were based on the Behavioral Risk Factor Surveillance System.[23]

Outcome Measure

The primary outcome measure was county-level, age-adjusted cardiovascular mortality rates per 100 000 adults aged 45 to 64 years. As sensitivity measures, we also examined cardiovascular mortality rates of residents aged 25 to 64 years and 65 to 74 years.

Study Design and Intervention

We used a quasiexperimental study design based on a difference-in-differences (DID) estimator. This approach aims to isolate the association of an intervention in observational data by comparing differences in an outcome over time between groups that received an intervention vs groups that did not.[24]

The main intervention of interest was the expansion of Medicaid eligibility under the ACA. The following states expanded Medicaid eligibility effective January 1, 2014: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia.[25] Another 6 states expanded eligibility at a later date: Michigan (April 1,

2014), New Hampshire (August 15, 2014), Pennsylvania (January 1, 2015), Indiana (February 1, 2015), Alaska (September 1, 2015), and Montana (January 1, 2016). The remainder of the states were designated as nonexpansion states. Owing to prior Medicaid eligibility expansion in Massachusetts and coverage of adults up to 100% of the FPL in Wisconsin, these 2 states were excluded from the main analysis. Another 6 states (California, Connecticut, District of Columbia, Minnesota, New Jersey, and Washington) had limited expansions of Medicaid eligibility after the passage of the ACA but prior to 2014. These states were included in the main analysis but were excluded in a sensitivity analysis along with the 6 late-adopter states.

The years 2010 through 2013 were designated as the preexpansion period and 2014 through 2016 were the postexpansion period for most of the states. For the states that expanded Medicaid eligibility later than 2014, the postexpansion period began in the year expansion was implemented (ie, 2015 for New Hampshire, Pennsylvania, and Indiana, and 2016 for Alaska and Montana). States that expanded Medicaid after the beginning of the calendar year had the entire year designated as a postexpansion year.

Analysis

We first compared county-level variables between counties in states that expanded Medicaid eligibility and those that did not, using the *t* test and Pearson χ^2 test. We then estimated cardiovascular mortality rates for each of the study years separately for expansion and nonexpansion counties using a multilevel linear regression model with county fixed effects and random intercepts for each state. Huber-White heteroskedasticity-robust standard errors were calculated, accounting for clustering at the state level and autocorrelation of repeated measures across years. We then estimated adjusted mortality rates by including the following covariates: the 2013 National Center for Health Statistics Urban-Rural Classification designation (metropolitan vs nonmetropolitan county), the percentages of residents aged 45 to 64 years who were female, black, and Hispanic; the percentages of residents living in poverty and unemployed; the percentages of adult residents with diabetes and obesity in 2010; the percentage of adult residents who smoke in 2010; the percentage of residents aged 40 to 64 years with income less than 138% of the FPL who had health insurance in 2010; the median household income; the number of primary care clinicians per 100 000 residents; and the number of cardiologists per 100 000 residents.

To test the association of Medicaid expansion on mortality, we constructed another linear regression model with the same structure and added an indicator for Medicaid expansion status, an indicator for the preexpansion or postexpansion period, and an interaction term between expansion status and period as the independent variables in the model (eMethods 1 in the Supplement). The interaction term is the DID estimator. An indicator variable for the year was also included to account for the variation in years in which different states entered the postexpansion period. We repeated this model with the addition of previously mentioned county-level covariates. We then analyzed some subgroups of interest: metropolitan and nonmetropolitan counties, counties in which more than 10% of residents aged 45 to 64 years were black in 2010, counties in the top 50th percentile for the percentage of residents living in poverty in 2010, counties in the top 50th percentile of cardiovascular mortality in 2010, and counties in the top and bottom 50th percentiles for percentage of residents with low income aged 40 to 64 years without health insurance in 2010. We also repeated the DID analysis separately for the top and bottom 50th percentiles of the absolute change in the number of low-income residents with health insurance between 2010 and 2016.

We also conducted some sensitivity analyses. These included using cardiovascular mortality of individuals aged 65 to 74 years as the outcome, because this age group was not primarily affected by Medicaid expansion. Other analyses included excluding all early-adopter and late-adopter states and using data aggregated at the state level (to include deaths that were censored from the county-level analysis). We also tested the assumption that time trends were similar between the 2 groups prior to Medicaid expansion. Details are presented in eMethods 3, eTable 4, and eTable 5 in the Supplement.

Because the primary unit of measurement was at the county level and the variance of each aggregate point estimate is a function of its underlying population size,[26] we weighted all of these analyses with the county population of residents aged 45 to 64 years. Data are presented as means with SDs or 95% CIs or medians and interquartile ranges (IQR), as indicated. All *P* values were 2-sided, and *P* values of .05 or less were considered statistically significant. Analyses were conducted using SAS version 9.4 (SAS Institute).

Results

Baseline County Characteristics

Counties in 29 expansion states plus Washington, DC, were included in the intervention (expansion) group, while counties in 19 nonexpansion states were in the control (nonexpansion) group. After excluding censored counties with fewer than 10 deaths per year, the number of counties included ranged between 902 to 931 in expansion states and 985 to 1029 for nonexpansion states over the study period (**Table 1**). Censored counties accounted for less than 5% of the total 79.7 million middle-aged adults living in the included states. Expansion counties were less likely to be in the Southern US Census region compared with nonexpansion counties (200 [21.9%] vs 836 [84.1%]; *P* < .001). In 2010, counties in expansion states had a higher median population (16 595 [IQR, 9030-42 640] vs 11 114.5 [IQR, 6514-25 225]; *P* < .001). The percentage of black residents was lower (mean [SD], 9.6% [11.1%] vs 16.5% [14.0%]; *P* < .001) in counties in expansion states, with no significant difference in the percentage of Hispanic residents. In 2010, expansion counties also had a lower prevalence of diabetes (mean [SD], 8.5 % [1.5%] vs 9.7% [1.6%]; *P* < .001), obesity (mean [SD], 26.2% [4.6%] vs 29.1% [4.2%]; *P* < .001), and smoking (mean [SD], 17.1% [4.7%] vs 18.9% [5.2%]; *P* < .001); a lower percentage of poor residents (mean [SD], 14.4% [5.0%] vs 16.6% [5.4%]; *P* < .001); and a higher median house-

Table 1. County-Level Characteristics

Characteristic	Mean (SD)		P Value
	Medicaid Expansion States	Medicaid Nonexpansion States	
States, No.	30[a]	19	NA
Counties included, No.			
2010	912	994	
2011	902	989	
2012	905	992	
2013	923	985	NA
2014	923	1013	
2015	918	1012	
2016	931	1029	
US census region, %			
South	21.9	84.1	<.001
Northeast	18.9	1.5	<.001
Midwest	39.3	11.5	<.001
West	20.0	2.9	<.001
Nonmetropolitan counties, %	48.0	50.9	.21
Residents aged 45-64 y per county in 2010, median (IQR)[b]	16 595 (9030-42 640)	11 114.5 (6514-25 225)	<.001
County residents aged 45-64 y without insurance, %			
In 2010	14.6 (5.1)	19.5 (6.0)	<.001
Change in percentage, 2010-2016	7.3 (3.2)	5.6 (2.7)	<.001
County residents aged 45-64 y without insurance with income <138% of the federal poverty line, %			
In 2010	35.6 (8.0)	44.9 (7.9)	<.001
Percentage change, 2010-2016	19.8 (5.5)	13.5 (3.9)	<.001
Demographic attributes in county residents aged 45-64 y in 2010, %			
Female	51.2 (1.2)	51.5 (1.4)	<.001
Black	9.6 (11.1)	16.5 (14.0)	<.001
Hispanic	11.4 (12.0)	11.0 (16.2)	.57
Attributes of county residents in 2010, %			
Unemployed adults	10.1 (2.5)	9.5 (2.3)	<.001
In poverty	14.4 (5.0)	16.6 (5.4)	<.001
With diabetes	8.5 (1.5)	9.7 (1.6)	<.001
With obesity	26.2 (4.6)	29.1 (4.2)	<.001
Smoking	17.1 (4.7)	18.9 (5.2)	<.001
County household income in 2010, median (IQR), $[c]	57 653.6 (49 490.3-69 431.4)	50 369.4 (44 279.8-57 251.0)	<.001
Clinicians per 100 000 residents in 2010			
Primary care clinicians	78.3 (27.7)	65.7 (25.3)	<.001
Cardiologists	7.7 (6.4)	6.6 (5.3)	<.001

Abbreviations: IQR, interquartile range; NA, not available.

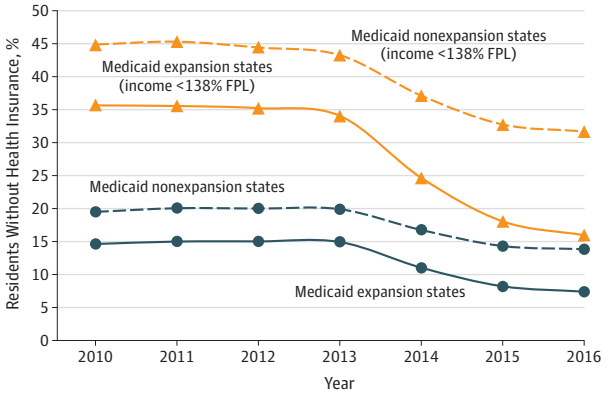
[a] Included 29 states and Washington, DC.

[b] Summary measure not weighted by county population.

[c] In 2016 dollars.

hold income (median [IQR], $57 653.60 [$49 490.30-$69 431.40] vs $50 369.40 [$44 279.80-$57 251.00]; $P < .001$) than nonexpansion counties.

Figure 1. Percentage of Residents Aged 40 to 64 Years Without Health Insurance Coverage



FPL indicates the federal poverty line.

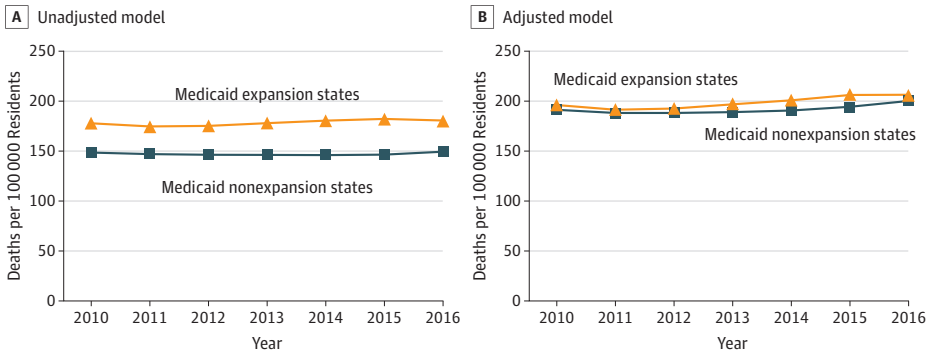
Health Insurance Coverage

In 2010, the proportions of residents aged 40 to 64 years without health insurance coverage were significantly lower in expansion counties than in nonexpansion counties for all income levels (mean [SD], 14.6% [5.1%] vs 19.5% [6.0%]; $P < .001$) and among those with income less than 138% of the FPL who were without insurance (mean [SD], 35.6% [8.0%] vs 44.9% [7.9%]; $P < .001$) (Table 1). Health insurance coverage for both groups of counties was relatively stable between 2010 and 2013 (**Figure 1** and eTable 1 in the Supplement). Between 2010 and 2016, there was a larger decrease in the percentages of residents aged 40 to 64 years without insurance in counties in expansion states compared with nonexpansion states at all income levels (mean [SD], 7.3% [3.2%] vs 5.6% [2.7%]; $P < .001$) and in residents with low income who were without insurance (mean [SD], 19.8% [5.5%] vs 13.5% [3.9%]; $P < .001$).

Cardiovascular Mortality Rates

Age-adjusted cardiovascular mortality rates for residents aged 45 to 64 years were significantly lower in counties in expansion states compared with counties in nonexpansion states between 2010 (147.9 [95% CI, 134.0-161.9] vs 177.6 [95% CI, 155.3-199.9] deaths per 100 000 residents per year) and 2013 (145.6 [95% CI, 131.4-159.8] vs 177.8 [95% CI, 154.7-200.8] deaths per 100 000 residents per year), but overall trends were similar between the 2 groups prior to expansion (**Figure 2**; eTable 2 and eTable 4 in the Supplement). Accounting for differences in the previously mentioned covariates significantly reduced the differences between the 2 groups (2010: expansion counties, 190.7 [95% CI, 181.5-200.0] deaths per 100 000 residents per year for vs nonexpansion counties; 195.3 [95% CI, 184.9-205.8] deaths per 100 000 residents per year for nonexpansion counties). The differences between the 2 groups increased in 2014 and 2015 and narrowed again in 2016 (adjusted cardiovascular mortality: expansion counties, 2014, 190.1 [95% CI, 180.4-199.8] vs nonexpansion counties, 199.8 [95% CI, 188.4-211.1] deaths per 100 000 residents per year; 2015: 193.6 [95% CI, 183.8-203.5] vs 204.9 [95% CI, 192.8-216.9] deaths per 100 000 residents per year; 2016: 199.2 [95% CI, 188.6-209.8] vs 205.1

Figure 2. Annual Cardiovascular Mortality Rates in Residents Aged 45 to 64 Years by State Medicaid Expansion Status



[95% CI, 193.5-216.7] deaths per 100 000 residents per year; eMethods 2 and eTable 3 in the Supplement).

Difference-in-Differences Estimates

In counties in expansion states, cardiovascular mortality was stable between the preexpansion and postexpansion periods (146.5 [95% CI, 132.4-160.7] to 146.4 [95% CI, 131.9-161.0] deaths per 100 000 residents per year) (**Table 2**). There was an increase in cardiovascular mortality rates in nonexpansion counties between the preexpansion and postexpansion periods (176.3 [95% CI, 154.2-198.5] to 180.9 [95% CI, 158.0-203.8] deaths per 100 000 residents per year). The unadjusted and adjusted DID estimates comparing expansion vs nonexpansion counties were −4.6 (95% CI, −7.5 to −1.8; $P = .001$) and −4.3 (95% CI, −6.9 to −1.8; $P = .001$), respectively. Therefore, after accounting for differences in demographic, clinical, economic, and health access variables, counties in expansion states had 4.3 (95% CI, 1.8-6.9) fewer deaths from cardiovascular causes per 100 000 residents per year after Medicaid expansion compared with the deaths that would have occurred if they had followed the same trajectory as seen in counties in nonexpansion states. Among the included counties in expansion states, which had a population of 47.4 million middle-aged adults in 2014; this translates to a total of 2039 (95% CI, 853-3271) fewer total deaths per year in residents aged 45 to 64 years from cardiovascular causes after Medicaid expansion.

Subgroup and Sensitivity Analyses

In the subgroup analyses, the adjusted DID estimate was attenuated but statistically significant in metropolitan counties (−3.7 [95% CI, −6.3 to −1.2]; $P = .005$; Table 2). The adjusted DID estimate was larger for nonmetropolitan counties but not significantly so (−6.2 [95% CI, −12.5 to 0.10]; $P = .05$). The DID estimate was also larger for counties in the top 50th percentile for residents living in poverty in 2010 (−5.3 [95% CI, −9.0 to −1.6]; $P = .01$). The adjusted DID estimate was more prominent for counties in the bottom 50th percentile for baseline percentage of uninsured residents (−7.5 [95% CI, −12.0 to −3.0]; $P = .001$) compared with counties in the top 50th percentile (−3.4 [95% CI, −6.6 to −0.2]; $P = .04$).

The adjusted DID estimate was significant when comparing the top 50th percentile of expansion counties for change in the number of residents with low income and health insurance with all nonexpansion counties (−4.8 [95% CI, −7.5 to −2.2]; $P < .001$) (**Table 3**). However, the DID estimate was not significant when comparing the bottom 50th percentile of expansion counties with all nonexpansion counties. The DID estimate was more prominent when comparing all expansion counties with the bottom 50th percentile of nonexpansion counties for change in the number of residents with low income and health insurance (−12.2 [95% CI, −16.0 to −8.4]; $P < .001$) compared with when the top 50th percentile of nonexpansion counties was used (−3.2 [95% CI, −5.7 to −0.8]; $P = .01$).

We also analyzed the cardiovascular mortality of residents aged 65 to 74 years over the same period. The adjusted DID estimate was −6.6 (95% CI, −16.2 to 3.1; $P = .18$; eTable 4 in the Supplement). Other sensitivity analyses had significant DID estimates, including ones that excluded all early-adopter and late-adopter states from the analysis (−3.6 [95% CI, −6.8 to −0.4]; $P = .03$) and ones using data aggregated at the state level, which included all deaths excluded from the county level analysis (−2.8 [95% CI, −5.1 to −0.5]; $P = .02$). The different sensitivity analyses are detailed in the online supplement (eMethods 3 in the Supplement).

Discussion

Counties in states that expanded Medicaid eligibility had a significantly smaller increase in age-adjusted cardiovascular mortality rates among residents aged 45 to 64 years after expansion compared with counties in nonexpansion states. Counties in expansion states had a mean of 4.3 fewer deaths per 100 000 residents per year than they would have had if they had followed the same trends as counties in nonexpansion states.

To our knowledge, this study is the first to show a population-level difference in rates of cardiovascular mortality among states that expanded Medicaid under the ACA. Such early changes in outcomes have also been also reported in other analyses of expansion in insurance coverage.[5,7] However, these prior analyses were either focused on a single state (Massachusetts) or a specific chronic disease population (end-stage renal disease). The only randomized clinical trial of Medicaid

Table 2. Difference-in-Differences Analysis[a]

Group	Cardiovascular Deaths per 100 000 Residents per Year, Unadjusted, Mean (SD)		Difference-in-Differences Estimate (95% CI)			
	Pre-Medicaid Expansion Period	Post-Medicaid Expansion Period	Unadjusted	*P* Value	Adjusted[a]	*P* Value
Overall						
Medicaid expansion states	146.5 (132.4-160.7)	146.4 (131.9-161.0)	−4.6 (−7.5 to −1.8)	.001	−4.3 (−6.9 to −1.8)	.001
Medicaid nonexpansion states	176.3 (154.2-198.5)	180.9 (158.0-203.8)				
Metropolitan counties						
Medicaid expansion states	139.4 (126.3-152.4)	139.6 (125.9-153.3)	−4.0 (−6.5 to −1.6)	.001	−3.7 (−6.3 to −1.2)	.005
Medicaid nonexpansion states	163.9 (144.1-183.7)	168.1 (147.8-188.4)				
Nonmetropolitan counties						
Medicaid expansion states	168.5 (1513-185.6)	168.9 (152.0-185.7)	−6.4 (−12.5 to −0.2)	.04	−6.2 (−12.5 to 0.1)	.05
Medicaid nonexpansion states	227.0 (200.9-253.0)	233.7 (206.4-261.0)				
Counties with >10% black residents in 2010						
Medicaid expansion states	176.9 (157.8-196.1)	175.2 (154.8-195.6)	−4.5 (−8.0 to −1.0)	.01	−4.3 (−7.7 to −0.9)	.01
Medicaid nonexpansion states	199.9 (178.2-221.5)	202.7 (179.6-225.7)				
Top 50th percentile for residents living in poverty in 2010[b]						
Medicaid expansion states	178.8 (160.9-196.4)	177.9 (159.1-196.6)	−6.6 (−10.7 to −2.5)	.002	−5.3 (−9.0 to −1.6)	.01
Medicaid nonexpansion states	205.4 (183.1-227.7)	211.1 (187.5-234.8)				
Top 50th percentile for cardiovascular mortality in 2010[c]						
Medicaid expansion states	185.7 (174.5-196.9)	187.0 (174.8-199.2)	−5.7 (−9.4 to −2.1)	.002	−5.2 (−9.1 to −1.4)	.01
Medicaid nonexpansion states	206.5 (191.1-221.8)	213.6 (197.2-229.9)				
Top 50th percentile for percentage of population uninsured in 2010[d]						
Medicaid expansion states	135.2 (117.5-152.8)	130.1 (112.5-147.8)	−4.4 (−8.2 to −0.5)	.03	−3.4 (−6.6 to −0.2)	.04
Medicaid nonexpansion states	174.1 (151.4-196.9)	173.5 (149.8-197.2)				
Bottom 50th percentile for percentage of population uninsured in 2010[e]						
Medicaid expansion states	155.0 (137.7-172.2)	155.3 (137.5-173.1)	−8.7 (−12.6 to −4.7)	<.001	−7.5 (−12.0 to −3.0)	.001
Medicaid nonexpansion states	205.9 (175.4-236.3)	214.9 (184.2-245.6)				

[a] Adjusted for 2013 National Center for Health Statistics Urban-Rural Classification designation (metropolitan vs nonmetropolitan county), percentage of residents living in poverty, percentage of adults unemployed, inflation-adjusted median household income, percentage of residents aged 40 to 64 years who were female, percentage of residents aged 40 to 64 years who were black, percentage of residents aged 40 to 64 years who were Hispanic, percentage of adult residents with diabetes in 2010, percentage of adult residents with obesity in 2010, percentage of adult residents who smoke in 2010, number of primary care clinicians per 100 000 residents, number of cardiologists per 100 000 residents, and percentage of residents aged 40 to 64 years with income less than 138% of the federal poverty limit with health insurance in 2010.

[b] Greater than or equal to 15.2% of residents.

[c] Greater than or equal to 145.1 deaths per 100 000 residents.

[d] Greater than or equal to 39% of residents aged 40 to 64 years with income less than 138% of the federal poverty limit.

[e] Less than 39% of residents aged 40 to 64 years with income less than 138% of the federal poverty limit.

expansion to date (the Oregon Health Study[6]) did not demonstrate significant improvements in cardiovascular risk factors, such as hypertension or hyperlipidemia.[6] However, in addition to including the substantially larger number of people affected by Medicaid expansion under the ACA, this study focused on middle-aged adults, an age group which represented around 28% of the Oregon Health study[6] population and one with a higher burden of cardiovascular disease than

Table 3. Difference-in-Differences Analysis by Change in Number of Residents in Low-Income Strata With Health Insurance

Increase in Number of Residents With Health Insurance[a]	Mean (95% CI) Cardiovascular Deaths per 100 000 Residents per y, Unadjusted		Difference-in-Differences Estimate			
	Period Before Medicaid Expansion	Period After Medicaid Expansion	Unadjusted	*P* Value	Adjusted[b]	*P* Value
Counties in Medicaid expansion states in top 50th percentile of increase[c]	142.3 (129.0-155.6)	142.2 (127.8-156.7)	−5.3 (−8.1 to −2.4)	.001	−4.8 (−7.5 to −2.2)	.001
All counties in Medicaid nonexpansion states	176.2 (154.1-198.4)	181.4 (158.4-204.4)				
Counties in Medicaid expansion states in bottom 50th percentile of increase[d]	162.8 (143.2-182.4)	165.8 (147.2-184.5)	0.3 (−2.3 to 2.9)	.81	−1.3 (−4.0 to 1.4)	.34
All counties in Medicaid nonexpansion states	176.7 (153.9-199.5)	179.5 (155.7-203.3)				
All counties in Medicaid expansion states[e]	146.4 (132.3-160.4)	146.2 (131.6-160.7)	−3.4 (−6.1 to −0.6)	.02	−3.2 (−5.7 to −0.8)	.01
Counties in Medicaid nonexpansion states in top 50th percentile of increase[e]	165.4 (144.1-186.6)	168.5 (146.6-190.4)				
All counties in Medicaid expansion states[f]	147.3 (133.1-161.6)	147.0 (132.4-161.7)	−13.8 (−17.4 to −10.2)	.001	−12.2 (−16.0 to −8.4)	.001
Counties in Medicaid nonexpansion states in bottom 50th percentile of increase[f]	223.0 (197.7-248.3)	236.4 (210.1-262.8)				

[a] Change in number of residents with health insurance refers to change in the number of residents aged 40 to 64 years with health insurance with an income less than 138% of the federal poverty limit between 2010 and 2016.

[b] Adjusted for 2013 National Center for Health Statistics Urban-Rural Classification designation (metropolitan vs nonmetropolitan county), percentage of residents living in poverty, percentage of adults unemployed, inflation-adjusted median household income, percentage of residents aged 40 to 64 years who were female, percentage of residents aged 40 to 64 years who were black, percentage of residents aged 40 to 64 years who were Hispanic, percentage of adult residents with diabetes in 2010, percentage of adult residents with obesity in 2010, percentage of adult residents who smoke in 2010, number of primary care professionals per 100 000 residents, number of cardiologists per 100 000 residents, and percentage of residents aged 40 to 64 years with income less than 138% of the federal poverty limit with health insurance in 2010.

[c] Expansion counties with a change in the number of residents with health insurance greater than 483 residents.

[d] Expansion counties with a change in the number of residents with health insurance fewer than 483 residents.

[e] Nonexpansion counties with a change in the number of residents with health insurance greater than 232 residents.

[f] Nonexpansion counties with a change in the number of residents with health insurance fewer than 232 residents.

younger adults. Given the small absolute differences in mortality between expansion and nonexpansion counties observed in this analysis, it is possible that such differences would not be observed in a study with a smaller sample size.

Studies of inpatient outcomes and quality of care of patients with heart failure and myocardial infarction did not show a significant association with Medicaid expansion.[14,15] This suggests that a possible influence of Medicaid expansion could be in the outpatient setting or access to care. One prior study[27] noted an association between lack of insurance coverage and delays in seeking emergency care by patients with myocardial infarction. Medicaid expansion has also been associated with higher rates of provision of cardiovascular medications, such as aspirin and better diabetes control.[28] There is also evidence of an increase in rates of coronary artery bypass graft surgery associated with Medicaid expansion.[29] Although we noted a stronger association between Medicaid expansion and cardiovascular mortality in the counties where there was a greater increase in the number of individuals gaining insurance coverage, there may be other indirect mechanisms by which expansion may be associated with the observations noted. The DID point estimate for individuals 65 to 74 years old suggests a possible beneficial association even for a population not directly affected by Medicaid expansion and the potential existence of a spillover phenomenon. This may be mediated by mechanisms such as strengthening of the financial health of institutions that provide care to individuals with lower incomes throughout the age spectrum (eg, community health centers, safety net hospitals).[30,31] Additionally, changes in insurance coverage in a population have been associated with access to health care and the quality of care received even by the insured population.[32]

Limitations

This study has certain limitations. Given the observational nature of the study, we are not able to make a causal association between expansion of Medicaid eligibility and differences in the cardiovascular mortality rates between the 2 groups of counties. It is possible that there were other unmeasured time-varying factors that can explain the observed association. Along with expanding eligibility for Medicaid, it is possible that other aspects of the ACA were implemented more in expansion states. Although the primary target of Medicaid expansion was adults with low income, the outcome measure is for residents of all income categories. However, we do observe a stronger association between Medicaid expansion and cardiovas-

cular mortality in counties with more residents in low income strata. The primary outcome is mortality from diseases of the circulatory system, which includes several different disorders. Although in a sensitivity analysis we did analyze a subset of these disorders, we did not analyze individual diseases to elucidate which ones are driving the overall mortality trend, owing to the small number of deaths from any individual cause. The primary analysis excluded counties with fewer than 10 deaths per year; however, a sensitivity analysis with outcome and covariates aggregated at the state level, which included all deaths in a state, had a significant association as well.

Conclusions

This study shows an association between Medicaid expansion and differences in cardiovascular mortality rates between expansion and nonexpansion states for middle-aged adults. Given the high burden of cardiovascular risk factors among individuals without insurance and those with lower socioeconomic status, these results may be a consideration as policymakers debate further changes to eligibility and expansion of Medicaid.

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Research Report

The Effect of the 2014 Medicaid Expansion on Insurance Coverage for Newly Eligible Childless Adults

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Preface

Following full implementation of the Affordable Care Act's (ACA's) coverage provisions on January 1, 2014, the share of U.S. adults without insurance fell substantially more in Medicaid expansion states than in nonexpansion states. These figures suggest that Medicaid expansion is succeeding at reducing uninsurance. However, existing estimates of the Medicaid expansion's effects do not specifically examine take-up of Medicaid among adults who became newly eligible following the Medicaid expansion. This report used data from the 2009–2014 National Health Interview Survey with restricted-use state geocodes to measure the effect of state Medicaid expansion decisions on insurance coverage and the source of coverage among childless adults who became newly eligible for Medicaid in 2014. This report uses a differences-in-differences approach to compare newly eligible adults to similar adults in nonexpansion states who were not eligible for subsidized coverage through the Health Insurance Marketplace in 2014.

This study addressed the following research questions:

- How did Medicaid expansion affect insurance status for low-income childless adults who became newly eligible?
- Of the newly eligible adults gaining Medicaid coverage because of the expansion, how many would otherwise have been uninsured, and how many would otherwise have been covered by private insurance?
- Which subgroups of the newly eligible population were more or less likely to take up Medicaid coverage in 2014?

This report may be of interest to state and federal health policymakers, as well as other analysts evaluating the ACA and the effects of Medicaid eligibility on insurance coverage.

This research was funded by the Robert Wood Johnson Foundation (RWJF) through its State Health Access Reform Evaluation (SHARE) initiative. SHARE is an RWJF national program that supports rigorous research on health reform issues at a state level, with a focus on state-level implementation of the ACA and other efforts designed to increase coverage and access. SHARE operates out of the State Health Access Data Assistance Center, an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. More information about SHARE is available at www.shadac.org/share. Support for activities related to this project prior to the award from RWJF was provided by the Bing Center for Health Economics at the RAND Corporation.

The research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

Abstract

The authors used the National Health Interview Survey (NHIS) to estimate how the Affordable Care Act Medicaid expansion affected health insurance enrollment, by source of coverage, among childless adults who became newly eligible for Medicaid in 2014. The NHIS data allowed the authors to report changes in enrollment by source of coverage and to conduct subgroup analyses of Medicaid take-up by gender, age, and other characteristics. Newly eligible childless adults in expansion states were 8.9 percentage points more likely to be insured in 2014 relative to similar adults in nonexpansion states, reflecting gains in Medicaid with little to no offsetting decrease in private coverage. Subgroup patterns of take-up among the newly eligible differed from findings previously reported for the wider low-income population, many of whom were previously eligible. Because these estimates isolate the behavior of newly eligible adults, these findings may be useful for anticipating take-up if nonexpansion states with limited Medicaid eligibility under current law choose to expand in the future. Similarly, because the control group excludes adults who became eligible for subsidized insurance coverage through the Health Insurance Marketplace, these findings provide insight into the effects of Medicaid expansion relative to a counterfactual involving neither Medicaid expansion nor Marketplace subsidies.

Acknowledgments

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The analysis reported in this paper was conducted at the UCLA Census RDC using restricted-use data provided by NCHS. The findings and conclusions in this paper are those of the authors and do not necessarily represent the views of the RDC, NCHS, or the Centers for Disease Control and Prevention.

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Abbreviations

ACA	Affordable Care Act
AFDC	Aid to Families with Dependent Children
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPS ASEC	Current Population Survey Annual Social and Economic Supplement
FPL	federal poverty level
GAMC	General Assistance Medical Care
IPUMS-CPS	Integrated Public Use Microdata Series, Current Population Survey
LPM	linear probability model
MAGI	modified adjusted gross income
NCHS	National Center for Health Statistics
NHIS	National Health Interview Survey
OLS	ordinary least squares
RDC	Research Data Center
RWJF	Robert Wood Johnson Foundation
SCHIP	State Children's Health Insurance Program
SHARE	State Health Access Reform Evaluation
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
UCLA	University of California, Los Angeles

Introduction

Following full implementation of the Affordable Care Act's (ACA's) coverage provisions on January 1, 2014, the share of U.S. adults without insurance fell substantially more in Medicaid expansion states than in nonexpansion states (Cohen and Martinez, 2015b). Between 2013 and 2014, Medicaid enrollment increased by 10.75 million nationwide (Centers for Medicare & Medicaid Services [CMS], 2015). These figures suggest that Medicaid expansion is succeeding at reducing uninsurance, but more detailed analysis is needed to distinguish the impact of the Medicaid expansion from the impact of other policies, like the establishment of the Health Insurance Marketplace. Further, the extent to which Medicaid expansion reached the newly eligible population, versus increasing enrollment among people who would have been eligible under the old rules (the welcome-mat effect), remains unclear. Finally, there is limited evidence on the extent to which increases in Medicaid enrollment resulting from the ACA expansion may have been offset by reductions in private insurance coverage.

We used data from the 2009–2014 National Health Interview Survey (NHIS) with restricted-use state geocodes to measure the effect of state Medicaid expansion decisions on insurance coverage and the source of coverage among childless adults who became newly eligible for Medicaid in 2014. Because there are important pre-ACA differences in the demographic, health policy, and economic environments of these two groups of states, we used a differences-in-differences research design to distinguish changes in outcomes resulting from the Medicaid expansion from permanent differences between states and from nationwide changes associated with ACA implementation.

Our study addressed the following research questions:

- How did Medicaid expansion affect insurance status for low-income childless adults who became newly eligible?
- Of the newly eligible adults gaining Medicaid coverage because of the expansion, how many would otherwise have been uninsured, and how many would otherwise have been covered by private insurance?
- Which subgroups of the newly eligible population were more or less likely to take up Medicaid coverage in 2014?

While a growing number of studies have examined the Medicaid expansion, no currently published studies estimate the impact of Medicaid expansion on newly eligible adults or use a control group that was not directly targeted by other ACA coverage expansions. We limited our sample to nondisabled childless adults and excluded from our analysis 13 states in which these adults were categorically eligible (i.e., they had the opportunity to qualify for Medicaid if their incomes were sufficiently low) for Medicaid before 2014. We also focused on adults in poverty—those with family incomes below the federal poverty level (FPL)—because adults with income above the FPL became eligible for Marketplace subsidies in nonexpansion states in 2014. While nondisabled childless adults in poverty constitute only about 9 million of the estimated 196 million adults aged 18–64 in 2014, this population is of particular policy interest because it

is a group of newly eligible adults who can readily be identified from survey data on poverty status, family structure, and sources of income.

Our narrower sample definition allows us to examine the effect of new Medicaid eligibility on coverage relative to a counterfactual scenario without Medicaid expansion or Marketplace subsidies. Currently published research addresses the impact of Medicaid expansion on the entire population covered by the new eligibility group—most of whom were already eligible for Medicaid before 2014—relative to a counterfactual scenario that includes Marketplace subsidies for those with incomes above the FPL (Sommers, Gunja, et al., 2015b; Wherry and Miller, 2016). Our analysis complements these studies by providing new evidence on patterns of take-up behavior and the effectiveness of the Medicaid expansion in reaching populations previously excluded from public insurance coverage.

Among newly eligible childless adults, we found that the 2014 Medicaid expansion led to an 8.9-percentage-point increase in the rate of insurance coverage, which was driven by take-up of Medicaid with limited crowd-out of private insurance. Take-up among the newly eligible varied significantly across age groups and racial/ethnic groups in ways that differed from previously available estimates. In addition, adults in worse health experienced larger gains in coverage, suggesting that individuals with greater health care needs were the first to enroll after expansion.

Related Literature

Most of the literature on state-level Medicaid expansions prior to the ACA suggests that coverage expansions increase Medicaid enrollment even though take-up of Medicaid coverage among the newly eligible is often low (Long, Zuckerman, and Graves, 2006; Sommers, Baicker, and Epstein, 2012; Sommers, Kenney, and Epstein, 2014). The literature is more mixed regarding the degree to which expansions lead to offsetting decreases in private coverage, a phenomenon known as crowd-out. Several studies of pre-ACA coverage expansions for low-income adults found limited crowd-out for adults in poverty, with crowd-out rates increasing for higher-income families (Gruber and Simon, 2008; Hamersma and Kim, 2013; Long et al., 2006). More recent studies of pre-ACA expansions yield larger estimates of crowd-out for low-income adults, although researchers studying California's early implementation of the ACA expansion found no significant changes in private coverage (Garthwaite, Gross, and Notowidigdo, 2014; Golberstein, Gonzales, and Sommers, 2015).

Researchers have now begun to measure the effects of the 2014 Medicaid expansion. Several early studies that used tracking surveys to analyze the effect of the ACA found larger increases in coverage in Medicaid expansion states, including one study that found this to be the case specifically for low-income adults (Carman, Eibner, and Paddock, 2015; Karpman and Long, 2015; Sommers, Gunja, et al., 2015b). However, these surveys may not reliably identify the source of coverage, and they have substantially lower response rates than the NHIS.

More recently, several papers have used large federal surveys to compare changes in insurance coverage between expansion and nonexpansion states. Our work is most closely related to a recent study that used the 2010–2014 NHIS (Wherry and Miller, 2016). That study found that Medicaid expansion was associated with a 7.4-percentage-point increase in overall insurance coverage for adults with incomes below 138 percent of the FPL, reflecting a 10.5-

percentage-point increase in Medicaid coverage. The gap between the increase in Medicaid coverage and the increase in overall insurance coverage may reflect a reduction in private health insurance coverage, but this effect is imprecisely estimated and was not statistically distinguishable from zero at the 95-percent confidence level. Another study using the 2013–2014 American Community Survey found that coverage gains among adults in poverty were larger in expansion states than in nonexpansion states (Courtemanche, Marton, and Yelowitz, 2016).

Findings have also begun to emerge about which demographic groups benefited most from the 2014 coverage expansions. Across all states and income groups, young adults experienced larger reductions in uninsurance between 2013 and 2014 than did older adults, and larger gains in insurance coverage have also been documented for Black and Hispanic adults relative to white adults (Buchmueller et al., 2016; Courtemanche, Marton, and Yelowitz, 2016; McMorrow et al., 2015a; McMorrow et al., 2015b).

Our study adds to the existing literature by narrowly focusing on take-up behavior among the newly eligible, whereas the studies described above included parents and childless adults who were categorically eligible for Medicaid in 2013. To be clear, outcomes for the broader population studied elsewhere are of considerable policy interest. However, it is challenging to infer from currently published studies how the Medicaid expansion affected insurance coverage relative to a baseline without other coverage expansions; it is also not straightforward to distinguish take-up among the newly eligible from enrollment among previously eligible populations, such as low-income parents or participants in federal disability programs. Estimates that address these narrower questions may be of value to researchers wishing to assess whether the Medicaid expansion has succeeded in reaching newly eligible populations. Information about the take-up behavior of newly eligible childless adults, meanwhile, may be useful to policymakers in nonexpansion states: Most of these states have very limited Medicaid eligibility for childless adults in comparison with states that adopted the Medicaid expansion in 2014 or earlier, meaning that the overall impact of Medicaid expansion in these states would reflect the experiences of the newly eligible to a greater extent than in expansion states that have historically made Medicaid available to a larger population.

Similarly, we view our subgroup analyses—which are driven by take-up behavior among the newly eligible—as answering a different question from studies that measure the ACA's impact on health insurance disparities more broadly. Existing reports of demographic patterns in insurance coverage between 2013 and 2014 either do not distinguish between expansion and nonexpansion states (Courtemanche, Marton, and Yelowitz, 2016; Cohen and Martinez, 2014) or do not stratify on income and pre-ACA eligibility in a way that allows conclusions to be drawn about take-up among the newly eligible (Cohen and Martinez, 2015b; McMorrow et al., 2015a; McMorrow et al., 2015b). This is true even of the estimates reported by Buchmueller et al. (2016), which captured changes in the uninsurance rate by race and ethnicity specifically for adults with family income below 138 percent of the FPL. The estimates in that study pooled parents and childless adults together and included Medicaid expansion states that had already expanded Medicaid eligibility to this income range prior to the ACA. The analysis presented here complements existing estimates of the ACA's impact on health insurance disparities by

isolating one mechanism—differences in Medicaid take-up and crowd-out for the newly eligible—that contributes to the overall impact of the ACA.

Data and Methods

We used individual-level data from the NHIS, a household survey designed by the National Center for Health Statistics (NCHS) and collected by the Census Bureau. Our research design used repeated cross-sectional data from 2009 through 2014, encompassing years before and after the 2014 Medicaid expansion. Our analysis focused on the average effect of the 2014 Medicaid expansion in the 14 expansion states in which childless nondisabled adults were categorically ineligible for Medicaid in 2013.

In order to obtain a sample of adults who became newly eligible for Medicaid in 2014, we restricted our analysis to childless adults in poverty who were not beneficiaries of Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). We focused on childless adults because low-income parents were categorically eligible for Medicaid in all states prior to the ACA. We excluded disabled individuals because SSI recipients are categorically eligible for Medicaid in most states, while SSDI recipients frequently qualify through other pathways.

In addition to limiting the sample to nondisabled childless adults in poverty, we excluded 13 states with categorical eligibility for nondisabled childless adults before 2014; our methodology for classifying states is presented in the appendix. The resulting sample consists of adults who were not eligible to enroll in comprehensive Medicaid coverage prior to 2014.

We classified insurance coverage into three categories: private, Medicaid, and non-Medicaid public insurance (such as Medicare and TRICARE). These categories provided an exhaustive classification of the types of insurance reported in the NHIS and allowed us to examine whether adults gaining Medicaid transitioned from other coverage.

We used a regression-adjusted differences-in-differences approach to model the effect of Medicaid eligibility on our sample, comparing changes in insurance over time between expansion and nonexpansion states. This approach controlled for permanent differences between states as well as nationwide changes over time that affect all states, including ACA reforms other than Medicaid expansion and the Marketplace subsidies. We also controlled for gender, age, marital status, race, educational attainment, and employment status. All estimates were weighted to represent the civilian noninstitutionalized population.

The basic differences-in-differences framework assumes that trends in outcomes would have been identical in expansion and nonexpansion states. We relaxed this assumption by controlling for a separate linear time trend in expansion states in addition to nationwide time effects that varied from quarter to quarter. Estimates without differential trends were qualitatively similar to our main specification, but, as we discuss in the next section, the magnitudes of the estimated effects were sensitive to assumptions about differential trends.

Limitations

Although we attempted to exclude adults who were categorically eligible for Medicaid prior to the ACA expansion, a small percentage of our sample (7 to 13 percent) reported having

Medicaid coverage prior to 2014. We cannot determine why these individuals reported having Medicaid coverage: Some might have been eligible through special pathways (e.g., pregnancy, breast or cervical cancer), some might have been enrolled in a limited benefits package, some might have been covered through programs that were closed to new enrollees, some might have enrolled in Medicaid as parents or caretakers prior to a change in family status, and some might have been misreporting their insurance type. Similarly, we did not observe immigration status, and so our sample may include some individuals who were ineligible for Medicaid because they were not lawful permanent residents. We wish to interpret our estimates as the effect on insurance coverage of becoming newly eligible for the comprehensive Medicaid benefits package available under the ACA expansion, and so nonzero rates of Medicaid coverage and unobserved immigration status may be problematic for this interpretation of our estimates.

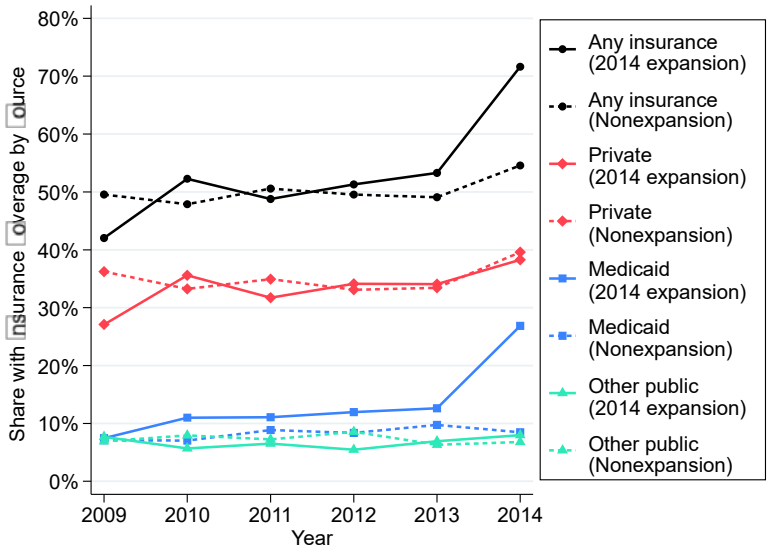
Despite the small percentage of seemingly ineligible childless adults reporting Medicaid coverage, the NHIS, like all other household surveys, undercounts participation in Medicaid relative to administrative data (Call, Davern, et al., 2013). The NHIS has several features—including a point-in-time coverage question and the use of state-specific plan names—that should mitigate limitations identified in other surveys (Cantor et al., 2007; Klerman et al., 2009). Previous audit studies suggested that survey reporting error may have a limited impact on estimates of the uninsurance rate in our setting (Call, Davidson, et al., 2008). However, we were also interested in the source of health insurance, and reporting error may have a larger impact on estimates of take-up and crowd-out. To the extent that the NHIS undercounts Medicaid coverage and overcounts private insurance, we may have tended to underestimate crowd-out. A more serious concern would be if Medicaid expansion leads to a reduction in Medicaid underreporting that is larger in expansion states than in nonexpansion states, which might bias our estimates of Medicaid take-up upward while biasing our estimates of crowd-out downward. We do not have any evidence that reporting styles have been affected by Medicaid expansion, but we cannot rule out this possibility, either.

A further limitation of our study is that our main model assumed that the Medicaid expansion occurred abruptly at the beginning of 2014 (or later in Michigan and New Hampshire). State and private outreach efforts, as well as public awareness of the ACA, could have changed insurance coverage or reporting behavior prior to the official implementation date. For example, expansion state Medicaid agencies may have reduced the frequency or stringency of recertification of eligibility immediately before expansion. Even though we defined our analysis sample to exclude states in which childless adults were eligible for Medicaid before 2014, we cannot rule out a priori the possibility that such preimplementation activities could affect our estimates. Any such effects may have caused us to underestimate the impact of the expansion, particularly in models with differential trends. To guard against bias caused by such preimplementation effects, we ran alternative models that excluded 2013 data, using 2012 and earlier years to define the pre-ACA baseline. We also estimated several models that used alternative assumptions about the presence and functional form of differential trends in coverage in expansion and nonexpansion states. These sensitivity analyses are discussed in the next section.

Results

Figure 1 shows unadjusted time trends in insurance coverage by state expansion status, along with trends in coverage for the three subtypes of insurance considered in this analysis. In 2014 expansion states, the fraction of nondisabled childless adults in poverty covered by health insurance increased by 18.3 percentage points between 2013 and 2014. There was a smaller increase in coverage of 5.5 percentage points in nonexpansion states. These changes in overall insurance coverage closely mirror the pattern observed for Medicaid coverage, which increased by 14.2 percentage points in expansion states with no meaningful change in nonexpansion states. Without adjusting for covariates or differential pre-ACA trends in coverage, these data imply that the Medicaid expansion increased the probability of any insurance coverage by 12.6 percentage points and increased the probability of Medicaid coverage by 14.9 percentage points. These unadjusted differences-in-differences are highly statistically significant ($p < 0.001$).

Figure 1. Insurance Coverage by Source for Nondisabled Childless Adults in Poverty, 2014 Expansion States Versus Nonexpansion States, 2009–2014



SOURCE: Authors' calculations, 2009–2014 NHIS Person File.
NOTES: This figure reports the probability of insurance coverage by source, year, and state Medicaid expansion status for nondisabled childless adults in families with income less than or equal to 100 percent of the FPL. Estimates use final annual person weights. 2014 expansion states are defined as states that began implementation of the ACA Medicaid expansion during 2014 and where childless adults were not categorically eligible for comprehensive Medicaid benefits in 2013 and earlier years. These 14 states are Arizona, Arkansas, Illinois, Kentucky, Maryland, Michigan, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oregon, Rhode Island, and West Virginia.

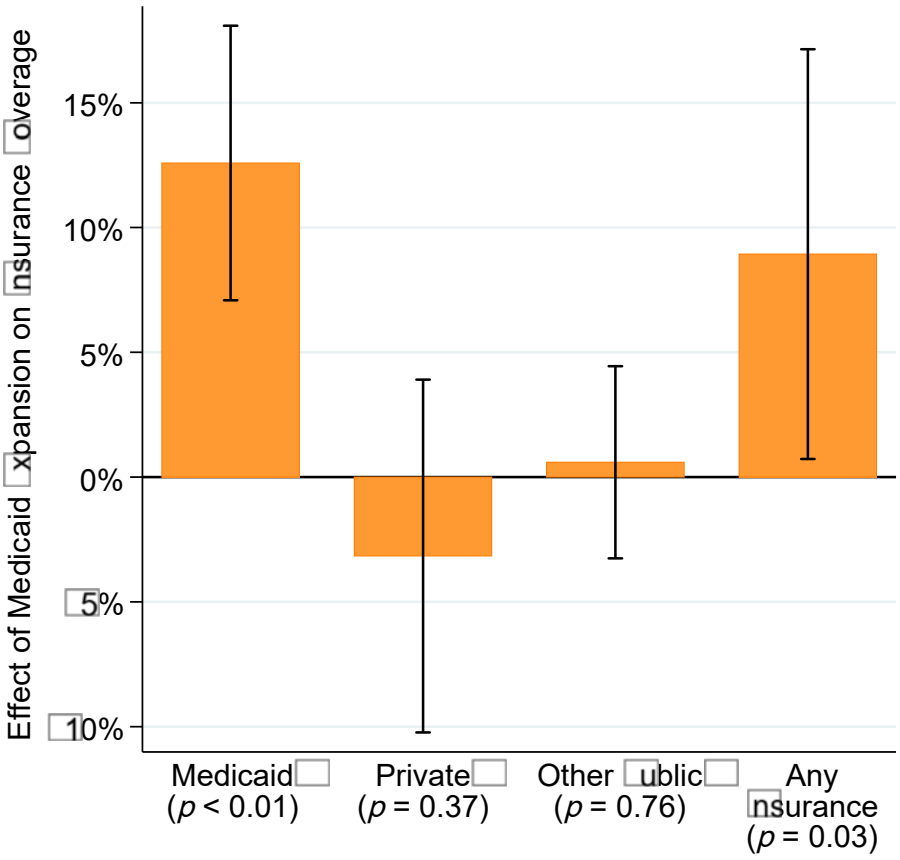
Nonexpansion states are defined as states that had not moved forward with the Medicaid expansion as of the fourth quarter of 2014. These 24 states are Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

Turning to the remaining forms of insurance, Figure 1 shows that rates of private and non-Medicaid public coverage were similar in expansion and nonexpansion states in all years, with the exception of a lower private coverage rate in 2009 for expansion states. Both expansion and nonexpansion states show an increase in private coverage between 2013 and 2014. The estimated increase is slightly larger in nonexpansion states, but unadjusted differences-in-differences estimates for an effect on private coverage were not significant ($p = 0.97$). Non-Medicaid public coverage did not change meaningfully in either group of states over the study period.

While Figure 1 clearly shows that differential increases in Medicaid coverage and overall insurance coverage were associated with Medicaid expansion, we also observed a slight increase in coverage between 2009 and 2013 in the expansion states and a slight decrease in nonexpansion states. Statistical tests reported in the appendix indicate that differential trends in insurance coverage and Medicaid were just barely insignificant at the 10-percent level. To ensure robustness to differential pre-ACA trends, we included a linear trend specific to the expansion states in our main regression model.

Figure 2 presents regression-adjusted estimates of the impact of Medicaid expansion on coverage for low-income childless adults. Overall, insurance coverage increased by 8.9 percentage points ($p = 0.03$), and Medicaid coverage increased by 12.6 percentage points ($p < 0.001$). Private coverage declined by a statistically insignificant 3.2 percentage points ($p = 0.37$). There was no effect on non-Medicaid public insurance ($p = 0.76$).

Figure 2. Effects of 2014 Medicaid Expansion on Insurance Coverage for Newly Eligible Childless Adults



SOURCE: Authors' calculations, 2009–2014 NHIS.
NOTES: This figure reports regression-adjusted differences-in-differences effects of ACA Medicaid expansion on insurance coverage by type. The effect is estimated as a coefficient on a dummy variable equal to 1 in expansion states after the implementation date and 0 otherwise. Effects are reported in percentage points.
Effects were estimated using linear regressions controlling for gender, age, marital status, race, educational attainment, employment status, time (year-quarter) fixed effects, state fixed effects, and a linear time trend specific to expansion states.
2014 expansion states are defined as states that began implementation of the ACA Medicaid expansion during 2014 and where childless adults were not categorically eligible for comprehensive Medicaid benefits in 2013 and earlier years. These 14 states are Arizona, Arkansas, Illinois, Kentucky, Maryland, Michigan, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oregon, Rhode Island, and West Virginia. The treatment dummy for Michigan switches from 0 to 1 in the second quarter of 2014. The treatment dummy for New Hampshire switches from 0 to 1 in the fourth quarter of 2014. Data from New Hampshire in the third quarter of 2014 were dropped as a wash-out period for New Hampshire expansion implementation.
Nonexpansion states are defined as states that had not moved forward with the Medicaid expansion as of the fourth quarter of 2014. These 24 states are Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine,

Mississippi, Missouri, Montana, Nebraska, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.
Error bars report 95-percent confidence intervals based on t-distribution with 37 degrees of freedom and standard errors clustered on state.

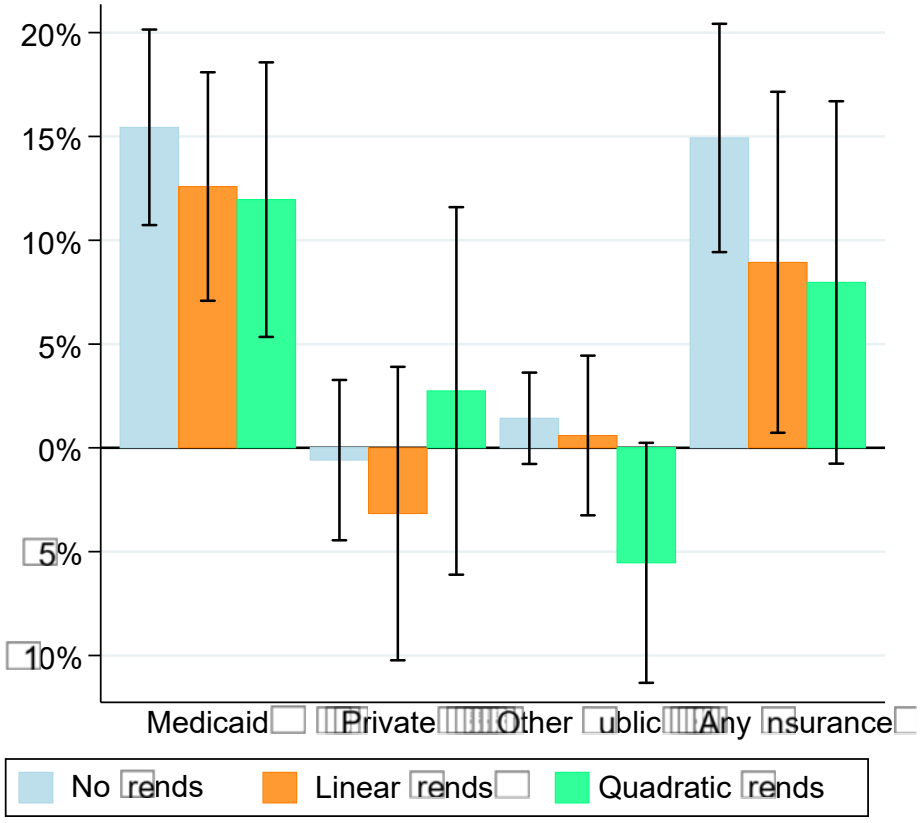
Although our estimate of the Medicaid expansion's impact on private insurance is statistically insignificant, it is negative. The point estimate is large enough to be substantively meaningful, suggesting that 25 percent of newly eligible childless adults gaining Medicaid coverage would have had private coverage in the absence of the Medicaid expansion. However, this estimate is imprecise: We cannot rule out decreases in private insurance coverage as large as 10.2 percentage points or increases as large as 3.9 percentage points at the 95-percent confidence level.

Sensitivity Analysis

To evaluate more fully whether newly eligible adults gaining Medicaid coverage in 2014 would have been privately insured in the absence of the Medicaid expansion, we estimated several additional models that rely on different assumptions about the presence and functional form of differential trends in coverage in expansion and nonexpansion states. Figure 3 presents estimates from these models side by side with our main specification. These alternative models did not provide any evidence that Medicaid expansion crowded out private coverage among newly eligible adults; the specification that includes linear differential trends yielded the most negative impacts on private coverage of any of the models we estimated.

Figure 3 indicates that the estimated change in private coverage is fairly sensitive to assumptions about differential trends in coverage between expansion and nonexpansion states. Evidence of decreases in private coverage for newly eligible adults appears to be limited to an imprecise point estimate in one specification. Estimated increases in Medicaid coverage were more robust to different assumptions about differential trends in expansion and nonexpansion states. While the impact of Medicaid expansion on overall coverage became slightly smaller and less significant when we controlled for quadratic trends, the point estimate was very close to the estimate in our main specification. These models and results are presented in greater detail in the appendix.

Figure 3. Estimates of Medicaid Expansion Impacts Under Alternative Modeling Assumptions



SOURCE: Authors' calculations, 2009–2014 NHIS.
NOTES: This figure reports regression-adjusted differences-in-differences effects of ACA Medicaid expansion on insurance coverage by type under alternative specifications for differential time trends in expansion and nonexpansion states. Effects were estimated as a coefficient on a dummy variable equal to 1 in expansion states after the implementation date and 0 otherwise. Effects are reported in percentage points.
Effects were estimated using linear regressions controlling for gender, age, marital status, race, educational attainment, employment status, time (year-quarter) fixed effects, state fixed effects, and a linear time trend specific to expansion states.
2014 expansion states are defined as states that began implementation of the ACA Medicaid expansion during 2014 and where childless adults were not categorically eligible for comprehensive Medicaid benefits in 2013 and earlier years. These 14 states are Arizona, Arkansas, Illinois, Kentucky, Maryland, Michigan, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oregon, Rhode Island, and West Virginia. The treatment dummy for Michigan switches from 0 to 1 in the second quarter of 2014. The treatment dummy for New Hampshire switches from 0 to 1 in the fourth quarter of 2014. Data from New Hampshire in the third quarter of 2014 were dropped as a wash-out period for New Hampshire expansion implementation.
Nonexpansion states are defined as states that had not moved forward with the Medicaid expansion as of the fourth quarter of 2014. These 24 states are Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota,

Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.
Error bars report 95-percent confidence intervals based on t-distribution with 37 degrees of freedom and standard errors clustered on state.

Figure 3 also highlights a methodological point that is relevant to other studies that exploit the policy variation created by state Medicaid expansion decisions: The treatment of preexisting trends can have a substantial effect on the conclusions that analysts draw about the impact of Medicaid expansion. The assumption that outcomes in expansion and nonexpansion states would have moved in parallel in the absence of Medicaid expansion should be evaluated carefully.

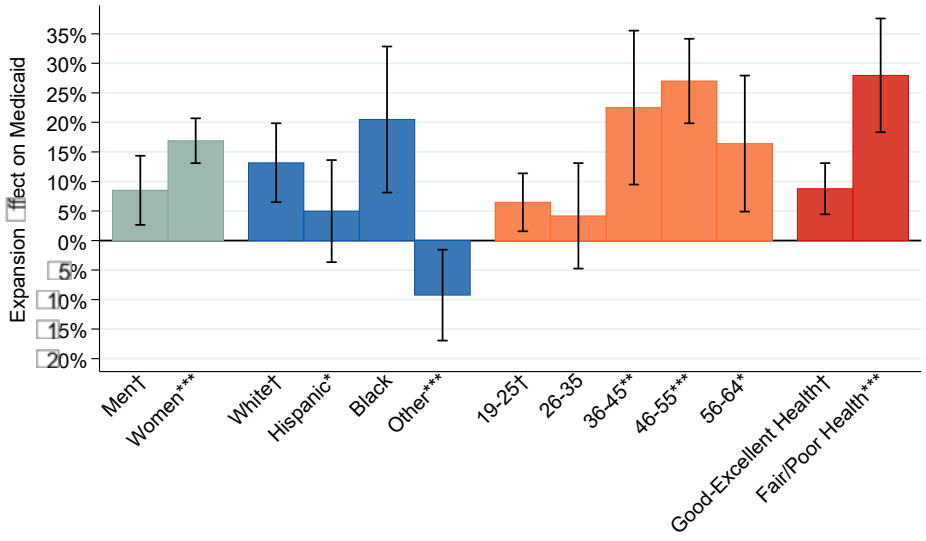
We estimated several further alternative specifications of our regression model to assess the robustness of our results to the preexpansion time period used as a baseline and our choice of estimation sample. Because of the concerns raised above about preimplementation activities, we ran several models that excluded 2013 data, using 2012 and earlier years as the pre-ACA baseline. These results, available in the appendix, show that our estimates are not sensitive to the inclusion or exclusion of data from the year preceding the expansion's implementation.

Readers may also be concerned that it is inappropriate to include employment status as a control variable because labor supply may respond to Medicaid eligibility (Garthwaite et al., 2014). In the appendix, we report estimates for models that did not control for employment status. These estimates are nearly identical to our main specification. We focused on a narrow group of expansion states to isolate the newly eligible. Estimates for a sample that includes four states with eligibility for some childless adults in poverty in 2014 are very similar to our main results (see the appendix).

Demographic Differences in Medicaid Take-Up

To better understand which individual characteristics were associated with take-up of Medicaid, we analyzed changes in Medicaid coverage by gender, race/ethnicity, age, and health status (Figure 4). Regression coefficients and estimates for other types of coverage can be found in the appendix.

Figure 4. Effects of 2014 Medicaid Expansion on Medicaid Coverage for Newly Eligible Childless Adults by Gender, Race, Age, and Health Status



SOURCE: Authors' calculations, 2009–2014 NHIS.
NOTES: This figure reports regression-adjusted differences-in-differences effects of ACA Medicaid expansion on Medicaid coverage for subgroups. Base effects are estimated as a coefficient on a dummy variable equal to 1 in expansion states after the implementation date and 0 otherwise. Interaction effects are estimated as a coefficient on interaction between an expansion dummy variable and a dummy variable for subgroup membership. Effects are reported in percentage points.
Effects are estimated using linear regressions controlling for gender, age, marital status, race, educational attainment, employment status, time (year-quarter) fixed effects, state fixed effects, and a linear time trend specific to expansion states.
† Indicates the base category in the regression model; other bars report the sum of base and interaction effects.
P-values for significance of pairwise difference from base category effect are indicated as follows: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.
Error bars report 95-percent confidence intervals based on t-distribution with 37 degrees of freedom and standard errors clustered on state. Confidence intervals for interaction effects treat base coefficients as known.

While Medicaid coverage increased for nearly all of the subpopulations examined, there were meaningful differences between demographic groups in the size of the increase. Men were 8 percentage points less likely than women to gain Medicaid coverage. The effect of the expansion did not differ significantly between Black and white non-Hispanic adults. Medicaid take-up among Hispanic adults was marginally significantly lower than among white non-Hispanic adults ($p = 0.06$), though these groups experienced identical gains in overall insurance coverage because Hispanic adults experienced larger increases in private coverage. Adults in the non-Hispanic "other" racial category (primarily Asian Americans) were significantly less likely to gain Medicaid coverage than other racial groups, and actually experienced reductions in Medicaid coverage relative to similar adults in nonexpansion states.

Our subgroup findings differ from corresponding nationwide changes in coverage between 2013 and 2014. For instance, the NHIS showed similar reductions in uninsurance for men (4.2 percentage points) and women (4 percentage points) (Cohen and Martinez, 2014, 2015a). Even though we were not able to condition on previous insurance status in the NHIS, the gender difference we observed in Medicaid take-up is similar to early estimates of insurance changes among previously uninsured adults (Vistnes and Cohen, 2015).

More striking differences were observed among subgroups defined by age and health status. Adults over age 35 were 10 to 21 percentage points more likely to gain Medicaid coverage than younger adults, and people in poor or fair health were 19 percentage points more likely to gain Medicaid coverage than those in good, very good, or excellent health.

Subgroup effects on any insurance coverage are similar to the results shown for Medicaid, except that the size of the Medicaid expansion effect on any insurance coverage for Hispanic adults is very close to the size of the effect for non-Hispanic white adults. We found no evidence of a statistically significant reduction in private insurance coverage for any of the groups considered. These estimates are reported in the appendix.

To provide additional insight into the demographic differences in take-up behavior implied by these estimates, Table 1 presents the subgroup effects underlying Figure 4 alongside the 2013 uninsurance rate for each subgroup in the expansion states included in our sample.

Table 1. Medicaid Coverage Gains, Preexpansion Uninsurance Rates, and Implied Medicaid Take-Up Rates by Demographic Group for Nondisabled Childless Adults in Poverty

Demographic Group	Expansion Effect on Medicaid Coverage	2013 Uninsurance Rate in Expansion States	Implied Medicaid Take-Up Rate
Total			
Nondisabled childless adults in poverty	13%	42%	30%
Gender			
Men (base)	8%	36%	23%
Women***	17%	33%	52%
Race/ethnicity			
White non-Hispanic (base)	13%	39%	34%
Hispanic*	5%	35%	14%
Black non-Hispanic	20%	33%	62%
Other non-Hispanic***	–9%	25%	–37%
Age			
19–25 (base)	6%	30%	22%
26–35	4%	47%	9%
36–45**	23%	48%	47%
46–55***	27%	36%	75%
55–64*	16%	25%	66%
Health status			
Good or better health (base)	9%	39%	23%
Fair or poor health***	28%	26%	108%

SOURCE: Authors' calculations, 2009–2014 NHIS.
The expansion effect on Medicaid coverage is the adjusted differences-in-differences point estimate presented in Figure 2 (for all nondisabled childless adults in poverty) or Figure 3 (for subgroups).
The 2013 uninsurance rate was calculated for the estimation sample of nondisabled childless adults in poverty for the expansion states included in our analysis.
The implied take-up rate is the increase in Medicaid coverage caused by Medicaid expansion divided by the 2013 uninsurance rate.
P-values for significance of pairwise difference from base category effect are indicated as follows: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.
See the appendix for details of estimation and standard errors on Medicaid coverage effects.

The NHIS does not capture information on the past insurance status of most currently insured respondents, making it infeasible to calculate a take-up rate among the population of previously

uninsured individuals. However, we can give readers a sense of how the change in Medicaid coverage compares to the size of the uninsured population by scaling our estimates by the 2013 uninsurance rate in expansion states for each subgroup we examine. We labeled this ratio the "implied take-up rate" in order to distinguish it from the take-up rate among the previously insured (which we cannot estimate). If only individuals who were uninsured in 2013 enrolled in Medicaid following the expansion and there was no churn in insurance status for reasons unrelated to the ACA, this ratio would yield the take-up rate among previously uninsured individuals. However, we caution that insurance transitions are widespread even in the absence of policy changes, and that some reductions in private coverage may have resulted from Medicaid expansion.

The implied take-up rate for the overall population of nondisabled childless adults in poverty suggests that the majority of uninsured individuals in this population who gained Medicaid eligibility in 2014 did not enroll; dividing the 12.9-percentage-point increase in Medicaid coverage by the 42-percent uninsurance rate for this group in 2013 yields an implied take-up rate of 30 percent.

As indicated by Figure 4, implied take-up varied widely across subgroups. While 2013 uninsurance rates were roughly similar across genders and racial/ethnic groups, older adults and those in fair or poor health had sharply higher implied take-up rates than younger and healthier adults because the former groups had both lower rates of uninsurance and larger Medicaid coverage gains. Thus, while the overall implied take-up rate was 30 percent, the implied take-up rates for adults 35 and older ranged from 47 percent to 75 percent. For adults in fair or poor health, meanwhile, the increase in Medicaid coverage was slightly larger than the 2013 uninsurance rate, leading to an implied take-up rate just above 100 percent.

Discussion

We estimate that Medicaid expansion made low-income childless adults in Medicaid expansion states 8.9 percentage points more likely to be insured than they would have been without the expansion. Virtually all of this increase came from enrollment in Medicaid, with no significant evidence of offsetting reductions in private coverage. Our estimates for overall take-up and crowd-out are qualitatively similar to the findings of other differences-in-differences studies of the 2014 Medicaid expansion (see the appendix for further discussion). Our findings confirm that Medicaid take-up by the newly eligible contributed meaningfully to the increases in coverage observed in expansion states.

Assuming that our sample excludes adults previously eligible for comprehensive Medicaid benefits, our results can be interpreted as the effect of becoming newly Medicaid eligible on the probability of coverage among nondisabled childless adults in poverty. Most uninsured adults in our sample did not gain coverage in the first year of the expansion, however: Our estimated 12.6-percentage-point increase in Medicaid coverage represents only 30 percent of the 2013 uninsurance rate in this population (see the appendix). While low, this estimate is consistent with prior estimates of take-up among newly eligible adults (Busch and Duchovny, 2005).

We note several possible explanations for low take-up in the first year of the expansion. This relatively low take-up rate may result, in part, from the fact that there is no open enrollment period for Medicaid, so eligible individuals can delay enrollment until they seek care. The individual mandate, which could incentivize take-up among higher-income Medicaid-eligible individuals, is not applicable to most adults in poverty: Individuals with income below the federal tax income filing threshold are exempt from the mandate, and very few adults in poverty are required to file tax returns. In addition, because we did not observe immigration status, it is possible that some people whom we classify as newly eligible are in fact ineligible because of Medicaid's residency and citizenship requirements. Administrative reports from CMS suggest that Medicaid take-up continued to increase in 2015 and 2016 (CMS, 2016).

Our finding that newly eligible whites and Blacks experienced the biggest increase in Medicaid coverage is also noteworthy. Between 2013 and 2014, the nationwide uninsurance rate decreased more for Hispanics (6.9 percentage points) and non-Hispanic Blacks (4.3 percentage points) than for non-Hispanic whites (2.9 percentage points) (Cohen and Martinez, 2014, 2015a). Our findings suggest that larger gains in insurance coverage for some minority groups observed among the overall adult population were not driven by differential take-up of Medicaid among newly eligible adults. Estimates from the American Community Survey reported in a recent study that simultaneously stratifies on race, income, and state expansion status also suggest that differences in Medicaid take-up across racial and ethnic groups did not closely resemble changes in the uninsurance rate for individuals of all income levels in all states (Buchmueller et al., 2016).

Similarly, the age gradient we observed in reductions in uninsurance differs from the nationwide pattern found in the early-release NHIS data, which showed that the uninsurance rate

fell most for adults aged 18–24 (6.1 percentage points), followed by adults aged 25–34 (4.4 percentage points) (Cohen and Martinez, 2014, 2015a). While the nationwide population of adults aged 45–64 had a small reduction in uninsurance between 2013 and 2014, we found that childless nondisabled adults in poverty in this age range experienced the largest coverage gains due to the Medicaid expansion. While we reiterate that the implied take-up rates reported above are a very rough calculation that should not be interpreted as the probability that an uninsured adult gained Medicaid coverage, Table 1 indicates that take-up in the first year of the Medicaid expansion was higher among some subgroups—older adults and those in fair or poor health—who were more likely to be insured prior to Medicaid expansion. We note that our subgroup estimates do not contradict previously reported subgroup findings for the nationwide population, as our population of interest is a small fraction of the nationwide adult population and our sample excludes California and several other large states with high pre-ACA Medicaid eligibility.

We also found that newly eligible adults in fair or poor health were more likely to gain Medicaid coverage than healthier adults. We caution that, because self-rated health is evaluated at the time of the survey, these results could potentially be biased due to reverse causation from Medicaid coverage to self-rated health status. In a study with a similar differences-in-differences research design to ours, Simon, Soni, and Cawley (2016) found that the 2014 Medicaid expansion led to a small but significant improvement in self-rated health for childless adults in poverty. If Medicaid coverage improves self-rated health status, our estimated interaction effect between poor health and Medicaid coverage will be biased downward (away from our finding that poor health predicted Medicaid take-up). We note that the short-term effect of coverage on self-rated health is theoretically ambiguous because increased access to care could make adults newly aware of health problems without yielding immediate improvements in health. The analysis of the 2014 NHIS by Wherry and Miller does not indicate that Medicaid expansion was associated with any changes in self-rated health status for the overall low-income adult population (Wherry and Miller, 2016). While we cannot rule out reverse causation, there is no evidence to date that the Medicaid expansion harmed self-rated health status among newly eligible adults, which is the relationship that would be needed to generate bias in the direction of our estimates.

When juxtaposed with our finding that older adults had higher take-up of Medicaid, our finding that worse self-rated health was associated with Medicaid take-up adds to the evidence that individuals with greater health care needs were the first to enroll in coverage under the 2014 expansion. This pattern is consistent with pre-ACA research on Medicaid take-up, and it mirrors a recent study showing that early enrollees in Marketplace policies were older and more likely to use medication than later enrollees (Donohue et al., 2015; Kenney et al., 2012).

An alternative explanation is that, unlike those with private insurance, Medicaid-eligible individuals can delay enrollment until they need to interact with the health care system. This phenomenon—which has been termed conditional coverage—is one mechanism that could lead to a mechanical association between health care utilization and Medicaid take-up among the newly eligible population. The importance of conditional coverage is likely to be most pronounced in the period immediately following Medicaid expansion, since a higher proportion of newly eligible individuals is likely to have encounters with health care providers as time

passes. While our analysis does not distinguish between conditional coverage and other mechanisms that might generate higher take-up among those in fair or poor health, the contribution of conditional coverage to observed patterns of Medicaid take-up under the ACA is a question that may warrant further attention from researchers and policymakers. For instance, the policy implications of early data on per-enrollee Medicaid spending may depend on assumptions about whether conditionally covered individuals who do not seek care in a given time frame should be included in or excluded from the risk pool. Analysis of data from 2015 and subsequent years will help determine the extent to which the association between poor health and Medicaid coverage documented here is a short-run or a long-run phenomenon.

Conclusion

Our results corroborate findings from other data sources that insurance coverage increases were larger in states that expanded Medicaid. Our estimates add to the existing literature because our treatment and control groups were more narrowly defined to exclude those previously eligible for Medicaid and those directly affected by other coverage expansions. By focusing on the group most likely to gain Medicaid eligibility (nondisabled low-income childless adults) and by focusing on states that implemented the Medicaid expansion in 2014, this study clarifies the important role played by increased Medicaid coverage in previously reported coverage gains. We found very little evidence of differential changes in private coverage between expansion and nonexpansion states. Although our best estimate of the increase in overall insurance coverage was somewhat smaller than the increase in Medicaid coverage, our estimates by insurance type yielded no significant evidence that the Medicaid expansion crowded out private coverage in the first year of the 2014 coverage expansion.

While we found substantial increases in Medicaid coverage, our estimates nevertheless suggest that take-up over the first year of the 2014 Medicaid expansion was limited relative to the size of the Medicaid-eligible uninsured population. Our subgroup analyses indicated that take-up was lower among men (compared with women), Hispanics and members of other racial/ethnic groups (compared with non-Hispanic whites and Blacks), and adults under age 36 (compared with older adults). Finally, we found that newly eligible adults in fair or poor health were more likely to gain Medicaid coverage than healthier adults.

Our subgroup analyses suggest that heterogeneity across demographic groups in coverage gains and Medicaid take-up among nondisabled childless adults in poverty were often quite different from the patterns observed among all adults, with women and older adults more likely to gain Medicaid coverage than men and younger adults. Differences in immigration status, which we did not include in our data, may account for some of these subgroup patterns. However, the differences are quite large in magnitude, and we suspect that they primarily reflect enrollment and take-up behavior.

Policymakers interested in increasing Medicaid take-up among the newly eligible may wish to consider these findings in targeting future outreach efforts. A clearer understanding of take-up and crowd-out among the newly eligible may be especially important for anticipating the likely outcome if nonexpansion states adopt the Medicaid expansion in the future, since many of these states have very limited Medicaid eligibility under current law.

Appendix: Methods and Sensitivity Analyses

Sample Construction and Descriptive Statistics

The population of interest in this study consisted of childless adults aged 19–64 living in families with income below 100 percent of the applicable U.S. Department of Health and Human Services Federal Poverty Guideline who were not receiving SSI or SSDI benefits. We used the edited family structure and relationship variables in the final-release NHIS to classify families by the number of children aged 18 or under. The NHIS family structure variables define 18-year-olds as adults even though 18-year-olds count as children for the purposes of determining categorical Medicaid eligibility for parents and caretakers. Using the family relationship codes, we defined children as persons aged 18 and under with a parent, caretaker, aunt/uncle, or grandparent aged 19 or over present in the household and then classified adults according to the presence of children in the family.

Income is measured in the NHIS over the calendar year preceding the survey. Our research design requires classification of households by poverty status but does not require a precise measure of the level of income. The final-release NHIS contains a categorical variable reporting previous-year poverty status as defined by the Census Bureau poverty threshold. We used this variable as a criterion for inclusion in our analysis sample. While the NHIS suffers high item nonresponse—typically 22 to 32 percent in recent years—for the exact income question, since 2007 the NHIS has used unfolding brackets to elicit a range for family income from respondents unable to report an exact amount. Unfolding brackets are a survey method that seeks to reduce nonresponse by asking respondents who do not report an exact amount to answer a series of yes-or-no questions about whether their income is above or below a certain threshold. Critically for our research design, the bracket boundaries have been based on Census poverty thresholds since 2011. Unfolding brackets have reduced nonresponse substantially even though many NHIS respondents remain unable or unwilling to report an exact income amount: Only 7.5 percent of persons in the 2014 NHIS (7 percent unweighted) failed to report any bracketed information on family income.[1] We observed whether family income was above or below 100 percent of the FPL for all other individuals in the NHIS. Although we did not use the NHIS imputed income files, the relatively low rate of missing data in our sample is likely to limit the scope for sample selection bias as a result of our choice to exclude individuals with no information on poverty status.

We also excluded all individuals who reported receiving SSI income or Social Security income for their own disability (which is a reasonable proxy for SSDI) at any time in the previous calendar year.

[1] Authors' calculations, 2014 public-use NHIS. An additional 3 percent of families have a poverty ratio edited to "undefinable" because the number of persons under age 18 is equal to the family size. These families would be excluded from our sample based on age.

Panel A of Table A.1 reports the impact of each step in our sample definition on the number of observations available in the public-use NHIS. For all 50 states and the District of Columbia, the pooled public-use NHIS from 2009 through 2014 contains 16,907 childless adults living in families with income below 100 percent of the FPL and not receiving SSI or SSDI. Panel B of Table A.1 presents unweighted sample sizes by year.

Table A.1. Sample Construction Step-by-Step and Final Sample Sizes by Year and State Group

A. Number of observations in 2009–2014 public-use file	
Sample criteria	N
Adults aged 19–64 at time of survey in person file	362,981
Restrict to families with income below 100 percent of the FPL	51,518
Restrict sample to childless adults	21,572
Restrict to those not receiving SSI or SSDI benefits	16,907

B. Number of observations by year in analysis sample

Year	Nonexpansion states	2014 expansion states	Estimation sample	Excluded expansion states	All states
2009	1,050	384	1,434	688	2,122
2010	1,134	447	1,581	776	2,357
2011	1,393	602	1,995	1,001	2,996
2012	1,589	688	2,277	948	3,225
2013	1,341	665	2,006	942	2,948
2014	1,470	821	2,291	968	3,259
All years	7,977	3,607	11,584	5,323	16,907

The sample sizes for the public-use NHIS in Panel A of Table A.1 include the entire country and therefore overstate the sample size available for our analysis. Panel B of Table A.1 shows the sample size available by year and group of states. The sample size increases substantially over the first three years of the sample in part because adult poverty rates climbed sharply following the 2008–2009 Great Recession (DeNavas-Walt and Proctor, 2014). The NHIS's increased sample size after 2011 is also apparent. Our final sample contained 11,584 individuals, of which just over two-thirds were in nonexpansion states. The sample of expansion state residents in 2014 who represent the treated group in our differences-in-differences models contains 821 individuals.

Sample Means

Table A.2 presents sample averages for our insurance coverage and demographic variables for all years (2009–2014) pooled together. This table reports summary statistics separately for the 2014 expansion states and the nonexpansion states. In this table, as in all other calculations reported in this appendix, final person sampling weights are used unless otherwise noted.

Table A.2. 2009–2014 Sample Means for Nondisabled Childless Adults in Poverty

Insurance Coverage		2014 Expansion States	Nonexpansion States
	Any insurance	54.1%	50.2%
	Private insurance	33.8%	35.1%
	Medicaid	14.1%	8.3%
	Any public insurance	20.8%	15.6%
	Non-Medicaid public	6.7%	7.3%
	SCHIP	0.2%	0.4%
	Other public insurance	1.4%	1.5%
	Other government insurance	1.2%	1.0%
	Military insurance	2.1%	2.8%
	Medicare	3.4%	3.2%
Demographics			
	Age	36.2	36.6
	Married	16.4%	18.9%
	Female	46.8%	47.4%
Education			
	Less than high school/GED	18.9%	20.5%
	High school diploma/GED	28.3%	29.7%
	Some college	31.6%	29.3%
	College or more	21.2%	20.5%
Employment			
	Employed	44.5%	47.4%
	Unemployment	20.6%	16.2%
	Not in labor force	34.9%	36.3%
Race/ethnicity			
	Non-Hispanic white	65.2%	56.0%
	Hispanic	10.5%	14.8%
	Non-Hispanic Black	18.7%	23.4%
	Other	5.6%	5.8%
Self-reported health status			
	Good, very good, or excellent	68.0%	68.4%
	Fair or poor	32.0%	31.6%
N (unweighted)		3,607	7,977

Final person sampling weights used

NOTE: SCHIP = State Children's Health Insurance Program.

Table A.2 indicates that nondisabled adults in poverty are roughly 4 percentage points more likely to have insurance coverage in 2014 expansion states, though these figures include the impact of the Medicaid expansion. As shown in Figure 1 in the main text, both groups of states have similar levels of private insurance coverage and overall coverage, but expansion states had higher levels of Medicaid coverage prior to the expansion. We classified the type of insurance coverage into three categories: private insurance, Medicaid, and non-Medicaid public insurance. The non-Medicaid public insurance category includes all forms of federal, state, and local government insurance coverage other than Medicaid. Respondents were assigned to this category only if they reported public insurance coverage but did not report Medicaid coverage. Inclusion of this category in the analysis gave us an exhaustive classification of the types of insurance reported in the NHIS and allowed us to examine whether adults gaining Medicaid coverage under the ACA might represent transfers of previously insured adults from other government programs. Table A.2 tabulates the specific insurance types that constitute the "Other public" category reported in the figures in the main text. Coverage from other sources of public insurance is similar between 2014 expansion and nonexpansion states, although military insurance is slightly more common in nonexpansion states.

The remainder of Table A.2 reports the average demographic characteristics of our sample. On some basic demographics, including age and gender, respondents from two groups of states are very close to being balanced. On other characteristics, however, including marital status, education, and employment, moderate differences on the order of 1 to 4 percentage points are apparent. The sharpest differences are apparent on race and ethnicity: 65 percent of our expansion state population are non-Hispanic whites versus 56 percent of nonexpansion state respondents. The proportions of respondents that are Black or Hispanic are correspondingly higher in nonexpansion states. We controlled for all demographic characteristics listed in Table A.2 in our regressions.

Protocol for Defining 2014 Expansion States

This section describes our procedure for identifying states with pre-ACA categorical eligibility for childless adults.

An incremental contribution of this study is our focus on a treatment group consisting only of adults who became newly Medicaid-eligible in 2014. At present, published differences-in-differences estimates of the Medicaid expansion's impact on insurance status use less narrowly drawn samples and report differences between all states moving forward with the Medicaid expansion and those not moving forward, or average take-up. While a binary classification of states into expansion and nonexpansion states is informative, generous pre-ACA Medicaid eligibility in many of the expansion states makes it challenging to assign a behavioral interpretation to a differences-in-differences coefficient estimated on the full group of expansion states. One issue is that parents were categorically eligible for Medicaid in all states, and many of the expansion states had relatively generous income limits for parents in 2013 and earlier years: Among families with income below 100 percent of the FPL in the 27 states that had adopted the ACA expansion by the end of 2014, we estimate that roughly 90 percent of parents were

Medicaid-eligible in 2013.[2] In order to isolate the newly eligible, we restricted attention to childless adults throughout this study.

Restricting attention to childless adults was not sufficient to isolate the newly eligible population, however, because childless adults were eligible for coverage in many of the states that adopted the Medicaid expansion by the end of 2014. We estimated that 55 percent of childless adults in these states were Medicaid-eligible in 2013.[3] In order to isolate the newly eligible population, we coded Medicaid income limits for parents and childless adults in all states and excluded states in which childless adults were categorically eligible for comprehensive Medicaid benefits. This led us to exclude the six "early-expansion" states that had implemented the ACA Medicaid expansion before 2014, but it also led us to exclude an additional seven states. We refer to the 14 remaining expansion states as "2014 expansion states" to distinguish them from the 13 "excluded expansion states" in which at least some childless nondisabled adults were eligible for some form of comprehensive Medicaid benefits in 2013. The 2014 expansion states served as the treatment group in our differences-in-differences analysis, while all 24 of the states that had not adopted the ACA Medicaid expansion by the end of 2014 served as the control group.

Table A.3 lists our classification of states as 2014 expansion states, excluded expansion states, and nonexpansion states, along with the highest income limit for each state in 2013. Income limits are reported in modified adjusted gross income (MAGI) as a percentage of the FPL.

The remainder of this subsection explains our procedure for collecting and coding state Medicaid eligibility rules.

[2] Authors' calculations, 2013 Current Population Survey Annual Social and Economic Supplement (CPS ASEC). Eligibility was imputed by comparing 2012 MAGI approximated following Czajka (2013) to the relevant 2013 MAGI income limits coded as discussed below. We used the Integrated Public Use Microdata Series, Current Population Survey (IPUMS-CPS) for this analysis (Flood et al., 2015).

[3] Authors' calculations, 2013 CPS ASEC.

Table A.3. Classification of State Expansion Status

2014 Expansion States			Excluded Expansion States			Nonexpansion States		
	2013 Income Limits			2013 Income Limits			2013 Income Limits	
		Childless			Childless			Childless
State	Parents	Adults	State	Parents	Adults	State	Parents	Adults
AR	17	n.a.	CA†	211	210	AL	11	n.a.
AZ	106	n.a.	CO†	107	10	AK	106	n.a.
IL	195	n.a.	CT†	198	56	FL	30	n.a.
KY	20	n.a.	DC†	216	210	GA	34	n.a.
MD	123	n.a.	DE	107	108	ID	22	n.a.
MI*	54	n.a.	HI	208	208	IN	208	n.a.
ND	54	n.a.	IA	246	240	KS	30	n.a.
NH**	59	n.a.	MA	138	138	LA	18	n.a.
NM	47	n.a.	MN†	102	75	ME	208	n.a.
NV	30	n.a.	NJ†	61	25	MS	24	n.a.
OH	90	n.a.	NY	150	100	MO	18	n.a.
OR	50	n.a.	VT	195	157	MT	47	n.a.
RI	179	n.a.	WA†	133	133	NE	56	n.a.
WV	19	n.a.				NC	41	n.a.
						OK	41	n.a.
						PA	32	n.a.
						SC	62	n.a.
						SD	52	n.a.
						TN	99	n.a.
						TX	15	n.a.
						UT	42	n.a.
						VA	47	n.a.
						WI	201	n.a.
						WY	54	n.a.

Table reports highest income limit for 2013 reported in state MAGI conversion plans in terms of MAGI as a percentage of FPL.

Table reflects eligibility for comprehensive benefits (Medicaid state plan, Medicaid Managed Care, or waiver plans covering primary care, specialists, and hospital care). Plans with enrollment closed in 2011 or earlier are excluded.

* Michigan ACA expansion was implemented beginning in the second quarter of 2014.

** New Hampshire ACA expansion was implemented on August 15, 2014. We excluded data from the third quarter of 2014 for New Hampshire as a wash-out.

† indicates “early-expansion” states adopting the ACA expansion in part or in full prior to 2014.

MAGI Conversion Plans as Data Source on Medicaid Limits

In addition to the Medicaid coverage expansion, the ACA mandated major changes in how household income would be defined for the purposes of establishing Medicaid eligibility. Beginning in 2014, the ACA mandated that eligibility determinations for Medicaid, the Children's Health Insurance Program (CHIP), and exchange subsidies be made on the basis of MAGI.[4] Because pre-ACA net income concepts varied dramatically from state to state, the ACA required every state to calculate MAGI-based eligibility standards in 2013. MAGI conversion was required for groups involving parents/caretaker relatives, pregnant women, children under age 19, and childless adults. Even income standards that might seem irrelevant under the ACA Medicaid expansion (i.e., MAGI income limits for parents and children below 138 percent of the FPL in states moving forward with the expansion) were converted for several reasons, most notably that the health care costs of newly eligible and previously eligible beneficiaries are reimbursed at different Federal Medical Assistance Percentage rates.

Our primary sources for coding state Medicaid eligibility rules were the MAGI conversion plans submitted by the states to CMS. We collected MAGI conversion plans for 49 states and the District of Columbia from the CMS website (Medicaid.gov, undated[a]).[5] Two members of the research team reviewed the MAGI conversion plans available from the state web pages on the CMS website and independently entered the net income and MAGI income standards for every pathway covering families or childless adults. We did not enter pathways that applied to pregnant women or children. According to the Kaiser Family Foundation's survey of Medicaid program rules, the net income standard for pregnant women was above the poverty line in every state by 2013, meaning that the 2014 Medicaid expansion does not induce any variation in the eligibility of pregnant women (Heberlein, Brooks, Alker, et al., 2013).

The MAGI conversion plans often did not provide many details on the covered population or the type of benefits provided for each eligibility group. For the mandatory Section 1931 eligibility pathways (i.e., families meeting the former Aid to Families with Dependent Children [AFDC] income standards), it is clear that families with children are covered and traditional Medicaid benefits or Medicaid managed care is provided. However, there was significant ambiguity regarding the 1115 waiver pathways because the 1115 waivers encompass a very diverse group of programs and populations. We coded all 1115 waivers that were not clearly restricted to narrow benefits (e.g., family planning services) or targeted only to pregnant women or children.

Drawing guidance from the Kaiser Family Foundation's surveys of Medicaid eligibility (Heberlein, Brooks, Guyer, et al., 2011; Heberlein, Brooks, Guyer, et al., 2012; Heberlein, Brooks, Alker, et al., 2013), the first reviewer examined approved 1115 waivers obtained from the CMS website to identify the target population and scope of benefits for 1115 waivers

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[4] MAGI is a tax term that includes total gross income minus allowed deductions, plus certain tax-exempt income types, such as Social Security income, interest, and foreign income.

[5] All conversion plans were downloaded on March 13, 2015. All states except Massachusetts provided a conversion plan; we discuss our handling of Massachusetts below.

reported in the conversion plans that were ambiguous on these dimensions.[6] We determined that the MAGI conversion plans included a number of benefit plans that were significantly narrower than Medicaid in one of several ways, and we excluded from consideration 1115 pathways that met any of the following restrictions:

- Limited-benefit plans that do not cover both primary care and inpatient hospital care. Some 1115 plans cover only family planning services, or they cover only primary care in limited settings but do not cover hospital care. Our view is that these plans should be excluded from consideration because they are much less comprehensive than traditional Medicaid.
    - Maryland: The Primary Adult Care program provided "a limited primary care health benefit package to uninsured adults" (CMS, 2013a).
    - Michigan: The Adult Benefit Waiver program provided "a limited ambulatory care benefit package" (CMS, 2014).
    - Missouri: Gateway to Better Health is a program limited to St. Louis County providing "a limited primary care package" to beneficiaries who receive care at specified Federally Qualified Health Centers (CMS, 2013b).
    - Vermont: The Catamount health waiver program, available to those with incomes up to 300 percent of the FPL, is described as limited. (It also does not affect our analysis because another 1115 waiver goes up to 150 percent of the FPL.)
- Plans that provide premium assistance for private employer-sponsored coverage or the individual market. Some of these plans are limited to employees of participating employers. We also suspect that premium support for employer-sponsored insurance or individual market coverage is likely to be reported as private insurance in the NHIS rather than Medicaid.
    - Arkansas: The Safety Net Benefit Program provides premium assistance for employer-sponsored insurance (CMS, 2012b).
    - Oklahoma: Insure Oklahoma provides premium assistance for employer-sponsored insurance or individual market coverage (CMS, 2011).
- Plans that were closed to new enrollment in 2011 or earlier. While there may be a stock of enrollees in some closed plans prior to 2014, we assumed that closed plans were likely to have negligible enrollment.
    - Arizona: The 1115 program for childless adults with incomes up to 100 percent of the FPL was phased out in mid-2011 (CMS, 2012a).
    - Indiana: In the Healthy Indiana program, enrollment for childless adults was closed.
    - Maine: The 1115 program for childless adults up to 100 percent of the FPL was closed prior to 2014 (the timing is unclear from the waiver).
    - Wisconsin: BadgerCare Core covered childless adults up to 200 percent of the FPL with a limited benefits package. (The benefits package meets our criterion of covering both primary and inpatient care.) However, a binding enrollment cap was imposed shortly after coverage was expanded to childless adults, and the state

[6] All waiver applications cited were obtained from the Medicaid website on May 22–25, 2015 (Medicaid.gov, undated[b]).

reported in a waiver application that the childless adult waiting list was approximately seven times larger than the enrolled population in 2013.

Other plans that deviate in some way from traditional Medicaid but offer a comprehensive benefit were included in our database. In particular, we included

- Medicaid managed care
- state plans that charge premiums to some beneficiaries.

There are two states for which no family or childless adult income standards were reported in the MAGI conversion reports. A MAGI conversion plan for Massachusetts was not submitted to CMS. This may be due to the fact that Massachusetts had already implemented health care reform prior to the ACA. In any event, Massachusetts does not contribute any identifying variation to our research design because all low-income adults were eligible for Medicaid or subsidized coverage prior to 2014 (Heberlein et al., 2011). We assigned Massachusetts MAGI limits of 138 percent of the FPL for families and childless adults in all years so that all adults in our analysis sample were classified as Medicaid-eligible.

The other state missing MAGI conversion information was Texas. Texas submitted a conversion report, but the conversion report described the income limit for Section 1931 families as "AFDC" without further elaboration. We used the 2014 MAGI income standard of 15 percent for families reported for Texas by CMS as our proxy for the MAGI limit, and we used this standard to impute pre-ACA eligibility throughout the 2009–2013 period.[7]

The MAGI conversion plans are a valuable data source, but it was necessary to draw on additional references and data sources to verify the accuracy and completeness of the income standards reported in the conversion plans. For instance, one limitation of using the MAGI conversion plans is that states could choose not to provide conversion estimates for Medicaid pathways that would not be used in 2014 and later years.[8] The MAGI conversion plans also do not report pathways covering childless adults that were established in two states (Connecticut and Minnesota) following enactment of the ACA, nor do they report pathways in several other states (New York and Washington). We assigned MAGI limits to these states as follows:

- Connecticut: Childless adults, 56 percent of the FPL (early ACA expansion as reported in Sommers, Arntson, et al. [2013] and Herz [2012])
- Minnesota: Childless adults, 75 percent of the FPL (early ACA expansion as reported in Sommers, Arntson, et al. [2013] and Herz [2012])
- New York: Childless adults, 100 percent of the FPL; parents, 150 percent of the FPL (Family Plus taken from Kaiser Family Foundation)
- Washington: Childless adults and parents, 133 percent of the FPL (conversion of the state Basic Health plan to 1115 waiver, coded from Kaiser Family Foundation).

We compared the results of our coded income standards to the Kaiser Family Foundation's widely used survey of state Medicaid eligibility to identify any pathways that were omitted from

[7] The only change in eligibility for Texas parents reported by the Kaiser Family Foundation is a 1-percentage-point decline in the standard for working parents between 2012 and 2013. Texas does not report offering any optional eligibility groups for families in the MAGI report or the other sources we consulted.

[8] In practice, very few of the discontinued pathways represented the highest income limit for families, so this limitation did not affect our ability to classify state Medicaid policies in earlier years.

the MAGI conversion reports and to assist in locating additional sources clarifying the status of pathways that were incompletely described in the conversion plans (Heberlein, Brooks, Guyer, et al., 2012; Heberlein, Brooks, Alker, et al., 2013) We also drew on a Congressional Research Service report to identify the statutory authority used by certain states to support early implementation of the ACA expansion (Herz, 2012). For 1115 eligibility pathways, we also attempted to compare our database to the 2012 program rules coded in the Urban Institute's TRIM3 microsimulation model (TRIM3, 2012, accessed May 18–27, 2015). The TRIM3 rules agreed with our coded limits except for the following cases, which we resolved in favor of the MAGI conversion reports:

- Hawaii: TRIM3 reported 100 percent for parents versus 208 percent in the MAGI conversion plan.
- Minnesota: TRIM3 reported 215 percent for parents versus 102 percent in the MAGI conversion plan. We follow Sommers, Kenney, and Epstein (2014) in coding Minnesota's income limit as 75 percent of the FPL.[9]
- New Jersey: TRIM3 reported 200 percent for parents versus 27 percent (61 percent MAGI) in the MAGI conversion reports. The 200-percent threshold corresponds to the NJ FamilyCare waiver program. However, NJ FamilyCare's 2013 annual report states that enrollment is closed for all pathways applicable to adults with income above 100 percent of the FPL. The same source reports that the number of beneficiaries in the state was essentially flat between December 2010 and December 2013, consistent with enrollment being closed to higher-income adults. We ignored the 200-percent eligibility pathway for New Jersey.
- Tennessee: TRIM3 reported 400 percent for parents, which we did not find documented elsewhere and therefore ignored.

Statistical Methods

We applied a regression-adjusted differences-in-differences approach to estimate the effect of expanded Medicaid eligibility. Because we used multiple years of pre-2014 data, our main specification relaxed the assumption that outcomes would have evolved identically in expansion and opt-out states if the expansion states had also opted out. We modeled outcome of interest y_{ist} for individual i in state s in quarter t as the sum of a state-specific intercept term (μ_s) for people in state s, a time effect (ν_t) that varied freely by year and quarter but was common to all states, the effect of i's demographic characteristics (X_{it}), the effect of a linear time trend (t, coded as the number of quarters elapsed since the end of 2008) that was present only for the expansion

[9] "Based on a comparison of MinnesotaCare and General Assistance Medical Care (GAMC) populations that were transitioned to Medicaid at the outset of the expansion, versus March 2013 expansion enrollment statistics provided by the Minnesota Department of Human Services. GAMC had an income cutoff of 75 percent of poverty but also used an asset test (which was eliminated under the 2010 expansion). MinnesotaCare offered coverage as high as 250 percent of poverty but had a state cap on total spending that often limited enrollment" (Sommers, Kenney, and Epstein, 2014, p. 79).

states, the effect of a binary variable (T_{st}) that equaled 1 if the Medicaid expansion was in effect in state s during quarter t and equaled 0 otherwise, and a mean-zero error term (ε_{ist}):

$$y_{ist} = \tau_T T_{st} + X_{it}\beta_X + \beta_T t1\{\text{s is expansion state}\} + \mu_s + \nu_t + \varepsilon_{ist},$$

where β_X is a vector of coefficients on individual characteristics X_{it} and β_T is the coefficient on the differential time trend. The parameter of interest is τ_T, which can be interpreted as the average effect of the Medicaid expansion on outcome y, holding an individual's demographic characteristics constant. The coefficient τ_T directly captures the predicted change in the probability of y_{ist} associated with the Medicaid expansion and is scaled as a fraction; for example, if τ_T in a model for any insurance coverage were 0.1, we would conclude that the Medicaid expansion had increased the probability that a nondisabled childless adult in poverty had insurance coverage by 10 percentage points.

The basic differences-in-differences approach effectively compares trends over time in expansion and nonexpansion states to assess whether trends diverged after the Medicaid expansion took effect on January 1, 2014. Because the approach focuses on changes within states rather than absolute differences, it enables us control for any fixed differences between expansion and nonexpansion states, including permanent unobserved differences. For example, the approach controls for underlying differences in the quality of hospitals and physicians across states, time-invariant differences in the stigma or hassle associated with Medicaid enrollment, fixed differences in individuals' awareness of the law, and any other time-invariant factors that may influence outcomes. The inclusion of individual characteristics X_{it} corrects the estimated differences-in-differences effect τ_T for differences in the composition of our population of interest across states and over time and improves the statistical power of the model by reducing the unexplained variation in the outcome y_{ist}.

The potential advantage of our model over differences-in-differences without trends is that the benchmark for changes in outcomes in expansion states takes into account trends observed in those states in 2009 through 2013, as well as any deviation from 2009 through 2013 trends observed in the opt-out states in 2014. While the differences-in-differences model with group-specific time trends can be unreliable when the number of time periods observed before policy implementation is small relative to the number of time periods observed in postimplementation data (Wolfers, 2006), we have enough preimplementation time periods (20 quarters) relative to postimplementation time periods (four quarters) that this is unlikely to be a major concern. Another risk of using trends is that unmodeled preimplementation activities (e.g., outreach starting in 2013) could affect our estimated trends, potentially biasing the estimated effects of Medicaid expansion on coverage downward. We address this possibility below by estimating alternative models that drop 2013 data as a preimplementation wash-out period.

For most of the 2014 expansion states, T_{st} is equal to 1 in 2014 and 0 in all other years. Two states in our sample—Michigan and New Hampshire—began the Medicaid expansion after January 1, 2014. Michigan's ACA expansion was implemented beginning in the second quarter of 2014. We coded the treatment indicator T_{st} for Michigan to 0 in the first quarter of 2014 and to 1 in subsequent quarters. New Hampshire's ACA expansion was implemented on August 15,

2014. We excluded data from the third quarter of 2014 for New Hampshire as a wash-out period and coded the treatment indicator T_{st} for New Hampshire to 1 only in the fourth quarter of 2014.

Alternative Specifications

In this appendix, we also report basic differences-in-differences estimates that do not control for a differential time trend in the expansion states:

$$y_{ist} = \tau_T T_{st} + X_{it}\beta_X + \mu_s + \nu_t + \varepsilon_{ist}.$$

This model makes stronger assumptions than the model in our main specification, and so it delivers more precise estimates, but it is not robust to violations of the assumption that expansion and nonexpansion states would have had parallel trends in coverage in the absence of the ACA.

To address the possibility that Medicaid expansion activities would affect coverage or reporting behavior prior to the 2014 implementation date, we estimated models both with and without differential trends that dropped 2013 data.

Estimation and Statistical Inference

Our regression specification is a linear probability model (LPM), and we estimated this model by ordinary least squares (OLS) regression. While the LPM does not explicitly account for the binary nature of the outcome variable, it can be justified as an approximation to the conditional expectation function of y_{ist} given the explanatory variables (Angrist and Pischke, 2008). Because all of our explanatory variables except the linear time trend are all binary or categorical, inconsistency arising from values of the regression function outside the unit interval may be limited in our specification. Our choice of the LPM over a fully parametric binary choice model, such as logistic regression, was motivated largely by our concerns about clustering—i.e., unmodeled correlation of the error term within states and over time. Standard maximum likelihood estimates of the logistic regression model are inconsistent in this setting, while OLS remains consistent as long as the error term is uncorrelated with the regressors.

Classical inference assuming independent and identically distributed error terms is inappropriate in our setting for several reasons. First, our outcomes are binary variables, leading to conditional heteroskedasticity. Second, the stratified sampling design of the NHIS requires estimation procedures that account for sampling design using the stratum and primary sampling unit variables on the NHIS files in addition to sampling weights. However, standard survey estimation procedures using the NHIS design variables are inappropriate for our application because these procedures assume statistical independence of error terms across survey strata, and many states contain multiple strata—the public-use NHIS identifies 300 unique strata.

We believe that error terms are most likely correlated across time periods within states. To the extent that state health policy, economic conditions, labor market regulation, and other factors that vary at the state level cause states to experience different dynamics of insurance coverage prior to ACA implementation, error terms will be correlated across states within time. This can be the case even if our regression model is correctly specified. Furthermore, our identifying variation exists at the state level. While our regression estimates would remain

consistent in such a scenario, inference that uses the NHIS survey design variables may lead to underestimates of standard errors and overrejection of null hypotheses.

We used standard errors clustered by state to account for arbitrary correlation of the error term within state as well as conditional heteroskedasticity. Survey strata are nested within states, so our inference approach should be viewed as more conservative than inference using the NHIS design variables. Our main estimation sample contains 38 clusters (states). We calculated p-values and confidence intervals using a t-distribution with 37 degrees of freedom, as suggested by Cameron and Miller (2015).

Results and Robustness Checks

Table A.4 presents our main regression estimates (Column 5) in addition to a range of other specifications used to assess the robustness of our results. Column 1, which includes no covariates except for state and time fixed effects, is used to assess the significance of the "unadjusted differences-in-differences" effects of Medicaid expansion referenced in the main text. Column 2 presents analogous estimates using all available pre-ACA years (2009–2013) as the baseline instead of only 2013 data.

Column 3 reports basic regression-adjusted differences-in-differences estimates that control for individual covariates but do not include differential trends in coverage in the expansion states. Omitting the differential trends yields estimated increases in Medicaid and private coverage that are each roughly 3 percentage points higher than in our main specification. However, the point estimates for our main model (Column 5) fall well within the 95-percent confidence intervals implied by Column 3, and vice versa, and we view these findings as being qualitatively similar. The model without differential time trends (Column 3) does yield a meaningfully larger increase in overall insurance coverage (14.9 percentage points versus 8.9 percentage points in our main model), though this point estimate also falls within the 95-percent confidence interval for our main model.

Table A.4. Differences-in-Differences and Regression-Adjusted Estimates of Medicaid Expansion Effect

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Years	2013–2014	2009–2014	2009–2014	2009–2012, 2014	2009–2014	2009–2012, 2014	2009–2014	2009–2014	2009–2014
Control for covariates?			Y	Y	Y	Y	Y	Y	Y
State group–specific time trends?					Linear	Linear	Quadratic		Linear
Model excludes employment?								Y	Y
Any insurance	0.126	0.173	0.149	0.160	0.089	0.100	0.080	0.161	0.106
	(0.030)	(0.028)	(0.027)	(0.028)	(0.041)	(0.043)	(0.043)	(0.028)	(0.042)
	0.000	0.000	0.000	0.000	0.034	0.025	0.072	0.000	0.016
Medicaid	0.149	0.158	0.154	0.155	0.126	0.108	0.120	0.163	0.135
	(0.033)	(0.023)	(0.023)	(0.024)	(0.027)	(0.028)	(0.033)	(0.023)	(0.026)
	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.000	0.000
Private insurance	-0.001	0.016	-0.006	-0.002	-0.032	-0.027	0.027	-0.008	-0.029
	(0.033)	(0.023)	(0.019)	(0.018)	(0.035)	(0.045)	(0.044)	(0.020)	(0.034)
	0.967	0.501	0.758	0.926	0.371	0.559	0.534	0.700	0.386
Non-Medicaid public insurance	-0.010	0.013	0.014	0.021	0.006	0.029	-0.055	0.019	0.011
	(0.019)	(0.010)	(0.011)	(0.010)	(0.019)	(0.021)	(0.029)	(0.011)	(0.020)
	0.611	0.232	0.197	0.050	0.755	0.178	0.060	0.095	0.592
N	4,297	11,584	11,584	9,578	11,584	9,578	11,584	11,584	11,584

SOURCE: 2009–2014 National Health Interview Survey.
NOTES: Each cell reports the differences-in-differences regression coefficient for the effect of the 2014 Medicaid expansion from a separate OLS regression model.
Standard errors clustered on state (38 clusters) are in parentheses; two-sided p-values for equality to 0 are reported below standard errors. P-values were calculated based on a t-distribution with 37 degrees of freedom.
The sample consists of nondisabled childless adults aged 19–64 with annual family income below 100 percent of the FPL.
States with any categorical eligibility for nondisabled childless adults in 2013 are excluded from the sample. These 13 states are California, Colorado, Connecticut,

Delaware, the District of Columbia, Hawaii, Iowa, Massachusetts, Minnesota, New Jersey, New York, Vermont, and Washington.
All regressions include state and quarter fixed effects. Covariates include age categories (19–25, 26–35, 46–55, and 56–64), gender, binary marital status, four racial/ethnic groups (non-Hispanic white, Hispanic, non-Hispanic Black, and other), educational attainment (less than high school, high school diploma or GED, some college, college diploma, and more than college), and employment status (employed, unemployed, not in labor force, and unknown).

Columns 4 and 6 report regression specifications that are identical to those in Columns 3 and 5 but that are estimated on a sample that excludes data from 2013 as a wash-out period that could potentially be affected by state-specific activities related to the 2014 Medicaid expansion. These estimates do not differ meaningfully from the corresponding estimates that include 2013 data.

Column 7 adds a quadratic term to the specification of the differential time trend in the expansion states. The estimated impacts on overall insurance coverage and Medicaid are very close to those estimated in our main model, as reported in Column 5. The estimated effect of expansion on private coverage is insignificant and positive, while the effect on non-Medicaid public coverage becomes negative and statistically significant. This specification yields estimated impacts on private and other public coverage that do not resemble any of the other specifications we estimated. We view these results as a warning that the quadratic specification of the differential trends may be undesirably sensitive to the data from 2009, when the expansion states had lower rates of private coverage and higher rates of other public coverage relative to the nonexpansion states than in later years.

Finally, Columns 8 and 9 report regression specifications that are identical to those in Columns 3 and 5 but that omit the control variable for current employment status; some readers may be concerned that it is inappropriate to include employment status as a control variable because labor supply may respond to Medicaid eligibility (Garthwaite, Gross, and Notowidigdo, 2014). These estimates do not differ meaningfully from the corresponding estimates based on our main specification.

Comparison with Other Published Differences-in-Differences Estimates

We stated in the main text that our basic findings about take-up with limited crowd-out were qualitatively consistent with the other published differences-in-differences estimates using large federal surveys. Here we provide a more detailed comparison of our results and the two peer-reviewed studies to date that used large federal surveys to estimate differences-in-differences models for the coverage effects of Medicaid expansion. An earlier paper by Sommers et al. also used a differences-in-differences research design with tracking survey data from the Gallup-Healthways Well-Being Index (Sommers, Gunja, et al., 2015b). Sommers et al. were not able to reliably distinguish between different sources of coverage, and they did not distinguish between expansion states with different pre-ACA Medicaid policies, but they also found significant reductions in uninsurance (5.2 percentage points) among adults with family income of 138 percent of the FPL or below.

Compared with the 2016 paper by Wherry and Miller that also analyzed the 2014 NHIS, we found larger increases in Medicaid and overall coverage. Wherry and Miller estimated that Medicaid expansion increased overall insurance coverage by 7.4 percentage points and increased Medicaid coverage by 10.5 percentage points. We also found slightly weaker evidence of reductions in private insurance, which Wherry and Miller calculate decreased by a marginally significant 3.7 percentage points ($p = 0.07$) in their main estimates.

There are two major differences between our research design and Wherry and Miller's, which should have offsetting impacts on the magnitude of our estimated effects. On the one hand, because we focus on a population that experienced sharper increases in Medicaid

eligibility, our estimates may tend to be larger than those reported by Wherry and Miller. Specifically, we excluded adults with incomes between 100 percent and 138 percent of the FPL, we excluded parents, we used data collected in all quarters of 2014 while they dropped the first two quarters as a wash-out period, and we excluded eight expansion states included in their analysis (California, Colorado, Connecticut, Hawaii, Iowa, Minnesota, New Jersey, and Washington).

On the other hand, because, unlike Wherry and Miller, we control for differential linear trends in expansion and nonexpansion states, our estimates may tend to be smaller. The models reported in Column 3 of Table A.3, which omit pre-trends and thus correspond most closely to Wherry and Miller's specification, yield much larger estimated increases in overall coverage and Medicaid coverage with no evidence of reductions in private coverage.

Courtemanche, Marton, and Yelowitz (2016) analyzed data from the 2013–2014 American Community Survey to track changes in insurance by poverty ratio and state expansion status. They estimated that adults in poverty in expansion states became 8.8 percentage points more likely to be insured between 2013 and 2014, versus 4.7 percentage points in nonexpansion states, suggesting that Medicaid expansion was associated with a 4.1-percentage-point increase in insurance coverage for adults in poverty. They also reported rates of public and private coverage. Those estimates imply that Medicaid expansion was associated with a 6.1-percentage-point increase in public coverage and a 1.9-percentage-point decrease in private coverage. However, this study is not directly comparable to ours because it groups childless adults and parents together, and because the main models report results for all 50 states and the District of Columbia.

Take-Up and Crowd-Out Rates

Our regression coefficient for Medicaid coverage may be interpreted directly as a take-up rate because it captures the change in the probability of Medicaid coverage that resulted from gaining eligibility. To provide additional context for interpreting this estimate, we can scale this estimate by the 2013 uninsurance rate for nondisabled childless adults in poverty in our sample, which we estimated to be 42.0 percent. The increase in Medicaid coverage was equivalent to 30 percent of the pre-ACA uninsurance rate. Similarly, the reduction in uninsurance was equivalent to 21.3 percent of the pre-ACA uninsurance rate.

We can also scale our estimated change in private coverage by the change in Medicaid coverage to obtain a crowd-out rate in terms of the change in private coverage per new Medicaid enrollee. The point estimate from the model controlling for differential trends is 25 percent crowd-out, but we note that the change in private coverage is not significantly different from 0, and so the crowd-out ratio is too imprecisely estimated to be very informative: The 95-percent confidence interval based on delta-method standard errors covers crowd-out rates from –26 percent to 76 percent. The crowd-out estimate from the model without differential trends is close to 0 (4 percent), with a delta-method 95-percent confidence interval covering [–21 percent, 28.5 percent].

Because the ratio of two normal random variables can be highly non-normal if the denominator is close to 0, we also used the variance-covariance matrix of our regression

estimates for private coverage and Medicaid to examine the distribution of the crowd-out ratio by simulation. The resulting 95-percent confidence interval was [–38 percent, 71 percent], which is not meaningfully different from the delta-method estimate. This is not surprising; the estimated increase in Medicaid coverage is highly significant, so there were essentially no draws that were very close to 0. The estimated increase in Medicaid is even larger when pre-trends are omitted, so the delta-method confidence interval falls within 1 percentage point of the simulated confidence interval.

Assessing the Importance of Differential Time Trends

The only specification choice that had a substantial effect on our estimates was the inclusion of a differential time trend in the expansion states: The estimated effect of the expansion on Medicaid and private coverage was slightly less positive when differential trends were included, and the impact on overall coverage was lower. To assess the importance of differential trends, Table A.5 reports the coefficients β_T for the differential time trends, standard errors, and p-values for equality to 0. Coefficients and standard errors were multiplied by 4 so that they could be interpreted as the predicted annual increase in insurance coverage in expansion states relative to nonexpansion states after controlling for individual covariates and state and time fixed effects.

As suggested by Figure 1 in the main text, insurance coverage was trending upward in expansion states relative to nonexpansion states by 2 percentage points per year prior to 2014. Point estimates in Column 1 suggest that this increase was accounted for by both Medicaid coverage and private coverage, although the private coverage pre-trend was imprecisely estimated.

In our main model (Column 1 of Table A.5), the coefficients β_T on the linear pre-ACA time trends were not statistically significant when compared with the t-distribution that we considered appropriate for our clustering scheme. However, the pre-trends for any insurance (p = 0.102) and Medicaid coverage (p = 0.105) were extremely close to being significant at the 10-percent level. In fact, comparison to critical values from the normal distribution (1.64 for the 10-percent level) rather than the t-distribution with 37 degrees of freedom (1.69) would identify both of these coefficients as marginally significant. Thus, even though the differential trends were insignificant at conventional levels, they were close enough to significance that we did not feel comfortable relying on the parallel trends assumption for our main estimates.

A potential limitation of our main specification is that the pre-ACA time trend could be contaminated by postimplementation dynamics if 2014 Medicaid expansion led to a trend break in insurance coverage, with effects increasing over the course of 2014. We viewed this as a minor concern for our main specification because our dataset contained five years of preimplementation data but only one year of postimplementation data. To examine whether failure to allow for dynamics following implementation affected our estimates of differential time trends by expansion status, we estimated a model that allowed the differences-in-differences treatment effect to vary freely from quarter to quarter in 2014. In this specification, any postimplementation trend in outcomes was absorbed by the quarter-specific treatment effects and therefore could not affect our estimate of the differential trend in insurance for expansion states. The resulting estimates of the time trend are reported in Column 2 of Table A.5. The estimates

are very close to the time trends estimated in our main specification, suggesting that postimplementation dynamics do not account for the differential trends we estimate.

Finally, Column 3 of Table A.5 reports coefficients on trends that omitted 2013 data as a wash-out period, since it is reasonable to attribute differential trends to the early effects of activities associated with Medicaid expansion. The magnitudes of the preexisting trends were similar to the estimates including 2013 data, however, and the trend in Medicaid coverage was larger and clearly significant ($p = 0.034$) when 2013 data were excluded. We have included Table A.5 to allow interested readers to understand our motivations for favoring the model with differential pre-ACA trends as our main specification and to place the estimates with and without differential trends in context.

Table A.5. Coefficients on Preexpansion Linear Time Trends

	(1)	(2)	(3)
Years	2009–2014	2009–2014	2009–2012, 2014
Control for covariates?	Y	Y	Y
Quarter-specific effects of 2014 expansion?*		Y	
Preimplementation trend: Any insurance	0.021	0.022	0.018
	(0.013)	(0.012)	(0.013)
	0.102	0.067	0.185
Preimplementation trend: Medicaid	0.010	0.013	0.014
	(0.006)	(0.006)	(0.007)
	0.105	0.037	0.034
Preimplementation trend: Private insurance	0.009	0.007	0.008
	(0.009)	(0.009)	(0.012)
	0.312	0.467	0.536
Preimplementation trend: Non-Medicaid public insurance	0.003	0.004	-0.002
	(0.004)	(0.004)	(0.005)
	0.506	0.281	0.656
N	11,584	11,584	9,578

Table reports coefficients on linear time trends specific to expansion states included in models from columns 5–6 in Table A.4.

Time trend coefficients and standard errors scaled up by 4 to represent predicted increase in insurance coverage over 1 year for expansion states relative to nonexpansion states.

Regressions also control for sociodemographics, year-quarter time effects, state fixed effects, and dummy variable for expansion states in 2014.

* Model contains four dummies for the quarters of 2014 interacted with the indicator for expansion state status.

Standard errors clustered by state (38 clusters) are in parentheses.

P-values for equality of time trend to 0 are below standard errors.

P-values are based on t-distribution with 37 degrees of freedom and standard errors clustered on state.

Subgroup Analyses

We estimated that the majority of nondisabled childless adults in poverty who gained Medicaid eligibility in 2014 did not enroll in Medicaid. In order to learn more about the characteristics of those individuals who gained insurance because of the ACA Medicaid expansion, we conducted several subgroup analyses. We interacted the treatment variable in our main differences-in-differences regression models with indicators for group membership to yield the following model, which allows the effect of the 2014 Medicaid expansion to vary freely across groups indexed by G:

$$y_{ist} = \tau_T T_{st} + \sum_{G \in \mathbb{G}} \tau_G T_{st} 1\{i \text{ is in } G\} + X_{it}\beta_X + \mu_s + \nu_t + \varepsilon_{ist}$$

where G is a set of subgroups excluding a base category. We estimated this model for the following groups:

- race (base category: non-Hispanic white)
- gender (base category: male)
- age (base category: ages 19–25)
- self-reported health status (base category: good, very good, or excellent health).

Table A.6 reports coefficients from these four models for three sets of outcomes: any insurance coverage, Medicaid, and private coverage. The Medicaid estimates are reported in Figure 3 in the main text. Similar figures for the other insurance types are presented as Figures A.1 and A.2. As discussed in the main text, subgroup patterns for any insurance are very similar to the patterns observed for Medicaid, while none of the subgroups experienced a significant decrease in private coverage.

Table A.6. Subgroup Effects of Medicaid Expansion on Insurance Coverage

Years	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014
Control for covariates?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
State group–specific time trends?	Linear	Linear	Linear	Linear	Linear	Linear	Linear	Linear	Linear	Linear	Linear	Linear	Linear
Subgroup model	Gender	Gender	Race Non-Hispanic white	Race	Race Non-Hispanic Black	Race Other non-Hispanic	Age	Age	Age	Age	Age	Health Good or better health	Health Fair or poor health
Subgroup	Men	Women		Hispanic			19–25	26–35	36–45	46–55	55–64		
Effect type	Base	Interaction	Base	Interaction	Interaction	Interaction	Base	Interaction	Interaction	Interaction	Interaction	Base	Interaction
Any insurance	0.052	0.076	0.100	0.000	-0.013	-0.180	0.036	0.005	0.145	0.123	0.127	0.054	0.181
	(0.038)	(0.028)	(0.039)	(0.083)	(0.034)	(0.061)	(0.034)	(0.049)	(0.069)	(0.040)	(0.076)	(0.039)	(0.032)
	0.183	0.011	0.013	0.997	0.704	0.005	0.304	0.922	0.044	0.004	0.101	0.173	0.000
Medicaid	0.085	0.084	0.132	-0.082	0.073	-0.224	0.065	-0.023	0.160	0.205	0.099	0.088	0.192
	(0.029)	(0.019)	(0.033)	(0.043)	(0.061)	(0.038)	(0.024)	(0.044)	(0.064)	(0.035)	(0.057)	(0.021)	(0.048)
	0.006	0.000	0.000	0.062	0.238	0.000	0.011	0.605	0.017	0.000	0.089	0.000	0.000
Private insurance	-0.026	-0.011	-0.028	0.103	-0.071	-0.040	-0.029	0.032	-0.003	-0.075	0.039	-0.032	0.004
	(0.032)	(0.037)	(0.026)	(0.070)	(0.068)	(0.064)	(0.037)	(0.087)	(0.051)	(0.056)	(0.052)	(0.033)	(0.048)
	0.421	0.765	0.282	0.148	0.303	0.534	0.432	0.710	0.958	0.187	0.466	0.342	0.937
N	11,584	11,584	11,584	11,584	11,584	11,584	11,584	11,584	11,584	11,584	11,584	11,584	11,584

SOURCE: 2009–2014 National Health Interview Survey.

NOTES: Subgroup analysis was conducted using regression specifications in which a differences-in-differences treatment variable was interacted with dummies for subgroup membership.

The base category coefficient is the effect of the expansion, but the interaction coefficient is the difference in the effect of the expansion between the subgroup at hand and the base category.

Standard errors clustered on state (38 clusters) are in parentheses; two-sided p-values for equality to 0 are reported below standard errors. P-values were calculated based on a t-distribution with 37 degrees of freedom.

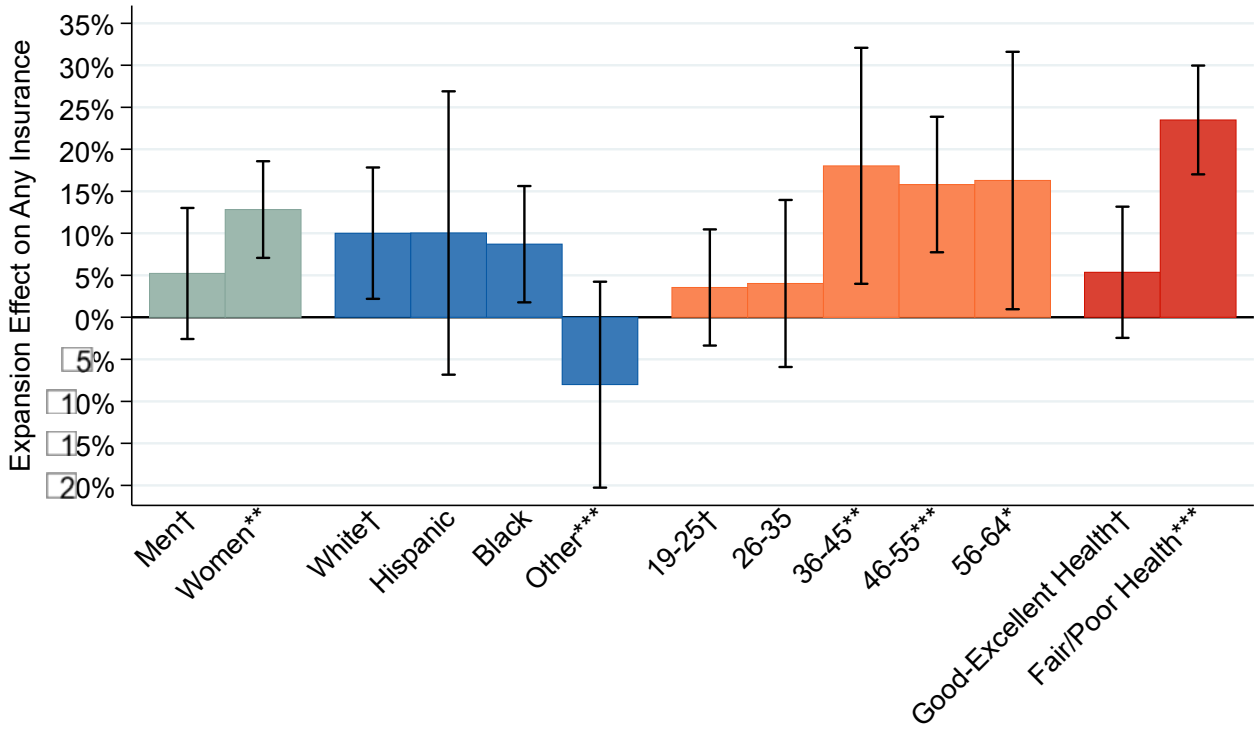
The sample consists of nondisabled childless adults aged 19–64 with annual family income below 100 percent of the FPL.

States with any categorical eligibility for nondisabled childless adults in 2013 are excluded from the sample. These 13 states are California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Iowa, Massachusetts, Minnesota, New Jersey, New York, Vermont, and Washington.

All regressions include state and quarter fixed effects. Covariates include age categories (19–25, 26–35, 36–45, 46–55, and 56–64), gender, binary marital status, four racial/ethnic groups (non-Hispanic white, Hispanic, non-Hispanic Black, and other), educational attainment (less than high school, high school diploma or

GED, some college, college diploma, and more than college), and employment status (employed, unemployed, not in labor force, and unknown).

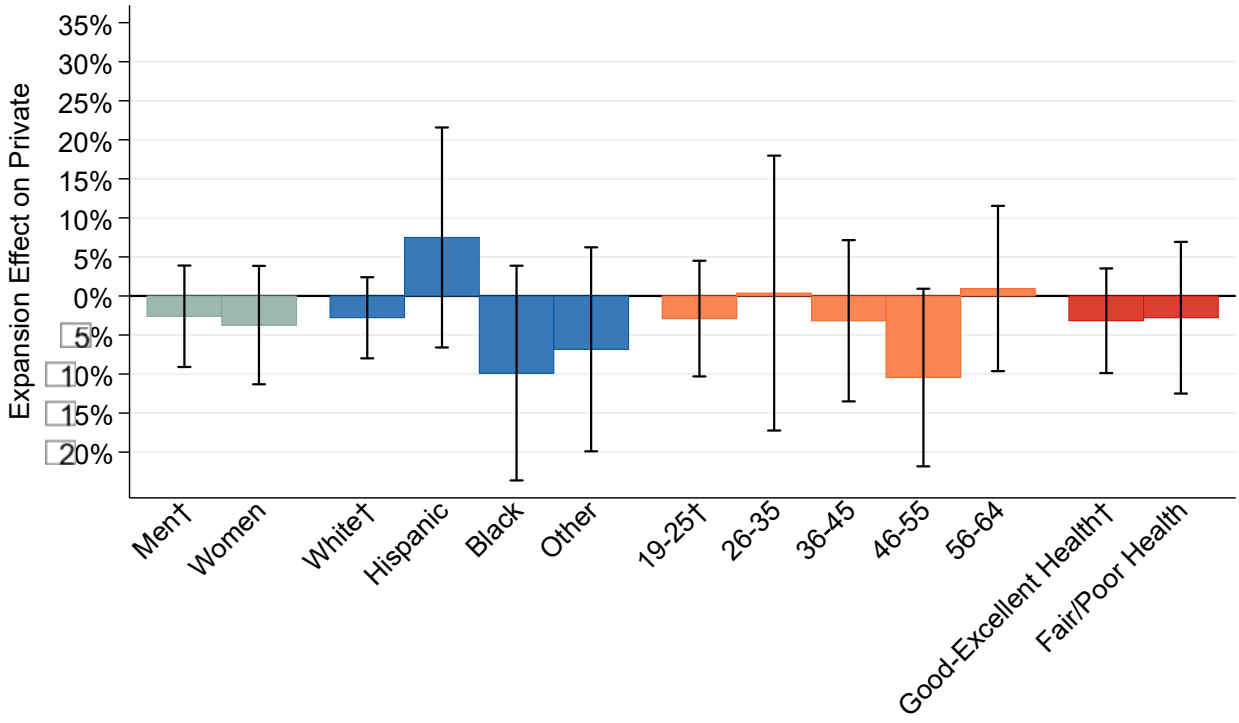
Figure A.1. Subgroup Effects on Probability of Any Insurance Coverage



NOTES: This figure shows the regression-adjusted differences-in-differences effects of ACA Medicaid expansion on any insurance coverage for subgroups. Base effects are estimated as a coefficient on a dummy variable equal to 1 in expansion states after the implementation date and equal to 0 otherwise. Interaction effects are estimated as a coefficient on interaction between the expansion dummy variable and a dummy variable for subgroup membership. Effects are reported in percentage points.

Effects are estimated using linear regressions controlling for gender, age, marital status, race, educational attainment, employment status, time (year-quarter) fixed effects, state fixed effects, and a linear time trend specific to expansion states.
† This indicates the base category in the regression model; other bars report the sum of base and interaction effects.
P-values for difference from base category effect are indicated as follows: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.
Error bars report 95-percent confidence intervals based on t-distribution with 37 degrees of freedom and standard errors clustered on state. Confidence intervals for interaction effects treat base coefficients as known.

Figure A.2. Subgroup Effects on Probability of Private Coverage



NOTES: This figure shows the regression-adjusted differences-in-differences effects of ACA Medicaid expansion on private insurance coverage for subgroups. Base effects are estimated as a coefficient on a dummy variable equal to 1 in expansion states after the implementation date and equal to 0 otherwise. Interaction effects are estimated as a coefficient on interaction between the expansion dummy variable and a dummy variable for subgroup membership. Effects are reported in percentage points.
Effects are estimated using linear regressions controlling for gender, age, marital status, race, educational attainment, employment status, time (year-quarter) fixed

effects, state fixed effects, and a linear time trend specific to expansion states.
† This indicates the base category in the regression model; other bars report the sum of base and interaction effects.
P-values for difference from base category effect are indicated as follows: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.
Error bars report 95-percent confidence intervals based on t-distribution with 37 degrees of freedom and standard errors clustered on state. Confidence intervals for interaction effects treat base coefficients as known.

Differences-in-Differences Effects of Medicaid Expansion for Wider Groups of States

In order to isolate a population of low-income childless adults with limited Medicaid eligibility prior to implementation of the 2014 Medicaid expansion, we excluded from our analysis 13 of the 27 states that had implemented the expansion by the end of 2014. To place our main coverage estimates and subgroup findings in context, Table A.7 reports estimates for several expanded samples that encompass these excluded expansion states.

Column 1 of Table A.7 reproduces our main estimates for reference, and Column 4 reproduces estimates for our main sample from a model that omits differential trends. Columns 2 and 5 of Table A.7 present estimates of our model with and without differential time trends for an expanded sample of 2014 expansion states that adds to the treatment group four expansion states that provided Medicaid eligibility to childless adults in 2013 but that imposed income limits below 100 percent of the FPL. We refer to these four states (Colorado, Connecticut, Minnesota, and New Jersey) as partial expansion states. We prefer to exclude them from our main specification because pre-2014 eligibility undermines the interpretation of our differences-in-differences model as capturing the effect of Medicaid expansion among the newly eligible. Adding these states to our main specification (Column 2) yields estimates that are close to the estimates for the 2014 expansion states. However, the effects of Medicaid expansion on Medicaid and private insurance are slightly lower, resulting in a lower estimate of the increase in overall insurance coverage that is no longer significant at the 5-percent level ($p = 0.073$).

However, because all four of these partial expansion states used early implementation of the ACA to expand Medicaid between 2010 and 2014, controlling for pre-2014 trends in a sample that includes these states seems inappropriate. Estimates that omit pre-2014 differential time trends were indistinguishable from estimates of the same specification for our sample of 2014 expansion states.

Columns 3 and 6 of Table A.7 expand the sample further to include all 50 states and the District of Columbia. The increase in Medicaid coverage is highly significant and is very close to the estimate for the 2014 expansion states in both the model with differential trends (13.1-percentage-point increase) and the model without differential trends (15.2-percentage-point increase). The change in private coverage becomes more negative (5.8-percentage-point decrease) and statistically significant ($p = 0.033$) when differential trends are included, but inclusion of differential trends is even less appropriate in this sample because this differential trend is likely to reflect coverage gains resulting from early implementation of the ACA, most notably in California (Sommers, Chua, et al., 2015a; Golberstein, Gonzales, and Sommers, 2015). Even if differential trends are omitted from the model, however, we find a marginally statistically significant ($p = 0.057$) reduction in private coverage (3.3-percentage-point reduction) associated with the 2014 Medicaid expansion when all expansion states are included in the sample.

Comparison of these results (Table A.7, Column 6) with the our main estimates for the 2014 expansion states (Table A.7, Column 4) and the sample including partial expansion states (Table A.7, Column 5) suggests strongly that this reduction in private coverage is driven by the nine expansion states where all adults with income below 100 percent of the FPL were Medicaid-

eligible in 2013. Because this population was fully eligible prior to 2014, estimates for this group of states reflect welcome-mat effects. These findings warrant further investigation, but we did not focus on them in this study because we suspect that insurance coverage changes in 2014 among the previously Medicaid-eligible are likely to reflect fundamentally different mechanisms than coverage changes among the newly eligible. That is, we think that welcome-mat effects and take-up among the newly eligible should be studied separately. We are exploring these differences further in work in progress using the NHIS, but larger surveys, such as the CPS ASEC or the American Community Survey, may be better suited to examining state-specific differences among the low-income adult population. (We are also limited by the terms of our access agreement with NCHS, which does not provide for disclosure of state-specific estimates.)

Table A.7. Coverage Effects for Broader Groups of States

	(1)	(2)	(3)	(4)	(5)	(6)
Years	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014	2009–2014
Main sample included*	Y	Y	Y	Y	Y	Y
Sample includes partial 2014 expansion states**		Y	Y		Y	Y
Sample includes all expansion states***			Y			Y
Control for covariates?	Y	Y	Y	Y	Y	Y
State group–specific time trends?	Linear	Linear	Linear			
Any insurance	0.089	0.066	0.044	0.149	0.138	0.104
	(0.041)	(0.036)	(0.037)	(0.027)	(0.024)	(0.026)
	0.034	0.073	0.238	0.000	0.000	0.000
Medicaid	0.126	0.118	0.131	0.154	0.142	0.152
	(0.027)	(0.026)	(0.028)	(0.023)	(0.022)	(0.024)
	0.000	0.000	0.000	0.000	0.000	0.000
Private insurance	-0.032	-0.040	-0.058	-0.006	0.001	-0.033
	(0.035)	(0.032)	(0.026)	(0.019)	(0.019)	(0.017)
	0.371	0.220	0.033	0.758	0.968	0.057
Non-Medicaid public insurance	0.006	-0.007	-0.024	0.014	0.004	-0.008
	(0.019)	(0.020)	(0.015)	(0.011)	(0.012)	(0.011)
	0.755	0.716	0.132	0.197	0.766	0.469
Number of states in model	38	42	51	38	42	51
N	11,584	†	16,907	11,584	†	16,907

* This sample was restricted to nonexpansion states and expansion states with no categorical eligiblity for

nondisabled childless adults in 2013.
** Partial 2014 expansion states had categorical eligibility for childless adults with an income limit below 100 percent of the FPL in 2013. These states are Colorado, Connecticut, Minnesota, and New Jersey.
*** This sample includes all expansion states.
† Sample size including partial expansion states was not released from the NCHS RDC.
SOURCE: 2009–2014 National Health Interview Survey.
NOTES: Each cell reports the differences-in-differences regression coefficient for the effect of the 2014 Medicaid expansion from a separate OLS regression model.
Standard errors clustered on state are in parentheses; two-sided p-values for equality to 0 are reported below standard errors. P-values were calculated based on a t-distribution with G minus 1 degree of freedom, where G is the number of clusters.
All samples consist of nondisabled childless adults aged 19–64 with annual family income at or below 100 percent of the FPL.
All regressions include state and quarter fixed effects. Covariates include age categories (19–25, 26–35, 36–45, 46–55, and 56–64), gender, binary marital status, four racial/ethnic groups (non-Hispanic white, Hispanic, non-Hispanic Black, and other), educational attainment (less than high school, high school diploma or GED, some college, college diploma, and more than college), and employment status (employed, unemployed, not in labor force, and unknown).

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The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review

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Issue Brief

A substantial body of research has investigated effects of the Medicaid expansion under the Affordable Care Act (ACA) on coverage; access to care, utilization, affordability, and health outcomes; and various economic measures. This issue brief summarizes findings from 202 studies of the impact of state Medicaid expansions under the ACA published beginning in January 2014 (when the coverage provisions of the ACA went into effect) and updates earlier versions of this brief with studies through February 2018.[1] More recent studies continue to support earlier findings but provide additional findings in key areas, including expansion's effects on health outcomes, access to services and medications for behavioral health and other needs, and providers' financial stability.

Key Findings

This body of research suggests that the expansion presents an opportunity for gains in coverage, improvements in access and financial security, and economic benefits for states and providers.

- **Coverage:** Studies show that Medicaid expansion states experienced significant coverage gains and reductions in uninsured rates, among the low-income population broadly and within specific vulnerable populations. States that implemented the expansion through a waiver have seen coverage gains, but some waiver provisions appear to compromise coverage. Data do not support a relationship between states' expansion status and community-based services waiver waiting lists.
- **Access to care, utilization, affordability, and health outcomes:** Most research demonstrates that Medicaid expansion has positively affected access to care, utilization of services, the affordability of care, and financial security among the low-income population. However, findings on provider capacity were mixed, with some studies suggesting that provider shortages are a challenge in certain contexts. Studies show improved self-reported health following expansion, and multiple new studies demonstrate a positive association between expansion and health outcomes. Further research is needed to more fully determine effects on outcomes given that it may take additional time for measureable changes in health outcomes to occur.
- **Economic measures:** Analyses find positive effects of expansion on numerous economic outcomes, despite Medicaid enrollment growth initially exceeding projections in many states. Total (federal and state) Medicaid spending increased following expansion implementation, but research suggests that there were no significant increases in state spending from state funds as a result of the expansion through 2015 (although an uptick in state Medicaid spending growth was projected for 2017 and later years as the federal share for the expansion population phases down from 100% to 90%). Studies also show that Medicaid expansions result in reductions in uncompensated care costs for hospitals and clinics as well as positive or neutral effects on employment and the labor market.

This literature review includes studies, analyses, and reports published by government, research, and policy organizations using data from 2014 or later. This brief only includes studies that examine impacts of the Medicaid expansion in expansion states. It excludes studies on impacts of ACA coverage expansions generally (not specific to Medicaid expansion alone), studies investigating potential effects of expansion in states that have not (or had not, at the time of the study) expanded Medicaid, and reports from advocacy organizations and media sources. Findings are separated into three broad categories: Medicaid expansion's impact on coverage; access to care, utilization, affordability, and health outcomes; and economic outcomes for the expansion states. The Appendix at the end of the brief provides a list of citations for each of the included studies, grouped by the three categories of findings.

Recently published studies from late 2017 and early 2018 have continued to support earlier findings while using the additional years of experience with expansion to deepen findings in many areas, including expansion's effects on health outcomes, access to services and medications for behavioral health and other needs, and providers' financial stability. Among other findings, new studies in these areas show that expansion is associated with infant mortality rate reductions, increases in cancer diagnosis rates (especially early-stage diagnosis rates), increases in prescriptions for and Medicaid coverage of medications to treat opioid use disorder and opioid overdose, and reduced probability of hospital closure (particularly in rural areas).

We will continue to monitor and update these findings as additional studies and state experiences provide insight into how various factors shape coverage, access to care, and costs in Medicaid expansion states and as states continue to consider expansion and reshape Medicaid coverage. While future research will be necessary to study the effects of new waiver provisions recently approved by or pending approval (https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/) from the Trump administration, findings from this literature review on states with existing expansion waivers (such as Indiana) suggest that adding new restrictions or program complexities to Medicaid through Section 1115 waivers could compromise coverage and access gains achieved under expansion or slow future progress.

Impacts on Coverage

UNINSURED RATE AND MEDICAID COVERAGE CHANGES

Studies show that Medicaid expansion results in significant coverage gains and reductions in uninsured rates.

- States expanding their Medicaid programs under the ACA have seen large increases in Medicaid enrollment, driven by enrollment of adults made newly eligible for Medicaid as well as enrollment growth among individuals who were previously eligible for but not enrolled in Medicaid (known as the "woodwork" or "welcome mat" effect that occurred largely due to incentives to increase enrollment in coverage provided under the broader ACA). In comparison, non-expansion states have experienced slower enrollment growth.[2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24]
- Numerous analyses demonstrate that Medicaid expansion states experienced large reductions in uninsured rates and that these reductions significantly exceed those in non-expansion states.[25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55,56]
    - Recent studies have shown that expansion-related enrollment growth in Medicaid and declines in uninsured rates in expansion states continued in 2015 and 2016, and that the gap between coverage rates in expansion and non-expansion states continued to widen after 2014. One study found that the greater uninsured rate decline in expansion compared to non-expansion states was isolated among the population that is ineligible for ACA coverage in non-expansion states (those below 100% FPL).[57,58,59,60,61,62]

- The sharp declines in uninsured rates among the low-income population in expansion states are widely attributed to gains in Medicaid coverage.[63,64,65,66,67,68]
- Research does not support a relationship between states' Medicaid expansion status and home and community-based services (HCBS) waiver waiting lists. One study found that most expansion states either had no HCBS waiver waiting list or had a decrease in their waiting list from 2014 to 2015, and more non-expansion states than expansion states experienced an HCBS waiver waiting list increase between 2014 and 2015.[69]
- Studies exploring the potential for Medicaid expansion to "crowd-out" private insurance have found mixed results, with most showing no evidence of "crowd-out" and some showing slight declines in private coverage in expansion states following expansion.[70,71,72,73,74,75,76,77,78]

Similar coverage gain patterns have occurred within specific vulnerable populations.

- While many studies focused on the low-income population broadly, several studies identified larger coverage gains in expansion versus non-expansion states for specific vulnerable populations, including young adults, prescription drug users, people with HIV, veterans, parents, mothers, women of reproductive age (with and without children), children, lesbian, gay, and bisexual adults, newly diagnosed cancer patients, women diagnosed with a gynecologic malignancy, low-income workers, low-educated adults, early retirees, and childless adults with incomes under 100% FPL.[79,80,81,82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98,99,100,101,102]
- Multiple recent analyses demonstrate that Medicaid expansion is having a disproportionately positive impact in rural areas in expansion states, where growth in Medicaid coverage and declines in uninsured rates have exceeded those in metropolitan areas in expansion states and both rural and metropolitan areas in non-expansion states. One study found higher Medicaid growth rates in metropolitan counties compared to rural counties in both expansion and non-expansion states, but the geographic differential in growth rates was much less dramatic in expansion states and analysis at the state level showed much variability across the states.[103,104,105,106]
- Multiple studies showed that this trend of larger uninsured rate reductions and Medicaid coverage gains in expansion states compared to non-expansion states occurred across the major racial/ethnic categories. Additional research also suggests that Medicaid expansion has helped to reduce disparities in coverage by income and age, and research shows improvements in disparities by race/ethnicity, with mixed outcomes for some specific racial and ethnic groups.[107,108,109,110,111,112,113,114,115,116]
- One 2017 study demonstrated a clear "welcome-mat" effect of Medicaid expansion on enrollment in public coverage among children who were already eligible for Medicaid. Enrollment increases in 2014 and 2015 among children whose parents became newly eligible for Medicaid under the expansion outpaced coverage increases among children in families without newly eligible parents by more than double.[117]

COVERAGE EFFECTS UNDER SECTION 1115 MEDICAID EXPANSION WAIVERS

States implementing the expansion through a waiver have seen similar gains in coverage, but some provisions in these waivers may present barriers to coverage.

- Studies show that states expanding Medicaid through Section 1115 waivers have experienced coverage gains that are similar to gains in states implementing traditional Medicaid expansions. Research comparing Arkansas (which expanded through a premium assistance model) and Kentucky (which expanded through a traditional, non-waiver model) showed no significant differences in uninsured rate declines between 2013 and 2015 in the two states. An analysis of expansion waiver programs in Michigan and Indiana showed that both states experienced uninsured rate reductions between 2013 and 2015 that were higher than the average decrease among expansion states as well as large gains in Medicaid enrollment.[118,119,120,121]
- Data from Indiana, which implemented the expansion through a Section 1115 waiver, show that its required monthly contributions may have created an enrollment barrier for some adults. In the Healthy Indiana Plan (HIP) 2.0 Medicaid expansion program, individuals above 100% FPL are either not enrolled or disenrolled from HIP 2.0 coverage for unpaid monthly contributions. A report assessing the program showed that between February 1, 2015 and November 30, 2016, 57,189 members were disenrolled or not enrolled due do non-payment (representing 29% of those that could be affected by the policy).[122,123]
- Evidence also suggests that beneficiaries and other stakeholders often do not fully understand complex enrollment policies such as the HIP 2.0 monthly contribution policy, and these policies can deter eligible people from enrolling in coverage. The March 2017 HIP 2.0 evaluation found that 14% of all HIP enrollees above 100% FPL, 33% of individuals who were disenrolled for not making a monthly contribution, and 40% of individuals who were not enrolled because they did not make a first monthly contribution reported being unaware that they could be disenrolled for non-payment.[124,125,126]

Impacts on Access to Care, Utilization, Affordability, and Health Outcomes

ACCESS TO CARE AND UTILIZATION

Most research demonstrates that Medicaid expansion positively impacts access to care and utilization of health care services among the low-income population, but some studies have not identified significant effects in these areas.

- Many expansion studies point to improvements across a wide range of measures of access to care as well as utilization of some medications and services. Some of this research also shows that improved access to care and utilization is leading to increases in diagnoses of a range of diseases and conditions and in the number of adults receiving consistent care for a chronic condition.[127,128,129,130,131,132,133,134,135,136,137,138,139,140,141,142,143,144,145,146,147,148,149,150,151,152,153,154,155,156,157,158,159,160,161,162,163,164,165,166,167,168,169,170,171,172,173,174,175,176,177] For example:
  - Two studies found that expansion was associated with significantly greater increases in cancer diagnosis rates (especially early-stage diagnosis rates), and another study showed an association of expansion with an increase in the probability of early uncomplicated presentation for patients admitted to hospitals for one of five common surgical conditions. A fourth study found that Medicaid expansion was correlated with increased heart transplant listing rates for African

American patients (both overall and among Medicaid enrollees, specifically).[178,179,180,181]

- Recent evidence demonstrates that compared to non-expansion states, Medicaid expansion states have seen greater improvements in access to medications and services for the treatment of behavioral and mental health conditions. This evidence includes studies that have shown that Medicaid expansion is associated with increases in overall prescriptions for, Medicaid-covered prescriptions for, and Medicaid spending on medications to treat opioid use disorder and opioid overdose. Additional research found increased utilization and Medicaid coverage of evidence-based smoking cessation medications post-expansion in expansion states relative to non-expansion states.[182,183,184,185,186,187,188,189,190,191,192,193]
- Multiple recent studies have also found expansion to be associated with improvements in disparities by race and income, education level, and employment status in measures of access to and affordability of care.[194,195,196,197]
- Studies conducted in 2017 and 2018 began to explore the effect of the Medicaid expansion on quality of care. A January 2018 study found that for patients with one of five common surgical conditions admitted to an academic medical center or affiliated hospital, expansion was associated with a significantly greater probability of receiving optimal care. Another study found that at federally funded community health centers, expansion was associated with improved quality on four of eight measures examined: asthma treatment, Pap testing, body mass index assessment, and hypertension control. A third study found some improvement in perceived quality of care associated with expansion in 2015, but this result did not persist in 2016.[198,199,200]
- Some studies point to changes in patterns of use of emergency departments (EDs). Two recent single-state studies in Maryland and Illinois found declines in uninsured ED visits and increases in Medicaid-covered ED visits following expansion implementation. Some studies have explored expansion's impact on total emergency department (ED) volume and utilization patterns. A single-state study in Maryland found no significant relationship between Medicaid expansion and changes in total ED volume by hospital. An Illinois study found an increase in total ED visits after ACA implementation, but this included an increase in visits by individuals with private coverage. One study in a single hospital in Maryland found that, in the year after expansion, there was a small but statistically significant reduction in the proportion of ED patients that were high utilizers and a reduction in visits to the ED for ambulatory care sensitive conditions. However, high utilizers remained more likely than low utilizers to have ED visits for ambulatory care sensitive conditions before and after Medicaid expansion.[201,202,203]
- Two studies found that Medicaid expansion was associated with declines in hospital length-of-stay for Medicaid patients. Another analysis found that, contrary to past studies associating Medicaid insurance with longer hospitalizations and higher in-hospital mortality, the shift in payer mix in expansion states (increase in Medicaid discharges and decrease in uninsured discharges) did not influence length of stay or in-hospital mortality for general medicine patients at academic medical centers.[204,205,206]

- Evidence suggests that beneficiaries and other stakeholders lack understanding of some waiver provisions designed to change utilization or improve health outcomes.

Multiple studies have demonstrated confusion among beneficiaries, providers, and advocates in expansion waiver states around the basic elements of the programs or requirements for participation, as well as beneficiary reports of barriers to completion of program activities (including internet access and transportation barriers). These challenges have resulted in increased costs to beneficiaries, beneficiaries being transitioned to more limited benefit packages, low program participation, or programs not operating as intended in other ways.[207,208,209,210,211]

- A few studies did not find significant positive effects of expansion on certain measures of access or utilization. For several of the earlier studies in this group, these results may reflect the additional time needed for persons to enroll in Medicaid and establish care following initial expansion implementation. Authors of early studies using 2014 data note that changes in utilization may take more than one year to materialize. Consistent with this premise, a longer-term study found improvements in measures of access to care and financial strain in year two of the expansion that were not observed in the first year.[212,213,214,215,216,217]
- While some research indicates that provider shortages are a challenge in certain contexts, many studies show that providers have expanded capacity and are meeting increased demands for care.[218,219,220,221,222,223,224,225,226,227,228,229,230,231,232,233,234,235,236,237] For example:
  - One study found that Medicaid expansion was associated with longer wait times for appointments, suggesting remaining access challenges despite improvements in coverage and access measures.[238]
  - In contrast, another study found that Medicaid primary care appointment availability increased significantly in the five expansion states included in the analysis, whereas there were no significant changes in appointment availability in the non-expansion states studied.[239]
  - An additional study found improvements in receipt of checkups, care for chronic conditions, and quality of care even in areas with primary care shortages, suggesting that insurance expansions can have a positive impact even in areas with relative shortages.[240]

AFFORDABILITY AND FINANCIAL SECURITY

Research suggests that Medicaid expansion improves the affordability of care and financial security among the low-income population.

- Several studies show that expansion states have experienced greater reductions in unmet medical need because of cost than non-expansion states. Although a few studies did not identify statistically significant differences in changes in unmet medical need due to cost between expansion and non-expansion states,some of these findings may have been affected by study design or data limitations.[241,242,243,244,245,246,247,248,249,250,251,252,253,254,255,256,257,258]
- Research suggests that Medicaid expansion results in significant reductions in out-of-pocket medical spending. One study found that previously uninsured prescription drug users who gained Medicaid coverage in 2014 saw, on average, a $205 reduction in annual out-of-pocket spending in 2014. The January 2018 study noted above that focused on the 100-138% FPL population in expansion and non-expansion states also found that Medicaid expansion coverage produced far greater reductions than

subsidized Marketplace coverage in average total out-of-pocket spending, average out-of-pocket premium spending, and average cost-sharing spending.[259,260,261,262,263]

- Multiple studies found larger declines in trouble paying as well as worry about paying future medical bills in expansion states relative to non-expansion states.[264,265,266,267,268,269,270,271,272,273,274,275] For example:
  - One study found that, among those residing in areas with high shares of low-income, uninsured individuals, Medicaid expansion significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies. Similarly, other studies have found that Medicaid expansion has significantly reduced the percentage of people with medical debt, reduced the average size of medical debt, reduced the average number of collections, improved credit scores, reduced the probability of having one or more medical bills go to collections in the past 6 months, and reduced the probability of a new bankruptcy filing, among other improvements in measures of financial security.[276,277,278,279]
  - A study of Ohio's Medicaid expansion found that the percentage of expansion enrollees with medical debt fell by nearly half since enrolling in Medicaid (55.8% had debt prior to enrollment, 30.8% had debt at the time of the study).[280]

SELF-REPORTED HEALTH AND HEALTH OUTCOMES

Continually emerging research has documented improvements in self-reported health and certain health outcomes measures following Medicaid expansion.

- Multiple studies have found improvements in measures of self-reported health following Medicaid expansions, and additional research has documented provider reports of newly eligible adults receiving life-saving or life-changing treatments that they could not obtain prior to expansion.[281,282,283,284,285,286]
- One 2017 study found that Medicaid expansion was associated with improved health outcomes for cardiac surgery patients, including a significant decrease in predicted preoperative risk of morbidity or mortality and a decreased risk-adjusted rate of postoperative major morbidity.[287]
- A January 2018 study suggests that expansion may contribute to infant mortality rate reductions. While the mean infant mortality rate rose slightly in non-expansion states between 2014 and 2016, it declined in expansion states over that period. This effect was particularly pronounced among the African-American population.[288]
- A 2018 study found no evidence of expansion affecting drug-related overdoses or fatal alcohol poisonings.[289]
- Four analyses did not find significant changes in self-reported health status. Given that it may take additional time for measureable changes in health to occur, researchers suggest that further work is needed to provide longer-term insight into expansion's effects on self-reported health and health outcomes.[290,291,292,293]

Economic Effects

STATE BUDGETS AND ECONOMIES

Analyses find positive effects of expansion on multiple economic outcomes, despite Medicaid enrollment growth initially exceeding projections in many states and increases in total Medicaid spending, largely driven by increases in federal spending given the enhanced federal match rate for expansion population costs provided under the ACA (the federal share was 100% for 2014-2016 and phases down to 90% for 2020 and subsequent years).

- National, multi-state, and single state studies show that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth. A 2016 study found that growth in state Medicaid spending in expansion states has been lower relative to non-expansion states, but an uptick was predicted for state fiscal year (SFY) 2017, primarily due to the phase-down in the federal share for the expansion population from 100% to 95% in 2017. As of the end of Summer 2016, several expansion states planned to use provider taxes or fees to fund all or part of the state share of expansion costs beginning in 2017. While studies showed higher growth rates in total Medicaid spending (federal, state, and local) following initial expansion implementation in 2014 and 2015, this growth rate slowed significantly in 2016.[294,295,296,297,298,299,300,301,302,303,304,305,306]
    - National research found that there were no significant increases in spending from state funds as a result of Medicaid expansion and no significant reductions in state spending on education, transportation, or other state programs as a result of expansion during FYs 2010-2015.[307]
    - A Louisiana annual report on Medicaid expansion reported that expansion saved the state $199 million in FY 2017 due to multiple factors, including the higher federal match rate for Medicaid populations that were previously funded at the regular state match rate, additional revenue from a premium tax on managed care organizations, and a decrease in state disproportionate share payments to hospitals as the uninsured population decreased.[308]
- Multiple studies suggest that Medicaid expansion can result in state savings by offsetting state costs in other areas, including state costs related to behavioral health services, crime and the criminal justice system, and Supplemental Security Income program costs. For example, a study on Montana revealed that as Medicaid's role in financing substance use disorder (SUD) services has grown under the state's decision to expand Medicaid, federal Medicaid dollars have replaced federal block grant and state dollars previously used to fund services for uninsured Montanans with SUD.[309,310,311,312,313,314,315,316]

MEDICAID SPENDING PER ENROLLEE

- National studies have found lower Medicaid spending per enrollee for the new ACA adult eligibility group compared to traditional Medicaid enrollees and that per enrollee costs for newly eligible adults have declined over time since initial implementation of the expansion.[317,318,319]
    - One analysis found that in 2014, among those states reporting both spending and enrollment data, spending per enrollee for the new adult group was much lower than spending per enrollee for traditional Medicaid enrollees.[320]

- A June 2017 study showed that per enrollee Medicaid spending declined in expansion states (-5.1%) but increased in non-expansion states (5.1%) between 2013 and 2014. Researchers attributed these trends to the ACA Medicaid expansion, which increased the share of relatively less expensive enrollees in the Medicaid beneficiary population mix in expansion states.[321]
- The 2016 Actuarial Report on the Financial Outlook for Medicaid shows that while the average per enrollee costs for newly eligible adults in initial years following expansion were higher than for previously eligible adults, these per enrollee costs have declined over time as states have adjusted capitation rates to better reflect actual use. By 2018, the cost for newly eligible adults is projected to be less than that of previously eligible adults.[322]

MARKETPLACE EFFECTS

- Research suggests that Medicaid expansion may contribute to lower Marketplace premiums—one study found that Marketplace premiums are about 7% lower in expansion compared to non-expansion states. The study authors suggested that the difference in premiums reflects a difference in risk pool between expansion and non-expansion states, where individuals between 100 and 138% FPL make up a greater share of Marketplace enrollment in non-expansion compared to expansion states. Another study found that the state average plan liability risk score was higher in non-expansion than expansion states in 2015 (higher risk scores are associated with sicker state risk pools and likely translate to higher premiums).[323,324,325]
  - A study in Arkansas showed that the "private option" expansion has helped to boost the number of carriers offering Marketplace plans statewide, generated a younger and relatively healthy risk pool in the Marketplace, and contributed to a 2% drop in the average rate of Marketplace premiums between 2014 and 2015. A study of New Hampshire's Premium Assistance Program (PAP) population (Medicaid expansion population enrolled in the Marketplace), however, showed higher medical costs for the PAP population compared to other Marketplace enrollees.[326,327]

IMPACTS ON HOSPITALS AND OTHER PROVIDERS

Medicaid expansion results in reductions in uncompensated care costs for hospitals, clinics, and other providers.

- Research shows that Medicaid expansions result in reductions in uninsured hospital or other provider visits and uncompensated care costs, whereas providers in non-expansion states have experienced little or no decline in uninsured visits and uncompensated care. One study suggested that Medicaid expansion cut every dollar that a hospital in an expansion state spent on uncompensated care by 41 cents between 2013 and 2015, corresponding to a reduction in uncompensated care costs across all expansion states of $6.2 billion over that period.[328,329,330,331,332,333,334,335,336,337,338,339,340,341,342,343,344,345,346,347,348,349,350,351,352,353,354,355,356,357,358,359,360,361,362,363,364]
  - Some studies point to improvements in patterns of use of emergency departments (EDs), specifically. Two recent single-state studies in Maryland and Illinois, a study comparing California to Florida (a non-expansion state), and a study across 25 expansion and non-expansion states, found significant declines

in uninsured ED visits and increases in Medicaid-covered ED visits following expansion implementation (the studies that included non-expansion states found much smaller changes on these measures in the non-expansion states).[365,366,367,368]

- One study found that expansion significantly increased Medicaid coverage of treatment at specialty substance use disorder (SUD) treatment facilities and decreased the probability that patients at these facilities were uninsured. A second study found large shifts in sources of payment for SUD treatment among justice-involved individuals following Medicaid expansion in 2014, with significant increases in those reporting Medicaid as the source of payment.[369,370]
- Evidence suggests that Medicaid expansion significantly reduced variation in provision of uncompensated care between hospitals that treat a disproportionate share of low-income patients (DSH hospitals) and those that do not, with DSH hospitals experiencing significantly larger reductions in uncompensated care days per bed.[371]

- A new study published in January 2018 found that Medicaid expansion was associated with improved hospital financial performance and significant reductions in the probability of hospital closure, especially in rural areas and areas with higher pre-ACA uninsured rates.[372]
- Additional studies demonstrate that Medicaid expansion has significantly improved hospital operating margins. One analysis found that while all types of hospitals in expansion states experienced reductions in uncompensated care costs and increases in Medicaid revenue compared with their counterparts in non-expansion states, expansion's effects on margins were strongest for small hospitals, for-profit and non-federal-government-operated hospitals, and hospitals located in non-metropolitan areas.[373,374,375,376]

EMPLOYMENT AND LABOR MARKET EFFECTS

Studies find that Medicaid expansion has had positive or neutral effects on employment and the labor market.

- State-specific studies have documented or predicted significant job growth resulting from expansion. A study in Colorado found that the state supports 31,074 additional jobs due to Medicaid expansion as of FY 2015-2016, and a study in Kentucky estimated that expansion would create over 40,000 jobs in the state through SFY 2021 with an average salary of $41,000.[377,378,379]
- No studies have found negative effects of expansion on employment or employee behavior. Studies examining employment rates and other measures such as transitions from employment to non-employment, the rate of job switches, transitions from full- to part-time employment, labor force participation, and usual hours worked per week have not found significant effects of Medicaid expansion. One study showed that adults with disabilities living in expansion states are significantly more likely to be employed and less likely to be unemployed due to disability compared to adults with disabilities in non-expansion states.[380,381,382,383,384]
- In an analysis of Medicaid expansion in Ohio, most expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it easier to

seek employment. Over half of expansion enrollees who were employed reported that Medicaid enrollment made it easier to continue working.[385]

- One study found an association between Medicaid expansion and volunteer work (both formal volunteering for organizations and informally helping a neighbor), with significant increases in volunteer work occurring among low-income individuals in expansion states in the post-expansion period (through 2015) but no corresponding increase in non-expansion states. The researchers connect this finding to previous literature showing an association between improvements in individual health and household financial stabilization and an increased likelihood of volunteering.[386]
- An additional analysis found that Medicaid expansion is associated with increased responsiveness of the program to meet coverage needs during periods of high unemployment.[387]

Conclusion and Implications

As a whole, the large body of research on the effects of Medicaid expansion under the ACA suggests that expansion has had largely positive impacts on coverage; access to care, utilization, and affordability; and economic outcomes, including impacts on state budgets, uncompensated care costs for hospitals and clinics, and employment and the labor market. However, findings on provider capacity are mixed, with some studies suggesting that provider shortages are a challenge in certain contexts. Overall, these findings suggest potential for gains in coverage and access as well as economic benefits to states and providers in the remaining non-expansion states that may be considering adopting the expansion in the future.

While future research will be necessary to study the effects of new waiver provisions recently approved by or pending approval (https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/) from the Trump administration, findings from this literature review on states with existing expansion waivers (such as Indiana) suggest that adding new restrictions or program complexities to Medicaid through Section 1115 waivers could compromise coverage and access gains achieved under expansion or slow future progress. Key questions for future consideration include whether increased flexibility under Section 1115 waiver authority will result in roll-backs in coverage, whether additional states will adopt the expansion and under what conditions, and how new Medicaid expansion-related restrictions and requirements will impact states, beneficiaries, and providers. We will continue to monitor and update this literature review as additional studies and state experiences provide insight into how various factors shape coverage, access to care, and costs in Medicaid expansion states and as states continue to consider expansion and reshape Medicaid coverage.

Appendix: Study list by category

APPENDIX: STUDY CITATIONS BY CATEGORY OF FINDINGS AND GEOGRAPHIC SCOPE

Coverage Effects of Expansion

- Nationwide Studies
- Multi-State Studies
- Single State Studies

Impact of Expansion on Access to Care, Utilization, Affordability, and Health Outcomes

- Nationwide Studies
- Multi-State Studies
- Single State Studies

Economic Effects of Expansion

- Impacts on State Budgets And Economies
    - Nationwide Studies
    - Multi-State Studies
    - Single State Studies
- Impacts on Payer Mix for Hospitals and Clinics
    - Nationwide Studies
    - Multi-State Studies
    - Single State Studies
- Impacts on Employment and the Labor Market
    - Nationwide Studies
    - Single State Studies

Coverage Effects of Expansion

NATIONWIDE STUDIES

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Economic Effects of Expansion

Impacts on State Budgets and Economies

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Department of Health & Human Services

2017 ACTUARIAL REPORT

ON THE FINANCIAL OUTLOOK

FOR MEDICAID

Office of the Actuary

Centers for Medicare & Medicaid Services

United States Department of Health & Human Services

2017 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID

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Office of the Actuary
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STATEMENT FROM THE CHIEF ACTUARY

The Medicaid program is of critical importance to American society. After Medicare, it is the largest health program as measured by expenditures, representing one-sixth of the health economy, and it is the largest as measured by enrollment. In 2016, its outlays of $582 billion accounted for a sizeable portion of Federal and State budgets and were a significant source of revenue for health care providers and insurers. As importantly, Medicaid serves as a safety net for the nation's most vulnerable populations, covering an estimated 72 million beneficiaries in 2016, including more than 11 million expansion adults under the Affordable Care Act. In this report, we analyze key historical Medicaid trends—both financial and demographic—and include projections of expenditures and enrollment to inform the public and help policy makers gain insight into the future of the program.

The Medicaid projections shown here are developed under current law, and they do not assume any changes in future legislation. The economic assumptions used to generate the projections are the same as those used by the 2017 OASDI and Medicare Boards of Trustees in their annual reports to Congress.

Projections of health care costs are inherently uncertain. For Medicaid, such projections present an even greater challenge as enrollment and costs are very sensitive to economic conditions. Since CMS is still working to ensure the quality of data received through T-MSIS, these projections rely on MSIS data that are mostly complete through 2013. Our analysis finds that, without data from the last 4 years, there could be substantial variation in estimated and actual per enrollee expenditure costs. Therefore, we believe that the credibility of the per enrollee expenditure estimates is lower than in previous reports, and I caution readers against relying on these estimates and projections. Because of the greater degree of uncertainty, these projections have been moved into the Appendix of this year's report. If data of sufficient quality for analysis are not available going forward, it is possible that other estimates and projections provided in future reports may be less reliable as well. I also note that, because Medicaid financial reports include expenditures for expansion adults, the data we use for reporting historical per enrollee expenditures and projecting future expenditures for this population are more credible.

It is my opinion that (i) the techniques and methodology used herein to project the future costs of the Medicaid program are based upon sound principles of actuarial practice and are generally accepted within the actuarial profession, and (ii) the principal assumptions and resulting actuarial estimates are, individually and in the aggregate, reasonable for the purpose of projecting such costs under current law. Considering the substantial uncertainties inherent in projecting future health care costs, readers should be aware that actual future Medicaid costs could differ significantly from these estimates.

I would like to thank team leader Christopher Truffer and team members Christian Wolfe and Kathryn Rennie for their diligent efforts in preparing this report. We welcome feedback from readers; comments may be sent to Christian.Wolfe@cms.hhs.gov.

Paul Spitalnic, ASA, MAAA
Chief Actuary
Centers for Medicare & Medicaid Services

EXECUTIVE SUMMARY

The joint Federal-State Medicaid program provides health care assistance to certain low-income people and is one of the largest payers for health care in the United States. This report presents an analysis of past Medicaid trends and 10-year projections of expenditures and enrollment under current law. Underlying demographic or economic experience that is different than assumed or significant changes in legislation can materially affect the cost and enrollment projections included in this report.

HIGHLIGHTS AND FINDINGS

2016 Medicaid Information

- Total estimated Medicaid outlays in Federal fiscal year (FY) 2016 amounted to $580.9 billion and increased by 4.9 percent between 2015 and 2016. This is a slower rate of growth than in recent history, reflecting slower growth in expansion adult enrollment and expenditures.

- Federal Medicaid outlays in 2016 were $368.2 billion and grew 5.3 percent over the previous year. Federal outlays represented 63 percent of total spending on the program. State and local governments' estimated outlays were $212.7 billion, which constituted 37 percent of total program costs.

- Medicaid provided health care assistance for an estimated 72.2 million enrollees on average in 2016, including those enrolled in Territory Medicaid programs and 11.2 million expansion adults.[1] Enrollment is estimated to have grown by 3.1 percent between 2015 and 2016; expansion adult enrollment is estimated to have increased by 22.3 percent, and all other enrollment is estimated to have increased by 0.3 percent.

2017 Medicaid Estimates

- Medicaid expenditures are estimated to have increased 2.6 percent to $592.2 billion in 2017, with Federal expenditures having grown an estimated 1.7 percent to $370.6 billion. The Federal share of all Medicaid expenditures is estimated to have been 63 percent in 2017. State Medicaid expenditures are estimated to have increased 4.2 percent to $221.6 billion.

- Average Medicaid enrollment is estimated to have increased 2.1 percent to 73.8 million enrollees in 2017. The majority of the enrollment growth is

[1] Adults made newly eligible for Medicaid under the Affordable Care Act beginning in 2014 pursuant to section 1902(a)(10)(A)(i)(VIII) of the Social Security Act [42 U.S.C. § 1396a] are referred to in this report as expansion adults. The Affordable Care Act technically specifies an upper income threshold of 133 percent of the Federal Poverty Level (FPL) but also allows a 5-percent income disregard, making the effective threshold 138 percent.

estimated to have been among expansion adults (1.0 million of the 1.5-million increase).

10-Year Medicaid Projections (2017-2026)

- Over the next 10 years, expenditures are projected to increase at an average annual rate of 5.7 percent and to reach $1,005.7 billion by 2026. The Gross Domestic Product (GDP) is expected to grow by an average rate of 4.1 percent. As a result, Medicaid expenditures are projected to increase from 3.1 percent of GDP in 2016 to 3.7 percent of GDP in 2026. The increase in expenditures would place a growing strain on Federal and State budgets.

- Expenditures for capitated payments and premiums are projected to grow 7.8 percent per year on average from 2017 to 2026 and reach $578 billion in 2026. Acute care services are projected to grow by 3.9 percent per year to $220.5 billion in 2026. Long-term care spending is projected to grow by 3.2 percent per year and reach $158.7 billion in 2026. The average annual growth in disproportionate share hospital (DSH) payments is projected to be 2.4 percent, with projected expenditures of $24.8 billion in 2026.

- Enrollment is projected to increase at an average annual rate of 1.3 percent over the next 10 years and reach 82.3 million in 2026.

- Medicaid expenditures for expansion adults are projected to amount to $938 billion over the period 2017 through 2026. Most of these expenditures—$855 billion, or about 91 percent—are projected to be financed by the Federal government.

- An estimated 12.2 million expansion adult enrollees were covered in 2017, based on enrollment counts included in 2017 financial data reported by the States to CMS. By 2026, the expansion adult population is projected to grow to 13.3 million. These estimates are based on the assumption that 55 percent of potential expansion enrollees reside in States with expanded eligibility in 2017 and after.

Comparison to 2016 Actuarial Report Projections

- Compared to the prior report, total projected Medicaid expenditures for benefits and administrative costs are expected to be $104.1 billion less from 2016 through 2025, or 1.4 percent lower, reflecting slower growth in benefit expenditures (particularly for long-term care services). In addition, annual per enrollee costs are projected to grow by 4.2 percent, or at a 0.1-percent lower rate, over the same period.

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I. INTRODUCTION

Medicaid is a cooperative program between the Federal and State governments to pay for health care and medical services for certain low-income persons in the United States and its Territories. The Federal and the State governments share responsibilities in designing, administering, and funding the program. The Centers for Medicare & Medicaid Services (CMS) is the agency charged with administering Medicaid for the Federal government.

This is the ninth annual Medicaid report prepared by the Office of the Actuary (OACT) at CMS. Its purpose is to describe the past and projected trends for Medicaid expenditures and enrollment, including estimates for Federal fiscal year (FY) 2017 and projections over the next 10 years. It also describes the data available on Medicaid spending and enrollment, as well as the methodology and assumptions used in the projections. Finally, this report places the Medicaid program within the context of Federal and State government spending and the U.S. health care system.

II. OVERVIEW OF MEDICAID

Authorized by Title XIX of the Social Security Act, Medicaid was signed into law in 1965 and is an optional program for the States. Currently all States, the District of Columbia, and five U.S. Territories have Medicaid programs.[2]

The Federal government establishes certain requirements for the States' Medicaid programs. The States then administer their own programs, determining the eligibility of applicants, deciding which health services to cover, setting provider reimbursement rates, paying for a portion of the total program, and processing claims.

Eligibility for enrollment in Medicaid is determined by both Federal and State law. Title XIX of the Social Security Act specifies which groups of people must be eligible, and States have the flexibility to extend coverage to additional groups. In addition to income, eligibility is typically based on several other factors, including age, disability status, other government assistance, other health or medical conditions such as pregnancy, and in some cases financial resources (or assets). As of January 2014, States have had the authority to expand Medicaid eligibility to almost all individuals under age 65 who are living in families with income below 138 percent of the Federal poverty level (FPL) (and who are citizens or eligible legal residents), with the Federal government initially paying 100 percent of the costs for expansion adults, to be reduced to 90 percent by 2020.[3]

Title XIX specifies that certain medical services must be covered under Medicaid, while also granting the States flexibility to cover many other benefits. Services usually covered include hospital care, physician services, laboratory and other diagnostic tests, prescription drugs, dental care, and many long-term care services. The States also have the option to use managed care plans to provide and coordinate benefits, and they may apply for waivers of certain requirements that allow more flexibility in developing specialized benefit packages for specific populations. Generally, States must provide the same benefit package to most Medicaid enrollees. Exceptions to these requirements include the use of waivers, demonstration projects, and alternative benefit plans, and States must provide an alternative benefit plan, including all essential health benefits, to the expansion adult population. In addition, there may be limited benefits provided for individuals who are eligible based only on

[2] For more information on Medicaid, including information on eligibility and covered services, see B. Klees, C. Wolfe, and C. Curtis, "Brief Summaries of Medicare & Medicaid," November 2017, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2017.pdf.

[3] The estimated enrollment and expenditures for the expansion adults are presented in section III.D of this report.

medical need, through Medicare savings programs, or through family planning programs.[4]

The Federal government and the States share the responsibility for funding Medicaid. States pay providers or managed care plans for Medicaid costs and then report these payments to CMS. The Federal government pays for a percentage of the costs of medical services by reimbursing each State; this percentage, known as the Federal Medical Assistance Percentage (FMAP), is calculated annually for each State based on a statutory formula that takes into account State per capita income with some adjustments prescribed by legislation.[5] A separate FMAP is specified for expansion adults. Additionally, the Federal government pays for a portion of each State's administration costs. Beneficiary cost sharing, such as deductibles or co-payments, and beneficiary premiums are very limited in Medicaid and do not represent a significant share of the total cost of health care goods and services for Medicaid enrollees.

In contrast to the Federal Medicare program, Medicaid's financial operations are not financed through trust funds. Other than a very small amount of premium revenue from enrollees, as noted above, and certain other sources of State revenue (such as some provider taxes), there are no dedicated revenue sources comparable to the Medicare Hospital Insurance payroll tax. Medicaid costs are met primarily by Federal and State general revenues, on an as-needed basis; the States may also rely on local government revenues to finance a portion of their share of Medicaid costs. The Federal financing is authorized through an annual appropriation by Congress. These funds are then spent through daily draws from the general fund of the Treasury in the amounts required to pay that day's Federal matching amounts on the State program expenditures. As a result, Medicaid outlays and revenues are automatically in financial balance, there is no need to maintain a contingency reserve, and, unlike Medicare Part A, the *financial status* or funding adequacy of the program is not in question from an actuarial perspective.

Medicaid coverage is extremely valuable to the low-income individuals and families who qualify for the health care services provided by the program. By extension, the program is also valuable to society at large, as it enables the least-fortunate members of the population to obtain the health care they need in an orderly way and diminishes their financial burdens. Furthermore, the program provides financial benefits to

[4] The Medicare Savings Programs provide assistance to low-income aged persons and persons with disabilities for their share of Medicare costs. Different programs cover a combination of the beneficiary's Part A premium (if any), Part B premium, Part A deductible, and Part B cost-sharing requirements.

[5] In general, Title XIX specifies that the FMAP for each State cannot be lower than 50 percent or higher than 83 percent; in FY 2016, FMAPs ranged from 50.00 percent to 74.17 percent. Also, Title XIX provides for specific FMAP levels for certain States and, in some cases, for specific services or populations.

entities such as governments and health care providers that may otherwise not be compensated for providing health care services to these individuals and families. It is also important, of course, to consider the costs to society of providing this coverage and to anticipate likely future trends in such costs. The balance of this report is intended to describe these trends.[6]

[6] This report does not cover expenditures or enrollment under the Children's Health Insurance Program (CHIP), whether such expenditures are made for a program operated under Title XIX or Title XXI of the Social Security Act. CHIP provides health coverage to many children in households with income above Medicaid eligibility levels. Currently, funding for CHIP is authorized through 2027.

III. ACTUARIAL ANALYSIS

A. FISCAL YEAR 2016 MEDICAID OUTLAYS AND ENROLLMENT

The Federal government and the States collectively spent an estimated $580.9 billion for Medicaid in 2016. Of this amount, the Federal government paid $368.2 billion, representing about 63 percent of net program outlays, and the States paid an estimated $212.7 billion, or about 37 percent of net outlays. Table 1 summarizes total Medicaid outlays for 2016.

Table 1—Medicaid Outlays for Fiscal Year 2016 by Type of Payment
(in billions)

Title XIX Outlays[1]	Federal Share	State Share	Total
Medical Assistance Payments:			
Acute Care Benefits2	$92.7	$57.6	$150.3
Long-Term Care Benefits2	65.9	49.9	115.8
Capitation Payments and Premiums2	182.2	90.6	272.8
Disproportionate Share Hospital (DSH) Payments[2]	11.2	8.5	19.7
Adjustments[3]	−4.6	−3.5	−8.2
Subtotal, Medical Assistance Payments	347.4	203.0	552.1
Administration Payments	17.2	9.7	26.9
Vaccines for Children Program	4.4	—	4.4
Gross Outlays	369.1	212.7	581.8
Collections[4]	−0.9	—	−0.9
Net Outlays	368.2	212.7	580.9

Totals may not add due to rounding.

[1] Federal outlays are the funds drawn from the U.S. Treasury by the States. The State and total outlays are estimated, reflecting spending as reported by the States for the purposes of drawing Federal funding from the U.S. Treasury. Expenditures represent the spending as it was paid by the State to health care plans or providers. While expenditures and outlays are generally similar, they are not equal mainly due to the timing differences between the States paying for services and the States receiving Federal funds. Neither outlays nor expenditures include Title XIX costs in support of the Children's Health Insurance Program.

[2] Benefit expenditures as reported on the CMS-64 (Net Services).

[3] Adjustments include net adjustments of benefits from prior periods and the difference between expenditures and outlays.

[4] Collections from Medicare Part B for the Qualifying Individuals (QI) program and from other miscellaneous sources.

The great majority of Medicaid spending—95 percent of total outlays in 2016—was for medical assistance payments. In table 1, these payments are divided into four major categories: acute care benefits, long-term care benefits, capitation payments and premiums, and disproportionate share hospital (DSH) payments.

Acute care benefits include fee-for-service spending for inpatient and outpatient hospital care, physician and other medical professional services, prescription drugs, dental care, laboratory and imaging tests, mental health facility services, and case management costs, as well as coinsurance payments for beneficiaries in managed care plans. Long-term care benefits include fee-for-service spending on nursing home

services, home health care, intermediate care facility services for individuals with intellectual and developmental disabilities, and home and community-based services. Capitation payments and premiums include premiums paid to Medicaid managed care plans, pre-paid health plans, other health plan premiums, and premiums for Medicare Part A and Part B. DSH payments are provided to certain hospitals that have furnished care for a significant number of uninsured persons and Medicaid beneficiaries and that have acquired, as a result, a substantial amount of uncompensated care costs.

Of these four categories, capitation payments and other premiums represented the largest portion of Medicaid spending in 2016, accounting for $272.8 billion or 49 percent of Medicaid benefit expenditures. Capitation payments and other premiums grew significantly as a share of Medicaid benefit spending, increasing from 34 percent in 2013 to 49 percent by 2016. Fee-for-service acute care benefit expenditures were the next largest expenditure category, constituting $150.3 billion or 27 percent of benefit expenditures (a decrease from 31 percent in 2015). Medicaid spending for fee-for-service long-term care amounted to $115.8 billion, representing 21 percent of expenditures on benefits, and DSH payments accounted for $19.7 billion, or 4 percent, of Medicaid benefits in 2016 (each about the same share as in 2015).

Medicaid outlays for program administration totaled $26.9 billion in 2016—$17.2 billion in Federal outlays and $9.7 billion in State outlays—and represented 5 percent of Medicaid outlays. Included in administration outlays were $1.2 billion in health information technology incentive payments to providers.[7]

Medicaid also provided $4.4 billion in 2016 for the Vaccines for Children program.[8]

Enrollment is measured as *person-year equivalents*, or the average enrollment over the course of a year. In 2016, 72.2 million individuals are estimated to have been enrolled in Medicaid (including enrollment in the U.S. Territories).[9] Children are estimated to have numbered 28.1 million, representing 39 percent of overall Medicaid

[7] Health information technology incentive payments were provided for by the American Recovery and Reinvestment Act of 2009 and are paid entirely by the Federal government. This figure does not include payments to States to administer the health information technology incentive payment program.

[8] The Vaccines for Children program is administered by the Centers for Disease Control and Prevention and provides vaccines for children enrolled in Medicaid, as well as for other children who might otherwise not be able to afford vaccines. All Vaccines for Children program costs are paid by the Federal government.

[9] Since data for some States are not available for 2013 and 2014, and no data are available for 2015 and 2016, enrollment figures in this report are estimates for these years, as described further in section IV of the report. In addition, past reports have provided figures for *ever-enrolled* enrollment, or the number of people who were enrolled at any time during the year. As no data are currently available that show the number of expansion adults who were ever-enrolled, and since there is no historical experience with this population, this report does not provide an estimate of ever-enrolled enrollment for 2016.

enrollment. There were an estimated 15.3 million non-expansion adults (21 percent of enrollment) and an estimated 11.2 million expansion adults (15 percent). Finally, enrollees with disabilities and aged enrollees are estimated to have numbered 10.6 million and 5.7 million (15 percent and 8 percent of Medicaid enrollment, respectively). Another 1.4 million enrollees (2 percent) were estimated for the five U.S. Territories with Medicaid programs (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands).

In previous reports, this section has provided estimates of enrollment, expenditures, and per enrollee spending by eligibility group; however, the most recent data on enrollment and expenditures by eligibility group are from 2013 or 2014 for most States, and no information is available for 2015 or 2016. Given the lack of more recent data, estimates of expenditures per enrollee by eligibility category are less reliable than in past reports, and readers should be aware that expenditures per enrollee by eligibility group could vary significantly from those provided in this report. These figures can be found in section VI.F.

B. HISTORICAL MEDICAID TRENDS

Since the start of the program, the year-to-year growth rates of total Medicaid expenditures (Federal and State expenditures combined) and enrollment have varied substantially, as can be seen in figure 1 and figure 2. The growth in expenditures over time reflects growth in the number of enrollees in the program and growth in the cost per enrollee. Enrollment growth is a result of a change in the number of people eligible and electing to participate in the program, but it is also strongly influenced by legislative changes to the eligibility criteria. Similarly, per enrollee costs vary over time due to (i) changes in the use of medical services and the prices paid to providers of health care services and supplies, (ii) legislative and other policy changes to the benefits offered by State Medicaid programs, and (iii) changes in the relative shares of enrollment by eligibility group in Medicaid.

Figure 1— Historical and Projected Medicaid Expenditures and Annual Growth Rates, Fiscal Years 1966–2026

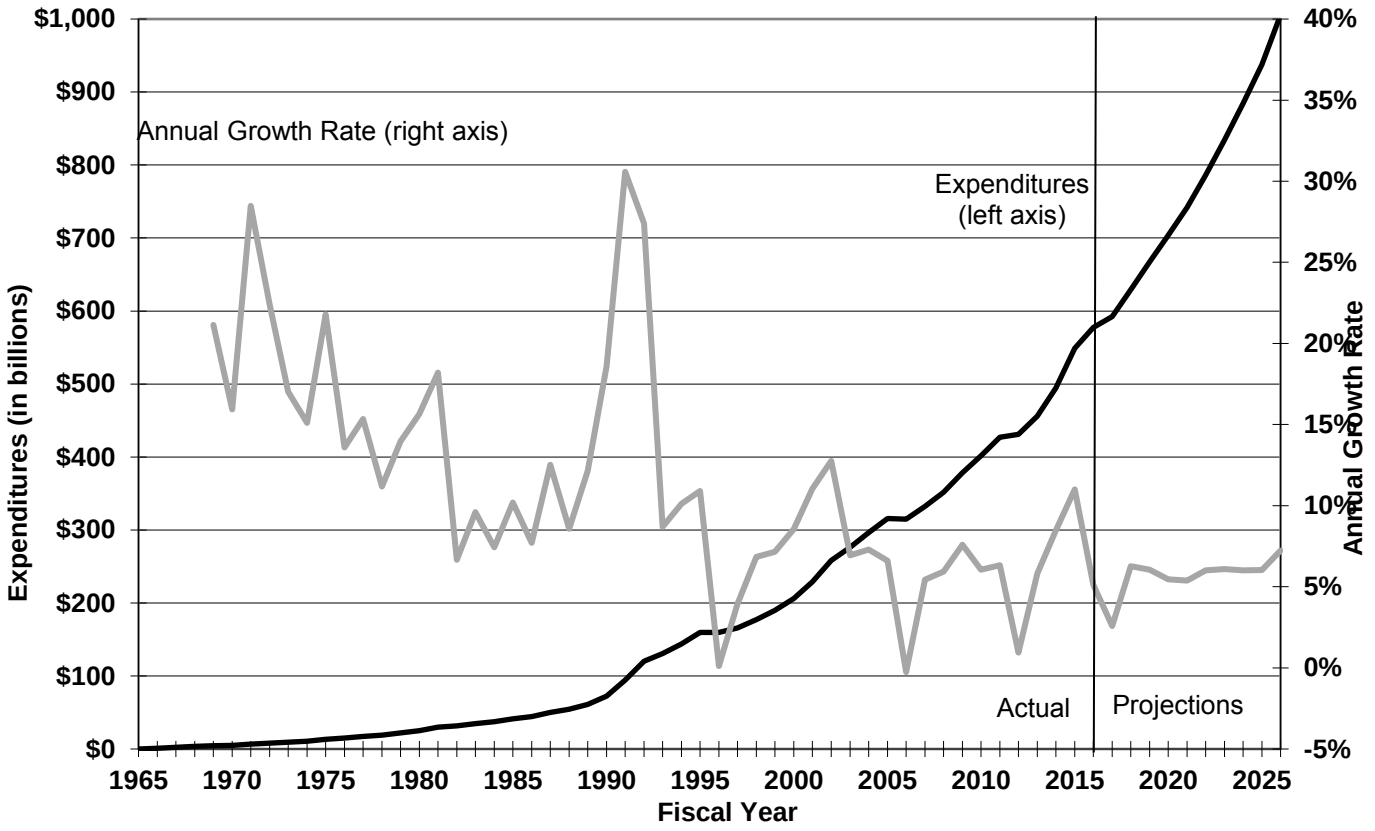
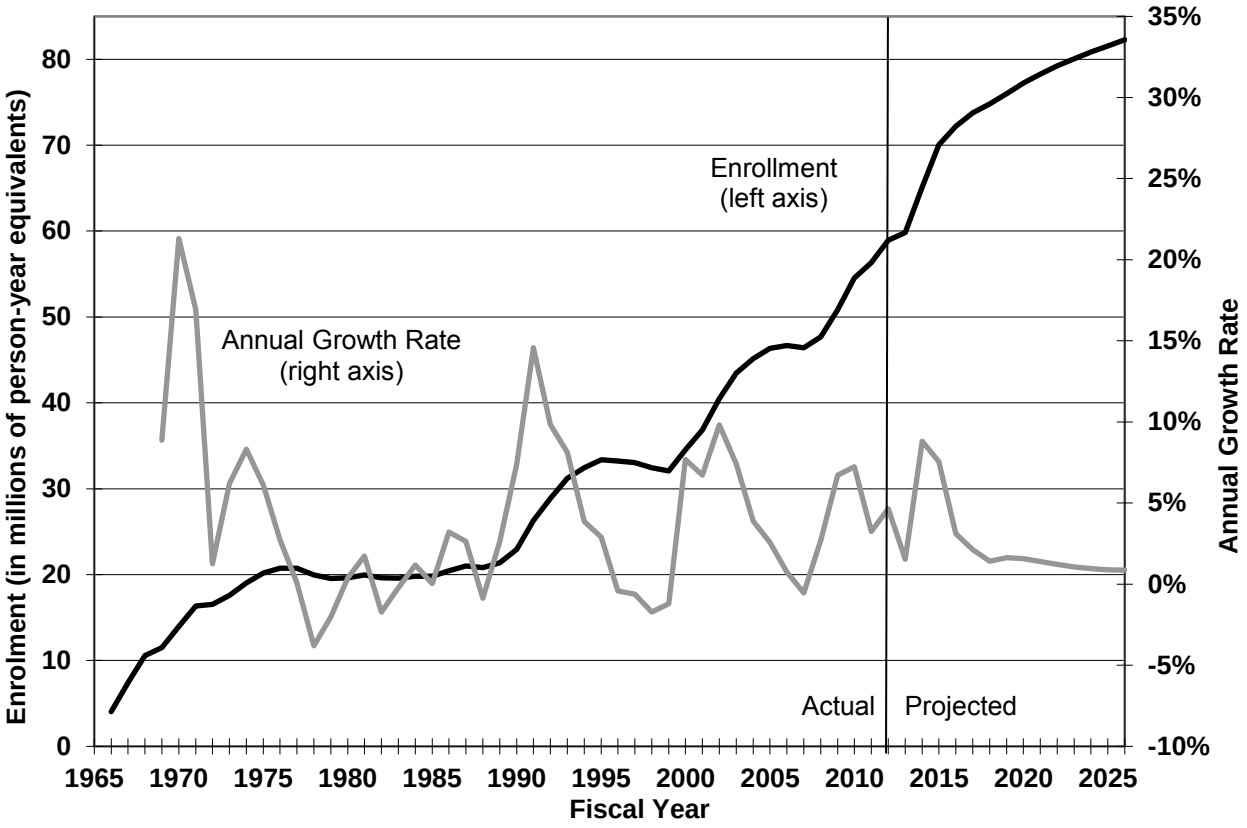


Figure 2—Historical and Projected Medicaid Enrollment and Annual Growth Rates, Fiscal Years 1966–2026



Note: Enrollment levels for 2013 through 2016 are estimated, and projected afterward.

From 2007 to 2016, Medicaid expenditures grew at an average annual rate of 6.2 percent, but during this period, annual growth rates varied from a low of 0.9 percent in 2012 to a high of 11.0 percent in 2015. Growth in health care expenditures is driven primarily by several key factors: growth in the population, changes in the use of health care services, and changes in the prices of health care services. In addition to these, several other factors affected Medicaid expenditure trends in recent history.

The American Recovery and Reinvestment Act of 2009 provided for temporary increases in the Federal share of Medicaid payments in 2009, 2010, and 2011, as well as for health information technology incentive payments that were funded entirely by the Federal government. While the increase in the Federal share of Medicaid payments was significant, it is not estimated to have affected total Medicaid expenditure growth in those years; in 2012, however, after the Federal share returned to typical levels, expenditure growth slowed considerably (from 6.3 percent in 2011 to 0.9 percent in 2012).

Although the Affordable Care Act had a number of provisions that affected Medicaid starting in 2010, most of the changes to the Medicaid program through 2013 are

estimated to have had only minor effects on Medicaid expenditure growth rates. Beginning in 2014, the expansion of eligibility to adults with incomes less than 138 percent of the FPL led to a significant increase in expenditures and enrollment. Continued expansion of State programs to cover expansion adults in 2015 (and further in 2016) resulted in the fastest program growth in more than a decade.

Medicaid expenditure growth is also affected by States' decisions in operating their programs. In the past, States took steps to control the costs of their Medicaid programs, especially during periods of relatively faster growth, and many States have taken such steps to slow the rate of expenditure growth in recent history.[10] Common methods have included freezing or reducing provider reimbursement rates and limiting or curtailing optional health care benefits. States have also used managed care and alternative care delivery approaches to control costs in their Medicaid programs.

Medicaid enrollment grew at an average annual rate of 4.5 percent from 2007 to 2016. Annual growth rates varied substantially, from a low of −0.5 percent in 2007 to a high of 8.8 percent in 2014. Outside of legislation affecting eligibility, changes in Medicaid enrollment are mainly driven by population growth and by changes in economic growth and unemployment rates. In general, Medicaid enrollment increases more quickly during economic recessions, and growth slows as the economy expands. Faster Medicaid enrollment growth in turn typically leads to increases in expenditure growth. Medicaid enrollment and expenditure trends followed these historical patterns during the 2001 recession, the 2007-2009 recession, and the subsequent economic recoveries. The Affordable Care Act provided for an expansion of Medicaid eligibility, which contributed to the substantial increase in enrollment in 2014 and 2015. Enrollment growth is estimated to have slowed to 3.1 percent in 2016, as growth in expansion adult enrollment decelerated following the start of the eligibility expansions.

[10] These State actions are well documented in the annual 50-State survey of Medicaid programs conducted by the Kaiser Family Foundation; see V. Smith, *et al.*, "Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017," Kaiser Family Foundation, October 2016.

C. MEDICAID EXPENDITURES AND ENROLLMENT PROJECTIONS, FISCAL YEARS 2017–2026

The projections presented in this report reflect Medicaid medical assistance payments (or *benefit* expenditures) and Medicaid enrollment from the Mid-Session Review of the President's FY 2018 Budget. The benefit expenditure projections are based on current law, including legislation passed in 2018 prior to the publication of this report.[11] Administrative expenditures are also included and are based on the most recent estimates from OACT, as well as on administrative cost data reported to CMS.[12] Other Title XIX expenditures (such as the Vaccines for Children program) are not included. Historical and projected Medicaid expenditures for medical assistance payments and administration are shown in table 2.[13,14,15]

[11] Up to and including the Bipartisan Budget Act of 2018 (P. L. 115-123). This bill contained several provisions that affected Medicaid expenditures, though the impacts are not broken out in this report.
[12] The projections of administration expenditures are adjusted to be consistent with the expenditures reported in the CMS-64; total expenditures are also projected for administration, whereas the President's Budget projects only Federal outlays.
[13] In table 3, enrollment and expenditure data for the period 1966-1976 have been revised to be consistent with the current definition of the Federal fiscal year (October-September).
[14] There are differences between Medicaid outlays and Medicaid expenditures, mainly due to timing disparities between States paying for services and States receiving Federal funds. Thus, the levels and trends in outlays and expenditures differ slightly, and the amounts shown in table 4 differ from those shown in table 3.
[15] The projections of Territory expenditures include additional funding provided to Territory Medicaid programs through the Affordable Care Act and the Bipartisan Budget Act of 2018. Consistent with current law, these projections assume that the additional funds would not continue in future years.

Table 2—Historical and Projected Medicaid Enrollment and Expenditures and Average Federal Share of Expenditures, Selected Years

(Enrollment in millions of person-year equivalents, expenditures in billions of dollars)

Fiscal Year	Enrollment	Total Expenditures			Benefit Expenditures			Administration Expenditures			Avg. Federal Share
		Total	Federal	State	Total	Federal	State	Total	Federal	State	
Historical data:											
1966	4.0	$0.9	$0.5	$0.4	$0.9	$0.4	$0.4	$0.0	$0.0	$0.0	50%
1970	14.0	5.1	2.8	2.3	4.9	2.6	2.2	0.2	0.1	0.1	54
1975	20.2	13.1	7.3	5.9	12.6	6.9	5.6	0.6	0.3	0.3	55
1980	19.6	25.2	14.0	11.2	24.0	13.3	10.7	1.2	0.7	0.5	55
1985	19.8	41.3	22.8	18.4	39.3	21.7	17.6	2.0	1.2	0.8	57
1990	22.9	72.2	40.9	31.3	68.7	38.9	29.8	3.5	2.0	1.5	57
1995	33.4	159.5	90.7	68.8	151.8	86.5	65.3	7.7	4.2	3.4	57
2000	34.5	206.2	117.0	89.2	195.7	111.1	84.6	10.6	5.9	4.7	57
2005	46.3	315.9	180.4	135.5	300.7	172.1	128.7	15.1	8.3	6.8	57
2006	46.7	315.1	179.3	135.8	299.0	170.6	128.5	16.0	8.7	7.3	57
2007	46.4	332.2	189.0	143.2	315.8	180.0	135.8	16.4	9.0	7.5	57
2008	47.7	351.9	200.2	151.7	334.2	190.6	143.6	17.7	9.6	8.1	57
2009	50.9	378.6	246.3	132.3	360.3	236.3	124.0	18.3	10.0	8.3	65
2010	54.5	401.5	269.8	131.7	383.6	260.0	123.6	17.9	9.8	8.1	67
2011	56.3	427.0	270.5	156.4	407.5	259.6	147.9	19.5	10.9	8.6	63
2012	58.9	431.0	248.8	182.2	408.8	235.1	173.8	22.2	13.7	8.4	58
2013	59.8	456.0	263.0	193.0	433.1	248.8	184.3	22.9	14.2	8.7	58
2014	65.1	494.7	299.3	195.4	470.3	284.1	186.2	24.4	15.2	9.2	61
2015	70.0	549.1	346.0	203.1	523.9	329.8	194.0	25.2	16.2	9.0	63
2016	72.2	577.3	364.5	212.7	550.9	347.7	203.2	26.3	16.8	9.6	63
Projections:											
2017	73.8	592.2	370.6	221.6	563.7	352.1	211.6	28.5	18.4	10.0	63
2018	74.8	629.3	393.0	236.3	600.6	374.5	226.1	28.8	18.4	10.3	62
2019	76.0	667.4	419.7	247.6	638.5	401.4	237.1	28.9	18.3	10.5	63
2020	77.2	703.9	438.1	265.7	673.8	419.0	254.8	30.1	19.2	10.9	62
2021	78.3	741.7	461.1	280.6	710.1	441.0	269.2	31.6	20.1	11.4	62
2022	79.2	786.3	488.3	298.0	754.6	468.6	286.0	31.7	19.7	12.0	62
2023	80.1	834.2	518.0	316.2	801.0	497.5	303.6	33.1	20.5	12.6	62
2024	80.9	884.4	549.2	335.2	849.8	527.7	322.1	34.6	21.4	13.2	62
2025	81.6	937.7	582.1	355.6	901.6	559.8	341.8	36.1	22.4	13.8	62
2026	82.3	1,005.7	623.6	382.1	968.0	600.3	367.7	37.7	23.4	14.4	62

Note: Enrollment is estimated for 2013 through 2016.

Expenditures

Total Medicaid expenditures (Federal and State combined) for medical assistance payments and administration are estimated to have grown 2.6 percent in 2017 to $592.2 billion and are projected to reach $1,005.7 billion by 2026, increasing at an average rate of 5.7 percent per year through the projection period. Federal government spending on Medicaid medical assistance payments and administration costs is estimated to have increased by 1.7 percent to $370.6 billion in 2017, representing 63 percent of total Medicaid benefit expenditures. Federal spending on Medicaid is projected to reach $623.7 billion by 2026, or 62 percent of total spending. State Medicaid expenditures for benefits and administration are estimated to have increased to $221.6 billion in 2017, a growth rate of 4.2 percent, and are projected to reach $382.1 billion by 2026.

For much of history, the average annual Federal share has been about 57 percent of total expenditures, with several years of greater Federal shares due to changes specified in legislation. The average Federal share was 58 percent in 2013 and increased to 61 percent in 2014 due mainly to the higher FMAP for expansion adults, and it is estimated to have increased to 63 percent in 2015, 2016, and 2017. The matching rate for the expansion adults is set to decline gradually from 100 percent in 2016 to 95 percent in 2017 (and eventually to 90 percent by 2020), and the average Federal share is projected to decrease from 63 percent to 62 percent from 2018 through 2026.

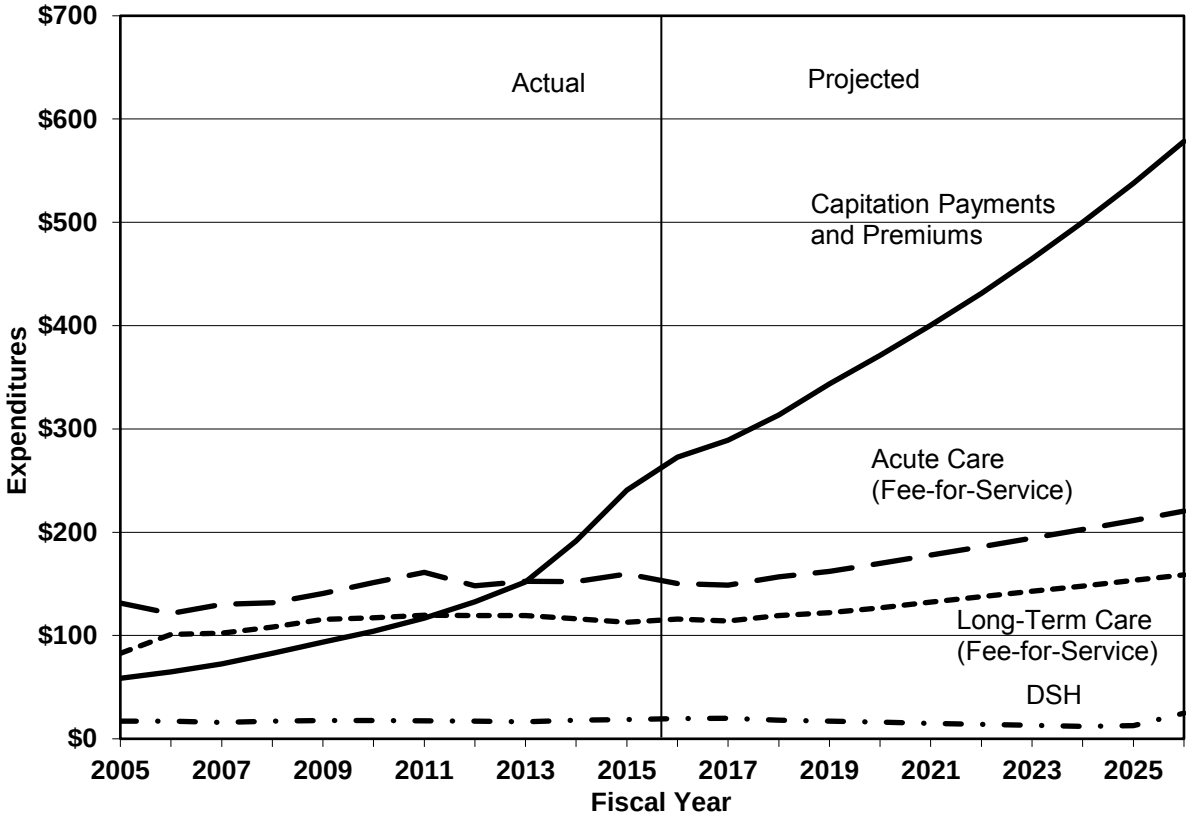
Total Medicaid expenditures (Federal and State combined) for medical assistance payments, excluding those for administration, are estimated to have grown 2.3 percent in 2017 to $563.7 billion. This is a slower rate of growth than in 2016 (5.2 percent) and is expected to be the result of continuing decelerations in enrollment growth (from 3.1 percent in 2016 to 2.1 percent in 2017) and per enrollee expenditure growth (from 1.9 percent in 2016 to 0.8 percent in 2017). Medicaid expenditures on total medical assistance payments are projected to reach $968.0 billion by 2026, increasing at an average rate of 5.8 percent per year through the projection period. Federal government spending on these Medicaid payments is estimated to have been $352.1 billion in 2017 and is projected to grow to $600.3 billion by 2026.

Administrative expenditures are estimated to have amounted to $28.5 billion in 2017, reflecting an increase of 8.2 percent, up from a growth rate of 4.5 percent in 2016. They are projected to reach $37.7 billion by 2026, growing at an average annual rate of 3.7 percent over the 10-year period. While administrative expenditures are estimated to have constituted 4.8 percent of total Medicaid costs in 2017, this percentage is projected to decline slightly to 3.7 percent by 2026.

Figure 3 shows historical and projected Medicaid benefit expenditures by four major categories of services: acute care fee-for-service, long-term care fee-for-service, capitation payments and premiums, and DSH payments.[16]

Figure 3—Past and Projected Medicaid Expenditures for Medical Assistance Payments, by Type of Payment, Fiscal Years 2005–2026[17]

(in billions)



Over the next 10 years, expenditures for capitation payments and premiums are expected to continue to grow more rapidly than expenditures for the other major Medicaid service categories, as shown in figure 3. These expenditures are projected to grow 7.8 percent per year on average from 2017 to 2026 (from $272.8 billion in 2016 to $578.4 billion in 2026), which would be 2.0 percentage points faster than overall Medicaid benefit growth. In 2014 through 2016, relatively faster growth in these payments was driven by the Medicaid eligibility expansion under the Affordable Care Act, since most of the expansion adults are enrolled in managed care plans. In addition, States increased the use of these plans by including managed long-term care services and support programs for their aged enrollees and persons with disabilities. From 2001 to 2013—prior to the Medicaid expansion in 2014—Medicaid payments for managed care plans and other premiums grew on average 12.2 percent per year, more rapidly than the overall Medicaid benefit expenditure growth rate of

[16] The data for selected figures in the report can be found in section VI.D.
[17] The data for this graph can be found in table 15 of section VI.D.

6.5 percent. In 2015 alone, these payments increased by 25.7 percent, due primarily to the continued enrollment of expansion adults in managed care programs. The use of managed care plans within Medicaid increased over time, with 80 percent of enrollees covered by at least one such plan and 65 percent covered by a comprehensive managed care program in 2015.[18] The increase in the use of these plans accounts for much of the difference between the capitation payment and overall Medicaid expenditure growth rates; however, this increase does not necessarily imply differences in per enrollee cost growth between those enrolled in managed care and those not enrolled.

Acute care fee-for-service expenditures are estimated to have decreased by 5.9 percent in 2016, due in part to continued managed-care contract use replacing fee-for-service delivery in the Medicaid program. Over the next decade, these expenditures are projected to grow at an average rate of 3.9 percent per year, from $150.3 billion in 2016 to $220.5 billion in 2026. States are expected to continue to approach the challenge of cost growth for aged beneficiaries and persons with disabilities through increased use of managed care programs for those populations.

Medicaid spending on fee-for-service long-term care is projected to grow by 3.2 percent on average for 2017 through 2026, increasing from $115.8 billion in 2016 to $158.7 billion in 2026. Aged enrollees and persons with disabilities receive the vast majority of long-term care services, and growth in these expenditures is driven in part by growth in enrollment among these beneficiaries. In recent years, Medicaid expenditures on these services declined; from 2011 through 2015, long-term care expenditures decreased at an average rate of 0.8 percent per year, compared to average annual growth of 7.2 percent from 2005 through 2010. This deceleration reflects relatively slower growth in reimbursement rates and utilization of long-term care. Additionally, over the last several years, there was an increase in the use of managed care for long-term care services in Medicaid, which resulted in several years of slow growth or contraction in fee-for-service expenditures for long-term care.

[18] Centers for Medicare & Medicaid Services, *Medicaid Managed Care Enrollment and Program Characteristics, 2015,* available at https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2015-medicaid-managed-care-enrollment-report.pdf.

Accordingly, long-term care expenditures are estimated to have declined 1.6 percent in 2017.[19]

Medicaid DSH expenditures are typically expected to grow at the same rate as the Medicaid Federal DSH allotments, which are based on the Consumer Price Index (CPI). The Affordable Care Act, however, prescribes reductions in Medicaid DSH allotments, and subsequent legislation has extended those reductions through 2025.[20] Thus, the average growth rate for DSH spending is projected to be 1.4 percent over the next 10 years, with DSH expenditures decreasing from $19.7 billion in 2016 to $12.7 billion in 2025 before rising to $24.8 billion in 2026.

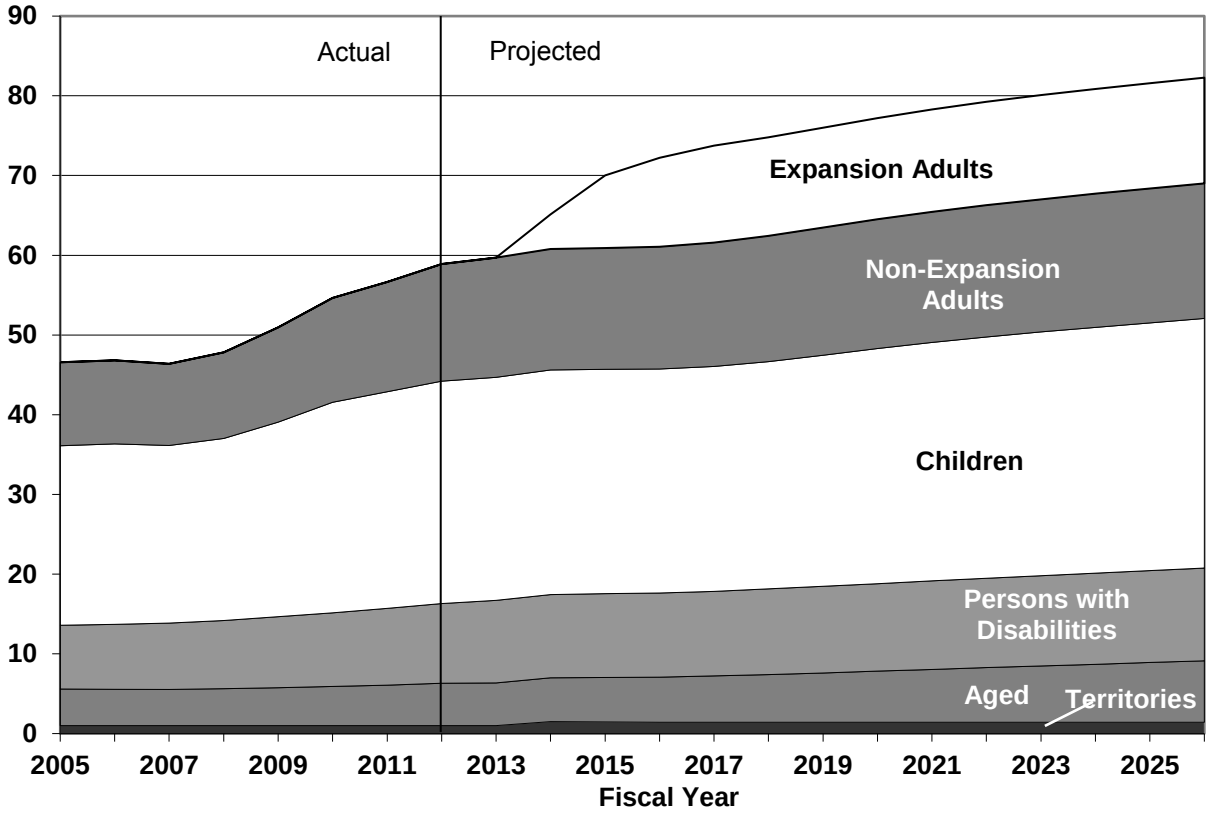
[19] Use of home and community-based services can substantially reduce expenditures for enrollees who would otherwise have had to enter a nursing home or who transition from institutional to community settings. Conversely, the expanding use of these services, by those who would not otherwise have had nursing home care, adds to overall program costs and may offset some amount of the savings realized by reducing the use of institutional long-term care services. Growth in the use of home and community long-term care reflects the increase in the number of home and community-based waivers in Medicaid, as well as the provision of such care through State plans. In addition, in *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999), the Supreme Court ruled that, under the Americans with Disabilities Act of 1990, States must provide community-based placement for persons with disabilities when appropriate and consistent with consumer wishes. This ruling is also expected to have led to an increase in non-institutional long-term care expenditures in Medicaid.

[20] Several acts of legislation have combined to delay the start of DSH reductions until 2020 and extend the duration of the reductions through 2025: the Middle Class Tax Relief and Job Creation Act (Public Law 112-96); the American Taxpayer Relief Act (Public Law 112-240); the Bipartisan Budget Act (Public Law 113-67); the Protecting Access to Medicare Act (Public Law 113-93); the Medicare Access and CHIP Reauthorization Act (Public Law 114-10); and the Bipartisan Budget Act of 2018 (Public Law 115-123).

Enrollment

Increasing levels of Medicaid enrollment are expected to contribute to expenditure growth over the next 10 years. Historical and projected Medicaid enrollments are shown by category in figure 4.

Figure 4—Past and Projected Numbers of Medicaid Enrollees, by Category, Fiscal Years 2005–2026[21]
(in millions of person-year equivalents)



Note: Enrollment levels after 2012 are estimated for all but the expansion adults, whose levels are reported through 2016.

Total enrollment is estimated to have grown from 72.2 million in 2016 (including 1.4 million enrollees in the U.S. Territories) to 73.8 million in 2017—with the majority of the increase driven by expansion adults (1.0 million of the 1.5-million increase). Growth is estimated to have slowed after many States expanded Medicaid eligibility in 2014 and 2015; enrollment is estimated to have increased 8.8 percent in 2014 and 7.6 percent in 2015, but only 3.1 percent in 2016 and 2.1 percent in 2017. While fewer States expanded eligibility in 2016 (and none did so in 2017), expansion adults still account for the majority of enrollment growth. Excluding expansion adults, enrollment is estimated to have increased 0.2 percent in 2016 and 0.3 percent in 2017—a result that likely reflects recent economic growth and low unemployment

[21] The data for this graph can be found in table 16 of section VI.D.

rates, which would result in fewer people becoming eligible for Medicaid and more individuals finding other forms of health coverage.

During 2017 through 2026, the total number of Medicaid enrollees is projected to increase at a rate of about 1.3 percent per year, reflecting expected U.S. population growth and an increase in the number of aged enrollees as baby boomers continue to reach age 65. Growth in the number of aged adults is expected to be faster than that for the other categories of enrollment; the average annual growth rate for aged adults is projected to be 2.9 percent over the next 10 years. By 2026, Medicaid enrollment is projected to increase to 82.3 million.[22]

[22] Territory enrollment is projected to remain level at about 1.4 million persons from 2017 to 2026, despite the projected reduction in Federal expenditures for Territory Medicaid programs due to the expiration of additional funds provided by the Affordable Care Act and the Bipartisan Budget Act of 2018. These projections are based on the assumption that Territories would provide additional funding or make other program changes to maintain enrollment levels as Federal funding is reduced.

D. IMPACTS OF THE MEDICAID ELIGIBILITY EXPANSION

Expansion of Medicaid eligibility to almost all persons under age 65 who are living in families with incomes below 138 percent of the FPL (and who are citizens or eligible legal residents) began in 2014. Expansion adult enrollment was 11.2 million in 2016. In 2017, an estimated 12.2 million expansion adults were enrolled, and these adults are projected to number 13.3 million by 2026.

Total Medicaid benefit expenditures for the expansion adult population amounted to $66.5 billion in 2016. Expenditures are estimated to have increased to $70.8 billion in 2017 and are projected to reach $119.9 billion by 2026. For expansion adult beneficiaries, a higher Federal matching rate is specified, decreasing from 100 percent through 2016 to 95 percent in 2017 and then gradually declining to 90 percent by 2020 and beyond. By 2026, the States are projected to pay $12.0 billion of the costs for expansion adults.

Unlike the per enrollee costs for non-expansion populations (which are excluded from the body of this year's report for reasons explained in section VI.F), expansion adult expenditures per enrollee are calculated from the CMS-64 financial statements, which include a reliable accounting of the number of expansion adults enrolled in each State for every month of its expansion. As a result, the calculated per enrollee costs for this population are considered credible and are included below.

The average per enrollee costs for expansion adults grew from $5,511 in 2014 to $6,365 in 2015 (an increase of 15.5 percent). These per enrollee costs were notably higher than those for non-expansion adults, as many States included adjustments to reflect a higher level of acuity or morbidity. In most States, these adjustments were positive, and in some cases the adjustments were substantial.[23] States also included other adjustments in the capitation rates for expansion adults; many projected increased costs due to pent-up demand, expecting that those who were previously uninsured would use additional services in the first several months of coverage. In addition, some States included adjustments for adverse selection with the anticipation that the persons who were most likely to enroll in the first year would be those with the greatest health care needs.

[23] It is difficult to generalize about the adjustments estimated by the States for several reasons. States may have used different definitions for the non-expansion adult population that served as the basis for comparison with the expansion adults. (For example, States may have compared the expansion adults to only non-expansion childless adults or to childless adults and parents or caretaker adults, or States may have compared the expansion adults to only non-disabled adults or to non-disabled adults and some adults with disabilities.) Most States also removed from the comparison pregnant women who are not expansion adults under Medicaid, but the projections in this report include pregnant women among non-expansion adults; thus, it is difficult to directly compare the assumptions made by the States with the projections and analyses in this report. In addition, the States used various methodologies to develop these adjustments and in some cases combined them with other adjustments (for example, for adverse selection or pent-up demand).

In 2016, expansion adult per enrollee costs are estimated to have decreased by 6.3 percent to $5,965. These costs are estimated to have decreased further to $5,813 in 2017 (a decline of 2.5 percent). The effects of pent-up demand and adverse selection are expected to end after the earliest years of the eligibility expansion, and more recent information (including the results of risk-sharing arrangements between States and managed care plans) indicates that the actual average costs of expansion adults were significantly lower than the States anticipated. Moreover, prior period adjustments by some States indicate that certain adjustments significantly lowered payments made in 2015 and 2016.

Data for the expansion adult population are still limited. While CMS has reported some enrollment and expenditure information for this group, data on claims and managed care encounters, and on the health status and demographics of these enrollees, are not available. Thus, there is still uncertainty about the health care costs of expansion adults in 2014 through 2017, as well as for future years. (As additional data are provided in the financial reports for the expansion adults, it is possible to provide per enrollee cost estimates for this group. See section IV for more information.)

Given the uncertainty inherent in covering a large new population in Medicaid (many of whom were expected to have been previously uninsured), most States that implemented the eligibility expansion included risk-sharing arrangements in their contracts with managed care plans for expansion adults in 2014 and 2015, with some States continuing these arrangements into 2016.[24] The most common approaches were to use a risk corridor or to use a minimum medical loss ratio. Under a risk corridor, the managed care plans would return some payments to the State and the Federal government if the average benefits per enrollee or loss ratio fell below a certain level or ratio, and the plans would receive additional payments from the State and the Federal government if the average benefits per enrollee or loss ratio exceeded a certain level or ratio. In States requiring a minimum medical loss ratio, the managed care plans would return some payments to the State and the Federal government if the loss ratio fell below a certain level, but the plans would not receive additional funding if the loss ratio was higher than expected.

As a result of these arrangements, there is the potential that the ultimate payments for expansion adults in 2014, 2015, and 2016 may be notably different from those currently reported. By the end of 2017, most States had reported at least preliminary 2014 and 2015 results, but several of these contractual arrangements have yet to be finalized. Some States without finalized arrangements effectively made prepayments to the Federal government through prior period adjustments (which are adjustments to payments prior to the settlement of risk corridors and minimum loss ratios). Based

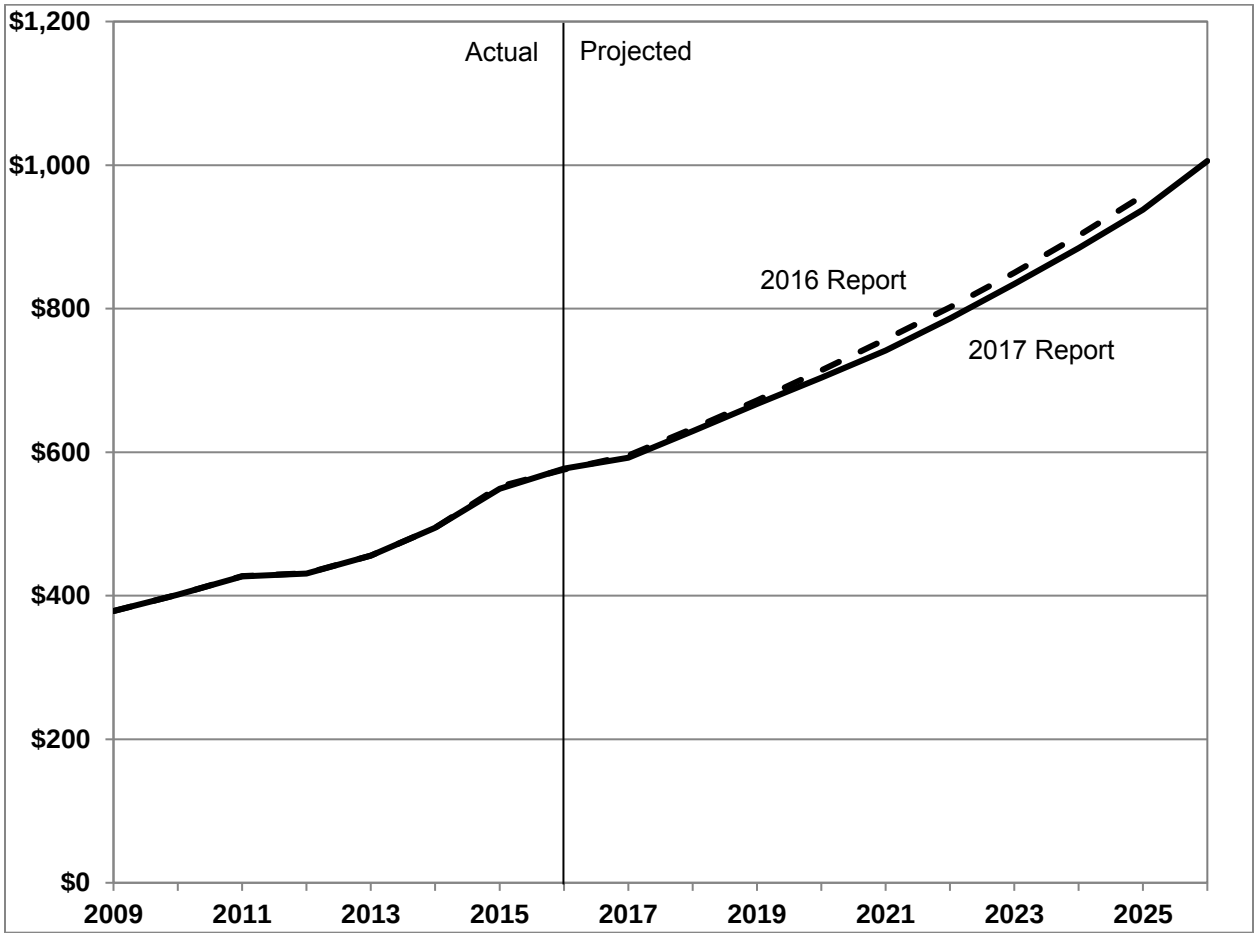
[24] Of the States that did not use a risk-sharing arrangement, several covered expansion adults under fee-for-service arrangements, and one covered enrollees through private health insurance plans using premium assistance. Several other States chose not to use risk-sharing arrangements.

on the results of States that have reported such information and on comparisons of the costs for expansion and non-expansion adults enrolled in Medicaid, the Federal government is expected to receive an estimated $3.2 billion from the risk-mitigation strategies and prior period adjustments due from 2014 experience, an estimated $5.5 billion due from 2015, and an estimated $4.0 billion due from 2016. These figures represent about 9 percent of capitation payments for expansion adults in 2014 and 2015 and about 8 percent in 2016. Of the total $12.7 billion estimated to ultimately be paid to the Federal government, $1.2 billion was paid in 2016, while 2017 and 2018 recoveries are estimated to total $4.1 billion and $7.4 billion, respectively. In 2016, the entire $1.2 billion in recoveries was paid through the settlement of risk-mitigation arrangements. The $4.1 billion estimated to have been paid in 2017 was only $0.8 billion in such settlements, with the remaining $3.3 billion being accounted for through prior period adjustments. In 2018, the $7.4 billion in estimated recoveries is projected to be $5.4 billion in settlements and $2.0 billion in prior period adjustments. Since only some States have reported the results of these contractual provisions, and because of the various arrangements employed by those States and the uncertainty regarding the costs of the new adult enrollees, it is possible that the actual amounts returned to the Federal government could differ significantly from those estimated here. In addition, it is possible that the actual payments to the Federal government (or potentially from the Federal government) could occur later than expected.

E. COMPARISON TO 2016 REPORT PROJECTIONS

The projections of Medicaid expenditures in this report are slightly lower than in the *2016 Actuarial Report on the Financial Outlook for Medicaid*. Figure 5 compares the 2017 projections of total Medicaid expenditures (including Federal and State) to those in last year's report.

Figure 5—Projected Medicaid Expenditures: Comparison of 2017 versus 2016 Actuarial Reports on the Financial Outlook for Medicaid, Fiscal Years 2009–2025[25]
(in billions)



Expenditures in 2017 ($592.2 billion) are estimated to have been slightly lower than estimated last year ($595.5 billion), representing a 0.6-percent difference resulting from lower estimated benefit expenditures for eligibility groups other than expansion adults. Projected spending of $937.7 billion in 2025 is 2.1 percent lower than the corresponding amount from last year ($957.5 billion). In total, the 10-year projections from 2016 through 2025 are $104.1 billion, or 1.4 percent, lower. The decrease over

[25] The data for this graph can be found in table 18 of section VI.D.

the 10-year period is primarily due to revised projections of the growth in use and complexity of certain services.

In addition, projected increases in utilization (or the residual factors) were slower in this year's report than in last year's (including those for long-term care services). As recent historical expenditures have grown more slowly, the outlook for future utilization growth in the program has changed accordingly.

Medicaid enrollment is projected to be slightly higher over the 10-year projection period than in last year's report, partially offsetting lower 2016 spending and slower growth in the utilization of some services. Increases in the projected enrollment of expansion adults in 2016 and beyond reflect higher reported enrollment than was previously anticipated.

Medicaid enrollment is projected to reach 81.6 million by 2025, which is about the same as projected in the 2016 report. Historical enrollment across all categories was higher than previously estimated for 2012 and 2013, resulting in higher enrollment levels over the projection period. In addition, expansion adult enrollment is estimated to have been 1.8 percent higher in 2017 than previously estimated (12.2 million as opposed to 12.0 million in the previous report), and it is projected to reach 13.2 million by 2025 (about the same as previously projected).

F. MEDICAID IN CONTEXT

From the estimates and analysis of health spending in the United States provided by the national health expenditure accounts (NHEA), additional insight can be obtained into the role of Medicaid within the total U.S. health care system.[26] Medicaid spending in the 2016 NHEA represented 16.9 percent of total national health expenditures. Private health insurance was the largest source of spending on health care in 2016, accounting for 33.7 percent of total national health expenditures, while Medicare paid for 20.1 percent.[27]

The historical NHEA also present health care spending by the original source of financing (or sponsor). In calendar year (CY) 2016, Medicaid represented 37.9 percent of Federal government expenditures on health services and supplies and 36.8 percent of such spending by State and local governments. For the third consecutive year, Medicaid was larger than Medicare as a share of Federal government expenditures on health services and supplies. (Trust fund and general revenue Medicare expenditures accounted for 31.3 percent of Federal spending on health services and supplies in 2016.)[28] Medicaid is the largest source of Federal general revenue-based spending on health services. A sizeable portion of Medicare spending is funded by income from dedicated revenue sources—which include Medicare Part A payroll taxes and Part B and Part D beneficiary premiums—with the balance from Federal general revenues. In contrast, Medicaid does not have any dedicated Federal revenue source; all Federal spending on Medicaid comes from general revenue. For State governments, Medicaid is the largest source of general revenue-based spending on health services.[29]

Moreover, Medicaid has a greater number of enrollees than Medicare. In FY 2016, Medicaid is estimated to have covered 72.2 million individuals (including persons residing in U.S. Territories). In comparison, Medicare covered an average of

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[26] The historical Medicaid spending data and projections presented in this report differ slightly from the national health expenditure estimates and projections in several ways. Some of the differences are as follows: (i) the data and projections featured in this report are shown on a fiscal year basis, whereas the national health expenditure amounts are on a calendar year basis; (ii) the NHEA make several adjustments to Medicaid, such as classifying Medicaid spending for Medicare premiums as Medicare spending; and (iii) the NHEA use somewhat different definitions of services than do the data presented in this report.

[27] M. Hartman, *et al*., "National Health Spending in 2016: Spending and Enrollment Growth Slow after Initial Coverage Expansions," *Health Affairs*, 37, no.1 (2018): 150-160.

[28] National Health Expenditures Historical 2016, Tables 5.3, 5.4. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

[29] *Ibid*. There are some State dedicated revenues for Medicaid. For more detail on this analysis of health care spending by sponsor, see the methodology paper at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-11.pdf.

56.8 million people during CY 2016.[30] Within these totals, there are substantial differences between the programs in the number and nature of people covered. For example, Medicare automatically covers nearly all people over age 65 (47.8 million beneficiaries in 2015), but only those aged individuals with very low incomes and assets—and who apply for the coverage—become Medicaid enrollees (estimated at 5.7 million). Enrollment for persons with disabilities was more similar between the two programs in 2016; Medicaid covered an estimated average of 10.6 million such persons that year, while Medicare covered 9.0 million of these beneficiaries. Although the definition of disability is essentially the same for both programs, the other eligibility criteria are entirely different.[31] Finally, as noted earlier, a majority of Medicaid enrollees are either children or non-disabled non-aged adults in families with low incomes; Medicare does not have comparable categories of beneficiaries. The Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC) found that 9.5 million persons (or about 15 percent of all enrollees) were dually eligible in 2013 and that, in that year, dual-eligible beneficiaries accounted for $118.9 billion in Medicaid expenditures (or about 32 percent of Medicaid benefit spending).[32]

Among the different types of health care services, Medicaid plays the largest role in the funding of long-term care. According to the 2016 NHEA, during that year Medicaid is estimated to have paid for 36.8 percent of all freestanding home health care and 30.7 percent of all freestanding nursing home care in the United States. In addition, Medicaid covered an estimated 56.7 percent of other health, personal, and residential care in 2016, including Medicaid payments for intermediate care facilities for individuals with intellectual and developmental disabilities and such payments for home and community-based waivers.[33] Medicaid has a major responsibility for providing long-term care because the program covers some aged persons and many persons with disabilities of all ages—individuals who tend to be the most frequent and most costly users of such care—and because private health insurance and Medicare often furnish only limited coverage for these benefits. Many people who pay privately for nursing home care or community-based long-term care become

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[30] *The 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2017.pdf.

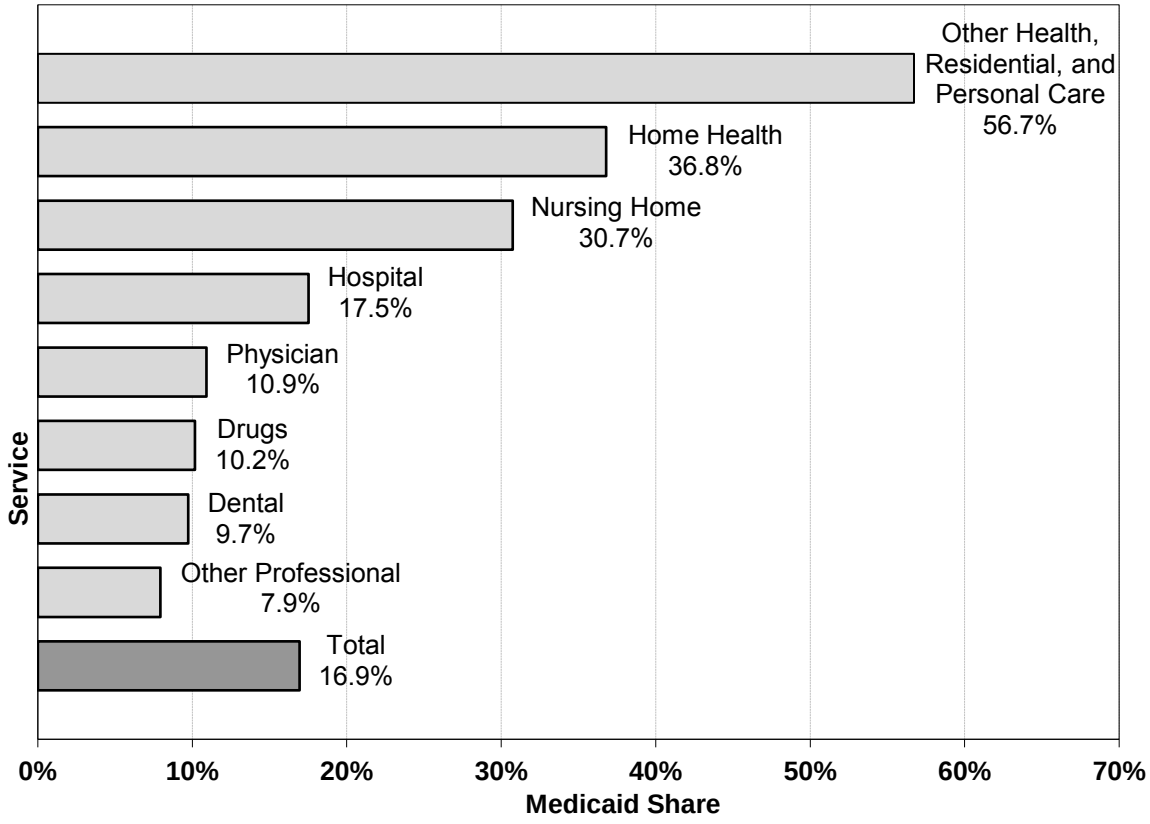
[31] Medicaid eligibility for persons with disabilities is based on income and asset criteria (among other measures). Medicare eligibility for persons with disabilities generally depends on an individual's sufficient participation in the paid work force prior to disability. Furthermore, in many cases the time period to determine eligibility for Medicare on the basis of disability is longer than that for determining Medicaid eligibility. Despite these different requirements, a significant number of persons with disabilities qualify for coverage under both Medicaid and Medicare.

[32] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, January 2018, available at http://medpac.gov/docs/default-source/data-book/jan18_medpac_macpac_dualsdatabook_sec.pdf?sfvrsn=0 .

[33] M. Hartman, *et al.*, "National Health Spending in 2016: Spending and Enrollment Growth Slow after Initial Coverage Expansions."

impoverished due to the expense; as a result, these people eventually become eligible for Medicaid. Figure 6 shows the percentage of total spending for the major health care services that Medicaid covers.

Figure 6—Medicaid Expenditures as Percentage of Total U.S. Health Expenditures, by Service Category, Calendar Year 2016



Medicaid represents a significant share of the Federal and State budgets. In FY 2017, out of a total of $4,062 billion spent by the Federal government for all purposes, $378 billion (or 9.3 percent) can be attributed to Medicaid. Under the President's FY 2019 Budget, Federal outlays on Medicaid are projected to account for 9.2 percent of all Federal outlays by 2027.[34]

According to the National Association of State Budget Officers (NASBO), Medicaid represented an estimated 28.7 percent of all State government spending in State fiscal year 2016.[35] This amount, however, includes all Federal contributions to State Medicaid spending, as well as expenditures from State general revenue funds and

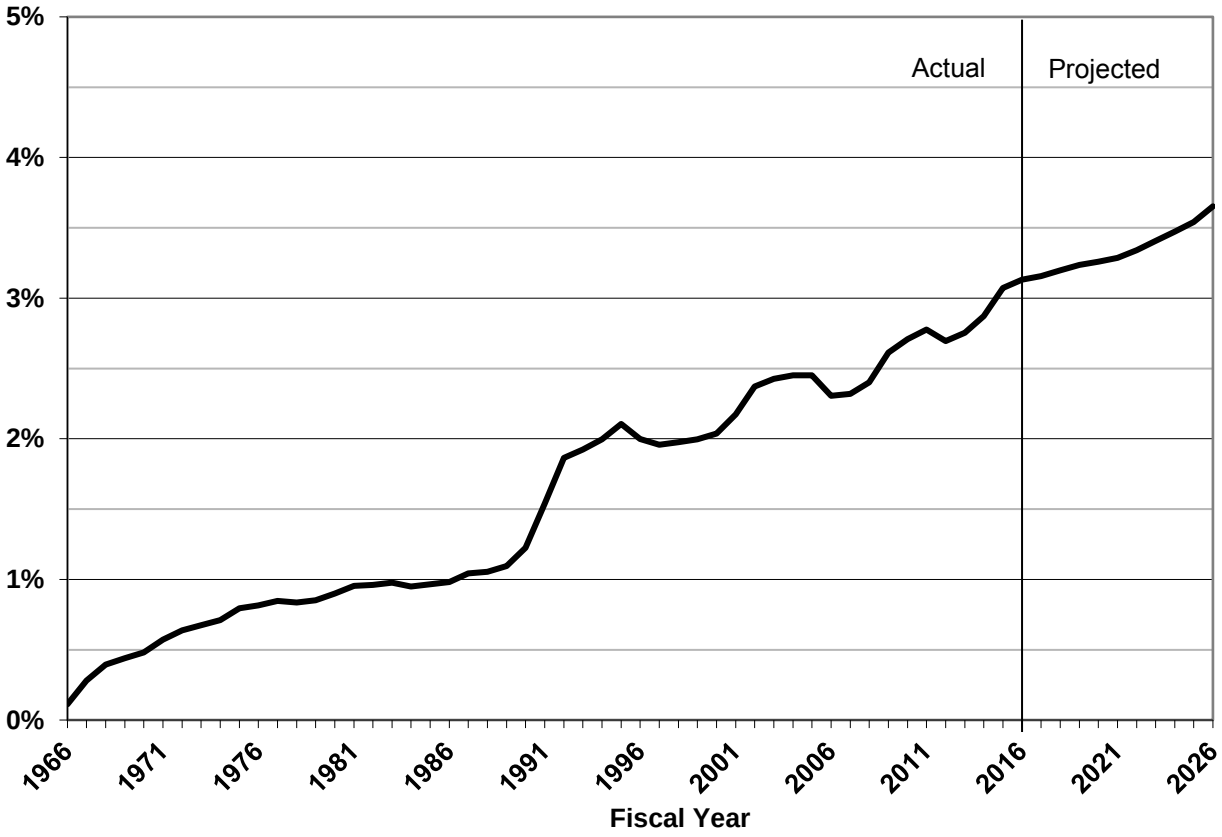
[34] Figures from the President's Budget differ from those shown in this report. More information on the Federal budget is available in *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2019*.

[35] *State Expenditure Report: Examining Fiscal 2015–2017 State Spending*, National Association of State Budget Officers, 2017.

other State funds (which for Medicaid may include provider taxes, fees, donations, assessments, and local funds). According to NASBO, Medicaid was the largest program in 2016. When only State general revenues are considered, however, Medicaid spending constituted an estimated 15.9 percent of State expenditures in 2016, placing it well behind elementary and secondary education. Overall in 2016, State general revenue expenditures for Medicaid increased by 4.0 percent, which was faster than the overall State general revenue expenditure growth rate of 3.2 percent.

As shown in figure 7, Medicaid represented about 3.1 percent of the Gross Domestic Product (GDP) in 2016. This gradual increase from 2.8 percent in 2013 largely reflects the continued growth in Medicaid expenditures associated with the eligibility expansion starting in 2014.

Figure 7—Past and Projected Medicaid Expenditures as Share of GDP, Fiscal Years 1966–2026[36]



Note: Percentages are affected by economic cycles.

In 2017, GDP is estimated to have grown by 1.7 percent. This growth rate is slightly less than that for Medicaid spending, which is estimated to have increased by 2.6 percent, as the main effects of the coverage expansion under the Affordable Care

[36] The data for this graph can be found in table 19 of section VI.D.

Act slowed. Medicaid spending is estimated to have increased to 3.2 percent as a share of GDP in 2017.

As seen in figure 7, the program's expenditures are projected to continue to grow to 3.7 percent of GDP by 2026. From 2017 through 2026, Medicaid expenditures are projected to increase about 1.6 percentage points faster than GDP per year. This difference is driven by relatively faster projected growth in per enrollee spending for the program overall, averaging 4.5 percent from 2017 through 2026, as well as by increases in DSH expenditures starting in 2026 following the expiration of the temporary DSH allotment reductions most recently updated in the Bipartisan Budget Act of 2018 (Public Law 115-123).

This projection of Medicaid spending as a share of GDP is greater than that included in last year's report. The share of GDP devoted to Medicaid in 2025 is projected to be 3.5 percent, about 0.1 percentage point higher than the 2016 projection. This result is due to the fact that GDP is projected to grow more slowly than previously assumed, averaging 4.0 percent annually from 2015 through 2025 as opposed to 4.8 percent over the same period in the 2016 report.

IV. SUMMARY OF DATA, ASSUMPTIONS, AND METHODOLOGY

Projections of Medicaid expenditures and enrollment are highly dependent on both demographic and economic assumptions. The most important such assumptions are those regarding the growth of health care prices, growth in the use of health care goods and services, overall economic growth, individual wage growth, and population growth. In addition, there are various programmatic factors that have historically influenced Medicaid expenditure and enrollment trends, including decisions by the States regarding eligibility and payment rules for their Medicaid plans, the coverage of and enrollment in other health insurance programs, including Medicare and private health insurance, and changes in the participation rates of eligible persons in Medicaid. The projections also depend on the nature and quality of the available data on Medicaid operations. This section briefly describes the sources of data and assumptions that are used to generate the Medicaid projections shown in this report; further detail is provided in sections VI.A and VI.B.

Data Sources

The data and assumptions on which these Medicaid projections are based are derived from three major sources. The first source is CMS data, which are submitted by the States to CMS on a regular basis. These data include the CMS-64 Financial Management Report (FMR) and the Medicaid Analytic eXtract (MAX).

The FMR provides separate Federal and State expenditures for all Medicaid fee-for-service programs and capitation arrangements.[37] The data and projections in this Medicaid actuarial report rely on the *Net Services* FMR, while Medicaid reports prior to 2015 used the *Base* FMR. Both the Net Services and Base FMRs provide the same total expenditures, but the former allocates prior period adjustments by service, while the latter does not. Neither the total expenditures reported nor the projected total expenditures are changed as a result of the switch from the Base to the Net Services FMR, but the benefit expenditures per enrollee are generally increased (since the benefit expenditures are more complete and thus are greater), as are the benefit expenditures for some categories of service. OACT made this change because using the Net Services FMR provides a more accurate allocation of the costs (by category of service and by enrollment category) than does reporting a significant portion of expenditures as prior period adjustments, and because further complications arise when the Base FMR is used and adjustments are allocated to the expansion adults. The effects of changing from the Base to the Net Services FMR are described more fully in section VI.A.

[37] More information on the CMS-64 is available on the CMS website at https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/expenditure-reports/index.html. Additional detail is provided in section VI.A.

Table 3 shows the 2016 Medicaid medical assistance payments and administration costs reported in the Net Services FMR.

Table 3—Total Medical Assistance Payments and Administration Expenditures from the CMS-64 Financial Management Report, Fiscal Year 2016

Type of Payment	Total	Federal	State
Medical Assistance Payments	$550,881,322,328	$347,661,763,592	$203,219,558,736
Administration Costs	26,323,092,634	16,754,797,718	9,568,294,916
Total Expenditures	577,204,414,962	364,416,561,310	212,787,853,752

Note: The complete CMS-64 Financial Management Report for medical assistance payments and administrative costs in FY 2016 is provided in section VI.D and is available on the CMS website at https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/expenditure-reports/index.html.

CMS data also include MAX, which contains both service and demographic data supplied by the States, including provider payments and enrollment counts, and are derived from the Medicaid Statistical Information System (MSIS).[38] MAX expenditure data include only total Medicaid expenditures and do not provide data separately for Federal or State expenditures. Several adjustments are made to merge the CMS-64 and MAX data together for use in preparing projections.

Table 4 shows average annual Medicaid enrollment by enrollment category for the last 4 years of complete enrollment data (2009 through 2012).Enrollment data are available in only 44 States in 2013. Enrollment levels are estimated for all States after 2013.

[38] More information regarding MAX can be found on the CMS website at https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaiddatasourcesgeninfo/maxgeneralinformation.html.

Table 4—Average Annual Medicaid Enrollment by MAX Enrollment Category, Fiscal Years 2009–2012

Enrollment Category	2009	2010	2011	2012
Aged	4,742,798	4,906,857	5,070,917	5,281,836
Persons with Disabilities	8,915,394	9,223,315	9,651,883	10,069,328
Children	23,338,750	25,314,793	26,079,135	26,802,765
Adults	11,675,142	12,875,583	13,550,526	14,446,790
Children (Unemployed Parent)	182,751	217,681	234,629	235,524
Unemployed Adults	148,525	181,847	200,381	204,703
Foster Care Children	897,986	880,464	839,805	848,280
Breast and Cervical Cancer Act Enrollees	38,152	39,968	41,963	43,300
Total	49,939,498	53,640,509	55,669,239	57,932,526

Note: MAX data for 2012 are supplemented with 2011 MAX data for Colorado and Idaho, as information for these two States is unavailable in the 2012 MAX data.

Key Assumptions

The Boards of Trustees for Old-Age, Survivors, and Disability Insurance (OASDI, or Social Security) and Medicare constitute the second source for the data and assumptions.[39] The projections in this Medicaid report are based on the same economic and demographic assumptions that were developed by the Trustees and used to determine the intermediate estimates presented in their statutory 2017 annual reports to Congress on the financial status of the OASDI and Medicare programs. The Trustees' intermediate economic assumptions are also used to develop the health care service price forecasts underlying the projections in this report.[40]

The third source of underlying data and assumptions—national health expenditure historical data and projections—is used for comparing Medicaid expenditures and enrollment with Medicare, private health insurance, and total health care spending

[39] *The 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2017.pdf, and *The 2017 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds,* available at https://www.ssa.gov/OACT/TR/2017/.

[40] These assumptions are different from those used for projections in the President's FY 2018 Budget. Consequently, the projections presented in this report usually differ somewhat from the President's Budget projections. In addition, due to differences in the timing of this report and the Budget, later data are generally available for use in this report. Finally, while the Trustees' economic assumptions underlie both the Medicare Trustees Report and the Medicaid actuarial report, the two sets of health care service price growth forecasts are not the same. The two programs have significantly different statutory mechanisms for setting provider price updates, and these differences are reflected in the updated assumptions for each program.

in the United States. OACT develops the national health expenditure data and projections.[41]

For the purpose of projecting enrollment of, and expenditures for, expansion adults, OACT developed assumptions regarding States' decisions to implement the eligibility expansion. Of all people who were potentially newly eligible Medicaid enrollees, 45 percent are estimated to have resided in States that elected to expand Medicaid eligibility in 2014, and 50 percent are estimated to have resided in States that expanded eligibility by 2015. Assumptions about the effective national participation rate of the States for the eligibility expansion after 2015 were developed using public information and statements for each State regarding its intent to implement the expansion. Based on this information, OACT assumed that 50 percent of all people who were potential expansion adults in 2016 resided in States that elected to expand Medicaid eligibility and, for 2017 and thereafter, that 55 percent of such individuals will reside in expansion States. This assumption is the same as the percentages assumed in the 2016 report.

In the future, actual participation by States could differ from these assumptions. A greater or lesser number of States could elect to expand eligibility than has been assumed, and States' decisions may change over time (either to expand if they have not done so previously or to end the expansion sometime in the future).[42]

The Medicaid expenditure and enrollment projections shown in this report are based on current law. That is, they are consistent with current legislation and administrative policy regarding Medicaid as of February 9, 2018 to include the signing of the Bipartisan Budget Act of 2018, which extended funding for the Children's Health Insurance Program (CHIP) through the projection window.[43] No other attempts have been made to forecast any future changes in policy or legislation

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[41] More information on the historical NHEA and projections is available on the CMS website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html. Also, see M. Hartman, *et al.*, "National Health Spending in 2016: Spending and Enrollment Growth Slow after Initial Coverage Expansions," *Health Affairs*, 37, no.1 (2018): 150-160; and S. Keehan, *et al.*, "National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Section to 20 Percent of Economy," *Health Affairs*, 36, no. 3 (2017): 553-563.

[42] Currently we assume all states that have expanded prior to January 1, 2018 will remain expansion states. The only state we presume will expand after this in our current modeling is Maine, which we estimated would expand in July 2018. Since these projections were completed, the start of the eligibility expansion in Maine has been delayed, and Virginia is expected to expand eligibility. These changes are not reflected in the projections in this report.

[43] This report does not cover expenditures and enrollment under CHIP, whether operated under Title XIX or Title XXI of the Social Security Act. CHIP provides health coverage to many children in households with income above Medicaid eligibility levels. In addition, this report does not consider any potential effects on Medicaid if CHIP funding exhausted prior to FY 2027. Should CHIP experience a shortfall in available funding, children enrolled in Medicaid expansion CHIP would be eligible for coverage in Medicaid, and projected Medicaid expenditures and enrollment would be higher than the projections in this report.

that, if realized, would affect the Medicaid program—including Federal Medicaid, State Medicaid, or Medicare policy and legislation or other legislation that could affect private health insurance plans. Thus, while changes in Federal or State Medicaid policy have been significant factors affecting the patterns of growth in expenditures and enrollment over the historical period, no future changes in policy are assumed (beyond those already scheduled under current law).

Methodology

Health actuaries typically base estimates of medical expenditures on three major factors:

- C – the number of people enrolled in the program (*caseload*),
- U – the quantity of services each person uses (*utilization*), and
- P – the reimbursement (*price*) for each unit of service.

The product of these three factors yields an estimate of total expenditures for medical services:

$$E = C \times U \times P \qquad (1)$$

Direct application of equation (1) requires data on utilization and reimbursement rates for Medicaid that are not currently available or practical to maintain.[44] An alternative recursive approach is therefore used for the projections, as described below.

Instead of using equation (1), the projection algorithm begins with development of data on the current level of Medicaid expenditures, by eligibility category and by type of medical service, to serve as a projection base. *Changes* in the three determinants of expenditures in equation (1) are then projected for future years and applied sequentially to the base year expenditures. Thus, if E_y represents expenditures in year y, then

$$E_{y+1} = E_y \times (1 + c_{y+1}) \times (1 + u_{y+1}) \times (1 + p_{y+1}) \qquad (2)$$

where c_{y+1}, u_{y+1}, and p_{y+1} are the assumed or projected rates of change in caseload, utilization, and prices, respectively, between years y and y+1. Equation (2) is applied separately to expenditures for each combination of the Medicaid eligibility categories and categories for type of service.

[44] No comprehensive sources are available that track reimbursement rates and use by service for all Medicaid programs. Because the expenditure data reported by the States in the CMS-64 are at an aggregate service level, each category likely includes various services with different numbers of claims and distinct reimbursement rates. Additionally, reimbursement rates and service use are different for each State.

With a few exceptions, caseload factors vary by eligibility category, price factors vary by type of service, and utilization factors can vary by both eligibility category and type of service. The projected caseload factors are determined by trend and regression analysis of Medicaid enrollment data. Projections of future enrollment by eligibility category are based on estimates of the change in the share of the U.S. population enrolled in Medicaid, which has historically varied with changes in the unemployment rate. The relationship between Medicaid enrollment and unemployment reflects (i) how many people are without other forms of insurance and (ii) how many people might qualify for Medicaid based on its income requirements. Historically, this relationship has varied by eligibility category; in general, child and adult enrollment in Medicaid has been more sensitive to changes in the unemployment rate, and the enrollment of aged persons and persons with disabilities has been relatively less sensitive.

Price changes are derived from economic forecasts produced for the 2017 Medicare Trustees Report, including forecasts for economy-wide inflation, inflation for prices of medical services, and wage growth. Utilization is treated as the residual between total growth and the growth due to enrollment and price changes. The estimate of utilization is determined by an analysis of the historical interrelationship of expenditure, caseload, and price factor growth.[45] The residual factor, while termed *utilization*, reflects not only the change in the average number of services per enrollee but also changes in the *intensity* or average complexity of the services. In addition, any errors in the measurement of the number of enrollees and price per service are implicitly included in the residual.

The methodology used to develop the utilization factor for the projections is calculated by service and by enrollment category. While for some services historical utilization is similar across enrollment categories, utilization in services disproportionately concentrated in one or two enrollment categories can vary significantly by enrollment category. In these cases, projecting utilization by both type of service and enrollment category improves the accuracy of the forecast. In addition, the growth of managed care in Medicaid has reduced historical fee-for-service utilization for several types of service. The extent to which States appear to have maximized their use of managed care or are likely to continue to expand is measured and projected in the utilization factor for managed care services and the affected fee-for-service categories.

The results obtained from the *Caseload, Utilization, Price* (*CUP*) recursive forecast, using equation (2), are frequently adjusted to be consistent with recent expenditure data and outlay trends.

It is important to note that some of the reported line items in the financial data are not projected using category- or service-specific growth rates with respect to caseload, utilization, or price. Collections reported by the States constitute the largest such

[45] More details on the trend residual methodology are included in section VI.C.

item, and they are projected to grow at the underlying total Medicaid expenditure growth rate, calculated net of all reported collections. In addition, payments for the Medicare Part A and Part B premiums are projected to grow at rates based on the most recent premium amounts and projections developed for the Social Security and Medicare Boards of Trustees in their 2017 reports to Congress. Separate utilization and price trends are not developed.

The projections of expansion adult enrollment and costs are based on currently available data from the CMS-64 and on several assumptions, including projections of population growth, eligibility for and enrollment in other forms of health care coverage (such as employer-sponsored insurance and the Health Insurance Marketplaces), and growth in the utilization and prices of health care services. In addition, preliminary indications are that the actual costs for these beneficiaries are significantly less than the payments made to managed care plans to cover them. These results are considered in developing the projected per enrollee costs for expansion adults. Section III of the report discusses this issue in more detail.

The projections in the report also include estimated payments that the Federal government is anticipated to receive from managed care plans (via the States), through risk corridors and minimum medical loss ratio requirements, for the expansion adults covered in managed care in 2014 and 2015 and for some States in 2016. (These payments are described in more detail in section III.D of the report.) To develop these estimates, per enrollee costs of the expansion adults in 2014, 2015, and 2016 were compared to projections of the costs of non-expansion adults. The costs for the non-expansion adults were based on data from the MAX files, adjusted to discount the costs of pregnant women (as pregnant women are not expected to be among the expansion population) and projected forward using the data and assumptions of per enrollee costs underlying this report. The costs of the expansion adults were compared to the projected costs for non-expansion adults after adjusting for assumptions of additional costs due to pent-up demand among the new enrollees. The amounts estimated to be owed by plans in each State were then determined using a model risk corridor (reflecting average terms for the risk corridor, such as how much risk remained with the plan and how much remained with the Federal government), and those amounts were adjusted to match in the States that have reported preliminary risk corridor or minimum medical loss ratio amounts to CMS. While this methodology provides a reasonable indication of the amounts that the Federal government is likely to receive from the managed care plans, in actuality the amounts could be significantly greater, or less, than estimated.

In addition to benefit expenditures, this report includes projections of administration costs that are based on historical administrative cost reporting, as well as projected growth rates from the Mid-Session Review of the President's FY 2018 Budget, updated to include more recent data.

Like any projection of future health care costs, the Medicaid projections presented here are necessarily uncertain. Actual numbers of enrollees, the number of services used, and the reimbursement levels per service will depend on all of the factors described previously—none of which can be predicted with certainty. Past increases in Medicaid and other health care costs have often been relatively volatile, adding to the difficulty of correctly anticipating future trends. Moreover, the impacts of the numerous sections of the Affordable Care Act that affect Medicaid, especially the broadening of Medicaid eligibility in 2014, introduce additional uncertainty into these projections. Finally, there is relatively limited experience for people who became eligible for and enrolled in Medicaid between 2014 and 2017; accordingly, while these estimates are more certain than those in previous reports, they should still be considered uncertain due to the relative lack of program data and experience to inform them and the uncertainty about which States will expand their eligibility standards in the future.

The projections shown in this report should be regarded only as a reasonable indication of future Medicaid costs under current law and from today's perspective. It is important to recognize that actual costs in the future could differ significantly from these projections, as a result of (i) unanticipated developments in demographic, economic, or health cost growth trends and (ii) any further changes in the legislation governing Medicaid.

Sections VI.A and VI.B include additional detail regarding the data, assumptions, and methodologies used in the projections in this report.

V. CONCLUSION

Medicaid expenditures are estimated to have grown 2.6 percent in 2017, down from 5.1 percent in 2016, and to have reached $592.2 billion. Growth is estimated to have decelerated in 2017 due to the slowdown in enrollment of expansion adults, decreases in per enrollee costs for expansion adults, and the collection of payments from States for managed care risk mitigation strategies that were put in place for those individuals. In 2018 and beyond, enrollment and expenditures are expected to steadily increase, with total Medicaid expenditures growing to a projected $1,005.7 billion by 2026. The projected annual average growth rate of Medicaid expenditures from 2017 to 2026 is 5.7 percent—notably faster than the projection of average annual GDP growth of 4.1 percent over the same period. Should these trends continue as projected under current law, Medicaid's share of State budgets would continue to expand absent other changes to the program, budget expenditures, or budget revenues, while its share of the Federal budget would remain about the same.

The proportion of Medicaid expenditures for capitation payments and premiums is projected to increase, as is the number of enrollees that receive all or some of their Medicaid benefits through a managed care plan. This trend has accelerated since 2014 as many States have covered expansion enrollees through managed care plans. In addition, States have continued to expand the use of managed care to cover aged enrollees and persons with disabilities and to provide for long-term care services through managed care programs. Thus, understanding how the use of managed care in Medicaid will affect future expenditure growth—and how fee-for-service expenditures for acute care and long-term care will also be affected—will be an important consideration for Medicaid programs in the future.

Because Medicaid does not have any dedicated revenue source at the Federal level or a trust fund approach to financing, the solvency of the program is not an issue in the same way it may be for the Medicare Hospital Insurance (or Part A) trust fund; the expenditures of each State (or Territory) program are covered by the State's revenues plus Federal matching general revenues. However, even without solvency as a concern, Medicaid constitutes a significant portion of spending by both Federal and State governments and thus is important to evaluate as part of the respective budgets. A growing share of budget expenditures on the Medicaid program could displace spending on other important programs, or additional taxes or other revenue sources could be required to fund Medicaid.

Typically the cost growth rates of different payers and programs, such as Medicare, Medicaid, and private health insurance plans, are related. Attempts by one payer or program to affect costs can have a direct or indirect impact on other payers and programs. Whether such efforts are focused on the payment or management of health care specific to certain programs, or on the delivery or practice of health care generally, it will be important to consider the potential effects not just on Medicaid but across all health care payers. Programs and demonstrations that focus on health

care provided for persons enrolled in both Medicare and Medicaid (dual-eligible beneficiaries), or that focus on Medicare but also include some dual-eligible beneficiaries, may have effects on the costs and quality of care paid for by Medicaid.

This report includes projections of the current-law Medicaid program. As policy makers consider changes or reforms to the program, for Medicaid specifically or for the broader health care system, particular attention may need to be paid to the ways in which Medicaid differs from other types of health care coverage—for example, in its administration, the benefits offered, the populations covered, and the ways in which it pays for health care. Other important issues for consideration, as Medicaid's role continues to evolve, are provider participation, Medicaid payment rates, and beneficiary access to services.

VI. APPENDIX

A. DATA SOURCES

Projections of Medicaid expenditures and enrollment are highly dependent on both demographic and economic assumptions, as well as on program data. This section describes the sources and limitations of data and assumptions that are used to generate the Medicaid projections shown in this report.

CMS-64 (Financial Management Reports)

The CMS-64 reports (Financial Management Reports, or FMRs) are products of the Medicaid and CHIP Budget and Expenditure Systems (MBES/CBES). These reports are submitted by the States quarterly and provide current fiscal year spending. The expenditure amount shown on the FMR is a summary of expenditures for the various mandatory and optional services covered by the Medicaid State programs. In addition, in 2014 the CMS-64 began reporting monthly enrollment data by enrollment category as well as quarterly expenditures for expansion adults.[46]

The mandatory services contained in the FMR include inpatient and outpatient hospital care, physician services, nursing facility care for individuals aged 21 or older, family planning services, rural health clinic services, home health care, laboratory and x-ray tests, other practitioner services, federally qualified health center services, and early and periodic screening, diagnostic, and treatment services for children under age 21 (EPSDT). Among the many reported optional services that States may provide are clinic services, prescription drugs, services furnished by intermediate care facilities for the intellectually disabled, hospice care, home and community-based care to certain persons with chronic impairments, and targeted case management services. Additionally, the FMR captures expenditures for DSH payments, offsets to drug spending through rebates, Medicare Part A and Part B premiums paid for those dually eligible for Medicare and Medicaid, premiums paid for Medicaid-only capitated arrangements, and expenditures for home and community-based waiver programs.

The FMR also includes the separate Federal and State expenditures for all Medicaid fee-for-service programs and capitation arrangements. The FMR is available on a *Net Services* basis and a *Base* basis, both of which report the same total expenditures. The historical data and projections provided here are based on the expenditure data

[46] The CMS-64 reports enrollment and expenditures for enrollees in the *VIII group*, which includes those persons who are eligible under the criteria of section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Most enrollees in this group are expansion adults, but some adults who may have been eligible under pre-2014 criteria are in this group as well. The CMS-64 provides data on both expansion adults and other enrollees in the VIII group separately starting in 2014.

in the Net Services reports. All Medicaid reports published prior to 2015 used the Base reports for historical data and projections.

The main difference between the Net Services and Base reports is that the Base report provides service-level expenditures that were both incurred and paid in the current quarter, whereas the Net Services report shows expenditures by service on a paid basis. The Base report allocates expenditures that were paid in a different quarter than the services were incurred as prior period adjustments, and it similarly groups all collections (negative adjustments to payments) together. The Net Services report allocates all prior period adjustments to individual services, and it reports as collections only those collections that are not associated with a specific service (such as recoveries for fraud, waste, and abuse). Total expenditures are the same in both reports.

Because the Net Services report allocates prior period adjustments by service, the net effect is that the amount of prior period adjustments to expenditures is reduced while expenditures by category of service are increased. Therefore, the amounts reported for benefit expenditures by category of service and for benefit expenditures per enrollee are more complete and effectively higher under the Net Services report than under the Base report, and, as a result, these benefit expenditures by category of service and the accompanying projections are greater than shown in previous Medicaid reports.

Medicaid Analytic eXtract (MAX) and the Medicaid Statistical Information System (MSIS)

The Medicaid Statistical Information System (MSIS) is the basic source of State-submitted eligibility and claims data on the Medicaid population, its demographic characteristics, utilization of health care services, and payments. The purpose of MSIS is to collect, manage, analyze, and disseminate information on eligible individuals, beneficiaries, utilization, and payment for services that are covered. States provide CMS with quarterly files consisting of specified data elements for persons covered by Medicaid and adjudicated claims for medical services reimbursed with Title XIX funds. Four types of claims files representing inpatient services, long-term care, prescription drugs, and non-institutional services are submitted. Claims records contain information on the types of services used, providers, service dates, costs, and types of reimbursements. Eligibility characteristics, such as basis-of-eligibility and maintenance assistance status, are the foundation of the enrollment projections; specifically, the primary basis-of-eligibility categories consist of aged persons, persons who are blind or have other disabilities, non-disabled children (including foster care children), and non-disabled non-aged adults (including women eligible under the Breast and Cervical Cancer Act eligibility expansion).

The data and projections in this report generally rely on the Medicaid Analytic eXtract (MAX). MAX contains both service and demographic data supplied by the States, including provider payments and enrollment counts, and is derived from MSIS.[47] As is the case with MSIS, MAX expenditure data include only total Medicaid expenditures, and MAX does not provide data separately for Federal or State expenditures. Several adjustments are made to the CMS-64 and MAX data to merge them together for use in preparing projections.

Prior to the 2015 Medicaid report, historical data and projections relied on data from MSIS—mainly from the Annual Person Summary (APS) files. It is worth noting that MAX data are based on claims data from MSIS, and although there are differences in the way the claims are summarized, these differences do not have a significant impact on the projections in this report. Historical data shown in the report from 2000 through 2004 are based on MSIS.

Users of Medicaid data may note discrepancies between the expenditure information captured in MAX and the CMS-64. For example, DSH payments and Medicare premiums do not appear in MAX. Whereas actual payments are reflected in the CMS-64, in MAX adjudicated claims data are used. Service definitions vary in these two sources as well. Territorial data for American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands appear in the CMS-64, but not in MAX. Each State has a different system for capturing statistical (MSIS) and financial (CMS-64) data.

It is important to note the limitations that are associated with the data described in this section. First, MAX data are available for 48 States through 2011, for 49 in 2012, for 44 in 2013, and for only 20 states in 2014. MAX (and the MSIS data from which MAX is derived) is the only available source of complete enrollment data.[48] Consequently, to relate 2011, 2012, 2013, and 2014 actual expenditures to the number of enrollees, estimates of Medicaid enrollment are prepared for those years for the missing States.[49] For 2015 (and for the projections for 2016 through 2025), enrollment is estimated using a regression model and historical data, including available (2011, 2012, 2013, and 2014) State data. MAX also does not provide data on enrollment in Territory programs, and thus enrollment figures for Territories are

[47] More information regarding MAX can be found on the CMS website at https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaiddatasourcesgeninfo/maxgeneralinformation.html.

[48] While the CMS-64 provides enrollment data starting in 2014, the MSIS and MAX data overlap with the CMS-64 in 2014 for only a small number of States, and thus it is not possible to determine how closely the two sources match. Further, the 2014 MAX data do not differentiate between expansion adults and non-expansion adults. The figures in this report are based on the MAX data, and the CMS-64 enrollment data are used only for expansion adults and for enrollment in the Territories.

[49] In this report, child Medicaid enrollees consist of non-disabled children, children of unemployed parents, and foster care children; adult Medicaid enrollees consist of non-disabled non-aged adults, unemployed adults, and women covered under the Breast and Cervical Cancer Act expansion; and disabled Medicaid enrollees consist of blind or disabled persons.

estimated from previous data; to estimate enrollment in the Territories for 2014 and 2015, for example, data from the CMS-64 are used.

CMS is currently implementing a new data system to replace MSIS: the Transformed Medicaid Statistical Information System, or T-MSIS. This new system will collect and report data from 2014 onwards (although States may have switched from MSIS to T-MSIS at different points in time in 2014 and 2015). T-MSIS is currently not available for use in providing historical data or in projecting Medicaid expenditures or enrollment, due to limited access to the data, incomplete data, and concerns about data quality. As a result, this report does not rely on T-MSIS data in any way. Also unavailable at this time are MAX data derived from T-MSIS data. As a result of the lack of recent data on Medicaid enrollment and expenditures by eligibility group, some of the projections in this report are less credible—most notably, the expenditures per enrollee by eligibility group, the estimates and projections for which can be found in section VI.

Another qualification is that it was only in 2014 that the CMS-64 began providing data on enrollment or spending by enrollment category (and, in the case of spending by enrollment category, only for expansion adults or other adults in the *VIII group*).[50] In addition, the definitions of medical service categories are not consistent between MAX (or MSIS) and the other data sources. Adjustments are made to develop a data set that contains not only service-level expenditures that match the CMS-64 data but also expenditures by enrollment group; accordingly, MAX and the CMS-64 are merged together to provide a more complete understanding of Medicaid spending. Since the service definitions are different between these two sources, MAX data are used to estimate spending by enrollment group for each Medicaid service reported in the CMS-64.[51] While every State that chose to expand its program is reporting enrollment data in the CMS-64, regular updates to these submissions indicate that the data are not yet final for FY 2016. To develop the enrollment estimates and projections for this report, the CMS-64 enrollment data were used only for the number of expansion adults enrolled.

Finally, OACT reviewed the data sources used in these projections for reasonableness but relied on CMS program components and the States to ensure the quality of the data.

[50] The *VIII group* refers to enrollees who are eligible under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, including expansion adults.

[51] Certain services in the CMS-64 for which there is little to no history are combined with other services assumed to have a matching underlying distribution of spending by eligibility category.

B. KEY ASSUMPTIONS

The primary demographic, economic, and health cost inflation assumptions underlying the Medicaid projections shown in this report are the same as those used by the Social Security and Medicare Boards of Trustees in their 2017 reports to Congress.[52] Final 2018 Medicare premium amounts were used in place of projected premium amounts to more accurately reflect anticipated expenditures.

The price assumptions used to develop the Medicaid expenditure projections are derived from the assumptions included in the Social Security and Medicare Trustees Reports. While these price assumptions are specifically meant to measure the changes in the prices that Medicare would pay providers, they also generally reflect the projected growth in the prices of health care services.

As noted in section IV of this report, there is no single data source available that tracks all Medicaid prices or price changes. In addition, since States do not have a prescribed methodology for updating provider reimbursement rates, there are no specific or consistent forecasts of the changes in the prices for health care services that can be used across all Medicaid programs. Accordingly, OACT relies on other forecasts from Medicare, which are assumed to be reasonable projections of the underlying growth in health care prices that States would consider when changing provider reimbursement rates within their Medicaid programs.

The principal economic assumptions include growth in average wages and the CPI. These and other assumptions are used to generate health care service input price indices (or *market baskets*) for inpatient hospital and home health care services. These indices serve as indicators of increases in Medicaid payments per service.

It is important to note that these price assumptions may not accurately measure the underlying changes in the prices paid by Medicaid programs year to year. States have significant discretion in setting reimbursement rates, and in any given year the changes in rates paid to providers may differ from the changes in the price assumptions that are used to project future price changes for Medicaid expenditures. Thus, while these price forecasts are expected to reasonably estimate the changes in prices over time, they may not be precise measures of the actual changes in prices in any State Medicaid program. Moreover, to the extent that any specific price assumption is not an accurate assessment of the change in the price paid for any particular service, the difference between the actual change in price and the change in the price assumption would be reflected in the residual factor. While in general the

[52] Further information on the Trustees' population projections and economic assumptions is available in the 2017 Social Security and Medicare Trustees Reports, the latter of which can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2017.pdf.

residual factor is meant to represent changes in utilization, it would also incorporate errors in the measurement of prices.

Medicaid enrollment is projected by eligibility category: aged persons, persons with disabilities, children, expansion adults, and other adults. The model measures enrollment by eligibility category as a percentage of the U.S. population by relevant age group (aged—U.S. population aged 65 and over; disabled—U.S. population aged 0-64; children—U.S. population aged 0-19; and adults—U.S. population aged 20-64). Historical enrollment is measured for 1992 through 2013—the period for which reliable enrollment data exist in MSIS (1992-2004) and MAX (2005-2013).

The relationship between the change in the share of the U.S. population enrolled in Medicaid by eligibility category and the change in the national U.S. unemployment rate is measured using a regression model. Analysis conducted in developing this enrollment model has shown that the unemployment rate is the most meaningful factor in analyzing changes in historical Medicaid enrollment. Other economic variables either are not statistically significant or do not improve the accuracy of the model. In addition, changes in the unemployment rate have a strong theoretical relationship with Medicaid enrollment. As the unemployment rate increases, fewer people have jobs, leading in turn to a greater number of people with lower incomes and more individuals likely to be eligible for Medicaid. Moreover, a decrease in the number of people with jobs is likely to lead to fewer people with private health insurance, and as a result more people may enroll in Medicaid for health care coverage. Conversely, as the unemployment rate decreases, an increase in the number of people with jobs is likely to lead to increases in income and more people with private health insurance, and consequently enrollment growth in Medicaid may be slower. The Trustees do not typically forecast economic cycles, and thus the projections of Medicaid enrollment in this report do not exhibit the same cyclical variation that enrollment has experienced historically.

The change in the share of the U.S. enrolled population is projected forward using the results of the regression model and forecasts of the unemployment rate from the 2017 Social Security Trustees Report for each eligibility category. Enrollment is projected using those results and the forecasts of the U.S. population from the 2017 Trustees Report. The projections from the model may be adjusted, in particular for estimates of enrollment in recent years (in this Medicaid report, enrollment is estimated for 2014 through 2016, and for any States missing data in prior years); in estimating historical enrollment, other data or information is often used to adjust the results from the Medicaid enrollment models. Typically, other sources do not provide enrollment at the same level of detail as shown in MAX or in this Medicaid report, but such sources may inform the overall level of enrollment or the growth rate of total enrollment in those historical years.

Changes in the utilization of services and other changes in expenditures not reflected in changes in enrollment or prices are reflected in the *residual* factors in the model.

The trend residual approach to projecting Medicaid expenditures begins with an analysis of historical Medicaid expenditures per enrollee on a service-by-service basis. The annual percent change in these per enrollee expenditures is compared to the change in the applicable price indicator (listed below), and the differential, or residual, is calculated. This residual measures the collective impact of changes in utilization and *intensity* (average complexity) of services, case mix effects, and other factors, and it is calculated by service and by eligibility category. For the purpose of developing projected expenditures, the residual may be calculated as the average across all eligibility categories (typically when the residuals across eligibility categories have similar values, or when the amount of spending for one or more eligibility categories is relatively small and there are potential concerns about the credibility of the residual factor). The basis of the projected residual is the historical average of the residual value (either as a weighted average or an unweighted average over the previous several years), but adjustments may be made by gradually increasing or decreasing the residual toward the average residual for a broader category of services (such as all acute care, all long-term care, or all medical services).

The residuals are adjusted to limit the value of any particular service from significantly increasing or decreasing more than the value of all services (or broader categories of services). In general, the residual of all services (or broader categories of services) tends to be more stable, but it is necessary to use residuals by service to account for changes in the Medicaid program as well. Often, these adjustments are made to reflect areas in which there has likely been a shift between services or categories of services in recent history, but projecting those changes to continue at the same rate over 10 years would not necessarily be the best estimate of future expenditures.

One key example concerns the historical shifts of Medicaid expenditures from fee-for-service programs (especially acute care services, such as hospital services, physician and other professional services, and prescription drugs) to managed care. As part of the adjustment, managed care expenditures as a share of total expenditures were reviewed by State and by eligibility category. This review provided more detailed information on the use of managed care across States, as well as some evidence regarding the extent to which recent expenditure growth in managed care programs was driven by the States' expansion of their use of these programs. The analysis suggested that managed care expenditures were likely to continue to grow relatively quickly but, over time, were more likely to slow, as the rate at which States shift expenditures to managed care programs slows. Similarly, the analysis suggested that the residuals for acute care services in general would increase over the same period as the shift from fee-for-service programs decelerates.

The following table 5 shows the price indicators currently used to produce Medicaid expenditure projections.

Table 5—Price indicators for selected Medicaid Types of Service

Type of Service	Price Indicator
Inpatient and outpatient hospital	Medicare hospital input price index (market basket), before the application of productivity adjustment
Physician, clinic, and related services	Medical CPI increase
Institutional long-term care	Maximum of CPI increase and average wage increase
Community long-term care and home and community-based waiver services	Medicare home health input price index, before the application of productivity adjustment
Prescription drugs	CPI increase
Managed care	Medical CPI increase

One exception to the trend residual methodology occurs in the case of some premiums. The costs for Medicare premiums financed by Medicaid are based on the projected premium rates for Medicare Parts A and B in the President's FY 2018 Budget. The proportions of aged and blind or disabled enrollees whose Medicare costs are financed by the States or the Federal government through premium payments are assumed to remain at historical levels.

C. RESIDUAL ANALYSIS RESULTS AND ASSUMPTIONS

This section provides the results of the analysis used to calculate the residual factors for the projections. The following tables show the historical residual factors and the projected values by eligibility category and by service for the largest five services (as measured by total 2016 expenditures); however, due to the lack of more recent data, the estimates of expenditures by eligibility group are subject to considerable uncertainty.

Table 6—Historical and Projected Residual Factors for Aged Enrollees, Selected Services, Fiscal Years 2011–2026

Fiscal Year	Nursing Facility	Managed Care	Home and Community-Based Waivers	Inpatient Hospital	Personal Care
Historical data:					
2011	−3.5%	6.8%	−0.4%	−10.5%	24.0%
2012	−10.8	28.2	−6.6	−10.6	−15.4
2013	−3.0	12.6	−3.1	2.7	0.2
2014	−7.7	−0.1	−3.3	−5.6	−17.5
2015	−12.9	21.3	10.0	−4.6	5.8
2016	−7.1	15.9	0.2	−5.1	−3.6
Projections:					
2017	−6.5	13.4	0.2	−4.5	−3.1
2018	−5.8	10.9	0.2	−3.8	−2.6
2019	−5.2	8.5	0.2	−3.2	−2.1
2020	−4.5	6.0	0.2	−2.5	−1.6
2021	−3.9	3.5	0.2	−1.9	−1.1
2022	−3.9	3.5	0.2	−1.9	−1.1
2023	−3.9	3.5	0.2	−1.9	−1.1
2024	−3.9	3.5	0.2	−1.9	−1.1
2025	−3.9	3.5	0.2	−1.9	−1.1
2026	−3.9	3.5	0.2	−1.9	−1.1

Table 6 shows the residual factors for the largest five services for aged enrollees based on estimates of 2016 expenditures; spending for these services constituted 82 percent of total estimated Medicaid expenditures for aged enrollees, as shown in table 7. (Medicare Part B premiums are shown below, but residual factors are not calculated for Medicare premiums.)

Table 7—Fiscal Year 2016 Selected Service Expenditures for Aged Enrollees
(in billions)

Service	2016 Expenditures
Nursing Facility	$32.9
Managed Care	16.5
Home and Community-Based Waivers	7.3
Medicare Part B Premiums	6.3
Inpatient Hospital	3.5
Personal Care	2.1
Total Expenditures for Aged Enrollees	83.6

Table 8—Historical and Projected Residual Factors for Persons with Disabilities, Selected Services, Fiscal Years 2011–2026

Fiscal Year	Managed Care	Home and Community-Based Waivers	Inpatient Hospital	Nursing Facility	Prescription Drugs
Historical data:					
2011	7.9%	−4.0%	5.6%	−2.6%	−14.7%
2012	28.5	−3.7	−15.1	−8.4	−45.7
2013	15.3	−1.8	−0.3	−3.2	−26.2
2014	18.4	−2.9	−17.3	−1.6	5.9
2015	16.9	6.4	1.5	−14.6	31.9
2016	14.1	0.2	−4.6	−5.8	−4.8
Projections:					
2017	8.8	0.2	−4.0	−5.3	−4.2
2018	3.5	0.2	−3.4	−4.8	−3.5
2019	3.5	0.2	−2.8	−4.3	−2.9
2020	3.5	0.2	−2.2	−3.8	−2.3
2021	3.5	0.2	−1.6	−3.3	−1.7
2022	3.5	0.2	−1.6	−3.3	−1.7
2023	3.5	0.2	−1.6	−3.3	−1.7
2024	3.5	0.2	−1.6	−3.3	−1.7
2025	3.5	0.2	−1.6	−3.3	−1.7
2026	3.5	0.2	−1.6	−3.3	−1.7

Table 8 shows the residual factors for the top five services for persons with disabilities based on estimates of 2016 expenditures; spending for these services constituted 72 percent of total estimated Medicaid expenditures for persons with disabilities, as shown in table 9. (Prescription drug expenditures shown in table 9 do not include Medicaid prescription drug rebates.)

Table 9—Fiscal Year 2016 Selected Service Expenditures for Persons with Disabilities
(in billions)

Service	2016 Expenditures
Managed Care Organizations	$62.4
Home and Community-Based Waivers	42.5
Inpatient Hospital	21.9
Prescription Drugs	12.3
Nursing Facility	10.5
Total Expenditures for Persons with Disabilities	208.5

Table 10—Historical and Projected Residual Factors for Child Enrollees, Selected Services, Fiscal Years 2011–2026

Fiscal Year	Managed Care	Inpatient Hospital	Prescription Drugs	Physician	Outpatient Hospital
Historical data:					
2011	7.3%	0.1%	−11.9%	−2.0%	−1.4%
2012	−4.6	−13.9	−35.4	−17.9	−16.5
2013	14.6	2.4	−24.3	−10.0	1.3
2014	9.8	−11.0	2.4	−4.9	−8.8
2015	16.5	1.8	−0.3	−17.1	−10.0
2016	5.7	−4.5	−5.2	−7.4	−6.9
Projections:					
2017	3.6	−3.0	−3.6	−5.2	−4.8
2018	1.4	−1.6	−1.9	−3.0	−2.8
2019	1.4	−1.6	−1.9	−3.0	−2.8
2020	1.4	−1.6	−1.9	−3.0	−2.8
2021	1.4	−1.6	−1.9	−3.0	−2.8
2022	1.4	−1.6	−1.9	−3.0	−2.8
2023	1.4	−1.6	−1.9	−3.0	−2.8
2024	1.4	−1.6	−1.9	−3.0	−2.8
2025	1.4	−1.6	−1.9	−3.0	−2.8
2026	1.4	−1.6	−1.9	−3.0	−2.8

Table 10 shows the residual factors for the top five services for the child population based on estimates of 2016 expenditures; spending for these services constituted 83 percent of total estimated Medicaid expenditures for children, as shown in table 11. (Prescription drug expenditures shown in table 11 do not include Medicaid prescription drug rebates.)

Table 11—Fiscal Year 2016 Selected Service Expenditures for Child Enrollees
(in billions)

Service	2016 Expenditures
Managed Care Organizations	$60.5
Inpatient Hospital	12.1
Prescription Drugs	4.4
Physician Services	2.9
Outpatient Hospital	2.7
Total Expenditures for Children	99.9

Table 12—Historical and Projected Residual Factors for Adult Enrollees, Selected Services, Fiscal Years 2011–2026

Fiscal Year	Managed Care	Inpatient Hospital	Outpatient Hospital	Prescription Drugs	Physician
Historical data:					
2011	11.8%	14.1%	5.2%	−10.5%	1.3%
2012	3.1	−13.2	−12.1	−49.9	−16.3
2013	12.0	4.6	8.7	−27.5	−8.5
2014	10.2	−11.2	−8.3	4.0	−5.0
2015	12.9	9.5	−5.7	25.0	−20.6
2016	8.8	−1.4	−2.5	−0.5	−7.8
Projections:					
2017	5.2	−0.7	−1.6	−0.1	−5.5
2018	1.5	0.0	−0.6	0.4	−3.2
2019	1.5	0.0	−0.6	0.4	−3.2
2020	1.5	0.0	−0.6	0.4	−3.2
2021	1.5	0.0	−0.6	0.4	−3.2
2022	1.5	0.0	−0.6	0.4	−3.2
2023	1.5	0.0	−0.6	0.4	−3.2
2024	1.5	0.0	−0.6	0.4	−3.2
2025	1.5	0.0	−0.6	0.4	−3.2
2026	1.5	0.0	−0.6	0.4	−3.2

Table 12 shows the residual factors for the top five services for the adult population based on estimates of 2016 expenditures; spending for these services constituted 92 percent of total estimated Medicaid expenditures for adults, as shown in table 13. (Prescription drug expenditures shown in table 13 do not include Medicaid prescription drug rebates.)

Table 13—Fiscal Year 2016 Selected Service Expenditures for Adult Enrollees
(in billions)

Service	2016 Expenditures
Managed Care Organizations	$49.4
Inpatient Hospital	14.0
Outpatient Hospital	4.1
Prescription Drugs	2.5
Physician Services	2.4
Total Expenditures for Adults	79.1

Table 14—Historical and Projected Price Factors and Unemployment Rates, Fiscal Years 2010–2026

Fiscal Year	Medical consumer price index	Consumer price index	Home health input price index	Inpatient price index	Wages	Unemployment rate (CY)
Historical data:						
2010	3.4%	1.7%	2.2%	2.1%	1.6%	9.6%
2011	3.1	2.7	2.1	2.6	2.9	8.9
2012	3.5	2.0	2.3	3.0	3.2	8.1
2013	2.8	1.6	2.3	2.6	1.7	7.4
2014	2.4	1.6	2.3	2.5	2.9	6.2
2015	2.6	0.1	2.5	2.9	3.4	5.3
2016	3.6	0.6	2.4	2.4	2.9	4.9
Projections:						
2017	4.1	1.9	2.7	2.7	3.7	5.0
2018	4.5	2.8	3.5	3.9	4.7	5.3
2019	4.4	2.7	3.6	3.8	4.6	5.5
2020	4.2	2.6	3.4	3.7	4.5	5.5
2021	4.2	2.6	3.4	3.6	4.3	5.5
2022	4.2	2.6	3.3	3.5	4.0	5.5
2023	4.2	2.6	3.1	3.4	3.8	5.5
2024	4.2	2.6	3.1	3.4	3.8	5.6
2025	4.2	2.6	3.1	3.4	3.8	5.6
2026	4.2	2.6	3.1	3.4	3.8	5.6

D. DATA FOR SELECTED FIGURES

The following tables provide the data underlying selected figures in the report.

Table 15—Past and Projected Medicaid Expenditures for Medical Assistance Payments, by Type of Payment, Fiscal Years 2000–2026
(Data for Figure 3)
(in billions)

Fiscal Year	Acute care FFS	Long-term care FFS	Capitation payments & premiums	Disproportionate share hospital payments
Historical data:				
2000	$78.8	$67.9	$33.9	$14.4
2001	88.2	73.9	37.8	15.5
2002	103.2	81.1	44.7	15.4
2003	114.0	84.2	50.7	13.0
2004	124.0	87.3	52.7	15.4
2005	131.4	82.8	58.6	17.1
2006	121.3	101.1	65.0	17.1
2007	130.1	102.3	72.6	16.0
2008	131.7	108.1	82.8	17.1
2009	140.7	115.7	93.5	17.8
2010	151.2	117.2	104.3	17.6
2011	161.3	119.5	116.9	17.3
2012	148.0	119.3	132.5	17.1
2013	152.6	119.4	151.8	16.4
2014	152.2	116.3	191.6	18.1
2015	159.7	112.8	240.9	18.6
2016	150.3	115.8	272.8	19.7
Projections:				
2017	148.8	114.0	289.1	19.8
2018	156.8	119.2	313.4	17.9
2019	162.0	122.0	343.5	17.0
2020	169.7	126.9	371.3	16.1
2021	177.8	132.3	400.3	15.1
2022	186.0	137.6	431.4	14.1
2023	194.2	142.8	464.7	13.0
2024	202.7	148.0	500.0	12.0
2025	211.5	153.3	537.8	12.7
2026	220.5	158.7	578.4	24.8

Table 16—Past and Projected Numbers of Medicaid Enrollees, by Category, Fiscal Years 2000–2026
(Data for Figure 4)
(in millions of person-year equivalents)

Fiscal Year	Aged	Disabled	Children	Adults	Expansion adults	Territories[53]
Historical data:						
2000	3.6	6.7	16.1	6.9	n/a	0.9
2001	3.7	6.9	17.3	7.7	n/a	0.9
2002	4.0	7.2	19.1	8.9	n/a	1.0
2003	4.3	7.5	20.9	9.7	n/a	1.0
2004	4.4	7.7	21.9	10.1	n/a	1.0
2005	4.6	8.0	22.5	10.5	n/a	1.0
2006	4.5	8.2	22.6	10.5	n/a	1.0
2007	4.5	8.3	22.3	10.2	n/a	1.0
2008	4.6	8.6	22.8	10.8	n/a	1.0
2009	4.7	8.9	24.4	11.9	n/a	1.0
2010	4.9	9.2	26.4	13.1	n/a	1.0
2011	5.1	9.7	27.2	13.8	n/a	1.0
2012	5.3	10.0	27.9	14.7	n/a	1.0
Projections:						
2013	5.4	10.4	28.0	15.0	n/a	1.0
2014	5.5	10.4	28.2	15.2	4.3	1.5
2015	5.6	10.5	28.1	15.2	9.1	1.5
2016	5.7	10.6	28.1	15.3	11.2	1.4
2017	5.8	10.6	28.2	15.5	12.2	1.4
2018	6.0	10.7	28.5	15.8	12.4	1.4
2019	6.2	10.9	29.0	16.0	12.5	1.4
2020	6.4	11.0	29.5	16.2	12.7	1.4
2021	6.6	11.1	29.9	16.4	12.8	1.4
2022	6.9	11.2	30.3	16.5	13.0	1.4
2023	7.1	11.3	30.6	16.6	13.0	1.4
2024	7.3	11.4	30.9	16.7	13.1	1.4
2025	7.5	11.5	31.1	16.8	13.2	1.4
2026	7.7	11.6	31.3	16.9	13.3	1.4

[53] Territory enrollment is projected to remain level at about 1.4 million persons from 2016 to 2025, despite the projected reduction in Federal expenditures for Territory Medicaid programs due to the expiration of additional funds provided by the Affordable Care Act and the Bipartisan Budget Act of 2018. These projections are based on the assumption that Territories would provide additional funding or make other program changes to maintain enrollment levels as Federal funding was reduced.

Table 17—Projected Medicaid Expenditures: Comparison of 2016 versus 2017 Actuarial Reports on the Financial Outlook for Medicaid, Fiscal Years 2000–2026
(Data for Figure 5)
(in billions)

Fiscal Year	2017 Report	2016 Report
Historical data:		
2000	$206.2	$206.2
2001	229.0	229.0
2002	258.2	258.2
2003	276.2	276.2
2004	296.3	296.3
2005	315.9	315.9
2006	315.1	315.1
2007	332.2	332.2
2008	351.9	351.9
2009	378.6	378.6
2010	401.5	401.5
2011	427.0	427.4
2012	431.0	431.2
2013	456.0	455.6
2014	494.7	494.7
2015	549.1	552.3
2016	577.3	575.9
Projections:		
2017	592.2	595.5
2018	629.3	632.9
2019	667.4	672.0
2020	703.9	713.8
2021	741.7	757.4
2022	786.3	801.9
2023	834.2	850.1
2024	884.4	901.5
2025	937.7	957.5
2026	1005.7	n/a

Table 18—Past and Projected Medicaid Expenditures as Share of GDP, Fiscal Years 1966–2026, Selected Years
(Data for Figure 7)
(in billions)

Fiscal Year	Total expenditures	Expenditures as share of GDP
Historical data:		
1966	$0.9	0.1%
1970	5.1	0.5
1975	13.1	0.8
1980	25.2	0.9
1985	41.3	1.0
1990	72.2	1.2
1995	159.5	2.1
2000	206.2	2.0
2001	229.0	2.2
2002	258.2	2.4
2003	276.2	2.4
2004	296.3	2.5
2005	315.9	2.5
2006	315.1	2.3
2007	332.2	2.3
2008	351.9	2.4
2009	378.6	2.6
2010	401.5	2.7
2011	427.0	2.8
2012	431.0	2.7
2013	456.0	2.8
2014	494.7	2.9
2015	549.1	3.1
2016	577.3	3.1
Projections:		
2017	592.2	3.2
2018	629.3	3.2
2019	667.4	3.2
2020	703.9	3.3
2021	741.7	3.3
2022	786.3	3.3
2023	834.2	3.4
2024	884.4	3.5
2025	937.7	3.5
2026	1005.7	3.7

E. FINANCIAL MANAGEMENT REPORT DATA

Table 19—CMS-64 Financial Management Report, Net Services, Medical Assistance Payments, Fiscal Year 2016

Service Category	Total	Federal	State
Inpatient Hospital - Reg. Payments	$32,840,778,823	$20,842,639,363	$11,998,139,460
Inpatient Hospital – DSH	16,528,701,585	9,411,564,140	7,117,137,445
Inpatient Hospital - Sup. Payments	19,803,423,427	11,426,180,187	8,377,243,240
Inpatient Hospital - GME Payments	1,866,406,424	1,135,395,000	731,011,424
Mental Health Facility Services - Reg. Payments	3,066,009,469	1,860,296,663	1,205,712,806
Mental Health Facility – DSH	3,131,569,896	1,752,214,479	1,379,355,417
Nursing Facility Services - Reg. Payments	41,001,035,349	23,609,823,065	17,391,212,284
Nursing Facility Services - Sup. Payments	3,037,256,523	1,807,340,437	1,229,916,086
Intermediate Care Facility - Public	4,962,404,008	2,828,585,755	2,133,818,253
Intermediate Care Facility - Private	4,747,490,579	2,693,925,628	2,053,564,951
Intermediate Care Facility: Supplemental Payments	124,124,055	62,947,776	61,176,279
Physician & Surgical Services - Reg. Payments	8,173,579,368	5,385,475,453	2,788,103,915
Physician & Surgical Services - Sup. Payments	1,318,461,061	780,604,008	537,857,053
Phys. & Surg. Services - Evaluation and Mgmt.	440,352,522	440,336,782	15,740
Physician & Surgical Services - Vaccine codes	2,841,225	2,841,204	21
Outpatient Hospital Services - Reg. Payments	10,644,593,144	7,311,042,001	3,333,551,143
Outpatient Hospital Services - Sup. Payments	4,505,451,231	2,608,507,920	1,896,943,311
Prescribed Drugs	22,807,196,019	14,950,913,498	7,856,282,521
Drug Rebate Offset – National	-12,885,689,016	-8,500,166,255	-4,385,522,761
Drug Rebate Offset - State Sidebar Agreement	-864,806,347	-591,633,060	-273,173,287
MCO - National Agreement	-15,859,240,388	-10,495,826,039	-5,363,414,349
MCO - State Sidebar Agreement	-230,435,858	-143,805,577	-86,630,281
Increased ACA OFFSET - Fee for Service	-576,527,028	-576,527,028	0
Increased ACA OFFSET – MCO	-776,169,673	-776,169,673	0
Dental Services	3,929,375,134	2,454,127,420	1,475,247,714
Other Practitioners Services - Reg. Payments	2,331,687,868	1,365,224,804	966,463,064
Other Practitioners Services - Sup. Payments	15,464,622	7,889,828	7,574,794
Clinic Services	5,013,155,117	3,324,893,599	1,688,261,518
Laboratory/Radiological	1,371,001,448	940,188,681	430,812,767
Home Health Services	3,740,533,822	2,136,858,816	1,603,675,006
Sterilizations	59,208,444	47,863,278	11,345,166
Abortions	78,918	48,010	30,908
EPSDT Screening	846,860,331	530,769,662	316,090,669
Rural Health	1,106,824,986	736,349,746	370,475,240
Medicare - Part A	3,076,553,587	1,674,863,377	1,401,690,210
Medicare - Part B	12,206,565,579	7,066,953,051	5,139,612,528
120% - 134% Of Poverty	787,244,932	787,244,932	0
Coinsurance	1,088,990,259	654,333,684	434,656,575
Medicaid – MCO	249,597,719,407	168,372,890,152	81,224,829,255
Medicaid MCO - Evaluation and Management	200,373,644	195,196,048	5,177,596
Medicaid MCO - Vaccine codes	133,593,110	133,593,111	-1
Medicaid MCO - Community First Choice	6,927,060,089	3,964,848,354	2,962,211,735
Medicaid MCO - Preventive Services	144,418,246	86,332,595	58,085,651
Prepaid Ambulatory Health Plan	1,456,917,029	944,205,602	512,711,427
MCO PAHP - Evaluation and Management	1,603,357	1,605,124	-1,767
MCO PAHP - Vaccine codes	-34,270	-34,270	0
MCO PAHP - Community First Choice	0	0	0
MCO PAHP - Preventive Services	0	0	0
Prepaid Inpatient Health Plan	12,566,672,684	8,213,361,058	4,353,311,626
MCO PIHP - Evaluation and Management	6,734	6,734	0

Service Category	Total	Federal	State
MCO PIHP - Vaccine codes	238	238	0
MCO PIHP - Community First Choice	0	0	0
MCO PIHP - Preventive Services	0	0	0
Medicaid - Group Health	1,395,501,528	1,273,767,366	121,734,162
Medicaid – Coinsurance	282,289,969	276,309,801	5,980,168
Medicaid – Other	575,183,476	499,891,117	75,292,359
Home & Community-Based Services (HCBW)	42,919,167,616	23,984,049,480	18,935,118,136
HCBW – (State Plan 1915−i) Only Payments	878,856,833	456,235,875	422,620,958
HCBW – (State Plan 1915−j) Only Payments	91,318,070	55,959,080	35,358,990
HCBW – (State Plan 1915−k) Comm. First Choice	6,871,400,739	4,133,677,509	2,737,723,230
All-Inclusive Care Elderly	1,572,021,276	853,577,711	718,443,565
Personal Care Services - Reg. Payments	7,465,527,291	4,187,070,696	3,278,456,595
Personal Care Services - SDS 1915−j)	85,349,390	48,419,103	36,930,287
Targeted Case Man. - Com. Case-Man.	2,100,529,888	1,205,437,033	895,092,855
Case Management - State Wide	538,173,157	304,549,277	233,623,880
Primary Care Case Management	431,701,827	284,786,672	146,915,155
Hospice Benefits	1,988,000,999	1,191,752,544	796,248,455
Emergency Services for Undocumented Aliens	1,670,732,934	974,236,690	696,496,244
Federally-Qualified Health Center	4,492,402,625	2,955,921,818	1,536,480,807
Non-Emergency Medical Transportation	1,690,965,367	1,121,335,935	569,629,432
Physical Therapy	127,873,768	78,451,732	49,422,036
Occupational Therapy	98,175,912	59,187,015	38,988,897
Services for Speech, Hearing & Language	259,119,586	159,568,635	99,550,951
Prosthetic Devices, Dentures, Eyeglasses	363,567,887	234,507,702	129,060,185
Diagnostic Screening & Preventive Services	58,851,624	41,036,414	17,815,210
Preventive Services Grade A OR B, ACIP Vaccines	213,238,139	129,889,172	83,348,967
Nurse Mid-Wife	22,690,437	16,002,321	6,688,116
Emergency Hospital Services	1,800,626,492	1,185,616,742	615,009,750
Critical Access Hospitals	749,345,055	497,048,318	252,296,737
Nurse Practitioner Services	229,212,137	154,995,041	74,217,096
School Based Services	3,296,004,079	1,868,066,990	1,427,937,089
Rehabilitative Services –(non-school-based)	3,558,152,166	2,281,796,370	1,276,355,796
Private Duty Nursing	732,631,808	429,494,194	303,137,614
Freestanding Birth Center	11,191,956	7,194,292	3,997,664
Health Home w Chronic Conditions	750,289,448	430,709,804	319,579,644
Tobacco Cessation for Preg Women	254,999	169,028	85,971
Other Care Services	16,817,148,852	9,114,865,939	7,702,282,913
Balance	558,548,179,043	351,961,696,777	206,586,482,266
Collections	-7,666,856,715	-4,299,933,185	-3,366,923,530
Total Net Expenditures	550,881,322,328	347,661,763,592	203,219,558,736
Total Expansion	65,162,107,693	65,160,286,902	1,820,791
Total Not Newly	17,099,611,520	12,838,613,125	4,260,998,395
Total VIII Group	82,261,719,213	77,998,900,027	4,262,819,186

Table 20—CMS-64 Financial Management Report, Net Services, Administration Costs, Fiscal Year 2016

Service Category	Total	Federal	State
Family Planning	$29,943,111	$26,948,809	$2,994,302
MMIS - Inhouse Activities	127,400,230	109,878,697	17,521,533
MMIS - Private Sector	855,573,688	740,478,492	115,095,196
Skilled Professional Medical Personnel - Single State Agency	273,952,571	205,159,233	68,793,338
Skilled Professional Medical Personnel - Other Agency	443,489,284	332,617,012	110,872,272
Approved MMIS: Inhouse	467,878,742	350,580,885	117,297,857
Approved MMIS: Private	1,774,966,501	1,328,544,506	446,421,995
Mechanized Systems - In-House	49,851,449	24,980,346	24,871,103
Mechanized Systems: Private Sector	251,029,781	125,514,940	125,514,841
Mechanized Systems - Not Approved under MMIS Procedures: Interagency	20,815,942	10,407,974	10,407,968
Peer Review Organizations	224,764,353	168,573,308	56,191,045
TPL - Recovery	2,582,056	1,291,035	1,291,021
TPL - Assignment Of Rights	853,632	426,823	426,809
Immigration Status	2,042,463	2,042,463	0
Nurse Aide Training Costs	18,281,777	9,140,967	9,140,810
Preadmission Screening	111,957,580	83,968,248	27,989,332
Resident Review	15,968,238	11,976,195	3,992,043
Drug Use Review	14,152,515	7,076,306	7,076,209
Outstationed Eligibility	54,705,263	27,991,915	26,713,348
TANF Base	0	0	0
TANF Secondary 90%	0	0	0
TANF Secondary 75%	0	0	0
External Review	30,289,573	22,396,918	7,892,655
Enrollment Brokers	200,873,082	100,436,579	100,436,503
School Based Administration	1,197,098,370	603,109,935	593,988,435
Program Integrity/Fraud, Waste, and Abuse Activities	52,645,354	26,322,714	26,322,640
County/Local ADM Costs	2,397,838,022	1,198,919,042	1,198,918,980
Interagency Costs (State Level)	3,295,831,427	1,647,921,519	1,647,909,908
Translation and Interpretation	28,255,024	21,191,280	7,063,744
Health Insurance Technology Administration	0	0	0
HIT: Planning: Cost of In-house Activities	0	0	0
HIT: Planning: Cost of Private Contractors	0	0	0
HIT: Implementation and Operation: Cost of In-house Activities	40,640,038	36,576,051	4,063,987
HIT: Implementation and Operation: Cost of Private Contractors	191,404,254	172,263,843	19,140,411
HIT Incentive Payments: Eligible Professionals	746,041,049	746,041,049	0
HIT Incentive Payments: Eligible Hospitals	270,764,783	270,764,783	0
Citizenship Verification Technology CHIPRA	0	0	0
CVT Development CHIPRA	0	0	0
CVT Operation CHIPRA	0	0	0
Planning for Health Home for Enrollees with Chronic Conditions	456,357	319,876	136,481
Recovery Audit Contractors Contigency Fee	0	0	0
Recovery Audit Contractors State Administration	6,259,346	3,129,685	3,129,661
Design Development/Installation of Medicaid Elig. Determ. Sys. – Cost of In-house Activities	282,714,157	250,367,602	32,346,555
Design Development/Installation of Medicaid Elig. Determ. Sys. – Cost of Private Sec. Contractors	1,265,229,480	1,131,375,648	133,853,832
Operation of an Approved Medicaid Eligibility Determination Systems – Cost of In-house Activities	246,873,852	185,155,428	61,718,424
Operation of an Approved Medicaid Eligibility Determination Sys. – Cost of Private Sec. Contractors	570,629,690	427,951,478	142,678,212

Service Category	Total	Federal	State
Eligibility Determination Staff – Cost of In-house Activities	3,451,315,417	2,588,486,606	862,828,811
Eligibility Determination Staff – Cost of Private Sector Contractors	406,093,952	304,570,499	101,523,453
Eligibility Determination Staff – Cost of In-house Activities – 50% FFP	201,435,299	100,717,677	100,717,622
Eligibility Determination Staff – Cost of Private Sector Contractors – 50% FFP	113,314,312	56,657,171	56,657,141
Non-Emergency Medical Transportation	332,451,228	166,225,629	166,225,599
Other Financial Participation	6,266,766,767	3,133,574,639	3,133,192,128
Balance	26,335,430,009	16,762,073,805	9,573,356,204
Collections	-12,337,375	-7,276,087	-5,061,288
Total Net Expenditures	26,323,092,634	16,754,797,718	9,568,294,916

F. EXPENDITURES PER ENROLLEE ESTIMATES AND PROJECTIONS

CMS is currently implementing a new data system to replace MSIS: the Transformed Medicaid Statistical Information System, or T-MSIS. This new system will collect and report data from 2014 onwards (although States may have switched from MSIS to T-MSIS at different points in time in 2014 and 2015). T-MSIS is currently not available for use in providing historical data or in projecting Medicaid expenditures or enrollment, due to limited access to the data, incomplete data, and concerns about data quality. As a result, this report does not rely on T-MSIS data in any way. Also unavailable at this time are MAX data derived from T-MSIS data. As a result of the lack of recent data on Medicaid enrollment and expenditures by eligibility group, some of the projections in this report (most notably, the expenditures per enrollee by eligibility group) are less credible.

In the interest of providing the estimates and projections that underlie the projections shown in this report, we have moved detail that was contained in the Analysis section of past reports (section III) to the Appendix (section VI). These estimates and projections are more uncertain due to the lack of more recent data, and caution should be exercised in relying on them for any other purposes.

Table 21 shows estimated enrollment and expenditures by eligibility group for 2016.[54] Historically, children have been the largest group of Medicaid enrollees. In 2016, children are estimated to have numbered 28.1 million, representing 40 percent of overall Medicaid enrollment. There were an estimated 15.3 million non-expansion adults (22 percent of enrollment) and an estimated 11.2 million expansion adults (16 percent). Finally, enrollees with disabilities and aged enrollees are estimated to have numbered 10.6 million and 5.7 million (15 percent and 8 percent of Medicaid enrollment, respectively). Another 1.4 million enrollees (2 percent) were estimated for the five U.S. Territories with Medicaid programs (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands).

[54] There are some differences between Medicaid outlays and Medicaid expenditures, mainly due to timing differences between States paying for services and States receiving Federal funds. Thus, the levels and trends in outlays and expenditures differ slightly.

Table 21—Estimated Enrollment, Expenditures, and Per Enrollee Expenditures, by Enrollment Category, Fiscal Year 2016

Eligibility Group	Enrollment[1] (in millions)	Expenditures (in billions)	Per Enrollee Spending (2016)	Per Enrollee Spending (2015)	Percent Change
Children	28.1	$99.9	$3,555	$3,339	6.5%
Adults	15.3	79.1	5,159	5,103	1.1
Expansion Adults	11.2	66.5	5,965	6,365	−6.3
Persons with Disabilities	10.6	208.4	19,754	19,152	3.1
Aged	5.7	83.6	14,700	14,365	2.3
Subtotal	70.8	537.5	7,590	7,451	1.9
Territories[2]	1.4	2.6	1,864	1,696	9.9
Collections and Adjustments	—	−8.2	—	—	—
DSH	—	19.7	—	—	—
Administration	—	26.3	—	—	—
Total	72.2	592.2	8,029	7,993	0.5

Totals may not add due to rounding.

[1] Measured in person-year equivalents.

[2] Territory enrollment is estimated and based on the data reported in the CMS-64. Expenditures reflect only the amounts paid by the Federal government and the corresponding Territory share; some Territory programs spend additional amounts beyond what is covered by the Federal allotments and Territory share.

The average per enrollee cost for 2016 is estimated to have been $7,590 (including Federal and State shares, based on person-year equivalent enrollment, and excluding DSH outlays, Territorial enrollees and costs, adjustments, and administration costs). In estimated average benefits for 2016, children in Medicaid received $3,555, non-expansion adults received $5,159, and expansion adults received $5,965. These average costs reflect the relatively healthier status of children and adults enrolled in the program, as compared to aged enrollees and persons with disabilities; however, among adult enrollees, a significant number are pregnant women, whose costs are on average relatively greater than those for other adults. As would be expected, expenditures are substantially greater for the aged and persons with disabilities. Aged beneficiaries received an estimated $14,700 in benefits on average, a 2.3-percent increase. Beneficiaries with disabilities are estimated to have received an average of $19,754 in benefits, a 3.1-percent increase from 2015.[55]

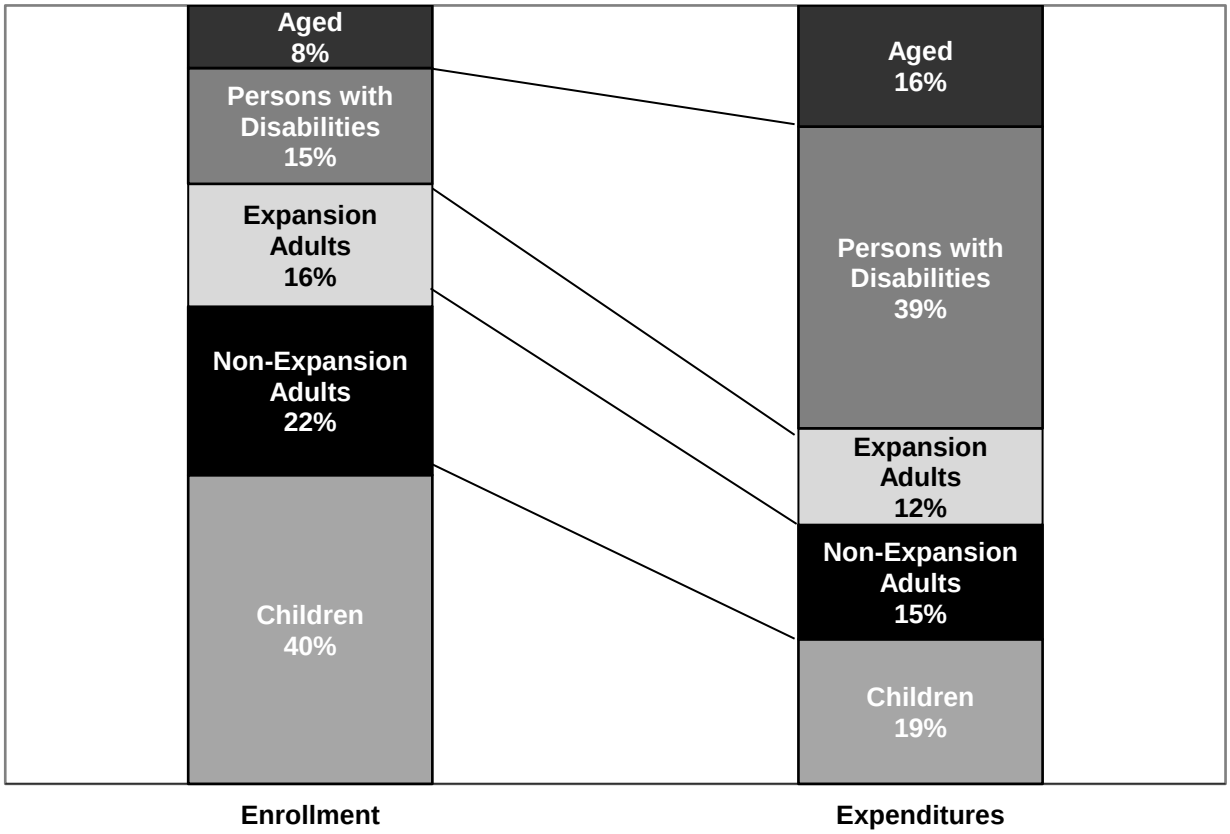
Territory per enrollee expenditures ($1,864 in 2016) are less than those of other populations covered by Medicaid, as costs of care are lower in the Territories and fewer services are provided by Territory programs. In addition, these amounts reflect only the Federal allotments and the Territory expenditures necessary to draw down

[55] The average per enrollee costs may also vary substantially among States. These variations may reflect differences in State Medicaid programs (for example, eligibility levels, benefits offered, provider reimbursement rates, or program design) and differences in the overall health care market across States.

those allotments (including additional funds provided by the Affordable Care Act); some Territory programs spend above this amount for their Medicaid programs.

Figure 8 shows each enrollment group's relative share of enrollment and expenditures in Medicaid in 2016. While enrollees with disabilities and aged enrollees are the smallest enrollment groups in Medicaid, they account for the majority of spending. Conversely, children and adults are the largest enrollment groups in Medicaid, but they account for a relatively smaller share of expenditures.

Figure 8—Estimated Medicaid Enrollment and Expenditures by Enrollment Group, as Share of Total, Fiscal Year 2016



Note: Totals and components exclude DSH expenditures, Territorial enrollees and expenditures, and adjustments. Totals may not add to 100 percent due to rounding.

Combined, spending on aged beneficiaries and beneficiaries with disabilities constituted 54 percent of Medicaid benefit expenditures in 2016, but these groups accounted for only 23 percent of all enrollees. Children and adults represented 77 percent of all enrollees in 2016, while only 46 percent of benefit expenditures were for enrollees in these groups.

These differences between the relative shares of enrollment and expenditures result from per enrollee costs that vary dramatically among the enrollment groups. The differences in average costs, while substantial, actually understate the impact of

differences in health status for these groups. In particular, Medicaid pays almost all health care costs for enrolled children and adults. However, many aged beneficiaries or beneficiaries with disabilities are also enrolled in Medicare, which is the primary payer of benefits before Medicaid; thus, the per enrollee Medicaid estimates are less than the total cost of such beneficiaries' annual health care across all payers.[56]

In the third year of the eligibility expansion provided for by the Affordable Care Act, expenditures and enrollment grew more slowly in 2016 than in recent years. Expenditures increased 5.2 percent, as compared to 11.4 percent in 2015. Enrollment is estimated to have grown 3.1 percent, compared to 7.6 percent in 2015.

Per enrollee benefit costs are estimated to have risen from $7,451 to $7,590 (an increase of 1.9 percent from 2015), as costs for children (who constitute the majority of Medicaid enrollment) grew at faster rates than in recent history. Meanwhile, expansion adults saw a 6.3-percent decrease in per enrollee costs from $6,365 in 2015 to $5,965 in 2016.

Projections

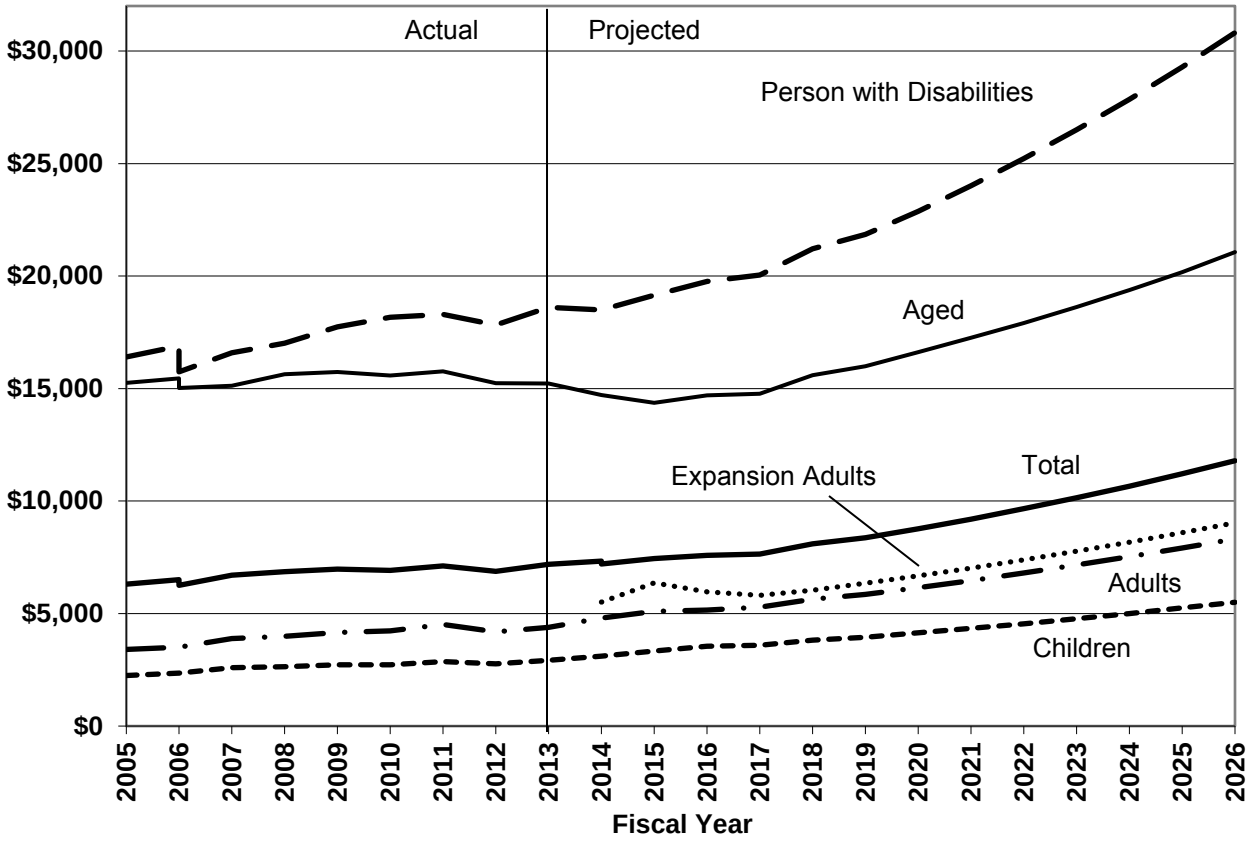
Per Enrollee Costs

As stated previously in the report, the most recent data on enrollment and expenditures by eligibility group are from 2013 or 2014 for most States, and no data are available for 2015 or 2016. Given the lack of more recent data, estimates of expenditures per enrollee by eligibility category are less credible than in past reports, and readers should be aware that actual per enrollee expenditures could vary significantly from those provided below.

The average costs of benefits for all enrollees are projected to increase over the next 10 years. Figure 9 displays historical and projected average Medicaid benefit expenditures per enrollee for all enrollees collectively and by eligibility group.

[56] In 2013, Medicaid expenditures for persons eligible for Medicare and full Medicaid benefits (full-benefit dual-eligible beneficiaries) amounted to $118.9 billion, and Medicare expenditures for these persons were $193.5 billion, for a total of $312.4 billion in expenditures between both programs. Medicaid accounted for about 38 percent of the total spending on full-benefit dual-eligible beneficiaries. In addition, for persons eligible for Medicare and limited Medicaid benefits (generally payments for Medicare premiums or cost sharing), Medicaid benefits are typically an even smaller proportion of their total benefits ($2.1 billion of $47.9 billion, or 4.4 percent, in 2013). See Exhibit 3 in *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, 2018.

Figure 9—Past and Projected Medicaid Expenditures on Medical Assistance Payments Per Enrollee, by Enrollment Category, Fiscal Years 2005–2026[57]



Note: Per enrollee amounts for 2013, 2014, 2015, and 2016 are based on actual expenditures and estimated enrollment.

In 2017, per enrollee benefit costs are projected to have increased 0.8 percent, down from growth of 1.9 percent in 2016. For most populations, per enrollee costs grew in 2017. Costs are projected to have increased for aged enrollees (from $14,700 to $14,769, 0.5 percent), children (from $3,555 to $3,592, 1.1 percent), enrollees with disabilities ($19,754 to $20,048, 1.5 percent), and adults ($5,159 to $5,288, 2.5 percent). For expansion adults, projected per enrollee costs decreased from $5,965 to $5,813 in 2016 (−2.5 percent); these trends are described in more detail later in this section of the report.

Per enrollee benefit costs are projected to grow somewhat faster from 2017 through 2026 than they did in the previous 10 years.[58] For aged Medicaid enrollees, benefit costs per enrollee fell from $15,023 in 2006 to $14,700 in 2016 (an average annual

[57] The data for this graph can be found in table 17 of section VI.D.

[58] The years from 2007 to 2015 are used as a reference as they cover a sufficiently long period to compare long-term trends while excluding the effects of the start of the Medicare prescription drug program in 2006, which significantly lowered Medicaid per enrollee costs, especially for aged enrollees and persons with disabilities.

growth rate of −0.5 percent over the period) but are projected to reach $21,063 in 2026 (an average annual rate of 3.7 percent over 2017 to 2026). Per enrollee benefit costs for persons with disabilities increased from $15,743 in 2006 to $19,754 in 2016 (an average annual growth rate of 2.3 percent) and are projected to reach $30,815 in 2026 (4.5-percent average annual growth over 2017 to 2026).

The slow rate of growth of long-term care expenditures in recent history contributed to limited growth in the benefit costs for aged enrollees and persons with disabilities, as these individuals receive the vast majority of long-term care services. Expenditures for institutional long-term care (primarily nursing facility services) grew very slowly, while costs for community long-term care (including home and community-based waiver services) grew relatively quickly in comparison. Slow cost growth for long-term care through fee-for-service programs was partially offset by increasing managed care expenditures, especially for managed long-term care services. During and immediately after the 2007-2009 recession, States took stronger actions to limit Medicaid expenditure growth, including freezing or reducing provider reimbursement rates.[59]

Aged enrollees are projected to experience the lowest average per enrollee benefit cost growth over the next 10 years compared to other enrollee groups, due in large part to projected relatively slower growth in the cost of long-term care services. States are expected to continue to use more home and community-based long-term care to postpone enrollees' need for long-term care facilities as long as possible. In addition, States are projected to shift long-term care expenditures from fee-for-service programs into managed care. As a result, managed care expenditures are expected to grow more quickly and to constitute a larger share of benefits for aged enrollees.

While average benefit cost growth is expected to be slower over the next 10 years for aged enrollees than for other populations in Medicaid, it is expected to be faster than in recent history. States have instituted fewer provider reimbursement rate freezes and reductions and have allowed for more recent rate increases, and these increases are expected to continue in the future.[60]

Benefit costs per enrollee for adults (excluding the expansion adults) are projected to grow somewhat more rapidly over the next 10 years. Adult per enrollee costs increased from $3,503 in 2006 to $5,159 in 2016 (a 3.9-percent annual average growth rate), and they are projected to increase to $8,317 by 2026 (a 4.9-percent average annual growth rate). Benefit costs per enrollee for children are also expected to grow faster over the next decade, though only slightly, having grown from $2,348 in 2006 to $3,555 in 2016 (a 4.2-percent average annual growth rate), and such costs are projected to grow to $5,502 by 2026 (a 4.5-percent average annual growth rate). As was the case for aged enrollees, States took steps to control Medicaid expenditure

[59] V. Smith, *et al.*, "Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017."
[60] *Ibid.*

growth that occurred during and after the 2007-2009 recession, especially in limiting or reducing provider reimbursement rates, but more recently States have implemented fewer rate reductions and freezes and more rate increases, which are expected to continue.[61] The Affordable Care Act also provided for temporary increases in primary care physician payments in CYs 2013 and 2014, which contributed to faster growth in expenditures for physician services in those years, particularly among children and adults (as many aged enrollees and enrollees with disabilities receive physician services through Medicare). Spending for managed care represented more than 60 percent of Medicaid expenditures for adults and children in 2015, and, for these enrollees, this type of care is expected to be the fastest growing service category over the next 10 years.

Although the average benefit costs for expansion adults were greater than those for other adults in 2014 and 2015, per enrollee costs for the expansion adults are estimated to have declined in 2016 and to have continued declining through 2017, when relative costs for these individuals are expected to have been lower than those for non-expansion adults. After 2017, per enrollee costs for expansion adults are projected to grow at a similar rate as those for other adults. More detail on these projections is provided below.

Enrollment Mix

The growth in average Medicaid benefit expenditures per enrollee for all enrollment categories is significantly affected by the relative proportion of enrollment across these categories. In this report, the *enrollment mix* is defined as the contribution of the change in these relative proportions to the growth in Medicaid benefit expenditures per enrollee. This concept is similar to *age-gender mix* effects in other health care plans or programs (which measure the contribution to health care expenditures of changes in the relative proportion of enrollees by age and by gender in a plan). The enrollment mix differs in that it does not specifically consider gender and considers age in only broad ranges, but it does take into account the disability status of enrollees.

The enrollment mix is an important consideration in analyzing and projecting Medicaid benefit expenditures. While the effects of age-gender mix on other programs are usually relatively small and do not change significantly from year to year, the effect of enrollment mix on Medicaid expenditures can be substantially larger or smaller and may vary greatly from year to year. This variation can occur because Medicaid enrollment categories experience substantially different average costs—average Medicaid costs for aged enrollees and persons with disabilities are much greater than those of child and adult enrollees—and because the enrollment growth for these groups may vary among categories and may fluctuate annually.

[61] *Ibid.*

For this report, the enrollment mix is measured as the difference between the increase in Medicaid benefit expenditures per enrollee and the increase in Medicaid benefit expenditures per enrollee if enrollment were held constant each year. To calculate this difference, enrollment was set at 2012 levels for each enrollment category.[62]

From 2007 to 2015, Medicaid benefit expenditures per enrollee grew at an average annual rate of 2.0 percent (including expansion adults). The effects of changes in enrollment mix over this time period reduced spending growth by an average of 0.6 percentage point per year; that is, excluding the impacts of changes in enrollment, Medicaid benefit expenditures per enrollee would have grown 2.6 percent per year. The effects of the changes in enrollment mix on spending ranged from −2.2 percent to 1.0 percent over these 9 years. The negative effects were the result of relatively faster enrollment growth for children and adults than for aged enrollees and persons with disabilities, especially from 2008 to 2010, and the addition of expansion adults in 2014 and 2015.

Medicaid benefit expenditures per enrollee are estimated to have increased only 1.3 percent in 2016 (including expansion adults). Excluding the impact of the change in the enrollment mix, these Medicaid expenditures are estimated to have increased 2.0 percent. This relatively large difference is primarily the result of an increase in the enrollment of expansion adults, whose per enrollee costs are estimated to have been relatively lower than the average costs of all enrollees.

While Medicaid benefit expenditures per enrollee are projected to grow more rapidly from 2017 to 2026 at an average annual rate of 4.4 percent, changes in enrollment mix are projected to negligibly decrease this growth by an average of less than 0.1 percentage point per year over this time period.

The average effect of enrollment mix changes is projected to be small over the next 10 years, but there are some differences year to year. The projected enrollment of more expansion adults in 2016, 2017, and 2018 (with costs that are projected to be less than the average Medicaid cost per enrollee) contributes to negative and slow enrollment mix effects through 2018 (from −0.7 percent to 0.1 percent per year). After 2018, the enrollment mix effect is projected to be positive (between 0.1 percent and 0.3 percent per year) because the projected growth rate of aged Medicaid enrollees is expected to be faster than that of other populations as more members of the baby boom generation reach age 65. Excluding the expansion adults, the projected effect of enrollment mix from 2017 through 2026 would be an average increase of 0.1 percent.

Medicaid benefit expenditures per enrollee grew at an average annual rate of 1.7 percent per year from 2007 through 2016, excluding the effects of changes in the

[62] As the base year for enrollment, 2012 was selected because it was the latest year for which nearly all States reported Medicaid enrollment data to CMS. A review of the measurement of enrollment mix using other years as the base year showed no significant differences in results.

enrollment mix. For 2017 through 2026, such expenditures are projected to increase 4.4 percent per year on average. This difference is the result of two factors: (i) efforts by States to limit Medicaid expenditure growth (most notably, in 2011 and 2012) are not projected to continue with the same intensity into the future; and (ii) medical price inflation is projected to be modestly faster after 2016 than in recent history—averaging 4.2 percent from 2017 through 2026, as compared to 3.3 percent over the prior 10 years.

Table 22—Past and Projected Medicaid Expenditures on Medical Assistance Payments Per Enrollee, by Enrollment Category, Fiscal Years 2000–2026
(Data for Figure 9)
(in dollars per person-year equivalent enrollee)

Fiscal Year	Aged	Disabled	Children	Adults	Expansion adults	Average of all enrollees
Historical data:						
2000	$14,222	$12,237	$1,819	$2,962	n/a	$5,496
2001	15,068	13,240	1,925	2,968	n/a	5,718
2002	15,682	14,453	2,076	3,123	n/a	5,969
2003	14,782	15,168	2,124	3,169	n/a	5,960
2004	15,314	15,869	2,125	3,311	n/a	6,124
2005	15,254	16,405	2,247	3,407	n/a	6,308
2006	15,023	15,743	2,348	3,503	n/a	6,255
2007	15,124	16,589	2,591	3,894	n/a	6,700
2008	15,631	17,013	2,640	3,987	n/a	6,863
2009	15,738	17,744	2,723	4,162	n/a	6,982
2010	15,577	18,172	2,731	4,225	n/a	6,926
2011	15,757	18,295	2,865	4,517	n/a	7,124
2012	15,235	17,824	2,762	4,192	n/a	6,874
Projections:						
2013	15,220	18,614	2,924	4,385	n/a	7,188
2014	14,708	18,499	3,109	4,799	$5,511	7,202
2015	14,365	19,152	3,339	5,103	6,365	7,451
2016	14,700	19,754	3,555	5,159	5,965[63]	7,590
2017	14,769	20,048	3,592	5,288	5,813	7,648
2018	15,595	21,209	3,822	5,645	6,036	8,093
2019	15,991	21,853	3,952	5,855	6,355	8,371
2020	16,623	22,878	4,139	6,152	6,682	8,770
2021	17,252	24,016	4,338	6,467	7,019	9,198
2022	17,909	25,223	4,550	6,803	7,385	9,658
2023	18,616	26,500	4,772	7,156	7,770	10,146
2024	19,373	27,851	5,003	7,524	8,167	10,662
2025	20,178	29,291	5,248	7,914	8,591	11,212
2026	21,063	30,815	5,502	8,317	9,031	11,793

[63] Per Enrollee costs for 2016 and 2017 exclude payments made to the Federal government from the States for risk-sharing arrangements and MLRs to avoid distorting the paid trend.

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Medicaid Expansion Spending and Enrollment in Context: An Early Look at CMS Claims Data for 2014

Laura Snyder, Katherine Young, Robin Rudowitz and Rachel Garfield

There have been long-standing questions about the effect the Medicaid expansion would have on spending and enrollment. Preliminary data from the Medicaid Budget and Expenditure System (MBES) released by the Centers for Medicare and Medicaid Services (CMS) may provide some early insights into these questions. CMS released preliminary spending and enrollment data from the MBES that covers the period from January 2014 through December 2014. This period is of particular interest because these are the first quarters that the Medicaid expansion was in effect. During this period, 27 states including DC, had implemented the Medicaid expansion; all but two of these states – Michigan (April 1, 2014) and New Hampshire (August 15, 2014) – implemented the Medicaid expansion January 1, 2014.

The MBES provides monthly Medicaid enrollment and quarterly Medicaid expenditure data with specific information about enrollment and spending for the new adult eligibility group, also referred to as the "Group VIII." The new adult group includes both those newly eligible under the Medicaid expansion (eligible for 100% federal match through December 2016) and those previously eligible (that were matched at traditional match rates but now receive a higher federal match.) While all states have reported expenditure data for the January – December 2014 period, California and North Dakota have not reported enrollment data for that same period.[1] This brief examines the MBES data to be able to put the spending and enrollment for the expansion into the context of total Medicaid spending and enrollment. Key findings from this data show:

- The new adult group represented a relatively small share (10%) of total Medicaid spending across all states in CY 2014. Looking at just expansion states, spending for the new adult group made up a slightly larger share (16%) total spending. The vast majority of spending for the new adult group is federal dollars (94%). This is driven by the 100% federal match available for those newly eligible adults, which make up three-quarters of enrollment in the new adult group.
- Looking at current enrollment data available, the new adult group made up a relatively small share (13%) of total enrollment. The new adult group made up a larger share of total enrollment in expansion states. However, data are preliminary and enrollment data for large states like California are missing.
- Spending per enrollee for the new adult group is notably lower than spending per enrollee across all groups ($4,513 vs. $7,150.)

Since this data claiming and reporting process is new, ensuring that the data are comparable and accurate across states may take time. This analysis is preliminary and will continue to be updated as data from missing states are added and data continue to be revised and updated.

Background

Data from the Medicaid Budget and Expenditure System (MBES) released by the Centers for Medicare and Medicaid Services (CMS) provides monthly enrollment and quarterly expenditure data with specific information about enrollment and spending on the new adult group (Group VIII). Historically, states have reported only expenditure data through the MBES, not enrollment data. However, to enable states to claim the enhanced funding available for adults made newly eligible by the ACA, CMS revised the form to require states to report claims separately by eligibility group, including separate reporting of claims for the new adult eligibility group, also referred to as the "Group VIII." Group VIII or the new adult group consists of those who are newly eligible as well as some other adults described in the box below. Those that do not qualify under the new adult group are referred to as "traditional Medicaid" for this analysis, which includes individuals with disabilities, the elderly, children, pregnant women and some low-income parents. Since this data claiming and reporting process is new, ensuring that the data are comparable and accurate across states may take time. Additionally, the enrollment data reported through the MBES differ in important ways from other enrollment data reported by CMS through the Performance Indicator process (see Appendix A for more details.)

Data included in this analysis looks at enrollment and expenditure data for January 1, 2014 through December 31, 2014, the first calendar year that the Medicaid expansion was in effect. During this period, 27 states including DC, had implemented the Medicaid expansion; all but two of these states – Michigan (April 1, 2014) and New Hampshire (August 15, 2014) – implemented the Medicaid expansion January 1, 2014. States that expanded after December 31, 2014 (Pennsylvania, Indiana, Alaska and Montana) are treated as non-expansion states in this analysis.

While all states have reported expenditure data for the January – December 2014 period, California and North Dakota have not reported enrollment data for that same period; other states had reported some but not all quarters.[2] This brief examines the MBES data to be able to put the spending and enrollment for the expansion into the context of total spending and enrollment.

Who is eligible under the New Adult Group (Group VIII)

Newly-Eligible Adults. Beginning in 2014, newly eligible adults consist of non-elderly, non-disabled adults with incomes up to 138% FPL who would not be eligible for Medicaid under the rules that a state had in place on December 1, 2009. The ACA provides 100% federal financing for those made newly eligible for Medicaid by the law; the federal match rate falls to 95% in 2017, 94% in 2018, 93% in 2019, and then 90% in 2020 and beyond.

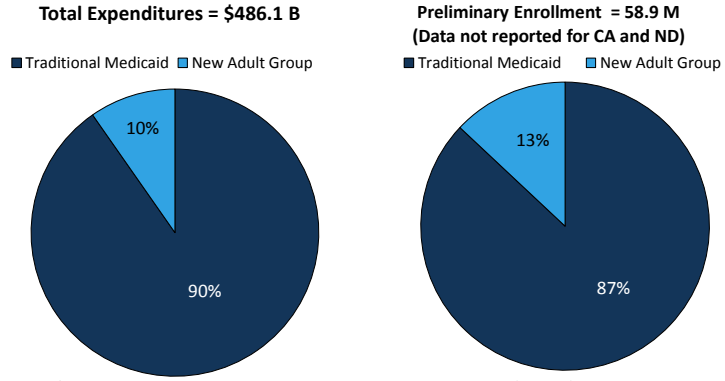
Other Group VIII Adults. Other Group VIII Adults include some childless adults in early expansion states as well as those who may be subject to technical adjustments. Some states already provided coverage at the traditional match rate to parents and adults without dependent children up to at least 100% FPL statewide as of March 23, 2010, when the ACA was enacted. The law provides additional federal funding to these states through the "expansion state match rate" for adults without dependent children under age 65; this "expansion state match rate" is higher than the traditional match rate.[3] A few states were able to make adjustments to account for individuals who would not have been eligible because of asset test requirements in place on December 1, 2009, enrollment caps in effect for waiver populations receiving full benefits as of December 1, 2009, and other special circumstances. These adjustments may result in some adults being enrolled in the expansion category who do not qualify for the 100% federal match for newly eligible adults.[4]

Trends across All States

During calendar year 2014, Medicaid expenditures totaled $486.1 billion dollars. This includes Medicaid spending for all groups – the new adult group as well as the traditional Medicaid population (individuals with disabilities, the elderly, children, etc.) (Appendix Table 2) Spending for the new adult group represented only 10 percent of all Medicaid spending – the vast majority of Medicaid spending was for the traditional population, funded at the regular matching rate. (Figure 1) Across all states and all groups, federal dollars made up nearly 62 percent of Medicaid spending – reflecting both the regular matching rates for the traditional Medicaid population as well as the enhanced funds for the new adult group. The share of federal dollars funding Medicaid spending has increased; historically the federal share has been lower (57%.)

Figure 1

Across all states, the vast majority of Medicaid spending in CY 2014 was for the traditional Medicaid population.

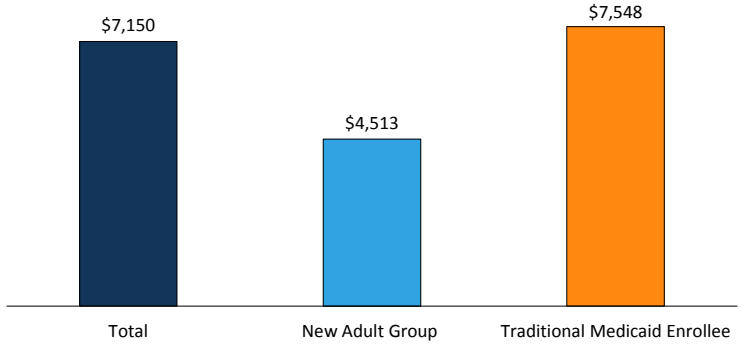


NOTES: Data for January through December 2014. All states reported expenditure data, while all but 2 states (CA and ND) reported enrollment data. Enrollment data reflect the highest enrollment for each state during this period.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Over calendar year 2014, at least 58.9 million individuals were enrolled in Medicaid for at least some part of the year across the states that reported data. (Appendix Table 3) The inclusion of enrollment data as part of the MBES reporting process was new in 2014. While all states reported data for expenditures, not all states were able to report enrollment data, including large states like California. As revised data are published, this figure is expected to increase. Just as with spending, the new adult group made up a relatively small share (13%) of total Medicaid enrollment. (Figure 1) Among those states reporting both spending and enrollment data, spending per enrollee for the new adult group was much lower than total spending per enrollee across all groups (traditional Medicaid and the new adult group) - $4,513 vs. $7,150. (Figure 2)

Figure 2

Spending per enrollee for the new adult group was much lower than total spending per enrollee.



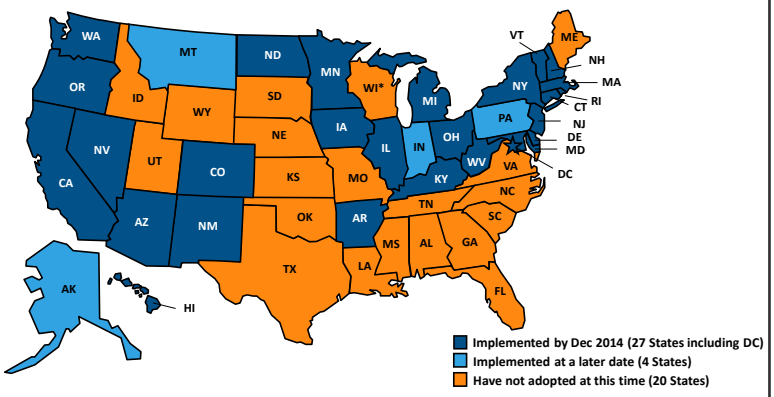
NOTES: Data for January through December 2014. Data are not reported for California and North Dakota. Total spending per enrollee refers includes the new adult group and the traditional Medicaid population.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Trends in Expansion States

One of the major changes in the Affordable Care Act was the Medicaid expansion – establishing a new eligibility floor for non-elderly, non-disabled groups at 138 percent FPL and eliminating the long-standing exclusion of childless adults. The June 2012 Supreme Court decisions effectively made this optional for states. As of December 31, 2014, there were 27 states that had implemented the Medicaid expansion; states that expanded later (Pennsylvania, Indiana, Alaska and Montana) are treated as non-expansion states in this analysis. (Figure 3) The remainder of this analysis focuses on spending and enrollment trends in the 27 expansion states only.

Figure 3

Twenty-seven states had the Medicaid expansion in place as of December 2014.



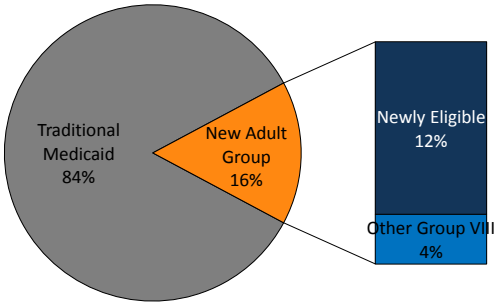
NOTES: Status of Medicaid expansion implementation as of December 31, 2014. All but 2 of the states (MI and NH) had implemented the Medicaid expansion effective January 1, 2014. MI implemented the Medicaid expansion effective April 1, 2014; New Hampshire implemented effective August 15, 2014. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

Total and New Adult Group Spending

Across the 27 states that implemented the expansion during calendar year 2014, spending for the new adult group totaled $47.2 billion, representing 16 percent of total Medicaid spending across these states. (Figure 4) The vast majority of this spending (78%) was for those newly eligible adults whose expenditures qualify for the 100 percent federal match. The remaining share of spending for the new adult group was for those adults that were previously eligible at traditional match rates or subject to technical adjustments (see Box 1 for more details); expenditures for these adults are still matched at a higher rate than the traditional match rate, but not the 100 percent federal match.

Figure 4

Looking just at the Expansion states, spending for the new adult group still represents a small share of total spending.

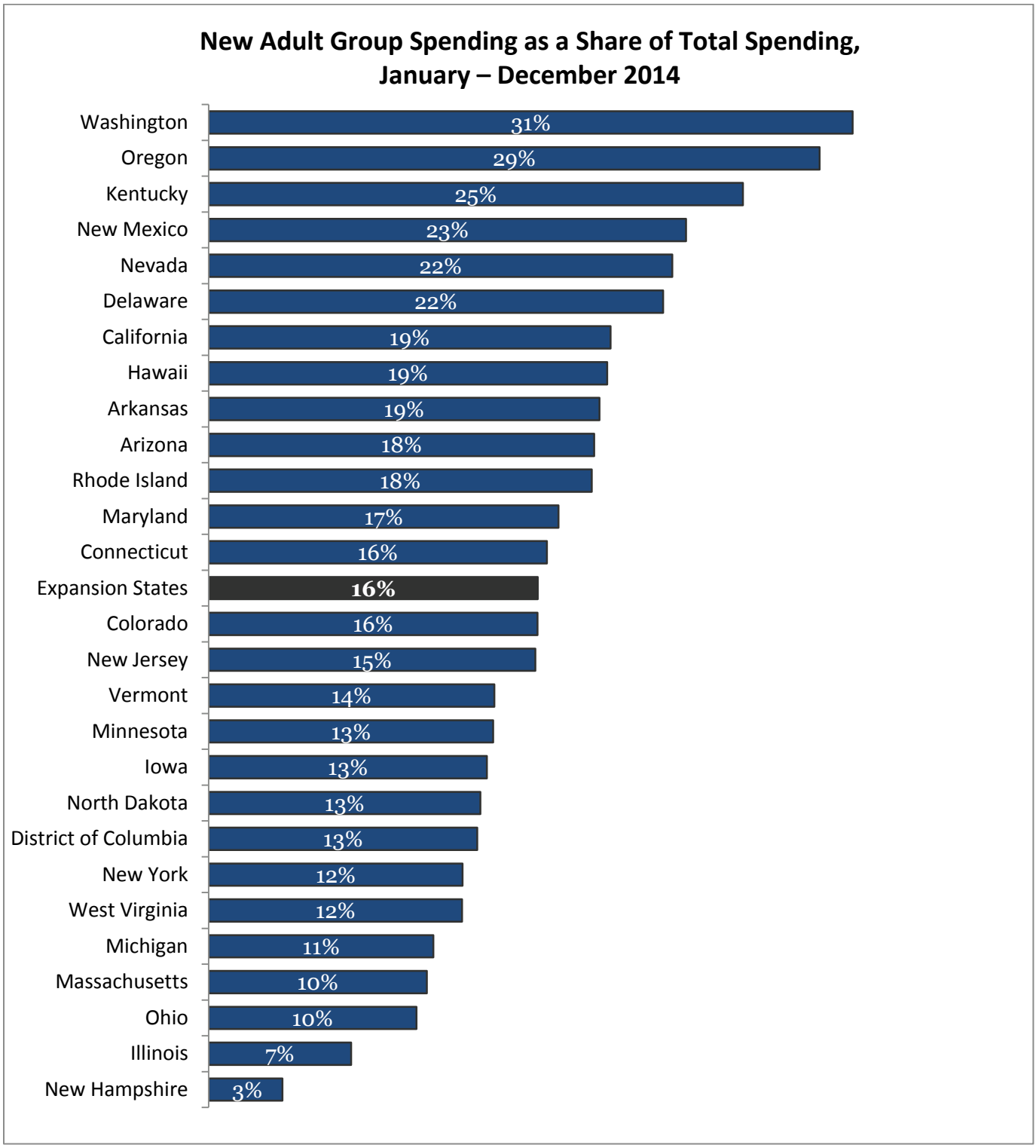


Total Spending in Expansion States, CY 2014 = $301.8 Billion

NOTES: Data are limited to expenditures in the 27 states that had implemented the Medicaid expansion as of December 31, 2014. Data reflect expenditures for January through December 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Spending for the new adult group as a share of total Medicaid spending for this period varies across expansion states, ranging from more than 25 percent in Washington, Oregon and Kentucky to less than 10 percent in Illinois and New Hampshire (New Hampshire implemented the Medicaid expansion later - August 15, 2014.) (Figure 5)

Figure 5: The share of spending for the new adult group varies across expansion states.



NOTES: Data are limited to expenditures in the 27 states that had implemented the Medicaid expansion as of December 31, 2014. Data reflect expenditures for January through December 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

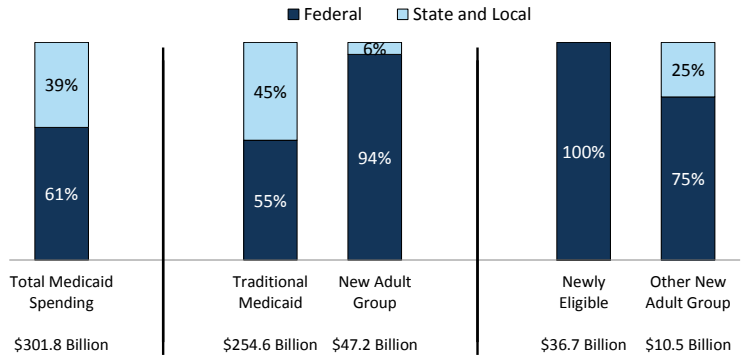
Federal and State Spending Distribution of Spending

Across all expansion states, the federal share for all Medicaid spending in calendar year 2014 was 61 percent and the state share of spending was 39 percent (virtually the same as at the national level.) (Figure 6) However, there were large differences in these shares for the traditional Medicaid program and the new adult group.

The federal government paid more than half of the costs for the traditional Medicaid population in expansion states (55%). This share varies by state according to the traditional FMAP. For the new adult group, virtually all of the expenditures (94%) were paid for with federal dollars. As noted earlier, the new adult group consists of spending for those newly eligible (which are paid for with 100% federal dollars) as well as some other adults that qualify for the new adult group but are not newly eligible. The newly eligible group accounted for more than 3 out of 4 dollars spent on the new adult group ($36.7 billion of the $47.2 billion in new adult group spending). While the other new adult enrollees are not eligible for the 100 percent federal match, the federal share for this group is still well above the traditional match rates that had previously applied to expenditures for these adults.

Figure 6

The vast majority of the expenditures for the new adult group are paid for with federal dollars.



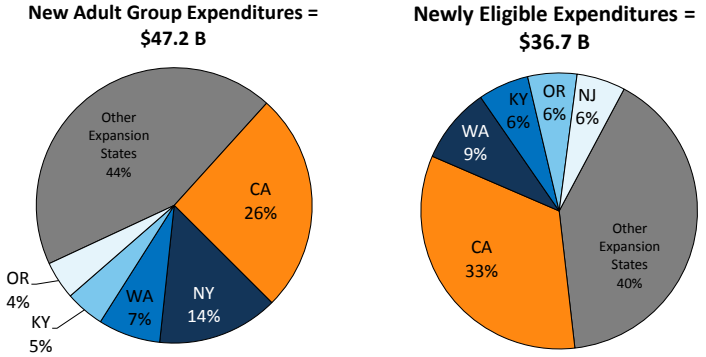
NOTES: Data are limited to expenditures in the 27 states that had implemented the Medicaid expansion as of December 31, 2014. Data reflect expenditures for January through December 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Distribution of Spending for the New Adult Group by State

In calendar year 2014, states claimed $47.2 billion in total Medicaid spending for the new adult group. Looking at the distribution across states, it is not surprising that larger expansion states had a higher share of expenditures for this group. Expenditures for the new adult group in California represent one quarter (26%) of all the expenditures for the new adult group during this period, followed by New York (14%), Washington (7%), Kentucky (5%) and Oregon (4%). Focusing just on expenditures for the newly eligible (which are 100% federally funded,) California reported one-third of all of these expenditures during this period, followed by Washington (9%), Kentucky, Oregon and New Jersey (all at 6%.) (Figure 7) Some large states, such as New York, Massachusetts and Arizona, which had expanded coverage prior to the ACA, reported larger shares of new adult group spending for other new adult group enrollees whose expenditures don't qualify for the 100 percent federal match. However, even in these states the vast majority of expenditures for the new adult group were federal, as the expenditures for the other new adult group enrollees still received a higher federal match than the traditional match rate available before.

Figure 7

Expenditures for the new adult group are concentrated in larger Expansion states.



NOTES: Data for January through December 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed August 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

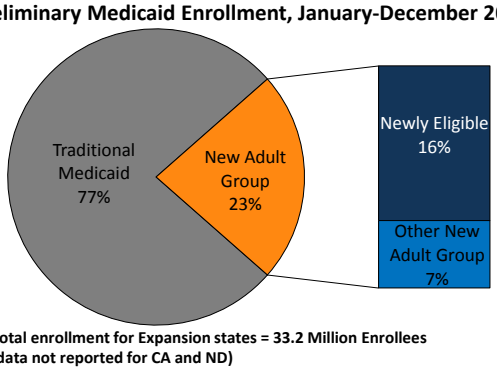
Total and Group VIII Enrollment

The MBES data have historically not included information about enrollment or spending by eligibility group. To account for the newly eligible federal match rate, CMS has revised the CMS-64 form to require states to report claims separately by eligibility group, including separate reporting for newly eligible adults, as well as to report enrollment by eligibility group. Since this data reporting process is new, ensuring that the data are comparable and accurate across states may take time. Moreover, because these initial data are preliminary, states may continue to provide updates to the enrollment data over time, so the numbers will change. Not all states were able to report enrollment data; enrollment data are not reported for California and North Dakota for all three quarters.

In the expansion states that reported enrollment data, approximately 23 percent of Medicaid enrollment was for the new adult group. (Figure 8) The remaining 77 percent of Medicaid enrollment was for those eligible under the "traditional" Medicaid program (e.g. children, pregnant women, elderly and individuals with disabilities.) However, this varies across expansion states. Enrollment in the new adult group made up nearly half of total enrollment in Oregon (48%) ranging down to 17 percent in Ohio, Minnesota and Massachusetts. (Figure 9)

Figure 8

Enrollment among the new adult group makes up a relatively small share of total enrollment among expansion states.

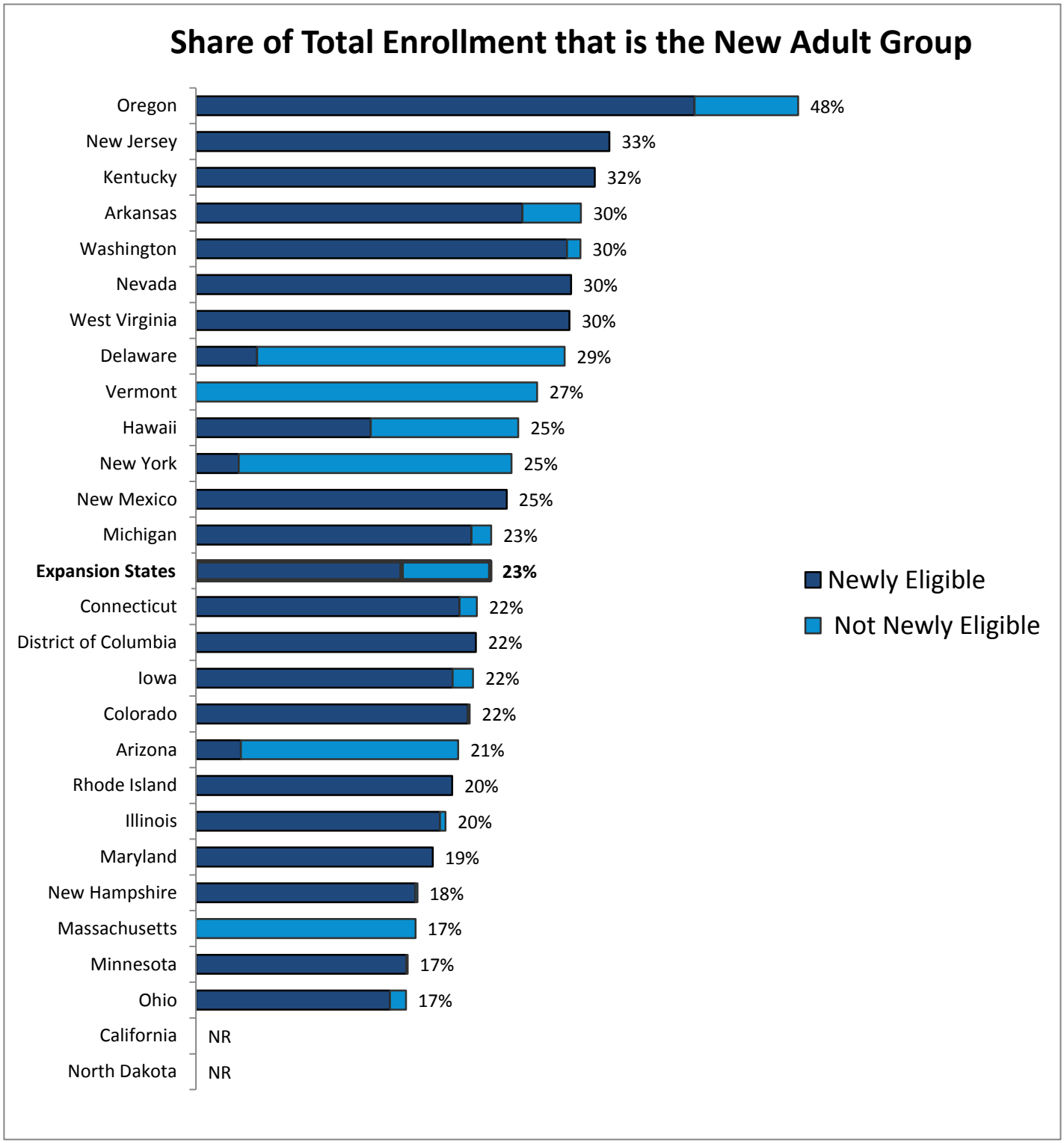


NOTES: Data for January through December 2014. Data are limited to 27 states that implemented the Medicaid expansion as of December 31, 2014. Enrollment data reflect the highest enrollment for each state during this period. Data were not reported for California and North Dakota.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

The make-up of the new adult group (newly eligible vs. other) differs across expansion states. Across all expansion states, over two-thirds of enrollment in the new adult group were newly eligible (those whose expenditures are eligible for 100% federal match through December 2016.) While newly eligible adults made up the vast majority of new adult enrollment in many of the expansion states, there were a handful that saw the majority of enrollment in the new adult group among those not newly eligible (Arizona, Delaware, New York and Massachusetts.) (Figure 9) These states had expanded coverage to adults prior to the ACA.

Among the expansion states that reported enrollment data, the largest share of new adult enrollment was in New York (19% or nearly 1.5 million adults) followed by Illinois (8%), New Jersey, Washington and Michigan (7% each). These five states reported nearly half (47%) of all enrollment among the new adult group. However, the distribution of enrollment among newly eligible adults (those whose expenditures are eligible for 100% federal match through December 2016) differs slightly. Illinois accounted for the highest share of newly eligible adults (11%) followed by New Jersey (10%), Washington (9%), Michigan (9%) and Ohio (8%). As mentioned earlier, New York had expanded coverage to adults prior to the ACA so nearly 9 out of 10 adults eligible under the new adult group in New York are not newly eligible.

Figure 9: The share of enrollment in the new adult group varies across states.



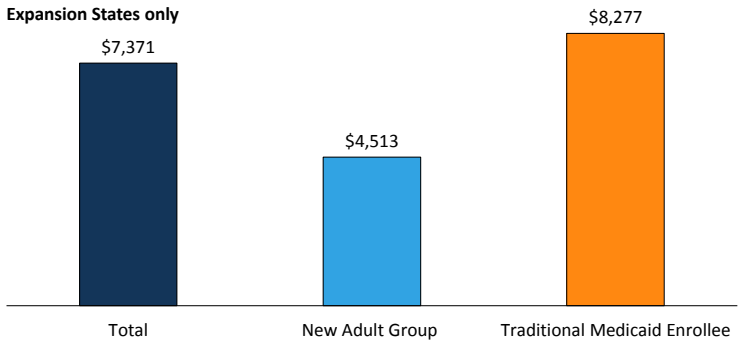
NOTES: Data for January through December 2014. Data are limited to the 27 states that implemented the Medicaid expansion as of December 2014. Data reflect the highest enrollment for each state during this period. Data were not reported for California and North Dakota. All but 2 of these states (MI and NH) implemented the expansion January 2014; MI's expansion became effective April 1, 2014 and NH's expansion became effective August 15, 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Spending per enrollee

Because childless adults were historically excluded from the Medicaid program prior to the ACA, there was limited data and experience to draw on for determining what utilization and expenditures for this group would be. While the data are preliminary and missing large states such as California, the MBES data provides a window into what spending per enrollee for the new adult group looks like and how it compares to the rest of the Medicaid population. Spending per enrollee for the new adult group is notably lower than spending per enrollee across all groups in expansion states; average spending per enrollee for the new adult group was $4,513 compared to $7,371 per enrollee (new adult group and traditional Medicaid population). (Figure 10) This is in line with historical data on adult spending per enrollee, which has been roughly 60 percent of total spending per enrollee figures.

Figure 10

Spending per enrollee for the new adult group was much lower than spending per enrollee across all groups in expansion states.



NOTES: Data for January through December 2014. Data reflect only expansion states. Expansion states include 27 states with the Medicaid expansion in effect December 31, 2014. States that adopted the Medicaid expansion after that period (PA, IN, AK, MT) are counted as non-expansion states. Data are not reported for California and North Dakota.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Spending per enrollee for those in the new adult group varied widely across states; spending per new adult group enrollee ranged from $8,461 in Rhode Island to $1,706 in New Hampshire (which implemented the Medicaid expansion later). (Appendix Table 4) This level of variation mirrors in large part variation in total spending per enrollee seen across these states as well as patterns in historic spending per enrollee data for adults. There are a number of factors that can lead to this wide dispersion in spending per enrollee figures including differences in health care costs across states and the relative health status of the underlying populations.

Looking Ahead

Data from the MBES released by the CMS provide monthly enrollment and quarterly expenditure data with specific information about enrollment and spending for the new adult eligibility group, also referred to as the "Group VIII." This new MBES data on spending and enrollment provide further insight into the early effects of the Medicaid expansion on Medicaid spending and enrollment. However, the data are preliminary and this is the first time enrollment data have been collected as part of the claiming process. It also is incomplete with enrollment data missing from some states (California and North Dakota.) With additional updates and data from missing states, additional analyses can be conducted to understand differences across expansion states as well as difference across expansion and non-expansion states in terms of spending and enrollment patterns.

Methodology

Data from the Medicaid Budget and Expenditure System (MBES) released by the Centers for Medicare and Medicaid Services (CMS) provides monthly enrollment and quarterly expenditure data with specific information about enrollment and spending for the new adult eligibility group, also referred to as the "Group VIII." States began reporting enrollment data for the quarter beginning January 1, 2014 and more recently began reporting expenditure data for the new adult group on the Form CMS-64.

Spending data made public reflect the first full year that the Medicaid expansion was in effect: the last three quarters of FFY 2014 (January – September 2014) and the first quarter of FFY 2015 (October – December 2014.) During this period, 27 states including DC, had implemented the Medicaid expansion; all but two of these states – Michigan (April 1, 2014) and New Hampshire (August 15, 2014) – implemented the Medicaid expansion January 1, 2014.

Expenditure data reported in this brief were summed across the four quarters. Data reflect all Title XIX expenditures reported by states; data do not include expenditures under Title XXI (CHIP).

Enrollment data reported are based on the maximum enrollment level reported across the four quarters in each state for Title XIX only (enrollment for under Title XXI or CHIP are excluded.) While this measure is used to try to capture the total number of enrollees over the entire period, it is likely an undercount of the number of enrollees ever on the program; more detailed forthcoming data sources on enrollment (such as the T-MSIS) will yield more accurate (and likely higher) enrollment data. Because different states saw higher levels of enrollment among the newly eligible and the not newly eligible in the new adult group (Group VIII) the Group VIII enrollment reported for states reflects the sum of the maximum newly eligible and the maximum of the not newly eligible. Traditional Medicaid figures are calculated taking the maximum total enrollment figure and subtracting the maximum Group VIII enrollment figure. National numbers for total, traditional Medicaid, Group VIII, newly eligible and not newly eligible enrollment all reflect summations of state maximums and therefore will not match data as reported by CMS. While all states have reported expenditure data for the January – December 2014 period, California and North Dakota have not reported enrollment data for that same period; DC, Colorado, Nevada New Jersey and Washington had reported some but not all months.

Spending per enrollee data are calculated taking the sum of expenditure data over the 4 quarters over the maximum enrollment level. Expenditure data from California and North Dakota were excluded from national calculations since these states did not report enrollment data. The maximum enrollment figure is intended to better capture all people touched by the program over the calendar year examined; however this figure is likely low and is expected increase over time as data are updated and missing data from states like California are added.

Appendices

- Appendix A: Comparison to Other Available Data Sources
- Appendix Table 2: Total Medicaid Expenditures, CY 2014
- Appendix Table 3: Preliminary Medicaid Enrollment, CY 2014
- Appendix Table 4: Spending per Enrollee in Expansion States, CY 2014

APPENDIX A: COMPARISON TO OTHER AVAILABLE DATA SOURCES

Spending. States have historically reported expenditure data through the MBES for claiming purposes; this is sometimes referred to as CMS-64 data. However, the expenditure data in this report may differ from other data reported from the MBES due to differences in timing as well as adjustments made to the data. For example, expenditure data from the MBES is commonly reported on a Federal Fiscal Year (FFY) basis (October 1 – September 30) whereas the data in this report reflect the calendar year (January 1 – December 31).

Enrollment Data. Since December 2013, CMS has been providing another source of monthly enrollment data for Medicaid and CHIP as part of its Medicaid and CHIP Performance Indicator Project. There are important differences between the Performance Indicator and MBES enrollment data that limit the ability to make comparisons between the two datasets, as discussed below and highlighted in Appendix Table 1:

- **The data vary in their intended purpose.** The MBES enrollment data are collected as part of the claiming process for federal Medicaid matching funds only, not CHIP. The Performance Indicator data are intended to provide timely insight into Medicaid and CHIP eligibility and enrollment trends to support program management and oversight.

- **There are key differences in who is included in the enrollment data.** The MBES enrollment data include all enrollees whose spending is eligible for Medicaid matching funds (including limited benefit waiver enrollees and Medicare enrollees that receive cost-sharing and premium assistance from Medicaid). In contrast, the Performance Indicator enrollment data only include enrollees that receive full benefit coverage. Moreover, the MBES enrollment data only include enrollment in Medicaid and not CHIP; the claiming process for CHIP, which has different matching rates, is done separately. The Performance Indicator data include enrollment for both Medicaid and CHIP.

- **There are differences in the timing of the data**. The MBES data include individuals enrolled in the state's Medicaid program at any time during the month of the reporting period. In contrast, the Performance Indicator data are a point-in-time count based on the number of individuals enrolled as of the last day of the month. The MBES enrollment data cover the period between January and June 2015 (though only data through December 2014 is used in this analysis), while the most recent monthly Performance Indicator report included data through October 2015.

Appendix Table 1: Differences Between CMS MBES and Performance Indicator Enrollment Data

	MBES Data	Performance Indicator Data
Eligibility Groups included	All Medicaid enrollees, including those receiving limited benefits (e.g., limited benefit waiver enrollees and Medicare enrollees receiving cost-sharing and premium assistance from Medicaid). Does not include CHIP enrollees.	Includes enrollees in Medicaid and CHIP enrollment. Does not include enrollees receiving limited benefits.
Enrollment data period	Total number of enrollees ever enrolled during the month. (Data are reported on a quarterly basis.)	Total number of enrollees as of the last day of the month.
Frequency of reporting	Quarterly	Monthly
Most recent data available as of December 2015	June 2015 (only data through Dec 2014 are used in this analysis)	October 2015
Data purpose	Collected as part of the claiming process for federal Medicaid matching funds.	Collected as part of new Medicaid and CHIP Performance Indicator Project to inform program management and oversight.

Appendix Table 2: Total Medicaid Expenditures, CY 2014				
State	Total	New Adult Group	Newly Eligible	Not Newly Eligible
Alabama	$5,309,736,744	N/A	N/A	N/A
Alaska	$1,618,158,522	N/A	N/A	N/A
Arizona	$9,460,028,885	$1,727,768,395	$145,541,925	$1,582,226,470
Arkansas	$5,226,774,523	$967,920,039	$967,920,039	N/A
California	$64,055,189,072	$12,199,943,279	$12,199,943,279	N/A
Colorado	$6,368,524,285	$992,468,785	$968,850,624	$23,618,161
Connecticut	$7,494,388,273	$1,200,936,868	$1,181,124,042	$19,812,826
Delaware	$1,760,894,949	$379,235,466	$32,930,545	$346,304,921
DC	$2,334,112,770	$297,107,909	$282,271,893	$14,836,016
Florida	$21,336,121,602	N/A	N/A	N/A
Georgia	$9,613,091,392	N/A	N/A	N/A
Hawaii	$1,975,301,415	$373,037,821	$242,011,231	$131,026,590
Idaho	$1,683,668,434	N/A	N/A	N/A
Illinois	$16,084,380,996	$1,085,547,824	$1,072,644,820	$12,903,004
Indiana	$9,317,184,653	N/A	N/A	N/A
Iowa	$4,216,928,813	$556,162,683	$531,449,280	$24,713,403
Kansas	$2,842,501,614	N/A	N/A	N/A
Kentucky	$8,595,156,527	$2,176,007,998	$2,176,007,998	N/A
Louisiana	$7,031,732,700	N/A	N/A	N/A
Maine	$2,497,790,662	N/A	N/A	N/A
Maryland	$9,725,772,438	$1,612,599,592	$1,612,599,592	N/A
Massachusetts	$15,033,457,934	$1,554,743,109	N/A	$1,554,743,109
Michigan	$14,116,055,764	$1,503,736,391	$1,444,562,564	$59,173,827
Minnesota	$10,638,087,779	$1,433,646,514	$1,427,247,012	$6,399,502
Mississippi	$4,973,795,953	N/A	N/A	N/A
Missouri	$9,034,749,004	N/A	N/A	N/A
Montana	$1,105,703,601	N/A	N/A	N/A
Nebraska	$1,831,650,567	N/A	N/A	N/A
Nevada	$2,538,887,096	$557,912,077	$557,912,077	N/A
New Hampshire	$1,437,357,944	$50,174,127	$49,928,108	$246,019
New Jersey	$13,422,100,485	$2,077,884,888	$2,077,884,888	N/A
New Mexico	$4,488,133,924	$1,015,477,316	$1,015,477,316	N/A
New York	$55,839,970,423	$6,717,924,807	$446,736,046	$6,271,188,761
North Carolina	$12,049,566,135	N/A	N/A	N/A
North Dakota	$995,053,014	$128,096,920	$125,595,143	$2,501,777
Ohio	$19,867,991,538	$1,955,996,607	$1,842,525,912	$113,470,695
Oklahoma	$5,045,035,311	N/A	N/A	N/A
Oregon	$7,279,593,596	$2,107,572,240	$2,107,572,240	N/A
Pennsylvania	$22,961,627,929	N/A	N/A	N/A
Rhode Island	$2,522,983,052	$457,942,487	$457,942,487	N/A
South Carolina	$5,646,426,012	N/A	N/A	N/A
South Dakota	$781,309,878	N/A	N/A	N/A
Tennessee	$8,763,278,224	N/A	N/A	N/A
Texas	$33,027,788,301	N/A	N/A	N/A
Utah	$2,110,973,692	N/A	N/A	N/A
Vermont	$1,561,688,259	$211,439,523	N/A	$211,439,523
Virginia	$7,633,684,545	N/A	N/A	N/A
Washington	$11,262,917,875	$3,437,117,412	$3,267,848,402	$169,269,010
West Virginia	$3,500,885,440	$420,573,988	$420,573,988	N/A
Wisconsin	$7,547,033,281	N/A	N/A	N/A
Wyoming	$540,533,820	N/A	N/A	N/A
United States	**$486,105,759,645**	**$47,198,975,065**	**$36,655,101,451**	**$10,543,873,614**

NOTES: Data reflect expenditures for January through December 2014. See Methodology for more details.
SOURCE: KCMU analysis of Medicaid spending and enrollment data collected from the MBES, CMS, accessed December 2015.

Appendix Table 3: Preliminary Medicaid Enrollment, CY 2014				
State	Total	New Adult Group	Newly Eligible	Not Newly Eligible
Alabama	1,050,254	N/A	N/A	N/A
Alaska	121,405	N/A	N/A	N/A
Arizona	1,732,726	359,093	61,709	297,384
Arkansas	871,098	265,032	224,870	40,162
California		Data Not Reported		
Colorado	976,972	211,389	210,013	1,376
Connecticut	851,013	188,969	177,393	11,576
Delaware	205,356	59,841	9,961	49,880
DC	243,852	53,954	53,954	-
Florida	3,954,371	N/A	N/A	N/A
Georgia	1,793,252	N/A	N/A	N/A
Hawaii	333,090	84,838	46,061	38,777
Idaho	290,376	N/A	N/A	N/A
Illinois	2,992,947	590,415	577,455	12,960
Indiana	1,096,804	N/A	N/A	N/A
Iowa	553,661	121,275	112,326	8,949
Kansas	369,784	N/A	N/A	N/A
Kentucky	1,200,615	378,364	378,364	-
Louisiana	1,351,281	N/A	N/A	N/A
Maine	300,720	N/A	N/A	N/A
Maryland	1,160,217	217,282	217,282	-
Massachusetts	1,981,413	343,836	-	343,836
Michigan	2,162,402	504,430	470,828	33,602
Minnesota	1,105,285	185,011	183,824	1,187
Mississippi	736,517	N/A	N/A	N/A
Missouri	840,679	N/A	N/A	N/A
Montana	152,200	N/A	N/A	N/A
Nebraska	237,519	N/A	N/A	N/A
Nevada	556,116	164,906	164,906	-
New Hampshire	167,988	29,406	29,124	282
New Jersey	1,652,548	539,902	539,902	-
New Mexico	753,184	184,942	184,942	-
New York	5,992,264	1,494,419	202,684	1,291,735
North Carolina	1,935,493	N/A	N/A	N/A
North Dakota		Data Not Reported		
Ohio	2,924,123	485,312	448,378	36,934
Oklahoma	765,374	N/A	N/A	N/A
Oregon	1,035,570	492,687	407,990	84,697
Pennsylvania	2,110,761	N/A	N/A	N/A
Rhode Island	267,327	54,126	54,126	-
South Carolina	1,193,222	N/A	N/A	N/A
South Dakota	108,302	N/A	N/A	N/A
Tennessee	1,504,276	N/A	N/A	N/A
Texas	4,330,364	N/A	N/A	N/A
Utah	323,730	N/A	N/A	N/A
Vermont	192,515	51,911	-	51,911
Virginia	931,238	N/A	N/A	N/A
Washington	1,678,876	510,155	492,358	17,797
West Virginia	527,194	155,636	155,636	-
Wisconsin	1,201,672	N/A	N/A	N/A
Wyoming	73,744	N/A	N/A	N/A
United States	**58,891,690**	**7,727,131**	**5,404,086**	**2,323,045**

NOTES: Data reflect preliminary maximum enrollment in calendar year 2014. See Methodology for more details.
SOURCE: KCMU analysis of Medicaid spending and enrollment data collected from the MBES, CMS, accessed December 2015.

Appendix Table 4: Spending per Enrollee in Expansion States, CY 2014		
State	Spending per enrollee for the new adult group (Group VIII)	Spending per enrollee across all groups (Traditional and Group VIII)
Arizona	$4,811	$5,460
Arkansas	$3,652	$6,000
California		
Colorado	$4,695	$6,519
Connecticut	$6,355	$8,806
Delaware	$6,337	$8,575
District of Columbia	$5,507	$9,572
Hawaii	$4,397	$5,930
Illinois	$1,839	$5,374
Iowa	$4,586	$7,616
Kentucky	$5,751	$7,159
Maryland	$7,422	$8,383
Massachusetts	$4,522	$7,587
Michigan	$2,981	$6,528
Minnesota	$7,749	$9,625
Nevada	$3,383	$4,565
New Hampshire	$1,706	$8,556
New Jersey	$3,849	$8,122
New Mexico	$5,491	$5,959
New York	$4,495	$9,319
North Dakota		
Ohio	$4,030	$6,795
Oregon	$4,278	$7,030
Rhode Island	$8,461	$9,438
Vermont	$4,073	$8,112
Washington	$6,737	$6,709
West Virginia	$2,702	$6,641
Expansion State Average	**$4,513**	**$7,371**

NOTES: Data for January through December 2014. Data are limited to the 27 states that had implemented the Medicaid expansion effective December 2014. Data reflect spending per enrollee for each state during this period using expenditures summed across the 4 quarters and the highest level of enrollment reported. Data were not reported for California and North Dakota. All but 2 of these states (MI and NH) implemented the expansion January 2014; MI's expansion became effective April 1, 2014 and NH's expansion became effective August 15, 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Endnotes

[1] Additionally, not all states reported enrollment data for all periods. The District of Columbia reported enrollment data for all but the first quarter (January – March 2014). Colorado reported enrollment data for only the first quarter (January – March 2014). Hawaii reported enrollment data for all but the last quarter (October – December 2014). Nevada, New Jersey and Washington reported enrollment data in each quarter, they did not report enrollment data for each month in the 4th quarter of 2014 (data were reported for December only).

[2] Additionally, not all states reported enrollment data for all periods. The District of Columbia reported enrollment data for all but the first quarter (January – March 2014). Colorado reported enrollment data for only the first quarter (January – March 2014). Hawaii reported enrollment data for all but the last quarter (October – December 2014). Nevada, New Jersey and Washington reported enrollment data in each quarter, they did not report enrollment data for each month in the 4th quarter of 2014 (data were reported for December only).

[3] Expansion states that do not have any newly-eligible Medicaid beneficiaries because they already covered people up to 138% FPL or higher (e.g. Massachusetts) also receive a temporary (January 1, 2014 through December 31, 2015) 2.2 percentage point increase in their federal matching rate for all populations.

[4] Robin Rudowitz, "Understanding How States Access the ACA Enhanced Medicaid Match Rates", Kaiser Family Foundation, September 2014. http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/

Title

Increased service use following Medicaid expansion is mostly temporary: evidence from California's low income health program.

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et al.

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Health Policy Brief

October 2014

Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California's Low Income Health Program

Nigel Lo, Dylan H. Roby, Jessica Padilla, Xiao Chen, Erin N. Salce, Nadereh Pourat, Gerald F. Kominski

"Pent-up demand for care appears to decline rapidly after the first year of enrollment and becomes comparable to the demand of those with previous comprehensive coverage."

SUMMARY: The Affordable Care Act (ACA) has already resulted in expanded eligibility for Medicaid in 27 states, including California, as of 2014. One major concern about the Medicaid expansion is that a high level of need among the newly eligible may lead to runaway costs, which could overwhelm state budgets when federal subsidies no longer cover 100 percent of the expansion population's costs in 2017. Although cost increases as a result of the newly eligible are likely, an even more important question is whether these increases will be temporary or permanent. Evidence from California's Low Income Health Program (LIHP) suggests that cost and utilization increases among newly eligible Medicaid beneficiaries will be mostly temporary.

This policy brief presents data showing a significant decline in the use of hospital inpatient care and in emergency room visits after one year of enrollment in LIHP, and a stable, not increasing, rate of outpatient service use. Because LIHP provided health care coverage from 2011 to 2013 in advance of the full Medicaid expansion, our findings suggest that early and significant investments in infrastructure and in improving the process of care delivery can effectively address the pent-up demand for health care services of previously uninsured populations.

California's Medicaid Expansion

As of July 2014, California had enrolled 1.5 million newly eligible individuals in its Medicaid program, Medi-Cal, as a result of the Medicaid expansion authorized by the ACA and adopted by the California Department of Health Care Services.[1] The 1.5 million enrollees included approximately 650,000 individuals who were enrolled in California's Low Income Health Program (LIHP) as of December 2013 and who transitioned into Medicaid on January 1, 2014.[2] LIHP served as a bridge to the Medicaid expansion, providing potential future enrollees with health care coverage ahead of the legislated start date and facilitating their transition into Medicaid, as described in greater detail below.

Previous lack of affordable coverage, receipt of episodic care, and a high prevalence of chronic conditions among those formerly uninsured are major concerns for Medicaid programs in California and across the nation. Newly eligible Medicaid enrollees are expected to have a significant level of unmet need (pent-up demand) and disproportionally higher rates of costly emergency room visits and hospitalizations. In part, these concerns

appear supported by recently published evidence from the Oregon Health Insurance Experiment that suggests higher expenditures among newly enrolled Medicaid beneficiaries during their first year of enrollment.[3] Those findings have been cited as justification for states not to expand their Medicaid programs. Whether increased utilization following Medicaid expansion will be temporary or permanent cannot be answered by the Oregon experiment, however, because no measures were implemented to manage utilization, and the study was limited in both duration and geographic implementation. The question of whether increased utilization and expenditures among newly enrolled Medicaid beneficiaries is temporary or permanent has important implications for the sustainability of national Medicaid expansion. This policy brief addresses the issue directly, using evidence from California's pre–Medicaid expansion programs.

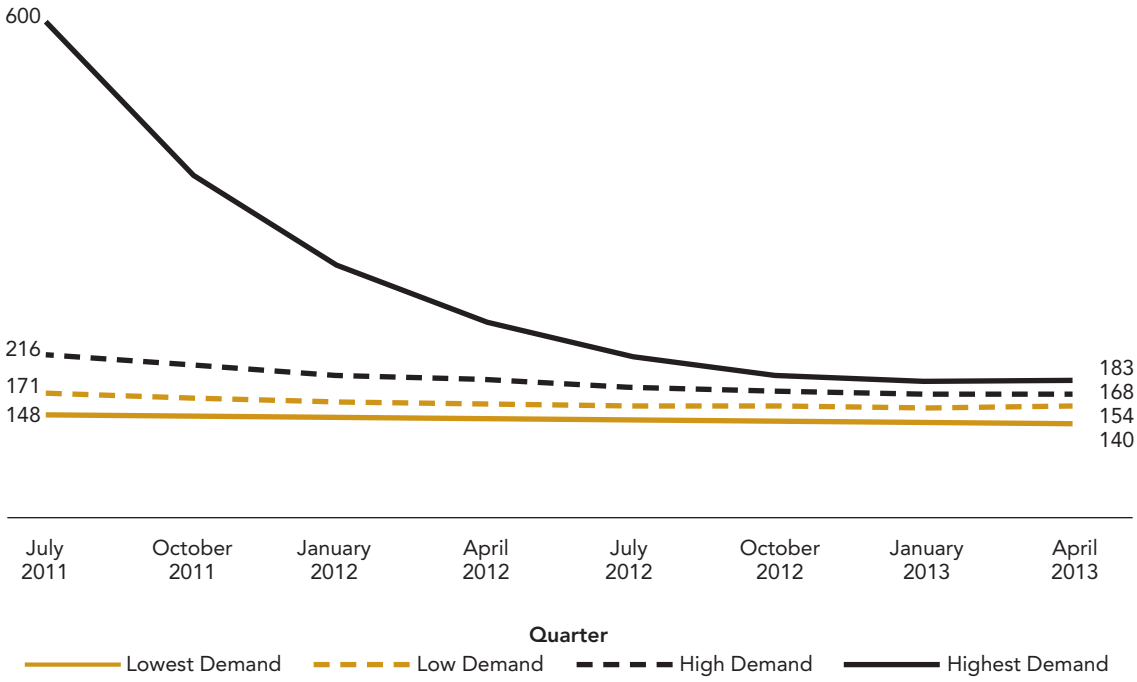
"The question of whether increased utilization and expenditures among newly enrolled Medicaid beneficiaries is temporary or permanent has important implications for the sustainability of national Medicaid expansion."

To assess the issue of both the magnitude and duration of pent-up demand among the newly eligible Medicaid population, we examined enrollment and claims data from two consecutive §1115 Medicaid waiver programs in California—the Health Care Coverage Initiative (HCCI), which ran from September 2007 to October 2010, and LIHP, which ran from July 2011 to December 2013. Both programs were designed to provide health care coverage to low-income uninsured adults (income up to 200 percent of the federal poverty level) who were not eligible for Medi-Cal or other public programs at the time, but who would become eligible for Medi-Cal or subsidies through the Health Benefit Exchange in 2014. The programs were funded and administered by participating counties, which received federal matching funds, relied on networks comprised in part of safety-net providers, had defined benefit packages, and met other requirements.[4,5,6]

The number of participating counties was 10 under HCCI and increased to 53 under LIHP. LIHP, which was authorized after the passage of the ACA, had more enrollees, more varied income eligibility levels, additional benefits, and a larger provider network per county than HCCI. Both programs used county dollars to leverage federal matching funds, doubling the county-level resources available for caring for the uninsured future Medi-Cal and subsidy eligible populations in participating counties.

We examined data from enrollees during the first year of LIHP who would have been eligible for the Medicaid expansion (up to 133 percent of the federal poverty level). We included 8 of the 10 counties (Alameda, Orange, San Diego, San Francisco, San Mateo, Ventura, Contra Costa, and Kern) that participated in both HCCI and LIHP. We focused on these counties because they reported data for two years prior to LIHP enrollment and two years after enrollment. We then divided 182,443 first-year LIHP enrollees in these counties into four distinct groups based on their expected level of pent-up demand: (1) 69,095 who had not used county indigent services prior to enrolling in LIHP (highest); (2) 16,596 who had used county indigent services prior to enrolling in LIHP (high); (3) 12,033 who had been enrolled in HCCI but had not used services while in HCCI (low); and 84,709 who had been enrolled in HCCI and had used services while in HCCI (lowest). We compared the rates (per 1,000 enrollees) of outpatient visits, emergency room visits, and hospitalizations for each group. We controlled for utilization differences related to county of residence, demographics, number of specified chronic medical conditions, and length of enrollment, using regression models.

Rates of Emergency Room Visits per Quarter per 1,000 LIHP Enrollees, California **Exhibit 1**

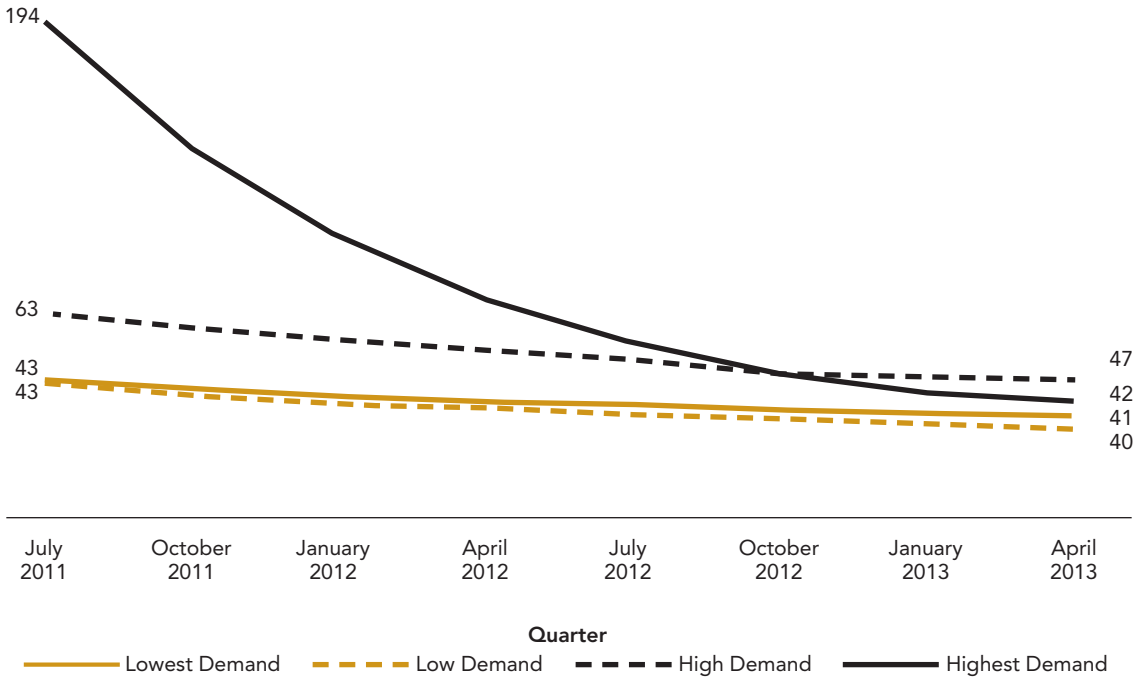


Note: Rates of ER visits are adjusted for county and enrollee characteristics.

Rates of Emergency Room Visits and Hospitalization Declined Among Those with Highest Pent-up Demand

LIHP enrollees with the highest demand (who had not previously used county services) had 600 emergency room visits per 1,000 enrollees in the first quarter of the program. This rate declined rapidly during the first year of the program and remained relatively constant during the second year of LIHP, reaching a low of 183 per 1,000 at the end of the second year (Exhibit 1). Those with high demand also showed a significant but smaller decline in the rate of ER visits, from 216 per 1,000 enrollees in the first quarter to 168 per 1,000 enrollees at the end of the second year. The rate of emergency room visits remained low and did not change significantly for those with low or lowest pent-up demand.

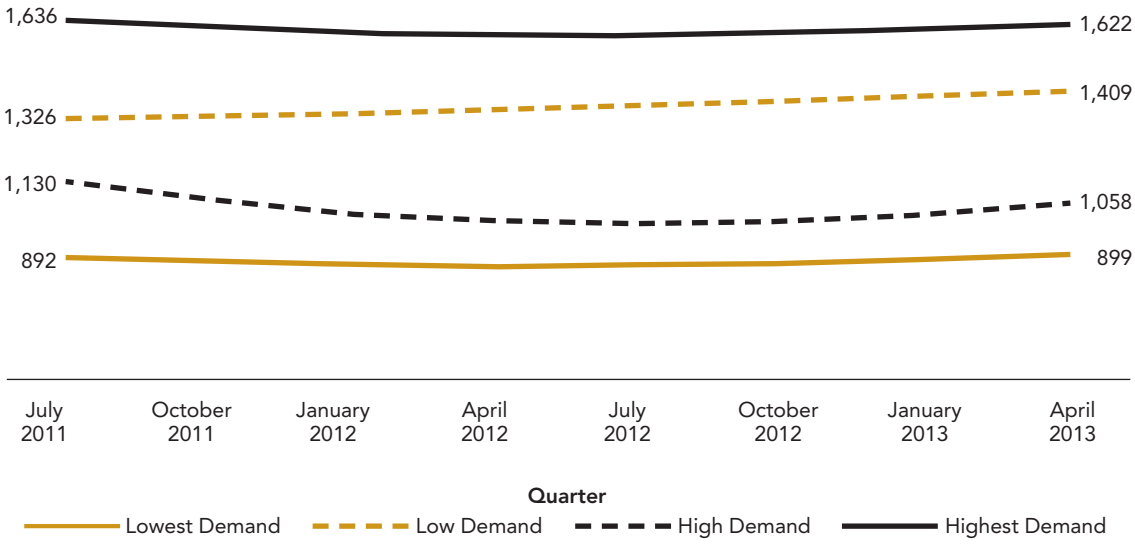
Exhibit 2 **Rates of Hospitalization per Quarter per 1,000 LIHP Enrollees, California**



Note: Rates of hospitalization are adjusted for county and enrollee characteristics.

Similar to ER use, LIHP enrollees with the highest demand had a significant and rapid decline in hospitalization rates, from 194 to 42, from the first to the last quarter studied (Exhibit 2). A slower but significant decline also occurred among those with high demand, from 63 to 47 hospitalizations per 1,000 enrollees. The hospitalization rates for those with low or lowest pent-up demand remained virtually the same during the first two years of the program.

Rates of Outpatient Visits per Quarter per 1,000 LIHP Enrollees, California **Exhibit 3**



Note: Rates of outpatient visits are adjusted for county and enrollee characteristics.

Rates of Outpatient Visits Remained Relatively Constant Among All LIHP Enrollees

The rate of outpatient visits by LIHP enrollees with highest demand was 1,636 per 1,000 enrollees in the first quarter, decreasing only slightly to 1,622 by the end of the second program year (Exhibit 3). The trend among enrollees with high demand and those with the lowest pent-up demand was essentially constant during the two years, and both groups had fewer visits than the group with the highest demand. Those with low pent-up demand (previously enrolled in the HCCI program but had not used services) had a slight increase in visit rates, with 1,326 per 1,000 enrollees in the first quarter and 1,409 by the end of the second year.

"Early and significant investments in infrastructure and in improving the process of care delivery can effectively address the pent-up demand for health care services of previously uninsured populations."

Policy Implications

As of January 1, 2014, 650,000 LIHP enrollees had been transitioned into Medi-Cal in California, accounting for about 34 percent of newly eligible Medi-Cal enrollees in the state. All new Medi-Cal beneficiaries were enrolled in participating managed care plans, but LIHP enrollees were able to retain their primary care providers if those providers participated in the Medi-Cal managed care network(s) available in their county.

The findings reported here have two significant implications for California and the nation. First, although newly eligible Medicaid enrollees have pent-up demand for care, this demand appears to decline rapidly after the first year of enrollment and becomes comparable to the demand of those with previous comprehensive coverage. Second, for populations who were "pre-enrolled" in coverage programs prior to Medicaid expansion in January 2014, much of the pent-up demand for expensive emergency room and hospital care has already been met.

The HCCI and LIHP programs required counties to develop several enhanced care processes that may have been responsible for the decline in emergency room and hospitalization rates reported in this policy brief. These enhanced processes included: (1) mandatory assignment of enrollees to a medical home; (2) care coordination and teamwork training for primary care providers; (3) health risk assessments to stratify enrollees into varying intensities of disease and case management; (4) improved access to specialty and other services required to prevent deterioration of patients with ambulatory care sensitive conditions; and (5) culturally competent self-care to help diverse populations maintain and improve their health.[5,6]

Although our results are not directly comparable to those of the Oregon Health Insurance Experiment,[3] they suggest that the higher costs and utilization among newly enrolled Medicaid beneficiaries is a temporary rather than permanent phenomenon. To the extent that California's experience with the pre-ACA HCCI and LIHP programs is generalizable to other states, policymakers and service providers can expect a reduction in demand for high-cost services after the first year of Medicaid enrollment.

The LIHP program was part of the early implementation of the ACA in California. This early implementation was expected to address the pent-up demand among LIHP enrollees prior to their transition into Medi-Cal, thus reducing the anticipated surge in program expenditures and crowding of emergency rooms. Our findings indicate that these program goals have been achieved.

Methods

We used data only for the first two years of LIHP because data for the entire LIHP program were not available at the time of this study. We used evaluation and management visits to assess outpatient care and excluded other services, such as labs and imaging. We excluded Contra Costa and Kern counties from these outpatient visits due to missing procedure codes or other data limitations.

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EFFECTS OF ACA MEDICAID EXPANSIONS ON HEALTH INSURANCE COVERAGE AND LABOR SUPPLY

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Working Paper 21836
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December 2015

Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply
Robert Kaestner, Bowen Garrett, Anuj Gangopadhyaya, and Caitlyn Fleming
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December 2015, Revised September 2016
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ABSTRACT

We examined the effect of the expansion of Medicaid eligibility under the Affordable Care Act on health insurance coverage and labor supply of low-educated and low-income adults. We found that the Medicaid expansions were associated with large (e.g., 50 percent) increases in Medicaid coverage and corresponding decreases in the proportion uninsured. There was relatively little change in private insurance coverage, although the expansions tended to decrease such coverage slightly. In terms of labor supply, estimates indicated that the Medicaid expansions had little effect on work effort despite the substantial changes in health insurance coverage. Most estimates suggested that the expansions increased work effort, although not significantly.

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1. Introduction

One of the key features of the Affordable Care Act (ACA) was the expansion of Medicaid to adults with incomes below 138% of the federal poverty level. Low-income adults were largely ineligible for Medicaid prior to the ACA and this group also had a relatively low rate of health insurance coverage. Therefore, expanding Medicaid to this group was seen as an important way to reduce the number of uninsured persons, which was one of the central goals of the ACA.

While the Medicaid expansions were clearly targeted at expanding health insurance coverage, the income-based eligibility criterion of the expansion may have unintended effects on work effort. There are several reasons why the Medicaid expansions may affect work.[1] First, some people may reduce work effort to lower their income and gain Medicaid eligibility. Second, some people may reduce work effort because Medicaid coverage virtually eliminates out-of-pocket medical expenditures and health insurance premium contributions, and allows a person to work less to generate the same amount of consumption (income effect). Third, some people may increase work effort because they can work and earn more than before the Medicaid expansion and still remain eligible for Medicaid due to the higher Medicaid income eligibility threshold.[2] Finally, the Medicaid expansions may have some, albeit small, positive effect on aggregate economic activity that could increase employment.

The Congressional Budget Office (2014) estimated that the ACA would reduce total hours worked by 1.7 percent, or 2 million fewer full-time equivalent workers. Of this decline in employment, the CBO (2014) estimated that the Medicaid expansions of the ACA would be responsible for a small part of the negative effect on employment.[3] To reach their conclusion about the possible effects of Medicaid, the CBO (2014)

[1] A report by the Congressional Budget Office (2014) describes the intuition underlying the causal links between Medicaid and labor supply, and earlier studies by Blank (1989), Matsudaira and Blank (2013) and Yelowitz (1995) present simple models that generate similar hypotheses. Also, see Bitler and Karoly (2015), Moffitt (2015) and, particularly, Mulligan (2013; 2015) for a description of the ACA labor supply incentives and potential behavioral responses.

[2] Another possibility is that some people will switch jobs from one that provides employer-provided insurance and a relatively low wage to one that does not provide employer-provided insurance and a relatively higher wage, but that still allows for Medicaid coverage. The higher wage of the new job would have substitution and income effects that could change work effort.

[3] See Appendix C of Congressional Budget Office (2014) report, "Labor Market Effects of the Affordable Care Act: Updated Estimates." *The Budget and Economic Outlook: 2014 to 2024*: 117-127. Feb. 2014:

relied on a synthesis of the evidence from a few, recent case studies of the effect of Medicaid expansions on labor supply. Perhaps the most important of these studies was Baicker et al. (2013), which examined the effect of expanding Medicaid to childless adults in Oregon in 2008. The findings from this study are particularly compelling because of the high degree of internal validity resulting from the experimental design that was used. Baicker et al. (2013) reported that gaining Medicaid coverage was associated with a small—1.6 percentage point (3%)—and statistically insignificant decrease in employment and earnings. Another study reviewed by CBO (2014) was DeLeire et al. (2013), which examined an expansion of Medicaid to childless adults in Wisconsin in 2009. A quasi-experimental research design (i.e., regression discontinuity) was used that exploited the capping of enrollment that left eligible people unable to enroll in Medicaid after a certain date. Results from the study indicated that Medicaid enrollment was associated with between a 2% to 18% percent decrease in employment. A third study included in the CBO (2014) review was by Garthwaite et al. (2014). This study examined the rollback of Medicaid eligibility in Tennessee in 2005. For this analysis, a difference-in-differences research design was used with Tennessee as the treated state and other Southern states the control states. Results of the analysis were mixed. Among low-educated, childless adults, the change in Medicaid policy was associated with a 25% increase in employment, but there was no effect for other educational groups.[4]

Besides these important pre-ACA studies, there are a couple of studies of the effect of the ACA Medicaid expansions on labor supply that were produced since the CBO (2014) report.[5] Gooptu et al. (2016) used a sample of low-income (<138% Federal Poverty Level) adults drawn from monthly Current Population

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http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf. Also see Congressional Budget Office (2015). "How CBO Estimates the Effects of the Affordable Care Act on the Labor Market." Working Paper 2015-09. December 2015.

[4] Estimates in Garthwaite et al. (2014) are intention-to-treat estimates and are not directly comparable to estimates from the Oregon and Wisconsin studies. Garthwaite et al. (2014) estimated that between 63 and 90 out of every 100 childless adults that lost public health insurance coverage found employment. This is a very large implied effect of Medicaid that differs dramatically from estimates in the Oregon and Wisconsin studies. Estimates in Garthwaite et al. (2014) also suggest employment responses to changes in income (the value of Medicaid) that are 20 to 60 times the size of estimates found in most prior studies. See McClelland and Mok (2012): https://www.cbo.gov/sites/default/files/cbofiles/attachments/10-25-2012-Recent_Research_on_Labor_Supply_Elasticities.pdf

[5] There is also a larger literature on the labor supply effects of the ACA as a whole—not specific to Medicaid. Garrett and Kaestner (2014; 2015) review this literature.

Surveys between January 2005 and March 2015 to examine the effect of Medicaid expansions on three outcomes: transitions from employed to unemployed; transitions from full-time to part-time employment; and job switches (employed in one job to employed in different job).[6] A difference-in-differences research design was used. The authors reported that the ACA Medicaid expansions had no significant effect on these outcomes. In an unpublished paper, Leung and Mas (2016) used data from the American Community Survey from 2010 to 2014 and monthly Current Population Surveys from January 2010 to July 2015 to examine the effect of the ACA Medicaid expansions on employment, hours of work and wages.[7] The research design for the analysis in this study was difference-in-differences. Leung and Mas (2016) reported that the ACA Medicaid expansions had no significant effect on employment, hours of work or wages.

As this brief review of the literature has revealed, previous studies of the effect of Medicaid on labor supply have not produced a consensus conclusion.[8] This is an important gap in knowledge because of the relevance of this issue for both economic theory and public policy. Economic theory predicts that social programs with income-based eligibility will bring forth behavioral responses with respect to work effort. Therefore, measuring the existence and magnitude of a behavioral, labor supply response to the large and recent expansion of Medicaid will provide empirical evidence to assess a fundamental theoretical tenet. Moreover, two of the recent case studies of the effect of Medicaid on labor supply (OR and WI studies) were conducted using a sample of persons always eligible for Medicaid and, therefore, do not allow for one potentially important labor supply response—"jumping on" Medicaid by lowering income to gain eligibility (Mulligan 2013). For public policy, knowing whether there are unintended consequences related to work effort associated with Medicaid is an important component of a cost-benefit analysis of

[6] Note that Gooptu et al. (2016) do not exhaust the possible employment transitions because they do not examine unemployed to employed or part-time to full time. In addition, the study selected the sample based on the income in the previous (baseline) year, which may be a noisy measure of potential income in the following year.
[7] Leung and Mas (2016) also examined the effect of ACA Medicaid expansions on health insurance coverage.
[8] There is also a literature that examined the effect of Medicaid expansions for pregnant women and children in late 1980s and 1990s: Yelowitz (1995); Montgomery and Navin (2000); Ham and Shore-Shepard (2005); Meyer and Rosenbaum (2001); and Decker et al. (2014). These studies also reported mixed results.

the effectiveness of Medicaid. If there are large changes in work effort associated with Medicaid, for example, declines in work along the lines suggested by the Garthwaite et al. (2014), then the net, social benefit of the Medicaid expansions would be substantially lower than otherwise believed.

In sum, the absence of a consensus from the relatively small prior literature related to whether Medicaid affects labor supply and the importance of the issue for theory and policy warrants additional study. In this paper, we examine the effect of the ACA Medicaid expansions on health insurance coverage and labor supply. While the original formulation of the ACA Medicaid expansions was that it would be implemented in all states, a Supreme Court ruling allowed states to opt out of the expansion and approximately half did so.[9] Thus, we exploit the state-variation in expansions resulting from the Supreme Court ruling to assess the effect of Medicaid on insurance coverage and labor supply. We use two research designs: difference-in-differences and synthetic control. Data for the analysis are drawn from the American Community Survey (ACS) from 2010 to 2014, the March Current Population Survey (CPS) from 2010 to 2015, and monthly CPS data from January 2010 to May 2016.

We study both health insurance coverage and labor supply because insurance coverage is itself an important outcome of interest, and because changes in labor supply will be partly reflected by changes in insurance coverage. For example, if people reduce labor supply to become eligible for Medicaid, then we should observe a decrease in employment; an increase in Medicaid coverage; a reduction in uninsured; and possibly a reduction in private insurance if the person replaced their private insurance with Medicaid. Thus, the size of the increase in Medicaid has implications for the magnitude of the potential labor supply response. Similarly, low-income, working persons may gain Medicaid coverage because of the expanded income eligibility. For this group the extra income associated with Medicaid may cause them to work less. Therefore, changes in insurance coverage, particularly Medicaid, provide some evidence of the extent of treatment and the size of the group that may change labor supply in response to the Medicaid expansion, although the association is not necessarily one-for-one.

[9] See http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf

Results of our study indicate that, among low-educated and low-income adults, the ACA Medicaid expansions significantly increased Medicaid coverage by between 23 percent and 54 percent for parents, and by between 51 percent to 70 percent for childless adults. Notably, these increases in Medicaid coverage were associated with significant decreases in the proportion uninsured with relatively little change in private health insurance coverage, although for some groups such as unmarried parents living in states with prior Medicaid expansions, there was substantial switching from private insurance to Medicaid with less significant decreases in the proportion uninsured. These substantial changes in insurance coverage were, in general, associated with few significant changes in labor supply. Estimates of the effect of Medicaid on labor supply were, in general, small and not statistically significant, and most were positive. Overall, there was very little evidence that the Medicaid expansions decreased work effort.

2. ACA Medicaid Expansions

As noted, the Supreme Court decision that allowed states to opt out of the ACA Medicaid expansions resulted in approximately half of the states not expanding Medicaid in 2014 (see Table 1). Moreover, among those that did expand, several states had already expanded Medicaid to adults, for example, parents. Therefore, these states may not have experienced any real change in Medicaid eligibility for some groups. Finally, several states expanded Medicaid in 2015 or later. In short, classifying states as to whether they did or did not experience an effective change in policy is not as simple as assessing whether they expanded Medicaid in 2014 as part of the ACA.

To classify states into those experiencing a change in Medicaid policy ("treated") and those not experiencing a change in Medicaid policy ("control"), we reviewed several sources of information.[10] Table 1 provides a list of states and how we classified them into treated and control groups as of 2014.

[10] Medicaid eligibility rules were determined using Kaiser Family Foundation's Annual 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP (2009 through 2015), Medicaid.gov demonstrations and waivers database (http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html), Kaiser Family Foundation's state-specific fact sheets, healthinsurance.org Medicaid state-specific fact sheets, and individual state Medicaid websites.

For analyses that use data from 2015 and 2016, we made appropriate modifications that we identify below. As of 2014, states included in the control group are:

States that did not expand Medicaid in 2014 and that had no prior Medicaid expansion between 2010 and 2014: AL, AK, FL, GA, ID, KS, LA, MS, MO, MT, NE, NC, OK, PA, SC, SD, TX, UT, VA, WY (20).

States that did not expand Medicaid in 2014 and that had prior, but limited Medicaid expansions between 2010 and 2014: IN, ME, TN, WI (4).

States that expanded Medicaid in 2014, but that had prior and comprehensive Medicaid expansion similar to ACA for both parents and childless adults between 2010 and 2014: DE, DC, MA, NY, VT (5).

The control group consists of 29 states. Note that we include IN, ME, TN and WI as control states even though they had some prior Medicaid expansions between 2010 and 2014. However, the prior Medicaid expansions in these states were limited (e.g., capped or closed enrollment). One state changed status between 2010 and 2013; Colorado expanded eligibility to childless adults in 2012, but capped the program at 10,000. To assess whether including states with prior expansions, either comprehensive as in MA or limited as in IN, made a difference, we re-estimated all models excluding these states from the analysis and we report the results below. We note here that dropping these states had little effect on estimates. As noted, four states expanded Medicaid in 2015 or 2016: PA (1/15), IN (2/15), AK (9/15), and MT (1/16). Analyses that use 2015 and 2016 data drop these states from the analysis.[11]

As of 2014, the treated states are the following:

States that expanded Medicaid in 2014 and that had no prior Medicaid expansion: AK, KY, MI, NH, NV, NM, ND, OH, WV (9).

States that expanded Medicaid in 2014 and that had a prior, but limited, Medicaid expansion for parents and/or childless adults: AZ, CA, CO, CT, HI, IA, IL, MD, MN, NJ, OR, RI, WA (13).

[11] We dropped these states because we wanted to use a common definition of treatment across the two research designs. The synthetic control method requires a common pre- and post-period, so these late expanders are dropped because we used 2014 as the beginning of the post-period. To be consistent, we also dropped these states from the difference-in-differences analysis.

We note that Michigan expanded Medicaid in April of 2014 and New Hampshire expanded Medicaid in August of 2014. We include both in treated group because Michigan expanded for most of the year and New Hampshire is a small state and the partial year expansion is unlikely to make a difference to estimates. Re-estimating models without these two states included in treatment group had no material effect on estimates. Finally, as already mentioned, states that expanded after 2014 (IN, PA, AK, and MT) are excluded from the analysis when data post 2014 is used.

The fact that some states had prior expansions motivated us to divide the treated states into two groups depending on whether they had a previous expansion. However, if a state had expanded Medicaid fully (comprehensively) to both parents and childless adults (DE, DC, MA, NY, VT), which is the equivalent of the ACA expansion, these states were included in the control group of states. Thus, the second group of states in the treated category consists of states with a full parental expansion of Medicaid and states with limited expansions for parents and/or childless adults. On the one hand, it is reasonable to expect that the effect of the 2014 (ACA) expansion of Medicaid will be smaller in states with previous expansions of Medicaid, although many of these expansions were quite limited. Most were focused on parents. On the other hand, if take-up of Medicaid among eligible persons was relatively low, the individual mandate that required all people to have health insurance and the public outreach (i.e. marketplaces) that became effective in 2014 may cause those always eligible for Medicaid to obtain it and this would suggest smaller differences between the two groups of states that expanded Medicaid in 2014. Empirically, we test whether the effect of Medicaid differed in the two groups of treated states. We also explored whether to divide the second group of treated states into a finer classification based on the type of previous expansion, but tests indicated that these two categories were the only empirically relevant groupings.[12]

3. Empirical Approach

3.a. Data

[12] Specifically, we divided the second group of treated states into those with and without a full Medicaid expansion to parents. We could not reject the hypothesis that these two groups had similar effects on outcomes.

The data used in the analysis come from three sources: the American Community Survey (ACS) from 2010 to 2014; the March Current Population Survey from 2010 to 2015; and monthly files of the Current Population Survey (CPS) from January 2010 to May 2016. From each of these datasets, we selected a sample of non-disabled, adults between the ages of 22 and 64 who have a high school education or less. We limit the sample to relatively low-educated adults because Medicaid is targeted at low-income persons and education is strongly related to income. We recognize that selecting a sample on the basis of income is problematic because Medicaid may affect labor supply and income and therefore, may lead to biased estimates.

We conduct analyses using all persons with a high school education or less and analyses stratified by marital status (married, not married), whether there is a child in the family and age.[13] We stratify the sample by marital status because it is associated with income; unmarried persons have lower incomes and may be more likely to be affected by the Medicaid expansions than married persons. We also conducted analyses for samples divided by whether or not there are children under the age of 18 in the household. Most prior Medicaid expansions were targeted toward low-income parents, so this group may be less affected by the ACA Medicaid expansions, and there may be differences in the effect of Medicaid by whether children are present because of differences in household income and preferences. Stratification by age is motivated by the same considerations with respect to income and also because age is correlated with health, which is an important determinant of health insurance coverage.

Data on earnings from the 2013 American Community Survey show that the low-educated sample we selected is quite disadvantaged. For example, unmarried parents in our sample have mean earnings of approximately $17,000 and unmarried, childless adults have mean earnings of approximately $18,000. However, as a sensitivity analysis, we also select a sample of persons with incomes less than 300% of the federal poverty limit. We chose 300% because we wanted to limit the selection bias associated with selecting the sample using income while simultaneously selecting a group that was likely affected by the

[13] Further stratification by marital status and education was not empirically meaningful—we could not reject the equality of estimates by education group within marital status category.

Medicaid expansions. Because the monthly CPS files do not report income accurately, we do not use the low-income sample in analyses that use these data. Descriptive information in Table 2 reveals that the low-educated and low-income samples are quite similar with respect to the health insurance coverage and labor supply. We discuss this further below.

The ACS collects information on approximately three million people each year covering over 92% of the U.S. population in each year. The survey is conducted on a monthly basis throughout the year and combined into an annual file. The ACS collects information on health insurance coverage at the time of interview, employment at the time of interview, usual hours of work in last year (one year prior to survey), and demographic characteristics. Because the ACS is conducted on a monthly basis, we focus on the health insurance and current employment variables. Information on usual hours of work, which refers to the past year, will span the pre-expansion period, so we do not use this outcome.

The Annual Social and Economic Supplement to the Current Population Survey, i.e., the "March CPS" conducted in March of each year (supplemented with data from February and April since 2002) collects similar information to the ACS including health insurance. The survey is of the civilian, non-institutional population of the United States. We use the March CPS only for its information on health insurance because it is available for March 2015 whereas the ACS data are through 2014 and, as noted, the ACS is conducted continuously throughout the year. One disadvantage of the March CPS is that there was a change in the health insurance question in 2014 (Turner and Boudreaux 2014; Pascale 2015). The redesigned survey was intended to address the problem related to the recall period (current v. past year) that affected past CPS surveys.

The monthly CPS files are similar to the March CPS files except they do not collect information on many social and economic indicators. However, the labor supply variables are available and refer to the survey week. Therefore, we can use the hours of work information in the monthly CPS files. In addition, the monthly CPS data are available through May 2016.

To summarize, the dependent variables and data sources for our analyses are the following:

Health Insurance: Medicaid, private insurance, and uninsured. The information on health insurance is from the ACS and March CPS.[14] The ACS and CPS allow people to report more than one health insurance category and approximately 2% to 3% report having Medicaid and another type of insurance. Labor Supply: employed at time of interview, usual hours worked per week; and worked 30 or more hours per week (full time). The employed at time of interview information is from the ACS and monthly CPS. The usual hours per week and part-time status are from the monthly CPS.

The key independent variables for the analysis are the treatment group indicators listed in the previous section and Table 1. We estimate regression models using alternate definitions of Medicaid expansion states: one model defines treatment states as all those that expanded in 2014 regardless of whether they had a prior expansion, and the second model separates treatment states into two depending whether they had a prior expansion. For the second model, we test whether the coefficients on the treatment states indicators differ. Other independent variables included in the regression include dummy variables for each year of age; dummy variables for race/ethnicity (non-Hispanic white, non-Hispanic black, non-Hispanic other, and Hispanic), dummy variables for marital status (married, never married, and other), dummy variables for education (high school degree and less than high school degree), dummy variables for number of children (0, 1, 2, and 3 or more), and dummy variables for family size (1, 2, 3, 4 and 5 or more).

Descriptive statistics of the variables used in the analysis are presented in Table 2.[15] These statistics are based on data from 2010, the baseline period. The left panel presents means for the samples selected using education. In general, the low-educated samples drawn from the ACS and CPS are quite similar. Approximately one-third are uninsured; 55 percent to 60 percent are covered by private insurance; 11 percent are covered by Medicaid; two-thirds are employed at the time of interview; and

[14] We do not divide private health insurance into employer-sponsored and non-group because of well-known problems of data quality that make the distinction between types of private insurance particularly problematic (Call et al. 2012; Claxton et al. 2014; Pascale 2016). Our focus is also on labor supply and changes in Medicaid and uninsured are most relevant outcomes related to labor supply. However, estimates for models that divide the privately insured into those with and without employer sponsored insurance are available from the authors.
[15] These are unweighted estimates.

approximately 60 percent work full-time (>30 hours). The low-educated sample drawn from the March CPS is slightly younger, less likely to be white, and more likely to have a child under age 18 in the household than the ACS sample, although none of the differences are that marked. The right panel of Table 2 presents means for the samples selected using income. Here too the ACS and CPS samples are very similar, and notably, not too different from the low-educated samples, which confirms that selecting the sample using education is an effective way to identify a group likely affected by the Medicaid expansions. The low-income samples are slightly more likely to be uninsured (e.g., 36 percent) and slightly less likely to work (full time) than the low-educated samples. However, differences are not substantial.

3.b. Difference-in-differences Research Design

The ACA Medicaid expansions provide state by year variation in Medicaid eligibility that can be used to obtain estimates of the effect of Medicaid eligibility on health insurance coverage and labor supply. The expansions represent a source of plausibly exogenous variation in Medicaid eligibility, although clearly states chose whether to expand or not and, therefore, the exogeneity of the expansions needs to be assessed. Accordingly, we use a difference-in-differences (DiD) research design to obtain estimates of the effect of the expansions on health insurance and labor supply. The DiD design is a straightforward approach that is intended to mimic the pre- and post-test with comparison group design of a true experiment.

We have already described the classification of states into treatment and control groups. Given this classification, DiD estimates can be obtained using the following regression model:

$$HEALTHINS_{ijt} = \alpha_0 + \beta_j + \delta_t + \lambda(TREAT_j * Y2014_t) + X_{ijt}\Gamma + e_{ijt}$$

Equation (1) indicates that the health insurance coverage, for example, Medicaid, of person "i" in state "j" and year "t" depends on state fixed effects (β_j), year fixed effects (δ_t), an indicator of whether the state is in treated group and the year is 2014 ($TREAT_j * Y2014_t$), and demographic characteristics (X_{ijt}) such as age that were previously described. In equation (1), the dependent variable is health insurance, but

analogous models will be estimated using labor supply measures. In addition, for data that extend to 2015 or 2016, the interaction between the treated indicator and post-expansion period will include the additional years.

We also estimate a version of equation (1) that allows there to be two treatment groups: states that expanded Medicaid in 2014 and had no prior expansions and states that expanded Medicaid in 2014, but had some form of prior expansion. The model that allows for effects to differ by treatment group type is:

$$HEALTHINS_{ijt} = \alpha_0 + \beta_j + \delta_t + \lambda_1(TREAT\_NOPRIOR_j * Y2014_t) + \lambda_2(TREAT\_PRIOR_j * Y2014_t) + X_{ijt}\Gamma + e_{ijt}$$

In equation (2), there are two treatment indicators and two coefficients measuring the effect of Medicaid expansions in the different types of treatment states. We test whether $\lambda_1 = \lambda_2$ to assess whether the prior expansion of Medicaid resulted in different effects of the 2014 expansion.

The key assumption underlying the validity of the DiD approach is the parallel trends assumption—that in the absence of the ACA Medicaid expansions changes in health insurance and labor supply would be the same in treated and control states. To assess the likely validity of this assumption, we estimate a model, which we refer to as an event history specification, allowing for a complete set of interactions between the indicator of treatment status and years:

$$HEALTHINS_{ijt} = \alpha_0 + \beta_j + \delta_t + \sum_{k=2011}^{2014} \lambda_k (TREAT_j * YEAR_t) + X_{ijt}\Gamma + e_{ijt}$$

The only difference between equations (1) and (3) is that the effect of treatment is allowed to differ for every year instead of just 2014 (2015 and 2016 too when relevant). The parallel trends assumption implies that the coefficients on the interaction terms between treatment and year (λ_k) would be zero in years prior to 2014. We test this hypothesis and report results below, but note here that the evidence from this analysis generally supports the validity of the research design.

3.b. Synthetic Control

A second approach to obtaining estimates of the effect of the Medicaid expansions on labor supply is the synthetic control approach proposed by Abadie et al. (2010). This approach uses a matching

procedure to create a synthetic comparison (control) group that is a weighted average of states that did not expand Medicaid. While technically not a DiD approach, the Abadie et al. (2010) approach is similar because the estimate of the effect of Medicaid is obtained by taking the difference in means between treated states and a weighted average of non-treated states. However, only the post-expansion difference is used to calculate the estimate because the approach assumes that pre-expansion differences between treated and non-treated states are zero. Indeed, the central feature of the Abadie et al. (2010) method is to select a comparison group in such a way as to minimize—reduce toward zero—the pre-expansion differences in means between treated states and the synthetic comparison group.

The key to the Abadie et al. (2010) approach is selecting the weights that are used to construct the synthetic comparison group, or counterfactual outcome. Abadie et al. (2010) suggest choosing weights that minimize differences between the pre-treatment mean outcome and covariates of treated and untreated observations.[16] The unit of observation in this approach is the state. The argument underlying this approach is that if the pre-treatment means of the treated and control states are equal, then the post-treatment difference is likely to represent a valid estimate of the policy. An advantage of the synthetic control approach is that the closeness of the match between the treated and control states can be assessed easily, for example, graphically, and the weight for each potential comparison state is provided.

There are a variety of ways to select weights that are used to construct the synthetic comparison group, for example, by minimizing the difference between each pre-period value of the dependent variable and covariates of treated and untreated states. Alternatives include using the average of pre-period outcomes to match on instead of each pre-period outcome, or to match on the average and only the last (first) pre-period outcome. We chose to match states using each pre-period value of the dependent variable and a select number of covariates (state means of age, proportion in race/ethnic categories and proportion with less than high school degree), but we also report estimates from an alternative approach that uses only the average value of pre-2014 dependent variable, the 2013 value and each pre-2014 value of select

[16] See Abadie et al. (2010) for details.

covariates.[17] Only states with positive weights are used to construct the synthetic control group. Notably, for our preferred method of matching, almost all (e.g., 25) potential control states had positive weights. For the alternative method, the number of states with positive weights was less fluctuating between 5 and 13 depending on the outcome and data set. Despite this difference, estimates from the two approaches were very similar.[18]

Once the weights are selected and the synthetic comparison group constructed, the estimate of the effect of the Medicaid expansion is derived by taking the difference between the mean outcome in the treated states (treated as one unit) and the mean outcome in the synthetic comparison group, which is just a weighted average of outcomes in the non-expanding states. Inferences for this estimate are derived from permutation tests (randomization inference) that consist of re-doing the analysis 1000 times, but each time using a randomly selected group of treatment states. After generating these 1000 "random" estimates, the p-value of the estimate of the effect of Medicaid expansion on labor supply is the fraction of "random" estimates that are larger in absolute value than the actual estimate for the true treated states.

4. Results

4.a. Estimates of the Effect of ACA Medicaid Expansions on Health Insurance Using American Community Survey 2010 to 2014

We begin the discussion of results with the effect of the Medicaid expansions on health insurance coverage, which is classified into three categories: Medicaid, uninsured, and private. Table 3 presents difference-in-differences estimates, which are derived from data from the ACS. The table is organized as follows. There are two panels that present results for parents (children under 18 in family)—the top panel—and childless adults (no children under 18 in family)—the bottom panel. Within each panel, estimates from two samples are shown: the low-educated sample and the low-income (<300 percent of

[17] See Kaul et al. (2015) for an analysis of the potential consequences of different approaches. We also used a third approach—matching on pre-2014 averages of dependent variable and select covariates. Estimates from this third approach were in all but a few cases similar to those from the other two approaches. Overall, the method of matching made little difference.

[18] For analyses that dropped states with prior expansions or because of late expansion dates, the number of potential control states was considerably less as was the number of state with positive weights.

federal poverty) sample. For each of the three health insurance outcomes—Medicaid, uninsured and private—estimates from two model specifications are presented in separate rows (top and bottom row). In one model (top row), we combine all states that expanded Medicaid in 2014 into one treatment group. In the second model (bottom row), we allow the effect of the Medicaid expansions to differ depending on whether the state had a prior expansion of some type. In addition, for the low-educated sample, we present estimates for each outcome and each sample (parents and childless adults) for observations further stratified by marital status.

Estimates in the top panel (parents) and top row of Table 3 indicate that the ACA Medicaid expansions were associated with an increase in Medicaid coverage, a decrease in the proportion uninsured, and a decrease in private insurance coverage. Estimates related to Medicaid and uninsured are always statistically significant. For the full ("All") low-educated sample of parents, the 2014 Medicaid expansions increased Medicaid coverage by 4 percentage points, or 24 percent of the 2010 mean of the proportion of uninsured. The expansion of Medicaid was associated with a 2.7 percentage point decline in uninsured and a 1.1 percentage point decline in private insurance. The decline in private insurance suggests some amount of crowd out of private for public insurance. For the sample of parents as a whole, approximately 25% of the increase in Medicaid may have come from private insurance. Estimates for the low-income sample are very similar to those for the low-educated sample, although slightly larger. The Medicaid expansion of 2014 was associated with a 4.6 percentage point (24 percent) increase in Medicaid; a 2.7 percentage point decrease in uninsured; and a 1.6 percentage point decrease in private insurance. These estimates suggest a slightly higher rate of crowd out (35 percent) of private for public insurance than in the low-educated sample.

Estimates in the bottom row of the top panel reveal that, among married parents, the effect of the 2014 Medicaid expansions did not differ significantly, or meaningfully, by whether a state had a prior Medicaid expansion. However, for not married parents, the effect of the 2014 expansion was noticeably, if not statistically, different by whether the state had a prior Medicaid expansion, which were mainly targeted at parents. Among the low-educated and unmarried group, the Medicaid expansion was associated with a

larger increase in Medicaid (5.6 percentage points v. 3.5 percentage points) and larger decrease in uninsured (4.9 percentage points v. 1.5 percentage points) in states that had no prior expansion than in states with a prior expansion. The substitution of private for public coverage appears to have occurred mostly among the not married, parent sample in states that had previously expanded Medicaid; for this group of parents, the 2014 Medicaid expansion was associated with a 3.5 percentage increase in Medicaid and a 2.4 percentage point decrease in private insurance suggesting a crowd out rate of 69 percent. Estimates in the bottom row of the top panel pertaining to the low-income sample also suggest that the effect of the 2014 expansion was larger in states that had no prior expansion, and that crowd out of private insurance was slightly greater in the prior expansion states.

In the bottom panel of Table 3, estimates of the effect of the 2014 expansions on childless adults are presented. Here too estimates indicate that the 2014 expansions were associated with an increase in Medicaid coverage (53 percent) and decrease in uninsured (11 percent), but in this case, there is little change in private insurance. However, there are substantial differences by marital status within the low-educated sample with effect sizes larger in absolute value for the not married group. Among the low-educated, married childless adults, the 2014 Medicaid expansions were associated with a 2.4 percentage point (63 percent) increase in Medicaid coverage and a 2.2 percentage point (11 percent) decrease in uninsured. For the not married group of childless adults, the 2014 expansion is associated with a 5.2 percentage point (48 percent) increase in Medicaid and a 4.4 percentage point (10 percent) decrease in uninsured. As estimates in the bottom row on the bottom panel indicate, the effect of the 2014 expansions on health insurance coverage of childless adults did not differ significantly by whether the state had a prior expansion, which is consistent with the fact that most prior expansions were targeted at parents. Estimates for the low-income sample are similar, but again, slightly larger than the corresponding estimates for the low-educated sample. Among low-income, childless adults, the 2014 Medicaid expansions were associated with a 6.3 percentage point (66 percent) increase in Medicaid; a 4.8 percentage point (12 percent) decrease in uninsured; and a 1.3 percentage point decrease in private

insurance. As with the low-educated sample, there is little evidence that the effect of the expansion differed by whether a state had a prior expansion.

As previously noted, the validity of the difference-in-differences estimates in Table 3 depends on the parallel trends assumption that in the absence of the Medicaid expansions changes in health insurance coverage would be the same in treated and control states. To assess the likely validity of this assumption, we re-estimated the models that produced the estimates in Table 3, but allowed the treatment indicator to differ by every year instead of just pre- and post-2014. We refer to estimates from these analyses as event history estimates. The parallel trends assumption implies that all pre-2014 interactions between the treatment indicator and the year dummy variables are zero.

Appendix Table 1 presents the event history estimates. While estimates are not all independent, there are 72 different estimates in Appendix Table 1 that are relevant—pertaining to coefficients on the interaction between treatment indicator and pre-2014 dummy variables. Only 7 of the 72 estimates are statistically different from zero. Even when estimates are different from zero, they are much smaller than the estimates associated with the 2014 interaction. Overall, the event history estimates support the validity of the DiD approach. Given this finding, it is reasonable to interpret the estimates in Table 3 as causal effects of the 2014 Medicaid expansions.

We also obtained estimates of the effect of the Medicaid expansions on health insurance coverage using a synthetic control approach. While not a difference-in-differences approach, the synthetic control approach is similar. In this case, the control states are chosen on the basis of a statistical, matching procedure instead of simply using all non-expansion states as controls, as in the difference-in-differences design. Figures 1 through 12 provide graphical evidence of the validity of the synthetic control approach. In all figures, the pre-2014 trend in each measure of health insurance is very similar—almost identical—between the treated states and synthetic control group of states.

In Table 4, we present estimates obtained using the synthetic control approach. For comparison, we also show the analogous difference-in-differences estimates from Table 3 in Table 4. Note that p-values for the synthetic control estimates are provided in brackets in Table 4 because the randomization inference

approach produces only p-values. Overall, synthetic control estimates are quite similar to difference-in-differences estimates. The only difference of note is that estimates from the synthetic control approach suggest less crowd out of private insurance. Despite this small difference, the similarity of the synthetic control and difference-in-differences estimates bolsters the case for interpreting the estimates as causal.[19] We also conducted analyses for samples stratified by age, which is a demographic factor related to income, and therefore likely eligibility, and other determinants of health insurance coverage such as health that could cause a different behavioral response. We report these results in Appendix Table 2 using the low-educated sample.[20] Estimates of the effect of the 2014 Medicaid expansions on health insurance coverage do not vary significantly or meaningfully by age. The expansions had a slightly larger effect on Medicaid coverage and the proportion uninsured among younger (ages 22 to 44), low-educated adults than older (ages 45 to 64), low-educated adults. The one notable difference by age is that there is more evidence that the Medicaid expansions resulted in a substantial amount of crowding out of private for public insurance among unmarried, parents between the ages of 45 and 64. For this group, the Medicaid expansions had virtually no effect on the proportion uninsured—the increase in Medicaid coverage was almost fully (84 percent) offset by a decrease in private coverage.

Finally, using the low-educated sample, we re-estimated all models dropping the nine control states that had prior expansions (DE, DC, MA, NY, VT, IN, ME, TN and WI) and the two treatment states that expanded late (NH and MI). We report both difference-in-differences and synthetic control estimates in Appendix Table 3 along with corresponding estimates from Tables 3 and 4 for comparison.[21] Estimates in Appendix Table 3 are quite similar quantitatively to the corresponding estimates in Tables 3 and 4, and

[19] We also estimated synthetic control models using a different approach to select weights for constructing the control group. Specifically, we used the average value of health insurance between 2010 and 2013 and the 2013 value instead of each individual value. Estimates from this alternative (not reported) were virtually identical to those reported in Table 4.

[20] Estimates by age are available upon request for the low-income sample. These are very similar to those reported for low-educated sample, which is unsurprising given the similarity of estimates between the two samples in Table 3 and 4.

[21] Appendix Figures A1 through A6 show that the synthetic control approach of Appendix Table 3 is valid as illustrated by the closeness of the pre-2014 trends in outcomes between the treated and synthetic control groups.

there are virtually no qualitative differences between estimates in Appendix Table 3 and estimates in Tables 3 and 4.

4.b. Estimates of the Effect of ACA Medicaid Expansions on Health Insurance Using March Current Population Survey 2010 to 2015

In addition to using the ACS, we obtained estimates of the effect of the 2014 Medicaid expansions on health insurance coverage using the March CPS from 2010 to 2015. One possible advantage of the March CPS is that it reports data as of March 2015 whereas the ACS collects information throughout the year and the last year is 2014. Thus, there is a longer post-expansion period in the March CPS than the ACS. The disadvantage of the March CPS is the change in the survey design related to health insurance in 2014. We do not take a position on which is the preferred data source because it is unclear whether one if preferable to the other. To present the evidence in an easily digestible form and one that facilitates comparing estimates from the ACS and March CPS estimates, we calculated the effect of the 2014 Medicaid expansions as the percentage change in health insurance coverage from the 2010 baseline. These results are reported in Table 5 and the full set of underlying estimates obtained using the March CPS are reported in Appendix Table 4.

Overall, estimates of the effect of Medicaid expansions on health insurance coverage from the March CPS are largely consistent with corresponding estimates obtained using the ACS, as the results in Table 5 illustrate. The main difference is that the estimates from the CPS indicate larger increases in Medicaid and larger decreases in uninsured. For example, among low-educated, parents, the 2014 Medicaid expansion was associated with a 6.5 percentage point (43 percent) increase in Medicaid in the CPS. The analogous estimates from the ACS were 4.0 percentage points (24 percent). For uninsured, CPS estimates indicate a 4.0 percentage point (13 percent) decrease where ACS estimates indicated 2.7 percentage point (9 percent) decrease. Estimates from the CPS also show that results are similar whether a low-educated or low-income sample is used. As with the ACS, estimates of the effect of the Medicaid expansions on Medicaid coverage and uninsured tend to be larger for the low-income sample than from the low-educated sample.

We also conducted a similar set of analyses using the March CPS as we did for the ACS: event history analysis assessing validity of the difference-in-differences research design; an analysis that used the synthetic control approach; and an analysis that stratified by age. With respect to the event history analysis (see Appendix Table 5), only 3 of 72 estimates associated with the interaction between the treatment indicator and pre-2014 dummy variables were significant. This provides considerable evidence that the DiD design is valid and results are plausibly interpreted as causal. Appendix Table 6 and Appendix Figures 7 through 18 present synthetic control estimates of the effect of Medicaid on health insurance using the March CPS. As was the case for the ACS, there is strong consistency between the DiD and synthetic control estimates further bolstering the case that our estimates be interpreted as causal. Appendix Figures 7 through 12 also illustrate the close match between the treated and synthetic control states and the likely validity of the synthetic control approach. Finally, Appendix Table 7 shows estimates from samples stratified by age. Given the smaller sample sizes of the March CPS than the ACS, these estimates are less precisely estimated. However, as with the ACS, estimates indicate that the expansions had a slightly larger effect on Medicaid coverage and the proportion uninsured among younger (ages 22 to 44), low-educated adults than older (ages 45 to 64), low-educated adults. Finally, we re-estimated all models dropping the nine states with prior expansions and the two late expanding states. Estimates from this analysis are presented in Appendix Table 8 and are quite similar to those from analyses that include all states.

4.c. Summary of Estimates of the Effect of ACA Medicaid Expansions on Health Insurance

In summary, estimates in Tables 3 through 5 and Appendix Tables 1 through 8 indicate that the 2014 Medicaid expansions significantly increased Medicaid coverage and decreased the proportion of uninsured among low-educated/low-income persons. Table 5 presents a summary of results. The largest effect sizes were found childless adults. For this group, which was arguably the target group of the Medicaid expansions, the proportion of adults enrolled in Medicaid increased by approximately 51 percent to 70 percent depending on the sample and data source. Correspondingly, the proportion of low-educated/low-income, childless adults who were uninsured decreased by approximately 9 percent to 14

percent depending on the sample and data source. For low-educated/low-income parents, the increase in Medicaid resulting from the ACA expansions were approximately half the size as for childless adults, but the decrease in the proportion uninsured was approximately the same (in relative terms). There was limited, and not always consistent evidence of a modest amount of crowding out of private for public insurance coverage. The largest amount of crowd out was found for unmarried, parents in states that had prior Medicaid expansions. Finally, our estimates are consistent with other recent papers that have examined the effect of the Medicaid expansions on health insurance using different data sources, samples and methods (Courtemanche et al. 2016; Frean et al. 2016; Wherry and Miller 2016).

4.d. Estimates of the Effect of ACA Medicaid Expansions on Labor Supply—American Community Survey 2010 to 2014

As documented above, the ACA Medicaid expansions had a significant impact on health insurance coverage, which raises the possibility that people altered their labor supply to take advantage of the new Medicaid benefit. We assess this hypothesis first using data from the ACS and then using data from monthly CPS surveys.

Table 6 presents estimates of the effect of the 2014 Medicaid expansion on whether a person is employed at the time of the interview using data from the ACS. The table is organized in a similar way as previous tables, although we present both difference-in-differences (labeled DD) and synthetic control (labeled SC) estimates in the same table. The top panel of Table 6 shows estimates for parents and the bottom panel shows estimates for childless adults. Within each of these two groups, we show estimates from a sample of low-educated (HS or less) adults and from a sample of low-income (<300 percent of FPL) adults. We also present estimates from a sample stratified by marital status for the low-educated group.

Estimates in Table 6 are remarkably consistent. Almost all (28 out of 32) are small, for example, less than 0.5 percentage points (<1 percent of baseline mean). All but two estimates are statistically insignificant. Most estimates are positive. Overall, estimates in Table 6 suggest that, on average, the Medicaid expansions had virtually no effect on employment as of 2014. If anything, it appears that the Medicaid expansions are associated with an increase in employment, although, as noted, only one estimate (of 32)

is statistically significant. Further, if we use standard errors derived from the difference-in-difference analyses as a reference, for example, a value of 0.003, in most cases, we can reject effect sizes less than approximately -0.005. Thus, estimates rule out decreases in employment of 1 percent or more. Estimates in Table 6 are somewhat larger in relative terms based on the proportion of the sample that experienced a change in Medicaid, or uninsured. Against this benchmark, which is at best suggestive of the size of the potentially treated group and do not include those affected who did not have to switch coverage to benefit[22], estimates in Table 6 can rule out decreases in employment for those who changed coverage of approximately 10 percent to 15 percent (e.g., -0.005/0.05) or greater. We reiterate, however, that most estimates are positive suggesting an increase in employment.

We also assess the validity of the difference-in-differences estimates in Table 6 using the event history approach described earlier. Estimates from this analysis are in Appendix Table 9 and provide substantial support for the validity of the difference-in-differences analysis—only 2 of the 24 interactions between treatment and pre-2014 year indicators are statistically significant. Similarly, Appendix Figures 19 through 24 show that there is a close match between the pre-2014 trends in employment between the treated and synthetic control groups of states, which provides support for the validity of this approach.[23] Moreover, there is substantial agreement between estimates obtained from the two approaches. Finally, in Appendix Table 10, we report DD and SC estimates of the effect of Medicaid expansions on labor supply omitting the nine states with prior expansions and two states with late expansions. Results from these analyses are very similar to those reported in Table 6.

4.e. Estimates of the Effect of ACA Medicaid Expansions on Labor Supply—Monthly Current Population Survey January 2010 to May 2016

The final set of results is for the effect of Medicaid on labor supply using monthly CPS files. These data extend through May 2016, which is nearly 2.5 years after the initial implementation, and allow for the

[22] This includes those on Medicaid prior to expansion who were potentially able to increase labor supply and still remain eligible for Medicaid.

[23] Synthetic control estimates that use the alternative approach to constructing weights that uses the 2010 to 2013 average value of the dependent variable and the 2013 value are very similar to those reported in Table 6.

analysis of more measures of labor supply, specifically, usual hours worked per week and whether a person worked full-time, defined here using a threshold indicating greater than 30 hours per week. For these data, we do not use a sample of low-income persons because income is not well measured in these data. We also omit all states that expanded in 2015/2016 (i.e., AK, MT, IN and PA).

Table 7 presents difference-in-differences estimates of the effect of Medicaid on labor supply using the monthly CPS. The table is divided into two panels depending on whether we are analyzing parents (top panel) or childless adults (bottom panel). Within each panel, we show estimates for three outcomes (employment, usual hours of work, and >30 hours per work) for the full sample, and for samples stratified by marital status.

Estimates in the top panel of Table 7, which pertain to parents, are not statistically significant. Estimates related to married parents are small, negative and not statistically significant. Among unmarried parents, estimates are positive, relatively small (e.g., 2% of mean) and not statistically significant. In addition, there is no evidence that the effect of Medicaid expansions on labor supply of low-educated parents differed by whether a state had a prior expansion.

For the childless adult sample (bottom panel of Table 7), estimates indicate that the Medicaid expansions were associated with an increase in employment and the probability of working more than 30 hours per week. While estimates are only statistically significant for the sample of married, childless adults, the magnitudes of the estimates are very similar for the unmarried sample. Similarly, estimates are very similar for states with and without a prior expansion. In terms of magnitudes, estimates indicate that the Medicaid expansions were associated with a 1.2 percentage point (1.8 percent) increase in the probability of employment and a 1.0 percentage point (1.7 percent) increase in probability of being employed full-time among childless adults.

Evidence in Appendix Table 11, however, raises a note of caution. In this table, we report estimates from the event history specification assessing the validity of the difference-in-differences approach underlying the estimates in Table 7. In this case, and particularly for the sample of unmarried parents and childless adults, we observe a substantial number of significant coefficients on the interactions between the

treatment indicator and the pre-2014, year dummy variables. The significant estimates in Appendix Table 11 are of similar magnitude to the significant estimates in Table 7. Given this evidence, we conclude that the small, significant estimates in Table 7 pertaining to the childless adult sample may not be reliable. Synthetic control estimates, which are presented in Table 8, reinforce the last conclusion. For the childless adult sample, synthetic control estimates of the effect of Medicaid expansions on labor supply are in almost all cases quite small and not statistically significant. In addition, as Figures 13 through 18 suggest, there is a close match (identical) between the treated and synthetic comparison group in the pre-ACA period, which bolsters the credibility of the synthetic control estimates. Therefore, we believe it is reasonable to give greater weight to the synthetic control estimates than the DiD estimates, and this leads us to conclude that the Medicaid expansions had virtually no effect on labor supply of childless adults. Synthetic control estimates in Table 8 for the parent sample (top panel) are small and consistent with the DiD estimates of Table 7 suggesting that for this sample the Medicaid expansions had no significant effect on labor supply.

4.f. Summary of Estimates of the Effect of ACA Medicaid Expansions on Labor Supply

The large majority of estimates of the effect of Medicaid expansions on labor supply shown in Tables 6 through 8 were small (e.g., one percent in relative terms) and statistically insignificant. Most estimates were positive. Moreover, in the few cases when estimates were statistically significant, estimates remained small and corresponding estimates obtained using different methods and/or samples were at odds with these significant estimates. Given this evidence, it appears that the Medicaid expansions did not have a significant effect on labor supply in the two years subsequent to its implementation. Moreover, the small and relatively precise estimates rule out all but the smallest negative effects of the Medicaid expansions on labor supply.

5. Conclusions

The Affordable Care Act (ACA) became law in 2010 when the unemployment rate in the U.S. was just under 10% and at a 30-year high, and the economy was just coming out of the Great Recession. With this backdrop, it is understandable that the potential work disincentives of the ACA garnered

considerable public attention. Specifically, the expansion of Medicaid income eligibility thresholds and the formation of the health insurance marketplaces that provided income-based subsidies created incentives for people to alter their labor supply. Moreover, most of the incentives generated by the ACA were likely to reduce work effort.

In this paper, we examined whether the expansions in Medicaid affected labor supply of low-educated (a high school education or less) and low-income persons, which are groups likely to be affected by the expansions. We first measured the effect of the Medicaid expansions on health insurance coverage to assess the extent of the "treatment" engendered by the expansions. Estimates indicate that the Medicaid expansions increased the proportion of the sample covered by Medicaid and decreased the proportion uninsured by a similar, but slightly lower amount because of some switching between private insurance and Medicaid. There was some variation in effects by demographic groups with larger changes in Medicaid coverage and the proportion uninsured observed for unmarried, childless adults.

Specifically, for samples of parents, estimates indicated that the Medicaid expansions:

increased Medicaid coverage by between 23 percent and 54 percent depending on the data source, time period examined and whether the state had a prior Medicaid expansion;

decreased the proportion uninsured by between 8 percent and 13 percent depending on the data source, time period examined and whether the state had a prior Medicaid expansion;

and decreased private health insurance coverage by between 0 percent and 5 percent.

For samples of childless adults, estimates indicated that the Medicaid expansions:

increased Medicaid coverage by between 54 percent and 70 percent depending on the data source, time period examined and whether the state had a prior Medicaid expansion;

decreased the proportion uninsured by between 9 percent and 15 percent depending on the data source, time period examined and whether the state had a prior Medicaid expansion;

and decreased private health insurance coverage by between 1 percent and 5 percent.

Estimates of the effect of Medicaid on labor supply were, in general, small and not statistically significant. In fact, most estimates of the effect of the Medicaid expansions on labor supply were positive.

Overall, there was very little evidence that the Medicaid expansions decreased work effort. Moreover, confidence intervals associated with estimates rule out modest to large decreases in employment and hours of work in response to the Medicaid expansions. The absence of much of a labor supply response to the expansion of Medicaid is consistent with the broader literature on the income effect of labor supply, which found small elasticities of labor supply with respect to income (McClelland and Mok 2012). Overall, the Medicaid expansions have significantly expanded health insurance coverage and reduced the proportion of people uninsured without significant unintended consequences related to work effort.

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Table 1. Classification of States into Treatment and Control Groups as of 2014

Control Groups			
No Expansion in 2014 No Prior Expansion		No Expansion in 2014 Prior Limited Expansions for Parents and/or Childless Adults	Expansion in 2014 Prior Full Expansions for Parents and Childless Adults
Alabama	Nebraska	Indiana	Delaware
Alaska	North Carolina	Maine	Washington, D.C.
Florida	Oklahoma	Tennessee	Massachusetts
Georgia	Pennsylvania	Wisconsin	New York
Idaho	South Carolina		Vermont
Kansas	South Dakota		
Louisiana	Texas		
Mississippi	Utah		
Missouri	Virginia		
Montana	Wyoming		

Treatment Groups	
Expansion 2014 No Prior Expansion	Expansion 2014 Prior Expansions for Parents and/or Childless Adults
Arkansas	Arizona
Kentucky	California
Michigan	Connecticut
Nevada	Colorado
New Hampshire	Hawaii
New Mexico	Illinois
North Dakota	Iowa
Ohio	Maryland
West Virginia	Minnesota
	New Jersey
	Oregon
	Rhode Island
	Washington

Table 2. Descriptive Statistics for 2010 from American Community Survey and Current Population Survey

	Low-educated Sample (HS or less)			Low-income Sample (<300% FPL)	
	ACS	Monthly CPS	March CPS	ACS	March CPS
Medicaid	0.11	N/A	0.11	0.14	0.13
Uninsured	0.30	N/A	0.32	0.34	0.36
Private Insured	0.60	N/A	0.56	0.52	0.49
- Non-Group Private Insurance	0.08	N/A	0.05	0.10	0.08
- Employer-Sponsored Insurance	0.52	N/A	0.51	0.43	0.42
Employed at Time of Survey	0.69	0.67	0.69	0.65	0.64
Usual Hours Worked per Week	27.3	26.3	27.3	24.3	24.3
	(20.5)	(20.6)	(20.2)	(20.3)	(20.3)
Full-Time	0.61	0.60	0.62	0.54	0.55
Age	43.9	43.2	41.8	40.7	39.3
	(12.0)	(12.02)	(11.6)	(12.2)	(11.5)
Male	0.52	0.51	0.51	0.46	0.45
Non-Hispanic White	0.62	0.62	0.52	0.59	0.51
Non-Hispanic Black	0.11	0.12	0.12	0.13	0.14
Hispanic	0.21	0.21	0.27	0.21	0.26
Other Race	0.06	0.06	0.07	0.08	0.08
Married	0.60	0.58	0.60	0.49	0.51
Divorced or Separated	0.16	0.15	0.14	0.19	0.17
Never Married	0.22	0.24	0.23	0.30	0.30
Widowed	0.02	0.02	0.02	0.02	0.21
Foreign Born	0.22	0.20	0.26	0.26	0.26
U.S. Citizenship	0.86	0.86	0.82	0.86	0.82
High School Educated	0.73	0.76	0.73	0.33	0.36
Has Children under age 18	0.35	0.37	0.46	0.43	0.53
Number of Children	0.92	0.71	0.90	1.08	1.11
	(1.22)	(1.12)	(1.20)	(1.33)	(1.31)
Family Size	3.09	3.32	3.14	3.07	3.15
	(1.80)	(1.75)	(1.70)	(1.92)	(1.82)
Observations	529,509	321,171	39,386	601,629	42,884

Notes: All data are from the 2010 American Community Survey, Current Population Survey March Supplement, and Current Population Survey monthly files. The sample in columns 1-3 is limited to non-disabled adults between ages 22-64 with a high school degree or less. The sample in the columns 4-5 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. Standard deviations for continuous variables are presented in parentheses.

Table 3. Difference-in-differences Estimates of Effect of ACA Medicaid Expansions on Health Insurance
American Community Survey 2010-2014

	Low-educated Sample (HS or less)									Low-income Sample (<300% FPL)		
	Medicaid			Uninsured			Private			Medicaid	Uninsured	Private
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried	All	All	All
Expand in 2014	0.040**	0.039**	0.041**	-0.027**	-0.027**	-0.024**	-0.011	-0.009	-0.019**	0.046**	-0.027**	-0.016**
	(0.008)	(0.009)	(0.009)	(0.011)	(0.012)	(0.011)	(0.007)	(0.008)	(0.006)	(0.009)	(0.010)	(0.007)
Expand in 2014, no prior policy	0.045**	0.040**	0.056**	-0.029**	-0.023	-0.049**	-0.011	-0.012	-0.008	0.051**	-0.033**	-0.014
	(0.013)	(0.013)	(0.018)	(0.013)	(0.012)	(0.019)	(0.009)	(0.009)	(0.011)	(0.015)	(0.015)	(0.009)
Expand in 2014, any prior policy	0.039**	0.039**	0.035**	-0.026	-0.029	-0.015	-0.011	-0.007	-0.024**	0.044**	-0.024	-0.017**
	(0.010)	(0.011)	(0.010)	(0.014)	(0.015)	(0.012)	(0.008)	(0.009)	(0.006)	(0.010)	(0.013)	(0.008)
p-value for test of difference between treatment effects	0.712	0.953	0.283	0.845	0.733	0.103	0.972	0.549	0.153	<0.001	0.032	0.083
Observations	857486	655254	202232	857486	655254	202232	857486	655254	202232	1257844	1257844	1257844
Mean of Dep. Var. in 2010	0.168	0.129	0.303	0.288	0.269	0.355	0.560	0.620	0.355	0.190	0.281	0.550
Panel B: Childless Adults												
Expand in 2014	0.039**	0.024**	0.052**	-0.034**	-0.022	-0.044**	-0.003	-0.001	-0.007	0.063**	-0.048**	-0.013
	(0.007)	(0.007)	(0.007)	(0.009)	(0.011)	(0.007)	(0.006)	(0.007)	(0.006)	(0.008)	(0.008)	(0.007)
Expand in 2014, no prior policy	0.035**	0.019**	0.052**	-0.028**	-0.012	-0.046**	-0.006	-0.006	-0.005	0.057**	-0.044**	-0.009
	(0.009)	(0.008)	(0.010)	(0.007)	(0.007)	(0.008)	(0.006)	(0.005)	(0.008)	(0.012)	(0.009)	(0.009)
Expand in 2014, any prior policy	0.040**	0.026**	0.052**	-0.037**	-0.026	-0.043**	-0.002	0.001	-0.007	0.066**	-0.050**	-0.014
	(0.008)	(0.008)	(0.009)	(0.012)	(0.014)	(0.009)	(0.006)	(0.008)	(0.006)	(0.009)	(0.009)	(0.008)
p-value for test of difference between treatment effects	0.637	0.488	0.992	0.484	0.328	0.853	0.536	0.334	0.683	<0.001	<0.001	0.207
Observations	1718309	855016	863293	1718309	855016	863293	1718309	855016	863293	1766166	1766166	1766166
Mean of Dep. Var. in 2010	0.073	0.038	0.108	0.305	0.191	0.421	0.614	0.763	0.462	0.095	0.386	0.506

Notes: Data are from years 2010-2014 of the American Community Survey. Estimates above dashed lines report coefficients on the interaction term between an indicator for whether a state expanded Medicaid and an indicator for whether the year is 2014. Estimates below dashed lines report coefficients on these interaction terms but distinguish between states that had no prior Medicaid policy and those that had any prior policy (except for those that had ACA-like Medicaid expansions prior to 2014). The p-value is for F-tests measuring whether Medicaid expansion effects are statistically different between states that had prior policies and those that did not. The sample in columns 1-9 is limited to non-disabled adults between ages 22-64 with a high school degree or less. The sample in columns 10-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. All standard errors (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Table 4. Synthetic Control Estimates of Effect of ACA Medicaid Expansions on Health Insurance American Community Survey 2010-2014

	Low-educated Sample (HS or less)									Low-income Sample (<300% FPL)		
	Medicaid			Uninsured			Private			Medicaid	Uninsured	Private
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried	All	All	All
Indicator of Expand in 2014	0.046**	0.034**	0.067**	-0.035**	-0.032**	-0.038**	-0.006	-0.007	-0.013	0.044**	-0.035**	-0.011
[p-value]	[<0.001]	[0.003]	[0.004]	[0.004]	[0.003]	[0.021]	[0.417]	[0.367]	[0.235]	[0.003]	[0.007]	[0.123]
Difference-in-differences	0.040**	0.039**	0.041**	-0.027**	-0.027**	-0.024**	-0.011	-0.009	-0.019**	0.046**	-0.027**	-0.016**
Estimates (From Table 3)	(0.008)	(0.009)	(0.009)	(0.011)	(0.012)	(0.011)	(0.007)	(0.008)	(0.006)	(0.009)	(0.010)	(0.007)
Observations	857486	655254	202232	857486	655254	202232	857486	655254	202232	1257844	1257844	1257844
Mean of Dep. Var. in 2010	0.168	0.129	0.303	0.288	0.269	0.355	0.560	0.620	0.355	0.190	0.281	0.550
Panel B: Childless Adults												
Indicator of Expand in 2014	0.044**	0.021**	0.062**	-0.040**	-0.028**	-0.057**	0.002	0.003	-0.002	0.062**	-0.054**	-0.006
[p-value]	[0.001]	[0.006]	[<0.001]	[<0.001]	[0.034]	[<0.001]	[0.771]	[0.681]	[0.750]	[<0.001]	[<0.001]	[0.547]
Difference-in-differences	0.039**	0.024**	0.052**	-0.034**	-0.022	-0.044**	-0.003	-0.001	-0.007	0.063**	-0.048**	-0.013
Estimates (From Table 3)	(0.007)	(0.007)	(0.007)	(0.009)	(0.011)	(0.007)	(0.006)	(0.007)	(0.006)	(0.008)	(0.008)	(0.007)
Observations	1718309	855016	863293	1718309	855016	863293	1718309	855016	863293	1766166	1766166	1766166
Mean of Dep. Var. in 2010	0.073	0.038	0.108	0.305	0.191	0.421	0.614	0.763	0.462	0.095	0.386	0.506

Notes: Data are from years 2010-2014 of the American Community Survey. Estimates report the difference in the dependent variables in 2014 between treatment states and the synthetic control group. The sample in columns 1-9 is limited to non-disabled adults between ages 22-64 with a high school degree or less. The sample in columns 10-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. P-values of synthetic control estimates [in brackets] are obtained through randomization inference. All standard errors of differences-in-differences estimates (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Table 5. Difference-in-differences Estimates of Effect of ACA Medicaid Expansions on Health Insurance Relative Effects (Percentage Change from 2010) for American Community Survey and March Current Population Survey

	Low-educated Sample (HS or less)						Low-income Sample (<300% FPL)					
	Medicaid		Uninsured		Private		Medicaid		Uninsured		Private	
Panel A: Parents	ACS	CPS	ACS	CPS	ACS	CPS	ACS	CPS	ACS	CPS	ACS	CPS
Indicator of Expand in 2014	24**	43**	-9**	-13**	-2	-2	24**	40**	-10**	-12**	-3**	-4
Mean of Dep. Var. in 2010	0.17	0.15	0.29	0.31	0.56	0.54	0.19	0.17	0.28	0.31	0.55	0.52
Expand in 2014, no prior policy	28**	54**	-10**	-13**	-2	-6	29**	53**	-12**	-13**	-2	-5**
Mean of Dep. Var. in 2010	0.16	0.14	0.29	0.30	0.57	0.56	0.17	0.15	0.28	0.31	0.56	0.54
Expand in 2014, any prior policy	23**	39**	-9	-13	-2	0	23**	35**	-8	-11	-3**	-3
Mean of Dep. Var. in 2010	0.17	0.16	0.30	0.32	0.55	0.53	0.19	0.18	0.29	0.32	0.54	0.52
Observations	857486	94079	857486	94079	857486	94079	1257844	123788	1257844	123788	1257844	123788
Panel B: Childless Adults												
Indicator of Expand in 2014	53**	63**	-11**	-12**	-1	1	66**	70**	-13**	-14**	-2	0
Mean of Dep. Var. in 2010	0.07	0.07	0.31	0.34	0.61	0.58	0.10	0.09	0.39	0.42	0.51	0.46
Expand in 2014, no prior policy	51**	56**	-9**	-11**	-1	1	62**	76**	-12**	-15**	-2	1
Mean of Dep. Var. in 2010	0.07	0.07	0.30	0.33	0.62	0.58	0.09	0.09	0.38	0.41	0.52	0.47
Expand in 2014, any prior policy	54**	64**	-12**	-13**	0	1	67**	65**	-13**	-14**	-3	0
Mean of Dep. Var. in 2010	0.07	0.07	0.31	0.34	0.61	0.57	0.10	0.10	0.39	0.42	0.50	0.46
Observations	1718309	114117	1718309	114117	1718309	114117	1766166	114727	1766166	114727	1766166	114727

Notes: Data are from years 2010-2014 of the American Community Survey and years 2010-2015 of the March CPS. Each value is the effect of the 2014 Medicaid expansion on the outcome expressed in percentage terms (estimate divided by 2010 mean). The sample in columns 1-6 is limited to non-disabled adults between ages 22-64 with a high school degree or less. The sample in columns 7-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. Estimates used to construct relative effects for ACS are in Table 3 and estimates for March CPS are in Appendix Table 4. (**) indicates significance at the 5 percent level.

Table 6. Difference-in-differences and Synthetic Control Estimates of Effect of ACA Medicaid Expansions on Labor Supply American Community Survey 2010-2014

	Low-educated Sample (HS or less)						Low-income Sample (<300% FPL)	
	Employed at Time of Survey						Employed at Time of Survey	
Panel A: Parents	All		Married		Unmarried		All	All
	DD	SC	DD	SC	DD	SC	DD	SC
Indicator of Expand in 2014	0.005	-0.003	0.003	0.013**	0.011	-0.005	0.004	-0.007
	(0.004)	[0.679]	(0.003)	[0.015]	(0.007)	[0.713]	(0.003)	[0.066]
Expand in 2014, no prior policy	0.002		0.001		0.003		0.002	
	(0.005)		(0.005)		(0.009)		(0.005)	
Expand in 2014, any prior policy	0.006		0.003		0.014		0.005**	
	(0.004)		(0.004)		(0.007)		(0.002)	
p-value for test of difference between treatment effects	0.507		0.731		0.288		0.128	
Observations	857486	857486	655254	655254	202232	202232	1257844	1257844
Mean of Dep. Var. in 2010	0.715	0.715	0.726	0.726	0.676	0.676	0.693	0.693
Panel B: Childless Adults								
Indicator of Expand in 2014	0.003	-0.002	0.003	-0.008	0.002	0.003	0.003	-0.0004
	(0.003)	[0.580]	(0.003)	[0.067]	(0.004)	[0.605]	(0.003)	[0.915]
Expand in 2014, no prior policy	0.002		0.0005		0.004		0.004	
	(0.006)		(0.006)		(0.006)		(0.004)	
Expand in 2014, any prior policy	0.003		0.004		0.002		0.003	
	(0.003)		(0.003)		(0.004)		(0.003)	
p-value for test of difference between treatment effects	0.910		0.525		0.685		0.462	
Observations	1718309	1718309	855016	855016	863293	863293	1766166	1766166
Mean of Dep. Var. in 2010	0.677	0.677	0.688	0.688	0.667	0.667	0.610	0.610

Notes: Data are from years 2010-2014 of the American Community Survey.. Estimates above dashed lines report the coefficient on the interaction term between an indicator for whether a state expands Medicaid and an indicator for whether the year is 2014. Estimates below dashed lines report coefficients on these interaction terms but distinguish between states that had no prior Medicaid policy and those that had any prior policy (except for those that had ACA-level Medicaid expansions prior to 2014). The p-value is for F-tests measuring whether Medicaid expansion effects are statistically different between states that had prior policies and those that did not. The sample used in columns 1-6 is limited to non-disabled adults between ages 22-64 with a high school degree or less. The sample used in columns 7-8 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. P-values of synthetic control estimates [in brackets] are obtained through randomization inference. All standard errors of differences-in-differences estimates (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Table 7. Difference-in-differences Estimates of Effect of ACA Medicaid Expansions on Labor Supply
Monthly Current Population Survey 2010-(May) 2016

	High School or Less								
	Employed at Time of Survey			Usual Hours Worked per Week			Full-Time		
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried
Indicator of Expand in 2014	0.001	-0.004	0.015	-0.039	-0.202	0.388	0.001	-0.003	0.012
	(0.005)	(0.005)	(0.008)	(0.222)	(0.234)	(0.356)	(0.005)	(0.006)	(0.009)
Expand in 2014, no prior policy	0.002	-0.004	0.016	-0.029	-0.227	0.388	-0.002	-0.007	0.008
	(0.009)	(0.010)	(0.011)	(0.431)	(0.502)	(0.514)	(0.010)	(0.011)	(0.014)
Expand in 2014, any prior policy	0.0002	-0.004	0.014	-0.043	-0.190	0.388	0.003	-0.001	0.013
	(0.004)	(0.005)	(0.008)	(0.200)	(0.208)	(0.370)	(0.005)	(0.006)	(0.009)
p-value for test of difference between treatment effects	0.817	0.980	0.873	0.974	0.941	>0.999	0.648	0.600	0.697
Observations	640572	459425	181147	640572	459425	181147	640572	459425	181147
Mean of Dep. Var. in 2010	0.685	0.706	0.627	27.1	28.3	23.9	0.615	0.639	0.548
Panel B: Childless Adults									
Indicator of Expand in 2014	0.012**	0.014**	0.012	0.426	0.446	0.459	0.010	0.012**	0.009
	(0.005)	(0.006)	(0.007)	(0.239)	(0.267)	(0.302)	(0.005)	(0.006)	(0.007)
Expand in 2014, no prior policy	0.012	0.017	0.007	0.378	0.585	0.215	0.007	0.012	0.003
	(0.009)	(0.008)	(0.011)	(0.377)	(0.352)	(0.478)	(0.008)	(0.007)	(0.011)
Expand in 2014, any prior policy	0.013**	0.012	0.014	0.455	0.358	0.596	0.012**	0.012	0.013
	(0.006)	(0.007)	(0.007)	(0.237)	(0.292)	(0.318)	(0.006)	(0.006)	(0.008)
p-value for test of difference between treatment effects	0.901	0.557	0.560	0.835	0.514	0.453	0.576	0.955	0.439
Observations	1141994	549419	592575	1141994	549419	592575	1141994	549419	592575
Mean of Dep. Var. in 2010	0.652	0.669	0.636	25.8	26.7	24.9	0.587	0.605	0.569

Notes: Data are from years 2010-2016 (May) of the Current Population Survey monthly files. Analysis excludes Alaska, Indiana, Montana and Pennsylvania due to expansions after 2014. Sample is limited to non-disabled adults between ages 22-64 with a high school degree or less. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. The p-value is for F-tests measuring whether Medicaid expansion effects are statistically different between states that had prior policies and those that did not. All standard errors (parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Table 8. Synthetic Control Estimates of Effect of ACA Medicaid Expansions on Labor Supply
Monthly Current Population Survey 2014-(May) 2016

	Low-educated Sample (HS or less)								
	Employed at Time of Survey			Usual Hours Worked per Week			Full-Time		
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried
Indicator of Expand in 2014	-0.009	-0.011	0.002	-0.121	-0.359	-0.301	-0.002	-0.004	-0.011
[p-value]	[0.285]	[0.206]	[0.885]	[0.728]	[0.335]	[0.621]	[0.853]	[0.618]	[0.489]
Difference-in-differences	0.001	-0.004	0.015	-0.039	-0.202	0.388	0.001	-0.003	0.012
Estimates (From Table 7)	(0.005)	(0.005)	(0.008)	(0.222)	(0.234)	(0.356)	(0.005)	(0.006)	(0.009)
Observations	640572	459425	181147	640572	459425	181147	640572	459425	181147
Mean of Dep. Var. in 2010	0.686	0.713	0.650	27.1	28.3	23.9	0.616	0.640	0.549
Panel B: Childless Adults									
Indicator of Expand in 2014	0.0005	0.001	-0.007	0.282	-0.412	0.081	0.002	-0.002	0.001
[p-value]	[0.963]	[0.924]	[0.562]	[0.547]	[0.404]	[0.886]	[0.859]	[0.856]	[0.940]
Difference-in-differences	0.012**	0.014**	0.012	0.426	0.446	0.459	0.010	0.012**	0.009
Estimates (From Table 7)	(0.005)	(0.006)	(0.007)	(0.239)	(0.267)	(0.302)	(0.005)	(0.006)	(0.007)
Observations	1141994	549419	592575	1141994	549419	592575	1141994	549419	592575
Mean of Dep. Var. in 2010	0.652	0.675	0.648	25.8	26.7	24.9	0.587	0.605	0.569

Notes: Data are from years 2010-2016 (May) of the Current Population Survey monthly files. Analysis excludes Alaska, Indiana, Montana and Pennsylvania due to expansions after 2014. The sample is limited to non-disabled adults between ages 22-64 with a high school degree or less. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. P-values of synthetic control estimates [in brackets] are obtained through randomization inference. All standard errors of differences-in-differences estimates (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 1. Event History Estimates of Effect of ACA Medicaid Expansions on Health Insurance American Community Survey 2010-2014

	Low-educated Sample (HS or less)									Low-income Sample (<300% FPL)		
	Medicaid			Uninsured			Private			Medicaid	Uninsured	Private
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried	All	All	All
Expand x Year 2014	0.040**	0.041**	0.035**	-0.026**	-0.030**	-0.013	-0.011	-0.007	-0.024**	0.048**	-0.027**	-0.017
	(0.010)	(0.011)	(0.010)	(0.012)	(0.014)	(0.012)	(0.009)	(0.009)	(0.008)	(0.010)	(0.012)	(0.009)
Expand x Year 2013	-0.0001	0.003	-0.013	0.004	-0.0002	0.020**	-0.002	-0.001	-0.005	0.004	0.001	-0.003
	(0.006)	(0.006)	(0.007)	(0.005)	(0.005)	(0.009)	(0.004)	(0.004)	(0.007)	(0.006)	(0.005)	(0.004)
Expand x Year 2012	0.001	0.002	-0.002	-0.002	-0.005	0.010	0.001	0.005	-0.010	0.001	-0.001	0.001
	(0.005)	(0.005)	(0.009)	(0.004)	(0.005)	(0.008)	(0.003)	(0.003)	(0.006)	(0.005)	(0.004)	(0.003)
Expand x Year 2011	-0.001	0.002	-0.012	-0.0001	-0.004	0.014	0.0001	0.002	-0.005	0.001	-0.001	-0.001
	(0.004)	(0.004)	(0.007)	(0.004)	(0.005)	(0.008)	(0.003)	(0.004)	(0.005)	(0.004)	(0.003)	(0.003)
p-value test of joint significance of pre-trend	0.870	0.948	0.037	0.374	0.391	0.136	0.765	0.275	0.493	0.779	0.868	0.634
Observations	857486	655254	202232	857486	655254	202232	857486	655254	202232	1257844	1257844	1257844
Mean of Dep. Var. in 2010	0.168	0.129	0.303	0.288	0.269	0.355	0.560	0.620	0.355	0.190	0.281	0.550
Panel B: Childless Adults												
Expand x Year 2014	0.039**	0.024**	0.052**	-0.037**	-0.022	-0.050**	-0.001	-0.001	-0.001	0.064**	-0.054**	-0.008
	(0.008)	(0.007)	(0.009)	(0.010)	(0.012)	(0.008)	(0.006)	(0.008)	(0.006)	(0.009)	(0.009)	(0.008)
Expand x Year 2013	0.002	0.001	0.001	-0.004	0.002	-0.008	0.001	-0.004	0.006	0.004	-0.006	0.002
	(0.003)	(0.002)	(0.005)	(0.004)	(0.004)	(0.006)	(0.003)	(0.004)	(0.004)	(0.004)	(0.005)	(0.003)
Expand x Year 2012	-0.001	-0.001	-0.002	-0.004	-0.002	-0.004	0.004	0.002	0.006	-0.001	-0.006	0.008**
	(0.003)	(0.002)	(0.004)	(0.003)	(0.003)	(0.005)	(0.002)	(0.003)	(0.003)	(0.003)	(0.003)	(0.003)
Expand x Year 2011	0.001	0.0005	0.001	-0.006**	-0.0001	-0.011**	0.005**	-0.0001	0.011**	0.002	-0.009**	0.008**
	(0.001)	(0.002)	(0.002)	(0.003)	(0.003)	(0.004)	(0.002)	(0.003)	(0.003)	(0.002)	(0.002)	(0.002)
p-value test of joint significance of pre-trend	0.303	0.420	0.566	0.156	0.505	0.035	0.060	0.212	0.010	0.092	0.007	0.001
Observations	1718309	855016	863293	1718309	855016	863293	1718309	855016	863293	1766166	1766166	1766166
Mean of Dep. Var. in 2010	0.073	0.038	0.108	0.305	0.191	0.421	0.614	0.763	0.462	0.095	0.386	0.506

Notes: Data are from years 2010-2014 of the American Community Survey.. Estimates report the coefficient on the interaction term between an indicator for whether a state expands Medicaid and year indicators. A p-value reports results from F-tests of joint significance from pre-2014 Medicaid expansion interaction terms. Sample used in columns 1-9 is limited to non-disabled adults between ages 22-64 with a high school degree or less. Sample used in columns 10-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. All standard errors (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 2. Difference-in-differences Estimates of Effect of ACA Medicaid Expansions on Health Insurance By Age
American Community Survey 2010-2014

	Low-educated Sample (HS or less)								
	Medicaid			Uninsured			Private		
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried
Age 22 to 44									
Expand in 2014	0.044**	0.044**	0.041**	-0.030**	-0.031**	-0.028**	-0.011	-0.009	-0.016**
	(0.008)	(0.008)	(0.010)	(0.010)	(0.012)	(0.011)	(0.007)	(0.009)	(0.006)
Observations	625684	461899	163785	625684	461899	163785	625684	461899	163785
Mean of Dep. Var. in 2010	0.186	0.141	0.324	0.315	0.297	0.367	0.518	0.582	0.325
Age 45 to 64									
Expand in 2014	0.030**	0.029**	0.037**	-0.018	-0.020	-0.008	-0.012	-0.008	-0.031**
	(0.010)	(0.011)	(0.010)	(0.014)	(0.015)	(0.013)	(0.008)	(0.009)	(0.012)
Observations	231802	193355	38447	231802	193355	38447	231802	193355	38447
Mean of Dep. Var. in 2010	0.118	0.099	0.215	0.214	0.197	0.306	0.680	0.717	0.487
Panel B: Childless Adults									
Age 22 to 44									
Expand in 2014	0.047**	0.036**	0.050**	-0.042**	-0.026**	-0.045**	-0.004	-0.009	-0.004
	(0.007)	(0.006)	(0.007)	(0.007)	(0.010)	(0.007)	(0.005)	(0.007)	(0.006)
Observations	594085	133989	460096	594085	133989	460096	594085	133989	460096
Mean of Dep. Var. in 2010	0.092	0.052	0.104	0.472	0.346	0.511	0.438	0.603	0.386
Age 45 to 64									
Expand in 2014	0.034**	0.022**	0.054**	-0.028**	-0.021	-0.041**	-0.004	0.001	-0.012
	(0.007)	(0.007)	(0.008)	(0.010)	(0.011)	(0.008)	(0.006)	(0.007)	(0.006)
Observations	1124224	721027	403197	1124224	721027	403197	1124224	721027	403197
Mean of Dep. Var. in 2010	0.062	0.035	0.113	0.214	0.159	0.315	0.710	0.795	0.552

Notes: Data are from years 2010-2014 of the American Community Survey. Estimates above dashed lines report the coefficient the interaction term between an indicator for whether a state expands Medicaid and an indicator for whether the year is 2014. Sample is limited to non-disabled adults between ages 22-64 with a high school degree or less. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. All standard errors (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 3. Comparison of Health Insurance Estimates With and Without Eleven States (Nine Prior Full Expansion or Limited Expansion Control States: DE, DC, MA, NY, VT, IN, ME, TN and WI, and Two Late Expansion Treatment States: MI and NH) American Community Survey

	Low-educated Sample (HS or less)									Low-income Sample (<300% FPL)		
	Medicaid			Uninsured			Private			Medicaid	Uninsured	Private
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried	All	All	All
Difference-in-differences	0.043**	0.043**	0.039**	-0.020	-0.020	-0.019	-0.021**	-0.019**	-0.025**	0.049**	-0.020	-0.026**
Estimates	(0.008)	(0.008)	(0.009)	(0.011)	(0.013)	(0.011)	(0.006)	(0.007)	(0.006)	(0.009)	(0.011)	(0.006)
Difference-in-differences	0.040**	0.039**	0.041**	-0.027**	-0.027**	-0.024**	-0.011	-0.009	-0.019**	0.046**	-0.027**	-0.016**
Estimates (From Table 3)	(0.008)	(0.009)	(0.009)	(0.011)	(0.012)	(0.011)	(0.007)	(0.008)	(0.006)	(0.009)	(0.010)	(0.007)
Synthetic Control	0.029	0.025	0.044	-0.040**	-0.031**	-0.020	-0.014	-0.007	-0.021	0.027	-0.062**	-0.021**
[p-value]	[0.073]	[0.085]	[0.079]	[0.002]	[0.023]	[0.247]	[0.068]	[0.407]	[0.085]	[0.097]	[<0.001]	[0.009]
Synthetic Control	0.046**	0.034**	0.067**	-0.035**	-0.032**	-0.038**	-0.006	-0.007	-0.013	0.044**	-0.035**	-0.011
[p-value] (From Table 4)	[<0.001]	[0.003]	[0.004]	[0.004]	[0.003]	[0.021]	[0.417]	[0.367]	[0.235]	[0.003]	[0.007]	[0.123]
Observations	703283	537870	165413	703283	537870	165413	703283	537870	165413	1035622	1035622	1035622
Mean of DV. In 2010	0.153	0.116	0.279	0.312	0.292	0.380	0.550	0.608	0.352	0.172	0.302	0.545
Panel B: Childless Adults												
Difference-in-differences	0.046**	0.030**	0.060**	-0.034**	-0.019	-0.045**	-0.011**	-0.009	-0.014**	0.075**	-0.049**	-0.023**
Estimates	(0.006)	(0.006)	(0.006)	(0.010)	(0.012)	(0.008)	(0.005)	(0.007)	(0.004)	(0.006)	(0.008)	(0.006)
Difference-in-differences	0.039**	0.024**	0.052**	-0.034**	-0.022	-0.044**	-0.003	-0.001	-0.007	0.063**	-0.048**	-0.013
Estimates (From Table 3)	(0.007)	(0.007)	(0.007)	(0.009)	(0.011)	(0.007)	(0.006)	(0.007)	(0.006)	(0.008)	(0.008)	(0.007)
Synthetic Control	0.042**	0.034**	0.065**	-0.041**	-0.028**	-0.060**	-0.006	-0.0002	-0.007	0.076**	-0.055**	-0.013
[p-value]	[0.002]	[0.003]	[0.001]	[<0.001]	[0.057]	[<0.001]	[0.325]	[0.966]	[0.316]	[<0.001]	[<0.001]	[0.127]
Synthetic Control	0.044**	0.021**	0.062**	-0.040**	-0.028**	-0.057**	0.002	0.003	-0.002	0.062**	-0.054**	-0.006
[p-value] (From Table 4)	[0.001]	[0.006]	[<0.001]	[<0.001]	[0.034]	[<0.001]	[0.771]	[0.681]	[0.750]	[<0.001]	[<0.001]	[0.547]
Observations	1375638	679664	695974	1375638	679664	695974	1375638	679664	695974	1435514	1435514	1435514
Mean of DV. In 2010	0.064	0.033	0.096	0.323	0.205	0.441	0.603	0.752	0.453	0.082	0.403	0.500

Notes: Data are from years 2010-2014 of the American Community Survey. Estimates report the difference in dependent variables in 2014 between treatment states and the synthetic control group. Sample used in columns 1-9 is limited to non-disabled adults between ages 22-64 with a high school degree or less. Sample used in columns 10-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. P-values of synthetic control estimates [in brackets] are obtained through randomization inference. (**) indicates significance at the 5 percent level.

Appendix Table 4. Difference-in-differences Estimates of Effect of ACA Medicaid Expansions on Health Insurance
March Current Population Survey 2010-2015

	Low-educated Sample (HS or less)									Low-income Sample (<300% FPL)		
	Medicaid			Uninsured			Private			Medicaid	Uninsured	Private
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried	All	All	All
Expand in 2014	0.065**	0.075**	0.043**	-0.040**	-0.038**	-0.050**	-0.011	-0.021	0.013	0.068**	-0.037**	-0.019
	(0.015)	(0.017)	(0.020)	(0.017)	(0.018)	(0.024)	(0.013)	(0.015)	(0.019)	(0.014)	(0.017)	(0.012)
Expand in 2014, no prior policy	0.074**	0.074**	0.074	-0.039**	-0.034**	-0.053	-0.031	-0.040**	-0.011	0.82**	-0.040**	-0.028**
	(0.021)	(0.021)	(0.037)	(0.017)	(0.014)	(0.044)	(0.017)	(0.018)	(0.029)	(0.020)	(0.017)	(0.010)
Expand in 2014, any prior policy	0.061**	0.075**	0.028	-0.041	-0.039	-0.049**	-0.002	-0.013	0.025	0.62**	-0.036**	-0.015
	(0.018)	(0.021)	(0.019)	(0.022)	(0.023)	(0.023)	(0.014)	(0.016)	(0.018)	(0.018)	(0.021)	(0.014)
p-value for test of difference between treatment effects	0.603	0.962	0.219	0.945	0.794	0.913	0.148	0.178	0.250	0.385	0.866	0.389
Observations	94079	68065	26014	94079	68065	26014	94079	68065	26014	123788	123788	123788
Mean of Dep. Var. in 2010	0.150	0.118	0.239	0.310	0.272	0.416	0.545	0.617	0.343	0.170	0.311	0.524
Panel B: Childless Adults												
Expand in 2014	0.045**	0.040**	0.049**	-0.041**	-0.033	-0.048**	0.006	0.007	0.004	0.065**	-0.060**	0.002
	(0.008)	(0.013)	(0.009)	(0.015)	(0.021)	(0.014)	(0.012)	(0.017)	(0.012)	(0.009)	(0.015)	(0.011)
Expand in 2014, no prior policy	0.039**	0.026	0.051**	-0.035**	-0.019	-0.053**	0.005	0.007	0.004	0.069**	-0.061**	0.004
	(0.011)	(0.013)	(0.015)	(0.015)	(0.019)	(0.018)	(0.018)	(0.023)	(0.011)	(0.013)	(0.019)	(0.011)
Expand in 2014, any prior policy	0.048**	0.046**	0.048**	-0.044**	-0.041	-0.045**	0.006	0.007	0.004	0.063**	-0.059**	0.001
	(0.009)	(0.014)	(0.009)	(0.020)	(0.026)	(0.018)	(0.016)	(0.020)	(0.015)	(0.012)	(0.020)	(0.014)
p-value for test of difference between treatment effects	0.516	0.163	0.851	0.713	0.459	0.738	0.957	0.990	0.972	0.716	0.965	0.824
Observations	114117	55253	58864	114117	55253	58864	114117	55253	58864	114727	114727	114727
Mean of Dep. Var. in 2010	0.071	0.058	0.084	0.337	0.217	0.451	0.575	0.712	0.445	0.094	0.422	0.460

Notes: Data are from years 2010-2015 of the March Current Population Survey. Estimates above dashed lines report the coefficient on the interaction term between an indicator for whether a state expands Medicaid and an indicator for whether the year is 2014. Estimates below dashed lines also report coefficients on these interaction terms but distinguish between states that had no prior Medicaid policy and those that had any prior policy (except for those that had ACA-level Medicaid expansions prior to 2014). A p-value reports results from F-tests measuring whether Medicaid expansion effects are statistically different between states that had prior policies and those that did not. Sample used in columns 1-9 is limited to non-disabled adults between ages 22-64 with a high school degree or less. Sample used in columns 10-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. All standard errors (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 5. Event History Estimates of Effect of ACA Medicaid Expansions on Health Insurance
March Current Population Survey 2010-2015

	Low-educated Sample (HS or less)									Low-income Sample (<300% FPL)		
	Medicaid			Uninsured			Private			Medicaid	Uninsured	Private
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried	All	All	All
Expand x Survey Year 2015	0.073**	0.088**	0.038	-0.043**	-0.037	-0.066**	-0.015	-0.030	0.029	0.078**	-0.044**	-0.018
	(0.018)	(0.019)	(0.023)	(0.021)	(0.023)	(0.025)	(0.016)	(0.019)	(0.022)	(0.018)	(0.019)	(0.014)
Expand x Survey Year 2014	0.030**	0.029	0.026	-0.007	-.003	-0.020	-0.013	-0.014	0.001	0.038**	-0.015	-0.003
	(0.014)	(0.017)	(0.017)	(0.018)	(0.023)	(0.022)	(0.013)	(0.016)	(0.024)	(0.014)	(0.015)	(0.013)
Expand x Survey Year 2013	0.010	0.020	-0.016	-0.019	-0.014	-0.037	0.007	-0.003	0.040**	0.010	-0.018	0.009
	(0.011)	(0.011)	(0.021)	(0.015)	(0.014)	(0.025)	(0.011)	(0.013)	(0.019)	(0.012)	(0.011)	(0.011)
Expand x Survey Year 2012	0.012	0.020	-0.011	0.007	0.009	0.0004	-0.018	-0.022	0.0002	0.011	-0.003	-0.007
	(0.009)	(0.010)	(0.019)	(0.010)	(0.011)	(0.019)	(0.010)	(0.012)	(0.020)	(0.010)	(0.008)	(0.010)
Expand x Survey Year 2011	-0.0003	0.004	-0.016	0.002	0.011	-0.025	0.002	-0.008	0.035	0.003	-0.003	0.003
	(0.008)	(0.009)	(0.015)	(0.009)	(0.012)	(0.017)	(0.010)	(0.013)	(0.021)	(0.009)	(0.010)	(0.011)
p-value test of joint significance of pre-2014 interactions	0.284	0.267	0.086	0.266	0.068	0.339	0.132	0.394	0.115	0.059	0.519	0.539
Observations	94079	68065	26014	94079	68065	26014	94079	68065	26014	123788	123788	123788
Mean of Dep. Var. in 2010	0.150	0.118	0.239	0.310	0.272	0.416	0.545	0.617	0.343	0.170	0.311	0.524
Panel B: Childless Adults												
Expand x Survey Year 2015	0.045**	0.035**	0.054**	-0.043**	-0.025	-0.060**	0.007	0.002	0.012	0.067**	-0.070**	0.008
	(0.011)	(0.014)	(0.012)	(0.015)	(.021)	(0.014)	(0.013)	(0.019)	(0.013)	(0.011)	(0.018)	(0.014)
Expand x Survey Year 2014	0.004	-0.003	0.011	-0.009	0.003	-0.023	0.006	-0.007	0.022	0.007	-0.019	0.012
	(0.011)	(0.011)	(0.014)	(0.010)	(0.015)	(0.013)	(0.011)	(0.017)	(0.016)	(0.010)	(0.015)	(0.014)
Expand x Survey Year 2013	0.002	-0.007	0.009	0.008	0.015	0.00003	-0.005	-0.005	-0.004	0.001	-0.001	0.001
	(0.008)	(0.009)	(0.011)	(0.011)	(0.014)	(0.014)	(0.010)	(0.013)	(0.014)	(0.008)	(0.014)	(0.012)
Expand x Survey Year 2012	-0.006	-0.010	-0.004	0.009	0.025	-0.007	-0.012	-0.023	-0.0002	-0.002	-0.008	0.002
	(0.006)	(0.009)	(0.008)	(0.012)	(0.013)	(0.016)	(0.011)	(0.012)	(0.016)	(0.007)	(0.013)	(0.001)
Expand x Survey Year 2011	0.004	-0.001	0.008	-0.019	-0.004	-0.034**	0.018	0.009	0.029	0.005	-0.024**	0.017
	(0.005)	(0.007)	(0.008)	(0.010)	(0.010)	(0.014)	(0.010)	(0.014)	(0.015)	(0.006)	(0.011)	(0.011)
p-value test of joint significance of pre-2014 interactions	0.190	0.838	0.111	0.098	0.298	0.026	0.050	0.139	0.038	0.754	0.082	0.335
Observations	114117	55253	58864	114117	55253	58864	114117	55253	58864	114727	114727	114727
Mean of Dep. Var. in 2010	0.071	0.058	0.084	0.337	0.217	0.451	0.575	0.712	0.445	0.094	0.422	0.460

Notes: Data are from years 2010-2015 of the March Current Population Survey. A p-value reports results from F-tests measuring whether Medicaid expansion effects are statistically different from 0 in pre-expansion periods. Sample used in columns 1-9 is limited to non-disabled adults between ages 22-64 with a high school degree or less. Sample used in columns 10-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. All standard errors (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 6. Synthetic Control Estimates of Effect of ACA Medicaid Expansions on Health Insurance
March Current Population Survey 2010-2015

	Low-educated Sample (HS or less)									Low-income Sample (<300% FPL)		
	Medicaid			Uninsured			Private			Medicaid	Uninsured	Private
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried	All	All	All
Indicator of Expand in 2014	0.061**	0.068**	0.049	-0.052**	-0.049	-0.045	0.003	-0.017	0.030	0.043	-0.041**	-0.011
[p-value]	[0.010]	[0.009]	[0.082]	[0.031]	[0.072]	[0.145]	[0.891]	[0.442]	[0.209]	[0.065]	[0.032]	[0.525]
Difference-in-differences	0.065**	0.075**	0.043**	-0.040**	-0.038**	-0.050**	-0.011	-0.021	0.013	0.068**	-0.037**	-0.019
Estimates (From A. Table 4)	(0.015)	(0.017)	(0.020)	(0.017)	(0.018)	(0.024)	(0.013)	(0.015)	(0.019)	(0.014)	(0.017)	(0.012)
Observations	94079	68065	26014	94079	68065	26014	94079	68065	26014	123788	123788	123788
Mean of Dep. Var. in 2010	0.150	0.118	0.239	0.310	0.272	0.416	0.545	0.617	0.343	0.170	0.311	0.524
Panel B: Childless Adults												
Indicator of Expand in 2014	0.043**	0.046**	0.042**	-0.032**	-0.031	-0.051**	0.020	0.002	0.016	0.067**	-0.047**	0.008
[p-value]	[0.003]	[0.035]	[0.010]	[0.043]	[0.074]	[0.007]	[0.202]	[0.915]	[0.290]	[<0.001]	[0.012]	[0.595]
Difference-in-differences	0.045**	0.040**	0.049**	-0.041**	-0.033	-0.048**	0.006	0.007	0.004	0.065**	-0.060**	0.002
Estimates (From A. Table 4)	(0.008)	(0.013)	(0.009)	(0.015)	(0.021)	(0.014)	(0.012)	(0.017)	(0.012)	(0.009)	(0.015)	(0.011)
Observations	114117	55253	58864	114117	55253	58864	114117	55253	58864	114117	114117	114117
Mean of Dep. Var. in 2010	0.071	0.058	0.084	0.337	0.217	0.451	0.575	0.712	0.445	0.094	0.422	0.460

Notes: Data are from years 2010-2015 of the March Current Population Survey. Estimates report the difference in dependent variables in survey year 2015 between treatment states and the synthetic control group. Sample used in columns 1-9 is limited to non-disabled adults between ages 22-64 with a high school degree or less. Sample used in columns 10-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. P-values of synthetic control estimates [in brackets] are obtained through randomization inference. All standard errors of differences-in-differences estimates (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 7. Difference-in-differences Estimates of Effect of ACA Medicaid Expansions on Health Insurance By Age
March Current Population Survey 2010-2015

	Low-educated Sample (HS or less)								
	Medicaid			Uninsured			Private		
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried
Age 22 to 44									
Expand in 2014	0.069**	0.081**	0.046**	-0.045**	-0.041**	-0.057**	-0.011	-0.024	0.018
	(0.016)	(0.017)	(0.021)	(0.017)	(0.017)	(0.025)	(0.013)	(0.014)	(0.018)
Observations	70818	49563	21255	70818	49563	21255	70818	49563	21255
Mean of Dep. Var. in 2010	0.166	0.130	0.258	0.334	0.260	0.429	0.506	0.582	0.316
Age 45 to 64									
Expand in 2014	0.056**	0.060**	0.036	-0.030	-0.032	-0.023	-0.011	-0.012	-0.007
	(0.016)	(0.019)	(0.032)	(0.023)	(0.026)	(0.031)	(0.025)	(0.025)	(0.043)
Observations	23261	18502	4759	23261	18502	4759	23261	18502	4759
Mean of Dep. Var. in 2010	0.101	0.087	0.156	0.236	0.206	0.357	0.664	0.716	0.461
Panel B: Childless Adults									
Age 22 to 44									
Expand in 2014	0.048**	0.054**	0.045**	-0.046**	-0.040	-0.046**	-0.002	-0.015	-0.0004
	(0.011)	(0.017)	(0.012)	(0.015)	(0.024)	(0.017)	(0.013)	(0.022)	(0.015)
Observations	45489	11214	34275	45489	11214	34275	45489	11214	34275
Mean of Dep. Var. in 2010	0.080	0.072	0.082	0.480	0.349	0.525	0.431	0.577	0.380
Age 45 to 64									
Expand in 2014	0.042**	0.035**	0.055**	-0.036**	-0.030	-0.049**	0.011	0.012	0.008
	(0.011)	(0.014)	(0.012)	(0.018)	(0.023)	(0.017)	(0.017)	(0.019)	(0.020)
Observations	68628	44039	24589	68628	44039	24589	68628	44039	24589
Mean of Dep. Var. in 2010	0.065	0.054	0.086	0.239	0.181	0.345	0.675	0.749	0.539

Notes: Data are from years 2010-2015 of the March Current Population Survey. Estimates above dashed lines report the coefficient on the interaction term between an indicator for whether state expands Medicaid and an indicator for whether the survey year is 2015. Sample is limited to non-disabled adults between ages 22-64 with a high school degree or less. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. All standard errors (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 8. Comparison of Health Insurance Estimates With and Without Eleven States (Nine Prior Full Expansion or Limited Expansion Control States: DE, DC, MA, NY, VT, IN, ME, TN and WI, and Two Late Expansion Treatment States: MI and NH) March Current Population Survey

	Low-educated Sample (HS or less)									Low-income Sample (<300% FPL)		
	Medicaid			Uninsured			Private			Medicaid	Uninsured	Private
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried	All	All	All
Difference-in-differences Estimates	0.054** (0.016)	0.067** (0.018)	0.027 (0.023)	-0.032 (0.020)	-0.027 (0.020)	-0.048 (0.029)	-0.010 (0.015)	-0.027 (0.016)	0.027 (0.020)	0.064** (0.015)	-0.027 (0.018)	-0.024 (0.013)
Difference-in-differences Estimates (From A. Table 4)	0.065** (0.015)	0.075** (0.017)	0.043** (0.020)	-0.040** (0.017)	-0.038** (0.018)	-0.050** (0.024)	-0.011 (0.013)	-0.021 (0.015)	0.013 (0.019)	0.068** (0.014)	-0.037** (0.017)	-0.019 (0.012)
Synthetic Control [p-value]	0.083** [0.005]	0.117** [0.001]	0.057 [0.099]	-0.040 [0.247]	-0.073** [0.039]	-0.149** [<0.001]	-0.016 [0.539]	-0.003 [0.899]	0.062 [0.073]	0.104** [<0.001]	-0.028 [0.238]	-0.042 [0.069]
Synthetic Control [p-value] (From A. Table 6)	0.061** [0.010]	0.068** [0.009]	0.049 [0.082]	-0.052** [0.031]	-0.049 [0.072]	-0.045 [0.145]	0.003 [0.891]	-0.017 [0.442]	0.030 [0.209]	0.043 [0.065]	-0.041** [0.032]	-0.011 [0.525]
Observations	73739	53599	20140	73739	53599	20140	73739	53599	20140	97741	97741	97741
Mean of DV. In 2010	0.130	0.103	0.206	0.340	0.300	0.453	0.532	0.601	0.338	0.145	0.338	0.520
Panel B: Childless Adults												
Difference-in-differences Estimates	0.052** (0.007)	0.049** (0.012)	0.054** (0.008)	-0.037** (0.017)	-0.030 (0.024)	-0.042** (0.015)	-0.001 (0.014)	-0.001 (0.019)	-0.002 (0.014)	0.069** (0.009)	-0.059** (0.016)	0.001 (0.012)
Difference-in-differences Estimates (From A. Table 4)	0.045** (0.008)	0.040** (0.013)	0.049** (0.009)	-0.041** (0.015)	-0.033 (0.021)	-0.048** (0.014)	0.006 (0.012)	0.007 (0.017)	0.004 (0.012)	0.065** (0.009)	-0.060** (0.015)	0.002 (0.011)
Synthetic Control [p-value]	0.061** [<0.001]	0.075** [0.005]	0.072** [<0.001]	-0.056** [0.002]	-0.057** [0.008]	-0.053** [0.045]	-0.006 [0.701]	0.002 [0.898]	0.005 [0.808]	0.078** [0.001]	-0.051 [0.059]	-0.004 [0.805]
Synthetic Control [p-value] (From A. Table 6)	0.043** [0.003]	0.046** [0.035]	0.042** [0.010]	-0.032** [0.043]	-0.031 [0.074]	-0.051** [0.007]	0.020 [0.202]	0.002 [0.915]	0.016 [0.290]	0.067** [<0.001]	-0.047** [0.012]	0.008 [0.595]
Observations	86576	42179	44397	86576	42179	44397	86576	42179	44397	88459	88459	88459
Mean of DV. In 2010	0.062	0.054	0.068	0.359	0.234	0.479	0.562	0.698	0.431	0.079	0.443	0.453

Notes: Data are from years 2010-2015 of the March Current Population Survey. Estimates report the difference in the dependent variables in survey year 2015 between treatment states and the synthetic control group. Sample used in columns 1-9 is limited to non-disabled adults between ages 22-64 with a high school degree or less. Sample used in columns 10-12 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. P-values of synthetic control estimates [in brackets] are obtained through randomization inference. (**) indicates significance at the 5 percent level.

Appendix Table 9. Event History Estimates of Effect of ACA Medicaid Expansions on Labor Supply
American Community Survey 2010-2014

	Low-educated Sample (HS or less)			Low-income Sample (<300% FPL)
		Employed at Time of Survey		Employed at Time of Survey
Panel A: Parents	All	Married	Unmarried	All
Expand x Year 2014	0.007	0.005	0.016	0.007
	(0.005)	(0.004)	(0.010)	(0.004)
Expand x Year 2013	0.006	0.006	0.008	0.006
	(0.003)	(0.003)	(0.008)	(0.003)
Expand x Year 2012	0.004	0.004	0.009	0.005
	(0.003)	(0.003)	(0.007)	(0.003)
Expand x Year 2011	-0.001	-0.002	0.005	0.001
	(0.003)	(0.003)	(0.007)	(0.003)
p-value test of joint significance of pre-trend	0.157	0.153	0.664	0.086
Observations	857486	655254	202232	1257844
Mean of Dep. Var. in 2010	0.715	0.726	0.676	0.693
Panel B: Childless Adults				
Expand x Year 2014	0.006	0.007	0.005	0.007
	(0.004)	(0.004)	(0.006)	(0.004)
Expand x Year 2013	0.007**	0.008**	0.007	0.006
	(0.004)	(0.004)	(0.005)	(0.003)
Expand x Year 2012	0.004	0.008**	0.001	0.005
	(0.003)	(0.003)	(0.005)	(0.003)
Expand x Year 2011	0.002	0.001	0.004	0.002
	(0.002)	(0.003)	(0.003)	(0.002)
p-value test of joint significance of pre-trend	0.214	0.002	0.245	0.251
Observations	1718309	855016	863293	1766166
Mean of Dep. Var. in 2010	0.677	0.688	0.667	0.610

Notes: Data are from years 2010-2014 of the American Community Survey. Estimates report the coefficient on the interaction term between an indicator for whether state expands Medicaid and year indicators. A p-value reports results from F-tests of joint significance from pre-2014 Medicaid expansion interaction terms. Sample used in columns 1-3 is limited to non-disabled adults between ages 22-64 with a high school degree or less. Sample used in column 4 is limited to non-disabled adults between ages 22-64 with family income below 300% of Federal Poverty Level. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. All standard errors (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 10. Comparison of Labor Supply Estimates With and Without Eleven States (Nine Prior Full Expansion or Limited Expansion Control States: DE, DC, MA, NY, VT, IN, ME, TN and WI, and Two Late Expansion Treatment States: MI and NH) American Community Survey

	Low-educated Sample (HS or less)			Low-income Sample (<300% FPL)
		Employed at Time of Survey		Employed at Time of Survey
Panel A: Parents	All	Married	Unmarried	All
Difference-in-differences Estimates	0.005 (0.004)	0.002 (0.004)	0.014 (0.008)	0.005 (0.003)
Difference-in-differences Estimates (From Table 6)	0.005 (0.004)	0.003 (0.003)	0.011 (0.007)	0.004 (0.003)
Synthetic Control: Expand in 2014 [p-value]	0.003 [0.532]	-0.001 [0.786]	0.001 [0.957]	0.008** [0.049]
Synthetic Control: Expand in 2014 [p-value] (From Table 6)	-0.003 [0.679]	0.013** [0.015]	-0.005 [0.713]	-0.007 [0.066]
Observations	703283	537870	165413	1035622
Mean of Dep. Var. in 2010	0.713	0.723	0.677	0.692
Panel B: Childless Adults				
Difference-in-differences Estimates	0.001 (0.003)	0.002 (0.003)	-0.001 (0.004)	0.002 (0.003)
Difference-in-differences Estimates (From Table 6)	0.003 (0.003)	0.003 (0.003)	0.002 (0.004)	0.003 (0.003)
Synthetic Control: Expand in 2014 [p-value]	-0.003 [0.470]	-0.007 [0.165]	-0.004 [0.384]	-0.008 [0.082]
Synthetic Control: Expand in 2014 [p-value] (From Table 6)	-0.002 [0.580]	-0.008 [0.067]	0.003 [0.605]	-0.0004 [0.915]
Observations	1375638	679664	695974	1435514
Mean of Dep. Var. in 2010	0.676	0.686	0.667	0.612

Notes: Data are from years 2010-2014 of the American Community Survey. Estimates report the difference in dependent variables in 2014 between treatment states and the synthetic control group. Sample used in columns 1-3 is limited to non-disabled adults between ages 22-64 with a high school degree or less. Sample used in column 4 is limited to non-disabled adults between ages 22-64 with

family income below 300% of Federal Poverty Level. P-values of synthetic control estimates [in brackets] are obtained through randomization inference. All standard errors of differences-in-differences estimates (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 11. Event History Estimates of Effect of ACA Medicaid Expansions on Labor Supply
Monthly Current Population Survey 2010-(May) 2016

	Low-educated Sample (HS or less)								
	Employed at Time of Survey			Usual Hours Worked per Week			Full-Time		
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried
Expand x Year 2016	-0.010	-0.013	-0.002	-0.270	-0.446	0.174	-0.006	-0.012	0.008
	(0.009)	(0.009)	(0.016)	(0.418)	(0.441)	(0.656)	(0.009)	(0.009)	(0.017)
Expand x Year 2015	0.004	-0.005	0.029**	0.103	-0.338	1.267**	0.008	-0.002	0.034**
	(0.007)	(0.008)	(0.013)	(0.342)	(0.368)	(0.580)	(0.007)	(0.008)	(0.014)
Expand x Year 2014	0.006	-0.006	0.042**	0.189	-0.260	1.414**	0.006	-0.007	0.042**
	(0.006)	(0.008)	(0.012)	(0.288)	(0.322)	(0.489)	(0.006)	(0.007)	(0.011)
Expand x Year 2013	0.006	0.001	0.021	0.256	-0.013	1.013	0.009	0.002	0.028**
	(0.007)	(0.009)	(0.011)	(0.320)	(0.371)	(0.510)	(0.007)	(0.008)	(0.013)
Expand x Year 2012	0.007	0.001	0.023	0.469	0.101	1.389**	0.012	0.001	0.040**
	(0.008)	(0.009)	(0.013)	(0.381)	(0.412)	(0.566)	(0.008)	(0.009)	(0.014)
Expand x Year 2011	-0.001	-0.008	0.018	0.051	-0.325	0.982**	0.001	-0.010	0.027**
	(0.006)	(0.007)	(0.011)	(0.292)	(0.317)	(0.431)	(0.007)	(0.007)	(0.011)
p-value test of joint significance of pre-2014 interactions	0.425	0.300	0.247	0.239	0.232	0.091	0.130	0.144	0.052
Observations	640572	459425	181147	640572	459425	181147	640572	459425	181147
Mean of Dep. Var. in 2010	0.685	0.706	0.627	27.1	28.3	23.9	0.615	0.639	0.548
Panel B: Childless Adults									
Expand x Year 2016	0.010	0.006	0.016	0.311	0.169	0.529	0.010	0.006	0.015
	(0.008)	(0.010)	(0.011)	(0.396)	(0.484)	(0.503)	(0.009)	(0.010)	(0.012)
Expand x Year 2015	0.011	0.012	0.014	0.295	0.239	0.504	0.009	0.008	0.014
	(0.008)	(0.008)	(0.011)	(0.350)	(0.381)	(0.454)	(0.008)	(0.008)	(0.011)
Expand x Year 2014	0.002	-0.010	0.016	-0.025	-0.401	0.469	0.001	-0.007	0.012
	(0.007)	(0.008)	(0.010)	(0.309)	(0.358)	(0.427)	(0.007)	(0.008)	(0.010)
Expand x Year 2013	-0.007	-0.017**	0.007	-0.360	-0.707**	0.134	-0.004	-0.014	0.008
	(0.006)	(0.008)	(0.009)	(0.254)	(0.337)	(0.370)	(0.006)	(0.007)	(0.009)
Expand x Year 2012	-0.012**	-0.024**	0.002	-0.509**	-0.892**	-0.042	-0.008	-0.019**	0.005
	(0.005)	(0.006)	(0.008)	(0.252)	(0.323)	(0.364)	(0.005)	(0.007)	(0.009)
Expand x Year 2011	-0.007	-0.018**	0.005	-0.363	-0.734**	0.033	-0.007	-0.017**	0.004
	(0.004)	(0.005)	(0.007)	(0.191)	(0.254)	(0.301)	(0.005)	(0.006)	(0.007)
p-value test of joint significance of pre-2014 interactions	0.182	0.001	0.766	0.204	0.028	0.939	0.422	0.017	0.828
Observations	1141994	549419	592575	1141994	549419	592575	1141994	549419	592575
Mean of Dep. Var. in 2010	0.652	0.669	0.636	25.8	26.7	24.9	0.587	0.605	0.569

Notes: Data are from years 2010-2016 (May) of the Current Population Survey monthly files. A p-value reports results from F-tests measuring whether Medicaid expansion effects are statistically different from 0 in pre-expansion periods. Analysis excludes Alaska, Indiana, Montana and Pennsylvania due to expansions after 2014. Sample limited to non-disabled adults between ages 22-64 with a high school degree or less. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. All standard errors (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Appendix Table 12. Comparison of Health Insurance Estimates With and Without Eleven States (Nine Prior Full Expansion or Limited Expansion Control States: DE, DC, MA, NY, VT, IN, ME, TN and WI, and Two Late Expansion Treatment States: MI and NH)
Monthly Current Population Survey

	Low-educated Sample (HS or less)								
	Medicaid			Uninsured			Private		
Panel A: Parents	All	Married	Unmarried	All	Married	Unmarried	All	Married	Unmarried
Difference-in-differences	0.001	-0.005	0.020**	-0.018	-0.227	0.562	0.002	-0.002	0.014
Estimates	(0.004)	(0.005)	(0.008)	(0.213)	(0.225)	(0.359)	(0.005)	(0.006)	(0.009)
Difference-in-differences	0.001	-0.004	0.015	-0.039	-0.202	0.388	0.001	-0.003	0.012
Estimates (From Table 7)	(0.005)	(0.005)	(0.008)	(0.222)	(0.234)	(0.356)	(0.005)	(0.006)	(0.009)
Synthetic Control	-0.0003	-0.013	0.011	0.245	-0.626**	-0.238	-0.004	-0.009	-0.014
[p-value]	[0.958]	[0.078]	[0.505]	[0.459]	[0.048]	[0.763]	[0.694]	[0.299]	[0.436]
Synthetic Control	-0.009	-0.011	0.002	-0.121	-0.359	-0.301	-0.002	-0.004	-0.011
[p-value] (From Table 8)	[0.285]	[0.206]	[0.885]	[0.728]	[0.335]	[0.621]	[0.853]	[0.618]	[0.489]
Observations	527338	381446	145892	527338	381446	145892	527338	381446	145892
Mean of DV. In 2010	0.693	0.709	0.653	27.7	28.8	25.0	0.628	0.649	0.573
Panel B: Childless Adults									
Difference-in-differences	0.013**	0.012	0.014	0.413	0.379	0.486	0.011	0.012	0.011
Estimates	(0.006)	(0.007)	(0.007)	(0.259)	(0.279)	(0.330)	(0.006)	(0.006)	(0.008)
Difference-in-differences	0.012**	0.014**	0.012	0.426	0.446	0.459	0.010	0.012**	0.009
Estimates (From Table 7)	(0.005)	(0.006)	(0.007)	(0.239)	(0.267)	(0.302)	(0.005)	(0.006)	(0.007)
Synthetic Control	0.002	-0.001	-0.013	0.072	-1.01**	0.023	0.001	0.010	-0.002
[p-value]	[0.861]	[0.942]	[0.280]	[0.882]	[0.030]	[0.957]	[0.932]	[0.298]	[0.814]
Synthetic Control	0.0005	0.001	-0.007	0.282	-0.412	0.081	0.002	-0.002	0.001
[p-value] (From Table 8)	[0.963]	[0.924]	[0.562]	[0.547]	[0.404]	[0.886]	[0.859]	[0.856]	[0.940]
Observations	901679	435294	466385	901679	435294	466385	901679	435294	466385
Mean of DV. In 2010	0.661	0.673	0.650	26.3	27.2	25.6	0.597	0.613	0.583

Notes: Data are from years 2010-2016 of the (May) Current Population Survey monthly files. Analysis excludes Alaska, Indiana, Montana and Pennsylvania due to expansions after 2014. Sample limited to non-disabled adults between ages 22-64 with a high school degree or less. Regressions are adjusted using indicators for state, year, age, sex, race, education levels, marital status, foreign-born status, citizenship status, number of children and family size. P-values of synthetic control estimates [in brackets] are obtained through randomization inference. All standard errors of differences-in-differences estimates (in parentheses) are clustered on state. (**) indicates significance at the 5 percent level.

Figure 1. Medicaid, Low-educated Parents (ACS)

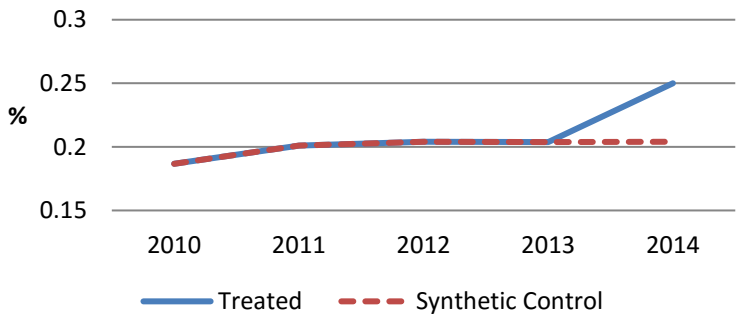


Figure 2. Uninsured, Low-educated Parents (ACS)

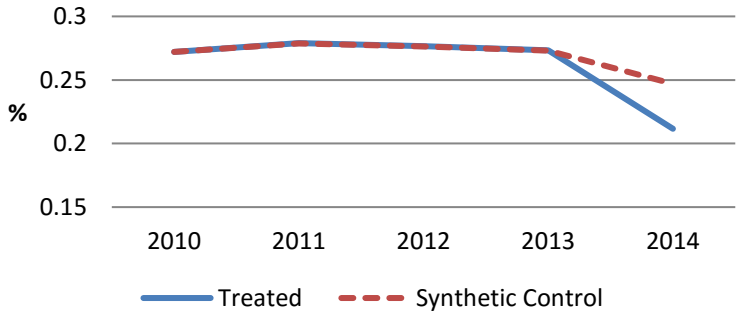


Figure 3. Private Insured, Low-educated Parents (ACS)

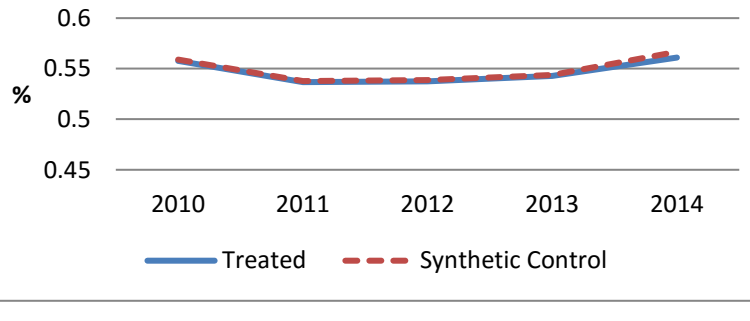


Figure 4. Medicaid, Low-educated Childless Adults (ACS)

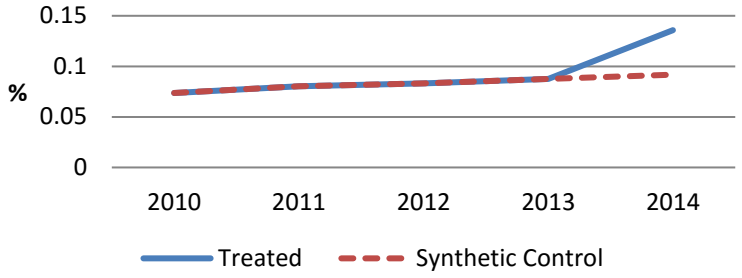


Figure 5. Uninsured, Low-educated Childless Adults (ACS)

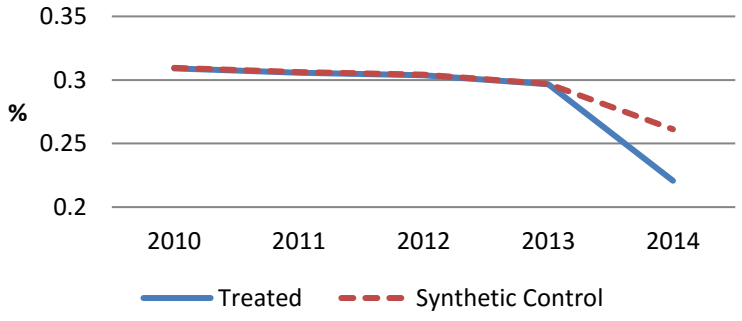


Figure 6. Private Insured, Low-educated Childless Adults (ACS)

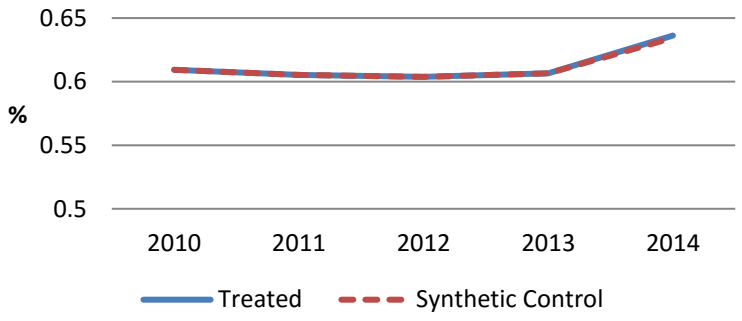


Figure 7. Medicaid, Low-income Parents (ACS)

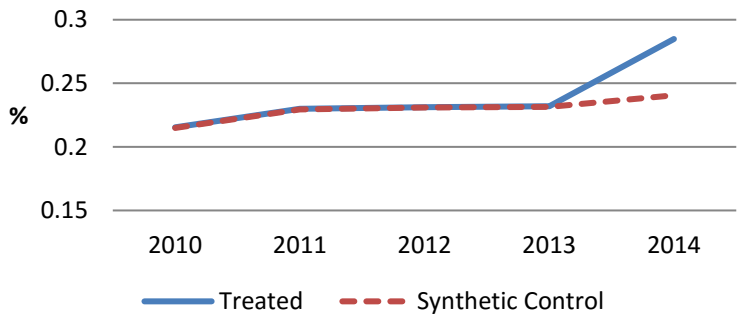


Figure 8. Uninsured, Low-income Parents (ACS)

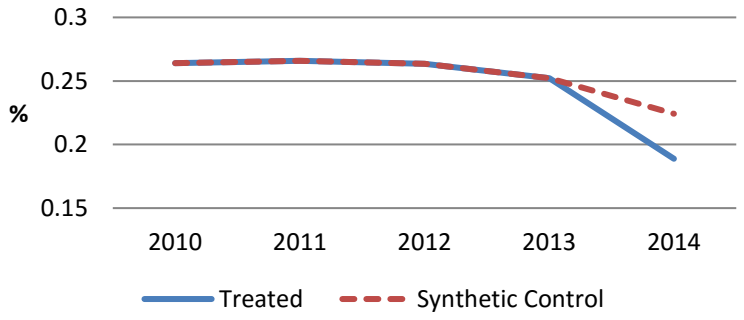


Figure 9. Private Insured, Low-income Parents (ACS)

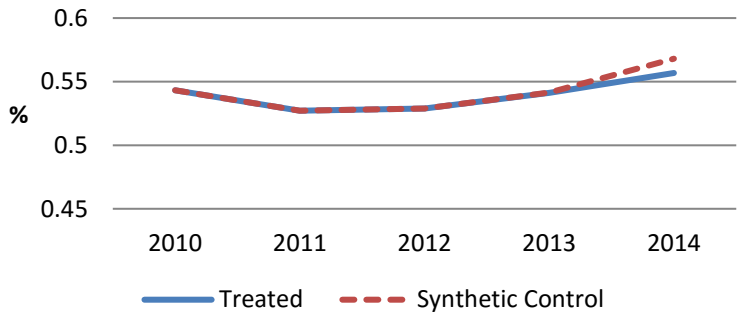


Figure 10. Medicaid, Low-income Childless Adults (ACS)

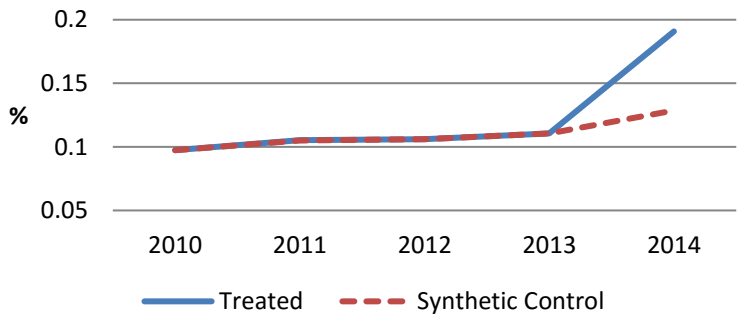


Figure 11. Uninsured, Low-income Childless Adults (ACS)

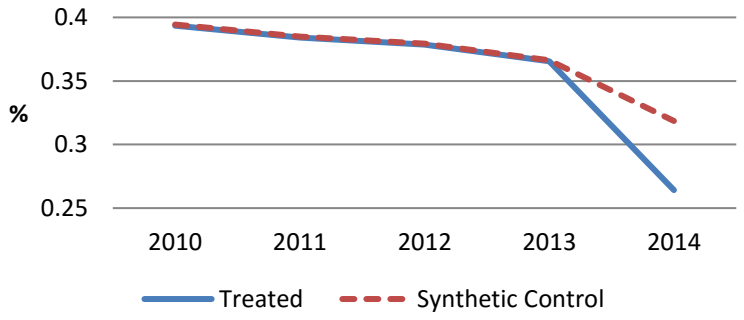


Figure 12. Private Insured, Low-income Childless Adults (ACS)

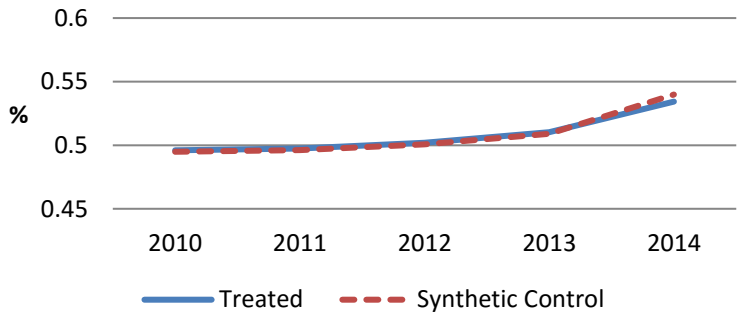


Figure 13. Employed, Low-educated Parents (Monthly CPS)

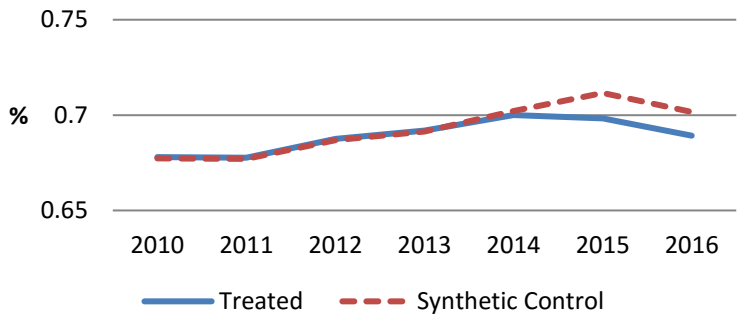


Figure 14. Usual Hours Worked per Week, Low-educated Parents (Monthly CPS)

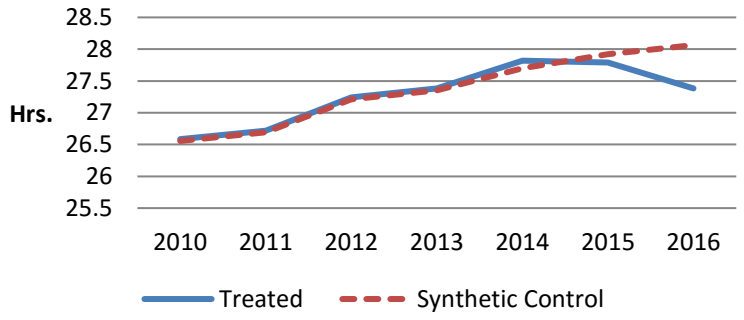


Figure 15. Full-Time, Low-educated Parents (Monthly CPS)

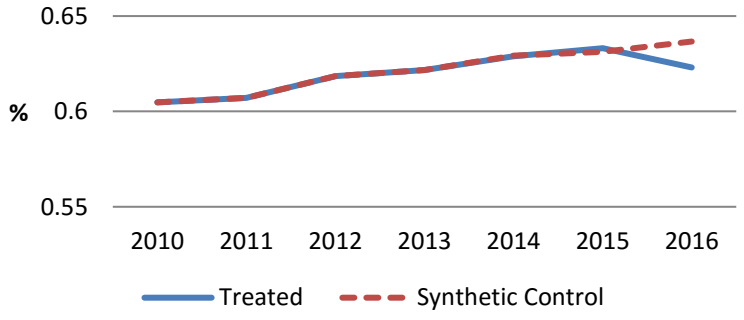


Figure 16. Employed, Low-educated Childless Adults (Monthly CPS)

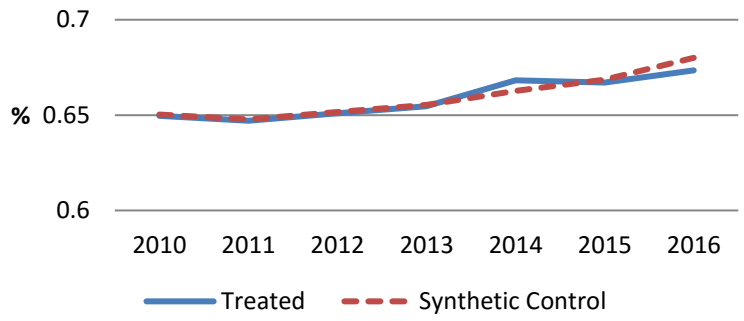


Figure 17. Usual Hours Worked per Week, Low-educated Childless Adults (Monthly CPS)

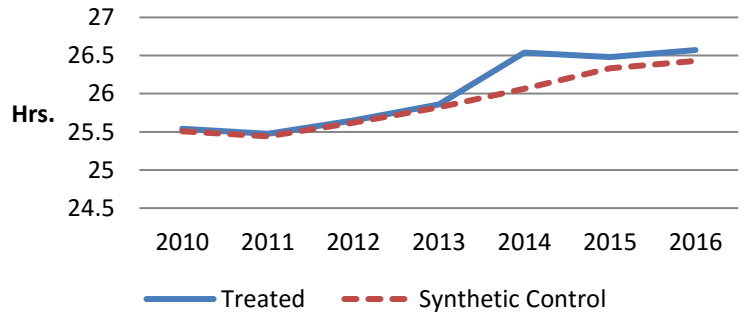


Figure 18. Full-Time, Low-educated Childless Adults (Monthly CPS)

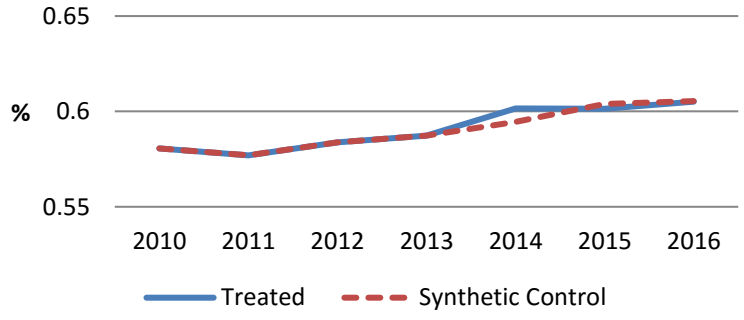


Figure A1. Medicaid, Low-educated Parents (ACS, Excluding 11 States)

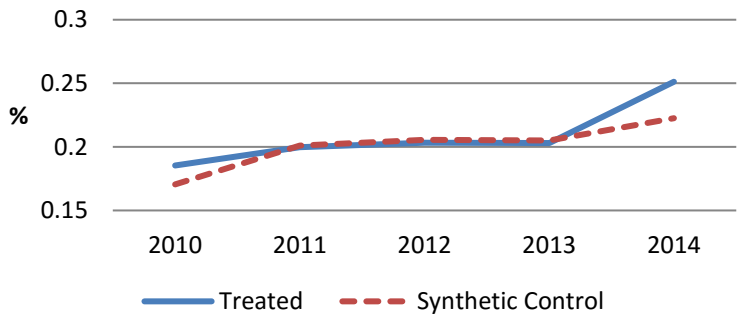


Figure A2. Uninsured, Low-educated Parents (ACS, Excluding 11 States)

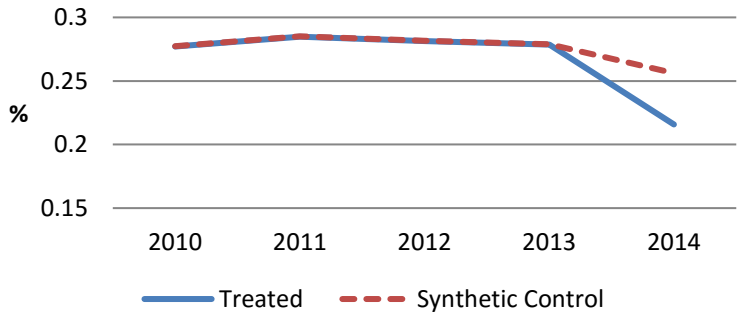


Figure A3. Private Insured, Low-educated Parents (ACS, Excluding 11 States)

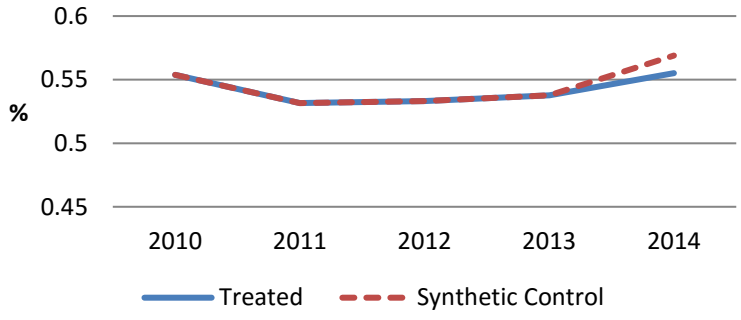


Figure A4. Medicaid, Low-educated Childless Adults (ACS, Excluding 11 States)

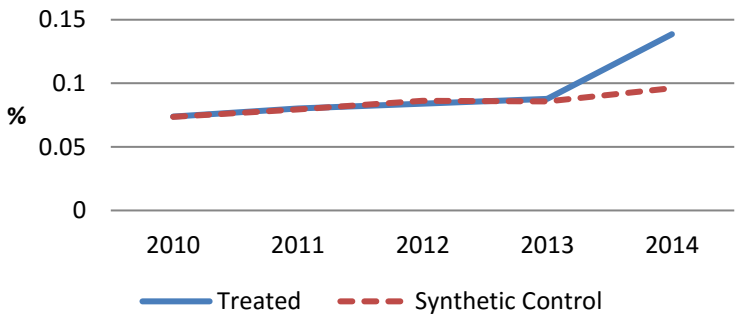


Figure A5. Uninsured, Low-educated Childless Adults (ACS, Excluding 11 States)

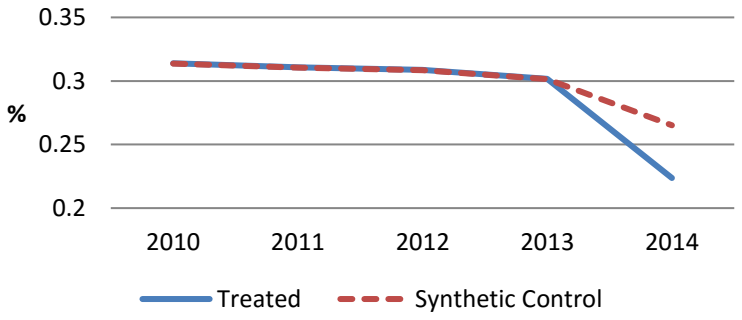


Figure A6. Private Insured, Low-educated Childless Adults (ACS, Excluding 11 States)

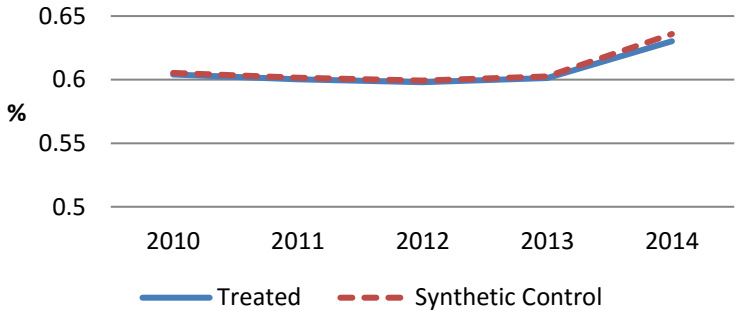


Figure A7. Medicaid, Low-educated Parents (March CPS)

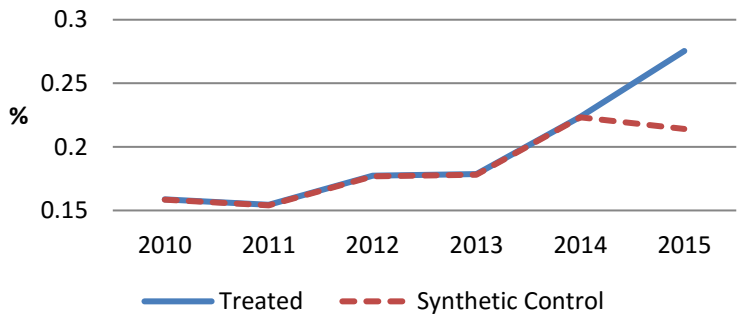


Figure A8. Uninsured, Low-educated Parents (March CPS)

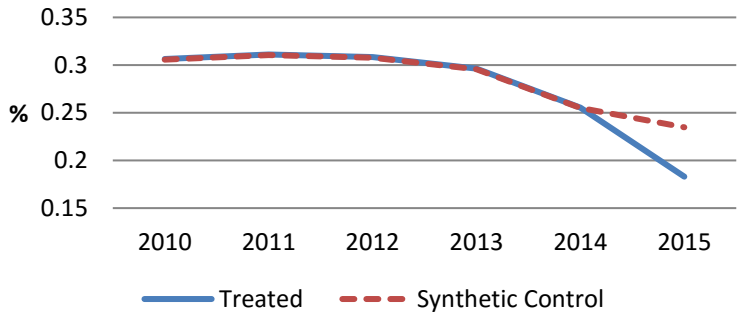


Figure A9. Private Insured, Low-educated Parents (March CPS)

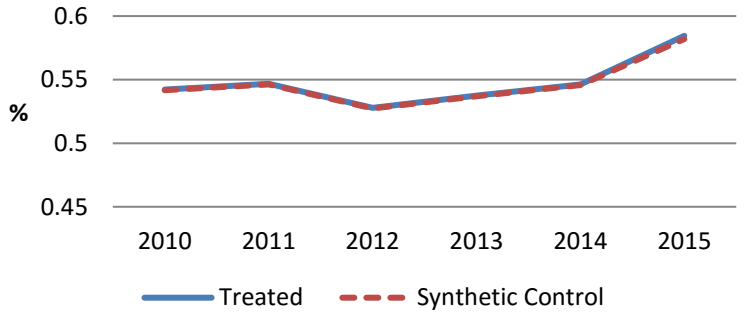


Figure A10. Medicaid, Low-educated Childless Adults (March CPS)

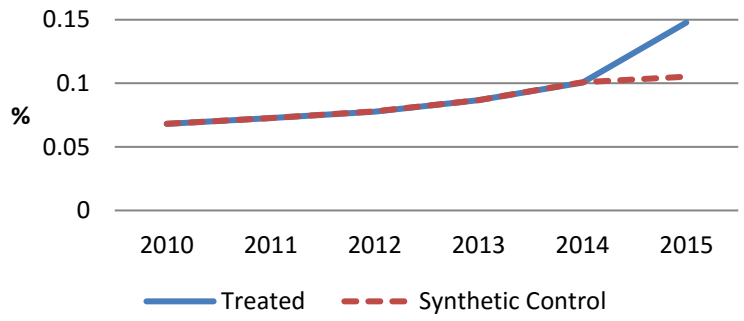


Figure A11. Uninsured, Low-educated Childless Adults (March CPS)

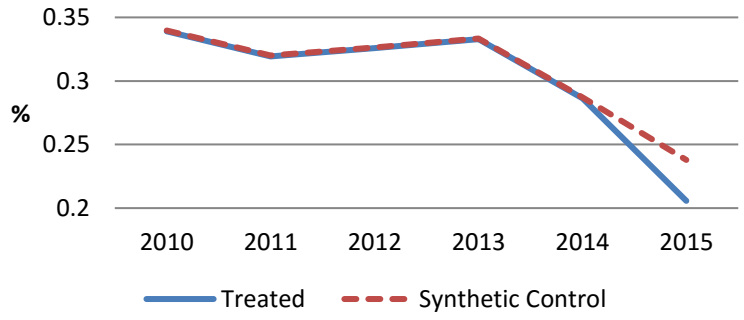


Figure A12. Private Insured, Low-educated Childless Adults (March CPS)

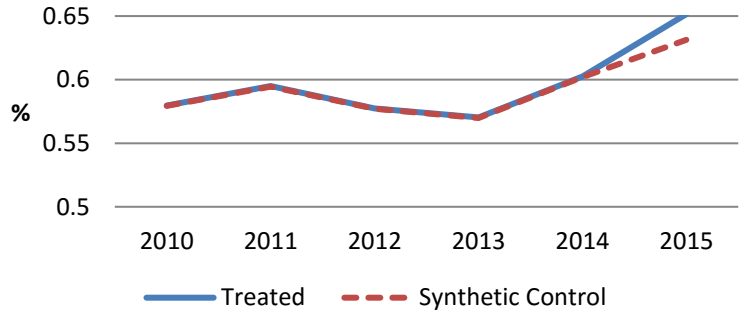


Figure A13. Medicaid, Low-income Parents (March CPS)

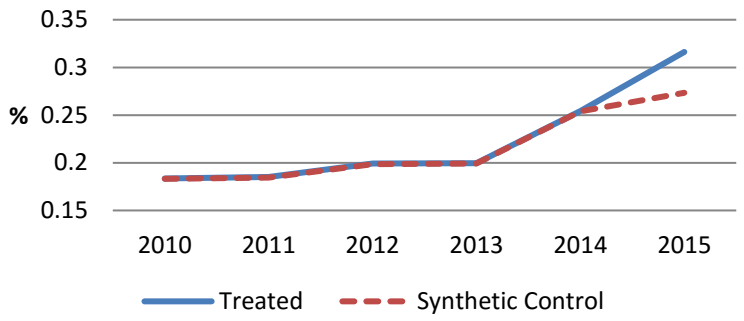


Figure A14. Uninsured, Low-income Parents (March CPS)

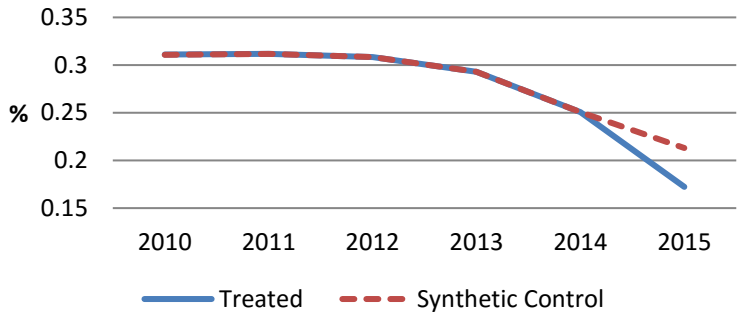


Figure A15. Private Insured, Low-income Parents (March CPS)

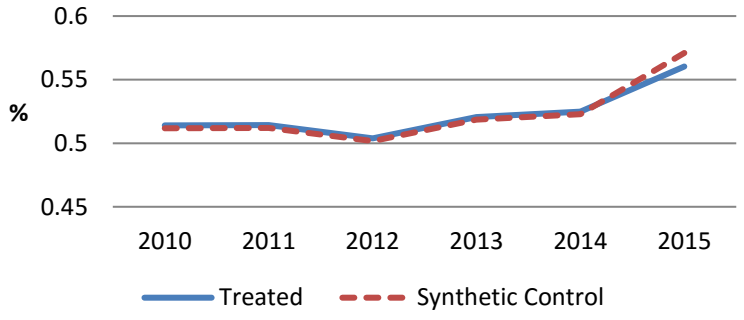


Figure A16. Medicaid, Low-income Childless Adults (March CPS)

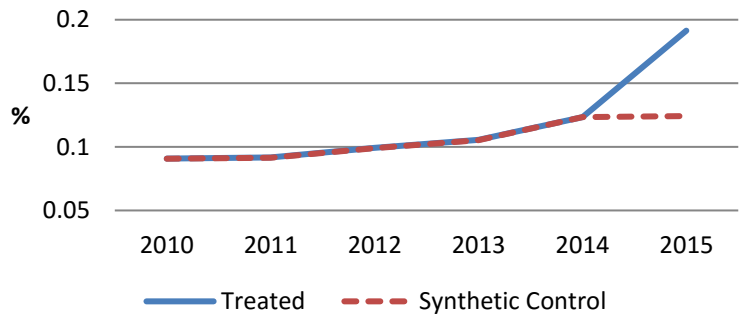


Figure A17. Uninsured, Low-income Childless Adults (March CPS)

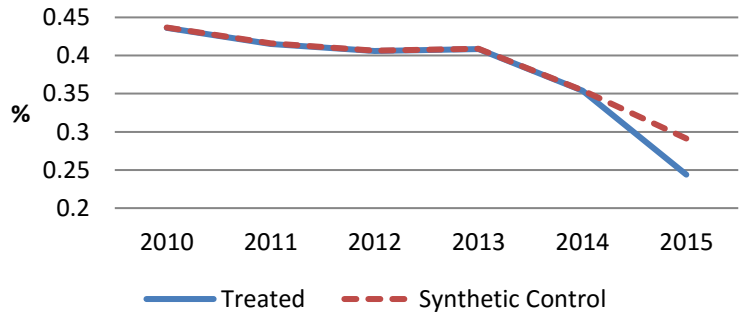


Figure A18. Private Insured, Low-income Childless Adults (March CPS)

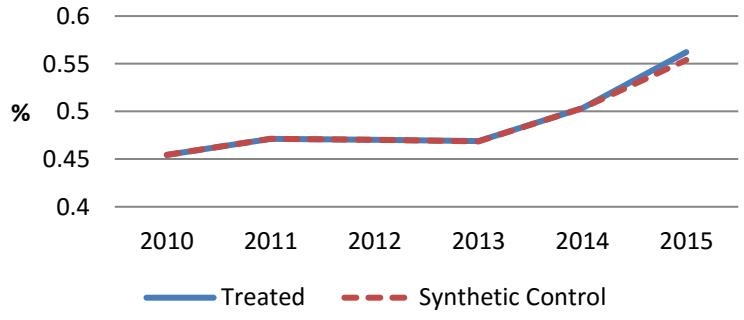


Figure A19. Employed, Low-educated Parents (ACS)

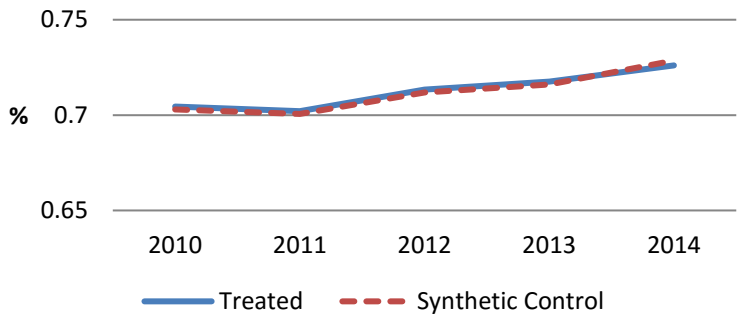


Figure A20. Employed, Low-educated Childless Adults (ACS)

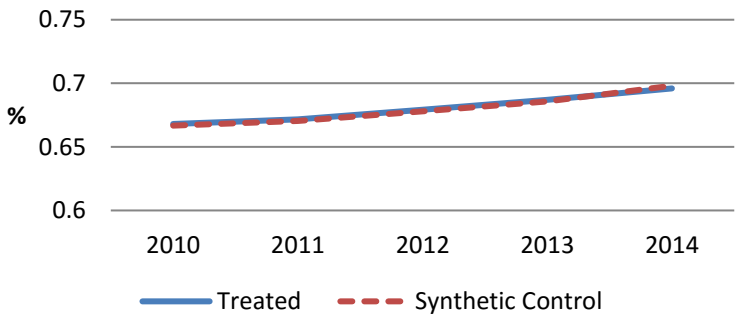


Figure A21. Employed, Low-income Parents (ACS)

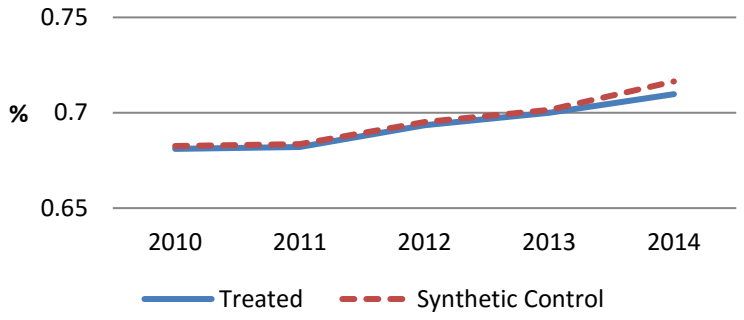


Figure A22. Employed, Low-income Childless Adults (ACS)

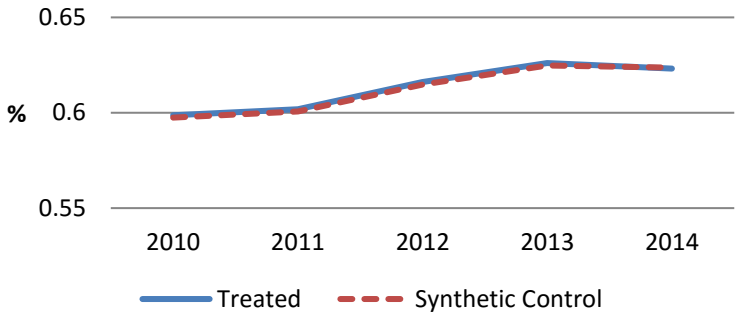


Figure A23. Employed, Low-educated Parents (ACS, Excluding 11 States)

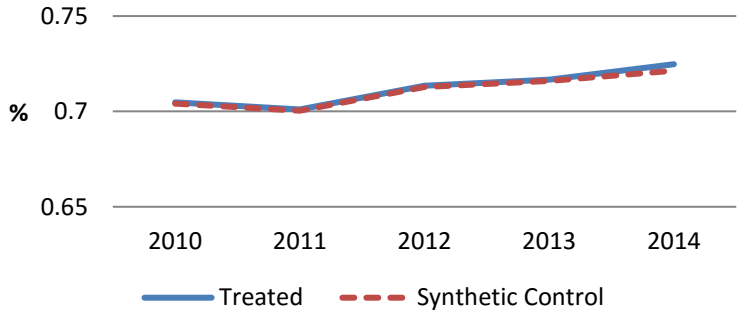
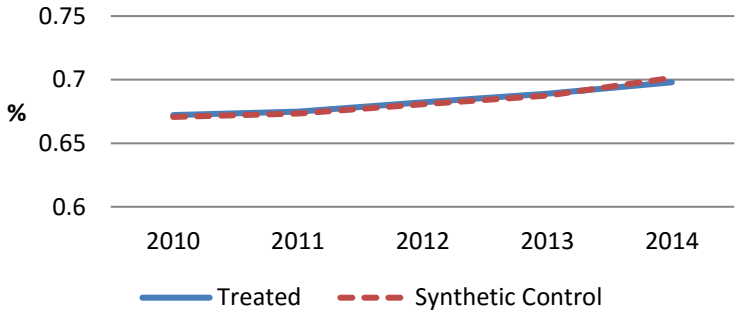


Figure A24. Employed, Low-educated Childless Adults (ACS, Excluding 11 States)



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EMPLOYMENT EFFECTS OF THE ACA MEDICAID EXPANSIONS

Pauline Leung
Alexandre Mas

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Employment Effects of the ACA Medicaid Expansions
Pauline Leung and Alexandre Mas
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ABSTRACT

We examine whether the recent expansions in Medicaid from the Affordable Care Act reduced "employment lock" among childless adults who were previously ineligible for public coverage. We compare employment in states that chose to expand Medicaid versus those that chose not to expand, before and after implementation. We find that although the expansion increased Medicaid coverage by 3.0 percentage points among childless adults, there was no significant impact on employment.

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1 Introduction

In 2010, the United States passed the Patient Protection and Affordable Care Act (ACA), a landmark legislation that overhauled the nation's existing healthcare system. A central debate around the implementation of this act has been its effects on employment. Prior to the ACA, Americans primarily obtained health insurance coverage through their employers, as individually purchased plans were often prohibitively expensive, and public insurance was limited only to certain segments of the population. As a result of this system of employer-sponsored coverage, some have predicted that many individuals sought employment purely to gain coverage. Several provisions of the new law, however, may loosen this "employment lock" by providing alternative affordable coverage options.

One of the ways that the original law made health insurance accessible to low-income populations was through a mandated expansion in the public means-tested Medicaid program to all those with incomes below 138 percent of the federal poverty line, starting in 2014. However, a 2012 Supreme Court ruling made the expansion optional and left the decision up to the individual states. As of this writing, only 32 states have elected to expand Medicaid. Since the program previously covered mostly families with children, the expansions had the greatest impact on non-elderly low-income adults who do not have children under the age of 18 (hereafter, "childless adults"). In states that did not expand Medicaid, most childless adults under the federal poverty line are left without coverage; they are ineligible for Medicaid and are also excluded from receiving the ACA's refundable tax credits toward the purchase of private insurance, which are available to workers above the poverty level.

In this paper, we ask whether the availability of Medicaid reduced "employment lock" among childless adults. Although the long-term impacts of the Medicaid expansion, and health reform more generally, will not be known for a few more years, one effect that should be apparent even at this early stage is whether or not the introduction of public insurance allowed those who were locked into jobs for insurance reasons to exit the labor force.[1] In fact, as detailed below, several studies have demonstrated that the expansions may have potentially large and immediate impacts on the labor market. To study this, we utilize state-level differences in Medicaid availability due to the Supreme Court's ruling. We compare the sources of health insurance coverage and employment rates of states that expanded Medicaid relative to those that did not,

[1] Although we focus on the impacts of Medicaid on the decision of whether or not to work ("employment lock") rather than on "job lock" due to a lack of data on job changes, there is evidence that the health reform may also lead to a reduction in job lock more generally (Heim and Lurie, 2014).

before and after the policy was in place, in a differences-in-differences strategy. In contrast to previous findings and predictions, we do not find any evidence of a reduction in employment lock in response to the expansions of Medicaid.

The best existing evidence on employment lock among the population most affected by the Medicaid expansions – low-income childless adults – come from two quasi-experimental studies and one experimental study of specific state programs that provide Medicaid or similar coverage to childless adults. The first of these is Garthwaite et al. (2014), who examine the employment effects of a large disenrollment in Tennessee's Medicaid program for the "uninsured and uninsurable" in 2005. Using a differences-in-differences strategy, they estimate that Medicaid enrollment was associated with an over 50 percentage point drop in employment. Dague et al. (2014) study a 2009 enrollment freeze in a Wisconsin public insurance program and find smaller, but economically and statistically significant negative employment effects. They use both regression discontinuity design and matched differences-in-differences strategies, and find that the employment drop from Medicaid coverage ranges from two to ten percentage points. Finally, Baicker et al. (2014) find that when Oregon randomly selected childless adults to be eligible for Medicaid coverage, there were no effects on employment. One explanation for the disparate results across states, supplied by both Baicker et al. (2014) and Dague et al. (2014), is that Tennessee's program covered relatively higher income individuals, who are more likely to be able to find jobs with health benefits. Another explanation is that worse labor market conditions may affect the ability of individuals to adjust to health insurance losses or gains through employment. Finally, it is also possible that the groups affected in each of the three states differed in terms of how much they valued health insurance, and therefore how likely they were to be "locked" into employment in the absence of Medicaid. In particular, since Oregon's Medicaid program was only open to those who did not recently have health insurance, those ultimately affected by the lottery would not have been a group that was highly dependent on health insurance. On the other hand, as a result of earlier recertification procedures, the Tennessee disenrollees were likely a population that had greater than average taste for coverage. In contemporaneous studies, Gooptu et al. (2016) and Kaestner et al. (2015) find limited employment effects from the ACA Medicaid expansion.

Our study is also related to the literature on how public insurance expansions crowd out private insurance, since the primary source of private coverage is employer-sponsored coverage. The seminal paper on this topic, Cutler and Gruber (1996), finds that when Medicaid eligibility was expanded for children in the late 1980s to early 1990s, reductions in private coverage offset 49 percent of the increase in Medicaid cover-

age. Furthermore, they find that this private coverage is entirely employer-sponsored coverage, rather than non-group private insurance. Later studies that have reexamined the same Medicaid expansions and subsequent policies for slightly higher income children generally find smaller crowdout effects, though estimates cover a wide range (Shore-Sheppard, 2008, Card and Shore-Sheppard, 2004, LoSasso and Buchmueller, 2004, Gruber and Simon, 2008, Ham and Shore-Sheppard, 2005b). There has been considerably less work examining the crowdout effects of expanding eligibility to adults, since there was very limited coverage for adults prior to the ACA. Hamersma and Kim (2013), Busch and Duchovny (2005), and Aizer and Grogger (2003) find little to no crowdout of private coverage when examining the effects of parental Medicaid expansions.

Finally, we distinguish our study from an earlier literature on the the labor supply effects of Medicaid for single mothers, which mainly focuses on the effects of the decoupling of Medicaid from cash assistance in the 1980s and early 1990s (Yelowitz, 1995, Ham and Shore-Sheppard, 2005a, and Meyer and Rosenbaum, 2001). The key question in these studies is whether raising the income threshold for Medicaid (from a lower cash assistance income threshold) increased labor force participation among potential cash assistance recipients (i.e., single mothers) and abstracts away from the potential effect of Medicaid reducing employment lock.[2] In contrast, we focus on a population that, prior to the expansion, was not eligible for Medicaid or comparable public coverage at any income level. Our estimates therefore should be unaffected by the potentially offsetting impact of relaxing income constraints.

The remainder of this paper is organized as follows. Section 2 gives a brief overview of the major provisions of the ACA and the Medicaid expansions, as well as some background on the insurance landscape prior to the reform. Sections 3 and 4 describe our data, sample, and empirical strategy. We present our results in Section 5. Section 6 concludes.

2 Background on the Affordable Care Act and Medicaid

The Patient Protection and Affordable Care Act (ACA) was passed in 2010 with the goal of providing near universal health insurance coverage in the United States. Prior to the reform, publicly provided health insurance was generally available only to certain segments of the non-elderly population. State Medicaid programs covered low-income families (mostly children), pregnant women, the blind, and the disabled. Pri-

[2] An exception is Hamersma and Kim (2009), who explicitly examine the effects of parental Medicaid expansions on job mobility, finding that Medicaid reduces job lock among unmarried women.

vate insurance was primarily obtained through employment, though not all employees were offered this coverage. Those who did not meet the criteria to qualify for public coverage, and who did not have access to employer-sponsored plans often faced high coverage costs in the private individual market. The health reform sought to bring affordable coverage to these uninsured individuals through a combination of individual and employer mandates, the introduction of premium subsidies and reduced cost plans, the establishment of health insurance exchanges where individuals can shop for coverage, and the expansion of public programs. Many of these provisions went into effect beginning in 2014, including the individual mandate, establishment of the exchanges, and the expansion of Medicaid programs. Indeed, as shown in Figure 1, our data show an increase of about 10 million in the number of people insured from 2013 to 2014.

Originally, the ACA targeted the uninsured at the lower end of the income distribution by requiring states that accept federal funding for Medicaid (currently, all states and the District of Columbia) to expand coverage to all individuals below 138 percent of the federal poverty line. Given that children at that income level were already covered in all states, either by existing Medicaid programs or the Children's Health Insurance Program (CHIP), this expansion mainly affected adults, and in particular, those without dependent children ("childless adults"). Those with incomes above 138 percent of the poverty line (up to 400 percent) would be eligible for premium subsidies in the form of a refundable tax credit when purchasing private insurance. Furthermore, those between 138-250 percent of poverty are eligible for plans with lower deductibles and co-payments.

In 2012, the Supreme Court ruled that requiring states to expand Medicaid was unconstitutional in National Federation of Independent Business (NFIB) v. Sebelius. Instead, states may *choose* to expand Medicaid, which was completely funded by the federal government starting in 2014, but will drop gradually to 90 percent funding after 2019. Following the ruling, only about half of the states took up the expansion in January 2014, and a handful more expanded later in 2014 and 2015. In states that did not expand Medicaid, premium subsidies were available for those between 100 to 400 percent of poverty, but many adults below poverty were left without affordable coverage options.

Prior to 2014, state Medicaid programs generally provided no coverage to the non-disabled, non-elderly adult population, with several exceptions. The only group of healthy adults that states were required to cover were very low-income parents of dependent children (typically with incomes well below poverty) and those who were transitioning out of cash welfare programs. If states wanted to expand eligibility outside of mandatory coverage groups, they had to receive approval for a "demonstration" waiver. Some states used

these waivers to offer coverage to childless adults, but since the programs were required to be budget neutral to the federal government, the programs were generally limited in scope.[3] According to surveys of state officials conducted by the Kaiser Family Foundation and the Georgetown University, as of 2013, eight states and the District of Columbia provided childless adults below certain income limits with Medicaid-equivalent coverage (i.e., the same comprehensive benefits at no cost) (Heberlein et al., 2013a). An additional 13 states provided a more limited package of benefits to low-income childless adults, though more than half of these programs were closed to new enrollment.[4]

Therefore, when the ACA Medicaid expansions were implemented in 2014, it simultaneously granted coverage to previously ineligible adults, while relaxing income limits for some who were already enrolled. Since we are interested in isolating the labor supply effects of providing public health insurance ("employment lock" effects) from the potentially confounding effects of raising eligibility limits for existing enrollees, our ideal sample includes only individuals who were not enrolled in Medicaid prior 2014. Since we do not observe prior coverage in our data, our analysis will be limited to childless adults living in states that did not have any Medicaid-equivalent coverage prior to 2014.[5] We keep the states with more limited benefits in our analysis, since it is unclear how accessible these programs were and whether they can be viewed as substitutes for employer-sponsored coverage. However, we probe the robustness of our results to the exclusion of these states below.

To summarize, the upper panel of Table 1 lists the states without any Medicaid-equivalent coverage for childless adults in 2013 that constitutes our main analysis sample, as well as their expansion status and date. We also denote which states in this group had limited benefits to childless adults. The lower panel lists the states that provided some childless adults with Medicaid-equivalent coverage and are therefore excluded from our analysis.

[3]The ACA also allowed states to begin covering childless adults beginning in April 2010, but the federal funding for this new coverage group was limited to the state's "regular" matching rate until 2014.

[4]This number excludes states that provided coverage contingent on employment or other non-income requirement.

[5]Focusing only on those who were previously ineligible for Medicaid also has the advantange of reducing any confounding "woodwork" or "welcome mat" effects, which occurs when previously eligible individuals begin to take up Medicaid ("come out of the woodwork") following the reform due to increased outreach and advertising (Sommers and Epstein, 2011 and Frean et al., 2016). To the extent that expansion states have larger "woodwork" effects, this may confound the interpretation of our employment estimates.

3 Data

Our analysis utilizes data from the annual American Community Survey (ACS) and the monthly Current Population Survey (CPS). Both surveys are nationally representative and contain labor market, health insurance, and demographic information. The ACS surveys a cross-sectional one-percent sample of U.S. households every year. The CPS surveys about 60,000 households per month, interviewing them for four consecutive months, followed by a break of eight months, and finally another four months. The ACS data we use cover 2010-2014, and the CPS data cover 2010 through July 2015.

We draw our health insurance information from the ACS. Although the CPS also contains health insurance information in its annual March supplement, a redesign of the health insurance questions coinciding exactly with the timing of the Medicaid expansions renders it unusable for our purposes (Pascale, 2015). The specific health insurance variables from the ACS that we use are indicators for being covered by the following types of insurance at the time of the survey: private insurance, private insurance through a employer-sponsored group plan, private insurance that is directly purchased, and public insurance (Medicaid or another government program for the low-income or disabled).

For labor market information, we use both ACS and CPS data. The ACS has the advantage of a larger sample size, but the CPS contains more nuanced questions on labor force participation, as well as a slightly longer time horizon post expansion. For both data sets, our main outcome variable is an indicator for being "at work" in the survey reference week. For intensive margin measures of employment, we use the question in the CPS that asks the worker for the number of actual hours worked in the reference week. Usual weekly earnings are reported in the CPS for those who are employed and interviewed in their fourth and eighth month in the survey. We measure wages by dividing weekly earnings by the number of usual hours worked per week.

As mentioned above, prior to the expansion, all states covered low-income parents to some degree, and several states also had programs that provided childless adults with Medicaid-equivalent coverage. To the extent that adults who were enrolled in Medicaid prior to the expansion were limiting their labor supply to stay under income thresholds, any evidence of employment lock would be confounded by workers who increase their labor supply in response to the relaxed income limits in expansion states. We therefore focus only on childless adults and restrict the sample to the 42 states in which there was no Medicaid-equivalent coverage for childless adults in 2013. Later in the analysis, we probe the robustness of our results to includ-

ing only states without *any* public insurance for childless adults. We consider an individual childless if they do not share a household with a child under 18. This definition of childless is likely to identify a subset of the actual population of adults who are excluded from public insurance coverage pre-ACA, as households with children may contain several families where only a subset of the adults qualify as parents or caregivers according to state program rules. To avoid potential interactions with military, aged, and dependent health coverage, we restrict our sample to non-institutionalized, civilian adults, ages 27-64.

Table 2 presents descriptive statistics for childless adults in the expansion states and non-expansion states in our sample. Expansion states have higher rates of coverage, mostly coming from employer-sponsored coverage, though higher rates of Medicaid coverage also contribute to the disparity. In terms of employment rates, however, the two sets of states look fairly similar, with employment in expansion states only slightly higher. In terms of demographic differences, the non-expansion states tend to be on average less educated, more likely to be non-white, and have a higher rate of poverty.

Since individuals with incomes above the federal poverty line (up to 400 percent of the poverty line) would be eligible for premium subsidies beginning in 2014 regardless of whether they live in a state that expanded Medicaid, the expansion will mostly impact those who are below the poverty line. We therefore also focus on a subsample of childless adults who are below the poverty line. Since a poverty measure is not readily available in the basic monthly CPS, we use the categorical variable on the total household income, in conjunction with the number of household members, as a proxy. We define an individual as below poverty if the upper threshold of their household income category is below the official poverty level of the interview year, assuming the number of household members is the family size. As expected, this understates the poverty rate: it is consistently about one percentage point below poverty rates obtained using the ACS. However, the fraction of individuals below poverty using this measure tracks changes in the ACS's poverty rates fairly well over time (not shown).

Finally, for robustness, we estimate the effects of the Medicaid expansion in a few other subsamples that utilize additional information available in the CPS. In one subsample, we take advantage of the short panel structure of the CPS and identify individuals who were employed when surveyed in the previous year. In linking the respondents over time, we follow Madrian and Lefgren (1999) and match by household and person identifiers, and invalidating matches that do not have consistent sex, race, and age information. Using this method, we are able to match about 77 percent of respondents who were in their fifth through eighth month in the survey. In another subsample, we use self-reported health status information, which fall into

five mutually exclusive categories: excellent, very good, good, fair, and poor, from the Annual Social and Economic Supplement of the CPS (the "March CPS").

4 Empirical Strategy

To identify the effects of an expansion in Medicaid coverage, we compare employment in states that did and did not expand Medicaid, before and after adoption of the policy. Specifically, we estimate differences-in differences (DD) specifications of the following form:

$$y_{st} = \beta Exp_{st} + \alpha_s + \gamma_t + \varepsilon_{st} \tag{1}$$

where y_{st} are measures of insurance coverage and employment in state s and time t (where t is a month in CPS samples, and a year in ACS samples), α_s are a set of state fixed effects, and γ_t includes a set of year fixed effects. When we have monthly data (i.e., in the CPS), γ_t also includes a set of calendar month fixed effects to control for seasonal fluctuations in insurance or employment that are common in all states. Exp_{st} is an indicator for whether state s covers childless adults under Medicaid in time t. In the ACS data, which is available yearly through 2014, states will have at most one period in which Exp_{st} is equal to 1.[6] In the monthly CPS analysis, for which we have data through July 2015, Exp_{st} will equal to 1 starting the month the expansion is implemented. The coefficient of interest is β, which captures the effect of expanding Medicaid.

We estimate the model on on data aggregated to state-year (ACS) or state-month (CPS) averages, and weight each aggregate by the number of observations in each state-year or state-month cell. In the absence of individually varying covariates, the weighted aggregate regression is identical to estimating using the individual level data, up to a degrees-of-freedom adjustment.[7] We choose to aggegate the data in this way to highlight the fact that the effective unit of observation in the context of our quasi-experiment is the state-year/month. In other words, if we observe more individuals in the states and years we already have in our existing sample, we are not gaining any more variation in the regressor of interest, and the aggregate analysis reflects this fact. However, more individual observations do reduce the variance of the estimated insurance

[6] States that expanded in the middle of 2014 and in 2015 (MI, NH, PA, IN) are considered not expanded in the ACS analyses.

[7] In our base specification, we do not include any controls other than state and time fixed effects, though our results are robust to controlling for the demographic composition of states (i.e., age, gender, race, education, and marital status), shown in Appendix Tables 3 and 4.

coverage or employment rates for each cell. Thus, the weighting can be viewed as a heteroskedasticity correction: Since state-year/month cells with more individuals have may have smaller error term variances, weighting by the cell sizes may improve precision.[8] All standard errors are clustered at the state level.

The identifying assumption is that the employment in expansion states and non-expansion states would have trended similarly the absence of the Medicaid expansion. One way this would be violated is if only states with strong or weak labor markets, and whose employment was on an upward or downward trajectory prior to 2014, choose to take up the expansion. To gauge whether there were pre-existing trends in the expansion states we replace Exp_{st} in equation (1) with a set of "event time" dummies:

$$y_{st} = \sum_{k=-3}^{1} \delta_k D_{st}^k + \alpha_s + \gamma_t + \varepsilon_{st} \tag{2}$$

where D_{st}^k is equal to 1 if in time t, state s is in its kth year of its Medicaid expansion, and 0 otherwise. If the outcome in the above equation is employment, the coefficients δ_k for $k < 0$ show whether, in the periods leading up to the expansion, the expansion states had significantly different employment rates relative to the control group.

In order to determine whether individuals reduced labor supply in response to the Medicaid availability from equation (1), there must not have been any offsetting differential increases in labor demand in expansion states relative to non-expansion states. One provision of the ACA that is predicted to have impacts on labor demand is the employer penalty, which penalizes large employers for not offering employer-sponsored coverage beginning in 2015. Although all states are subject to this penalty, one way in which the penalty may interact with the Medicaid expansion to impact labor demand is if the penalty is smaller in expansion states. This is possible because the penalty is applied to an employer only if an employee claims a premium tax credit, which may be less likely in states that expand Medicaid. To test this indirectly, we examine the effects of the expansion on wages, which should increase if there were an offsetting increase in demand.

We note that in addition to the Medicaid expansions, the ACA established premium subsidies and health insurance marketplaces in all states, which also had the potential to reduce employment lock. Our identification strategy, which compares states by expansion status, will therefore be unable to estimate the effect of the health reform on employment lock more generally. Rather, we will only detect employment effects

[8] Indeed, a modified Breusch-Pagan test that regresses OLS residuals on the inverse of cell sizes confirms the presence of heteroskedasticity when the outcome is employment in our main ACS and CPS samples (Solon et al., 2015). In addition, we report the estimates without weighting in Appendix Tables 3 and 4.

for a relatively low-income population whose incomes are not high enough to qualify for subsidies to purchase health insurance on the new exchanges. We therefore also estimate our models on low-income and "Medicaid-likely" subsamples described below in Section 5.

Finally, it is also possible that because the premium subsidies are only available to those between 100 to 400 percent of the federal poverty line, workers in non-expansion states may increase their labor supply in order to obtain subsidized private coverage. This effect works in same direction as the the employment lock effects (i.e., non-expansion states would have relatively higher employment), biasing our results upward in absolute value. For this reason, in some specifications, we estimate equation (1) on a sample of workers who were previously employed.

5 Results

We begin by graphically examining insurance and employment trends in our sample of childless adults in expansion states and non-expansion states. In Figures 2 and 3, we only include states that expanded in January 2014 (17 states) and states that have not expanded (21 states), though our estimates will also include the handful of states that expanded later than January 2014. Figure 2a shows that, as expected, Medicaid coverage sharply increased in expansion states after 2014, while the increase was much milder in non-expansion states. In Figure 2b, we plot overall coverage rates. In 2014, when several major provisions of the ACA came into effect, including the individual mandate and the opening of the health insurance exchanges, insurance rates in both expansion and non-expansion states increased, though the increase was larger in expansion states. The magnitude of this difference is smaller than the difference in Medicaid coverage, suggesting that individuals who were ineligible for Medicaid in non-expansion states were differentially more likely to obtain private insurance via employment or through the newly established exchanges. When we plot the annual employment rates in expansion and non-expansion states in Figure 3, however, there is no evidence that employment in expansion states is lower than in non-expansion states.[9] If anything, in states that expanded Medicaid, employment may have increased.

In Table 3, we present our DD estimates of the effect of the Medicaid expansions on health coverage

[9]The differences in employment rates and trends between the ACS and CPS data are likely due to the smaller sample sizes in the CPS. In Appendix Figure 1, we compare the employment-to-population ratio (16+ year-old) estimated from the CPS and ACS in expansion and non-expansion states to those obtained using the Current Employment Statistics (CES). Though we are unable to compare the employment rates in our main sample (childless adults) to the employment rates in the CES, the trends in the CES most closely match the ACS for the overall adult population. Note that the CES does not contain farm employment.

rates. Consistent with Figures 2 and 3, the first two columns of Panel A show that there was a significant difference in the fraction of childless adults insured and insured by Medicaid of 1.6 and 3.0 percentage points, respectively, between expansion states and non-expansion states after the policy was in place. Column 3 confirms that a relative decrease in private insurance contributed to the smaller overall increase in insurance coverage than implied by the increase in Medicaid coverage. In columns 4 and 5 we examine whether this crowdout is coming from employer-sponsored group coverage. The point estimates indicate that the 3.0 percentage point increase in Medicaid coverage in expansion states is crowded out by a 0.9 percentage point reduction in private direct purchase insurance, and 0.3 percentage point reduction in employer-sponsored coverage, though the latter is statistically insignificant.

The total "crowdout" implied by our estimates is 42 percent, with about 11 percent coming from employer-sponsored insurance and 31 percent from direct purchase insurance. These estimates are within the range of estimates of crowdout during the Medicaid and CHIP expansions to low-income children (Cutler and Gruber, 1996, LoSasso and Buchmueller, 2004 and Gruber and Simon, 2008). However, we note that it is somewhat misleading to relate previous measures of crowdout to the current setting, as many changes in health policy and overall insurance coverage coincide with this particular Medicaid expansion. In past work, the interpretation has been that expansions of public insurance led to some dropping of employer-sponsored coverage among already insured individuals or dependents. Due to the individual mandate, as well as other provisions in the ACA, the fraction insured increased sharply in 2014 for both expansion and non-expansion states. The expansion in Medicaid was "crowded out" in the sense that, in the absence of Medicaid coverage, some of the uninsured would have obtained coverage by purchasing insurance directly, perhaps through the newly established state exchanges, where they can select from a menu of affordable coverage options.

Turning to our employment results in the first two columns of Table 4, we find a statistically insignificant difference in employment rates in expansion states following the policy change. The point estimates from the CPS data indicate that there may even have been a positive employment effect in expansion states. In columns 3 and 4, we examine whether there were potential intensive margin responses to Medicaid coverage. If employer-sponsored coverage is only available to full-time employees, we may expect the Medicaid expansion to allow workers who previously worked full-time only to obtain health insurance to switch to a better-matched part-time job. We do not find evidence that individuals are reducing their hours worked following the Medicaid expansion: Part-time employment (those working fewer than 20 hours a week) remained unchanged and full-time employment (those working 30 or more hours a week) may even

have increased. Finally, since the employment lock effect is only relevant for the employed, we estimate employment effects among those who were employed in the prior year, using the CPS's short longitudinal structure. Column 5 shows that the expansion did not affect employment outflows.

In panels B and C of Tables 3 and 4, we present the analogous results for two subsamples of childless adults who are more likely to be impacted by the Medicaid expansion. As mentioned above, since subsidies for directly purchasing insurance are available for those above poverty in all states, employment lock among higher income groups is expected to be reduced regardless of expansion status and would not be detected by our DD strategy. We therefore examine the effects among those with incomes below the poverty line. Panel B of Table 3 shows that, relative to all childless adults, the Medicaid expansion had a much larger impact on the the overall insured rate among childless adults below poverty, increasing the rate of Medicaid coverage by 11.1 percentage points and overall coverage by 7.9 percentage points. There is evidence of some crowd out of both private employer-sponsored and direct purchase coverage of 1.0 and 2.0 percentage points, respectively. When we examine the effects of the expansion on employment in Table 4, we again find that there are no statistically significant effects on employment rates, nor any adjustment in labor supply along the intensive margin.[10]

We note that restricting the sample to only those below poverty is problematic if the composition of this groups differs in expansion and non-expansion states. In particular, workers may reduce labor supply in order to qualify for Medicaid, resulting in an increased poverty rate in expansion states.[11] In Panel C of Tables 3 and 4 we therefore also show an alternative subsample containing a subset of childless adults who are more likely to be enrolled in Medicaid as predicted by fixed demographic characteristics. To do this, we estimate a linear probability model of Medicaid enrollment, with household size, educational attainment, age categories, sex, marital status, and race as predictors.[12] We use the coefficients from this model to predict the probability of being on Medicaid in both the ACS and CPS childless adult samples. The "Medicaid likely" subsample shown in the bottom panels of Tables 3 and 4 are those who are above the median in terms of their predicted Medicaid probabilities. Columns 1 and 2 of Table 3 show that the first stage estimates of the Medicaid expansion on overall coverage (2.6 percentage points) and Medicaid

[10] Although we are able to estimate and report the results on continued employment and wages in the last two columns, we note that the estimates, especially in the below-poverty sample, suffer from small cell sizes.

[11] We also estimate equation (1) with y_{st} as the fraction of the population below poverty in state s at time t, and present the estimate of β in Appendix Table 1. The statistically insignificant negative coefficient indicates that increased rates of poverty in response to the Medicaid expansion is unlikely confound our findings.

[12] Specifically, we use indicators for each household size (7 dummies), detailed education categories (14 dummies), five-year age groups (8 dummies), sex, marital status (5 dummies), and race (2 dummies).

coverage (4.6 percentage points) are stronger in this subsample relative to all childless adults, as expected. However, the (insignificant) employment effects are of roughly similar magnitudes (Table 4).

Using the estimates from column 2 of Table 3 and column 1 of Table 4, a 95 percent confidence interval indicates that the implied "treatment effect on the treated" (TOT) of Medicaid on employment is no more negative than 15 percentage points (from "Medicaid-likely" subsample). To put these numbers in context, we compare our estimates with three recent studies on the impact of Medicaid on the labor supply of childless adults. As mentioned in the introduction, the most compelling evidence we have so far on the potential for the public insurance expansions in the ACA to reduce employment lock comes from states that have recently stopped or started enrollment in public insurance programs for childless adults. Garthwaite et al. (2014) examine a large disenrollment in Tennessee's childless adult program in 2005 and find that 63 percent of those who lost Medicaid increased their labor supply, though the 95 percent confidence interval ranges from about five percent to well over 100 percent.[13] Dague et al. (2014) find much smaller but still significant and precisely estimated employment effects ranging from 2.4 to 10.6 percentage points after an enrollment freeze in Wisconsin's childless adult program in 2009. Finally, Baicker et al. (2014)'s estimate from the Oregon Health Experiment, where wait-listed childless adults were randomly invited to enroll in the program, is that Medicaid reduced employment by 1.6 percentage points (statistically insignificant). Our point estimates are closest to Baicker et al. (2014)'s small and insignificant point estimates, though our estimates do not rule out the moderately sized effects that were found in Dague et al. (2014).

One possible explanation for the widely disparate findings in the state-specific case studies is that they may be studying very different subpopulations. Employment lock would be most relevant for those who highly value health insurance (i.e., those who are or who have dependents in poor health), and/or who have relatively low labor force attachment. The population studied in Garthwaite et al. (2014) are exactly those with higher than average taste for health insurance (due to earlier recertification reforms), while the population studied in Baicker et al. (2014) are those who have gone without coverage for at least six months, and may have lower than average taste for coverage. To see whether these differences across populations may explain the different results, we estimate our models on subgroups of childless adults who are likely to have larger employment responses to Medicaid coverage. First, we estimate the effects of the expansion on those who tend to have lower labor market attachment: females, those age 50 or older, and high school

[13]These numbers use only the confidence interval on the reduced form effect on employment, and does not account for the estimation of the first stage.

dropouts. Then, as a proxy for health insurance preferences, we also estimate the employment effects among those with a self-reported health of poor, fair, or good (available in the March CPS only). The first two panels of Table 5 show that the Medicaid expansions had similar effects on insurance coverage and employment among females and older individuals as in the overall childless adult population. Among high school dropouts, the expansions had a larger impact on Medicaid coverage, and there is also less evidence of private insurance crowdout. Correspondingly, there is no evidence of employment effects. Finally, in the last panel, we find no statistically significant employment effects among those with self-reported health ranging from poor to good (about 38 percent of respondents).

A potential explanation for the zero to positive employment response is that expansion states experienced a relative increase in labor demand. As mentioned above, since the ACA mandated that employers with over 50 full-time equivalent employees are required to provide group coverage and were penalized for every worker who claims a premium tax credit (excluding the first 30), it is possible that employers in states that expanded Medicaid anticipate lower labor costs because they are less likely to be penalized for lack of coverage.[14] We test for a possible increase in labor demand by examining the wage response in expansion states, which should be positive if there were simultaneous increases in labor demand and decreases in labor supply. In the last column of Table 4, we report the DD coefficient when we estimate equation (1) with the average log wages as outcomes. We find no significant effects of the Medicaid expansion on wages.

As mentioned above, the validity of the differences-in-differences strategy for identifying a causal effect of expanding Medicaid depends crucially on the idea that labor market trends were comparable in states that expanded relative to those that did not. One particular concern is that states that expected upward growth in employment are more likely to take up the Medicaid expansion, masking any employment lock effects. We check to see whether expansion states were on a different employment trajectory prior to the expansion by estimating equation (2) and plotting the estimates of δ_k in Appendix Figure 2. The statistically insignificant estimates of the δ_k coefficients for $k \leq 0$ and lack of visual pre-trends indicate that there were no systematic differences between expansion states and non-expansion states in the periods leading up to the policy change.

In Appendix Table 2, we probe the robustness of our results to the exclusion of certain states. First, as we mention in Section 2, 13 states provided low-income childless adults with limited benefit plans prior to 2014. Of these 13 states, 11 subsequently chose to expand coverage in 2014, as shown in Table 1. To

[14] Note that the employer mandate does not come into effect until the beginning of 2015.

the extent that the enrollees in these limited plans were previously constrained to work fewer hours due to the low income thresholds, it is possible that the Medicaid expansions led to increased labor supply, confounding the effects of employment lock. The upper panel of Appendix Table 2 shows the estimates of our main DD specifications using excluding these 13 states. A second concern is that while most expansion states implemented the policy at the beginning of 2014, a handful of states expanded later in the year and in 2015. In states that expanded later, it is possible that the timing of the policy was determined by factors related to the state's economy and labor market. Therefore, in the lower panel of Appendix Table 2, we include only the states that expanded in January of 2014 and non-expansion states.[15] The results from both of these alternative sample restrictions mirror the results from Table 4.

6 Conclusion

In this study, we examine whether the recent expansions in Medicaid reduced "employment lock" among childless adults who were previously ineligible for public coverage. To do this, we use a differences-in-differences strategy that compares employment in states that chose to expand Medicaid versus those that chose not to expand, before and after implementation. We find that although the expansion increased Medicaid coverage by 3.0 percentage points among childless adults, there was no significant impact on the employment. Our estimates rule out the large employment lock effects of Garthwaite et al. (2014) and are similar to that of Baicker et al. (2014).

We close with several potential explanations for the different estimates across studies. First, as noted by both Baicker et al. (2014) and Dague et al. (2014), the population studied by Garthwaite et al. (2014) is a higher income population than those most affected by the Medicaid expansions in the ACA. It is possible that the types of jobs that individuals living below poverty are able to obtain are less likely to come with health benefits. Another explanation is that the considerable policy uncertainty surrounding the ACA's Medicaid expansion may have dampened or delayed employment responses: If workers "locked" into employment for insurance reasons perceive the Medicaid expansions to be temporary due to constitutional or implementation challenges, they may be reluctant to leave their jobs and employer-sponsored insurance coverage. As the dust settles, however, it is possible that we will begin to see the predicted impacts on the labor market.

[15] This excludes PA, NH, IN AK, and MI. We also exclude WI because while it did allow childless adults in Medicaid starting in 2014, it is not considered technically expanded because the program is limited to those under 100 percent FPL and will not be accepting the enhanced federal funding for childless adult coverage.

Therefore, while our early estimates suggest that the labor market impacts of the Medicaid expansions are smaller than anticipated, medium- and long- term impacts remain an important avenue for future research.

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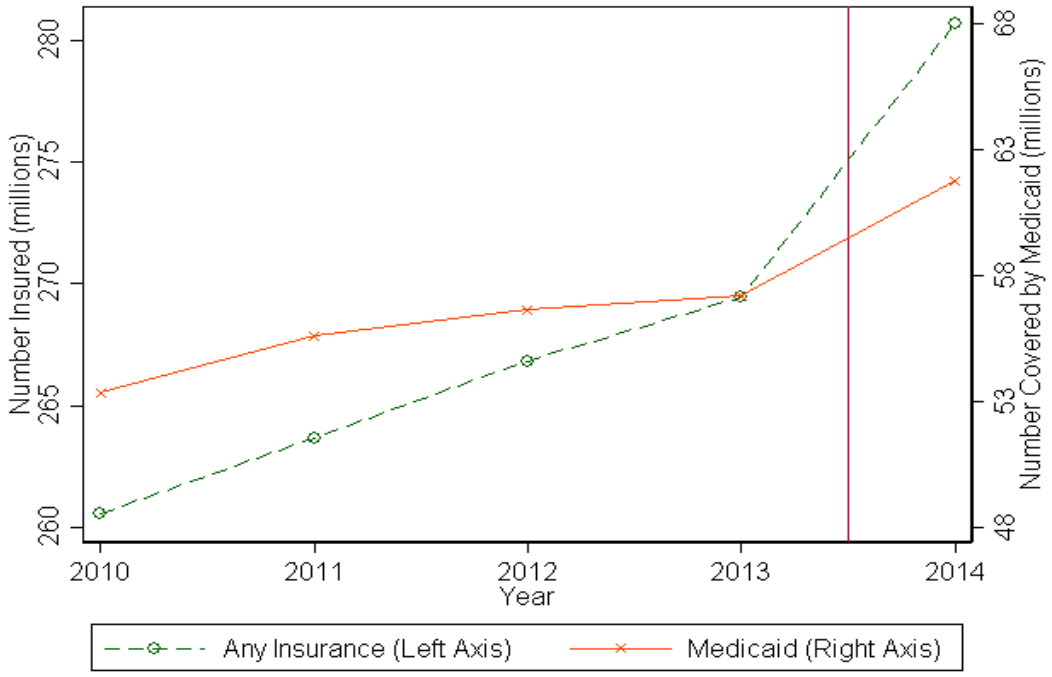
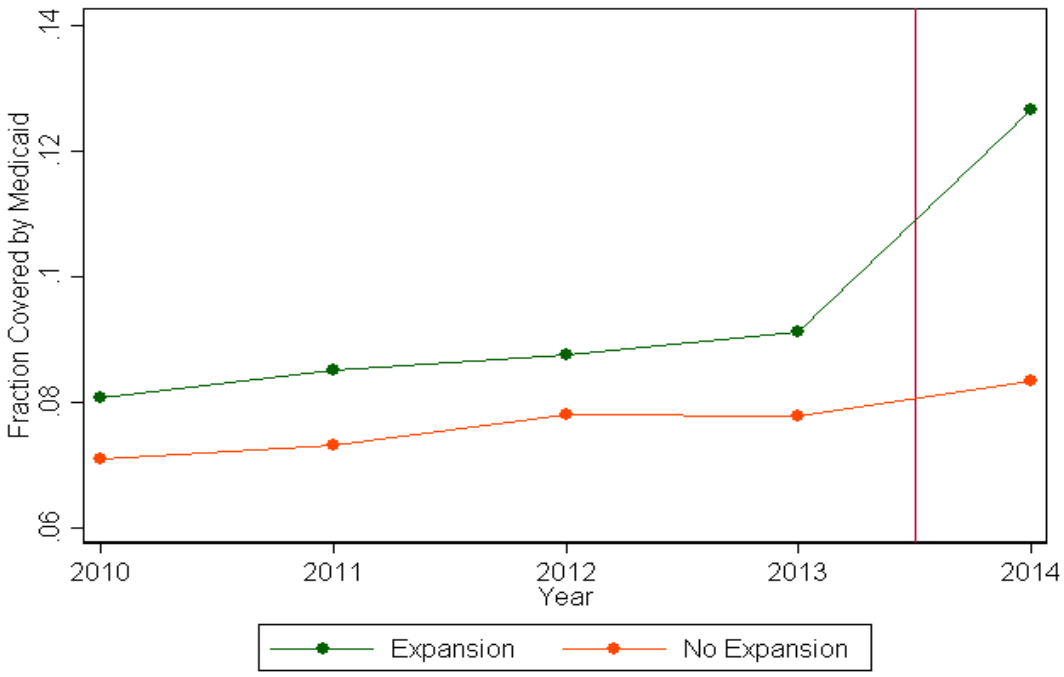
Figure 1: Number of Individuals with Health Insurance and Medicaid, 2010-2014



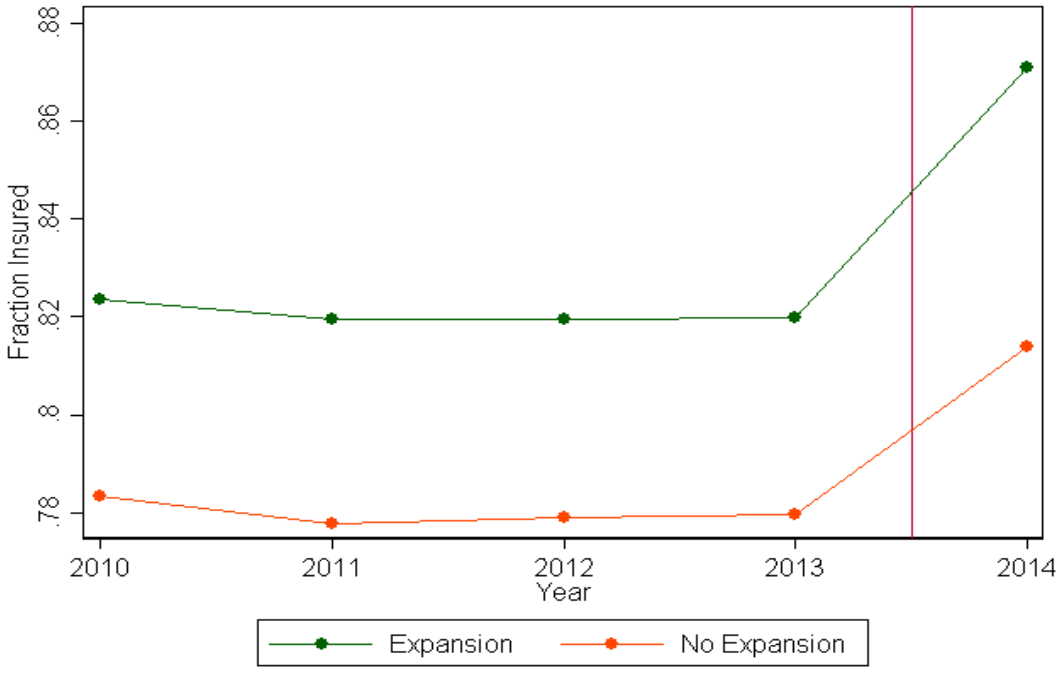
Notes: Author calculations using data from the American Community Survey.

Figure 2: Health Insurance Trends Among Childless Adults, Expansion vs. Non-expansion States

A. Medicaid Coverage



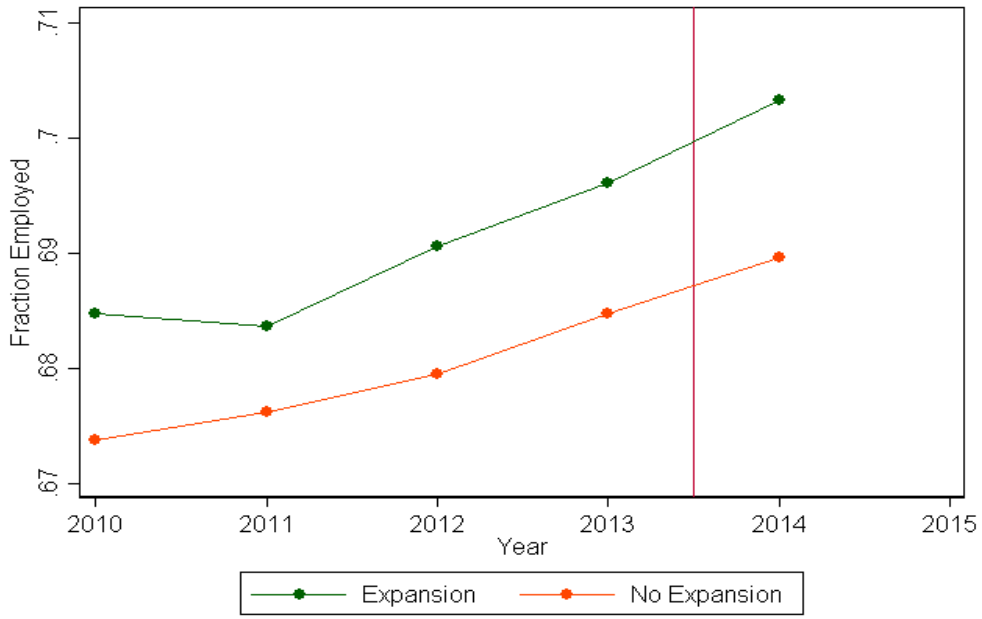
B. Overall Health Insurance Coverage



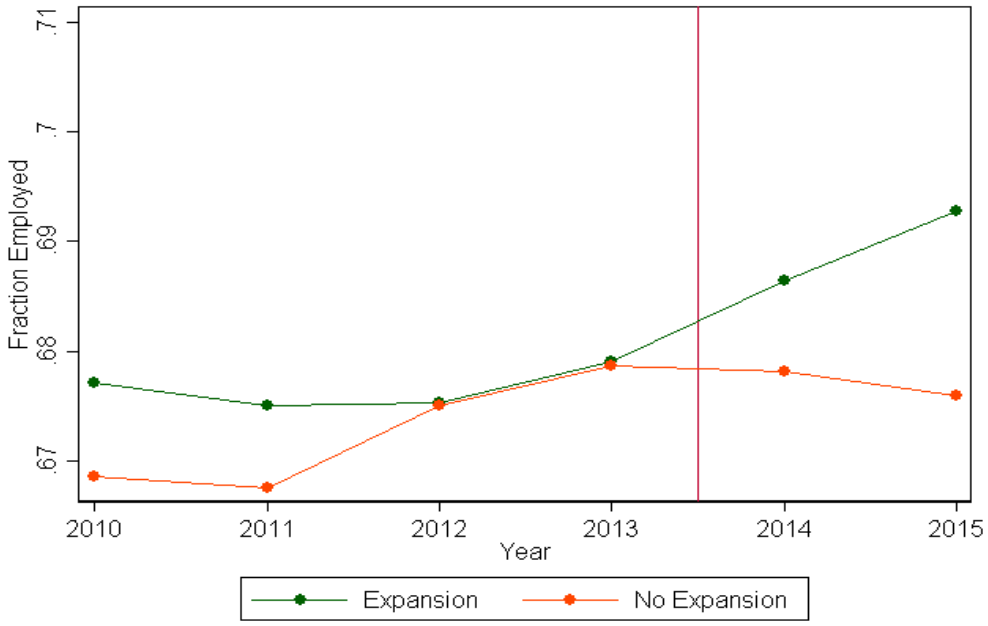
Notes: Sample includes childless adults in states with no prior Medicaid-equivalent coverage for childless adults, and that either expanded in January 2014 (17 states) or did not expand (21 states). Data is from the American Community Survey.

Figure 3: Employment Trends Among Childless Adults, Expansion vs. Non-expnsion States

A. American Community Survey



B. Current Population Survey



Notes: Sample includes childless adults in states with no prior Medicaid-equivalent coverage for childless adults, and that either expanded in January 2014 (17 states) or did not expand (21 states). Data is from the American Community Survey (panel A) or the Current Population Survey (panel B).

Table 1: State Expansion Status

A. Childless Adults Ineligible in 2013

Expansion States	Date Expanded	Non-Expansion States
AR	1/1/2014	AK**
CA†	1/1/2014	AL
IL	1/1/2014	FL
IA†	1/1/2014	GA
KY	1/1/2014	ID
MD†	1/1/2014	KS
MA†	1/1/2014	LA**
NV	1/1/2014	ME†
NJ†	1/1/2014	MO
NM†	1/1/2014	MS
ND	1/1/2014	MT**
OH	1/1/2014	NE
OR†	1/1/2014	NC
RI	1/1/2014	OK
WA†	1/1/2014	SC
WI*†	1/1/2014	SD
WV	1/1/2014	TN
MI†^	4/1/2014	TX
NH^	8/1/2014	UT†
PA^	1/1/2015	VA
IN†^	2/1/2015	WY

B. Childless Adults Eligible in 2013

AZ
CO
CT
DE
DC
HI
MN
NY
VT

Source: The Henry J. Kaiser Family Foundation

Notes: *WI did not take up federal funding for the newly covered group, but created a program that covers childless adults up to 100% FPL
**AK expanded Medicaid 9/2015, MT 1/2016, LA 7/2016
† Limited benefits to childless adult group in 2013
^ Considered not expanded in the ACS sample

Table 2: Descriptive Statistics

	Expansion States	No Expansion States
ACS 2010-2014		
Insured	83.6%	78.7%
Insured Through Employer	63.5%	58.4%
Insured, Own Purchase	10.9%	11.2%
Medicaid	9.5%	7.7%
CPS 2010-2015		
Employed	67.6%	67.4%
Employed, >=30 Hrs	58.7%	59.6%
Below Poverty	8.6%	10.4%
Female	49.1%	49.1%
HS Grad	91.6%	89.7%
Non-white	18.1%	22.1%
Average Age	48.7	48.7
Number of States	21	21

Notes: Sample for both ACS and CPS data are non-institutionalized civilians, ages 27-64, and childless (see text for details). Each number is calculated using CPS or ACS person-level weights.

Table 3: Effects of Medicaid Expansion on Health Insurance

	Insured (1)	Medicaid / Other Govt (2)	Privately Insured (3)	Private, Thr. Employer (4)	Private, Own Purchase (5)
A. Childless Adults					
Expansion x Post	0.016	0.030	-0.014	-0.003	-0.009
	(0.005)	(0.004)	(0.004)	(0.003)	(0.003)
	[2.96]	[8.07]	[-3.32]	[-1.25]	[-2.85]
Mean of Dep Var	0.842	0.086	0.738	0.628	0.124
B. Childless Adults Under the Poverty Line					
Expansion x Post	0.079	0.111	-0.030	-0.010	-0.020
	(0.011)	(0.012)	(0.005)	(0.004)	(0.004)
	[7.02]	[9.29]	[-5.63]	[-2.45]	[-5.36]
Mean of Dep Var	0.619	0.354	0.230	0.125	0.105
C. Medicaid-Likely Childless Adults					
Expansion x Post	0.026	0.046	-0.019	-0.008	-0.011
	(0.006)	(0.005)	(0.005)	(0.004)	(0.003)
	[4.25]	[9.48]	[-3.73]	[-2.05]	[-3.32]
Mean of Dep Var	0.764	0.149	0.591	0.490	0.113

Notes: Data is from ACS 2010-2014. Sample includes states in which childless adults were not eligible for Medicaid in 2013 (42 States). Observations are state-year averages (N=210). Regressions include year and state fixed effects and are weighted by cell sizes. Standard errors are clustered by state and in parentheses. t-stats are in brackets.

Table 4: Effects of Medicaid Expansion on Labor Market Outcomes

	Employed - ACS (1)	Employed - CPS (2)	Employed, <20 Hrs (3)	Employed, >=30 Hrs (4)	Still Employed (5)	Log Wage (6)
A. Childless Adults						
Expansion x Post	0.000	0.005	-0.001	0.006	-0.001	-0.006
	(0.002)	(0.003)	(0.001)	(0.003)	(0.003)	(0.007)
	[0.25]	[1.48]	[-0.98]	[1.99]	[-0.25]	[-0.88]
Mean of Dep Var	0.682	0.678	0.038	0.590	0.900	2.914
B. Childless Adults Under the Poverty Line						
Expansion x Post	0.002	0.009	-0.003	0.005	0.006	0.038
	(0.004)	(0.011)	(0.005)	(0.008)	(0.020)	(0.035)
	[0.48]	[0.77]	[-0.58]	[0.60]	[0.31]	[1.09]
Mean of Dep Var	0.246	0.318	0.056	0.208	0.731	2.420
C. Medicaid-Likely Childless Adults						
Expansion x Post	-0.002	0.007	-0.001	0.007	-0.003	-0.009
	(0.002)	(0.004)	(0.001)	(0.004)	(0.005)	(0.010)
	[-0.96]	[1.81]	[-0.61]	[1.91]	[-0.54]	[-0.91]
Mean of Dep Var	0.609	0.617	0.037	0.530	0.889	2.770

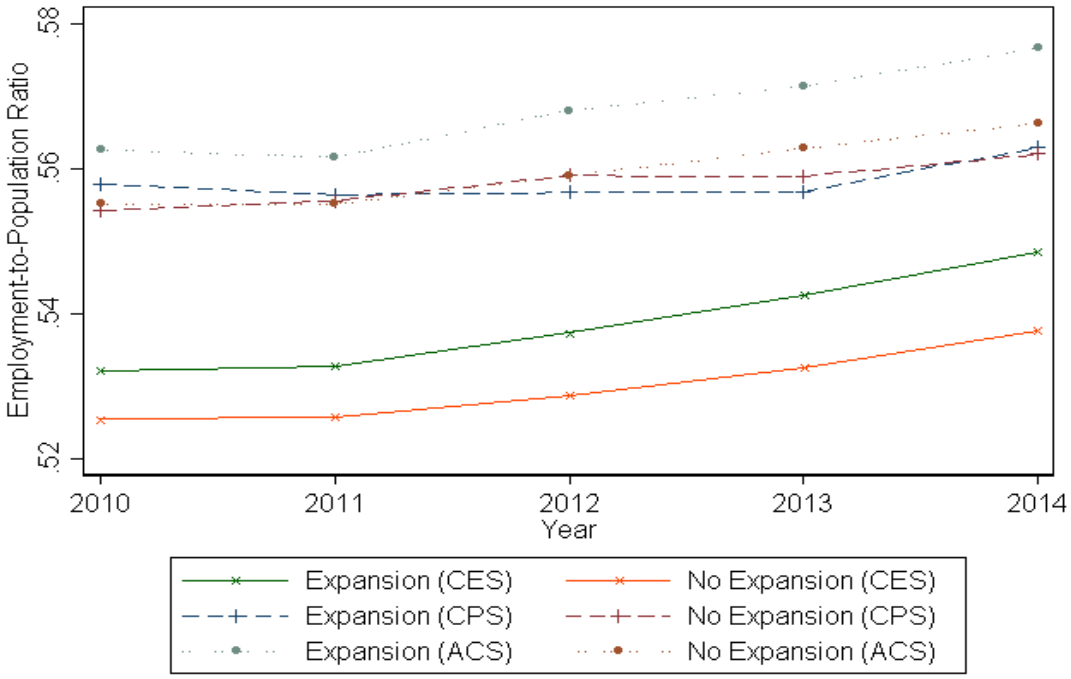
Notes: Data is from ACS 2010-2014, CPS 2010-July 2015. Sample includes all states in which childless adults were not eligible for Medicaid in 2013 (42 States). Observations are state-year averages for ACS (N=210) and state-month averages for CPS (N=2814). Regressions include year and state fixed effects, month-in-year effect (CPS only) and are weighted by cell sizes. Standard errors are clustered by state and in parentheses. t-stats are in brackets.

Table 5: Effects of Medicaid Expansions in Subgroups of Childless Adults

	Insured (1)	Medicaid (2)	Employed (CPS) (3)
A. Females			
Expansion x Post	0.016	0.032	0.003
	(0.005)	(0.004)	0.005
	[3.17]	[7.78]	[0.71]
Mean of Dep Var	0.860	0.089	0.644
B. Age 50 or Older			
Expansion x Post	0.013	0.027	0.004
	(0.005)	(0.004)	(0.005)
	[2.41]	[6.60]	[0.94]
Mean of Dep Var	0.880	0.085	0.627
C. High School Dropouts			
Expansion x Post	0.049	0.055	0.017
	(0.009)	(0.008)	(0.008)
	[5.45]	[7.23]	[2.13]
Mean of Dep Var	0.692	0.262	0.462
D. In Poor Health (Health Rated Poor - Good)			
Expansion x Post	-	-	-0.008
			(0.008)
			[-0.93]
Mean of Dep Var			0.540

Notes: Health insurance data is from ACS 2010-2014. Labor market data are from basic CPS 2010-July 2015 (Panels A-C) and March CPS 2010-2015 (Panel D). Sample includes all states in which childless adults were not eligible for Medicaid in 2013 (42 States). Observations are state-year averages for ACS (N=210), and state-month averages for CPS (N=2814 - basic, N=252 - March). Regressions include year and state fixed effects, month-in-year effect (basic CPS only) and are weighted by cell sizes. Standard errors are clustered by state and in parentheses. t-stats are in brackets.

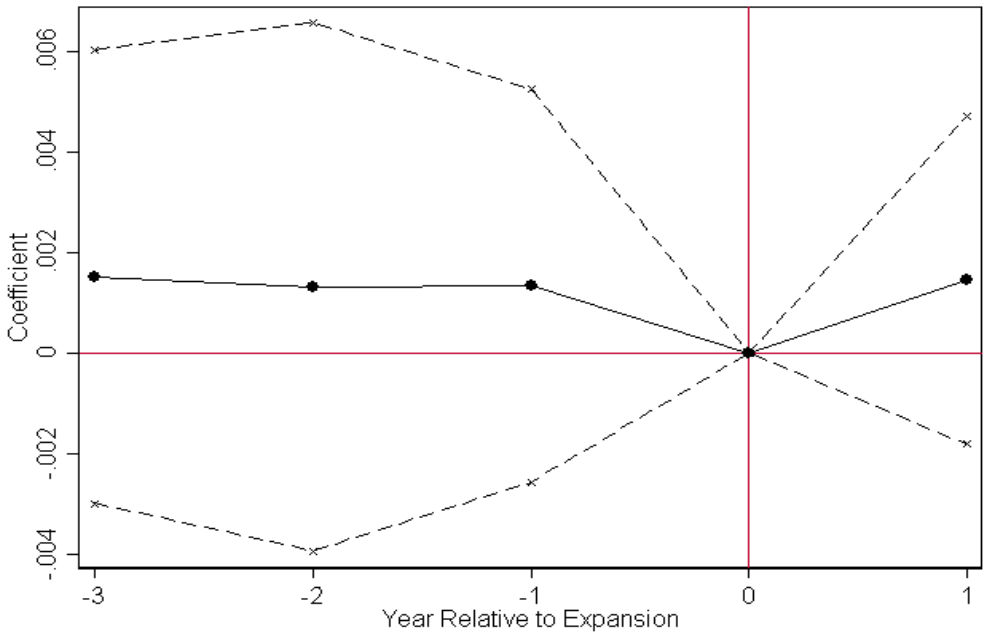
Appendix Figure 1: Comparison of Employment-to-Population Ratio Estimates Across Datasets



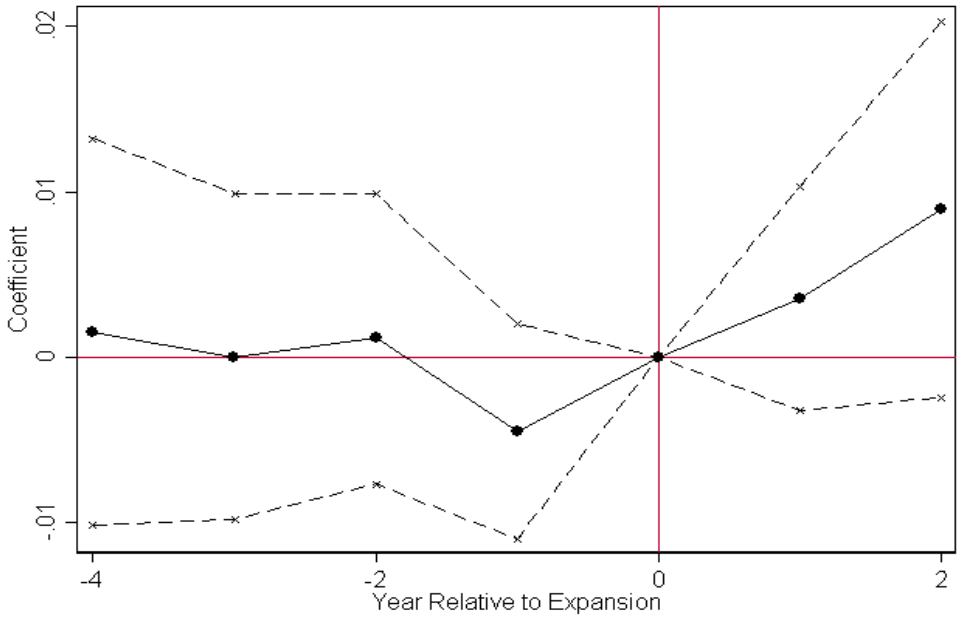
Notes: This plot shows the employment-to-population ratio in expansion and non-expansion states using CES, CPS, and ACS. The denominator for each series in the 16 and over population. Expansion status is defined as in Figure 1.

Appendix Figure 2: Event Study Estimates on Employment

A. American Community Survey



B. Current Population Survey



Notes: These figures plot the estimates of δ in equation (2) for k=-3 to k=1, where the the dependent variable is employment rate in the ACS (upper figure) or CPS (lower figure). Sample is as in Table 4.

Appendix Table 1: Effect of Medicaid Expansion on Fraction Below Poverty

	Fraction Below Poverty - ACS	Fraction Below Poverty - CPS
Childless Adults		
Expansion x Post	0.001	-0.004
	(0.001)	(0.003)
	[0.58]	[-1.12]
Mean of Dep Var	0.109	0.094

Notes: Data is from ACS 2010-2014, CPS 2010-July 2015. Sample includes all states in which childless adults were not eligible for Medicaid in 2013 (42 States). Observations are state-year averages for ACS (N=210) and state-month averages for CPS (N=2814). Regressions include year and state fixed effects, month-in-year effect (CPS only) and are weighted by cell sizes. Standard errors are clustered by state and in parentheses. t-stats are in brackets.

Appendix Table 2: Robustness to Inclusion of Different States

	Insured	Medicaid / Other Govt	Employed (CPS)
A. Excluding Limited Plan States			
Expansion x Post	0.021	0.035	0.003
	(0.004)	(0.005)	(0.004)
	[4.88]	[7.05]	[0.78]
Mean of Dep Var	0.833	0.081	0.674
B. Including Only 2014 Expansion States			
Expansion x Post	0.016	0.033	0.005
	(0.005)	(0.003)	(0.004)
	[2.99]	[10.09]	[1.41]
Mean of Dep Var	0.841	0.841	0.677

Notes: Data is from ACS 2010-2014, CPS 2010-July 2015. Panel A includes all states in which childless adults were not eligible for any coverage (Medicaid-equivalent or limited) in 2013 (29 States). Panel B includes all states in which childless adults were not eligible for Medicaid in 2013, excluding MI, NH, PA, IN (36 States). Observations are state-year averages for ACS and state-month averages for CPS. Regressions include year and state fixed effects, month-in-year effect (CPS only) and are weighted by cell sizes. Standard errors are clustered by state and in parentheses. t-stats are in brackets.

Appendix Table 3: Effects of Medicaid Expansion on Health Insurance

	Insured			Medicaid / Other Govt			Private, Thr. Employer			Private, Own Purchase		
A. Childless Adults												
Expansion x Post	0.018	0.019	0.017	0.031	0.031	0.030	-0.003	-0.002	-0.003	-0.009	-0.009	-0.008
	(0.005)	(0.004)	(0.005)	(0.004)	(0.004)	(0.004)	(0.003)	(0.002)	(0.002)	(0.003)	(0.003)	(0.003)
	[3.94]	[4.57]	[3.60]	[7.44]	[7.29]	[7.48]	[-1.22]	[-0.81]	[-1.08]	[-3.23]	[-3.13]	[-2.93]
Mean of Dep Var	0.842	0.842	0.842	0.086	0.086	0.086	0.628	0.628	0.628	0.124	0.124	0.124
B. Childless Adults Under the Poverty Line												
Expansion x Post	0.085	0.091	0.083	0.108	0.107	0.112	-0.010	-0.007	-0.009	-0.013	-0.009	-0.017
	(0.015)	(0.014)	(0.010)	(0.014)	(0.014)	(0.010)	(0.004)	(0.004)	(0.003)	(0.005)	(0.005)	(0.003)
	[5.75]	[6.66]	[8.64]	[7.55]	[7.88]	[10.86]	[-2.33]	[-1.67]	[-2.64]	[-2.76]	[-1.88]	[-5.93]
Mean of Dep Var	0.619	0.619	0.619	0.354	0.354	0.354	0.125	0.125	0.125	0.105	0.105	0.105
C. Medicaid Likely Childless Adults												
Expansion x Post	0.029	0.032	0.029	0.048	0.048	0.047	-0.008	-0.007	-0.006	-0.009	-0.009	-0.010
	(0.006)	(0.006)	(0.006)	(0.006)	(0.006)	(0.005)	(0.005)	(0.003)	(0.003)	(0.003)	(0.003)	(0.003)
	[4.58]	[5.61]	[5.06]	[7.80]	[7.88]	[9.65]	[-1.71]	[-2.10]	[-1.86]	[-3.01]	[-2.95]	[-3.53]
Mean of Dep Var	0.764	0.764	0.764	0.149	0.149	0.149	0.490	0.490	0.490	0.113	0.113	0.113
Weighting	No	No	Yes	No	No	Yes	No	No	Yes	No	No	Yes
Controls	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes

Notes: Data is from ACS 2010-2014. Sample includes states in which childless adults were not eligible for Medicaid in 2013 (42 States). Observations are state-year averages (N=210). Regressions include year and state fixed effects. Controls include: Percent of childless adults that are female, married, married and female, in 5-year age categories (8 groups), nonwhite, have less than a high school diploma, and have a bachelor's degree. Standard errors are clustered by state and in parentheses. t-stats are in brackets.

Appendix Table 4: Effects of Medicaid Expansion on Employment

	Employed - ACS			Employed - CPS			Employed, >=30 Hrs Worked		
A. Childless Adults									
Expansion x Post	-0.001	-0.004	-0.001	0.003	0.003	0.005	0.004	0.004	0.007
	(0.003)	(0.003)	(0.002)	(0.004)	(0.004)	(0.003)	(0.004)	(0.004)	(0.003)
	[-0.41]	[-1.23]	[-0.51]	[0.82]	[0.91]	[1.48]	[0.99]	[1.26]	[2.26]
Mean of Dep Var	0.682	0.682	0.682	0.678	0.678	0.678	0.590	0.590	0.590
B. Childless Adults Under the Poverty Line									
Expansion x Post	0.001	-0.001	0.000	0.010	0.002	0.001	0.003	-0.004	-0.001
	(0.007)	(0.007)	(0.003)	(0.013)	(0.012)	(0.010)	(0.009)	(0.008)	(0.007)
	[0.14]	[-0.20]	[0.05]	[0.81]	[0.18]	[0.10]	[0.33]	[-0.53]	[-0.19]
Mean of Dep Var	0.246	0.246	0.246	0.318	0.318	0.318	0.208	0.208	0.208
C. Medicaid Likely Childless Adults									
Expansion x Post	-0.006	-0.005	-0.001	0.006	0.006	0.007	0.005	0.005	0.007
	(0.004)	(0.004)	(0.002)	(0.005)	(0.005)	(0.004)	(0.005)	(0.005)	(0.003)
	[-1.32]	[-1.37]	[-0.55]	[1.31]	[1.31]	[1.93]	[1.13]	[1.12]	[2.06]
Mean of Dep Var	0.609	0.609	0.609	0.617	0.617	0.617	0.530	0.530	0.530
Weighting	No	No	Yes	No	No	Yes	No	No	Yes
Controls	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes

Notes: Data is from ACS 2010-2014, CPS 2010-July 2015. Sample includes all states in which childless adults were not eligible for Medicaid in 2013 (42 States). Observations are state-year averages for ACS (N=210) and state-month averages for CPS (N=2814). Regressions include year and state fixed effects, month-in-year effect (CPS only). Controls include: Percent of childless adults that are female, married, married and female, in 5-year age categories (8 groups), nonwhite, have less than a high school diploma, and have a bachelor's degree. Standard errors are clustered by state and in parentheses. t-stats are in brackets.

ISSUE BRIEF
MAY 2017

The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal

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ABSTRACT

ISSUE: By increasing health insurance coverage, the Affordable Care Act's Medicaid eligibility expansion was also expected to lessen the uncompensated care burden on hospitals. The expansion currently faces an uncertain future.

GOAL: To compare the change in hospitals' uncompensated care burden in the 31 states (plus the District of Columbia) that chose to expand Medicaid to the changes in states that did not, and to estimate how these expenses would be affected by repeal or further expansion.

METHODS: Analysis of uncompensated care data from Medicare Hospital Cost Reports from 2011 to 2015.

FINDINGS AND CONCLUSIONS: Uncompensated care burdens fell sharply in expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs. Estimated savings across all hospitals in Medicaid expansion states totaled $6.2 billion. The largest reductions in uncompensated care were found for hospitals in expansion states that care for the highest proportion of low-income and uninsured patients. Legislation that scales back or eliminates Medicaid expansion is likely to expose these safety-net hospitals to large cost increases. Conversely, if the 19 states that chose not to expand Medicaid were to adopt expansion, their uncompensated care costs also would decrease by an estimated $6.2 billion.

KEY TAKEAWAYS

- The Affordable Care Act's Medicaid expansion has significantly reduced hospitals' uncompensated care costs.
- Safety-net hospitals with high total uncompensated care costs have seen the greatest financial benefits.
- If all nonexpansion states were to expand Medicaid, total uncompensated care costs would fall by an estimated $6.2 billion.

The Commonwealth Fund

BACKGROUND

Prior to the Affordable Care Act (ACA), childless, nondisabled adults were ineligible for Medicaid in most states. The ACA allowed states to expand eligibility to nonelderly adults with incomes up to 138 percent of the federal poverty level (roughly $16,400 for an individual and $33,600 for a family of four in 2017). As of March 2017, 31 states and the District of Columbia had expanded Medicaid, while 19 states had not.[1]

One intended benefit of the Medicaid expansion was to reduce uncompensated care burdens that hospitals face. Uncompensated care is any treatment or service not paid for by an insurer or patient. We define uncompensated care costs as the sum of a hospital's losses on both charity care (when hospitals forgo or reduce the cost of care) and bad debt (when hospitals bill for services but cannot collect payment).

Our previous research, detailed in a 2016 *Health Affairs* article, found that hospitals in Medicaid-expansion states experienced a sizeable reduction in their uncompensated care costs between 2013 and 2014, from 4.1 percentage points to 3.1 percentage points of operating costs.[2] To see if this uncompensated care decrease has continued, we extended our analysis to 2015 and explored which hospitals saw the greatest decreases in uncompensated care costs.

This issue brief is intended to guide decisions around a possible ACA repeal and further state Medicaid expansions, as well as inform policies aimed at alleviating hospitals' uncompensated care burden. In 2015, U.S. hospitals provided a total of $35.7 billion in uncompensated care, according to the American Hospital Association.[3] However, this burden is unevenly distributed. Safety-net hospitals care for a larger-than-typical share of low-income and uninsured patients. In the past, Medicare and Medicaid disproportionate share hospital (DSH) payments provided significant financial relief to safety-net hospitals. But the ACA mandates a sizeable reduction in DSH payments.

FINDINGS

Uncompensated Care Declines in Expansion States Are Substantial Relative to Profit Margins

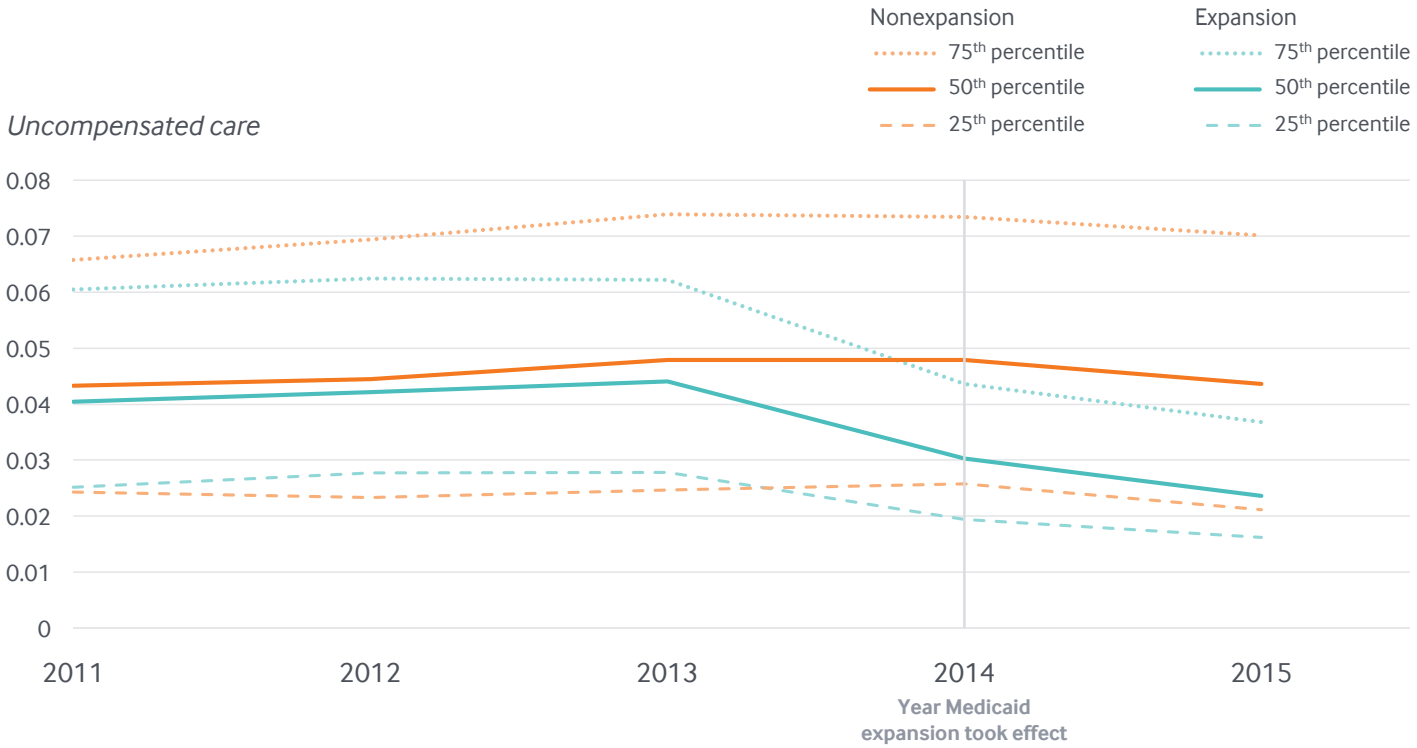
To identify trends in uncompensated care burdens for hospitals in expansion and nonexpansion states, we used data from Medicare Hospital Cost Reports to create a sample of 1,154 hospitals that report financial data for the calendar year. Focusing on hospitals within the 75th percentile, 50th percentile, and 25th percentile of the uncompensated care cost distribution, we found that between 2013 and 2014, these costs markedly declined in expansion states, and this downward trend continued into 2015 (Exhibit 1). The trajectories of uncompensated care costs were similar for hospitals across the three percentiles. In contrast, we found no similar break from historical trend in nonexpansion states.

The decline in uncompensated care costs in expansion states is economically meaningful. For example, the share of uncompensated care costs between 2013 and 2015 fell from just over 6.2 percent to just under 3.7 percent of operating costs among hospitals with high burdens. Overall, this is a cumulative decrease of roughly 40 percent. The decreases among hospitals with medium and low uncompensated care burdens were smaller but also meaningful: 2 percentage points and 1.2 percentage points of operating costs, respectively.

These results suggest that all hospitals benefited from the expansion and that the hospitals that had the highest levels of uncompensated care prior to 2014 benefited the most. Pooling the hospitals in expansion states together, we found that uncompensated care costs decreased between 2013 and 2015 from 3.9 percentage points to 2.3 percentage points of operating costs, a decline of 1.6 percentage points of operating costs.

These reductions in uncompensated care costs are substantial relative to hospital profit margins. Roughly 40 percent of hospitals in our sample had operating margins less than 1.6 percentage points of operating costs in 2011.

Exhibit 1. Uncompensated Care by Medicaid Expansion Status, Year, and Percentile of Uncompensated Care



Note: Uncompensated care is presented as a share of operating costs.

Data: 2011–2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

For Every Dollar of Uncompensated Care Costs Hospitals in Expansion States Had in 2013, the ACA Erased 41 Cents by 2015

While hospitals in nonexpansion states did not experience dramatic declines in uncompensated care costs between 2013 and 2015, they did see small declines in these costs of 0.3–0.4 percentage points. To identify how much hospitals saved in uncompensated care costs from the Medicaid expansion versus other market changes, we conducted a trend analysis, computing the average change in uncompensated care costs from 2013 to 2015 (Exhibit 2).

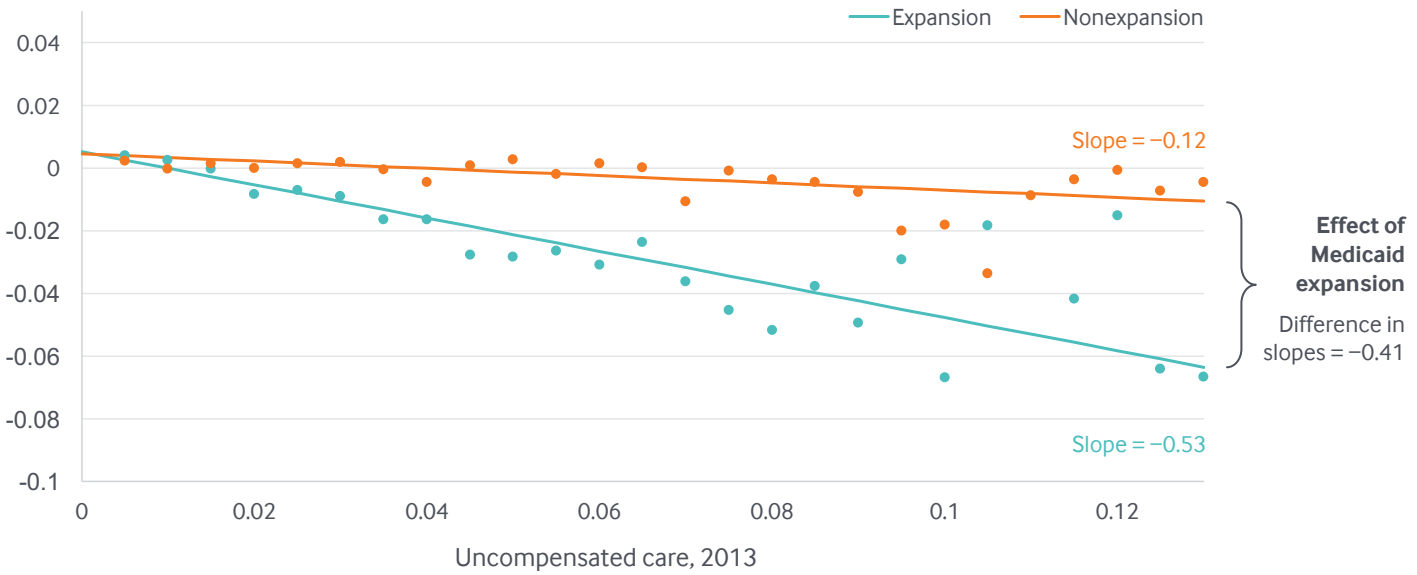
Hospitals in Medicaid expansion states saw their uncompensated care costs decline by 0.53 percentage points between 2013 and 2015 for each additional percentage point of uncompensated care costs in 2013. In comparison, hospitals in nonexpansion states saw their uncompensated costs fall by only 0.12 percentage points for each additional percentage point of uncompensated costs.

Overall, these estimates suggest that Medicaid expansion cut every dollar that a hospital spent on uncompensated care by 41 cents between 2013 and 2015.[4] Scaling these numbers to all hospitals in the 31 states (plus the District of Columbia) that expanded eligibility suggests that offering Medicaid to nonelderly adults reduced uncompensated care costs in these states by nearly $6.2 billion.[5]

If the 19 nonexpansion states were to expand Medicaid, uncompensated care in those states would fall from 6.1 percent of operating costs to an estimated 3.6 percent. This would reduce uncompensated care by $6.2 billion, the same amount as in the 31 states (plus D.C.) that expanded Medicaid. That is because prior to the ACA taking effect, hospitals in both groups of states had the same amount, dollarwise, of uncompensated care. Despite being much smaller in population than the expansion states, the nonexpansion states tend to have higher uncompensated care burdens.

Exhibit 2. Change in Uncompensated Care Costs, 2013–2015

Change in uncompensated care, 2013–2015



Notes: Uncompensated care is presented as a share of operating costs. Hospitals are placed into bins based on their 2013 uncompensated care costs. For each bin, we calculated the average change in uncompensated care costs from 2013 to 2015. Bins for expansion states are presented as teal dots, bins for nonexpansion states are presented as orange dots. The orange line is a regression line through the nonexpansion hospitals, and the teal line is a regression line through the expansion hospitals. For computing the least squares lines, uncompensated care values above or below the 2.5 percentile or the 97.5 percentile are replaced with values at those respective percentiles. For creating the bins, we replace all hospitals above 13 percentage points of operating costs with 13 percentage points of operating costs.

Data: 2011–2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

Medicaid Expansion Reduced Uncompensated Care Burdens for Safety-Net Hospitals Not "Made Whole" by Medicaid DSH Payments

We also explored how the Medicaid expansion specifically impacted uncompensated care costs in safety-net hospitals compared to other hospitals. First we divided hospitals by their share of patients on Medicaid, which is one common measure of whether a hospital is a safety-net provider (Exhibit 3).

In expansion states, hospitals with the highest Medicaid shares in 2013 had slightly larger decreases in uncompensated care costs than hospitals with the lowest shares (0.020% vs. 0.011% of operating costs). While statistically significant, the relationship is weak.

This finding does not suggest that "safety net" hospitals are not benefiting from the Medicaid expansion. Instead, it indicates that looking only at Medicaid share is inadequate for identifying safety-net hospitals. To illustrate this point, we categorized hospitals by their total uncompensated and undercompensated care burden (Exhibit 4).[6] This analysis considered shortfalls from all low-income patients, including the uninsured as well as those covered under Medicaid and the Children's Health Insurance Program. We also included safety-net compensation that is tied to serving these patients, such as Medicaid DSH payments, to determine whether these supplemental payments provide adequate financial assistance.

This analysis provides strong evidence that hospitals with higher overall uncompensated and undercompensated care burdens in 2013 benefited more from the Medicaid expansion than hospitals without large low-income populations. For example, among hospitals with the highest burdens, those in expansion states saw uncompensated care costs decrease by 2.6 percentage points more than hospitals in nonexpansion states. By contrast, among hospitals with the lowest safety-net burdens, those in expansion states saw uncompensated care costs decrease by only 0.7 points more than hospitals in nonexpansion states.

Exhibit 3. Uncompensated Care Costs by Medicaid Share, 2013–2015

	2013	2015	Change, 2013–2015
High 2013 hospital Medicaid share (>11%)			
Expansion states	0.049	0.029	−0.020
Nonexpansion states	0.061	0.057	−0.004
Difference	−0.012	−0.028	−0.016
Medium 2013 hospital Medicaid share (3.9%–11%)			
Expansion states	0.039	0.023	−0.016
Nonexpansion states	0.053	0.055	0.002
Difference	−0.014	-0.031	−0.017
Low 2013 hospital Medicaid share (<3.9%)			
Expansion states	0.030	0.019	−0.011
Nonexpansion states	0.033	0.032	−0.001
Difference	−0.003	−0.013	−0.010

Notes: Uncompensated care is presented as a share of operating costs. Uncompensated care values above or below the 2.5 percentile or the 97.5 percentile are replaced with values at those respective percentiles.

Data: 2011–2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

Exhibit 4. Uncompensated Care Costs by Total Uncompensated Care Burden, 2013–2015

	2013	2015	Change, 2013–2015
High 2013 burden (>7.9% of operating costs)			
Expansion states	0.071	0.038	−0.033
Nonexpansion states	0.093	0.086	−0.007
Difference	−0.022	-0.048	−0.026
Medium 2013 burden (4.7%–7.9% of operating costs)			
Expansion states	0.042	0.025	−0.017
Nonexpansion states	0.053	0.052	−0.001
Difference	−0.011	−0.027	−0.016
Low 2013 burden (<4.7% of operating costs)			
Expansion states	0.021	0.016	−0.006
Nonexpansion states	0.029	0.030	0.001
Difference	−0.008	−0.015	−0.007

Notes: Uncompensated care is presented as a share of operating costs. Uncompensated care values above or below the 2.5 percentile or the 97.5 percentile are replaced with values at those respective percentiles.

Data: 2011–2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

Hospitals that have benefited from the Medicaid expansion are hospitals that faced substantial shortfalls from serving low-income and uninsured populations. Existing federal funding mechanisms like DSH payments were not designed to mitigate shortfalls of this size. This analysis suggests that eliminating the Medicaid expansions and restoring Medicaid DSH as the primary mechanism for supplementary reimbursement to safety-net hospitals will reintroduce systematic disparities in hospital uncompensated care burdens. It also suggests that, if the Medicaid expansions are eliminated, policymakers will want to consider changing the way DSH payments are targeted so as to include a broader set of metrics.

CONCLUSION

Our analysis suggests that the Medicaid expansion has met the ACA goal of reducing uncompensated care burdens for hospitals. For each additional dollar spent on hospital services for Medicaid patients in expansion states, hospitals enjoyed an approximate 41-cent reduction in uncompensated care costs. When all hospitals in expansion states are considered, this translates into a $6.2 billion reduction in uncompensated care costs. If the 19 nonexpansion states were to expand Medicaid, uncompensated care costs in those states would, coincidentally, also fall by $6.2 billion.

There have been noticeable, but much smaller, decreases (0.3–0.4 percentage points) in uncompensated care costs in nonexpansion states. An important question beyond the scope of this brief is whether these decreases have been driven by other features or consequences of the ACA (for example, the individual mandate, the health insurance marketplaces, or outreach efforts to increase coverage) or whether other economic or hospital behavior factors are at play.

Further, our analysis suggests that reductions in uncompensated care costs were concentrated among hospitals that had large budget shortfalls from providing care to low-income and uninsured patients prior to the Medicaid expansions. This suggests that the expansions complemented other programs, such as Medicaid DSH payments, that offer help to safety-net hospitals.

The future of the Medicaid expansions remains uncertain. There is a chance that more of the 19 states that have not yet expanded Medicaid will do so in the future. It is also possible that these expansions will be scaled back or eliminated by future legislation. For example, the American Health Care Act, if it had become law, would have ended the ACA Medicaid expansion by 2020 and likely decreased the number of people gaining insurance through the marketplaces. Our results demonstrate the close relationship between the Medicaid program and hospital finances, suggesting there would be large decreases in uncompensated care costs from further expansion and large increases in those costs if the expansions are rolled back.

HOW THIS STUDY WAS CONDUCTED

This issue brief updates our 2016 *Health Affairs* article, in which we examined the evolution of uncompensated care costs from 2011 to 2014. We extend the analysis to include 2015 and see how these effects have evolved over time. For methodological details, we refer readers to our previous article.[7]

In this update, we rely on data from the 2011–2015 Medicare Hospital Cost Reports. Our sample is restricted to 1,154 hospitals that report financial data on the calendar year. We created a sample of states that increased Medicaid eligibility for childless adults in 2014 and a sample of states that did not. Six states that made other substantive changes to their Medicaid programs between 2011 and 2015 were excluded.[8] We dropped hospitals that were not present in all years or had missing or inconsistent data.

We measure a hospital's uncompensated care costs to be the sum of losses from charity care and bad debt, computed as a percentage of total operating costs. To make numbers that are comparable across hospitals of different sizes, we divided each hospital's uncompensated care costs by that hospital's 2011 operating costs. We examine how uncompensated care costs change after the 2014 Medicaid expansions for hospitals in expansion states compared to hospitals in nonexpansion states.[9] We also examine whether safety-net hospitals (defined using a number of possible criteria) disproportionately benefited from the Medicaid expansion.

NOTES

[1] Under the ACA, individuals who earn less than 100 percent of the federal poverty level are not eligible for subsidized coverage in the individual health insurance marketplaces.

[2] D. Dranove, C. Garthwaite, and C. Ody, "Uncompensated Care Decreased at Hospitals in Medicaid Expansion States but Not at Hospitals in Nonexpansion States," *Health Affairs*, Aug. 2016 35(8):1471–79.

[3] American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet* (AHA, Dec. 2016).

[4] This is calculated as the differences in slopes between expansion and nonexpansion states: 0.53 – 0.12 = 0.41.

[5] The $6.2 billion figure is based on acute-care and critical-access hospitals filing a cost report and excludes Arizona, California, Massachusetts, and Minnesota. It extrapolates our estimates to all hospitals that had expanded Medicaid as of March of 2017. This includes five states that did not expand in 2014 but have since expanded: Pennsylvania, Indiana, Alaska, Michigan, and Louisiana.

[6] This is based on row 31 of schedule S-10 of the Medicare cost reports and is titled "Total unreimbursed and uncompensated care cost."

[7] See note 2.

[8] We continue the decision in our prior research to discard hospitals in Arizona, California, Massachusetts, and Minnesota. We also exclude Indiana and Pennsylvania because they expanded in 2015.

[9] In our *Health Affairs* article, we provide further confirmation that the changes in uncompensated care were, in fact, driven by the Medicaid expansion by illustrating that the decreases were largest for hospitals with populations in their catchment areas with incomes less than 138 percent of the federal poverty level—the new eligibility limit for childless adults.

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The Commonwealth Fund

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Apply for Medicaid & CHIP through the Health Insurance Marketplace

The Marketplace helps individuals and families get health coverage. Some people who apply for coverage through the Marketplace are eligible for coverage through Medicaid or the Children's Health Insurance Program (CHIP). They'll be enrolled in coverage by their state Medicaid or CHIP agency. Medicaid and CHIP are free or low-cost health programs that cover many benefits including hospitalizations, doctor services, and prescription drugs. Visit **www.HealthCare.gov/medicaid-chip-program-names** to learn the Medicaid and CHIP program names in your state.

How do I apply for Medicaid or CHIP?

You can apply through the Marketplace or directly with your state Medicaid or CHIP agency. To apply through the Marketplace, visit **HealthCare.gov** to create a Marketplace account and complete an application. The Marketplace will use your application to see if anyone applying for coverage may be eligible for Medicaid or CHIP. You can also call the Marketplace Call Center at 1-800-318-2596 to apply. TTY users can call 1-855-889-4325.

Who qualifies for Medicaid or CHIP?

In all states, Medicaid and CHIP provide health coverage for some individuals and families, including children, parents, pregnant women, the elderly with certain incomes, and people with disabilities. In some states the programs cover other adults below a certain income level. Children in families with income too high to qualify for Medicaid may still be eligible to enroll in CHIP.

If you live in a state that expanded Medicaid, you may qualify if you make up to $12,060 a year for 1 person, or $24,600 for a family of 4 (income thresholds are different in Alaska and Hawaii). You may qualify for reasons other than just income. Each state has different requirements that can affect your eligibility for Medicaid and CHIP, like if you have children, are pregnant, or have a disability. That's why it's important to apply to see if you qualify.

If your income is higher than the usual qualifying amounts, you may still qualify for Medicaid in some states, depending on your medical needs. To see if you qualify based on these reasons, you can check a box to request a full Medicaid determination after you submit your Marketplace application.

What does Medicaid cover?

Medicaid generally covers:

- Inpatient hospital services
- Outpatient hospital services
- Doctor services
- Nursing facility services
- Certified pediatric and family nurse practitioner services
- Nurse midwife services
- Family planning services
- Home health services
- Rural Health Clinic (RHC) services
- Laboratory and X-ray services
- Smoking cessation for pregnant women
- Federally Qualified Health Center (FQHC) services
- Necessary transportation to and from medical providers
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services

States can choose to cover more services than those listed above.

What does CHIP cover?

Each state plans its own CHIP program. States can decide on the benefits covered by CHIP, but all states cover regular check-ups, immunizations, emergency services, hospital care, dental care, and lab and X-ray services. Children get free preventive care, but low cost sharing, like a deductible or copayment, may be required for other services.

If I have Medicaid or CHIP, do I need to buy a Marketplace plan?

No. If you're found eligible for Medicaid or CHIP that counts as qualifying coverage, you don't need to buy a Marketplace plan. If you still want to buy one, you'll have to pay full price for the Marketplace plan premium and covered services. To learn more about Medicaid or CHIP that counts as qualifying coverage, visit **www.HealthCare.gov/medicaid-limited-benefits**.

When can I apply?

You can apply for Medicaid and CHIP at any time. If you qualify, your coverage will be retroactive back to the date you applied, or up to 3 months earlier in some states.

How can I find out more?

To learn more about Medicaid and CHIP:

- Visit **HealthCare.gov/medicaid-chip**.
- Visit **InsureKidsNow.gov**, or call 1-877-543-7669 for more about CHIP programs in your state.
- Call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

You have the right to get Marketplace information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html**, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users can call 1-855-889-4325.

Paid for by the Department of Health & Human Services.

Health Insurance Marketplace

CMS Product No.11800
Revised October 2018

Medicaid & CHIP

Canceling a Marketplace plan when you get Medicaid or CHIP

Once you get a final determination that you're eligible for Medicaid or the Children's Health Insurance Program (CHIP) that counts as qualifying health coverage (/glossary/qualifying-health-coverage) (or "minimum essential coverage"):

- You're no longer eligible for a Marketplace plan with advance payments of the premium tax credit (/glossary/advanced-premium-tax-credit) and savings on out-of-pocket costs (/glossary/out-of-pocket-costs)
- You should **immediately** end Marketplace coverage with premium tax credits or other cost savings for anyone in your household who is determined eligible for or already enrolled in Medicaid or CHIP that counts as qualifying health coverage
- If you still want a Marketplace plan after you're found eligible for Medicaid or CHIP, you will have to pay full price for your share of the Marketplace plan without premium tax credits or other cost savings

Note: Most programs through Medicaid and CHIP count as qualifying health coverage under the health care law. If your Medicaid program **doesn't** count as qualifying health coverage, you **may be** eligible for advance payments of the premium tax credit and other savings on a Marketplace health plan, if you qualify based on your income and other factors. Find out if your Medicaid program counts as qualifying health coverage (/medicaid-limited-benefits/).

> **Important: Make sure you're eligible**
>
> Don't end your Marketplace plan before you get a final decision of your Medicaid or CHIP eligibility. If you're found ineligible for Medicaid or CHIP, you can't re-enroll in the Marketplace plan unless you qualify for a Special Enrollment Period (/glossary/special-enrollment-period). You'd have to wait for the next Open Enrollment Period and may have a gap in coverage.

You may get a notice from the Marketplace

If our records show you're enrolled in both a Marketplace plan with premium tax credits or other cost savings **and** Medicaid or CHIP — something we check a few times a year — you may get a notice in the mail that lists the household members who are enrolled in both kinds of coverage. The notice explains what to do next.

> **Take action within 30 days**
>
> Update your Marketplace application to show you're not enrolled in Medicaid or CHIP, or end your Marketplace coverage with premium tax credits or other cost savings by the date indicated on your initial warning notice (within **30 days** from the date of the notice).
>
> If you don't take action:
>
> - The Marketplace will end the advance payments of the premium tax credit and any extra savings being paid on your behalf for your share of the Marketplace plan premium and covered services
> - You'll still be enrolled in your Marketplace plan **without financial assistance** and will be responsible for paying the full cost of your share of the Marketplace plan premium and covered services

If you want more information about Medicaid or CHIP, or if you aren't sure if you or others in your household are enrolled in Medicaid or CHIP, you can contact the office in your state:

- For Medicaid, choose your state (/medicaid-chip/getting-medicaid-chip/#howtoapply)
- For CHIP, visit www.insurekidsnow.gov (http://www.insurekidsnow.gov/), or call 1-877-543-7669

If you decide to pay full price for a Marketplace plan

You can have both a Marketplace plan **and** Medicaid or CHIP, but you're not eligible to receive advance payments of the premium tax credit or other cost savings to help pay for your share of the Marketplace plan premium and covered services. If you or others on your Marketplace

application choose to have Medicaid or CHIP **and** full-price Marketplace coverage:

- End your Marketplace plan with premium tax credits if you're the only one on the application. (If others in your household are on the same Marketplace plan, you'll need to "report a life change" and then select that you're enrolled in Medicaid or CHIP. When you get to the "Eligibility Results" page, continue to "Enrollment" and select a Marketplace plan for those who are still eligible for Marketplace coverage. Once you've confirmed your selection for the rest of the household, enrollment in a Marketplace plan with financial help will end for those who are eligible for Medicaid or CHIP.)
- Submit a new application for Marketplace coverage without premium tax credits or other cost savings. **Note:** You can only enroll in Marketplace coverage during the annual Open Enrollment Period or if you qualify for a Special Enrollment Period.
- Notify your state Medicaid or CHIP agency of your Marketplace enrollment. **Note:** You may no longer be eligible for CHIP.

Ending your Marketplace plan

Answer a few questions for step-by-step instructions on how and when to end your Marketplace plan with premium tax credits and other cost savings.

More Answers

› What if I have Medicaid now, but I only have limited benefits?

› What if I'm not enrolled in or eligible for Medicaid or CHIP, but I got a notice?

Can we improve this page?

ASPE
ISSUE BRIEF

THE EFFECT OF MEDICAID EXPANSION ON MARKETPLACE PREMIUMS

Aditi P. Sen and Thomas DeLeire

September 6, 2016

Since the enactment of the Affordable Care Act (ACA), health insurance coverage has dramatically increased, primarily through the establishment of Health Insurance Marketplaces ("Marketplaces") and Medicaid expansion. These two forms of coverage have worked together to improve access to affordable and comprehensive health insurance for all Americans. As of early 2016, an estimated 20 million additional individuals have gained health coverage as a result of provisions of the ACA.[1] Additionally, as this brief estimates, the Medicaid expansion helps lower premiums for Marketplace enrollees; we estimate that Marketplace premiums are about 7 percent lower in states that expanded Medicaid compared to those that have not done so yet.

These findings suggest that implementing the ACA's two major coverage expansions together as intended can benefit all three affected groups: individuals with incomes below 100% FPL who gain coverage only through expansion, individuals with incomes between 100 and 138% FPL, who gain coverage through Medicaid that is more likely to fit their budget, and individuals with coverage through the Marketplace, who may benefit from the positive impact of Medicaid expansion on premiums.

Coverage through the Marketplaces and Medicaid differ in both design and population covered. The ACA's Medicaid expansion was designed to cover individuals with incomes up to 138% FPL, who benefit from a robust package of benefits with no or low cost (e.g., limited cost-sharing), while the Marketplaces were expected to serve individuals with income above 138%

[1] Uberoi, N., Finegold, K., and Gee, E. Health insurance Coverage and the Affordable Care Act, 2010-2016. ASPE Issue Brief, March 2016, https://aspe.hhs.gov/pdf-report/health-insurance-coverage-and-affordable-care-act-2010-2016.

FPL.While Marketplace and Medicaid coverage differ, they work together in many ways. As a result of the ACA, the two programs' eligibility criteria and processes are closely aligned. Individuals move from one type of coverage to another as their incomes and other circumstances change, insurers participate in one or both markets, and there are interactions between the programs' risk pools.

States that have expanded Medicaid coverage under the ACA effectively have private insurance risk pools comprised largely of individuals with incomes *above* 138% FPL since those with incomes below this level are covered by Medicaid.[2] In non-expansion states, individuals with incomes below 100% FPL generally have no option for subsidized coverage, but individuals with incomes in the 100%-138% FPL range can access financial assistance through the Marketplace.[3] In these states, individuals with incomes between 100 and 138% FPL make up close to 40% of the Marketplace population, on average, *versus* 6% in states that have expanded Medicaid.[4] Because low-income individuals on average have poorer health status than those with higher incomes (but better health status than those with incomes below poverty), a state's decision to expand Medicaid has the potential to affect the invididual market risk pool and ultimately Marketplace premiums.[5]

According to our analysis of states that used HealthCare.gov in 2015, Marketplace premiums in states that have expanded Medicaid are, on average, substantially lower than in states that have not (see Figure 1). While there are many differences between expansion and non-expansion states, this brief examines whether and to what extent the Marketplace premium differences are due to the direct impact of states' decisions to expand Medicaid. We estimate that Marketplace premiums are about 7 percent lower in expansion states, controlling for differences across states in demographic characteristics, pre-ACA uninsured rates, health care costs, and state policy decisions other than Medicaid expansion (e.g., allowing transitional policies, rating area design), and limiting the analysis to neighboring counties, which might be expected to have similar populations. Our findings are consistent with direct evidence on differences in health status

[2] Note that legal immigrants in this income range may not be covered due to a five-year waiting period between obtaining qualified immigration status and enrolling in Medicaid.
[3] Those lawfully present with incomes below 100% FPL and in the five-year waiting period between obtaining qualified immigration status and Medicaid eligibility are eligible for subsidized Marketplace coverage.
[4] Some individuals in expansion states with incomes between 100 and 138% FPL are nevertheless eligible for subsidized coverage through the Marketplace. This can occur if they are lawfully present but in the five-year waiting period between obtaining qualified immigration status and becoming eligible for Medicaid. In addition, individuals who are eligible for Medicaid are permitted to enroll in unsubsidized Marketplace coverage if they prefer that coverage to Medicaid coverage.
[5] Center on Budget and Policy Priorities, Why a State's Health Insurers Should Support Expanding Medicaid. September, 2012.

across income groups, as well as with statements from insurers, who have noted that states could improve the financial stability of their Marketplaces by expanding Medicaid.[6]

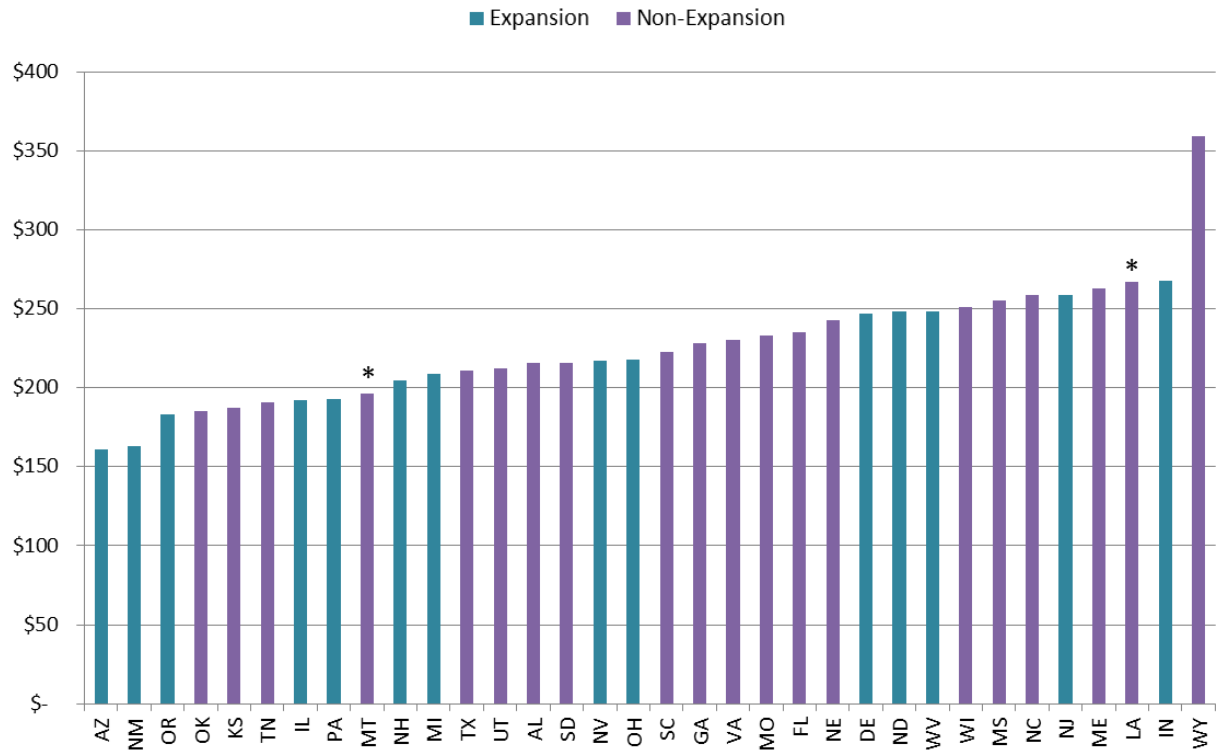
Medicaid Expansion is Associated with Lower Marketplace Premiums

Health insurance premiums of plans offered through the Marketplaces reflect a number of factors, including the health status and expected health care costs of expected enrollees (i.e., the risk pool). Thus, changes in the risk pool may impact Marketplace premiums. As discussed above, whether a state expands Medicaid determines whether individuals with incomes between 100% FPL and 138% FPL will generally be included in the Marketplace risk pool or will instead get coverage through Medicaid. Because low-income individuals report poorer health status than individuals with higher incomes, the presence of these individuals could affect the Marketplace risk pool and, hence, Marketplace premiums.

We use 2015 administrative data on Marketplace plans and enrollment to assess how Medicaid expansion affected premiums due to changes in the underlying risk pool of eligible enrollees. In 2015, Marketplace premiums for the second-lowest cost silver plan were, on average, about 8% lower in expansion states than non-expansion states among states that used HealthCare.gov (excluding Alaska because it expanded Medicaid after Marketplace rates were set) (Figure 1). This raw difference, however, does not control for any other state factors that might vary between expansion and non-expansion states and affect premiums (e.g., population demographics, market characteristics, insurer networks, policy decisions).

[6] See, for example, Murawski, J. "Blue Cross CEO says insurer may leave ACA market in NC in 2017." *The News & Observer*, Feb. 10, 2016.

Figure 1. Average Monthly Premium (for 27-year-old) of Second-Lowest Silver Plan, Medicaid Expansion vs. non-Expansion FFM States (excluding Alaska), 2015



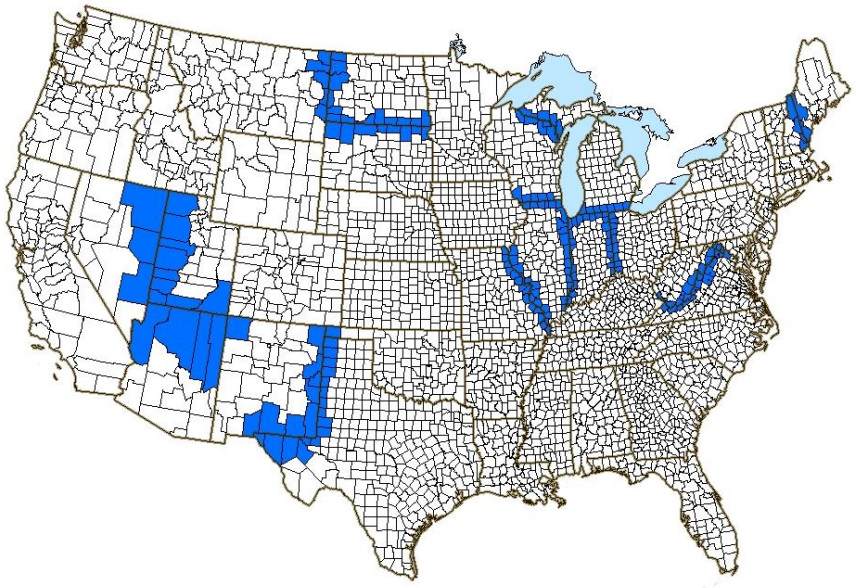
Notes: *LA and MT expanded Medicaid in 2016. AK is excluded because it expanded Medicaid in late 2015 after Marketplace rates were set. Average of second-lowest silver plan premiums across counties within each state, weighted by plan selections, see Avery, K., et al. "Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace," ASPE Research Brief, October 30, 2015.

To obtain estimates of the relationship between Medicaid expansion and Marketplace premiums that are less subject to these potential confounding factors, we use geographic matching analysis, which is based on comparing premiums across border counties that are within a unified geographic area but located in states that made different Medicaid expansion decisions. While there are likely to be many (unobservable) differences between Medicaid expansion and non-expansion states, our method allows us to compare risk pools and premiums in geographic areas where it is more likely that the population is relatively homogeneous (e.g., in terms of ethnicity, race, economic status) and there are fewer unobservable differences that would affect premiums.

We compare Marketplace premiums within county pairs that span expansion and non-expansion states, using regression analyses to control for population characteristics, state policies that may be related to premiums (e.g., allowing transitional policies, rating area design), market characteristics (e.g., hospital concentration, number of Marketplace issuers), and characteristics of the county-pair through fixed effects. We also weight regressions by Marketplace enrollment.

Due to limitations in data available from State-based Marketplaces, both states in the expansion and non-expansion comparison counties must use the HealthCare.gov platform to be included in the analysis. There are 94 county-pairs across 19 states where one county is located in a Medicaid expansion state and the paired county is in a non-expansion state and both states use the HealthCare.gov platform (Figure 2).[7] These matched border counties are statistically similar across a range of population characteristics, suggesting that this approach allows us to control for a range of demographic characteristics that might influence premiums (Technical Appendix Table A2, columns 7-8). We have the data to include controls as discussed above for 91 of the 94 county-pairs. Full details on the regression specification and robustness checks are available in the technical appendix.

Figure 2. Counties included in Matched Border Analysis (HealthCare.gov States Only)



Notes: Map shows counties included in matched border analysis. County-pairs must include one county in a Medicaid expansion state and one county in a non-expansion state and both states must use the HealthCare.gov platform.

Results from this analysis suggest that Medicaid expansion was associated with 7% lower Marketplace premiums in this sample of matched border counties. As is shown in Technical Appendix Table A1, the significant reduction in Marketplace premiums associated with Medicaid expansion is consistent across several analytic approaches; while the estimated size of the reduction varies, it is greater than or equal to 7% under all approaches. In other versions of

[7] We omit Iowa and Arkansas, which have expanded Medicaid under a waiver that allows them to enroll certain Medicaid eligible populations into private insurance with premium assistance. We classify states that expanded after January 1, 2015 (such as Indiana) as non-expansion states because Marketplace premiums are established in the fall of 2014 and would not have accounted for this expansion.

the analysis, we broaden our analysis to include all FFM counties and estimate the effect of expansion (without matching) and use external data to estimate the effect across FFM and SBM states (Appendix Table A1).

There is the potential for other factors to be driving these differences in premiums between expansion and non-expansion states. Although we cannot control for these differences perfectly, we control for several policy choices as well as for other county and state characteristics that might be expected to have the greatest impact on premiums and also mitigate this issue to a certain degree by restricting our main analysis to FFM states.

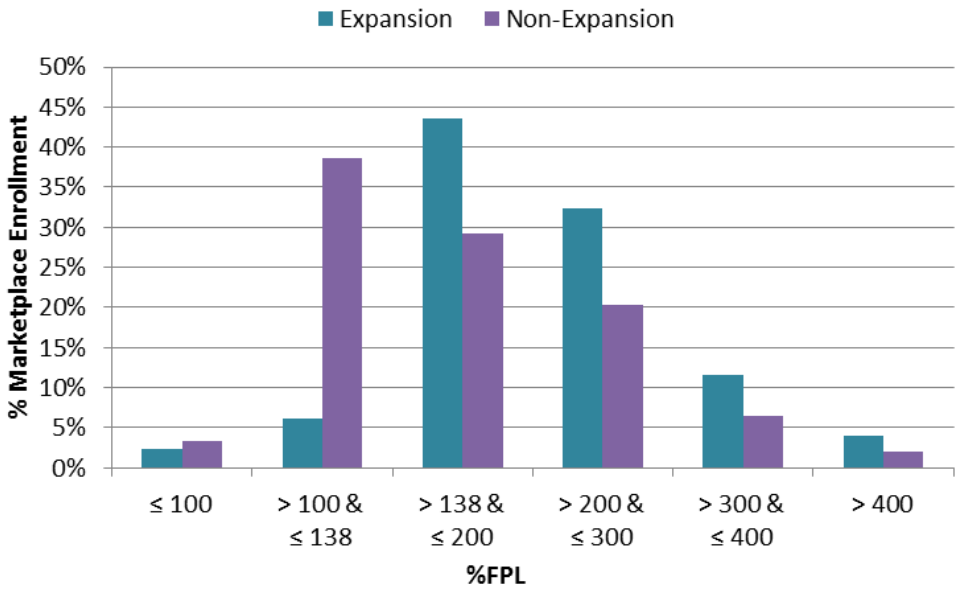
Higher Marketplace Premiums in Non-Expansion States Reflect a Different Risk Pool

The 7% premium difference in expansion *versus* non-expansion states is consistent with differences in expected spending of Marketplace enrollees across these types of states due to the variation in enrollment and expected spending by income.

Income and Marketplace Enrollment

In states that have not yet expanded Medicaid, individuals with family incomes between 100 and 138% FPL are eligible for subsidized Marketplace coverage, while in states that have expanded Medicaid, subsidized coverage is generally only available to those with incomes above 138% FPL. As a result, low-income individuals (100-138% FPL) make up a greater share of Marketplace enrollment in Medicaid non-expansion states than in expansion states (Figure 3). Enrollees with incomes between 100 and 138% FPL represent close to 40% of total enrollment in non-expansion states.

Figure 3. Marketplace Enrollment by Income, Expansion vs. non-Expansion States, 2015



Notes: Data from MI, NH, PA, IN, and AK, which expanded Medicaid after January 2014 but before January 1, 2016 are not included in this figure (all states that expanded before 1/1/2015 are included in the main regression analysis). LA and MT, which expanded Medicaid in 2016 are included as non-expansion states.

Income and Health Status

A substantial body of scientific literature confirms a persistent connection between low income and poor health.[8] Not only are most diseases more common among the poor and near-poor at all ages, but there is evidence that poverty also results in faster progression of diseases, more complications, and poorer survival rates.[9]

Data from the Current Population Survey shows that low-income individuals are more likely to report that they are in fair or poor health than individuals with higher incomes. Close to 20% of individuals with incomes between 100 and 138% FPL report being in fair or poor health compared to approximately 8% of individuals with incomes above 138% FPL. Combining these rates with the enrollment data above suggests that we would expect the share of enrollees in fair or poor health (compared to good, very good, or excellent health) to be 2 percentage points higher in non-expansion states compared to expansion states due to the difference in the percent

[8] See, for example, Case, A., Lubotsky, D., and Paxson, C. (2002). Economic Status and Health in Childhood: the Origins of the Gradient, *American Economic Review*, 92(5):1308-34. Also see Deaton, A.S. and Paxson, C. (1999). Mortality, Education, Income and Inequality among American Cohorts, NBER Working Paper No. 7140.
[9] Kaplan, G. A. (2009). The Poor Pay More – Poverty's High Cost to Health. Federal Reserve Bank of San Francisco. Accessed 7/25/16 at: http://www.frbsf.org/community-development/files/poor_pay_more.pdf.

of low-income enrollees.[10] In turn, data suggest that those in relatively poorer health are likely to have higher health care expenditures than those in better health, which may lead to higher expected spending per enrollee in expansion *versus* non-expansion states, consistent with the increase in premiums we find.[11]

At the same time, individuals with incomes between 100 and 138% FPL have better health status and lower average costs than individuals with incomes below 100% FPL. Current Population Survey data shows that 22% of individuals with incomes below 100% FPL report being in fair or poor health compared to the approximately 20% of individuals with incomes between 100 and 138% FPL. While there may be pent-up demand as uninsured people gain coverage through the Medicaid expansion, the Congressional Budget Office and the Office of the Actuary estimate that, over time, the cost of newly eligible adults will be less than that of previously eligible adults.

Conclusion

As of February 2016, 20 million individuals have gained health insurance thanks to provisions of the ACA, including Medicaid expansion and the establishment of Health Insurance Marketplaces. A comparison of cross-border counties shows that, on average, the benchmark premium in the Marketplace was 7% lower in 2015 in states that expanded Medicaid relative to states that did not, taking into account other state differences such as non-expansion policy choices, population demographics, and health care costs as measured by employer market premiums. It will be important to extend this analysis to future years to see if premium differences continue. These findings suggest that implementing the ACA's two major coverage expansions together as intended can benefit all three affected groups: individuals with incomes below 100% FPL who gain subsidized coverage only through expansion, individuals with incomes between 100 and 138% FPL, who gain coverage through Medicaid that is more likely to fit their budget, and individuals with coverage through the Marketplace, who may benefit from the impact of Medicaid expansion on premiums.

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[10] At the same time, the evidence shows that individuals who are newly eligible for Medicaid due to expansion are relatively healthier than Medicaid beneficiaries who were eligible for Medicaid prior to the ACA; see Jacobs, P. D., Duchovny, N., and Lipton, B. J. (2016). Changes in Health Status and Care Use after ACA Expansions Among the Insured and Uninsured. *Health Affairs* 35(7):1184-88.

[11] According to the 2013 Medical Expenditure Panel Survey (MEPS)-Household Component, those who are under 65 years old and in good, very good, or excellent health, have median spending of $945 annually conditional on having a health expense, compared to $4,115 among those who are <65 but report being in fair or poor health. These spending differences, combined with the difference in the percent of enrollees in fair or poor health, suggest that expected spending per capita would be approximately 6% higher in non-expansion vs. expansion states. This is consistent with the 7% higher premiums estimated in our matched border county analysis. Note that we do not have data to estimate differences in spending by health status by age. Younger individuals who report fair or poor health may have relatively lower spending than older individuals in fair/poor health; in turn, this could have implications for expected spending among enrollees in expansion vs. non-expansion states. In addition, if enrollees pick different types of plans (e.g., different benefit structures) in expansion vs. non-expansion states, this may impact spending in ways we cannot capture.

TECHNICAL APPENDIX

The U.S. Census County Adjacency File was used to identify all counties in states using the HealthCare.gov platform in 2015 that also expanded Medicaid as of January 1, 2015 that were adjacent to one or more counties in a state that also used the HealthCare.gov platform in 2015 but that had not yet expanded Medicaid as of January 1, 2015.

There are 94 counties in expansion states that are adjacent to counties in non-expansion states that we were able to use for the analysis. Each expansion county was grouped with one or more adjacent non-expansion county. We estimated the average difference between the age-adjusted Marketplace premiums of the second-lowest-cost silver plan in each expansion county and its adjacent non-expansion counties. (Results are consistent for premiums of the lowest-cost silver, average silver, lowest bronze, and average bronze plans; results not shown.) We estimated the relationship between expansion and premiums with no controls, controls only for local demographics (variables included as control measures are available for 91 expansion state counties), and a full set of controls including demographic and market characteristics as well as state policies. The full list of controls is listed in Table A1 below.

Because our results may be specific to the states included in the analysis, we broaden our analysis to estimate the effect of expansion on premiums in the following samples. Results are shown in Table A1.

1. All counties in FFM states
    - Counties not matched; this specification includes a dummy indicator of whether or not the county was in a state that had expanded Medicaid.
2. All counties in FFM border states
    - All counties in the 19 FFM border states listed in the notes of Table A1.
    - As above, this specification includes a dummy indicator of whether or not the county was in a state that had expanded Medicaid.
3. Border counties in FFM border states
    - All *border* counties in the 19 FFM border states listed in the notes of Table A1.
    - As above, this specification includes a dummy indicator of whether or not the county was in a state that had expanded Medicaid.
4. Matched border counties in FFM border states [main specification]
    - Expansion counties matched to adjacent non-expansion counties.
    - Fixed effects regression.
5. Matched border counties in FFM and SBM states
    - Expansion counties matched to adjacent non-expansion counties, all states.
    - Rating area-level premiums (rather than county-level as in FFM specifications); no data on control variables for SBMs available; fixed effects regression.

Table A1. Analysis of 2015 Premium Differences in Medicaid Expansion vs. Non-Expansion States

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
	All FFM Counties			**All Counties in FFM Border States**			**Border Counties in FFM Border States**			**Matched Border Counties in FFM Border States**			**Matched Border Counties (SBM + FFM)**
Difference between Counties in Expansion States and Counties in Non-Expansion States	-$23.89	-$41.75	-$32.13	-$22.19	-$35.37	-$28.20	-$31.30	-$24.89	-$31.71	-$30.52	-$24.94	-$15.44	-$32.00
	(5.38) {10.34}	(4.78) {8.76}	(4.57) {10.19}	(6.61) {11.05}	(3.85) {7.44}	(4.20) {12.65}	(9.56) {11.43}	(3.60) {6.08}	(4.75) {7.05}	(8.06)	(3.25)	(5.60)	(5.16)
Mean SLS Premium in Non-Expansion Counties		$219.40			$210.92			$217.00			$223.94		$232.22
Percent Effect	-10.89%	-19.03%	-14.64%	-10.52%	-16.77%	-13.37%	-15.11%	-13.21%	-14.61%	-13.63%	-11.14%	-6.89%	-13.78%
Exogenous controls	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No
Market/policy controls	No	No	Yes	No	No	Yes	No	No	Yes	No	No	Yes	No
Method		Weighed OLS			Weighed OLS			Weighed OLS			Fixed Effects		Fixed Effects
Number of counties	2,544	2,152	2,152	1,349	1,055	1,055	249	211	211	249 (94 groups)	211 (91 groups)	211 (91 groups)	570 (186 groups)

Notes:

Border states include: AZ, IL, MI, ND, NH, NM, NV, OH, WV (Expansion) and IN, ME, MO, MT, OK, SD, TX, UT, VA, WI.

Exogenous controls include: population density, per-capita income, percent uninsured, percent in poverty, ESI spending, CMS wage index, adult smoking rate, adult obesity rate, and NCHS rural county indicators.

Market/policy controls include number of issuers, hospital market concentration, indicator for transitional policies, indicator for county-based rating areas, pcps per capita, doctors per capita, and hospital beds per capita.

Robust standard errors in parentheses; State-level clustered standard errors in brackets.

Second-lowest silver premium is for age 21 and is calculated at the county level, except for column (13) in which SLS is for age 27 and is calculated by rating area.

Expansion states include those that expanded as of 1/1/2015.

Premium information for column (13) comes from RWJF HIX Compare, accessed at: http://www.rwjf.org/en/library/research/2015/12/hix-compare-2015-2016-datasets.html

Lower premiums in Medicaid expansion states are observed in all samples, though effect sizes vary. Moving from columns (1) – (3) to (10) – (12) improves the comparability of expansion vs. non-expansion counties on a range of demographic factors that are likely to influence premiums (Table A2). The lack of statistical differences in matched border counties is the main factor making this our preferred specification.

Table A2. Difference between expansion and non-expansion counties (to test for balance) for FFM specifications

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	All FFM Counties		**All Counties in FFM Border States**		**Border Counties in FFM Border States**		**Matched Border Counties in FFM Border States**	
County Characteristic	*Difference between expansion and non-expansion counties*	*t-stat (bold indicates statistical significance)*	*Difference between expansion and non-expansion counties*	*t-stat (bold indicates statistical significance)*	*Difference between expansion and non-expansion counties*	*t-stat (bold indicates statistical significance)*	*Difference between expansion and non-expansion counties*	*t-stat (bold indicates statistical significance)*
Population Density	668	1.64	270	0.49	1447	1.16	161	0.2
Per-capita Income	1,710	1.38	-1,679	-0.91	4,075	1.47	21	0.01
Median Income	2,916	**1.81**	-2,760	-1.23	3,171	1.09	532	0.3
% <65 without Health Insurance 2012	-5.82%	**-5.67**	-4.39%	**-3.63**	-0.39%	-0.21	-1.11%	-1.1
Unemployment Rate 2014	0.55%	**3.16**	1.48%	**6.2**	0.74%	**2.41**	0.43%	**2.22**
Employer-Sponsored Insurance Personal Healthcare Expenditures Per Enrollee	204	**1.87**	572	**4.23**	463	**2.46**	88	0.39
Hospital Wage Index from CMS	6.56%	**4.84**	4.01%	**2.46**	6.83%	**2.4**	0.50%	0.34
Number of Issuers	1.18	**2.39**	2.88	**4.3**	1.51	**2.69**	0.56	1.17
Percent of Adults that Smoke	1.06%	**1.71**	1.22%	**1.88**	0.16%	0.2	-0.26%	-0.23
Percent of Adults that are Obese	-0.31%	-0.44	-0.48%	-0.56	-1.80%	-1.55	-1.03%	-0.84
Percent in Poverty	-1.33%	**-1.94**	0.48%	0.55	0.32%	0.21	0.11%	0.12
Percent with College Education	1.58%	1.4	-0.37%	-0.22	2.55%	0.94	0.28%	0.12
Primary Care Docs per-1000 pop	0.1027	**3.29**	0.1215	**2.47**	0.0943	1.01	0.0198	0.27
MDs per 1000 pop	0.4223	**2.08**	0.4143	1.42	0.2079	0.31	-0.42	-0.65
Percent in Poor or Fair Health 2014	-0.57%	-1.38	-0.54%	-0.91	0.42%	0.33	0.74%	1.18
Percent in Poor or Fair Health 2015	-0.57%	-1.38	-0.54%	-0.91	0.42%	0.33	0.74%	1.18
Percent Rural 2014	1.00%	0.35	-2.33%	-0.56	-2.23%	-0.3	0.32%	0.08
Percent Rural 2015	1.00%	0.35	-2.33%	-0.56	-2.23%	-0.3	0.32%	0.08

For our main analysis, we did not include Arkansas or Iowa. These states expanded Medicaid under a premium assistance model through a Section 1115 waiver under which they use Medicaid funds to purchase private coverage for Medicaid beneficiaries through the Marketplaces. Medicaid enrollees in these states may be considered to be part of the Marketplace risk pool and therefore these states may not be comparable to other Medicaid expansion states.

Table A3. Full Regression Results for the Analysis Summarized in Table A1

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	
	All FFM Counties			All Counties in FFM Border States			Border Counties in FFM Border States			Matched Border Counties in FFM Border States			Matched Border Counties (SBM + FFM)	Variable Notes [Source]
Expansion State	-23.89***	-41.75***	-32.13***	-22.19***	-35.37***	-28.20***	-31.30***	-24.89***	-31.71***	-30.52***	-24.94***	-15.44***	-32.00	Expansion states include those that expanded as of 1/1/2015.
	(5.380)	(4.782)	(4.571)	(6.609)	(3.846)	(4.200)	(9.564)	(3.602)	(4.749)	(8.062)	(3.251)	(5.598)	(5.16)	
Population Density in County, 2010		-0.000129	-0.000585		0.000961	-0.000358		-0.00573***	-0.00753***		-0.00812*	-0.0100***		[Area Resources File]
		(0.00169)	(0.00141)		(0.00232)	(0.00235)		(0.00163)	(0.00184)		(0.00485)	(0.00375)		
Per-capita Income, 2013		0.000424	0.000589***		0.000621**	0.000361		0.00106***	0.000738**		0.00112**	0.00113**		[Area Resources File]
		(0.000262)	(0.000198)		(0.000287)	(0.000256)		(0.000253)	(0.000298)		(0.000504)	(0.000556)		
Percent of Adults < Age 65 without Health Insurance, 2013		-58.42	35.58		-180.4***	-198.3***		-147.6**	-180.3**		186.5*	334.8***		[Area Resources File]
		(47.94)	(40.45)		(48.47)	(55.48)		(61.35)	(77.53)		(99.75)	(105.0)		
ESI Personal Healthcare Expenditures Per Enrollee, 2013		0.00807***	0.00624***		0.00628***	0.00642***		0.00152	-0.000131		0.00257	0.00471		Employer-Sponsored Insurance Personal Healthcare Expenditures Per Enrollee [MarketScan]
		(0.00117)	(0.00106)		(0.00204)	(0.00174)		(0.00209)	(0.00248)		(0.00341)	(0.00328)		
Hospital Wage Index from CMS		140.6***	140.7***		47.92	53.29*		26.27	-6.068		47.91	18.01		[CMS FY 2015 Wage Index Home Page]
		(24.69)	(21.91)		(29.83)	(28.27)		(38.66)	(39.44)		(52.31)	(65.00)		
Percentage of Adults Who Are Current Smokers, 2015		116.6***	79.14**		79.89**	61.34		228.1***	224.5***		158.7**	129.7*		[Robert Wood Johnson Foundation County Health Rankings, 2015]
		(33.95)	(32.89)		(39.08)	(39.76)		(48.37)	(54.17)		(62.15)	(71.63)		
Percentage of Adults Who Report a BMI of 30 or Higher, 2015		42.56	111.9***		217.4***	206.8***		112.6	133.5		85.68	-25.45		[Robert Wood Johnson Foundation County Health Rankings, 2015]
		(59.86)	(40.77)		(50.10)	(53.76)		(74.88)	(88.54)		(81.56)	(105.9)		
Central County of MSA > 1 million pop (omitted)														
Fringe County of MSA > 1 million pop		2.662	-3.152		5.478	-1.980		1.898	-11.74		7.683	4.465		
		(7.258)	(6.149)		(6.537)	(6.406)		(6.595)	(8.750)		(21.01)	(16.92)		
County within MSA of 250,000-999,999 pop		12.10*	4.475		6.724	3.415		9.233	34.01***		12.59	2.621		[National Center for Health Statistics Urban-Rural Classification Scheme for Counties, 2013]
		(7.072)	(6.918)		(7.473)	(7.674)		(9.226)	(11.46)		(21.89)	(18.34)		
County within MSA of 50,000 to 249,999 pop		19.10***	9.291		22.03***	18.01**		16.96*	38.21**		12.63	-9.119		
		(7.212)	(7.706)		(7.799)	(9.119)		(10.03)	(16.08)		(23.29)	(20.94)		
County within Micropolitan Statistical Area		33.21***	17.84**		24.61***	19.43**		12.75	36.00**		21.30	-0.747		
		(7.207)	(8.350)		(7.698)	(9.792)		(9.081)	(16.70)		(25.85)	(22.05)		
Noncore County not within Micropolitan Statistical Area		32.80***	16.10*		28.18***	23.08**		26.16***	50.33***		18.62	-2.000		
		(6.844)	(8.493)		(7.966)	(10.52)		(9.664)	(18.84)		(25.71)	(22.56)		
Percent of Persons in Poverty, 2013		0.543	0.456		0.651	0.870*		1.494***	2.044***		1.142*	1.287		[Area Resources File]
		(0.345)	(0.377)		(0.555)	(0.525)		(0.491)	(0.686)		(0.619)	(0.850)		

(continued on the next page)

Table A3 continued

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	
Number of Issuers in the County			-3.923***			-1.845***			-1.318			-5.473**		[Marketplace Plan Landscape File]
			(0.935)			(0.708)			(1.288)			(2.342)		
State did not allow Transitional Policies			-1.780			8.367*			-8.517**			14.56**		[CCIIO]
			(2.883)			(4.359)			(3.705)			(5.879)		
State used MSA+1 definition for rating areas			-18.79***			6.077			-5.070			34.88***		[CCIIO: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-
			(3.800)			(5.876)			(7.681)			(12.95)		
Hospital Beds Per Capita, 2012			-919.7			-1,385**			-3,921***			-977.8		[Area Resources File]
			(750.2)			(588.8)			(1,008)			(1,141)		
Primary Care Physicians Per Capita, 2013			23,658***			11,051			27,724**			-4,001		[Area Resources File]
			(8,278)			(8,082)			(10,773)			(9,900)		
Physicians Per Capita, 2013			-3,429**			-458.4			-1,629			860.7		[Area Resources File]
			(1,418)			(1,854)			(1,853)			(2,611)		
Hospital HHI<2500			-1.203			9.096			48.76***			-3.254		
			(6.832)			(7.058)			(12.29)			(17.82)		
Hospital HHI>2500 and < 5000			-3.939			-0.730			1.055			-0.693		[American Hospital Association Annual Survey, 2013]
			(4.798)			(5.563)			(9.978)			(10.11)		
Hospital HHI>5000 and <10000			-4.253			-0.356			14.61*			8.342		
			(3.973)			(4.547)			(7.890)			(6.854)		
Hospital HHI missing (omitted)														
Constant	219.4***	-3.279	-6.399	210.7***	50.38	62.86	217.0***	66.55	86.88	223.9***	14.47	71.44	232.2***	
	(2.007)	(40.33)	(33.21)	(2.823)	(44.66)	(44.62)	(4.368)	(52.68)	(56.97)	(2.368)	(81.55)	(90.94)	(1.43)	
Observations	2,544	2,152	2,152	1,349	1,055	1,055	249	211	211	249 (94 groups)	211 (91 groups)	211 (91 groups)	570 (186 groups)	
R-squared	0.093	0.321	0.407	0.107	0.500	0.535	0.251	0.728	0.772	0.443	0.734	0.768	0.386	

Notes:
Border states include: AZ, IL, MI, ND, NH, NM, NV, OH, WV (Expansion) and IN, ME, MO, MT, OK, SD, TX, UT, VA, WI.
Robust standard errors in parentheses.
Second-lowest silver premium is for age 21 and is calculated at the county level, except for column (13) in which SLS is for age 27 and is calculated by rating area.
Premium information for column (13) comes from RWJF HIX Compare, accessed at: http://www.rwjf.org/en/library/research/2015/12/hix-compare-2015-2016-datasets.html
*** p<0.01, ** p<0.05, * p<0.1

Tab 5

Economic Analysis

Financial Impact Estimating Conference: Required Economic Analysis

Office of Economic and Demographic Research

June 28, 2019

CS/CS/HB 5: Ballot Measures

This is the first FIEC called since the passage of CS/CS/HB 5 which—among other things—made a number of changes to the FIEC's traditional process. Most importantly, the bill made the following adjustments:

- Specifies a 75-day timeframe instead of 45 days from start to finish.
- Expands the maximum length of the financial impact statement from 75 words to 150 words.
- Requires an additional analysis of the estimated economic impact on the state and local economy. This requirement broadens the analysis from the more limited review of public sector impacts previously considered.
- Requires an additional analysis of the overall impact to the state budget.

"… the Financial Impact Estimating Conference shall complete an analysis and financial impact statement to be placed on the ballot of the estimated increase or decrease in any revenues or costs to state or local governments, estimated economic impact on the state and local economy, and the overall impact to the state budget resulting from the proposed initiative."

Economic Analysis

- A comprehensive policy analysis technique that evaluates the direct, indirect and induced economic impacts of a policy change, where:
  - Direct economic effects – are the changes in expenditures made by the industry(ies) directly impacted by a change in policy. Most analyses by the various estimating conferences focus on direct effects, which are generally static, immediate and "first round" effects.
  - Indirect economic effects – are the changes in expenditures made by industries that supply goods/services to the directly impacted industry(ies).
  - Induced economic effects – are most commonly measured as the changes in expenditures by households whose income is changed by the direct and indirect activity; however other examples exist.
- In this case, the goal is to predict and quantify the probable path of economic responses over time to the change brought about by the petition initiative.
  - Projections are relative to a forecast of the expected path of the economy absent the change caused by the petition; this is referred to as the economic baseline.
  - In some cases, there will be no discernible or probable effects.

Secondary Effects—The "Ripple"

Tool: Statewide Model

- The Statewide Model is a state-of-the-art, customized, dynamic computable general equilibrium model (CGE) originally developed for Florida by Monash University (Melbourne, Australia) in 2011. This model:
  - Contains a vast amount of data to replicate the Florida's economy, tax structure, and state budget.
  - Uses hundreds of mathematical equations to account for the relationships (linkages and interactions) between the various economic agents, as well as likely responses by businesses and households to changes in the economy. Started with 388 equations with 1,699,000 total elements within those equations.
  - Has a time dimension that adheres to the state fiscal year (July 1 to June 30) to be useful in the state government budgeting process.
  - Allows different programs to be evaluated on the same footing.
  - Can be modified to reflect research results and targeted developments specific to the analysis being performed.

Analysis

- When the Statewide Model is deployed to evaluate economic effects, the model is shocked using static analysis to develop the initial or direct effects attributable to the petition-induced change that is under review. In this analysis, the direct effects (shocks) will likely consider:
  - Infusion of federal dollars from Medicaid match.
  - Changed distribution of state expenditures to meet Florida's share of the costs.
  - Additional demand for and supply of health care workers and the impact on directly related fields.
  - To the extent that they are identifiable and credible, any expected changes in overall health, productivity, capital investment or the cost of uncompensated care.

Standard Variables

The core economic variables that are available for reporting include:

1. Population…focuses on the change in population projections caused by altered economic circumstances.
2. Jobs…focuses on the change in employment projections caused by altered economic circumstances.
3. Personal Income…nearly two-thirds of this metric typically comes from compensation of employees.
4. Household Consumption…consumer spending.
5. Gross Domestic Product…the total value of goods and services produced within the state during one year; based on final output.
6. Gross Output…principally a measure of sales or revenue from production for most industries, although it is measured as sales or revenue less cost of goods sold for margin industries like retail and wholesale trade.
7. Investment & Savings…from a business perspective, this leads to an increase in the capital stock (physical and human) with the intent to increase productivity, efficiency and output of goods and services.
8. State Government Revenues and Expenditures…largely conditioned by Florida's tax policy.

Proposed Style of Model Results

- Relative to the economic baseline, the change in each of the eight Standard Variables will be reported numerically with the appropriate direction indicated (+ or -). Positive changes improve the economy relative to the baseline, while negative changes reflect a weakening of the baseline condition.

- In addition, each variable's change will be reported as a percentage of the variable's total value in order to provide context.

Key Protocols

- The Statewide Model almost always treats Florida as a single region…this means that typically the analysis will be generalized statewide. A specific local economy will only be considered in rare circumstances where the localized impact must be considered due to a unique feature of the proposed amendment under review (for example, the Slots amendment).
- Balanced budget requirement by fiscal year…however, this does not mean that the budget is strictly held to official forecasts (for example, the inclusion of federal dollars grows the available revenues for expenditure).
- The underlying model is calibrated for current budget policy and the official economic and revenue forecasts which comprise the baseline. All analyses performed in a given year will be compared to the same baseline.

Tab 6

Materials from the Sponsor

Date: June 25, 2019

To: Financial Impact Estimating Conference

From: Florida Decides Healthcare

Subject: Constitutional Amendment to Provide Medicaid Coverage to Eligible Low-Income Adults - Ballot #18-16

PURPOSE OF AMENDMENT

The purpose of this constitutional amendment is to provide Medicaid coverage to Floridians over age 18 and under age 65 whose incomes are at or below 138 percent of the federal poverty level ("FPL") and to do so with no greater burdens placed on eligibility, enrollment, or benefits for these newly eligible individuals compared to other Medicaid beneficiaries.

INTRODUCTION

Under the Affordable Care Act, Medicaid was expanded to cover adults under the age of 65 whose incomes are below 138% of the federal poverty level. As part of this expansion, the federal government provided additional funding to states in the form of an enhanced Federal Assistance Matching Percentage ("FMAP") covering 100% of the costs for this population until 2016, and then gradually scaling back to 90% in 2020 where it shall remain. In June 2012, The U.S. Supreme Court rendered a decision making the expansion optional for states. Currently, 36 states and Washington, DC have elected to expand Medicaid. Florida has not. Not expanding Medicaid has already impacted Florida's economy. Because of this decision, the state has failed to draw as much as $18 billion from the federal government. Those funds would generate tens of thousands of jobs and more than $500 million in annual state and local revenues, while replacing approximately $620 million in current state spending on low income and high need populations. [1]

To assist the Financial Impact Estimating Conference ("FIEC") in its duty to analyze our amendment and produce a financial impact statement, we offer the following analysis drawn from the experiences of the 36 states that have already expanded Medicaid and analyses conducted by the Office of Economic and Demographic Research ("EDR") and the Agency for Health Care Administration ("AHCA"). Further, because of the recent passage of House Bill 5, we also offer insight into the anticipated impact this initiative will have on our economy and overall state budget. We will illustrate how this constitutional amendment will result in net annual savings of $199 million and generate new annual revenue of more than $402 million for the State of Florida and local governments. All told, this amendment will yield a total positive net annual impact in excess of $600 million. These savings and

new revenues will be achieved by replacing current state health care related spending with federal dollars, e.g. inpatient health care for incarcerated populations, and drawing down the enhanced FMAP for some populations already covered, e.g. the medically needy. Further, based on other states' experiences, we can expect Florida to receive new revenues from existing provider fees and from the macroeconomic effects of returning billions of federal dollars to the state. [2]

STATE SAVINGS FROM ACCESSING ENHANCED FEDERAL MATCHING FUNDS

Prior to the passage of the ACA, many states, including Florida, provided coverage to high need populations such as the "medically needy," individuals with disabilities, and pregnant women. While they did receive federal matching dollars, these states were still responsible for roughly 30% to 50% of the cost of providing care to these populations. Under Medicaid expansion many of these populations became eligible for full Medicaid benefits. Now the states that expanded Medicaid are receiving an enhanced FMAP of 90% of the cost to provide benefits to these populations, saving them hundreds of millions per year. Below are some examples.

- **Arkansas.** Since expanding its Medicaid program in January 2014, Arkansas has saved $91-$111 million per year as a share of its medically needy; aged, blind, and disabled; SSI disability population; and pregnant women became eligible for Medicaid expansion and its associated enhanced FMAP. Additionally, Arkansas was able to discontinue a number of optional Medicaid waiver programs because their income eligibility thresholds overlapped with the expansion population. It is now saving an additional $23-$26 million per year after it discontinued its ARHealthNetwork, Family Planning, Tuberculosis, and Breast and Cervical Cancer programs.[3]

- **Virginia** expanded Medicaid in 2018 and just began enrollment in January of 2019. The state projects that the expansion will create $342 million in state budget savings over the next biennium as newly covered populations will receive the enhanced federal matching rate.[4] These populations include low income residents covered under the Governor's Access Plan for the Serious Mentally Ill, the indigent care program, those hospitalized under the state's Temporary Detention Order program, and others.[5]

- **Missouri.** While Missouri has not yet expanded its Medicaid program, a recent study by the Center for Health and Economic Policy at the Institute for Public Health at Washington University found that if Missouri were to expand it could generate more than $930 million in annual savings by 2024. Specifically, it would save more than $17 million per year on its permanently and totally disabled program and another $55 million per year on its SSI waiting list population because a percentage of those meeting expansion eligibility requirements will forgo the lengthy SSI determination process. It also expects to generate "significant savings" as many currently enrolled in its Blind Pensions, Presumptive Eligibility, Ticket to Work Health

Assurance, Breast/Cervical Cancer Treatment, and Women's Health Services programs become eligible to receive the enhanced FMAP.[6]

The State of Florida has at least four programs providing services for populations that may qualify for the enhanced FMAP including its Medically Needy, Adults with Disabilities, Adults with AIDS, and Adults with Breast and Cervical Cancer programs. In addition, the Pregnant Women program would experience significant savings because a number of eligible women would have already enrolled in the expansion program and qualify for the enhanced match.

Medically Needy Program

In its analysis of Senate Bill 2-A, the EDR estimated that the state would save more than $172 million per year on its Medically Needy program in FY2022-23.[7]

Pregnant Women

Currently, low-income women who become pregnant can qualify for Medicaid during their pregnancies. The state is receiving its standard FMAP (61.47%) for providing these services. In April 2019, there were approximately 105,000 women with incomes below 138% of the FPL receiving these services. Under Medicaid expansion, we can conservatively assume that 45% of these women would be eligible, saving the state more than $52 million annually.[8]

Adults with Disabilities

There are a number of adults waiting for a disability determination in both the SSI and "Meds AD" programs, who like in Arkansas and Missouri, will choose to forgo their determination and enroll directly in Medicaid, if the state expanded its Medicaid program. If we assume just a 4% attrition rate, which is the median attrition rate according to a recent study (see endnote for more details), 12,720 would forego their determinations. Based on current per member per month rates ("PMPMs") for the SSI population, we estimate annual savings to be more than $36 million per year.[9]

Adults with AIDS

Similarly, Florida has a federal waiver program extending Medicaid to individuals diagnosed with AIDS with incomes below 300% of the Federal Benefit Rate, or 222% of the FPL, that meet certain criteria. Potential enrollees must go through the Comprehensive Assessment and Review for Long-Term Care Services offered by Department of Elder Affairs to enroll. Assuming a 4% attrition rate, similar to the Adults with Disabilities population above, among those whose income eligibility is below 138%, or about 62% of monthly enrollees, we would expect savings of nearly $3.9 million per year.[10]

Breast and Cervical Cancer Program

Lastly, we expect a number of those enrolled in the Mary Brogan Breast and Cervical Cancer Program to be eligible for the enhanced FMAP, saving the state an estimated $1.3 million.[11]

SUMMARY OF STATE SAVINGS FROM ACCESSING ENHANCED FEDERAL MATCHING FUNDS

STATE	PROGRAMS	ANNUAL SAVINGS
Virginia	▪ Governor's Access Plan for the Seriously Mentally Ill ▪ Indigent Care program ▪ Temporary Detention Order program	$342M[a]
Arkansas	▪ Medically Needy ▪ Aged, Blind, and Disabled ▪ SSI Disability ▪ Pregnant Women ▪ Family Planning ▪ Breast and Cervical Cancer	$124-137M
Missouri	▪ Permanently and Totally Disabled ▪ SSI ▪ Breast/Cervical Treatment ▪ Women's Health Services	$72M[b]
Florida	▪ **Medically Needy Program** ▪ **Adults with Disabilities** ▪ **Breast and Cervical Cancer Program** ▪ **Adults with HIV/AIDs** ▪ **Pregnant Women**	**$266M**

STATE SAVINGS FROM REPLACING STATE HEALTH CARE FUNDING WITH FEDERAL FUNDS

Another area of savings could come from replacing state funding for health care for low income populations with federal funds. Many states have traditionally supported services for the uninsured population through general revenue spending. Some of the largest categories of such spending are mental health and substance abuse, health care for incarcerated populations, and indigent care funding. If Florida expanded its Medicaid program many of these costs would be covered by Medicaid and matched at the enhanced FMAP. See the examples below.

- **Michigan** has already replaced nearly $1.3 billion in state spending on mental health and other programs with federal funds and expects to continue to use federal dollars to replace $235 million in state spending on these programs each year going forward.[12]

- **Louisiana's** Department of Health estimated that it will save $313 million in FY2019 alone by replacing what it was spending on care for the uninsured and the incarcerated population.[13]

[a] This is a biennial figure.
[b] This figure does not include savings from its Blind Pensions, Presumptive Eligibility, Ticket to Work Health Assurance, Breast/Cervical Cancer Treatment, and Women's Health Services programs.

- **Virginia**. By replacing general fund dollars currently being spent on programs for inpatient health care for inmates and substance abuse and mental health care services for low income Virginians, the state will save another $86 million.[14]

- **Arkansas** has reduced its general fund spending on uncompensated care since expansion and projects it will save $43 million in FY2020 and another $45 million in FY2021.[15]

If Florida were to expand Medicaid it would draw down federal dollars to replace some of what it spends on state mental health and substance abuse services. The Agency for Health Care Administration reported to the Legislature in 2016 that 132,940 Floridians dealing with a Serious Mental Illness or Substance Use Disorder being served by the Department of Children and Families ("DCF") met eligibility requirements for Medicaid expansion. The same report identified that DCF spent more than $412 million per year to provide these services to this population. Based on that report and using the PMPM rates for "SSI Medicaid Only SMI," we estimate expanding Medicaid to this population would reduce state costs by more than $200 million per year.[16]

Based on the experience of other states that expanded Medicaid, additional savings will be realized as inpatient care for prisoners and uncompensated care services for the uninsured and underinsured become eligible for federal funding under the expansion. Between these two categories we estimate that this would save the state nearly $155 million per year.[17]

SUMMARY OF STATE SAVINGS FROM REPLACING STATE HEALTH CARE FUNDING WITH FEDERAL FUNDS

STATE	PROGRAMS	ANNUAL SAVINGS
Michigan	▪ Mental Health ▪ Inpatient Care for the Incarcerated	$235M
Louisiana	▪ Inpatient Care for the Incarcerated ▪ Care for the uninsured	$313M
Virginia	▪ Inpatient health care for inmates ▪ Substance abuse and mental health care services	$86M[c]
Arkansas	▪ Uncompensated Care	$41-$45M
Florida	▪ **Mental Health and Substance Abuse** ▪ **Uncompensated Care** ▪ **Inpatient Care for Prisoners**	**$355M**

NEW REVENUES FROM PROVIDER TAXES

Not only has Medicaid expansion proven to create state savings, it has also increased state revenues. This often comes in the form of existing hospital or managed care provider taxes. Nearly every state raises revenue through fees or assessments on hospitals and health plans. As more people secure

[c] This is a biennial figure.

health coverage through Medicaid expansion, additional net revenues are generated for hospitals and health plans, which in turn, create new income for the state. A few examples of this include:

- **Michigan** has already raised $685 million from its Health Insurance Claims Assessment, Use Tax, and its provider assessment program. It expects to raise an additional $168-$171 million from these sources in each of the next two years.[18]

- **Arkansas** has and will continue to raise $25-$27 million per year in increased premium tax revenues on health policies associated with its expansion.[19]

- **Louisiana** has raised additional revenue from a premium tax on managed care organizations. In FY2019, it will generate more than $260 million, which is significantly more than the state contribution for the expansion.[20]

Florida currently has a provider assessment program, the Public Medical Assistance Trust Fund, which assesses 1.5% on inpatient net operating revenue and 1% on outpatient net operating revenue. Expanding Medicaid has been shown to produce additional net revenues for hospitals.[21] These additional revenues would generate $19 million annually in new assessments, according to an analysis from the Florida Policy Institute.[22]

SUMMARY OF NEW REVENUES FROM PROVIDER TAXES

STATE	NEW ANNUAL REVENUE FROM PROVIDER ASSESSMENTS
Michigan	$164-171M
Arkansas	$25-27M
Louisiana	$260M
Florida	$19M

NEW REVENUE FROM INCREASED ECONOMIC ACTIVITY

Since the passage of House Bill 5 in the 2019 session, the FIEC must now also determine the amendment's estimated economic impact on the state's economy. We found that many expansion states experienced a macroeconomic stimulus from the influx of new federal expenditures. This increase in economic activity benefitted the states by creating new jobs and increasing personal income, which in turn had a multiplier effect of producing additional spending and employment in other industries. This additional consumer spending produced new revenues for state and local governments. Here are some examples:

- **Michigan** has already received more than $18 billion in federal revenues since it expanded Medicaid. This increased economic activity has yielded between $145 and $153 million in annual state tax revenues. Further, it has created and sustained more than 30,000 jobs and generates more than $2.3 billion in annual personal income for Michiganders.[23]

- **Arkansas** projects that the federal match for expansion will exceed $9 billion over the next five years and will generate $67-$77 million per year in "economically sensitive taxes."[24] The macroeconomic activity has also created and sustained more than 6,100 jobs and generates more than $320 million in annual personal income.[25]

- **Colorado** estimates that the federal dollars from Medicaid expansion support more than 31,000 jobs. Further, the influx of federal dollars has generated more than $102 million in General Fund revenues from sales and use taxes and will generate up to $248M each year in the future.[26]

A 2013 study of the potential macroeconomic impacts of Medicaid expansion found that the additional federal dollars flowing into the state would generate an average of more than $540 million per year in state and local taxes; alone more than enough to cover any potential new costs incurred by the state. Further, it projected more than 120,000 jobs would be created and sustained. It should be noted that this study was based on significantly higher enrollment numbers and higher costs than what are currently projected by EDR. If we scaled this analysis to reflect current projections it would still generate an estimated $402.5 million in additional state and local revenues. [27] We expect an updated analysis to be released during this comment period.

SUMMARY OF NEW REVENUE FROM INCREASED ECONOMIC ACTIVITY

STATE	ANNUAL NEW REVENUE FROM MACROECONOMIC ACTIVITY
Michigan	$148-153M
Arkansas	$72-77M
Colorado	$102M
Florida	**$403M**

SUMMARY OF STATE BUDGET SAVINGS AND NEW REVENUES

As a result of this amendment, we anticipate a positive net annual impact for state and local governments of nearly $602 million. Using data from an EDR analysis of potential Medicaid expansion enrollment, approximately 964,000 adults would enroll in Medicaid expansion by FY2022-2023.[28] We chose FY2022-2023 assuming that enrollment would be close to fully ramped up by this time. The state share to cover these costs is estimated to be $442 million.[29] We then used the most recent enrollment and cost data available from AHCA and EDR, most of which is from FY2018-2019, unless noted otherwise below. To be conservative, we elected not to project the future costs of these programs, even though costs are likely to rise by FY2022-23, and could potentially yield greater budgetary savings.

SUMMARY OF POTENTIAL FY2022-FY2023 STATE BUDGET SAVINGS AND NEW REVENUES	
State-only cost of Expansion	$441,900,000
State savings from accessing enhanced federal matching funds	
Medically Needy Program	$172,300,000
Adults with Disabilities	$36,437,000
Adults with Breast and Cervical Cancer	$1,291,000
Adults with AIDS	$3,876,000
Pregnant Women	$52,481,000
Total	**$266,385,000**
State savings from replacing state health care funding with federal funds	
Substance Abuse and Mental Health Services	$200,482,000
Prisoner Hospitalization Costs	$57,524,000
Uncompensated Care (Low Income Pool)	$97,394,000
Total	**$355,400,000**
Total State Savings	**$621,785,000**
Estimated Revenue Gains	
Increased Hospital Taxes/Provider Tax Assessment	$19,110,000
Macroeconomic Effects of New Federal Funds	$402,545,000
Total	**$421,655,000**
Total Savings and New Revenues	**$1,043,440,000**
Net Savings from Amendment	***$601,540,000***

CONCLUSION

Based on the experience of states across America that have expanded Medicaid and the work of EDR and AHCA, this amendment will reduce existing state spending on high need populations and health care services for low income people. It will also generate additional revenues from existing taxes like Florida's hospital provider fee and from the multiplier effect of bringing back more than $4 billion dollars in federal funding to our state each year.[30] The combination of increased revenues and reduced spending will more than cover the state's share of the cost for this new population, like it has most recently in Virginia, Arkansas, Louisiana and Michigan.

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[1] Hodges, A. and Rahmani, M. *Economic Impacts of Extending Health Care Coverage in Florida*, May 2013, p. 10. http://www.fha.org/reports-and-resources/show-details/Economic-Impacts-of-Extending-Health-Care-Coverage-in-Florida/75. The $620 million figure is based on the analysis contained in this paper.

[2] Brown, C. and Bennett J. *Economic Impacts of the Arkansas Private Option,* August 2015 http://www.arkhospitals.org/Misc.%20Files/August2015APOEconomicImpacts.pdf; *Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015-16 through FY 2034-35*, Colorado Futures Center, September 2016 https://www.coloradohealth.org/reports/assessing-economic-and-budgetary-impact-medicaid-expansion-colorado-fy-2015-16-through-fy; *Economic and Fiscal Impact of Medicaid Expansion in New Mexico,* Bureau of Business and Economic Research, February 2016 http://bber.unm.edu/media/publications/Medicaid_Expansion_Final2116R.pdf; and *Healthy Michigan Plan*

Savings and Cost Estimates, Michigan House Fiscal Agency, September 2016. https://www.house.mi.gov/hfa/PDF/HealthandHumanServices/HMP_Savings_and_Cost_Estimates.pdf

[3] *Final Report,* Arkansas Health Reform Legislative Task Force, December 2016, p. 9. http://www.arkleg.state.ar.us/assembly/Meeting%20Attachments/836/I14804/TF%20FinalDraftReport.12-14-2016.pdf

[4] *Overview of the Governor's Introduced Budget*, January 2018, pp. 16-18. http://sfc.virginia.gov/pdf/health/2018/010818_No1_Jones_DMAS%20Budget%20Briefing.pdf

[5] *New Developments in Human Services: Health Care Expansion* Virginia Department of Medical Assistance Services, October 2018, p. 18. https://www.vml.org/wp-content/uploads/2018/10/New-Developments-in-Human-Services-Health-Care-Expansion_Jennifer-Lee.pptx

[6] *Analysis of the Fiscal Impact of Medicaid Expansion in Missouri*. Center for Health Economics and Policy, February 2019, pp. 5-6. https://publichealth.wustl.edu/wp-content/uploads/2019/02/Analysis-of-the-Fiscal-Impact-of-Medicaid-Expansion-in-Missouri-IPH.pdf

[7] *Impact Analysis of SB 2-A, As Filed*, Office of Economic and Demographic Research, June 2015, p. 7. http://edr.state.fl.us/Content/presentations/affordable-care-act/SB2-AHousePresentation_ImpactAnalysisAsFiled.pdf

[8] *Eligibles Report,* Agency for Health Care Administration, April 2019. We used the PMPM from Medicaid Eligibility Groups for 2016 of $377.36 for those earning <100% of the FPL and $363.33 for those earning more than 100%, but < 138%. http://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/docs/age_program_group_sex_2019-04-30.pdf

[9] PMPMs come from *Medicaid Eligibility Groups 2018-2019,* Agency for Health Care Administration, for the March 2019 Social Services Estimating Conference and the source for the estimated enrollment is *Eligibles Report,* Agency for Health Care Administration, April 2019 http://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/docs/age_program_group_sex_2019-04-30.pdf. The 4% attrition comes from *Alabama Medicaid Expansion: Summary of Estimated Costs and Savings,* Alabama Hospital Association, February 2019, p. 17. https://www.alaha.org/wp-content/uploads/2019/02/MedicaidExpansionReportCostsSavings.pdf

[10] PMPMs and enrollment come from *Medicaid Eligibility Groups 2018-2019,* Agency for Health Care Administration, for the March 2019 Social Services Estimating Conference. The 4% attrition comes from *Alabama Medicaid Expansion: Summary of Estimated Costs and Savings,* Alabama Hospital Association, February 2019, p. 17. https://www.alaha.org/wp-content/uploads/2019/02/MedicaidExpansionReportCostsSavings.pdf.

[11] PMPMs and enrollment come from *Medicaid Eligibility Groups 2016-2017,* Agency for Health Care Administration, for the January 2016 Social Services Estimating Conference. We assumed equal distribution of enrollment for incomes up to 200% of FPL would convert to the enhanced FMAP. This translates to roughly 69% of enrollees.

[12] *Healthy Michigan Plan Savings and Cost Estimates*, Michigan House Fiscal Agency, September 2016, p.4. https://www.house.mi.gov/hfa/PDF/HealthandHumanServices/HMP_Savings_and_Cost_Estimates.pdf

[13] *Medicaid expansion not diverting resources from traditional Medicaid*. Louisiana Budget Project, September 2018, https://www.labudget.org/wp-content/uploads/2018/09/Medicaid-HCBS.pdf

[14] Ibid. *Overview of Governor's Budget*.

[15] Ibid. *Arkansas Final Report.*

[16] *Behavioral Health Services Revenue Maximization Plan,* Agency for Health Care Administration, December 2016, p. 26. https://ahca.myflorida.com/medicaid/recent_presentations/SB_12_Behavioral_Health_Services_Revenue_Maximization_Plan_123016.pdf. We used a weighted PMPM of $1,328.48 to calculate the savings for this population. 1,328.48 X 132,940 = $2,119,297,574 in total cost. The state share of which would be $211,929,757. $412,411,814 (current DCF spending on this population) less $211,929,757= $200,482,057. The PMPMS are from Agency for Health Care Administration's *Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program's Monthly Base Rates*

http://ahca.myflorida.com/medicaid/Finance/data_analytics/actuarial/docs/MMA_Final_Base_Rates_SMMC-Imp_2019-09.pdf

[17] *Potential Budget Savings and Revenue Gains from Medicaid Expansion in Florida,* The Florida Policy Institute, June 2019.

[18] *Healthy Michigan Plan Savings and Cost Estimates*, Michigan House Fiscal Agency, September 2018, p.5. https://www.house.mi.gov/hfa/PDF/Alpha/Fiscal_Briefing_HMP_Savings_and_Cost_Estimates.pdf

[19] Ibid. *Arkansas Final Report.*

[20] Ibid. *Medicaid expansion not diverting resources*.

[21] *How Has the ACA Changed Finances for Different Types of Hospitals? Updated Insights from 2015 Cost Report Data*, Urban Institute, April 2017. https://www.urban.org/research/publication/how-has-aca-changed-finances-different-types-hospitals-updated-insights-2015-cost-report-data

[22] Ibid. *Potential Budget Savings*.

[23] Ayanian, J. et al. *Economic Effects of Medicaid Expansion in Michigan*, New England Journal of Medicine, February 2017.

[24] Ibid. *Arkansas Final Report*.

[25] Brown, C. and Bennett J. *Economic Impacts of the Arkansas Private Option,* August 2015, p. 9. http://www.arkhospitals.org/Misc.%20Files/August2015APOEconomicImpacts.pdf

[26] *Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015-16 through FY 2034-35*, Colorado Futures Center, September 2016, pp. 5-6. https://www.coloradohealth.org/reports/assessing-economic-and-budgetary-impact-medicaid-expansion-colorado-fy-2015-16-through-fy

[27] Ibid. Hodges, A and Rahmani, M., pp. 7, 10.

[28] Ibid. *Impact Analysis of SB 2-A.*

[29] Ibid. *Impact Analysis of SB 2-A.* Using the data from this report we determined the per capita cost and simply scaled it to the more recently projected enrollment numbers.

[30] Ibid. *Impact Analysis of SB 2-A*.

Potential Budget Savings and Revenue Gains from Medicaid Expansion in Florida

June 2019

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Overview

- The Takeaway
- The Context
- By the Numbers
- Potential Savings from Enhanced Federal Matching Funds
- Potential Savings from Replacing State Funds with Federal Funds
- Summary Savings and Revenue Gains

The Takeaway: Outcomes

Based on the experience of other states, legislative projections and our own analysis, Medicaid expansion could:

- Significantly reduce the number of uninsured Floridians.
- Reduce state costs for uncompensated health care.
- Result in significant budget savings and increased state revenues.
- Free up state general revenue funds for other priorities.

Sources:
Buettgens, M., *The Implications of Medicaid Expansion in the Remaining States: 2018 Update*, Urban Institute, May 2018. https://www.urban.org/research/publication/implications-medicaid-expansion-remaining-states-2018-update
Dorn, S. et al., *The Cost of Not Expanding Medicaid: An Updated Analysis.* Robert Wood Johnson Foundation. April 2017. https://www.rwjf.org/en/library/research/2017/04/the-cost-of-not-expanding-medicaid.html
Antonisse, Larisa et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*. Kaiser Family Foundation. March 2018. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/
Bachrach et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data Shows Consistent Economic Benefits Across Expansion States*. Robert Wood Johnson Foundation. March 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

The Takeaway: Net Savings

TOTAL NET ESTIMATED SAVINGS OF MEDICAID EXPANSION IN FLORIDA FOR FY 2022-2023:

$198,995,000

Notes:

- This report focuses on specifically identified state programs where budget savings could be realized with Medicaid expansion. However, it is important to note that there are additional state funded programs, not analyzed in this report, where millions more in savings could be generated. This includes multiple public health programs delivered through county health departments and disease prevention and treatment programs, such as those focused on HIV/AIDS, STDs and TB.
- Also not considered in this estimate is new revenue likely to be generated for state and local governments from overall increased economic activity due to the infusion of billions of new federal dollars.
- Additional state costs that would be imposed are based on Office of Economic & Demographic Research (EDR) projections for FY 2022-23.
- Medically Needy gross savings are based on EDR's projected savings for FY 2022-23. We chose FY 2022-2023 assuming that expansion enrollment would be close to fully ramped up at this time.
- Other Medicaid program estimated savings are based on the most recently available Agency for Health Care Administration (AHCA) enrollment and cost data, typically 2018-19 data. However, these costs are likely to rise in the future, meaning that potentially there are even greater savings that could be gained through expansion.
- The report also considers the experience of other Medicaid expansion states.

The Takeaway: Long-Term Savings

- Even with the lower enhanced federal match, the state will experience long term savings.
- Other states that have already expanded Medicaid have experienced state budget gains since expansion.

Sources:
Buettgens, M., *The Implications of Medicaid Expansion in the Remaining States: 2018 Update*, Urban Institute, May 2018.
https://www.urban.org/research/publication/implications-medicaid-expansion-remaining-states-2018-update
Antonisse, L. et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, Kaiser Family Foundation, 2018.
https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/
Dorn, S. et al., *The Cost of Not Expanding Medicaid: An Updated Analysis*, Urban Institute. 2017.
https://www.rwjf.org/en/library/research/2017/04/the-cost-of-not-expanding-medicaid.html
Dorn, S. et al., *The Cost to States of Not Expanding Medicaid.* 2016. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000886-The-Cost-to-States-of-Not-Expanding-Medicaid.pdf

The Context: What is Expansion?

- Medicaid expansion under the Affordable Care Act (ACA) includes adults under the age of 65 with incomes up to 138 percent of the Federal Poverty Level (FPL). For 2019, this is $17,236 for an individual and $29,435 for a family of three.
- A June 2012 U.S. Supreme Court ruling made expansion of Medicaid optional for states.
- Florida is one of 14 states that have opted not to expand Medicaid.
- For Medicaid expansion states, the federal government covered 100 percent of the Medicaid costs for newly eligible enrollees in 2016, and covered 94 percent of costs starting in FY 2018. The federal share phases down to 90 percent in 2020 and thereafter.

Sources:
Dorn, S. et al., *The Cost of Not Expanding Medicaid: An Updated Analysis.* Urban Institute. 2017. https://www.urban.org/sites/default/files/publication/98467/the_implications_of_medicaid_expansion_2001838_2.pdfhttps://www.rwjf.org/en/library/research/2017/04/the-cost-of-not-expanding-medicaid.htm
Kaiser Family Foundation, *Status of State Action on Medicaid Expansion*, May 13, 2019. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
U.S. Dept. of Health & Human Services. *2019 Federal Poverty Guidelines.* https://aspe.hhs.gov/2019-poverty-guidelines

The Context: When Can States Expand?

- There is no deadline for states to expand Medicaid.
- The current Medicaid expansion Federal Medical Assistance Percentage (FMAP) would apply:

FMAP for New Enrollees				
Fiscal Year	**2017**	**2018**	**2019**	**2020**
FMAP	95	94	93	90

Source:
Office of Economic and Demographic Research. *Social Services Estimating Conference, Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs.* March 7, 2013.
http://edr.state.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf

The Context: Who Qualifies Now?

- To qualify for Medicaid in Florida, a family of three with dependent children must not earn more than 32 percent of the FPL, or $6,825 per year.
- To qualify for marketplace health insurance assistance, a family of three with dependent children must earn at least $21,330 per year. Families between $6,825 and $21,330 annual income are not eligible for any coverage, representing the coverage gap.
- Adults without dependent children are currently ineligible for Medicaid unless they have severe, long-term disabilities.

Sources:
U.S. Dept. of Health & Human Services. *2019 Federal Poverty Guidelines.* https://aspe.hhs.gov/2019-poverty-guidelines
The Florida Legislature, Office of Economic and Demographic Research (EDR). *Impact Analysis of SB 2-A, As Filed (With Preliminary numbers for proposed Amendment)*. June, 2015. edr.state.fl.us/Content/presentations/affordable-care-act/SB2-AHousePresentation_ImpactAnalysisAsFiled.pdf

The Context: Who Would Benefit?

- With Medicaid expansion, families with incomes up to 138 percent of the FPL would be eligible for Medicaid coverage - $17,236 for an individual and $29,435 for a family of three in 2019.
- Expansion would guarantee healthcare coverage to:
  - Floridians who are currently in the coverage gap.
  - Floridians who are struggling to afford marketplace health insurance.
- If Florida were to expand Medicaid, EDR projects that for FY 2022-23, 964,056 Floridians would gain access to affordable health care. This includes adults in the coverage gap and those with incomes up to 138% of poverty.

Notes:
This report assumes enrollment based on EDR's FY 2022-2023 enrollment projections. We selected FY 2022-2023 because at at that time we expect enrollment will be close to fully ramped up by this time.
Sources:
The Florida Legislature, Office of Economic and Demographic Research (EDR). *Impact Analysis of SB 2-A, As Filed (With Preliminary numbers for proposed Amendment)*. June 1, 2015. http://edr.state.fl.us/Content/presentations/affordable-care-act/SB2-AHousePresentation_ImpactAnalysisAsFiled.pdf; U.S. Dept. of Health & Human Services, 2019 Poverty Guidelines. https://aspe.hhs.gov/2019-poverty-guidelines; U.S. Centers for Medicaid and Medicare Services, https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/

The Context: FMAP

- The Federal Medical Assistance Percentage (FMAP) is a formula through which the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average and smaller portion for states with higher per capita incomes.
- For the current federal fiscal year, Florida's regular FMAP is 61.47 and the state share is 38.53. This means for every $1 Florida spends on Medicaid, it receives $0.61 from the federal government while only $0.38 comes from Florida funds.
- However, with expansion the state would get an enhanced federal match for newly-eligible people. In 2020 the enhanced match is 90 percent.

Sources:
Office of Economic and Demographic Research,SSEC Official FMAP, Feb. 28, 2019.
http://edr.state.fl.us/Content/conferences/fmap/index.cfm;Rudowitz
R., et al., *10 things to Know About Medicaid*, Kaiser Family Foundation, March 6, 2019. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/

The Context: Benefits to States

- States that expand Medicaid benefit financially by accessing enhanced federal matching funds for income-based Medicaid beneficiaries under expansion.
- If Florida were to expand Medicaid, at least 90 cents of every dollar spent could come from the federal government for newly eligible low-income adults, and other services would qualify for this higher reimbursement.
- The current Medicaid coverage groups that would benefit from higher FMAP includes:
  - Medically Needy program
  - Pregnant Women
  - Adults with Disabilities
  - Adults with Breast and Cervical Cancer
  - Adults with AIDS

Notes: The ACA definition of "newly eligible" or income-based Medicaid beneficiaries under expansion includes some groups currently covered by Medicaid with full or limited benefits (e.g., "Medically Needy" or pregnant women). With expansion some individuals who would have otherwise been covered under these existing Medicaid coverage categories would now be covered in the expansion group. For these individuals, the state will be able to access the enhanced federal match, thereby replacing state dollars with federal dollars.

Sources:

Bachrach et al., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data Shows Consistent Economic Benefits Across Expansion States,* State Health Assistance Reform Network, April 2015. https://www.shvs.org/resource/states-expanding-medicaid-see-significant-budget-savings-and-revenue-gains/

Antonisse, L.,et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review, Kaiser Family Foundation*, March 28, 2018. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

The Context: Benefits to States

- States that expand Medicaid benefit financially by replacing state health care funding with federal funds.
    - Many states have supported programs and services for the uninsured — mental and behavioral health programs, public health programs, health care services for prisoners etc. — with state general fund dollars.
    - With expansion, many of the beneficiaries of these programs and services are able to secure Medicaid coverage in the new adult category, which means states can fund these services with enhanced federal — not state — dollars.
- If Florida were to expand Medicaid, the services that would be newly covered by federal funds include:
    - State mental health and substance abuse services
    - Hospital inpatient care services for prisoners
    - Uncompensated care services for the uninsured and underinsured Floridians

Source:
Bachrach et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data shows consistent Economic Benefits Across Expansion States*. Robert Wood Johnson Foundation. March 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

The Context: Benefits to States

- States that expanded Medicaid have benefited financially by:
  - Increasing revenue
    - States raise revenue through individual income taxes or sales taxes. Many also have corporate income taxes, property taxes and other revenue sources. When economic activity increases, these revenue sources yield more funds.
    - Medicaid expansion increases economic activity within a state. The additional federal dollars buy more health care services. A "multiplier effect" ensues when health care providers use their increased revenue to employ more personnel and buy more goods and services within the state.
  - Increasing revenue generated from existing taxes on health plans and health care providers.
    - Many states raise revenue through assessments or fees on providers and health plans. Provider and health plan revenues increase with expansion, the fees generate additional revenue.
    - Florida would gain additional tax revenue from provider assessments.

Note: This report does not address potential state revenue gains from increased economic activity throughout the state with Medicaid expansion. A 2013 economic analysis found that over a 10 year period the infusion of additional federal dollars into Florida's economy would generate more than $400 million annually in additional state and local taxes. An updated analysis is expected to be released shortly.
Sources: Bachrach et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data shows consistent Economic Benefits Across Expansion States*. Robert Wood Johnson Foundation. March 2016 . http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097; *Dorn, S. et al. The Cost to States of Not Expanding Medicaid.* Urban Institute. August 2016. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000886-The-Cost-to-States-of-Not-Expanding-Medicaid.pdf ; Hodges, A. and Rahmani, M. *Economic Impacts of Extending Health Care Coverage in Florida*, May 2013, p. 10. http://www.fha.org/reports-and-resources/show-details/Economic-Impacts-of-Extending-Health-Care-Coverage-in-Florida/75

The Context: Other States' Savings

Virginia	FY2019	FY2020	FY2021
Total Cost of New Enrollees	$81	$226	No data available
Savings from Enhanced Federal Match	$121	$221	No data available
Savings from Replacing State General Fund Revenues with Medicaid Funds	$34	$52	No data available
Total Estimated Savings Related to Medicaid Expansion (millions)	$74	$47	

Michigan	FY2019	FY2020	FY2021
Total Cost of New Enrollees	$408	$448	$456
Savings from Replacing State General Fund Revenues with Medicaid Funds	$235	$235	$235
Estimated Revenue Gains from the Provider Taxes	$164	$168	$171
Revenue Increase from State Tax Benefits	$153	$150	$148
Total Estimated Savings Related to Medicaid Expansion (millions)	$141	$101	$95

Sources:
Overview of the Governor's Introduced Budget, January 8, 2018.
http://sfc.virginia.gov/pdf/health/2018/010818_No1_Jones_DMAS%20Budget%20Briefing.pdf
Ayanian, John Z. ,et al., *Economic Effects of Medicaid Expansion in Michigan*, New England Journal of Medicine 2017, 376:407-410, Feb. 2017.
https://www.nejm.org/doi/full/10.1056/NEJMp1613981
Koorstra, K., *Healthy Michigan Plan Savings and Cost Estimates*, Fiscal Brief, House Fiscal Agency, October 30, 2018.
https://www.house.mi.gov/hfa/PDF/Alpha/Fiscal_Briefing_HMP_Savings_and_Cost_Estimates.pdf

The Context: Other States' Savings

Louisiana	FY2019	FY2020	FY2021
Total Cost of New Enrollees	$210	no data available	no data available
Savings from Replacing State General Fund Revenues with Medicaid Funds	$313	no data available	no data available
Estimated Revenue Gains from the Hospital and Managed Care Fee	$260	no data available	no data available
Total Estimated Savings Related to Medicaid Expansion (millions)	$363		

Arkansas	FY2019	FY2020	FY2021
Total Cost of New Enrollees	$125	$173	$215
Savings from Enhanced Federal Match	$124	$131	$137
Savings from Reduction in State Spending on Uncompensated Care	$41	$43	$45
Increase in Premium Tax Revenues	$25	$26	$27
Revenue Increase from State Tax Benefits	$72	$74	$77
Total Estimated Savings Related to Medicaid Expansion (millions)	$137	$101	$71

Sources:
Medicaid expansion not diverting resources from traditional Medicaid, Louisiana Budget Project, Sept. 2018. https://www.labudget.org/wp-content/uploads/2018/09/Medicaid-HCBS.pdfttps://www.labudget.org/wp-content/uploads/2018/09/Medicaid-HCBS.pdf
tps://www.labudget.org/wp-content/uploads/2018/09/Medicaid-HCBS.pdf
Final Report (Draft), Arkansas Health Reform Legislative Task Force, December 2016. Access via:
http://www.arkleg.state.ar.us/assembly/Meeting%20Attachments/836/I14804/TF%20FinalDraftReport.12-14-2016.pdf

The Context: Other States' Savings

Virginia:

Expansion will lead to $422 in state budget savings in FY2019-20.

- Virginia has already forgone more than $10.5 billion in federal funding for failing to expand prior to FY2019.
- The Expansion will create $342 million in state budget savings over the next biennium as newly covered populations will receive the enhanced federal matching rate.
- By replacing general fund dollars currently being spent on inpatient healthcare for inmates and substance abuse and mental health care services for low income Virginians, the state will save another $86 million.
- All told, even after the required state matching funds, Virginia will cover more than 400,000 new people and save more $121 million over the next biennium.

Source:
Overview of the Governor's Introduced Budget, January 2018,
http://sfc.virginia.gov/pdf/health/2018/010818_No1_Jones_DMAS%20Budget%20Briefing.pdf

The Context: Other States' Savings

Michigan:

State costs of expansion continue to be fully covered by savings and new revenue.

- Michigan has already received more than $18 billion in federal funding to provide coverage for more than 630,000 people.
- MI has saved nearly $1.3 billion in state spending on mental health and other programs, while generating more than $1.6 billion in new state revenue through contributions from hospitals, health plans, and new economic activity.
- The state has cumulatively saved nearly $2.3 billion since it expanding Medicaid.
- In FY2020 and FY2021, the state will save $235 million each year by replacing previous state spending on mental health and other programs and generate $318 million and $319 million in revenue gains from hospitals, health plans, and from new economic activity, resulting in net savings for the state for the next two years of $101 million and $95 million, respectively.

Source:
Ayanian, John Z., et al. *Economic Effects of Medicaid Expansion in Michigan*, New England Journal of Medicine, 376:407-410, Feb. 2017
https://www.nejm.org/doi/full/10.1056/NEJMp1613981
Koorstra, K., Healthy Michigan Plan Savings and Cost Estimates, House fiscal Agency, Oct. 30, 2018.
https://www.house.mi.gov/hfa/PDF/Alpha/Fiscal_Briefing_HMP_Savings_and_Cost_Estimates.pdf

The Context: Other States' Savings

Louisiana:

Expansion will lead to net savings of $361 million in FY2018-19.

- With a higher federal match rate for Medicaid populations previously funded at the regular matching percentage and additional revenue from a premium tax on managed care organizations, Louisiana recognized state savings in in FY2016/2017 of $199 million due to expansion.
- This is expected to continue as fees from hospitals and insurance providers are projected to generate $260 million and savings from replacing general fund spending on the uninsured and the incarcerated populations will total $313 million. Combined these sources will exceed the state share by more than $361 million.

Source:
Medicaid expansion not diverting resources from traditional Medicaid, Louisiana Budget Project, Sept. 2018. https://www.labudget.org/wp-content/uploads/2018/09/Medicaid-HCBS.pdfttps://www.labudget.org/wp-content/uploads/2018/09/Medicaid-HCBS.pdf

The Context: Other States' Savings

Arkansas:

State savings and new revenues continue to more than cover the cost of expansion.

- In FY2020 and FY2021, Arkansas expects to save $131 and $137 million, respectively, through enhanced federal matching dollars by shifting populations from traditional Medicaid to expansion coverage. And another $43 and $45 million, respectively, by reducing state spending on uncompensated care.
- Further, it expects to generate new premium tax revenues of $26 million and $27 million and another $74 million and $77 million in new revenue due to increased state economic activity.
- Between the new revenues and state savings in FY 2020 and FY2021, the state will continue to cover 320,000 more Arkansans and even with the state share of the expenses, come out ahead by $101 million in FY2020 and $71 million in FY2021.

Source:
Final Report (Draft), Arkansas Health Reform Legislative Task Force, December 2016. Access via:
http://www.arkleg.state.ar.us/assembly/Meeting%20Attachments/836/I14804/TF%20FinalDraftReport.12-14-2016.pdf

Medicaid in Florida: By the Numbers

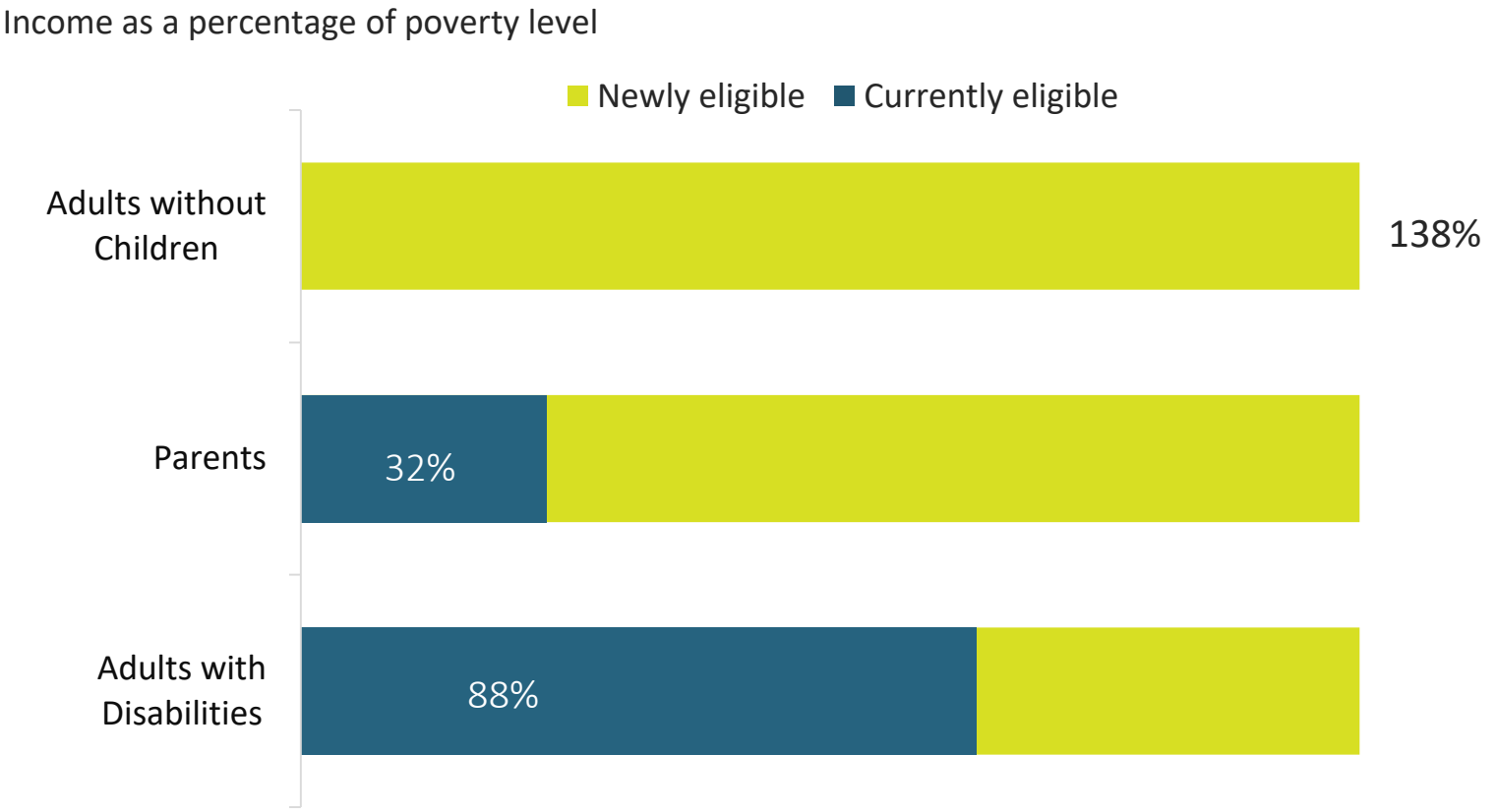
By the Numbers: FY 2018-19

Average Monthly Caseload	3,845,450
Per Member, Per Year (PMPY) Cost	$7,210
Total Costs (Federal and State)	$27.7 billion
FMAP	60.87%
Total State Appropriations	$10.5 billion

Notes:
The current FMAP for federal FY 2019-2020 is 61.47%.
Sources:
AHCA, Medicaid Eligibility Groups for 2018-19, estimated costs, average monthly caseload & PMPM), based on March 2019 EDR Social Services Estimating Conference. (Copy provided by AHCA to FPI). http://edr.state.fl.us/Content/conferences/medicaid/index.cfm
EDR, Medicaid Federal Share of Matching Funds, Feb. 28, 2019. http://edr.state.fl.us/Content/conferences/fmap/fmap.pdf

By the Numbers: Who Gets Benefits?

New coverage groups would be added and income eligibility would increase up to 138% of the Federal Poverty Level for most adults.



The Potential Savings with Expansion Outweighs Costs

Medicaid expansion could result in a substantial net savings to Florida's budget

Potential Budget Impacts of Medicaid Expansion in Florida, FY 2022-2023

Estimated Costs of Expansion	$441,900,000
Estimated Savings from Accessing Enhanced Federal Matching Funds	$266,385,000
Estimated Savings from Replacing State General Revenue funds with Medicaid Funds	$355,400,000
Estimated Revenue Gains	$19,110,000
Net Estimated Savings of Medicaid Expansion in Florida	**$198,995,000**

Note: Based on available data, estimates from the Office of Economic and Demographic Research (EDR) and Agency for Health Care Administration .
Source: Dorn, S., et al. *The Cost to States of Not Expanding Medicaid*. Urban Institute. 2016.
http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000886-The-Cost-to-States-of-Not-Expanding-Medicaid.pdf

Expansion Caseload: New State Costs

Fiscal Year	Expansion Caseload	State Cost of Expansion
2022-23	964,056	$441.9 million

It's important to note that for the same fiscal year, $4.1 billion of new federal funding would flow to Florida. As state costs grow, so would federal dollars.

New federal dollars are also projected to stimulate substantial increased economic activity throughout the state.

Notes:

- The newly eligible caseload projection (which includes the crowd-out, new uninsured presenters and the conversion of the Medically Needy into the expansion program based on 2011-2013 ACS Public Use Microdata Sample). The total and state cost of expansion is based on the Office of Economic and Demographic Research (EDR) projection. However, the caseload projection does not include Floridians who are currently eligible, but not enrolled in Medicaid.
- The currently eligible, but not enrolled population might be already realized. With economic recovery, more people can benefit from health insurance marketplace subsidies.
- The state cost of expansion reflects the specific cost for new uninsured presenters and the crowd-out population.
- Hodges, A. and Rahmani, M. *Economic Impacts of Extending Health Care Coverage in Florida*, May 2013, p. 10. http://www.fha.org/reports-and-resources/show-details/Economic-Impacts-of-Extending-Health-Care-Coverage-in-Florida/75. An updated study will be issued shortly.

Source: The Florida Legislature, Office of Economic and Demographic Research (EDR). *Impact Analysis of SB 2-A, As Filed (With Preliminary numbers for proposed Amendment)*. June 1, 2015. http://edr.state.fl.us/Content/presentations/affordable-care-act/SB2-AHousePresentation_ImpactAnalysisAsFiled.pdf

Potential State Savings from Accessing Enhanced Federal Matching Funds

Potential Savings: Sources

Florida could generate budgetary savings by accessing enhanced FMAP for programs serving:

- Medically Needy Floridians
- Adults with Disabilities
- Adults with AIDS
- Adults with Breast and Cervical Cancer
- Pregnant Women

Potential Savings Amount from Enhanced Federal Matching funds

State Savings From Enhanced Federal Matching Fund

Medically Needy Program	$172,300,000
Adults with Disabilities	$36,437,000
Adults with AIDS	$3,876,000
Adults with Breast and Cervical Cancer	$1,291,000
Pregnant Women	$52,481,000
Total	**$266,385,000**

Potential Savings: Medically Needy

STATE BUDGETARY SAVINGS FROM THE MEDICALLY NEEDY PROGRAM: $172,300,000

Notes and Key Assumptions:

- EDR projects that the state will save $172,300,000 million from the Medically Needy program due to a higher FMAP in FY 2022-2023.
- Expansion states' experience reveals that, "High-need and high-cost individuals who previously would have only qualified for Medicaid by 'spending down' their incomes to the medically needy eligibility group instead were able to enroll in the new adult group, where the federal government provides enhanced match for their services. This is a significant area of savings for states with medically needy programs…"
- Other expansion states have realized savings in their medically needy programs.

Sources:

The Florida Legislature, Office of Economic and Demographic Research (EDR). *Impact Analysis of SB 2-A, As Filed (With Preliminary numbers for proposed Amendment)*. June, 2015. p. 7 http://edr.state.fl.us/Content/presentations/affordable-care-act/SB2-AHousePresentation_ImpactAnalysisAsFiled.pdf

Bachrach, D. et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data shows consistent Economic Benefits Across Expansion States.* Robert Wood Johnson Foundation. March 2016..
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

Potential Savings: Adults with Disabilities (SSI & MEDS-AD Programs)

STATE BUDGETARY SAVINGS FROM SSI & MEDS-AD PROGRAMS: $36,437,000

Notes and Key Assumptions:

- Savings from enrollees in these programs assume that some low-income individuals who previously would have had to pursue a disability determination to qualify for Medicaid will enroll into the new adult group based on income alone. Accordingly, there should be a reduction in the number of individuals seeking disability determinations for Medicaid eligibility and reduced corresponding administrative costs.
- AHCA April 2019 enrollment data show a total of 318,012 adults ages 19-64 enrolled in the SSI and MEDS-AD programs. We assume 4% annual attrition in program enrollment-12,720. The 2018-19 annual PMPM for these groups is $10,450.68. Applying the regular state match for FY 2022-23 (37.41%) and comparing it to the enhanced match with expansion, the state is projected to save $36,437,000. Savings would be cumulative over time.
- A study commissioned by AHCA also confirms that potential budgetary savings from the Disabled Adults Program are possible if the state chooses to expand Medicaid. Additionally, other expansion states have realized savings in these coverage categories.

Sources:

AHCA Medicaid Eligibles Report, Age by Program, April 30, 2019.
http://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/index.shtml
AHCA Medicaid Eligibility Groups for 2018-19. (provided to FPI by AHCA).
Manatt, *Alabama Medicaid Expansion, Summary of Estimated Costs and Savings, SFYs 2020-2023,* Alabama Hospital Association, February 2019.
https://www.manatt.com/Insights/White-Papers/2019/Alabama-Medicaid-Expansion-Summary-of-Estimated-Co
Navigant, *Study of Hospital Funding and Payment Methodologies for Florida Medicaid: Prepared for Agency for Health Care Administration,* p. 125, 2015. https://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf
Bachrach et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains: Early Data shows Consistent Economic Benefits Across Expansion States.* Robert Wood Johnson Foundation, March 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

Potential Savings: Adults with AIDS

STATE BUDGETARY SAVINGS FROM ADULTS WITH AIDS:
$3,876,000

Notes and Key Assumptions:

- The 2017 Florida Legislature amended section 409.904, Florida Statutes to allow certain individuals diagnosed with AIDS to qualify for Medicaid coverage. They must meet the following eligibility criteria: Have income at or below 222% of the federal poverty level (or 300% of the federal benefit rate), and meet hospital level of care, as determined by the Department of Elder Affairs, Comprehensive Assessment and Review for Long-term Care Services (CARES). We assume that individuals at or below 138% of poverty who previously would have had to pursue an assessment by CARES to qualify for Medicaid would instead opt to enroll in the new adult expansion group based on income alone. Accordingly, there should be a reduction in the number of individuals seeking assessments from CARES and reduced corresponding administrative costs.
- For 2018-19, the average monthly caseload was 18,028. We assume that 62% of the caseload had income at or below 138% of poverty (138/222) – or 11,177 eligible for Medicaid expansion. As with other adult disability coverage groups, we assume a 4% annual attrition rate from this program which would be 447 individuals. Based on a PMPM cost of $2,636.19 and a regular match rate of 37.41, state savings are projected to be $3,876,000 for one year. Savings would be cumulative over time.
- Since this eligibility group was created through a federal waiver AHCA could opt to amend it if expansion was implemented. Then this coverage group could be limited to persons with income 139-222% of poverty. All individuals with income at or below 138% of poverty could instead qualify through expansion coverage. It is projected that this change could save the state $98.5 million.

Sources:

AHCA Medicaid Eligibles Report, Age by Program, April 30, 2019.
http://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/index.shtml
AHCA Medicaid Eligibility Groups for 2018-19, provided to FPI by AHCA.

Potential Savings: Breast and Cervical Cancer Program

STATE BUDGETARY SAVINGS ON THE BREAST AND CERVICAL CANCER PROGRAM: $ 1,291,000

Notes and Key Assumptions:

- Based on data available from the state Medicaid office, for FY 2016-17 the total budget allocated for the Breast and Cervical Cancer Program was $6,823,518. Using the 2022-2023 FMAP of 37.41 percent, the state share would be $2,552,678 based on the state's 2022-2023 FMAP of 37.41%.
- Cost savings are achieved by transitioning women below 138% FPL to Medicaid.
- Accordingly, FPI assumed even distribution of the current income requirement of 200% Federal Poverty Level (FPL) for all program-eligible low-income, uninsured and underinsured women. (138%/200%=69% of enrollees). With expansion the state share would be reduced to just 10 percent resulting in estimated net savings of $1,291,000.
- Other expansion states have realized savings from their Breast and Cervical Cancer programs.

Sources:

AHCA Medicaid Eligibility Groups for 2016-17. (provided to FPI by AHCA).

Bachrach et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data shows consistent Economic Benefits Across Expansion States.* Robert Wood Johnson Foundation March 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

Potential Savings: Pregnant Women

STATE BUDGETARY SAVINGS FROM PREGNANT WOMEN PROGRAM : $ 52,481,000

Notes and Key Assumptions:

- The pregnant women program covers women up to 196% of the poverty level. AHCA's April 2019 Medicaid eligibles report only shows enrollment for pregnant women who are at or below poverty level. (87,505) To account for the lack of data for women earning 100-138% we constructed a ratio based on 2016-2017 AHCA data for women in both categories. We estimate the current total for both groups to be 104,433. Based on the PMPMs for both groups included in AHCA's 2016-17 data and applying the 2022-2023 state match of 37.41%, the state could realize total savings exceeding $130 million, if all pregnant women converted to the expansion group. However, a conservative estimate is that 45% of these women would shift to the expansion group in FY 2022-2023 amounting to $ 52,481,000 in state savings.
- Expansion states' experience reveals that, "Many women who are enrolled in the new adult group and become pregnant will remain in the new adult group, where the states receive the enhanced federal match for their services, at least until women renew their coverage. Savings occur even if states maintain their previous Medicaid eligibility levels for pregnant women."

Sources:

ACHA 2016-2017 Eligibility Groups for 2016-17, Total Estimate, Avg Monthly Caseload, PMPM, obtained by FPI from AHCA.

AHCA Medicaid Eligibility Groups for 2018-19, provided to FPI by AHCA

AHCA Medicaid Eligibles Report, Age by Program, March 31, 2019.
http://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/index.shtml

Manatt, *Alabama Medicaid Expansion, Summary of Estimated Costs and Savings, SFYs 2020-2023*, Alabama Hospital Association, February 2019.
https://www.manatt.com/Insights/White-Papers/2019/Alabama-Medicaid-Expansion-Summary-of-Estimated-Co

Bachrach et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data shows consistent Economic Benefits Across Expansion States,* p. 3, Robert Wood Johnson Foundation. 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

Potential State Savings from Replacing General Revenue Funds with Federal Medicaid Funds

Potential Savings: Sources

Florida could generate budgetary savings by replacing state General Revenue (GR) funds with Medicaid funds for:

- Mental Health and Substance Abuse Programs
- Prisoner Hospitalization Costs
- Uncompensated Care

Potential Savings Amount from Replacing State General Revenue With Medicaid Funds

Substance Abuse and Mental Health Services	$200,482,000
Prisoner Hospitalization Costs	$57,524,000
Uncompensated Care (Low Income Pool)	$97,394,000
Total	**$355,400,000**

GR Savings: Mental Health and Substance Abuse

STATE BUDGETARY SAVINGS FROM MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM:
$200,482,000

Notes and Key Assumptions:

- The Department of Children and Families estimates that there are 132,940 adults receiving general revenue funded mental health/substance abuse services and that $412,411,814 in general revenue could be used for state Medicaid match. These numbers are from 2016 and are likely to be higher today. Savings are projected using AHCA 2018/19 MMA Capitation rates for SSI SMI Ages 14+. A weighted average across all regions of $1,328.48 PMPM was used. The cost of converting these adults into coverage under Medicaid expansion has been deducted from the savings.
- These savings could help mitigate critical mental health funding priorities of the state, particularly for community-based agencies providing mental health care services.
- Other states' experience reveal that, "The largest savings in this category come as individuals who previously relied on state-funded behavioral health programs and services—including mental health and substance use disorder services—are able to secure Medicaid coverage in the new adult group, which means states can fund these services with federal—not state—dollars without reducing services."
- The Georgetown University Center for Children and Families has estimated even higher savings- $250 million annually- from the community substance abuse and mental health program if the state opted to expand Medicaid.

Sources:

Agency for Health Care Administration, *Behavioral Health Services Revenue Maximization Plan, Report to the Florida Legislature*, December 31, 2016. https://ahca.myflorida.com/medicaid/recent_presentations/SB_12_Behavioral_Health_Services_Revenue_Maximization_Plan_123016.pdf

Agency for Health Care Administration , Medical Actuarial Services. http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/actuarial/index.shtml

Alker, J. et al. *Florida's Medicaid Choice: Understanding Implications of Supreme Court Ruling on Affordable Health Care Act,* p. 7, 2012. http://ccf.georgetown.edu/wp-content/uploads/2012/11/florida-medicaid-choice-nov-2012.pdf

Bachrach, D. et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data shows consistent Economic Benefits Across Expansion States,* p. 4, Robert Wood Johnson Foundation, March 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

GR Savings: Prisoner Hospitalization Costs

STATE BUDGETARY SAVINGS FROM HOSPITAL INPATIENT CARE FOR PRISONERS:
$57,524,000

Notes and Key Assumptions:

- "Medicaid's 'inmate exclusion' prohibits payment of care of services for any individual who is an inmate of a public institution. However, Medicaid will cover services provided to an inmate during an inpatient stay of at least 24 hours in a medical institution such as an acute care facility. To qualify, the inmate must be otherwise Medicaid-eligible. Expansion states are seeing health care related savings in their correction budgets for newly Medicaid-eligible prisoners who are treated in an inpatient medical facility outside of the state correctional system."

- FPI presumes that nearly all state prisoners are likely to qualify for the new adult group. Applying an expansion take-up rate of 85.8 percent, we assume that the state could save $45,903,000 of its $53,500,000 hospital inpatient care spending based on costs for FY 2016-17 (the last year of data available to FPI). From FY 2016-17 to FY 2018-19, state appropriations for inmate health services increased 24%. Applying this increase to the 2016-17 costs, we project $57,524,000 in savings.

Sources:

The Florida Department of Corrections. Florida's FY 2016-17 allocated budget for inmate health care services is $383,388,630, of which $53,500,000 is allocated for Inpatient Cost of Care for inmates. (Information provided to FPI by the Department of Corrections).

General Appropriations Acts, FYS 2017-18, 2018-19. http://laws.flrules.org/files/Ch_2017-071.pdf; http://laws.flrules.org/files/Ch_2018_009.pdf

Bachrach, D. et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data shows consistent Economic Benefits Across Expansion States*. Robert Wood Johnson Foundation. March 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

EDR. *Impact Analysis LIP, IGTs and SB2512* , p. 5, (take-up rate of 85.8 percent), April 2015. http://edr.state.fl.us/Content/presentations/affordable-care-act/Expansion2015PresentationtoSenate.pdf

GR Savings: Uncompensated Care/ Low Income Pool

STATE BUDGETARY SAVINGS
FROM UNCOMPENSATED CARE COSTS:
$97,394,000

Notes and Key Assumptions:

- Medicaid expansion is projected to lower the number of uninsured by 29% with a moderate caseload enrollment. This figure is based on a 29% reduction of the state's uncompensated care costs. The FY 2017-2018 General Appropriations Act allotted $586,762,066 for the state share to access a total pool of $1.5 billion of combined state and federal funding. (Nearly identical amounts have been appropriated in subsequent FYs). However, local entities, such as counties and hospital taxing districts, which are charged with raising the state share just raised $335,839,712 for FY 2017-18. The LIP savings projection is based on this reduced amount.

- Another potential source of state savings due to a reduction in the uninsured rate is the disproportionate share hospital (DSH) payments program. Through this program, the state spends millions of dollars annually for uncompensated hospital care. This analysis does not include these potential savings.

Sources:

FY 2017-18 General Appropriation Act, HB 5001. Medical Hospital Funding Programs, Fiscal Year 2016-17.
https://www.flsenate.gov/PublishedContent/Session/2016/Appropriations/Documents/2016_Medcaid_Hospital_Funding_Conference_Report.pdf
Local Funding Revenue Maximization Report for FY 2017-18, Agency for Health Care Administration. Accessed via:
ahca.myflorida.com/medicaid/recent.../IGT_Rev_Max_SFY17-18.pdf
Buettgens, M. et al. *What if More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured*. Urban Institute. 2016.
http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000866-What-if-More-States-Expanded-Medicaid-in-2017-Changes-in-Eligibility-Enrollment-and-the-Uninsured.pdf

Potential Revenue Gains from Provider Taxes

$19,110,000

Notes and Key Assumptions:

- Figure is based on 1.5% tax on inpatient care and 1% on outpatient, with a revenue distribution of 73% and 27%, respectively. This distribution is applied to $2.1 billion in increased revenue if the state expanded Medicaid in FY 2016. Also, 1/3 of Medicaid revenue gains are offset by lost marketplace revenues, resulting in net revenues of $19.11 million.
- Other states' experience reveals increased state revenue from existing assessments on insurers and providers. These gains occurred as local insurer and provider revenues increased, resulting in higher state collections on insurer and provider assessments.
- Other states have also experienced macroeconomic benefits from billions of new federal dollars flowing through their local and state economies generating more state and local revenues. Those potential fiscal gains are not addressed in this report.

Sources:

Dorn, S. et al. *The Financial Benefits to Hospitals From State Expansion of Medicaid*. Urban Institute. 2013.
http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412770-The-Financial-Benefit-to-Hospitals-from-State-Expansion-of-Medicaid.pdf
Bachrach, D. et al. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains. Early Data shows consistent Economic Benefits Across Expansion States*. Robert Wood Johnson Foundation. March 2016.
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

Summary of Potential Savings

Potential FY 2022-2023 State Budget Savings And Revenue Gain Estimates In Florida

State-only Cost of Expansion	$441, 900,000
SAVINGS FROM ENHANCED FEDERAL MATCHING RATES	
Medically Needy Program	$172,300,000
Adults with Disabilities	$36,437,000
Adults with AIDS	$3,876,000
Breast and Cervical Cancer Program	$1,291,000
Pregnant Women	$52,481,000
Total	**$266,385,000**
SAVINGS FROM REPLACING STATE FUNDS WITH FEDERAL MEDICAID FUNDS	
Substance Abuse and Mental Health Services	$200,482,000
Prisoner Hospitalization Costs	$57,524,000
Uncompensated Care (Low Income Pool)	$97,394,000
Total	**$355,400,000**
ESTIMATED REVENUE GAINS	
Increased Hospital Taxes/Provider Tax Assessments	$19,110,000
Total	**$19,110,000**
Total Savings and Revenue Gains	**$640,895,000**
Net Savings with Medicaid Expansion	**$198,995,000**

For Additional Information

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The Economic and Employment Benefits of Expanding Medicaid in North Carolina:

June 2019 Update

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The George Washington University

Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY

CONE HEALTH FOUNDATION
Investing in Health. Creating Change.

Kate B. Reynolds Charitable Trust
Investing in Impact

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The Economic and Employment Benefits of Expanding Medicaid in North Carolina: A 2019 Update

Executive Summary

Governor Roy Cooper has proposed expanding eligibility in North Carolina's Medicaid health insurance program. North Carolina currently covers parents with incomes up to 42 percent of the poverty line and generally does not cover adults without dependent children. The expansion would lift income criteria to 138 percent of the poverty line for adults 19 to 64 ($29,400 for a family of three). North Carolina is one of 14 states that has not expanded Medicaid; only eight states in the U.S. have more austere income guidelines.

This brief is an update of a December 2014 report about the potential economic and employment consequences of expanding Medicaid in North Carolina. The earlier report examined the consequences of not expanding Medicaid in 2014 and then estimated what would happen if the Tar Heel state expanded it in 2016. This report addresses the consequences of the Governor's proposal to expand Medicaid beginning November 2019. It offers a nonpartisan analysis of potential changes in economic growth at the state level and in each of North Carolina's 100 counties.

Briefly, the analysis indicates that if Medicaid is expanded:

- In Calendar Year 2020, about 464,000 more people will gain Medicaid coverage. This will rise to about 634,000 people in 2022, then stabilize.

- New federal funding flowing into North Carolina will rise by $2.8 billion in 2019 and gradually climb to $4.7 billion by 2022 because the federal government would pay 90 percent of Medicaid costs for newly eligible adults. From 2020 to 2022, North Carolina will gain $11.7 billion more in federal funding.

- The injection of billions of dollars into North Carolina's economy will spur business activity, which will in turn create more jobs. We estimate that 24,400 additional jobs would be created in 2020, climbing to 37,200 more jobs in 2022, compared to levels if Medicaid is not expanded.

- The Gross State Product (a measure of economic activity in North Carolina) would be increased by $1.9 billion in 2020 and $2.9 billion in 2022.

- The increased economic activity and employment would trigger increases in state and county tax revenues, totaling $500 million in state revenue from 2020 to 2022 and $100 million in county revenue over the three-year period. The additional revenues can help the state and the counties address other budgetary needs.

Since more low-income people will get health insurance coverage, increasing health care access across the state, the benefits will be broadly dispersed. This analysis estimates economic gains in all 100 counties. Almost half the job gains – 17,900 jobs by 2022 -- will occur in six large counties

(Buncombe, Durham, Forsyth, Guilford, Mecklenburg and Wake Counties), while the other 19,200 new jobs will be distributed across the rest of the state, including rural areas.

Slightly more than half of the job growth (20,600 jobs) would be in the health care field, hardly surprising since Medicaid is a health insurance program. But the other 16,600 jobs created would be in other fields such as construction, retail sales, professional and management services, etc. Although Medicaid funds would first flow to health care providers, they would then ripple out into other parts of the economy as staff employed in health and other fields purchase food, pay their rent and mortgages, and make other consumer purchases. The economic growth would increase North Carolina's tax base and ultimately increase both state and county tax revenues.

The current employment estimates are similar to but a little lower than we projected in 2014. The main reason is that the current proposal would not be effective until late 2019, as compared to the 2016 start assumed before. In addition, projected Medicaid expenditures are somewhat lower than estimated before.

These estimates are projections, based on a sophisticated, dynamic economic model produced by Regional Economic Models, Inc. As with any projection, there is uncertainty and other factors may affect the outcomes. The economic methods employed are well-respected and widely used to estimate effects of changing state and local policies for local economies.

An alternative to the Governor's proposal has been introduced in the House of Representatives, House Bill 655. It also presents a health insurance option for adults with incomes up to 138 percent of the poverty line but adds requirements that low-income beneficiaries pay monthly premiums and comply with work requirements. We are not aware of detailed analyses of that bill and cannot conduct a comparable analysis. This bill would also increase Medicaid participation and federal funding flowing into the state, compared to current law. However, when compared to the expansion proposed by the Governor, the premiums and work requirements would depress participation. Enrolling fewer North Carolinians would yield lower federal revenue and reduced economic and employment gains.

Medicaid expansion could be an important engine for economic growth and job creation across the breadth of North Carolina. More fundamentally, expanding Medicaid coverage will empower 634,000 low-income North Carolinians get Medicaid coverage by 2022 which will help assure they can get affordable care when they are sick and preventive and primary care to help them stay healthy.

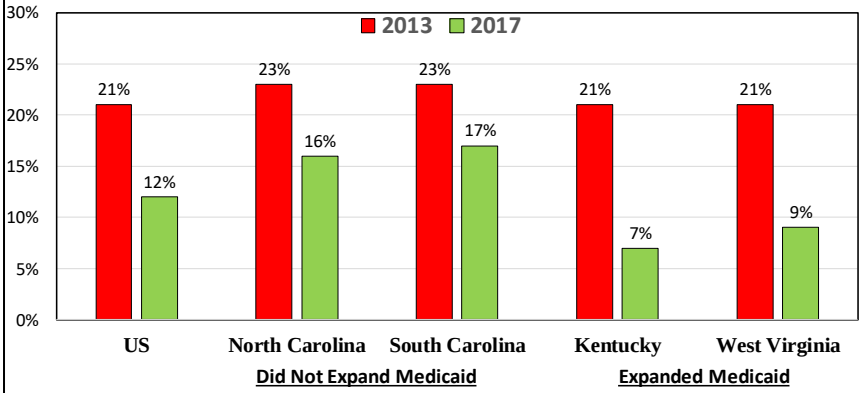
Introduction

As of May 2019, North Carolina was one of 14 states that has not expanded its Medicaid program, an option under the Patient Protection and Affordable Care Act (ACA).[1] Thirty-four states (including the District of Columbia) have implemented expansions, while Idaho, Nebraska and Utah voters passed referenda to expand Medicaid and are pending implementation. Governor Roy Cooper has proposed expanding North Carolina's Medicaid eligibility, effective November 2019. This issue is currently before the legislature.

Most states in the nation now offer Medicaid to low-income adults with incomes up to 138 percent of the federal poverty level ($29,400 for a family of three). In North Carolina, parents are not eligible if their incomes exceed 42 percent of poverty and most adults without dependent children are ineligible for Medicaid.

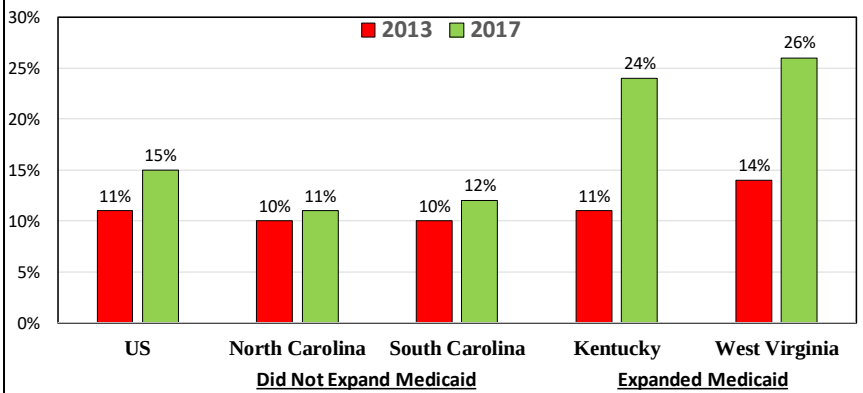
As a result, North Carolinians are about twice as likely to be uninsured as their neighbors in Kentucky or West Virginia, which expanded Medicaid (see Figure 1). The most recent Census data indicates that almost a million (994,000) North Carolina adults 19 to 64 lacked health insurance coverage in 2017, roughly one-sixth (16%) of the state's adult population, far higher than the 7% of adults uninsured in Kentucky or 9% in West Virginia. The differences were primarily driven by the Medicaid expansions (see Figure 2).

Fig 1. Changes in Percent of Adults 19-64 Who Are Uninsured



Source: Census Bureau, American Community Survey data

Fig 2. Changes in Percent of Adults 19-64 with Medicaid Coverage



Source: Census Bureau, American Community Survey data

The ACA requires the federal government to cover most (or all) of the cost of expanding Medicaid eligibility. From 2014 to 2016 the federal government financed 100 percent of the costs of Medicaid eligibility expansions. The federal share declined after the initial period, reaching 93 percent in 2019. In 2020 and thereafter, the federal government will pay 90 percent of the cost. As a result, expansion will bring a substantial inflow of additional federal funding to the state, triggering economic and employment growth, particularly in the health care sector.

An earlier report[2], issued in December 2014, indicated that by failing to adopt a Medicaid expansion, North Carolina lost access to billions of federal dollars, and did not gain the economic growth opportunities experienced by most states. The analysis estimated that if North Carolina expanded Medicaid in 2016, the number of jobs could increase by 43,000 by 2020. And while much of the job growth would occur in the health care sector, growth would occur in other areas too, due to the "economic multiplier" effect.

This brief updates the 2014 report, based on more recent information such as changes in estimates of Medicaid costs. This update focuses on the effects of Medicaid expansion and does not address other important changes under discussion in the state, including the transformation of the state Medicaid's system of delivering health care from fee-for-service to managed care and an expansion of services to address the opioid crisis. A bill proposed in the legislature (House Bill 655) would also expand Medicaid but would require that newly eligible adults pay monthly premiums and comply with new work requirements, unless they have a dependent child or are exempt (e.g., medically frail or pregnant).

Key differences between this update and the 2014 report are:

- The earlier report examined effects if Medicaid expansion began in 2016. Based on the current proposal, this analysis assumes Medicaid expansion begins November 2019 and takes two years for enrollment to ramp up.

- As a result, federal revenue increases are lower than estimated before due to the later start date. Our earlier report projected that federal revenue would rise from $5.05 billion in 2020 to $5.78 billion in 2022, while we now estimate additional federal revenue of $2.85 billion in 2020, rising to $4.69 billion in 2022. The change in projections appears to be because Medicaid costs grew more slowly in North Carolina than anticipated earlier.

- Since the economic benefits of Medicaid expansion are related to the contribution of new federal funding into North Carolina's economy, the projected economic effects are somewhat lower, particularly in the initial years. While the 2014 report estimated that Medicaid expansion could lead to 43,000 additional jobs by 2020, this update estimates employment growth of 24,400 jobs in calendar year 2020. By 2022, 37,200 more jobs would exist across the state than would exist if Medicaid does not expand.

Research About Benefits of Medicaid Expansion

A March 2018 review by the Kaiser Family Foundation identified over 200 studies about the effects of Medicaid expansions across a variety of areas.[3] The review found that Medicaid expansions (a) increased insurance coverage and reduced the number of uninsured, benefiting both rural and urban residents and those who are African-American, white and Latino, (b) strengthened access to health care services, (c) increased low-income families' financial security, (d) improved a variety of health outcomes, (e) reduced uncompensated care costs and stabilized safety net health care providers and (f) have done so with without creating major cost increases for states.

A more focused review on health benefits, published in the *New England Journal of Medicine*, found consistent evidence that expanding health insurance coverage, especially Medicaid, improves access to and utilization of appropriate health care, such as cancer screening, improves

assessments of health, eases depression, increases financial security and appears to lower mortality.[4]

Some additional impacts of expansion that may be important in North Carolina:

- Medicaid expansions lower hospitals' uncompensated care burdens, improves their balance sheets and reduces the risk that rural hospital close.[5] This may be particularly relevant to North Carolina, where six rural hospitals (Washington County Hospital, Our Community Hospital (Halifax County), Davie Medical Center-Mocksville, Yadkin Valley Community Hospital, Vidant Pungo Hospital, and Blowing Rock Hospital) closed between 2014 and May 2019 (Note: The reopening of Washington County Hospital was announced in late April.).[6] Of the 76 rural hospitals that closed across the nation in that period, 83% were in states that did not expand Medicaid, while only 17% were in the more numerous states that expanded Medicaid, according to data from the Sheps Center at the University of North Carolina.[7] Other North Carolina rural hospitals could be at risk if Medicaid is not expanded.[8] Randolph Health has reported being in severe distress.[9]

- Medicaid expansions have also benefited other safety net facilities that provide care to low-income and uninsured patients, including community health centers.[10]

- Expansions of Medicaid eligibility help get more people into treatment for opioid use disorder and have not fueled greater addiction. States that expanded Medicaid have been able to increase access to buprenorphine and related medications used to help treat opioid addiction, compared to states that did not expand Medicaid.[11] Both expansion and non-expansion states have reduced prescriptions of opioid pain relief medications in recent years at roughly equal rates to curb future addiction. Medicaid expansions also help finance hospital care for treatment of opioid use disorder; they reduced uncompensated care costs and gained Medicaid revenue to support treatment services.[12]

- Contrary to some criticisms, Medicaid expansions have not created serious budget problems for states; in fact they sometimes helped state budgets.[13] [14] This is in part because state spending on uncompensated care and mental health services can decline if more health care use is covered under Medicaid.[15] [16] Prof. Mark Hall of Wake Forest University explained that "claims that the costs of Medicaid expansion have far exceeded expectations are overstated, misleading and substantially inaccurate, based on a review of the credible evidence from either academic or government sources."[17]

- Medicaid programs have been particularly effective in holding down increases in health care costs. A recent analysis compared growth in per person insurance costs from 2006 to 2017. The annual growth in Medicaid costs per person averaged 1.6% per year, lower than increases in Medicare costs, which averaged 2.4%. Growth in both Medicaid and Medicare were below average cost increases in private insurance costs (4.4% per year).[18]

- The financial performance above is consistent with research that it is less expensive to insure low-income adults through Medicaid than through private insurance.[19] [20] In addition, Medicaid beneficiaries – who are quite poor – have lower out-of-pocket cost

burdens than similarly low-income people with private insurance, improving their ability to get necessary preventive and primary care, as well as medications.

- Some critics have inaccurately claimed that Medicaid expansions prevent states from meeting the needs of elderly or residents with disabilities who are on waiting lists to receive home or community-based care service. In fact, analyses have shown that between 2013 and 2017, waiting lists were much likely to grow in states that did not expand Medicaid (69%) than in expansion states (41%).[21] Expanding Medicaid and providing more home and community-based care need not be mutually exclusive choices. Both choices would earn additional federal matching funds as well as help meet residents' health needs. However, Medicaid expansion earns a 90% matching rate while increasing support for home and community-based care setting would earn the regular 67% federal match.

North Carolina's Medicaid Program and Proposed Expansion

North Carolina currently provides Medicaid coverage to parents with family incomes up to 42 percent of the federal poverty line, but does not cover most non-elderly, non-disabled adults without dependent children, regardless of their incomes.[22] (Some childless adults may be eligible for Medicaid if they are disabled or pregnant.) Only eight states (Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri and Texas) have lower income eligibility guidelines. In the past year, Virginia and Maine expanded Medicaid and voter-approved referenda to expand Medicaid in Idaho, Nebraska and Utah are pending implementation.

North Carolina's "regular" federal Medicaid match rate is 67.16% for federal fiscal year 2019, falling slightly to 67.03% in 2020. That is, the state generally pays about 33% of the total cost of Medicaid services. If North Carolina had expanded Medicaid in the 2014 to 2016 period, the federal government would have covered the full cost of the Medicaid expansion. Even now, the government will provide an enhanced match rate of 93% for eligibility expansion costs in 2019 and 90% in 2020 and later years.

If Medicaid expands, it is likely some additional Medicaid enrollees who are already eligible (i.e., parents with incomes at or below 42% of poverty) will enroll, but the number should be modest. This effect, sometimes called the "woodwork" effect, occurs because already eligible people come "out of the woodwork" and enroll after publicity about expansions. In North Carolina, most of the woodwork effect of the ACA already occurred, due to the publicity about ACA implementation and the development of the HealthCare.gov website, which referred income-eligible people to the Medicaid program. Between SFY 2012-13 and 2015-16, North Carolina's Medicaid enrollment grew by 227,000.[23] (Since then, there has been growth in Medicaid due to an increase in the number of women and men getting a very limited family planning benefit; the number of other Medicaid enrollees declined slightly through SFY 2017-18.) Thus, it is expected that a modest number of already eligible people would join Medicaid if expansions occur later this year, further reducing the number of uninsured. These individuals are eligible for the regular 67% match.

A recent report by the Urban Institute, a nonpartisan think tank, estimated that Medicaid expansion in North Carolina could increase the number of Medicaid enrollees in North Carolina by 626,000 and reduce the number of uninsured by 365,000.[24] Some of those who will gain Medicaid currently have other forms of insurance, primarily subsidized insurance from the ACA's health insurance

marketplace. There are budgetary advantages to such a shift; supporting Medicaid may be less costly than subsidizing marketplace beneficiaries.[25]

North Carolina Governor Roy Cooper has proposed to expand Medicaid eligibility from 42 percent of the poverty line for parents and zero percent for other low-income adults to 138 percent for both groups. The state estimated the following budget impacts of his proposal to expand Medicaid beginning November 2019:[26]

- In Governor Cooper's budget proposal, the SFY 2019-20 costs of care for the expansion group are projected to require a total of $2.13 billion, of which $1.91 billion will be covered by federal matching funds and $216 million will be covered by non-federal funds (primarily hospital assessments). The budget proposes to fund the remaining need of $3.3 million with a tax on managed care capitation payments made on behalf of the expansion population. In addition, the state will need $63 million to meet the additional costs of existing eligible people and will gain $46 million in federal matching funds and $2 million in non-federal funds (hospital assessments).

- The budget anticipates that costs will ramp up in SFY 2020-21 as the expansion takes hold: the costs of the expansion group will increase to $4.17 billion, of which federal matching revenue will cover $3.74 billion and non-federal revenue will cover $356 million. The budget anticipates the tax on managed care capitation payments for the expansion population will generate the remaining balance of $75 million. The projected costs of serving additional people who are already eligible is estimated at $126 million and North Carolina will receive $92 million from federal and non-federal sources.

- The costs ought to rise a little more in SFY 2021-22, after which the enrollment and cost increases are expected to plateau. Based on the experience of other states, it should take about two years to reach a steady state.

Some of the costs of Medicaid expansion are expected to be offset by savings of about $31 million in SFY 2019-20 and $69 million in SFY 2020-21 for other care, mental health services, corrections, the state health plan and state operated health facilities.[27]

These projections are consistent with Urban Institute analyses, based on its Health Reform Policy Simulation Model, which estimated that expanding Medicaid in North Carolina would increase federal funding by $4.012 billion if it was fully implemented in 2019. [28] This includes not only the additional costs of Medicaid, but accounts for the fact that some North Carolinians who currently receive premium tax credits under the ACA health insurance marketplaces (Obamacare) would transfer to Medicaid, reducing federal spending on marketplace coverage.

Other important changes in North Carolina's Medicaid program are afoot as well, particularly a major transformation from providing care under a fee-for-service delivery system to a managed care program. This report focuses exclusively on the effects of a Medicaid expansion, although we note that it is possible to simultaneously expand Medicaid to implement other major delivery system changes, as other states have done.

The Updated Economic Analysis

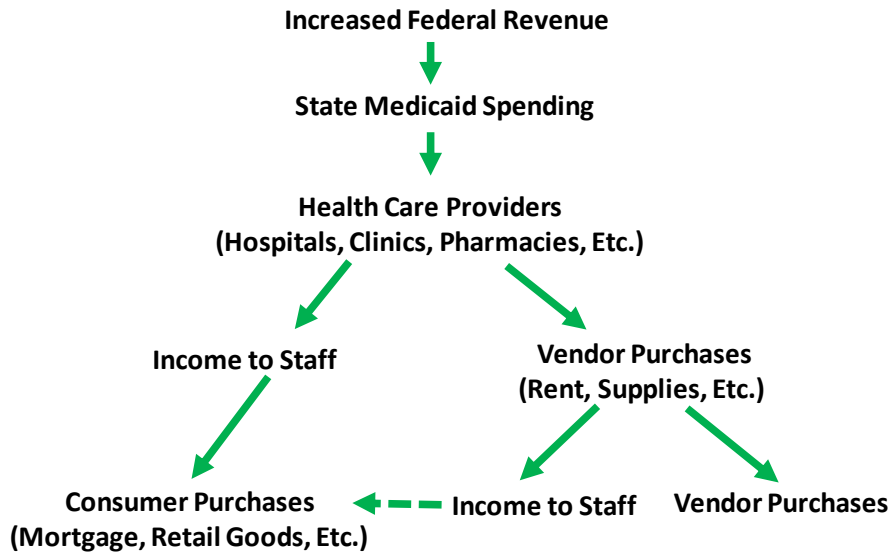
This brief updates our December 2014 report on the economic and employment effects of expanding Medicaid in North Carolina. The earlier report considered the effects of expanding Medicaid beginning in 2016. We now estimate the effects of an expansion beginning in November 2019. We project that effects will phase-in over a two-year period. Thus, we estimate effects for calendar years 2020, 2021 and 2022.

This analysis, like the earlier one, is based on an economic model developed by Regional Economic Models, Inc. (REMI)[29] The model is well-respected and has been used by governments and universities around the nation, including North Carolina's Office of State Budget and Management and the State Legislature. The model examines the flows of revenue and outputs through the state's economy and the effect of economic multipliers. The use of multiplier estimates in economic impact studies is well-accepted; the approach is used by not only ourselves and those in North Carolina, but by economists at the Congressional Budget Office[30], the International Monetary Fund,[31] the White House Office of Economic Advisers[32] and business economists[33] in analyses of how policies and investments can stimulate (or depress) additional economic growth.

Other researchers have also conducted similar economic analyses of the benefits of Medicaid expansion in increasing employment.[34] [35] [36] [37] Their conclusions are like those presented in this analysis; Medicaid expansions can fuel economic development and employment.

In this model, the key determinant of the economic stimulus is the injection of new federal revenue into North Carolina's economy because of the Medicaid expansion. Figure 3 illustrates how the additional federal revenue would flow and multiply through the state, boosting employment and economic growth.

Figure 3. Illustration of Multiplier Effect in Medicaid



- As the state expands Medicaid, additional federal funds flow to health care providers (hospitals, clinics, pharmacies, etc.) as the newly eligible individuals get medical care supported by Medicaid.

- Health care providers used these funds to increase staffing (the largest expense for most health providers) as well as to purchase goods from other vendors, such as paying to build out their facilities, pay rent, purchase supplies and other services.

- Increased employment lets the workers purchase consumer goods. Their salaries are used to pay their mortgages or rent, buy retail goods like food, clothing or furniture, and they also pay more taxes to their state and local governments.

- In turn, businesses such as medical good suppliers, grocery stores and real estate companies gain increased consumer activity, hire more staff and pay other vendors.

- As the funds flow through the local economies, the economic impact multiplies.

Some critics of economic impact studies argue that they are unrealistic because they fail to consider the effects of alternative uses of the resources.[38] That is, rather than spending, say $20 million on Medicaid, North Carolina might spend $20 million more on building roads or prisons and these too would yield economic benefits. Our methodology addresses this problem by being based *entirely* on the net federal funds that will flow into the state solely due to Medicaid expansion; we exclude the use of state funds which might be used for other purposes. The additional federal matching funds derive from external sources and would not flow into North Carolina if there was no Medicaid expansion. The new federal funds received will fuel additional benefits for North Carolinians. Federal taxes paid by North Carolinians will not change, aside from taxes paid because state residents and businesses have higher incomes.

North Carolina contributes about 2.4% of total federal tax collections.[39] However, since most states have already expanded Medicaid, North Carolinians have helped pay for expansions and economic gains in most of the country with their federal taxes, while they have not reaped the benefits so far.

When we compute the net federal revenue gained by North Carolina under a Medicaid expansion, we use a blend of estimates from the Office of State Budget and Management and the Urban Institute, assuming that the Medicaid expansion begins November 2019. We include additional federal revenue gained because the federal government will cover 90% of the cost the Medicaid expansion. We subtract the federal tax credits that would otherwise have been paid for individuals with incomes between 100% and 138% of poverty for premium tax credits in the health insurance marketplaces. To the extent that North Carolina uses in-state sources to fund the expansion, these funds are subtracted in computing the net federal funding created by expansion.

Using the approach described in our 2014 report, additional federal Medicaid revenue generates additional spending on hospital care, ambulatory care and pharmaceuticals (plus slight amounts for long-term care services); these are distributed across North Carolina's 100 counties, based on the expected growth in Medicaid spending in each county. These are used as inputs (i.e., new spending) in the REMI model, which then produce estimates of outputs, such as increased

employment, state or county gross state product and county revenue. For this brief report, we re-estimated the federal revenue inputs to the model, based on the more recent budget data, described in the paragraph above, and compare them to our prior estimates for Calendar Years 2020, 2021 and 2022. We apply the percentage difference in federal revenue inputs to the outputs from the 2014 report to generate our new estimates. This proportionate adjustment is a rough approximation but should be close to what would be found if the entire model was run again.

Key terms used in this report are:

- Employment: This is the number of jobs that would be added or lost in the county or state related to Medicaid expansion, full-time plus part-time. These include jobs in all sectors, including health-related jobs, construction, retail, professional jobs, state or local government, etc.

- Business Activity (Output): This is equivalent to the sum of all revenue (public and private) generated by the Medicaid expansion at the state or county levels. For example, if a retail firm buys a product from a wholesaler for $1,000 and a customer pays $1,500 to the retailer for that same product, the increase in business activity is the sum of both levels of purchase, or $2,500.

- Gross State (or County) Product: Gross State Product (GSP) is a subset of output and refers to the "value added" by economic activity. GSP can be thought of as all net new economic activity or output minus the goods and serves used as inputs to production. Effectively, it measures only the final stage of a transaction. In the example above, it would be the $1,500 paid by the customer to the retailer.

- State Tax Revenue: This is the value of additional state government revenue related to the expansion, not including any health taxes that may change under the proposal.

- County Tax Revenue: This is the value of additional county/local government revenue related to the expansion, separate from state revenues.

What Would Be the Effects of Expanding Medicaid Beginning November 2019?

The results of our analysis, aggregated at the state level, are summarized in Table 1 below. All levels are compared to a baseline in which Medicaid does not expand. If Medicaid is expanded:

- Estimated additional federal revenue that North Carolina earns would rise from $2.8 billion in calendar year 2020, to $4.2 billion by 2021 and to $4.7 billion in 2022, for a total of $11.7 billion over the three years. After that, it would be relatively stable, growing due to inflation and population changes.

- The number of additional Medicaid enrollees would grow by 464,000 in 2020, increasing to 634,000 by 2022.

- In 2020, an additional 24,400 jobs would be added, rising to 34,500 in 2021 and to 37,200 in 2022.

Table 1. Estimated State-Level Changes in Federal Revenue, Medicaid Enrollees, Jobs, Business Activity, Gross State Product, State and County Tax Revenue If Medicaid Expands in Late 2019

Calendar Years	2020	2021	2022	2020-22
Federal Revenue (billions)	$2.85	$4.19	$4.69	$11.73
New Medicaid Enrollees*	464,000	582,000	634,000	N.A.
Total Jobs Added*	24,400	34,500	37,200	N.A.
Business Activity (billions)	$2.94	$4.19	$4.54	$11.67
Gross State Product (billions)	$1.88	$2.65	$2.92	$7.45
State Tax Revenue (millions)	$124	$181	$200	$506
County Tax Revenues (millions)	$25	$38	$43	$106

* Unlike dollars, the number of new enrollees and the number of new jobs do not sum over the years.

- Total business activity would increase from $2.9 billion in 2020 to $4.7 billion in 2022, or $11.7 billion over three years.

- Gross State Product, the net increase in state economic activity, would be $1.9 billion higher in 2020 and $2.9 billion higher by 2022.

- The state of North Carolina would earn $506 million more in tax revenue from 2020 to 2022 and North Carolina counties would earn $106 million more due to the additional economic activity caused by the Medicaid expansion. These additional revenues would help the state and the counties address other budgetary needs in the future.

The growth in economic activity and employment would be varied. As seen in Table 2, there would be an increase of 20,600 jobs in the health care sector by 2022. But other sectors would gain almost 16,600 more jobs, such as construction, retail sales, administrative and professional services. As described earlier, though Medicaid funds would first flow to the health sector, economic benefits and employment gains ripple out to other sectors of the economy.

Table 2. Composition of Additional Jobs by Sector, 2022

Industrial Sector	2022
Ambulatory health care services	16,200
Hospitals	4,400
Construction	4,000
State & local	3,300
Retail & wholesale trade	1,900
Administrative and support services	1,400
Professional, scientific, and technical services	1,100
Food services & hospitality	1,100
All others	3,800
Total	37,200

The growth in employment would be shared across the state, flowing from increased Medicaid enrollment and revenue in both urban and rural areas. Table 3 estimates the number of additional jobs created in each of North Carolina's 100 counties. About 17,900 jobs would be created by 2022 would be in six large counties (Buncombe, Durham, Forsyth, Guilford, Mecklenburg and

Table 3. Estimated Number of New Jobs If Medicaid Expands, by County

County	2020	2021	2022
Alamance	516	731	787
Alexander	48	67	72
Alleghany	75	107	116
Anson	28	39	43
Ashe	55	78	84
Avery	38	54	58
Beaufort	86	122	132
Bertie	19	27	29
Bladen	40	57	62
Brunswick	142	202	218
Buncombe	845	1,199	1,293
Burke	297	421	456
Cabarrus	361	510	547
Caldwell	127	180	195
Camden	2	3	4
Carteret	91	130	141
Caswell	25	35	38
Catawba	342	484	523
Chatham	152	214	228
Cherokee	49	69	75
Chowan	17	25	27
Clay	10	14	15
Cleveland	251	357	386
Columbus	150	213	232
Craven	107	154	169
Cumberland	452	649	710
Currituck	6	8	8
Dare	34	48	51
Davidson	369	523	562
Davie	51	71	76
Duplin	87	124	135
Durham	2,875	4,044	4,351
Edgecombe	68	96	105
Forsyth	1,159	1,642	1,772
Franklin	163	231	248
Gaston	548	780	845
Gates	3	5	5
Graham	8	11	12
Granville	89	125	135
Greene	36	51	56
Guilford	1,779	2,514	2,706
Halifax	85	122	133
Harnett	220	316	344
Haywood	65	92	99
Henderson	214	303	326
Hertford	89	127	138
Hoke	51	72	78
Hyde	2	3	3
Iredell	375	529	568
Jackson	172	244	263

County	2020	2021	2022
Johnston	435	617	662
Jones	8	11	12
Lee	191	270	292
Lenoir	132	187	203
Lincoln	88	123	131
McDowell	62	88	95
Macon	41	58	62
Madison	31	44	48
Martin	48	69	75
Mecklenburg	2,514	3,517	3,751
Mitchell	31	44	47
Montgomery	44	62	67
Moore	277	395	428
Nash	182	258	278
New Hanover	577	815	876
Northampton	13	18	19
Onslow	101	146	161
Orange	409	581	629
Pamlico	22	31	34
Pasquotank	48	68	74
Pender	75	106	114
Perquimans	6	8	9
Person	78	111	120
Pitt	344	493	537
Polk	28	40	44
Randolph	335	474	508
Richmond	85	122	133
Robeson	397	567	616
Rockingham	176	250	270
Rowan	239	339	367
Rutherford	138	196	212
Sampson	62	89	97
Scotland	78	111	120
Stanly	133	190	205
Stokes	52	73	77
Surry	161	227	242
Swain	21	30	32
Transylvania	46	66	71
Tyrrell	1	2	2
Union	237	333	354
Vance	95	135	146
Wake	2,691	3,794	4,076
Warren	14	19	21
Washington	8	12	13
Watauga	183	259	279
Wayne	249	356	386
Wilkes	98	139	149
Wilson	177	250	268
Yadkin	36	51	54
Yancey	21	30	32

Wake Counties), while 19,200 new jobs are shared by the other 94 North Carolina counties. While the more populous counties gain more jobs, job growth will occur in all corners of the state.

Detailed, county-level estimates of changes in Medicaid caseloads, gross county product and county tax revenues increases are shown in Appendix Tables A-1 to A-3.

House Bill 655

The analysis above is for an unencumbered Medicaid expansion, as it has been implemented in most expansion states and proposed by the Governor. An alternative, House Bill 655, has been proposed in the legislature by Representative Donny Lambeth and his colleagues.[40] Because of the lack of detailed analyses of the bill, we are unable to provide comparable estimates of the economic impacts.

HB 655 would also increase health insurance eligibility for adults with incomes up to 138 percent of the poverty line. In addition, it would require that newly eligible adults pay monthly premiums and comply with new work requirements, unless they have a dependent child or are exempt due to conditions like pregnancy or medical frailty. Both changes could potentially reduce the number of people who would be newly covered. While HB 655 ought to expand Medicaid participation and lead to an increase in federal funding and economic and employment gains, it would result in much lower Medicaid enrollment gains. Although most Medicaid beneficiaries work, some have difficulties finding steady employment and also encounter problems with the paperwork needed to comply with work requirements. Because of that, the reduction in the number of uninsured and the economic and employment gains would be much smaller than the expansion proposed by the Governor.

The work requirements in HB 655 are modeled on those used in the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps). A preliminary analysis indicates that SNAP work requirements reduces the participation of those targeted by more than one-third.[41] This is comparable to the losses that occurred when Arkansas implemented work requirements in its Medicaid program.[42] Other analyses have found that SNAP work requirements substantially lower participation by eligible people, while providing, at best, scant gains in employment.[43] [44] In addition, new administrative systems needed to manage the new requirements could be costly.[45]

Research and experience also show that participation is depressed when low-income participants are charged premiums to enroll.[46] [47] This would further lower enrollment and federal revenue gained, while increasing the amount low-income North Carolinians must spend, thereby limiting economic growth opportunities.

Adopting these changes, particularly the work requirement, would require federal approval of a Medicaid Section 1115 demonstration waiver, since these depart from statutory rules for Medicaid. The federal Centers for Medicaid & Medicare Services (CMS) might approve such a waiver; it has approved waivers for several states already. But it is not clear if work requirements are lawful and consistent with the federal statute that governs Medicaid. Approval of these projects has been challenged in court and the first three federal court decisions found that CMS acted improperly and invalidated the waivers in Kentucky and Arkansas.[48] These rulings are being appealed.

Appendix Table A-1. Estimated Number of Additional Medicaid Enrollees If Medicaid Expands

	2020	2021	2022
Alamance	7,639	9,570	10,428
Alexander	1,734	2,172	2,367
Alleghany	747	936	1,020
Anson	1,224	1,534	1,671
Ashe	1,678	2,102	2,291
Avery	1,031	1,292	1,407
Beaufort	2,355	2,951	3,215
Bertie	893	1,119	1,219
Bladen	2,222	2,784	3,034
Brunswick	5,060	6,339	6,907
Buncombe	12,363	15,489	16,877
Burke	4,838	6,061	6,604
Cabarrus	7,528	9,432	10,277
Caldwell	3,833	4,803	5,233
Camden	325	407	443
Carteret	2,998	3,756	4,092
Caswell	1,003	1,257	1,369
Catawba	7,236	9,066	9,878
Chatham	2,690	3,371	3,673
Cherokee	1,358	1,701	1,853
Chowan	637	798	869
Clay	573	718	782
Cleveland	4,717	5,910	6,439
Columbus	2,944	3,688	4,019
Craven	4,190	5,250	5,720
Cumberland	13,516	16,934	18,451
Currituck	938	1,175	1,280
Dare	1,501	1,881	2,049
Davidson	7,236	9,066	9,878
Davie	1,610	2,018	2,198
Duplin	4,406	5,520	6,014
Durham	15,261	19,121	20,834
Edgecombe	2,789	3,495	3,808
Forsyth	18,665	23,385	25,480
Franklin	3,138	3,931	4,283
Gaston	9,943	12,457	13,573
Gates	463	580	632
Graham	448	561	612
Granville	2,437	3,053	3,327
Greene	1,168	1,464	1,595
Guilford	25,781	32,300	35,194
Halifax	2,547	3,192	3,478
Harnett	6,081	7,619	8,302
Haywood	2,505	3,139	3,420
Henderson	5,023	6,293	6,857
Hertford	1,205	1,509	1,645
Hoke	3,054	3,826	4,169
Hyde	319	399	435
Iredell	7,121	8,922	9,721
Jackson	2,417	3,028	3,299

	2020	2021	2022
Johnston	9,219	11,550	12,585
Jones	542	679	740
Lee	3,393	4,251	4,632
Lenoir	3,311	4,148	4,519
Lincoln	3,296	4,129	4,499
McDowell	2,102	2,633	2,869
Macon	969	1,213	1,322
Madison	1,254	1,571	1,711
Martin	2,267	2,841	3,095
Mecklenburg	47,088	58,996	64,281
Mitchell	645	808	880
Montgomery	1,767	2,214	2,412
Moore	3,471	4,348	4,738
Nash	4,598	5,761	6,277
New Hanover	9,660	12,103	13,188
Northampton	983	1,231	1,342
Onslow	7,095	8,889	9,686
Orange	5,314	6,658	7,254
Pamlico	496	622	677
Pasquotank	1,745	2,186	2,382
Pender	2,697	3,380	3,682
Perquimans	580	727	792
Person	1,776	2,225	2,424
Pitt	9,583	12,006	13,082
Polk	891	1,116	1,216
Randolph	7,937	9,944	10,834
Richmond	2,708	3,392	3,696
Robeson	10,070	12,617	13,747
Rockingham	4,282	5,365	5,846
Rowan	7,094	8,888	9,684
Rutherford	3,522	4,413	4,809
Sampson	4,023	5,040	5,492
Scotland	1,908	2,390	2,604
Stanly	2,489	3,119	3,398
Stokes	1,888	2,365	2,577
Surry	4,159	5,210	5,677
Swain	809	1,014	1,105
Transylvania	1,452	1,820	1,983
Tyrrell	238	298	324
Union	7,063	8,850	9,643
Vance	2,547	3,192	3,478
Wake	32,899	41,218	44,911
Warren	1,106	1,386	1,510
Washington	596	747	814
Watauga	3,222	4,036	4,398
Wayne	6,699	8,393	9,145
Wilkes	4,100	5,136	5,597
Wilson	4,673	5,854	6,379
Yadkin	1,859	2,329	2,538
Yancey	869	1,088	1,186

Appendix Table A-2. Estimated Changes in Gross County Products If Medicaid Expands (millions)

	2020	2021	2022	2020-22
Alamance	$40	$57	$63	$159
Alexander	$2	$3	$3	$7
Alleghany	$2	$3	$3	$8
Anson	$2	$3	$3	$7
Ashe	$3	$5	$5	$13
Avery	$2	$3	$3	$8
Beaufort	$5	$7	$8	$19
Bertie	$1	$2	$2	$5
Bladen	$3	$4	$4	$11
Brunswick	$11	$15	$17	$43
Buncombe	$67	$95	$105	$267
Burke	$19	$26	$29	$74
Cabarrus	$25	$35	$39	$99
Caldwell	$9	$12	$14	$34
Camden	$0	$0	$0	$1
Carteret	$7	$9	$11	$26
Caswell	$1	$2	$2	$5
Catawba	$30	$42	$46	$118
Chatham	$7	$10	$11	$28
Cherokee	$3	$4	$4	$11
Chowan	$1	$2	$2	$5
Clay	$1	$1	$1	$2
Cleveland	$17	$23	$26	$66
Columbus	$8	$11	$12	$31
Craven	$9	$13	$14	$35
Cumberland	$35	$50	$56	$141
Currituck	$0	$1	$1	$2
Dare	$3	$4	$5	$12
Davidson	$19	$26	$29	$74
Davie	$3	$5	$5	$13
Duplin	$5	$7	$8	$21
Durham	$119	$159	$166	$444
Edgecombe	$5	$7	$8	$20
Forsyth	$106	$151	$167	$424
Franklin	$8	$11	$12	$30
Gaston	$41	$58	$65	$164
Gates	$0	$0	$0	$1
Graham	$1	$1	$1	$2
Granville	$7	$10	$11	$27
Greene	$2	$3	$3	$8
Guilford	$171	$243	$268	$683
Halifax	$6	$8	$9	$24
Harnett	$13	$18	$20	$51
Haywood	$5	$7	$8	$20
Henderson	$15	$21	$24	$60
Hertford	$4	$5	$6	$15
Hoke	$3	$4	$4	$11
Hyde	$0	$0	$0	$1
Iredell	$31	$44	$48	$122
Jackson	$9	$13	$15	$37

	2020	2021	2022	2020-22
Johnston	$27	$38	$42	$107
Jones	$1	$1	$1	$3
Lee	$15	$21	$23	$59
Lenoir	$10	$15	$16	$42
Lincoln	$7	$9	$10	$26
McDowell	$4	$6	$7	$17
Macon	$2	$4	$4	$10
Madison	$2	$3	$3	$8
Martin	$3	$5	$5	$13
Mecklenburg	$254	$356	$389	$1,000
Mitchell	$2	$3	$3	$8
Montgomery	$2	$3	$4	$9
Moore	$22	$32	$36	$90
Nash	$15	$21	$23	$59
New Hanover	$48	$69	$76	$193
Northampton	$1	$1	$1	$3
Onslow	$7	$11	$12	$30
Orange	$35	$50	$56	$141
Pamlico	$1	$1	$2	$4
Pasquotank	$4	$5	$6	$14
Pender	$5	$8	$8	$21
Perquimans	$0	$0	$0	$1
Person	$5	$7	$8	$20
Pitt	$28	$41	$46	$115
Polk	$1	$2	$2	$6
Randolph	$24	$34	$37	$95
Richmond	$6	$9	$10	$24
Robeson	$24	$35	$39	$98
Rockingham	$11	$16	$17	$44
Rowan	$19	$26	$29	$74
Rutherford	$9	$12	$14	$35
Sampson	$5	$7	$8	$21
Scotland	$5	$8	$9	$22
Stanly	$9	$13	$14	$36
Stokes	$3	$4	$4	$11
Surry	$12	$17	$19	$49
Swain	$1	$1	$2	$4
Transylvania	$3	$4	$5	$12
Tyrrell	$0	$0	$0	$0
Union	$18	$25	$27	$70
Vance	$7	$10	$11	$29
Wake	$276	$392	$433	$1,101
Warren	$1	$1	$1	$4
Washington	$0	$1	$1	$2
Watauga	$13	$18	$20	$52
Wayne	$19	$28	$31	$78
Wilkes	$7	$10	$11	$28
Wilson	$15	$21	$23	$59
Yadkin	$3	$4	$4	$10
Yancey	$1	$2	$2	$5

Appendix Table A-3. Estimated Changes in County Tax Revenue If Medicaid Expands (1000s)

	2020	2021	2022	2020-22
Alamance	$554	$846	$976	$2,375
Alexander	$46	$69	$78	$194
Alleghany	$27	$42	$49	$118
Anson	$19	$29	$33	$82
Ashe	$57	$89	$104	$251
Avery	$29	$46	$54	$130
Beaufort	$49	$74	$85	$208
Bertie	$22	$33	$38	$93
Bladen	$30	$45	$52	$128
Brunswick	$143	$216	$247	$605
Buncombe	$860	$1,314	$1,519	$3,694
Burke	$291	$447	$520	$1,258
Cabarrus	$477	$726	$833	$2,035
Caldwell	$125	$190	$219	$534
Camden	$5	$7	$8	$20
Carteret	$96	$147	$170	$413
Caswell	$51	$77	$87	$216
Catawba	$346	$516	$585	$1,448
Chatham	$322	$483	$548	$1,353
Cherokee	$32	$51	$60	$143
Chowan	$15	$22	$26	$63
Clay	$10	$16	$19	$46
Cleveland	$210	$323	$374	$907
Columbus	$94	$145	$168	$406
Craven	$91	$139	$160	$390
Cumberland	$304	$470	$548	$1,322
Currituck	$0	-$1	-$3	-$5
Dare	$30	$46	$54	$129
Davidson	$383	$583	$670	$1,636
Davie	$113	$168	$190	$471
Duplin	$77	$119	$138	$334
Durham	$496	$606	$557	$1,659
Edgecombe	$68	$105	$123	$295
Forsyth	$1,196	$1,805	$2,067	$5,067
Franklin	$195	$308	$364	$868
Gaston	$655	$1,020	$1,198	$2,873
Gates	$3	$5	$6	$14
Graham	$10	$16	$19	$44
Granville	$129	$197	$227	$553
Greene	$48	$77	$93	$218
Guilford	$1,802	$2,731	$3,135	$7,668
Halifax	$62	$95	$109	$266
Harnett	$322	$512	$612	$1,446
Haywood	$122	$188	$217	$527
Henderson	$250	$378	$433	$1,061
Hertford	$35	$53	$62	$150
Hoke	$120	$184	$214	$519
Hyde	$2	$3	$4	$10
Iredell	$408	$620	$713	$1,740
Jackson	$105	$159	$181	$445

	2020	2021	2022	2020-22
Johnston	$620	$976	$1,152	$2,749
Jones	$27	$42	$51	$119
Lee	$146	$220	$252	$619
Lenoir	$107	$169	$199	$475
Lincoln	$165	$249	$283	$696
McDowell	$50	$75	$85	$209
Macon	$39	$60	$71	$170
Madison	$32	$49	$57	$138
Martin	$36	$55	$63	$154
Mecklenburg	$2,802	$4,141	$4,646	$11,589
Mitchell	$20	$30	$34	$83
Montgomery	$39	$58	$66	$164
Moore	$295	$449	$518	$1,262
Nash	$174	$264	$303	$740
New Hanover	$630	$952	$1,089	$2,671
Northampton	$17	$26	$29	$72
Onslow	$46	$74	$91	$210
Orange	$888	$1,329	$1,508	$3,724
Pamlico	$18	$27	$31	$75
Pasquotank	$32	$50	$58	$140
Pender	$88	$135	$155	$378
Perquimans	$5	$8	$10	$23
Person	$100	$155	$180	$436
Pitt	$431	$662	$770	$1,863
Polk	$24	$36	$42	$102
Randolph	$415	$635	$733	$1,783
Richmond	$66	$102	$119	$288
Robeson	$316	$497	$588	$1,401
Rockingham	$165	$249	$285	$699
Rowan	$236	$357	$410	$1,002
Rutherford	$107	$163	$189	$459
Sampson	$88	$135	$156	$379
Scotland	$57	$88	$103	$247
Stanly	$142	$219	$255	$615
Stokes	$131	$196	$223	$549
Surry	$249	$390	$457	$1,097
Swain	$9	$13	$14	$36
Transylvania	$46	$70	$82	$198
Tyrrell	$2	$3	$3	$7
Union	$441	$677	$780	$1,897
Vance	$92	$139	$159	$390
Wake	$3,945	$5,956	$6,840	$16,741
Warren	$16	$24	$27	$68
Washington	$5	$7	$8	$20
Watauga	$153	$231	$264	$648
Wayne	$240	$373	$436	$1,050
Wilkes	$120	$181	$208	$509
Wilson	$161	$248	$286	$695
Yadkin	$70	$107	$124	$302
Yancey	$22	$34	$40	$95

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Behavioral Health Services Revenue Maximization Plan

Report to the Florida Legislature

Pursuant to Section 394.761(5), Florida Statutes

December 31, 2016

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Executive Summary

The Agency for Health Care Administration (Agency) serves as the single state agency responsible for administering the Florida Medicaid program, while the Department of Children and Families (DCF) serves as the single state agency for the provision of mental health and substance abuse services. Collectively, these entities are responsible for operating a system of care responsible for the medical and behavioral health care of approximately 680,041 individuals living with chronic health conditions such as serious mental illness (SMI) or substance use disorder (SUD). The services provided to this population are primarily funded through the use of federal dollars and state general revenue.

During the 2016 legislative session, the Agency and DCF were directed in Senate Bill 12 to develop a written plan to evaluate alternative uses of increased Medicaid funding, in order to advance the goal of improved integration of behavioral health services and primary care services for individuals eligible for Medicaid through the development and effective implementation of the behavioral health system of care. Information contained in the report solely focuses on adults, because children (recipients under the age of 21) can receive all medically necessary services through Florida Medicaid regardless of any service limitations that may be specified in policy. Additionally, this report explores how maximizing federal Medicaid funding can assist DCF in redirecting some state general revenue to meet the needs of other vulnerable populations who, as a result of their mental illness and/or substance abuse disorder, require a more intensive level of community-based services and supports.

As required by Senate Bill 12 (codified in section 394.761(2), F.S.), DCF has identified $412,411,814 in general revenue funding appropriated during fiscal year 2016-2017 for mental health and substance abuse services that may be eligible to be used as state match to receive additional federal Medicaid funding depending upon the delivery system enhancements that are implemented.

The Agency and DCF examined ways in which the State could seek federal approval to extend Medicaid eligibility for individuals contending with SMI or SUD (approximately 132,940 individuals) who currently are served through DCF's system of care and who do not meet the criteria for any of the eligibility categories currently covered under Medicaid. This extension of eligibility would be through an 1115 Research and Demonstration Waiver or a 1915 (c) or 1915(i) Home and Community-Based Services Waiver.

The Agency and DCF evaluated alternative uses of increased Medicaid funding to cover targeted case management as a Medicaid-funded service for the SUD population. Implementation of this option could be achieved in one of the following ways:

- The Agency could contract with the Statewide Medicaid Managed Care Managed Medical Assistance (MMA) plans to provide this service (to the extent the recipient is mandatory for enrollment in a health plan).
- The Agency could enter into contracts with the managing entities to provide TCM for recipients with a SUD.

- The Agency could require the MMA plans to subcontract with the managing entities to provide the service.

As a part of this report, the Agency and DCF also examined alternative uses of increased federal Medicaid funding to cover other services provided to the target population through the managing entities that are not available through the Medicaid program (e.g., residential detox services, mobile crisis support services, etc.).

If the Agency is directed to expand eligibility for the SMI and/or SUD population or to cover additional services and those services were provided through the MMA plans, the capitation rates paid to the health plans would need to be adjusted. The report also highlights some value based purchasing opportunities that can be achieved through the MMA program and/or through the managing entities in which behavioral health providers could be eligible for enhanced payments that are tied to specific quality indicators/performance.

Three supplemental payment opportunities were explored in the analysis – many of the options resulting in enhanced payments for providers. The most complex opportunity examined was the use of Designated State Health Programs (DSHP) to receive federal Medicaid match funding. The DSHP option may present an opportunity to address state needs and undertake a reform/transformational approach to the needs of persons with SMI and SUD who are currently residing in or at risk for hospitalization. The final component of the report is a review of Delivery System Reform Incentive Payment (DSRIP) programs (including how DSHP helps to finance DSRIP strategies) and the use of health homes as innovative programs to provide incentives for improved outcomes for behavioral health conditions.

The six alternative funding options identified in the report each might improve Florida's behavioral health system of care while maximizing existing state funding. If directed to implement any of the options described, the Agency could receive approximately 60 cents in federal matching funding for every 40 cents the state spends of its own resources on mental health and SUD services.

Section I. Background

A. Purpose of the Report

This report fulfills the requirements of section 394.761 (1-2), Florida Statutes. The 2016 Legislature passed Senate Bill 12, which amended section 394.761, Florida Statutes to do the following:

(1) The agency and the department shall develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care. Increased funding shall be used to advance the goal of improved integration of behavioral health services and primary care services for individuals eligible for Medicaid through the development and effective implementation of the behavioral health system of care as described in s. 394.4573.

(2) The agency and the department shall identify in the plan the amount of general revenue funding appropriated for mental health and substance abuse services eligible to be used as state Medicaid match. The agency and the department shall evaluate alternative uses of increased Medicaid funding, including seeking Medicaid eligibility for the severely and persistently mentally ill or persons with substance use disorders, increased reimbursement rates for behavioral health services, adjustments to the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders, targeted case management for individuals with substance use disorders as a Medicaid-funded service, supplemental payments to mental health and substance abuse service providers through a designated state health program or other mechanisms, and innovative programs to provide incentives for improved outcomes for behavioral health conditions. The agency and the department shall identify in the plan the advantages and disadvantages of each alternative and assess each alternative's potential for achieving improved integration of services. The agency and the department shall identify in the plan the types of federal approvals necessary to implement each alternative and project a timeline for implementation.

(5) The agency and the department shall submit the written plan and report required in this section to the President of the Senate and the Speaker of the House of Representatives by December 31, 2016.

As directed by the Florida Legislature, the Agency for Health Care Administration, in collaboration with the Department of Children and Families, has explored potential uses of increased Medicaid funding within Florida's existing behavioral health system of care for individuals diagnosed with a serious mental illness or substance use disorder. Because children can receive all medically necessary services through Florida Medicaid regardless of any service limitations that may be specified in policy, the focus of this revenue maximization exercise is on adults (individuals ages 21 and older).

B. Serious Mental Illness and Substance Use Disorder Populations

Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder (excluding development and substance use disorders) among those currently diagnosed or within the past year, is of sufficient duration to meet diagnostic criteria specified within the DSM-V, and results in serious functional impairment, which substantially interferes with or limits one or more major life activities.[1] The general description normally involves one or a combination of the following conditions: Psychotic disorders, bipolar disorders major depression, schizoaffective disorder, delusional disorder, or obsessive-compulsive disorder.

The prevalence of SMI among adults ages 18-64 was 5.2% in Florida (6.0% nationally) in 2012.[2] Many individuals with SMI lack insight into the illness and, as a result, may be resistant to psychiatric treatment (including medication adherence). These individuals may suffer from overt psychotic symptoms such as hallucinations and delusional thinking, severe depression, problems with substance use, social impairment, co-morbid medical conditions such as hypertension and diabetes, and incidences of criminal justice involvement. For this group, recovery from the illness can be difficult. Additional areas of consideration identified in research literature and by national quality organizations include: low quality medical care, underuse or overuse of services, lack of medication adherence, and lack of housing and transitional services.

Substance Use Disorders (SUD) are defined as the use, abuse, or dependence of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[3] The level of severity can be indicated as mild, moderate, or severe. The prevalence of SUD among uninsured adults ages 18-64 in Florida is 13.7% (14.6% nationally) in 2012.[4]

Individuals with SUDs encounter various academic, health-related, relational, and legal challenges. These issues bring cost and consequences to families, communities, and society. There is a high incidence of substance abuse among individuals diagnosed with a serious mental illness; this is commonly referred to as having co-occurring disorders. As compared to a person with either a mental illness or SUD alone, those with co-occurring disorders often have significantly more impairment in functioning, more severe symptoms,

[1] National Institute of Mental Health (2016). Serious mental illness (SMI) among U.S. adults. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml

[2] SAMHSA (March 2012). Enrollment under the Medicaid expansion and health insurance exchanges: A focus on those with behavioral health conditions in Florida. Retrieved from http://store.samhsa.gov/shin/content//PEP13-BHPREV-ACA/NSDUH_state_profile_Florida_508_final_exam.pdf

[3] http://www.samhsa.gov/disorders/substance-use

[4] SAMHSA (March 2012). Enrollment under the Medicaid expansion and health insurance exchanges: A focus on those with behavioral health conditions in Florida. Retrieved from http://store.samhsa.gov/shin/content/PEP13-BHPREV-ACA/NSDUH_state_profile_Florida_508_final_exam.pdf

and are at an increased risk of health problems, hospitalization, incarceration, and suicide, amongst other negative consequences.[5]

[5] Weatherford, J.A. (2012). Co-occurring mental health and substance use disorders: A review of issues and clinical approaches for dual diagnosis. *Research Papers,* Paper 209.

Section II. Florida's System of Care Overview

A. The Agency for Health Care Administration, Florida Medicaid Program

Medicaid is an entitlement program that provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, in accordance with federal requirements codified in the Social Security Act. The Agency for Health Care Administration is the single state Medicaid agency responsible for administering the Florida Medicaid program. Each state operating a Medicaid program has a state plan, which serves as an agreement between the state and the federal government describing how that state administers its Medicaid program. States can also request approval from the federal Centers for Medicare and Medicaid Services (CMS) for a waiver of certain requirements found in 1902(a) of the Social Security Act. Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid. There are three primary types of waivers and demonstration projects:

- Section 1115 Research & Demonstration Waivers
- Section 1915(b) Selective Contracting/Managed Care Waivers
- Sections 1915(c) Home and Community-Based Services Waivers

The Agency administers numerous waivers under the Florida Medicaid program. See Attachment I for a detailed description of each waiver.

Medicaid is jointly funded by states and the federal government. For every dollar that a state government spends on Medicaid, the federal government pays an average of 57 cents (and between 90 and 100 cents of every dollar for those who are newly eligible under the Affordable Care Act Medicaid expansion provision). As of December 2015, it is estimated that over 72 million people are covered by Medicaid nationwide and the program costs accounted for over $532 billion in spending in the federal and state budgets. In state fiscal year 2016-2017, Florida's Medicaid program is estimated to cost $25.8 billion and is projected to serve approximately 4.0 million Floridians.

The Florida Medicaid program provides a comprehensive benefit package for eligible recipients. Recipients under the age of 21 years are entitled to a comprehensive array of prevention, diagnostic, and treatment services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

The behavioral health services that are covered under the Medicaid state plan for adults and children include:

- Psychiatric physician services

- Individual, group, and family therapy services
- Assessment services
- Support/rehabilitative services
- Mental health targeted case management
- Inpatient hospital services (psychiatric and medical detoxification services)
- Substance abuse county match services

In addition to the services listed above, recipients under the age of 21 years are also eligible to receive the following:

- Therapeutic group care services
- Specialized therapeutic foster care services
- Statewide Inpatient Psychiatric Program services
- Therapeutic behavioral on-site services

See Attachment II for a more detailed description of the services covered under the Florida Medicaid program, including the associated rates listed on the fee schedule.

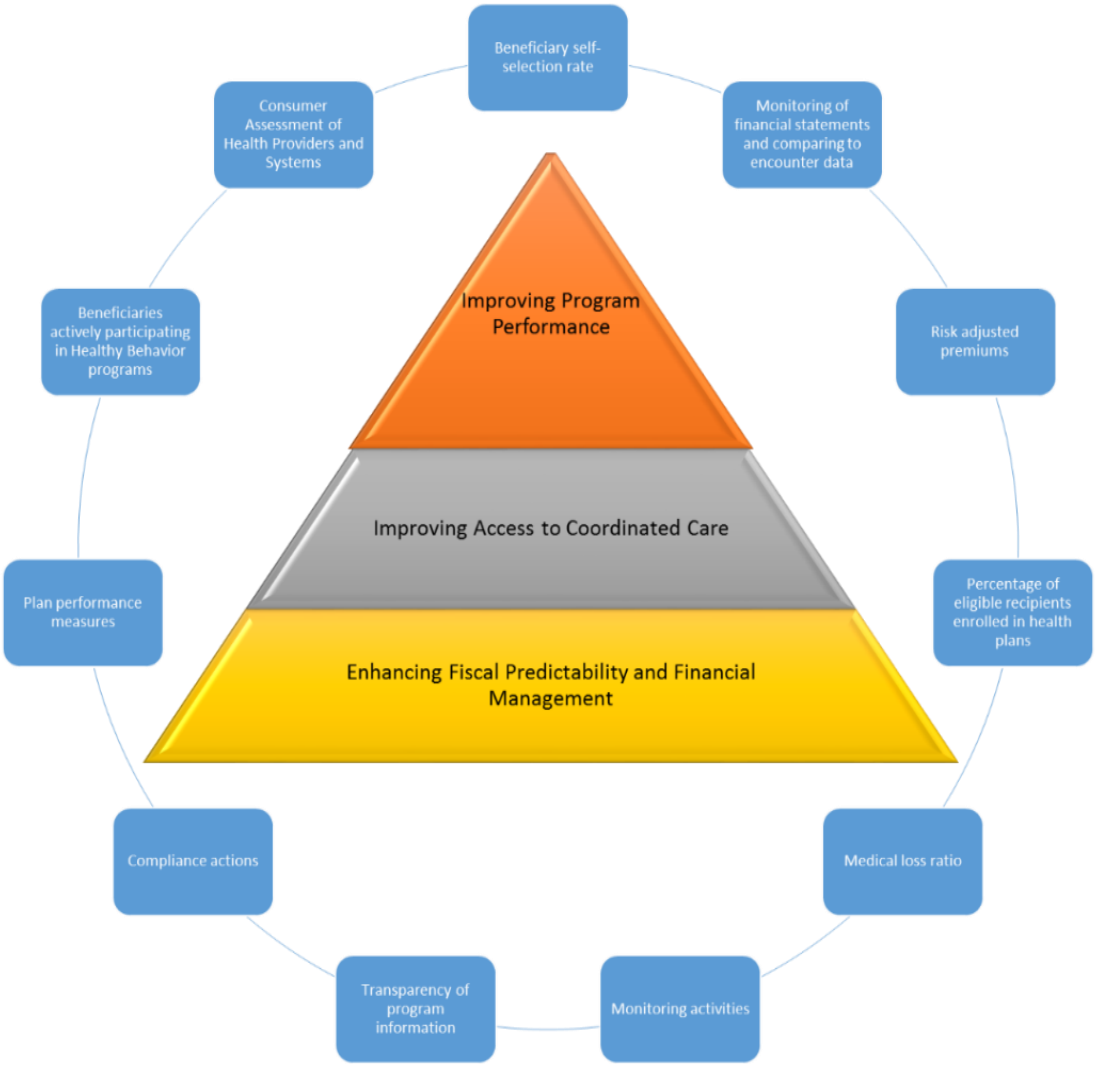
Statewide Medicaid Managed Care – Managed Medical Assistance Program

Florida has transitioned to a delivery model wherein the majority of fully Medicaid eligible recipients receive their services through a health plan. The Statewide Medicaid Managed Care (SMMC) program was fully implemented in August 2014 and has two components: the Managed Medicaid Assistance (MMA) program and the Long-term Care program [see Part IV of Chapter 409, Florida Statutes]. The Agency received approval from CMS to operate the MMA program through an 1115 Research and Demonstration waiver.

The MMA program covers most medical and acute care services for health plan enrollees, including substance use and mental health treatment services. The objectives of the SMMC program are to improve health outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. These objectives are achieved by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and a high rate of customer satisfaction. Florida Medicaid actively encourages all stakeholders to report any potential issue, concern, or complaint regarding the SMMC program to the SMMC Complaint Operations Center. This is one mechanism that enables the Agency to remain aware of performance of the SMMC program.

The goals of the SMMC program are depicted below in Figure 1.

Figure 1: SMMC Goals



Most Medicaid recipients who are eligible for the full array of Medicaid benefits are enrolled in a health plan. In addition to providing coverage for an array of substance use and mental health treatment services, health plans are required to coordinate all aspects of care for their enrollees including the coordination of services that are not covered by the plan. Through care coordination efforts, health plans are responsible for assessing enrollees and identifying factors that may impact their ability to manage health care needs, such as homelessness and comorbid conditions. Specifically, health plans are responsible for:

- Developing a process that plans, implements, coordinates, evaluates, and monitors the options and services required to meet an enrollee's health needs using available resources to promote quality outcomes.
- Providing proper care coordination/case management across the continuum of care and making appropriate referrals to ensure needs are met.
- Providing outreach to enrollees experiencing homelessness or who are at risk for involvement with the court system.
- Maintaining written protocols for identifying, assessing and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care.
- Conducting comprehensive assessments that identify enrollee needs across multiple domains (e.g., current medical/behavioral health needs, caregiver support availability, transportation barriers, medication management, and treatment preferences).
- Developing a comprehensive treatment plan that contains goals that are outcomes based and measureable and include the interventions and services to be provided to obtain goals. Interventions should include community service linkage, improving support services and lifestyle management as appropriate based on the enrollee's identified issues.
- Identifying enrollees with co-morbid mental health and substance abuse disorders, including through a depression screening, and addressing those disorders.

Medicaid health plans can provide additional behavioral health services that are not covered under the state plan, called "in lieu of" services. In lieu of services are offered as an alternative to services covered under the State Plan when the health plan has determined that the alternative service is a medically appropriate and cost effective substitute. Some health plans have received approval from the Agency to cover in lieu of services including: peer support, ambulatory detoxification, community-based wrap around, and mobile crisis services. In addition, health plans have the option to provide expanded benefits, which are offered to all enrollees in specific population groups, for which the plan receives no direct payment from the Agency. Examples of expanded benefits include, but are not limited to: adult dental services, adult hearing services, newborn circumcision, etc.

Health plans can participate in the MMA program as a standard plan or a specialty plan. A specialty plan is a type of MMA plan for Medicaid recipients who have a chronic medical condition or a specific diagnosis, or who are in a certain age range. The MMA specialty plans cover the same health care services as the standard MMA plans. Specialty plans are required to have enhanced care coordination and provider network standards and may offer expanded benefits that are more targeted to the population that they serve. The Agency contracts with Magellan Complete Care as a specialty plan to

serve recipients diagnosed with a serious mental illness. Currently, Magellan Complete Care has over 58,000 enrollees and provides services in most areas of the state.

Medicaid Expenditures on Behavioral Health Services

The table below demonstrates the Medicaid program expenditures for behavioral health services provided to 352,517 Medicaid recipients during state fiscal year 2015-2016. Total expenditures, including those made through the fee-for-service program and the SMMC program, were $614,252,990.

Table 1: Medicaid Total Expenditures

Total Medicaid Expenditures for Substance Abuse and Mental Health Treatment Services		
Service	**FFS Amount**	**Encounter Health Plan Payment***
Substance Abuse Services	$ 982,335	$ N/A
Mental Health Services	$ 216,806,246	$ N/A
Behavioral Health Services (Total)	$ 217,788,581	$396,464,409

**These numbers represent the amount that health plans paid to their providers. Data Source: SQL Server FY1516 Claim and Encounter Table as of 9/26/2016*

B. The Department of Children and Families, Substance Abuse and Mental Health

The Department of Children and Families (DCF) Office of Substance Abuse and Mental Health (SAMH) serves as the single state authority for mental health and substance abuse services and is comprised of four major areas:

- Community Substance Abuse and Mental Health
- State Mental Health Treatment Facilities
- The Sexually Violent Predator Program
- Quality Assurance

The Office of Substance Abuse and Mental Health administers a statewide system of safety-net services for substance abuse and mental health prevention, treatment, and recovery services. This system serves children and adults who are otherwise unable to obtain mental health and substance abuse treatment services. This group includes individuals who are eligible for Medicaid, Medicaid enrolled individuals who require services not covered under Florida Medicaid, and those who are not financially able to cover medical expenses independently.

Florida law requires DCF to implement a system of care to provide substance abuse treatment and mental health services as follows:

Substance Abuse Services

The Department of Children and Families is authorized to provide substance abuse services to the following priority populations:

- Adults who have substance abuse disorders and a history of intravenous drug use
- Individuals diagnosed as having co-occurring substance abuse and mental health disorders
- Parents whose substance abuse disorder put their children at risk for involvement in the dependency system
- Individuals who have a substance abuse disorder and have been ordered by the court to receive treatment
- Children at risk for initiating drug use
- Children under state supervision
- Children who have a substance abuse disorder but who are not under the supervision of a court or in the custody of a state agency
- Individuals identified as being part of a priority population as a condition for receiving services funded through federal Substance Abuse Treatment and Prevention Block Grants

The Department of Children and Families' system of care is required to prevent and remediate the consequences of substance abuse for persons with substance abuse problems through the provision of a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and treatment services in the least restrictive environment of optimum care (see section 394.67, F.S.). The system of care is comprised of the following broad categories of substance abuse services:

- Prevention services
- Assessment services
- Intervention services
- Rehabilitation services
- Ancillary services, including:
  - Self-help and other support groups and activities
  - Aftercare provided in a structured, therapeutic environment
  - Supported housing
  - Supported employment
  - Vocational services
  - Educational services

Mental Health Services

The Department of Children and Families is authorized to provide mental health services to the following priority populations:

- Adults who have severe and persistent mental illness, including:
  - Older adults in crisis

  - Older adults who are at risk of being placed in a more restrictive environment because of their mental illness
  - Individuals deemed incompetent to proceed or not guilty by reason of insanity under chapter 916, F.S.
  - Other persons involved in the criminal justice system
  - Individuals diagnosed as having co-occurring mental illness and substance abuse disorders
  - Individuals who are experiencing an acute mental or emotional crisis
- Children who are at risk of emotional disturbance
- Children who have an emotional disturbance
- Children who have a serious emotional disturbance
- Children diagnosed as having a co-occurring substance abuse and emotional disturbance or serious emotional disturbance

The Department of Children and Families' system of care related to mental health services is designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders (see section 394.67, F.S.). The system of care is comprised of the following broad categories of mental health services:

- Treatment services
- Rehabilitative services, including:
  - Assessment of personal goals and strengths
  - Readiness preparation
  - Specific skill training
  - Designing of environments that enable individuals to maximize functioning and community participation
- Support services, including:
  - Income supports
  - Housing supports
  - Vocational supports
- Case management services

The majority of individuals within this population receive services in the community; individuals who require a more restrictive clinical setting are served in state funded mental health treatment facilities.

Managing Entities

In the past, the Office of SAMH contracted directly with behavioral health providers to implement services. The Florida Legislature found that a managing structure that places responsibility for publicly-funded behavioral health services in local entities would promote access to care and continuity, be more efficient and effective, and streamline administrative processes to create cost efficiencies and provide flexibility to better match services to need. As a result, the Office of SAMH now contracts with seven managing entities for the

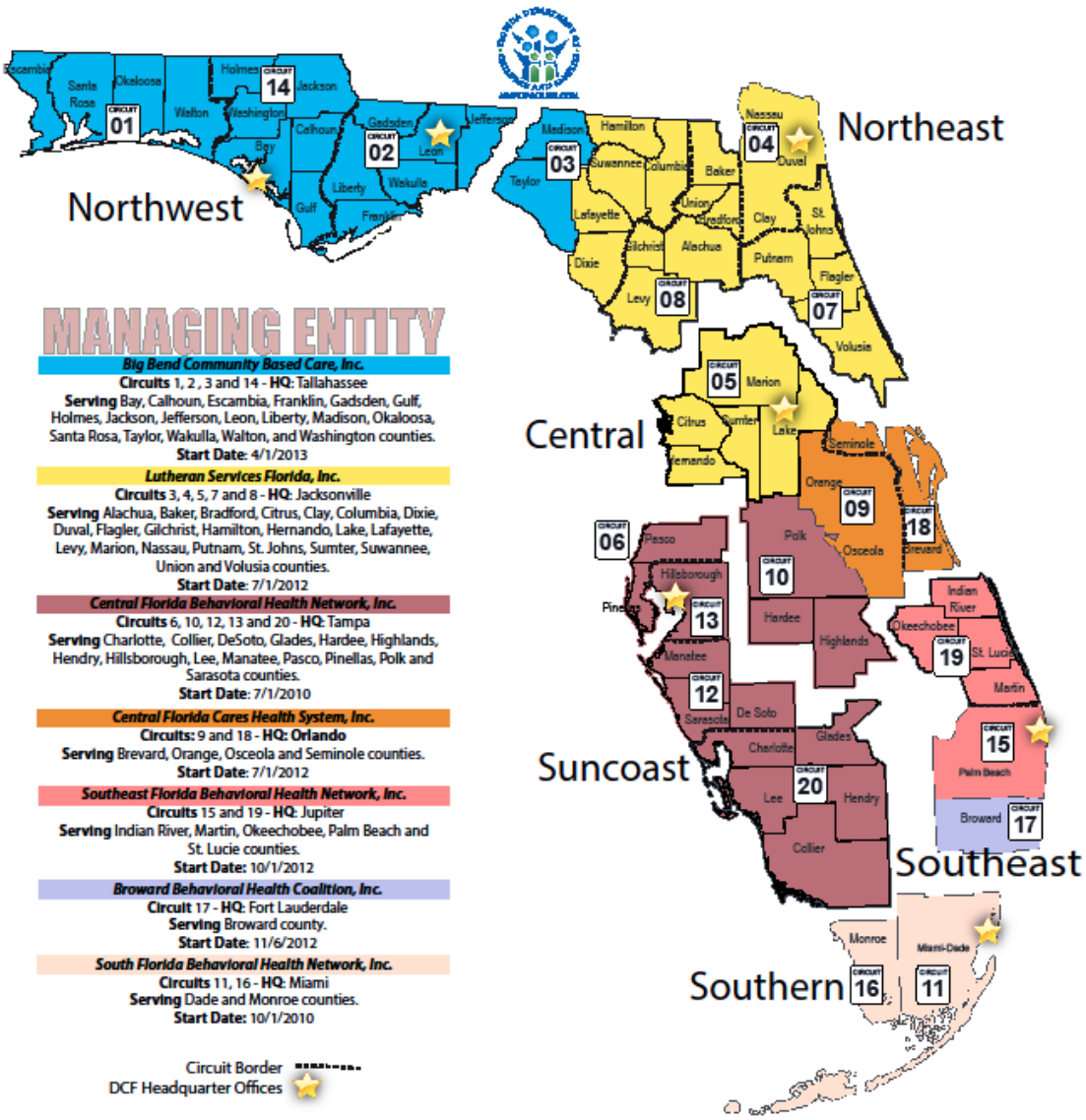
administration and management of regional behavioral health systems of care throughout the state.

The managing entities are private, non-profit organizations responsible for planning, implementation, administration, monitoring, and data collection, reporting, and analysis for behavioral health care in their regions. Managing entities do not provide services, but contract with local service providers for the provision of prevention, treatment, and recovery support services. Procurement of the contracts with the managing entities is governed by both Chapter 287, F.S., which applies generally to all state contracts, and section 402.7305, F.S., which applies specifically to DCF contracts. In accordance with both Florida and federal law, the contracts were competitively procured. The contracts with each managing entity are based upon a fixed-payment methodology, where the managing entity receives the equivalent of a two-month advance payment, and equal monthly payments thereafter. The managing entity is also permitted to carry up to 8% of state general revenue from fiscal year to fiscal year, for the life of the contract.

In state fiscal year 2015-2016, there were 303,768 clients served through DCF's system of care (238,286 adults and 66,995 children).

The Department of Children and Families contracts with the following managing entities listed in Figure 2.

Figure 2: DCF Managing Entities by Counties Served



General Revenue and Block Grant Funding

The services provided through DCF's system of care are funded through state general revenue, federal discretionary grants, county matching funds, and federal block grant funding. A block grant is a noncompetitive, formula grant mandated by the U.S. Congress. Eligible entities must submit an annual application to demonstrate statutory and regulatory compliance in order to receive the formula-based funding. The Department of Children and Families is currently approved on an annual basis for the following federal block grants related to substance abuse and mental health: the Substance Abuse Prevention and Treatment Block Grant (SAPT) and the Community Mental Health Block Grant (MH).

States are required to maintain non-federal funding (i.e., state general revenue) for activities described in the block grant application at a level which is not less than the average eligible expenditures reported for such activities during the two fiscal years prior to receiving the grant – this is called maintenance of effort (MOE). In addition to MOE requirements, states are also required to meet threshold spending amounts for specific target populations. These thresholds are based on the reported expenditures for a particular fiscal year specified in federal statute. The underlying principle of this provision is to ensure that federal grantees (and cooperative agreement awardees) are committed to maintaining the same level of services already being provided after receipt of a federal grant award. More specifically, the federal government wants grantees to rely on state and local funds as much as possible in order to maximize those resources thus ensuring that federal funds supplement rather than supplant normal activities.

The SAPT and MH block grants received by DCF have MOE and threshold requirements. According to DCF, state general revenue funds that must be maintained for MOE purposes can also serve a dual purpose and be used as the state match to receive federal Medicaid funding for covered services provided to Medicaid recipients. The expenditures must be reported to the Substance Abuse and Mental Health Services Administration (SAMHSA) and meet all applicable service level information. In addition, the use of this funding for federal Medicaid match obligates DCF to meet Title XIX CMS 64 reporting requirements as well. The table below demonstrates managing entities' budget for behavioral health services during SFY 15-16.

Table 2: Managing Entity Budget SFY 2015-2016

Total Managing Entity Budget for Adult and Children Substance Abuse and Mental Health Services	
Service	Managing Entity
Substance Abuse Services	$224,719,253
Mental Health Services	$337,870,637
Behavioral Health Services (Total)	$562,589,890*

* The listed figure does not include the cost of operational expenditures.

C. Collaboration and Integration Efforts

Collectively, Florida Medicaid and DCF cover a comprehensive array of behavioral health services. The table below compares the services available through both Florida Medicaid and the managing entities.

Table 3: Services Covered by Medicaid and DCF for Adults

Behavioral Health Services (Available for Adults)	Medicaid	DCF
Assessment/Treatment Plan Development and Modifications		
Assessment	X	X

Treatment Plan Development	X	X
Treatment Plan Review	X	X
Therapy Services		
Group Therapy	X	X
Individual Therapy	X	X
Family Therapy	X	X
Psychosocial Rehabilitation		
Outpatient Detoxification		X
Day Treatment	X	X
Supportive Housing*	X	X
Supportive Employment		X
Recovery Support (Individual/Group)**	X	X
Mental Health Clubhouse Services	X	X
Medication-assisted treatment services	X	X
Medical Services	X	X
Residential Services		
Residential Treatment		X
Room and Board w/Supervision		X
Case Management Services		
Case Management	X	X
Intensive Team Case Management		X
Crisis Management		
Crisis Stabilization***	X	X
Crisis Support		X
Substance Abuse Inpatient Detoxification	X	X
Inpatient Hospital Services	X	X
Other Support Services		
Day Care Services		X
Drop-in Center/Self Help		X
Respite		X
Intervention (Individual/ Group)		X
Treatment Alternative for Safer Communities (TASC)		X
Incidental Expenses		X
Aftercare/Follow-up		X
Outreach		X
Florida Assertive Community Treatment (FACT)		X
Prevention		X
Comprehensive Community Service Team		X

*The Agency is seeking approval for a pilot to provide housing support services under the Medicaid MMA program.
**These services can be received through the Medicaid's therapy benefit.
***Florida Medicaid's health plans have the flexibility to offer this service as an in lieu of service when medically appropriate.

DCF and the Agency's behavioral health services are intended to complement each other, establishing a comprehensive system of care. Florida Medicaid provides medically necessary behavioral health services up to specified limits. DCF funds rehabilitative and community support services, essential to the successful recovery of a person, including services not covered by Medicaid. As an example, DCF can cover services in an institution for mental disease, provide housing financial support (i.e., room and board), and provide services to incarcerated individuals, which are not generally allowable under Medicaid programs. DCF offers community-based services as well,

such as individual therapy, intended to serve uninsured individuals or Medicaid recipients whose service needs exceed the limit established by Medicaid or are deemed not medically necessary.

Collaboration among the Agency and DCF is essential to aid in the continual integration of services under Florida's behavioral health system of care which will serve to avoid duplication of services and eliminate undue confusion for individuals seeking care. Both agencies continually seek ways to further improve upon this framework to provide the best quality services to the SMI and SUD population. Most recently, the Agency and DCF implemented an initiative to enroll all managing entities as Medicaid providers to afford managing entities greater access to Medicaid eligibility and health plan enrollment information. In August 2016, the SMMC contract was amended to require health plans to coordinate with DCF's managing entities to establish specific organizational supports and protocols that enhance the integration and coordination of primary care and behavioral health services. The Agency and DCF are actively working to operationalize these new contract requirements.

Section III. Evaluation of Revenue Maximization Options

A. Eligible General Revenue Funding

As required by Senate Bill 12 (codified in section 394.761(2), F.S.), DCF has identified $412,411,814[6] in general revenue funding appropriated during fiscal year 2016-2017 for mental health and substance abuse services that may be eligible to be used as state match to receive additional federal Medicaid funding depending upon the delivery system enhancements that are implemented. The entirety of this funding is allocated within DCF's substance abuse and mental health budget, as appropriated by the Florida Legislature. Of the $412.4 million identified, $190.8 million is tied to MOE requirements for the SAPT and MH grants currently awarded to DCF.

The following chart provides the budget by fund source type allocated to the Managing Entities for State Fiscal Year 2016-17. This table breaks out both the Federal and State sources including MOE.

Table 4: Managing Entities Funding Sources

	Funding Source	Description	Total Budget
1	Federal	Mental Health Block Grant	33,026,605
2	Federal	Substance Abuse and Mental Health Services Federal Project Grants	8,415,679
3	Federal	Substance Abuse Prevention and Treatment Block Grant	122,422,116
4	Federal	Temporary Assistance for Needy Families	13,529,978
5	Federal	Title XIX Medicaid Administration	8,972,330
6	Federal	Title XXI Children's Health Insurance Program	5,481,296
7	**Total Federal Sources**		**191,848,004**
8	State	MOE Mental Health Block Grant	87,640,612
9	State	MOE Substance Abuse Block Grant (Must Remain in Cognizant Program Budget)	103,145,590
10	State	Match Title XIX Medicaid Administration	8,972,330
11	State	MOE Temporary Assistance for Needy Families	14,319
12	State	State General Revenue - Non MOE *(includes $795K Fee Funding)*	180,157336
13	State	State General Revenue - Non MOE Special Projects	41,453,957
14	**Total State Sources**		**421,384,144**
15	**Total Managing Entity Budget By Source SFY 2016-17**		**613,232,148**

[6] This number was derived by adding lines 8, 9, 11, 12, and 13 in Table 4.

The Legislature further directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding, including the following:

1. Seeking Medicaid eligibility for the severely and persistently mentally ill or persons with substance use disorders who are not currently Medicaid eligible
2. Covering targeted case management for individuals with substance use disorders as a Medicaid-funded service
3. Adjusting the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders
4. Increasing Medicaid reimbursement rates for behavioral health services
5. Making supplemental payments to mental health and substance abuse service providers who serve Medicaid recipients through a designated state health program or other mechanisms
6. Implementing innovative programs to provide incentives for improved outcomes for behavioral health conditions

This section of the report evaluates ways in which the above referenced objectives could be accomplished. Because children can receive all medically necessary services through Florida Medicaid regardless of any service limitations that may be specified in policy, the focus of this revenue maximization exercise is on adults (recipients ages 21 and older). In addition, this report explores how maximizing federal Medicaid funding can assist DCF in redirecting some state general revenue to meet the needs of other vulnerable populations who, as a result of their mental illness and/or substance abuse disorder, require a more intensive level of community-based services and supports. Without these services, this population experiences multiple admissions/readmissions to emergency rooms, inpatient settings, and short-term acute care settings; and has high rates of homelessness and arrest. These individuals include:

- Individuals with mental health or substance abuse disorders enrolled in Medicaid Managed Medical Assistance plans that represent the highest 15-20% of plan expenditures
- Individuals with a mental illness awaiting discharge from state treatment facilities
- Individuals with multiple admissions to community acute care settings including: psychiatric inpatient units, crisis stabilization units, addiction receiving or detoxification facilities
- Individuals with criminal justice involvement, with a mental illness or substance use disorder requiring services as a result of their release from jail, Department of Corrections, or court ordered treatment
- Parents and caretakers with substance abuse and/or mental health issues who have children involved in the state's child welfare system
- Mothers with substance use disorders

Although these individuals represent a small number of individuals as compared to the overall Medicaid or SAMH caseload, they represent an inordinate level of demand on

services and are very high cost to multiple health care, rehabilitative, social services and community providers.

B. Federal Authorities

In order to implement one or more of the alternative options, the Agency would likely need to seek authority from CMS through a Medicaid waiver. Though use of a Medicaid State Plan amendment is the most common means of seeking authority, it does not afford much flexibility to achieve the intent of the bill language. A brief description of each waiver option is presented below in order to facilitate the discussion throughout the report.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

There are general criteria CMS uses to determine whether Medicaid program objectives are met. These criteria include whether the demonstration will:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- Improve health outcomes for Medicaid and other low-income populations in the state; or
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Demonstrations must also be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending would have been without the demonstration[7].

An 1115 Research and Demonstration Waiver is the broadest and most flexible authority in which the State can implement strategies to achieve many of the funding alternative options described in Senate Bill 12 for the target population.

Section 1915 Home and Community-Based Services Waivers

Home and community-based services (HCBS) provide opportunities for Medicaid recipients to receive services in their own home or community rather than institutions or other isolated

[7] https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html

settings. These programs serve a variety of targeted population groups, such as people with intellectual or developmental disabilities, physical disabilities, and mental illnesses or co-occurring mental illness and substance use disorders. Below is a brief overview of the two HCBS options that appear most viable in achieving the objectives set forth in the SB 12.

Table 5: Overview of 1915(c) and 1915(i) Home and Community-Based Services Waivers

SECTION 1915 (c) and (i) WAIVERS		
	Home and Community-Based Services 1915(c)	**Home and Community-Based Services 1915(i)**
Authority Type	Waiver	State Plan Option
Requirements Waived	• Comparability • Community income rules • Statewideness	• Comparability • Community income rules
Purpose	Provides home and community-based services to individuals who met institutional level of care, however prefer to receive long-term care services and supports in their home or community	Provides home and community-based services to individuals who require less than institutional level of care and who would therefore not be eligible for a §1915(c) HCBS waiver. Also allows states to provide services to individuals who meet institutional level of care.
Services	States can offer services that are not covered in the State Plan (like homemaker services, adult day health services, programs can also offer medical services and assistive technology) and long-term/home and community-based services (like respite, case management, supported employment and environmental modifications). States cannot cover room and board costs or educational services covered under the Individuals with Disabilities Education Act (IDEA).	States can offer a combination of acute-care medical services (like dental services, skilled nursing services) and long-term/home and community-based services (like respite, case management, supported employment and environmental modifications). States cannot cover room and board costs or educational services covered under the Individuals with Disabilities Education Act (IDEA). Must provide services statewide to all eligible target groups.
Clinical Eligibility	States can make waiver services available only to people with specific needs and risk factors or choose to target services on the basis of disease or condition. Allows states to target benefits to one or more target populations.	States can make waiver services available only to people with specific needs and risk factors or choose to target services on the basis of disease or condition. Allows states to target benefits to one or more target populations.

SECTION 1915 (c) and (i) WAIVERS		
	Home and Community-Based Services 1915(c)	**Home and Community-Based Services 1915(i)**
Financial Eligibility	Institutional financial eligibility criteria, which, expands income eligibility criteria to 300 percent of the Federal SSI benefit which is approximately 222% of the Federal Poverty Level; applies spousal impoverishment rules; does not deem parental income for dependent children; and allows exclusions from countable income when determining financial eligibility for services.	Individuals eligible for Medicaid under the state plan up to 150% of the Federal Poverty Level. May include special income group for individuals meeting an institutional level of care criteria (with incomes up to 300% of the SSI FBR).
Limits on the number of people served	Allowed	Not allowed
Waiting Lists	Allowed	Not allowed
Approval Duration	Initially three years and renewed in five-year increments.	One-time approval except when states choose to target the benefit to a specific population(s). If a state is targeting the benefit to certain populations, renewal is required every 5 years. Changes must be submitted to CMS and approved.
Self-Direction	Allowed	Allowed
Geographic Limitations	Allowed	Not allowed

C. Seeking Medicaid Eligibility for the SMI and/or SUD Population

Background

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to seek Medicaid eligibility for the severely and persistently mentally ill or persons with substance use disorders. This section of the report evaluates how this objective can be accomplished.

Medicaid eligibility in Florida is determined either by the DCF or the Social Security Administration (for individuals with Supplemental Security Income (SSI)). The Department of Children and Families determines Medicaid eligibility for:

- Parents and caretaker relatives of children under age 18
- Children (including newborns) up to 21 years of age
- Pregnant women
- Former foster care individuals

- Child in care:
  - Foster care
  - Special need adoption children
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving SSI
- Other populations including presumptively eligible newborn and pregnant women, family planning and women in the breast and cervical cancer program, which may be determined by qualified designated providers or with assistance from other state agencies providing screening and clinical eligibility criteria.

The Social Security Administration's eligibility determination for individuals with SSI includes the aged, blind, and disabled. In Florida, SSI recipients are automatically eligible for Medicaid. In order to qualify for Medicaid, individuals must meet categorical and financial (income/asset) requirements. In addition, the individual must meet citizenship and Florida residency requirements. Financial requirements are as follows:

Family-related Group	**Income Limit**
Children Under age 1	200% Federal Poverty Level
Children age 1 through 18 years	133% Federal Poverty Level
Pregnant Women	185% Federal Poverty Level
Parents, Caretakers, Children ages 19 – 20 years.	Approximately 18% Federal Poverty Level

Options

(1) The Agency could seek federal approval through an 1115 waiver to extend Medicaid eligibility for individuals contending with SMI or SUD who currently are served through DCF's system of care and who do not meet the criteria for any of the eligibility categories listed above. The individual would have to meet the basic minimum requirements specified below, in additional to any other technical requirements specified by DCF.

- Be 21 years or age or older and under age 65 years
- Not pregnant
- Not entitled to or enrolled in Medicare benefits under part A or B
- Not otherwise eligible for and enrolled in mandatory coverage under Florida Medicaid
- Have a household income that is at or below 100 percent of the federal poverty level (FP) for the applicable family size. Note: One hundred percent of the FPL is the minimum amount of income an individual can have and qualify for financial

assistance provided under the Affordable Care Act (ACA) when purchasing coverage through health insurance Marketplaces (also called exchange plans).

The Agency selected the criteria referenced above to address gaps in coverage for childless adults not currently eligible for Medicaid and who are also not eligible for coverage through an exchange plan or other plan purchased in the individual market.

There are approximately 132,940 individuals currently being served by DCF who meet the eligibility criteria specified above. The DCF is currently spending general revenue funding on this population to provide both Medicaid covered services and non-Medicaid covered services. If directed to extend Medicaid eligibility for individuals contending with SMI or SUD as described above, the receipt of federal matching funds for services provided to this population will free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services through DCF. This general revenue may be needed to fund expenditures as described below.

If the Agency sought authority for the population to gain full Medicaid benefits, they would be eligible for the array of medical, behavioral, and dental benefits currently available for adults under the Medicaid state plan. This may result in additional expenditures on medical/dental care that is not provided by DCF for this population, and the savings derived from the receipt of federal match for services provided to this population would likely need to be used to offset the costs associated with the medical and dental care not currently furnished by DCF; otherwise, the Legislature would have to appropriate additional general revenue to cover these costs.

a. Alternatively, the Agency could seek through the 1115 more limited eligibility options as listed below:
    - Limited Medicaid benefits (behavioral health services currently covered by DCF as described in Table 3 on page 18 of this report) for all adult individuals contending with SMI or SUD who currently are served through DCF's system of care and who do not meet the criteria for any of the eligibility categories listed on page 24.
    - Full Medicaid benefits for mothers of substance exposed newborns, for a period of three years after the birth. According to DCF, Florida is experiencing an increase in the rates of substance exposed newborns. Typically, the mother will lose her Medicaid eligibility three months after the birth of the child. Extending eligibility for mothers of substance exposed newborns would enable the mother to receive critical services that may aid in recovery. The number of potential individuals meeting this criterion is indeterminate, but is estimated to be substantially less than the larger target population described earlier.
    - Full Medicaid benefits for parents and caretakers of children involved in the state's child welfare system who are contending with substance use disorders

and co-occurring mental illness. When these children are removed from the home, many parents lose their Medicaid eligibility and cannot access medical, behavioral health, and rehabilitative services that are essential to restore the parents and caretaker's capacity to effectively care for their children. There are approximately 27,000 individuals who meet this criterion and are receiving services through DCF.

Unless otherwise exempted in state law, these newly eligible individuals would receive the majority of their medical care through an MMA plan, which would provide an opportunity for better integration and coordination of both medical and behavioral health care through an MMA health plan.

(2) Through other waiver authorities, such as the HCBS 1915(i) or 1915(c) waivers, the Agency could offer a limited array of services needed by the most vulnerable and at-risk individuals within the target population (i.e., individuals with multiple psychiatric admissions within a year, etc.), while also enabling these individuals, who would not otherwise qualify for Medicaid, to become eligible. The Agency could model the waiver program after states like Connecticut and Montana who have sought and received federal approval to serve this target population through 1915 HCBS waivers. An example of the eligibility criteria that could be utilized to serve the SMI and/or SUD population in Florida under a 1915(i) or 1915(c) waiver include:

- Be 21 years old or older
- Meet the following clinical eligibility criteria (e.g., be diagnosed with an SMI or SUD; have two or more inpatient psychiatric admissions or residential treatment admissions in two years or have a single inpatient psychiatric admission exceeding a 30-day length of stay; be unable to work full time; require supervision and support; be homeless or at risk of homelessness; be at greater risk for having an acute episode; etc.)
- Meet financial (income and asset) eligibility criteria

Through a 1915(i) waiver, the Agency would not be able to cap enrollment/participation levels. However, through a 1915(c) waiver, the state could limit participation as directed by the Legislature, thereby better controlling costs and forecasting expenditures in the long-term. A state must include in its waiver application request, the list of home and community-based services that will be available to recipients enrolled in the 1915(c) or 1915(i) waiver. Services that may be beneficial for this population include peer support, crisis support, and supported employment. These services are not currently available through the Medicaid state plan, but are covered by DCF. In addition, waiver participants would receive case management services to assist with their recovery and/or stabilization.

Again, unless otherwise exempted in state law, these newly eligible individuals enrolled in the 1915(c) or 1915(i) waiver would receive the majority of their medical care through

an MMA plan. The State would have to decide how recipients will receive the covered home and community-based services (e.g., fee-for-service, managed care, etc.). Options are provided below for consideration:

- The Agency could enter into contracts with the managing entities to provide the home and community-based services through a capitated or fee-for service payment arrangement. The managing entities are already providing the types of services that would likely be included in the HCBS waiver application; this option also leverages the existing systems (e.g., provider network) that are in place to serve this population.
- The Agency could contract with the MMA plans to provide the home and community-based services through a capitated payment arrangement. This option provides an opportunity for the majority of the recipient's behavioral health care to be provided through a single entity – the MMA plan.

Regardless of the waiver authority sought (e.g., 1115 or 1915 HCBS waiver), the Agency will likely need to engage in extensive negotiations and discussions with CMS prior to receiving federal approval to implement any of these options. In addition, once approved, administration and maintenance of these waivers generally come with increased federal reporting and oversight requirements to ensure funding is being expended as stated in the approved waiver application. It would likely take the Agency and DCF approximately 12 – 18 months to fully implement any of these options (this includes obtaining federal approval and engaging in transition activities).

D. Covering Targeted Case Management and Other Services as Medicaid-Funded Services for the SUD Population

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to cover targeted case management as a Medicaid-funded service for the SUD population. This section of the report evaluates how this objective can be accomplished and also explores additional services currently not covered by Medicaid.

Targeted Case Management

Targeted case management (TCM) are services that assist eligible individuals to gain access to needed medical, social, educational, and other services and are provided only to specific classes of individuals, or to individuals who reside in specified areas of the state (or both). Currently, under Florida Medicaid, TCM is a covered service for children and adults with a mental health diagnosis; children at-risk of abuse or neglect; children at risk of a developmental delay (birth up to age 3); and children receiving medical foster care services. Medicaid recipients who meet the eligibility criteria for mental health TCM with a co-occurring mental health and substance use disorder could receive TCM services through Florida Medicaid. However, individuals who are only diagnosed with a substance use disorder are not eligible to receive TCM through Florida Medicaid because TCM for the SUD population is not available through the Medicaid State Plan.

The Department of Children and Families currently covers TCM services for individuals with a SUD. There are approximately 8,051 Medicaid recipients with a SUD receiving TCM services through the managing entities using general revenue funding. If the Agency is directed to cover TCM for individuals with SUD under Florida Medicaid, the receipt of federal matching funds for TCM services for individuals with SUD will free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services under DCF.
Implementation of this option is most easily implemented through a state plan amendment. It generally takes the Agency 3 – 6 months to obtain CMS approval for state plan amendments; it can also be implemented through amendment of the existing 1115 MMA waiver. Approval of an 1115 waiver amendment request by CMS has no specific deadlines and typically takes 6 – 12 months.

The State would have to decide how recipients will receive this newly covered service. Options are provided below for consideration:

- The Agency could contract with the MMA plans to provide this TCM service (to the extent the recipient is mandatory for enrollment in a health plan). The MMA plans are responsible for coordinating all aspects of their enrollee's care. Requiring the MMA plans to provide this service reduces the opportunity for duplication of services, particularly for recipients with a co-occurring SMI and SUD who may be eligible for both mental health TCM services and this newly covered TCM for recipients with a SUD.
- The Agency could enter into contracts with the managing entities to provide TCM for recipients with a SUD; in this scenario, the service would be carved out of managed care for those recipients receiving services through a health plan. The managing entities are currently providing this service through its network of providers; this option avoids any disruption in care for recipients.
- The Agency could require the MMA plans to subcontract with the managing entities to provide the service. This option ensures continuity of care, facilitates greater collaboration among the MMA plan and the managing entities, and reduces opportunities for duplication. This, however, limits the health plans' flexibility to manage their network of providers.

Any option that requires the managing entities to contract directly with the Agency or the MMA plans in order to receive Medicaid reimbursement for services (i.e., the federal Medicaid match) would take time and careful planning. The managing entities are not required to reimburse for services using standard medical claims forms (i.e., UB-04 or CMS 1500) or standard transactions that are federally required to protect a patient's privacy and are needed for federal reporting purposes if the services are covered by Medicaid;

managing entities would likely need several months to adapt their systems to such a change.

Other DCF Funded Services

The Department of Children offers certain services, through its system of care, above the service level provided under Florida Medicaid. The services that are covered under Florida Medicaid that have specific coverage limitations that may be exceeded through DCF's system of care, include:

- Assessment services
- Group therapy
- Individual therapy
- Day treatment
- Medical services
- Case management
- Substance abuse inpatient detoxification
- Inpatient hospital services

The Department of Children and Families is currently spending general revenue funding on these services for individuals with SMI and SUD. One potential opportunity is to eliminate the service limitations that are in place under Florida Medicaid for these eight services that the Agency and DCF cover in common, eliminating the need for Medicaid recipients to access these services through the managing entities. If directed to cover these services in this manner, the receipt of federal matching funds would free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services provided through the managing entities.

Since these services are already covered under Florida Medicaid, it would be fairly seamless to require the MMA health plans to provide the services through their networks of providers. This option provides administrative simplification for providers, eliminating the need for providers to have to seek payment from two different payment sources for the same service provided to Medicaid recipients. As stated previously, it also affords greater coordination/integration of care as a single entity is responsible for providing like services.

Implementation of this option is most easily implemented through a state plan amendment. It generally takes the Agency 3 – 6 months to obtain CMS approval for state plan amendments; it can also be implemented through an 1115 waiver if the desire is to place certain restrictions in place that are not permitted for services covered through the state plan. Approval of an 1115 waiver amendment request by CMS typically takes 6 – 12 months.

The Department of Children and Families also offers (using state general revenue funding) certain services that are not covered at all under Florida Medicaid. The most heavily utilized

services by Medicaid recipients that are paid for by the managing entities are: residential services, room and board with supervision, incidental expenses, crisis stabilization, residential detoxification, supportive housing and supportive employment. If directed to cover these types of services in order to maximize federal Medicaid funding, the Agency could pursue authority through an 1115 waiver to provide these non-covered services (through the managing entities) to Medicaid recipients contending with an SMI and/or SUD.

In this model, the Agency would make direct payments to the managing entities for services provided – the services would be carved out of managed care. This framework permits all providers currently contracted with the managing entities to continue providing care with minimum impact to the recipients. This leverages the managing entities' knowledge, history, and relationships with non-traditional Medicaid providers and offers stability in the transition to a new payment source. It is recommended that the managing entities and the health plans be required to collaborate in the delivery of care to the recipients they have in common in order to further the goals of integration and improve care coordination for the population. It would likely take the Agency and DCF 12–18 months to fully implement this option (this includes obtaining federal approval and engaging in transition activities).

For reference purposes, Attachment III is a breakdown of services and units of service provided through the managing entities for non-covered Medicaid services.

E. Adjusting the Capitation Rate for Medicaid Enrollees with Chronic Mental Illness and Substance Use Disorders

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to adjust the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders. This section of the report evaluates how this objective can be accomplished.

Under the SMMC program, the State has contractual agreements with health plans to provide comprehensive health care services and coordinate all care delivered to Medicaid recipients. The Agency reimburses health plans with a monthly capitation payment. A capitation rate is a per-member, per-month amount, including any adjustments, that is paid by the Agency to a health care plan for each Medicaid recipient enrolled in the plan for the provision of Medicaid services during a payment period. The Agency calculates capitation rates annually.

Capitation rates for the MMA health plans are developed in accordance with 42 CFR 438.6. The Agency develops actuarially sound, risk-adjusted premiums by assessing historical Florida Medicaid expenditures and encounter data. Health-based risk adjusters use individuals' historical diagnoses to predict expected future expenditures more effectively than age and gender. The health-based risk adjustment provides a risk score for each

individual to reflect predicted health care needs. The scores of all of the recipients enrolled in each MMA plan determine the collective risk score, and the resulting capitation rates for that MMA plan. This approach provides an incentive for MMA plans to take all necessary steps to identify enrollees who have undiagnosed chronic conditions. The MMA plan may receive a higher premium only if an enrollee is diagnosed with a condition that merits the additional premium. Once an MMA plan identifies an enrollee with a chronic condition, it is in the plan's financial interest to properly manage the enrollee's condition to avoid the need for higher cost services typical of untreated chronic conditions.

If the Agency is directed to expand coverage for the SMI/SUD population or to cover additional services, as discussed thus far, the capitation rates paid to the health plans would need to be adjusted. One high-risk population group mutually served by the health plans and the managing entities are individuals with mental health or substance abuse disorders enrolled in MMA plans that represent the highest 15-20% of plan expenditures. By identifying general revenue dollars spent on this population that could serve as the match for federal Medicaid funding, the Agency could fund changes in the health plan contracts (reflected in the resulting capitation rates) that require the plans to provide additional health benefits for the target population, implement innovative quality improvement programs (such as the healthy behavior programs required by the Legislature in Part IV of Chapter 409, F.S.), or to pay providers more based on certain quality outcomes. This can also be accomplished if a portion of the general revenue savings achieved from implementation of any of the previously discussed options (in Sections III.C. and III.D. of this report) are used for this purpose. All of these initiatives would have an impact on the capitation rates to ensure they remain actuarially sound. If directed to implement such changes by the Legislature, it is recommended that the MMA plans partner with the managing entities (through formal or informal agreements) to effectuate the best outcomes. The idea of requiring plans to pay providers an increased rate based upon quality outcomes is explored in the next section of the report.

If the Agency adjusted the capitation rates for the MMA plans, the Agency would need to seek federal approval of these changes by submitting the SMMC contract amendment that contained the changes. The process to obtain CMS approval of the capitation rate changes can, at times, take several months.

F. Increasing Reimbursement Rates for Behavioral Health Services

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to increase reimbursement rates for behavioral health services. This section of the report evaluates how this objective can be accomplished.

Providers of mental health and substance abuse treatment services can be reimbursed for services in two ways. If the individual is enrolled in Medicaid, the provider can either submit claims directly to the Agency's fiscal agent if the recipient is receiving services through the

fee-for-service system or submit the claim directly to the appropriate MMA health plan if the recipient is enrolled in managed care. The Agency maintains a fee schedule that lists covered services and the fee-for-service rates paid by Medicaid for those services. They are promulgated in Florida Administrative Code, in accordance with Chapter 120, F.S. requirements. The rates listed on the fee schedule are established based on appropriations made by the Florida Legislature and are not modified unless the Legislature appropriates additional funding. Health plans have the flexibility to negotiate mutually agreed upon rates with their networks of providers, unless otherwise specified in Florida law. Fee schedules dictate payment under the fee-for-service system and health plans are not bound by the rates established on the Agency's fee schedules.

Managing entities pay their providers through availability or utilization based contracts. They have the flexibility to negotiate rates with their network of providers and are not bound by the rates that DCF previously paid providers when DCF contracted directly with the providers to render services. If an individual is not enrolled in Medicaid or any other health plan, mental health and substance abuse treatment providers may seek reimbursement for services through a managing entity.

In the context of revenue maximization, one of the ways that is feasible to increase rates for behavioral health services would be to reinvest any savings achieved through implementation of the other system reforms described thus far in this report in increased rates for providers. Given the heavy focus for both state agencies on ensuring the quality of care received, any rate increases for providers should be tied to performance. To the extent that the options that have been presented thus far generate additional funding, one option is to use the additional funding to enhance capitation rates paid to MMA plans or the amounts paid to the managing entities, requiring them to pay better performing providers higher reimbursement rates for services provided. For services provided in the fee-for-service delivery system, the Legislature could reinvest any savings achieved through appropriations to increase reimbursement rates for behavioral health services directly paid to providers.

G. Increasing Reimbursement Rates to Providers Through Incentive Payments

Another option is to require the MMA plans to contract with the managing entities to provide services and require that the plan establish certain benchmarks for the managing entities, that when met, entitles the managing entity to increased reimbursement for providing services.

One method of increasing awareness and focus on improved outcomes is through the development of an incentive payment program. Incentive payments are a mechanism that can be replicated within the MMA program and applied across a number of service areas including services for individuals contending with SMI and SUD. This strategy moves away from the traditional model of purchasing services based on quantity and toward value based purchasing focused on improving quality. In the incentive based model, providers are not

simply paid more for doing the same thing; they must achieve certain identified goals or improvements to earn the incentive payment.

For example, the Agency has designed a Managed Medical Assistance Physician Incentive Program that requires the health plans to furnish higher reimbursement to physicians out of the managed care savings they achieved from efficiencies through care coordination, as specified by section 409.967(2) (a), F.S. The intent of the program is to incentivize access and quality through select measures; qualified providers who meet the specific criteria are eligible for enhanced payments that are equivalent to Medicare rates.

Each health plan was granted the opportunity to either adopt an Agency defined Managed Medical Assistance Physician Incentive program or develop their own. The Agency had the ability to reject health plan proposals. A key component of this program is that all qualified providers must have a reasonable opportunity to earn the incentive payment. This incentive program is an example of one tool that could be used to enrich the quality of services provided to eligible Medicaid recipients by behavioral health providers contracted with Medicaid health plans.

If the Agency or DCF established a similar program for behavioral health services, there could be a focus on the following performance outcomes, as examples:

- Reduce the time of individuals' wait for discharge to less restrictive services
- Provide enhanced access to the most appropriate, least restrictive settings for care
- Reduce readmissions to most expensive community settings such as crisis stabilization units, inpatient detox
- Increase tenure in the community through stable housing, assertive community treatment, care coordination
- Reduce recidivism and increase successful community tenure for persons with high rates of arrest/incarceration
- Reduce costs associated with readmissions and recidivism to residential treatment

H. Making Supplemental Payments to Providers

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to make supplemental payments to mental health and substance abuse service providers through a designated state health program or other mechanisms. This section of the report evaluates how this objective can be accomplished through several different types of supplemental payment options, including:

- Intergovernmental transfers
- Certified public expenditures, and
- Designated State Health Program

Supplemental payments have historically been established to provide funding for services in specific facility settings such as hospitals, nursing facilities, intermediate care facilities for

individuals with intellectual disabilities, and clinics. In unique instances, supplemental payments have been approved by CMS for medical school faculty group physicians. Medicaid supplemental payment programs for mental health and substance abuse treatment providers are atypical, but that does not mean that the State could not seek and receive federal approval to implement such a program. The federal government would have full discretion to accept or reject the state's proposal. An 1115 demonstration waiver would be needed in order for these supplemental payments to be made to providers for services provided through a Medicaid health plan or for more complicated supplemental payment options such as Delivery System Reform Incentive Payment programs. For services provided through the Medicaid fee-for-service delivery system, most supplemental payment options can be implemented through a state plan amendment.

Intergovernmental Transfers

The primary source of funding for the non-federal share (the state share) for the Medicaid program comes from state general revenue fund appropriations. States can also fund the non-federal share of Medicaid with other state funds which may include funding from local governments or revenue collected from provider taxes and fees. Intergovernmental transfers (IGTs) are transfers of funds from another governmental entity (e.g., counties, local taxing districts, county health departments, publicly funded hospitals, and in some cases other state agencies) to the Medicaid agency which are used to draw down additional federal match for the Medicaid program. If IGTs were contributed for the purpose of funding behavioral health and substance abuse services, the increased funding generated through the use of IGTs could result in increased payments to safety-net providers, such as crisis stabilization units, community behavioral health centers, etc.

In recent years, there has been increased scrutiny at the federal level over states' use of IGTs and other types of supplemental payment funding. One disadvantage to this option is the potential for increased federal oversight and reporting requirements to ensure the funding is being used appropriately. More specifically, IGTs cannot be used as a funding source to:

- Raise the federal share of total Medicaid funding far above their nominal statutory federal matching rate
- Make federal matching funds available for purposes other than purchasing covered services for Medicaid recipients
- Inflate the overall Medicaid spending growth rates without commensurate increase in spending for services for Medicaid recipients
- Create incentive for states to reduce the use of public funding

The Agency and DCF would need to engage in further discussions with providers and local county governments to better determine the availability of IGTs that could be used for enhanced funding to behavioral health and substance abuse providers. The Florida legislature would also have to authorize the Agency to seek federal approval to implement the use of IGTs.

Certified Public Expenditures

Certified public expenditures (CPEs) can be implemented in the same fashion as the IGTs to provide increased payments to eligible providers such as publicly funded crisis stabilization units. CPEs are expenditures made by a governmental entity, including a provider operated by a state or local government, for health care services provided to Medicaid recipients. Federal rules allow certain health care provider organizations to utilize certified public expenditures to draw down federal funds to account for uncompensated costs for medical care provided to Medicaid recipients.

There are two primary requirements in order to receive federal match under a CPE methodology. First, providers are required to expend local funds in lieu of state funds. Second, providers cannot be reimbursed for more than the cost of providing the service. Under a CPE arrangement, no additional state general revenue is expended. This funding tool can also be used to offset payment differences to providers for Medicaid compensable services that DCF provides as well. Reducing the amount of uncompensated care experienced by providers may lead to an increase in access to services. In the state of Florida, CPEs account for 5.4 percent of the state's federal matching funds arrangements.[8]

The Agency and DCF would need to engage in further discussions with providers to better determine the availability of CPEs that can be used for enhanced funding to behavioral health and substance abuse providers. The Florida legislature must authorize the Agency to seek federal approval to implement CPEs.

Designated State Health Programs

Designated State Health Programs (DSHP) are health care programs that are funded only with state general revenue dollars that can be eligible to receive federal Medicaid funding, on a time limited basis, if they meet certain federal requirements.

DSHPs provide safety-net health care services for low-income or uninsured individuals (e.g., adult day care, outpatient substance abuse treatment, etc.). Federal funding for DSHPs generally support the goals of a health system transformation.

While CMS has not published any regulations or technical assistance on how to access DSHP funding, states that have received approval did so through an 1115 waiver. The National Governors Association published a toolkit called the *Future of Medicaid Transformation: A Practical Guide for States* that contains useful information about the design and implementation steps of DSHPs. To seek DHSP funding, states are required to clearly identify how funds will support Medicaid transformation and due to the time limited nature of the funding, how the efforts will be sustained once federal funding is no longer

[8] United States Government Accountability Office (July 2014). Medicaid financing: States' increase reliance on funds from health care providers and local governments' warrants improved CMS data collection (GAO-14-627). Retrieved from: http://www.gao.gov/assets/670/665077.pdf

available. When requesting DSHP funding, states must provide CMS with detailed information on how the programs are currently funded, who is served, and how the program will be maintained once federal funding is no longer available. Approvals are made on a case-by-case basis through negotiations with CMS.

Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state may be required to document DSHP payment requests through a specific accounting system. Sources of non-federal funding must be compliant with section 1903(w) of the Social Security Act and applicable regulations. Finally, states are required to report all expenditures on their CMS-64 reports (this report reflects expenditures for all services for which federal matching funds are sought).

Historically, federal matching funds have not been allowed for state expenditures associated with prison health care, institutions for mental disease, housing, school-based services, programs that serve undocumented persons, individuals who would be eligible for Medicaid through Medicaid expansion, and non-health care related state spending. This seems to hold true for states seeking approval for DSHP funding. This appears to limit the scope of how the State can utilize the DSHP in the behavioral health system of care. For example, providers who qualify as an institution for mental disease would not be eligible to participate and some services that DCF provides that Medicaid does not, such as housing, may not be allowable.

CMS has approved federal matching payments for designated state health programs in several states (e.g., California, Massachusetts, New York, New Hampshire, and Oregon). Oregon and New Hampshire have received approval of DSHP funding related to their substance abuse and mental health programs. State general revenue funds dedicated to the following programs operated by DCF could be included in the initial application request:

- Community Substance Abuse and Mental Health
- State Mental Health Treatment Facilities

It is recommended that, if directed to implement a DSHP, the eight services (listed on page in Section III.D. of this report) that are covered under both Medicaid and the managing entity delivery systems be consolidated under the responsibility of the Agency through Medicaid and the additional federal funding received through the DSHP be utilized to cover services and populations currently provided by the managing entities that are not eligible for Medicaid funding.

The DSHP model could be used to target one or more of the elements specified in the revenue maximization component of Senate Bill 12 (e.g., increasing rates for behavioral health services, implementing innovative programs targeted towards individuals with chronic SMI or SUD, etc.). In order to preserve and leverage the infrastructure established by the managing entities, it is recommended that any increased federal funding be directly paid to

the managing entities for the delivery of services through their networks of providers. Given the level of increased documentation of expenditures that would be required by CMS, it is recommended that the Agency have an agreement with the managing entities in addition to DCF to ensure all federal Medicaid reporting requirements are met and to ensure the Agency has the necessary authority in place to provide oversight of the DSHP expenditures.

Here is a brief overview of the DSHP components:

Goals and Objectives: In collaboration with DCF, the following goals and objectives were identified if this financing strategy were pursued:

- Reduce hospitalizations
- Reduce admissions to crisis stabilization units/residential detox services, emergency rooms, and arrest rates
- Increase community tenure through stable housing
- Improve the coordination of care across health care, behavioral health care, and community support providers
- Improve access to health and behavioral health
- Improve patient/client and family outcomes

Eligible Populations: As described earlier in the report, DCF has identified certain priority populations that require more intensive level of community-based services and supports, including care coordination, access to primary health care, and behavioral health treatment services. These populations include:

- Individuals with a mental illness awaiting discharge from state treatment facilities
- Individuals with multiple admissions to community acute care settings including; psychiatric inpatient units, crisis stabilization units, addictions receiving or detoxification facilities
- Individuals with criminal justice involvement, with a mental illness or substance use disorder requiring services as a result of their release from jail, Department of Corrections, or court ordered treatment

Eligible Services: To be successful, a full range of community health, rehabilitative and support services need to be in place. The DSHP appears to offer the opportunity to build the community systems of care needed to reduce demand for most restrictive state hospital placements. Community-based services that would be viewed as essential to this effort include:

- Assertive Community Teams
- Mobile Crisis Response
- Assessment services,
- Care coordination
- Targeted case management
- Housing and housing support services
- Short-term residential treatment

- Community support services
- Peer support
- Intensive outpatient/Day treatment
- Outpatient primary care services
- Inpatient mental health and detoxification services.

If directed, the Agency would likely request authority for DSHP federal funding by amending its existing 1115 MMA waiver. The length of time to receive federal approval is indeterminate at this time, as there are no prescribed timeframes for CMS to address 1115 waiver amendment requests. Typically, it takes six to twelve months to negotiate approval of an 1115 waiver amendment request with CMS – more complex waiver amendment requests such as a DSHP typically take a significantly longer period of time. It should also be noted that states who received approval from CMS did so in conjunction with Delivery System Reform Incentive Payment programs.

In general, use of supplemental payment methods have the benefit of increasing funding for providers and local delivery systems that enable them to addresses uncompensated care costs or maximize the available funding to address underserved populations (both Medicaid and non-Medicaid). However, federal funding under a DSHP program is time-limited, with states expected to transform their system to support the DSHP without federal funding in the long-term. The state will have to be cognizant of additional federal regulatory and administrative requirements that are associated with these supplemental payment funding opportunities and in some cases, the limited duration in which the funding may be available. DSHP has auditing and reporting standards that may require additional staff which may be a disadvantage in terms of State resources available to design, implement, and maintain a DSHP. This places an increased burden on states to use the funding to achieve sustainable systemic reforms that are not reliant upon the federal funding in the long-term to maintain successes. For a DSHP program, states must be aware that approvals are made on a case-by-case basis through negotiations with CMS, which could be lengthy.

I. Implementing Innovative Programs to Provide Incentives for Improved Outcomes for Behavioral Health Conditions

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to implement innovative programs to provide incentives for improved outcomes for behavioral health conditions. This section of the report evaluates how this objective can be accomplished through a Delivery System Reform Incentive Payment (DSRIP) program and health homes. Delivery System Reform Incentive Payments are another form of supplemental payment, but because it is exclusively focused on system transformation and improving outcomes, the DSRIP option is discussed in this section of the report.

Delivery System Reform Incentive Payment

Prompted by an interest in improving the health of the population and enhancing the experience and outcome of the patient, more states are seeking ways to implement innovative programs. Delivery System Reform Incentive Payment programs are one of the ways that states can achieve such reforms.

Delivery System Reform Incentive Payment programs allow states to make incentive payments that are linked to performance-based incentive initiatives, or projects aimed at improving health care processes, clinical outcomes, and that otherwise positively transform health service delivery. The overall goal of state DSRIP initiatives must be transformation of the Medicaid payment and delivery system in an effort to achieve measurable improvements in quality of care and overall population health.

Normally, progress on these projects is tracked and payments are adjusted based on providers' successes in meeting agreed-upon milestones. DSRIP demonstrations require states to work closely with CMS throughout the duration of the program given the complexity of designing broad system transformations specific to each state and the need for accountability for investments of billions of dollars. Significant time spent by providers, states, and CMS are needed to launch DSRIP programs and most require substantial resources dedicated to implementation and eventual administration. Most states report the need for increased staff/consulting capacity and expertise in clinical quality and performance improvement. To undertake this option, the Agency will need to enter into discussion with CMS and DCF regarding options available and the best way to proceed in designing a program. Examples from other state programs sourced though DSRIP are complicated, and the State must fully understand how best to incentivize the changes sought and determine how to measure that change in an efficient and effective way.

Seven states have acquired federal authority to employ DSRIP as an umbrella for systemic payment reform. For the state of Florida, a DSRIP could be used to incentivize providers and health plans to improve behavioral health performance outcomes.

CMS has approved seven states' DSRIP programs as part of 1115 waivers to advance payment and delivery system reform. Other states are applying or are negotiating. See Attachment IV for more information on states that have been approved to use this model. Delivery System Reform Incentive Payment initiatives provide states with significant funding that can be used to support providers in changing how they provide care to Medicaid recipients. Approval of a DSRIP program is dependent upon the following:

- **Goals and Objectives:** The State must evaluate its existing Medicaid programs and identify specific goals and measureable outcomes that reduce costs, increase efficiency and improve quality of care. CMS and the state use these goals and metrics to assess whether providers meet, exceed or fall short of the necessary milestones. Providers only receive enhanced DSRIP funding if they meet the measures approved in the DSRIP project plan.

  - In collaboration with DCF, the following goals and objectives were identified if this financing strategy could be pursued:
    - Reduce the time of individuals' wait for discharge to less restrictive services
    - Enhance access to the most appropriate, least restrictive settings of care
    - Reduce readmissions to most expensive community settings such as crisis stabilization units and inpatient detox
    - Increase community tenure through stable housing, assertive community treatment, care coordination
    - Improve functioning and overall wellness
    - Reduce recidivism and increase successful community tenure for persons with high rates of arrest/incarceration
    - Reduce cost associated with readmissions and recidivism to residential treatment
    - Improve the coordination of care across health care, behavioral health care, and community support providers
    - Improve coordination of benefits across multiple payors of services
    - Reduce denials of services as a result of improved care coordination
    - Improve access to health and behavioral health care services
    - Improve patient/client and family outcomes

- **Eligible Providers:** The State must determine which providers are eligible to receive DSRIP funds. In some states, only public hospitals are eligible entities, while in others "safety net providers" (including nonpublic hospitals and other categories of providers) are eligible through a collaborative provider network or through affiliation with an anchor public hospital.

  - The primary focus of DCF's goals and objectives is on reducing the use of crisis stabilization and residential treatment services for vulnerable populations by creating greater capacity and availability of outpatient services. As such, the providers eligible for the incentive payments could be those who provide community-based/outpatient services through the managing entities and Medicaid health plans to the target populations.

- **Funding Sources:** The State must identify the source of funding for the program. Other states have used IGTs from public entities, provider taxes, state general revenue, and DSHP. Many states struggle with how to finance the state share to contribute to the DSRIP program. While IGT's have become the most common source of funding used by states, it can be a challenge for the entity providing the IGT to meet the high level of funding required.

  - It is recommended to utilize a combination of IGT's, state general revenue funding, and a DSHP as funding sources if this option is selected by the Legislature.

- **Funding Allocation:** The State must describe the methodology for allocating the DSRIP funding. State waivers including DSRIP programs have prioritized certain types of

projects (e.g., integrated healthcare delivery, expanded primary care capacity, and/or population-focused improvements), as well as certain provider types (e.g., those with the largest percentages of Medicaid and uninsured individuals).

  - It is recommended that any increased federal funding be directly paid to the managing entities or Medicaid health plans for the delivery of services through their networks of providers.

- **Data Collection and Evaluation:** Providers have varying data collection and reporting systems which may present a challenge for project evaluation. The data infrastructure needed by a provider to participate in DSRIP is a potential disadvantage of this option. A large hospital provider in one state reported the need for a complete overhaul of their data infrastructure and often the ability to share data amongst participating providers is important. This is an area of concern for behavioral health providers who are generally smaller and less sophisticated in terms of information technology.

  The State must establish data collection and reporting requirements that adequately measure provider performance against approved process and outcome metrics to determine whether participating providers have achieved the necessary milestones to receive DSRIP funds.

  - As part of systemic reform, the Agency and DCF can identify new performance measures that can be used to evaluate health plan performance toward improving the delivery of behavioral health services and integration of care. Performance measures can be designed to target a known system weakness or gap to focus improvements to that specific issue. For example, an additional behavioral health performance measure can be designed to measure reductions in the number of recipients who experience repeated Baker Act and Marchman Act admissions. Health plans can be required to report the frequency of care management contacts following an inpatient episode to demonstrate intensive effort to connect these recipients with community-based services and supports and improve compliance with discharge recommendations and prescribed medications. This strategy can also be used to assist health plans in improving scores on existing behavioral health performance measures, such as follow-up after hospitalization for mental illness.

Health Homes

The use of health homes is an innovative mechanism for increasing access to federal funding. The significance of this model must be considered when examining payment reform.

The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care designed to achieve improved outcomes for Medicaid enrollees with chronic conditions and ensure care and value for state Medicaid programs. This provision supports CMS's primary objective of improving health care while

achieving three goals: improving the experience of care; improving the health of populations; and reducing per-capita costs of health care.[9]

The health home provision offers States flexibility in designing their payment methodologies and a significant financial incentive by providing an eight-quarter enhanced federal match for health home services received by eligible Medicaid enrollees. The federal government pays 90 percent of the cost for the specific health home services for a total of eight quarters for one enrollee.

Under the health home state plan benefit, a health home provider delivers a comprehensive system of care by integrating and coordinating all primary, acute, behavioral health (including mental health and substance use) and long term services and supports for individuals with chronic conditions to treat the "whole-person." The main goals for the health home are to improve health outcomes that will result in lower rates of emergency room use, reduction in hospital admissions and readmissions, reduction in health care costs, create less reliance on long-term care facilities and improve experience of care for Medicaid individuals with chronic conditions.

The Secretary of Health and Human Services has the authority to approve entities or providers as a health home.[10] CMS outlines three distinct types of health home providers that can provide health home services: designated providers; a team of health care professionals; and a health team.

- A designated provider may be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider.
- A team of health professionals may include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center.
- A health team must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractic, and licensed complementary and alternative practitioners.

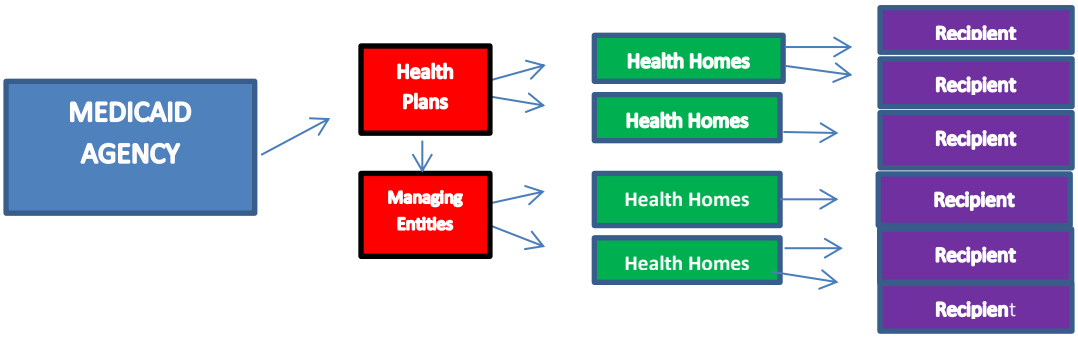
The Medicaid health plans and managing entities could work collaboratively to implement this initiative as depicted below.

Figure 3: Health Home Option

Health plan + third party contracts with health homes

[9] Centers for Medicare and Medicaid Services (2010, November 16). Health homes for enrollees with chronic conditions. *Medicaid Directors Letter* (SMDL# 10-024, ACA# 12). Retrieved from: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

[10] Centers for Medicare and Medicaid Services (February 2012). Health homes consideration for a Medicaid managed care delivery system: Avoiding duplication of services and payments. *Technical Assistance Tool.* Retrieved from http://www.chcs.org/media/hh-managed-care-options-matrix_020312.pdf



The Medicaid health plans could contract with the managing entities for additional care coordination activities provided to their enrollees. To the extent that the managing entities are contracting with providers meeting the qualifications of a health home, the additional federal funding generated could flow through to both the managing entity and the providers.

CMS envisions payment of a health home model of service delivery with either a fee-for-service or capitated payment structure, although they would consider other methods or strategies utilizing additional payment models. States may structure a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the "capabilities" of the designated provider, the team of health care professionals operating with the designated provider, or the health team.

This option would require submission of waiver request to CMS; likely an 1115 waiver.

Section IV. Summary

This report contains a comprehensive overview of mechanisms to increase federal funding for behavioral health services. If directed to implement certain options described, the receipt of federal matching funds for services provided to individuals with SMI and/or SUD will free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services through DCF. A more formal fiscal analysis can be conducted on any of the options discussed in the report, upon request of the Agency and DCF by the Florida Legislature.

The report also explores the federal authority vehicles for increasing access to federal funding including research and demonstration and home and community-based waiver programs. While there are various options available for the state to choose, the 1115 Research and Demonstration Waiver provides the state with the greatest flexibility to achieve one or all of the potential alternative uses of enhanced federal matching funding.

Attachment I: Florida Medicaid Waivers

Section 1115 Research & Demonstration Waivers	
Family Planning Waiver	Provides family planning and family planning-related services to all women of child bearing ages (14-55) losing Medicaid coverage, who have a family income at or below 185 percent of the federal poverty level and who are not otherwise eligible for Medicaid, Children's Health Insurance Program, or other health insurance coverage providing family planning services.
Managed Medical Assistance Waiver	Provides primary care, acute medical care, dental care, and behavioral health care for Florida Medicaid recipients through contracts with managed care plans.
MEDS AD Waiver	Provides Medicaid eligibility for people with disabilities who are 65 years of age or older, disabled, and who have resources below $5,000 for an individual and $6,000 for a couple and whose income is less than 88 percent of the federal poverty level.
Sections 1915(b) Selective Contracting/Managed Care Waivers	
Non–emergency Transportation Waiver	Provides non-emergency services eligible Medicaid recipients who are not enrolled in a health plan.
Long-term Care (LTC) Waiver* **The LTC Program operates under a combination 1915(b)/1915(c) waiver authority*	Provides LTC services and supports to eligible disabled individuals age 18-59 years and elderly individuals age 65 years or older.
Sections 1915(c) Home and Community-Based Services Waivers	
Adult Cystic Fibrosis Waiver	Provides home and community-based services to recipients over 18 years of age who have been diagnosed with cystic fibrosis.
Developmental Disabilities Individual Budgeting Waiver	Provides home and community-based services to recipients three years of age or older who have been diagnosed with a developmental disability.
Familial Dysautonomia Waiver	Provides home and community-based services to recipients 3 through 64 years of age who have been diagnosed with familial dysautonomia.
Model Waiver	Provides home and community-based services to children under 21 years of age who are complex/medically fragile or diagnosed with degenerative spinocerebellar disease.
Project AIDS Care Waiver	Provides home and community-based services to individuals diagnosed with AIDS.
Traumatic Brain Injury and Spinal Cord Injury Waiver	Provides home and community-based services to recipients 18 years of age or older who have been diagnosed with traumatic brain injury or spinal cord injury.

Attachment II: Medicaid Behavioral Health Services and Fees

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Service Limitations
Assessments/Evaluations					
Psychiatric evaluation: A comprehensive evaluation that investigates the recipient's clinical status. The purpose of a psychiatric evaluation is to establish a therapeutic doctor–patient relationship, gather accurate data in order to formulate a diagnosis, and initiate an effective treatment plan.					
Psychiatric evaluation by physician	H2000	HP		$210.00 per evaluation	Max of 2 per state fiscal year (SFY)
Psychiatric evaluation by physician—telemedicine	H2000	HP	GT	$210.00 per evaluation	
Psychiatric evaluation by non-physician	H2000	HO		$150.00 per evaluation	
Brief behavioral health status exam: A brief clinical, psychiatric, diagnostic, or evaluative interview to assess behavioral stability or treatment status. A brief behavioral health status examination must be completed prior to the development of the recipient's individualized treatment plan.					
Brief behavioral health status exam	H2010	HO		$14.66 per quarter hour	Max. daily limit of 2 15-minute units
Brief behavioral health status exam—telemedicine	H2010	HO	GT	$14.66 per quarter hour	Max. 10 15-minute units per SFY
Psychiatric review of records: A review of a recipient records, psychiatric reports, psychometric or projective tests, and clinical and psychological evaluation data for diagnostic use in evaluating and planning for recipient care. A written report must be done by the individual rendering the service and must be included in the recipient's clinical record.					
Psychiatric review of records	H2000			$26.00 per review	Max 2 reviews per SFY
In-depth assessment: A diagnostic tool for gathering information to establish or support a diagnosis, to provide the basis for the development of or modification to the treatment plan, and to develop the discharge criteria.					
In-depth assessment, new patient, mental health	H0031	HO		$125.00 per assessment	Max 1 per SFY Not reimbursable on same day as a bio-psychosocial
In-depth assessment, new patient, mental health-telemedicine	H0031	HO	GT	$125.00 per assessment	
In-depth assessment, established patient, mental health	H0031	TS		$100.00 per assessment	
In-depth assessment, established patient, mental health-telemedicine	H0031	TS	GT	$100.00 per assessment	
In-depth assessment, new patient, substance abuse	H0001	HO		$125.00 per assessment	
In-depth assessment, new patient, substance abuse-telemedicine	H0001	HO	GT	$125.00 per assessment	
In-depth assessment, established patient, substance abuse	H0001	TS		$100.00 per assessment	
In-depth assessment,	H0001	TS	GT	$100.00 per	

established patient, substance abuse-telemedicine				assessment	
Bio-psychosocial evaluation: An evaluation to describe the biological, psychological, and social factors that may have contributed to the recipient's need for services. The evaluation includes a brief mental status exam and preliminary service recommendations.					
Bio-psychosocial evaluation, mental health	H0031	HN		$48.00 per assessment	Max 1 per SFY Not reimbursable after in-depth assessment unless documented changed in status and additional information is needed to modify treatment plan.
Bio-psychosocial evaluation, mental health - telemedicine	H0031	HN	GT	$48.00 per assessment	
Bio-psychosocial evaluation, substance abuse	H0001	HN		$48.00 per assessment	
Bio-psychosocial evaluation, substance abuse - telemedicine	H0001	HN	GT	$48.00 per assessment	
Psychological testing: The assessment, evaluation, and diagnosis of the recipient's mental status or psychological condition through the use of standardized testing methodologies.					
Psychological testing	H2019			$15.00 per quarter hour	Max 40 15-min units per state fiscal year
Limited functional assessment: Administration of the Functional Assessment Rating Scale (FARS), and the Children's Functional Assessment Rating Scale (C-FARS), the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R), or any other functional assessment required by the DCF.					
Limited functional assessment, mental health	H0031			$15.00 per assessment	Max 3 assessments per SFY
Limited functional assessment, mental health - telemedicine	H0031	GT		$15.00 per assessment	
Limited functional assessment, substance abuse	H0001			$15.00 per assessment	
Limited functional assessment, substance abuse - telemedicine	H0001	GT		$15.00 per assessment	
Treatment Plan Development and Modification					
Treatment planning services is an individualized, structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level.					
Treatment plan development, new and established patient, mental health	H0032			$97.00 per event	Max 1 per SFY Authorized by treating practitioner
Treatment plan development, new and established patient, substance abuse	T1007			$97.00 per event	
Treatment plan review, mental health	H0032	TS		$48.50 per event	Max 4 per SFY authorized by treating practitioner
Treatment plan review, substance abuse	T1007	TS		$48.50 per event	
Medical and Psychiatric Services					
Medical and Psychiatric services include evaluation of the need for medication; evaluation of clinical effectiveness					

and side effects of medication; prescribing, dispensing, and administering of psychiatric medications; medication education and facilitating informed consent (including discussing side effects, risks, benefits, and alternatives with the recipient or other responsible persons); planning related to service delivery; and evaluating the status of the recipient's community functioning.					
Medication management	T1015			$60.00 per event	As medically necessary. Not reimbursable on same day as brief group medical therapy or brief individual medical therapy
Medication management - telemedicine	T1015	GT		$60.00 per event	
Brief individual medical psychotherapy, mental health	H2010	HE		$15.00 per quarter hour	Max daily limit of 2 15-minute units Max limit of 16 quarter hour units per SFY Not reimbursable on same day as brief group medical therapy or med management
Brief individual medical psychotherapy, mental health—telemedicine	H2010	HE	GT	$15.00 per quarter hour	
Brief individual medical psychotherapy, substance abuse	H2010	HF		$15.00 per quarter hour	
Brief individual medical psychotherapy, substance abuse—telemedicine	H2010	HF	GT	$15.00 per quarter hour	
Brief group medical therapy	H2010	HQ		$8.65 per quarter hour	Max daily limit of 2 15-minute units. Max limit of 18 quarter hour units per SFY Not reimbursable on same day as brief individual medical therapy or med management
Behavioral health medical screening, mental health	T1023	HE		$43.62	Max 2 per SFY Not reimbursable on same day as BH related medical services: verbal interaction or med management
Behavioral health medical screening, substance abuse	T1023	HF		$43.62	
Behavioral health—related medical services: verbal interaction, mental health	H0046			$15.00 per event	Max 52 per SFY Not reimbursable on same day as behavioral health screening services
Behavioral health-related medical services: verbal interaction, mental health—telemedicine	H0046	GT		$15.00 per event	
Behavioral health-related medical services: verbal interaction, substance abuse	H0047			$15.00 per event	
Behavioral health-related medical services: verbal interaction, substance abuse—telemedicine	H0047	GT		$15.00 per event	
Behavioral health-related medical services: medical	T1015	HE		$10.00 per event	

procedures, mental health					Max 52 times per SFY
Behavioral health-related medical services: medical procedures, substance abuse	T1015	HF		$10.00 per event	
Behavioral health-related medical services: alcohol and other drug screening specimen collection	H0048			$10.00 per event	Max 52 times per SFY
Medication-assisted treatment services	H0020			$67.48, weekly rate	Max 52 times per SFY (once per seven days) Not reimbursable with any other procedure code
Behavioral Health Therapy Services					
Behavioral health therapy services are the provision of insight-oriented, cognitive behavioral or supportive therapy interventions to an individual recipient or a recipient's family. Individual and family therapy may involve the recipient, the recipient's family without the recipient present, or a combination of therapy with the recipient and the recipient's family.					
Individual and family therapy	H2019	HR		$18.33 per quarter hour	Max 104 quarter hour units per SFY
Individual and family therapy - telemedicine	H2019	HR	GT	$18.33 per quarter hour	Max per day= 4 quarter hour units
Group therapy	H2019	HQ		$6.67 per quarter hour	Max 156 quarter hour units per SFY
Behavioral health day services, mental health	H2012			$12.50 per hour	Max 190 hour units per SFY Not reimbursable on same day as PSR
Behavioral health day services, substance abuse	H2012	HF		$12.50 per hour	
Community Support and Rehabilitative Services					
Community support and rehabilitative services encompass rehabilitation-focused, community-based psychosocial services. Community support and rehabilitative services are designed to assist recipients in strengthening or regaining interpersonal skills and in developing environmental supports necessary to function in their community.					
Psychosocial rehabilitation services	H2017			$9.00 per quarter hour	Max 1,920 units per SFY
Clubhouse services	H2030			$5.00 per quarter hour	Max 1920 units SFY
Therapeutic Behavioral On-Site Services for Recipient Under the Age of 21 Years					
Therapeutic behavioral on-site services are intended to prevent recipients who have complex needs from requiring placement in a more intensive, restrictive behavioral health setting. These services are coordinated through individualized treatment teams and are designed to assist recipients and their families.					
Therapeutic behavioral on-site services, therapy	H2019	HO		$16.00 per quarter hour	Max 36 quarter hour units per month
Therapeutic behavioral on-site services, behavior management	H2019	HN		$10.00 per quarter hour	Max 36 quarter hour units per month
Therapeutic behavioral on-site services, therapeutic support	H2019	HM		$4.00 per quarter hour	Max 128 quarter hour units per month
Mental Health Targeted Case Management					
Mental health targeted case management services assist adults with a serious mental illness and children with a serious emotional disturbance gain access to needed medical, social, educational, and other necessary services as					

they relate to the recipient's mental health.					
Targeted Case Management for Children (birth through 17)	T1017	HA		$12.00 per quarter unit	344 per month
Targeted Case Management for Children (18 and older)	T1017			$12.00 per quarter unit	344 per month
Intensive Team Targeted Case Management	T1017	HK		$12.00 per quarter unit	48 per day
Specialized Therapeutic Services					
Specialized therapeutic services contributes to the maximum reduction of the recipient's disability and restoration to the best possible functional level, and include comprehensive behavioral health assessments, specialized therapeutic foster care, and therapeutic group home services provided to recipients under the age of 21 years with mental health, substance use, and co-occurring mental health and substance use disorders.					
Comprehensive Behavioral Health Assessment	H0031	HA		$12.12 per quarter hour	Max 1 per SFY, and limited to a total of 20 hours per SFY Not reimbursable for Juvenile Justice recipients
Specialized Therapeutic Foster Care, Level I	S5145			$87.30 per day	
Specialized Therapeutic Foster Care, Level II	S5145	HE		$135.80 per day	
Specialized Therapeutic Foster Care, Crisis Intervention	S5145	HK		$135.80 per day	
Therapeutic Group Care Services	H0019			$180.00 per day	Not reimbursable if the provider has been paid for the provision of the same service or type of service by another purchasing entity.
Behavioral Health Overlay Services					
Behavioral health overlay services contributes to the maximum reduction of the recipient's disability and restoration to the best possible functional level in order to avoid a more intensive level of care by providing mental health, substance abuse and supportive services designed to meet the behavioral health treatment needs of recipients in the care of Medicaid enrolled, certified agencies under contract with the Department of Children and Families, Child Welfare and Community-Based Care organization.					
Behavioral health overlay services	H2020	HA		$32.75 per day	Not reimbursable if the provider has been paid for the provision of the same service or type of service by another purchasing entity or for Juvenile Justice recipients

Attachment III: Behavioral Health Services Covered by DCF but Not Covered by Medicaid

Services Not-Covered by Medicaid				
	FY1415		FY1516	
	Clients	Units	Clients	Units
Day Care Services	80	2,360.00	106	4,394.58
Intervention	51,564	204,751.19	52,471	190,700.64
Substance Abuse Detoxification	20,159	102,502.00	18,270	87,857.00
TASC	12,962	49,813.05	10,662	46,989.49
Incidental Expenses	15,992	210,365.58	15,180	236,638.18
Aftercare/Follow-up	1,580	11,865.34	929	8,530.31
FACT Team	3,370	50,184.39	2,443	36,379.96
Room & Board w/Supervision, Level 1	218	20,953.00	96	18,160.00
Room & Board w/Supervision, Level 2	1,222	144,134.00	1,379	149,429.00
Room & Board w/Supervision, Level 3	1,131	76,669.00	1,009	85,825.00
Intervention - Group	12,509	70,848.57	8,410	103,289.71
Aftercare - Group	878	12,850.38	634	8,871.57
MH Comprehensive - Individual	8,942	40,478.35	4,510	40,704.89
MH Comprehensive - Group	92	3,753.95	34	1,000.24
Indicated Prevention	0	0	25	15,695.00

This table reflects clients served by the Department by program, who were identified as Medicaid recipients as indicated by a weekly data feed from AHCA, and the current clients estimated to be Medicaid eligible based on:

1. *with a household income at or below 133 % of the federal poverty level (for the applicable family size),*
2. *over 21 and under 65,*
3. *not pregnant.*

Attachment IV: States DSRIP Summaries

States with DSRIP programs as part of 1115 waivers to advance payment and delivery system reform are California, Kansas, Massachusetts, New Jersey, New York, and Texas. Each state falls within a common framework, but varies in program specifics and funding sources, and has been approved as a component of a larger Medicaid Section 1115 demonstration waiver.

California

California was the first state approved to implement DSRIP and has entered into a five-year renewal of its DSRIP program using the Hospital System Transformation model. The State was looking for a way to stabilize reductions in public hospital funding and providing comparable funding levels to replace its supplemental payment program. The California DSRIP was considered as part of a bridge to reform as the safety net was transitioning and transforming into a coordinated system. Over the course of the DSRIP, California's public hospitals assigned more than 500,000 individuals to a medical home or a primary care provider and entered over one million individuals into disease registries for care management purposes. Fifteen counties have a DSRIP plan, which cover all 21 eligible public hospitals (Designated Public Hospitals). Each DSRIP plan sets its own measures within a set of categories.

Kansas

The Kansas DSRIP pool was created through the approval of the Section 1115 demonstration waiver for the KanCare program, which allows special payments to certain hospitals that participated in reforms that benefit the health care delivery system widely. These hospitals must plan and implement significant system reform projects over five years that are consistent with the three-part aim CMS has for improving health care: better individual care, better population health, and lower cost through improvement. Currently, two hospitals are eligible to participate in the project. They are eligible due to their status as a large public teaching or border city children's hospital. Payments to the hospital will be funded by state funds, IGT's and federal funds.

Massachusetts

The Massachusetts DSRIP initiative, referred to as the "Delivery System Transformation Initiative" or "DSTI" within the state – has its origins in an 1115 Medicaid waiver originally approved by the federal government in the mid-1990s. The original waiver established a safety net care pool that enabled Massachusetts to dramatically expand coverage and continue supporting safety net hospitals that were significantly impacted by the growth in Medicaid membership. In more recent years, some of the funding available for safety net institutions has been incorporated into a DSRIP-type incentive payment program for selected providers implementing projects and meeting performance metrics. In order to be potentially eligible for DSRIP payments, hospitals must have both a high share of Medicaid patients and a low share of commercially-insured patients. As a result, seven hospitals within the state are eligible for DSRIP payments. In order to secure funding, they must develop projects, largely of their own choosing, and meet metrics established by internal work groups.

New Jersey

In New Jersey, the 49 DSRIP-participating hospitals focus on improving care management for common chronic conditions: asthma; behavioral health and substance use disorder; cardiac care; diabetes; HIV/AIDS; obesity; or pneumonia. Hospitals must meet requirements over four stages to receive funds. The project activities funded by the DSRIP Program will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with this DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. Hospitals qualify to receive incentive payments (DSRIP payments) for fully meeting performance and outcome metrics (as specified in this Planning Protocol, as well as the Funding and Mechanics Protocol), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care. The stages are spread out over four years and one of the eight listed conditions must be the focus.

New York

New York's DSRIP seeks to change how care is paid for and provided in the state by developing a number of Performing Provider Systems (PPSs), which are generally multi-county in size. The program was created to incentivize provider collaboration at the community level to improve care for Medicaid recipients while lowering costs and improving health. By 2020, 90 percent of managed care organization payments to providers must be value-based and emergency department visits must be reduced by 25 percent. CMS took the uncommon step of approving a 5.5-year waiver in 2014. The projects are all regional in nature and both population health and statewide measure will be used; there are no options for addressing hospital-specific operations as cross provider collaboration is required in every case. The primary goal of the waiver is to prepare providers for capitation payment, and reduce unnecessary utilization of emergency departments by 25 percent over 5 years.

Texas

Texas' waiver allows for managed care expansion to additional areas of the state and split incentive payment across 20 Regional Healthcare Partnerships (RHPs), which are generally multi-county in size. DSRIP payments to these regional provider groups are based on various outcome measures, such as the average inpatient length of stay. The five-year waiver was approved in 2011 with a strong focus on population health. Much negotiation was driven by CMS, including the focus on a regional approach and the inclusion of both public and private providers. The primary goal of the Texas waiver was to prepare hospital providers for carving inpatient care into managed care, which had historically been left out for state financing reasons. The state has relied on IGTs and state behavioral health funding as the source of the non-federal share. There have been some ongoing financing issues, with CMS recently issuing a deferral on some of the state's IGTs. DSRIP has helped alleviate the initial distrust between public and private providers in Texas by helping both provider classes realize that all providers are needed to make the safety net work.

Attachment V: Department of Children and Families Substance Abuse and Mental Health Program Office: Behavioral Healthcare Rate Comparison between the Department and Medicaid Fee-For-Service

Behavioral Healthcare Rate Comparison between the Department and Medicaid Fee-For-Service

Department of Children and Families
Substance Abuse and Mental Health Program Office

January 1, 2017

Mike Carroll
Secretary

Rick Scott
Governor

Pursuant to s. 394.761(3) and (4) F.S., the Florida Department of Children and Families submits the following analysis of rates between Department covered behavioral healthcare services and Florida Medicaid Fee-for-Service.

Analysis of DCF Services Cost Compared with Medicaid Fee-for-Service:

The Department presently has 51 covered services defined in 65E-14.021, F.A.C. A majority of these services represent direct to consumer activities such as outpatient treatment or case management, however others are related to prevention activities such as universal indirect prevention. The Department's covered services are related, but not equivalent, to services funded by other sources such as Medicaid. The principle difference in services funded by the Department and those funded by other payors is the unit of measure for each service (see Table 1).

Table 1 Department Covered Services and Units of Measure as Defined in 65E-14.021, F.A.C.

Unit of Measure	Department Covered Services
Direct Staff Hour	Aftercare Assessment Case Management Comprehensive Community Service Team Crisis Support/Emergency Day Care Day Treatment Information and Referral In-Home and On-Site Intensive Case Management Intervention Medical Services Mental Health Clubhouse Services Outpatient Prevention – Indicated Recovery Support Respite Services Substance Abuse Outpatient Detoxification Supported Employment Supportive Housing/Living Treatment Alternatives for Safer Communities
Non-Direct Staff Hour	Drop-in/Self-Help Centers Outreach Prevention – Selective Prevention – Universal Direct Prevention – Universal Indirect
Day	Crisis Stabilization Inpatient Residential Level I to IV Room and Board with Supervision Level I to III Short-term Residential Treatment Substance Abuse Inpatient Detoxification
Dollars	Incidental Expenses
Dosage	Medication-Assisted Treatment
Enrollment	Florida Assertive Community Treatment Team

Unit of measure is important because many of the Department funded services do not directly relate to a Florida Medicaid service. For example, the Department and Florida Medicaid each

pay for assessment services. However, the Department only has a single code while Florida Medicaid has 23 codes. Florida Medicaid uses the Healthcare Common Procedure Coding System (HCPCS) for tracking service events and for billing purposes. HCPCS represent is a set of standardized health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT). CPT codes describe medical, surgical, and diagnostic services. All healthcare providers that receive funding through the Centers for Medicare and Medicaid Services utilize HCPCS and CPT.

Differences between how the Department tracks and pays for services with the larger healthcare community create challenges for comparing costs and tracking service utilization in the context of treatment outcomes. For example, Florida Medicaid reimburses a maximum of two psychiatric evaluations per recipient per state fiscal year. The duration for each evaluation is not a factor in reimbursement. The Department pays for assessments based on duration. Comparing Florida Medicaid psychiatric evaluations with Department funded assessments is likely to result in an inaccurate accounting of cost and units delivered because the unit of measure between each organization are so widely different. Of the 51 covered services offered by the Department, eight services are closely related to services paid for by the Florida Medicaid Fee-for-Service schedule (see Table 2 below).

Table 2. Covered Services and Medicaid Equivalents with Service Limits[11]

COVEREDSERVICE	MEDICAID LIMITS	PROCEDURE CODE
Assessment	Two psychiatric evaluations per year	H2000HP; H2000HP GT; H2000HO
	2.5 hours of brief MSE per year	H2010HO; H2010HO GT
	Two record reviews per year	H2000
	One in-depth assessment per year	H0031HO; H0031HO GT; H0031TS; H0031TS GT; H0001HO; H0001HO GT; H0001TS; H0001TS GT
	One bio-psychosocial per year	H0031HN; H0031HN GT; H001HN; H0001HN GT
	10 hours testing per year	H2019
	Three limited functional assessments per year	H0031; H0031GT; H0001; H0001GT
Day / Night	47.5 hours or 11.9 half-days per recipient per year	H2012; H2012HF
In-Home and On-Site Services Overlay	9 hours per year	H2019HO; H2019HN
	32 hours on-site per year	H2019HM
Medical Services	4 brief individual medical psychotherapy per year	H2010HE; H2010HE GT; H2010HF; H2010HF GT
	4.5 hours of group medical therapy per year	H2010HQ
	Two medical screenings per year	T1023HE; T1023HF
	52 behavioral health services per year	H0046; H0046GT; H0047; H0047GT
	52 alcohol and drug screening specimen collections	T1015HE; T1015HF
Methadone Maintenance	52 medication-assisted treatment per year	H0020
Outpatient-Individual	26 hours of individual or family therapy per year	H2019HR; H2019HR GT
Supported Housing/Living	480 hours or 20 days per year	H2017
Outpatient-Group	39 hours of group per year	H2019HQ
Mental Health Clubhouse Service	480 hours or 20 days per year	H2030

Other services such as Crisis Stabilization or Inpatient Detoxification are covered, in limited quantity, through Managed Medical Assistance programs.

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https://www.flrules.org/gateway/readRefFile.asp?refId=3749&filename=Community%20Behavioral%20Health%20Services%20Coverage%20and%20Limitations%20Handbook_Adoption.pdf pages A1 to A10

The Department presently does not have restrictions on the number of services provided to each person served. The relevance of the Medicaid Fee-for-Service restrictions is that persons that continue to require specialized services may exhaust their Medicaid funded services and then have their services continued under a contract with a Managing Entity.

Comparison of Department Funded Services and Florida Medicaid Services

The Department received Fee-for-Service data from the Agency for Health Care Administration for State Fiscal Year 2015-16. The Florida Medicaid unit rate was taken from the Community Behavioral Health Services Coverage and Limitations Handbook. DCF unit rate was determined by taking the average Managing Entity contracted rate for State Fiscal Year 2015-16. Table 3 shows the relative difference in fees based on the nature of the service.

Table 3. Comparison of Florida Medicaid Fee-for-Service Rate and Average Managing Entity Rate for Comparable Services.

DCF Covered Service	Procedure Code and Modifiers	Service Description	Medicaid Unit Rate	DCF Unit Rate	Difference DCF (-) Medicaid
Assessment	H0001	Limited Functional Assessment, substance abuse per quarter hour	$ 15.00	$ 19.17	$ 4.17
Assessment	H0001HN	Bio-psychosocial Evaluation, substance abuse per assessment	$ 48.00	$ 76.67	$ 28.67
Assessment	H0001HO	In-Depth Assessment, new patient, substance abuse per assessment	$ 125.00	$ 76.67	$ (48.33)
Assessment	H0001TS	In-Depth Assessment, established patient, substance abuse per assessment	$ 100.00	$ 76.67	$ (23.33)
Assessment	H0031	Limited Functional Assessment, mental health	$ 15.00	$ 76.67	$ 61.67
Assessment	H0031HN	Bio-psychosocial Evaluation, mental health per assessment	$ 48.00	$ 76.67	$ 28.67
Assessment	H0031HO	In-Depth Assessment, new patient, mental health per assessment	$ 125.00	$ 76.67	$ (48.33)
Assessment	H0031TS	In-Depth Assessment, established patient, mental health per assessment	$ 100.00	$ 76.67	$ (23.33)
Assessment	H2000	Psychiatric Review of Records per review	$ 26.00	$ 76.67	$ 50.67
Assessment	H2000HO	Psychiatric Evaluation by a Non-Physician per assessment	$ 150.00	$ 76.67	$ (73.33)
Assessment	H2000HP	Psychiatric Evaluation by a Physician per assessment	$ 210.00	$ 76.67	$ (133.33)
Assessment	H2000HPGT	Psychiatric Evaluation by a Physician - Telemedicine per evaluation	$ 210.00	$ 76.67	$ (133.33)
Assessment	H2010HO	Brief Behavioral Health Status Exam per quarter hour	$ 14.66	$ 19.17	$ 4.51
Assessment	H2010HOGT	Brief Behavioral Health Status Exam - Telemedicine per quarter hour	$ 14.66	$ 19.17	$ 4.51
Assessment	H2010HQ	Brief Group Medical Therapy per quarter hour	$ 8.65	$ 19.17	$ 10.52
Assessment	H2019	Psychological Testing per quarter hour	$ 15.00	$ 19.17	$ 4.17
Day Treatment	H2012	Behavioral Health Day Services, mental health per quarter hour	$ 12.50	$ 11.12	$ (1.38)
Medical Services	H2010HE	Brief Individual Medical Psychotherapy, mental health per quarter hour	$ 15.00	$ 83.92	$ 68.92
Medical Services	H2010HF	Brief Individual Medical Psychotherapy, substance abuse per quarter hour	$ 15.00	$ 83.92	$ 68.92
Medical Services	T1015	Medication Management per event	$ 60.00	$ 335.68	$ 275.68
Medical Services	T1015GT	Medication Management - Telemedicine per event	$ 60.00	$ 335.68	$ 275.68
Medical Services	T1015HE	Behavioral Health related services: medical procedures, mental health per event	$ 10.00	$ 335.68	$ 325.68
Medical Services	T1015HF	Behavioral Health related services: medical procedures, substance abuse per event	$ 10.00	$ 335.68	$ 325.68
Medical Services	T1023HE	Behavioral Health Medical Screening, mental health per event	$ 42.62	$ 335.68	$ 293.06
Medical Services	T1023HF	Behavioral Health Medical Screening, substance abuse per event	$ 43.62	$ 335.68	$ 292.06
Medication Assisted Treatment	H0020	Medication-assisted Treatment Services Weekly Rate	$ 67.48	$ 11.69	$ (55.79)
Mental Health Clubhouse Services	H2030	Clubhouse Services per quarter hour	$ 5.00	$ 2.68	$ (2.32)
Outpatient	H2019HQ	Group Therapy per quarter hour	$ 6.67	$ 3.83	$ (2.84)
Outpatient	H2019HR	Individual and Family Therapy per quarter hour	$ 18.33	$ 15.31	$ (3.02)
Supportive Housing	H2017	Psychosocial Rehabilitation Services per quarter hour	$ 9.00	$ 14.48	$ 5.48

*NOTE: All recipients served by Florida Medicaid though Fee-for-Service providers in SFY15/16. Claims submitted and adjudicated as of 10/21/2016

Items in blue in Table 3 represent services where there is no direct equivalency in the unit of measure. For example, Florida Medicaid pays $125.00 per In-Depth Assessment, new patient, substance abuse regardless of how long the assessment takes. The Department pays based on time at an average rate of $76.17 per hour. Likewise, Florida Medicaid pays $60.00 for each Medication Management service. The Department pays $335.00 per hour for medical services which covers medication management.

Items in beige in Table 3 represent services where equivalency was established. The average Managing Entity rate is based on an hour of service. The hourly average Managing Entity rate was divided into quarter hours to compare with Florida Medicaid units of measure. For example, Florida Medicaid pays $14.66 per quarter hour of a Brief Behavioral Health Status Exam. The average Managing Entity rate of $76.67 was divided by 4 to arrive at a quarter-hour rate of $19.17.

A comprehensive review of fees payable by Florida Medicaid and the Department can be completed but will not yield accurate results at this time. Differences in units of measure complicate the analyses such that Florida Medicaid services paid for as a distinct event are not directly comparable to Department funded services paid for by duration. It is unlikely that a Medication Management event at the rate of $60.00 per event, as paid by Florida Medicaid, would cost the Department $335.68, as shown in Table 3. The Department in unable to accurately account for how many Medical Services are equivalent to T1015 Medication Management per event, and the Department is unable to determine the average length of time it takes to complete a Medication Management review. If it takes 20 minutes, then the Department rate would be $83.92 ($335.68 divided by 4). In such a scenario, the Department would pay $23.92 more than the Florida Medicaid rate. However, if it takes 10 minutes, the Department rate would be $55.95 or $4.05 less than the Florida Medicaid rate.

The comparison between the Department and Florida Medicaid rates illustrates the problem of having different units of measure. In order for the Department to better compare fee schedules with Florida Medicaid, the Department would need to adopt HCPCS codes. Adoption of such codes would require changes to 65E-14.021, F.A.C., and 394.74, F.S. In addition to allowing for true rate comparisons, the adoption of HCPCS codes will also eliminate an administrative burden on providers as they would not have to maintain one set of service codes for Department funded services and another, standardized set of codes, for all other healthcare services.

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The Implications of Medicaid Expansion in the Remaining States: 2018 Update

Matthew Buettgens

Timely Analysis of Immediate Health Policy Issues

MAY 2018

In Brief

Under the Affordable Care Act (ACA), states can expand Medicaid eligibility for nonelderly people up to 138 percent of the federal poverty level (FPL). As of March 2018, 31 states and the District of Columbia had expanded and 19 states had not. Amidst congressional efforts to repeal the ACA and recent administrative actions encouraging states to experiment with work requirements, time limits, and other previously prohibited modifications to the Medicaid program, political efforts to expand Medicaid continue in some of the states that have not done so.

We estimate the following outcomes if the remaining 19 states were to fully implement a Medicaid expansion in 2019 and all else stayed the same:

- Between 4.3 and 4.7 million fewer people would be uninsured, a reduction of between 24 and 26 percent.
- Federal spending on health care would increase by between $32.1 billion and $37.8 billion, while
- State spending on Medicaid would increase by between $2.3 billion and $3.0 billion.
- This additional state spending would fully or largely be offset by savings in other areas. Several comprehensive analyses of current expansion states have found that Medicaid expansion had a net positive impact on state budgets.

Introduction

Under the Affordable Care Act (ACA), states can expand Medicaid eligibility for nonelderly people up to 138 percent of the federal poverty level (FPL). So far, 31 states and the District of Columbia have taken that option, and 19 states have not. In the nonexpansion states, Medicaid eligibility is very limited for nondisabled, nonpregnant adults, particularly those who do not have dependent children. In nonexpansion states, uninsured people with incomes between 100 and 138 percent of FPL can qualify for tax credits to purchase coverage in the marketplaces if no member of their family has access to affordable employer-sponsored coverage, but tax credits are available to very few uninsured people with incomes below the federal poverty level.[1] Thus, many uninsured people with incomes below 138 percent of FPL in these states are caught in an assistance gap, qualifying for neither Medicaid nor tax credits to purchase marketplace coverage.

After Congress failed to repeal the ACA in 2017, efforts to expand Medicaid have continued in some nonexpansion states.[2] Maine voters approved Medicaid expansion in a November 2017 referendum, but Governor LePage has so far resisted implementation. The Virginia legislature concluded its scheduled session in March 2018 without passing a budget because of a deadlock on Medicaid expansion; as of this writing, the legislature was in a special session to resolve the deadlock.

In this report, we estimate the effects of expanding Medicaid on health care coverage and government costs in each of the nonexpansion states in 2019. Our current-law scenario reflects the latest available data on Medicaid and marketplace enrollment in each state, as well as the elimination of individual mandate penalties starting in the 2019 plan year under the Tax Cuts and Jobs Act of 2017. We assume that each nonexpansion state will see enrollment equal to the average rate expected across all current expansion states in 2019. In practice, Medicaid expansion enrollment rates have varied across states, although states that expanded Medicaid after 2014 have generally seen strong enrollment.

Our new estimates of the impact of Medicaid expansion on the number of uninsured people are different from what we published last year[3,4] and higher than estimates of the "coverage gap" published last year by the Kaiser Family Foundation.[5] The main reason for this difference is that we compare full expansion with estimates of coverage under current law in 2019. We anticipate that more people will be uninsured in 2019 than in 2016 or 2017 because of the repeal of the individual mandate penalties and because of administrative decisions that have already affected the marketplaces.[6] Kaiser's estimates of the "coverage gap" differ for three additional reasons. First, their results are based on data from a different household survey.[7] All surveys have uncertainty and measurement error, so

some differences are inevitable. Second, Kaiser only counted uninsured adults, but some uninsured children currently eligible for Medicaid would newly enroll as their parents seek coverage. Third, the "coverage gap" can be used to assess the potential impact of Medicaid expansion on the number of uninsured, it is not suited to estimates of new Medicaid enrollment resulting from expansion because not all new enrollees would otherwise be uninsured. Based on marketplace enrollment data, we project that roughly 2 million marketplace enrollees with incomes between 100 and 138 percent of FPL would become eligible for Medicaid under expansion.

Methods

The estimates in this report were produced using the Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the American Community Survey, which provides a representative sample of families that is large enough for us to produce estimates for individual states. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures project. HIPSM is designed to incorporate timely, real-world data when they are available. As described below, we regularly update the model to reflect published Medicaid and marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives.

HIPSM is unique among microsimulation models of health coverage and costs because it combines the two most common types of microsimulation decision-making in individual and family decisions: elasticity and expected utility. Decision-making follows an expected-utility framework that captures factors such as individual health risk, but we add a latent preference term for each observation that represents factors involved in observed choices that the expected-utility approach alone could not capture. These terms are set so that the model leads to each person in the data making the choice they reported in the survey, and the distribution of latent preference terms is set so that the model replicates premium elasticity targets from the literature. This approach makes it easier to simulate novel policies consistently, while calibrating the model to a wide range of real-world data, such as Medicaid and marketplace enrollment.

Our current-law ACA simulation for 2019 is based on real-world information on Medicaid and marketplace enrollment in each state from the end of the 2018 open enrollment period. The current-law simulation also eliminates the ACA's individual mandate penalties.[8] As of March 2018, no data were available on 2018 nongroup enrollment outside the marketplaces, so this was simulated by HIPSM based on the increases in nongroup premiums from 2017 to 2018 and the elimination of individual mandate penalties. Estimates for 2018 are then adjusted to 2019 for projected medical inflation and sociodemographic changes.

We simulated the changes in Medicaid enrollment that would result if the remaining states that have not expanded Medicaid were to do so. Based on enrollment data from the end of 2017 released by the Department of Health and Human Services, enrollment experiences appear to have been heterogeneous across states that have expanded Medicaid.[9] Based on enrollment data and HIPSM simulation, we estimate that around 76 percent of uninsured adults in Medicaid expansion states who gained eligibility had enrolled in Medicaid by 2017, and that this rate would decline to 73 percent by 2019 because of the elimination of individual mandate penalties.

For this report, we simulated enrollment under full Medicaid expansion for three scenarios, each assuming a uniform take-up rate across the new expansion states. We expect that 73 percent of the uninsured who gain Medicaid eligibility would enroll. Thus, expected take-up assumes that new expansion states will have the same take-up as existing expansion states under current law. We assume this rate would be 76 percent in the expected take-up scenario if new expansion states are more successful than average with outreach and enrollment assistance. We assume a rate of 70 percent in the low take-up scenario, where the elimination of individual mandate penalties affects enrollment more than expected and/or state waivers for work requirements and lifetime benefit limits reduce Medicaid enrollment. We did not model specific waivers because of the uncertainty about which states will apply, which waivers will be approved, and how waivers will be implemented.

We have recently updated our estimated Medicaid costs per person based on updated data from the 2014–2016 Medicaid Statistical Information System and data published online by state Medicaid agencies. Medicaid spending in our model is calibrated based on the most recent available state-specific estimates of per capita spending for disabled people, nondisabled adults, and nondisabled children.

There are several important sources of uncertainty surrounding the impact of Medicaid expansion. First, HIPSM is based on the American Community Survey, which, like all household surveys, contains uncertainty in the accuracy of reported income and health coverage. Second, the baseline for this analysis is current law in 2019. This must be simulated because it involves policy changes that happened within the past year or have not happened yet. In particular, individual mandate penalties will be eliminated for 2019. The most recent survey data do not reflect these changes. Simulating the impact of the elimination of individual mandate penalties involves additional uncertainty. Third, outreach and assistance activities and work requirements, lifetime benefit limits, and other conditions of Medicaid eligibility can affect enrollment. We cannot foresee what decisions each state will make, so we produced estimates for each state using the same low, expected, and high take-up assumptions.

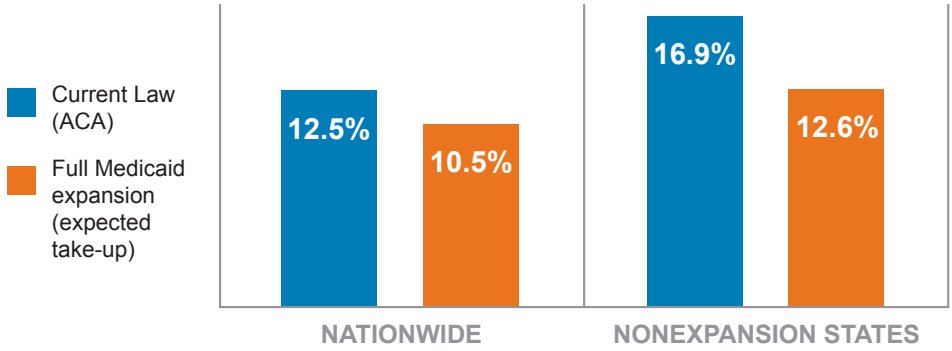
Results

Overall health coverage changes (Table 1, Figure 1). If all 19 nonexpansion states expanded Medicaid, 7.4 million more people would be expected to obtain Medicaid coverage. New Medicaid enrollment could range from 7.1 million to 8.0 million, and 4.5 million fewer people would be uninsured. Depending on enrollment, the decline in the number of uninsured people would range from 4.3 million to 4.7 million. The uninsured rate for nonelderly people in nonexpansion states would decline from 16.9 percent to 12.6 percent under expected Medicaid take-up—in other words, consistent with that observed in the current expansion states. Nationwide, the uninsured rate would decline from 12.5 percent to 10.5 percent.

Nearly 2 million of the new Medicaid enrollees would be people with incomes between 100 and 138 percent of FPL who are currently enrolled in the marketplaces with tax credits but would be transferred to Medicaid. The remainder of the new Medicaid enrollees—1.0 million people with expected take-up, 800,000 with low take-up, and 1.3 million with high take-up—would have had employer coverage or other nongroup coverage without tax credits in the absence of Medicaid expansion (data not shown).

With or without full Medicaid expansion, millions of uninsured people will be eligible for but not enrolled in assistance to make health coverage more affordable. If all states expanded Medicaid, 6.6 million uninsured people would be eligible for Medicaid or CHIP and 6.1 million would be eligible for marketplace tax credits, under our expected take-up assumptions (data not shown). These uninsured people could be reached by additional outreach efforts or enrollment assistance programs such as express-lane eligibility,[10] or they could enroll when seeking medical care.

Figure 1. Uninsured Rates With and Without Full Implementation of Medicaid Expansion 2019



Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Table 1. Health Insurance Coverage Distribution of the Nonelderly Population in Nonexpansion States, 2019

	Current Law (ACA)		Full Implementation of Medicaid Expansion								
			Lower Take-Up			*Expected Take-Up*			Higher Take-Up		
	Number of people (thous.)	Share of nonelderly population	Number of people (thous.)	Share of nonelderly population	Difference (thous.)	*Number of people (thous.)*	*Share of nonelderly population*	*Difference (thous.)*	Number of people (thous.)	Share of nonelderly population	Difference (thous.)
Insured	**88,387**	**83.1%**	**92,736**	**87.2%**	**4,349**	***92,925***	***87.4%***	***4,538***	**93,123**	**87.5%**	**4,737**
Employer	56,311	52.9%	55,658	52.3%	-653	*55,487*	*52.2%*	*-823*	55,144	51.8%	-1,166
Nongroup (with tax credits)	3,878	3.6%	1,990	1.9%	-1,888	*1,990*	*1.9%*	*-1,888*	1,990	1.9%	-1,888
Nongroup (without tax credits)	2,355	2.2%	2,188	2.1%	-167	*2,187*	*2.1%*	*-168*	2,186	2.1%	-169
Medicaid/ CHIP	21,646	20.3%	28,703	27.0%	7,057	*29,064*	*27.3%*	*7,418*	29,606	27.8%	7,960
Other (including Medicare)	4,196	3.9%	4,196	3.9%	0	*4,196*	*3.9%*	*0*	4,196	3.9%	0
Uninsured	17,991	16.9%	13,642	12.8%	-4,349	*13,453*	*12.6%*	*-4,538*	13,255	12.5%	-4,737
Total	**106,378**	**100.0%**	**106,378**	**100.0%**	**0**	***106,378***	***100.0%***	***0***	**106,378**	**100.0%**	**0**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Higher take-up = 2017 take-up rate across all current expansion states. Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate. Lower take-up = lower enrollment because of greater effect of the loss of the mandate and/or state waivers.

Medicaid enrollment by state (Table 2). Under current law, Medicaid and CHIP would cover roughly 20 percent of nonelderly people in the 19 nonexpansion states in 2019, and Medicaid enrollment rates would vary by state because of differences in the states' income distributions and Medicaid eligibility rules. The states with the highest shares of nonelderly people enrolled in Medicaid (22 percent or more) would be Maine, Mississippi, Tennessee, North Carolina, South Carolina, Alabama, and Florida. In Maine and Tennessee, Medicaid eligibility extends to parents with incomes up to 105 percent and 98 percent of FPL, respectively—much higher than the Medicaid income limits in most other nonexpansion states.[11] We project that Virginia, Wyoming, Utah, Nebraska, and Kansas will have the lowest shares of nonelderly people enrolled in Medicaid or CHIP (less than 15 percent).

If all 19 remaining states expanded Medicaid, each state except Wisconsin, Maine, and Tennessee would see Medicaid enrollment increase by 30 percent or more in the expected take-up scenario. In Wisconsin, all adults with incomes up to 100 percent of FPL are already eligible for Medicaid, and Maine and Tennessee have high eligibility limits for parents. The two highest percent increases in Medicaid enrollment would be in states where an unusually low share of the population is currently enrolled: Wyoming and Utah.

Table 2. Medicaid Enrollment in Nonexpansion States, 2019

State	Current Law (ACA)		Full Implementation of Medicaid Expansion		
			Expected Take-Up		
	Number of people (thousands)	Share of nonelderly population	Number of people (thousands)	Difference	Percent difference
Alabama	928	22.7%	1,242	314	33.8%
Florida	3,639	22.5%	5,001	1,362	37.4%
Georgia	1,873	19.9%	2,599	726	38.8%
Idaho	299	20.5%	418	119	40.0%
Kansas	383	15.3%	512	129	33.7%
Maine	259	25.1%	314	56	21.5%
Mississippi	664	26.7%	874	210	31.6%
Missouri	1,028	20.1%	1,380	352	34.2%
Nebraska	234	14.7%	320	86	36.6%
North Carolina	2,079	23.8%	2,705	626	30.1%
Oklahoma	695	20.5%	927	233	33.5%
South Carolina	906	22.5%	1,218	312	34.5%
South Dakota	125	17.3%	168	43	34.5%
Tennessee	1,435	25.8%	1,817	381	26.6%
Texas	4,726	19.4%	6,412	1,685	35.7%
Utah	371	13.2%	529	158	42.6%
Virginia	983	13.0%	1,406	423	43.0%
Wisconsin	956	19.9%	1,132	176	18.4%
Wyoming	63	12.7%	91	27	43.1%
Total	**21,646**	**20.3%**	**29,064**	**7,418**	**34.3%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

Change in the number of uninsured people by state (Table 3, Table 4). We project that 16.9 percent of nonelderly people in nonexpansion states will be uninsured in 2019 under current law. Uninsurance rates vary across states because of differences in income distribution, Medicaid eligibility rules, prevalence of employers offering employer-based insurance, state and other organizational involvement in marketplace outreach and enrollment assistance, health care costs, and other factors. Uninsured rates under current law will vary from 9.1 percent in Wisconsin (which has already expanded Medicaid for adults with incomes up to 100 percent of FPL) to 21.8 percent in Texas. Texas, Oklahoma, Georgia, and Mississippi would have the highest uninsured rates (18 percent or higher).

If all nonexpansion states expanded Medicaid under the ACA, the number of uninsured people would decline by 25.2 percent with expected take-up. Individual states would see declines ranging from 19.7 percent in Wyoming to 33.9 percent in Mississippi. The uninsurance rate across these 19 states would fall from 16.9 percent to 12.6 percent of the nonelderly population with expected take-up. Only three states would have uninsured rates above the 19-state average: Texas (17.2 percent), Oklahoma (15.2 percent), and Georgia (13.8 percent). Wisconsin, Maine, Tennessee, Missouri, Nebraska, and Idaho would have uninsured rates in the single digits.

Table 3. Uninsured Rate in Nonexpansion States, 2019

State	Current Law (ACA)	Full Implementation of Medicaid Expansion	
		Expected Take-Up	
		Number	Percentage Point Difference
Alabama	17.5%	12.5%	-5.0%
Florida	15.7%	11.1%	-4.5%
Georgia	18.9%	13.8%	-5.0%
Idaho	14.6%	9.9%	-4.7%
Kansas	14.5%	11.2%	-3.3%
Maine	11.6%	8.3%	-3.3%
Mississippi	18.0%	11.9%	-6.1%
Missouri	14.1%	9.8%	-4.3%
Nebraska	12.4%	9.6%	-2.8%
North Carolina	16.3%	12.2%	-4.2%
Oklahoma	19.7%	15.2%	-4.5%
South Carolina	16.4%	11.6%	-4.8%
South Dakota	15.1%	11.5%	-3.5%
Tennessee	13.8%	9.9%	-3.9%
Texas	21.8%	17.2%	-4.6%
Utah	13.3%	10.5%	-2.7%
Virginia	14.2%	10.9%	-3.3%
Wisconsin	9.1%	6.9%	-2.2%
Wyoming	15.7%	12.6%	-3.1%
Total	**16.9%**	**12.6%**	**-4.3%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

Table 4. Uninsured People in Nonexpansion States, 2019 (thousands of people)

State	Current Law (ACA)	Full Implementation of Medicaid Expansion		
		Expected Take-Up		
		Number	Difference	Percent difference
Alabama	715	510	-205	-28.7%
Florida	2,532	1,798	-734	-29.0%
Georgia	1,778	1,305	-473	-26.6%
Idaho	213	144	-69	-32.3%
Kansas	363	280	-83	-23.0%
Maine	120	86	-34	-28.1%
Mississippi	448	296	-152	-33.9%
Missouri	723	503	-220	-30.4%
Nebraska	197	152	-45	-22.7%
North Carolina	1,430	1,065	-365	-25.5%
Oklahoma	668	515	-153	-22.9%
South Carolina	660	466	-194	-29.3%
South Dakota	109	83	-25	-23.3%
Tennessee	769	552	-216	-28.1%
Texas	5,304	4,180	-1,124	-21.2%
Utah	373	297	-76	-20.4%
Virginia	1,069	823	-247	-23.1%
Wisconsin	441	333	-108	-24.5%
Wyoming	78	63	-15	-19.7%
Total	**17,991**	**13,453**	**-4,538**	**-25.2%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

Table 5. Federal Spending on Medicaid, CHIP, and Marketplace Tax Credits in Nonexpansion States, 2019 ($ million)

State	Current Law (ACA)	Full Implementation of Medicaid Expansion		
		Expected Take-Up		
		Spending	Difference	Percent Difference
Alabama	5,009	6,549	1,540	30.7%
Florida	23,380	27,329	3,949	16.9%
Georgia	10,697	13,711	3,015	28.2%
Idaho	1,981	2,648	667	33.7%
Kansas	1,985	2,505	519	26.2%
Maine	1,939	2,090	151	7.8%
Mississippi	4,411	5,716	1,305	29.6%
Missouri	8,182	10,218	2,036	24.9%
Nebraska	1,864	2,095	231	12.4%
North Carolina	15,155	19,167	4,012	26.5%
Oklahoma	4,724	5,828	1,105	23.4%
South Carolina	5,185	6,524	1,339	25.8%
South Dakota	784	1,022	238	30.3%
Tennessee	9,541	10,327	786	8.2%
Texas	29,219	39,076	9,858	33.7%
Utah	3,618	4,369	751	20.8%
Virginia	6,852	8,961	2,110	30.8%
Wisconsin	5,355	6,099	744	13.9%
Wyoming	567	661	94	16.6%
Total	**140,447**	**174,895**	**34,448**	**24.5%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

Federal spending on Medicaid, CHIP, and marketplaces (Table 5 and Figure 2). Without any new Medicaid expansions, the federal government would spend $140.4 billion on Medicaid, CHIP, and marketplace coverage for nonelderly people in nonexpansion states in 2019. If these states expanded Medicaid eligibility, federal spending would rise to $174.9 billion, a 24.5 percent increase under our expected take-up rate assumptions. But depending on actual take-up, the increase in federal spending could range from $32.1 billion to $37.8 billion, or from 22.9 percent to 26.9 percent.

Nonexpansion states with the lowest increases in federal spending have a few distinguishing features:

1. **Higher-than-average current Medicaid eligibility limits for parents.** We have already discussed Medicaid eligibility in Wisconsin, Maine, and Tennessee. Wyoming and Nebraska also have higher-than-average Medicaid eligibility limits for adult parents, covering those with incomes up to 55 percent and 63 percent of FPL, respectively.[11]

2. **High marketplace enrollment** (Nebraska, Wyoming, and Florida) leading to a larger federal cost offset, as those with incomes between 100 and 138 percent of FPL transition from marketplace tax credits to Medicaid.

3. **Low current uninsured rates** (Wisconsin, Maine, Nebraska).

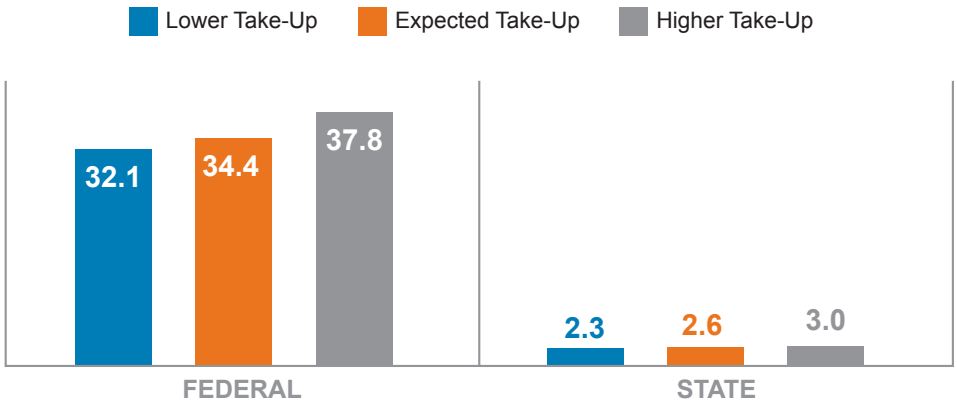
The opposite characteristics—lower parent Medicaid eligibility limits, lower marketplace tax credit savings, and higher current uninsured rates—lead to larger increases in federal spending. For example, Texas has the highest uninsured rate and is tied for the largest increase in federal spending.

State spending on Medicaid and CHIP (Table 6 and Figure 2). Under current law, nonexpansion states will spend $62.2 billion on Medicaid and CHIP acute care for the nonelderly in 2019. If these 19 states expanded Medicaid eligibility, state spending on Medicaid would rise by $2.6 billion, or 4.2 percent. Depending on enrollment, the increase in state spending could range from $2.3 billion to $3.0 billion, or from

3.7 percent to 4.8 percent. The expected 4.2 percent increase in state Medicaid costs is small, despite the projected 34.3 percent increase in Medicaid enrollment, because the federal government would pay 90 percent of the costs for newly eligible Medicaid enrollees (a higher share than that paid for the traditional Medicaid-eligible population). However, this increase overestimates the effect of Medicaid expansion on state budgets because states would see additional savings that would at least partially offset additional spending. Evidence from the expansion states for which comprehensive analyses are available indicates that Medicaid expansion had a net positive budgetary impact.

In Wisconsin, state spending on Medicaid and CHIP would decline after Medicaid expansion (4.0 percent under expected take-up) because the federal government would pay a higher share of the costs

Figure 2. Difference in Federal and State Medicaid Spending with Full Medicaid Expansion, 2019 ($ billions)



Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Higher take-up = 2017 take-up rate across all current expansion states. Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate. Lower take-up = lower enrollment because of greater effect of the loss of the mandate and/or state waivers.

Table 6. State Spending on Medicaid and CHIP in Nonexpansion States, 2019 ($ millions)

State	Current Law (ACA)	Full Implementation of Medicaid Expansion		
		Expected Take-Up		
		Spending	Difference	Percent Difference
Alabama	1,683	1,780	97	5.7%
Florida	9,577	9,763	187	2.0%
Georgia	3,927	4,172	246	6.3%
Idaho	569	608	39	6.9%
Kansas	1,050	1,108	58	5.5%
Maine	859	884	25	3.0%
Mississippi	1,441	1,535	93	6.5%
Missouri	3,998	4,099	101	2.5%
Nebraska	768	804	36	4.7%
North Carolina	5,673	5,785	112	2.0%
Oklahoma	1,921	2,038	117	6.1%
South Carolina	1,631	1,742	111	6.8%
South Dakota	490	512	22	4.5%
Tennessee	3,776	3,967	191	5.0%
Texas	16,707	17,692	984	5.9%
Utah	975	1,042	67	6.9%
Virginia	4,207	4,401	193	4.6%
Wisconsin	2,666	2,559	-107	-4.0%
Wyoming	304	319	15	4.9%
Total	**62,222**	**64,808**	**2,586**	**4.2%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

of some existing Medicaid enrollees. Wisconsin is currently receiving the standard 58.77 percent federal matching rate for nondisabled adults with incomes up to 100 percent of FPL.[12] If the state expanded Medicaid, the federal government would pay 90 percent of the costs of adult nonparents in this group, in addition to paying 58.77 percent of the costs of adult parents. The state's savings on nondisabled, nonparent adults more than outweighs the additional costs of new enrollees.

Potential reductions in uncompensated care spending (Table 7). Uncompensated care has declined in Medicaid expansion states.[13,14] However, the financing of uncompensated care is very complex and varies widely across states. Reductions in spending on uncompensated care may require changes to state law, which means that reduced demand for uncompensated care may not automatically translate into lower state spending. Because of this uncertainty, we focus on estimating the overall differences in demand for uncompensated care resulting from increased enrollment in Medicaid and fewer uninsured people, instead of forecasting the savings for each state.

Without any new Medicaid expansions, uncompensated care for uninsured people in nonexpansion states would total $35.5 billion in 2019. We estimate that the federal government will fund $14.2 billion of this total, state and local governments $8.9 billion, and health care providers $12.4 billion.[15]

If all the nonexpansion states expanded Medicaid, the demand for uncompensated care in these 19 states would decline by $8.0 billion under expected take-up (estimates range from $7.8 billion to $8.4 billion). The federal government would potentially save $3.2 billion, state and local governments $2.0 billion, and providers $2.8 billion. This is only one of several state cost offsets for Medicaid expansion.

Discussion

If all 19 nonexpansion states fully implemented the Medicaid expansion, 4.5 million more people would be enrolled in health coverage in 2019, reducing the nonelderly uninsured rate in those states from 16.9 percent to 12.6 percent, and reducing the national uninsured rate from 12.5 percent to 10.5 percent. With full expansion, 6.6 million uninsured people nationwide would be eligible for but not enrolled in Medicaid, and 6.1 million uninsured people would be eligible for marketplace premium tax credits, leaving room for additional outreach and enrollment activities to lower the uninsurance rate further.

The resulting increase in Medicaid enrollment would increase federal spending on health care financial assistance by an estimated $34.4 billion. This increase in spending on health care could have positive impacts on the economies of the affected states, particularly in states running at less than full employment. For example, a recent study in Montana found that Medicaid expansion led to an additional $350 to $400 million circulating in the state's economy each year, supporting 5,000 jobs and $280 million in personal income.[16]

If all the nonexpansion states expanded Medicaid, these states' spending on Medicaid would increase by $2.6 billion—but that does not account for the full budgetary impact. Medicaid expansion could yield savings in other areas:

- $2.0 billion in potential savings on state and local spending on uncompensated care
- Higher federal matching rates for beneficiaries who, without expansion, would have been covered through pre-ACA Medicaid eligibility categories[17]
- Increased tax revenue from increased economic activity produced by increased federal Medicaid spending on health care within the state
- Increased revenue from state taxes on health care providers and/or health coverage premiums
- Lower demand for non-Medicaid state-funded programs for uninsured low-income people (not counted as uncompensated care)

A recent study covering all expansion states found that as of 2015, "there were no significant increases in

Table 7. Uncompensated Care in Nonexpansion States by Payer, 2019 ($ millions)

	Current Law (ACA)	Full Implementation of Medicaid Expansion					
		Lower Take-Up		*Expected Take-Up*		*Higher Take-Up*	
		Spending	Difference	*Spending*	*Difference*	Spending	Difference
Federal government	14,200	11,100	-3,100	*11,000*	*-3,200*	10,800	-3,400
State/local government	8,900	6,900	-2,000	*6,900*	*-2,000*	6,800	-2,100
Health care providers	12,400	9,700	-2,700	*9,600*	*-2,800*	9,500	-2,900
Total	**35,500**	**27,700**	**-7,800**	***27,500***	***-8,000***	**27,100**	**-8,400**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Higher take-up = 2017 take-up rate across all current expansion states. Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate. Lower take-up = lower enrollment because of greater effect of the loss of the mandate and/or state waivers.

spending from state funds as a result of the expansion."[18] Comprehensive analyses of the budget impact of Medicaid expansion concluded that, on balance, Medicaid expansion yielded net state budget gains in the following states: Arkansas,[19] Alaska,[20] California,[19] Colorado,[21] the District of Columbia,[19] Kentucky,[22] Maryland,[19] Michigan,[19] New Jersey,[23] New Mexico,[24] Oregon,[19] Pennsylvania,[19] Washington State,[25] and West Virginia.[19] Ten of these studies covered calendar year 2020 and beyond, when federal Medicaid funding for expansion will reach its final (and lowest) 90 percent matching rate. Eight of the ten studies found that the impact on the state budget would be positive throughout this period. Two analyses projected eventual net budget losses, but these results may not be generalizable to other states.[26]

Several states are seeking changes to their Medicaid programs such as work requirements and lifetime benefit limits.[27] There is tremendous uncertainty about which states will ultimately submit such waivers, what the proposals will look like, what will be approved, and how the policies will be implemented. However, such waivers would reduce Medicaid enrollment, making our low take-up scenario more likely.

The research shows that, compared with nonexpansion states, Medicaid expansion states have seen larger declines in the number of uninsured people, lower uncompensated care, economic benefits from additional health care spending, and net gains to state budgets. There is also evidence that state cost increases resulting from higher caseloads are outweighed by state savings and revenue growth caused by expansion in most states with available data. Most states with relevant analyses expect net fiscal gains, even after states begin paying 10 percent of expansion costs. Our estimates suggest that the remaining 19 nonexpansion states would see similar benefits if they expanded Medicaid eligibility.

NOTES

1 The law was written anticipating that all states would expand Medicaid eligibility under the ACA, so it limited premium tax credits to the population above the poverty level. The Supreme Court's decision in *National Federation of Independent Business v. Sebelius* (2012) effectively made the ACA's Medicaid expansion voluntary for states. The only adults with incomes below 100 percent of FPL who are eligible for marketplace premium tax credits are lawfully present immigrants who would otherwise be eligible for Medicaid but have not yet completed the requisite five-year waiting period for benefits. Also, people with incomes between 100 and 138 percent of FPL who are ineligible for marketplace premium tax credits because a family member has an offer of affordable coverage would be eligible for Medicaid if their state expanded.

2 For more on how recent administrative actions would affect health coverage, see: Blumberg LJ, Buettgens M, Wang R. Updated: the potential impact of short-term limited duration policies on insurance coverage, premiums, and federal spending. Washington: Urban Institute; 2018. https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending.

3 Buettgens M, Kenney GM. What if more states expanded Medicaid in 2017? Changes in eligibility, enrollment, and the uninsured. Washington: Urban Institute; 2017. https://www.urban.org/research/publication/what-if-more-states-expanded-medicaid-2017-changes-eligibility-enrollment-and-uninsured.

4 Dorn S, Buettgens M. The cost of not expanding Medicaid: an updated analysis. Washington: Urban Institute; 2017. https://www.urban.org/research/publication/cost-not-expanding-medicaid-updated-analysis.

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7 Specifically, Kaiser's estimates are based on the Current Population Survey. The data underlying HIPSM are based on the American Community Survey, and HIPSM simulation results replicate the latest available estimates of the uninsured population from the National Health Interview Survey.

8 For details on how HIPSM simulates the ACA's individual mandate, see: Blumberg LJ, Buettgens M, Wang R. Updated: the potential impact of short-term limited duration policies on insurance coverage, premiums, and federal spending. Washington: Urban Institute; 2018. https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending.

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10 Centers for Medicare & Medicaid Services. Re: express lane eligibility option. Baltimore: Centers for Medicare & Medicaid Services; 2010. https://www.medicaid.gov/federal-policy-guidance/downloads/sho10003.pdf.

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12 Federal financial participation in state assistance expenditures; federal matching shares for Medicaid, the Children's Health Insurance Program, and aid to needy aged, blind, or disabled persons for October 1, 2017 through September 30, 2018. *Fed Regist.* 2016;81(220):80078–80080.

13 Dranove D, Garthwaite C, Ody C. The impact of the ACA's Medicaid expansion on hospitals' uncompensated care burden and the potential effects of repeal. New York: Commonwealth Fund; 2017. http://www.commonwealthfund.org/publications/issue-briefs/2017/may/aca-medicaid-expansion-hospital-uncompensated-care.

14 Antonisse L, Garfield R, Rudowitz R, Artiga S. The effects of Medicaid expansion under the ACA: updated findings from a literature review. Menlo Park, CA: Kaiser Family Foundation; 2018. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/. See also the state-specific analyses cited in the Discussion section.

15 These proportions are based on analysis of uncompensated care in 2013: Coughlin TA, Holahan J, Caswell K, McGrath M. *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*. Menlo Park, CA: Kaiser Family Foundation; 2014. https://www.urban.org/research/publication/uncompensated-care-uninsured-2013.

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25 Dorn S, Francis N, Rudowitz R, Snyder L. The effects of the Medicaid expansion on state budgets: an early look in select states. Menlo Park, CA: Kaiser Family Foundation; 2015. http://files.kff.org/attachment/issue-brief-the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states.

26 New Mexico's analysis projects net state budget gains until state fiscal year 2020–2021, when a small net adverse budget impact is anticipated. Reynis notes that his revenue estimates are conservative. In Alaska, net state budget losses are forecast starting in federal fiscal year 2017. Alaska does not have sales or individual income taxes, so the analysis by Evans and colleagues concluded that state general revenue would not be affected by expansion-generated economic activity. Every other state collects sales taxes, individual income taxes, or both, so these fiscal conditions in Alaska do not apply to nonexpansion states. Lee C, Pome E, Beleacov M, Pyon D, Park M. *State Government Tax Collections Summary Report: 2014, Economy-Wide Statistics Brief: Public Sector*. Washington: US Census Bureau; 2015. https://www2.census.gov/govs/statetax/G14-STC-Final.pdf. Even Alaska collects corporate income tax, but Evans and colleagues did not estimate the impact of expansion on such tax revenues.

27 As of March 2018, work requirement waivers had been approved for Arkansas, Kentucky, and Indiana; see: Luhby T. Thousands of Arkansas Medicaid recipients must start working in June. *CNN Money*. March 5, 2018. http://money.cnn.com/2018/03/05/news/economy/arkansas-medicaid-work-requirements/index.html. No waivers for lifetime benefit limits have been approved, but Maine, Arizona, Utah, Wisconsin, and Kansas have applied for them; see: Weixel N. Trump officials face decision on lifetime limits for Medicaid. *The Hill*. February 13, 2018. http://thehill.com/policy/healthcare/373544-trump-officials-face-decision-on-lifetime-limits-for-medicaid.

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https://www.healthcarefinancenews.com/news/repeat-emergency-department-users-changed-how-they-used-eds-after-gaining-medicaid-coverage

Jun 27 More on Policy and Legislation

Repeat emergency department users changed how they used EDs after gaining Medicaid coverage

Patients in Medicaid expansion states shifted their ED usage toward more critical injuries and illnesses.

Jeff Lagasse, Associate Editor

The Affordable Care Act expanded health insurance coverage, including eligibility for Medicaid, and states have the ability to decide whether to expand eligibility for Medicaid coverage. As of earlier this year, 36 states and the District of Columbia had adopted Medicaid expansion, and other states are still debating whether to do so.

Against this background, a new study seeks to determine how the nature of visits to emergency departments changed for previously uninsured patients who gained Medicaid insurance expansion under the ACA in 2014, and who went to the ED at least once before and once after expansion.

It found that compared with patients who remained uninsured in states where Medicaid was not expanded, these patients shifted their use of the ED toward conditions that required subsequent hospitalization, and predominantly for illnesses that were not easily avoided by robust outpatient care.

The study, by researchers at Carnegie Mellon University and U.S. Acute Care Solutions, appears in Medical Care Research and Review.

WHAT'S THE IMPACT

The findings suggest that newly insured patients may be relying more on outpatient care for less severe conditions, affecting utilization by avoiding unnecessary ED visits -- effectively freeing up hospital EDs for their intended purpose.

The researchers looked at data on patient visits from 30 EDs in seven states -- Illinois, Nevada, North Carolina, Ohio, Oklahoma, Rhode Island and West Virginia -- from April 2013 through September 2015. Of these seven states, 19 EDs were in five states (Illinois, Nevada, Ohio, Rhode Island, West Virginia) that expanded Medicaid in January 2014, and 11 were in two states (North Carolina and Oklahoma) that did not expand Medicaid before the end of 2015. ED visits in the facilities examined are comparable to ED visits nationally.

Visits to the ED were nearly 29% more likely to result in hospital admission for newly insured patients in expansion states, compared with those visiting the ED who remained uninsured in non-expansion states.

Researchers also found a similar increase, 31 percent, for conditions for which hospital admissions may not be avoided by robust treatment in an outpatient setting. The authors point to these findings as important for the patients studied because using the ED for less severe conditions is of particular concern.

One of the implications is that ending Medicaid expansion may increase the use of EDs for less severe cases, negatively affecting ED efficiency when it comes to treating critically ill patients, a trend both policymakers and clinicians would rather avoid.

THE LARGER TREND

Among private health plan enrollees in recent years, there has been a substantial shift from EDs to urgent care centers when it comes to patients receiving care for low-acuity conditions, at least according to a 2018 Brigham and Women's Hospital study.

Treatment for new health problems, or acute care visits, encompass over one-third of all ambulatory care delivered in the U.S. Given the high costs of EDs, many insurance plans have created incentives to encourage patients to receive that care elsewhere.

In response to patient expectations for more convenience, and to long wait times at traditional physician outpatient practices, alternative care facilities such as urgent care centers, retail clinics, and telemedicine have rapidly emerged.

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The Effect of Medicaid Expansion on the Nature of New Enrollees' Emergency Department Use

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Abstract

We examine changes in emergency department (ED) visit acuity and care intensity for uninsured patients who gained Medicaid insurance in 2014 under the Patient Protection and Affordable Care Act. We use 2013-2015 longitudinal patient visit-level data from 30 EDs across 7 states from an emergency medicine group. We examine changes in ED use by previously uninsured Medicaid patients and patients remaining uninsured who were repeat ED users ($\geq$1 visit before and after expansion) using a propensity-score weighted approach with statistical machine learning to estimate the weights. Compared with those remaining uninsured in nonexpansion states, newly covered Medicaid patients in expansion states showed a 29% relative increase in hospital admissions and 32% increase in admissions for nonambulatory care sensitive conditions with no increases in care intensity. Obtaining Medicaid insurance increased the relative proportion of ED visits requiring hospital admission suggesting increased outpatient access for low-acuity conditions previously addressed with ED care.

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Introduction

With nearly one in five of the country's nonelderly population having no health insurance in 2010, a major focus of the Patient Protection and Affordable Care Act of 2010 (ACA) was to expand health insurance coverage (Gruber, 2011). One of the ACA's key provisions expanded eligibility for Medicaid insurance, the public insurance program for low-income Americans. The original ACA required all states to expand Medicaid eligibility in 2014 to all able-bodied adults with ≤138% income relative to the federal poverty level ($16,245 for an individual in 2015 dollars) (Kaiser Family Foundation, 2012). Subsequently, a Supreme Court ruling left Medicaid expansion to the discretion of states (Kaiser Family Foundation, 2015a, 2015b). As of February 2019, 36 states and the District of Columbia have adopted Medicaid expansion, while 14 states have not, mostly concentrated in the Southeast and Central United States.

Considerable political divisions exist on the perceived value and impact of Medicaid expansion on health care utilization and there are active ongoing policy changes. Medicaid expansion was on the ballot in a number of states in the 2018 midterm elections, where voters in Idaho, Nebraska, and Utah approved ballot referendums for expansion, while voters in Montana rejected a proposal to make Medicaid expansion permanent (Galewitz, 2018). Maine's newly elected governor implemented Medicaid expansion in January 2019, which was overwhelmingly approved by the state's voters through a ballot initiative in 2017 (Meyer, 2019). Finally, a recent federal court ruling in Texas struck down as invalid all provisions of the ACA, including Medicaid expansion (Goodnough & Pear, 2018). These legislative and judicial efforts and the number of people affected by the legislation highlight the importance of empirical findings on the impacts of Medicaid expansion, particularly in settings like emergency departments (ED), which are perceived to be high cost.

One concern regarding Medicaid expansion is its potential to increase ED use among the newly insured, as had occurred in two prior state-level expansions (Taubmam et al., 2014; Smulowitz, O'Malley, Yang, & Landon, 2014; Nikpay et al., 2017). Similarly, in Anderson, Dobkin, and Gross (2014), the authors study young adults who lose their health insurance after turning 23, and found the transition led to a decrease in ED visits. These results were hypothesized to occur due to the lower cost to the patient of always accessible ED care with insurance relative to being uninsured. Moreover, barriers to outpatient care often remain for those with Medicaid insurance as providers may not accept Medicaid patients, making the ED an easier or the only option for care (Centers for Disease Control and Prevention, 2015; Decker, 2011). On the other hand, these outpatient barriers are certainly lower for Medicaid beneficiaries than for the uninsured, as outpatient providers are not required to provide care to the uninsured and typically do not. In Antwi, Moriya, Simon, and Sommers (2015), the

authors study young adults who remain as dependents on their parents' private health plans until age 26 years under the ACA's dependent coverage provision, and found a statistically significant yet modest decrease in ED use compared with a slightly older comparison group. This study suggests that some use of EDs could decrease, in particular ED use that was the result of insufficient access to outpatient care.

In a study of ED visits to over 500 hospitals, Pines et al. (2016) dispelled concerns that newly insured Medicaid patients would flood into EDs. Using data on early results from the 2014 natural experiment that some states did and did not expand Medicaid under the ACA, aggregate ED use was found not to have increased in Medicaid expansion states compared with nonexpansion states. Two factors were hypothesized to underlie this finding. First, in 2014, there was "payment parity" where primary care providers were paid Medicare rates, and new Medicaid patients may therefore have had better than usual access to outpatient care relative to earlier state-level expansions. Second, the newly insured covered under the 2014 Medicaid expansion may have been different than other Medicaid patients, specifically they had relatively higher incomes and thus may have patterns of health care use that rely less on EDs regardless of insurance status.

In a recent study by Xu et al. (2018), the authors study one of the states that expanded Medicaid, Maryland, and compare changes in ED utilization between matched uninsured and insured adult Maryland residents who visited an ED in the preexpansion period. Relative to those with any kind of health insurance at baseline, those who start out uninsured were found to increase their ED use, with most of the increase for high-acuity visits, meeting the rates for the insured. The finding that this increase was driven primarily by higher acuity visits and those leading to admissions is broadly consistent with the hypotheses proposed by Pines et al. (2016) that payment parity for Medicaid services might have limited increases in ED visits relative to earlier state-level Medicaid expansions. The Xu et al. (2018) study, however, assesses changes at the time of Medicaid expansion along with other ACA-related policies on all ED visiting uninsured, those who gained insurance (Medicaid/commercial) or remained uninsured in the post–insurance expansion period, and not just on those who gained Medicaid coverage under the ACA. Their comparison group also comprised patients insured at baseline in the same state—a very different demographic from those who were uninsured. Apart from focusing on just one state (which expanded Medicaid), the study does not assess the effect of gaining Medicaid insurance for those who gain it, relative to their remaining uninsured.

The Pines et al. (2016) study was limited in that it only examined aggregate visit volumes and did not assess changes in the nature of ED use among those individuals newly gaining Medicaid coverage. If greater access to outpatient care was the mechanism for the lack of observed aggregate increase in ED visits, we would expect the newly insured to use EDs for relatively more serious conditions, while relying on primary care providers for lower acuity health care needs. If the lack of aggregate increase in ED use under the ACA was due to those newly eligible for Medicaid having different health care use patterns that rely less on ED care, regardless of insurance coverage, we would expect to see similarly infrequent use of the ED for low-acuity care both before and after they gained Medicaid coverage.

New Contributions

In this study, we use longitudinal patient-/visit-level data to examine the acuity and intensity of ED visits of previously uninsured people in Medicaid expansions states who gained Medicaid insurance in 2014 compared with similar patients who remained uninsured in states that did not expand Medicaid coverage. The target population is a specific subgroup of patients: Those who visited the ED multiple times in the study period, at least once while uninsured before expansion and at least once after expansion and under Medicaid. We acknowledge that this is a selective group and also a group of considerable policy interest among those concerned about overuse of the ED (Althaus et al., 2011; LaCalle & Rabin, 2010). Our analysis is focused on evaluating changes in the nature of these patients' ED use (and not their number of ED visits). In our study, we were able to link individual patients' ED visits to the same facility over time enabling us to track changes in individual patient's behavior as they switch from uninsured to Medicaid or remain uninsured. The ability to track individual patients who newly gained Medicaid coverage under the expansion over time distinguishes this study by enabling us to utilize each patient's preexpansion uninsured ED use as an internal control for their postexpansion ED use, and to compare changes in use over time for a comparable uninsured population from nonexpansion states.

Study Data and Methods

The main data source for this study was patient visit–level data from a national emergency medicine group which staffs 101 hospital-based EDs across 16 U.S. states.[1] The data included unique patient identifiers allowing us to link visits for the same patient over time to the same ED. Thus, we were able to track visits by a patient to the same facility over time. We analyzed visits from April 1, 2013 to September 30, 2015 by patients aged 18 to 64 years to 30 facilities in 7 states—Illinois, Nevada, Ohio, Rhode Island, West Virginia, North Carolina, and Oklahoma.[2] We selected these seven states on the basis of continuity of longitudinal data availability (before and after January 1, 2014 when Medicaid expansion went into effect) and having similar preexpansion Medicaid eligibility income limits. We detail the criteria for selecting these states in Table A.1 in the appendix (supplemental material available online). We defined "treatment" facilities as those in the states which expanded Medicaid on January 1, 2014. In our sample, these were 19 EDs in Illinois, Nevada, Ohio, Rhode Island, and West Virginia. "Control" facilities were those in states that did not expand Medicaid any time before the end of 2015. These were 11 EDs in North Carolina and Oklahoma. The study was approved by the institutional review board at Carnegie Mellon University.

We studied patients who visited the ED facilities in the 7 selected states at least once in the "preexpansion period" (April 1, 2013 to December 31, 2013) and at least once in the "postexpansion period" (January 1, 2014 to September 30, 2015). This inclusion criterion enabled us observe changes in patients' insurance status over time. "Treatment" group patients were those in expansion states who visited the ED while

uninsured in the preexpansion period and who visited the ED with Medicaid insurance in the postexpansion period. "Control" group patients were those in nonexpansion states who visited the ED while uninsured in both the preexpansion and the postexpansion periods.

For each visit, we used data on patient demographics—age, gender, and zip code; and on visit characteristics—diagnosis codes (ICD-9), relative value units (RVUs)—a marker of visit intensity, disposition, payments, charges, and primary insurance type. While we did not have access to specific patient income data (the key criteria for Medicaid eligibility), we were able to link zip-code-level household median income and percentage of uninsured among the age 18- to 64-year-old population, from the 2009 to 2013 5-Year American Community Survey (ACS) file,[3] with patient zip code of residence. To address external validity, we compared the EDs in our data with nationally representative data. For this purpose, we made use of Emergency Department summary tables from the National Hospital Ambulatory Medical Care Survey (NHAMCS)[4]—an annual nationally representative sample survey of visits to EDs.

Outcome Variables

Our unit of analysis was the patient-time period, where the time period was defined as being before or after Medicaid expansion. The outcome variables were proxies for high acuity and intensity of ED visits: proportion of a patient's visits in the postexpansion period which led to hospital admissions, proportion of a patient's postexpansion visits which led to admissions and were for nonambulatory care sensitive conditions, average probabilities of postexpansion visits being "emergent and unavoidable," and average RVUs per visit (where averages are over multiple visits for the same patient in the postexpansion year when a patient has more than one visit) (Proctor, 2012). We used ED visit ICD-9 diagnosis codes to assess if ED visits were for "ambulatory care sensitive conditions" (ACSCs). The Agency for Healthcare Research and Quality has defined a list of ACSCs, which are conditions "for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease."[5,6] To evaluate the "emergent" nature of an ED visit, we used the New York University Emergency Department visit severity algorithm (Billings, Parikh, & Mijanovich, 2000). The algorithm uses the primary ICD-9 diagnosis code to assign each visit a probability of falling into one of four categories: nonemergent; emergent/primary care treatable; emergent (ED care needed) but preventable/avoidable; and emergent (ED care needed), not preventable/avoidable. Figure A.1 in the appendix provides a visual depiction of the classification process. RVUs are an administrative measure of visit intensity and complexity.

Statistical Analysis

We first examined trends in total monthly ED visits, by payer type, separately for treatment and control EDs in our analytic sample. This served to demonstrate the extent to

which the "treatment" of expanding Medicaid was taken up by those using the ED and to compare the general pattern of ED utilization in this study to that in previously cited literature. We then compared summary statistics of all visits with the EDs in our analysis sample in the "pre" period with those of a nationally representative sample of patients with ED visits using the 2013 ED summary tables from the NHAMCS. We also compared visits in the "post" period with those of a sample from the 2014 ED summary tables from the NHAMCS to assess if national trends after expansion are in line with trends at the facilities in our sample. These comparisons address the external validity of our analytic sample. We then focus our primary analysis at the patient level.

Propensity-Score Weighting Using Boosted Regression Trees. We defined control patients as those uninsured in both the pre- and postexpansion periods who visited EDs in states that did not expand Medicaid. This group provides an estimate of what the time trend in ED usage would have been for those gaining Medicaid, in states that did expand Medicaid, if they had instead remained uninsured. As shown in Appendix Figure A.2, the demographics and medical diagnoses of the uninsured treatment and control patients in the preexpansion period were generally similar while there were some differences in the distributions of the acuity of ED visits.

To address this, we used a machine learning approach to reduce potential bias in the treatment effect estimates by weighting the control patients to obtain a close approximation to the joint distribution of covariates of our treatment patients (Haviland, Eisenberg, Mehrotra, Huckfeldt, & Sood, 2016). Because the goal of the procedure was to balance the full joint distribution, if successful, it removed reliance on the particular specification of covariates in the outcome model. The propensity score weights stood in for the set of potentially complex nonlinear interactions required to obtain balance in the joint distribution of covariates for the patients.

To construct the propensity score weights, we used the statistical machine learning methodology generalized boosted regression (implemented in a streamlined version of the R package TWANG). Using generalized boosted regression in this context can be preferable to the more commonly estimated logit model for two reasons. First, generalized boosted regression fits highly flexible models incorporating potentially complex interactions of the covariates, leading to weights that produce better balance on the full joint distribution rather than just the marginal for each variable individually (McCaffrey, Ridgeway, & Morral, 2004). Second, this method produces a distribution of weights that is less extreme and hence less able to cause variance inflation, a well-known problem with the logit (Lee, Lessler, & Stuart, 2011).

We balanced treatment and control groups on covariates most likely to determine their Medicaid eligibility (treatment) and type of ED use (outcomes): patient demographics (age, gender) and detailed characteristics of ED visits preexpansion (number of visits, average RVU of visits, proportion of visits which led to admissions/discharges/transfers, Multilevel Clinical Classification Software codes associated with the visits, proportion of emergent/nonemergent visits, proportion of visits which led to non-ACSC admissions, and proportion of visits which were unreimbursed).

Empirical Model

We sought to identify the average effect of enrollment in Medicaid after the ACA expansion went into effect on the nature of previously uninsured ED visiting patients' subsequent ED use. We used the following patient-level propensity-score weighted lagged dependent variable (LDV) outcome model to estimate the average effect of Medicaid expansion on the new enrollees. Specifically, we estimate the differential changes in ED usage behavior between treatment and control patients:

$$Y_{post,i} = \beta_0 + \beta_1 Expansion_i + \beta_2 Y_{pre,i} + \beta_3 Age_i + \beta_4 Female_i + \beta_5 Inc_i + \beta_6 PctUn_i + \epsilon_i \quad (1)$$

Here, $Y_{post,i}$ was the outcome variable of interest for patient i in the postexpansion period. $Expansion_i$ was the indicator for treatment state—it equals 1 if the patient obtained Medicaid coverage in the postperiod and visits a facility in a state which expanded Medicaid on January 1, 2014, and 0 otherwise. The treatment effect was captured by β_1. $Y_{pre,i}$ was the value of the outcome variable of interest in the preexpansion period. Age_i was the age of the patient averaged over all their visits in the sample and was a continuous variable. $Female_i$ was a 0/1 indicator. Inc_i was the zip-code-level median income based on patient residence. $PctUn_i$ was the zip-code-level percentage of 18- to 64-year olds who are uninsured. We clustered the standard errors at the facility level. We run the outcome models in STATA using the clustered sandwich estimator, where the standard errors allow for intragroup correlation within facility, relaxing the usual requirement that the observations be independent. We cluster the errors at the facility level instead of the state level to account for correlation of care practices and coding practices at the ED level and patient correlation related to living in proximity to the ED.

In a simulation study, LDV model has been demonstrated to produce the most efficient and least biased estimates when the unconditional parallel trends assumption is violated (O'Neill, Kreif, Grieve, Sutton, & Sekhon, 2016). As we are not able to track preexpansion ED use before April 2013, this model serves as an attractive estimation approach in our setting. Furthermore, it has been proven in early propensity score literature that including pretreatment covariates in the outcome model in addition to weighting to obtain balance on the same covariates provides "double robustness," whereby the outcome regression model results are unbiased if either the outcome model or the propensity score model are correctly specified (Bang & Robins, 2005; Ho et al., 2007; Hullsiek & Louis, 2002; Stuart, 2010). As a robustness check, we also estimate the effects using a weighted difference-in-differences model.

One source of potential bias in our analysis was the possibility that among those who are uninsured but newly eligible for Medicaid, sicker patients preferentially obtained Medicaid insurance. Thus, even while we weighted the control group patients to match the treatment group patients on the joint distribution of their preexpansion clinical and demographic characteristics, if our treatment group patients enrolled in Medicaid because they were sicker in ways that are not observable from prior ED

visits, we may observe an upward bias in our estimates. To address this possibility, we performed a robustness analysis using the same regression model as in Equation (1) to estimate the effect of expansion on patients potentially eligible for Medicaid expansion, by redefining our treatment and control groups. In this analysis, "Treatment" group patients were those in expansion states who were uninsured in the preexpansion period and were uninsured or had Medicaid insurance in the postexpansion period. "Control" group patients were those in nonexpansion states who were uninsured in the preexpansion period and were uninsured or had Medicaid insurance in the postexpansion period. As before, we weighted our redefined "control" group to match the joint distribution of the preexpansion characteristics of the "treatment" group. Thus, if this selection bias was present, our redefined "treatment" group now included individuals who would have been eligible for Medicaid under the ACA but chose not to enroll as they were not "sick enough," along with the ones not eligible under the ACA expansion. This in turn would suggest that rates of high-acuity ED use for the presumed healthier nonswitching patients added to the original "treatment" group should be similar to or lower than for the "controls" (who were a mix of healthy and unhealthy). Under this scenario, the estimates of the average effect on the potentially eligible patients (AEP) are a weighted average of the positive estimate of the average effect on the switching patients (AES) and at most a zero estimate for the nonswitching patients resulting in a maximum result of the AES * take-up rate (proportion of switchers). We compared our AEP estimate with this expected result.

Another concern was the possibility that the overall pool of patients visiting facilities in expansion states might be systematically different than the pool visiting those in nonexpansion states. To address this, we ran a falsification test using a similar empirical model as in Equation (1) but on patients enrolled in Medicare, whose eligibility requirements did not change during the study period. Here the "treatment" and "control" group patients were Medicare patients who visited at least once before and after expansion in expansion and nonexpansion states, respectively.

We also note that we cover a limited number of states in our sample. As discussed earlier, this was largely because we restricted our analysis to states which had similar preexpansion eligibility limits for Medicaid. We had access to data from an additional 18 ED facilities which are in five states which expanded Medicaid in January 2014 (namely Arizona, California, Connecticut, Hawaii, New York), but which we excluded in our primary analysis as some of them already had some income-based eligibility limits for nonelderly able-bodied adults (Table A.1 in the appendix details criteria) and one other (CA) which expanded Medicaid prior to January 2014 in some of their counties. We performed robustness checks by using a similar empirical model as in Equation (1) and included these 18 facilities in the 5 states mentioned above in this sample.

Results

Facility-Level Trends

Figure 1 depicts the trends in insurance status of all patients visiting the included EDs through the period of Medicaid expansion, April 2013 to September 2015. We

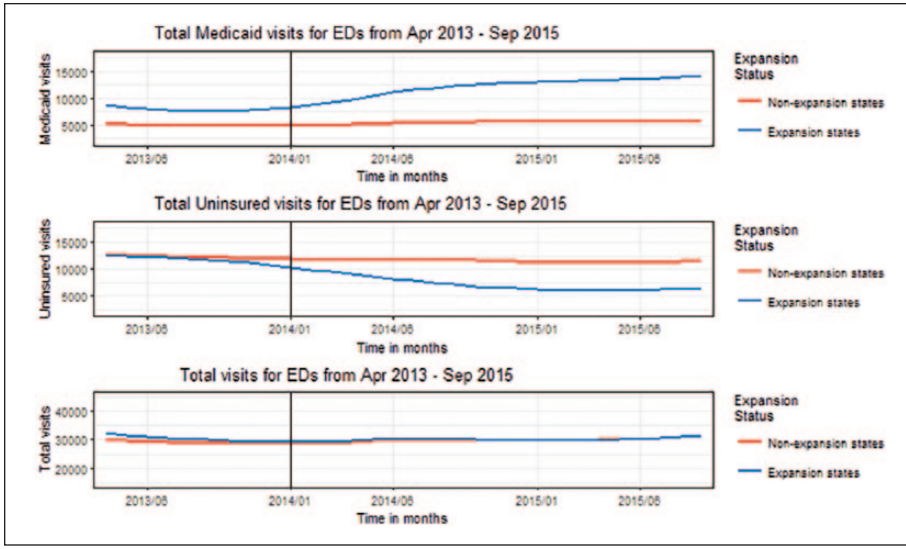

Figure 1. Facility-level emergency department (ED) visit trends during Medicaid expansion.
Note. Authors' analysis of monthly visits using data from 30 ED facilities across 7 U.S. states, April 2013 through September 2015.

observe a sharp increase in Medicaid covered visits and a decline in uninsured visits after expansion went into effect that occurs only in expansion states. These trends are consistent with findings from Pines at al. (2016) showing strong take-up of Medicaid by ED users where Medicaid expansion occurred. EDs in this study were notably not the same ones used for the Pines et al. (2016) study. Our findings also span an additional 9 months into 2015. Also consistent with the prior study, no substantial change in the total number of ED visits in either treatment or control facilities is observed.

Descriptive Statistics on Patient Visits

Table 1 presents descriptive statistics for all visits to the EDs in the analysis sample in the year 2013 compared with data from the nationally representative 2013 NHAMCS. In general, the diagnoses and demographics of those visiting the EDs in our analysis sample are similar to those seen in ED visits nationwide. One exception is the difference in payment source. The percent of uninsured visits to the ED facilities in our sample exceeds that in the national survey data by almost 13% and the percentage of commercial visits in the sample is correspondingly smaller. As our focus is on the pre-ACA uninsured population, having a larger number of them in the EDs in our data relative to EDs nationally is an advantage to evaluate a treatment effect in our study. In Table A.2 in the appendix, we perform a similar comparison using 2014 data from the NHAMCS ED Summary Tables and find similar trends.

Table 1. Comparison of 2013 Visits in the Data Set With the 2013 National Hospital Ambulatory Medical Care Survey (NHAMCS).

	% Distribution of visits, sample	% Distribution of visits, NHAMCS
A: Comparison on selected patient characteristics		
Age (years)		
<15	11.2	18.2
15-24	15.4	15.1
25-44	32.6	27.5
45-64	24.7	23.3
≥65	16.1	15.9
Sex		
Female	56.8	56.0
Payment source		
Medicaid	24.6	34.1
Medicare	21.5	19.6
Commercial	22.3	36.0
Self-pay	28.9	15.1
Others	2.6	5.6
B: Comparison on primary diagnosis codes		
Infectious and parasitic diseases	2.2	2.8
Neoplasms	0.1	0.1
Endocrine, nutritional, metabolic diseases, and immunity disorders	2.0	1.5
Mental disorders	2.4	3.6
Diseases of the nervous system and sense organs	4.0	5.0
Diseases of the circulatory system	4.2	3.4
Diseases of the respiratory system	9.5	10.9
Diseases of the digestive system	5.9	6.3
Diseases of the genitourinary system	6.3	5.2
Diseases of the skin and subcutaneous tissue	4.3	3.7
Diseases of the musculoskeletal system and connective tissue	7.7	7.2
Symptoms, signs, and ill-defined conditions	23.8	22.6
Injury and poisoning	23.3	21.4
Supplementary classification	1.2	2.5
All others	3.2	3.0

Note. The 2013 sample comprises 1.249 million visits to 30 facilities across the 7 states in our sample: Illinois, North Carolina, Nevada, Ohio, Oklahoma, Rhode Island, and West Virginia. Data for the 2013 NHAMCS survey is available at https://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2013_ed_web_tables.pdf

Table 2. Comparison Between Treatment and Control Group[a] Patients Before Medicaid Expansion.

		Control group	
	Treatment group	After weighting	Before weighting
Number of patients	7,822	12,826.71[b]	20,873
Average age	38.62	38.27	36.12
Proportion of patients female	0.55	0.55	0.50
Average no. of visits	1.60	1.62	1.90
Average RVU of visits	3.58	3.54	3.47
Proportion of visits which led to hospital admission	0.15	0.14	0.07
Proportion of visits which led to non-ACSC admissions	0.12	0.12	0.06
Proportion of emergent and unavoidable visits	0.14	0.14	0.12

Note. RVU = relative value unit; ACSC = ambulatory care sensitive conditions. Authors' analysis of treatment and control group patients using data from 30 emergency department (ED) facilities across 7 U.S. states, April 2013 through December 2013.

[a]Treatment group patients were those in expansion states who visited the ED while uninsured in the preexpansion period and who visited the ED with Medicaid insurance in the postexpansion period. Control group patients were those in nonexpansion states who visited the ED while uninsured in both the preexpansion and the postexpansion periods. [b]This is the effective sample size of the control group, after weighting. It gives an estimate of the number of control group patients that are comparable to the treatment group after weighting.

Table 2 compares control and treatment group patients in the preexpansion period on demographic and visit-level characteristics before and after the control group is propensity score weighted. Here, the effective sample size (ESS) of the weighted control group is approximately the number of observations from a simple random sample that yields an estimate with sampling variation equal to the sampling variation obtained with the weighted comparison observation (Ridgeway, McCaffrey, Morral, Burgette, & Griffin, 2014). It gives an estimate of the number of control group patients that are comparable to the treatment group after weighting. On average, in the preperiod, treatment group patients are somewhat more likely to be female, older, visit the same ED fewer number of times, have higher visit intensity (based on average RVUs/visit), have higher rates of visits which led to admissions, and have higher rates of "emergent" and unavoidable preexpansion visits. The propensity score weighting was successful in making the control group comparable to the treatment group on all preexpansion characteristics. We present the detailed weighting criteria and show the full unadjusted (preweighting) and adjusted (postweighting) covariate balance in Table A.3 in the appendix. We perform graphical diagnoses as shown in Figure A.2 in the appendix using cobalt (Greifer, 2018) in R (R Core Team, 2018) to assess the balance and do not use hypothesis tests that incorporate information on the sample size

Table 3. Average Effect on the Switching Patients: Results on Measures of High-Acuity and High-Intensity Use.

	Proportion of visits which led to hospital admission	Proportion of visits which led to non-ACSC admissions	Proportion of emergent and unavoidable visits	Average RVUs/visit
Newly covered by Medicaid (vs. those remaining uninsured)[a]	0.043** (0.018)	0.038** (0.016)	0.010 (0.007)	0.055 (0.067)
No. of patients	28,223	28,223	28,223	28,222
Average treatment group values before Medicaid	0.15	0.12	0.14	3.58
% Change[b]	28.7	31.7	7.1	1.5
95% CI for % change	[4.7, 52.7]	[4.2, 60]	[−2.9, 17.1]	[−2.4, 5.4]

Note. RVU = relative value unit; ACSC = ambulatory care sensitive conditions. Authors' analysis of patient-level emergency department (ED) use using data from 30 ED facilities across 7 U.S. states, April 2013 through September 2015. Standard errors in parentheses are clustered at the facility level *$p < .1$, **$p < .05$, ***$p < .01$. These are propensity score weighted ordinary least squares models where the dependent variable is patient-level outcome variable in the postexpansion period. Controls: age, sex, zip-code-level median income, zip-code-level percentage uninsured, value of outcome variable of interest in preexpansion period.

[a]This is the β_1 coefficient associated with the $Expansion_i$ indicator in Equation (1). Those newly covered by Medicaid were in expansion states, while the comparison group remained uninsured and visited EDs in nonexpansion states. Median income and percentage uninsured in zip code were sourced from the 2009 to 2013 American Community Survey 5-Year Estimates. [b]Percentage change and the 95% confidence intervals are calculated using average treatment values before Medicaid expansion as the denominator.

(e.g., *t*-tests) as measures of balance, as recommended in Stuart (2010), as they can be misleading as measures of balance because they often conflate changes in balance with changes in statistical power.

Patient-Level Regression Results

Table 3 summarizes the effects of gaining Medicaid coverage on measures of high-acuity ED use. Those patients who gained Medicaid coverage had increases of 4.3 percentage points ($p < .05$) in the proportion of visits resulting in hospital admissions relative to control patients. Relative to the base rate of 15% of ED visits resulting in admission to the hospital in the preperiod, this represents a nearly 29% increase. Compared with the control group, those who gained Medicaid coverage also had increases of 3.8 percentage points ($p < .05$) in the proportion of visits which led to admissions for "non-ACSCs." Relative to the base rate of 12% of ED visits resulting in admission to the hospital for a health condition that was not ambulatory care sensitive in the preperiod, this represents a nearly 32% increase. For our other proxy measures of high-intensity ED use: proportion of unavoidable "emergent" visits and the

average RVUs/visit, the point estimates for the coefficients of interest were positive, but not statistically significant. We observe negative, but statistically insignificant, differences in measures of low-acuity visits, the proportion of nonemergent visits and emergent but primary care treatable visits. These results along with changes in individual Multi-level Clinical Classification Software codes are detailed in Tables A.4 and A.5 in the appendix. Due to the modest number of clusters in our analysis sample (30 EDs), effect sizes needed to be fairly large for us to have the power to detect them. Table A.6 in the appendix details the results of the traditional difference-in-differences model specification. We note that our estimates are of a similar magnitude and significance as that of the weighted LDV model. One concern is the number of clusters (facilities) and their unbalanced nature which might lead to over rejection of the null (Cameron & Miller, 2015). To mitigate that concern, we run our models using the pairs bootstrap clustering method. Because of complications involved with weighting, we compare our unweighted estimates from the sandwich cluster method to that from bootstrap clustering, and found the results to have similar statistical significance. Results are shown in Table A.7 in the appendix.

Table 4 summarizes the AEP, when we compare the outcome measures of the redefined groups. We observe that for the outcomes with statistically significant AES findings, our coefficients of interest are in the same direction as in the original outcome model and reduced substantially less than what the take-up rate in the "treatment" group would suggest (where we would expect them to be reduced more if the potential bias were present). The AEP estimates are marginally statistically significant with an increase of 3.1 percentage points ($p < .1$) in the proportion of visits resulting in hospital admissions, and 2.7 percentage points ($p < .1$) in the proportion of visits which led to admissions for "non-ACSCs." We note the increases in the number of observations within clusters (EDs), but the same number of clusters results in effectively unchanged power for the AEP and AES analyses. These results are suggestive that our findings of an increase in high-acuity visits in expansion compared with nonexpansion states are robust to the potential source of bias of unobservably sicker patients enrolling in Medicaid. Detailed results are shown in Table A.8 in the appendix.

In our falsification analysis on patients continually enrolled in Medicare, we do not observe any statistically significant differences between our "treatment" and "control" group patients on the outcome measures described above. This mitigates potential concerns about the pool of patients visiting facilities in expansion states being systematically different than the pool visiting those in nonexpansion states. Results are shown in Table A.9 in the appendix.

For our analysis where we included visits to 18 additional facilities in the five states (Arizona, California, Connecticut, Hawaii, New York) we previously excluded from our analysis, we observe that the point estimates of our coefficients of interest are in the same direction as in the original outcome model. The estimates are marginally statistically significant with an increase of 3.1 percentage points ($p < .1$) in the proportion of visits resulting in hospital admissions, 2.8 percentage points ($p < .1$) in the proportion of visits which led to admissions for "non-ACSCs," and 1 percentage point ($p < .1$) in the proportion of unavoidable "emergent" visits. The drop in effect size is

Table 4. Average Effect on the Potentially Eligible Patients: Results on Measures of High-Acuity and High-Intensity Use.

	Proportion of visits which led to hospital admission	Proportion of visits which led to non-ACSC admissions	Proportion of emergent and unavoidable visits	Average RVUs/visit
Patients in expansion states (vs. those in nonexpansion)[a]	0.031* (0.016)	0.027* (0.015)	0.006 (0.006)	0.005 (0.062)
No. of patients	40,975	40,975	40,975	40,972
Average "treatment group" values before Medicaid	0.13	0.11	0.14	3.53
% Change[b]	23.9	24.6	4.3	1.4
95% CI for % change	[−1.5, 50]	[−3.6, 52.7]	[−5, 13.6]	[3.4, 3.7]

Note. RVU = relative value unit; ACSC = ambulatory care sensitive conditions. Authors' analysis of patient-level emergency department (ED) use using data from 30 ED facilities across seven U.S. states, April 2013 through September 2015. Standard errors in parentheses are clustered at the facility level *$p < .1$, **$p < .05$, ***$p < .01$. These are propensity score weighted ordinary least squares models where the dependent variable is patient-level outcome variable in the postexpansion period. Controls: age, sex, zip-code-level median income, zip-code-level percentage uninsured, value of outcome variable of interest in preexpansion period.

[a]This is the β_1 coefficient associated with the $Expansion_i$ indicator in Equation (1). The modified "treatment group" patients were in expansion states and were uninsured in the preexpansion period and remained uninsured or switched to Medicaid insurance postexpansion, while the "control group" patients were similar patients in nonexpansion states. Median income and % uninsured in zip code were sourced from the 2009 to 2013 American Community Survey 5-Year Estimates. [b]Percentage change and the 95% confidence intervals are calculated using average treatment values before Medicaid expansion as the denominator.

expected as now our "treatment" group also includes relatively more well-off individuals (as these new states already had some degree of coverage for the poorest able-bodied adults), whose inclusion potentially dilutes the expansion effect. Detailed results are in Table A.10 in the appendix.

Discussion

In the complex health care landscape of the United States, EDs occupy a unique position and have been the focus of a number of interventions and studies to assess their use, particularly for low-acuity conditions that could potentially be treatable elsewhere (Ragin et al., 2005; Trueger et al., 2017). Our study finds that gaining Medicaid coverage under the ACA shifts previously uninsured patients toward using the ED for conditions that were more likely to result in hospital admission and in admissions for nonambulatory sensitive conditions than the same patients had been using the ED for previously, compared to trends for those who remained uninsured in nonexpansion states.

This study is the first to our knowledge to demonstrate that individual patients gaining Medicaid coverage under the ACA shifted their ED use toward visits for higher

acuity conditions. Moreover, this is the first study that follows individual patients gaining Medicaid insurance through the 2014 Affordable Care Act Medicaid expansion and compares their changes in ED use to patients who are similar in their baseline ED use and remain uninsured in states not expanding Medicaid. Our results are broadly consistent with Xu et al. (2018) despite their estimation of a different parameter, use of an insured rather than uninsured comparison group with different baseline ED use, and focus on one state. The effect size in our study was large—specifically ED encounters were nearly 29% more likely to result in hospital admission in expansion states, compared with those visiting the ED who remained uninsured in nonexpansion states. We also find an increase of similar magnitude (nearly 32%) in admissions for non-ACSCs. This is a particularly important finding for the repeat ED user population studied here, for whom low-acuity ED use is especially of concern.

An explanation for these results is that newly insured Medicaid patients' access to outpatient care may have been relatively improved. Hence, they may seek lower acuity care elsewhere, more often using the ED for truly "sick" care. This is consistent with the findings of a previous study regarding reduction in low-acuity ED use among young adults gaining private insurance coverage by being just under versus just above the age cutoff for obtaining health insurance coverage through their parents' plans under the ACA (Antwi et al., 2015). This is also consistent with findings in Roberts and Gaskin (2015) that adults with Medicaid coverage have (on average) higher visits per year to primary care providers than low-income adults without Medicaid. Our study also confirmed prior studies showing that despite clear take-up of Medicaid in expansion states, aggregate ED use did not disproportionately increase in expansion relative to nonexpansion states (Pines et al., 2016). Our confirmatory finding extends to the first 9 months of 2015 and in a different sample of facilities.

We note two other potential explanations of these findings. First is that admission and related decisions in the ED may be influenced by patient insurance status changing from uninsured to Medicaid (Kindermann, Mutter, Houchens, Barrett, & Pines, 2015). However, federal law—Emergency Medical Treatment and Labor Act—requires all EDs and emergency physicians working in EDs to treat and stabilize patients to the capability of the facility regardless of insurance status (Centers for Medicare & Medicaid Services, 2014). This law is likely to limit the extent to which care choices in the EDs are affected by insurance status. Second, there is a concern that Medicaid-managed care network arrangements could influence their Medicaid enrollees to use EDs at different hospitals than those in our data set. Medicaid is required to fully cover ED costs at any hospital if it is determined that the need for care was an emergency. If it is determined that the need for care was not an emergency, there can be nominal cost sharing, which can vary by state (American College of Emergency Physicians, 2018; Siddiqui, Roberts, & Pollack, 2015). There is no evidence, however, that this cost sharing differs for EDs in different hospitals (e.g., by network status), thus helping mitigate this concern.

One possible reason for the different results here than in Oregon, where those gaining Medicaid coverage increased ED use by 40% for both high- and low-acuity conditions, is the Medicaid Parity Demonstration Program (Finkelstein et al., 2012; Taubman

et al., 2014). This program increased the amount Medicaid paid for primary care visits to Medicare payment levels for just the first year of Medicaid expansion. This may have resulted in greater than usual gains in access to primary care for those newly obtaining Medicaid coverage under the ACA relative to Oregon's lottery-based expansion. It is also possible that there were psychological effects of winning access to Medicaid coverage via a lottery versus obtaining it through federal legislation that affected subsequent health care use patterns (Haisley, Mostafa, & Loewenstein, 2008).

It is unclear if gains in access to outpatient care that may have led to reductions in low-acuity ED use will persist now that the Parity program has ended. In our sample, only Nevada continued with higher primary care fees in 2015 (Snyder, Paradise, & Rudowitz, 2014). Recent work on access to outpatient care during the first two years of the ACA Medicaid expansions continued to find increased access during the second year of implementation, but also with longer wait times for appointments, which suggests that some challenges in access to outpatient care reemerged (Miller & Wherry, 2017). Therefore, future work is needed to confirm that increased use of outpatient care for repeat ED users gaining Medicaid coverage is the reason for shifts in the nature of ED use and to understand how this evolves over time as parity payment levels change in some states.

For hospitals, our findings suggest that more hospital resources may be required to care for Medicaid-insured populations per visit after Medicaid expansion, particularly as care shifts to patients requiring more ED and hospital resources, including inpatient beds. Therefore, the changing nature of ED use after insurance expansions has implications for resource planning in these facilities. From a policy perspective, understanding the impact of the ACA's Medicaid expansion is important considering that there remains significant political controversy on the perceived value of Medicaid expansion. Our finding that repeat users are shifting their ED use to care for higher acuity conditions suggests that on this dimension the Medicaid expansion is doing what it was intended to do: move ED use to those who really need it and improve the efficiency of health care delivery. This shift in ED use may have been enabled by better outpatient management for acute and chronic conditions, lowering acute exacerbations of ambulatory sensitive conditions in this population.

Limitations

As study subjects were not randomized, our results could have been affected by selection bias on unobserved factors—the treatment and control group patients could be dissimilar in ways we cannot observe. In particular, the lack of patient-specific income data means we could not definitively ascertain if the uninsured control patients would have been eligible for Medicaid if they were in the treatment states. However, our robust weighting and regression control strategy mitigated this bias to the extent that the rich set of observables in our models—demographics, preexpansion ED visit clinical and payment information, and zip-code-level characteristics—proxy for patient income and other potential unobserved confounders. Future research should consider taking into account heterogeneity in Medicaid patient acceptance rates of primary care

physicians in specific locations and studying how this affects local ED use. Furthermore, our findings may not be generalizable beyond the specific subgroup of patients studied: repeat ED users. Our analysis was enabled by our ability to track patient visits within the same facility but limited in that this tracking was not available across facilities. The Billings algorithm for classification of emergent and nonemergent visits has well-known limitations (Raven, Lowe, Maselli, & Hsia, 2013). In particular, the algorithm leaves a significant proportion of visits unclassified. To that end, we examine other measures of visit acuity: proportion of visits which led to admissions, proportion of visits which led to admissions for non-ACSCs, and visit intensity: RVUs/visit. Furthermore, while in Table A.5 in the appendix we see changes in the case-mix for some clinical categories for which patients present to the ED after gaining Medicaid access, future work could also examine why specific sets of conditions might have changed after expansion. Finally, this study had modest power to detect impacts due to the clustering of patients within a limited number of EDs. Because of this limitation, the hypotheses we failed to reject in this study deserve additional study with greater numbers of EDs.

Conclusion

Our study suggests that the impact of Medicaid expansion on previously uninsured repeat ED users' subsequent ED utilization was to increase the proportion of ED visits for higher acuity conditions. Specifically, individuals who acquired Medicaid insurance after being uninsured presented more often to the ED for conditions that required hospitalization after their ED visit and hospitalizations for nonambulatory care sensitive conditions. Our findings suggest that ending Medicaid expansion may increase low-acuity use of EDs for those who lose insurance and reduce the efficiency of EDs for their intended design: to take care of critically ill and injured patients that require acute services.

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Notes

1. Not every ED in the database is hospital based. Some may be free standing. There are 101 facilities across all years in the database. In any particular year, the number of EDs would be lower as facilities get added and subtracted as contracts change. The 16 states are: Arizona, California, Connecticut, Hawaii, Illinois, Kentucky, Michigan, North Carolina, New Hampshire, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, and West Virginia.
2. We restricted our analysis to visits after April 1, 2013 as we were unable to link patient IDs before this date.
3. The ACS is an ongoing survey that provides data every year—giving communities the current information they need to plan investments and services. The ACS covers a broad range of topics about social, economic, demographic, and housing characteristics of the U.S. population (https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2013/5-year.html)
4. The NHAMCS is designed to collect data on the utilization and provision of ambulatory care services in hospital emergency and outpatient departments and ambulatory surgery locations. Findings are based on a national sample of visits to the EDs, outpatient departments, and ambulatory surgery locations of noninstitutional general and short-stay hospitals (https://www.cdc.gov/nchs/data/nhamcs/web_tables/2014_ed_web_tables.pdf)
5. Agency for Healthcare Research and Quality. Prevention Quality Indicators Overview (http://qualityindicators.ahrq.gov/Modules/pqi_resources.aspx).
6. ACSC visits are determined using a mix of visit diagnosis and procedure codes. Since we do not have access to the procedures that admitted patients underwent, we only use the visit diagnosis codes for classification.

Supplemental Material

Supplemental material for this article is available online.

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From:	Anne Swerlick
To:	edrcoordinator
Subject:	Follow Up Resources to July 12th Meeting
Date:	Monday, July 22, 2019 12:06:25 PM
Attachments:	image001.png GeorgetownREport2012.pdf Revenue Maximization Plan 123016.pdf

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Dear FEIC Members,

In follow up to the FIEC's discussion on July 12th, we are providing the following additional resources and information.

Mental Health/Substance Abuse Savings

The attached Georgetown study conservatively projects $250 million in annual savings for mental health and substance abuse services even after backing out significant state funding for maintenance of safety net services.

Likewise DCF's revenue maximization report (attached) also highlights ways that the state could free up GR by drawing down more federal Medicaid dollars. (see excerpt below) However, with expansion the state would be eligible for a 90% federal match for services provided to the newly eligible rather than the 60% referenced below.

> "There are approximately 132,940 individuals currently being served by DCF who meet the eligibility criteria specified above. The DCF is currently spending general revenue funding on this population to provide both Medicaid covered services and non-Medicaid covered services. If directed to extend Medicaid eligibility for individuals contending with SMI or SUD as described above, the receipt of federal matching funds for services provided to this population will free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services through DCF."

The DCF report also recognizes that this freed up GR could be used to fund new costs for additional medical and dental services which would now be available to "new eligibles" under expansion.

With expansion, FPI projects that the state would see as much as $200.4 million of savings, ***even after backing out the cost of the 10% match for those mental health/ substance abuse program participants who are newly eligible***. This figure is based on 2016 data and is likely to be higher today. Savings are projected using AHCA 2018/19 MMA Capitation rates for SSI SMI Ages 14+. A weighted average across all regions of $1,328.48 PMPM was used. The cost of converting these adults into coverage under Medicaid expansion has been deducted from the savings

Also, as noted in the DCF report, additional savings through expansion could be gleaned if the state opted to eliminate service limits on some Medicaid covered services, enabling the state to replace GR dollars currently funding these services with federal dollars. This includes targeted case management, assessment services, individual therapy, day treatment and substance abuse inpatient hospital services. (see DCF report, pp. 30-31).

Study Shows that Expansion Enrollees Spend Less and Use Less Care Than Adults Previously Eligible

We also urge the FIEC to review the Health Affairs article available at the link below pertaining to the costs of newly eligible enrollees. The researchers reviewed 2012-2014 data from the Medical Expenditure Panel Survey to compare health care spending and utilization of newly eligible enrollees with those of non- disabled adults who were previously eligible and enrolled. Their analysis found evidence of lower spending and utilization for newly eligible Medicaid enrollees compared with those previously eligible and enrolled. Specifically average monthly expenditures for the newly eligible were 21 percent less.
https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0252?journalCode=hlthaff;
As you complete your fiscal analysis of the proposed constitutional amendment, we appreciate your consideration of these additional resources.

Sincerely,

Anne Swerlick

Senior Health Policy Analyst & Attorney
www.fpi.institute
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FLORIDA POLICY INSTITUTE
Common sense ideas for Florida's future.

Florida's Medicaid Choice:
Understanding Implications of Supreme Court Ruling on Affordable Health Care Act

Key Points *As a result of the recent U.S. Supreme Court ruling, Florida must decide whether or not to extend Medicaid coverage to persons with incomes below 133 percent of the federal poverty level – a decision that has significant consequences:*

- *An estimated 800,000 to 1,295,000 uninsured adults and children in Florida will gain coverage if the state moves forward.*
- *The state can expand coverage without assuming any new net costs by achieving savings in other areas of the state's budget. In fact, overall state costs are likely to be reduced by some $100 million annually because some safety net programs will become less necessary.*
- *If the state does not expand coverage, Florida's hospitals will lose federal revenue without offsetting gains in coverage for their patients.*

Florida's Experience with
MEDICAID REFORM

OVERVIEW

On June 28, 2012, the U.S. Supreme Court handed down its much-anticipated decision on the constitutionality of the Patient Protection and Affordable Care Act, the major health care reform law passed by Congress in 2010.[1] Much to the surprise of most observers, the Court ruled that the entire act was constitutional with one exception – the federal Department of Health and Human Services' authority to enforce the Act's mandatory expansion of Medicaid coverage benefits.[2] This feature of the Act extends Medicaid coverage to adults with incomes less than 133 percent of the federal poverty level (FPL) -- equivalent to $14,856 for a single person or $25,390 for a three-person family.

The practical consequence of the Court's ruling is that states now have a choice as to whether to extend coverage to these low-income adults.

Reducing the number of uninsured Americans is a key aim of the Affordable Care Act as the United States moves toward a system of universal coverage on January 1, 2014.

The Act includes two principal means to reduce the number of uninsured Americans:

- Federally funded tax credits for insurance premiums to be offered to individuals to purchase coverage through health insurance exchanges, which the Congressional Budget Office estimates will cover between 20 million and 25 million persons;
- An expansion of the Medicaid program to adults with incomes below 133 percent of the federal poverty level, which, prior to the Supreme Court decision, was estimated to cover 16 million to 17 million persons.[3]

In Florida, an estimated 1.295 million uninsured adults would be newly eligible to gain coverage if the state elects to extend coverage.[4] In addition, adults and children who are currently eligible but not enrolled in Medicaid are more likely to gain coverage should the state take up the Medicaid option – 500,000 children and 250,000 adults in Florida fall into this category.[5] Many of these children and adults are likely to sign up for Medicaid in 2014 even if the state opts against extending new coverage.

The new Medicaid coverage comes with an unprecedented infusion of federal matching dollars – the federal government picks up 100 percent of the cost for the newly eligible population from 2014 to 2016, and federal support tapers down to 90 percent in 2020.[6] The state's own estimates show no costs for the newly eligible adults for the first three years and comparatively modest costs through 2023.[7]

The federal government has made clear that states can opt in and out of covering this newly eligible population at any time. Thus, Florida could pick up the expansion population in 2014 and withdraw from participation when the state had to start putting up matching dollars.

Under Florida law, any major change to Medicaid requires action by the Legislature. An extension of Medicaid eligibility to new populations and any other modification of program eligibility clearly fall under this requirement.

JESSIE BALL DUPONT FUND

This educational brief is one of a series commissioned by the Jessie Ball duPont Fund and the Winter Park Health Foundation and authored by Joan Alker, Jack Hoadley and Wesley Prater of the Health Policy Institute at Georgetown University.

WINTER PARK HEALTH FOUNDATION

WHAT DOES THE SUPREME COURT'S DECISION MEAN FOR FLORIDA'S MEDICAID PROGRAM?

No doubt constitutional legal scholars and courts will debate the legal implications of the Supreme Court decision in decades to come. For the purposes of thinking about Florida's implementation of the Affordable Care Act, however, the ruling has two key outcomes specific to Medicaid:

1) ***It appears that other Medicaid provisions of the Act remain intact with important consequences – especially for Florida's children.***

The Act also requires that eligibility levels for children covered by Florida Medicaid and the Children's Health Insurance Program (CHIP) must remain stable until October 1, 2019. Florida currently covers these children at a combined Medicaid/CHIP eligibility level of 200 percent FPL and thus cannot lower this threshold. And the state cannot make it harder for children to enroll during this time period; for example, states may not add new premiums, as Florida attempted to do in 2011.[8]

The Act includes a requirement that the state must align and simplify eligibility for all children in Medicaid, regardless of age, at 133 percent of FPL as of January 1, 2014. In Florida, this means that children over age 5 who are currently covered in Healthy Families between 100 and 133 percent of the federal poverty level must be transferred to Medicaid by January 1, 2014. The state will continue to receive the higher CHIP match rate for these children, often called the "stairstep kids," after they move to Medicaid. (Figure 1)

The state also needs to adopt a new nationally uniform and simpler way of calculating income, known as Modified Adjusted Gross Income (MAGI), for the purposes of determining Medicaid and CHIP eligibility for all non-disabled populations by January 1, 2014. This will affect primarily children and parents who are currently covered. Persons over 65 and those who are disabled are not affected by this change.

2) ***Florida must make a choice on whether or not to extend Medicaid coverage to adults with incomes less than 133 percent of the poverty level – a decision with important consequences for low-income individuals and Florida's health system.***

If Florida chooses not to move forward with this new Medicaid option, a gap in coverage will ensue for some of the poorest adults. (Figure 2)

The Affordable Care Act offers tax credits for insurance premiums to those with incomes between 100 percent and 400 percent of FPL if they are not otherwise eligible for Medicaid. No credits are provided if income is less than 100 percent of FPL, since the law assumed this group would be eligible for Medicaid.

But Florida has relatively parsimonious Medicaid coverage for adults, and does not currently provide Medicaid coverage for most adults with incomes below 100 percent of FPL.

FIGURE 1: CHILDREN'S COVERAGE IN FLORIDA, 2014

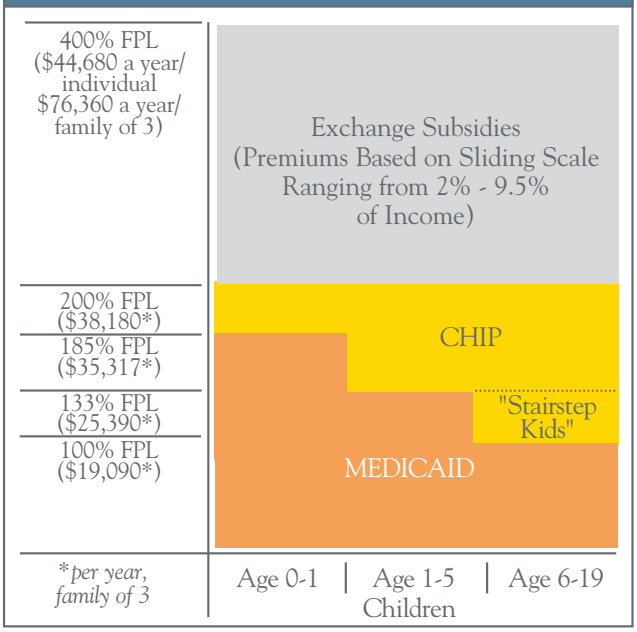
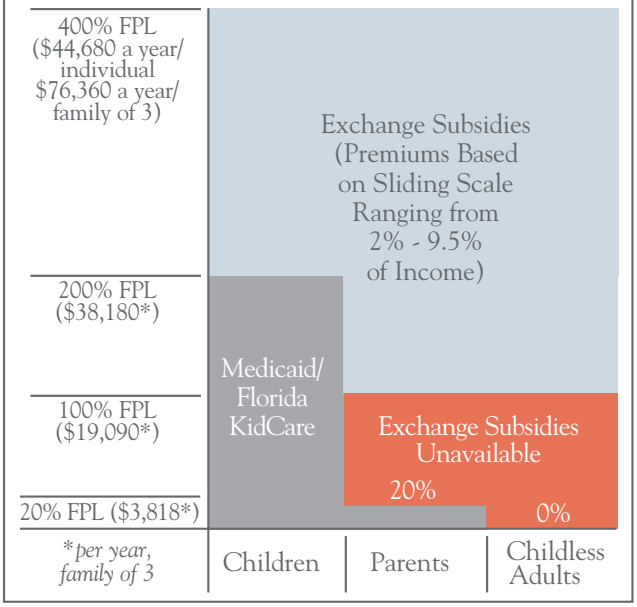


FIGURE 2: WHO WILL REMAIN UNCOVERED WITHOUT BROADER MEDICAID COVERAGE?



The result of rejecting the Medicaid expansion will be that childless adults with incomes between 0 percent and 100 percent FPL would have no affordable coverage while those at higher incomes would have access to federal tax credits.[9]

Florida currently only covers parents with incomes of 20 percent FPL or less.[10] Thus a hole in coverage between 20 percent and 100 percent of FPL would exist. The Urban Institute estimates that just fewer than a million Floridians - 995,000 - would fall into this gap and remain uninsured.[11] The vast majority of those would gain insurance should the state choose to extend Medicaid coverage

WHAT DOES THE SUPREME COURT DECISION MEAN FOR FLORIDA'S HOSPITALS?

The Supreme Court's decision places hospitals, particularly those serving large numbers of uninsured persons, at significant new risk in states where Medicaid coverage is not extended.

The Affordable Care Act included significant cuts to payments under the Medicare and Medicaid Disproportionate Share Hospital (DSH) funding programs, which are designed to provide funding for hospitals that provide a high level of uncompensated care to patients without insurance coverage.

The Act stipulates that $22 billion[12] must be cut from Medicaid DSH between FY2014 and FY2022 – a reduction of approximately 50 percent. The Act also cuts Medicare DSH payments by approximately 75 percent starting in FY2014.[13]

The Secretary of HHS has broad discretion in determining how the Medicaid DSH cuts will be allocated to states; as of yet no guidance has been issued by HHS to address this question. However, it is clear from the size of the cut in federal dollars that Florida's hospitals can expect to see significant reductions.

The theory behind the cuts, which helped to pay for the new coverage, was that the move to universal coverage – especially to those populations that would be newly served by the Medicaid program – would result in significantly less uncompensated care for hospitals.

Hospitals in states that choose not to move ahead with the extension of Medicaid are now at significant risk because the DSH cuts will occur regardless.

While precise estimates on the impact on Florida's hospitals cannot be determined until further regulatory guidance becomes available, the combined impact of federal Medicare and Medicaid DSH cuts may reduce income from this source by about two-thirds – in the range of $640 million annually.

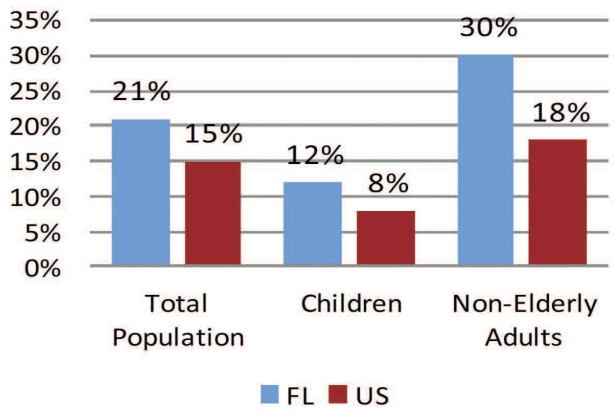
Florida's hospitals face another unique challenge should the state not move forward with the Medicaid expansion.

Currently the state's Section 1115 Medicaid Research and Demonstration waiver, which is operating in five counties, contains a statewide fund of federal dollars known as the Low Income Pool (LIP). Many hospitals (and some other safety net providers) currently receive approximately $2 billion from the LIP – these dollars are primarily intergovernmental transfers from local governments that are matched by federal dollars.

This waiver agreement is scheduled to expire on June 30, 2014. Since the intent of the LIP is to provide additional support to hospitals providing uncompensated care, whether the federal government would continue matching these funds for Florida should the state choose not to pick up the Medicaid expansion at 100 percent federal cost in 2014 is highly uncertain.

FIGURE 3: RATE OF UNINSURED IN FLORIDA COMPARED TO THE UNITED STATES

2011 American Community Survey



WHICH FLORIDIANS WILL BE COVERED IF THE STATE CHOOSES TO EXTEND MEDICAID?

Florida has much to gain from enacting the Medicaid expansion as the state's uninsurance rate is the fourth highest in the country and considerably higher than the national average for both children and adults. (Figure 3)

Nearly 4 million Floridians do not have health insurance today. It is estimated that 1,295,000 uninsured adult Floridians would become newly eligible for coverage if the state chooses to extend coverage. (Figure 4) Parents and children currently eligible also would be more likely to enroll.[14]

FIGURE 4: PROJECTED MEDICAID COVERAGE FOR FLORIDA'S ADULTS AND CHILDREN UNDER DIFFERENT ASSUMPTIONS				
	ADULTS NEWLY ELIGIBLE FOR MEDICAID	ADULTS CURRENTLY ELIGIBLE FOR MEDICAID	CHILDREN CURRENTLY ELIGIBLE FOR MEDICAID	TOTAL
Total uninsured	1,295,000	257,000	500,000	2,052,000
Projected take-up rate (low assumption)	57%	10%	10%	
Number projected to gain Medicaid coverage (low assumption)	740,000	25,000	50,000	815,000
Projected take-up rate (high assumption)	75%	40%	40%	
Number projected to gain Medicaid coverage (high assumption)	970,000	100,000	200,000	1,270,000

THE NEWLY ELIGIBLE

Adults are more likely than children to lack insurance coverage today as a result of the decline in employer-sponsored insurance, the increasing costs of health insurance and, most importantly, lower levels of Medicaid eligibility.

Florida's Medicaid and CHIP eligibility level for children is 200 percent of the FPL. However, Florida's eligibility threshold for parents is just 20 percent of the FPL (less than $4,000 annually for a family of three in 2012).

Some pregnant women and some adults with disabilities are eligible for Medicaid at higher income levels. But for the most part, Florida offers no coverage to non-disabled adults without dependent children.

Between 57 and 75 percent of newly eligible adults are expected to enroll in an expanded Medicaid program, based on estimates from the Urban Institute, relying in part on assumptions made by the Congressional Budget Office.

The higher participation rate generally assumes a more aggressive state effort to enroll the population.[15] The lower rates could be more realistic for Florida, given that Florida's participation rate is low by national standards. (For example, enrollment of eligible children in Florida is 77 percent, well below the national average of 85 percent, in fact, the fourth lowest of all states.)[16]

Based on the Urban Institute participation rates, 740,000 to 970,000 newly eligible adults would gain coverage.[17] (Figure 4)

THOSE CURRENTLY ELIGIBLE BUT NOT ENROLLED

Implementation of the Affordable Care Act is also expected to spur enrollment among those who currently are eligible for Medicaid, but have not yet enrolled.

This projection is driven by a new "culture of coverage" that is likely to develop as new tax penalties start creating a greater incentive for uninsured Americans to acquire insurance as of 2014, whether or not the state chooses to extend Medicaid benefits. The changing climate is expected to motivate some current non-participants to enroll themselves and their children – even though very low-income families are not subject to the tax penalty.[18]

Most of those who benefit from this culture change are expected to be children, since eligibility criteria for adults are limited under current law.

Because these eligible adults and children are not currently enrolled in Medicaid, they are assumed to sign up at a lower rate than those who are newly eligible.[19] Based on participation rates in the Urban Institute analysis, about 25,000 to 100,000 currently eligible adults and 50,000 to 200,000 currently eligible children would be added to Medicaid. (Figure 4)

FAMILIES AND CHILDREN HAVE MUCH AT STAKE IN THE STATE'S MEDICAID CHOICE

There currently are 883,000 parents who are uninsured in Florida, and 223,000 of these uninsured parents – the most vulnerable among them – would become newly eligible for Medicaid should the state decide to extend coverage.[28]

Florida also has a significant number of parents (approximately 145,000) who currently are eligible for Medicaid but not enrolled.[29]

Covering parents clearly improves the lives of those parents, but there also are many tangible benefits for their children. Parents' health has a positive impact on a child's health and well-being, such as the child's ability to do better in school. Children are also more likely to be insured and have access to preventive care and receive other health care services when their parents are insured.[30] Fully insured families also gain financial stability as medical debt is a leading cause of bankruptcy.

Covering parents also would lead to more eligible children enrolling in Medicaid and CHIP and accessing coverage themselves.

An estimated 500,000 children in Florida are eligible for Medicaid/CHIP but not enrolled.[31] The average Medicaid/CHIP participation rate in the United States for children is 85 percent and Florida's Medicaid/CHIP **participation** rate is well below that at 77 percent.

If Florida's participation rate increased to the national average, about 175,000 children would gain coverage.

THE COMBINED IMPACT

After calculating the impact of full implementation of the Affordable Care Act on both groups of beneficiaries (the newly eligible and the currently eligible but not enrolled), between 815,000 and 1,295,000 children and adults in Florida with no health insurance today are projected to gain coverage from Medicaid expansion and the Affordable Care Act. (Figure 4)

MEDICAID COVERAGE SAVES LIVES AND IMPROVES HEALTH

Numerous studies have shown the value of Medicaid coverage.

A 2012 study examined adults in three states that extended Medicaid to childless adults, five years before and after the change. The research found that mortality rates for these adults declined by more than 6 percent.[32] The study also found that the number of people who delayed care due to costs declined after gaining Medicaid coverage and that individuals who self-reported their health as "very good" or "excellent" increased.

Similarly, a new and very comprehensive study looking at Oregon found that having Medicaid coverage for one year improved the lives of those enrolled.[33]

Access to care was improved, as those with Medicaid were more likely than the uninsured to have a regular source of care and access to prescription drugs. Those with Medicaid coverage also reported more financial security and had fewer unpaid medical bills. Lastly, the individuals with Medicaid coverage, compared to the uninsured, were less likely to indicate that their health status had declined over the previous six months and were less likely to be depressed.

WHAT IS THE IMPACT OF FLORIDA'S MEDICAID CHOICE ON ITS BUDGET?

In an April 2011 policy brief, we presented information on the costs of broader Medicaid coverage required under the Affordable Care Act.[20] At that time, we concluded that the state's cost projection for implementing the Act's Medicaid provisions was based on unrealistic assumptions. We found that more realistic assumptions generated a much lower cost estimate and the possibility that offsetting savings might be greater than the new costs to the state.

In August, Florida's Social Services Estimating Conference released new figures on the projected cost of Medicaid expansions – figures that are much closer to those presented in our earlier brief.[21]

The estimates presented in this brief rely on the best available information on the impact on Florida's budget of the Medicaid expansion and other Medicaid changes resulting from the Affordable Care Act. Although we rely primarily on these new state cost estimates, we also look at some potential offsetting savings for state and local support of the health safety net and the changing landscape in 2014 – factors not considered by the Estimating Conference. A more comprehensive look is important for Florida policymakers to consider as implementation of many aspects of the Affordable Care Act begin in 2014

Should Florida choose to extend Medicaid coverage to adults with incomes up to 133 percent of FPL, federal funding will be available to cover a large share of costs for this new coverage. Florida would not need any state funds for newly eligible adults between 2014 and 2016 and no more than 10 percent of these costs into the future.

According to the state's Estimating Conference, over a 10-year period through state fiscal year 2022-2023, the total cost to the state if it chooses to extend coverage would fall below $300 million per year from 2017 forward – about 3 percent more than the state currently spends each year on Medicaid.

These estimates may be high, however.

For example, the state assumes that about 80 percent of the newly eligible population would enroll in Medicaid – well above the current rate of enrollment for eligible adults and higher than the assumptions of between 57 percent and 75 percent made in the Urban Institute's analysis.[22] Achieving 80 percent enrollment, as the state assumes, would be a significant increase when compared to Florida's past performance.

The state's Estimating Conference opted not to issue "official" enrollment projections or cost estimates for those already eligible but not enrolled in Medicaid – the increase in enrollment that would be a likely response to a new "culture of coverage." While this new enrollment should be encouraged as increasing access to health care, it will come with some new costs to the state.

For this population, neither the full federal funding for 2014 through 2016 nor the high matching funds rate thereafter would apply. Normal federal matching funds, however, would be available for these new enrollees.

Even if all eligible children and adults were to enroll – a highly improbable outcome – new costs to the state would be in the range of $325 million per year, according to numbers issued by the Estimating Conference. Based on the Urban Institute enrollment assumptions described above, it is probably realistic to expect no more than one-third of these new costs or about $100 million per year.

Thus, total new costs to the state for all newly covered or enrolled likely represent no more than a 1 percent increase in the state share of Medicaid spending in 2014 to 2016, and no more than a 4 percent increase in later years.

There are several other factors that may lead to state costs being lower than the estimates made by the state's Estimating Conference.

The Estimating Conference assumes that the average newly eligible enrollee will cost Medicaid $315 per person per month – about 8 percent below the current rate for adults enrolled based on receiving Temporary Assistance for Needy Families, a generally comparable population.

According to a 2010 study, adults who enroll in Medicaid under reform are likely to be less expensive than those already in Medicaid (although more expensive than those who remain uninsured).[23] This is because the sickest, most costly beneficiaries are likely already enrolled in Medicaid by virtue of a disability or because a health care provider has taken steps to make sure they are enrolled as a way to ensure payment. It remains unclear whether the 8 percent lower average spending assumed by the state fully reflects this group's better health – and thus whether an even lower per-person rate would be appropriate.

Although some adjustments might lower the Estimating Conference estimate, other sources of potential costs could increase the estimate modestly.

For example, state administrative expenses could rise as a result of having more people in the program, pushing total spending up somewhat. The impact of some other health reform provisions, such as changes to how prescription drugs are paid for, also have not been considered.

HOW WOULD MORE INSURANCE COVERAGE CREATE OFFSETTING SAVINGS?

Florida's Estimating Conference looks at new state costs for covering a larger Medicaid population, but it does not take into account any potential offsetting savings for the state.

More insurance coverage, through both Medicaid coverage and the health insurance exchanges, will change the nature of the health care safety net.

Today people without insurance typically receive at least some health services through clinics, safety-net hospitals and other community programs that make primary care and other health services available. Persons with mental health problems likely receive some services through state funded programs. When patients lack any means of payment, services are supported by payments from a variety of state and local programs.

IMPROVING ACCESS TO PRIMARY CARE

One additional possible source of new costs to the state comes from a provision in the Affordable Care Act that increases payments to physicians for primary care services.

These higher payments are intended to ensure that an adequate number of physicians will be available to treat both current and new Medicaid beneficiaries.

The most recent available data show that primary care rates paid by Florida Medicaid are only 55 percent of Medicare rates, compared to a national average of 66 percent (only six states rank lower).[34] The federal government has committed to paying the entire cost of higher payments at the full Medicare rate in 2013 and 2014.

Florida will face a decision on whether to continue these higher payment rates or to revert to the rates in place today – or somewhere in between.

If the state chooses to keep the higher rates, normal federal matching rates will apply. But new costs to the state could be as high as about $375 million annually, using the most extreme assumptions about enrollment, but lower based on more realistic participation rate assumptions.

New sources of insurance coverage should reduce the burden on these programs.

Nationally, an analysis by the Lewin Group found that, collectively, state and local governments will save $198 billion over the 10 years between 2014 and 2023 from a reduced need for safety-net programs.[24] If true, these savings would dwarf the $21 billion to $45 billion in new state costs throughout the country as identified by the Urban Institute study.

Some of these savings were presumably captured in the Affordable Care Act through the cuts to both Medicaid and Medicare DSH payments that are made to hospitals serving a low-income population. (As mentioned previously, these cuts will occur even if Florida opts not to extend Medicaid eligibility.)

In addition to DSH funds and payments from the LIP, Florida's safety net providers rely on other sources of state and local funding to pay a portion of the cost of care for those without health insurance.

For example, 12 Florida counties currently operate 16 independent hospital taxing districts with authority to levy taxes. In 2007 (the most recent available numbers), these districts collected about $600 million in taxes, a 75 percent increase over 2002.[25] Typically, these districts support local hospitals that care for poor and uninsured county residents.

If coverage expansions substantially lower the number of uninsured patients, the hospitals, doctors and others who treat them may have less need for support from public dollars – even after taking into account cuts made to DSH and LIP payments. This in turn could allow Florida counties to lower these special taxes.

Although hospital care is probably the largest source of offsetting savings, state funds also support many mental health and substance abuse service programs aimed at people with no source of payment. It is likely that many who use these services today will gain coverage through Medicaid, federal premium tax credits used in the exchange, or through private insurance that no longer imposes pre-existing condition requirements.

It is reasonable to assume that new Medicaid coverage could allow the state to scale back state-funded mental health and substance abuse service programs considerably, thus freeing up a substantial share of the $500 million to $600 million of state appropriated funds currently spent by the state and substituting federal or private insurance dollars.

A similar (but smaller) source of savings might be the state's current $10 million contribution to federal AIDS Drug Assistance Program (ADAP), a portion of which would become unnecessary if more people with HIV/AIDS gained private insurance, tax credits or Medicaid coverage.[26]

The state of Florida has submitted a Section 1115 Medicaid Research and Demonstration waiver request to begin a premium-based system for its "medically needy" program, which includes people whose incomes are too high to qualify for regular Medicaid but who experience catastrophic medical expenses. Nearly 50,000 people qualify each month for the program; a total of 250,000 people use the program at least one month out of the year.

These people have the highest average per-person costs of any group in Medicaid and collectively cost more than $1 billion in 2011-12,[27] using nearly $500 million in state general revenues. Many in this group today lack other sources of insurance.

Once health insurance exchanges are created and subsidies go into effect in 2014, some of these individuals should be able to purchase private insurance using tax credits in the exchange, and some might become eligible at 100 percent federal cost if the state extends Medicaid coverage. The result could be considerable savings if the state alters or eliminates its Medically Needy program without any loss of access to health services.

In fact, a proposal in the state's budget submission for state FY 2013-14 would drop Medicaid coverage for some medically needy individuals, based on their ability to get coverage through the new insurance exchanges in 2014. The state has a similar proposal for some pregnant women now covered by Medicaid. Together, these proposals would reduce state spending by about $60 million, a recognition on the state's part that the Act has the potential to save state funds.

WHAT IS THE BOTTOM LINE ON THE COSTS OF EXTENDING MEDICAID IN FLORIDA?

The financial impact for the state of the various changes under way in Medicaid will depend on a variety of factors. These include the decisions by the state on whether to exercise the option to extend Medicaid coverage to many people not currently eligible, as well as further decisions about the future role for various safety-net programs that could become less important as more people obtain coverage from private insurance or Medicaid.

FIGURE 5: IMPACT ON FLORIDA'S BUDGET	BEST ESTIMATE
NEW STATE COSTS PER YEAR	
Cost of Medicaid Coverage for Newly Eligible Population	$300 million
Cost of Medicaid Coverage for New Enrollment by Currently Eligible Population	$100 million
Cost of Continuing Higher Primary Care Payment Rates for Physicians	$200 million
TOTAL NEW STATE COSTS PER YEAR	**$600 million**
OFFSETTING STATE SAVINGS PER YEAR	
State Support for Safety Net Providers	$200 million
State Mental Health, Substance Abuse Programs	$250 million
Medicaid Eligibility Changes, for example, to the Medically Needy Program	$250 million
TOTAL OFFSETTING STATE SAVINGS PER YEAR	**$700 million**
NET STATE SAVINGS PER YEAR	**$100 million**

NOTE: Estimates are based on a single year after 100 percent federal funding is phased out. New state costs will be lower in earlier years, especially from 2014 through 2016.

The financial impact on the state will also be affected by the decisions of individual Florida citizens in responding to new opportunities for health insurance.

Figure 5 represents our best estimate of this financial impact for the later years after full federal support for the new group phases down. Our estimate shown here illustrates possible costs and savings, but exact numbers will vary based on state, federal and individual decisions.

Our estimate relies on the newest estimates by the state Estimating Conference for the cost of coverage for the newly eligible Medicaid population, although we suspect that actual costs may be somewhat lower than the estimate. Although the Estimating Conference did not present a final estimate for the cost of new coverage for the currently eligible, but uninsured, population, we include what we think is a realistic estimate for those costs. We also include an estimate for higher payment rates to physicians for primary care services, even though the state could decide not to continue these higher payments after 2014 or the federal government could extend them. The estimate here is about half the maximum potential cost, reflecting a possible state decision to continue higher physician payment rates, but at a lower level than in 2013 and 2014 at full federal cost.

It is also important to recognize that improved insurance coverage, as of 2014, will result in offsetting savings in several of the ways that the state supports the health care safety net (some of which already are recognized in the state's latest budget documents). Because some Floridians will continue to require safety net services, even after the expansion of coverage, we generally assume no more than a 50-percent reduction in state support for these programs. But even with these conservative assumptions, the cost of new Medicaid coverage should be more than offset by these savings.

The bottom line for Florida is that the state should incur no net costs for taking up the optional extension of Medicaid coverage even after accounting for the state covering more people who are currently eligible but not enrolled.

In fact, overall state costs may well be reduced by an estimated $100 million per year because some safety net programs will become less necessary.

Furthermore, extending Medicaid coverage to Florida citizens should have positive effects in terms of lower mortality, less illness, improved economic stability and a higher quality of life for those gaining coverage. In turn, improved health may well lead to lower overall health costs for both these individuals and the state.

ENDNOTES

(1) The case in which the Court rendered its verdict is National Federation of Independent Business v. Sebelius.
(2) In particular the Court ruled that HHS could not withhold all of a state's Medicaid funds for not extending coverage to the new mandatory adult coverage group.
(3) The CBO is now estimating that the higher number of 25 million persons will be enrolled in exchanges as a consequence of the Supreme Court decision. The estimate also suggests that Medicaid coverage will drop to 11 million as a result of the decision although as the estimate points out there are many unknowns. Congressional Budget Office, July 24, 2012. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision.
(4) Estimates for adults are based on G. Kenney et al., Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage? Urban Institute August, 2012. Estimates include both those eligible under expanded Medicaid coverage and those current eligible for Medicaid.
(5) Estimates for eligible children are derived from G. Kenney et al., August 2012, and G. Kenney et al., Making the Medicaid Expansion an ACA Option: How Many Low-Income Americans Could Remain Uninsured, June 2012, Urban Institute.
(6) For more on the matching rate and related issues see our previous brief in this series, J. Hoadley and J. Alker, Understanding Florida Medicaid Today and the Impact of Federal Health Care Reform, Georgetown University Health Policy Institute, April 2011.
(7) Social Services Estimating Conference, Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs, August 14, 2012.
(8) An effort to charge a $10 monthly premium regardless of income or age was passed by the Legislature and included in the state's Section 1115 Medicaid Research and Demonstration request and was rejected by the federal Department of Health and Human Services because it violated the "MOE" provisions. See letter from CMS to AHCA, February 9, 2012. These premiums would have resulted in large numbers of children losing coverage. See J. Alker and J. Hoadley, Proposed Medicaid Premiums Challenge Coverage for Florida's Children and Parents, Georgetown University Health Policy Institute, December 2011.
(9) There is currently much speculation about whether a state could do a partial expansion – for example to 100 percent of FPL - through use of Section 1115 waiver authority. As of this writing HHS has not opined on this matter, but there are reasons to believe this will not be a viable avenue – chief among them that permitting states to go this route would incur very substantial costs to the federal government.
(10) If they are working, parents can disregard earned income bringing their eligibility level to 58 percent FPL. However this exclusion will disappear in 2014 regardless of whether or not the state expands coverage.
(11) Kenney et al., August 2012.
(12) CBO estimate, p. 10 footnote 17.
(13) The ACA also provides for additional Medicare payments where evidence shows that hospitals continue to have an uncompensated care burden.
(14) Kenney et al., August 2012.
(15) J. Holahan and I. Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133 percent FPL, Kaiser Commission on Medicaid and the Uninsured, May 2010.
(16) G. Kenney et al., "Gains for Children: Increased Participation in Medicaid and CHIP in 2009," Urban Institute, August 2011.

(17) These estimates (and those for the currently eligible) are based on the take-up rate proposed by Holahan and Headen, May 2010, and the number of uninsured from Kenney et al., August 2012.
(18) The penalty will not apply to persons who do not have enough income to file taxes and there will be a "hardship exemption," which has not yet been defined in regulation.
(19) Among those who are currently eligible for Medicaid, but have not enrolled, it is assumed that from 10 percent to 40 percent will choose to enroll during the period when other new coverage begins. Holahan and Headen, May 2010.
(20) J. Hoadley and J. Alker, Understanding Florida Medicaid Today and the Impact of Federal Health Care Reform, Georgetown University Health Policy Institute, April 2011.
(21) Social Services Estimating Conference, Estimates Related to Federal Affordable Care Act
(22) Holahan and Headen, May 2010.
(23) J. Holahan et al., The Health Status of New Medicaid Enrollees Under Health Reform, Urban Institute, August 2010.
(24) Lewin Group, Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers, Staff Working Paper #11, June 8, 2010.
(25) Florida Tax Watch, Florida's Fragmented Hospital Taxing District System in Need of Reexamination, February 2009.
(26) National Alliance of State & Territorial AIDS Directors, National ADAP Monitoring Project Annual Report, August 2012.
(27) "Florida Medically Needy Waiver Demonstration Amendment to the Florida MEDS AD section 1115 Demonstration," submitted by Florida to CMS, April 26, 2012.
(28) Kenney et al, August 2012, p. 9.
(29) Florida: Uninsured Parents Potentially Eligible for Medicaid under the ACA, Georgetown Center for Children and Families, June 2012.
(30) Center on Budget and Policy Priorities and Georgetown University Health Policy Institute Center for Children and Families, Expanding Coverage for Parents Helps Children, 2012. M. Heberlein et al., Medicaid Coverage for Parents Under the Affordable Care Act, Georgetown University Health Policy Institute Center for Children and Families, June 2012.
(31) Estimates for eligible children are derived from G. Kenney et al., August 2012, and G. Kenney et al., June 2012.
(32) B. Sommers, K. Baicker, and A. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," New England Journal of Medicine 367:1025-1034, 2012.
(33) A. Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," The Quarterly Journal of Economics, 127(8): 1057-1106, August 2012
(34) S. Zuckerman et al., "Trends In Medicaid Physician Fees, 2003-2008," Health Affairs 28(3): w511-w520, April 2009.

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From:	Anne Swerlick
To:	edrcoordinator
Cc:	Bell.Stephanie; Schenker, Pamela
Subject:	Studies on Medicaid expansion and disability related
Date:	Friday, August 02, 2019 3:37:12 PM
Attachments:	image001.png Final Report Arkansas Health Taskforce12-15-16.pdf

Dear Conference Members:

At the FIEC meeting on July 29th, the conference discussed whether there are potential budget savings from a drop in disability-related Medicaid enrollment with Medicaid expansion. The discussion suggested that there were no studies showing that states expanding Medicaid had already experienced these enrollment declines.

However, attached and below are three studies that show otherwise. Examples include Arkansas, which expanded in 2014, and Massachusetts which expanded prior to enactment of the ACA .

In Arkansas the ***SSI Disabled enrollment dropped 6.6%*** according to the Arkansas Health Reform Legislative Task Force Report, p. 11, December 2016.
http://www.arkleg.state.ar.us/assembly/Meeting%20Attachments/836/I14804/TF%20FinalDraftReport.12-14-2016.pdf

In Massachusetts, in counties with low rates of health insurance coverage, ***decreases of 3.8% to 6% in SSI application rates*** occurred. *Disability Insurance and Health Insurance Reform Evidence from Massachusetts*, Nicole Maestas, Kathleen J. Mullen, and Alexander Strand, Working Paper, Rand Labor and Population, January 2014.
https://pdfs.semanticscholar.org/22d7/024c7bb6c43541e2b9d5887b2b53bb519932.pdf

Similarly, in another study researchers looked at data from 2001-2013 in states which expanded Medicaid prior to expansion under the ACA. It finds significant reductions of SSI participation:

> "Overall we find that the implementation of Medicaid coverage for childless adults results in an ***average reduction in SSI participation of 5% to 9%*** relative to no such coverage." (emphasis added)

The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation, p. 30, Institute for Research on Poverty at the University of Wisconsin–Madison, March 2016. https://www.irp.wisc.edu/wp/wp- content/uploads/2018/05/dp143016.pdf . This study also gives a good explanation of why people choose to forgo pursuing the cumbersome federal SSI disability application process and instead enroll in expansion.

Finally, a recent 2019 Manatt report summarizing estimated Alabama costs and savings for SFYs 2020-2023 settles on a "midpoint" enrollment decline number based on available studies on the effects of Medicaid expansions on disabled group enrollment. ***It projects $11.5 million in savings triggered by a 4% decline in disability enrollment.*** https://www.manatt.com/Insights/White-Papers/2019/Alabama-Medicaid-Expansion-Summary-of-Estimated-Co

We urge the conference to consider these studies as it finalizes its costs and savings estimates for Florida Medicaid expansion. Thank you for your consideration and please feel free to contact me if you need additional information or have questions.

Sincerely,
Anne Swerlick

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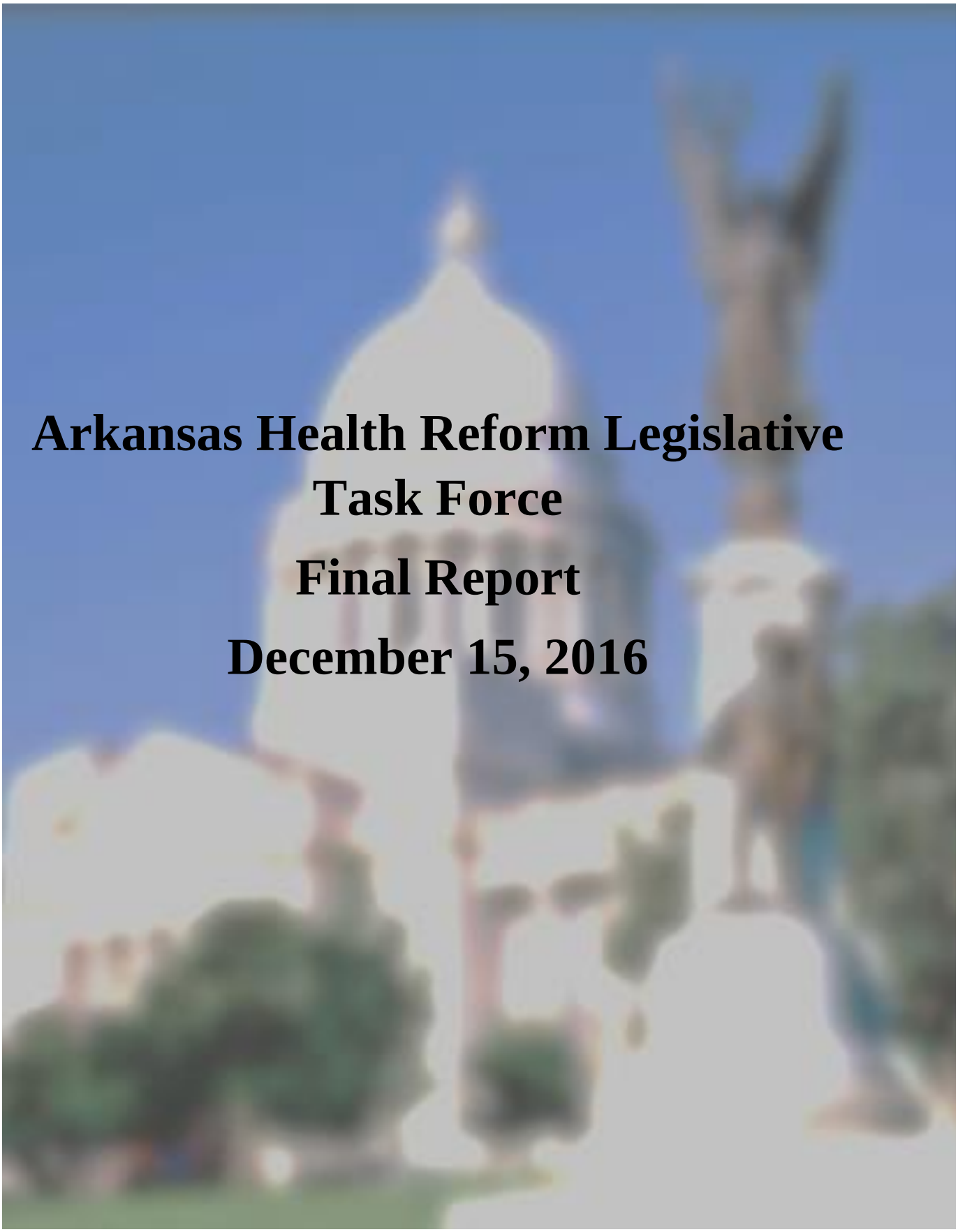


Arkansas Health Reform Legislative Task Force

Final Report

December 15, 2016

Initial Note: The Task Force would like to specifically recognize and thank the many stakeholders who offered testimony and assistance over the past few months. We would also like to thank the Arkansas Department of Human Services for its steadfast commitment in helping us achieve our mission, and our consultant, The Stephen Group, for their outstanding research, analysis and expertise in addressing our many issues.

I. Background

Legislative Authorization and Intent

In the 2015 session the Arkansas Legislature passed a bill, known as the Arkansas Health Reform Act of 2015, that established the Arkansas Health Reform Legislative Task Force ("Task Force") to "(A) Recommend an alternative healthcare coverage model and legislative framework to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program established by the Health Care Independence Act (HCIA) of 2013, §§ 20-77-2401 et seq., upon program termination; and (B) Explore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled."

As the authorization of the Health Care Independence Program (HCIP) was set to expire on December 31, 2016, the Arkansas Health Reform Act of 2015 required that "On or before December 31, 2015, the Task Force shall file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate, a written report of the Task Force's activities, findings, and recommendations." This preliminary report was filed on December 15, 2015.

Additionally, the Act states that "The Task Force may file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate a final written report on or before December 30, 2016." The authorization for the Task Force expires on December 31, 2016.

Finally, the Task Force issued an RFP for the services of a Medicaid consultant to assist it in its research, analysis and in meeting its statutory objective. Through a competitive process, The Stephen Group, LLC. was selected to provide expert consulting services.

II. Task Force Findings

A. Key Findings: Private Option (PO)/HCIP

- Through September 2016, there were approximately 293,882 adults eligible since the passage of the Health Care Impendence Program (now Arkansas Works) (270,573 Private Option (PO) and 23,309 Medically Frail, who currently utilize traditional fee-for-service Medicaid)

- 80% of all individuals selecting insurance through the marketplace in Arkansas are enrolled via the PO.
- PO participants are younger and thus healthier and lower cost. 65% of those enrolled through the Private Option are younger than 45 years old, compared to 45% of those enrolled through the Arkansas marketplace.
- PO participants have access to substantially more providers than through traditional Medicaid due to access to the private insurance company provider networks.
- PO beneficiaries utilized Emergency Department services at a rate greater than traditional Medicaid beneficiaries, despite being a healthier population.
- Health disparities and use of Emergency Departments appear to be due, in part, to a lack of understanding of how to use the health care system by individuals who are new to having coverage, or because there are no incentives for utilizing more appropriate care.
- Over the next five years, the federal share of the PO, in its current form, would result in roughly $9 billion in Medicaid federal match payments for Arkansas.
- Hospitals report a substantial reduction in uncompensated care visits and costs since the beginning of the Private Option. Uninsured admissions dropped 48.7% between 2013 and 2014, uninsured Emergency Department visits dropped 38.8%, and uninsured outpatient visits dropped 45.7%. This drop could also be partly attributed to the availability of insurance policies with subsidies for incomes above 138% Federal Poverty Level (FPL) on the Arkansas Health Connector, or a drop in unemployment which likely indicates an increase in employer insurance.
- The Arkansas rate of uninsured among non-elderly adults dropped from 27.5% to 15.6% from 2013 to 2014. The PO was clearly a substantial factor in this drop.
- Many PO enrollees are not working at all or not working substantially. Forty percent of beneficiaries have an annual income of $0. Over 54% had incomes below 50% of the FPL. Only a little over 15% were between 100-138% FPL.
- Average ratio of claims to premiums among the three QHP carriers is 79%, lower than the 80% (85% for large group carriers) allowed under the Affordable Care Act.
- Physician licensure rates appear largely not to be impacted by the PO.
- The Health Independence Accounts appear largely to have missed their mark. Only 10,806 cards have been activated of the 45,839 issued, with only roughly 2,500 individuals contributing to these accounts monthly.
- If Arkansas rejects Medicaid and returns to program status prior to 2014, the negative impact to the state budget is approximately $438 M (2017 – 2021), taking into account cost shifting, uncompensated care, premium tax and macro-economic effects).
- The state may have options available to limit some of the impact by not renewing optional programs or funding uncompensated care.
- An analysis of claims data among two of the three PO insurance carriers indicates a substantial increase in costs per claims by enrollees, driven largely by cost increases in the pharmacy benefit.

- PO has achieved state general fund savings through the use of shifting populations from traditional Medicaid (70% federal match) to PO/Arkansas Works (95% federal match). These populations include:
    - Medically needy
    - Aged blind disabled
    - SSI disability
    - Pregnant women
- Additionally, after the establishment of the PO, the state has achieved general fund savings through the discontinuation of the following programs:
    - ARHealthNetwork
    - Family Planning
    - Tuberculosis
    - Breast and Cervical

B. Key Findings: Traditional Medicaid

- Arkansas Medicaid program is on an unsustainable path, using conservative growth estimate of 5% for next five years.
- Between now and 2021, the general revenue portion to fund traditional Medicaid is projected to grow by $500 Million.
- Currently, the state has not implemented best practices that other states have used in Medicaid for a large part of costs, such as:
    - Hospital payment initiatives based on value and risk
    - Care Management strategies based on full or substantial risk and particularly involving management of aged, blind and disabled and other high cost populations – example: complex care for children
- 74% of traditional Medicaid claims are for the aged, blind, disabled (ABD) population. These claims fall heavily under the institutional care categories of service (hospitals and nursing homes) for services to the high risk, high cost elderly, disabled and behavioral health populations, and include additional medical costs ('halo' effect).
- Almost 20% of Medicaid expenditures are paid outside of the stringent controls of the Medicaid Management Information System (claims payment processing system).
- Key health value improvement programs (Patient-Centered Medical Homes, Episodes of Care) do not address the 74% of Medicaid costs incurred by the ABD population, but focus on the 26% of the Medicaid population who are not ABD.
- There is overly high use of nursing homes and other institutional settings.
    - Two-thirds of care costs for Arkansas' elders are paid to nursing homes. The average cost for caring for an elder in a private nursing home is approximately $67,000 per year, more than twice the $27,000 cost of caring for an elder in the home and community based programs, including the Elder Choice Waiver.

    - Institutional care accounts for one third of total developmental disability claims, of which 80% is for adult care and 20% is for pediatric care. The average cost for adult institutional care is $135,000 per person per year, compared with $69,000 in the Alternative Choices Waiver program. Pediatric institutional care averages $162,809, compared to $45,937 for community-based care under a waiver program.
- Arkansas hospitals are generally reimbursed at a maximum per diem amount, with a few paid on a cost basis, reconciled annually; both models include several different supplemental payments.
- In the past, the state has not been successful in rebalancing long term care. There is a lack of active and effective transitional services between hospitalization, nursing facility rehabilitative treatment paid for by Medicare, and community options. Combined with the lack of a single assessment process for LTC services, this results in a fragmented approach to care coordination and choice of least restrictive environment.
- The lack of an independent standardized clinical assessment for treatment planning and efficiency strategies for individuals who access mental health services is a major driver of the growth in mental health care expenditures.
- There is a lack of a comprehensive public mental health strategy designed to support recovery within a community-based care environment and divert individuals from unnecessary inpatient psychiatric hospitalizations, residential placements, and avoidable jail admissions. The mental health system lacks evidence-based practices and incentives for comprehensive care coordination.
- There are over 2,900 people who are now on the Developmental Disabilities Wait list, of which 2,640 already incur a total of almost $32 million in Medicaid costs.
- Among individuals receiving services for developmental disability, 96% of Waiver Spending is for Supportive Living
    - 20% of beneficiaries spend less than $20,000 – 80% less than $70,000
- The Stephen Group conducted a survey of the families of developmentally disabled individuals to determine the services they prefer. This survey found:
    - Supportive Living is the most highly valued service
    - Respite and Case Management were in respondents top 5 almost as often as Supportive Living, Supportive Employment is a distant fourth
- Wait list survey respondents seemed to value the full range of benefits – all services ranked in the top-5 for a substantial number of people
- The mental health system is highly siloed and fragmented. Case Management services are available in the DAAS and DDS home and community based services programs, but are not included in the mental health structure within DBHS. There is currently no IT capacity to track beneficiaries across program codes. However, the creation of the DMS Data Warehouse should provide DHS the ability to track beneficiaries across all treatment types.

- Arkansas implemented the PCMH model with 295,000 Medicaid beneficiaries in 2013, excluding the Aged, Blind and Disabled population and all waivers, and with limited risk. The model is based on care coordination and attention to transitions of care, primary care provider (PCP) practice transformation, and improved access based on 24/7 beneficiary telephone access. The full implementation timeline is three to five years; the model has so far seen some positive results in cost avoidance, primary care investments, and shared savings between the state and providers.
- Episodes of Care is a national best practice example, although the return on investment for the program is unclear.
- Arkansas has an atypically high cost for traditional Medicaid.
- Four of Arkansas' neighbors – Tennessee, Mississippi, Texas and nearby Kansas – all utilize full risk managed care for aspects of their populations and according to reports reviewed:
    - Texas saved over $3.8 B since FY 10 according to an independent Milliman study and is estimated to save $7.1 B through FY 2018.
    - Kansas reduced spending growth from 7.5% to 5% in the first two years and then used over $60 million in GF savings for their DD wait list, amounting to over $140 Million in total funds.
    - Tennessee significantly reduced reliance on nursing homes by changing levels of care while achieving budget neutrality for LTC.
- The Task Force found that the Rehabilitative Services for Persons with Mental Illness (RSPMI) Behavioral Health benefits program had significantly increased in costs for several years prior to 2014 without a corresponding decrease in high cost psychiatric inpatient and residential services. In 2014, DHS/DBHS attempted to introduce effort to bring accountability to these services. For a variety of competing interests, the necessary Rules and Benefits changes were not implemented at that time.
- The Stephen Group conducted a detailed claims and services code level analysis on utilization for 2014. Findings indicated a large number of beneficiaries (40,000+) using an unreasonably low amount of services for BH Rehabilitative level services, a small group of consumers using an abnormally high amount of services clustered among few providers, and an unusual pattern of RSMPI services being delivered in school settings.
- Simultaneous to the RSPMI claims/code analysis, the Office of the Medicaid Inspector General (OMIG) was engaged in a multi-state analysis of a certain Group Psychotherapy service billing code that indicated that Arkansas utilization of this service far surpassed that of neighboring states at a substantially higher rate. In reviewing the school based claims data with OMIG, there was a correlation with the use of this code regarding overutilization.
- OMIG reported their recommended changes to the Group Psychotherapy benefit (daily and annual unit caps and a rate reduction) to the Task Force, who supported OMIG

moving forward through the necessary rules and rate changing processes. This will result in an expected savings of $15 million in FY 17.

- DHS has implemented a comprehensive pharmacy reform that resulted in an anticipated $52.5 M annual savings.
- Two Committees of the Task Force were appointed to solicit testimony, conduct further research and develop findings and recommendations relative to Diagnostic Related Groups (DRG) and Human Development Centers (HDC). Their recommendations are listed below.

C. Key Findings Across Both Programs

- Arkansas Health Status is low compared to other states.
- Not enough emphasis is placed on health care value, meaning the return on investment of Medicaid dollars.
- There is an across-the-board focus on large claims processing and not on an outcome based model.
- There is no benchmarking of outcomes for quality and improved health.
- Medicaid is only one piece of the total health status outcome, but an important one.
- Health care professionals and community members believe that the PO has had a positive impact on health disparities, with many people having access to health coverage for the first time. However, they recognize the need for education and community-based assistance on the process of navigating the health care system to help people learn how to access the right services at the right time, thereby addressing access disparity, increasing self-responsibility, and avoiding unnecessary costs such as unnecessary ER use.
- Audits at the facility and provider level and of providers and associated care plans are limited.
- Traditional and PO conversion to MAGI, the new ACA financial eligibility standard, coupled with the effort to convert to a new eligibility software system has led to significant obstacles and setbacks in eligibility verification. DHS is working to improve the eligibility system today, but has in the past experienced a significantly increased workload to verify eligibility and enroll expanded Medicaid applicants, with little increase in resources. DHS is still in the transition from the legacy Medicaid administration system to the new systems.
- There have been delays in the updating of Curam – the eligibility system software – and that has caused problems in the past with timely eligibility reviews.
- The current Curam software to manage the basic enrollment and re-enrollment process does not manage all basic Medicaid requirements, including removing incarcerated beneficiaries from receiving services, and must be supported with manual DHS processes.

- A data scrub by Lexis Nexis flagged a substantial number of out of state addresses for participants of both PO and Traditional Medicaid (Traditional Medicaid 22,781, PO 20,110). Note: The out of state addresses could be for individuals that resided out of state but moved into Arkansas prior to PO or Medicaid eligibility.
- DHS paid average claims of $301 for brand name drugs and $32 for generic drugs, compared to PO carriers paying a combined average of $190 for comparable brand name drug claims and $15.66 for generic drugs.
- Private Option carriers had roughly twice the claims for opioids as a percent of all drugs, as compared to DHS, and a higher percent of drug utilizers with at least one opioid claim. The numbers are less pronounced when considering that the average age of Private Option beneficiaries is 42 years old, compared to 24 years old for traditional Medicaid. The top conditions reported for high utilizing beneficiaries do not support long term use of opioids. Clinical personnel at DHS do not have access to the State Prescription Drug Monitoring Program database.
- The expenditures of the 1.6% of DHS beneficiaries who approached or hit the per person per month claim limit made up 40% of total drug claims. However, much of this population requires consistent access to maintenance drug therapy for chronic health conditions and interruptions in drug treatments could lead to preventable complications resulting in additional health care costs.
- DHS' preferred drug list covers 38% of all claims paid in the FFS program, compared to an average of 64% in comparable states and a best practice figure of 80%. Eighty five percent of claims at DHS are for generic drugs, accounting for 30% of total drug spend, slightly higher than the 22% average of other states reviewed.
- DHS contracts with more than one call center for its Medicaid pharmacy benefit.

D. Task Force Votes

- The Task Force voted to pass the following resolutions and objectives at the December 22, 2015 meeting:
    - "We move to support the Governor's efforts to negotiate waivers from the Centers for Medicaid Services (CMS) consistent with the Arkansas Works framework and we further agree that a minimum of $835 million over 5 years need to be saved from the Medicaid budget and we support further efforts to identify those savings"
    - "We move to task The Stephen Group to assist the Task Force to find at least $835 million in savings without managed care, with the exception of dental."
    - Support the Governor's efforts to negotiate waivers CMS consistent with the Arkansas Works framework
    - Conduct further hearings consistent with its statutory charge
    - Make specific recommendations that will identify a minimum of $835 million in savings over 5 years

E. Arkansas Works

On June 28, 2016, Governor Hutchinson submitted the Arkansas Works waiver to the federal Secretary of Health and Human Services Sylvia Burwell. That waiver can be found here: https://www.medicaid.state.ar.us/Download/general/comment/ARWorksAppFinal.pdf. On December 8, 2016, the Arkansas Works waiver received final approval by the Secretary.

The Arkansas Works waiver, in its entirety, will make the following changes in Medicaid for those individuals newly eligible for Medicaid under the Affordable Care Act:

- Premium Assistance to those with employer sponsored health care – this change would require those with access to health insurance through their employer to take that coverage, with Medicaid providing coverage for premiums sharing, deductibles and co-payments
- Cost sharing for those not in poverty – this change would require all those between 100-138% of the federal poverty limit to pay 2% of their income in cost sharing payments; failure to pay premiums would result in the loss of enhanced benefits
- Elimination of retroactive eligibility – this change would cause eligibility to start upon application for Medicaid coverage, and end the practice of having Medicaid pay claims for up to 90 days prior to applying for Medicaid
- Work referrals – this change would give work referrals to the Department of Workforce Services to all individuals who apply for Medicaid and have an income less than 50% of the federal poverty limit and would have DHS offer work training opportunities to those of all incomes
- Wellness promotion – beneficiaries would be required to have a wellness visit with a primary care provider (PCP) within the first year or lose enhanced benefits
- Elimination of the Health Independence Accounts – this change would eliminate Health Independence Accounts under the Private Option, which were determined to be an inefficient way of promoting consumer choice and personal responsibility among beneficiaries

These change were put in place with the goal of enhancing accountability, personal responsibility and shifting the focus of the newly eligible, able-bodied population to focus on work participation.

F. Findings relative to Financial Impact and Cost Shift

Through the Private Option/Arkansas Works, the state has been able to shift state costs away from the traditional Medicaid program by moving populations to the newer programs, which offer a higher federal matching rate. This shifting occurred through both eliminating some programs in the traditional Medicaid program that were then picked up in expansion or by

moving some of those who were eligible for traditional Medicaid who were also eligible for expansion to the newer program.

Private Option Impact on Traditional Medicaid Spending

The following table shows the apparent impact of the PO on the general fund, through reductions in expenditures from traditional Medicaid, other impacts on expenditures, and new revenue from premium taxes and other economically sensitive taxes, based on data available from DHS.

Projected Aggregate Private Option Impact (SFY 2017-2021)							
(all figures millions $ unless otherwise indicated)							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures (all funds)		1,721	1,820	1,924	2,035	2,152	9,652
Impact on State Funds							
Impact on state expenditures	**State match on Private Option**	43	100	125	173	215	656
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(21)	(22)	(23)	(25)	(26)	(117)
	State fund savings from cost-shifting from traditional Medicaid to PO	(91)	(96)	(101)	(106)	(111)	(504)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	**(104)**	**(54)**	**(37)**	**3**	**37**	**(154)**
Impact on state revenues	**Increase in premium tax revenue**	22	23	25	26	27	123
	Increase in collections from economically-sensitive taxes (4%)	67	69	72	74	77	360
	Total impact on revenues	**89**	**92**	**97**	**100**	**105**	**483**
Net impact on state funds		**193**	**146**	**133**	**97**	**68**	**637**

Private Option Impact on Traditional Medicaid Enrollment

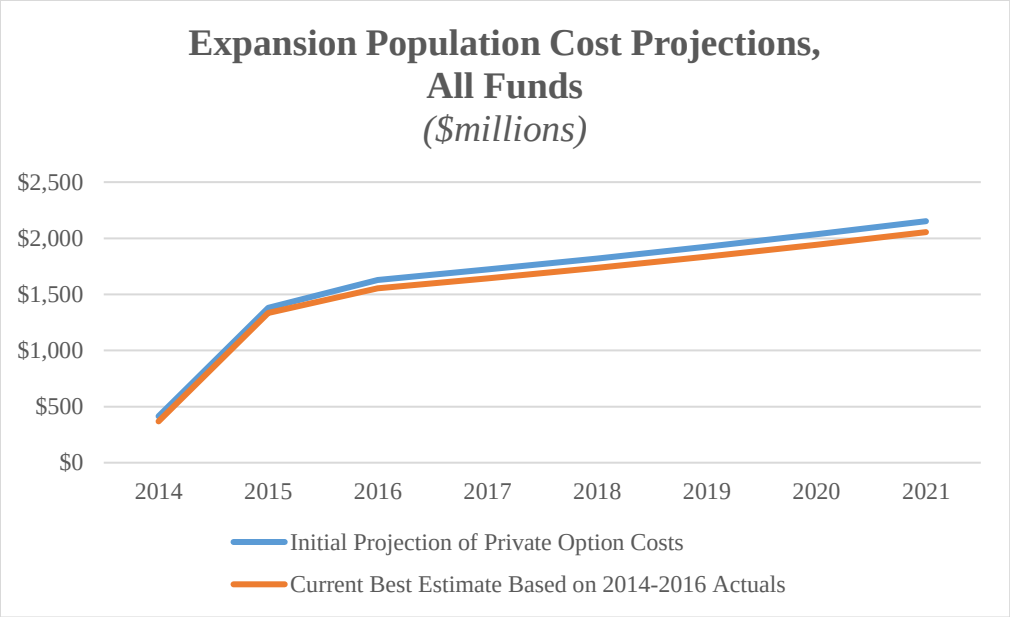
The following analysis shows the changes in enrollment in different Aid Categories after the establishment of the PO. The 'Other' aid category shown below, which includes ARHealthNetwork and the several waiver programs that were discontinued after the PO was established, disappears.

Aid Category	Average Enrollment 2011-2013	Average Enrollment 2014-2016	% Change	Average Annual Cost of Aid Category (2016)
Low Income Children & Pregnant Women	306,580	347,165	13.2%	$3,130
SSI Disabled	115,955	108,344	-6.6%	$12,357
ARKids	76,426	58,281	-23.7%	$1,526
Other	61,503	754	-98.8%	$14,770
Medically Needy Aged	61,426	64,205	4.5%	$11,390
Medically Needy Families & TANF	27,644	41,997	51.9%	$2,991
Medically Needy Disabled	28,805	30,795	6.9%	$16,043
SSI Aged	6,644	5,700	-14.2%	$6,644
Adoption and Foster Care	7,091	8,550	20.6%	$9,929
Spenddown Disabled	1,596	205	-87.2%	$93,929
Spenddown Families & TANF	534	13	-97.7%	$76,550
Newly Eligible Adults	19	249,057		$5,811

Current Cost Projections

Currently, the cost of the Private Option has held slightly below the initial cost estimates when the program was first implemented. There was some concern about costs, driven largely by overruns on the Medically Frail population.

Maintaining the PO cost under the estimates is critical, since the Private Option was included in a federal waiver that requires a cap of federal participation, meaning state taxpayers would be responsible for costs above the cap.



Expansion Population Cost Projections, All Funds ($millions)								
	2014	2015	2016	2017	2018	2019	2020	2021
Initial Projection of Private Option Costs	$414	$1,379	$1,627	$1,721	$1,820	$1,924	$2,035	$2,152
Current Best Estimate Based on 2014-2016 Actuals	$368	$1,335	$1,553	$1,643	$1,737	$1,837	$1,943	$2,054

III. Task Force Recommendations

A. General Statement Regarding Recommendations

Over the duration of the Task Force, there has been substantial change in the nature of the Medicaid program. The Private Option was replaced by Arkansas Works, with many changes recommended by this body.

The Task Force commends the many individuals, groups and fellow legislators that offered their ideas, opinions and knowledge. The list of those who testified, submitted information and made personal contact to Task Force members was both expansive and comprehensive, and added a great deal to the work of this effort. In particular, the Task Force would like to offer our sincere thanks to the Department of Human Services for its assistance and responsiveness.

However, under the limitations of time and bandwidth, there was only so much time for this group to make good on the charge of the Legislature to advance change. With the termination of this group, we offer a number of substantive suggestions to continue to "[e]xplore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled."

Many of these recommendations tie directly to the responsibility the Task Force assumed to work to identify savings in the state's Medicaid program totaling, at a minimum, $835 million. Others relate to program improvements to advance the goals of the Medicaid program and improve beneficiary health status efficiently and effectively.

B. Arkansas Works: Continued Review

Clearly, there will be a number of opportunities to reshape the Medicaid program in 2017 and beyond. The changes taking place at the federal level will undoubtedly impact Arkansas in ways that are currently unknowable.

The incoming administration has clearly signaled two top priorities: repealing the Affordable Care Act and enhancing state flexibility through block grants. Both of these changes, if implemented would have a dramatic impact on the landscape of both traditional Medicaid and Arkansas Works.

Should the Medicaid program become a true block grant, many of the prior ideas raised during Task Force hearings and in prior reports could be implemented. This includes such items as:

- Work requirements for eligibility for able-bodied adults
- A Wellness Scorecard for incentivizing prevention
- Tailoring health benefits to meet individual needs
- Co-payments for inappropriate use of services (such as non-emergent ER visits)
- Cost sharing among the able-bodied adult population
- Tailoring eligibility standards to mitigate health disparities
- Payments to employers for insuring workers who might otherwise be Medicaid eligible
- Asset tests, and asset limits, for some Medicaid applicants
- Benefit limits for able-bodied adults

These are merely a small sample of potential changes that might become available to Arkansas Medicaid. Clearly, federal action will drive much of the program's future, so a great deal of vigilance by the Legislature will be necessary over the coming months to ensure that the state is prepared to move quickly to adapt and adjust to the new landscape.

C. Traditional Medicaid Program Reform

Traditional Medicaid in Arkansas's annual growth of 5% represents a pathway that requires reform, as it is the largest program in state government and on its current trajectory, threatens the future viability of other critical programs across the state. Instituting cost controls that limit Medicaid program growth are essential to the state's long-term solvency.

The Task Force has resolved to support the Governor's proposed $835 million savings initiative over five years to identify sufficient state general funds to support the state share of Arkansas

Works. Beyond this, the Task Force established a benchmark of $1 billion in savings over five years in order to take the necessary steps to limit program growth to ensure the long-term future of the Medicaid program.

These savings targets inform the basis for a number of the following recommendations in this report.

Through an analysis of program data, the Task Force identified the primary cost drivers among the high cost populations, many of which are not managed in any way. By isolating these areas, the Task Force has been able to work with providers and stakeholders, many of whom have submitted cost savings plans on their own.

Additionally, based upon findings and recommendations by this Task Force, DHS is moving forward with a number of reforms and program changes that will assist in identifying these savings, operating in a very proactive manner.

These changes, including major organizational changes at DHS, help to reduce the need for more dramatic changes by the Legislature, particularly in the areas with long-term populations, who critically need appropriate Medicaid services.

D. Recommended Behavioral Health Program Savings and Investments

The Task Force recommends and supports the Arkansas Department of Human Services moving forward transforming the Rehabilitative Services for Persons with Mental Illness (RSPMI) benefit into an evidence based/best practice Adult and Children/Adolescent Mental Health Rehabilitation Option benefit and that access to the revised benefit should be based on identified diagnoses and an independent assessment.

A report to the Task Force last year included recommendations for revision of the RSPMI Behavioral Health benefits program to an acuity based program eligibility model based on independent assessment, identified Adult and Child Behavioral Health services, evidenced based practices, and an increase in targeted services for adults, children and youth that are community based and designed to decrease reliance on expensive psychiatric inpatient for adults and residential services for children/youth, plus care coordination and an identified Behavioral Health home.

To a large extent, these recommendations mirrored the efforts of DHS/DBHS in 2014. Specific changes include:

- Redefine the SED and SMI category based on clinically-driven parameters (Counseling, Tiers II and III)
- Implement evidence based practices to a greater degree
- Implement independent assessment

- Reduce reliance on Inpatient Psychiatric Hospitalizations and Residential Treatment through Rules, process, approval changes and further development of Systems of Care and Wrap Around for SED children/youth
- Create a Therapeutic Residential services per diem benefit that addresses the 911 population
- Increase process efficiency and reduction of administrative burden upon providers
- Refine clinical eligibility for school based BH Outpatient services
- Reduce utilization of RSPMI Collateral and MHP/MHPP Intervention units (90887 HA, 90887 HA UB)
- Reduce utilization of Group Outpatient RSPMI benefit (90853)
- Ensure that multiple at school services rehabilitative level services and intensive level services in the school setting are necessary
- Assure that school- based programs are actually being operated during the summer while schools are closed or moved to another location without proper coding
- Care coordination and health homes for those served by DBHS is under consideration through either a managed fee for service or provider-led Accountable Care Organization model

As a result of the work of the Task Force, Medicaid Behavioral Health Services will improve in quality and outcomes, increase appropriate and effective use, and decrease costs. Savings of $15 million are expected in FY 2017 as a result of the OMIG led changes to the Group Psychotherapy benefit. Total savings of $215 million are projected for Behavioral Health Services from SFY 2018 to SFY 2022, inclusive of projected costs for Independent Assessment and Care Coordination investments.

E. Recommended Developmental Disability Program Savings and Investments

The Task Force recommends and supports the Arkansas Department of Human Services moving forward with a new waiver for a comprehensive revision of the Developmentally Disabled Services (DDS) Alternative Community Services waiver that is based on independent assessment, three levels of care, an institutional cost limit, tiered payments, and focuses on employment and community choices.

The Task Force found that DHS/DDS program expenditures were concentrated in the Human Development Centers, Alternative Community Services Waiver, and the Developmental Day Treatment Clinic (DDTCS) and Child Health Management Services (CHMS) programs that deliver Occupational, Physical, and Speech Therapy and Language (OT, PT, SL) state plan services.

Findings included a lack of independent assessment and authorization for OT, PT, and SL services, the volume of services was provider driven, and there were no annual benefit limits for

these services. The Task Force also found that the current waiver plans of care and cost were not based on need for services derived from an independent assessment, that the waiver had an upper payment limit of $176 a day ($64,064 annually) regardless of level of need for services, and that case management was not independent from the waiver services providers.

The Task Force recommends that DHS/DDS implement a three tier based waiver, similar to the current Tennessee Developmental Disabilities Home and Community Based Services waiver, as follows: 1) Essential Family Supports when a person chooses to live at home with their families (capped at $15,000 per year); 2) Essential Supports for Employment and Independent Living when a person chooses to live independently in the community and wishes to be employed (capped at $30,000 per year plus $6,000 for emergency situations); and, 3) Comprehensive Supports for Employment and Community Living when a person requires more complex services and supports to live in the community and be employed (capped between $45,000 and $60,000 per year). The Tennessee waiver uses an independent assessment to determine a person's tier of care.

The necessary Rules changes for the OT, PT, and SL state plan services (90 minutes per week each for these services) have been filed and reflective of the benefits of the DHS reorganization implemented by Director Gillespie related to integrated Medicaid policy development and shared services. Rule changes are scheduled to be voted on by the Arkansas Legislative Council on 12/16/16 for implementation on 7/1/2017. The Task Force recommends these Rule reforms.

The Task Force also recommends the implementation of an independent assessment for tier based DDS Home and Community Based Services waiver services and the implementation of Occupational, Physical, and Speech and Language therapy caps based on an Independent Developmental Screen that are expected to result in savings of $205 million between SFY 2018 and SFY 2022, including $8 million total costs for the independent assessment. Care coordination costs for the people served by DDS are in the process of being determined.

F. Recommended Care Management Model for BH and DD

The Task Force recommends and supports the Arkansas Department of Human Services developing and implementing a comprehensive approach that provides care management and coordination to all behavioral health and non-institutional intellectual and developmentally disabled populations eligible for Medicaid services. Care management includes the identification, stratification, and prioritization of high risk and complex individuals for the coordination of evidence based services, supports, and interventions that are provided in a cost effective and non-duplicated plan of care, and include provider payment accountability and risk for outcomes and quality.

The Task Force identified the critical importance of the implementation of comprehensive care coordination strategies for complex, high cost Aged, Blind, and Disabled beneficiaries served by Arkansas' Behavioral Health, Developmental Disabilities and Long Term Care services regardless of whether DHS evolves to a managed fee for service, managed care, or maintenance of the fee for service system in place.

The Task Force's assessment of the Arkansas Medicaid program as a whole found that comprehensive care coordination for the high cost BH and DDS populations was fragmented in relation to other medical services, resulting in a lack of integrated care for these individuals, and that there is a lack of alignment of financial incentives and risk among all providers serving the high cost populations. Importantly there are no incentives and risk for high quality outcomes and cost savings resulting from improved health status in the current services delivery model.

The Task Force has reviewed and discussed the care coordination aspects of the PCMH, "Diamond Care"/managed fee for services, managed care models and accountable care organizations, including projections of savings for SFY 2018 through SFY 2022.

Whatever the final model selected, the Task Force recommends that the model work to integrate and coordinate the care of each individual receiving Medicaid services, instead of continuing the siloed approach to care that results in uncoordinated care, increases cost and produces health outcomes that could be improved.

G. Recommended Long Term Care Program Savings and Investments

The Task Force supports the memorandum of understanding entered into by the Arkansas Department of Human Services and Arkansas Health Care Association on Mary 20, 2016 to achieve $250 Million in savings over a 5-year period through improved, high quality, person-centered, and cost-efficient Long Term Services and Support care delivery reform. The Task Force supports reforms to ensure supports and services in the community are cost effective, effectively serve transitions among care settings, and eliminate fragmentation and duplication in service coordination and delivery. Other reforms contained in the memorandum of agreement, including independent assessment, tiered levels of care, acuity-based and risk adjusted, and effective care management, coordination, and transition strategies, designed to enhance the most cost effective and quality enriched care are also supported.

Governor Hutchinson and the Arkansas Health Care Association entered into a memorandum of understanding (http://ee-governor-2015.ark.org/images/uploads/160520_MOU.pdf) to work closely to expand the use of community based care. This effort would result in expanded community choices and savings of $250 million over five years, while also ensuring a better continuum of care for those who qualify for long-term care services.

The Task Force fully supports these efforts and recommends they continue. The Legislature will need to monitor the progress of this MOU to ensure that this agreement yields the quality and cost savings included.

H. Recommended Pharmacy Program Savings

The Task Force recommends and supports the Arkansas Department of Human Services continuing implementation of the pharmacy quality and programmatic savings initiatives to achieve $262.5 Million is savings over a 5-year period through expansion of the preferred drug list (PDL), expansion of the CAP initiative, comprehensive management of antipsychotic medications by a Department psychiatrist for adults and children, limiting waste and clinically managing patients requiring hemophilia factor products, and reconfiguring reimbursement structure and rates for retail pharmacy providers. These initiatives are either fully underway or in the final stages of approval (CMS or State) prior to full implementation.

Prescription drug coverage is essential to an effective Medicaid program. However, Prescription spending is growing faster than other medical expenses, 12.9% in 2014 and 9% in 2015, an unsustainable rate. DHS pharmacy program costs over $400 million per year made up of over 5 million claims. The Task Force supports the ongoing efforts by DHS to implement the pharmacy quality and programmatic savings initiatives above.

The total annual estimated pharmacy savings are broken down as follows:

Total Annual Savings	**Savings $ millions**	**Effective Date**
PDL expansion	$10	Q4 2016
CAP expansion	$1	Q1 2017
Comprehensive antipsychotic management in adults (Abilify generic)	$20.5	Ongoing
Antipsychotic review (7,8,&9year olds)	included	Q1 2017
Manual Review Antidepressants (<4year olds)	included	Q1 2017
Manual review long acting antipsycotics	included	Q2 2016
Antipsychcotic review (10,11,&12year olds)	included	Q4 2017

Hemophilia factor waste and clinical management	$1	Q1 2017
Retail Pharmacy Reimbursement Reconfiguration	$20	Q2 2017
Total	$52.5	

I. Recommended Dental Managed Care Savings

The Task Force recommends that the Legislature closely monitor the implementation of managed care for dental services in Medicaid. Notably, ensuring network adequacy, vendor oversight and seeing that the Department meets its cost saving estimates.

The Dental Managed Care RFP was issued, responses received, and evaluated. An announcement of the anticipation to award contracts to two dental managed care organizations is expected imminently. The contracts will be submitted to the Legislature for review and contracts are anticipated to start in quarter one 2017. The dental managed care plans are expected to enroll members and begin services effective 1/1/18.

Currently, DHS offers dental providers a deferred compensation package that offers providers tax savings. As part of the RFP, DHS asked bidders to respond to how they would address deferred compensation. Dental providers have threatened to not participate in the dental MCO networks if deferred compensation is not addressed. DHS needs to monitor network adequacy as a result of this issue.

It is important for DHS to understand and plan for the fundamental shift in moving from fee for service oversight to managed care health plan oversight. DHS staff needs to be reorganized and retrained so that their focus shifts to health plan contract oversight and monitoring for dental managed care. If the dental MCO contracts are not monitored properly, savings from the move to managed care could be jeopardized.

J. Patient-Centered Medical Home (PCMH)

The Task Force recommends that DHS should expand the Patient-Centered Medical (PCMH) Home Program to include more enrollees and services, and should share

information on provider Episode-of-Care (EOC) performance with primary care practices participating in the PCMH program.

The Task Force identified several ways that the patient-centered medical home (PCMH) program could be adjusted to increase potential cost savings.

- Increasing the number of beneficiaries covered by PCMH by lowering the required number of beneficiaries served by a practice to include more primary care providers (PCPs).
- Increasing the effectiveness of PCMH by providing PCPs with information about the cost-effectiveness of Principal Accountable Providers associated with Episodes of Care.
- Increasing the services managed by PCMH by including low-level behavioral health services in the primary care office.

DHS is already implementing certain program changes to increase the cost and clinical effectiveness of the PCMH program, including the following:

- Lowering the required number of beneficiaries served by a practice, which will make more PCPs eligible and align with the federal Comprehensive Primary Care Plus (CPC+) initiative.
- Doing additional outreach to bring more PCPs into the program.
- Authorizing billing for behavioral health services on the same day and in the same location as primary care services.

While the agency anticipates that these initiatives will result in additional cost savings, the specific level of savings anticipated has not been identified.

K. Five Year Net Savings Plan for Traditional Medicaid along with program savings and investment recommendations

The Task Force recommends and supports that the Arkansas Department of Human Services develop and implement a Five-Year Medicaid Program Savings Plan that is in excess of the $835 million in net savings to trend proposed by Governor Asa Hutchinson starting no later than July 1, 2017. Savings must be achieved through an increase in care management and coordination resulting in improved outcomes, quality, appropriate utilization based on need, reduction of duplication and unnecessary services, and the introduction of value based purchasing strategies and some degree of provider risk. The Department of Human Services will provide a Comprehensive Medicaid Budget Savings Dashboard Report tracking savings to trend to the Bureau of Legislative Research every quarter commencing September 1, 2017 and thereafter for five years.

This analysis, by The Stephen Group, considers three primary models for reducing spending in Arkansas' traditional Medicaid program below:

1) The "Current Model" – a set of benefit modifications and program adjustments that have been identified over the last 2 years with the Task Force.
2) A Provider-led "Collaborative Care Organization" model that has been put forth by the DHS for the behavioral health and developmental disability enrollee populations.
3) A capitated managed care model for the behavioral health and developmental disability enrollee populations that is being analyzed for comparison

In the following sections, the savings assumptions for the different models and the anticipated savings are described. For all of the models, the baseline is a 5% annual cost increase starting with SFY 2015 actual expenditures.

Baseline and Savings Models

The following table shows the baseline spending projection, along with the spending projections with the implementation of the different cost savings models. The baseline and cost savings model projections are shown with and without Arkansas Works expenditures.

All Figures in $Millions; Years are SFY								
Model/ Program	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2017 – 2021**	**2018 – 2022**
Baseline, Traditional Only	$5,379	$5,648	$5,930	$6,227	$6,538	$6,865	$29,722	$31,208
"Current Model", Traditional Only	$5,302	$5,495	$5,757	$6,026	$6,322	$6,649	$28,902	$30,249
Provider-Led CCO for BH and DD, Traditional Only	$5,302	$5,495	$5,757	$6,026	$6,227	$6,549	$28,806	$30,053
Capitated Managed Care for BH and DD, Traditional Only	$5,302	$5,495	$5,757	$5,951	$6,202	$6,523	$28,707	$29,928
Arkansas Works	$1,721	$1,820	$1,924	$2,035	$2,152	$2,276	$9,652	$10,207
Baseline, Traditional and AW	$7,100	$7,468	$7,855	$8,262	$8,690	$9,141	$39,374	$41,415
"Current Model", Traditional and AW	$7,023	$7,315	$7,681	$8,061	$8,474	$8,925	$38,554	$40,456
Provider-Led CCO for BH and DD, Traditional and AW	$7,023	$7,315	$7,681	$8,061	$8,379	$8,824	$38,458	$40,260
Capitated Managed Care for BH and DD, Traditional and AW	$7,023	$7,315	$7,681	$7,986	$8,354	$8,798	$38,359	$40,135

Current Model

The following table describes the cost saving strategy for each program under the "Current Model", and the assumptions regarding the timing of the cost savings and any administrative costs that will need to be borne by the agency to affect such changes.

	Savings Strategy	Savings Timing	Admin Considerations and Costs
DD	$18M per year in therapy caps; $14M/yr. from screenings for children[1]; $17M/yr. from independent assessment and tiers for waiver services	therapy caps and screenings for children begin July 1, 2017 (savings over 5 years); independent assessment and tiers start July 1, 2019	$2M per year for independent assessments starting July 1, 2019
BH	Updated outpatient policy, reduction in inpatient from independent assessment	Begins July 1, 2017; savings over 5 years	$108M investment over 5 years for independent assessment and care coordination
Dental	$5M per year in savings from capitated managed care	Begins Jan 1, 2018	
Elder	Industry MOU to save $250M over 5 years	Begins July 1, 2016; savings evenly spread across 5 years; assume $50M/yr. savings continues into SFY2022	None
Low-cost	No program changes		
Pharmacy	$250M in savings	Begins July 1, 2016; savings evenly spread across 5 years	

The following table shows the anticipated savings from the programmatic changes already being implemented.

[1] Note: The DDTCS and CHMS providers have a lower savings estimate of $5 Million per year due to the screening changes

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
DD Savings - Therapy Caps	$0	$18	$18	$18	$18	$18	$72	$90
DD Savings - Screenings for Children	$0	$14	$14	$14	$14	$14	$56	$70
DD Savings - Independent Assessment and Tiers/Waiver Changes	$0	$0	$0	$17	$17	$17	$34	$51
DD Cost - Independent Assessment	($0)	($0)	($2)	($2)	($2)	($2)	($6)	($8)
Net DD Savings	$0	$32	$30	$47	$47	$47	$156	$203
BH Savings - Updated Outpatient Benefits Policy	$12	$16	$33	$33	$33	$33	$127	$148
BH Savings - Inpatient	$0	$15	$25	$35	$50	$50	$125	$175
BH Cost - Independent Assessment	($0)	($1)	($2)	($2)	($2)	($2)	($7)	($9)
BH Cost - Care Coordination	($0)	($15)	($21)	($21)	($21)	($21)	($78)	($99)
Net BH Savings	$12	$15	$35	$45	$60	$60	$167	$215
Dental Savings - Capitated Managed Care	$0	$3	$5	$5	$5	$5	$18	$23
Dental Premium Tax	$0	$3	$3	$4	$4	$4	$14	$18
Net Dental All-Funds Impact	$0	$6	$8	$9	$9	$9	$32	$41
Elder Savings	$15	$50	$50	$50	$50	$50	$215	$250
Low-Cost Populations	$0	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$50	$50	$50	$50	$50	$50	$250	$250
Net Fiscal Impact	**$77**	**$153**	**$173**	**$201**	**$216**	**$216**	**$820**	**$959**

If the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $963 million between SFY2018 and SFY2022.

Provider-Led CCO Model

DHS has put forward the concept of provider-led coordinated care organizations for the BH and DD programs. The following table describes the cost saving assumptions for the CCO-based approach proposed by DHS.

	Savings Strategy	Savings Timing	Admin Considerations and Costs
Current strategy	All savings from current strategy as above	As above	As above
DD Provider-led CCO model	Care coordination for DD halo services	5% savings off of halo spend starting year 4	Savings net of admin costs (admin under APCCO/RCCO payment)
BH Provider-led CCO model	Care coordination for BH halo services	5% savings off of halo spend starting year 4	Savings net of admin costs (admin under APCCO/RCCO payment)

The following table describes the projected cost savings from the provider-led CCO model. The starting point for these cost savings are the cost savings from the programmatic changes already identified and described in the previous tables. There remains an opportunity for additional savings within the DD and BH programs through greater care coordination, specifically with respect to the medical and pharmacy benefits (the "halo" spend for the BH and DD populations).

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
All cost savings from current model	$77	$153	$173	$201	$216	$216	$820	$959
DD Provider-Led CCO Model Savings	$0	$0	$0	$0	$12	$13	$12	$25
DD Provider-Led CCO Model Premium Tax	$0	$0	$0	$0	$26	$27	$26	$52
Net additional DD all funds impact	$0	$0	$0	$0	$38	$40	$38	$77
BH Provider-Led CCO Model Savings	$0	$0	$0	$0	$28	$29	$28	$57
BH Provider-Led CCO Model Premium Tax	$0	$0	$0	$0	$30	$31	$30	$61
Net additional BH all funds impact	$0	$0	$0	$0	$58	$61	$58	$118
Net Fiscal Impact	**$77**	**$153**	**$173**	**$201**	**$311**	**$316**	**$915**	**$1,154**

If the DD and BH provider-led CCO models, and the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $1,159 million between SFY2018 and SFY2022. Note that this assumes $61 Million in premium tax revenue, which DHS is currently reviewing the issue to determine if future legislation is required should the state move in this direction.

Capitated Full Risk Managed Care Model

Recognizing that most states are moving toward greater use of capitated managed care in their Medicaid programs, TSG has developed the following projections of capitated full risk Medicaid managed care for the BH and DD populations. The following table describes the cost saving assumptions for the capitated managed care approach.

	Savings Strategy	**Savings Timing**	**Admin Considerations and Costs**
Current strategy	All savings from current strategy as above	As above	As above
DD Capitated Managed Care	Care coordination for DD halo services	8.07% savings off of halo spend starting year 3	Savings net of admin costs (admin under MCO payment)
BH Capitated Managed Care	Care coordination for BH halo services	8.07% savings off of halo spend starting year 3	Savings net of admin costs (admin under MCO payment)

The following table describes the projected cost savings from the capitated managed care model. As above, the starting point for these cost savings are the cost savings from the programmatic changes already identified and described in the previous tables.

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
All cost savings from current model	$77	$153	$173	$201	$216	$216	$820	$959
DD Capitated Managed Care Savings	$0	$0	$0	$19	$20	$21	$39	$59
DD Capitated Managed Care Premium Tax	$0	$0	$0	$24	$26	$27	$50	$77
Net DD additional all funds impact	$0	$0	$0	$43	$45	$48	$88	$136
BH Capitated Managed Care Savings	$0	$0	$0	$3	$45	$47	$48	$96
BH Capitated Managed Care Premium Tax	$0	$0	$0	$28	$30	$31	$58	$89
Net additional BH all funds impact	$0	$0	$0	$32	$75	$78	$107	$185
Net Fiscal Impact	**$77**	**$153**	**$173**	**$276**	**$336**	**$342**	**$1,015**	**$1,280**

If the DD and BH capitated managed care models, and the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $1,284 million between SFY2018 and SFY2022.

IV. Other Recommendations

A. Eligibility and Enrollment Framework Project

The Task Force recommends that the Arkansas Legislature continue to monitor progress and receive timely updates to ensure the successful award and implementation of the Arkansas Medicaid Integrated Eligibility - Benefits Management System (IE-BM).

DHS has hired a consultant, Gartner, to assess the systems and make recommendations to enhancing the EEF project. It will be incumbent upon the Legislature to monitor this closely, as the DHS has worked to reduce the backlog successfully, but must also ensure that the Department moves forward effectively on resolving the system issues. DHS currently is prepared to issue an RFP on this project, and should check in with the Legislature throughout the process.

B. DD Wait List

The Task Force recommends that DHS develop a plan to provide services to those on the Developmental Disability Waiting List, either through a benefit structure that is capped with tiered levels of payment for some services, or through the Governor's plan to use Tobacco Settlement Funds to provide services for those currently waiting for waiver services on the Developmental Disabilities Waiting List.

Currently there are over 2,900 individuals on the Arkansas Alternative Community Services Waiver Waiting List. During hearings we received testimony and showing that all of these individuals are receiving Medicaid covered health services and some are also receiving state plan services. However, most are waiting to be approved for home and community based waiver services that they are unable to access today, such as the supportive living benefit. These Medicaid home and community based services are effective and designed to keep individuals from a more expensive and more restrictive setting.

Task Force heard testimony from DHS about the Governor's desire to use Tobacco Settlement funds to provide services for those currently waiting for waiver services. The total amount of Tobacco Settlement dollars available is approximately $8.5 Million. The federal matching funds bring that total to approximately $28 Million dollars. These funds could be used to cover approximately 499 individuals with developmental disabilities with home and community based waiver services in the next fiscal year.

The Task Force supports the Governor's plan to use Tobacco Settlement dollars to provide waiver services for those currently on the developmentally disabled waiting list and encourages DHS to identify cost effective ways of serving even more individuals with developmental disabilities who are eligible for the full array of home and community based waiver services in the future.

C. Organizational recommendations to support DHS Transformation

The Task Force recommends that DHS continue its ongoing efforts to enhance care integration and focusing the organization of the department around bringing services to individuals, as opposed to keeping individuals in distinct systems of care that lead to fragmented services. Additionally, DHS should continue to expand its efforts to leverage greater efficiency of economy of scale through a shared service model that promotes excellence across the Department. The Arkansas Legislature should monitor these efforts to ensure they maximize both quality improvements and cost reductions.

An earlier review of DHS organization found that the structure did not support moving the entire Medicaid program into an integrated services care coordination model. Instead, it prioritized single issue policy making and forced individuals to travel through different systems of care. This led to poor customer service, lack of accountability and coordination and inefficient service delivery.

The Stephen Group's "Recommendations Report" last year recommended that the reorganization of DHS into a value based enterprise be based on elevating the Medicaid program to the DHS Director's Office, including the integration of Behavioral Health, Developmental Disabilities, and Long Term Care under the Medicaid Director, to support integrated policy and budget development, integrated care coordination, and integrated care management. Coordination with Medical Services and Pharmacy would focus on quality, population health, and cost while moving away from a "compliance only" mentality across DHS.

Additionally, TSG recommended that DHS integrate all IT functions under an Information and Data Analytics framework, create an Office of General Council, Office of Communications, and Office of (General) Operations. TSG also recommended that the DHS of the future would require new skills, including IT, data analytics, project management, and contracts management, at comparable market salaries.

In June, 2016 DHS Director Cindy Gillespie announced a business oriented reorganization. Cutting through the silos of separate DHS Division practices for procurement, contracting, human resources management, Information and Technology Director Gillespie implemented the creation of the Offices of Finance, Procurement, Human Resources, Information Technology, Legislative and Intergovernmental Affairs, and General Counsel. The new centralized functional offices will serve the DHS enterprise on a platform of shared services, integrated policy and management practices, reduced duplication and increased efficiency resulting in a net reduction of 25 FTE positions and net savings of $597,583. Simultaneously, Director Gillespie announced the cessation of two vendor contracts resulting in savings of $23 million annually.

In addition, Director Gillespie implemented the reorganization of the Arkansas Medicaid program based on the creation of the position of Deputy Director for Health and Medical Services encompassing the Divisions of Behavioral Health, Medical services, Aging and Adult Services, Developmental Disabilities, and County Operations resulting in an anticipated dramatic improvement of the integration of Medicaid policy, care coordination strategies, budget control and financial planning, and implementation strategies.

The attributes of this reorganization should achieve improved quality, improved care coordination across all high needs populations, and cost savings over the next several years.

DHS has added a national level expert to the Director's Office as Senior Advisor for Medicaid and HealthCare Reform to lead the necessary changes to the Medicaid program's benefits design, purchasing, and population health improvement strategies. All Children and Family services provided by DHS have been reorganized in the Director's Office under the Deputy Director for Children and Families position.

Additionally, Director Gillespie has created a DHS interdisciplinary leadership team to serve as the Department's Policy Review Committee. Much progress in the transformation of DHS into a more integrated, quality and customer oriented and accountable organization has been made over the past year.

The Task Force applauds these efforts and encourages DHS to continue moving forward to reorganize the Department around the needs of the beneficiaries, not the agency. This will lead to less fragmented services, higher quality and cost savings. The Legislature should continue to monitor these efforts closely to ensure that they achieve success and DHS has the tools it needs to continue.

D. Increase State Vaccination Rates

The Task Force recommends that Public Health reevaluate vaccination reimbursement to all providers, including separating the ingredient reimbursement from the professional administration fee for adult vaccinations, and reevaluate the professional administration fee for the free vaccines distributed in the vaccines for children (VFC) program.

The public and individual health benefits of high vaccination rates are well understood. Unfortunately, according to federal data, Arkansas's young children rank behind all but two states, Kentucky and West Virginia. One impediment to provider participation and promotion of vaccinations is the low reimbursement rates. The Task Force believes that the entire vaccine program should be reevaluated to promote more vaccinations.

E. Monthly Prescription Limits

The Task Force recommends the removal of the monthly prescription limit for approved maintenance medications used in approved chronic conditions and maintenance of a monthly prescription limit for all other drugs.

Prescription medications are among the most cost effective medical interventions; this is most true for chronically ill patients requiring maintenance medications to treat their conditions. Currently there are various limits on access to needed prescriptions based on age and site of care. These limitations in pharmacy can cause unintended medical costs which actually outstrip the pharmacy savings from limiting prescription access. The Task Force recommends that prescribers should be alleviated from having to request an extension every six months of benefits for chronically ill beneficiaries requiring maintenance medications.

F. Combating the Opioid Crisis

The Task Force makes the following recommendations to help combat the opioid epidemic in Arkansas. #1) Allow DHS clinical staff to access the State Prescription Drug Management Program (PDMP). #2) Recommend that DHS pharmacy group continue to tighten opioid dispensing limits, measure limited quantities in morphine milligram equivalents, and tightly manage early opioid prescription refill requests. #3) Expand the frequency and number of drug take-back locations. #4) Encourage prescribers to consult the PDMP prior to prescribing drugs of potential abuse.

Opioid overuse, misuse and abuse remain significant threats to public health in the US and in Arkansas. There are positive efforts taking place, which are beginning to show signs of positive impact, but there is a long way to go. Arkansas Medicaid is controlling access to opioids in a logical and progressive manner and seems poised to continue to add new and sophisticated drug utilization management tools as they emerge. As e-prescribing continues to flourish (now approximately 85% of all prescriptions), it is expected that controlled substances will also be primarily e-prescribed. The Task Force recommends a multi-faceted approach to managing this critical reality.

G. State Data Integration/research and decision making

The Task Force recommends that the Arkansas Legislature consider the feasibility of establishing a statewide, comprehensive data sharing system at a public university to coordinate the multiple systems to ensure efficiency and effectiveness of human service programs.

The State of Arkansas has a vested interest in developing a data system to assist the Governor, General Assembly, and other policymakers to make data-driven decisions that result in more efficient usage of taxpayer funds and better matching of state needs with state priorities. To accomplish this goal, the Task Force recommends that the state explore the feasibility of establishing such a data system in cooperation with a research-based public university with a proven track record of analytical research and data system development and implementation.

H. Eligibility Integrity

The Task Force supports the use of both state and publicly available databases to promote public integrity in the Medicaid eligibility process, through an electronic identity, asset and income verification solution pre-and post-eligibility.

There are considerable data available to the State, both currently in agency databases and among private data vendors, which could be used to enhance eligibility screening to ensure that only those who truly meet the criteria to enroll in state benefit programs actually receive them. The Task Force recommends that DHS review national best practices and to use these tools to ensure program integrity of public assistance programs.

I. Certified Agents Role

The Task Force recommends that DHS work with National Association of Insurance and Financial Advisors (NAIFA) and clarify the authority of Exchange Certified Producer (certified agents who are compensated from Insurance plan premiums) to represent and speak on behalf of applicants, when given the proper signed authority and consent by applicants, with DHS on any matter involving enrollment and eligibility for the Private Option or the proposed alternative to replace it.

It is understood that such Exchange Certified Agents will provide assistance governed by the State and Federal guideline as they have abided by for years. The Certified Agents should be included in the development of the DHS guidelines that will govern their role in the enrollment process for all the new plans.

J. Independent Medicaid Provider Rate Review

The Task Force recommends a yearly Medicaid provider rate review conducted by an independent actuarial or professional consulting firm, with experience in Medicaid rate methodology that compares Arkansas' Medicaid provider rates to those of other state Medicaid programs, and Medicare and commercial insurance as well, and to provide an annual report of its findings to DHS and the legislature for review and consideration.

K. Medicaid Fairness Act

The Task Force supports amending certain provisions of the Medicaid Fairness Act to allow prior authorizations to be based on recognized standards of evidence-based practice or professionally recognized standards for health care. Moreover, the Task Force supports legislation making it clear that DHS is not required to promulgate rules to incorporate recognized standards of evidence-based practice or professionally recognized standards of care that practitioners use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

L. Health Disparities and Access

The Task Force supports cost effective policies that serve to reduce health disparities, increase access to health care and allow for appropriate use of health care services for those eligible for Medicaid

The Center for Disease Control and Prevention's "national data on health disparities indicates that heart disease, cancer, stroke, diabetes, and unintentional injuries are the leading causes of death among African Americans, resulting in shorter comparative life spans." Further, the CDC reported that Arkansas ranked among the least healthy states in the country based on indicators

such as incidence of diabetes, cardiovascular deaths, infectious disease, and deaths by stroke, and obesity. Child health measures for child immunization, infant mortality, and preventable hospitalizations also ranked Arkansas among the least healthy states in the country.

The Task Force recommends that the reduction of health disparities in Arkansas be included in the Medicaid services spectrum of services and current and future delivery systems through beneficiary education at the community level on appropriate use of the health care system including Emergency Department care, access and use of primary care, and treatment of chronic medical conditions. Further, DHS should track Arkansas' Medicaid population health status improvement through a "State Health Scorecard" approach as tracked by the CDC.

M. Task Force Sub-Committee Recommendations

DRG Sub-Committee Recommendation

The Task Force supports DHS, to the extent possible, and after collaboration with the Arkansas Hospital Association, converting hospital reimbursement systems under the traditional Medicaid programs to a diagnosis-related groups (DRG) methodology that will allow DHS to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The Task Force also supports DHS promulgating rules to achieve this purpose that shall address how supplemental payments would be considered, whether transition funding should be provided and whether certain providers should be carved out.

DRG payments are a common way of health care payors to hold providers accountable for health care costs. Additionally, this payment method helps to deliver great cost certainty to payors. Many insurers utilize DRG payment structures, so this change should not be out of the norm for providers.

HDC Sub-Committee Recommendations

DHS should create a long-term plan for the legislature that considers the following over the next five years:

- ***Forecasted demand for HDC services at state and regional level, assuming changes in resident acuity if applicable;***
- ***Forecasted cost for operation of the HDC system (aggregated and per diem cost information);***
- ***Analysis of how DHS can most effectively and efficiently meet forecasted need through existing HDCs or changes to the system (size, location); and,***
- ***Cost estimate to meet forecasted demand (including estimated infrastructure needs). As part of the long-range planning, conduct an appraisal of any lands or properties***

not in use that could be sold that are not essential to current services that would create revenue for capital improvement projects.

This recommendation contemplates a different planning process than the annual strategic planning process used at each center and is not intended to supplant that process. HDC strategic plans outline current and future initiatives and center goals and are very client outcome-focused. They are developed by a multi-disciplinary group of local stakeholders. The center-level plans serve a different purpose and do not analyze long-term system needs.

Based on this planning process, the legislature should ensure availability of adequate funding for repair and maintenance of existing facilities and new construction, as needed.

Conduct an evaluation of the current capacity and quality of the home and community based care system for serving those with developmental disabilities.

The Task Force and this Committee has heard testimony concerning the future focus of the DHS to enhance capacity and opportunities for individuals with disabilities to live in homes and communities as part of the continuum of care. DHS should conduct a thorough evaluation of community provider current capacity and needs, and make recommendations to ensure adequate provider capacity, infrastructure, quality and support.

Publish data about licensing and maltreatment across programs

Making data about licensing violations and abuse/neglect/exploitation of consumers across DDS programs available online increases transparency about the quality of service delivery in those settings. It may inform decisions of consumers, their families, and legal guardians about whether to transfer to another program or aid in provider selection.

Centralize DHS investigations and licensing functions

Centralization of DHS investigations and licensing functions would allow DHS to gain additional efficiencies and organizational benefits, as well as enhance the rigor of investigations across programs by cross-pollinating some of the best practices and tools.

Continue to evaluate the capacity of licensing function

DHS should continue to monitor the ratio of licensing/oversight FTE resources to consumers served in its programs to ensure that the agency is providing an appropriate level of resources. While not a concern at present, if enrollment in community-based programs grows, it will be important for the agency to ensure that oversight resources keep pace with that growth.

DDS should review its current process of informing families/guardians of community waiver placement options to determine if additional methods are available to increase awareness of alternative placement options.

The current system informs families/guardians alternative placement options prior to admission, during the admission process, and at a minimum, annually thereafter. Each facility also conducts a provider fair at least annually, in which community providers come to the facility campuses to visit with parents/guardians.

DDS should adapt its post-placement monitoring tool as needed to incorporate best practices from other states.

The monitoring tool should prompt the worker to assess the person's safety and capture data in that area, as well as considered whether quality of life and person-centered care is being delivered. DDS should establish a survey to measure parental/guardian/resident satisfaction with the transitions process. In reviewing the tool**,** DDS should also consider formalizing in a written policy or protocol its operating procedures and guidelines for post-placement monitoring for persons who transfer from an HDC to a community setting

The DHS Office of the Chief Financial Officer, in conjunction with DDS, should conduct further analysis to understand cost variations across HDCs and identify efficiencies that can be replicated at other facilities. Examples to investigate include:

- ***Heath Care – This category comprises a large share of the total daily rate. It includes direct care staff. While most of the facilities are comparable here and maintain similar staffing ratios, Booneville's total cost per bed day is lower than the other HDCs and this should be explored.***
- ***Room and Board – Warren's costs here are higher than its three other peers of a similar size. There may be practices it can replicate from its peers to bring down these costs.***
- ***Maintenance and Operations – Conway has the lowest cost per bed day, which is likely due to efficiencies gained due to its larger relative size, but Jonesboro's cost is low relative to its peers of a similar size and its experience may be instructive.***

Savings and efficiencies identified by DHS/DDS, as well as other DHS cost containment strategies such as use of bulk contracting and purchasing and identifying more efficient approaches to contracting for professional services (such as dental services) should be monitored and tracked by DHS.

DHS Should establish a new supervisor development program

Quality supervision is important in the provision of services at HDCs and is critical to staff retention. Literature across disciplines suggests that a supervisor can be a key reason a worker leaves or stays at a job. The Department provides mandatory four days of policy and procedures training and a mandatory three-day leadership training for new supervisors. There is also a mandatory supervisory update training that occurs after a person has been a supervisor for five years. The department does offer a menu of professional and personal growth training opportunities through its internal staff development section and its inter-agency training program, but most of these items are not mandatory. There is currently no mandatory, ongoing training program to strengthen the managerial and leadership skills of its supervisory workforce outside of those mentioned above. Exit interviews with workers suggest there are concerns with the quality of supervision in certain areas of the state and that some new supervisors may struggle with the role of manager. An on-going mandatory training and development program for supervisors throughout the course their career would not only improve the quality of supervision and strengthen supervisory skills, but would also provide supervisors with guidance on how to develop their staff. Such a program could include supportive features (such as mentoring) to provide personal and professional support to supervisors. It is expected that this program would aid in the retention of both supervisors and workers.

DHS should explore the feasibility and cost of establishing a career ladder for supervision/management

Absence of an extended career ladder/low pay is a factor contributing to supervisor turnover, especially in areas with direct competitors (i.e., a new healthcare facility). Direct care staff members advance from the entry-level position of Residential Care Assistant to the next level (Residential Care Technician) in a career ladder format but must apply, interview, and be selected for positions beyond that. There is currently no other career ladder mechanism outside the traditional interview/selection process that allows a direct services staff person to promote, though they are eligible for annual bonuses based on performance. Providing for an extended career ladder for staff could address a reason direct services personnel leave HDC employment.

DHS should ensure adequacy of entry-level worker salaries

Each HDC operates in a local labor market and competes with other regional employers for staff. DHS staff has analyzed the salaries of other major employers in the markets where the HDCs are located and found DDS salaries to be less competitive in some areas (though benefits tend to be more robust at DDS compared to its competitors). In parts of state where economic opportunities result in the expansion of industry, HDCs may have an especially difficult time attracting and retaining staff. The state's Office of Personnel Management establishes the pay plan for the state.

DDS has received permission previously to offer the mid-point of the salary range (instead of the bottom of the range as is typically offered) for certain positions in certain areas of the state and is currently in the process of implementing that salary adjustment. This recommendation is for a more generalized increase of salaries across the direct care staff positions to enable DDS to attract the best applicants for HDCs statewide and prevent loss of qualified staff to other employers.

DHS should ensure adequate funding for the demolition of vacant buildings on HDC campuses that produce potential risk to residents.

Demolition of such buildings has been prioritized by current DDS leadership and the process is underway to remove the buildings in question. Going forward, the legislature should ensure that adequate funding exists to ensure the timely demolition or repair of these buildings to mitigate any adverse resident impact. DDS should include such needs in its long-range plan to the legislature.

Note: A copy of the complete HDC Committee Report (filed with the Task Force October 2016) can be obtained by contacting the Arkansas Bureau of Legislative Research

Arkansas Health Reform Legislative Task Force

Final Report

December XX, 2016

I. Background

Legislative Authorization and Intent

In the 2015 session the Arkansas Legislature passed a bill, known as the Arkansas Health Reform Act of 2015, that established the Arkansas Health Reform Legislative Task Force ("Task Force") to "(A) Recommend an alternative healthcare coverage model and legislative framework to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program established by the Health Care Independence Act (HCIA) of 2013, §§ 20-77-2401 et seq., upon program termination; and (B) Explore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled."

As the authorization of the Health Care Independence Program (HCIP) was set to expire on December 31, 2016, the Arkansas Health Reform Act of 2015 required that "On or before December 31, 2015, the Task Force shall file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate, a written report of the Task Force's activities, findings, and recommendations." This preliminary report was filed on December 15, 2015.

Additionally, the Act states that "The Task Force may file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate a final written report on or before December 30, 2016." The authorization for the Task Force expires on December 31, 2016.

Finally, the Task Force issued an RFP for the services of a Medicaid consultant to assist it in its research, analysis and in meeting its statutory objective. Through a competitive process, The Stephen Group, LLC. was selected to provide expert consulting services.

II. Task Force Findings

A. Key Findings: Private Option (PO)/HCIP

- Through September 2016, there were approximately 293,882 adults eligible since the passage of the Health Care Impendence Program (now Arkansas Works) (270,573 Private Option (PO) and 23,309 Medically Frail, who currently utilize traditional fee-for-service Medicaid)

- 80% of all individuals selecting insurance through the marketplace in Arkansas are enrolled via the PO.
- PO participants are younger and thus healthier and lower cost. 65% of those enrolled through the Private Option are younger than 45 years old, compared to 45% of those enrolled through the Arkansas marketplace.
- PO participants have access to substantially more providers than through traditional Medicaid due to access to the private insurance company provider networks.
- PO beneficiaries utilized Emergency Department services at a rate greater than traditional Medicaid beneficiaries, despite being a healthier population.
- Health disparities and use of Emergency Departments appear to be due, in part, to a lack of understanding of how to use the health care system by individuals who are new to having coverage, or because there are no incentives for utilizing more appropriate care.
- Over the next five years, the federal share of the PO, in its current form, would result in roughly $9 billion in Medicaid federal match payments for Arkansas.
- Hospitals report a substantial reduction in uncompensated care visits and costs since the beginning of the Private Option. Uninsured admissions dropped 48.7% between 2013 and 2014, uninsured Emergency Department visits dropped 38.8%, and uninsured outpatient visits dropped 45.7%. This drop could also be partly attributed to the availability of insurance policies with subsidies for incomes above 138% Federal Poverty Level (FPL) on the Arkansas Health Connector, or a drop in unemployment which likely indicates an increase in employer insurance.
- The Arkansas rate of uninsured among non-elderly adults dropped from 27.5% to 15.6% from 2013 to 2014. The PO was clearly a substantial factor in this drop.
- Many PO enrollees are not working at all or not working substantially. Forty percent of beneficiaries have an annual income of $0. Over 54% had incomes below 50% of the FPL. Only a little over 15% were between 100-138% FPL.
- Average ratio of claims to premiums among the three QHP carriers is 79%, lower than the 80% (85% for large group carriers) allowed under the Affordable Care Act.
- Physician licensure rates appear largely not to be impacted by the PO.
- The Health Independence Accounts appear largely to have missed their mark. Only 10,806 cards have been activated of the 45,839 issued, with only roughly 2,500 individuals contributing to these accounts monthly.
- If Arkansas rejects Medicaid and returns to program status prior to 2014, the negative impact to the state budget is approximately $438 M (2017 – 2021), taking into account cost shifting, uncompensated care, premium tax and macro-economic effects).
- The state may have options available to limit some of the impact by not renewing optional programs or funding uncompensated care.
- An analysis of claims data among two of the three PO insurance carriers indicates a substantial increase in costs per claims by enrollees, driven largely by cost increases in the pharmacy benefit.

- PO has achieved state general fund savings through the use of shifting populations from traditional Medicaid (70% federal match) to PO/Arkansas Works (95% federal match). These populations include:
    - Medically needy
    - Aged blind disabled
    - SSI disability
    - Pregnant women
- Additionally, after the establishment of the PO, the state has achieved general fund savings through the discontinuation of the following programs:
    - ARHealthNetwork
    - Family Planning
    - Tuberculosis
    - Breast and Cervical

B. Key Findings: Traditional Medicaid

- Arkansas Medicaid program is on an unsustainable path, using conservative growth estimate of 5% for next five years.
- Between now and 2021, the general revenue portion to fund traditional Medicaid is projected to grow by $500 Million.
- Currently, the state has not implemented best practices that other states have used in Medicaid for a large part of costs, such as:
    - Hospital payment initiatives based on value and risk
    - Care Management strategies based on full or substantial risk and particularly involving management of aged, blind and disabled and other high cost populations – example: complex care for children
- 74% of traditional Medicaid claims are for the aged, blind, disabled (ABD) population. These claims fall heavily under the institutional care categories of service (hospitals and nursing homes) for services to the high risk, high cost elderly, disabled and behavioral health populations, and include additional medical costs (‘halo’ effect).
- Almost 20% of Medicaid expenditures are paid outside of the stringent controls of the Medicaid Management Information System (claims payment processing system).
- Key health value improvement programs (Patient-Centered Medical Homes, Episodes of Care) do not address the 74% of Medicaid costs incurred by the ABD population, but focus on the 26% of the Medicaid population who are not ABD.
- There is overly high use of nursing homes and other institutional settings.
    - Two-thirds of care costs for Arkansas’ elders is paid to nursing homes. The average cost for caring for an elder in a private nursing home is approximately $67,000 per year, more than twice the $27,000 cost of caring for an elder in the home and community based programs, including the Elder Choice Waiver.

    - Institutional care accounts for one third of total developmental disability claims, of which 80% is for adult care and 20% is for pediatric care. The average cost for adult institutional care is $135,000 per person per year, compared with $69,000 in the Alternative Choices Waiver program. Pediatric institutional care averages $162,809, compared to $45,937 for community-based care under a waiver program.
- Arkansas hospitals are generally reimbursed at a maximum per diem amount, with a few paid on a cost basis, reconciled annually; both models include several different supplemental payments.
- In the past, the state has not been successful in rebalancing long term care. There is a lack of active and effective transitional services between hospitalization, nursing facility rehabilitative treatment paid for by Medicare, and community options. Combined with the lack of a single assessment process for LTC services, this results in a fragmented approach to care coordination and choice of least restrictive environment.
- The lack of an independent standardized clinical assessment for treatment planning and efficiency strategies for individuals who access mental health services is a major driver of the growth in mental health care expenditures.
- There is a lack of a comprehensive public mental health strategy designed to support recovery within a community-based care environment and divert individuals from unnecessary inpatient psychiatric hospitalizations, residential placements, and avoidable jail admissions. The mental health system lacks evidence-based practices and incentives for comprehensive care coordination.
- There are over 2,900 people who are now on the Developmental Disabilities Wait list, of which 2,640 already incur a total of almost $32 million in Medicaid costs.
- Among individuals receiving services for developmental disability, 96% of Waiver Spending is for Supportive Living
    - 20% of beneficiaries spend less than $20,000 – 80% less than $70,000
- The Stephen Group conducted a survey of the families of developmentally disabled individuals to determine the services they prefer. This survey found:
    - Supportive Living is the most highly valued service
    - Respite and Case Management were in respondents top 5 almost as often as Supportive Living, Supportive Employment is a distant fourth
- Wait list survey respondents seemed to value the full range of benefits – all services ranked in the top-5 for a substantial number of people
- The mental health system is highly siloed and fragmented. Case Management services are available in the DAAS and DDS home and community based services programs, but are not included in the mental health structure within DBHS. There is currently no IT capacity to track beneficiaries across program codes. However, the creation of the DMS Data Warehouse should provide DHS the ability to track beneficiaries across all treatment types.

- Arkansas implemented the PCMH model with 295,000 Medicaid beneficiaries in 2013, excluding the Aged, Blind and Disabled population and all waivers, and with limited risk. The model is based on care coordination and attention to transitions of care, primary care provider (PCP) practice transformation, and improved access based on 24/7 beneficiary telephone access. The full implementation timeline is three to five years; the model has so far seen some positive results in cost avoidance, primary care investments, and shared savings between the state and providers.
- Episodes of Care is a national best practice example, although the return on investment for the program is unclear.
- Arkansas has an atypically high cost for traditional Medicaid.
- Four of Arkansas' neighbors – Tennessee, Mississippi, Texas and nearby Kansas – all utilize full risk managed care for aspects of their populations and according to reports reviewed:
    - Texas saved over $3.8 B since FY 10 according to an independent Milliman study and is estimated to save $7.1 B through FY 2018.
    - Kansas reduced spending growth from 7.5% to 5% in the first two years and then used over $60 million in GF savings for their DD wait list, amounting to over $140 Million in total funds.
    - Tennessee significantly reduced reliance on nursing homes by changing levels of care while achieving budget neutrality for LTC.
- The Task Force found that the Rehabilitative Services for Persons with Mental Illness (RSPMI) Behavioral Health benefits program had significantly increased in costs for several years prior to 2014 without a corresponding decrease in high cost psychiatric inpatient and residential services. In 2014, DHS/DBHS attempted to introduce effort to bring accountability to these services. For a variety of competing interests, the necessary Rules and Benefits changes were not implemented at that time.
- The Stephen Group conducted a detailed claims and services code level analysis on utilization for 2014. Findings indicated a large number of beneficiaries (40,000+) using an unreasonably low amount of services for BH Rehabilitative level services, a small group of consumers using an abnormally high amount of services clustered among few providers, and an unusual pattern of RSMPI services being delivered in school settings.
- Simultaneous to the RSPMI claims/code analysis, the Office of the Medicaid Inspector General (OMIG) was engaged in a multi-state analysis of a certain Group Psychotherapy service billing code that indicated that Arkansas utilization of this service far surpassed that of neighboring states at a substantially higher rate. In reviewing the school based claims data with OMIG, there was a correlation with the use of this code regarding overutilization.
- OMIG reported their recommended changes to the Group Psychotherapy benefit (daily and annual unit caps and a rate reduction) to the Task Force, who supported OMIG

moving forward through the necessary rules and rate changing processes. This will result in an expected savings of $15 million in FY 17.

- DHS has implemented a comprehensive pharmacy reform that resulted in an anticipated $52.5 M annual savings.
- Two Committees of the Task Force were appointed to solicit testimony, conduct further research and develop findings and recommendations relative to Diagnostic Related Groups (DRG) and Human Development Centers (HDC). Their recommendations are listed below.

C. Key Findings Across Both Programs

- Arkansas Health Status is low compared to other states.
- Not enough emphasis is placed on health care value, meaning the return on investment of Medicaid dollars.
- There is an across-the-board focus on large claims processing and not on an outcome based model.
- There is no benchmarking of outcomes for quality and improved health.
- Medicaid is only one piece of the total health status outcome, but an important one.
- Health care professionals and community members believe that the PO has had a positive impact on health disparities, with many people having access to health coverage for the first time. However, they recognize the need for education and community-based assistance on the process of navigating the health care system to help people learn how to access the right services at the right time, thereby addressing access disparity, increasing self-responsibility, and avoiding unnecessary costs such as unnecessary ER use.
- Audits at the facility and provider level and of providers and associated care plans are limited.
- Traditional and PO conversion to MAGI, the new ACA financial eligibility standard, coupled with the effort to convert to a new eligibility software system has led to significant obstacles and setbacks in eligibility verification. DHS is working to improve the eligibility system today, but has in the past experienced a significantly increased workload to verify eligibility and enroll expanded Medicaid applicants, with little increase in resources. DHS is still in the transition from the legacy Medicaid administration system to the new systems.
- There have been delays in the updating of Curam – the eligibility system software – and that has caused problems in the past with timely eligibility reviews.
- The current Curam software to manage the basic enrollment and re-enrollment process does not manage all basic Medicaid requirements, including removing incarcerated beneficiaries from receiving services, and must be supported with manual DHS processes.

- A data scrub by Lexis Nexis flagged a substantial number of out of state addresses for participants of both PO and Traditional Medicaid (Traditional Medicaid 22,781, PO 20,110). Note: The out of state addresses could be for individuals that resided out of state but moved into Arkansas prior to PO or Medicaid eligibility.
- DHS paid average claims of $301 for brand name drugs and $32 for generic drugs, compared to PO carriers paying a combined average of $190 for comparable brand name drug claims and $15.66 for generic drugs.
- Private Option carriers had roughly twice the claims for opioids as a percent of all drugs, as compared to DHS, and a higher percent of drug utilizers with at least one opioid claim. The numbers are less pronounced when considering that the average age of Private Option beneficiaries is 42 years old, compared to 24 years old for traditional Medicaid. The top conditions reported for high utilizing beneficiaries do not support long term use of opioids. Clinical personnel at DHS do not have access to the State Prescription Drug Monitoring Program database.
- The expenditures of the 1.6% of DHS beneficiaries who approached or hit the per person per month claim limit made up 40% of total drug claims. However, much of this population requires consistent access to maintenance drug therapy for chronic health conditions and interruptions in drug treatments could lead to preventable complications resulting in additional health care costs.
- DHS' preferred drug list covers 38% of all claims paid in the FFS program, compared to an average of 64% in comparable states and a best practice figure of 80%. Eighty five percent of claims at DHS are for generic drugs, accounting for 30% of total drug spend, slightly higher than the 22% average of other states reviewed.
- DHS contracts with more than one call center for its Medicaid pharmacy benefit.

D. Task Force Votes

- The Task Force voted to pass the following resolutions and objectives at the December 22, 2015 meeting:
    - "We move to support the Governor's efforts to negotiate waivers from the Centers for Medicaid Services (CMS) consistent with the Arkansas Works framework and we further agree that a minimum of $835 million over 5 years need to be saved from the Medicaid budget and we support further efforts to identify those savings"
    - "We move to task The Stephen Group to assist the Task Force to find at least $835 million in savings without managed care, with the exception of dental."
    - Support the Governor's efforts to negotiate waivers CMS consistent with the Arkansas Works framework
    - Conduct further hearings consistent with its statutory charge
    - Make specific recommendations that will identify a minimum of $835 million in savings over 5 years

E. Arkansas Works

On June 28, 2016, Governor Hutchinson submitted the Arkansas Works waiver to the federal Secretary of Health and Human Services Sylvia Burwell. That waiver can be found here: https://www.medicaid.state.ar.us/Download/general/comment/ARWorksAppFinal.pdf. On December 8, 2016, the Arkansas Works waiver received final approval by the Secretary.

The Arkansas Works waiver, in its entirety, will make the following changes in Medicaid for those individuals newly eligible for Medicaid under the Affordable Care Act:

- Premium Assistance to those with employer sponsored health care – this change would require those with access to health insurance through their employer to take that coverage, with Medicaid providing coverage for premiums sharing, deductibles and co-payments
- Cost sharing for those not in poverty – this change would require all those between 100-138% of the federal poverty limit to pay 2% of their income in cost sharing payments; failure to pay premiums would result in the loss of enhanced benefits
- Elimination of retroactive eligibility – this change would cause eligibility to start upon application for Medicaid coverage, and end the practice of having Medicaid pay claims for up to 90 days prior to applying for Medicaid
- Work referrals – this change would give work referrals to the Department of Workforce Services to all individuals who apply for Medicaid and have an income less than 50% of the federal poverty limit and would have DHS offer work training opportunities to those of all incomes
- Wellness promotion – beneficiaries would be required to have a wellness visit with a primary care provider (PCP) within the first year or lose enhanced benefits
- Elimination of the Health Independence Accounts – this change would eliminate Health Independence Accounts under the Private Option, which were determined to be an inefficient way of promoting consumer choice and personal responsibility among beneficiaries

These change were put in place with the goal of enhancing accountability, personal responsibility and shifting the focus of the newly eligible, able-bodied population to focus on work participation.

F. Findings relative to Financial Impact and Cost Shift

Through the Private Option/Arkansas Works, the state has been able to shift state costs away from the traditional Medicaid program by moving populations to the newer programs, which offer a higher federal matching rate. This shifting occurred through both eliminating some programs in the traditional Medicaid program that were then picked up in expansion or by

moving some of those who were eligible for traditional Medicaid who were also eligible for expansion to the newer program.

Private Option Impact on Traditional Medicaid Spending

The following table shows the apparent impact of the PO on the general fund, through reductions in expenditures from traditional Medicaid, other impacts on expenditures, and new revenue from premium taxes and other economically sensitive taxes, based on data available from DHS.

Projected Aggregate Private Option Impact (SFY 2017-2021)							
(all figures millions $ unless otherwise indicated)							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures (all funds)		1,721	1,820	1,924	2,035	2,152	9,652
Impact on State Funds							
Impact on state expenditures	**State match on Private Option**	43	100	125	173	215	656
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(21)	(22)	(23)	(25)	(26)	(117)
	State fund savings from cost-shifting from traditional Medicaid to PO	(91)	(96)	(101)	(106)	(111)	(504)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	**(104)**	**(54)**	**(37)**	**3**	**37**	**(154)**
Impact on state revenues	**Increase in premium tax revenue**	22	23	25	26	27	123
	Increase in collections from economically-sensitive taxes (4%)	67	69	72	74	77	360
	Total impact on revenues	**89**	**92**	**97**	**100**	**105**	**483**
Net impact on state funds		**193**	**146**	**133**	**97**	**68**	**637**

Private Option Impact on Traditional Medicaid Enrollment

The following analysis shows the changes in enrollment in different Aid Categories after the establishment of the PO. The 'Other' aid category shown below, which includes ARHealthNetwork and the several waiver programs that were discontinued after the PO was established, disappears.

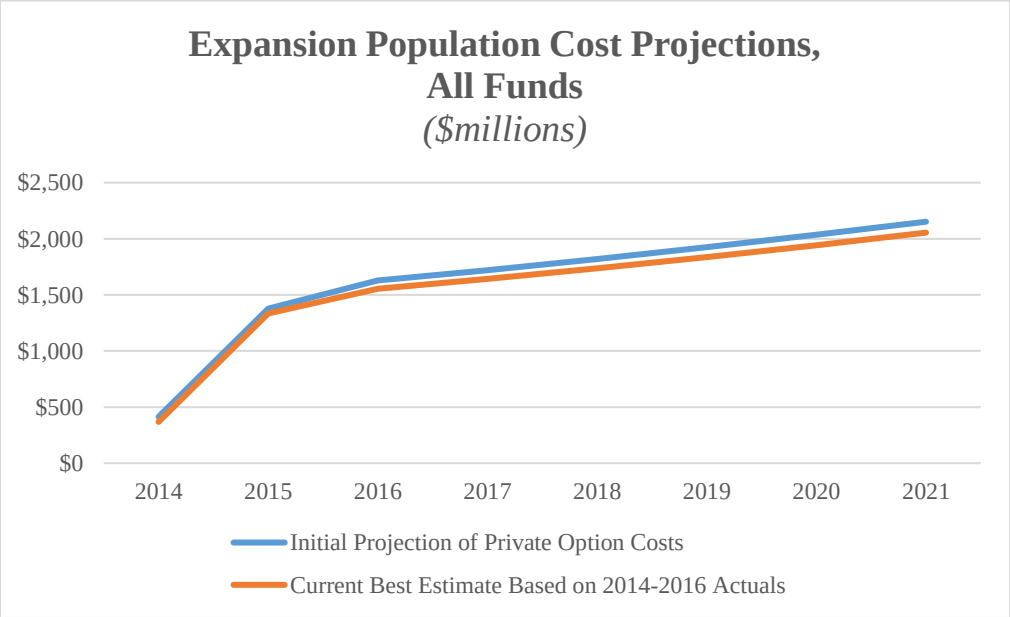
Aid Category	Average Enrollment 2011-2013	Average Enrollment 2014-2016	% Change	Average Annual Cost of Aid Category (2016)
Low Income Children & Pregnant Women	306,580	347,165	13.2%	$3,130
SSI Disabled	115,955	108,344	-6.6%	$12,357
ARKids	76,426	58,281	-23.7%	$1,526

Other	61,503	754	-98.8%	$14,770
Medically Needy Aged	61,426	64,205	4.5%	$11,390
Medically Needy Families & TANF	27,644	41,997	51.9%	$2,991
Medically Needy Disabled	28,805	30,795	6.9%	$16,043
SSI Aged	6,644	5,700	-14.2%	$6,644
Adoption and Foster Care	7,091	8,550	20.6%	$9,929
Spenddown Disabled	1,596	205	-87.2%	$93,929
Spenddown Families & TANF	534	13	-97.7%	$76,550
Newly Eligible Adults	19	249,057		$5,811

Current Cost Projections

Currently, the cost of the Private Option has held slightly below the initial cost estimates when the program was first implemented. There was some concern about costs, driven largely by overruns on the Medically Frail population.

Maintaining the PO cost under the estimates is critical, since the Private Option was included in a federal waiver that requires a cap of federal participation, meaning state taxpayers would be responsible for costs above the cap.



Expansion Population Cost Projections, All Funds *($millions)*								
	2014	2015	2016	2017	2018	2019	2020	2021
Initial Projection of Private Option Costs	$414	$1,379	$1,627	$1,721	$1,820	$1,924	$2,035	$2,152
Current Best Estimate Based on 2014-2016 Actuals	$368	$1,335	$1,553	$1,643	$1,737	$1,837	$1,943	$2,054

III. Task Force Recommendations

A. General Statement Regarding Recommendations

Over the duration of the Task Force, there has been substantial change in the nature of the Medicaid program. The Private Option was replaced by Arkansas Works, with many changes recommended by this body.

The Task Force commends the many individuals, groups and fellow legislators that offered their ideas, opinions and knowledge. The list of those who testified, submitted information and made personal contact to Task Force members was both expansive and comprehensive, and added a great deal to the work of this effort. In particular, the Task Force would like to offer our sincere thanks to the Department of Human Services for its assistance and responsiveness.

However, under the limitations of time and bandwidth, there was only so much time for this group to make good on the charge of the Legislature to advance change. With the termination of this group, we offer a number of substantive suggestions to continue to "[e]xplore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled."

Many of these recommendations tie directly to the responsibility the Task Force assumed to work to identify savings in the state's Medicaid program totaling, at a minimum, $835 million. Others relate to program improvements to advance the goals of the Medicaid program and improve beneficiary health status efficiently and effectively.

B. Arkansas Works: Continued Review

Clearly, there will be a number of opportunities to reshape the Medicaid program in 2017 and beyond. The changes taking place at the federal level will undoubtedly impact Arkansas in ways that are currently unknowable.

The incoming administration has clearly signaled two top priorities: repealing the Affordable Care Act and enhancing state flexibility through block grants. Both of these changes, if implemented would have a dramatic impact on the landscape of both traditional Medicaid and Arkansas Works.

Should the Medicaid program become a true block grant, many of the prior ideas raised during Task Force hearings and in prior reports could be implemented. This includes such items as:

- Work requirements for eligibility for able-bodied adults
- A Wellness Scorecard for incentivizing prevention
- Tailoring health benefits to meet individual needs
- Co-payments for inappropriate use of services (such as non-emergent ER visits)
- Cost sharing among the able-bodied adult population
- Tailoring eligibility standards to mitigate health disparities
- Payments to employers for insuring workers who might otherwise be Medicaid eligible
- Asset tests, and asset limits, for some Medicaid applicants
- Benefit limits for able-bodied adults

These are merely a small sample of potential changes that might become available to Arkansas Medicaid. Clearly, federal action will drive much of the program's future, so a great deal of vigilance by the Legislature will be necessary over the coming months to ensure that the state is prepared to move quickly to adapt and adjust to the new landscape.

C. Traditional Medicaid Program Reform

Traditional Medicaid in Arkansas's annual growth of 5% represents a pathway that requires reform, as it is the largest program in state government and on its current trajectory, threatens the future viability of other critical programs across the state. Instituting cost controls that limit Medicaid program growth are essential to the state's long-term solvency.

The Task Force has resolved to support the Governor's proposed $835 million savings initiative over five years to identify sufficient state general funds to support the state share of Arkansas Works. Beyond this, the Task Force established a benchmark of $1 billion in savings over five years in order to take the necessary steps to limit program growth to ensure the long-term future of the Medicaid program.

These savings targets inform the basis for a number of the following recommendations in this report.

Through an analysis of program data, the Task Force identified the primary cost drivers among the high cost populations, many of which are not managed in any way. By isolating these areas, the Task Force has been able to work with providers and stakeholders, many of whom have submitted cost savings plans on their own.

Additionally, based upon findings and recommendations by this Task Force, DHS is moving forward with a number of reforms and program changes that will assist in identifying these savings, operating in a very proactive manner.

These changes, including major organizational changes at DHS, help to reduce the need for more dramatic changes by the Legislature, particularly in the areas with long-term populations, who critically need appropriate Medicaid services.

D. Recommended Behavioral Health Program Savings and Investments

The Task Force recommends and supports the Arkansas Department of Human Services moving forward transforming the Rehabilitative Services for Persons with Mental Illness (RSPMI) benefit into an evidence based/best practice Adult and Children/Adolescent Mental Health Rehabilitation Option benefit and that access to the revised benefit should be based on identified diagnoses and an independent assessment.

A report to the Task Force last year included recommendations for revision of the RSPMI Behavioral Health benefits program to an acuity based program eligibility model based on independent assessment, identified Adult and Child Behavioral Health services, evidenced based practices, and an increase in targeted services for adults, children and youth that are community based and designed to decrease reliance on expensive psychiatric inpatient for adults and residential services for children/youth, plus care coordination and an identified Behavioral Health home.

To a large extent, these recommendations mirrored the efforts of DHS/DBHS in 2014. Specific changes include:

- Redefine the SED and SMI category based on clinically-driven parameters (Counseling, Tiers II and III)
- Implement evidence based practices to a greater degree
- Implement independent assessment
- Reduce reliance on Inpatient Psychiatric Hospitalizations and Residential Treatment through Rules, process, approval changes and further development of Systems of Care and Wrap Around for SED children/youth
- Create a Therapeutic Residential services per diem benefit that addresses the 911 population
- Increase process efficiency and reduction of administrative burden upon providers
- Refine clinical eligibility for school based BH Outpatient services
- Reduce utilization of RSPMI Collateral and MHP/MHPP Intervention units (90887 HA, 90887 HA UB)
- Reduce utilization of Group Outpatient RSPMI benefit (90853)
- Ensure that multiple at school services rehabilitative level services and intensive level services in the school setting are necessary
- Assure that school- based programs are actually being operated during the summer while schools are closed or moved to another location without proper coding

- Care coordination and health homes for those served by DBHS is under consideration through either a managed fee for service or provider-led Accountable Care Organization model

As a result of the work of the Task Force, Medicaid Behavioral Health Services will improve in quality and outcomes, increase appropriate and effective use, and decrease costs. Savings of $15 million are expected in FY 2017 as a result of the OMIG led changes to the Group Psychotherapy benefit. Total savings of $215 million are projected for Behavioral Health Services from SFY 2018 to SFY 2022, inclusive of projected costs for Independent Assessment and Care Coordination investments.

E. Recommended Developmental Disability Program Savings and Investments

The Task Force recommends and supports the Arkansas Department of Human Services moving forward with a new waiver for a comprehensive revision of the Developmentally Disabled Services (DDS) Alternative Community Services waiver that is based on independent assessment, three levels of care, an institutional cost limit, tiered payments, and focuses on employment and community choices.

The Task Force found that DHS/DDS program expenditures were concentrated in the Human Development Centers, Alternative Community Services Waiver, and the Developmental Day Treatment Clinic (DDTCS) and Child Health Management Services (CHMS) programs that deliver Occupational, Physical, and Speech and Language (OT, PT, SL) state plan services.

Findings included a lack of independent assessment and authorization for OT, PT, and SL services, the volume of services was provider driven, and there were no annual benefit limits for these services. The Task Force also found that the current waiver plans of care and cost were not based on need for services derived from an independent assessment, that the waiver had an upper payment limit of $176 a day ($64,064 annually) regardless of level of need for services, and that case management was not independent from the waiver services providers.

The Task Force recommends that DHS/DDS implement a three tier based waiver, similar to the current Tennessee Developmental Disabilities Home and Community Based Services waiver, as follows: 1) Essential Family Supports when a person chooses to live at home with their families (capped at $15,000 per year); 2) Essential Supports for Employment and Independent Living when a person chooses to live independently in the community and wishes to be employed (capped at $30,000 per year plus $6,000 for emergency situations); and, 3) Comprehensive Supports for Employment and Community Living when a person requires more complex services and supports to live in the community and be employed (capped between $45,000 and $60,000 per year). The Tennessee waiver uses an independent assessment to determine a person's tier of care.

The necessary Rules changes for the OT, PT, and SL state plan services (90 minutes per week each for these services) have been filed and reflective of the benefits of the DHS reorganization implemented by Director Gillespie related to integrated Medicaid policy development and shared services. Rule changes are scheduled to be voted on by the Arkansas Legislative Council on 12/16/16 for implementation on 7/1/2017. The Task Force recommends these Rule reforms.

The Task Force also recommends the implementation of an independent assessment for tier based DDS Home and Community Based Services waiver services and the implementation of Occupational, Physical, and Speech and Language therapy caps based on an Independent Developmental Screen that are expected to result in savings of $205 million between SFY 2018 and SFY 2022, including $6 million total costs for the independent assessment. Care coordination costs for the people served by DDS are in the process of being determined.

F. Recommended Care Management Model for BH and DD

The Task Force recommends and supports the Arkansas Department of Human Services developing and implementing a comprehensive approach that provides care management and coordination to all behavioral health and non-institutional intellectual and developmentally disabled populations eligible for Medicaid services. Care management includes the identification, stratification, and prioritization of high risk and complex individuals for the coordination of evidence based services, supports, and interventions that are provided in a cost effective and non-duplicated plan of care, and include provider payment accountability and risk for outcomes and quality.

The Task Force identified the critical importance of the implementation of comprehensive care coordination strategies for complex, high cost Aged, Blind, and Disabled beneficiaries served by Arkansas' Behavioral Health, Developmental Disabilities and Long Term Care services regardless of whether DHS evolves to a managed fee for service, managed care, or maintenance of the fee for service system in place.

The Task Force's assessment of the Arkansas Medicaid program as a whole found that comprehensive care coordination for the high cost BH and DDS populations was fragmented in relation to other medical services, resulting in a lack of integrated care for these individuals, and that there is a lack of alignment of financial incentives and risk among all providers serving the high cost populations. Importantly there are no incentives and risk for high quality outcomes and cost savings resulting from improved health status in the current services delivery model.

The Task Force has reviewed and discussed the care coordination aspects of the PCMH, "Diamond Care"/managed fee for services, managed care models and accountable care organizations, including projections of savings for SFY 2018 through SFY 2022.

Whatever the final model selected, the Task Force recommends that the model work to integrate and coordinate the care of each individual receiving Medicaid services, instead of continuing the siloed approach to care that results in uncoordinated care, increases cost and produces health outcomes that could be improved.

G. Recommended Long Term Care Program Savings and Investments

The Task Force supports the memorandum of understanding entered into by the Arkansas Department of Human Services and Arkansas Health Care Association on Mary 20, 2016 to achieve $250 Million in savings over a 5-year period through improved, high quality, person-centered, and cost-efficient Long Term Services and Support care delivery reform. The Task Force supports reforms to ensure supports and services in the community are cost effective, effectively serve transitions among care settings, and eliminate fragmentation and duplication in service coordination and delivery. Other reforms contained in the memorandum of agreement, including independent assessment, tiered levels of care, acuity-based and risk adjusted, and effective care management, coordination, and transition strategies, designed to enhance the most cost effective and quality enriched care are also supported.

Governor Hutchinson and the Arkansas Health Care Association entered into a memorandum of understanding (http://ee-governor-2015.ark.org/images/uploads/160520_MOU.pdf) to work closely to expand the use of community based care. This effort would result in expanded community choices and savings of $250 million over five years, while also ensuring a better continuum of care for those who qualify for long-term care services.

The Task Force fully supports these efforts and recommends they continue. The Legislature will need to monitor the progress of this MOU to ensure that this agreement yields the quality and cost savings included.

H. Recommended Pharmacy Program Savings

The Task Force recommends and supports the Arkansas Department of Human Services continuing implementation of the pharmacy quality and programmatic savings initiatives to achieve $262.5 Million is savings over a 5-year period through expansion of the preferred drug list (PDL), expansion of the CAP initiative, comprehensive management of antipsychotic medications by a Department psychiatrist for adults and children, limiting waste and clinically managing patients requiring hemophilia factor products, and reconfiguring reimbursement structure and rates for retail pharmacy providers. These initiatives are either fully underway or in the final stages of approval (CMS or State) prior to full implementation.

Prescription drug coverage is essential to an effective Medicaid program. However, Prescription spending is growing faster than other medical expenses, 12.9% in 2014 and 9% in 2015, an unsustainable rate. DHS pharmacy program costs over $400 million per year made up of over 5 million claims. The Task Force supports the ongoing efforts by DHS to implement the pharmacy quality and programmatic savings initiatives above.

I. Recommended Dental Managed Care Savings

The Task Force recommends that the Legislature closely monitor the implementation of managed care for dental services in Medicaid. Notably, ensuring network adequacy, vendor oversight and seeing that the Department meets its cost saving estimates.

The Dental Managed Care RFP was issued, responses received, and evaluated. An announcement of the anticipation to award contracts to two dental managed care organizations is expected imminently. The contracts will be submitted to the Legislature for review and contracts are anticipated to start in quarter one 2017. The dental managed care plans are expected to enroll members and begin services effective 1/1/18.

Currently, DHS offers dental providers a deferred compensation package that offers providers tax savings. As part of the RFP, DHS asked bidders to respond to how they would address deferred compensation. Dental providers have threatened to not participate in the dental MCO networks if deferred compensation is not addressed. DHS needs to monitor network adequacy as a result of this issue.

It is important for DHS to understand and plan for the fundamental shift in moving from fee for service oversight to managed care health plan oversight. DHS staff needs to be reorganized and retrained so that their focus shifts to health plan contract oversight and monitoring for dental managed care. If the dental MCO contracts are not monitored properly, savings from the move to managed care could be jeopardized.

J. Patient-Centered Medical Home (PCMH)

The Task Force recommends that DHS should expand the Patient-Centered Medical (PCMH) Home Program to include more enrollees and services, and should share information on provider Episode-of-Care (EOC) performance with primary care practices participating in the PCMH program.

The Task Force identified several ways that the patient-centered medical home (PCMH) program could be adjusted to increase potential cost savings.

- Increasing the number of beneficiaries covered by PCMH by lowering the required number of beneficiaries served by a practice to include more primary care providers (PCPs).

- Increasing the effectiveness of PCMH by providing PCPs with information about the cost-effectiveness of Principal Accountable Providers associated with Episodes of Care.
- Increasing the services managed by PCMH by including low-level behavioral health services in the primary care office.

DHS is already implementing certain program changes to increase the cost and clinical effectiveness of the PCMH program, including the following:

- Lowering the required number of beneficiaries served by a practice, which will make more PCPs eligible and align with the federal Comprehensive Primary Care Plus (CPC+) initiative.
- Doing additional outreach to bring more PCPs into the program.
- Authorizing billing for behavioral health services on the same day and in the same location as primary care services.

While the agency anticipates that these initiatives will result in additional cost savings, the specific level of savings anticipated has not been identified.

K. Five Year Net Savings Plan for Traditional Medicaid along with program savings and investment recommendations

The Task Force recommends and supports that the Arkansas Department of Human Services develop and implement a Five-Year Medicaid Program Savings Plan that is in excess of the $835 million in net savings to trend proposed by Governor Asa Hutchinson starting no later than July 1, 2017. Savings must be achieved through an increase in care management and coordination resulting in improved outcomes, quality, appropriate utilization based on need, reduction of duplication and unnecessary services, and the introduction of value based purchasing strategies and some degree of provider risk. The Department of Human Services will provide a Comprehensive Medicaid Budget Savings Dashboard Report tracking savings to trend to the Bureau of Legislative Research every quarter commencing September 1, 2017 and thereafter for five years.

This analysis, by The Stephen Group, considers three primary models for reducing spending in Arkansas' traditional Medicaid program below:

1) The "Current Model" – a set of benefit modifications and program adjustments that have been identified over the last 2 years with the Task Force.
2) A Provider-led "Collaborative Care Organization" model that has been put forth by the DHS for the behavioral health and developmental disability enrollee populations.
3) A capitated managed care model for the behavioral health and developmental disability enrollee populations that is being analyzed for comparison

In the following sections, the savings assumptions for the different models and the anticipated savings are described. For all of the models, the baseline is a 5% annual cost increase starting with SFY 2015 actual expenditures.

Baseline and Savings Models

The following table shows the baseline spending projection, along with the spending projections with the implementation of the different cost savings models. The baseline and cost savings model projections are shown with and without Arkansas Works expenditures.

All Figures in $Millions; Years are SFY								
Model/ Program	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2017 – 2021**	**2018 – 2022**
Baseline, Traditional Only	$5,379	$5,648	$5,930	$6,227	$6,538	$6,865	$29,722	$31,208
"Current Model", Traditional Only	$5,299	$5,492	$5,755	$6,026	$6,322	$6,649	$28,894	$30,244
Provider-Led CCO for BH and DD, Traditional Only	$5,299	$5,492	$5,755	$6,026	$6,227	$6,549	$28,799	$30,049
Capitated Managed Care for BH and DD, Traditional Only	$5,299	$5,492	$5,755	$5,951	$6,202	$6,523	$28,699	$29,923
Arkansas Works	$1,721	$1,820	$1,924	$2,035	$2,152	$2,276	$9,652	$10,207
Baseline, Traditional and AW	$7,100	$7,468	$7,855	$8,262	$8,690	$9,141	$39,374	$41,415
"Current Model", Traditional and AW	$7,020	$7,312	$7,679	$8,061	$8,474	$8,925	$38,546	$40,451
Provider-Led CCO for BH and DD, Traditional and AW	$7,020	$7,312	$7,679	$8,061	$8,379	$8,824	$38,451	$40,256
Capitated Managed Care for BH and DD, Traditional and AW	$7,020	$7,312	$7,679	$7,986	$8,354	$8,798	$38,351	$40,130

Current Model

The following table describes the cost saving strategy for each program under the "Current Model", and the assumptions regarding the timing of the cost savings and any administrative costs that will need to be borne by the agency to affect such changes.

	Savings Strategy	**Savings Timing**	**Admin Considerations and Costs**

DD	$18M per year in therapy caps; $14M/yr. from screenings for children; $17M/yr. from independent assessment and tiers for waiver services	therapy caps and screenings for children begin July 1, 2017 (savings over 5 years); independent assessment and tiers start July 1, 2019	$2M per year for independent assessments starting July 1, 2019
BH	Updated outpatient policy, reduction in inpatient from independent assessment	Begins July 1, 2017; savings over 5 years	$108M investment over 5 years for independent assessment and care coordination
Dental	$5M per year in savings from capitated managed care	Begins July 1, 2017	
Elder	Industry MOU to save $250M over 5 years	Begins July 1, 2016; savings evenly spread across 5 years; assume $50M/yr. savings continues into SFY2022	None
Low-cost	No program changes		
Pharmacy	$250M in savings	Begins July 1, 2016; savings evenly spread across 5 years	

The following table shows the anticipated savings from the programmatic changes already being implemented.

Savings by year and program	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**	**SFY22**	**SFY17-21**	**SFY18-22**
DD Savings - Therapy Caps	$0	$18	$18	$18	$18	$18	$72	$90
DD Savings - Screenings for Children	$0	$14	$14	$14	$14	$14	$56	$70
DD Savings - Independent Assessment and Tiers/Waiver Changes	$0	$0	$0	$17	$17	$17	$34	$51
DD Cost - Independent Assessment	$0	$0	$0	$2	$2	$2	$4	$6
Net DD Savings	$0	$32	$32	$47	$47	$47	$158	$205
BH Savings - Updated Outpatient Benefits Policy	$15	$16	$33	$33	$33	$33	$130	$148
BH Savings - Inpatient	$0	$15	$25	$35	$50	$50	$125	$175
BH Cost - Independent Assessment	$0	$1	$2	$2	$2	$2	$7	$9
BH Cost - Care Coordination	$0	$15	$21	$21	$21	$21	$78	$99

Net BH Savings	$15	$15	$35	$45	$60	$60	$170	$215
Dental Savings - Capitated Managed Care	$0	$5	$5	$5	$5	$5	$20	$25
Dental Premium Tax	$0	$3	$3	$4	$4	$4	$14	$18
Net Dental All-Funds Impact	$0	$8	$8	$9	$9	$9	$34	$43
Elder Savings	$15	$50	$50	$50	$50	$50	$215	$250
Low-Cost Populations	$0	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$50	$50	$50	$50	$50	$50	$250	$250
Net Fiscal Impact	**$80**	**$155**	**$175**	**$201**	**$216**	**$216**	**$827**	**$963**

If the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $963 million between SFY2018 and SFY2022.

Provider-Led CCO Model

DHS has put forward the concept of provider-led coordinated care organizations for the BH and DD programs. The following table describes the cost saving assumptions for the CCO-based approach proposed by DHS.

	Savings Strategy	**Savings Timing**	**Admin Considerations and Costs**
Current strategy	All savings from current strategy as above	As above	As above
DD Provider-led CCO model	Care coordination for DD halo services	5% savings off of halo spend starting year 4	Savings net of admin costs (admin under APCCO/RCCO payment)
BH Provider-led CCO model	Care coordination for BH halo services	5% savings off of halo spend starting year 4	Savings net of admin costs (admin under APCCO/RCCO payment)

The following table describes the projected cost savings from the provider-led CCO model. The starting point for these cost savings are the cost savings from the programmatic changes already identified and described in the previous tables. There remains an opportunity for additional savings within the DD and BH programs through greater care coordination, specifically with respect to the medical and pharmacy benefits (the "halo" spend for the BH and DD populations).

Savings by year and program	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**	**SFY22**	**SFY17-21**	**SFY18-22**

All cost savings from current model	$80	$155	$175	$201	$216	$216	$827	$963
DD Provider-Led CCO Model Savings	$0	$0	$0	$0	$12	$13	$12	$25
DD Provider-Led CCO Model Premium Tax	$0	$0	$0	$0	$26	$27	$26	$52
Net additional DD all funds impact	$0	$0	$0	$0	$38	$40	$38	$77
BH Provider-Led CCO Model Savings	$0	$0	$0	$0	$28	$29	$28	$57
BH Provider-Led CCO Model Premium Tax	$0	$0	$0	$0	$30	$31	$30	$61
Net additional BH all funds impact	$0	$0	$0	$0	$58	$61	$58	$118
Net Fiscal Impact	**$80**	**$155**	**$175**	**$201**	**$311**	**$316**	**$923**	**$1,159**

If the DD and BH provider-led CCO models, and the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $1,159 million between SFY2018 and SFY2022. Note that this assumes $61 Million in premium tax revenue, which DHS is currently reviewing the issue to determine if future legislation is required should the state move in this direction.

Capitated Full Risk Managed Care Model

Recognizing that most states are moving toward greater use of capitated managed care in their Medicaid programs, TSG has developed the following projections of capitated full risk Medicaid managed care for the BH and DD populations. The following table describes the cost saving assumptions for the capitated managed care approach.

	Savings Strategy	**Savings Timing**	**Admin Considerations and Costs**
Current strategy	All savings from current strategy as above	As above	As above
DD Capitated Managed Care	Care coordination for DD halo services	8.07% savings off of halo spend starting year 3	Savings net of admin costs (admin under MCO payment)

BH Capitated Managed Care	Care coordination for BH halo services	8.07% savings off of halo spend starting year 3	Savings net of admin costs (admin under MCO payment)

The following table describes the projected cost savings from the capitated managed care model. As above, the starting point for these cost savings are the cost savings from the programmatic changes already identified and described in the previous tables.

Savings by year and program	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**	**SFY22**	**SFY17-21**	**SFY18-22**
All cost savings from current model	$80	$155	$175	$201	$216	$216	$827	$963
DD Capitated Managed Care Savings	$0	$0	$0	$19	$20	$21	$39	$59
DD Capitated Managed Care Premium Tax	$0	$0	$0	$24	$26	$27	$50	$77
Net DD additional all funds impact	$0	$0	$0	$43	$45	$48	$88	$136
BH Capitated Managed Care Savings	$0	$0	$0	$3	$45	$47	$48	$96
BH Capitated Managed Care Premium Tax	$0	$0	$0	$28	$30	$31	$58	$89
Net additional BH all funds impact	$0	$0	$0	$32	$75	$78	$107	$185
Net Fiscal Impact	**$80**	**$155**	**$175**	**$276**	**$336**	**$342**	**$1,022**	**$1,284**

If the DD and BH capitated managed care models, and the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $1,284 million between SFY2018 and SFY2022.

IV. Other Recommendations

A. Eligibility and Enrollment Framework Project

The Task Force recommends that the Arkansas Legislature continue to monitor progress and receive timely updates to ensure the successful award and implementation of the Arkansas Medicaid Integrated Eligibility - Benefits Management System (IE-BM).

DHS has hired a consultant, Gartner, to assess the systems and make recommendations to enhancing the EEF project. It will be incumbent upon the Legislature to monitor this closely, as the DHS has worked to reduce the backlog successfully, but must also ensure that the Department moves forward effectively on resolving the system issues. DHS currently is prepared to issue an RFP on this project, and should check in with the Legislature throughout the process.

B. DD Wait List

The Task Force recommends that DHS develop a plan to provide services to those on the Developmental Disability Waiting List, either through a benefit structure that is capped with tiered levels of payment for some services, or through the Governor's plan to use Tobacco Settlement Funds to provide services for those currently waiting for waiver services on the Developmental Disabilities Waiting List.

Currently there are over 2,900 individuals on the Arkansas Alternative Community Services Waiver Waiting List. During hearings we received testimony and showing that all of these individuals are receiving Medicaid covered health services and some are also receiving state plan services. However, most are waiting to be approved for home and community based waiver services that they are unable to access today, such as the supportive living benefit. These Medicaid home and community based services are effective and designed to keep individuals from a more expensive and more restrictive setting.

Task Force heard testimony from DHS about the Governor's desire to use Tobacco Settlement funds to provide services for those currently waiting for waiver services. The total amount of Tobacco Settlement dollars available is approximately $8.5 Million. The federal matching funds bring that total to approximately $28 Million dollars. These funds could be used to cover approximately 499 individuals with developmental disabilities with home and community based waiver services in the next fiscal year.

The Task Force supports the Governor's plan to use Tobacco Settlement dollars to provide waiver services for those currently on the developmentally disabled waiting list and encourages DHS to identify cost effective ways of serving even more individuals with developmental disabilities who are eligible for the full array of home and community based waiver services in the future.

C. Organizational recommendations to support DHS Transformation

The Task Force recommends that DHS continue its ongoing efforts to enhance care integration and focusing the organization of the department around bringing services to individuals, as opposed to keeping individuals in distinct systems of care that lead to fragmented services. Additionally, DHS should continue to expand its efforts to leverage greater efficiency of economy of scale through a shared service model that promotes

excellence across the Department. The Arkansas Legislature should monitor these efforts to ensure they maximize both quality improvements and cost reductions.

An earlier review of DHS organization found that the structure did not support moving the entire Medicaid program into an integrated services care coordination model. Instead, it prioritized single issue policy making and forced individuals to travel through different systems of care. This led to poor customer service, lack of accountability and coordination and inefficient service delivery.

The Stephen Group's "Recommendations Report" last year recommended that the reorganization of DHS into a value based enterprise be based on elevating the Medicaid program to the DHS Director's Office, including the integration of Behavioral Health, Developmental Disabilities, and Long Term Care under the Medicaid Director, to support integrated policy and budget development, integrated care coordination, and integrated care management. Coordination with Medical Services and Pharmacy would focus on quality, population health, and cost while moving away from a "compliance only" mentality across DHS.

Additionally, TSG recommended that DHS integrate all IT functions under an Information and Data Analytics framework, create an Office of General Council, Office of Communications, and Office of (General) Operations. TSG also recommended that the DHS of the future would require new skills, including IT, data analytics, project management, and contracts management, at comparable market salaries.

In June, 2016 DHS Director Cindy Gillespie announced a business oriented reorganization. Cutting through the silos of separate DHS Division practices for procurement, contracting, human resources management, Information and Technology Director Gillespie implemented the creation of the Offices of Finance, Procurement, Human Resources, Information Technology, Legislative and Intergovernmental Affairs, and General Counsel. The new centralized functional offices will serve the DHS enterprise on a platform of shared services, integrated policy and management practices, reduced duplication and increased efficiency resulting in a net reduction of 25 FTE positions and net savings of $597,583. Simultaneously, Director Gillespie announced the cessation of two vendor contracts resulting in savings of $23 million annually.

In addition, Director Gillespie implemented the reorganization of the Arkansas Medicaid program based on the creation of the position of Deputy Director for Health and Medical Services encompassing the Divisions of Behavioral Health, Medical services, Aging and Adult Services, Developmental Disabilities, and County Operations resulting in an anticipated dramatic improvement of the integration of Medicaid policy, care coordination strategies, budget control and financial planning, and implementation strategies.

The attributes of this reorganization should achieve improved quality, improved care coordination across all high needs populations, and cost savings over the next several years.

DHS has added a national level expert to the Director's Office as Senior Advisor for Medicaid and HealthCare Reform to lead the necessary changes to the Medicaid program's benefits design, purchasing, and population health improvement strategies. All Children and Family services provided by DHS have been reorganized in the Director's Office under the Deputy Director for Children and Families position.

Additionally, Director Gillespie has created a DHS interdisciplinary leadership team to serve as the Department's Policy Review Committee. Much progress in the transformation of DHS into a more integrated, quality and customer oriented and accountable organization has been made over the past year.

The Task Force applauds these efforts and encourages DHS to continue moving forward to reorganize the Department around the needs of the beneficiaries, not the agency. This will lead to less fragmented services, higher quality and cost savings. The Legislature should continue to monitor these efforts closely to ensure that they achieve success and DHS has the tools it needs to continue.

D. Increase State Vaccination Rates

The Task Force recommends that Public Health reevaluate vaccination reimbursement to all providers, including separating the ingredient reimbursement from the professional administration fee for adult vaccinations, and reevaluate the professional administration fee for the free vaccines distributed in the vaccines for children (VFC) program.

The public and individual health benefits of high vaccination rates are well understood. Unfortunately, according to federal data, Arkansas's young children rank behind all but two states, Kentucky and West Virginia. One impediment to provider participation and promotion of vaccinations is the low reimbursement rates. The Task Force believes that the entire vaccine program should be reevaluated to promote more vaccinations.

E. Monthly Prescription Limits

The Task Force recommends the removal of the monthly prescription limit for approved maintenance medications used in approved chronic conditions and maintenance of a monthly prescription limit for all other drugs.

Prescription medications are among the most cost effective medical interventions; this is most true for chronically ill patients requiring maintenance medications to treat their conditions. Currently there are various limits on access to needed prescriptions based on age and site of care.

These limitations in pharmacy can cause unintended medical costs which actually outstrip the pharmacy savings from limiting prescription access. The Task Force recommends that prescribers should be alleviated from having to request an extension every six months of benefits for chronically ill beneficiaries requiring maintenance medications.

F. Combating the Opioid Crisis

The Task Force makes the following recommendations to help combat the opioid epidemic in Arkansas. #1) Allow DHS clinical staff to access the State Prescription Drug Management Program (PDMP). #2) Recommend that DHS pharmacy group continue to tighten opioid dispensing limits, measure limited quantities in morphine milligram equivalents, and tightly manage early opioid prescription refill requests. #3) Expand the frequency and number of drug take-back locations. #4) Encourage prescribers to consult the PDMP prior to prescribing drugs of potential abuse.

Opioid overuse, misuse and abuse remain significant threats to public health in the US and in Arkansas. There are positive efforts taking place, which are beginning to show signs of positive impact, but there is a long way to go. Arkansas Medicaid is controlling access to opioids in a logical and progressive manner and seems poised to continue to add new and sophisticated drug utilization management tools as they emerge. As e-prescribing continues to flourish (now approximately 85% of all prescriptions), it is expected that controlled substances will also be primarily e-prescribed. The Task Force recommends a multi-faceted approach to managing this critical reality.

G. State Data Integration/research and decision making

The Task Force recommends that the Arkansas Legislature consider the feasibility of establishing a statewide, comprehensive data sharing system at a public university to coordinate the multiple systems to ensure efficiency and effectiveness of human service programs.

The State of Arkansas has a vested interest in developing a data system to assist the Governor, General Assembly, and other policymakers to make data-driven decisions that result in more efficient usage of taxpayer funds and better matching of state needs with state priorities. To accomplish this goal, the Task Force recommends that the state explore the feasibility of establishing such a data system in cooperation with a research-based public university with a proven track record of analytical research and data system development and implementation.

H. Eligibility Integrity

The Task Force supports the use of both state and publicly available databases to promote public integrity in the Medicaid eligibility process, through an electronic identity, asset and income verification solution pre-and post-eligibility.

There are considerable data available to the State, both currently in agency databases and among private data vendors, which could be used to enhance eligibility screening to ensure that only those who truly meet the criteria to enroll in state benefit programs actually receive them. The Task Force recommends that DHS review national best practices and to use these tools to ensure program integrity of public assistance programs.

I. Certified Agents Role

The Task Force recommends that DHS work with National Association of Insurance and Financial Advisors (NAIFA) and clarify the authority of Exchange Certified Producer (certified agents who are compensated from Insurance plan premiums) to represent and speak on behalf of applicants, when given the proper signed authority and consent by applicants, with DHS on any matter involving enrollment and eligibility for the Private Option or the proposed alternative to replace it.

It is understood that such Exchange Certified Agents will provide assistance governed by the State and Federal guideline as they have abided by for years. The Certified Agents should be included in the development of the DHS guidelines that will govern their role in the enrollment process for all the new plans.

J. Independent Medicaid Provider Rate Review

The Task Force recommends a yearly Medicaid provider rate review conducted by an independent actuarial or professional consulting firm, with experience in Medicaid rate methodology that compares Arkansas' Medicaid provider rates to those of other state Medicaid programs, and Medicare and commercial insurance as well, and to provide an annual report of its findings to DHS and the legislature for review and consideration.

K. Medicaid Fairness Act

The Task Force supports amending certain provisions of the Medicaid Fairness Act to allow prior authorizations to be based on recognized standards of evidence-based practice or professionally recognized standards for health care. Moreover, the Task Force supports legislation making it clear that DHS is not required to promulgate rules to incorporate recognized standards of evidence-based practice or professionally recognized standards of care that practitioners use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

L. Health Disparities and Access

The Task Force supports cost effective policies that serve to reduce health disparities, increase access to health care and allow for appropriate use of health care services for those eligible for Medicaid

The Center for Disease Control and Prevention's "national data on health disparities indicates that heart disease, cancer, stroke, diabetes, and unintentional injuries are the leading causes of death among African Americans, resulting in shorter comparative life spans." Further, the CDC reported that Arkansas ranked among the least healthy states in the country based on indicators such as incidence of diabetes, cardiovascular deaths, infectious disease, and deaths by stroke, and obesity. Child health measures for child immunization, infant mortality, and preventable hospitalizations also ranked Arkansas among the least healthy states in the country.

The Task Force recommends that the reduction of health disparities in Arkansas be included in the Medicaid services spectrum of services and current and future delivery systems through beneficiary education at the community level on appropriate use of the health care system including Emergency Department care, access and use of primary care, and treatment of chronic medical conditions. Further, DHS should track Arkansas' Medicaid population health status improvement through a "State Health Scorecard" approach as tracked by the CDC.

M. Task Force Sub-Committee Recommendations

DRG Sub-Committee Recommendation

The Task Force supports DHS, to the extent possible, and after collaboration with the Arkansas Hospital Association, converting hospital reimbursement systems under the traditional Medicaid programs to a diagnosis-related groups (DRG) methodology that will allow DHS to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The Task Force also supports DHS promulgating rules to achieve this purpose that shall address how supplemental payments would be considered, whether transition funding should be provided and whether certain providers should be carved out.

DRG payments are a common way of health care payors to hold providers accountable for health care costs. Additionally, this payment method helps to deliver great cost certainty to payors. Many insurers utilize DRG payment structures, so this change should not be out of the norm for providers.

HDC Sub-Committee Recommendations

DHS should create a long-term plan for the legislature that considers the following over the next five years:

- ***Forecasted demand for HDC services at state and regional level, assuming changes in resident acuity if applicable;***
- ***Forecasted cost for operation of the HDC system (aggregated and per diem cost information);***
- ***Analysis of how DHS can most effectively and efficiently meet forecasted need through existing HDCs or changes to the system (size, location); and,***
- ***Cost estimate to meet forecasted demand (including estimated infrastructure needs).As part of the long-range planning, conduct an appraisal of any lands or properties not in use that could be sold that are not essential to current services that would create revenue for capital improvement projects.***

This recommendation contemplates a different planning process than the annual strategic planning process used at each center and is not intended to supplant that process. HDC strategic plans outline current and future initiatives and center goals and are very client outcome-focused. They are developed by a multi-disciplinary group of local stakeholders. The center-level plans serve a different purpose and do not analyze long-term system needs.

Based on this planning process, the legislature should ensure availability of adequate funding for repair and maintenance of existing facilities and new construction, as needed.

Conduct an evaluation of the current capacity and quality of the home and community based care system for serving those with developmental disabilities.

The Task Force and this Committee has heard testimony concerning the future focus of the DHS to enhance capacity and opportunities for individuals with disabilities to live in homes and communities as part of the continuum of care. DHS should conduct a thorough evaluation of community provider current capacity and needs, and make recommendations to ensure adequate provider capacity, infrastructure, quality and support.

Publish data about licensing and maltreatment across programs

Making data about licensing violations and abuse/neglect/exploitation of consumers across DDS programs available online increases transparency about the quality of service delivery in those settings. It may inform decisions of consumers, their families, and legal guardians about whether to transfer to another program or aid in provider selection.

Centralize DHS investigations and licensing functions

Centralization of DHS investigations and licensing functions would allow DHS to gain additional efficiencies and organizational benefits, as well as enhance the rigor of investigations across programs by cross-pollinating some of the best practices and tools.

Continue to evaluate the capacity of licensing function

DHS should continue to monitor the ratio of licensing/oversight FTE resources to consumers served in its programs to ensure that the agency is providing an appropriate level of resources. While not a concern at present, if enrollment in community-based programs grows, it will be important for the agency to ensure that oversight resources keep pace with that growth.

DDS should review its current process of informing families/guardians of community waiver placement options to determine if additional methods are available to increase awareness of alternative placement options.

The current system informs families/guardians alternative placement options prior to admission, during the admission process, and at a minimum, annually thereafter. Each facility also conducts a provider fair at least annually, in which community providers come to the facility campuses to visit with parents/guardians.

DDS should adapt its post-placement monitoring tool as needed to incorporate best practices from other states.

The monitoring tool should prompt the worker to assess the person's safety and capture data in that area, as well as considered whether quality of life and person-centered care is being delivered. DDS should establish a survey to measure parental/guardian/resident satisfaction with the transitions process. In reviewing the tool**,** DDS should also consider formalizing in a written policy or protocol its operating procedures and guidelines for post-placement monitoring for persons who transfer from an HDC to a community setting

The DHS Office of the Chief Financial Officer, in conjunction with DDS, should conduct further analysis to understand cost variations across HDCs and identify efficiencies that can be replicated at other facilities. Examples to investigate include:

- ***Heath Care – This category comprises a large share of the total daily rate. It includes direct care staff. While most of the facilities are comparable here and maintain similar staffing ratios, Booneville's total cost per bed day is lower than the other HDCs and this should be explored.***
- ***Room and Board – Warren's costs here are higher than its three other peers of a similar size. There may be practices it can replicate from its peers to bring down these costs.***

- ***Maintenance and Operations – Conway has the lowest cost per bed day, which is likely due to efficiencies gained due to its larger relative size, but Jonesboro's cost is low relative to its peers of a similar size and its experience may be instructive.***

Savings and efficiencies identified by DHS/DDS, as well as other DHS cost containment strategies such as use of bulk contracting and purchasing and identifying more efficient approaches to contracting for professional services (such as dental services) should be monitored and tracked by DHS.

DHS Should establish a new supervisor development program

Quality supervision is important in the provision of services at HDCs and is critical to staff retention. Literature across disciplines suggests that a supervisor can be a key reason a worker leaves or stays at a job. The Department provides mandatory four days of policy and procedures training and a mandatory three-day leadership training for new supervisors. There is also a mandatory supervisory update training that occurs after a person has been a supervisor for five years. The department does offer a menu of professional and personal growth training opportunities through its internal staff development section and its inter-agency training program, but most of these items are not mandatory. There is currently no mandatory, ongoing training program to strengthen the managerial and leadership skills of its supervisory workforce outside of those mentioned above. Exit interviews with workers suggest there are concerns with the quality of supervision in certain areas of the state and that some new supervisors may struggle with the role of manager. An on-going mandatory training and development program for supervisors throughout the course their career would not only improve the quality of supervision and strengthen supervisory skills, but would also provide supervisors with guidance on how to develop their staff. Such a program could include supportive features (such as mentoring) to provide personal and professional support to supervisors. It is expected that this program would aid in the retention of both supervisors and workers.

DHS should explore the feasibility and cost of establishing a career ladder for supervision/management

Absence of an extended career ladder/low pay is a factor contributing to supervisor turnover, especially in areas with direct competitors (i.e., a new healthcare facility). Direct care staff members advance from the entry-level position of Residential Care Assistant to the next level (Residential Care Technician) in a career ladder format but must apply, interview, and be selected for positions beyond that. There is currently no other career ladder mechanism outside the traditional interview/selection process that allows a direct services staff person to promote,

though they are eligible for annual bonuses based on performance. Providing for an extended career ladder for staff could address a reason direct services personnel leave HDC employment.

DHS should ensure adequacy of entry-level worker salaries

Each HDC operates in a local labor market and competes with other regional employers for staff. DHS staff has analyzed the salaries of other major employers in the markets where the HDCs are located and found DDS salaries to be less competitive in some areas (though benefits tend to be more robust at DDS compared to its competitors). In parts of state where economic opportunities result in the expansion of industry, HDCs may have an especially difficult time attracting and retaining staff. The state's Office of Personnel Management establishes the pay plan for the state. DDS has received permission previously to offer the mid-point of the salary range (instead of the bottom of the range as is typically offered) for certain positions in certain areas of the state and is currently in the process of implementing that salary adjustment. This recommendation is for a more generalized increase of salaries across the direct care staff positions to enable DDS to attract the best applicants for HDCs statewide and prevent loss of qualified staff to other employers.

DHS should ensure adequate funding for the demolition of vacant buildings on HDC campuses that produce potential risk to residents.

Demolition of such buildings has been prioritized by current DDS leadership and the process is underway to remove the buildings in question. Going forward, the legislature should ensure that adequate funding exists to ensure the timely demolition or repair of these buildings to mitigate any adverse resident impact. DDS should include such needs in its long-range plan to the legislature.

Note: A copy of the complete HDC Committee Report (filed with the Task Force October 2016) can be obtained by contacting the Arkansas Bureau of Legislative Research

WORKING PAPER

Disability Insurance and Health Insurance Reform

Evidence from Massachusetts

Nicole Maestas, Kathleen J. Mullen, and Alexander Strand

RAND Labor & Population

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Disability Insurance and Health Insurance Reform: Evidence from Massachusetts

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Abstract

As health insurance becomes available outside of the employment relationship as a result of the Affordable Care Act (ACA), the cost of applying for Social Security Disability Insurance (SSDI)—potentially going without health insurance coverage during a waiting period totaling 29 months from disability onset—will decline for many people with employer-sponsored health insurance. At the same time, the value of SSDI and Supplemental Security Income (SSI) participation will decline for individuals who otherwise lacked access to health insurance. We study the 2006 Massachusetts health insurance reform to estimate the potential effects of the ACA on SSDI and SSI applications.

The unfolding reforms to the U.S. healthcare system under the Affordable Care Act (ACA) will fundamentally alter the costs and benefits of applying for federal disability benefits through the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. SSDI recipients are entitled to health insurance coverage through the Medicare program, but only after they satisfy a two-year waiting period that begins with the date they qualify for benefits.[1] SSI recipients are entitled to Medicaid coverage immediately upon qualifying for benefits.

Because most non-elderly adults in the United States obtain health insurance coverage through their employer, individuals who experience a work-limiting health condition face a difficult dilemma: attempt to keep working in spite of an uncomfortable impairment in order to maintain employer-sponsored health insurance (ESHI) or stop working in order to apply for SSDI or SSI and risk an extended period of uninsurance. Some of these individuals may be able to obtain subsidized coverage through a spouse's employer. Others may be able to retain their employer coverage temporarily under COBRA provisions, but at full cost during a period without labor earnings.[2] If the disincentive arising from loss of health insurance coverage presently discourages labor force withdrawal and disability benefit application, then the ACA's introduction of affordable health insurance coverage outside of employment could free workers from "employment lock," and consequently *increase* both disability-related labor force withdrawal and disability applications. On the other hand, the introduction of affordable coverage options outside of SSDI and SSI could reduce the relative value of disability benefits for those who did not have ESHI or were uninsured at the time of disability onset, and hence

[1] The 24-month Medicare waiting period begins after the 5-month waiting period for entitlement to cash benefits.
[2] COBRA provisions allow for an extended time limit (from 18 months to 29 months) in the event the former employee receives a disability determination from SSA within the first 60 days of continuation coverage.

could *decrease* federal disability applications. Indeed, health insurance benefits are more valuable than cash benefits for many beneficiaries (Mashaw, 1997). Which of these two countervailing effects is likely to dominate the other is an important empirical question.

The 2006 implementation of health insurance reform in the state of Massachusetts (MA) offers a unique opportunity to forecast the impact of the ACA on SSDI and SSI applications. The MA reform shares many key features with the ACA, most notably, a new individual coverage mandate, an expansion of subsidized coverage for low-income individuals, the creation of a state health insurance exchange as a source of lower-cost individual coverage, and new requirements for employers. The MA reform legislation was passed in April 2006 and phased in primarily between October 2006 and July 2007. The reform was associated with an increase in the rate of insurance coverage among the nonelderly in MA from 88 percent in 2004-2006 to 94 percent in 2008-2009, an increase of nearly 7 percent or, alternatively, a decrease in the uninsurance rate of 48 percent (Kolstad and Kowalski, 2012). The ACA is expected to increase insurance coverage by a similar magnitude (Truffer et al., 2010).

In this paper we use administrative data from the Social Security Administration (SSA) to examine changes in SSDI and SSI application rates in MA before and after the reform relative to a group of comparison states that are similar in size, demographics and geographic location. We find disability applications increased modestly, by 1-3 percent, in MA relative to neighboring states in the first year following the completion of the reform with no statistically significant difference thereafter. However, this (temporary) increase masks substantial heterogeneity at the county level: the total number of disability applications (SSDI and SSI combined) increased in counties with relatively high rates of health insurance coverage prior to the reform (consistent with the release of employment lock) and decreased in counties with low rates (consistent with a

decrease in the relative value of SSI). Surprisingly, applications for SSDI only (i.e., excluding "concurrent" applications for both SSDI and SSI) increased everywhere even in counties with low coverage rates, where employment lock would have been relatively low. We argue this pattern is suggestive of state-level incentives to shift Medicaid costs to the federal Medicare program whenever possible. Because health insurance coverage in the rest of the U.S. is generally lower than in MA prior to the 2006 reform, our results imply that the ACA may lead to a net decrease in disability applications in the U.S., with some shift, at least initially, in the composition of new applications to SSDI.

I. The Health Insurance Landscape in Massachusetts before and after the Reform

Prior to the enactment of its health insurance reform law in 2006, MA had a generous system of public health insurance and low uninsurance rate compared to other states. In addition to the mandatory Medicaid programs that all states were required to offer, MA offered most of the optional Medicaid programs and under a Medicaid demonstration waiver used relatively generous income and asset thresholds for determining eligibility.[3] MA residents who were long-term unemployed or who were certified disabled[4] could enroll in fully subsidized Medicaid coverage if their incomes were below 133% of the Federal Poverty Guidelines (FPG). In theory, the long-term unemployed program (MassHealth Essential) was an option for people whose disabilities did not meet SSA's strict severity standard, but who had been unable to work for at least a year. However, enrollment in the two programs was capped and there was a long waiting list (itself equal to 29% of the cap) at the time the reform was implemented (Blue Cross MA

[3] See Bruen, Wiener and Thomas (2003) for a description of state mandatory and optional Medicaid programs for disabled beneficiaries prior to the MA health reform.

[4] MA uses the SSA standard for defining disability. To be considered disabled for the purpose of qualifying for the state Medicaid program (MassHealth), individuals must provide evidence of a disability determination from SSA or the state Disability Determination Unit, or a certification of legal blindness from the MA Commission for the Blind.

Foundation, 2006). MA residents who were "working disabled" (those with certified disabilities who were working at least 40 hours per month) and had incomes *above* 133% FPG could pay an income-adjusted premium for Medicaid coverage through the state's Medicaid Buy-In program (CommonHealth Working)).[5] On the eve of reform in 2006, the MA Medicaid Buy-In program was the largest such program in the country, but even at that time the program enrolled only about 5% of the working-age disabled (60% of whom were already SSDI/SSI beneficiaries) (Gimm et al., 2008). Thus, even under this relatively generous public coverage landscape, people whose disabilities did not meet SSA's disability standard lacked an option for affordable coverage—whether working (because the Medicaid Buy-In program also used the SSA disability standard) or not working (because the long-term unemployed program was closed and there were no other subsidized options).

It was in this context that the MA legislature passed health insurance reform in April 2006. The reform was implemented in several steps. The first step was the raising of the enrollment cap on the long-term unemployed program (available to those with incomes below 100% of FPG) in October 2006. Subsidized insurance plans for lower-income individuals (up to 300% of FPG) were made available through Commonwealth Care in January 2007. In May 2007 open enrollment began for Commonwealth Choice, which enabled individuals who were not eligible for Commonwealth Care to purchase insurance offered by private health plans through a newly created health insurance exchange, called the Health Connector. An individual mandate – which required most MA adults to carry health insurance – and an employer mandate – which required employers with more than 10 full-time equivalent employees to offer health insurance

[5] The program was generous compared to other state Medicaid Buy-In programs in that it had no upper limit on income or assets.

or face a penalty – went into effect in July 2007. By the end of 2007, MA adults were required to show on their state taxes that they were enrolled in a health insurance plan, with tax penalties for noncompliance increasing in 2008. By January 1, 2009 the reform was fully phased in.

For people whose disability clearly met SSA's disability standard, the reform maintained Medicaid coverage with subsidies that varied by income level. However, for those whose disabilities did *not* clearly meet SSA's disability standard (i.e., those who were "moderately disabled"), it created new subsidized insurance options. It raised the enrollment cap on the long-term unemployed program by 36% (more than enough to absorb the waiting list), and created fully subsidized private insurance options (independent of employment or disability status) for people with incomes below 150% FPG and partially subsidized private insurance options for people between 150-300% FPG—all available through the state insurance exchange. In addition, (unsubsidized) private plans became available at more affordable prices through the exchange.

By creating a path to subsidized coverage that did not require employment or a disability determination, working individuals could leave their jobs, apply for SSDI, and obtain health insurance on the exchange while waiting for their cases to be processed or to fulfill the two-year Medicare waiting period. This easing of "employment lock" could have caused an increase in SSDI applications from people with incomes between 150-300% FPG (who gained access to subsidized coverage) and also from people with incomes above 300% FPG (who gained access to more affordable private coverage through the exchange). At the same time, by creating new options for health insurance, the MA reform decreased the relative value of SSDI and SSI and may have discouraged applications from people without access to affordable health insurance coverage prior to the reform, including the long-term unemployed and workers without ESHI.

II. Data and Empirical Strategy

Our primary data source is the Social Security Administration's 831 files which contain the universe of all SSDI and SSI applications that received a medical determination. These data contain the application filing date, whether the applicant filed for SSDI or SSI benefits or for both concurrently, and other application characteristics. Importantly, it includes the applicant's zip code, which enables us to identify county of residence for the vast majority of applicants. We match zip codes to counties probabilistically using the Census Bureau's definitions of zip code tabulation areas (ZCTAs) and a geographic correspondence engine.[6] Although most ZCTA codes in our sample correspond to only one county, in cases where the ZCTA corresponds to more than one county we allocate partial applications to the corresponding counties using 2010 Census population weights.[7] We aggregate applications by county and quarter of filing. Our main dependent variable is number of initial applications filed in a quarter per 1,000 working age (ages 20-59) residents, where the denominator is taken from Census population estimates. We drop counties with fewer than five applications filed in any quarter during the sample period.

We restrict our sample to applications filed by disabled workers ages 18-64 between October 2004 and September 2009 in MA and the other states in the Northeast Census division.[8,9] These states were chosen because they are geographically close to MA and also similar in terms of observable characteristics such as population size, income, race, education

[6] http://mcdc1.missouri.edu/MableGeocorr/geocorr2010.html

[7] A very small portion of ZCTAs are not matched to any county by the correspondence engine (2% of applications in our data). These are approximately divided equally into unusable codes ("00000" or "99999") and potentially usable codes for which our correspondence engine may be out of date.

[8] Starting in 2009, the incidence of missing zip codes increases dramatically in MA as well as CT, RI and VT. This was due to a glitch in the software program that managed the electronic records that affected 30 states/territories. RI is excluded from the county-level analysis because of a large number of missing zip codes prior to 2009.

[9] Maine and Vermont also implemented health reforms in 2003 and 2006, respectively. All three reforms created new coverage options and expanded public coverage, although only Massachusetts implemented a mandate. See Kaye and Snyder (2007) for more details. The results are robust to exclusion of ME and VT in the control group.

and, importantly, unemployment rates and disability application rates (approximately 2.6 applications filed per 1,000 working age residents, per quarter), which were falling in MA and the Northeast prior to the reform (see Table A-1 in the online appendix).

We estimate the effect of the MA reform on SSDI and SSI applications and other outcomes using a difference-in-differences research design where we examine changes in application rates in MA after the reform relative to changes in the comparison states. This approach allows us to control for any structural shifts in the post-period assuming they are the same in the treatment (MA) and comparison states. Our main specification is:

$$y_{ct} = \sum_{J=1}^{3}\left[\beta_J\left(MA_c * Post_t * Y_J\right) + \gamma_J Post_t * Y_J\right] + \delta UE_{ct} + \alpha_t + \mu_c + \varepsilon_{ct}, \quad (1)$$

where y_{ct} measures an outcome of interest (e.g., the rate of disability applications per 1,000 working-age residents) in county (or state) *c* in quarter *t*, MA_c is an indicator for whether the county is in Massachusetts, $Post_t$ is an indicator for whether quarter *t* occurs in the post-reform period (beginning in 2006 Q4) and Y_J is an indicator for the year of the post-reform period. The specification includes controls for the local unemployment rate (UE_{ct}), indicators for quarter-year (α_t) to flexibly control for common factors such as macroeconomic conditions that influence disability applications and awards in each quarter. Similarly, μ_c is a county effect that controls for fixed, county-specific components of application flows. We cluster standard errors at the state level. The coefficients of interest are the β_J, which measure the change in applications in year *j* after the reform for MA relative to the other states.

We examine heterogeneity in the impact of the MA reform in two ways. First, we examine changes in SSDI and SSI applications separately. The types of individuals eligible to

apply for SSDI and SSI differ in important ways. To apply for SSDI, individuals must have accumulated sufficient and recent work history. To apply for SSI individuals must have very low income and assets. Those eligible to apply for both programs concurrently must have sufficient recent work history *and* very low income and assets; thus, "concurrent" applicants are likely to consist of the long-term unemployed. Additionally, SSDI and SSI offer different types of insurance coverage (Medicare vs. Medicaid) at different times (after a two-year waiting period vs. immediately upon benefit entitlement). These features alter the balance of costs and benefits associated with disability application, and so it is reasonable to expect that the MA reform might affect the different programs in different ways. We might expect non-concurrent applications for SSDI to increase as the reform eases employment lock among the employed and applications for SSI to decrease as the reform reduces the relative value of SSI to nonworkers.

Second, we examine heterogeneity at the county level, by estimating the effect of the reform separately for counties with low vs. high rates of pre-reform (2005) insurance coverage, defined as below and above 88% (which divides the working age population approximately in half). Since increased access to Medicaid may have discouraged SSI applications from the previously uninsured, we expect any decreases in SSI applications to be concentrated in counties with low pre-reform coverage rates. Similarly, easing of employment lock may encourage SSDI applications from individuals previously covered by ESHI, so we expect increases in SSDI applications to come from counties with high pre-reform coverage rates.

III. Results and Discussion

Prior to health insurance reform in MA and during the economic expansion, application rates for SSDI and SSI had been declining in the Northeastern states, including MA (see Panel A of Table A-1). However, after the reform was implemented in fiscal year (FY) 2007, MA

experienced a modest increase in applications that was not experienced in the comparison states. By FY 2009, sharp increases in the unemployment rate (Panel E) led to sizeable increases in disability applications in all the states in the Northeast.

Panel A of Table 1 shows estimated changes in applications for fiscal years 2007, 2008 and 2009 while controlling for common shocks and differences in unemployment rates using state-level data in the difference-in-differences framework. We find little effect of the MA reform in FY 2007, consistent with the fact that the reform had not yet been fully implemented. In FY 2008, we estimate that disability applications in MA increased by 0.08 per 1,000 working age residents, or 3 percent, compared to neighboring states. This effect disappears in FY 2009. This suggests that health insurance reform may have led to a temporary increase in applications, possibly due to "pent-up demand" for disability benefits among those who had been working. It is also possible that the dramatic increase in unemployment in *all* states around that time may have dampened the differential effects of the reform on disability applications. The increase in applications is driven primarily by increases in applications for SSDI only, excluding concurrent applications. Panel B of Table 1 reproduces the state-level estimates using county-level data through FY 2008. (Due to data limitations described in footnote 8 we cannot conduct county-level analyses past FY 2008.)

Our county-level analysis allows us to decompose the total effect in MA into effects in counties with low and high health insurance rates before the reform. While the estimates for the high-insurance counties mirror the overall estimates, the low-insurance counties actually experienced a net *decrease* in disability applications relative to neighboring counties in FY 2008. This finding is consistent with our expectation that the Medicaid expansion would reduce the relative value of SSI, particularly in areas of low pre-reform coverage. The effect is also present

in FY 2007, perhaps due to the fact that the Medicaid expansions occurred earliest in the implementation period. This net decrease in applications occurred despite the fact that, surprisingly, SSDI-only applications increased even in the low-insurance counties where there was relatively less ESHI before the reform (and hence less employment lock).

One potential explanation for this surprising pattern is that state incentives may offset individual incentives. For example, one way for states to reduce the financial burden of expanded public health insurance coverage is to encourage all qualifying individuals to apply for federal programs. If this is the case, then we might expect to see an increase in applications from those who had been disabled for a long period of time.[10] On the other hand, if release of employment lock was the source of the new applications, then we would expect a *decrease* in applications from those who had been disabled a long time before filing. In Table 2, we estimate the impact of the reform on the average time between onset of impairments (as defined by SSA) and filing for benefits in low and high insurance counties. SSDI-only applicants in low insurance counties filed on average 0.5-1 months *later* after the reform vs. before the reform, while SSDI-only applicants in high-insurance counties filed on average 1-2 months *earlier* after vs. before the reform. This is consistent with state incentives dominating in counties where the Medicaid expansion was more costly (low-insurance counties) and individual incentives dominating where it was less costly (high-insurance counties).

Finally, viewing the MA reform as a test case for the ACA, because health insurance coverage is lower in most U.S. states (84% in 2010) than it was in MA prior to its reform, our

[10] Individuals with congenital conditions or the long-term unemployed would have relatively long delays, compared to newly unemployed individuals, due to SSA's definition of onset as the intersection of poor health and earnings falling below the threshold for substantial gainful activity ($1,010 per month in 2010). We only observe onset for individuals who were allowed into the program at the initial level (approx. one-third of applications).

estimates point to a likely decrease in the overall SSDI and SSI caseload relative to current trends, with some shift, at least initially, in the composition of new applications toward SSDI compared with SSI. Our results highlight the potential for the ACA to affect disability applications as a result of not only individual incentives but also *state* incentives to shift public health insurance costs to federal programs when possible.

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Table 1 Effect of MA Health Insurance Reform on Number of Disability Applications

	All applications	SSDI only	SSI total	SSDI total
Panel A States				
MA*FY2007	0 0407*	0 0295*	0 0113	0 0295
	(0 0198)	(0.0134)	(0.0254)	(0 0247)
MA*FY2008	0 0800***	0 0647***	0 0153	0 0703**
	(0 0152)	(0 0170)	(0 0189)	(0 0264)
MA*FY2009	0 0148	0 0405	-0 0257	0 0234
	(0.0560)	(0 0325)	(0.0374)	(0 0272)
Panel B Counties				
MA*FY 2007	-0 00724	0 00347	-0 0107	-0 0050
	(0 0121)	(0 0068)	(0 0133)	(0 0184)
MA*FY 2008	0 0340*	0 0469***	-0.0129	0 0483
	(0 0161)	(0.0085)	(0 0164)	(0 0285)
Panel C Low-insurance Counties				
MA*FY 2007	-0 0617***	0 00482	-0 0665***	-0 0470***
	(0 0048)	(0 0111)	(0 0121)	(0 0084)
MA*FY 2008	-0.0610***	0 0448***	-0 106***	-0 0266**
	(0 0090)	(0 0108)	(0 0073)	(0 0080)
Panel D High-insurance Counties				
MA*FY 2007	0 0405	0 00782	0 0327	0 0372
	(0 0361)	(0 0082)	(0 0300)	(0 0351)
MA*FY 2008	0 133**	0 0540***	0 0794*	0 137*
	(0 0393)	(0 0134)	(0 0396)	(0 0458)

Notes: All regressions weighted by working age population and include geography and calendar-quarter fixed effects Robust standard errors in parentheses clustered at state level Mean application rates per 1,000 working age residents per quarter in MA prior to reform 2 6 all applications, 0.86 SSDI only, 1.74 SSI total, 2.03 SSDI total Low-insurance counties defined by 2005 health insurance coverage rate < 88% All applications includes SSDI only, and SSI total (SSI only and concurrent applications) *** p<0 01, ** p<0.05, * p<0 1

Table 2. Effect of MA Health Insurance Reform on Time to Filing

	SSDI only	SSI total
Panel A Low-insurance Counties		
MA*FY 2007	1 099***	5 378***
	(0 267)	(0 366)
MA*FY 2008	0 511***	9 199***
	(0 134)	(0 695)
Panel B High-insurance Counties		
MA*FY 2007	-1 438***	3 733***
	(0 318)	(0 254)
MA*FY 2008	-2 098**	6 697***
	(0 586)	(0 487)

Notes. All regressions weighted by working age population and include county and calendar-quarter fixed effects Robust standard errors in parentheses clustered at state level Mean time in months from SSA-defined onset to filing conditional on initial allowance in MA prior to reform. 14 1 SSDI only, 2 6 concurrent, 1 4 SSI only Low-insurance counties defined by 2005 health insurance coverage rate < 88%
*** p<0 01, ** p<0 05, * p<0 1

Online appendix for "Disability Insurance and Health Insurance Reform: Evidence from Massachusetts"

TABLE A-1— DESCRIPTIVE STATISTICS

	Massachusetts	Other Northeast states
Panel A All applications (rate per 1,000 working age residents, per quarter)		
FY 2003	2 69	2 72
FY 2004	2 74	2 78
FY 2005	2 67	2 62
FY 2006	2.60	2 63
FY 2007	2 58	2 56
FY 2008	2 62	2.56
FY 2009	2 88	2 89
Panel B SSDI only (rate per 1,000 working age residents, per quarter)		
FY 2003	0 94	1 07
FY 2004	0 93	1 07
FY 2005	0 90	1 01
FY 2006	0.86	0 98
FY 2007	0 85	0 94
FY 2008	0 86	0.92
FY 2009	0 97	1.05
Panel C SSI total (rate per 1,000 working age residents, per quarter)		
FY 2003	1 76	1 66
FY 2004	1.82	1 71
FY 2005	1 77	1 61
FY 2006	1 74	1 65
FY 2007	1 73	1 62
FY 2008	1 75	1 64
FY 2009	1 92	1 84
Panel D SSDI total (rate per 1,000 working age residents, per quarter)		
FY 2003	2 03	1 97
FY 2004	2 10	2 06
FY 2005	2 04	1.93
FY 2006	1 97	1.93
FY 2007	1 95	1.86
FY 2008	1 98	1 85
FY 2009	2 17	2.09
Panel E. Unemployment rate		
FY 2005	4 85	4.88
FY 2006	4 81	4.70
FY 2007	4 54	4 37
FY 2008	4 88	5 00
FY 2009	7 58	7 68
Panel F Uninsurance rate		
CY 2005	8 6	11.3
CY 2010	5 5	13 4

Source Authors' calculations for panels A-D, Bureau of Labor Statistics for panel E; Census Bureau Health Insurance Historical Tables for panel F Means in non-MA states weighted by working age population taken from Census

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The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation

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Abstract

Low-income adults without dependent children have historically had few paths to obtain public health insurance unless they qualified for Supplemental Security Income (SSI) cash benefits because of a disability. However, in states that expand their Medicaid programs, childless adults may obtain Medicaid without undergoing an intensive SSI disability review process and with substantially higher income and assets than the SSI program allows. This expanded availability of Medicaid coverage, independent of SSI participation, creates an opportunity to increase earnings and savings without jeopardizing health insurance coverage. In this paper, we use the natural experiments created by state decisions to expand Medicaid to nondisabled, nonelderly adults without dependent children to study the effect of decoupling Medicaid eligibility and cash assistance using a difference-in-differences study design. We collected data on the income eligibility limits, enrollment caps, and coverage characteristics of state Medicaid expansions to childless adults from 2001–2013. We combine these data with the nationally representative American Community Survey to estimate the effects of state expansion on SSI participation. We find relative declines in SSI participation caused by Medicaid expansions of 0.17 percentage points, a 7 percent relative decrease; this finding suggests the potential for small but important efficiency gains from separating SSI and Medicaid eligibility.

Keywords: Health insurance, Medicaid, Disability Policy, Supplemental Security Income (SSI)

INTRODUCTION

The federal Supplemental Security Income (SSI) program provides cash assistance to poor adults with work-limiting disabilities who have few assets. Nationwide, 4.9 million non-elderly adults with disabilities receive SSI benefits totaling $34 billion per year in federal cash payments (Social Security Administration, 2015a) and an average of $9,250 per beneficiary per year in federal Medicaid expenditures (Congressional Budget Office, 2012). Historically, participation in the SSI program has also served as the primary route to Medicaid coverage for adults with disabilities (Medicaid and CHIP Payment and Access Commission, 2012).

Because determining disability status can be imprecise and subjective, changes in the absolute or relative value of program benefits may affect individual decisions to apply or continue their participation (Daly and Burkhauser, 2003). Such behavioral responses are important because they may increase program costs and decrease social welfare by distorting labor supply and asset accumulation decisions. Changes in the attributes of the disability program itself or those of related transfer programs may influence an individual's valuation of an SSI award and the decision to participate (Moffitt 1992). The availability of Medicaid coverage, that is independent of SSI program participation, provides a financial cushion to support the health care needs of potential or current SSI beneficiaries; it decreases the value of an SSI award to them. The purpose of this paper is to study how the availability of such stand-alone Medicaid coverage affects enrollment in SSI.

The Affordable Care Act (ACA) authorized and incentivized states to offer Medicaid coverage to adults with incomes at or below 138% of the federal poverty level (FPL), regardless of health, parental, or disability status. Prior to the ACA, coverage for non-disabled adults

without dependent children was less common, as it required a special waiver from the federal government to use Medicaid funds or an independent fully state-funded initiative. In states that choose to expand their programs, low-income adults with disabilities may obtain Medicaid coverage without pursuing the federal disability application process and with relatively higher income and assets than the SSI program allows. Decoupling Medicaid eligibility from SSI eligibility may decrease SSI participation if it reduces the transaction costs associated with obtaining Medicaid and decreases the relative value of an SSI award to a prospective or current beneficiary. Alternatively, SSI participation may increase to the extent that the greater availability of Medicaid improves access to the health care needed for a disability determination, or increases awareness and take-up of other welfare programs. Although not uniform in their findings, the few empirical studies that have considered the interactions between health insurance and SSI adult participation provide stronger support for the hypothesis that they are net substitutes (Yelowitz, 1998; Yelowitz, 2000; Baicker et al., 2013; Maestas, Mullen & Strand, 2014).

In this paper, we contribute to the literature on disability program participation by providing the first estimates of the effects of adult Medicaid expansions on SSI participation for a population we expect to be particularly affected by the separation of health insurance from cash benefits, nonelderly adults without dependent children ("childless adults.") We combine a new national dataset that characterizes state Medicaid expansions with the nationally representative American Community Survey (U.S. Census Bureau, 2014; Ruggles et al., 2015). Using a difference-in-differences design, we compare the changes in SSI program participation for low-income childless adults who resided in states that implemented a Medicaid expansion

for childless adults from 2001-2013 (prior to the implementation of ACA-incentivized expansions) to those in states without such expansions.

We find that on average introducing Medicaid coverage for childless adults decreases the proportion of non-elderly childless adults enrolled in SSI by approximately 0.17 percentage points, a relative decline of 7%. This finding is robust to several definitions of Medicaid coverage, adjustment for the presence of Medicaid enrollment caps or freezes, and a variety of alternative model specifications. Our findings offer a preview of the potential consequences of the ACA Medicaid expansions on participation in social welfare programs and provide insight into the relative value of health insurance coverage and cash benefits for low-income adults with disabilities.

BACKGROUND

The Supplemental Security Income program: Eligibility, benefits, and participation incentives

The Social Security Administration (SSA) administers the SSI program. This means-tested program provides income maintenance to several low-income populations including the elderly, children with disabilities, and the population of interest for this study, non-elderly adults with disabilities.[1] The SSA defines disability as the inability to engage in "substantial gainful activity" (SGA) because of a medical condition that is expected to result in death or last for at least 12 months.[2] In addition to a designation of disability, initial SSI eligibility requires

[1] For an excellent and comprehensive description of the SSI program, see Duggan, Kearney & Rennane (2015).
[2] The SSI program is distinct from the Supplemental Security Disability Insurance (SSDI) program. Both are federal disability cash assistance programs and share the same medical eligibility criteria. However, SSDI is a social insurance program available to any individual with a sufficient work history who meets the medical eligibility criteria. Thirty percent of nonelderly adult SSI beneficiaries also receive SSDI benefits (Social Security Administration 2014a). These "concurrent beneficiaries" have a sufficient work history to receive SSDI payments, yet their income and assets fall below the SSI maximum thresholds.

that the applicant's earnings fall below the federal indicator of SGA (i.e., $1090/month in 2015), and the applicant may possess no more than $2,000 in assets net of several exclusions (e.g., a home, a car, personal effects). The maximum federal cash benefit for adult SSI beneficiaries corresponds to an income of 75% of the federal poverty level (FPL) or $733/month in 2015. However, the average monthly federal payment is substantially less, about $550 (SSA, 2014a). Many states supplement the SSI federal cash benefits. In the most generous state, that supplement results in a total maximum monthly SSI income of 90% FPL (SSA, 2014b). In addition to monthly cash payments, an SSI award typically confers immediate Medicaid eligibility.[3] The Medicaid coverage available to SSI beneficiaries includes the full benefits specified in each state's Medicaid plan.

Although SSI program eligibility is limited to adults who are unable and unexpected to work, the SSI review process for disability is inherently subjective because the disabling effect of many medical conditions is not straightforward (Strand, 2002; Daly & Burkhauser, 2003; Keiser, 2010). The uncertainty of an SSI award combined with the transaction costs of applying may reduce the desirability of SSI program participation and the incentive to apply for some individuals. An offer of Medicaid coverage independent of an SSI award may reduce SSI participation to the extent that Medicaid coverage alone is a substitute for Medicaid coverage plus a cash benefit for the marginal SSI applicant or beneficiary.

[3] All states must offer Medicaid coverage to poor adults with disabilities (Social Security Act Title XIX). The large majority of states satisfy this federal requirement by adopting the SSI eligibility criteria as their Medicaid criteria. In the remaining 11 states, the SSI award satisfies the disability eligibility criterion for Medicaid; however, the SSI beneficiary must also meet income and/or asset eligibility criteria that is typically lower than the federal SSI thresholds (Bruen, Wiener &Thomas, 2003).

Several considerations suggest the plausibility of Medicaid as a substitute for an SSI award for some applicants and beneficiaries: the relative value of Medicaid may be greater than the cash benefit; the transaction costs of obtaining/maintaining SSI eligibility may exceed the value of the cash award; and the applicant or beneficiary may have the capacity to earn or save income above the SSI maximum thresholds. There is some evidence that the Medicaid benefit may be more valuable than the cash benefit to a subset of potential or current SSI beneficiaries. The expected cumulative expenditures for a disabled adult from SSI program entry through the first six years of participation (or death) in 2012 dollars are just under $12,000 in cash benefits and $55,000 in Medicaid spending (Riley & Rupp, 2014). Additionally, the transaction costs of applying to the SSI program are non-trivial. At a minimum, the application process for disability-based benefits includes a review of medical records, an interview with the applicant, and substantial documentation of work history and education (Daly & Burkhauser, 2003). Throughout the application process, an applicant's income and assets may not exceed the SSI maximum thresholds without jeopardizing the possibility of an award.

The SSI program's stringent financial eligibility criteria create disincentives for prospective and current beneficiaries to work and accumulate assets. Daly and Burkhauser (2003) review the basic economic theory. These disincentives are operative for the SSI beneficiaries that have (or regain) the capacity to earn or save income beyond the SSI eligibility criteria. Approximately one-quarter of successful and unsuccessful SSI applicants had some positive earnings in the years preceding application to the program (Bound, Burkhauser & Nichols, 2003). According to the National Beneficiary Survey, about 19% of working age SSI beneficiaries expect to earn enough to leave the SSI program within 5 years (Livermore, 2011). This expectation signals a

widespread interest and orientation toward employment although SSI benefit suspension rates also suggest it is optimistic. Ben-Shalom and Stapleton (2015) find that SSI payments were suspended or terminated because of earnings that exceeded the maximum allowable amount during at least 1 month for almost 10% of working age SSI awardees from program entry through a seven year follow-up period. Empirical evidence suggests that SSI induces some moral hazard for at least a subset of beneficiaries (Neumark and Powers 1998, 2000, 2005; Kaushal, 2010); a large body of work on SSDI provides additional support for the idea that disability benefit programs can have work and asset disincentive effects (Gruber & Kubik, 1997; Black, Daniel, & Sanders, 2002; Autor & Duggan, 2003; Chen & van der Klaauw, 2008; Maestas, Mullen, & Strand, 2013; French & Song, 2014; Moore, 2015; Shu, 2015).

With a standard static consumption-leisure model in mind, there are two important elements of the potential effect of Medicaid expansion on SSI participation. First, since Medicaid income eligibility thresholds under expansions are typically higher than SSI income eligibility thresholds, the incentives behind the substitution effect for marginal SSI applicants (those close to the SSI income threshold) are reduced. Second, because marginal applicants can now qualify for Medicaid regardless of SSI status, the income effect of SSI is reduced. As pointed out by Autor and Duggan (2007), each of these effects is important for policy, because the substitution effect implies first-order deadweight losses while the income effect does not. Therefore, to the extent that Medicaid availability reduces the substitution effect, Medicaid expansion could actually increase efficiency for the SSI population.[4]

[4] While Medicaid coverage for childless adults may itself have labor supply disincentives (Dague, DeLeire, and Leininger, 2013; Garthwaite, Gross, and Notowidigdo 2014), the income thresholds are typically significantly higher

There are many potential impediments to gainful employment for prospective and current SSI beneficiaries that are refractory to the availability of Medicaid coverage (Bound, Burkhauser, & Nichols, 2003; Livermore, 2011). However, it is notable that the SSI program includes several provisions to support employment among beneficiaries that explicitly recognize the importance of Medicaid coverage to SSI beneficiaries. Once enrolled, an SSI beneficiary may continue to receive full Medicaid coverage after her earned income reaches the SGA threshold (roughly 111% FPL) if she continues to meet the asset and disability SSI eligibility criteria. The SSI cash benefit is reduced according to a marginal tax rate of 50% on earnings and 100% on other income after exclusion of a very modest amount. When her total income becomes too high to receive any SSI cash payment (approximately 150%FPL), she may retain Medicaid benefits if the disability persists, assets remain below the $2,000 eligibility threshold, the Medicaid coverage is needed to work, and gross earned income does not exceed a state-determined threshold (SSA, 2015b). Just under 3% of working age SSI beneficiaries participate in the latter two provisions (SSA, 2015a). Additionally, the Balanced Budget Act (1997) and the Ticket to Work and Work Incentives Improvement Act (1999) gave states additional flexibility to offer Medicaid coverage to adults with disabilities who rejoin the labor force by creating Medicaid Buy-in programs. However, SSI enrollees represent only 4% of "Buy-In" participants, or about 4,000 adults (Gimm et al., 2009). The recent adult Medicaid expansions represent a significant departure from these strategies to incentivize work and

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than those for SSI, so the marginal individuals for whom the substitution effect is salient are unlikely to be the same.

savings because they wholly sever the decision to participate in the SSI program from the decision to obtain or retain public health insurance.

State Medicaid Expansions for Adults without Dependent Children

Historically, Medicaid coverage for adults without dependent children was contingent upon a SSA determination of disability, low income and limited assets. The availability of Medicaid coverage for childless adults with or without disabilities began to significantly increase in the 2000's (Klein & Schwartz, 2008). As described in greater detail below, a total of 11 states introduced some type of Medicaid coverage to childless adults regardless of their disability status between 2001 – 2013. Because these Medicaid expansions focused on childless adults in general without regard to health status, no SSA disability award was required to enroll. Moreover, the maximum income thresholds were typically more generous than the income eligibility criterion for SSI participation (Dorn et al., 2004; Sommers, Kenney & Epstein, 2014; DeLeire et al., 2013). As such, in these states low-income childless adults could obtain Medicaid benefits without pursuing the SSI application process and with relatively higher income than the SSI program permits. In states without early adult Medicaid expansions, the paths to Medicaid coverage for childless adults who were not enrolled in the SSI program remained very limited.

Previous Research on SSI and Health Insurance

There is a large literature that examines economic, epidemiological, and demographic determinants of adult SSI participation (e.g., Rupp & Stapleton, 1995; Rupp, 2012; Schmidt, 2012; Black, Kermit & Sanders, 2002; Aizer, Gordon & Kearney, 2013), as well as the impact of welfare program attributes and changes on SSI participation among children and single mothers

(Garrett & Glied, 2000; Schmidt & Sevak, 2004). However, the empirical research on the interactions between Medicaid and SSI program participation is relatively limited. Yelowitz (1998) found that the rising value of Medicaid coverage, defined as average Medicaid expenditures for blind SSI beneficiaries, explained 13-20% of the SSI caseload growth for adults with disabilities between 1987-1993. Coe and Rupp (2013) observed a positive association between the generosity of Medicaid availability in a state and earnings among SSI beneficiaries, a potential signal of transitioning out of the SSI program. However, because the study data included only SSI and SSDI beneficiaries, the authors were unable to evaluate the relationship between Medicaid availability and SSI participation at the extensive margin.

Only three studies directly consider the effect of expanded health insurance eligibility on SSI participation. Yelowitz (2000) evaluated the introduction of the Qualified Medicare Beneficiary (QMB) program in the early 1990's on SSI participation among elderly, non-disabled adults. The QMB program increased the income eligibility limit for Medicaid and offered this coverage to eligible seniors without the need to participate in the SSI program. SSI participation among elderly adults declined after the introduction of the Qualified Medicare Beneficiary (QMB) program. More recently, Baicker et al. (2014) assessed the effects of the Oregon Health Insurance Experiment on participation in a variety of social welfare programs including SSI. The Oregon Medicaid program randomly allocated a limited number of openings for an adult Medicaid expansion to low-income adults that were not already eligible for Medicaid. The authors did not anticipate an effect on SSI participation because individuals who were eligible for Medicaid through other eligibility categories such as SSI were excluded from the lottery-allocated spots. Consistent with their expectations, one-year after the lottery, there

were no significant differences in SSI participation among adults who were and were not allocated to the Medicaid expansion.

Finally, in the study that most closely resembles our own, Maestas et al. (2014) evaluated the effects of the 2006 Massachusetts (MA) expansion of public and private health insurance on the SSI application rate among non-elderly adults, including concurrent applications to SSI and SSDI and applications to SSI-alone. On average, they found no substantial change in SSI application rates between MA and the comparator states. However, in counties with low (high) insurance rates pre-expansion, the SSI application rate decreased (increased) following the insurance expansion. The decreased rate of SSI applications in low-insurance counties is consistent with a decline in the relative value of SSI as new paths to health insurance became available. The increased applications within high-insurance counties may reflect a release from job lock among those with greater attachment to the labor force, concurrent SSI/SSDI applicants.

We conclude from the previous research that the introduction of Medicaid coverage, independent of SSI eligibility, reduced age-related SSI participation among seniors and has had mixed effects on SSI participation among working age adults. The current study builds upon and extends this research. We estimate the effects on SSI participation of childless adult Medicaid expansions in nearly a dozen states over 13 years, increasing the generalizability of findings beyond a single state or time period. We focus exclusively on the childless adult population, the population that we expect to be most affected by the decoupling of Medicaid coverage from SSI eligibility because of their previously limited access to Medicaid coverage. Finally, we examine Medicaid expansions that preceded the majority of the ACA-induced

changes to the private health insurance market strengthening our capacity to identify the consequences of the Medicaid expansions on SSI participation apart from simultaneous changes in the private health insurance market.

METHODOLOGY

Data Sources

We combine nationally representative survey data, the American Community Survey (ACS) with a new comprehensive primary data source on state Medicaid programs for adults without dependent children, the Medicaid Waiver Dataset (MWD). We describe each in turn as well as how we construct the variables of interest and the sample for analysis.

The ACS is an annual cross-sectional national household survey that collects detailed housing and population characteristics (U.S. Census Bureau, 2014; Ruggles et al., 2015). Beginning in 2001, these data have supported yearly national and state estimates that are representative of the U.S. non-institutionalized population. The annual sample size from 2001-2005 ranged from approximately 513,000 to 602,000 housing units. In 2005, the U.S. Census bureau substantially increased the ACS sample sizes and added individuals who resided in group quarters (i.e., nursing facilities, college residence halls, and correctional facilities). These modifications resulted in annual sample sizes of 1.9 – 2.3 million housing units, made possible sub-state area estimates, and the capacity to generalize survey results to the full U.S. population. The ACS is part of the decennial census, and response is mandatory. The annual response rate is well above 90% each year. For this study, we pool data from 2001-2013 and restrict our sample to the non-institutionalized population.

There is currently no centralized and publicly available resource that synthesizes state Medicaid programs for childless adults. Our Medicaid Waiver Dataset (MWD) is intended to address that gap. The dataset characterizes the presence and attributes of childless adult Medicaid coverage for each state and the District of Columbia from 1996 through 2014. It includes coverage authorized and funded through state-only initiatives, Section 1115 waiver programs, and State Medicaid Plans. We constructed this dataset through a systematic review of multiple sources including state and federal Medicaid documents, research publications, state news, and onsite data collection at the Centers for Medicare and Medicaid Services. The documentation for this dataset including information regarding its public availability is included in Appendix A.

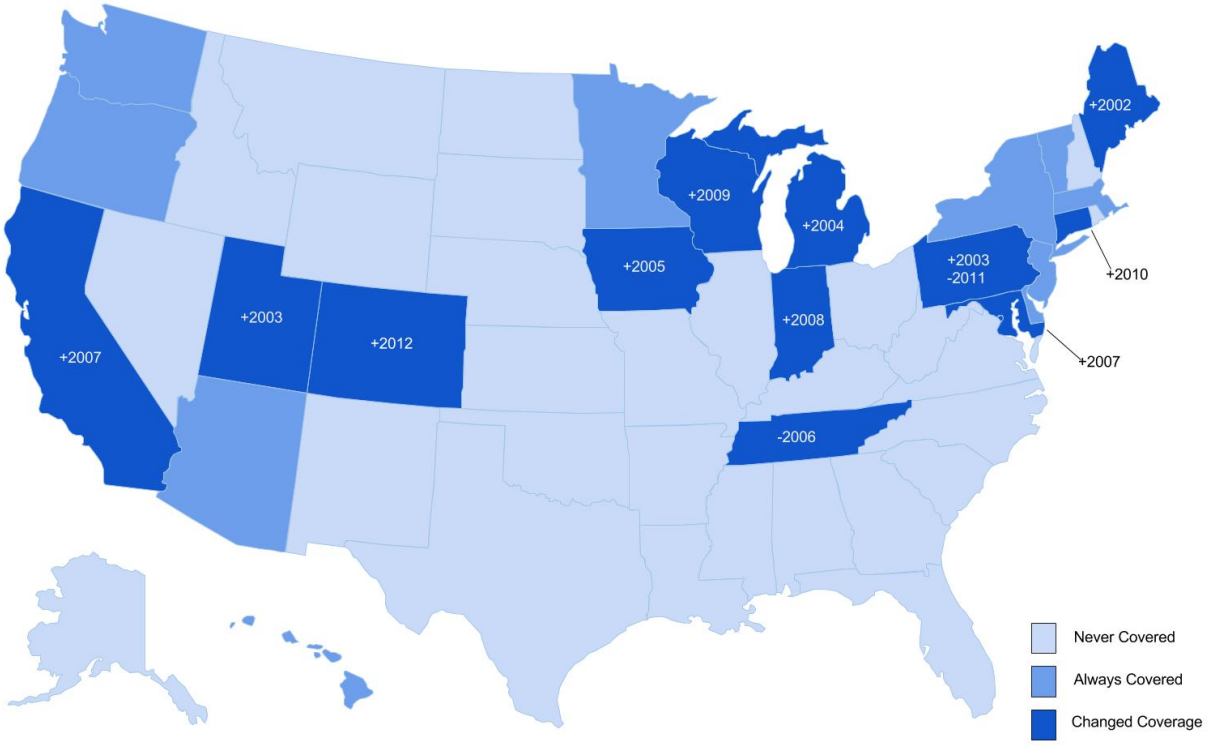
Defining Medicaid Coverage

There is significant variation across states and years regarding the type and generosity of Medicaid program assistance with health care for non-disabled, childless adults ranging from traditional Medicaid enrollment and benefits to very limited assistance with private insurance premiums for employers. Because we are interested in identifying those states in which non-SSI Medicaid would be a true substitute for a marginal applicant, we only considered a state to have childless adult Medicaid coverage for purposes of this paper if the program was similar in covered services and structure to the type of traditional Medicaid coverage available to SSI beneficiaries. In particular, we exclude programs that offered only premium assistance and programs in which the state funded select facilities to subsidize care delivery to poor adults. Within the state-years in which Medicaid coverage for childless adults was present according to our definition, we identified two program characteristics that may influence the relative costs

and benefits to the individual of pursuing Medicaid coverage independent of SSI participation. These include the maximum income eligibility threshold for childless adult Medicaid coverage, and the presence of enrollment ceilings, wait lists, or freezes for childless adult Medicaid coverage.

After determining the childless adult Medicaid coverage status for each state-year in the dataset, we identified the treatment group for this study as those states that implemented and/or discontinued childless adult Medicaid coverage between 2001-2013. We refer to this group as our "change states." These include the following: ten states that introduced and maintained Medicaid coverage for childless adults, CA, CO, CT, IN, IA, ME, MD, MI, UT, WI; one state that introduced and discontinued childless adult coverage, PA; and one state that discontinued Medicaid coverage for childless adults that had been introduced before 2001, TN. The comparison group includes eleven states that offered some Medicaid childless adult coverage throughout the study period (AZ, DE, DC HI, MA, MN, NJ, NY, OR, VT, WA) and twenty-eight states that never offered Medicaid coverage to childless adults during the study period (AL, AK, AR, FL, GA, ID, IL, KS, KY, LA, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, RI, SC, SD, TX, VA, WV, WY). Figure 1 illustrates the timing of Medicaid coverage changes for childless adults by state. The maximum income eligibility threshold in most states and years was at or below 200% FPL while the use of enrollment caps or freezes became increasingly common over the study period as summarized in Figure 2. In 2013, half of states with Medicaid coverage for childless adults had an enrollment cap or ceiling.

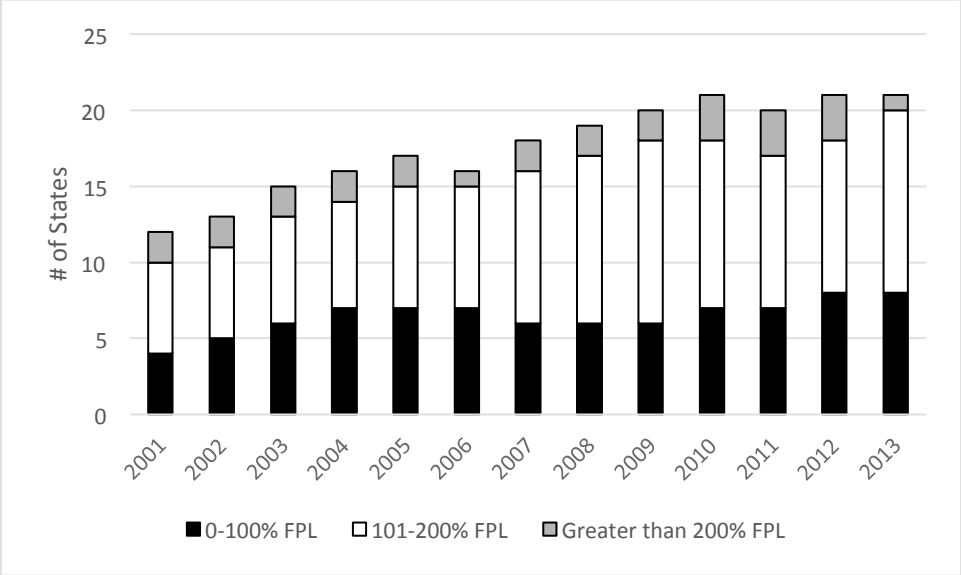
Figure 1. Summary Map of Medicaid Coverage for Childless Adults, 2001 – 2013



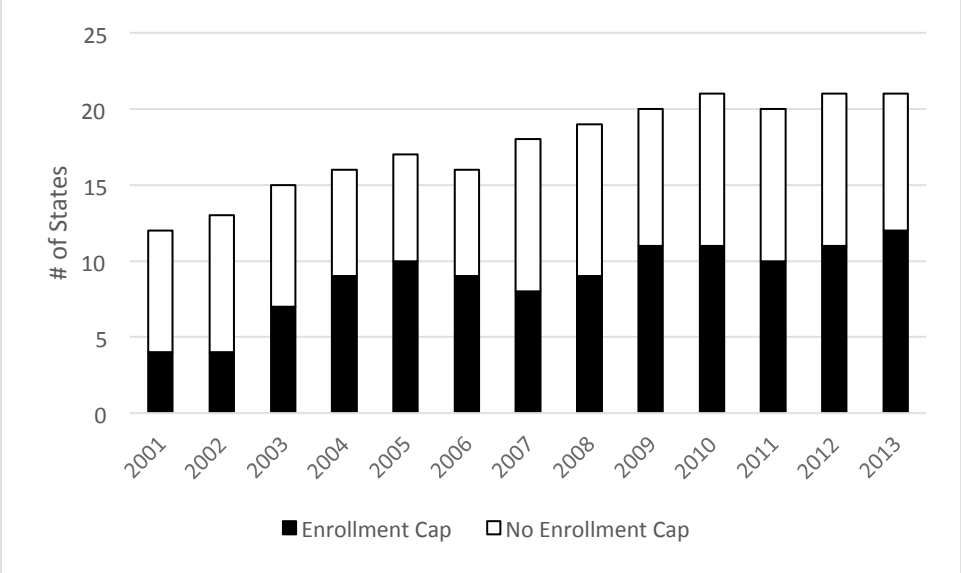
Notes: Authors' calculations using the Medicaid Waiver Dataset. "Always covered" states provided continuous Medicaid coverage for some childless adults between 2001 - 2013. "Changed coverage" states expanded or eliminated Medicaid coverage for childless adults between 2001 - 2013. "Never covered" states did not offer Medicaid coverage for childless adults from 2001 - 2013.

Figure 2. Characteristics of Medicaid coverage for childless adults among states that offered coverage between 2001 – 2013

a) Maximum Income Eligibility



b) Presence of an enrollment cap or freeze

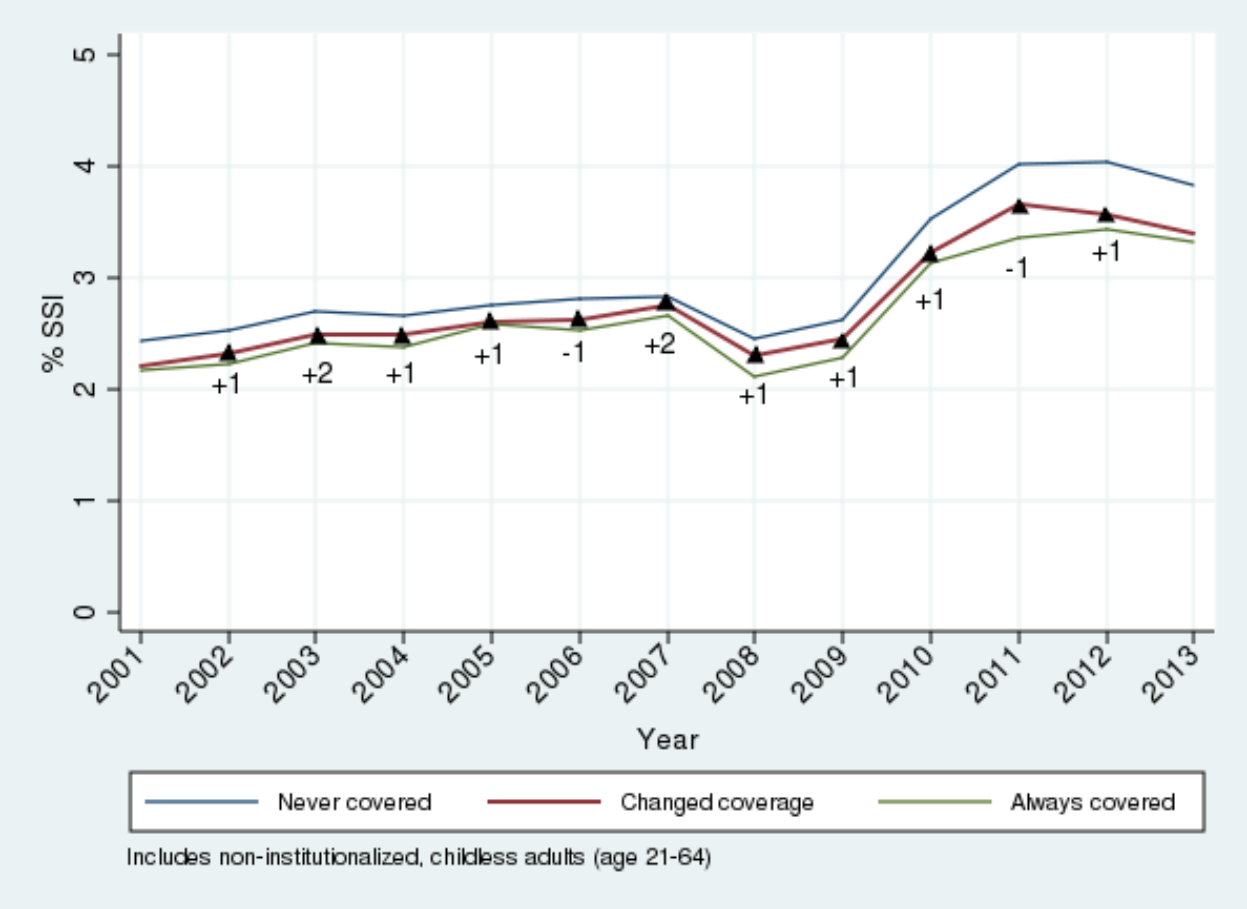


Notes: Authors' calculations using the Medicaid Waiver Dataset. See Appendix A for documentation.

Defining SSI Participation

The study's outcome of interest is SSI participation. In the ACS, respondents are asked to report annual income from a variety of sources including the SSI program. We define SSI participation as a binary variable in which 1 indicates receipt of any SSI income during the past 12 months (Schmidt & Sevak, 2004). In Figure 3, we illustrate the trend in SSI participation among working age, non-institutionalized childless adults from 2001-2013. We plot this trend for three mutually exclusive groups of states: states that never offered Medicaid coverage to childless adults during this time period; states that changed Medicaid coverage for childless adults during this time period; and states that provided Medicaid coverage to some childless adults continuously from 2001-2013. Additionally, we indicate the number of states (if any) that introduced or eliminated coverage for childless adults by year. Overall the proportion of working age adults with SSI benefits is low at 2 – 3.5% and rising over time in each of the state groups similar to published estimates for the working-age SSI population more generally during this time period (Duggan, Kearney, & Rennane, 2015). Consistent with the notion that offering Medicaid coverage apart from an SSI award reduces the relative value of the SSI award, we see relatively lower rates of SSI participation in states with childless adult Medicaid coverage.

Figure 3. Annual SSI Participation rates by state Medicaid coverage status for childless adults



Notes: Authors' calculations using the American Community Survey for SSI participation data. Analyses are weighted to represent the non-institutionalized working age population of the United States. The Medicaid Waiver Dataset was used to identify state Medicaid coverage status for childless adults. The number of states that introduced or eliminated childless adult coverage in each year (if any) is indicated.

Analytic Sample

We select non-institutionalized adults ages 21-64 without dependent children from the ACS. Table 1 shows the weighted means and standard errors calculated across states for several relevant sample demographic characteristics. Standard errors are clustered at the state-level. Table 1 uses only data from the 2001 ACS in order to capture any differences at the baseline period. The table groups states together according to the same 3 categories described

above: states that introduced or stopped covering childless adults at some point during the study period; states that never covered childless adults during the study period; and states that covered childless adults throughout the study period. The table also includes the results of t-tests for the difference in means for always- and never- covered states relative to states that changed coverage status. For the most part, average state characteristics at baseline are very similar regardless of childless adult coverage status. Just over half of the sample is male for all three state groupings, and 15-18% are of non-white race across the three types. The average age of a person in the sample is just over 40 years old. The vast majority report speaking English well and were born in the United States. The t-test results show that the education levels are slightly lower (86% with at least a high school diploma or GED) in states that never had a childless adult program than those that changed status (88%), and slightly higher in states that always had a childless adult program (90%). None of these differences are particularly large or concerning, but as discussed below our preferred specification includes controls for all of these observable characteristics. We additionally compared the average state unemployment rate for adults aged 16 and older across the 3 groups of states (data not shown). These 2001 rates were similar across states that changed coverage status (3.47%), never offered coverage (3.56%), and always offered some coverage to childless adults (3.48%). We constructed this state-level measure from the ACS based on respondents' employment status in order to describe the macroeconomic conditions in the state. We excluded childless adult respondents (i.e., our analytic sample) in the construction of this measure because SSI participation is a determinant of employment status.

Table 1. State population characteristics at baseline according to Medicaid coverage status for childless adults between 2001 - 2013

	Change States	Comparison States	
		Never	Always
SSI Participation Rate (%)	**2.204**	**2.419**	**2.160**
	(0.134)	(0.195)	(0.153)
Male (%)	**51.33**	**51.03**	**51.07**
	(0.298)	(0.104)	(0.232)
Non-white (%)	**15.33**	**15.23**	**18.24**
	(3.669)	(1.439)	(3.202)
Age	**42.89**	**43.83**	**42.41**
	(0.580)	(0.219)	(0.276)
Speaks Eng. Well (%)	**97.09**	**97.96**	**97.13**
	(1.262)	(0.464)	(0.450)
Born in US (%)	**88.05**	**92.16**	**86.03**
	(4.675)	(1.400)	(2.068)
Married (%)	**46.85**	**50.94**	**43.25**
	(2.151)	(0.744)	(1.746)
HS Dip. or GED (%)	**88.32**	**86.10***	**90.22***
	(0.675)	(0.684)	(0.687)
Unweighted sample (N)	**110,806**	**181,098**	**74,228**
State (N)	**12**	**28**	**11**

Notes: Table reports the 2001 mean and standard error for each of the listed characteristics for non-institutionalized childless adults ages 21-64 in the American Community Survey. Each column represents a group of states defined by the availability of Medicaid childless adult coverage between 2001-2013: "Change" refers to states that expanded and/or eliminated Medicaid childless adult coverage; "Never" refers to states that never had childless adult Medicaid coverage; and "Always" refers to states that had Medicaid childless adult coverage throughout the study period. The reference group for t-test comparisons of means is the "Change" ** p-value < 0.01; * p-value <0.05.

Empirical Model

We use a difference-in-differences design in order to estimate the effect of Medicaid coverage expansions for childless adults on SSI participation rates. In particular, we compare SSI participation in states that changed Medicaid coverage for adults without dependent children relative to those that did not, before and after the change occurred. In most cases these

changes were expansions as described above. The following equation describes the basic model:

$$(1) \quad y_{ist} = \alpha_t + \beta_s + \boldsymbol{M_{st}\delta} + \boldsymbol{X_{ist}\theta} + \boldsymbol{Z_{st}\sigma} + \mu_{ist}$$

In this equation, *i* indexes individual, *s* state, and *t* year. The outcome of interest, SSI participation, is represented by y_{ist}. A full set of year effects (α_t) that control for differences over time common to all states and state effects (β_s) that control for differences across states that are constant over time are included. The vector $\boldsymbol{M_{st}}$ is a set of one or more Medicaid policy variables (described further below) that are defined for the states and years during which the relevant policies were in place, making $\boldsymbol{\delta}$ the coefficient(s) of interest. The vector $\boldsymbol{X_{ist}}$ is a set of individual-specific covariates that vary over time and may affect SSI participation including sex, race, age, marital status, born in the U.S., English proficiency, and educational achievement. However, since the policy variables vary only at state-year level, the inclusion or exclusion of these covariates should not affect the estimated treatment effect. While the empirical literature has identified disability status as a determinant of SSI participation, we do not include disability measures in our analyses. In a cross-sectional survey, we cannot distinguish whether these variables reflect the propensity to participate in SSI or a consequence of participation. The vector $\boldsymbol{Z_{st}}$ is a set of state-specific covariates that vary over time and may affect SSI participation; we focus on the role of fluctuations in state economies and so include the change in state unemployment rates and the level of the lagged unemployment rate**.** As described above, state unemployment variables represent unemployment among adults aged 16 years and older excluding childless adults. Unobserved individual-specific errors are represented by μ_{ist}.

We specify the potential set of Medicaid policy variables ($\boldsymbol{M_{st}}$) as follows: $CACov_{st}$, a dummy variable that is equal to one if a state has childless adult coverage in a particular year and zero otherwise; $Threshold_{st}$, a continuous variable that represents the size of the income threshold in %FPL for a state in a particular year; and Cap_{st}, a continuous measure that that represents the fraction of income eligible childless adults who may enroll when an enrollment cap or freeze is in place. For example, a 10% cap indicates Medicaid coverage is available to approximately 10% of the income-eligible childless adult population in the state. We are most interested in how the presence of an expansion influences SSI participation and so focus on $CACov_{st}$ for the majority of the analysis, but we also include specifications that consider only $Threshold_{st}$ to understand the role of higher income thresholds and specifications that include both $CACov_{st}$ and Cap_{st} to understand the role of enrollment closures.

We estimate the model using Ordinary Least Squares regression techniques. Since we are interested in the causal effect of Medicaid coverage changes and the data are not oversampled in a way that might bias the results, we follow the recommendation of Solon, Haider, and Wooldridge (2015) and estimate our preferred models without the ACS sample weights. Because of the possibility of correlation of individual observations within states over time, we estimate cluster-robust standard errors at the state level (Bertrand, Duflo, & Mullainathan, 2004). All estimation was performed in Stata 14 (StataCorp, College Station, TX).

We use two different sets of states to estimate the model. First, we provide estimates that include all states in the analysis including those that never implement a policy change, those that had some childless adult coverage in place throughout, and those that introduced or discontinued childless adult coverage at some point during the study period. Identification in

this model comes from both the within-state, over time variation and the across-state, within-year variation introduced by the Medicaid coverage changes for childless adults. Second, we provide estimates that limit the analysis to those 12 states that introduced or eliminated coverage for childless adults. In these specifications, the source of identification across states is only among those states that changed childless adult coverage, as they may serve as a more precise set of controls for one another. The downside of using this set of states is a loss of sample size. If the assumptions of the model are satisfied, we would expect similar results across these two sets of states.

We note that the use of a simulated eligibility measure is common in analyses studying the effects of Medicaid eligibility, dating from Currie and Gruber (1996). Simulated measures of eligibility are a response to the problem that unobserved factors (e.g., economic recession) that may determine both an individual's Medicaid eligibility and a study outcome (e.g., low birth weight) make it difficult to attribute the finding to the hypothesized cause, an individual's Medicaid eligibility. Operationally, the simulated measure isolates the extent to which *Medicaid policy or rules* influence an individual's eligibility from the influence of unobserved factors that affect a person's eligibility and her outcome. In doing so, this strategy reduces the threat of omitted variables bias in the resulting estimate of Medicaid eligibility's effects on a given outcome. In this study, however, the independent variable *is* a Medicaid policy, the state's introduction/elimination of coverage for childless adults, rather than an individual's eligibility for Medicaid. As such, there is no concern about the endogeneity of the independent variable and individual characteristics as there would be in an analysis that tries to link an individual's

Medicaid eligibility to SSI participation. Endogeneity of the independent variable and state characteristics is a concern that we address in our discussion of robustness checks below.

Although not necessary for identification, for purposes of consistency with a large literature that adopts simulated measures of eligibility and to provide an additional continuous measure of the size of a Medicaid policy change, we include specifications that feature $SimElig_{st}$ as the independent variable of interest. This variable takes on a value of 0 for all state-years in the comparison group. In the group of 12 states that expanded or eliminated Medicaid coverage for childless adults, the variable takes on a value of 0 in each year that Medicaid coverage is not available to childless adults. For the years in which such coverage is available, we derived the state-specific value of *SimElig* by applying each state's income eligibility criteria for childless adult coverage to a common sample of 2001 ACS respondents. This common sample included working age, non-institutionalized adults without dependent children who resided in any of the 28 states that did not offer Medicaid coverage for childless adults continuously from 2001-2013 (i.e., the "Never" states). The resulting values, the percentage of childless adults in 2001 that would have been eligible for Medicaid under the income criteria of each change state, populated the *SimElig* variable in the 12 change states during the years that they provided Medicaid benefits to childless adults.

RESULTS

Table 2 shows strong evidence that when states expand Medicaid to childless adults, SSI participation rates decrease. The table reports the results from several specifications of the difference-in-differences model in Equation (1), including data from all 50 states and the District

of Columbia. Each specification includes only one of the independent Medicaid policy variables as the variable of interest, and the table reports the estimated coefficient and standard error. Column (1) is a base model that includes only state and year fixed effects in addition to the policy variable of interest. Column (2) includes state unemployment variables in addition to state and year fixed effects. We focus on Column (3), which adds individual characteristics to the Column (2) model as the main specification. Regardless of the particular policy variable, the results are overwhelmingly negative and statistically different from zero, supporting the hypothesis that separating Medicaid eligibility from SSI eligibility reduces the number of people who use SSI benefits.

For our main policy variable of interest, $CACov_{st}$, the base model (Column 1) indicates that going from no childless adult Medicaid program to having one causes a .13 percentage point decrease in SSI participation. Adding state unemployment variables results in a similar decrease. Our preferred specification in Column (3), which incorporates individual characteristics in addition to the controls in Columns (1) and (2), shows that a childless adult Medicaid program results in a .17 percentage point decrease in SSI participation. Relative to a baseline of 2.42% in states that were never covered (Table 1), this is a 7% decrease.

The policy variable $Threshold_{st}$ is scaled so that the coefficient represents the change in SSI participation resulting from a 100-percentage point increase in the maximum FPL eligibility limit. The values of the variable ranges from 0 to 4. Results from our preferred specification in Column (3) show that increasing the income threshold in a childless adult Medicaid program, for example from 0 to 100% FPL, results in a .06 percentage point decline in SSI participation. This estimate is statistically significant at the 10% level. Relative to baseline SSI participation of

2.42, this is a 2.5% decrease, consistent with the $CACov_{st}$ results. The smaller effect size is sensible given the scale of the $Threshold_{st}$ in contrast to the $CACov_{st}$ variable that captures the average change in SSI participation for Medicaid expansions with variable maximum income thresholds (e.g. 0 to 400% FPL).

The Simulated Eligibility measure, $SimElig_{st}$ is scaled so that the estimated coefficient represents the change in SSI participation resulting from a 10 percentage point increase in the *portion* of childless adults eligible for Medicaid coverage. This measure ranges from 0 to 5.2 where 5.2 reflects a state in which, 52% of the working age, non-institutionalized childless adult sample was eligible for Medicaid coverage. Results from our preferred specification in Column (3) indicate that a 10 percentage point increase in the proportion of childless adults eligible for Medicaid coverage, for example from 0 to 10% of the population, results in a .06 percentage point decline in SSI participation; this is a 2.5% decrease which is statistically significant at the 5% level. Although not directly comparable, this result is consistent with the result from the $Threshold_{st}$ variable. Specifically, roughly 10% of the non-institutionalized childless adult sample is at or below 100% FPL suggesting that we should observe similar effect sizes for a Medicaid policy change that increases the proportion of childless adults affected from 0 to 10%.

Table 2. Difference-in-Differences estimates of the effect of Medicaid coverage for childless adults on SSI Participation, 2001 - 2013

Independent Variable	(1)	(2)	(3)	(4)	(5)
Childless Adult Coverage *(CACov)*	-0.00131**	-0.00137**	-0.00165***	-0.00188***	-0.00184***
	(0.000583)	(0.000553)	(0.000549)	(0.000455)	(0.000416)
Maximum Income Threshold *(Threshold)*	-0.000440	-0.000424	-0.000579*	-0.000722*	-0.000715*
	(0.000303)	(0.000284)	(0.000293)	(0.000380)	(0.000359)
Simulated Eligibility *(SimElig)*	-0.000448	-0.000444*	-0.000581**	-0.000559	-0.000547
	(0.000272)	(0.000253)	(0.000263)	(0.000390)	(0.000370)
N (individuals)	9804351	9438219	9438219	9804351	9804351
N (states)	51	51	51	51	51
Individual characteristics			X		X
Lagged unemployment		X	X		
Absolute change in unemployment		X	X		
State fixed effects	X	X	X	X	X
Year fixed effects	X	X	X		
Quadratic time trend				X	X
State-specific time linear trend				X	X

Notes: Table reports the coefficients of interest and standard errors (in parentheses) from unweighted Ordinary Least Squares regression analyses of different versions of the model using American Community Survey data and the Medicaid Waiver Dataset. Each independent variable and column combination is the result of a separate regression. Standard errors clustered at state level. *** indicates statistical significance at 1% level; ** at 5% level; * at 10% level.

Table 3 focuses attention on only those 12 states that either implemented new childless adult programs or eliminated their programs. These states are the main source of identifying variation for the estimates, and so we would expect similar results as found in Table 2. The estimated coefficients are always negative and nearly identical to those in Table 3, with slightly smaller magnitudes for some estimates and slightly larger magnitudes for others. In no case are the differences between the Table 2 and Table 3 coefficients statistically different from one another. The results in Table 3 should also ameliorate concerns about our classification of states. If, for example, we wrongly classified states as never having coverage when in fact that had expanded childless adult coverage (as defined above) we would expect to observe larger effect sizes in Table 3 relative to Table 2. However, the Table 3 results show that our estimates are nearly identical to those presented in Table 2 when we restrict the analysis to states that we identified as having expansions that are likely to be true substitutes for the version of Medicaid an SSI recipient would receive.

In Figure 4 we present results that capture the influence of an enrollment cap or freeze on SSI participation. This analysis includes only the subset of our treatment states for which we had sufficient detail regarding the presence and magnitude of enrollment caps or closures: CO; CT; IN; IA; ME; MD; MI; UT; and WI. We would expect that when caps are present or relatively more binding, the effect of a Medicaid expansion for childless adults on SSI participation would be diminished because the cap reduces the likelihood of obtaining coverage outside of SSI participation. We re-estimated our preferred specification including the independent variable for the presence of childless adult coverage (*CACov*), and a second independent variable that reflects the presence and magnitude of a cap (*Cap*) as described above. Using these regression

Table 3. Difference-in-Differences estimates of the effect of Medicaid coverage for childless adults on SSI Participation among states that changed coverage status, 2001 – 2013

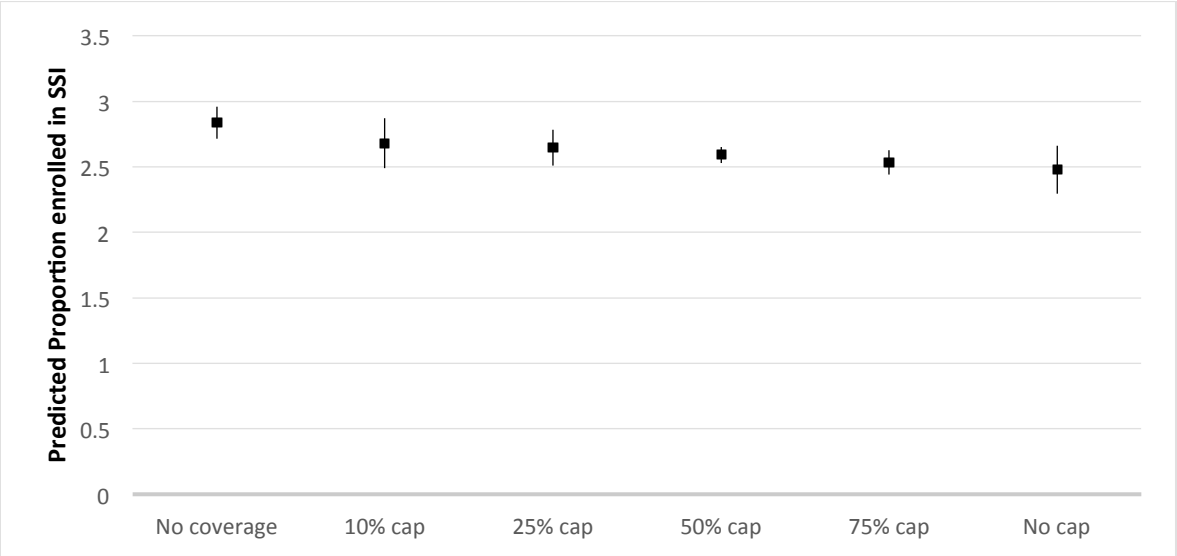
Independent Variable	(1)	(2)	(3)	(4)	(5)
Childless Adult Coverage *(CACov)*	-0.00129**	-0.00116**	-0.00147***	-0.00227***	-0.00222***
	(0.000478)	(0.000466)	(0.000406)	(0.000648)	(0.000594)
Maximum Income Threshold *(Threshold)*	-0.000519*	-0.000446*	-0.000598**	-0.000836	-0.000815
	(0.000287)	(0.000244)	(0.000232)	(0.000553)	(0.000524)
Simulated Eligibility *(SimElig)*	-0.000427	-0.000369	-0.000500**	-0.000665	-0.000649
	(0.000250)	(0.000210)	(0.000204)	(0.000528)	(0.000502)
N (individuals)	3121298	3010492	3010492	3121298	3121298
N (states)	12	12	12	12	12
Individual characteristics			X		X
Lagged unemployment		X	X		
Absolute change in unemployment		X	X		
State fixed effects	X	X	X	X	X
Year fixed effects	X	X	X		
Quadratic time trend				X	X
State-specific time linear trend				X	X

Notes: Table reports the coefficients of interest and standard errors (in parentheses) from unweighted Ordinary Least Squares regression analyses of different versions of the model using American Community Survey data and the Medicaid Waiver Dataset. Each independent variable and column combination is the result of a separate regression. Only states that changed (implemented or eliminated) their childless adult programs are included. Standard errors clustered at state level. *** indicates statistical significance at 1% level; ** at 5% level; * at 10% level.

estimates, we predicted the SSI participation rate for non-institutionalized childless adults under several scenarios ranging from no childless adult coverage to childless adult coverage with no enrollment cap or freeze. The intermediate possibilities range from a 10% to a 75% cap. For example, in a state with childless adult coverage and a 50% enrollment cap, 50% of the income-eligible population may enroll before the enrollment cap is met. The visual trend supports the idea of a dose-response relationship in which greater Medicaid availability leads to larger reductions in SSI participation. With no coverage available, approximately 2.84% of participate in the SSI program. As anticipated, that estimate declines when coverage is made available and enrollment caps become less restrictive: 2.68% of the childless adult population participates in SSI with a 10% cap in place; 2.53% of the childless adult participates in SSI with a 75% cap; and 2.47% participate in SSI with childless adult coverage and no cap present. The difference between the predicted participation rates under no coverage relative to 50% and 75% caps as well as no cap were statistically significant at the 5% level. There were no statistically significant differences between having no childless adult coverage and the presence of more restrictive caps.

Overall we find that the implementation of Medicaid coverage for childless adults results in an average reduction in SSI participation of 5% - 9% relative to no such coverage. These effect sizes are broadly consistent with available previous estimates for a working age population. Specifically, among counties with low rates of health insurance at baseline Maestas et al., (2014) observed decreases of 3.8% - 6% in SSI application rates after the Massachusetts expansion of private and public health insurance.

Figure 4. Predicted proportion of childless adults in SSI according to the presence and magnitude of Medicaid enrollment caps or freezes. Point estimates and 95% confidence intervals.



Notes: The predicted proportion of SSI enrollment is estimated from regression results that include individual characteristics, the absolute change in unemployment, lagged unemployment, state and year fixed effects. The sample includes the 9 states that changed Medicaid coverage between 2001-2013 for which detailed information was available regarding the presence and magnitude of the enrollment caps or freezes: CO; CT; IN; IA; ME; MD; MI; UT; WI. The "no coverage" point estimate reflects the predicted proportion of childless adults enrolled in SSI when there is no Medicaid coverage specific to childless adults. The 10% cap estimate is the predicted proportion of childless adults enrolled in SSI when Medicaid coverage is available to 10% of the income eligible childless adults. The "no cap" point estimate represents the predicted proportion of childless adults enrolled in SSI when Medicaid coverage is available to 100% of the income eligible childless adults

The delinking of Medicaid and SSI eligibility is reminiscent of the severing of Medicaid and the Aid to Families with Dependent Children program (AFDC) eligibility in the late 1980's and early 1990's as states raised Medicaid maximum income thresholds for children and pregnant women above AFDC criteria (Hakim, Boben, & Bonney, 2000). Concurrent changes during that period in AFDC eligibility, welfare benefit generosity, and the U.S. tax code have made it challenging to isolate the effect of the expanded Medicaid eligibility on participation in the AFDC cash assistance program. Early estimates reported a marked decrease in AFDC

participation among single mothers (Yelowitz, 1995); however, this finding has not been demonstrated in subsequent research (Ham Shore-Sheppard, 2005; Meyer and Rosenbaum, 2001). One interpretation that follows from these null findings is that an offer of Medicaid coverage – apart from AFDC eligibility—was an insufficient incentive to alter AFDC participation. That our results suggest a different response to a Medicaid expansion is not altogether surprising as SSI beneficiaries and applicants have significant health impairments that may increase the value that they place on health insurance coverage relative to cash benefits.

Robustness Tests

The key assumption behind the difference-in-differences analysis is that of parallel trends: states that did not expand (or had not yet expanded) Medicaid are assumed to have had similar trends in SSI participation (conditional on observables included in the model) as those that did expand, so that those states and years provide a good counterfactual. The main potential violation of this assumption is policy endogeneity: the idea that states that expanded Medicaid for childless adults were doing so in response to a perceived need in their population which may have independently affected SSI participation as well. While the parallel trends assumption is not directly testable, we provide several checks to assess the plausibility of our research design.

First, we provide estimates in Tables 2 and 3 from specifications that include state-specific linear time trends in addition to a general quadratic time trend. The main concern is essentially the omission of time-varying unobservable characteristics that may influence SSI participation at the state level and the state time trends provide a parameterization of these characteristics.

For these specifications, if the main difference-in-differences estimate remains unchanged, it would provide support for the design. Columns (4) and (5) in both Table 2 (all states) and Table 3 (only states implementing or eliminating programs) show that including these time trends in the regressions results in very similar estimates to the main results in Column (3). For $CACov_{st}$, results remain statistically significant at the 1% level and rather than attenuating are slightly more negative. $Threshold_{st}$ shows a similar pattern, remaining statistically significant at the 10% level in Table 2 but not Table 3; this change is due to increased standard errors rather than changes in the magnitude of the coefficients. $SimElig_{st}$ estimates are not statistically different from zero when time trends are included, but the coefficients are nearly identical in magnitude to the results obtained in the main specification. Overall, we conclude that the results are not particularly sensitive to the inclusion of state time trends.

Second, we explore how changes to our sample might affect the results obtained. In particular, we limit the analysis to the parts of the income distribution which are most likely to be affected by the policy: low income adults with family incomes below 400% FPL. We might expect the results to be even more pronounced if this group is the main population that responds to the policy. Table 4 shows the results of this analysis for regressions featuring each of the three independent policy variables in the main specification, for both the set of all states and for the set of states that changed their programs (Columns 3 and 4). Across all 6 regressions we find that the policy variable is statistically significant at least at the 10% level and that the magnitudes are even larger in absolute value than for the estimates that include individuals of all income levels. For $CACov_{st}$, results remain statistically significant at the 1% level and suggest that in this subpopulation, implementing a childless adult Medicaid program results in a .2 - .3

percentage point decline in SSI participation. The results for $Threshold_{st}$ suggest that a 100 percentage point increase in the income threshold results in a .10 percentage point decrease in SSI participation. Finally, $SimElig_{st}$ estimates show that a 10 percentage point increase in the proportion of childless adults eligible for Medicaid in a state results in a .1 percentage point decrease in SSI participation for this subpopulation. Together, the results in Table 4 strongly support our research design and that the population we would expect to be driving the results indeed appears to be doing so.

Table 4. Difference-in-Differences estimates of the effect of Medicaid coverage for childless adults on SSI participation, 2001 – 2013: Robustness Checks

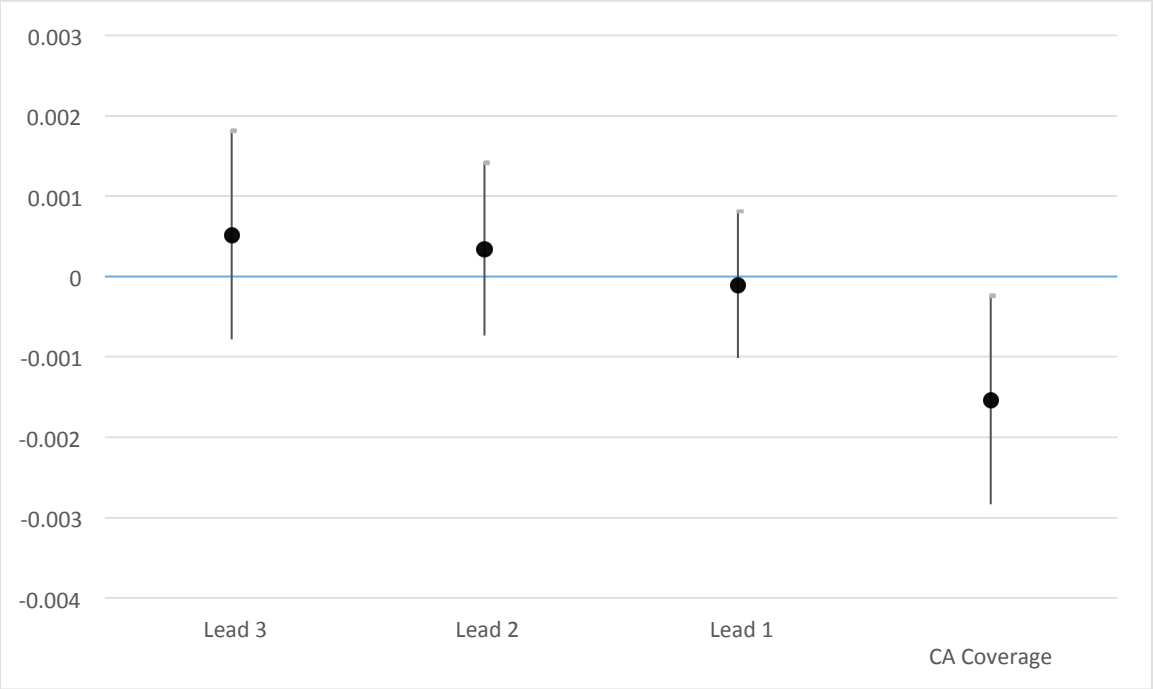
	Weighted Sample		Income < 400% FPL	
	(1)	(2)	(3)	(4)
Independent Variable	**All States**	**States that Changed Coverage**	**All States**	**States that Changed Coverage**
CA Coverage *(CACov)*	-0.00167***	-0.00166***	-0.00278***	-0.00218***
	(0.000468)	(0.000272)	(0.000985)	(0.000570)
Max Income Threshold *(Threshold)*	-0.000627***	-0.000680***	-0.00100*	-0.000981**
	(0.000228)	(0.000178)	(0.000576)	(0.000400)
Simulated Eligibility *(SimElig)*	-0.000622***	-0.000567***	-0.000986*	-0.000809**
	(0.000200)	(0.000158)	(0.000534)	(0.000364)
N (individuals)	9438219	3010492	4991173	1553540
N (states)	51	12	51	12
Less than 400%FPL			X	X
Weighted	X	X		
Individual characteristics	X	X	X	X
Lagged unemployment	X	X	X	X
Absolute change in unemployment	X	X	X	X
State fixed effects	X	X	X	X
Year fixed effects	X	X	X	X

Notes: Table reports the coefficients of interest and standard errors (in parentheses) from Ordinary Least Squares regression analyses using American Community Survey data and the Medicaid Waiver Dataset. Each independent variable and column combination is the result of a separate regression. Columns 1 and 2 present a weighted analysis of the main specification. Observations with family income >400% of the Federal Poverty Level are excluded from analyses presented in columns 3and 4. Standard errors clustered at state level. *** indicates statistical significance at 1% level; ** at 5% level; * at 10% level

Third, we perform a "Granger causality" test following Autor (2003), adding leads of the treatment variable $CACov_{st}$, to the model in order to test whether the effects of childless adult Medicaid coverage appear prior to actual implementation of a change. If the leads are not statistically different from zero, it suggests that SSI participation is only responsive to actual Medicaid program changes, as one would expect, supporting our design. Figure 5 illustrates the results of this analysis, with the graph illustrating the point estimates and 95% confidence intervals resulting from a regression including three leads in addition to the $CACov_{st}$ variable and the table below showing the exact point estimates and standard errors. None of the leads are statistically different from zero, while $CACov_{st}$ has a nearly identical magnitude as we find the main results. An F-test for joint significance of the leads indicates that in addition to lacking individual statistical significance, they are not jointly statistically different from zero either. This test suggests that state changes to their Medicaid programs are indeed driving the results.

Finally, we provide results from a "placebo" treatment simulation adapted for the multi-state, multi-year context, in which we randomly assign one of the years from a state's untreated pre-change period as the implementation year and estimate the model on only the pre-treatment data. We perform this random assignment of dates 1,000 times and report the average coefficient for $CACov_{st}$ and standard error. If our design is valid, the value of this average coefficient should be zero. Consistent with this expectation, the average coefficient and standard error were 0.000161 and 0.000608 respectively.

Figure 5. Point estimates and 95% confidence intervals, leads of childless adult coverage



	Lead 3	**Lead 2**	**Lead 1**	***CACov$_{st}$***
Coefficient	0.00051	0.00034	-0.00010	-0.00154**
Standard Error	(0.00065)	(0.00053)	(0.00045)	(0.00065)

Notes: Figure 4 shows the point estimates and 95% confidence interval bars resulting from a regression analysis that adds three leads of the Childless Adult Coverage variable. The model is otherwise identical to the preferred specification and includes state and year fixed effects, state unemployment variables and individual characteristics. The table reports coefficients and standard errors from this regression, ** indicates statistical significance at 5% level; * at 10% level

CONCLUSION

The Affordable Care Act authorized states to offer Medicaid coverage to adults with incomes at or below 138% of the FPL regardless of disability or parental status. Previously, childless adults had few paths to obtain Medicaid coverage unless they qualified for Supplemental Security Income (SSI) benefits because of a disability. In Medicaid expansion states, childless adults may obtain Medicaid coverage without undergoing an intensive federal disability review process and with relatively higher income and assets than the SSI program

allows. The expanded availability of Medicaid for this population- independent of SSI participation — creates an opportunity to increase earnings and savings without jeopardizing health insurance coverage. To the extent that individuals act on this opportunity, we would expect SSI participation rates to decrease. Using historical state Medicaid expansions for childless adults, this study's results offer the first estimates of the effects of changes in public health insurance eligibility for adults without dependent children on SSI participation.

We show that the implementation of Medicaid coverage for childless adults results in an average annual reduction in SSI participation among working age childless adults of 5% - 9%. Our results are remarkably consistent across model specifications and alternative measures of childless adult coverage. The results of multiple robustness checks, including a test for policy endogeneity and a placebo treatment test, strongly support the validity of our study design.

A few caveats to our study should be considered. In the ACS we cannot distinguish SSI program entry and exit. The availability of stand-alone Medicaid coverage may affect these decisions differently because the SSI income eligibility criterion increases in generosity for individuals once enrolled in the program. Our definition of Medicaid coverage for childless adults excludes programs that offer only premium assistance or very limited benefits in order to evaluate the effect of providing coverage that is equivalent to the Medicaid benefits available to SSI beneficiaries. However, some programs in state-years that we designate as having childless adult coverage are not exact substitutes -- most obviously those that imposed enrollment caps. Likewise, in the state-years that we identify as having "no childless adult coverage" some potential or current SSI beneficiaries may have used limited public health

benefits that we do not recognize in our classification as childless adult coverage. Both types of measurement error are likely to bias our results toward the null.

A decrease of 5% - 9% in SSI participation among non-institutionalized adults without dependent children may seem like a small change. However, using the proverbial back of the envelope we estimate that a reduction of this size translates into a reduction in beneficiaries of 19,000 to 57,000 and a decrease of $4.0 to $12 million in federal SSI payments for each enrollment month within the 12 affected states.[5] While these dollar amounts may be imprecise, this stylized estimate conveys the magnitude of the program-level effects following the Medicaid expansions in the study states on SSI participation. Additionally, we may expect gains in efficiency to the extent that the higher income and asset thresholds for Medicaid expansions (relative to SSI) reduce labor supply distortions. This study's findings signal the importance of evaluating the cross-program effects of the ACA expansions to capture the full implications of increased Medicaid availability on public welfare spending and labor force participation among low-income adults.

The current study results are likely a lower bound estimate of the effects of the ACA Medicaid expansions on SSI participation among childless adults for several reasons. States are required to provide a comprehensive set of "essential health benefits" to individuals eligibile for Medicaid through the ACA expansions (U.S. DHHS, 2012). Among early Medicaid expansions,

[5] To arrive at this estimate, we multiplied a range of potential reductions in SSI participation, from 3% to 9%, to the total monthly federal payments for childless adult SSI beneficiaries in the 12 states that changed Medicaid coverage between 2001 - 2013. We estimated the number of childless adults who participated in the SSI program within the 12 change states from the ACS in our baseline year (2001). We assumed that each beneficiary received 1/3 of the maximum monthly SSI federal cash benefit in 2008, mid-way through the study period, because we surmised that the individuals most likely to forego or exit SSI for Medicaid coverage are likely to have relatively low cash benefits due to earnings capacity.

the generosity of benefits varied by state (Silow-Carrol, Anthony & Meyer, 2000; Holahan & Pohl, 2002; Dorn et al., 2004). It is probable that the ACA related benefits are more generous than those offered under early expansions in at least some states. Early expansion states frequently used enrollment caps and freezes to manage the size and expense of their programs (Dorn et al., 2004; Klein & Schwartz, 2008). These mechanisms limited access to coverage as evidenced by large and persistent waitlists (Klein & Schwartz, 2008; Burns et al., 2014). By constrast, ACA expansions may not impose enrollment caps or freezes. Finally, state Medicaid programs may not consider assets or resources in their determination of individual eligbility for the ACA-related expansions in contrast to the early expansions (U.S. DHHS, 2014). This attribute of the ACA Medicaid expansions may be particularly salient for individuals considering SSI participation because the SSI asset limit is not inflation adjusted and has been fixed at $2,000 since the program's implementation in 1974. Together these differences in benefit generosity, coverage accessibility, and eligibility criteria suggest that Medicaid coverage for childless adults through ACA expansions may be of even higher value to a potential beneficiary relative to the early expansion Medicaid coverage.

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APPENDIX A

Medicaid Waiver Dataset

Childless Adults 1996 – 2014

Data Collection Objective

The objective of this data collection project was to identify the presence and characteristics of Medicaid coverage for adults without dependent children for each state in the U.S. and the District of Columbia between the years of 1996 – 2014 (excluding eligibility based on disability.) Table 1 of this document includes a summary of the variables contained within the dataset.

Several sources were consulted to construct this dataset: 1) section 1115 Waiver Demonstration documents from the Centers for Medicare and Medicaid Services; 2) state government documents and reports; 3) reports from national health policy organizations including The Henry J. Kaiser Family Foundation, the National Academy for State Health Policy, and the National Council of State Legislators; and 4) a range of local news articles and reports. To obtain and review documents for earlier years that have not been digitized, we conducted onsite data collection at the Centers for Medicare and Medicaid Services (January 2015). The specific sources from which we collected the data are listed at the end of this document by state.

There are two versions of this dataset, research and annotated. The research dataset, a Stata file, includes data elements only without textual explanations or references. The annotated dataset, an Excel file, includes the research dataset and additional text fields to facilitate interpretation and use of the data. Importantly, for each data element there is a corresponding "source" field in which we identify the source from which the value of that data element was obtained. Sources are identified using a labeling convention indicated at the end of this document. A unique identifier for each state-year-program is common to both the research and annotated datasets to enable researchers to locate the reference for a given data element from the research file in the annotated file.

Overall, the dataset is comprehensive and includes even the most limited Medicaid programs (e.g. premium assistance for small employers of low-income adults). We recommend that data users review the annotated dataset to interpret and/or transform that data to best meet their needs. We anticipate updating the dataset and documentation, and welcome corrections or additions.

Public Availability

This dataset and documentation will be made publicly available following completion of the grant supporting its construction. The anticipated release date is late 2016. Before that time, interested researchers may contact the study team directly for data access.

Table 1 Medicaid Waiver Dataset: Variables and Variable Definitions

Variable	Definition
ID #	Unique identifier for each data row
FIPS Code	
State	
Year	Calendar year
Program	0 = No program for childless adults in given year 1 = Program for childless adults in given year
Authorization Code	0 = No program 1 = *State* Medicaid program fully funded by state 2 = *1115 Waiver* Medicaid program authorized through Section 1115 waiver demonstration 3 = *ACA* Medicaid program authorized through ACA
Program Name (annotated dataset only)	Name of program, beginning with program authorization
Max Income Eligibility for Employed	Maximum income eligibility percentage relative to the federal poverty level for the employed
Max Income Eligibility for Unemployed	Maximum income eligibility percentage relative to the federal poverty level for those without employment
Enrollment Ceiling/Freeze	Indicator variable given a value of 1 if program had an enrollment cap or freeze at any time during the year
Benefits (annotated dataset only)	Textual description of exclusions or limits to program benefits
Premium	Indicator variable given a value of 1 if premiums were

	required for beneficiaries any time during the year
Other Financial Requirements	Indicator variable given a value of 1 if program contains financial requirements other than premiums such as contributions to health savings accounts or annual enrollment fees. Co-pays are not included in this variable.
Note (annotated dataset only)	Each data element collected has a corresponding notes field in which we include information to facilitate use or interpretation of the data element (e.g., effective dates for new or changed provisions).
Source (annotated dataset only)	There is a source variable for each data element in which the source for the value of the data element is identified.

Analytic Decisions

Coding:

- All numeric data elements receive a zero if no Medicaid program was present in the state for the given year.

Year:

- Program changes that occur at any time during a year are described in that year.
- In the annotated version of the dataset, the "note" field that corresponds to each data element will indicate the effective date for any change that occurred during the year if that was available in the documentation. If there was no change for a data element from year 1 to year 2, there will be no additional information in the note field for year 2.

Program authorization:

- When the authorizing source for a program changes mid-year (e.g. state funded program becomes Section 1115 program), the program is listed twice for that year, once under its former funding source and once with its new funding source.
- Specific program names are listed after authorizing source in the notes field.

Max Income Eligibility for Employed:

- This value is given without income disregard.
- In some cases a program is available for a specific income range e.g., 150%FPL to 200% FPL. The value of the max income eligibility field is the maximum (i.e., 200% in this case) as in all situations. The lower limit when it is other than 0 is indicated in corresponding notes field.
- If a program was only open to the unemployed, this field is left blank.

- In the annotated version of the dataset, the corresponding notes field contains information about enrollment and eligibility guidelines for the program that may facilitate interpretation or use of this element.
- We assume no change in maximum income eligibility between years in which specified values are explicit. For example, in 1997 for state Y the maximum income eligibility was 150%FPL. In 2001, credible documentation notes a change effective that year to 100%FPL. If after extensive research, we found no explicit documentation of the maximum income thresholds for 1998-2000, we assign the last documented value (i.e., 150%FPL) to those intervening years.

Max Income Eligibility for Jobless:

- This value is given without income disregard.
- In some cases a program is available for a specific income range e.g., 150%FPL to 200% FPL. The value of the max income eligibility field is the maximum (i.e., 200% in this case) as in all situations. The lower limit when it is other than 0 is indicated in corresponding notes field.
- In the annotated version of the dataset, the corresponding notes field contains information about enrollment and eligibility guidelines for the program that may facilitate interpretation or use of this element.
- We assume no change in maximum income eligibility between years in which specified values are explicit. For example, in 1997 for state Y the maximum income eligibility was 150%FPL. In 2001, credible documentation notes a change effective that year to 100%FPL. If after extensive research, we found no explicit documentation of the maximum income thresholds for 1998-2000, we assign the last documented value (i.e., 150% FPL) to those intervening years.

Enrollment Ceiling/Freeze:

- A value of '1' is assigned to this field if any of the following were present within a source of Medicaid coverage in the state (e.g., 1115 waiver) at any time in the year: enrollment cap/ceiling, enrollment cap/ceiling reached, enrollment freeze or suspension in place.
- In the annotated version of the dataset, the notes field contains any details that were available about the effective date of freeze/cap and/or size of enrollment cap.
- We assigned a value of '0' to state-years in which we found no evidence of an enrollment ceiling/freeze after extensive research.

Benefit exclusions or limitations (annotated data set only):

- The purpose of this field was to make note of benefits or limitations to benefits that reflected the generosity of covered services. Although we made every effort to populate this field, these details were inconsistently available across states, programs, and years.

- This field will indicate if the benefit exclusion/limitation reflects a change from the prior year. If there was no change for a data element from year 1 to year 2, there will be no additional information in the note field for Year 2.

Premium:

- A value of `1' was assigned to this field if payment of a monthly premium was required as a condition of enrollment at any time during the year.
- In some years, we were unable to find explicit mention of a premium although explicit documentation of its presence or absence was available in prior year(s). If we were also unable to find evidence of a change in the program, we assumed no change and assigned a value to this variable consistent with the most recent year in which a premium was explicitly mentioned

Financial requirements:

- A 1 was given for the year if a financial requirement other than a premium or co-pays was present for the program any time during that year. For example, this includes required payment into a health savings account, an annual enrollment fee, or the option to forgo payment of premiums by participating in a wellness program.
- In some years, we were unable to find explicit mention of other financial requirements (absence or presence) although explicit documentation was present in prior year(s). If we were also unable to find evidence of a change in the program, we assumed no change and assigned a value to this variable consistent with the most recent year in which other financial requirements were explicitly mentioned

Source (annotated dataset only):

- Each data element (e.g., enrollment freeze/ceiling) has a "source" field. This field indicates the specific source(s) for the value of the corresponding data element. In some cases the data element is populated, and the source field is blank. A blank source field indicates that we found no explicit documentation for the value of that data element in that year. If we additionally found no documentation of a change from the prior year we infer the value of the data element from the most recent prior year in which there was explicit documentation.
- The source names in this field correspond with the citation information below. PDF copies of any or all of the sources listed are available upon request.

Note (annotated dataset only):

- No text in the "Notes" field signals that we found no new information for this data element in that state-year-program relative to the prior year.

Limitations

In general, the source documents provided information on the programs' eligibility criteria, financial requirements and benefits at the start year, end year, and/or points along the way where these conditions had been modified. However, as noted above, it was necessary to infer the value of some elements. While such inferences were made only after extensive research, we will continue to update the dataset if and when we identify additional information. We welcome corrections.

Our preferred data sources were state and federal program documentation. Because that was inconsistently available, we relied in some cases upon news or Internet articles. When that was necessary, we made every attempt to find multiple sources. Finally, this dataset does not include information about the size of each program in terms of dollars or beneficiaries, or the enrollment process. These characteristics would be a welcome addition to it.

Source List

The 22-page source list is available upon request. It will be published with the dataset.

Alabama Medicaid Expansion: Summary of Estimated Costs and Savings

Prepared for the Alabama Hospital Association

Date: 02.01.19

Deborah Bachrach

Manatt Health

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Manatt Health

Alabama is currently one of only 14 states that have not expanded Medicaid, leaving more than $1 billion in federal money on the table each year that would boost economic activity and strengthen the ability of hospitals and other healthcare providers to serve residents throughout the state, and leaving hundreds of thousands of Alabama residents without health coverage. In response, Alabama hospital leaders are analyzing the costs and savings associated with expansion.

For the Alabama Hospital Association, Manatt Health produced an analysis building on evidence from states that have already expanded their Medicaid programs. Manatt's analysis estimates that Alabama stands to free up more than $58 million in state funds in the first year of expansion, and nearly $88 million in fiscal year 2023. These funds could be invested in the state's health system, including to help offset some of the costs of expanding Medicaid. Additionally, more than 300,000 individuals would gain coverage in the first year.

Click here to view the presentation sharing the findings.

Medicaid Expansion

It's time to invest in a

Healthy Alabama.

Alabama can provide health coverage to an estimated 340,000 more adults, create 30,000 new jobs and enjoy an economic impact in the billions. Find out more about how we can do this using a solution that's best for our state. Visit www.alhealthmatters.com for more information. Also be sure to follow us on ALHealthMatters Facebook page and ALHealthMatters Twitter.

NEW: Updated regional impact sheets to include more information can be found here, find your county/region. Print them, post them… **USE THEM.**

One-page summary report: Reports Build Strong Case for Medicaid Expansion in Alabama

2.1.19 Release: Reports Build Strong Case for Medicaid Expansion

Resources from 2.1.19:
Hospital Financial Fact Sheet
Report: Medicaid Expansion in Alabama: Revisiting the Economic Case for Expansion by David J. Becker, Ph.D.
Report: Alabama Medicaid Expansion by Manatt (Summary of Estimated Costs and Savings)

9.20.18 Release: Hospitals Launch Medicaid Expansion Public Awareness Initiative

Reports Build Strong Case for Medicaid Expansion in Alabama

Reports: Economic Impact

David Becker, PhD, UAB School of Public Health, and Manatt, a national consulting firm, provide strong evidence to support expanding Medicaid.

- Overall, the economic impact to the state of the additional federal funds would be **$11.4 billion** over four years. (Becker study)
- In that same time frame, another **$316 million** would be saved through a higher federal match rate and by paying for services that are currently funded with 100% state funds. These are savings that could be reinvested in the health care system. (Manatt)
- Alabama will receive $9 in federal funds for every $1 the state spends **indefinitely**. (Becker study)
- Additional state and local taxes would offset **$715 million** of the cost.
- After considering state savings and new tax revenue, the estimated cost for Medicaid expansion is **$239 million** over four years. (Becker report)

"In contrast to most economic development projects supported with state and local incentives, Medicaid expansion would provide benefits across all of Alabama's 67 counties." (Becker report)

Alabama's Hospitals Are Struggling

- 88 percent of rural hospitals operate in the red; 75 percent of all Alabama hospitals operate in the red.
- **13 hospitals** have closed in the last 8 years, **7** of which were rural.
- Alabama hospitals spend more than $500 million each year caring for the uninsured.

If nothing happens, other hospitals will be forced to cut services, eliminate staff or in the worst case, close.

The Benefits of Medicaid Expansion

- By expanding Medicaid, Alabama could provide health care coverage to an estimated **340,000 adults** who don't currently have health insurance.
- The rate of adults without health insurance dropped from 35 percent to 16 percent in expansion states (2008 – 2016).
- Hospitals are **84 percent** more likely to close in non-expansion states.
- Medicaid expansion leads to earlier cancer detection, fewer deaths, and better outcomes for patients.
- Expansion states have increased access to substance abuse treatment and other mental health services.

Medicaid Expansion: Alabama Can't Afford to Pass it Up!

Alabama is one of only 14 states that have not expanded Medicaid. This means our federal tax dollars are going to other states to pay for their health care coverage, while Alabama's health care delivery system struggles. With the challenges facing our health care system, particularly rural hospitals, it's an opportunity we cannot afford to pass up.

Find out more at www.alhealthmatters.com

Reports Build Strong Case for Medicaid Expansion

For more information, contact: Rosemary Blackmon, (800) 489-2542

Alabama has an opportunity to generate billions of dollars in economic activity and state savings and provide more than 340,000 Alabamians with health insurance coverage, according to two reports released this week regarding Medicaid expansion.

The first report, produced by David J. Becker, Ph.D., UAB School of Public Health, actually updates an earlier report he wrote in 2016. The new estimates reveal that 340,000 individuals would be covered under Medicaid expansion, providing Alabama with an economic boost of more than $11 billion over four years.

"While Alabama missed the first three years of 100-percent federal funds, the updated estimates show that the impact would be significant as the federal government will still provide $9 for every $1 the state spends on the expanded population," said Dr. Becker. "In addition, when you consider the additional state and local taxes and the predicted state savings, the costs to the state are minimal as compared to the benefits provided."

Dr. Becker explained the ripple effect of the influx of federal dollars and increased Medicaid enrollees, noting that the number of health care services and employees would increase as would the community services required to support the additional growth and the taxes paid by the newly created jobs.

Building on the evidence from states that have already expanded their Medicaid programs, Manatt, a national consulting firm, released a report that affirms Dr. Becker's enrollment estimates and adds to it the potential for state savings. "We predict Alabama could free up almost $60 million the first year of expansion, with an increasing amount each year … dollars that could be reinvested to help maintain the state's health care delivery system," said Deborah Bachrach, a partner with Manatt.

Alabama is currently one of only 14 states that have not expanded Medicaid, putting it in a precarious position with the upcoming federal cuts to hospitals. Dr. Becker highlights the potential harm. "When Congress passed the Affordable Care Act, the assumption was that states would expand Medicaid to help cover the uninsured. So to help offset the costs of expansion, Congress mandated cuts in payments hospitals receive to cover the cost of the uninsured."

"Alabama's hospitals are scheduled to lose $119 million in federal funding unless Congress takes action," said Owen Bailey, chairman of the board of the Alabama Hospital Association and CEO of USA Health. "Those are critical dollars for us as our hospitals currently spend more than $500 million each year in care for which they receive no reimbursement. In fact, three-fourths of our hospitals are currently operating in the red, and 12 hospitals have closed over the last 8 years. For many, the additional cuts won't be sustainable. Providing insurance through Medicaid expansion is vital to maintain access to care for everyone."

Highlights of the reports (both of which focus on 2020 through 2023):

- More than 340,000 individuals are estimated to enroll the first year. (based on both reports)
- Estimated economic impact of federal spending on Medicaid expansion - $2.7 billion in 2020 up to $2.97 billion in 2023 with overall impact for the four years of $11.4 billion. (Becker report)
- Additional taxes generated - $715 million over the four-year period, with $446 million in new state taxes and $269 million in new local taxes. (Becker report)
- Estimated state savings (based on increased federal match for existing populations and enrollment in expansion of those currently covered with 100 percent state funds) – range of $59 million in 2020 to $87.6 million in 2023. (Manatt report)

Download reports from www.alhealthmatters.com:

Medicaid Expansion in Alabama: Revisiting the Economic Case for Expansion - David J. Becker, Ph.D., UAB School of Public Health

Medicaid Expansion: Summary of Estimated Cost and Savings – Manatt Health

Alabama's Hospitals

The Facts about Finances

In Alabama, hospitals are a driving force in the state's economy, providing a $20 billion economic impact annually and 186,000 direct and indirect jobs. They are invested in the health care delivery system and in maintaining access to care for every Alabamian. However, many Alabama hospitals face challenges sustaining healthy margins and adequate reserves, often creating a fragile health care system in both urban and rural communities.

The following are responses to a July 2016 survey* of Alabama hospital CEOs. They were asked to compare this year to the last on the following measures:

25% saw a decrease in **charitable donations.**

63% saw an increase in **uninsured patients.**

48% reported an increase in **Medicaid patients.**

53% saw a drop in **inpatient admissions.**

72% experienced an increase in **visits to the emergency department.**

* Survey represents almost 90 percent of Alabama's hospitals.

Negative Margins:

The following information comes from Medicare Cost Reports, the reports used to submit financial information to Medicare and Medicaid. The data is from FY2016, the latest available.

⇒ Median operating margin - negative 6.5%

⇒ Median total margin - negative 0.1%

⇒ 52% of all hospitals had negative total margins.

⇒ 75% were operating in the red, meaning the revenue received for patient care wasn't enough to cover the cost of the care. So, for the vast majority of hospitals, the only way they are surviving financially is through other lines of business, investment income , charitable donations, etc.

Rural Hospitals FY2016:

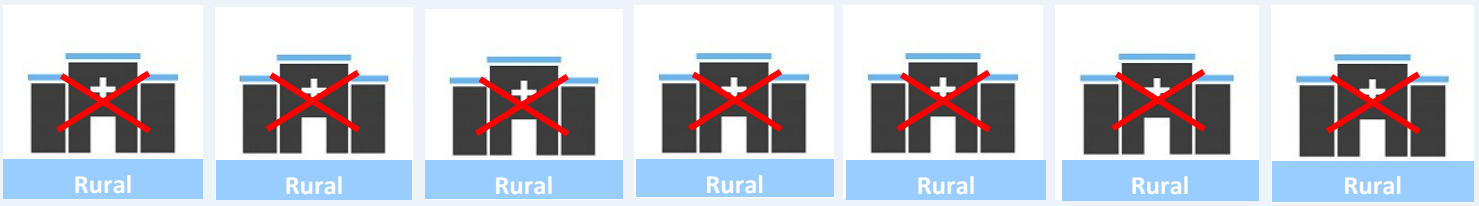
⇒ Median operating margin - negative 12.2%

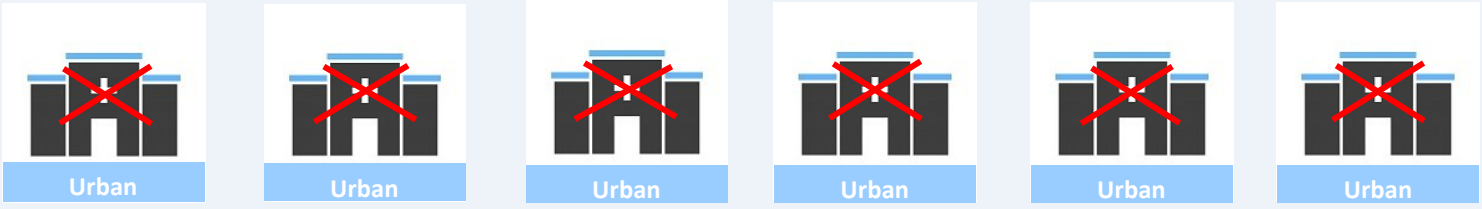
⇒ Median total margin - negative 3.5%

⇒ **88% operating in the red!**

Since 2011—Thirteen Hospitals have Closed

Seven of these hospital closures were in rural areas





Medicaid Expansion in Alabama:
Revisiting the Economic Case for Expansion

David J. Becker, Ph.D.

January 31, 2019

Department of Health Care Organization and Policy
School of Public Health
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Medicaid Expansion in Alabama:
Revisiting the Economic Case for Expansion

INTRODUCTION

Over six years have now passed since the Supreme Court's landmark decision which upheld the core provisions of the Affordable Care Act (ACA) but left the decision on Medicaid expansion to the states. Despite the generous Federal match rate structure (full federal funding for 3 years, gradually declining to 90% in 2020 and beyond) Alabama was one of 26 states which elected not to participate in Medicaid expansion prior to its inception in January 2014. Since that time, 9 additional states have expanded their programs. Louisiana Democratic Governor John Bel Edwards ran heavily on the issue -- and won -- expanding Medicaid by executive order on his second day of office in 2016. The Republican controlled Virginia legislature voted to expand Medicaid in April 2018, joining a growing list of states that expanded their programs with Republican support. The 2018 midterm elections provided further evidence of broad public support for Medicaid expansion, as voters in three reliably conservative states -- Idaho, Utah and Nebraska – approved ballot measures supporting expansion. Alabama is now one of just 14 states that have taken no action on Medicaid expansion under the ACA[1].

In November 2012 -- over a full year prior to the implementation of expansion – my former colleague Michael Morrisey and I released a monograph titled *An Economic Evaluation of Medicaid Expansion in Alabama under the Affordable Care Act*[2]. Our report projected the impact of Medicaid expansion in Alabama on new Medicaid enrollment, the uninsured population, costs to the state and Federal Government, economic activity and state tax revenues and presented a strong economic case for expansion. The report focused on the period from 2014 to 2020 and projected that roughly 300,000 Alabamians would be covered under a Medicaid expansion, reducing the state's uninsured population by over 230,000. The state's investment of $771 million during the initial seven-year period would generate $20 billion in new economic activity from increased federally funded health spending and spillover effects in other sectors of the state's economy. We concluded that net of the new costs to the state, expansion would yield a $935 million increase in tax revenues in the state of Alabama.

In October 2016, I drafted a second report that revised and expanded upon the earlier analysis in several important ways[3]. First, the report updated the earlier core economic impact projections (enrollment, state/federal costs, economic activity and budget impacts) over the period from 2017 to

2020. Since Alabama had already foregone the three year period (2014-2016) with the 100% Federal match rate, this would reduce the aggregate economic windfall from expansion to the state. Second, the report accounted for the fact that Alabama residents with incomes between 100-138% of the Federal poverty level who would have been eligible for Medicaid under expansion have instead enrolled in federally subsidized Marketplace plans. With expansion, these individuals would represent new costs to the state but would not generate new federal health spending in the state. Third, the report provided a more state-centric budgetary impact by distinguishing between tax revenues to state and local governments. Finally, the 2016 report examined the broader budgetary impact of expansion by incorporating estimates from Manatt Health of other potential cost-savings within the existing Medicaid program and other state funded health programs[4].

The 2012 and 2016 reports provided compelling evidence of the economic case for Medicaid expansion in Alabama. The findings of these Alabama specific *projections* are echoed by the actual *experiences* of states which have expanded their Medicaid programs. Medicaid expansion under the ACA has delivered the largest increases in public insurance coverage since the creation of Medicaid and Medicare under the 1965 Amendments to the Social Security Act. States that expanded Medicaid have experienced 3 to 4 percentage point larger declines in their rates of uninsured[5]. Central to the economic case for expansion, the budgetary savings projected in the prior Alabama studies have materialized in expansion states, including Louisiana which reported almost $200M in savings in Fiscal Year 2017[6-8].

This report updates the 2016 study and projects the direct impact of Medicaid expansion on program enrollment, state/federal costs, economic activity and state tax revenues in FY2020 to FY2023. As of 2020 the long term expansion FMAP of 90% has now been fully phased-in. More recent data on health insurance status from the American Community Survey and marketplace enrollment figures are used to refine the estimates of new Medicaid enrollment and transitions from Marketplace coverage to Medicaid. These new estimates are then combined with revised projections of cost-savings from other state programs generated by Manatt Health to generate comprehensive estimates of the net budgetary impact of expansion. In addition to the aggregate state-level projections, this report also provided estimates of new Medicaid enrollment, Federal Medicaid spending and economic activity by Public Use Microdata Area (PUMA) region, which highlight the broad impact of expansion across the state of Alabama.

SECTION 1: CORE ECONOMIC ANALYSIS OF EXPANSION

The first section of this report updates the 2016 economic analysis of Medicaid expansion with revised estimates of expansion enrollment, state and federal costs, aggregate economic impact and net tax revenues in Alabama over the period from 2020 to 2023. These estimates are constructed using more recent data on macroeconomic conditions, health care spending/growth, and health insurance coverage of the newly eligible population.

New Alabama Medicaid Enrollment under Expansion

Under the ACA's Medicaid expansion, eligibility is extended to adults (19-64) with family incomes less than 138% of the FPL (133% with a 5% income disregard) who are not currently eligible for Medicare or Medicaid. Legal immigrants who have lived in the United States fewer than 5 years, and all undocumented immigrants, are ineligible for Medicaid coverage. The potential Medicaid expansion population in Alabama is estimated using 2012 to 2016 American Community Survey (ACS) data from the University of Minnesota's Integrated Public Use Microdata Series (IPUMS). Income at the "health insurance unit" (HIU) level from the IPUMS data is used to identify the newly eligible population, and the distribution of its current health insurance coverage. As discussed in the data appendix, the HIU is the preferred method for simulating insurance coverage eligibility expansions under the ACA[9]. Of the newly eligible population in Alabama in 2016, approximately 295,000 were uninsured, another 293,000 had employer-sponsored (group) coverage and 99,000 had private non-group health insurance. For the eligible population, non-group coverage increased by roughly 50% between 2012 and 2016. Leveling off of Marketplace enrollments in 2016-2018 suggests that non-group coverage stabilized around 100,000, or just under 10% of the total newly eligible (0-138% FPL) population[10-12]. Since it is not possible to differentiate between Marketplace coverage and other forms of non-group coverage in the ACS data, actual Marketplace enrollment data for 2016 from the Center for Medicare and Medicaid Services (CMS) served as the basis for the assumption that 75% of non-group coverage is in subsidized Marketplace plans.

The sub-138% FPL population is then projected forward through FY2023 using population and employment growth forecasts, along with empirical estimates of the proportion of the uninsured that gain private coverage as the economy expands. The newly eligible population includes individuals who have a) no coverage (uninsured) b) private group (employer based) coverage, c) non-group coverage,

and d) non-group marketplace coverage. Total Medicaid expansion enrollment is estimated using the take-up rates reported in Table 1, which come from the Urban Institute's Health Insurance Policy

Table 1: Take-Up Assumptions

Uninsured	Private Group Coverage	Private Non-Group Coverage	Marketplace Non-Group Coverage
79%	15%	85%	85%

Simulation Model (ACS-HIPSM)[13]. These assumptions do not differentiate between the take-up behavior of individuals with (subsidized) marketplace non-group coverage (100-138% FPL) and individuals with other non-group coverage.

Table 2 presents estimates of the numbers of new Alabama Medicaid enrollees from FY2020 to FY2023. The eligibility expansion would lead to over 346,000 new Medicaid enrollees, of which

Table 2: Estimated Number of New Alabama Medicaid Enrollees under ACA Expansion

	FY2020	FY2021	FY2022	FY2023	Average FY2020-23
New Medicaid Enrollees	343,694	346,123	347,592	346,959	346,092
Non-Marketplace New Medicaid Enrollees	283,627	285,632	286,844	286,321	285,606

65% (~223,000) would be newly insured. However, it is important to note that approximately 60,000 of these expansion enrollees would be moving from federally subsidized marketplace plans. For these individuals, the subsidies for private health insurance from the Federal Government would be replaced with Federal funds that support Medicaid expansion. As such, these individuals represent new costs to the state of Alabama but will not generate new federal funds. Additional details on these enrollment projections are shown in the data appendix. This report does not examine the potential impact of Medicaid expansion on individuals who are currently eligible for Medicaid, but not enrolled -- the so-called "woodwork effect". Given the limited availability of adult Medicaid coverage in Alabama, any woodwork enrollees would almost exclusively be children. Children who are eligible for Medicaid, yet not enrolled, are likely to have limited health care needs and would not represent a significant new cost burden to the state. Additionally, published research has found no evidence of differential Medicaid take-up by previously eligible individuals in expansion vs. non-expansion states[14]. These enrollment estimates also assume that all the projected take-up occurs immediately in the first year of expansion. The expansion enrollment estimates reported in Table 2 are at the lower end of the estimated range developed by Alabama Medicaid's actuary, Optumas, but are higher than 2018 estimates from researchers at the Urban Institute[15-16].

State and Federal Costs of Medicaid Expansion

The counts of new Medicaid enrollees from Table 2, along with estimated per capita health care expenditures and administrative costs, are used to project the state and federal cost of Medicaid expansion from FY2020 to FY2023. The ACA provided a uniform Federal Matching Assistance Percentage (FMAP) to all states of 100% in 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in all years thereafter. Although, Alabama has now missed out on the period with more generous federal funding, Medicaid expansion continues to yield a significantly higher FMAP than the 71.9% that the state is currently receiving for the non-expansion population in FY2019. In addition to its share of the direct costs associated with the coverage expansion, the state of Alabama will also incur new administrative costs related to the expansion. Based on state's share of the current administrative costs for the existing Alabama Medicaid program, administrative costs of the expansion population are assumed to be 1.55 percent of total program benefit costs[17]. This approach likely overstates the administrative cost burden of expansion, as the marginal administrative costs for the expansion population are likely to be lower than the average administrative costs of the existing program. See the appendix for details of these administrative cost estimates.

Projections of health spending for the expansion population are derived using the Medical Expenditure Panel Survey (MEPS) from 2014-2016. The MEPS is a national survey of households conducted for the U.S. Agency for Health Care Research and Quality. Since state of residence is unavailable in the public use MEPS data, the expenditure estimates are based upon residents in the full South Census Region. Annual per capita expenditures by current insurance status are calculated for adults with family incomes less than 138% of the FPL. The per capita expenditure estimates are inflated by a factor of 1.10 to account for the well-documented underestimation of expenditures in the MEPS data[18]. It is assumed that the expenditures of the Medicaid expansion population will be similar to low-income individuals with private health insurance coverage. As shown in the data appendix, the expenditures of low-income privately insured adults are between those of the uninsured and Medicaid enrollees. Individuals who gain Medicaid coverage will utilize more health care services than when they were uninsured, but will consume fewer services than current adult Medicaid beneficiaries, who are disproportionately disabled. Table 3 presents estimated per capita health expenditures for the expansion population (in 2016 constant dollars) through FY2023 based upon the assumption of 2.6% annual growth in real per capita health care expenditures[19].

Table 3: Estimated Per Capita Expenditure of Expansion Population (2016 $)

	FY2020	FY2021	FY2022	FY2023
Per capita expenditures	$6,120	$6,279	$6,443	$6,610

The estimates of new Medicaid enrollment and per capita spending are used to project the aggregate costs of the Medicaid expansion to the state of Alabama and the Federal Government from FY2020 to FY2023. With the enhanced FMAP fully phased in to its long-term 90% as of January 2020, the projected increase in costs to the state after FY2020 is driven by a combination of rising real per capita health care spending and the expected slow-down of the US economy which will lead to increases in unemployment and Medicaid eligibility. The current unemployment rate in the US (and in Alabama) is below the "natural rate" and basic macroeconomic theory would predict that inflationary pressures should lead to a slowing economy and rising unemployment. Over the FY2020-FY2023 period, it is estimated that the state of Alabama would be responsible for $1.00 billion (10.88%) of the estimated $9.20 billion in new Medicaid program costs. This figure overstates the net costs of expansion to the state, as it does not capture potential cost-savings in other state health programs and traditional Medicaid. These issues are addressed in Section 2 of this report.

Table 4: Estimated State and Federal Costs Associated with Alabama Medicaid Expansion (in millions)

	FY2020	FY2021	FY2022	FY2023	Total FY2020-23
Alabama Costs	$227	$251	$258	$265	$1,001
Federal Costs	$1,969	$2,018	$2,080	$2,130	$8,197
Total Costs	$2,196	$2,269	$2,338	$2,394	$9,197

Economic Impact of Medicaid Expansion

In order to estimate the economic impact of Medicaid expansion in Alabama, it is first necessary to identify the new "outside" money that would come into the state. In this case, it is the new federal dollars that would finance health care in Alabama as a result of the decision to expand Medicaid. As discussed in the enrollment section, approximately 60,000 of the 346,000 new Medicaid enrollees would be individuals who currently have federally subsidized Marketplace coverage. This population, with incomes between 100-138% of the FPL, receives premium and cost-sharing subsidies that cover 94% of the actuarial cost of their marketplace plans. Since the federal government is already financing the majority of the cost of their health insurance coverage, the federal share of the Medicaid costs for this population cannot be included in the economic impact calculations. In fact, assuming comparable per enrollee spending in Medicaid and Marketplace plans, Federal spending on these enrollees would decline following their transition to Medicaid. As a result, although the federal government would

spend $1.97B on Medicaid expansion in FY2020, only $1.62B of this would represent new federal spending in the state. It is important to remember that this increased federal spending on Medicaid expansion (and Marketplace subsidies) will be offset by significant cuts in DSH payments that have been delayed repeatedly and are now slated to begin in FY2020. The consequences of these cuts for hospitals in non-expansion states will be discussed further in Section 4 of this report.

The aggregate economic impact associated with the new federal spending on Medicaid expansion is estimated using the IMPLAN input-output software model. This software provides industry specific multipliers which can be used to estimate the indirect economic impact of the initial increase in federally financed Medicaid spending. The intuition for a multiplier is that the initial direct Medicaid spending provides revenues to the health care sector which are in turn spent on other goods and services. These purchases yield new revenues to other individuals and firms who increase spending on other goods and services. The process continues with successive rounds of progressively smaller spending increases as the initial spending increase ripples through the economy. The estimates of the indirect impact use health-sector industry specific multipliers (e.g. hospitals, nursing homes, etc) which are weighted by their projected share of annual personal health care expenditures between FY2020 and FY2023. All of the multipliers ranged between 0.65 and 0.75, suggesting that a $1 increase in federal spending on the Medicaid spending yields an additional 65-75 cents of economic activity.

Table 5 presents the economic impact projections for FY2020-FY2023. In addition to the direct effect of the increase in federal health care spending in Alabama ($6.75 billion), these flows of new federal dollars would generate an additional $4.63 billion of new indirect economic activity over the FY2020-FY2023 period. In total, the new federal spending to support the Medicaid expansion (net reductions in marketplace subsidies) would generate $11.38 billion in new economic activity in Alabama between FY2020 and FY2023.

Table 5: Estimated Economic Impact of Federal Spending on Alabama Medicaid Expansion (in millions)

	FY2020	FY2021	FY2022	FY2023	Total FY2020-23
Direct	$1,623	$1,661	$1,712	$1,753	$6,749
Indirect	$1,114	$1,139	$1,173	$1,201	$4,628
Total Impact	$2,737	$2,800	$2,885	$2,954	$11,377

Budgetary Impact of Medicaid Expansion

Table 6 presents projections of the direct budgetary impact of a potential Medicaid expansion in Alabama over the period from FY2020 to FY2023. These figures do not include important cost-offsets to

the state associated with expansion that will be discussed further in Section 2. The state's investment of $1.00 billion in Medicaid expansion would generate $11.37 billion in increased economic activity between 2020 and 2023, and roughly $3B billion annually thereafter. The Federation of Tax Administrators (FTA) estimates Alabama's total tax burden at 8.5 percent of income with an overall state tax rate of 5.3 percent, and an average local tax rate of 3.2 percent[20]. The budgetary impact of expansion is estimated by applying these tax rates to the increase in economic activity. Conservatively, it is assumed that there is a one-year lag between new Medicaid spending associated with expansion and the resulting increases in tax revenues. As a result, the cost of expansion to the state is significantly higher in year 1 relative to all subsequent years.

Based upon the 5.3 percent state tax, the estimated increase in federal Medicaid spending would generate $446 million in new tax revenue, leading to a net cost to the state of $555 million from FY2020-FY2023. Expansion would also generate $269 million in local tax revenue meaning that over 70 percent of the cost of expansion would be offset by increased state and local tax revenues. The state's decision to forego expansion during the early years with the 100% federal match, the assumption of lagged tax revenue increases, and the updated analysis of marketplace enrollment that occurred in the absence of Medicaid expansion, explain the less favorable direct budgetary impact relative to the original 2012 study. However, the findings in Table 6 demonstrate that even at the long-term enhanced FMAP of 90%, the annual cost of Medicaid expansion would be almost completely offset by increases in state and local taxes, without accounting for the additional cost-savings associated with expansion which are addressed in the next section.

Table 6: Budgetary Impact of Medicaid Expansion (in millions)

	FY2020	FY2021	FY2022	FY2023	Total FY2020-2023
AL Cost of Expansion	($227)	($251)	($258)	($265)	($1,001)
New State Tax Revenue	---	$145	$148	$153	$446
State Budget Impact	**($227)**	**($106)**	**($110)**	**($112)**	**($555)**
New Local Tax Revenue	$0	$88	$90	$92	$269
Overall Budget Impact	**($227)**	**($18)**	**($20)**	**($19)**	**($285)**

SECTION 2: INCORPORATING OTHER COST SAVINGS

The previous section provides an incomplete picture of the net budgetary impact of Medicaid expansion in Alabama as the analysis considers only the new costs and tax revenues directly associated with Medicaid expansion, but not potential cost savings in the existing Alabama Medicaid program or other state funded health programs. Studies that have examined the actual experiences of expansion

states have shown significant additional cost savings during the early years of the expansion[6,21]. These cost savings have been generated by accessing the enhanced FMAP for previously covered groups and by using Medicaid funding to cover services for new enrollees had been financed entirely from state dollars, including mental health and substance abuse programs. Although the nature of these cost savings varies considerably across states based on pre-ACA Medicaid eligibility levels, state FMAP, and investments in other programs (e.g. mental health, uncompensated care pools), all states have experienced cost reductions with expansion.

In 2018, Manatt Health estimated the potential Medicaid and General Fund cost savings associated with Medicaid expansion[22]. Consistent with the experiences of expansion states, Manatt projected significant savings to the state of Alabama, both from accessing the enhanced FMAP for certain groups of existing Medicaid enrollees, and the use of expansion funding to finance services currently funded from state funds. The Manatt study provides estimates of cost-savings in multiple categories in FY2020 through FY2023. Together with the results from Section 1 of this report, these estimates allow for a more accurate assessment of the net impact of expansion on the state's finances after the phase-in of the long-run FMAP of 90%.

The Manatt report estimates that Medicaid expansion would save the state of Alabama between $58.9 and $87.6 million per year between FY2020 and FY2023. These savings come from two sources: 1) higher matching rates for existing Medicaid populations; and 2) the replacement of current state funding of health programs outside of Medicaid with Medicaid matched funding. The state's savings from the enhanced match rate would come primarily from pregnant women and disabled individuals who gain Medicaid coverage on the basis of income under expansion. They predict $11-$13 million in annual savings among pregnant women. Currently Alabama is responsible for approximately 28% of the health care costs of women who become eligible for Medicaid on the basis of a pregnancy. Expansion enrollees who become pregnant would remain covered at the enhanced match rate until coverage renewal, during which time the state would be responsible for just 10% of costs. Based on published work from other states, the Manatt estimates assume that 45% of pregnant women would shift from pregnancy-based eligibility to the expansion group. Second, the state would see reductions in costs associated with a decline in the proportion of low-income individuals who are covered on the basis of a disability determination. Based on mixed findings from published studies that examine the effect of eligibility expansions on disability determinations, Manatt projects relatively modest cost savings of $8-11 million annually. Other populations that would generate savings from the enhanced

match rate include low-include women who are currently covered on the basis of a breast or cervical cancer diagnosis and women receiving family planning services through the Plan First program.

The Manatt report also examines the potential impact of Medicaid expansion on other state funded services. The study predicts that expansion would yield $33.1 million in annual savings on mental health and substance abuse programs, $12.2 million in annual savings for inpatient hospital care for prisoners, and $16.5 in annual savings on public health programs. The estimates in the Manatt study appear reasonable and are generally in line with the reported experiences from other states[21].

Two potential areas of concern with these estimated cost-savings are the uncertainty regarding the eligibility status at renewal for pregnant expansion enrollees and the rate of decline in disability determinations in the long-run following Medicaid expansion. Table 7 presents the full budgetary impact of expansion between FY2020 and FY2023 with these additional savings in Medicaid and other state health programs included. The Manatt estimates allow for a gradual phase-in of the savings associated with existing categories of enrollees transitioning to the enhanced match rate. The assumptions of lagged tax revenue generation and phased-in cost savings create a less favorable budgetary impact in FY2020. Beginning in FY2021, the net cost to the state would be approximately $25 million per year after accounting for the tax revenues and cost savings that would be generated from Medicaid expansion. When local tax revenues are taken into account, expansion would provide net public budget savings of around $65-70 million per year.

Table 7: Complete Budget Impact of Medicaid Expansion, FY2020 to FY2023 (in millions)

	FY2020	FY2021	FY2022	FY2023	Total FY2020-2023
AL Cost of Expansion	($227)	($251)	($258)	($265)	($1,001)
New State Tax Revenue	$0	$145	$148	$153	$446
State Cost Savings	$59	$83	$87	$88	$316
Net State Budget Impact	**($168)**	**($23)**	**($23)**	**($24)**	**($239)**
New Local Tax Revenue	$0	$88	$90	$92	$270
Net Overall Budget Impact	**($168)**	**$64**	**$66**	**$68**	**$31**

SECTION 3: REGIONAL IMPACT ANALYSIS

In contrast to most economic development projects supported with state and local incentives, Medicaid expansion would provide benefits across all of Alabama's 67 counties. This section highlights the breadth of the impact of expansion on Medicaid enrollment, federal health care spending and economic activity across Alabama. The ability to estimate local impacts is limited by the geographic

data available in the ACS public use files. The smallest identifiable geographic area in the ACS is the Public Use Microdata Area (PUMA). The state of Alabama is divided into 34 PUMAs which vary in geographic size by population density. The major cities all have one or more PUMAs, while other PUMA regions are comprised by as many as seven counties. For the five largest metropolitan areas of the state (Birmingham, Huntsville, Mobile, Montgomery and Tuscaloosa), multiple PUMAs were grouped together for ease of interpretation.

The regional analysis follows the same approach as the state-level projections from section 1. First, the ACS data are used to identify the newly eligible population in each PUMA-based region. The expansion population in each region is then estimated using the same take-up assumptions as in the state-level analysis. Table 8 presents the estimated number of new Medicaid enrollees by region for FY2020-FY2023 In FY2020, the number of new expansion enrollees ranges from a high of 40,805 in the 3-county region near Huntsville (Limestone, Madison and Marshall) to a low of 4,825 Etowah County.

Table 8: Alabama Medicaid Expansion Enrollees by PUMA Region

PUMA Regions (Counties)	FY2020	FY2021	FY2022	FY2023
Limestone, Madison and Marshall (HUNTSVILLE)	40,805	41,093	41,267	41,192
Jefferson (BIRMINGHAM)	37,751	38,017	38,179	38,109
MOBILE	30,785	31,002	31,134	31,077
MONTGOMERY, Elmore, Autauga, Lowndes	27,687	27,883	28,001	27,950
TUSCALOOSA and Pickens	17,825	17,951	18,028	17,995
Houston, Dale, Geneva, and Henry	16,077	16,191	16,260	16,230
Russell, Pike, Barbour, Macon and Bullock	13,145	13,238	13,294	13,270
Lee	12,977	13,069	13,124	13,100
Clarke, Choctaw, Conecuh, Escambia, Monroe, Washington, Wilcox	12,262	12,349	12,402	12,379
Lauderdale, Colbert, Franklin and N. Marion	12,132	12,217	12,269	12,247
Shelby	11,587	11,668	11,718	11,697
Baldwin	11,577	11,659	11,709	11,687
Dallas, Bibb, Marengo, Hale, Sumter, Perry and Greene	11,077	11,156	11,203	11,182
Morgan and Lawrence	10,667	10,742	10,788	10,768
Dekalb and Jackson	10,177	10,249	10,292	10,274
Calhoun	9,241	9,306	9,346	9,329
Talladega, Cherokee, Randolph Cleburne, Clay	9,215	9,281	9,320	9,303
Walker, Fayette, Lamar and S. Marion	9,168	9,233	9,272	9,256
Cullman and Winston	9,055	9,119	9,158	9,141
St Clair and Blount	8,684	8,745	8,782	8,766
Chilton, Tallapoosa, Chambers and Coosa	8,666	8,727	8,764	8,748
Coffee, Covington, Butler and Crenshaw	8,308	8,367	8,402	8,387
Etowah County	4,825	4,859	4,880	4,871

Table 9 reports the new Federal spending related to Medicaid expansion by PUMA-based region in 2016 constant dollars. As before, this new spending is determined by the number of expansion enrollees who weren't previously covered through subsidized marketplace plans, per capita expenditures from MEPS, the administrative cost rate, and the enhanced FMAP. Since detailed information on patient flows are not available, it is assumed that all health spending occurs in the PUMA in which enrollees reside. As a result these estimates may understate the spending in the larger metro areas which provide regionalized health services. For example, in Jefferson County, Medicaid expansion would generate over $175 million in federally financed health care spending annually. Given the significant patient flows from more rural areas to UAB hospital, the economic impact would likely be larger in Jefferson County and lower in areas without hospitals and/or specialized medical services.

Table 9: New Federal Spending on AL Medicaid Expansion by PUMA Region (millions)

PUMA Regions (Counties)	FY2020	FY2021	FY2022	FY2023
Limestone, Madison and Marshall (HUNTSVILLE)	$194.3	$198.9	$204.9	$209.9
Jefferson (BIRMINGHAM)	$177.1	$181.2	$186.7	$191.2
MOBILE	$154.5	$158.2	$163.0	$167.0
MONTGOMERY, Elmore, Autauga, Lowndes	$140.1	$143.5	$147.9	$151.4
TUSCALOOSA and Pickens	$78.1	$79.9	$82.4	$84.4
Houston, Dale, Geneva, and Henry	$71.3	$72.8	$75.0	$76.9
Russell, Pike, Barbour, Macon and Bullock	$61.7	$63.2	$65.1	$66.6
Lee	$57.9	$59.2	$61.0	$62.5
Clarke, Choctaw, Conecuh, Escambia, Monroe, Washington, Wilcox	$56.7	$58.1	$59.9	$61.3
Lauderdale, Colbert, Franklin and N. Marion	$55.1	$56.3	$58.0	$59.4
Shelby	$53.4	$54.7	$56.3	$57.7
Baldwin	$49.3	$50.4	$51.9	$53.1
Dallas, Bibb, Marengo, Hale, Sumter, Perry and Greene	$48.7	$49.8	$51.3	$52.6
Morgan and Lawrence	$48.1	$49.1	$50.6	$51.9
Dekalb and Jackson	$47.6	$48.7	$50.2	$51.4
Calhoun	$45.3	$46.4	$47.8	$49.0
Talladega, Cherokee, Randolph Cleburne, Clay	$45.2	$46.3	$47.7	$48.9
Walker, Fayette, Lamar and S. Marion	$44.6	$45.7	$47.1	$48.2
Cullman and Winston	$43.5	$44.5	$45.9	$47.0
St Clair and Blount	$43.0	$44.0	$45.4	$46.5
Chilton, Tallapoosa, Chambers and Coosa	$41.0	$42.0	$43.3	$44.3
Coffee, Covington, Butler and Crenshaw	$40.5	$41.4	$42.7	$43.7
Etowah County	$26.0	$26.6	$27.4	$28.1

Table 10 shows the total economic impact of Medicaid expansion by PUMA region, which includes the direct health spending and the indirect economic activity generated by the new federal

health spending in Alabama. As with the state totals these estimates were generated using economic multipliers from the IMPLAN software that were applied uniformly to all new health care spending in the state of Alabama. The annual economic impact of Medicaid expansion ranges from $45-50 million in Etowah County to $325-350 million in the three county region (Limestone, Madison, Marshall) around Huntsville.

Table 10: Total Economic Impact of AL Medicaid Expansion by PUMA Region (millions)

PUMA Regions (Counties)	FY2020	FY2021	FY2022	FY2023
Limestone, Madison and Marshall (HUNTSVILLE)	$327.7	$335.3	$345.4	$353.7
Jefferson (BIRMINGHAM)	$298.6	$305.5	$314.7	$322.3
MOBILE	$260.5	$266.7	$274.8	$281.4
MONTGOMERY, Elmore, Autauga, Lowndes	$236.3	$241.9	$249.3	$255.2
TUSCALOOSA and Pickens	$131.7	$134.8	$138.8	$142.2
Houston, Dale, Geneva, and Henry	$120.2	$122.8	$126.5	$129.5
Russell, Pike, Barbour, Macon and Bullock	$104.0	$106.5	$109.7	$112.3
Lee	$97.7	$99.9	$102.9	$105.3
Clarke, Choctaw, Conecuh, Escambia, Monroe, Washington, Wilcox	$95.7	$98.0	$100.9	$103.3
Lauderdale, Colbert, Franklin and N. Marion	$92.8	$95.0	$97.8	$100.2
Shelby	$90.1	$92.2	$95.0	$97.3
Baldwin	$83.1	$84.9	$87.5	$89.6
Dallas, Bibb, Marengo, Hale, Sumter, Perry and Greene	$82.1	$84.0	$86.5	$88.6
Morgan and Lawrence	$81.2	$82.8	$85.3	$87.4
Dekalb and Jackson	$80.3	$82.1	$84.6	$86.6
Calhoun	$76.5	$78.3	$80.6	$82.6
Talladega, Cherokee, Randolph Cleburne, Clay	$76.3	$78.1	$80.4	$82.4
Walker, Fayette, Lamar and S. Marion	$75.2	$77.0	$79.3	$81.2
Cullman and Winston	$73.3	$75.0	$77.3	$79.2
St Clair and Blount	$72.5	$74.3	$76.5	$78.3
Chilton, Tallapoosa, Chambers and Coosa	$69.1	$70.8	$72.9	$74.7
Coffee, Covington, Butler and Crenshaw	$68.2	$69.8	$71.9	$73.7
Etowah County	$43.8	$44.9	$46.2	$47.4

SECTION 4: OTHER CONSIDERATIONS

The evidence presented in the previous sections focuses exclusively on the narrow short-term economic impact of Medicaid expansion and thus is necessarily incomplete. The state and federal funds that support Medicaid expansion should be viewed as an investment in health and human capital, and there is now broad evidence from other states showing significant returns on investments in expanded health insurance under the ACA. Alongside these additional benefits associated with Medicaid expansion there also may be additional cost-savings beyond the short-term effects identified by the

Manatt report and summarized in section 2. Finally, an analysis of the Medicaid expansion decision cannot ignore potential changes to the status quo with looming cuts to the Medicaid Disproportionate Share (DSH) Program. The rest of this section summarizes each of these issues to provide a more complete picture of the expansion decision in Alabama.

Other Potential Benefits of Expansion

This report does not attempt to place a formal value on the health benefits that would accrue to the 220,000 Alabamians who would gain insurance coverage under Medicaid expansion. However, the ACA has led to a flurry of new research which has found significant health benefits associated with Medicaid expansion and other gains in coverage. Research has shown improvements in self-reported health[23], reductions in depression symptoms[24], and reductions in adult[25] and infant mortality[26]. Other studies have found improvements in important quality and access metrics including increased screening and detection of early stage cancers[27], and increased identification and treatment of substance abuse disorder[28]. Medicaid expansion has also been associated with declining crime rates[29,30], with some research attributing this to improved access to substance abuse treatment[24,30] and mental health services. This suggests that the benefits of improved health associated with expansion are not limited to the newly insured.

Beyond these health benefits, research has also shown that Medicaid expansion is associated with significant improvements in financial well-being. A study examining the impact of early Medicaid expansion in certain California counties under an 1115 waiver found significant reductions in payday lending relative to similar counties in states that did not expand early[31]. Other work using credit bureau data and has found that Medicaid expansion is associated with improved credit scores, reductions in medical balances past due and collection balances, and reductions in bankruptcy filings[32]. These findings are consistent with earlier research showing reductions in medical debt associated with insurance expansions[33]. Medicaid expansion has also been shown to decrease non-medical debt to third party collection agencies[34]. Improvements in credit scores in expansion states have also been associated with better access to credit and lower costs of borrowing[35].

Additional Cost Savings from Expansion

The 2018 Manatt report estimates the annual cost-savings from Medicaid expansion in Alabama at $59-$88 million per year through FY2023. The most uncertain parts of this estimate are the cost

reductions from the transitioning of current enrollees (pregnant women and the disabled) to the enhanced FMAP under expansion. Based on empirical estimates of fairly modest reductions in SSI beneficiaries immediately following Medicaid expansion[36,37], Manatt used fairly conservative assumptions in estimating the cost savings for disabled enrollees. Although this is reasonable for the stock of current disabled enrollees, it is likely that the cost savings would rise over time, as the expansion of coverage to childless adults should reduce the flow of Medicaid disability determinations into the future. A second potential source of savings would arise from the relaxing of work disincentives that exist under the current Alabama Medicaid program. Parents and other care givers are currently eligible for Medicaid coverage only up to 16% of FPL. Medicaid expansion would eliminate the incentives to maintain incomes below the low eligibility threshold[38], and would provide the state with the enhanced FMAP as these parents/guardians transition to expansion coverage.

DSH Reductions and Access to Care

The ACA initially called for an $18B cut in Medicaid DSH funding between 2014 and 2020. These reductions were motivated by the expected drop in the uninsured population arising from Medicaid expansion and other coverage expansion provisions of the ACA. The DSH cuts were delayed until 2018 under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Under MACRA, Medicaid DSH payments were to be reduced by $43B between 2018 and 2025. The cuts were delayed yet again to FY2020 as part of the February 2018 budget bill that extended CHIP funding. Under current law, DSH payments are now scheduled to be reduced by $4 billion in 2020 and $8 billion annually between FY2021 and FY2025[39]. These cuts are slated to occur regardless of whether states have expanded Medicaid, and pose a significant financial threat to hospitals receiving DSH funding in Alabama and other non-expansion states. Although the CMS formula imposes smaller cuts on states with higher uninsured rates (non-expansion states), it penalize states that do not target their DSH payments to hospitals with high Medicaid volume.

Table 11 shows the projected reductions in the Federal Medicaid DSH allotments in Alabama through FY2025. The estimate for FY2020 comes from a 2018 Medicaid and CHIP Payment and Access Commission (MACPAC) report that projected state-level cuts based on the DSH Health Reform Reduction Methodology (DHRM)[40]. The $111.9 million in cuts in FY2020 corresponds to 30.9% of Alabama's baseline Federal FY2020 DSH allotment or 2.80% of the mandated $4 billion reduction in DSH payments nationally[40]. Estimated reductions for 2021 through 2025 assume that Alabama's share of

the mandated cuts would remain at 2.80%. The projected cuts of over $1.23 billion over this six year period will place additional financial pressure on Alabama hospitals and health care providers and threaten access to care for the populations that they serve.

Table 11: Projected Reductions in Federal Medicaid DSH Allotments (in millions)

	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
Change in DSH	($111.9)	($223.8)	($223.8)	($223.8)	($223.8)	($223.8)

CONCLUSIONS

This report gives an updated and more thorough assessment of the potential effects of an expansion of Alabama's Medicaid program under the Affordable Care Act. The study provides estimates of the number of new expansion enrollees, the costs of the coverage expansion to state and federal governments, the impact of the expansion on the Alabama economy and the budgetary impact on the state during period from FY2020 to FY2023. It is estimated that Medicaid expansion would reduce the state's uninsured population by approximately 223,000 individuals while generating nearly $3 billion in new economic activity annually. At the long-run enhanced FMAP of 90%, the costs of expansion to the state would be almost entirely offset by new tax revenues generated by expansion and reductions in existing state spending on current Medicaid enrollees and other health care programs. When the substantial tax benefits to local governments are included, expansion would provide a significant net benefit to the taxpayers of Alabama. Despite having missed out on the early years with extremely generous federal support, this study demonstrates that the economic case for Medicaid expansion in Alabama remains strong.

With Medicaid expansion, the uninsured rate in Alabama would decline from 12% in 2016 to under 8% according to projections from the Urban Institute[41]. Without expansion the uninsured rate would remain well above the national average. Adults with incomes below 100% of the FPL would remain caught in the coverage gap, with incomes too high to qualify for Medicaid and too low to qualify for subsidies for Marketplace coverage. In the absence of coverage, research suggests these individuals are likely to suffer both in terms of their health and financial well-being. Without expansion the state's hospitals will also face intense challenges from scheduled cuts in Federal DSH payments that provide funds to support the provision of indigent care. The pre-ACA "status quo" quite simply does not exist, and without expansion the state will face an exceptionally difficult road going forward.

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Data/Methodology Appendix

A. Enrollment Projections

The estimates of the number of new Medicaid enrollees in Table 2 are constructed using the 1-year American Community Survey (ACS) files for 2014 to 2016 from the Integrated Public Use Microdata Series (IPUMS) project at the University of Minnesota. The IPUMS data are used to estimate the size of the newly eligible population (adults 19-64, <138% FPL, resident of US at least 5 years) and to characterize their current distribution of health insurance coverage. As part of the IPUMS project, researchers at the State Health Access Data Assistance Center (SHADAC) added a "health insurance unit" (HIU) identifier to the ACS data which captures distinct family units within the household that are more likely to be the basis for public or private insurance coverage eligibility than the general census definition. Consistent with research done by SHADAC[9], Appendix Table 1 shows that HIU level income leads to higher estimates of the newly eligible population than the census family income. The newly eligible population declined between 2014 and 2016, due to continued improvement in the Alabama economy.

Appendix Table 1: Potential Alabama Medicaid Expansion Population, SHADAC Health Insurance Unit (2014-16)

	Year		
	2014	2015	2016
Newly Eligible Population			
Number of Individuals, N	1,078,919	1,079,537	1,025,488
Annual Growth Rate, %	-	0.1%	-5.0%
Insurance Status			
Uninsured Currently (SE)	374,856	336,960	294,251
	(9,550)	(8,271)	(8,260)
Private Group (SE)	293,325	301,373	292,734
	(7,538)	(7,555)	(7,074)
Private Non-Group (SE)	85,627	88,922	98,785
	(4,068)	(4,028)	(3,993)
Public/Other (SE)	325,111	352,282	339,718
	(6,990)	(9,250)	(7,434)

Source: Integrated Public Use Microdata Series (IPUMS). IPUMS-USA, University of Minnesota, www.ipums.org. Estimates are based on the population of 19-64 year olds with family incomes below 138% of the Federal Poverty Level, who have resided in the United States for at least 5 years. Standard errors reported in parentheses.

The data on non-group coverage from the ACS, together with Marketplace enrollment data from CMS[10-12] suggest that non-group insurance coverage has leveled off following the significant gains between 2012 and 2016. From the ACS it is not possible to differentiate between subsidized non-group coverage obtained through the marketplace and other non-group coverage. To address the first issue, CMS published data on Marketplace plan selections by income (for 2017 and 2018) are used to motivate the assumption that 75% of non-group enrollees are in subsidized Marketplace plans. Using this approach it is estimated that there were approximately 70,000 Marketplace enrollees in 2018 that would be eligible for Medicaid expansion, which is in-line with published data on marketplace enrollment in Alabama. As discussed in the main body of the report, it is assumed that 85% of non-group enrollees -- including subsidized Marketplace enrollees -- would switch to Medicaid coverage. This assumes that some fraction of subsidy eligible individuals will retain private insurance coverage.

With this 2018 baseline data in place, there are two additional issues that must be addressed to project the Medicaid expansion population into the future: 1) Trends in the working-age population; and 2) The impact of economic recovery on the % eligible for the Medicaid expansion. The Interim State Population Projections from the US Census Bureau are used to project trends in the 19-64 year old population in Alabama through 2023[42]. The working age population in Alabama is projected to decline slightly from 2.83 million in 2018 to 2.79 million individuals in 2023. Based on work by Cawley et al. (2015), it is assumed that a 1% increase in the unemployment rate will lead to a 0.57 percent increase in the share of 19-64 year olds who are eligible for the Medicaid expansion[43]. National unemployment rate projections from the Congressional Budget Office (2016) are used to

estimate the fraction of the working age population in Alabama who will be eligible for the Medicaid expansion in FY2020-FY2023[44].

Based on the above methodology the newly eligible population is projected through FY2023. As a simplification, it is assumed that the distribution of health insurance coverage among the newly eligible population observed in 2016 remains constant over time (Uninsured = 28.7%, Private Group = 28.5%, Marketplace Non-Group = 7.2%, Other Non-Group = 2.4%, Other = 33.1%) After projecting the eligible population through FY2023, Medicaid expansion enrollment is estimated using the take up assumptions derived from the Urban Institute's Health Insurance Policy Simulation Model.

B. Administrative Costs of Medicaid Expansion

The federal match for administrative costs does not vary by state and is set at 50/50 for most functions. However, for some activities including IT investments and family planning the federal government pays 75 percent or more. According to an Alabama Medicaid report from FY2015, total administrative costs were $257 million or 4.4% of total benefit costs. Overall the state paid 35% ($90.5 million) of total administrative costs in FY2015[17].

This report assumes that the state's administrative costs would the same 1.54% (0.044*0.35) of total benefit costs as under the current program. This approach is conservative and likely overstates the administrative cost burden of expansion since it is based on the average cost of administration rather than a more careful examination of the marginal administrative costs of expansion.

C. Per Capita Expenditures

The estimates of the per capita expenditures of newly eligible Medicaid beneficiaries in Table 2 are derived from the 2014-2016 Medical Expenditure Panel Survey (MEPS) data. The primary assumption in projecting expenditures and total program costs is that expansion Medicaid enrollees will have expenditures similar to those of low-income privately insured individuals. Appendix Table 2 shows the annual MEPS expenditure data by insurance status for 2014 to 2016. Owing to the imprecision of the 1-year MEPS estimates the pooled 2014-2016 mean is used as the baseline per capita expenditure for the Medicaid expansion population. The baseline per capita estimates are further inflated by 10% to account for the underreporting of expenditures in the MEPS data[10]. Appendix Table 2 demonstrates the inappropriateness of using the per capita expenditures of the uninsured or the

Appendix Table 2: Per Capita Total Health Expenditures, Expansion Population in South Census Region (2014-16)

Population	Mean Expenditure[1] (95% CI)		
	2014	2015	2016
Full-year Uninsured	$1,328	$1,196	$2,345
	(890,1767)	(792,1599)	(1019,3672)
Ever privately insured in year	$5,563	$5,124	$4,472
	(2314,8812)	(1439,8809)	(2807,6138)
Ever publicly insured in year	$8,499	$7,439	$7,249
	(6684,10315)	(6118,8759)	(6020,8479)
Overall	$4,889	$4,719	$4,906
	(4314,5465)	(4039,5398)	(6974,5838)

Notes: 1) Converted to 2016 dollars using CPI index (all items)

publicly insured population to estimate the cost of the expansion enrollees. Given the limited generosity of adult Medicaid coverage in the South, a large percentage of publicly insured 19-64 year olds are disabled, thus the average expenditures of publicly insured working age adults are much higher than adults with private coverage. With Medicaid coverage, the expenditures among the currently uninsured should become reasonably similar to those of the privately insured population. These expenditures are projected forward through FY2023 based upon the assumption of 2.6% annual growth in real per capita health expenditures.

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Alabama Medicaid Expansion

Summary of Estimated Costs and Savings, SFYs 2020 – 2023

Alabama Hospital Association

February 2019

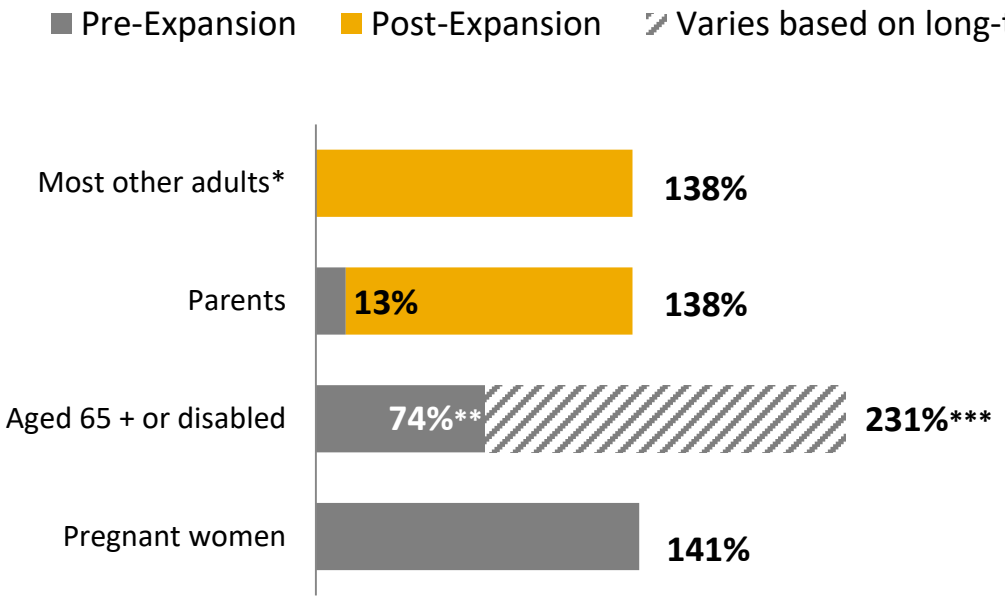
Agenda

- **Background and Overview of Alabama Medicaid Expansion Estimates**
- **Estimated Enrollment and Costs**
- **Estimated State Savings**
- **Impact of Expansion Beyond the State Budget**
  - Corrections and Recidivism
  - Opioid and Other Substance Use Disorders
  - Rural Health Care

Background and Overview of Estimates

Alabama Medicaid Expansion Would Provide Coverage for Parents and Other Low-Income Adults Up to 138% FPL

Alabama Adult Eligibility Levels (% of FPL)



2018 Annual Income Corresponding with Selected Alabama Eligibility Limits, by Family Size				
FPL	1	2	3	4
13%	$1,578	$2,140	$2,701	$3,263
74%	$8,984	$12,180	$15,377	$18,574
138%	$16,753	$22,715	$28,676	$34,638
141%	$17,117	$23,209	$29,300	$35,391

** Additional adults covered pre-expansion include those in need of family planning services (141% FPL); and women with breast/cervical cancer (200% FPL)*

*** SSI (Supplemental Security Income) level for aged, blind or disabled*

**** HCBS waiver eligibility level, eligibility for specific waivers depends on long-term care and disability status*

Alabama Medicaid Expansion Impact on State Budget

- State costs
  - Coverage for expansion group
  - Coverage for currently eligible but not enrolled individuals
  - Administrative activities

Federal Funding for Newly Eligible Adults by Calendar Year (CY)	
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

- State savings
  - Higher federal matching rate for some existing Medicaid populations now eligible to enroll under expansion group
  - Access to new federal Medicaid dollars that replace State-only spending on certain other health care programs and services for low-income adults

Alabama Medicaid Expansion Is a Unique Opportunity to Invest in the Health Care System

In the first year of expansion:

- **Alabama would receive almost $2 billion in new federal Medicaid funds, which in turn would result in more economic activity, higher state and local tax revenues, and lower uncompensated care costs**
- **More than 326,000 would gain coverage**
- **More than $58 million in current State spending could be replaced with federal funds**
- **State costs would be between $126 and $158 million, after accounting for State savings from expansion**

And coverage, state budget savings and economic gains from expansion would all increase over time.

The State savings and other economic gains from expansion could be reinvested in the health care system in Alabama, including to support expansion and other State priorities.

Summary of Alabama Medicaid Expansion Estimated New Federal Funds and State Costs, SFYs 2020-2023

	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Number of new enrollees				
Lower Estimate	326,700	337,300	345,900	353,400
Upper Estimate	387,000	398,200	407,400	415,500
New federal Medicaid spending in Alabama				
Lower Estimate	$ 1,715,800,000	$ 1,813,000,000	$ 1,920,100,000	$ 2,027,100,000
Upper Estimate	$ 2,013,400,000	$ 2,121,400,000	$ 2,242,400,000	$ 2,364,000,000
New State Medicaid spending in Alabama, prior to savings offsets				
Lower Estimate	$185,500,000	$212,100,000	$224,200,000	$236,400,000
Upper Estimate	$216,600,000	$247,200,000	$260,900,000	$274,700,000
State savings from expansion				
Savings from Medicaid and non-Medicaid programs	**($58,900,000)**	**($82,500,000)**	**($86,800,000)**	**($87,600,000)**
Remaining State costs if savings are re-invested in expansion				
Lower Estimate	**$126,600,000**	**$129,500,000**	**$137,400,000**	**$148,700,000**
Upper Estimate	**$157,700,000**	**$164,600,000**	**$174,100,000**	**$187,100,000**

Figures above do not include higher state and local tax revenues from increased economic activity and lower uncompensated care costs for providers.

Note: Figures in tables may not sum to totals due to rounding

Detailed Summary of Alabama Medicaid Expansion Estimated Costs and Savings, Lower Estimate, SFYs 2020-2023

LOWER ESTIMATE	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Number of new enrollees	**326,700**	**337,300**	**345,900**	**353,400**
Newly eligible	322,100	332,700	341,200	348,700
Currently eligible but not enrolled	4,600	4,600	4,700	4,700
Total costs by funding source	**$1,901,300,000**	**$2,025,000,000**	**$2,144,300,000**	**$2,263,400,000**
Federal	$1,715,800,000	$1,813,000,000	$1,920,100,000	$2,027,100,000
State	$185,500,000	$212,100,000	$224,200,000	$236,400,000
Total costs by category	**$1,901,300,000**	**$2,025,000,000**	**$2,144,300,000**	**$2,263,400,000**
Newly eligible	$1,867,000,000	$1,989,900,000	$2,108,300,000	$2,226,500,000
Woodwork	$11,400,000	$11,900,000	$12,500,000	$13,100,000
Administrative	$22,900,000	$23,200,000	$23,500,000	$23,900,000
State savings	**($58,900,000)**	**($82,500,000)**	**($86,800,000)**	**($87,600,000)**
Existing Medicaid populations	($15,300,000)	($20,800,000)	($25,100,000)	($25,900,000)
Pregnant women	($6,000,000)	($11,400,000)	($12,600,000)	($13,000,000)
SSI Blind or disabled, excluding aged	($8,200,000)	($8,100,000)	($11,100,000)	($11,500,000)
Non-dual HCBS waiver enrollees	($600,000)	($600,000)	($600,000)	($600,000)
Breast and cervical cancer	($500,000)	($800,000)	($800,000)	($800,000)
Family planning	($100,000)	-	-	-
Non-Medicaid programs	($43,600,000)	($61,800,000)	($61,800,000)	($61,800,000)
Corrections	($10,200,000)	($12,200,000)	($12,200,000)	($12,200,000)
Mental health and substance abuse	($22,300,000)	($33,100,000)	($33,100,000)	($33,100,000)
Public health	($11,100,000)	($16,500,000)	($16,500,000)	($16,500,000)
Net change in State costs	**$ 126,600,000**	**$ 129,500,000**	**$ 137,400,000**	**$ 148,700,000**

Note: Figures in tables may not sum to totals due to rounding

Detailed Summary of Alabama Medicaid Expansion Estimated Costs and Savings, Upper Estimate, SFYs 2020-2023

UPPER ESTIMATE	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Number of new enrollees	**387,000**	**398,200**	**407,400**	**415,500**
Newly eligible	380,900	392,000	401,200	409,300
Currently eligible but not enrolled	6,100	6,200	6,200	6,300
Total costs by funding source	**$2,230,100,000**	**$2,368,600,000**	**$2,503,300,000**	**$2,638,700,000**
Federal	$2,013,400,000	$2,121,400,000	$2,242,400,000	$2,364,000,000
State	$216,600,000	$247,200,000	$260,900,000	$274,700,000
Total costs by category	**$2,230,100,000**	**$2,368,600,000**	**$2,503,300,000**	**$2,638,700,000**
Newly eligible	$2,192,000,000	$2,329,500,000	$2,463,100,000	$2,597,400,000
Woodwork	$15,200,000	$15,900,000	$16,700,000	$17,400,000
Administrative	$22,900,000	$23,200,000	$23,500,000	$23,900,000
State savings	**($58,900,000)**	**($82,500,000)**	**($86,800,000)**	**($87,600,000)**
Existing Medicaid populations	($15,300,000)	($20,800,000)	($25,100,000)	($25,900,000)
Pregnant women	($6,000,000)	($11,400,000)	($12,600,000)	($13,000,000)
SSI Blind or disabled, excluding aged	($8,200,000)	($8,100,000)	($11,100,000)	($11,500,000)
Non-dual HCBS waiver enrollees	($600,000)	($600,000)	($600,000)	($600,000)
Breast and cervical cancer	($500,000)	($800,000)	($800,000)	($800,000)
Family planning	($100,000)	-	-	-
Non-Medicaid programs	($43,600,000)	($61,800,000)	($61,800,000)	($61,800,000)
Corrections	($10,200,000)	($12,200,000)	($12,200,000)	($12,200,000)
Mental health and substance abuse	($22,300,000)	($33,100,000)	($33,100,000)	($33,100,000)
Public health	($11,100,000)	($16,500,000)	($16,500,000)	($16,500,000)
Net change in State costs	**$ 157,700,000**	**$ 164,600,000**	**$ 174,100,000**	**$ 187,100,000**

Note: Figures in tables may not sum to totals due to rounding

Estimated Enrollment and Costs

Key Assumptions Regarding Enrollment and Costs

- Approximately 580,000 adults with incomes up to 138% FPL estimated as potentially eligible for Alabama Medicaid expansion coverage in SFY 2020
- When full enrollment is realized, Alabama expansion group enrollment is approximately 60% - 70% of all potentially eligible adults
- Full enrollment in coverage is not realized until state fiscal year (SFY) 2023
- PMPY costs applied for a given SFY reflect a blend of CY values provided by Optumas and Alabama Medicaid, and are based on current spending on adult populations and experience in other expansion states
- Federal matching rates applied for a given SFY are a blend of CY and federal fiscal year (FFY) values
  - Regular federal matching rate for most Alabama Medicaid populations and services is approximately 72% in FFY 2018
  - Enhanced rate for newly eligible adults is 90% in CY 2020+
  - Administrative costs are matched at 75% (for certain eligibility and data systems changes) or 50% (other)

All assumptions are from Optumas, as provided to AlaHA by Alabama Medicaid; Manatt blended CY PMPY costs of new expansion enrollees and administrative costs to translate them into SFY values.

Additional Information on Enrollment and Costs

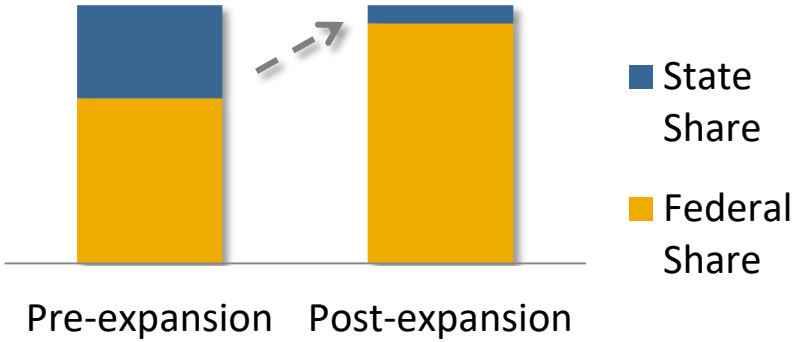
- Coverage for most adults without dependent children ("childless adults") in the expansion group is at the enhanced federal matching rate
  - As described later, some of these individuals (e.g., certain pregnant women and people with disabilities) previously would have been covered at the regular federal matching rate and will generate savings to the State by shifting to the expansion group that receives an enhanced rate
- Parents with incomes above the current Medicaid eligibility level will be covered at the enhanced federal matching rate
- Coverage for currently eligible but not enrolled individuals is at the regular federal matching rate*, with enrollment estimates provided by Optumas

* Under federal law, this population does not qualify for the enhanced expansion match.

Estimated Savings

Mechanisms for State Budget Savings

1 Higher federal matching rate for some existing Alabama Medicaid populations



2 Access to new federal dollars that replace State-only spending for certain other health care services and programs

In SFY 2023, Medicaid expansion will generate State savings of $25.9 million, as the State accesses enhanced federal match for some existing enrollees

Pregnant women: $13.0 million

SSI blind or disabled: $11.5 million

HCBS waiver enrollees: $0.6 million

Breast & cervical cancer: $0.8 million

Family planning: $0.1 million in SFY 2020 only

Savings Related to Pregnant Woman Group

Women enrolled in the expansion group who become pregnant would remain in that group until renewal. Alabama would receive enhanced federal match for these individuals until that time.

Potential Savings in Alabama

- An estimated 15,553 women with incomes up to 138% FPL were enrolled in Alabama through a pregnancy-related eligibility pathway in SFY 2017
- Using the midpoint of other states' percentage reductions in enrollment as a guide, an estimated 45% of these women shift from the pregnancy group to the expansion group by SFY 2023
- Expansion group coverage for these women draws a higher federal match, thereby generating annual State savings estimated at $13 million by SFY 2023

SFY	Estimated Current Spending, 0-138% FPL		Estimated State Savings Under Expansion
	Total	State	
2020	$145,100,000	$40,800,000	**($6,000,000)**
2021	$149,700,000	$42,100,000	**($11,400,000)**
2022	$154,400,000	$43,400,000	**($12,600,000)**
2023	$159,300,000	$44,800,000	**($13,000,000)**

Note: Figures in tables may not sum to totals due to rounding

Savings Related to SSI Disabled Enrollees

Alabama covers individuals with a disability determination whose income is below the Supplemental Security Income level (approximately 74% FPL). Under expansion, disabled individuals may choose to enroll in the new adult group, rather than pursuing a disability determination, and the State can receive the higher federal matching rate for these enrollees.

Potential Savings in Alabama

- 107,652 individuals with incomes up to 74% FPL were enrolled in Alabama through the SSI disabled eligibility pathway and were not dually eligible for Medicare* in FFY 2017
- Using the midpoint of available studies on the effects of Medicaid expansion on disabled group enrollment, an estimated 4% could instead enroll through the expansion group by SFY 2023
- Expansion group coverage for these individuals draws a higher federal match, thereby generating annual State savings estimated at $11.5 million by SFY 2023

SFY	Estimated Current Spending, 0-138% FPL		Estimated State Savings Under Expansion
	Total	State	
2020	$1,439,800,000	$404,900,000	**($8,200,000)**
2021	$1,485,200,000	$417,600,000	**($8,100,000)**
2022	$1,532,000,000	$430,800,000	**($11,100,000)**
2023	$1,580,300,000	$444,400,000	**($11,500,000)**

Note: Figures in tables may not sum to totals due to rounding
** Dually eligible individuals are not eligible for Medicaid expansion coverage*

Savings Related to HCBS Waiver Enrollees

Alabama covers individuals with certain disability or long-term-care status up to 231% FPL under HCBS waivers. Under expansion, some of these individuals would no longer require a disability determination to enroll and the State can receive the higher federal matching rate for these enrollees.

Potential Savings in Alabama

- An estimated 1,071 individuals with incomes between the SSI level (74% FPL) and 138% FPL who could potentially qualify under the expansion group were enrolled in Alabama through the HCBS waiver eligibility pathway in FFY 2017
- Using data on enrollment churn for this population, an estimated 8% are new enrollees each year who could instead enroll through the expansion group; it is assumed that 4% will take up this option
- Expansion group coverage for these individuals draws a higher federal match, thereby generating annual State savings estimated at $600,000 by SFY 2023

SFY	Estimated Current Spending, 74-138% FPL		Estimated State Savings Under Expansion
	Total	State	
2020	$73,700,000	$20,700,000	**($600,000)**
2021	$76,000,000	$21,400,000	**($600,000)**
2022	$78,400,000	$22,100,000	**($600,000)**
2023	$80,900,000	$22,700,000	**($600,000)**

Note: Figures in tables may not sum to totals due to rounding

Savings Related to Breast & Cervical Cancer Group

Alabama covers certain adults with breast or cervical cancer discovered through a screening program. With expansion, many of these individuals would receive screenings while enrolled in the new adult group, where their services receive a higher federal matching rate.

Potential Savings in Alabama

- An estimated 635 women with incomes up to 138% FPL were enrolled in AL Medicaid through the breast/cervical cancer eligibility pathway in SFY 2017
- Using the midpoint of other states' percentage reductions in enrollment as a guide, an estimated 35% of women in this group would shift to the expansion group each year
- Expansion group coverage for these women draws a higher federal match, thereby generating annual State savings estimated at $800,000 in SFY 2023

SFY	Estimated Current Spending, 0-138% FPL		Estimated State Savings Under Expansion
	Total	State	
2020	$22,100,000	$4,400,000	**($500,000)**
2021	$22,800,000	$4,500,000	**($800,000)**
2022	$23,600,000	$4,600,000	**($800,000)**
2023	$24,300,000	$4,800,000	**($800,000)**

Note: Figures in tables may not sum to totals due to rounding

Savings Related to Family Planning Group

Alabama's Family Planning Program – Plan First – provides coverage for family planning and family planning related services (including preventive care) for women with incomes below 141% FPL. With expansion, many of these individuals would qualify for the new adult group, and the State would receive a higher match for the costs of services.

Potential Savings in Alabama

- An estimated 78,373 women with incomes up to 138% FPL were enrolled in Plan First in SFY 2017
- An estimated 50% of these women would shift from Plan First to the expansion group on average each year
- Expansion group coverage for these individuals draws a higher federal match for the first quarter of SFY 2020 thereby generating annual State savings estimated at $100,000 in SFY 2020

SFY	Estimated Current Spending, 0-138% FPL		Estimated State Savings Under Expansion
	Total	State	
2020	$28,400,000	$2,800,000	**($100,000)**
2021	$29,300,000	$2,900,000	--
2022	$30,200,000	$3,000,000	--
2023	$31,200,000	$3,100,000	--

Note: Figures in tables may not sum to totals due to rounding

In SFY 2023, Medicaid expansion will generate State savings of $61.8 million, as the State accesses federal match for some state-funded services

Inpatient hospital care for prisoners: $12.2 million

Mental health and substance use programs: $33.1 million

Public health programs: $16.5 million

Expansion would allow Alabama to replace State spending with federal spending, and leverage millions in new increased federal revenues in these areas – freeing up funds for reinvestment in the health care system in Alabama.

Savings Related to State-Only Costs of Inpatient Hospital Care for Prisoners

Federal funding for Medicaid coverage of inmates is prohibited by federal law, with the exception of inpatient hospital care. Under expansion, the vast majority of inmates with inpatient hospitalizations will qualify for AL Medicaid coverage of those costs.

Potential Savings in Alabama

- Alabama spends an estimated $15 million in State general funds on inmate hospitalizations each year
- Under expansion, it is assumed that 75% of this spending in the first year and 90% thereafter will be under AL Medicaid
- Alabama expansion coverage draws a federal match, thereby generating annual State savings estimated at $12.2 million in SFY 2023

Note: Realizing these potential savings would require administrative changes, including to the State's current contract for prisoner health care.

SFY	Estimated State Savings Under Expansion
2020	($10,200,000)
2021	($12,200,000)
2022	($12,200,000)
2023	($12,200,000)

Note: Figures in tables may not sum to totals due to rounding

Savings Related to State Spending on Mental Health and Substance Use Disorders

Alabama currently operates community-based programs for the mentally ill and a substance abuse program for those not eligible for Medicaid. State-only funding of these programs can be reduced with expansion, while overall service funding still grows as previously uninsured individuals become eligible for Medicaid under the expansion group.

Potential Savings in Alabama

- In SFY 2017, Alabama spent an estimated $49 million in State general funds on non-Medicaid mental health and substance abuse services for adults
- Given maintenance of effort requirements for federal mental health and substance use disorder grants, and the makeup of these programs, it is assumed that this spending would be reduced by 50% in the first year of expansion, and 75% thereafter
- Alabama expansion coverage draws a federal match, generating annual State savings estimated at $33.1 million by SFY 2023

Savings from expansion could be reinvested in the mental health system to combat Alabama's growing challenges related to mental illness and substance abuse

SFY	Estimated State Savings Under Expansion
2020	($22,300,000)
2021	($33,100,000)
2022	($33,100,000)
2023	($33,100,000)

Note: Figures in tables may not sum to totals due to rounding

Savings Related to State Spending on Public Health

Alabama currently operates a disease prevention and control program focused on those with HIV/AIDS, STDs, and TB. State-only funding of these services can be reduced with expansion, while overall service funding still grows as previously uninsured individuals become eligible for Medicaid under the expansion group.

Potential Savings in Alabama

- In SFY 2018, Alabama spent an estimated $24.4 million in State general funds on non-Medicaid public health services for adults
- Given the makeup of these programs, it is assumed that this spending would be reduced by 50% in the first year of expansion, and 75% thereafter
- Alabama expansion coverage draws a federal match, thereby generating annual State savings estimated at $16.5 million by SFY 2023

Savings from expansion could be reinvested in additional public health priorities and programs, for which underfunding has been an issue in Alabama and nationwide

SFY	Estimated State Savings Under Expansion
2020	($11,100,000)
2021	($16,500,000)
2022	($16,500,000)
2023	($16,500,000)

Note: Figures in tables may not sum to totals due to rounding

Impact of Expansion Beyond the State Budget

manatt

Corrections and Recidivism*

Expansion provides new opportunities to connect prisoners to health care following release, reducing recidivism

- Prisoners have high rates of mental health problems (56% of State prisoners), substance use addiction (67% of prisoners), and communicable and chronic diseases
- With expansion, most prisoners are Medicaid eligible upon release and can be connected to coverage and care, including for treatment of behavioral health conditions
- Linking prisoners to coverage prior to or upon release improves access to needed care and reduces recidivism

New York and Colorado have estimated that 80 and 90% of their prison populations, respectively, were eligible for Medicaid.

In Ohio, Governor Kasich noted a 10% recidivism rate among prisoners who received addiction treatment after Medicaid expansion.

In Washington, a study done prior to expansion showed enrollment of prisoners in Medicaid resulted in 16% fewer detentions in the year after release.

*Citations follow on slide 28

Opioid and other Substance Use Disorders*

Expansion state residents have greater access to treatment for substance use dependency, and better treatment outcomes

- Adults in the expansion population have the highest rate of opioid use disorders among all Americans, and expansion dramatically increases insurance coverage for those with opioid use and other substance use disorders, providing a funding stream for and access to SUD treatment
- Expansion increases access to physical and behavioral treatment for substance use disorders (SUD). For example, adults with opioid addiction and Medicaid coverage are more than twice as likely as those with private insurance or no insurance to have received treatment.

Since Kentucky expanded its Medicaid program in 2014, Medicaid services for SUD increased by 700%.

From 2013-2015, there was a 79% decrease in opioid-related hospitalizations for uninsured patients in expansion states.

Expansion increased prescriptions for Medication Assisted Treatment methods for opioid addiction by more than 200% nationwide

*Citations follow on slide 28

Rural Health Care*

Expansion improves health coverage in rural areas, and has a positive impact on rural hospitals

- Rural hospitals in non-expansion states are more likely to close than those in expansion states. In 2015 to 2016, hospital closures were 84% less likely in expansion states as compared to states that did not expand Medicaid.
- In expansion states, hospital financial performance is more stable than in non-expansion states, particularly in rural markets.
- Expansion reduces rates of uninsurance statewide; however, small towns and rural areas have seen the sharpest declines.

Since 2011 six rural hospitals have closed in Alabama. By contrast, no rural hospitals closed in Arkansas (an expansion State).

In Montana's first year of Medicaid expansion, hospital uncompensated care costs were almost 45% lower than the prior year.

Uninsurance rates among rural adults in expansion states fell from 35% to 16% between 2008 and 2016. In non-expansion states, the rate dropped from 38% to 32%.

*Citations follow on slide 28

Index of Sources on Corrections, SUD/Opioid, and Rural Health

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Hospitals Share Impact Medicaid Expansion would have on Alabama

If Alabama expands Medicaid, almost 300,000 uninsured Alabamians would receive health insurance coverage, an estimated 30,000 jobs would be created, and $28 billion in new economic activity would be generated. Alabama would also save millions of dollars on current state services. For these reasons Alabama's hospitals are launching the ALhealthmatters campaign highlighting the importance of expanding Medicaid.

"On average, almost one out of every 10 hospital patients does not have health insurance, resulting in more than $530 million annually in uncompensated care," said Danne Howard, executive vice president and chief policy officer of the Alabama Hospital Association. "Currently, 75 percent of Alabama's hospitals are operating in the red, meaning the dollars they receive for caring for patients are not enough to cover the cost of that care. Expanding Medicaid would be a significant investment in the state's fragile health care infrastructure and would help maintain access to care for everyone."

Howard adds that hospitals and other health care providers are a critical piece of the state's infrastructure. "Alabama's hospitals employ about 90,000 individuals and indirectly support another 96,000 jobs," she said. "Not only are they often one of the largest employers in their communities, but hospitals also have a huge economic impact on their local economy. Statewide, the annual economic impact of Alabama hospitals is nearly $20 billion, not to mention the pivotal role access to quality health care plays in recruiting and keeping new businesses."

Throughout the next few months, hospitals will be talking with business, civic and government leaders to stress the importance of expanding Medicaid in Alabama and to share quantitative results of the positive impact it is having in other states.

Howard notes that a recent study showed that hospitals in expansion states were 84 percent less likely to close than hospitals in non-expansion states. "Alabama has had 12 hospitals close since 2011, and more are on the verge of closing if something doesn't change," she added. "Plus, the economic impact in other states has been tremendous; Louisiana has added 19,000 jobs; nearly 50 percent of new enrollees in Ohio have been able to receive mental health and substance abuse treatment, and the state has seen a 17-percent drop in emergency department use; Kentucky has seen an increase in state revenues of $300 million."

For more information on the impact Medicaid expansion could have in Alabama, visit www.alhealthmatters.com.

The Alabama Hospital Association, based in Montgomery, is a statewide trade organization that represents more than 100 hospitals and numerous other health care providers by offering services designed to enhance the provision of health care in Alabama.

Tab 7

Materials from Proponents

DANIELLA LEVINE CAVA
MIAMI-DADE COUNTY COMMISSIONER
DISTRICT 8

June 21, 2019

The Florida Legislature
Office of Economic and Demographic Research
111 West Madison, Suite 574
Tallahassee, FL 32399-6588

Re: Ballot # 18-16, Medicaid Coverage to Low Income Eligible Adults; Sponsor, Florida Decides Healthcare Inc.

Dear Conference Members:

I have served as a Miami-Dade County Commissioner since 2014. During that time, I have repeatedly voiced strong support for Medicaid expansion in Florida. This includes taking a leadership role in passage of four county resolutions to make this issue a critical County priority for the Florida Legislature.[i]

Medicaid expansion would provide multiple financial benefits to Miami-Dade County (Miami-Dade) and its residents. We have been disproportionately harmed by the state's failure to expand since we have the largest number of uninsured in the state (over 450,000) and the largest number falling into the coverage gap-those with with incomes below poverty (over 107,00). [ii]

Thus Miami-Dade also receives the highest amount of Low Income Pool (LIP) and other safety-net funding in the state and contributes the most funding for county intergovernmental transfers needed to meet state matching requirements.[iii] However, historically this funding has fluctuated and there is no guarantee that what the county contributes to the state match will be re-invested in our community.

The amount of federal dollars that would flow into our county through Medicaid expansion far exceeds the amounts we receive through supplemental funding. It is estimated that expansion would generate about $4.6 billion in new mostly federal revenue to our county providers taking care of low-income residents.[iv]

DANIELLA LEVINE CAVA
MIAMI-DADE COUNTY COMMISSIONER
DISTRICT 8

Medicaid expansion would also dramatically reduce the county's uncompensated care burden. For FY 2016, Miami-Dade's total uncompensated care costs were $686,759,305, including $607,952,387 uncompensated care hospital costs. Jackson Health System, the county's major safety net provider shouldered more than half of this cost.[v]

Other expansion states have experienced significant reductions in uncompensated care costs. One study has suggested that Medicaid expansion cut every dollar that a hospital spent on uncompensated care by 41 cents between 2013-2015.[vi] That could mean millions of dollars of savings for our county.

Miami-Dade is also disproportionately financially impacted by uninsured residents with chronic diseases, particularly those diseases more prevalent in our county. For example, Miami leads the country in new cases of HIV infection. Experience in other expansion states is that people with HIV/AIDS had a 60 percent reduction in hospitalizations for uninsured people who were HIV positive, while non-expansion states had an 8 percent increase over the same period. Further the state could save over a million dollars annually that it is currently paying through the AIDS Drug Assistance Program just for uninsured residents of MD who need anti-retroviral medications. [vii]

Additional millions of dollars of savings would accrue by providing coverage to low income uninsured Miami-Dade residents who have a mental health or substance abuse disorder. They now rely on free or charitable clinics and community mental health centers supported by Miami-Dade taxpayers. Many of these uninsured who go untreated end up needing Baker Act crisis services for which the county must contribute a 25 percent match.[viii]

We would also experience significant savings on hospital care costs for county jail inmates. In 2014, Miami-Dade spent a half million dollars for this care. With expansion, Medicaid reimbursement would be available for low income inmates admitted to a hospital offsite for at least 24 hours. [ix]

There would be positive multiplier effects on our local economy as a result of expansion, including thousands more jobs. The Miami region could see as much as 19,176 new jobs within and outside the health sector. Millions more in revenues would be raised through occupational fees and local sales tax. [x]

Medicaid expansion will also greatly improve access to health care and financial security for thousands of Miami-Dade residents. It will help people stay healthy so they can look for work and stay employed.

DANIELLA LEVINE CAVA
MIAMI-DADE COUNTY COMMISSIONER
DISTRICT 8

All the above-described factors will significantly boost the county's economic outlook. Thank you for this opportunity to share information on the financial benefits of Medicaid expansion for Miami-Dade County. Please let me know if you have questions or need additional information.

Sincerely,

Daniella Levine Cava

Daniella Levine Cava,
Commissioner, Miami-Dade County
District 8

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[i]Resolution supporting Medicaid expansion, 11/8/2018: File No. 182567; Resolution supporting Medicaid expansion, 10/18/2016: File No. 162298. Resolution supporting Medicaid expansion, 9/16/15: File No. 152116; Resolution supporting Medicaid expansion, 12/16/2014: File No. 142798

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[iv] Supra at p. x.

[v] Report Regarding Funding Indigent Health Care in Miami-Dade County prepared by Jackson Health System, July 30, 2018. File No. 18171

[vi] Antonisse, R., et al., The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review, p. 10, Kaiser Family Foundation. Accessed via: https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

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[viii] Supra at 6.

[ix] Supra at 5.

[x] Ibid.

From: edrcoordinator
To: Bell.Stephanie
Subject: FW: Medicaid Expansion
Date: Sunday, July 07, 2019 6:23:13 PM
Attachments: Health Benefits of MedEx_051619.pdf
Economic Benefits of Medicaid Expansion2.0.pdf

-----Original Message-----
From: Diane Dimperio <dimp@cox.net>
Sent: Saturday, July 06, 2019 4:16 PM
To: edrcoordinator <edrcoordinator@leg.state.fl.us>
Subject: Medicaid Expansion

Hi,
I am very supportive of Medicaid Expansion and have attached summaries of my review of some of the pertinent literature. You have some good references in your workbook, but as a Florida resident with a background in indigent health care feel I should add my voice in support of this important initiative. Diane Dimperio, Concerned Citizen

ECONOMIC BENEFITS OF MEDICAID EXPANSION 2.0

DIANE DIMPERIO

APRIL 15, 2019

The goal of the Patient Protection and Affordable Care Act (ACA) is to improve the health of Americans. A major objective of the legislation is to increase access to health care by reducing financial barriers by making affordable insurance universally available. Expanding Medicaid to include childless adults with family incomes at or below 138% Federal Poverty Level was included in the original legislation but was made optional by the Supreme Court. To date Florida's legislature refuses to participate in Medicaid expansion. The ACA has been in place long enough that data are now available to show ACA, including Medicaid expansion, results in increased numbers of insured, greater use of health care and improved health. (Antonisse) Available data suggest the failure to accept Medicaid expansion leads to a loss of state and individual benefits as described below.

INDIVIDUALS

Financial Status

Research suggests enrolling in Medicaid results in improved financial status. A comparison of Medicaid expansion enrollees in Arkansas to similar families in Kentucky, a non-expansion state, found Medicaid enrollees spent less on health care. Families with out-of-pocket expenses in Arkansas spent $754 per year less than those in Kentucky. The analysis showed "the average newly enrolled Medicaid family saved at least $3000 annually compared to what they would have spent without Medicaid". (Glied). Oregon expanded Medicaid to some but not all adults which provided the opportunity to compare those enrolled to those who did not. The comparison found that, even in the first post expansion year, enrollees were 40% less likely to borrow money or miss other payments because of medical bills. Families enrolled in Medicaid were also 25% less likely to have medical bills submitted to collection agencies. (Baicker and Finkelstein). Over half (56%) of Ohio residents who enrolled in expanded Medicaid reported they had medical debt before enrolling which was reduced to 31% after enrollment. This reduction in medical debt resulted in making it easier for families to buy food (59%), pay the rent/mortgage (48%) and pay other debts (44%). (Ohio)

Using enrollment and state consumer credit data in a nationally representative comparison also demonstrated Medicaid expansion decreased medical debt. Enrollment decreased newly accrued medical debt by 30-40% with the highest decrease among those with the most debt. People who had been "treated" (not defined by authors) had $900 less annual accrued medical debt. There were fewer bankruptcies in the two years following expansion. The researchers also found enrollees were able to improve their credit scores. Subsequently they received offers of credit with reduced interest rates, representing an additional financial improvement. (Brevoort).

During the 1990s states expanded Medicaid for children and their caretakers. The variation in the extent of expansions provided an opportunity to further evaluate the relationship of Medicaid expansion to fiscal health. This multi-state study found that a 10 percentage-point increase in the percent of low-income individuals enrolled in Medicaid expansion reduced personal bankruptcies by 8%. The authors speculated that improving the rate of repayment to community creditors could ultimately result in reduced rates for other borrowers. (Gross)

Scholars at UCLA conducted an interesting study on Medicaid expansion. Apparently the literature demonstrates that "better health and financial security, have been associated with an increased likelihood in volunteering". The research used the incidence of volunteering as a marker of physical and financial health and saw a positive correlation between Medicaid expansion volunteering. (Heeju and Sohn)

Employment
Michigan expanded Medicaid. The enrolled population was predominantly (74%) under 50 years old, most (80%) had incomes below 100% of poverty, almost half (49%) were employed, the majority (69%) had one or more chronic health condition, and, 43% had some physical or mental health limitation. After enrollment, almost 70% of employed beneficiaries reported they were able perform better at work and those out of work reported they were better able to look for work. Among those who changed jobs 37% reported getting a better job. The authors observed the report of work related improvements "were more likely among enrollees who reported improved health, particularly for older enrollees and those with chronic conditions". (Tipirnene)

Similar results were found in Ohio where the Medicaid program reported 43% of enrollees were employed and a majority of enrollees reported that Medicaid made it easier to find and keep employment. Among those who were employed over half (52%) reported having Medicaid made it easier to continue working, and 75% of those who were unemployed and seeking employment reported that having Medicaid coverage made it easier to look for work. (Ohio)

HOSPITALS

Hospitals have to accept anyone who asks for care and are sometimes referred to as the "insurer of last resort". Uninsured hospital patients usually result in uncompensated care which will affect a hospital's fiscal health. Since hospital payments represent a substantial portion of the cost of insurance, decreasing the number of uninsured using hospital care should have a moderating affect on the cost of insurance. Since the cost of health care and, therefore, insurance is not likely to decrease, improvement would be represented by a reduction in the *rate of increase*. Data support this supposition. "The year after ACA was signed into law premiums provided by employers for single coverage rose 18.5%.....(which) is lower than the 25.4% increase in …premiums for the five year period proceeding…." (Ho)

The cost of health insurance is a complex issue and not easily studied. There are multiple insurers and each may offer many plans with different benefits, payment options and networks. These and other factors such as covered population, benefits, region of the country and stockholder expectations will affect the costs. Data on employer costs are available but information on cost through the individual market is scant. The overlap of the populations receiving subsidized coverage in the ACA Marketplace and through Medicaid provided an opportunity to study the effect of expansion on the price of premiums. A national comparison of states which did and did not expand Medicaid found the cost of premiums in expansion states was about 7% lower than the non-expansion states. (Sen and DeLeire)

Uncompensated care is critical to the discussion of care for low-income populations. Uncompensated care is not generally distributed equitably among hospitals but in urban areas tends to be concentrated at "safety net hospitals". Hospitals in rural areas generally have a higher percentage of uninsured patients so are also sensitive to the effect of uncompensated care on financial sustainability. The economic underpinning of the ACA included reducing Medicare and direct Medicaid payments (UPL/LIP) to hospitals with the expectation that the increase in paying patients would balance the short fall from these cuts. Reductions were made assuming that mandated coverage, fully subsidized Medicaid coverage of those below 138% of poverty as well as partially subsidized Marketplace premiums would result in almost full insurance coverage of hospital care.

Florida refuses to expand Medicaid and the current administration in Washington has eliminated the mandate, reduced funds for Marketplace outreach and is establishing policies to make non-ACA compliant plans more available. These decisions have and will increase the number of

uninsured and underinsured. With decreased access to primary care the number of uninsured who need hospital services will increase. These factors make the issue of uncompensated hospital care essential to this discussion.

As hospitals lose revenue they need to cut operating costs, which eventually may affect quality of care. A study reviewed the effect of reduction of Medicare payment to hospitals due to the Balanced Budget Act and found a relationship between reduced payments and health outcomes. Comparing 30-day post discharge mortality found an inverse correlated between the profitability of the hospital cost center and mortality. (Lindrooth 2013). A national study of safety net hospitals found those with the highest burden of charges for uninsured or underinsured had higher rates of mortality and readmission than those with better financial status. (Hoehn) A study of Florida Hospitals looked at the relationship of financial pressure and patient safety (e.g., medical errors) for major surgeries. Results show an inverse relationship between patient safety events and hospital profit margins. (Encinosa)

Continued financial losses will eventually result in hospital closure. In a study, non-federal short-term general and critical care hospitals in states that expanded Medicaid were compared to hospitals in states that did not. Between 2012-2013 the rate of hospital closures doubled in states that did not expand Medicaid and decreased by half in states that expanded Medicaid. After 2014 the closure rate did not change in expansion states and continued to climb in non-expansion states. The rate of closure was affected by the number of uninsured adults with the rate of closure being positively correlated with the percent of uninsured. When the percent of uninsured in the county was less than 10% the closure rate was unaffected by Medicaid expansion. (Lindrooth 2018). Closure of teaching hospitals would shift uncompensated care to other hospitals, limit education of medical professionals and reduce the amount of tertiary and quaternary medical care available.

STATE

Multiple studies of Medicaid expansion demonstrate financial benefits to states (Antonisse). The increased revenues come from reduced spending on services previously provided through state funds that are subsequently covered by Medicaid e.g. mental health; transferring adults currently enrolled in Medicaid to expanded Medicaid[1], economic benefits from the infusion of federal dollars providing well paying jobs, and; money previously spent on health care by the previously uninsured can be spent on other goods and services which are taxed and stimulate jobs.

When the Michigan legislature approved Medicaid expansion in 2013, it did so with the condition that the state would achieve enough revenue to offset the costs of expansion. In the early years the federal government paid 100% of costs which decreased to 95% in 2017 and will decrease to 90% in 2020. The state has enrolled about 600,000 in expanded Medicaid. Projections for 2020 when the match rate falls to it's lowest rate of 90% of payment, the state is still expected to have 214.6 million dollars more than if Medicaid was not expanded. Michigan's increased revenue will come from contributions from providers and health plans, improved payment rate for enrolled beneficiaries, state taxes and reduced spending on health services that the state had provided in the past. In 2020 the state expects to have almost 32 thousand more jobs and an increase in personal income of over $2.3 billion. Although Florida has no state tax, the newly enrolled population would be similar to Michigan and the financial benefit to Michigan without state income tax would be 64.2 million dollars. (Ayanian)

SUMMARY

Medicaid expansion offers multiple financial benefits for enrollees and the state.

Enrollees

- Have less medical debt and are better able to afford food and other essential goods and services
- Have better credit and lower interest rates on borrowed money
- Are less likely to declare bankruptcy
- Have better work performance
- If unemployed are better able to look for work

Hospitals

- Are more sustainable
- Able to maintain quality care
- Less likely to close

States

- Have increased revenues from reduced funding for health related services
- Benefit from higher reimbursement rate for adults currently covered by regular Medicaid
- Experience increased employment
- Have increased economic activity

ADDENDUM

This paper is a review of some of the rigorously conducted studies evaluating the financial impact of Medicaid expansion. This addendum is added to call attention to a recent report which, although not a scientific study, offers relevant and timely observations. It also serves to put Medicaid expansion into context.

It is important to remember that Medicaid expansion is only one component of the ACA, which was developed as a comprehensive plan to improve health of Americans. The core of the ACA is an emphasis on health promotion and prevention, including substituting inexpensive primary care for expensive hospital services.

Historically the rate of health spending has grown faster than the rest of the economy. (Kamal) A recently published report of health care spending and utilization in the U.S. shows a "surge" in health care utilization in 2014-15, which could be due to the "pent up need" of newly insured adults. The report cites data to show between 2016 and January 2019 health care spending grew more slowly than the rest of the economy. During this time the greatest growth in health spending was in nursing home care and the lowest rate of growth in spending is in hospital care. (Altarum-Spending) Since hospital costs account for about one third of health spending it has an outsized contribution to the overall rate of growth. One of the main reasons health care spending decreased is a lower rate of utilization of hospital services. (Altarum-Price). Even though the rate of health spending decreased more jobs were added in the first quarter of 2019 than in any quarter in the 30 years the Center has been tracking data. Between March 2018 and March 2019 jobs in health care grew by 2.5% where as non-health care jobs increased by 1.6%. (Altarum-Labor) The decrease in health care spending and reduced use of hospital services is consistent with the goal of better health and less use of expensive care. In spite of the reduction in health spending there has been an increase in health care jobs. This is consistent with findings related to expanding Medicaid i.e. the infusion of federal dollars into states supports job growth.

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Health Benefits of Medicaid Expansion
Diane Dimperio
May 16, 2019

Introduction

Florida relies on tourism as a major source of revenue and employs over 1 million people in jobs described as "Accommodation and Food Service". (Florida Jobs) Many of these are low wage service jobs that do not offer subsidized health insurance or paid time off. People employed in the service industry are among the estimated 450,000 uninsured adults in Florida who would be eligible for Medicaid expansion. An additional 392,000 who are currently purchasing coverage through the Federal Marketplace would also be eligible for Medicaid, which would make their insurance coverage more affordable. (Garfield)

Florida is one of only 14 states not expanding Medicaid. This has deprived the state and it's citizens of both the financial and health benefits of expansion. (Dimperio) This lack of coverage for a substantial portion of our citizens has not gone unnoticed. US News and World Reports publishes an annual review of health care resources. The 2019 report ranked Florida 48th in the nation for access to care and 34th in quality of care. (US News) The Agency for Healthcare Research and Quality is a prestigious professional organization that establishes standards for quality in health care. It publishes a National Healthcare Quality and Disparities report which uses 82 measures to rank the quality of care offered by states. In the most recent Florida ranking Florida was third from the bottom. (AHRQ)

The purpose of the Affordable Care Act is to improve the health of Americans. A major strategy is reducing financial barriers to health care, which in America, means providing affordable health insurance. The fact that expanded Medicaid coverage (hereafter referred to as Medicaid) been accepted in several states and not in others provides an opportunity to study the impact of the program.

Research provides answers to three important questions. The first is: will low-income adults enroll in Medicaid? It requires time, reporting personal information, and, if enrollment is "on-line", requires a skill not all adults have. There is also the possibility of a stigma associated with Medicaid. The second question is: will people, who may have little history of going to the doctor unless they are sick, who may have barriers such as transportation and child care and, may not have paid sick leave, go to the doctor when they are well? The third question is: if they do go for regular check ups, does it matter i.e. will it promote better health?

Medicaid has been in place in some states for several years, which allows us to begin to answer these important questions. The results of multiple studies demonstrate that eligible adults **do** enroll in Medicaid. Data on enrollment are widely available and clearly answer the first question in the affirmative but are not reviewed in this paper. This paper will review only a few of the existing studies which clearly demonstrate Medicaid enrollees use, value and benefit from affordable health care

Primary care

The cornerstone of the comprehensive health care covered by Medicaid is primary care. Primary care provides screening, assessment, treatment and when needed, referral to specialty services. Screening of an apparently healthy person is designed to reveal health issues before they become a problem. The earlier health concerns are discovered, the easier they are to treat. Early intervention will reduce morbidity and mortality and is cheaper than discovering the condition later in the disease progress. For example, identifying and managing high blood pressure is better than treating a stroke.

People without insurance have less access to primary care than people who are insured. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and screening for major health conditions and chronic diseases. (KFF) After enrollment in Medicaid beneficiaries were more likely to report "having a usual source of care" (Sommers 2017) and not having to put off regular health care. (Ohio) Beneficiaries in expansion states were less likely to report they "needed health care but could not afford it" or that they took less medication to save money. (Miller) Enrollment in Medicaid expansion was associated with an increase in receipt of flu shots, preventive dental care (Clark) and screening for HIV. (Simon)

A study of three southern states, two of which expanded Medicaid and one that did not, found Medicaid enrollees were more likely to have a regular provider, to engage in preventive care, to go to outpatient office visits, and annual check ups. (Sommers 2016) Studies document Medicaid enrollees were more likely than uninsured in other states to be screened for diabetes, cancer and obesity (Sommers 2016, Amal). A multi-state study found states that expanded Medicaid demonstrated a significant increase in the overall rate of cancer diagnosis, and especially in identification of early stage cancer. (Soni)

In Ohio 27% of new enrollees were newly diagnosed as having one or more chronic health condition for which they could receive early and appropriate care. Chart reviews documented enrollees experienced reductions in blood pressure and high blood cholesterol. (Ohio) Most of the studies reviewed included a question about how people perceived their health and in all studies a substantial number of people reported their health had improved since enrolling in Medicare. Although this question seems to be too simplistic to mention, it is considered an excellent indicator of health. A peer reviewed article found the answer to this question to be highly correlated with mortality. (DeSalvo)

The evaluation of the Michigan program documented a decrease in use of the emergency room (ER). The enrollees who participated in primary care and those who agreed to participate in risk reduction also showed more improvements in ER use than others. (Clark) Other studies also report reduced use of the ER. (Ohio)

Enrollees appreciated having affordable access to health care. For example a man in the 19-34 year age range who was enrolled in the Michigan program said, "With moving around, you know, climbing a ladder (for work) and doing all that stuff, it helped a lot with my back and all that." (Tipirnneni)

Mental Health

In addition to screening for medical problems, primary care includes screening for mental health and substance abuse. Almost 36% of those enrolled in Ohio's expansion suffered from undiagnosed depression and, once enrolled in Medicaid, were able to access appropriate treatment, including medication. The medications used in treating substance abuse were consistent with best practices, as they were less likely to become addictive and result in deaths from overdose. (Ohio)

In Oregon enrollment of adults in Medicaid "reduce(d) the prevalence of undiagnosed depression by almost 50% and reduced untreated depression by more than 60%". Medicaid enrollment was associated with a significant increase in access to prescribed medications. (Baicker)

A quote from a man between 19-34 years old enrolled in Healthy Michigan who was receiving mental health services: " I have actually changed my life around from what I used to be. Instead of sitting around the house all day I can actually get out….. I am actually getting my life together and trying to work on getting my daughter back…" (Tipirnneni)

Oral Health

Dental care is so expensive many low-income adults cannot afford it. Florida's Medicaid program offers very limited dental services for adults but other states offer a richer benefit package. After enrollment almost 40% of Ohio beneficiaries reported improved dental health. (Ohio) The enrollees in Oregon reported significantly fewer unmet needs for dental services and were able to obtain needed medication for dental infections (Baicker).

A Michigan man between the age of 51-64 said: "My teeth were pretty bad…and they fixed it up fine….and I feel better when I look for a job. I feel better because my appearance has changed a lot. This has helped me a lot, physically and mentally." (Tipirnneni)

Specialty/Hospital Care

Although primary care and disease management will prevent unnecessary use of specialty care and hospital services there are occasions when these services are needed. Trauma is the leading cause of morbidity and mortality among young adults (19-44 years). Post hospital discharge to rehabilitation can be a key factor in regaining full capacity. A multi-state study found that young people who lived in states that expanded Medicaid were more likely to be insured and more likely to receive post injury rehabilitation. (Akande)

Another study compared surgery outcomes in states that accepted and those not accepting Medicaid. Data were collected on patients who needed one of five common surgeries (e.g. appendectomy). The adults in states that expanded Medicaid were significantly more likely to have an early and uncomplicated presentation and increased probability of receiving optimal management. (Loeher)

A study compared outcomes of patients who had cardiac surgery in Virginia, which did not expand Medicaid to those who had surgery in Michigan, which did. The patients who had surgery in Michigan had a significantly lower risk of post-operative major morbidity e.g. stroke, kidney failure. (Charles)

One-year mortality among patients with end stage renal disease who began dialysis and lived in expansion states was compared to that of patients who lived in states that did not expand Medicaid. The rate of death within 12 months was significantly lower in states that expanded Medicaid. (Shailender)

Disparities

Disparities in health outcomes are well documented i.e. identifiable populations have consistently worse outcomes than the mean. One disparity is income and this is what the expansion of Medicaid addresses. Other factors are associated with poor health and research has looked at the impact of Medicaid on some high-risk groups.

Rural Communities

Rural residents have few local providers, long distances to travel to obtain health care and higher death rates than those living in metropolitan areas (Moy). Fortunately, Community Health Centers (CHC) are often found in rural areas and offer care regardless of ability to pay. Typically a large percent of their patients are uninsured, which can strain resources. A review of CHCs located in states that did and did not expand Medicaid found CHCs in expansion states

improved quality of care. Research found improved treatment of asthma, more screening and treatment for obesity, better management of hypertension and increased follow-up care for issues such as mammograms, abnormal breast findings and substance abuse. (Cole)

In Oregon Medicaid beneficiaries were more likely to report that their health care needs were addressed. Rural participants reported improvements in access to primary care, receipt of preventive screenings, and continuity of care. They also reported feelings of greater financial security, better overall health and happiness. Despite the travel required getting to specialty care and some concern about the quality of available providers, rural Medicaid recipients reported satisfaction with their care. (Allen)

Medicaid expansion in Arkansas and Kentucky resulted in increased participation in medical check-ups and disease management as well as improvements in quality of care even in areas designated as health care shortage areas. (Sommers 2016)

Race

Minorities, especially blacks, have worse health outcomes than whites. For example, in Florida stroke related mortality is 36.5/100,000 in whites, and 56.0/100,000 in blacks. Hospitalization rate due to congestive heart failure is 205/100,000 in whites and 370/100,000 in blacks. (Florida CHARTS)

The study described above (in specialty/hospital care) on patients with end stage renal disease found the largest decrease in mortality among patients living in expansion states was among black patients. (Shailaender)

Although Florida increased the income limit for Medicaid during pregnancy Florida's infant mortality rate of 6.1/1000 births ranks us 27th in the nation. Among black women the infant mortality is 11.3 deaths/1,000 births and among white women the rate is 4.4/1,000 births. It has recently been recognized that the health of a woman before she conceives is critically important to the health of the pregnancy, which emphasizes the role of primary care in promoting healthy births. A national study comparing infant mortality in states that expanded Medicaid to those which did not, found the decrease in infant mortality was significantly greater in the states that had expanded Medicaid. The greatest improvement in infant mortality was among black mothers in expansion states, where infant mortality was reduced at twice the rate of non-expansion states. The data provide no explanation but the authors suggest primary care resulted in reducing "unintended pregnancies and improved preconception health including better management of maternal chronic disease, and mental health….". (Bhatt)

Chronic conditions

Adults with chronic conditions, like diabetes and high blood pressure, are more likely to suffer morbidity and premature death. As discussed, above, access to primary care increases early identification and management of chronic conditions which will mitigate the disease process.

Among adults with chronic conditions, Medicaid expansion resulted in more frequent use of preventive services (Clark) improved use of medication, and improved perceived health status. (Sommers 2016) People in Medicaid who had asthma, diabetes and other chronic conditions were more likely to engage in disease management, including ongoing monitoring and medication management. (Cole, Ohio).

Although, use of the emergency room of all Medicaid beneficiaries was reduced adults with asthma, diabetes, heart disease, and/or COPD demonstrated "more substantial" reductions than others. (Clark)

Tobacco
Many Floridians who smoke want to quit and many have tried, but nicotine addiction is notoriously difficult to overcome. In Florida, as in other states, income is inversely correlated with smoking. Adults with lower-incomes, the target population for Medicaid, are more likely to smoke than those with higher incomes. Best practices for cessation include use of nicotine replacement products and other medications. Medicaid expansion was found to increase access to medication recommended for tobacco cessation by 36%. (Macclean) A multi-state study concluded low-income adults living in expansion states reported higher rates of smoking cessation than those living in states that did not expand Medicaid. (Koma)

Substance Use
Widespread opioid addiction is destroying families and communities in Florida, and has been declared a public health emergency. In 2017, there were 3,245 opioid related-deaths in Florida—a rate of 16.3 deaths per 100,000 persons, which is higher than the national rate of 14.6 deaths per 100,000 persons. (NIDA)

Medicaid is the largest funder of behavioral health services and the most significant source of funding for treating substance in the country. In spite of the fact that the expansion population has a higher rate of substance abuse disorders than those enrolled in regular Medicaid, Florida funds limited substance abuse treatment services to this population using state dollars whereas expansion states use federal dollars to provide and comprehensive in-patient services, outpatient treatment and medication. (Bachrach)

A study of death files from the Center for Disease Control and Prevention found expansion states experienced 30% fewer heroine deaths and a 26% reduction from other narcotics related deaths. (McInerney)

Treatment of substance abuse can be effective but requires professional services and prescription medication which are not affordable by most uninsured. Substance abuse treatment is one of the essential health care services included in Medicaid. A multi-state study compared drug utilization files from the Center for Medicare and Medicaid services found that expansion states had a 70% increase in the number of filled prescriptions for buprenorphine, a key medication for treatment of opioid addiction. (Hefei)

West Virginia and Kentucky are two of the states with the highest rate of drug overdose deaths in the country. Both states expanded Medicaid and were able to offer their citizens effective treatment for opioid addiction. In the first year of operation West Virginia Medicaid enrolled a little over 4,400 adults diagnosed with Opioid Use Disorder (OUD) and the number rose to over 8,300 by the third program year. In the first year the about 15% of clinical services each month were provided to patients with OUD which after three years rose to about 30%. The total monthly number of clinical services plus prescriptions tripled over the first three years. The percent of patients who filled prescriptions increased from about 30% in year one to 75% in the third year. (Saloner)

Kentucky also began Medicaid expansion in 2014. In the first three months they provided 1,500 substance abuse services. In the second quarter of 2016 they offered over 11,000 services. Doses of buprenorphine, increased from 2 million in the first quarter of 2013 to 3.5 million in the second quarter of 2016. In-patient admissions for substance use treatment, which had been almost 23,000 in 2005, had declined to only a little over 19,005 in 2015. (FHK)

These studies demonstrate that Medicaid is a valuable resource for states to offer effective, affordable treatment to residents with OUD. Addressing the opioid crises through Medicaid expansion is the best option Florida has to offer comprehensive treatment for this debilitating condition.

Summary

The purpose of Medicaid Expansion is to improve the health of Americans and the data we have after a few years of experience suggest the program is meeting this goal. The expansion population is:

- Engaging in primary care - they are:
  - Going for routine health checks
  - Being screened for chronic conditions such as diabetes, hypertension and depression
  - Receiving referrals for dental care, mental health services and specialty care
  - Participating in disease management
  - Accessing and using needed medications
  - Improving health related behaviors
- Reporting
  - Improved health
  - Fewer unmet needs for health care
  - Fewer unmet needs for dental care
  - Appreciation for improved health, including dental and mental health
- Experiencing
  - Reductions in hypertension and high cholesterol
  - Earlier diagnosis and referral for cancer, surgery and dialysis
  - Decreased use of emergency rooms
  - Diagnosis and treatment of opioid addiction
  - Decreased in-patient admissions for substance use

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Tipirnneni R et al. Changes in Health and Ability to Work Among Medicaid Expansion Enrollees: a Mixed Methods Study The online version of this article J Gen Intern Med 2018; 34(2):272–80 (https://doi.org/10.1007/s11606-018-4736-8)

US News https://www.usnews.com/news/best-states/rankings/health-care

Tab 8

Materials from Opponents

(None Provided)

Tab 9

Materials from Interested Parties

To: Financial Impact Estimating Conference, via email to edrcoordinator@leg.state.fl.us

From: Florida Association of Counties

Subject: Financial Impact Statement for the Proposed Constitutional Amendment entitled "Provide Medicaid Coverage to Eligible Low-Income Adults" (18-16)

Date: July 12, 2019

The Florida Association of Counties represents all of Florida's 67 counties and, on their behalf, appreciate the opportunity to provide information regarding the impacts of the proposed amendment to Florida's counties. In its preparation of the Financial Impact Statement, the Financial Impact Estimating Conference ("FIEC") must provide the estimated increase or decrease in any revenues or costs to local governments resulting from the proposed amendment. Also, pursuant to Ch. 2019-64, Laws of Florida, adopted during the 2019 legislative session, the FIEC is now required to determine the estimated economic impact on the state and local economy. In summary, we would expect that the impacts to county revenue and costs and the local economy would generally trend in the same direction as the impacts to the state as a whole; however, we offer the following county-specific information for your consideration:

County Medicaid Cost-Share Mandate

Florida counties are obligated to contribute towards the state (non-federal) share of Medicaid funding. The mandatory county contributions made per sec. 409.915, F.S., go towards the state share of Medicaid costs, which are used as state matching funds to draw down the federal share of funds. Florida counties' total annual mandatory Medicaid contributions are calculated by a formula, which is currently based on historical payments and a negotiated growth rate (s. 409.915(2), F.S.). Additionally, each county pays a percentage of the total county annual Medicaid contribution, based on the county's number of Medicaid-enrolled residents (s. 409.915(3), F.S.). For instance, if 5% of Florida's Medicaid enrollees live in County A, then County A will pay 5% of the total county Medicaid contribution. A potential concern for counties over the proposed amendment is that a significant increase on enrollees statewide will increase the total state share of funding, thereby increasing the total county contribution. Additionally, Medicaid enrollment may increase more in some counties than others, based on various factors such as uninsured rates, as a result of the proposed amendment. This could result in a disproportionate financial impact on those counties, since individual county shares (of the total county contribution) are determined by a county's number of Medicaid enrollees.

Potential Indirect Impacts of Proposed Amendment

By increasing the rate of health insurance coverage, the proposed amendment may have indirect financial impacts on counties by reducing some costs and payments associated with uncompensated hospital care and indigent health care. Below are two examples, but not necessarily an exhaustive list of programs that could be affected.

Intergovernmental Transfers

In Florida, local governments (counties, but also special taxing districts, hospital districts, etc.) can also make voluntary contributions, as intergovernmental transfers (IGTs), to the state's Agency for Healthcare Administration (AHCA). The AHCA then uses those IGTs to draw down additional federal dollars, per Florida's federal medical assistance percentage. Voluntary IGT contributions are used to leverage federal monies which are used for supplemental hospital funding programs (DSH and LIP, the state's uncompensated care pool). The funds go towards the state's disproportionate share hospital (DSH) program and the state's Low-Income Pool (LIP) program. Both programs provide supplemental funds to hospitals that provide significant amounts of uninsured and uncompensated care. Consideration should be given to the potential for a reduced need for supplemental hospital funding programs if there are fewer indigent patients as a result of increased insurance coverage.

Health Care Responsibility Act (HCRA)

In Florida, the Health Care Responsibility Act (s. 154.301-154.331, F.S.) requires a county to reimburse out-of-county hospitals for the cost of emergency care provided to its indigent residents. The reasoning behind this is that hospitals and taxpayers of one county shouldn't be required to subsidize the care of out-of-county indigent persons. There are limitations on the types of care and services that qualify to be reimbursed, as well as the types of hospitals that can participate; however, all counties are required to participate per statute. Consideration should be given to the potential for a reduction in HCRA payments and related expenses if there are fewer indigent patients as a result of increased insurance coverage.

Additional information about HCRA including HCRA liability by county can be found here:
http://ahca.myflorida.com/MCHQ/Central_Services/Financial_Ana_Unit/HCRA/index.shtml

Thank you for the opportunity to provide these comments. Should you need additional information, please contact Laura Youmans, Legislative Counsel, at lyoumans@fl-counties.com.

From:	OSullivan, Owen
To:	Bell.Stephanie
Subject:	FW: Impact Estimate for the Medicaid Expansion
Date:	Thursday, July 11, 2019 12:46:30 PM

From: Baker, Amy <BAKER.AMY@leg.state.fl.us>
Sent: Monday, July 08, 2019 1:07 PM
To: OSullivan, Owen <OSULLIVAN.OWEN@leg.state.fl.us>
Subject: FW: Impact Estimate for the Medicaid Expansion

Owen...

See below. We need to discuss this.

Amy

From: Chris Doolin <cdoolin@nettally.com>
Sent: Monday, July 08, 2019 12:54 PM
To: Baker, Amy <BAKER.AMY@leg.state.fl.us>
Subject: Impact Estimate for the Medicaid Expansion

Ms. Baker –
I met with the folks from FAC last week to discuss the impending impact estimate for the Medicaid Expansion proposal – I thought you might want to see my suggestions.
Also – if there is an increase in costs at the local level. It would be important to identify which counties were at or close to the 10 mill limit and, possibly, determine what the estimated increase would be in relation to the value of the local millage.

Thank you,

Chris Doolin
President – Christian B. Doolin & Associates
Vice – President – Robert P. Jones & Associates
Mobile – 850-508-5492
Email – cdoolin@nettally.com

From: Chris Doolin [mailto:cdoolin@nettally.com]
Sent: Monday, July 08, 2019 12:51 PM
To: FAC - Davin Suggs (dsuggs@fl-counties.com)
Cc: Laura Youmans (lyoumans@fl-counties.com)
Subject: Impact Estimate for the Medicaid Expansion

Pursuant to our discussion last week, I think we should request EDR to look at the potential impact that the proposed amendment would have on the increase in the Overall State Medicaid and the Local Govt. Cost Share program. Also – if possible – is there a discernable impact based on various

subgroups that would be covered by the amendment that would have the impact of shifting the various participation percentage rates that each county would be responsible for in relation to the total number of participants?

These are the two questions that I would be concerned about at the outset!

Chris Doolin
President – Christian B. Doolin & Associates
Vice – President – Robert P. Jones & Associates
Mobile – 850-508-5492
Email – cdoolin@nettally.com

OBAMACARE'S MEDICAID EXPANSION

Financial Impact Estimating Conference

July 29, 2019

Nick Stehle
Senior Research Fellow
Foundation for Government Accountability

Good morning. My name is Nick Stehle. I am a senior research fellow at the Foundation for Government Accountability. I want to thank you all for the opportunity to provide analysis on the proposed Medicaid expansion's projected cost to taxpayers, which will be substantially higher than forecasted.

According to current estimates, 1.7 million adults would be newly eligible under a constitutional amendment to expand Medicaid under ObamaCare.[1] This should serve as the minimum baseline enrollment forecast, but it is almost certain than actual enrollment will exceed even this amount.

Let me explain why. First, states that opted into Medicaid expansion provide five and a half years of experience on which to draw. Second, the underlying data does not reflect how Medicaid calculates income for eligibility purposes. And finally, Medicaid expansion crowds out private coverage—which includes forcing individuals out of healthcare.gov and into Medicaid.

FLORIDA CAN LEARN FROM OTHER STATES' EXPERIENCES

States that have expanded Medicaid through ObamaCare have enrolled twice as many able-bodied adults as officials projected.[2] California, for example, projected 910,000 expansion enrollees, but more than 3.8 million eventually enrolled.[3-4] Actual enrollment was 276 percent higher than projected in New York and 92 percent higher than projected in Illinois.[5-8] Altogether, expansion states exceeded enrollment projections by an average of 110 percent.[9]

Estimates produced by other groups—such as Kaiser Family Foundation and Urban Institute—have also widely missed the mark. These groups predict that nearly 1.3 million individuals will sign up for expansion in Florida.[10-11] But these groups have underestimated enrollment in other states by an average of 55 to 60 percent.[12] **Based on this experience, Florida should expect nearly two million able-bodied adults to enroll.**[13]

THE ELIGIBLE UNIVERSE DATA DOES NOT REFLECT MEDICAID ELIGIBILITY RULES

One of the biggest reasons states and independent organizations underestimated potential enrollment was their reliance on data from the Census Bureau. This reliance was problematic for at least four major reasons.

First, the Census Bureau organizes individuals into households, while Medicaid eligibility rules are based on tax units.[14-15] Consider an able-bodied adult who does not work but lives at home with his parents. Census data would use his parents' income to determine his poverty status, as they are part of the same household. But Medicaid eligibility would be based on his personal income alone. This difference leads to a significant undercount in the number of people with income below 138 percent of the federal poverty level (FPL) for purposes of determining Medicaid eligibility.[16]

Second, the Census Bureau uses a different definition of income than the definition required by Medicaid eligibility rules. For example, the Census Bureau includes workers' compensation benefits, cash welfare, veteran payments, educational assistance, child support, and financial support from outside the home in its definition of income—none of which is countable under federal Medicaid rules.[17] Medicaid rules also exclude non-taxable pensions or retirement income, net operating loss carryforwards, capital gains carryforwards, and other adjustments to gross income for tax purposes.[18] This difference leads to a significant undercount in the number of people with income below 138 percent FPL for purposes of determining Medicaid eligibility.[19]

Third, the poverty thresholds used by the Census Bureau are different from the poverty guidelines used to determine Medicaid eligibility.[20] The Census Bureau's poverty thresholds vary based on age, household size, and the number of children in the household.[21] The poverty guidelines, on the other hand, vary by family size alone.[22]

Finally, the Census Bureau data is based on income information self-reported by a sample of survey respondents, while Medicaid eligibility is determined by actual tax filing data.[23] Data compiled by the Office of Tax Analysis at the U.S. Department of Treasury indicates that the Census data significantly undercounts the number of people with income below 138 percent FPL for purposes of determining Medicaid eligibility.[24]

According to researchers at the Office of Tax Analysis, the number of non-elderly individuals with income below 138 percent FPL for purposes of determining Medicaid eligibility is nearly 50 percent higher than the number reported by Census data.[25] **This would suggest that Florida's estimate of 1.7 million newly eligible adults—which is based on Census data—should be revised upward to at least 2.4 million adults, to adjust for this difference.**

This may even be an underestimate as Medicaid eligibility is determined primarily by *monthly* income, while this data is based on annual income. Individuals are more likely to fall below the eligibility thresholds based on monthly income. For example, a single, able-bodied adult who worked full-time at $17 per hour for six months and not at all for six months would have annual income above 138 percent FPL.[26] However, based on monthly income, this adult would qualify for Medicaid and his eligibility would generally not be redetermined for at least 12 months.[27] As a result, Florida should expect far more able-bodied adults to become eligible for Medicaid than these data sources suggest.

MEDICAID EXPANSION WILL FORCE NEARLY 860,000 OUT OF PRIVATE COVERAGE

If Florida were to expand Medicaid, nearly 860,000 individuals would be forced out their private coverage and into Medicaid. More than 980,000 individuals with income between 100 percent and 150 percent FPL currently receive federal premium subsidies from the ObamaCare exchange in Florida—more than any other state.[28]

The vast majority of exchange enrollees in this group have income that would fall within the Medicaid expansion guidelines. According to the latest federal data, more than 87 percent

of these enrollees have income below 138 percent FPL—the eligibility line for Medicaid expansion.[29]

However, individuals who become eligible for Medicaid expansion will automatically lose access to federal premium subsidies. Under federal law, individuals are only eligible for premium subsidies if they are "not eligible for minimum essential coverage," including government programs such as Medicaid.[30] In fact, federal law requires healthcare.gov to assess these individuals' eligibility for Medicaid and submit Medicaid applications on their behalf.[31]

This restriction explains why states that have expanded Medicaid under ObamaCare have few enrollees between 100 percent and 150 percent FPL: only those with income above 138 percent FPL can qualify for subsidies. On average, just 13 percent of exchange enrollees in Medicaid expansion states have incomes between 100 percent and 150 percent FPL.[32] By contrast, more than 55 percent of Florida's exchange enrollees are in this income range.[33]

Based on this data, nearly 860,000 individuals with income below the Medicaid expansion eligibility thresholds are currently enrolled in exchange plans in Florida.[34-39] Taxpayers should expect virtually all of these individuals to enroll in Medicaid if the state were to expand ObamaCare. Without premium subsidies, these individuals would be required to pay the entire cost of their premiums out of pocket—which averages $627 per month—to stay in their current plans and proactively cancel their automatic Medicaid application, or they could enroll in Medicaid and pay no premiums at all.[40]

MEDICAID EXPANSION CROWDS OUT PRIVATE COVERAGE

In states that have recently expanded Medicaid under ObamaCare, the number of individuals buying private coverage in the exchange has plummeted.

Montana's Medicaid expansion launched on January 1, 2016. In 2015, before the expansion took effect, approximately 17,600 individuals with income between 100 percent and 150 percent FPL were enrolled in the exchange.[41-42] Today, exchange enrollment among this group sits at just 4,900—a drop of more than 72 percent.[43]

Similarly, Louisiana expanded Medicaid on July 1, 2016. In early 2016, before the expansion took effect, approximately 97,600 individuals with income between 100 percent and 150 percent FPL were enrolled in the exchange.[44] Today, exchange enrollment among this group sits at just 19,200—a drop of more than 80 percent.[45]

In both states, thousands of able-bodied adults shifted out of the exchange and into Medicaid once federal premium subsidies were no longer available. Thousands of individuals purchasing individual market coverage outside of the exchange or insured through an employer-sponsored plan also became eligible for expansion.

This crowd out likely fueled these states' significant enrollment overruns. Louisiana, for example, predicted just 302,000 adults would sign up for expansion.[46-47] Today, actual

enrollment sits at nearly 455,000.[48] Similarly, Montana projected that fewer than 46,000 adults would enroll in its Medicaid expansion.[49] But actual enrollment has reached nearly 93,000.[50] Both states are now experiencing significant cost overruns.[51]

States that expanded Medicaid before ObamaCare's passage and implementation have also seen significant crowd out of private coverage.[52] These states saw significant drops in the number of individuals with private coverage.[53]

Arizona, for example, expanded Medicaid to able-bodied adults through a 2000 voter referendum.[54] After ten years of operation, the share of Arizona's population on Medicaid had grown by six percentage points.[55] But over that same time, the share of individuals with private insurance coverage dropped by an identical six percentage points.[56]

In 2002, Maine followed suit and expanded eligibility to able-bodied adults through a federal waiver.[57] Ten years later, the share of Mainers covered by Medicaid had grown by seven percentage points, while the share with private health insurance had dropped by seven percentage points.[58]

Similar patterns have played out after other expansions as well.[59] Economists, including ObamaCare architect Jonathan Gruber, have concluded that Medicaid expansions in the late 1990s and early 2000s produced a crowd-out effect of roughly 60 percent.[60] That means that for every ten new Medicaid enrollees, six left private insurance plans.[61] Worse yet, research focusing specifically on the ObamaCare expansion population estimate that the crowd-out rate could reach as high as 82 percent.[62] Any discussion of Florida's expansion costs should factor in the nearly one million Floridians who could shift from private insurance as that market is crowded out by newly eligible Medicaid enrollees.

TAKE-UP RATES IN OTHER STATES EXCEEDED 100 PERCENT

States underestimated Medicaid expansion for two primary reasons: they underestimated the universe of potentially eligible individuals and they underestimated actual take-up rates.

Few states that expanded Medicaid under ObamaCare provided details of all assumptions used to create their enrollment projections. Those with sufficient detail, however, show actual take-up rates of 100 percent or more of their projected universe.

Colorado officials, for example, assumed 75 percent of eligible individuals would enroll in the Medicaid expansion, boosting enrollment by 187,000 able-bodied adults.[63] By September 2017, 458,000 able-bodied adults had enrolled—a take-up rate of 184 percent.[64]

Montana officials assumed take-up rates of 85 percent for eligible uninsured adults and 70 percent for eligible privately insured adults—leading 46,000 adults to enroll in the program.[65] Today, nearly 93,000 adults have enrolled in the program, implying a take-up rate of more than 141 percent.[66]

North Dakota estimated that 20,500 individuals would be eligible for the expansion, with an estimated 13,600 eventually enrolling—an assumed take-up rate of 66 percent.[67] Actual

enrollment hit more than 21,000 by July 2017, implying a take-up rate of more than 100 percent.[68]

Pennsylvania officials assumed 75 percent of eligible individuals would ultimately enroll in Medicaid, with 531,000 able-bodied adults signing up.[69] By 2017, more than 706,000 able-bodied adults had enrolled in the program—a take-up rate of 100 percent.[70]

Washington estimated that 262,000 individuals would enroll in the program—an assumed take-up rate of 73 percent.[71] Actual enrollment hit more than 607,000 by May 2017, implying a take-up rate of 168 percent.[72]

Likewise, the Kaiser Family Foundation predicted a take-up rate of more than 60 percent nationally.[73] But actual enrollment exceeded its projections by an average of 55 percent, indicating an actual take-up rate of nearly 100 percent.[74]

While take-up rates of more than 100 percent may seem implausible, their existence is the result of bad data used to build the projected universe of eligible individuals.

TAKE-UP RATE ASSUMPTIONS SHOULD BE BASED ON ACTUAL ENROLLMENT, NOT SURVEYS

In 2016, the RAND Corporation published a study attempting to measure take-up rates of able-bodied childless adults. But rather than use actual enrollment data, the RAND study extrapolated results from a single survey—the 2014 National Health Interview Survey (NHIS)—to create an "implied" take-up rate.[75] The sample size RAND utilized for Medicaid expansion states totaled just 821 respondents in 2014.[76]

Worse yet, the RAND study was based on survey results for only the first year of expansion.[77] But expansion enrollment has nearly tripled since 2014, meaning that the RAND researchers ignored nearly two-thirds of enrollment in their analysis.[78] Additionally, because NHIS is conducted year-round, the RAND researchers relied on interviews as early as January 2014 to create the implied take-up rates, the first month expansion began in most states.

A review of take-up rates in the exchange show how implausibly low RAND's take-up rates are. In a 2015 report, the Robert Wood Johnson Foundation and Urban Institute found an average take-up rate of nearly 98 percent among individuals in non-expansion states with income between 100 percent and 150 percent FPL purchasing plans on the exchange.[79] That report estimated a take-up rate of nearly 170 percent for Florida.[80] It is beyond implausible that the take-up rate for exchange plans—which requires the payment of premiums—will be significantly higher than Medicaid, where no premiums are required.

PER-ENROLLEE COSTS HAVE ALSO EXCEEDED PROJECTIONS

States opted into ObamaCare expansion have also experienced far higher per-person costs than expected. For example, the Centers for Medicare and Medicaid Services underestimated per-person costs by a whopping 76 percent during the first three fiscal years.[81] This has led to even further cost overruns.

PROMISED "SAVINGS" HAVE NOT MATERIALIZED IN OTHER EXPANSION STATES

Florida should also be wary of promised "savings" created by expanding Medicaid. Many states that opted into ObamaCare expansion hoped that the expansion would produce savings, create jobs, and generate new revenues that would pay for the expansion. To support these claims, many pro-expansion groups have produced studies allegedly estimating the potential financial impact of expansion on states' economies. But these promised savings have not materialized.

The underlying studies were based on simulation models that, by definition, assume the studies' conclusions. These simulation models assume that Medicaid expansion is an automatic fiscal stimulus of new federal money, with no offsetting costs to pay for the expansion and no downstream effects.

Pro-expansion groups have repeatedly cited a report prepared by Deloitte claiming that Medicaid expansion boosted Kentucky's economy, created 40,000 jobs, and saved the state money.[82] This report even claimed that the massive cost overruns led to even more savings and economic stimulus.[83] But none of these promises materialized and the Kentucky Cabinet for Health and Family Services debunked the report based on actual data.[84] Instead of creating thousands of hospital jobs as estimated by Deloitte, Kentucky lost nearly 3,000 hospital jobs in 2014.[85]

Similar promises have gone unfulfilled elsewhere. The Iowa Hospital Association, for example, issued a report prepared by Regional Economic Models, Inc. (REMI) that claimed Medicaid expansion would create 2,400 new jobs by 2020, with 529 new hospital jobs in 2014 alone.[86] Instead, Iowa actually lost 983 hospital jobs in 2014.[87] Likewise, REMI promised Arkansas that expansion would create more than 1,000 new hospital jobs—but the state actually lost 819 hospital jobs in the first 18 months of expansion.[88]

Even the Congressional Budget Office notes that ObamaCare's Medicaid expansion will discourage work and shrink the economy.[89] As such, Florida should not expect Medicaid expansion to produce an economic stimulus.

CONCLUSION

Florida has the opportunity to learn from forecasting mistakes made by other states that opted into Medicaid expansion. Far more able-bodied adults will sign up than anticipated. Costs will be far higher than expected. Promised "savings" will never materialize. Ultimately, if Florida opts into Medicaid expansion, taxpayers, other state priorities, and the truly needy will pay the price as expansion costs soar higher and higher.

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34. Author's calculations based upon three independent models of Florida exchange enrollment, utilizing data provided by the U.S. Department of Health and Human Services. The three models produced consistent results.
35. At the close of 2019 open enrollment, Florida had 1,783,304 exchange enrollees. Approximately 981,323 of these individuals had income between 100 percent and 150 percent FPL. Approximately 801,981 of these individuals had income above 150 percent FPL. In states that expanded Medicaid, those with income above 150 percent FPL represented approximately 86.8 percent of all exchange enrollees. This suggests that if Florida expanded, total exchange enrollment would decline to approximately 924,445 – the total number with income above 150 percent FPL divided by 86.8 percent – as those with income between 100 percent and 138 percent FPL would move from the exchange to Medicaid. The difference between current enrollment and this projected enrollment is approximately 858,859 – the estimated number of individuals currently enrolled in exchange plans in Florida who have income below the Medicaid expansion eligibility thresholds.
36. In 2016, approximately 87.2 percent of enrollees with income between 100 percent and 150 percent FPL in Florida's exchange had income below the Medicaid expansion eligibility threshold. At the close of 2019 open enrollment, Florida had 981,323 exchange enrollees with income between 100 percent and 150 percent FPL. This suggests that approximately 855,285 exchange enrollees in Florida have income below the Medicaid expansion eligibility thresholds – the total number with income between 100 percent and 150 percent FPL multiplied by 87.2 percent.

37. In 2016, approximately 87.2 percent of enrollees with income between 100 percent and 150 percent FPL in Florida's exchange had income below the Medicaid expansion eligibility threshold. But this rate varied by county, from a low of 76.3 percent in Holmes County to a high of 89.8 percent in Hendry County. This suggests that approximately 855,975 exchange enrollees in Florida have income below the Medicaid expansion eligibility thresholds – the total number with income between 100 percent and 150 percent FPL in each county multiplied by the share of enrollees between 100 percent and 150 percent FPL who are below Medicaid expansion eligibility thresholds in each county.
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Members of the Financial Impact Estimating Conference:

As I stated in my July 29 testimony, a proposed constitutional amendment to expand Medicaid under ObamaCare would result enrollment and costs significantly higher than current estimates show. In fact, Florida should expect—at a minimum—nearly two million able-bodied adults to enroll in the proposed expansion based on experience from other states.

Crowding out poses a real threat to Florida's budget

Much of this is the result of the crowding out of private insurance. Nearly two-thirds of potential Medicaid expansion enrollees in Florida already have private coverage. This means that more than one million people in the Conference's assumed eligibility universe could potentially shift from their current plans and onto taxpayer-funded Medicaid, wreaking havoc on Florida's budget and causing headaches for policymakers and taxpayers alike. This will only be made even worse when adjusting for the differences between Census data and Medicaid eligibility rules, as I highlighted on July 29.

Crowd out fueled other states' cost overruns. Exchange enrollment dropped in other states that expanded Medicaid under ObamaCare, pushing more people into Medicaid. Crowding out also occurred in states which expanded Medicaid prior to ObamaCare.

A newly-released report (attached) from the Foundation for Government Accountability (FGA) details the extent of the Medicaid crowd out in Florida, including county-by-county analysis**.**

Federal premium subsidies would vanish

According to the report, if Florida voters expand Medicaid, nearly 860,000 people who currently receive federal premium subsidies would lose their subsidies and be forced out of private coverage. Under federal law, these individuals would then be required to pay the entire cost of their insurance plans out-of-pocket—which averages $627 per month—or they could enroll in Medicaid at no cost to them.

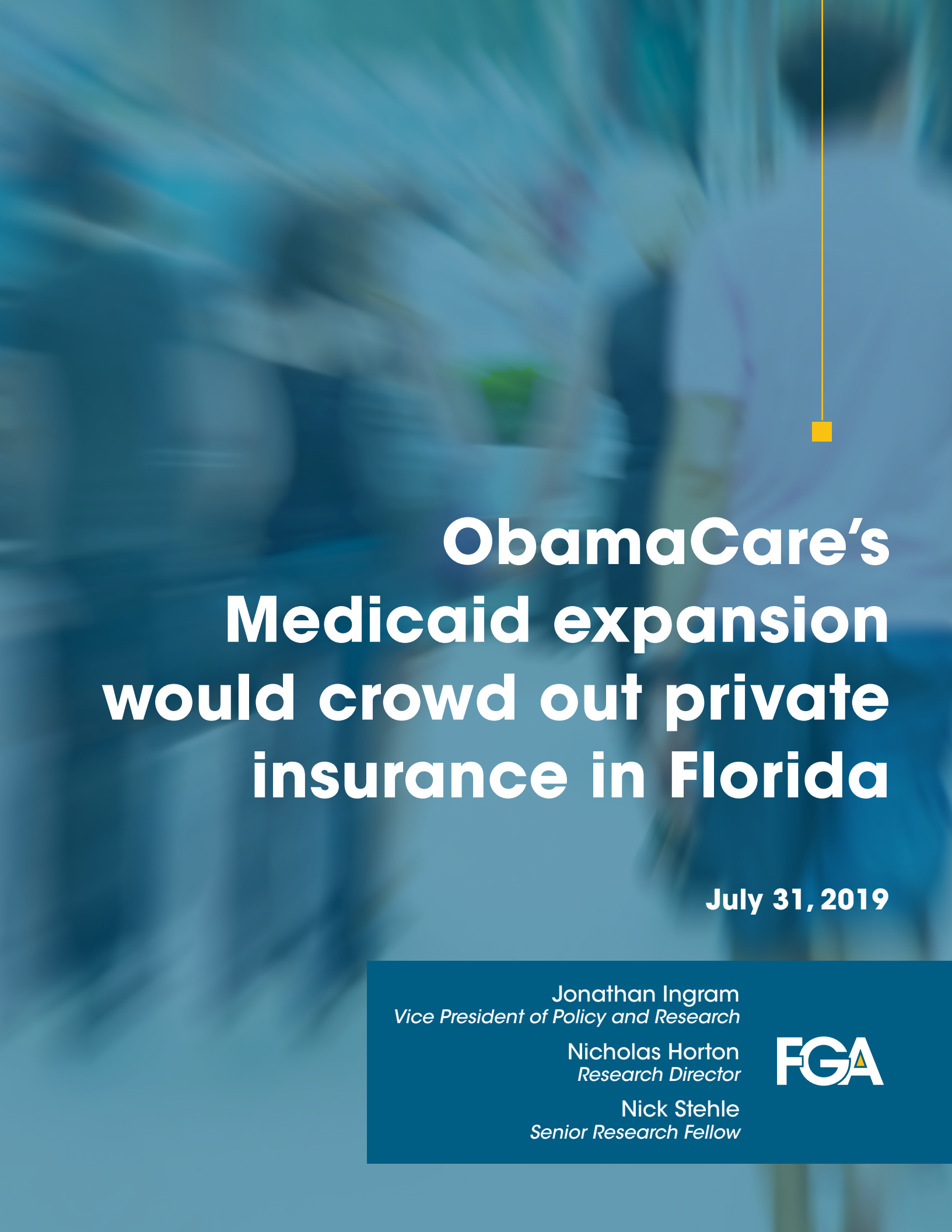
Moreover, healthcare.gov would **automatically apply to Medicaid** on their behalf, further increasing the likelihood that these individuals move out of private coverage and into taxpayer-funded Medicaid. It is difficult to imagine a scenario wherein a significant number of those affected choose to cancel their already-submitted Medicaid application and instead elect to pay hundreds of dollars or more each month for private insurance coverage.

Economists should expect **virtually all of these 860,000 individuals to enroll in Medicaid, shifting much of the cost to Florida taxpayers**.

I appreciate the opportunity to provide comments and hope you find this new research helpful as you seek to predict the impact that Medicaid expansion would have on Florida taxpayers.

Sincerely,

Nick Stehle
Senior Research Fellow



ObamaCare's Medicaid expansion would crowd out private insurance in Florida

July 31, 2019

Jonathan Ingram
Vice President of Policy and Research

Nicholas Horton
Research Director

Nick Stehle
Senior Research Fellow

FGA

KEY FINDINGS

1

NEARLY TWO-THIRDS OF POTENTIAL OBAMACARE EXPANSION ENROLLEES IN FLORIDA ALREADY HAVE PRIVATE COVERAGE.

2

OBAMACARE EXPANSION WOULD FORCE NEARLY 860,000 INDIVIDUALS IN FLORIDA OUT OF PRIVATE COVERAGE AND INTO MEDICAID.

3

STATES THAT RECENTLY EXPANDED OBAMACARE EXPERIENCED A MASSIVE SHIFT FROM PRIVATE COVERAGE TO MEDICAID.

4

OTHER MEDICAID EXPANSIONS HAVE LED TO SIGNIFICANT CROWDING OUT OF PRIVATE COVERAGE.

BOTTOM LINE:

IF FLORIDA EXPANDS OBAMACARE, HUNDREDS OF THOUSANDS OF ABLE-BODIED ADULTS WILL BE SHIFTED OUT OF PRIVATE INSURANCE AND INTO MEDICAID.

Background

The Affordable Care Act, commonly known as ObamaCare, gives states the option to expand Medicaid to a new class of able-bodied, working-age adults. Before this, Medicaid eligibility had traditionally been reserved for the truly needy, such as seniors, individuals with disabilities, and low-income kids.

In December 2018, a newly-formed political action committee filed paperwork to amend Florida's constitution and expand ObamaCare through a ballot initiative.[1] In May 2019, the group had gathered enough signatures to trigger the state to estimate the initiative's financial impact.[2] As state officials prepare those estimates, they should review the lessons learned in other states.

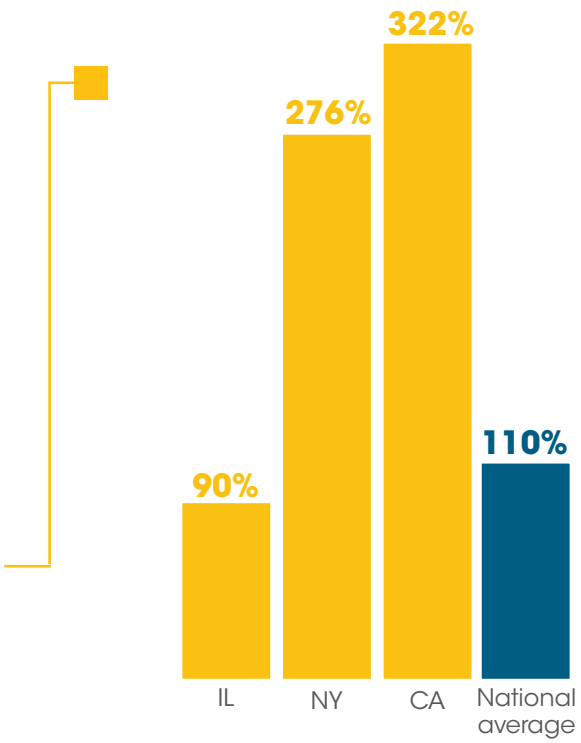
States that have expanded their Medicaid programs under ObamaCare have witnessed skyrocketing enrollment and massive cost overruns.[3-4] States have signed up more than twice as many able-bodied adults as initially projected.[5]

California, for example, projected just 910,000 expansion enrollees would sign up, but more than 3.8 million eventually enrolled.[6] Actual enrollment was 276 percent higher than expected in New York and 90 percent higher than projected in Illinois.[7] Altogether, expansion states exceeded enrollment projections by an average of 110 percent.[8]

In many cases, more able-bodied adults signed up for the programs than state officials predicted would ever even be eligible.[9] Worse yet, the per-person price tag has been nearly twice as high as projected, compounding the cost overruns even further.[10]

Much of the higher-than-expected enrollment has been driven by individuals who already had private insurance or would otherwise qualify for it.[11] If the ballot initiative passes in Florida, more than one million able-bodied adults could be shifted out of private coverage and into Medicaid.[12]

STATES HAVE ENROLLED MORE THAN TWICE AS MANY ABLE-BODIED ADULTS AS PROJECTED



Source: Authors' calculations

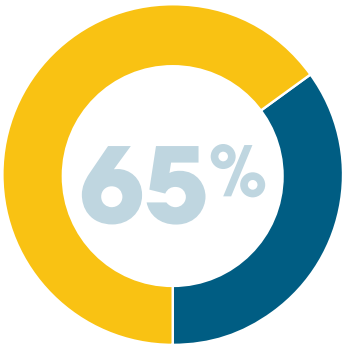
Nearly two-thirds of potential Medicaid expansion enrollees in Florida already have private coverage

The vast majority of able-bodied adults who would become eligible for Medicaid under ObamaCare expansion already have private health insurance. A recent analysis by the Florida Office of Economic and Demographic Research concluded that more than 65 percent of potential newly eligible adults are currently insured, such as through employer-sponsored coverage or in the individual market.[13-14]

In total, more than one million potential Medicaid expansion enrollees in Florida already have private coverage—all of whom could potentially move over from their current plans and onto taxpayer-funded Medicaid, blowing the lid off of the state's budget.

> "More than one million potential Medicaid expansion enrollees in Florida already have private coverage."

MORE THAN 65 PERCENT OF POTENTIAL MEDICAID EXPANSION ENROLLEES ALREADY HAVE PRIVATE COVERAGE



Source: Florida Office of Economic and Demographic Research

Nearly 860,000 individuals will lose federal premium subsidies if Florida expands Medicaid

More than 980,000 individuals with income between 100 percent and 150 percent of the federal poverty level (FPL) currently receive federal premium subsidies from the ObamaCare exchange in Florida—more than any other state.[15]

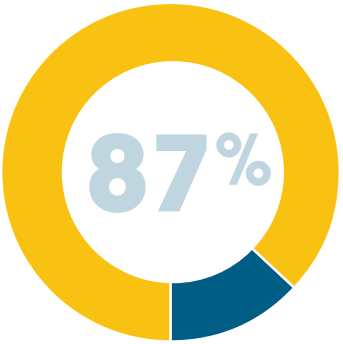
The vast majority of exchange enrollees in this income group have income that would fall within the Medicaid expansion guidelines. According to the latest federal data, more than 87 percent of these enrollees have income below 138 percent FPL—the eligibility line for Medicaid expansion.[16]

However, individuals who become eligible for Medicaid expansion will automatically lose access to federal premium subsidies. Under federal law, individuals are only eligible for premium subsidies if they are "not eligible for minimum essential coverage," including government programs such as Medicaid.[17] In fact, federal law requires healthcare.gov to assess these individuals' eligibility for Medicaid and submit Medicaid applications on their behalf.[18]

This restriction explains why states that have expanded Medicaid under ObamaCare have few exchange enrollees between 100 percent and 150 percent FPL: only those with income above 138 percent FPL can qualify for subsidies. On average, just 13 percent of exchange enrollees in Medicaid expansion states have incomes between 100 percent and 150 percent FPL.[19] By contrast, more than 55 percent of Florida's exchange enrollees are in this income range.[20]

Based on this data, nearly 860,000 individuals with income below the Medicaid expansion eligibility thresholds are currently enrolled in exchange plans in Florida.[21-26] Taxpayers can expect virtually all of these individuals to enroll in Medicaid if the state were to expand ObamaCare. Without premium subsidies, these individuals would be required to pay the entire cost of their premiums out of pocket—which averages $627 per month—to stay in their current plans and proactively cancel their automatic Medicaid application, or they could enroll in Medicaid and pay no premiums at all.[27]

MORE THAN 87 PERCENT OF EXCHANGE ENROLLEES BELOW 150 PERCENT FPL COULD BE FORCED OUT OF PRIVATE COVERAGE AND INTO MEDICAID



Source: Authors' calculations

EXCHANGE ENROLLMENT AMONG THOSE BELOW 150 PERCENT FPL DROPPED BY UP TO 80 PERCENT IN RECENT EXPANSION STATES

Source: Authors' calculations

States that recently expanded Medicaid experienced a massive shift from private coverage to Medicaid

In states that have recently expanded Medicaid under ObamaCare, the number of individuals buying private coverage in the exchange has plummeted.

Montana's Medicaid expansion launched on January 1, 2016. In 2015, before the expansion took effect, approximately 17,600 individuals with income between 100 percent and 150 percent FPL were enrolled in the exchange.[28-29] Today, exchange enrollment among this group sits at just 4,900—a drop of more than 72 percent.[30]

Similarly, Louisiana expanded Medicaid on July 1, 2016. In early 2016, before the expansion took effect, approximately 97,600 individuals with income between 100 percent and 150 percent FPL were enrolled in the exchange.[31] Today, exchange enrollment among this group sits at just 19,200—a drop of more than 80 percent.[32]

In both states, thousands of able-bodied adults shifted out of the exchange and into Medicaid once federal premium subsidies were no longer available. Thousands of individuals purchasing individual market coverage outside of the exchange or insured through an employer-sponsored plan also became eligible for expansion.

This crowd-out likely fueled these states' significant enrollment overruns. Louisiana, for example, predicted just 302,000 adults would sign up for expansion.[33-34] By July 2019, actual enrollment had reached nearly 455,000.[35] Similarly, Montana projected that fewer than 46,000 adults would enroll in its Medicaid expansion.[36] However, actual enrollment reached nearly 93,000.[37] Both states are now experiencing significant cost overruns, as well.[38]

Other Medicaid expansions have led to significant crowding out of private coverage

States that expanded Medicaid before ObamaCare's passage and implementation have also seen significant crowding out of private coverage.[39] Rather than reducing the number of people without insurance, these states saw substantial drops in the number of individuals with private coverage.[40]

Arizona, for example, expanded Medicaid to able-bodied adults through a 2000 voter referendum.[41] After ten years of operation, the share of Arizona's population on Medicaid had grown by six percentage points.[42] Over that same time, the share of individuals with private insurance coverage dropped by an identical six percentage points.[43]

In 2002, Maine followed suit and expanded eligibility to able-bodied adults through a federal waiver.[44] Ten years later, the share of Mainers covered by Medicaid had grown by seven percentage points, while the share with private health insurance had dropped by seven percentage points.[45]

Similar patterns have played out after other expansions as well.[46] Economists, including ObamaCare architect Jonathan Gruber, have concluded that Medicaid expansions in the late 1990s and early 2000s produced a crowd-out effect of roughly 60 percent.[47] That means that for every ten new Medicaid enrollees, six left private insurance plans.[48] Worse yet, research focusing specifically on the ObamaCare expansion population estimates that the crowd-out rate could reach as high as 82 percent.[49]

"Research focusing specifically on the ObamaCare expansion population estimates that the crowd-out rate could reach as high as 82 percent."

Medicaid expansion would siphon resources away from the truly needy to provide welfare to able-bodied adults who already have private insurance

Expanding Medicaid in Florida would crowd hundreds of thousands of able-bodied adults out of private insurance coverage and shift them into taxpayer-funded Medicaid. In fact, nearly two-thirds of these adults have private coverage already. Ultimately, ObamaCare's Medicaid expansion means taking resources away from the truly needy to fund a welfare expansion for those who already have private coverage.

APPENDIX 1

MORE THAN 981,000 EXCHANGE ENROLLEES IN FLORIDA HAVE INCOME BETWEEN 100 PERCENT AND 150 PERCENT FPL

Number of Florida exchange enrollees with incomes between 100 percent and 150 percent FPL, by county, during 2019 open enrollment period

COUNTY	ENROLLEES	COUNTY	ENROLLEES
Alachua County	7,292	Lee County	27,245
Baker County	397	Leon County	7,325
Bay County	5,445	Levy County	1,219
Bradford County	546	Liberty County	129
Brevard County	14,636	Madison County	471
Broward County	143,504	Manatee County	7,655
Calhoun County	245	Marion County	10,524
Charlotte County	3,790	Martin County	4,863
Citrus County	3,914	Miami-Dade County	289,972
Clay County	4,036	Monroe County	2,945
Collier County	15,319	Nassau County	1,574
Columbia County	2,571	Okaloosa County	3,513
DeSoto County	672	Okeechobee County	909
Dixie County	409	Orange County	84,307
Duval County	24,946	Osceola County	28,927
Escambia County	6,038	Palm Beach County	73,556
Flagler County	3,315	Pasco County	13,397
Franklin County	302	Pinellas County	24,713
Gadsden County	1,049	Polk County	16,596
Gilchrist County	345	Putnam County	1,651
Glades County	273	St. Johns County	4,671
Gulf County	355	St. Lucie County	13,070
Hamilton County	289	Santa Rosa County	2,704
Hardee County	536	Sarasota County	10,934
Hendry County	1,526	Seminole County	15,246
Hernando County	5,399	Sumter County	1,711
Highlands County	2,805	Suwannee County	1,269
Hillsborough County	43,470	Taylor County	371
Holmes County	367	Union County	243
Indian River County	4,978	Volusia County	16,539
Jackson County	918	Wakulla County	518
Jefferson County	332	Walton County	1,566
Lafayette County	155	Washington County	518
Lake County	10,298	**Statewide**	**981,323**

Source: U.S. Department of Health and Human Services

APPENDIX 2

MORE THAN 87 PERCENT OF EXCHANGE ENROLLEES WITH INCOME BETWEEN 100 PERCENT AND 150 PERCENT FPL ARE BELOW MEDICAID EXPANSION ELIGIBILITY THRESHOLDS

Florida exchange enrollees with incomes below 138 percent FPL as a share of enrollees with income between 100 percent and 150 percent FPL, by county, during 2016 open enrollment period

COUNTY	SHARE BELOW MEDICAID EXPANSION ELIGIBILITY	COUNTY	SHARE BELOW MEDICAID EXPANSION ELIGIBILITY
Alachua County	87%	Lee County	85%
Baker County	88%	Leon County	87%
Bay County	85%	Levy County	87%
Bradford County	86%	Liberty County	83%
Brevard County	85%	Madison County	85%
Broward County	88%	Manatee County	85%
Calhoun County	83%	Marion County	84%
Charlotte County	84%	Martin County	84%
Citrus County	87%	Miami-Dade County	89%
Clay County	84%	Monroe County	83%
Collier County	85%	Nassau County	87%
Columbia County	84%	Okaloosa County	83%
DeSoto County	84%	Okeechobee County	86%
Dixie County	89%	Orange County	87%
Duval County	87%	Osceola County	87%
Escambia County	85%	Palm Beach County	87%
Flagler County	84%	Pasco County	85%
Franklin County	87%	Pinellas County	86%
Gadsden County	85%	Polk County	86%
Gilchrist County	86%	Putnam County	89%
Glades County	84%	St. Johns County	82%
Gulf County	88%	St. Lucie County	86%
Hamilton County	81%	Santa Rosa County	83%
Hardee County	84%	Sarasota County	84%
Hendry County	90%	Seminole County	85%
Hernando County	84%	Sumter County	82%
Highlands County	86%	Suwannee County	87%
Hillsborough County	87%	Taylor County	85%
Holmes County	76%	Union County	87%
Indian River County	85%	Volusia County	85%
Jackson County	84%	Wakulla County	86%
Jefferson County	84%	Walton County	82%
Lafayette County	78%	Washington County	87%
Lake County	84%	**Statewide**	**87%**

Source: U.S. Department of Health and Human Services

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13. Ibid.
14. Other analyses have produced similar results. See, e.g., Nicholas Horton and Jonathan Ingram, "The ObamaCare cost shift: How Medicaid expansion is crowding out private insurance," Foundation for Government Accountability (2019), https://thefga.org/research/medicaid-crowding-out-private-insurance.
15. Centers for Medicare and Medicaid Services, "2019 marketplace open enrollment period: State-level public use files," U.S. Department of Health and Human Services (2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2019OEPStateLevelPublicUseFile.zip.
16. Authors' calculations based upon data provided by the U.S. Department of Health and Human Services on the number of Exchange enrollees in Florida with income between 100 percent and 138 percent FPL and between 138 percent and 150 percent FPL. Beginning in 2017, this data has been combined into a single group of individuals with incomes between 100 and 150 percent FPL. See, e.g., Centers for Medicare and Medicaid Services, "2016 qualified health plan selections by county and various demographic characteristics," U.S. Department of Health and Human Services (2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/County_Level_Demographics_20160615.zip.
17. 26 C.F.R. § 1.36B-2 (2018), https://www.govinfo.gov/content/pkg/CFR-2018-title26-vol1/pdf/CFR-2018-title26-vol1-sec1-36B-2.pdf.
18. 42 C.F.R. § 435.1200 (2018), https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec435-1200.pdf.
19. Authors' calculations based upon data provided by the U.S. Department of Health and Human Services on the number of Exchange enrollees with income between 100 percent and 150 percent FPL and the total number of Exchange enrollees, disaggregated by state and Medicaid expansion decision. See, e.g., Centers for Medicare and Medicaid Services, "2019 marketplace open enrollment period: State-level public use files," U.S. Department of Health and Human Services (2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2019OEPStateLevelPublicUseFile.zip.
20. Ibid.
21. Authors' calculations based upon three independent models of Florida exchange enrollment, utilizing data provided by the U.S. Department of Health and Human Services. The three models produced consistent results.
22. At the close of 2019 open enrollment, Florida had 1,783,304 exchange enrollees. Approximately 981,323 of these individuals had income between 100 percent and 150 percent FPL. Approximately 801,981 of these individuals had income above 150 percent FPL. In states that expanded Medicaid, those with income above 150 percent FPL represented approximately 86.8 percent of all exchange enrollees. This suggests that if Florida expanded, total exchange enrollment would decline to approximately 924,445 – the total number with income above 150 percent FPL divided by 86.8 percent – as those with income between 100 percent and 138 percent FPL would move from the exchange to Medicaid. The difference between current enrollment and this projected enrollment is approximately 858,859 – the estimated number of individuals currently enrolled in exchange plans in Florida who have income below the Medicaid expansion eligibility thresholds.

23. In 2016, approximately 87.2 percent of enrollees with income between 100 percent and 150 percent FPL in Florida's exchange had income below the Medicaid expansion eligibility threshold. At the close of 2019 open enrollment, Florida had 981,323 exchange enrollees with income between 100 percent and 150 percent FPL. This suggests that approximately 855,285 exchange enrollees in Florida have income below the Medicaid expansion eligibility thresholds – the total number with income between 100 percent and 150 percent FPL multiplied by 87.2 percent.
24. In 2016, approximately 87.2 percent of enrollees with income between 100 percent and 150 percent FPL in Florida's exchange had income below the Medicaid expansion eligibility threshold. But this rate varied by county, from a low of 76.3 percent in Holmes County to a high of 89.8 percent in Hendry County. This suggests that approximately 855,975 exchange enrollees in Florida have income below the Medicaid expansion eligibility thresholds – the total number with income between 100 percent and 150 percent FPL in each county multiplied by the share of enrollees between 100 percent and 150 percent FPL who are below Medicaid expansion eligibility thresholds in each county.
25. Centers for Medicare and Medicaid Services, "2019 marketplace open enrollment period: State-level public use files," U.S. Department of Health and Human Services (2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2019OEPStateLevelPublicUseFile.zip.
26. Centers for Medicare and Medicaid Services, "2016 qualified health plan selections by county and various demographic characteristics," U.S. Department of Health and Human Services (2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/County_Level_Demographics_20160615.zip.
27. Centers for Medicare and Medicaid Services, "2019 marketplace open enrollment period: State-level public use files," U.S. Department of Health and Human Services (2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2019OEPStateLevelPublicUseFile.zip.
28. Authors' calculations based upon data provided by the U.S. Department of Health and Human Services on county-level exchange enrollment for individuals with incomes between 100 percent and 150 percent FPL. See, e.g., Centers for Medicare and Medicaid Services, "2015 marketplace open enrollment period: County-level public use files," U.S. Department of Health and Human Services (2015), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2015_OEP_County-Level_Public_Use_File.zip.
29. Enrollment for Petroleum and Treasure counties was suppressed because the count was less than 10 enrollees. This analysis imputes 9 enrollees in each county, based on the share of enrollees in non-suppressed counties. Imputing 1 enrollee in each county would impact the total enrollment figure by less than 0.1 percent.
30. Centers for Medicare and Medicaid Services, "2019 marketplace open enrollment period: State-level public use files," U.S. Department of Health and Human Services (2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2019OEPStateLevelPublicUseFile.zip.
31. Authors' calculations based upon data provided by the U.S. Department of Health and Human Services on county-level exchange enrollment for individuals with incomes between 100 percent and 150 percent FPL. See, e.g., Centers for Medicare and Medicaid Services, "2015 marketplace open enrollment period: County-level public use files," U.S. Department of Health and Human Services (2015), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2015_OEP_County-Level_Public_Use_File.zip.
32. Centers for Medicare and Medicaid Services, "2019 marketplace open enrollment period: State-level public use files," U.S. Department of Health and Human Services (2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2019OEPStateLevelPublicUseFile.zip.
33. Authors' calculations based upon data provided by the Louisiana Legislative Fiscal Office on projected enrollment and expenditures under a Medicaid expansion plan sponsored by the governor when he was in the state legislature. See, e.g., Shawn Hotstream, "Fiscal note: Medicaid expansion," Louisiana Legislative Fiscal Office (2015), https://legiscan.com/LA/supplement/HB517/id/33239/Louisiana-2015-HB517-Fiscal_Note_-_HB517_Original.pdf.
34. Louisiana based its official fiscal note on a "moderate take-up model," but also produced a "high take-up model" for comparison. The state estimated that 298,000 uninsured adults would become eligible for expansion. Approximately 90 percent of these adults were expected to enroll in the high take-up model, at a cost of $5.6 billion over five years. Although state officials did not release the take-up assumption in the moderate take-up model, they did estimate that costs would be $4.9 billion over the same five-year period. Because both models relied on the same per-person cost, this implies the take-up rate for the moderate take-up model is roughly 12.5 percent lower than the high take-up model. This translates into an assumed take-up rate of 78.75 percent, with estimated enrollment of 234,675 uninsured adults. State officials also assumes approximately 67,000 adults would be crowded out of private coverage and move into Medicaid. Altogether, fewer than 302,000 newly eligible adults were expected to enroll.
35. Louisiana Department of Health, "LDH Medicaid expansion dashboard," Louisiana Department of Health (2019), http://www.ldh.la.gov/HealthyLaDashboard.
36. Medicaid and Health Services Branch, "Senate Bill 405: Fiscal note, 2017 biennium," Montana Governor's Office of Budget and Program Planning (2015), https://leg.mt.gov/bills/2015/FNPDF//SB0405_1.pdf.
37. Montana Department of Public Health and Human Services, "Montana Medicaid expansion dashboard," Montana Department of Public Health and Human Services (2019), https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.
38. Jonathan Ingram and Nicholas Horton, "A budget crisis in three parts: How ObamaCare is bankrupting taxpayers," Foundation for Government Accountability (2018), https://thefga.org/research/budget-crisis-three-parts-obamacare-bankrupting-taxpayers.
39. Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), https://thefga.org/wp-content/uploads/2013/03/UO-Medicaid-Expansion-We-already-know-how-the-story-ends.pdf.
40. Ibid.

41. Ibid.
42. Ibid.
43. Ibid.
44. Ibid.
45. Ibid.
46. Ibid.
47. Jonathan Gruber and Kosali Simon, "Crowd-out ten years later: Have recent public insurance expansions crowded out private health insurance?" Journal of Health Economists 27(2): 201-17 (2008), http://www.sciencedirect.com/science/article/pii/S0167629607000963.
48. Ibid.
49. Stephen D. Pizer et al., "The effect of health reform on public and private insurance in the long run," Social Science Research Network (2011), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1782210.

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THE BUCKEYE INSTITUTE

Testimony Before the Florida Financial Impact Estimating Conference

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My name is Greg R. Lawson. I am a research fellow at **The Buckeye Institute**, an independent research and educational institution—a think tank—whose mission is to advance free-market public policy in the states.

Medicaid expansion in Ohio has resulted in a much higher enrollment than had been projected, which has led to cost overruns even when the Medicaid expansion occurred during a period of economic growth.

Ohio's Medicaid expansion became effective in January 2014. During the debate in 2013 over whether to expand Medicaid, the administration of then-Governor John Kasich projected much smaller enrollment for the Group VIII expansion population than what ultimately materialized. According to estimates from early in 2013 (see attached document), the administration estimated that by the current fiscal year in Ohio (Fiscal Year 2020), 447,000 newly eligible individuals would enroll.

For most of **2017**, the Group VIII enrollment was consistently over 700,000, and as of **June 2019**, there are 612,000. In fact, Group VIII enrollment remained well above initial projections even as the **unemployment rate in Ohio** continued to fall from 7.5 percent in June 2013 to four percent in June 2019.

According to data provided by Ohio's Legislative Service Commission, in Fiscal Year 2009, total *state* spending (both general and non-general revenue) was $5.3 billion. By Fiscal Year 2019, total state spending was $8.5 billion, a 59 percent increase. While the increase is not all attributable to the expansion, these large increases undermine part of the major rationale for expansion, which was that the expansion would save the state money while placing the onus on the federal government.

Total costs for Ohio's expansion through the end of 2017 were $16.8 billion and were over $400 million per month. Additionally, the per member per month cost of those in Medicaid expansion is now projected to be approximately **$700** by Fiscal Year 2021, which shows a steady upward trend. Although the federal government initially paid for the cost of covering Group VIII enrollees, the state now covers almost 10 percent of the costs of coverage. Not only do these costs persist for the state, but additional administrative costs come with providing more individuals with access to the Medicaid program, stretching the ability of local offices to handle the workloads and make eligibility determinations, and crowding out access to Medicaid services from those in actual need of this health care option.

Thanks to a legislative change in the previous state budget, we finally have access to **monthly budget variance data**. Fortunately, actual spending on the Group VIII population has largely been coming in below budget on a monthly basis in the last year and a half. This fact correlates with falling enrollment due to a strengthening economy and **sustained job growth**.

What is shocking about Group VIII enrollment following Ohio's Medicaid expansion being well above initial projections was that the economy continued to expand. Research from the **Congressional Budget Office**, the **National Bureau of Economic Research**, and other **academic work** indicated that the increase of public insurance would likely result in some reduction in the

supply of labor to the market. As our economic expansion becomes the longest on record, people looking for jobs are still able to find them. However, if the Medicaid expansion continues to encourage people who could be working to stay out of the labor force, the next economic downturn could be worse for the state in terms of finding the money to cover those who would be in real need of Medicaid services.

We acknowledge there are going to be differences between Ohio and Florida projections and experiences. Yet, the fact that every other state that has expanded Medicaid has—similar to Ohio—under-projected its own enrollment should raise a red flag about how an expansion in Florida will play out over time.

Thank you again for the opportunity to testify today. I am happy to answer any questions that the Committee may have.

About The Buckeye Institute

Founded in 1989, The Buckeye Institute is an independent research and educational institution—a think tank—whose mission is to advance free-market public policy in the states.

The staff at Buckeye accomplish the organization's mission by performing timely and reliable research on key issues, compiling and synthesizing data, formulating sound free-market policies, and promoting those solutions for implementation in Ohio and replication across the country.

The Buckeye Institute is located directly across the street from the Ohio Statehouse on Capitol Square in Columbus, where it assists legislative and executive branch policymakers by providing ideas, research, and data to enable the lawmakers' effectiveness in advocating free-market public policy solutions.

The Buckeye Institute is a non-partisan, non-profit, and tax-exempt organization, as defined by section 501(c)(3) of the Internal Revenue code. As such, it relies on support from individuals, corporations, and foundations that share a commitment to individual liberty, free enterprise, personal responsibility, and limited government. The Buckeye Institute does not seek or accept government funding.

Office of Health Transformation

Extend Medicaid Coverage and Automate Enrollment

Background:

Eligibility determination for health and human services programs in Ohio are fragmented, overly complex, and reliant on outdated technology. For example, Ohio has more than 150 categories of eligibility just for Medicaid. Variation in Medicaid income eligibility creates gaps in coverage that result in unnecessary costs for local government, uncompensated costs for hospitals, and cost-shifting to private sector insurance premiums, all of which are paid for by taxpayers and businesses. Eligibility reforms in the budget have the potential to significantly improve care for vulnerable Ohioans, increase program efficiencies, and reduce costs for Ohio's taxpayers.

Applying for Medicaid is confusing and time consuming. More than 2.3 million Ohioans were enrolled in Medicaid in December 2012. Many families came through the front door of one of the 88 local County Department of Job and Family Services (CDJFS) service centers and had to physically meet with a caseworker to get through the application process, providing information whenever it was determined more was needed, and often requiring multiple repeat visits to the county office. These families qualified through a myriad of requirements, computations, and verifications. Income disregards or special income treatment was used as needed with each family or, in some cases, different individuals in the same family.

Current Medicaid eligibility policies leave gaps in coverage. An estimated 1.5 million Ohioans do not have health insurance, most of them from working families, and some of them very poor (Appendix C shows the number of low-income uninsured Ohioans by county).[1] Medicaid plays a critical role in protecting the health of low-income Ohioans, but it leaves out many people (see Figure 1). Like many states, Ohio does not extend Medicaid coverage to adults unless they have children or are disabled. Beginning in January 2014, the federal government will establish a Health Insurance Exchange to offer tax credits for insurance premiums to Ohioans with incomes between 100 percent and 400 percent FPL, but no credits will be provided below 100 percent FPL. As a result, parents between 90 percent and 100 percent FPL and childless adults with income below 100 percent FPL will be caught in a "coverage gap" without access to Medicaid or tax credits on the Exchange (Figure 1).

Federal funding is available to eliminate the coverage gap. In June 2012, a U.S. Supreme Court ruling gave states the option to increase Medicaid eligibility for all adults to 138 percent FPL,[2] with the federal government paying 100 percent of the costs for the newly eligible population during the first three years, decreasing to 90 percent by 2020. States have flexibility to decide

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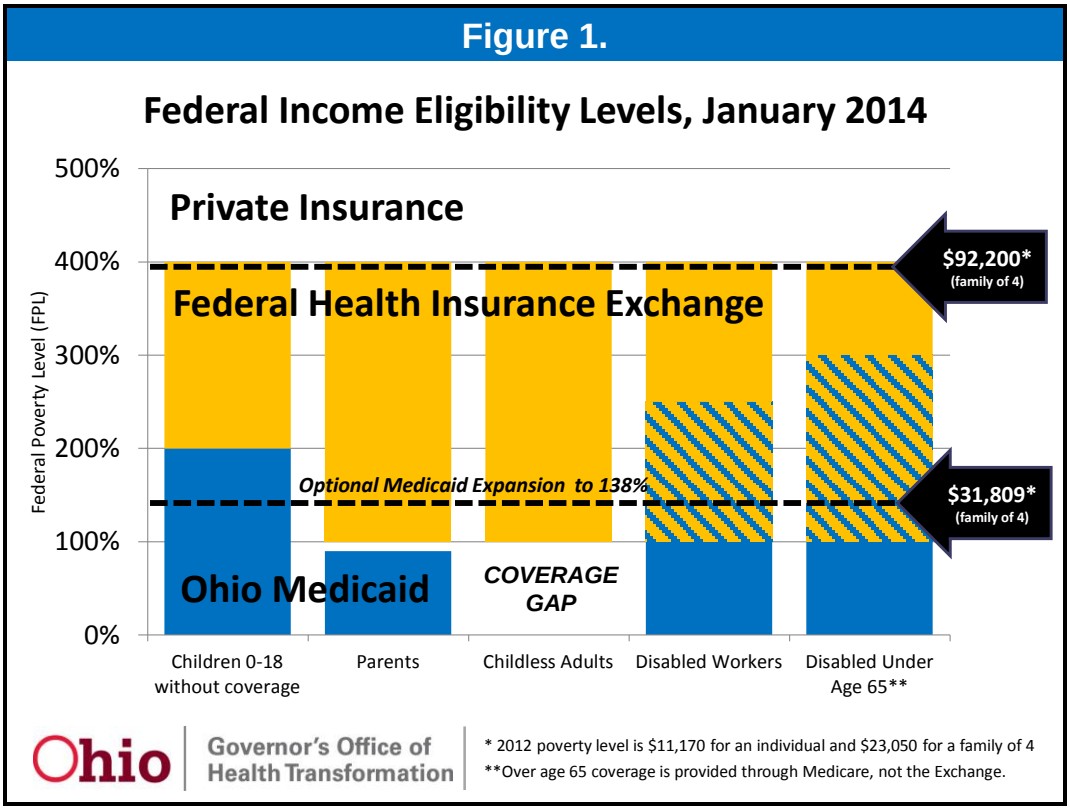
[1] US Census Bureau, *Health Insurance Coverage Status by State for All People* (2011).

[2] The Affordable Care Act requires eligibility for adults to be set at 133 percent FPL but also establishes a 5 percent income disregard, so the effective eligibility level is up to 138 percent FPL.

whether or not and when to extend coverage, but the years of federal funding are fixed[3] and enhanced federal funding is not available for a partial expansion.[4]

Figure 1.



Federal funding also is available to simplify and automate eligibility systems. In August 2011, the federal government announced a time-limited opportunity for states to use enhanced (90 percent) federal matching funds to integrate eligibility determination functions across programs based on income eligibility.[5] The new policy allows health and human services programs – including Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program and Child Care and Development Fund – to utilize systems designed for determining a person's Medicaid eligibility without sharing in the common system development costs, so long as those costs would have been incurred to develop systems for Medicaid. States may access the 90-percent enhanced federal funding up to but not after December 31, 2015.

Ohio law requires eligibility modernization. Governor Kasich's Jobs Budget (HB 153), enacted June 2011, directed Ohio Medicaid "to reduce the complexity of the eligibility determination processes for the Medicaid program caused by different income and resource standards for the

[3] The Federal Medical Assistance Percentage (FMAP) for the expansion is fixed at 100 percent in 2014, 2015 and 2016, and then decreases to 95 percent in 2015, 94 in 2018, 93 in 2019, and 90 percent in 2020 and beyond.
[4] CMS, *Frequently asked questions on Exchanges, market reforms, and Medicaid* (December 10, 2012), page 12.
[5] Joint USDA, CMS, ACF *Guidance on developing integrated eligibility determination systems* (August 11, 2011).

numerous Medicaid eligibility categories" and "obtain to the extent necessary the approval of the United States Secretary of Health and Human Services."[6] The Governor's Office of Health Transformation prepared an application to modernize Ohio's eligibility systems, but put the waiver on hold pending a decision about whether or not to change Medicaid eligibility levels.[7]

Executive Budget Proposal and Impact:

The Executive Budget includes a comprehensive package of reforms to simplify eligibility based on income, streamline state and local responsibility for eligibility determination, and update eligibility systems technology. The goal is for most enrollees to become eligible for Medicaid and other programs based on income tax information without needing to undergo any additional eligibility tests. The two major features of the plan are to simplify eligibility policy and to automate eligibility determination systems.

SIMPLIFY ELIGIBILITY POLICY

Consolidate Medicaid eligibility into three basic groups. As a first step, Ohio will map the state's current 150+ Medicaid eligibility categories into three groups: (1) children and pregnant women, (2) individuals who are age 65 or older, who have Medicare coverage, or who need long-term services and supports, and (3) community adults (non-pregnant adults who do not need long-term services and supports), including individuals eligible as parents or caretaker relatives.[8] The eligibility criteria and standards for the first two simplified groups will not change (income, resources, spend-down, disability determination, and other creditable coverage will be treated the same). Only the third group, community adults, will see significant changes in eligibility standards for Medicaid. All three groups will benefit from simplified processes, including for most applicants conversion to a new federally mandated modified adjusted gross income (MAGI) standard that will allow for real-time eligibility determination.[9]

Simplify eligibility standards and increase coverage for community adults. Beginning January 1, 2014, community adult applicants will qualify for Medicaid with MAGI at or below 138 percent FPL. There will be no application of spend-down processes, no resource test, and no state or federal disability determination requirement, although there will be other qualifying criteria such as legal residency. The new policy is expected to impact the following populations:

- Newly eligible. Community adults with MAGI below 138 percent FPL, including parents with MAGI between 90 percent and 138 percent FPL, will be newly eligible to enroll in Medicaid. Ohio Medicaid estimates 366,000 individuals will enroll, including 270,000 previously uninsured Ohioans (Figure 2). The total cost of services for this group is

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[6] ORC 5111.0123

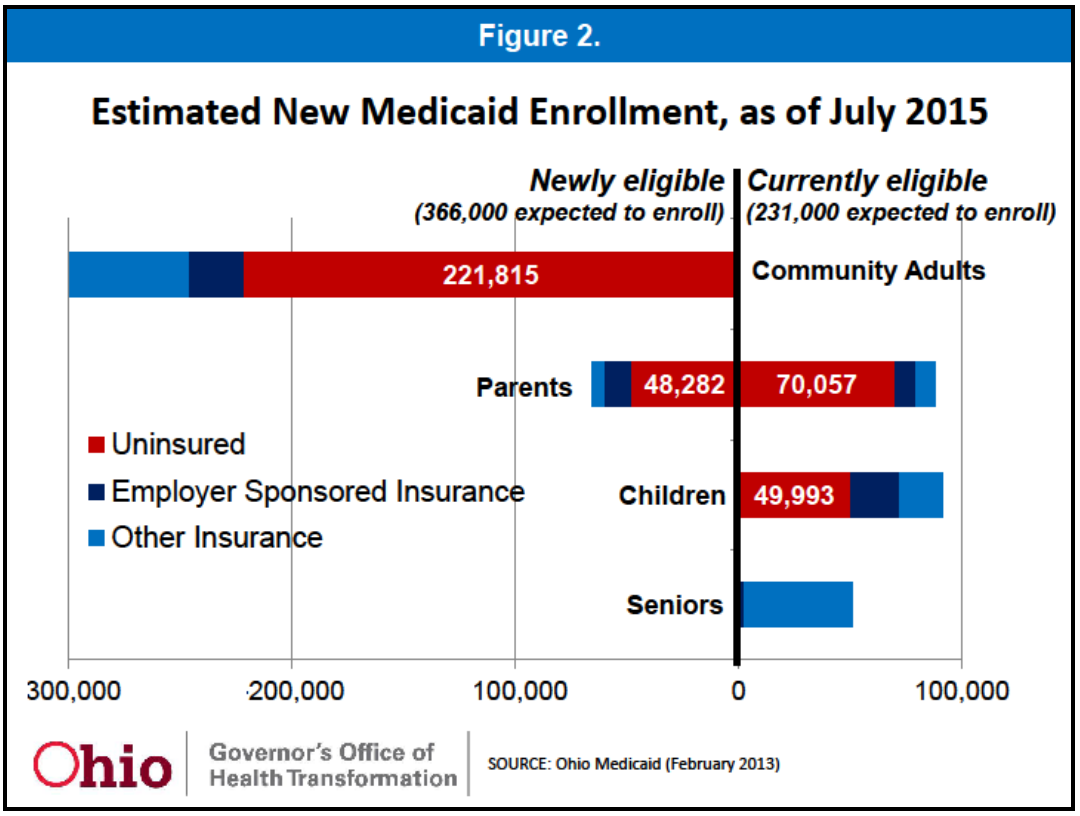
[7] Office of Health Transformation, *Proposed Section 1115 Demonstration: Eligibility Modernization* (June 2012).

[8] Community adults include the expansion population called "Group VIII" by the federal government based on the section of law that defines the group; CMS, *New option for coverage of individuals under Medicaid* (April 9, 2010).

[9] CMS, *Conversion of net income standards to MAGI equivalent income standards* (December 28, 2012).

estimated to be $2.6 billion over the biennium, all of which will be paid by the federal government. In some cases, state and local government will see savings result when Ohioans who are covered by other programs move onto Medicaid. For example, the Ohio Department of Rehabilitation and Correction estimates it will save $27 million over the biennium on inpatient hospital costs for prisoners, and the county community mental health and addiction services system is expected to save $105 million over the biennium on services that shift to Medicaid, primarily for adults who do not currently have access to coverage. (Appendix B summarizes the newly eligible impact on federal, state and local resources.)

Figure 2.



- Currently eligible but not enrolled. Some people who are currently eligible but not yet enrolled in Medicaid are expected to enroll in January 2014, regardless of whether or not eligibility expands. This "woodwork effect" results from the new federal requirement to have health insurance, easier access to insurance through the federal Health Insurance Exchange, and increased awareness about the availability of health coverage. Ohio Medicaid estimates an additional 92,000 children, 88,000 parents, and 51,000 seniors will enroll in Medicaid as a result of the woodwork effect (Figure 2). Ohio will receive the regular federal match rate for this population, resulting in higher state Medicaid costs. Ohio Medicaid estimates the cost of these individuals will be $1.5 billion

($521 million state share) over the biennium.[10] (Appendix B summarizes the impact of woodwork on federal, state and local resources; the woodwork effect is *not included* in the estimated cost of eligibility simplification and automation because it is expected to occur with or without changes in Medicaid income eligibility policy).

- Previously eligible. Some community adults qualify for Medicaid today at income levels above 138 percent FPL as a result of income disregards, transitional medical assistance, and other exceptions. Ohio Medicaid estimates that 90,863 individuals who would have qualified for Medicaid under current policies will not under the new MAGI policy (Figure 3). However, these individuals will have access to tax credits on the Health Insurance Exchange, up to 400 percent FPL. Ohio Medicaid estimates the savings from not covering this group on Medicaid will be $246 million over the biennium, and because the state would have paid the regular match for this population, the state will save $91 million over the biennium. (Appendix B summarizes the impact of this group on federal, state and local resources.)

Figure 3.
Estimated Medicaid Enrollment from Eligibility Simplification

Newly Eligible Population	Estimated Gain/(Loss) as of June 2015
Previously uninsured	270,097
Previously had other insurance	95,519
Subtotal new enrollment	***365,616***
Previously had Medicaid	(90,863)
Total change in enrollment	**274,753**

Source: Appendix A provides more detail about estimated enrollment.

Eligibility simplification will result in some Ohioans becoming newly eligible for Medicaid, and some who would have been eligible under the old rules not being eligible in the future. The federal, state and local financial impact of these changes is summarized in Figure 4.

[10] Ohio Medicaid's earlier estimates of woodwork were higher than current estimates because: (1) the earlier estimate counted eight quarters of expanded enrollment and spending beginning January 2014 when the Medicaid expansion takes effect, but the budget estimate is for the period beginning July 2013, which begins six months prior to the expansion, so the budget estimate counts six quarters of expanded enrollment and spending not eight; and (2) the earlier estimate was based on the 2010 Family Health Survey (FHS) and the current estimate is based on the 2012 FHS.

Figure 4.
Estimated Financial Impact Resulting from Eligibility Simplification

Source of Funds	SFY14-15 Costs/(Savings)
Federal	
Newly eligible enrollment cost	$2.6 billion
Previously eligible enrollment savings	($155 million)
Total	$2.4 billion
State	
Newly eligible enrollment cost	$0
Previously eligible enrollment savings	($91 million)
State inpatient hospital for prisoners	($27 million)
Net HIC and sales tax revenue	($117 million)
Total	($235 million)
County	
Service costs that shift to Medicaid	($105 million)
Net sales tax revenue	($25 million)
Total	($130 million)
Source: Appendix B provides more detail about estimated enrollment.	

Expect personal responsibility from Ohioans who benefit from Medicaid. In order to ensure individuals in the Medicaid program take personal responsibility for their health care services and also become ready to move off of Medicaid and into private insurance, Medicaid is proposing new cost sharing requirements for every adult above 100 percent of poverty. This proposal is in line with proposed federal regulations on cost sharing. Ohio will require an $8 co-payment for use of an emergency room for non-emergency conditions, $8 co-pays for non-preferred drugs, and $3 co-pays for preferred drugs. Certain long-term maintenance drugs (such as insulin) will have no co-pay. Also, under new federal rule changes, a provider can deny a service if the person does not pay the co-pay. For example, a pharmacist could deny the person the non-preferred drug for not paying the $8 co-pay but instead offer the preferred drug at the $3 co-pay.

Opt out if federal funding is reduced. The federal government has made it clear that states may opt in and out of covering newly eligible populations at any time.[11] The Executive Budget codifies an automatic opt out trigger so that if for any reason the federal government reduces its financial participation for expanded coverage, then the program for newly eligible groups shuts down, and Ohio taxpayers are not stuck holding the bill. In addition, Ohio Medicaid may

[11] CMS, Frequently asked questions on exchanges, market reforms and Medicaid (December 2012), question 24

turn off eligibility for newly eligible populations if the state is required as a result of federal action to reduce or eliminate any tax that provides financial support for the Medicaid program.

AUTOMATE ELIGIBILITY DETERMINATION SYSTEMS

Replace Ohio's 34-year-old eligibility determination system. Ohio's Enhanced Client Registry Information System (CRIS-E) provides intake and eligibility determination support for several of Ohio's health and human services programs and provides some case management functions for several Ohio Department of Job and Family Services programs. When CRIS-E was implemented in 1978, it was able to meet the needs of the counties by allowing for 18,000 users to manually enter cases for Ohio citizens. As time went by, many processes were added to allow the original system to do more, but all of the additions were built on the original foundation, which could only extend so far and long ago reached its limit of new applications. The problem is so severe that Ohio Medicaid estimates 60 percent of CRIS-E's eligibility determinations for Medicaid need to be manually overridden to prevent eligible applicants from being denied coverage. CRIS-E is so fragile and technically obsolete that it is no longer practical or cost effective to invest in enhancing the system.

Replace CRIS-E with a new integrated eligibility system. The Ohio Department of Administrative Services is contracting with a vendor to replace CRIS-E with a new, integrated, enterprise solution that supports both state and county operations.[12] The new system will provide the technology necessary for integrating eligibility across Ohio's health and human services agencies. The project will focus first on Medicaid eligibility, then expand to other programs that currently depend on CRIS-E (this phase will retire CRIS-E), and finally expand to support other health and human services programs. The new system will give individuals and families seeking Medicaid coverage an option to apply online and provide real-time determination for most people who apply. The budget includes $230 million for this system ($26 million state share) over the biennium.

Change eligibility processes and workflow to be more efficient. In addition to the CRIS-E replacement, the Ohio Department of Administrative Services will release a second request for proposals (RFP) in February 2013 to acquire an organizational change management (OCM) vendor to coordinate the transition from the current business environment to a new, more efficient and effective business environment. Combined with the simplification of eligibility policy, the new integrated eligibility system provides the opportunity to improve the business processes involved with enrolling Ohio citizens in HHS programs. The state is working with county agencies to improve the processes at both the county and state levels. The Executive Budget includes funding for this project and leverages 90 percent federal funds.

Updated January 31, 2013

[12] DAS, *Integrated eligibility and HHS business intelligence procurement*

Appendix A.
Projected Medicaid ENROLLMENT for Newly Eligible, Currently Eligible but not Enrolled, and Previously Eligible Medicaid Populations

Current Source of Coverage	Ultimate Take-Up Rates	Best Estimate of Participation SFY 2015	Best Estimate of Participation SFY 2020
NEWLY ELIGIBLE			
Parents (19-64 years)			
Uninsured	70%	48,282	58,981
Individual	70%	3,459	4,225
Employer	20%	11,994	14,658
Other/unknown	20%	2,076	2,538
Newly eligible parents		***65,811***	***80,402***
Childless Adults (19-64 years)			
Uninsured	55%	221,815	271,082
Individual	55%	36,986	45,200
Employer	15%	25,025	30,583
Other/unknown	15%	15,979	19,527
Newly eligible childless adults		***299,805***	***366,392***
NEWLY ELIGIBLE TOTAL ENROLLMENT		**365,616**	**446,794**
CURRENTLY ELIGIBLE NOT ENROLLED (WOODWORK)			
Children (up to age 19)			
Uninsured	80%	49,993	83,134
Individual	80%	13,057	21,721
Employer	15%	22,141	36,833
Medicare Only	15%	914	1,521
Other/unknown	15%	5,469	9,098
Woodwork children		***91,574***	***152,307***
Parents (19-64 years)			
Uninsured	65%	70,057	116,549
Individual	65%	3,239	5,389
Employer	20%	9,112	15,153
Medicare Only	20%	2,376	3,953
Other/unknown	20%	3,535	5,879
Woodwork parents		***88,319***	***146,923***
Aged (65 and over)			
Uninsured	20%	1,189	1,999
Individual	20%	1,149	1,932
Employer	20%	1,506	2,531
Medicare Only	20%	45,190	75,933
Other/unknown	20%	1,865	3,133
Woodwork aged		***50,899***	***85,528***
WOODWORK TOTAL ENROLLMENT		**230,792**	**384,758**
PREVIOUSLY ELIGIBLE			
Breast and cervical cancer		6	8
Family planning		26,378	27,516
Transitional Medicaid to six months		54,123	55,419
Parent coverage		10,356	10,671
PREVIOUSLY ELIGIBLE TOTAL ENROLLMENT		**90,863**	**93,614**

2020 number based on June 2015 participation estimate (caseload trend information is not available)

2015 is average monthly enrollment

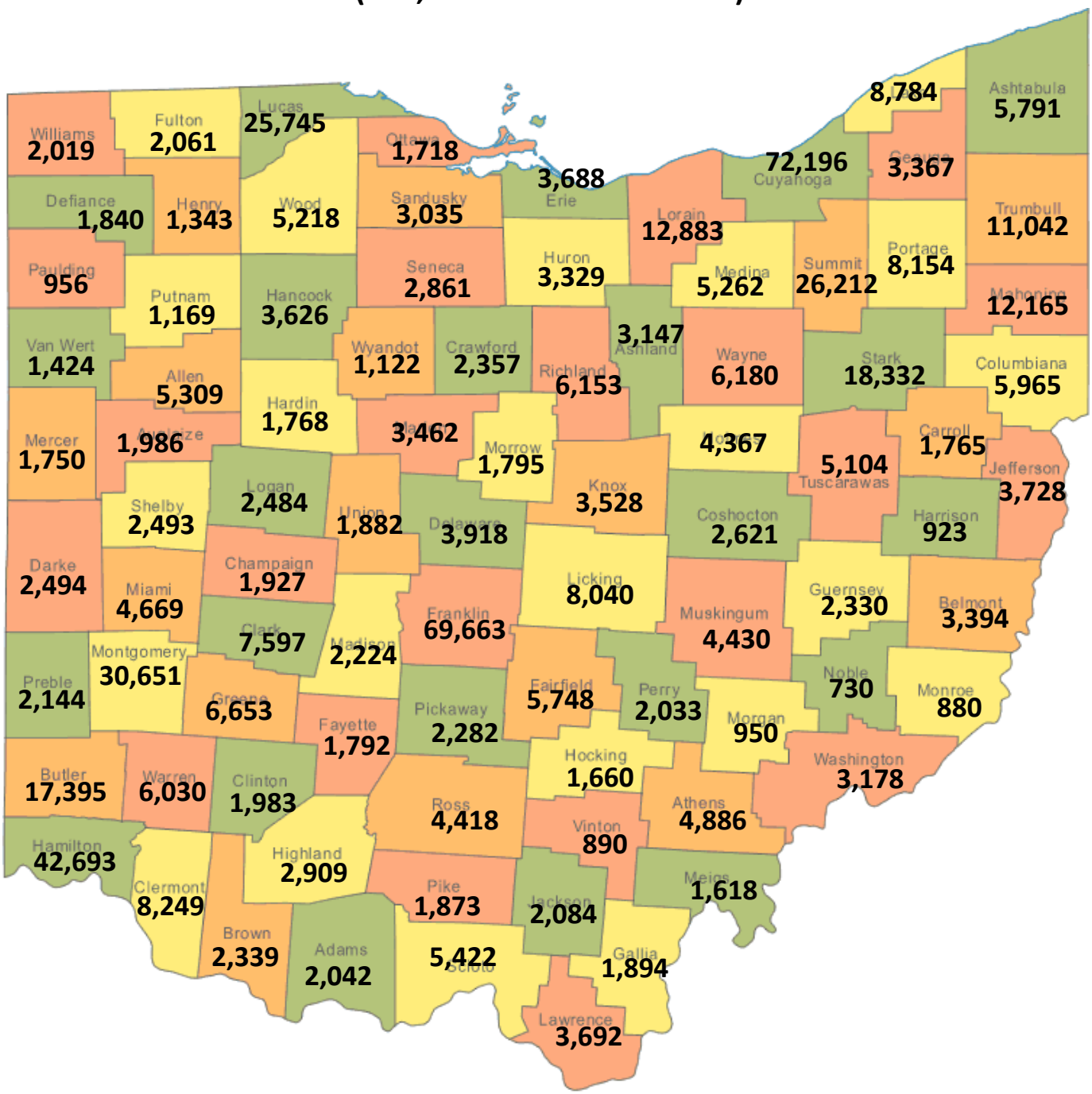
Appendix B.

Federal, State and County COST AND REVENUE IMPACTS of Newly Eligible, Currently Eligible not Enrolled, and Previously Eligible Medicaid Populations

COST/(SAVINGS) in millions				
	SFY 2014	**SFY 2015**	**SFY 2014-2015**	**SFY 2014-2020**
ALL FUNDS				
Newly eligible enrollment cost*	$ 562	$ 2,000	$ 2,561	$ 14,481
Woodwork enrollment cost*	$ 529	$ 952	$ 1,481	$ 9,188
Previously eligible enrollment savings	$ (62)	$ (184)	$ (246)	$ (1,289)
Total Medicaid spend (all funds)	**$ 1,029**	**$ 2,768**	**$ 3,796**	**$ 22,380**
FEDERAL SHARE				
Newly eligible enrollment cost*	$ 562	$ 2,000	$ 2,561	$ 13,895
Woodwork enrollment cost*	$ 343	$ 617	$ 960	$ 6,171
Previously eligible enrollment savings	$ (39)	$ (116)	$ (155)	$ (812)
Total Medicaid spend (state share)	**$ 865**	**$ 2,501**	**$ 3,366**	**$ 19,253**
STATE SHARE				
Newly eligible enrollment cost*	$ -	$ -	$ -	$ 586
Woodwork enrollment cost*	$ 186	$ 335	$ 521	$ 3,018
Previously eligible enrollment savings	$ (23)	$ (68)	$ (91)	$ (477)
Total Medicaid spend (state share)	**$ 163**	**$ 267**	**$ 430**	**$ 3,127**
OTHER				
State inpatient hospital for prisoners	$ 9	$ 18	$ 27	$ 117
County behavioral health services	$ 35	$ 70	$ 105	$ 455
TAX AND FEE REVENUE in millions				
STATE SHARE				
Newly eligible (HIC + sales/use)	$ 21	$ 107	$ 129	$ 838
Woodwork (HIC + sales/use)	$ 21	$ 44	$ 65	$ 447
Previously eligible (HIC + sales/use)	$ (3)	$ (10)	$ (12)	$ (73)
Total State Tax and Fee Revenue	**$ 40**	**$ 141**	**$ 181**	**$ 1,212**
COUNTY SHARE				
Newly eligible (Sales/use)	$ 5	$ 23	$ 28	$ 176
Woodwork (Sales/use)	$ 5	$ 9	$ 14	$ 94
Previously eligible (Sales/use)	$ (1)	$ (2)	$ (3)	$ (15)
Total County Tax and Fee Revenue	**$ 9**	**$ 30**	**$ 39**	**$ 255**
* Costs include two-year primary care physician fee increase and prescription drug rebates.				

Appendix C.

Number of Ohio county residents who are uninsured with income below 138 percent of poverty (593,912 statewide in 2010)



SOURCE: U.S. Census, *Small Area Health Insurance Estimates* (2010)

Tab 10

Requested Agency Material

Florida Medicaid

Presented to the
Fiscal Impact Estimating Conference

Tom Wallace
Assistant Deputy Secretary for
Medicaid Finance and Data Analytics

June 28, 2019

What is Medicaid?

- Medicaid is a federal program through which states partner with the federal government to provide health care coverage to low income children, families and the disabled.
- Medicaid is a voluntary program – states are not required to have a Medicaid program.
- The federal government establishes basic mandatory program parameters that states must meet in order to participate – and provides additional options that each state can chose to expand their program.
- States develop their unique Medicaid programs based on federal rules – each program must be approved by the Federal Centers for Medicare and Medicaid Services (CMS).

What is Medicaid?

- Jointly financed by state and federal funds.
  - Part of the cost of the program is borne by the federal government and part by the state government.
  - Both partners are obligated to pay their share.

Examples of Federal Share for Various State Medicaid Program Costs (Not Florida Specific)	
Administrative Costs (Expenses, supplies, etc.)	50%
Salaries	50% except for certain specialized categories which are 75%
Technology	90%
Medical Services	FMAP Rate: • Regular State FMAP Rate for most groups • 90% for Family Planning Services • 90% for Affordable Care Act Expansion group, for a limited time

What is the FMAP?

- The Federal Medical Assistance Percentage, or FMAP, is used to calculate the amount of federal share for state Medicaid program expenditures
  - Varies from state-to-state
  - Based on state per capita income
- The FMAP formula is based upon the ratio of the state per capita income to the national per capita income.
- Uses three most recent calendar years for which satisfactory data are available from the Department of Commerce, Bureau of Economic Analysis.
  - The lower the state's average per capita income, the more FMAP and vise versa.
  - All states receive at least 50% FMAP.

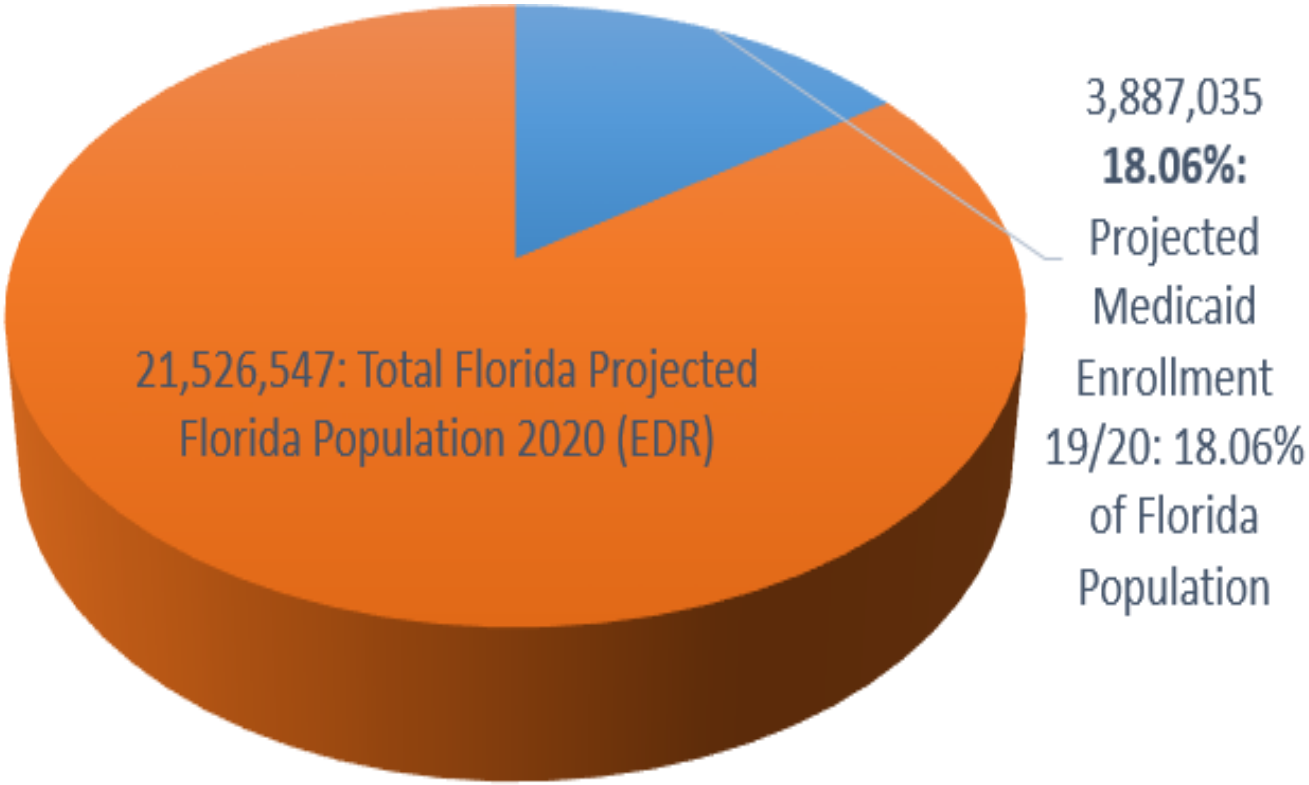
Federal Medicaid Mandatory and Optional Groups and Services

- The federal government identifies “Mandatory” groups and services a state program MUST cover:
  - Groups: Categories of people covered (children, pregnant women, etc.)
  - Services: Categories of medical care covered (physician services, hospital services, etc.)
- The federal government also identifies “Optional” groups and services that a state program can CHOOSE to cover

About Florida Medicaid

- Florida Medicaid:
  - 3.9 million recipients
    - Third largest in nation
  - $28 billion budget
    - Fifth largest in nation
- Florida FMAP:
  - 61.1% federal funding
  - 38.9% state funding
- Florida Delivery System:
  - Most people in the Florida Medicaid program receive their services through a managed care plan
  - The Agency pays the plan a capitated per member per month rate for each recipient enrolled.

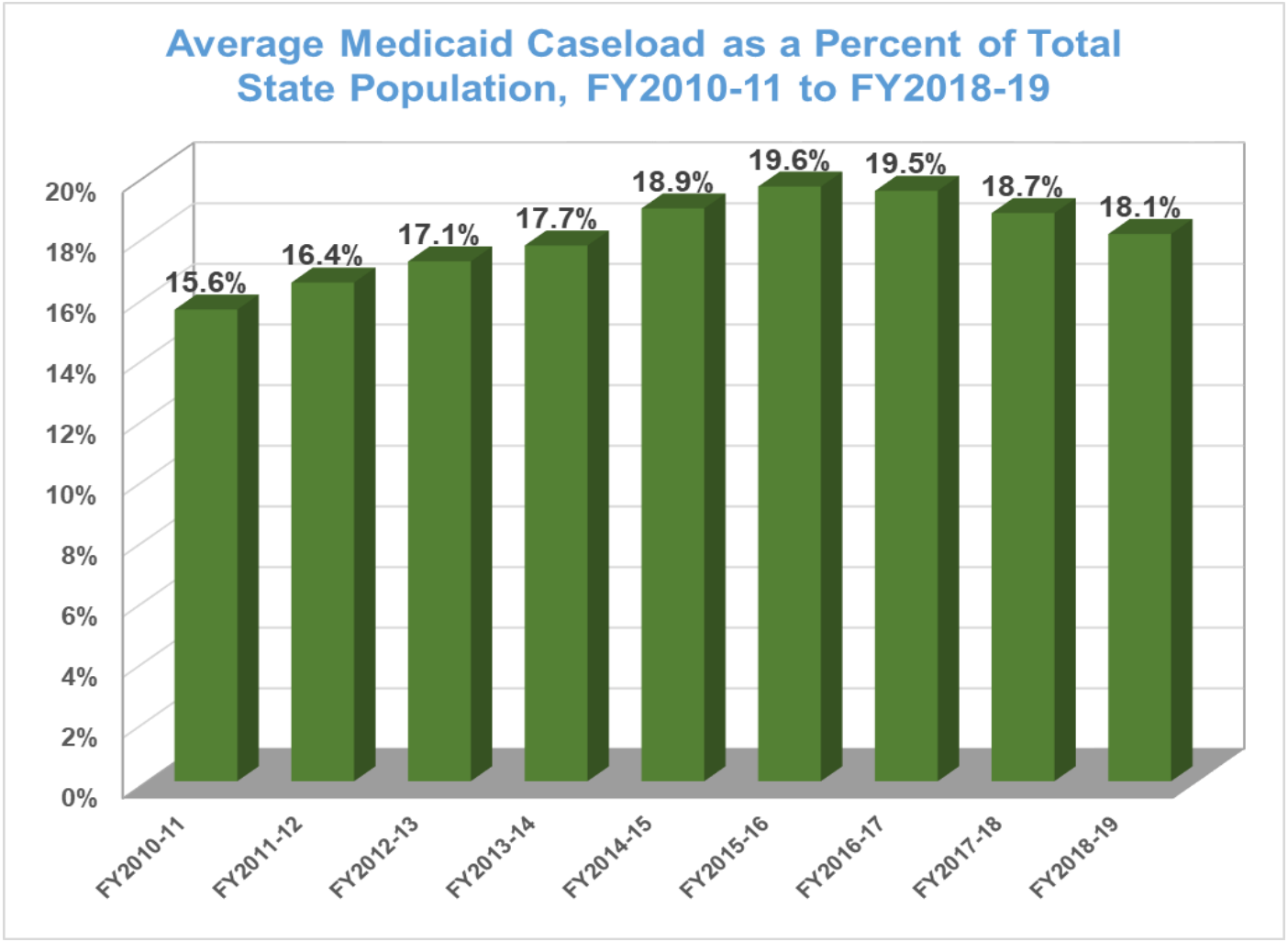
18% of Floridians Enrolled in Medicaid



Population, Medicaid Enrollment, and Medicaid as % of Total Population, 2018

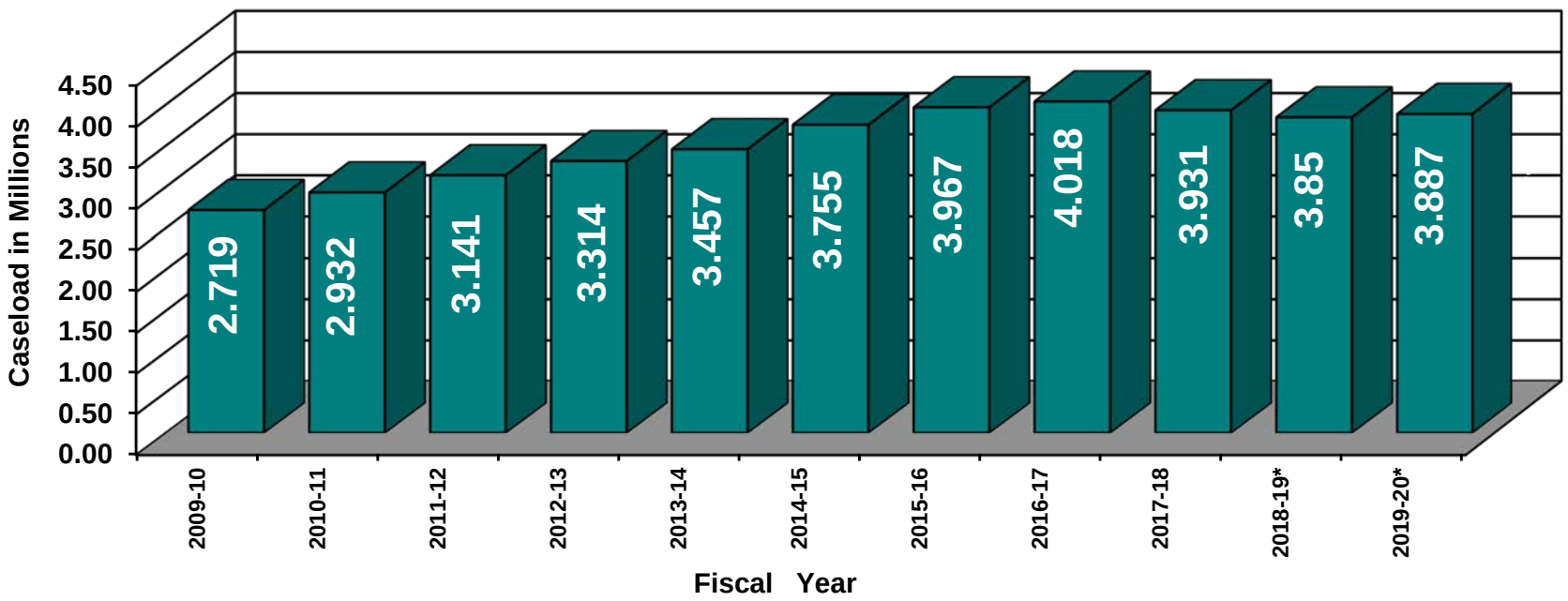
State	Total Population (7/1/2018)	Medicaid Enrollment (12/1/2018)	Medicaid as % of Total Population
United States	**327,167,434**	**66,350,839**	**20.3%**
California	39,557,045	10,625,303	26.9%
New York	19,542,209	5,881,178	30.1%
Florida	**21,299,325**	**3,981,126**	**18.7%**
Texas	28,701,845	3,701,865	12.9%
Pennsylvania	12,807,060	2,770,326	21.6%

Source: U.S. Census Bureau, 2010-2018 Population Estimates; CMS Monthly Medicaid Enrollment Reports, December 1, 2018



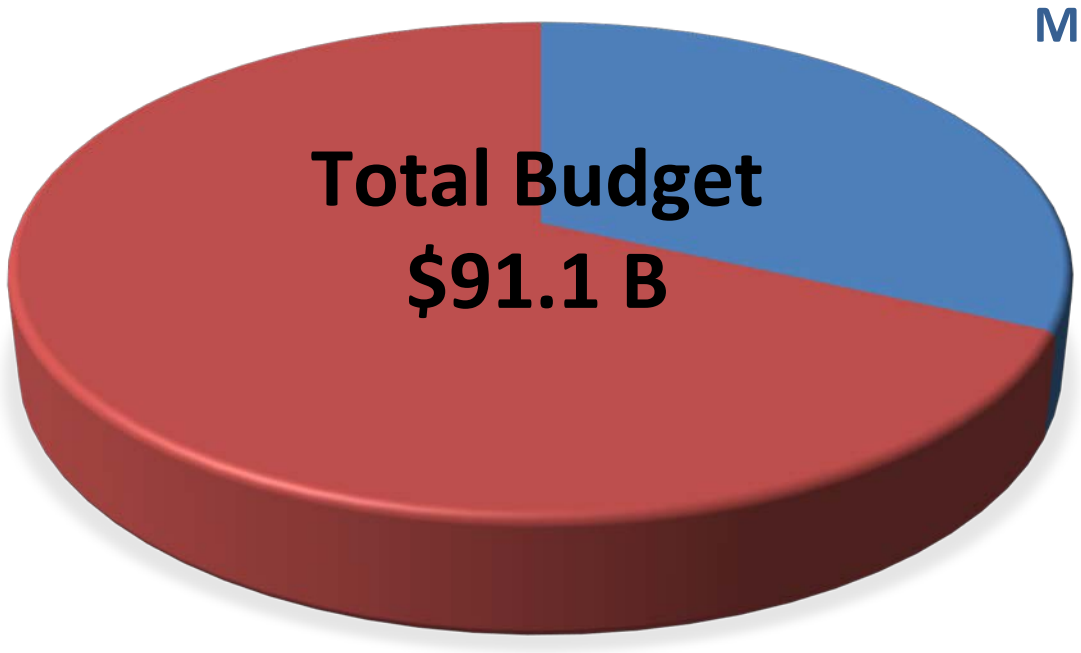
Source: Medicaid and GR Expenditure Reports, Bureau of Medicaid Finance; U.S. Census Bureau, 2010-2018 Population Estimates

Growth in Medicaid
Average Monthly Caseload



Source: Medicaid Services Eligibility Subsystem Reports.
*FY 2018-19, 2019-20 February 2019 Caseload Social Services Estimating Conference

Fiscal Year 2019-2020
Total State Budget
Compared to Medicaid Appropriations



MEDICAID
31%
$28.4B

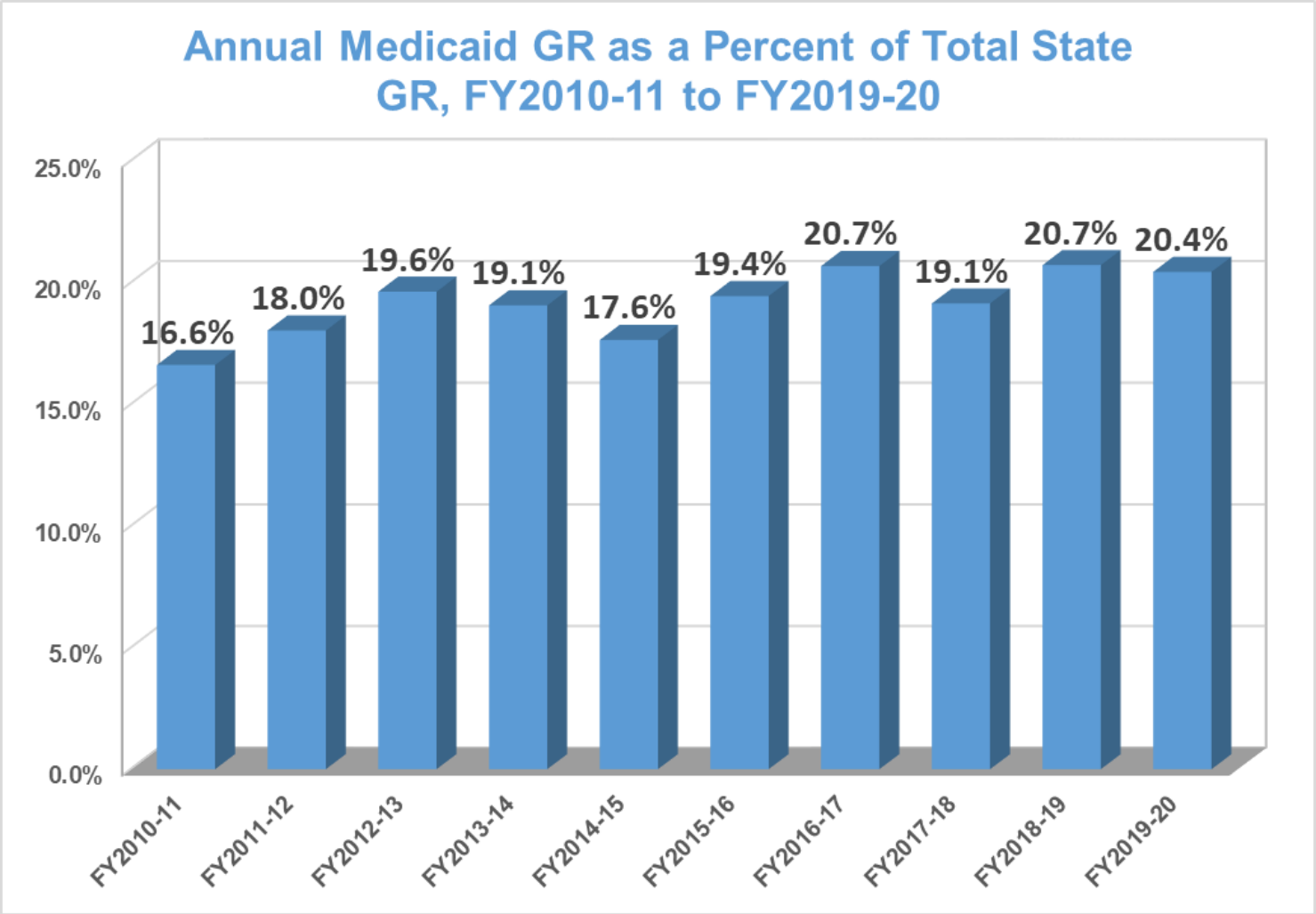
OTHER
69%
$62.7B

Source:
2019-20 GAA

Per Capita Medicaid Expenditures by State (per Total Population) for the Top Overall Medicaid Spenders, 2017

State	Total Medicaid Expenditures	Per Capita Medicaid Spending	Per Capita Spending Rank
United States	**$576,638,219,100**	**$1,770**	**--**
New York	$77,822,213,820	$3,921	2
Pennsylvania	$28,279,207,441	$2,208	12
California	$83,033,300,314	$2,100	15
Texas	$36,344,383,885	$1,284	37
Florida	$23,281,486,557	**$1,109**	**44**

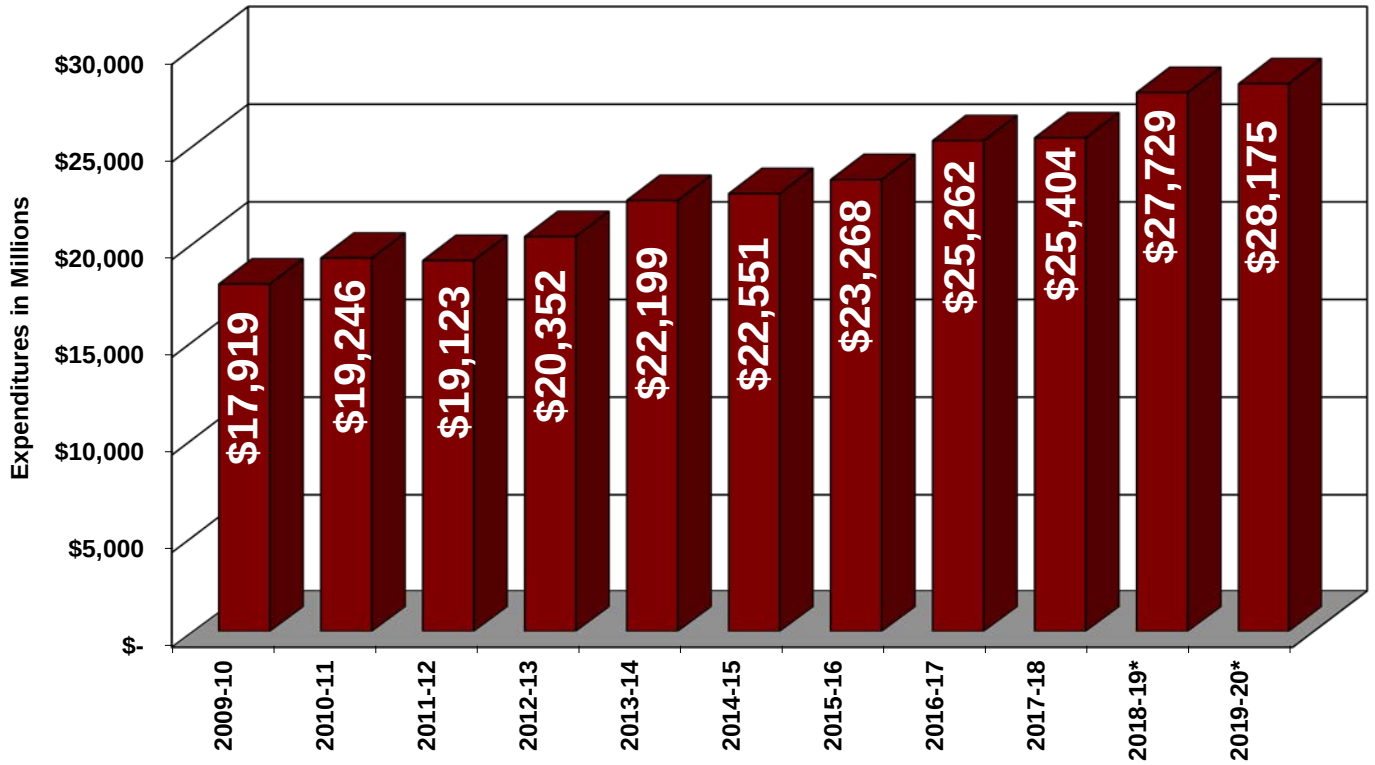
Source: Kaiser Family Foundation Medicaid Expenditures by State, FY 2017; U.S. Census Bureau, 2010-2018 Population Estimates



Source: Medicaid Services Budget Forecasting System Reports.

***FY 2018-19, 2019-20 March 2019 Social Services Estimating Conference**.

Growth In Medicaid Service Expenditures



Source: Medicaid Services Budget Forecasting System Reports.
***FY 2018-19, 2019-20 March 2019 Social Services Estimating Conference.**

Florida Medicaid Eligibility

- To be eligible for Florida Medicaid services, you must be:

  (1) In a mandatory or optional group

  (2) Meet financial requirements (have income and assets less than established thresholds)

  (3) Meet technical requirements (residency, have SS#, etc.)
- Florida covers all federal mandatory groups, and has chosen to cover some optional groups.
- Florida covers parents and 19-20 yr. at low-income levels only.
- Florida does **not currently cover non-pregnant, non-disabled single childless adults at any income level.**
- If you are not in a covered group, you cannot receive Florida Medicaid regardless of your income.

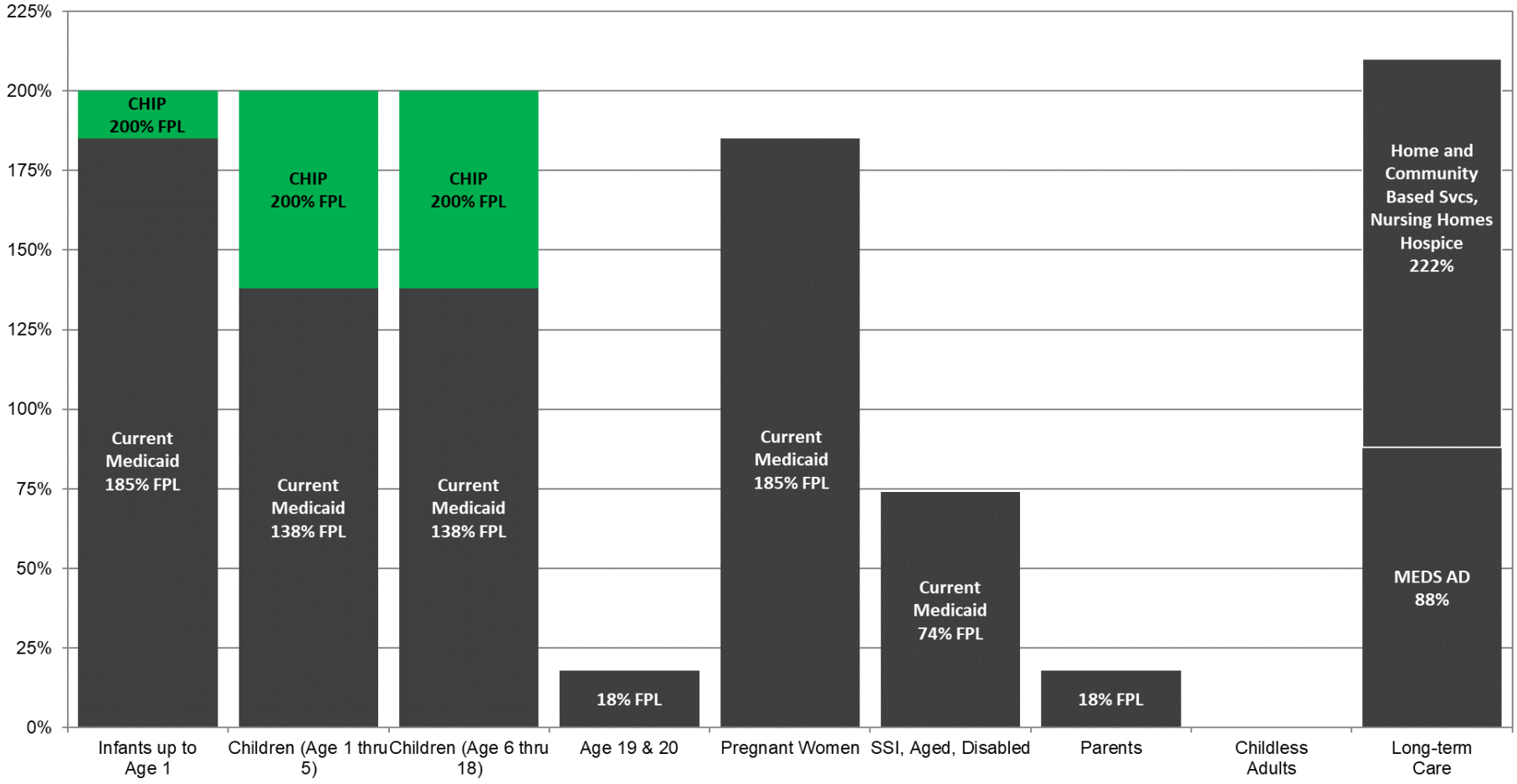
Florida Medicaid:
Optional Eligibility Groups

- The Florida Medicaid program includes the following optional eligibility groups:
  - Medically Needy
  - Breast and Cervical Cancer
  - Children under 1 - Medicaid Expansion under title XXI (185-200% FPL)
  - Children 19 and 20 year olds
  - MEDS-AD (Authorized under 1115 waiver)
  - Family Planning Waiver (Authorized under 1115 waiver)
  - Lawfully residing children during their first 5 years of residence.

Florida Medicaid Covers:

- 51% of children in Florida
- 57% of deliveries in Florida
- 62% of nursing home days in Florida
- more than 600,000 seniors age 65+
- Nearly 800,000 children under age 6

Florida Medicaid Groups Today



Florida Medicaid Provider Reimbursement

- Florida Medicaid reimburses providers either:
  - Through the fee-for-service system
    - Payments are made directly to individual providers by the state Medicaid program.
    - Providers do not bear any financial risk for their patients.
  - Through the managed care delivery system:
    - Health plans paid through a capitated arrangement.
    - Under managed care, the health care organization/ health plan may be “at risk”
    - Health plans have the flexibility to negotiate mutually agreed upon reimbursement rates with their network providers.
    - Health plans are responsible for making payments to their network providers.
  - On average, practitioners are reimbursed 68% of their cost through the managed care plans, and approximately 60% of their costs through the fee-for-service system

Florida Statewide Medicaid Managed Care

- Most Medicaid recipients are required to enroll with a Medicaid Managed Care Plan through the Statewide Medicaid Managed Care Program (SMMC).
  - Limited exceptions are made, mostly for Florida Medicaid recipients with limited eligibility. These recipient either have access to a limited set of services or have time limited eligibility
- Currently, the SMMC program has two key components:
  - Integrated Managed Medical Assistance (MMA) and Long-Term Care (LTC), and
  - Dental

SMMC: Capitation Rates

- Plans are paid a capitation rate for each recipient enrolled in their plan.
  - A capitation rate is the *per-member, per-month (PMPM) amount*, including any *adjustments*, that is paid by the Agency to a Managed Care Plan for *each* Medicaid recipient enrolled under a Contract for the provision of Medicaid services during the payment period.
  - Rates paid to the plans must be certified by an actuary and be "Actuarially Sound"
  - The capitation rate is paid regardless of the level of claims of the recipient.
- Plans are "at risk" because their costs may exceed the total capitated payments.

Federal Authority: Types of Waivers

- Section 1115 Research and Demonstration Waiver
- Section 1915(b) Managed Care Waiver
- Section 1915(c) Home and Community-Based Services Waiver
- Concurrent Section 1915(b) and 1915(c) Waivers

Federal Authority: 1115 Research & Demonstration Waivers

- **Commonly known as "Demonstration Waivers"**
- **Purpose:**
  - Give states additional flexibility to design and improve their programs to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.
  - Experimental, Pilot or Demonstration Projects:
    - States Commit to a Policy Experiment that must be formally evaluated.

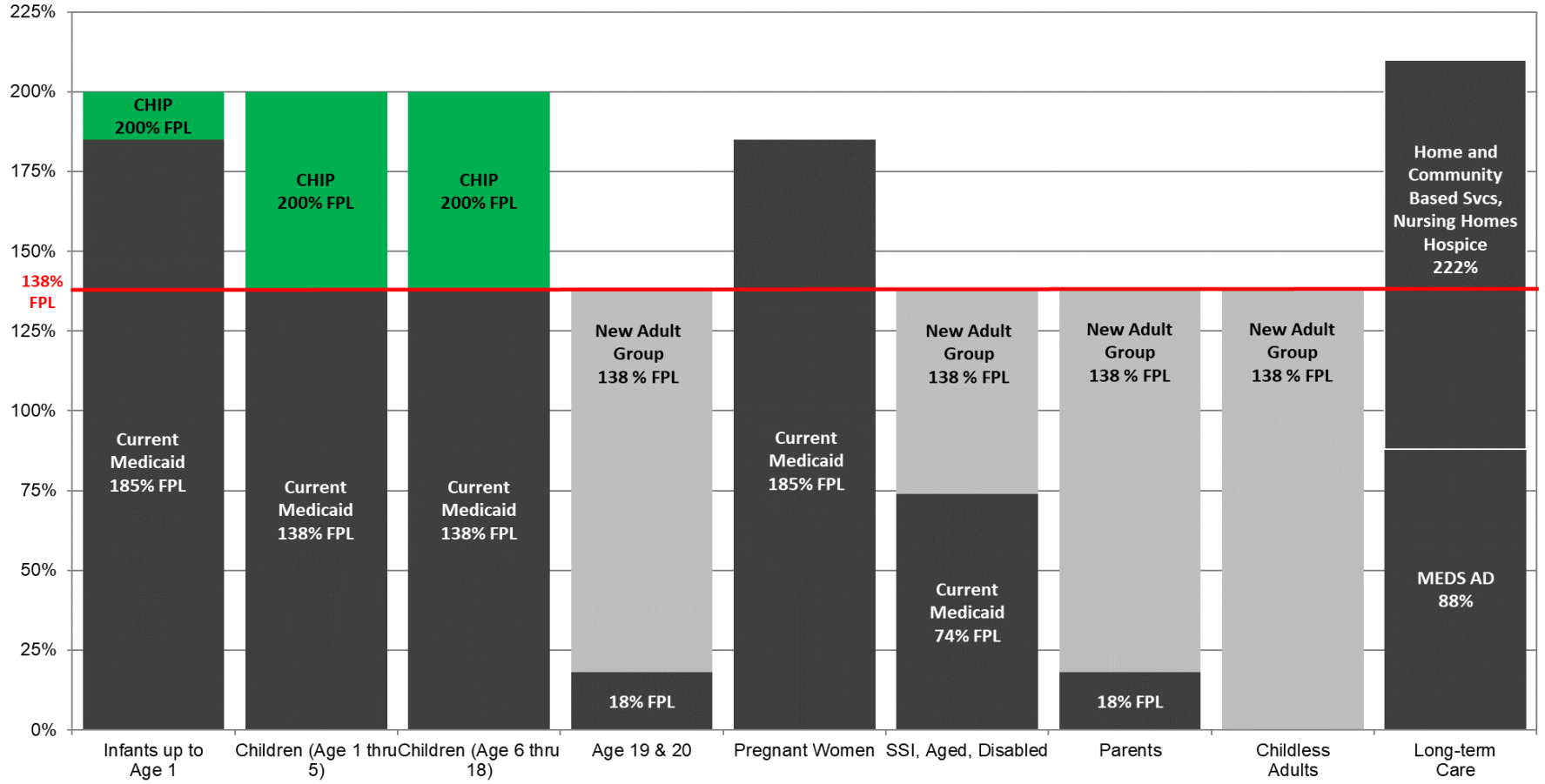
Florida's Largest 1115 Waiver		
Name	**Total Enrolled**	
Managed Medical Assistance Waiver	MMA Program	2,965,432
	Dental Program	3,097,633

Federal Authority: 1915(c) Waivers

- **Commonly Known as "Home and Community Based Services Waivers"**
  - **Purpose:** allow state Medicaid programs to cover services traditionally viewed as "long-term care" and provide them in a community setting to individuals instead of nursing home, hospital, or Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).
  - Under 1915(c) waivers, state can established a fixed number of slots to limit program enrollment based on funding, etc.

Florida's Largest 1915(c) HCBS Waivers		
Name	**Total Enrolled**	**Waitlist**
Long-Term Care Managed Care	~ 110,000	~ 57,000
iBudget	~ 34,000	~ 22,000

New Adult Group Included in Proposed Amendment



Better Health Care for All Floridians
AHCA.MyFlorida.com

From: Wallace, Thomas J. <Thomas.Wallace@ahca.myflorida.com>
Sent: Thursday, July 11, 2019 12:33 PM
To: OSullivan, Owen <OSULLIVAN.OWEN@leg.state.fl.us>
Cc: Scanlon, Stephanie <Stephanie.Scanlon@ahca.myflorida.com>
Subject: FIEC - Rate Information

Owen,

As I requested from Milliman, they researched the per member per month (PMPM) claim cost of Medicaid Expansion in other states to assist the FIEC as they value the potential cost implications of Expansion to Florida voters. Note that the claim cost of Medicaid Expansion in each state may significantly vary based on a wide array of factors including but not limited to the Medicaid eligibility criteria, benefits covered, provider reimbursement levels, access to care, demographics, and overall population health. The information provided below is intended to provide a range of observed PMPM claim costs for other states, and is not necessarily indicative of what Florida's claim costs would be for Medicaid Expansion.

Milliman reviewed data for six states that implemented Medicaid Expansion (AK, AR, IN, IA, MI and NV). Below are some high level notes for each state:

Table
Statewide Medicaid Managed Care Program
Medicaid Expansion Data for Select States
Claim Costs (Excluding Administrative Costs and Margin)

State	Start Date of Expansion	Traditional vs. Waiver Expansion	Work Requirements?	Expansion PMPM Claim Costs
Alaska	9/1/2015	Traditional	No	SFY 2018: $686 (Non-Tribal) $1,090 (Tribal)
Arkansas	1/1/2014	Waiver	No	CY 2017: $550 (net of cost sharing)
Indiana	2/1/2015	Waiver	Yes	SFY 2017: $566 SFY 2018: $576
Iowa	1/1/2014	Waiver	No	SFY 2018: $462
Michigan	4/1/2014	Waiver	Yes	SFY 2017: approx. $600
Nevada	1/1/2014	Traditional	No	CY 2018 Managed Care: $401 CY 2018 FFS Waiting Period: $718

Note that the expansion costs provided in the table above exclude administrative costs or margin that would normally be included in capitation rate development. Some additional notes based on our review:

- The PMPM cost of Medicaid Expansion in Alaska is higher than other states due to materially higher provider reimbursement levels and the large Tribal population.
- Arkansas and Iowa use a private option where the states purchase coverage for eligible members on the ACA exchange.
- Healthy Michigan PMPM costs are lower than other states because some expansion costs in Michigan are paid through a separate capitation rate or through fee-for-service.
- The PMPM claim costs for Medicaid Expansion members in Nevada were more than double the PMPM claim costs for TANF members, and the PMPM claim costs for Medicaid Expansion members in Indiana and Iowa ranged were about 30% and 16% higher than for TANF members, respectively. TANF members are not covered by managed care in Arkansas, and we were not able to review TANF PMPM claim costs in Michigan to determine the relationship.
- The PMPMs generally increased in the second year of Medicaid Expansion, and generally declines in the third year.

Also note that the Expansion Population includes members that may have been bucketed into several different traditional categories, had they had a lower FPL. For example, some of the Expansion Population is typically considered medically frail, and those members have similar medical conditions as traditional Medicaid members that are classified as SSI, while the non-medically frail expansion population is typically closer in acuity to a traditional Medicaid TANF population. Under the Expansion population, these subclassifications may or may not be made, given that they are covered under the higher FFP matching.

As another point of clarification, the populations enrolled into each Expansion population may be somewhat different. States had varying levels of coverage prior to expansion to 138% FPL. Additionally, in some states, the medically frail population may be included to varying degrees in these costs depending on the delivery system in which they are enrolled, which can have a significant impact on the claim costs shown in the table. For these reasons, comparing cost relativities of the Expansion population to the TANF population can result in different results by state. Therefore, Milliman did not supply these relativities, since we do not believe they would be useful in the consideration of projected costs without additional research.

Finally, there is a lot of attention on Medicaid Expansion in Kansas. I have attached the same issue brief I sent you back at the end of June that was published by the Kansas Health Institute just a few weeks ago. According to the report, the average per-enrollee claim costs for expansion adults ranged from $5,511 to $6,365 per enrollee between 2014 and 2017. This appears to be in line with historical costs Milliman is seeing in the states they analyzed, assuming an average enrollee is enrolled in a Medicaid program around 10 to 11 months out of the year.

In addition to evaluating the cost of Medicaid Expansion, this issue brief addresses some other interesting considerations including:

- Actual enrollment versus projected enrollment,
- Population health,
- Safety-net hospitals, and
- Other economic impacts.

I do have another question out to Milliman regarding our current TANF and SSI rates. If they are able to provide me with anything additional that I think will be helpful I will send that to you as well as soon as I can.

Hopefully this is helpful and I look forward to calling in tomorrow.

Tom

Tom Wallace
Assistant Deputy Secretary
Medicaid Finance and Analytics
Agency for Health Care Administration
850-412-4000

KANSAS HEALTH INSTITUTE

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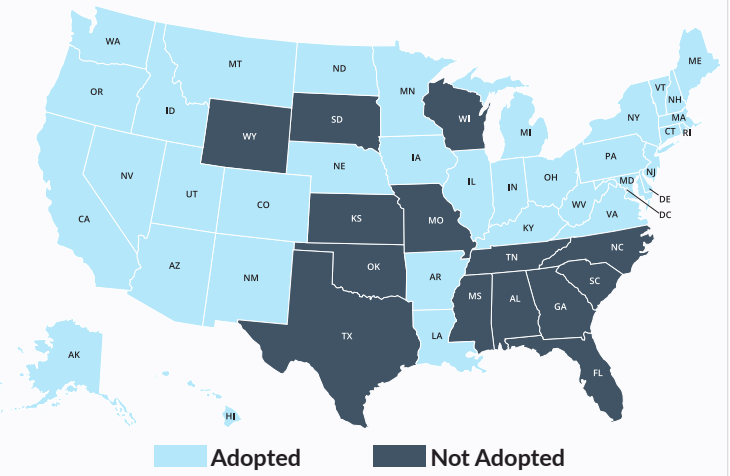
ISSUE BRIEF

JUNE 2019

WHAT KANSAS CAN LEARN FROM MEDICAID EXPANSION IN OTHER STATES

Almost nine years after the passage of the Affordable Care Act (ACA), 36 states and the District of Columbia have expanded their Medicaid programs. Fourteen states, including Kansas, have not (*Figure 1*). This issue brief examines different state approaches to expansion, as well as enrollment and cost trends and the effects of expansion on health outcomes and state economies.

Figure 1. **Status of State Action on Medicaid Expansion**



Source: Kaiser Family Foundation, as of April 26, 2019, accessed April 29, 2019.

Most states have expanded Medicaid simply by raising the eligibility level to 138 percent of the federal poverty level (FPL) ($35,535 for a family of four in 2019) as envisioned by the ACA. However, eight states (AZ, AR, IN, IA, KY, MI, MN, NH) have implemented Medicaid expansion under Section 1115 demonstration waivers. These states have proposed a variety of approaches, only some of which have been approved by the Centers for Medicare and Medicaid Services (CMS) (*Figure 2*, page 2).

Enrollment Results

States that expanded Medicaid have experienced large increases in Medicaid enrollment, in some cases far exceeding initial projections, especially among states that expanded on January 1, 2014 (*Figure 3*, page 3). However, in states that expanded after 2014, enrollment projections have improved in some cases (*Figure 4*, page 4). The enrollment gains have come from three distinct groups: uninsured adults made "newly eligible" for Medicaid under expansion; uninsured children and adults who already were eligible

KEY POINTS

- ✓ Between mid-2013 and August 2018, total Medicaid enrollment in expansion states increased by 37.3 percent. Among non-expansion states for the same period, total enrollment increased by 11.1 percent.
- ✓ Multiple studies suggest that Medicaid expansion can result in (1) the offsetting of state costs in other areas, such as costs related to behavioral health services and crime, (2) lower marketplace premiums, and (3) growth in the economy, in the form of new jobs.
- ✓ According to the CMS actuary, the average per-enrollee costs for expansion adults in 2014 were $5,511. These costs grew to $6,365 in 2015, then decreased to $5,965 in 2016 and $5,813 in 2017.
- ✓ Studies have found an association between Medicaid expansion and improved patient outcomes, including improved glucose monitoring rates for patients with diabetes, better hypertension control, improved rates of cancer screenings and reductions in self-reported rates of psychological distress and days of poor mental health.
- ✓ For safety-net hospitals, recent studies suggest there have been reductions in uncompensated care and improved financial status of hospitals in states that have expanded Medicaid compared to those in states that have not.

before expansion but not enrolled (known as the "woodwork" or "welcome mat" effect); and children and adults who had private insurance before expansion but switched to Medicaid after expansion (known as the "crowd-out" effect).

Figure 2. **Alternative Medicaid Waiver Approaches Proposed to CMS, as of April 2019**

APPROVED	
Allowing "private option," which is the use of Medicaid funds to purchase private insurance coverage for newly eligible residents (AR, NH[1])	Cost sharing that is higher than allowed under Medicaid law (KY[2])
Work requirement and referral programs (AZ, AR, IN, KY[2], MI, NH, OH, UT, WI)	No coverage for costs incurred three months prior to Medicaid eligibility[3] (AZ, AR, IA, IN, KY[2], NH, NM)
Health savings accounts for enrollees (AZ, AR, IN, KY[2], MI)	No coverage for non-emergency medical transportation (IA, IN, KY[2])
Premium payments required for some enrollees (AZ, AR, IA, IN, KY[2], MI, MT, NM)	No coverage for EPSDT (early and periodic screening, diagnosis and treatment for conditions that can affect development) (UT[4])
Lock-out periods or disenrollment for non-payment of premiums, non-renewal filing, failure to report work hours (AZ, IN, KY[2], MI, MT, NM)	Lock-out periods for nonpayment of premiums for enrollees below 100 percent of FPL (WI[5])
NOT YET APPROVED	
Block grants	Time limits on number of months individuals are eligible for coverage (KS[6])
Partial expansion to 100 percent of FPL with enhanced federal match (UT, WI)	Drug screening and testing as condition of coverage (WI)
Asset test (counting assets in addition to income when determining eligibility) (ME, NH)	Adoption of closed prescription drug formularies (MA)

[1] NH was approved to terminate its public option in Nov. 2018

[2] KY waiver is currently on hold pending outcome of pending litigation

[3] Six other states received approval for this waiver prior to March 2010

[4] Approved only for 19-20 year olds

[5] Disenrollment and lock-out for 6 months

[6] Rejected by CMS in May 2018

Source: KHI analysis of decisions by CMS about alternative Medicaid waiver principles.

The first full state fiscal year (SFY) that included Medicaid expansion was 2015. Between July and September 2013 and August 2018, total enrollment in Medicaid expansion states increased by 13.8 million enrollees or 37.3 percent. Among non-expansion states for the same period, total enrollment increased by 2.2 million or 11.1 percent.

Spending on the Newly Eligible

According to the CMS actuary, the average per-enrollee costs for expansion adults in 2014 were $5,511. These costs grew to $6,365 in 2015, then decreased to $5,965 in 2016 and $5,813 in 2017.

In fiscal year (FY) 2015, total Medicaid spending growth in expansion states far exceeded growth in non-expansion states. Across the 29 expansion states (including D.C.) in FY 2015, total spending increased by 17.7 percent. Across the 22 states not implementing expansion in FY 2015, total spending growth was 6.1 percent.

After the large increases in spending in 2015, growth of total Medicaid spending slowed in SFYs 2016 and 2017 for both expansion and non-expansion states. For 2016, the median rate of growth in total Medicaid spending in expansion states was 7.1 percent compared to 3.8 percent for non-expansion states.

Beginning in SFY 2017, state spending growth began to rise as expansion states were required to start paying 5 percent of the costs of their newly eligible adult enrollees on January 1, 2017. Most states have reported they are financing the state share of expansion costs with general fund dollars, while a few states have listed other sources of financing, including new or increased provider taxes/fees or other savings that accrue from the expansion.

How Expansion Affects Health and Quality of Life

In a study published in the journal *Health Affairs* in June 2018, the authors analyzed 77 studies published since 2014 addressing the association between ACA Medicaid expansion and changes in health insurance coverage, access to care, health care costs and patient outcomes. While some of the studies reviewed by the authors reached differing conclusions, overall they found:

- Expansion was associated with an increase in insurance coverage among all potentially eligible

Figure 3. **Medicaid Expansion Enrollment Experiences in Select States Expanding on January 1, 2014, Initial Estimate Versus 2017 Actual Enrollment of "Newly Eligible" Adults**

Colorado	Iowa	Nevada	New Mexico	North Dakota
Initial Enrollment Estimate: 160,000	**Initial Enrollment Estimate:** 100,000	**Initial Enrollment Estimate:** 78,000	**Initial Enrollment Estimate:** 64,810-89,114	**Initial Enrollment Estimate:** 20,500-32,000
September 2017 Enrollment: 451,018	**September 2017 Enrollment:** 137,631	**September 2017 Enrollment:** 211,428	**September 2017 Enrollment:** 249,748	**September 2017 Enrollment:** 19,287

Source: KHI analysis of governors' statements and research reports, and https://catalog.data.gov/dataset/medicaid-enrollment-new-adult-group, accessed May 15, 2019.

individuals, including major racial, ethnic, age, marital status and income groups, with the largest coverage gains for adults without a college degree.

- Improvements in appointment availability or wait times followed expansion.
- The share of adults who reported problems accessing care due to cost and problems paying medical bills in the past year decreased.
- The likelihood of U.S. citizens age 19-64 with incomes below 138 percent of FPL having a personal physician increased and reliance on the ED as a usual source of care decreased.
- Expansion was associated with an increase in the use of primary care, mental health and preventive visits among Medicaid enrollees, but studies showed mixed results regarding hospitalization and emergency department (ED) visits. Several studies showed decreases in hospitalizations and hospital lengths of stay among newly insured Medicaid enrollees, while others reported increases in hospitalizations and ED visits.
- There were improved glucose monitoring rates for patients with diabetes, better hypertension control, improved rates of prostate cancer screenings and higher rates of Pap testing.
- There were reductions in self-reported rates of psychological distress and days of poor mental health.

While it is too early to have much of the data needed to fully understand the impact, early studies suggest that states that expanded Medicaid had a significantly smaller increase in cardiovascular mortality rates among middle-aged adults and have shown modest improvement in access to cancer treatment, including higher rates of diagnosis and treatment of patients with certain cancers at earlier stages. Other recent studies found that expansion has reduced the percentage of people with medical debt and the probability of new bankruptcy filings related to medical debt.

Impact on Safety-Net Hospitals

For safety-net hospitals, including public hospitals, academic medical centers and certain private hospitals, recent studies suggest there have been reductions in uncompensated care and improved financial status of hospitals in states that have expanded Medicaid compared to those in states that have not. In a study published by the Commonwealth Fund in November 2017, the authors looked at the changes in financial status of 326 hospitals in states that expanded Medicaid prior to 2015 compared to 268 hospitals in states that did not expand or expanded in 2015 or after and found:

- Operating margins for safety-net hospitals in Medicaid expansion states improved compared with declines for those in states that did not.
- From 2012 to 2015, safety net hospitals in expansion states experienced larger growth in Medicaid utilization than those in non-expansion states, including a rise in inpatient days of 13.5 percent compared with a decrease of 0.9 percent for hospitals in non-expansion states.

- From 2012 to 2015, safety-net hospital Medicaid revenues as a share of net patient revenues rose 12.7 percent in expansion states compared to a 1.8-percent decline in non-expansion states.
- Profit margins on Medicaid patients fell from 6.8 percent to 0.7 percent at safety-net hospitals in expansion states, suggesting revenues for the newly eligible patients did not keep pace with the cost of treating them.
- By 2015, uncompensated care costs among safety-net hospitals declined from 6.7 percent in 2012 in expansion states to 3.5 percent (a 47.4-percent reduction), compared to a decline from 5.7 percent in 2012 to 5.3 percent in non-expansion states.

Economic Effects

Multiple studies suggest that Medicaid expansion can result in offsetting state costs in other areas, including costs related to behavioral health services, crime and the criminal justice system, and Supplemental Security Income program costs. For example, a study in Montana revealed that as the Medicaid role in financing substance use disorder (SUD) services has grown under expansion, federal Medicaid dollars have replaced federal block grant and state dollars previously used to fund services for uninsured Montanans with SUD, freeing up these dollars to be reinvested in Medicaid and other state priorities.

Research suggests that Medicaid expansion also may contribute to lower marketplace premiums. A study in Arkansas showed that the private option has increased the number of carriers offering marketplace plans statewide, generated a younger and relatively healthy risk pool and contributed to a 2-percent drop in the average rate of marketplace premiums.

For the effects of expansion on employment, a study in Colorado found that growth in the economy, as a result of Medicaid expansion, added more than 31,000 additional jobs as of SFY 2015. A study in Kentucky has estimated expansion will create over 40,000 jobs in the state through SFY 2021. In early 2017, researchers projected that additional employment associated with increased Medicaid spending in Michigan beginning in 2014 will yield approximately $145 million to $153 million annually in new state tax revenue, which nearly would offset all the projected new spending by the state for expansion in 2017 and 37 percent of costs in 2021.

In Ohio, most expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment and over half of the expansion enrollees who already were employed reported that enrollment made it easier to continue working. No studies have found any negative effects of expansion on employment or employee behavior, such as transitions from employment to non-employment or from full- to part-time employment.

For more information about this subject, visit khi.org for the list of reference materials used in this analysis.

Figure 4. **Medicaid Expansion Enrollment Experiences in Select States Expanding in 2015 and 2016, Initial Estimate Versus 2017 Actual Enrollment of "Newly Eligible" Adults**

Alaska	Louisiana	Montana
Initial Expansion Date: Sept. 1, 2015	**Initial Expansion Date:** July 1, 2016	**Initial Expansion Date:** Jan. 1, 2016
Enrollment Estimate: 41,910-42,260	**Enrollment Estimate:** 365,000-653,305	**Enrollment Estimate:** 65,319
September 2017 Enrollment: 37,144	**September 2017 Enrollment:** 445,598	**September 2017 Enrollment:** 85,212

Source: KHI analysis of state government documents and research reports, and https://catalog.data.gov/dataset/medicaid-enrollment-new-adult-group, accessed May 15, 2019.

ABOUT THE ISSUE BRIEF

This issue brief is based on work done by Linda J. Sheppard, J.D., and Sydney McClendon. It is available online at khi.org/policy/article/19-33.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute supports effective policymaking through nonpartisan research, education and engagement. KHI believes evidence-based information, objective analysis and civil dialogue enable policy leaders to be champions for a healthier Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, KHI is a nonprofit, nonpartisan educational organization based in Topeka.

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From: Wallace, Thomas J.
Sent: Thursday, June 27, 2019 9:30 AM
To: OSullivan, Owen <OSULLIVAN.OWEN@leg.state.fl.us>
Subject: ACA Medicaid Expansion Rates

Owen,

This is all that I was able to come up with and may help you. Milliman provided the attachments and the first three bullets. The attached files are what Milliman has shared in the past.

- "CY 2018 Illinois Medicaid Managed Care Certification – FINAL.PDF": Page 82 of the PDF provides a breakout of the Expansion population rate ranges for existing managed care counties and new managed care counties in Illinois for CY 2018. **The overall statewide range excluding CCHHS and Managed Care Access Payments (which are both supplemental payments) is between $370.19 and $384.77 PMPM for CY 2018. Table 3 on page 9 of the PDF shows a summary of the rate ranges for the existing managed care counties only ($371.78 – $385.47 PMPM), and you can compare the expansion rate ranges to the Non-Disabled Children and Adults population for reference.**

- "17-SFY 2018 Capitation Rate Certification.PDF": Page 52 of the PDF provides the Expansion population rate for Michigan (Healthy Michigan Program) for October 1, 2017 through September 30, 2018 (SFY 2018). **The overall statewide SFY 2018 rate for the Expansion population (excluding directed payments and other supplemental payments) is $343.90 PMPM. Table 2 of page 9 of the PDF shows a summary of the rates where you can easily compare the expansion rates to the TANF rates for reference.**

- Ohio's Expansion capitation rates are available at the following link as part of the managed care contract:
  - http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/ManagedCare-PA-201801.pdf?ver=2017-12-21-132810-680
  - Page 99 of the pdf shows the statewide Expansion rates (called "Extension") for CY 2018. **The overall statewide CY 2018 rate for the Expansion population is $547.72 PMPM. The average CFC rate of $272.60 PMPM shown on page 99 of the pdf is similar to Florida's TANF population and can be compared to the Expansion rate as reference.**

- Nevada: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/Rates/20170929%20Nevada%20Capitation%20Rate%20Certification%20CY%202018.pdf

Table 1
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed CY 2018 Capitation Rates (Incl Maternity)

Population	July 2017 Rate	Jan 2018 Rate	Rate Change
TANF/CHAP	$ 199.72	$ 212.79	6.5%
Check-up	113.81	115.02	1.1%
Expansion	438.08	490.88	12.1%
Composite	**$ 286.27**	**$ 313.88**	**9.6%**

Milliman

Calendar Year 2018 Medicaid Managed Care Capitation Rate Certification

January 1, 2018 through December 31, 2018

State of Illinois

Department of Healthcare and Family Services

Prepared for:
Dan Jenkins
Bureau Chief of Rate Development and Analysis

Prepared by:
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FSA, MAAA
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January 11, 2018

Table 2 State of Illinois, Department of Healthcare and Family Services CY 2018 Capitation Rate Development – Existing Managed Care Counties Gross Capitation Rates Effective January 1, 2018			
Population	Estimated CY 2018 Average Monthly Enrollment	CY 2018 Low Rate Range Composite	CY 2018 High Rate Range Composite
Non-Disabled Children and Adults	1,158,000	$256.34	$264.51
Disabled Adults SPI	85,000	1,639.24	1,684.53
Disabled Adults SPII	13,000	1,848.08	1,922.47
ACA Adults	355,000	485.81	499.51
State Only IMD	1,000	6,413.85	6,499.33
Composite	**1,600,000**	**$400.07**	**$412.11**

Notes:
1. CY 2018 composite rates were developed based on CY 2018 projected monthly enrollment.
2. Values shown in Table 2 exclude amounts related to the Health Insurer Providers Fee (HIPF).
3. Monthly enrollment values are rounded to the nearest thousand.

Table 3 provides similar information as contained in Table 2; however, illustrated rate values reflect the managed care organization (MCO) effective rate (the capitated amount excluding the hospital MCAP and the CCHHS access fee).

Table 3 State of Illinois, Department of Healthcare and Family Services CY 2018 Capitation Rate Development – Existing Managed Care Counties MCO Effective Capitation Rates Effective January 1, 2018			
Population	Estimated CY 2018 Average Monthly Enrollment	CY 2018 Low Rate Range Composite	CY 2018 High Rate Range Composite
Non-Disabled Children and Adults	1,158,000	$ 176.06	$ 184.23
Disabled Adults SPI	85,000	1,144.74	1,190.04
Disabled Adults SPII	13,000	1,848.08	1,922.47
ACA Adults	355,000	371.78	385.47
State Only IMD	1,000	6,413.85	6,499.33
Composite	**1,600,000**	**$290.29**	**$302.33**

Notes:
1. CY 2018 composite rates were developed based on CY 2018 projected monthly enrollment.
2. Values shown in Table 3 exclude amounts related to the Health Insurer Providers Fee (HIPF), hospital MCAP, and CCHHS access fee.
3. Monthly enrollment values are rounded to the nearest thousand.

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State Fiscal Year 2018 Medicaid Capitation Rate Certification:

Managed Care Health Plan

Children's Special Health Care Services

Healthy Michigan Plan

October 1, 2017 through September 30, 2018

State of Michigan, Department of Health and Human Services

Prepared for:
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Director, Actuarial Division

Prepared by:
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August 25, 2017

Table 2 State of Michigan Department of Health and Human Services SFY 2018 Capitation Rate Development – Contracted Rate MCO Effective Capitation Rates Effective October 1, 2017 Comparison with April 2017 Rates (PMPM Rates)				
Population	Estimated Monthly Average Enrollment	April 2017 Composite Capitation Rates	SFY 2018 Composite Capitation Rates	% Change
TANF/Program L Male	417,900	$ 112.51	$ 111.30	(1.1%)
TANF/Program L Female	547,100	157.02	154.32	(1.7%)
Blind and Disabled	175,600	634.35	650.27	2.5%
Dual Eligibles (MME)	35,600	78.11	80.95	3.6%
CSHCS	19,100	1,331.38	1,456.68	9.4%
Healthy Michigan Male	264,500	320.96	320.46	(0.2%)
Healthy Michigan Female	281,300	378.31	365.94	(3.3%)
Maternity Case Rate	3,500	5,248.38	5,478.39	4.4%
Composite	**1,741,100**	**$ 276.96**	**$ 277.24**	**0.1%**

Notes:

1. April 2017 and SFY 2018 composite rates were developed with monthly projected enrollment.
2. Values shown in Table 2 exclude amounts related to HRA, GME, SNAF and the Health Insurance Providers Fee (HIF).
3. Member month values are rounded to the nearest hundred.
4. HMP-CSHCS population has been included in the Healthy Michigan Male line.
5. Maternity member months represent projected SFY 2018 delivery counts across all programs and are not included in the composite member month figure.
6. Maternity rates reflect per delivery case rates.

FISCAL IMPACT ESTIMATE

The estimated fiscal impact of the SFY 2018 capitation rates documented in this report is a $30.5 million decrease to aggregate expenditures, excluding impact of the HRA. This amount is on a state and federal expenditure basis using the projected monthly enrollment for SFY 2018. Table 3 provides the development of estimated total expenditures, as well as federal only expenditures, under the current contracted capitation rates and the proposed SFY 2018 capitation rates illustrated in Table 1 which exclude amounts related to HRA. The federal expenditures illustrated in Table 3 are based on the Federal Fiscal Year 2018 FMAP of 64.78% for non-HMP populations and 95% for October to December 2017 and 94% for January to September 2018 for HMP.

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2018
Calendar Year 2018 Rate Change Summary

Region: Northeast Central

Rate Cell	Member Months / Deliveries	July 2017 Capitation Rate	Calendar Year 2018 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	62,316	$ 761.52	$ 878.07	15.30%
HF/HST 1 M+F	57,753	191.65	159.45	(16.80%)
HF/HST 2-13 M+F	614,683	149.31	142.76	(4.39%)
HF/HST 14-18 M	99,799	211.01	185.43	(12.12%)
HF/HST 14-18 F	103,464	220.22	229.10	4.03%
HF 19-44 M	80,950	226.17	257.86	14.01%
HF 19-44 F	248,606	340.73	361.60	6.13%
HF 45+ M+F	40,680	537.54	507.88	(5.52%)
HST 19-64 F	36,156	423.96	425.58	0.38%
Subtotal - CFC	**1,344,407**	**$ 248.70**	**$ 253.42**	**1.90%**
Extension				
EXT 19-34 M	105,968	$ 282.55	$ 271.99	(3.74%)
EXT 19-34 F	97,988	329.75	346.41	5.05%
EXT 35-44 M	52,656	414.66	440.45	6.22%
EXT 35-44 F	49,188	549.56	541.67	(1.44%)
EXT 45-54 M	52,068	647.29	639.14	(1.26%)
EXT 45-54 F	59,460	679.99	721.43	6.09%
EXT 55-64 M	43,356	810.76	798.19	(1.55%)
EXT 55-64 F	50,496	759.76	762.72	0.39%
Subtotal - Extension	**511,180**	**$ 506.22**	**$ 512.34**	**1.21%**
ABD				
ABD <21	37,421	$ 832.16	$ 925.64	11.23%
ABD 21+	100,685	1,291.39	1,357.31	5.10%
Subtotal - ABD	**138,106**	**$ 1,166.96**	**$ 1,240.35**	**6.29%**
AFK	**28,149**	**$ 370.08**	**$ 342.82**	**(7.37%)**
CFC & EXT Delivery	**3,763**	**$ 4,508.93**	**$ 4,357.97**	**(3.35%)**
Total	**2,021,842**	**$ 386.62**	**$ 395.65**	**2.34%**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2018
Calendar Year 2018 Rate Change Summary

Region: Statewide

Rate Cell	Member Months / Deliveries	July 2017 Capitation Rate	Calendar Year 2018 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	881,868	$ 962.08	$ 1,021.00	6.12%
HF/HST 1 M+F	831,447	206.24	205.03	(0.59%)
HF/HST 2-13 M+F	8,782,823	158.81	150.19	(5.43%)
HF/HST 14-18 M	1,424,401	201.98	191.59	(5.14%)
HF/HST 14-18 F	1,457,923	233.23	232.57	(0.28%)
HF 19-44 M	1,179,864	256.23	264.75	3.33%
HF 19-44 F	3,580,874	363.05	378.67	4.30%
HF 45+ M+F	642,628	549.57	582.32	5.96%
HST 19-64 F	472,270	404.46	432.20	6.86%
Subtotal - CFC	**19,254,098**	**$ 269.50**	**$ 272.60**	**1.15%**
Extension				
EXT 19-34 M	1,682,842	$ 309.34	$ 314.47	1.66%
EXT 19-34 F	1,498,200	360.98	357.81	(0.88%)
EXT 35-44 M	833,778	497.00	486.54	(2.10%)
EXT 35-44 F	696,014	585.61	570.11	(2.65%)
EXT 45-54 M	807,417	718.44	721.39	0.41%
EXT 45-54 F	851,093	750.24	764.23	1.86%
EXT 55-64 M	629,410	843.51	852.84	1.11%
EXT 55-64 F	725,491	804.84	817.74	1.60%
Subtotal - Extension	**7,724,245**	**$ 545.92**	**$ 547.72**	**0.33%**
ABD				
ABD <21	585,256	$ 929.42	$ 972.91	4.68%
ABD 21+	1,709,930	1,401.83	1,475.10	5.23%
Subtotal - ABD	**2,295,186**	**$ 1,281.37**	**$ 1,347.05**	**5.13%**
AFK	**419,315**	**$ 385.63**	**$ 327.29**	**(15.13%)**
CFC & EXT Delivery	**52,262**	**$ 4,833.26**	**$ 4,962.55**	**2.68%**
Total	**29,692,843**	**$ 429.77**	**$ 436.72**	**1.62%**

Nevada Medicaid Managed Care:
Calendar Year 2018 Capitation Rate Development

State of Nevada, Division of Health Care Financing and Policy

Prepared for:
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Deputy Administrator

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September 29, 2017

M1. EXECUTIVE SUMMARY

INTRODUCTION

Milliman, Inc. (Milliman) has been retained by the State of Nevada, Division of Health Care Financing and Policy (DHCFP) to provide actuarial and consulting services related to the development of actuarially sound medical capitation rates for the Nevada TANF, Check-up and Expansion populations. This report provides the supporting documentation for capitation rates which will be paid to managed care organizations (MCOs) during the calendar year (CY) 2018 contract period.

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2017-2018 Medicaid Managed Care Rate Development Guide (CMS Guide), published April 2017:

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
- The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

CMS Guide Index [Section I.1.C]

Throughout this report, sub-headings (like the one above) are utilized to identify the page number for items described within the CMS Guide in order to index each section within the table of contents.

CAPITATION RATES

Table 1 illustrates composite capitation rates effective January 1, 2018 through December 31, 2018 by population category. Composite values have been calculated utilizing our projected CY 2018 membership distribution. The values include estimated amounts for SOBRA and LBW case rate payments converted to per member per month (PMPM) spending. The values do not contain provision for any medical cost incurred during a stay of greater than 15 days within a month at institutions for mental disease (IMDs). MCOs will be compensated for these claims through a separate state-funded capitation rate.

Table 1
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed CY 2018 Capitation Rates (Incl Maternity)

Population	July 2017 Rate	Jan 2018 Rate	Rate Change
TANF/CHAP	$ 199.72	$ 212.79	6.5%
Check-up	113.81	115.02	1.1%
Expansion	438.08	490.88	12.1%
Composite	**$ 286.27**	**$ 313.88**	**9.6%**

Florida Medicaid Population for May 2019

including MediKids age 1-5

	Total	Female	Male
Infants up to Age 1	133,621	65,187	68,434
Children age 1-5	648,137	316,143	331,994
Children 6-18	1,325,106	647,124	677,982
Age 19-20	72,448	42,258	30,190
Pregnant Women	80,921	80,921	-
Family Planning up to 185% FPL	65,245	65,245	-
Subtotal Pregnant Woman	**146,166**	**146,166**	**-**
SSI-Aged and Disabled	496,437	286,938	209,499
Parents	300,730	228,077	72,653
LTC NH	47,795	30,321	17,474
LTC HCBS	35,800	23,879	11,921
MedsAD*	40,007	23,445	16,562
Breast & Cervical Cancer	844	844	-
QMB/SLMB	452,744	262,277	190,467
PACE	1,449	954	495
Subtotal Long Term Care	**578,639**	**341,720**	**236,919**
Medically Needed**	28,794	18,351	10,443
Refugee	4,434	1,616	2,818
TANF (Age 21+)***	71,583	52,470	19,113
	3,806,095	2,146,050	1,660,045

* MEDS AD total of 40,007 includes:

MedsAD in HCBS	272	162	110
MedsAD in NH	471	337	134

** Medically Needed total of 28,794 includes

Under 21	3,555	1,837	1,718
Over 21	25,239	16,514	8,725

***TANF

Includes population in Transitional Medicaid Due to Caretaker Earned Income

Florida Medicaid Population for May 2019

without MediKids population

	Total	Female	Male
Infants up to Age 1	133,621	65,187	68,434
Children age 1-5	608,381	296,718	311,663
Children 6-18	1,325,106	647,124	677,982
Age 19-20	72,448	42,258	30,190
Pregnant Women	80,921	80,921	-
Family Planning up to 185% FPL	65,245	65,245	-
Subtotal Pregnant Woman	**146,166**	**146,166**	**-**
SSI-Aged and Disabled	496,437	286,938	209,499
Parents	300,730	228,077	72,653
LTC NH	47,795	30,321	17,474
LTC HCBS	35,800	23,879	11,921
MedsAD*	40,007	23,445	16,562
Breast & Cervical Cancer	844	844	-
QMB/SLMB	452,744	262,277	190,467
PACE	1,449	954	495
Subtotal Long Term Care	**578,639**	**341,720**	**236,919**
Medically Needed**	28,794	18,351	10,443
Refugee	4,434	1,616	2,818
TANF (Age 21+)***	71,583	52,470	19,113
	3,766,339	2,126,625	1,639,714

* MEDS AD total of 40,007 includes:

MedsAD in HCBS	272	162	110
MedsAD in NH	471	337	134

** Medically Needed total of 28,794 includes

Under 21	3,555	1,837	1,718
Over 21	25,239	16,514	8,725

***TANF

Includes population in Transitional Medicaid Due to Caretaker Earned Income

Agency for Health Care Administration
Medicaid Data Analytics

Department of Corrections

Centurion of Florida - Aggregate Offsite - Ages 19-64 on Date of Service

Data current as of 7/10/2019

Row Labels	Distinct Claims	Total Spend	Avg. Claim Cost	Total IP Days	Avg. IP Stay (days)
FY16/17	**12,836**	**$47,398,398**			
Emergency Room	7,810	$2,843,634	$364		
Hospital Inpatient	2,372	$34,066,971	$14,362	11,964	5.21
Hospital Outpatient	2,654	$10,487,793	$3,952		
FY17/18	**15,621**	**$57,867,087**			
Emergency Room	8,841	$3,180,300	$360		
Hospital Inpatient	2,609	$41,490,339	$15,903	13,387	5.26
Hospital Outpatient	4,171	$13,196,448	$3,164		

Department of Corrections

Centurion of Florida - Aggregate Offsite - Ages 19-64 on Date of Service

Data current as of 7/15/2019

Row Labels	Distinct Claims	Total Spend	Avg. Claim Cost	Total IP Days	Avg. IP Stay (days)
FY16/17	**12,836**	**$47,398,398**			
Emergency Room	**7,810**	**$2,843,634**			
All Others	7,587	$2,064,017	$272		
Memorial / Larkin	223	$779,617	$3,496		
Hospital Inpatient	**2,372**	**$34,066,971**			
All Others	1,011	$12,555,667	$12,419	5,054	5.13
Memorial / Larkin	1,361	$21,511,304	$15,806	6,910	5.28
Hospital Outpatient	**2,654**	**$10,487,793**			
All Others	1,039	$1,080,803	$1,040		
Memorial / Larkin	1,615	$9,406,990	$5,825		
FY17/18	**15,622**	**$57,867,087**			
Emergency Room	**8,841**	**$3,180,300**			
All Others	8,634	$2,578,057	$299		
Memorial / Larkin	207	$602,243	$2,909		
Hospital Inpatient	**2,610**	**$41,490,339**			
All Others	1,215	$16,681,250	$13,729	6,198	5.25
Memorial / Larkin	1,395	$24,809,089	$17,784	7,192	5.27
Hospital Outpatient	**4,171**	**$13,196,448**			
All Others	1,577	$2,126,153	$1,348		
Memorial / Larkin	2,594	$11,070,294	$4,268		

DRAFT: Division of Medicaid Operational/ Administrative Costs Associated with Initiative #18-16 (Florida Medicaid Expansion Initiative)

NOTE: All costs below are based on an estimated increased enrollment of 250,000. Costs associated with incrementally higher enrollment in the amounts of 500,000 and 750,000, can be provided as needed.

Summary:

Program Area	*Description*	*Fiscal Impact*
Medicaid Data Analytics	Increased Cost for Actuarial Contract	$300,000
Medicaid Fiscal Agent Operations	Increased Cost for Fiscal Agent Contract	$812,500
Medicaid Enrollment Broker Operations	Increased Cost for Enrollment Broker Contract	$669,214
Medicaid Recipient and Provider Services	Increased Staffing Need for Contact Center and Customer Service	$506,007
Office of the General Counsel	Increased Staffing Need for Office of Fair Hearings	$85,772
	Total Fiscal Impact:	**$2,373,493**

Additional Detail on Fiscal Impact, by Program Area:

Increased costs for actuarial contract	$300,000 is needed for the Agency's actuarial contract to cover the additional rate setting work associated with the new population.
Increased costs for the Medicaid Fiscal Agent	The Medicaid fiscal agent will incur increased costs associated with processing of additional Medicaid Gold Cards, generation of 1095B forms, and systems changes in the amount of $812,500.
Increased costs for Enrollment Broker Services	An additional $669,214 is needed for the Enrollment Broker per contact language regarding enrollment levels.
Increase costs for Division of Medicaid, Bureau of Recipient and Provider Services	An additional 6 FTEs is needed to staff increased contact center and customer service activities associated with the higher enrollment levels. In additional to the costs associated with the new positions, the Agency is currently maximizing all available office space and additional space will need to be leased. $506,007 is needed for the 6 FTEs and additional office space, $74,490 of which is for additional office space.
Increase costs for Office of Fair Hearings	One additional hearing officer (Senior Attorney, $81,000 per year plus benefits) will be needed based on estimated increase fair hearings due to overall increased caseload.

Schenker, Pamela

From: Zander, Lindsey
Sent: Friday, July 26, 2019 11:27 AM
To: Schenker, Pamela
Cc: OSullivan, Owen; Wickersheim, Michael; Fiore, John Paul
Subject: RE: Data Request for FIEC
Attachments: CMHBG MOE Guidance.pdf; SAPTBG MOE Guidance.pdf

Good Morning Pam,

Please see our response in blue front to you questions below:

Please see below for the full breakdown. FY2018-19 data is from July 1, 2018 to June 30, 2019 but Managing Entities have until August 18, 2019 to do a reconciliation of data for the entire fiscal year.

PROGRAMDESCRIPTION	FY2015-16	FY2016-17	FY2017-18	FY2018-19
Mental Health - Adult	169,856	170,594	175,835	137,115
Mental Health - Child	43,133	41,830	41,401	32,786
Substance Abuse - Adult	83,798	91,878	97,435	61,116
Substance Abuse - Child	27,079	26,957	25,572	15,366

Additionally, when Ute presented at the last FIEC meeting (Friday, July 12), I've included our response to the question posed in blue font below:

Can state funds that are counted toward MOE also be utilized for Medicaid match?
MOE should be an allowable use for Medicaid match as long as the costs are allowable pursuant to the State's Medicaid State plan as well as allowable for Title XIX reimbursement. In the past, we have counted costs CMH BG as MOE and Medicaid Match but have not had a situation where we used MOE for the SAPT BG as Medicaid Match. Attached, please find two letters where the issue of match was addressed and answered.

Please let me know if we can be of further assistance. Thank you.

Best,

Lindsey Zander
Deputy Director of Legislative Affairs
Department of Children and Families
1317 Winewood Blvd.
Tallahassee, Florida 32399
(o): (850) 488-9410 | (c): (850) 228-1833
lindsey.zander@myflfamilies.com

From: Schenker, Pamela
Sent: Thursday, July 25, 2019 11:12 AM
To: Zander, Lindsey
Cc: OSullivan, Owen
Subject: Data Request for FIEC

Lindsey –

As per our phone conversation, EDR would like to request data for the FIEC - *Provide Medicaid Coverage to Eligible Low-Income Adults (18-16).* Our office would lie to request a count of program clients for the Mental Health and Substance Abuse programs; with the number of clients separated out for each of the two programs. We would like these data for the most recent time period and also historically for the past 3 to 5 years.

The next FIEC meeting is Monday, July 29th, so it would be ideal if we could receive these counts by Friday of this week. If that is not possible, please let us know when to expect the data.

Thank you and please let me know if you have any questions on this request.
--pam

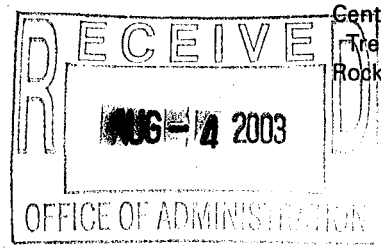
Pam Schenker
Florida Legislative Office of Economic and Demographic Research
111 West Madison Street, Suite 574
Tallahassee, FL 32399-6588
Office Phone: 850.487.1402
Direct Phone: 850.717.0471
Fax: 850.922.6436
http://EDR.state.fl.us

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

July 31, 2003



Robert Fagan
Chief Financial Officer
Office of Administration
Florida Dept. of Children and Families
1317 Winewood Boulevard
Tallahassee, Florida 32399-0700

Dear Mr. Fagan:

This letter is in response to your request for written clarification on use of Maintenance of Effort (MOE) dollars as match for other Federal programs. The MOE is a requirement in the authorizing legislation for the Substance Abuse Prevention and Treatment (SAPT) Block Grant program that the principal agency of a State for carrying out authorized activities must maintain aggregate State expenditures for authorized activities at a level that is not less than the average of the previous two years (42 U.S.C. 300x-30).

The MOE is not a match but an eligibility requirement to receive the block grant. Cost Sharing or Matching is defined in the HHS Grants Policy Directive Number 1.02 as "The value of allowable third party in kind contributions and the allowable costs of a federally assisted project or program not borne by the Federal Government." The Directive's definition of Maintenance of Effort "A requirement contained in authorizing legislation, regulation, or administrative policy stating that in order to receive Federal Grant funds a recipient must agree to contribute and maintain a specified level of financial effort for the grant from its own resources or other non Federal sources. This requirement is usually given in terms of meeting a previous base-year dollar amount." Match dollars used for one Federal program cannot be used as match for another Federal program. But as the MOE is not a match those dollars can be used as match for other Federal programs.

Our Office of General Counsel has confirmed that MOE dollars under the SAPT Block Grant can be used as a match for other Federal programs.

I hope this information is helpful. If you have any other questions, please do not hesitate to contact me on 301-443-4456 or my email LRICE@SAMHSA.GOV.

Sincerely,

LouEllen M. Rice
Grants Management Officer
Grants Management Branch, OPS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

September 12, 2001

Amy Baker
Chief Financial Officer
Office of Administration
Florida Dept. of Children and Families
1317 Winewood Boulevard
Tallahassee, Florida 32399-0700

Dear Ms. Baker:

This letter is a follow up to our conversation on August 29th concerning Maintenance of Effort (MOE). The issue initially was could State expenditures for community mental health services included in Florida's MOE under the CMHS block grant program be used as match in other Federal programs. As my letter of October 27, 2000 to Dennis L. Croft states, our Office of General Counsel confirmed that MOE dollars under the CMHS Block grant can be used as a match for other Federal programs.

The concern now seems to be questions about the applicability of 45 CFR 92.24 Matching and Cost Sharing to MOE. That section does not apply here because MOE is not matching or cost sharing. Cost sharing or Matching is defined in the HHS Grants Policy Directive Number 1.02 as "The value of allowable third part in-kind contributions and the allowable costs of a federally assisted project or program not borne by the Federal Government." The Directive's definition of Maintenance of Effort is "A requirement contained in authorizing legislation, regulation, or administrative policy stating that in order to receive Federal grant funds a recipient must agree to contribute and maintain a specified level of financial effort for the grant from its own resources or other non-Federal sources. This requirement is usually given in terms of meeting a previous base-year dollar amount." As you can see, Maintenance of Effort is not defined as a match or cost share but as an agreement to maintain a previous base-year dollar amount as a requirement to receive Federal grant funds. So, MOE dollars under the CMHS Block Grant can be used as a match for other Federal programs.

I hope this information is helpful. If you have any other questions, please do not hesitate to contact me on 301-443-4456 or my email LRICE@SAMHSA.GOV.

Sincerely,

LouEllen M Rice

LouEllen M. Rice
Grants Management Officer
Division of Grants Management, OPS

Medicaid-to-Medicare Fee Index | The Henry J. Kaiser F Foundation

Timeframe: 2016

Location	All Services	Primary Care	Primary Care for Physicians Eligible for Increased Fee	Obstetric Care	Other Services
United States	**0.72**	**0.66**		**0.81**	**0.82**
Alabama	0.75	0.65	1.00	0.88	0.84
Alaska	1.26	1.27		1.25	1.24
Arizona	0.80	0.73		0.92	0.84
Arkansas	0.80	0.65		0.70	1.34
California	0.52	0.41		0.60	0.76
Colorado	0.80	0.84	0.84	0.67	0.84
Connecticut	0.76	0.76		0.81	0.68
Delaware	0.96	0.99		0.84	0.97
District of Columbia	0.79	0.80		0.79	0.78
Florida	0.56	0.48	0.53	0.82	0.58
Georgia	0.77	0.65	0.89	0.85	0.99
Hawaii	0.62	0.54		0.64	0.83
Idaho	0.95	1.00	1.00	0.89	0.88
Illinois	0.61	0.48		0.85	0.79
Indiana	0.77	0.75	0.75	1.00	0.75
Iowa	0.82	0.72	0.98	0.83	1.10
Kansas	0.78	0.73		0.74	0.96
Kentucky	0.77	0.67		0.93	0.92
Louisiana	0.70	0.67		0.70	0.80
Maine	0.64	0.60	1.00	0.66	0.73
Maryland	0.88	0.92	0.92	0.86	0.81
Massachusetts	0.79	0.70		0.96	0.81
Michigan	0.65	0.57	0.71	0.91	0.55
Minnesota	0.75	0.78		0.67	0.72
Mississippi	0.89	0.90	1.00	0.89	0.88
Missouri	0.60	0.55		0.57	0.79
Montana	1.09	1.06		1.17	1.05
Nebraska	0.92	0.71	1.01	1.05	1.33
Nevada	0.95	0.95	0.95	0.97	0.92
New Hampshire	0.58	0.56		0.59	0.60
New Jersey	0.42	0.42	0.53	0.35	0.52
New Mexico	0.89	0.78	1.00	0.98	1.05
New York	0.56	0.44		0.73	0.68
North Carolina	0.78	0.79		0.67	0.91
North Dakota	0.98	1.00		0.99	0.92
Ohio	0.63	0.59		0.65	0.74
Oklahoma	0.86	0.87		0.85	0.84

Oregon	0.81	0.71	0.77	1.12	0.68
Pennsylvania	0.69	0.51		1.06	0.68
Rhode Island	0.38	0.33		0.41	0.51
South Carolina	0.79	0.70	1.00	1.30	0.87
South Dakota	0.84	0.71		0.89	1.11
Tennessee	N/A	N/A		N/A	N/A
Texas	0.65	0.58		0.66	0.85
Utah	0.86	0.86	0.86	0.90	0.80
Vermont	0.80	0.81	0.84	0.79	0.78
Virginia	0.92	0.84		1.03	0.97
Washington	0.71	0.65		0.93	0.58
West Virginia	0.81	0.74		1.04	0.71
Wisconsin	0.62	0.48		0.63	1.00
Wyoming	0.98	0.93		1.05	1.04

NOTES

Notes

The Medicaid-to-Medicare fee index measures each state's physician fees relative to Medicare fees in each state. The Medicaid data are based on su
Urban Institute to the forty-nine states and the District of Columbia that have a fee-for-service (FFS) component in their Medicaid programs (only Te
These fees represent only those payments made under FFS Medicaid. The Medicare-to-Medicaid fee index is a computed ratio of the Medicaid fee f
state to the Medicare fee for the same services. Comparable Medicare fees are calculated using relative value units, geographic adjusters, and conv
primary care indices were calculated for physicians eligible for the primary care fee bump and those ineliglbe for the fee bump. Click here for a disc
methodology.

The ACA included a mandatory two-year increase in fees for primary care services to Medicare levels for both Medicaid FFS and managed care in 20
as the "fee bump". Federal funding for the fee bump ended in 2014; however, a number of states continued to fully or partially fund the fee increas

Sources

Stephen Zuckerman, Laura Skopec, and Marni Epstein, "Medicaid Physician Fees after the ACA Primary Care Fee Bump," Urban Institute, March 201

Definitions

Primary Care: defined as services subject to the Affordable Care Act's Medicaid primary care parity provision.

Primary Care for Physicians Eligible for Increased Fee: fee index for physicians eligible to receive increased rates for primary care services in stat
Medicaid primary care fee bump in whole or in part.

N/A: Not applicable because Tennessee does not have a Medicaid fee-for-service program.

Medicaid Physician Fees after the ACA Primary Care Fee Bump

19 States Continue the Affordable Care Act's Temporary Policy Change

Stephen Zuckerman, Laura Skopec, and Marni Epstein

March 2017

Introduction

Medicaid has historically paid physicians lower fees than either private insurance or Medicare for the same services (Zuckerman and Goin 2012; Zuckerman, Skopec, and McCormack 2014; Zuckerman, Williams, and Stockley 2009). Research has shown that before the Affordable Care Act (ACA) was implemented, low Medicaid fees created a barrier to health care access for Medicaid enrollees because of physicians' reluctance to take on new Medicaid patients (Berman et al. 2002; Davidson 1982; Decker 2012; Sloan, Mitchell, and Cromwell 1978; Zuckerman et al. 2004). Still, policymakers included an expansion of Medicaid eligibility in the ACA to increase access to health insurance coverage. The 2012 Supreme Court decision that preserved most ACA provisions made the Medicaid expansion optional for states. As of July 2016, 31 states and the District of Columbia had expanded Medicaid to low-income adults,[1] adding an estimated 9 million enrollees by early 2016 (Blumberg and Holahan 2016).

Even if the Medicaid expansion had remained mandatory, low Medicaid physician fees could impact physicians' willingness to accept newly enrolled Medicaid patients. To address this, the ACA included a mandatory two-year increase in fees for primary care services to Medicare levels for both Medicaid fee-for-service and managed care in 2013 and 2014. The federal government paid for the full costs of this increase, raising fees for primary care physicians including pediatricians. Implementation difficulties and delays in federal rulemaking meant that most eligible physicians did not begin receiving higher fees until mid- to late 2013, though physicians received the higher primary care fees retroactively through the beginning of 2013.

Initial evidence is mixed on whether the increase in primary care fees, or "fee bump," successfully increased access to primary care for Medicaid enrollees. One study found a 7.7 percentage-point increase in the availability of appointments for Medicaid enrollees between 2012 and 2014 in 10 states

(Polsky et al. 2015). The increase in availability was greater for states with larger increases in reimbursement rates, suggesting that the fee bump likely contributed to the greater availability of physicians. The Medicaid and CHIP Payment and Access Commission conducted semistructured interviews with officials in eight states and found that the increased payments had, at most, a modest effect on provider willingness to take on new Medicaid patients (MACPAC 2015). Respondents cited initial operational difficulties and the delayed start of the increased payments as major challenges. Another study found no overall increase in primary care physicians' acceptance of new Medicaid patients from 2011 to 2014, using the National Electronic Health Records Survey and the National Health Interview Survey (Decker 2016).

Federal lawmakers did not reauthorize funding for the increased payments to primary care services, ending the fee bump in December 2014. States could continue to finance the higher primary care payments using their own funds and conventional federal matching rates, or they could drop fees back down to pre–fee bump levels. Though most states rolled fees back, a number of states continued the fee bump in whole or in part. This paper updates previous research on Medicaid physician fees by considering how fees vary both across states and relative to Medicare payments, with a special focus on states that chose to continue the fee bump with state funds (Zuckerman and Goin 2012; Zuckerman, Skopec, and McCormack 2014; Zuckerman, Williams, and Stockley 2009).

Data and Methods

The Urban Institute has been tracking Medicaid physician payment rates through a survey of Medicaid physician fees in 49 states and the District of Columbia since 1993.[2] We collected publicly available July 2016 Medicaid fees from state websites for 27 procedures, including primary care, obstetrical care, and other services (appendix table A.1).[3] We calculated comparable Medicare fees using the relative value units, geographic adjusters, and conversion factor available on the Centers for Medicare and Medicaid Services (CMS) website.

We constructed three indexes to compare Medicaid payment rates across states: the Medicaid fee index, which compares Medicaid fees across states in 2016; the Medicaid-to-Medicare fee index, which compares Medicaid-to-Medicare payments within states; and the Medicaid fee change index, which compares 2016 Medicaid fees with 2014 fees within states. These three indexes use primary care fees for providers who were ineligible for the fee bump. For each index, we first computed a simple average fee for each service in each state. The Medicaid fee index measures each state's average fee relative to the national average. We computed the ratio of each state's fee for a given service to the national average. The national average Medicaid fee for a service is a weighted average fee across states, using 2016 Medicaid enrollment numbers as weights. We then aggregated these fee ratios across procedure codes for each state, defining procedure weights as the share of total US Medicaid spending across the surveyed procedures in 2000, based on Medicaid spending data obtained from CMS.

The Medicaid-to-Medicare fee index measures the ratio of each state's average Medicaid fee to the Medicare fee for the same service. We combined these fee ratios into a single state index using the same

Medicaid spending weights as in the Medicaid fee index. We computed an overall index and indexes by type of service (primary care, obstetric care, and other services). These indexes used fees for providers ineligible for the fee bump.

We then computed the same Medicaid-to-Medicare primary care fee index for states that partially or fully continued the fee bump, using the same methods as in the previous index with fees for providers eligible for the fee bump.

Finally, we computed the Medicaid fee change index, comparing 2016 Medicaid fees with 2014 Medicaid fees. We calculated the difference in the 2016 and 2014 fee for all 27 services for each state and then aggregated them to the state and national level using the same service weighting as in the previously described fee indexes.

The services included in the primary care index are different from those included in the primary care index in previous iterations of this study. To simplify our discussion of the primary care fee bump, the new primary care index includes only those seven services that were eligible for the fee bump and for which we collected data in past years.[4] We identified states continuing the fee bump either by a separate primary care fee schedule provided by the state or by changes in the primary care index from 2012 to 2016.

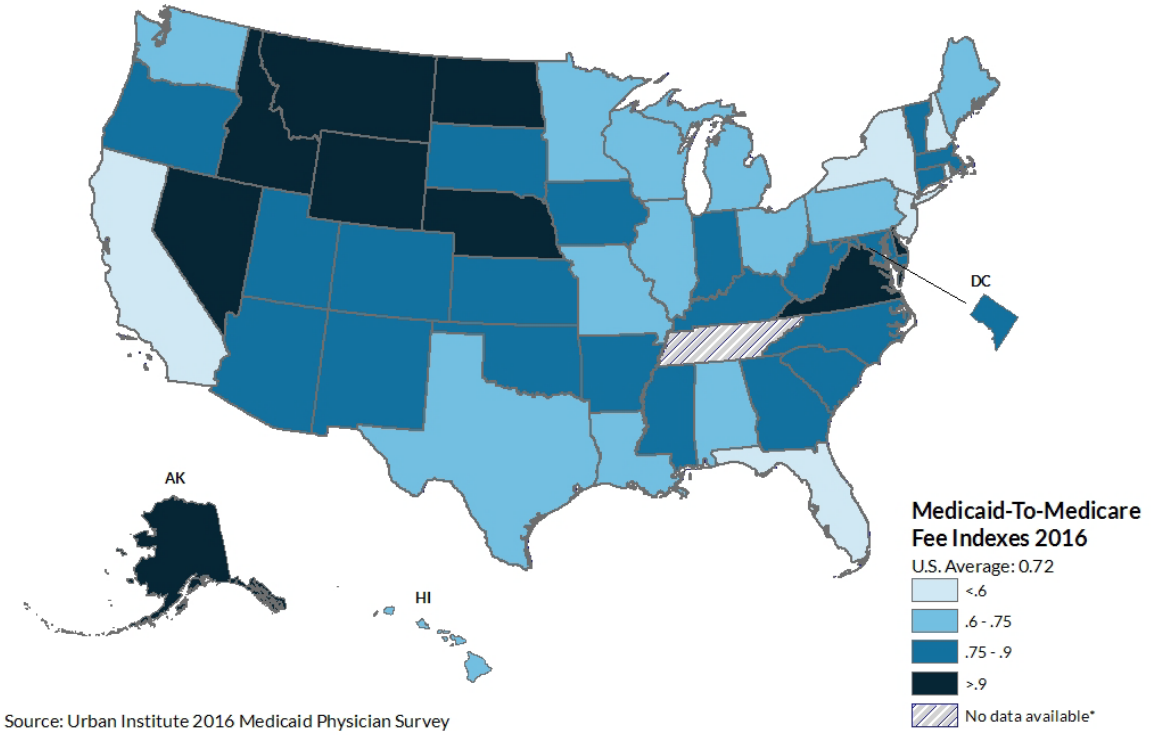
Results

As of July 2016, Medicaid programs paid physicians fees at 72 percent of Medicare rates (index value of 0.72).[5] Across the country, state Medicaid-to-Medicare fee indexes range from 0.38 in Rhode Island to 1.26 in Alaska (see figure 1 and table 1). In general, the 2016 Medicaid-to-Medicare fee index is lower for primary care (0.66) than for obstetric care or other services (0.81 and 0.82, respectively). Medicaid fees have been fairly stable relative to Medicare fees over time, hovering around 70 percent of Medicare for more than a decade (69 percent in 2003, 72 percent in 2008, 66 percent in 2012, and 66 percent in 2014; Zuckerman and Goin 2012; Zuckerman, Skopec, and McCormack 2014; Zuckerman, Williams, and Stockley 2009).

Between 2014 and 2016, Medicaid physician fees increased by an average of 4.1 percent (see appendix table A.2). Fee increases were greater for primary care and obstetric care than for other services, on average. Though a few states saw average fee reductions of more than 2 percent between 2014 and 2016, most had fairly stable or increasing Medicaid fees.

FIGURE 1

Medicaid-to-Medicare Fee Indexes for All Services for Physicians Ineligible for the Fee Bump, 2016



Source: Urban Institute 2016 Medicaid Physician Survey

As of July 2016, 19 states fully or partially continued the primary care fee bump in 2016, according to publicly available fee schedules.[6] Of the 19 states, 14 have Medicaid-to-Medicare primary care fee ratios above 0.80 for eligible providers. These 19 states fall into three broad categories:

- States that fully continued the fee bump for primary care providers: Alabama, Iowa, Maine, Mississippi, Nebraska, New Mexico, and South Carolina (table 2)
- States that partially continued the fee bump for primary care physicians: Florida, Georgia, Michigan, New Jersey, Oregon, and Vermont (table 2)
- States that maintained higher primary care fees for all types of physicians following the 2013–14 fee bump: Colorado, Idaho, Indiana, Maryland,[7] Nevada, and Utah (table 1)

For states that continued a partial fee bump for primary care, Medicaid primary care fees stayed between 11 percent (Georgia) and 47 percent (Florida and New Jersey) below Medicare. Medicaid primary care fees in Alaska, Montana, and North Dakota were at or above Medicare fees for all types of physicians before the implementation of the fee bump and are not included in these lists.

TABLE 1

Medicaid-to-Medicare Fee Index by Service Type in 2016

State	All services	Primary care[a]	Obstetric care	Other services
US	***0.72***	***0.66***	***0.81***	***0.82***
AL	0.75	0.65	0.88	0.84
AK	1.26	1.27	1.25	1.24
AZ	0.80	0.73	0.92	0.84
AR	0.80	0.65	0.70	1.34
CA	0.52	0.41	0.60	0.76
CO	0.80	0.84[b]	0.67	0.84
CT	0.76	0.76	0.81	0.68
DE	0.96	0.99	0.84	0.97
DC	0.79	0.80	0.79	0.78
FL	0.56	0.48	0.82	0.58
GA	0.77	0.65	0.85	0.99
HI	0.62	0.54	0.64	0.83
ID	0.95	1.00[b]	0.89	0.88
IL	0.61	0.48	0.85	0.79
IN	0.77	0.75[b]	1.00	0.75
IA	0.82	0.72	0.83	1.10
KS	0.78	0.73	0.74	0.96
KY	0.77	0.67	0.93	0.92
LA	0.70	0.67	0.70	0.80
ME	0.64	0.60	0.66	0.73
MD	0.88	0.92[b]	0.86	0.81
MA	0.79	0.70	0.96	0.81
MI	0.65	0.57	0.91	0.55
MN	0.75	0.78	0.67	0.72
MS	0.89	0.90	0.89	0.88
MO	0.60	0.55	0.57	0.79
MT	1.09	1.06	1.17	1.05
NE	0.92	0.71	1.05	1.33
NV	0.95	0.95[b]	0.97	0.92
NH	0.58	0.56	0.59	0.60
NJ	0.42	0.42	0.35	0.52
NM	0.89	0.78	0.98	1.05
NY	0.56	0.44	0.73	0.68
NC	0.78	0.79	0.67	0.91
ND	0.98	1.00	0.99	0.92
OH	0.63	0.59	0.65	0.74
OK	0.86	0.87	0.85	0.84
OR	0.81	0.71	1.12	0.68
PA	0.69	0.51	1.06	0.68
RI	0.38	0.33	0.41	0.51
SC	0.79	0.70	1.30	0.87
SD	0.84	0.71	0.89	1.11
TX	0.65	0.58	0.66	0.85
UT	0.86	0.86[b]	0.90	0.80
VT	0.80	0.81	0.79	0.78
VA	0.92	0.84	1.03	0.97
WA	0.71	0.65	0.93	0.58
WV	0.81	0.74	1.04	0.71
WI	0.62	0.48	0.63	1.00
WY	0.98	0.93	1.05	1.04

Source: Urban Institute 2016 Medicaid Physician Survey.

Notes: [a] Primary care is defined as services subject to the Affordable Care Act's Medicaid primary care parity provision. [b] These states paid increased fees for primary care to all physician types in 2016.

TABLE 2

Medicaid-to-Medicare Primary Care[a] Fee Index for States That Fully or Partially Continued the Fee Bump for Primary Care Physicians, 2016

State	Physicians *in*eligible for fee bump–increased rates	Physicians eligible for fee bump–increased rates
Full fee bump		
AL	0.65	1.00
IA	0.72	0.98
ME	0.60	1.00
MS	0.90	1.00
NE	0.71	1.01
NM	0.78	1.00
SC	0.70	1.00
Partial fee bump		
FL	0.48	0.53
GA	0.65	0.89
MI	0.57	0.71
NJ	0.42	0.53
OR	0.71	0.77
VT	0.81	0.84

Source: Urban Institute 2016 Medicaid Physician Survey.
Note: [a] Primary care is defined as services subject to the Affordable Care Act's Medicaid primary care parity provision.

Limitations

Our study only includes fees for fee-for-service Medicaid and does not include fees for Medicaid managed care. According to CMS, 77 percent of Medicaid beneficiaries were enrolled in a managed care organization as of 2014, the most recent year for which data are available (DMCP 2016). A 20-state survey conducted by the US Government Accountability Office found that managed care plans paid fees quite similar to those for fee-for-service Medicaid, with some variation among states (GAO 2014). The differences were small (5 percent or less) for most states. In this study, we may misstate true Medicaid-to-Medicare fee ratios to a greater extent for physicians with larger shares of patients in Medicaid managed care plans.

We identified states continuing the fee bump by comparing publicly available data on their fees in 2016 to publicly available fees in 2014. We did not review state budgets, regulations, or other documents to assess each state's rationale for its approach to primary care fees in 2016. Our list of states continuing the fee bump does not completely correspond to reports of state plans gathered from a survey of state Medicaid programs.[8]

Discussion

The ACA included a federally funded Medicaid primary care fee bump, in part to address health care access concerns related to historically low Medicaid reimbursement and an expected increase in

Medicaid beneficiaries in 2014. The fee was limited to two years in order to minimize its budget impact. Some argued that such a short-term fee increase would do little to encourage additional physicians to accept Medicaid, but others noted that physicians already accepting Medicaid may have seen additional Medicaid patients (Tollen 2015). This brief explores how state choices about the fee bump affected Medicaid fees for primary care and other services.

Operational challenges delayed the start of the ACA Medicaid primary care payment changes and may have shortened the period during which physicians could adjust to these new fees. Implementation delays also made it more difficult to measure the effect of the fee bump on provider participation and access to care. In addition, many changes occurred simultaneously in the health system between 2012 and 2014, complicating efforts to link changes in access to care to the primary care fee bump. To date, evidence on the effectiveness of the fee bump is mixed, though some studies suggest it may have had a modest effect in increasing Medicaid enrollees' access to primary care (Polsky et al. 2015). States had to decide whether to continue the primary care fee bump with very little evidence about its effectiveness. Our results show that when the temporary federal policy expired, many states continued to pay higher fees for primary care than they did in 2012, suggesting that even a temporary federal policy had lasting effects on some states' approaches to Medicaid reimbursement.

Continuing the fee bump with regular Medicaid financing may furnish additional evidence of the policy's effects on access to care, particularly if these state-level initiatives are longer-lived than the ACA fee bump. Additionally, the natural experiment created by states' choices—continuing the fee bump, not continuing the fee bump, and various options in between—could allow for more definitive estimates of the effects of Medicaid fees on physician participation and beneficiary access to care.

Appendix A

APPENDIX TABLE A.1

Mean, Maximum, and Minimum Medicaid Fees and Standard Deviations for Selected States, 2016

Code	Procedure	Share of expenditures (%)	Mean fee ($)	Maximum fee ($)	Minimum fee ($)	Coefficient of variation
Primary care[a]						
99203	Office visit, new patient, 30 minutes	2.7	73.08	174.87	29.00	25.42
99204	Office visit, new patient, 45 minutes	2.3	106.60	271.74	45.00	29.04
99213	Office visit, established patient, 15 minutes	25.5	45.45	118.70	20.64	33.62
99214	Office visit, established patient, 25 minutes	9.5	68.63	176.19	27.00	31.92
99222	Initial hospital care, new or established patient, 50 minutes	1.4	91.18	236.05	29.50	28.03
99232	Hospital visit, new patient, 45 minutes	4.4	46.90	124.81	17.00	29.27
99283	Emergency department visit	8.1	47.26	109.36	24.17	19.66
Obstetric care						
59400	Total obstetric care, vaginal delivery	8.6	1,636.01	3,447.30	815.00	23.04
59409	Vaginal delivery only, no postpartum care	4.7	750.75	1,371.90	277.00	24.47
59410	Vaginal delivery and postpartum care	6.7	914.81	1,747.50	296.00	20.54
59510	Total obstetric care, cesarean delivery	2.9	1,756.36	3,816.70	815.00	25.07
59514	Cesarean delivery and no postpartum care	1.7	816.81	1,544.80	398.50	26.70
59515	Cesarean delivery and postpartum care	2.0	1,085.24	2,113.00	417.50	28.67
Other services						
43235	Upper gastrointestinal endoscopy	0.4	216.42	476.46	124.03	21.85
43239	Upper gastrointestinal endoscopy with biopsy	1.3	261.21	603.32	126.00	25.33
58120	Dilation and curettage	0.2	199.12	421.99	123.14	18.97
58150	Total hysterectomy	0.3	776.76	1,706.50	518.50	18.65
66984	Cataract removal with lens implant	1.5	647.98	1,550.60	358.76	33.64
69436	Tympanostomy	1.5	127.14	262.52	80.50	21.02
70450	Computerized axial tomography scan, head or brain	1.9	140.48	276.10	64.78	31.29
71020	X-ray, chest, two views	3.1	24.77	42.63	15.00	22.09
76805	Echography, pregnant uterus	3.7	106.21	218.07	36.00	24.61
88305	Surgical pathology	1.4	56.64	116.51	18.72	23.60

Code	Procedure	Share of expenditures (%)	Mean fee ($)	Maximum fee ($)	Minimum fee ($)	Coefficient of variation
92004	Ophthalmological services, new patient	1.1	88.35	99.93	28.07	35.21
92014	Ophthalmological services, established patient	0.8	71.49	241.90	28.07	35.14
93000	Electrocardiogram	0.5	19.95	240.53	9.51	57.81
93307	Echocardiography, transthoracic	1.4	127.61	198.53	48.00	25.94

Source: Urban Institute 2016 Medicaid Physician Survey.

Note: [a] Primary care is defined as services subject to the Affordable Care Act's Medicaid primary care parity provision.

APPENDIX TABLE A.2

Cumulative Change in Medicaid Fees by Service Type, 2014–16, and Medicaid Fee Indexes, 2016

	Cumulative Change in Medicaid Fee, 2014–16				2016 Medicaid Fee Indexes			
State	All services	Primary care[a]	Obstetric care	Other services	All services	Primary care[a]	Obstetric care	Other services
US	***4.1%***	***5.1%***	***5.5%***	***0.3%***	***1.00***	***1.00***	***1.00***	***1.00***
AL	-0.2%	2.7%	-10.4%	5.8%	0.95	0.93	0.98	0.93
AK	-1.2%	-0.6%	-0.8%	-3.7%	2.28	2.55	1.99	1.94
AZ	-0.5%	-0.2%	-0.3%	-1.7%	1.11	1.11	1.13	1.07
AR	0.0%	0.0%	0.0%	0.0%	0.98	0.92	0.78	1.44
CA	2.9%	0.0%	17.7%	-2.8%	0.76	0.66	0.79	1.00
CO	25.3%	15.4%	2.5%	84.3%	1.13	1.31	0.84	1.04
CT	-4.0%	-2.3%	-5.9%	-6.3%	1.16	1.27	1.09	0.92
DE	-1.5%	1.1%	-8.5%	-3.3%	1.40	1.55	1.02	1.28
DC	-0.1%	1.0%	-0.5%	-2.6%	1.27	1.39	1.11	1.15
FL	-1.0%	0.2%	0.9%	-5.5%	0.79	0.74	1.05	0.75
GA	2.7%	0.0%	10.1%	0.0%	1.02	0.97	1.03	1.14
HI	0.0%	0.0%	0.0%	0.0%	0.89	0.86	0.79	1.09
ID	8.0%	16.5%	-1.6%	-2.7%	1.25	1.45	1.00	1.03
IL	0.1%	0.1%	0.0%	0.0%	0.85	0.76	1.11	0.93
IN	35.9%	49.0%	19.1%	4.5%	1.05	1.10	1.06	0.90
IA	1.0%	0.0%	0.0%	4.9%	1.04	1.03	0.92	1.22
KS	-1.6%	-2.9%	0.0%	0.0%	1.01	1.07	0.85	1.09
KY	0.0%	0.0%	0.0%	0.0%	0.98	0.96	1.03	1.01
LA	-0.5%	-0.8%	0.0%	0.0%	0.97	1.00	0.81	0.93
ME	0.3%	0.0%	0.0%	1.7%	0.85	0.89	0.77	0.87
MD	-3.9%	-6.3%	0.0%	0.0%	1.35	1.51	1.09	1.09
MA	0.5%	0.9%	0.0%	0.0%	1.12	1.11	1.18	1.07
MI	24.4%	34.7%	24.2%	-4.4%	0.90	0.86	1.14	0.69
MN	0.0%	0.9%	0.0%	-2.6%	1.04	1.18	0.73	0.92
MS	-0.2%	1.2%	-1.0%	-3.4%	1.17	1.29	0.95	1.01
MO	1.0%	1.0%	1.0%	1.0%	0.79	0.81	0.69	0.88
MT	5.4%	6.5%	4.9%	2.9%	1.56	1.65	1.51	1.36
NE	2.4%	1.0%	4.0%	4.1%	1.14	1.02	1.14	1.45
NV	25.0%	50.2%	-5.7%	-3.3%	1.37	1.50	1.23	1.21
NH	0.1%	0.0%	0.0%	0.3%	0.81	0.88	0.73	0.74
NJ	-0.4%	0.0%	0.0%	-1.9%	0.64	0.70	0.48	0.71
NM	-1.4%	-0.6%	-0.1%	-5.2%	1.19	1.16	1.21	1.25
NY	0.0%	0.0%	0.0%	0.0%	0.85	0.74	1.03	0.92
NC	0.0%	0.0%	0.0%	0.2%	1.05	1.17	0.79	1.06
ND	-29.8%	-30.2%	-31.0%	-27.7%	1.35	1.52	1.16	1.15
OH	4.4%	5.9%	0.0%	5.4%	0.85	0.88	0.78	0.87
OK	-2.9%	-2.0%	-3.2%	-4.9%	1.14	1.26	1.00	0.99
OR	0.5%	1.5%	0.5%	-2.1%	1.11	1.08	1.34	0.87
PA	3.7%	6.8%	0.0%	0.0%	0.93	0.78	1.31	0.81
RI	0.0%	0.0%	0.0%	0.0%	0.53	0.51	0.50	0.62
SC	-0.2%	-0.2%	0.0%	-0.2%	1.05	1.03	1.40	1.00
SD	4.4%	4.4%	4.4%	4.4%	1.10	1.06	1.00	1.34
TX	0.2%	0.4%	0.0%	-0.4%	0.88	0.86	0.75	1.04
UT	17.6%	15.9%	31.3%	3.4%	1.19	1.30	1.13	0.95
VT	-0.2%	0.7%	0.1%	-3.0%	1.11	1.23	0.95	0.99
VA	-0.6%	0.1%	0.0%	-3.7%	1.10	1.11	1.08	1.07
WA	-1.3%	1.2%	-5.5%	-2.3%	0.98	1.01	1.10	0.76
WV	-0.6%	0.3%	-0.8%	-2.7%	1.08	1.07	1.29	0.82
WI	-0.4%	-0.7%	0.0%	0.0%	0.80	0.71	0.72	1.17
WY	2.8%	0.0%	0.0%	14.3%	1.38	1.44	1.35	1.27

Source: Urban Institute 2016 Medicaid Physician Survey.

Note: [a] Primary care is defined as services subject to the Affordable Care Act's Medicaid primary care parity provision.

Notes

1. "Medicaid Expansion States," Centers for Medicare and Medicaid Services, https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf.
2. Tennessee was excluded because its Medicaid program does not have a fee-for-service component.
3. We contacted state Medicaid offices directly through phone calls or emails when the information available online did not seem plausible or was unclear.
4. Though the ACA increased primary care fees for nearly 150 services, only seven are included in our index. Our earlier research indicates that these seven fees provide a reasonable estimate of the overall change in primary care fees attributable to the fee bump. See Zuckerman and Goin (2012).
5. Fees are for physicians ineligible for the increased primary care rates in states that continued the fee bump.
6. These findings differ from the Kaiser Family Foundation's list of states that would continue the fee bump. They reported that 10 states fully continued the fee bump in 2015: Alabama, Colorado, DC, Hawaii, Iowa, Maine, Mississippi, Nebraska, Nevada, and New Mexico. Nine of these states indicated that they would continue the full increase in 2016 (Smith et al. 2015, 50).
7. Maryland maintained higher fees for all primary care services but did not fully match Medicare levels in 2016.
8. See note 6.

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About the Authors

Stephen Zuckerman is a senior fellow and codirector of the Health Policy Center at the Urban Institute. He has studied health economics and health policy for almost 30 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services, and he is studying the implementation and impact of the Affordable Care Act.

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From: "Baker, Amy" <BAKER.AMY@leg.state.fl.us>
Date: August 6, 2019 at 10:53:54 AM EDT
To: "Vickers, Mary Beth" <MaryBeth.Vickers@LASPBS.STATE.FL.US>
Cc: "Pridgeon, Eric" <Eric.Pridgeon@LASPBS.STATE.FL.US>, "Kidd, Tonya" <Tonya.Kidd@LASPBS.STATE.FL.US>, "Ciupalo, Holger" <Holger.Ciupalo@LASPBS.STATE.FL.US>, "Langston, Don" <Don.Langston@LASPBS.STATE.FL.US>, "Diez-Arguelles, Jose" <Jose.Diez-Arguelles@LASPBS.STATE.FL.US>
Subject: Re: Medicaid Expansion Impact to ACA

Adding to the complexity of this issue and the possible outcomes for the remaining Exchange recipients, please review the attached Issue brief from the US Department of Health and Human Services. There may be more analyses that are on point, but I haven't had time to complete a literature search.

https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf

Amy

On Aug 6, 2019, at 7:35 AM, Vickers, Mary Beth <MaryBeth.Vickers@laspbs.state.fl.us> wrote:

Good morning. Included below is the information from OIR as requested. Thank you.
Mary Beth

Mary Beth Vickers, Policy Coordinator
Health and Human Services Unit
Governor's Office of Policy and Budget

From: Wright, Craig <Craig.Wright@floir.com>
Sent: Tuesday, August 6, 2019 12:12 AM
To: Vickers, Mary Beth <MaryBeth.Vickers@LASPBS.STATE.FL.US>
Cc: Yaworsky, Mike <Mike.Yaworsky@floir.com>; Struk, Christopher <Christopher.Struk@floir.com>; Murray, Caitlin <Caitlin.Murray@floir.com>; Silver, Derek <Derek.Silver@floir.com>; Wright, Craig <Craig.Wright@floir.com>; VanSickle, Erin <Erin.VanSickle@floir.com>
Subject: Medicaid Expansion Impact to ACA

Below are the comments I presented today, with some modifications based on revised assumptions discussed in the meeting.

Expanding Medicaid to cover consumers who earn up to 138% of the Federal Poverty Level (FPL) has significant ramifications in the ACA market. Specifically:

- Premium subsidies will be reduced, causing bronze premiums to increase substantially
- ACA Enrollment expected to be reduced by approximately 60,000 to 250,000 non-Medicaid consumers leaving as a result of market contraction.
- Federal revenues entering Florida in the form of premium subsidies reduced between $4.8 billion and $6.2 billion

Background
Florida's ACA market consists of 1.8 million consumers and is the largest On-Exchange market in the country. Over the last two years, while nationwide ACA enrollment has decreased 15%, Florida's has grown 5%. Approximately 85% of that growth is found in lower income consumers earning between 100% and 150% of FPL. There are approximately 900,000 consumers enrolled in the ACA with incomes between 100%-150% of FPL. Separately, there are over 500,000 consumers enrolled in bronze plans.

Expanding Medicaid would move consumers who earn between 100%-138% of FPL from their ACA plans to Medicaid. Removing those consumers from the market will have substantial consequences to the premium subsidies for the remaining consumers and likely lead many to disenroll because they can no longer afford the premiums.

Number of Medicaid Eligible consumers with incomes between 100% and 138% of FPL.
Before quantifying the various impacts to the market we first have to get alignment on the number of consumers that would be moved from the ACA market to the Medicaid Market.

- CMS's Public Use File indicates there were 981,323 consumers with incomes between 100% and 150% FPL who selected an ACA plan. OIR enrollment data shows that 92% of consumers who selected a plan ultimately paid the premium and enrolled.
    - This leads to a starting point of 903,000 consumers with incomes between 100% and 150% FPL.
- We then apply the following assumptions from the Office of Economic & Demographic Research to adjust to get only those earning between 100% and 138% that will be eligible for Medicaid:
    - 76% - to get to all consumers with incomes between 100% and 138%
    - 90.8% - to get to the number of consumers between the ages of 19 and 64
    - 87.6% - to get to the number of consumers who are citizens.
- This leads us to an ending enrollment of 546,000 consumers who would be leaving the ACA market. (That is 903,000 * .76 * .908 * .876 = 546,000)

Using this number, the following are the impacts observed in the ACA market.

Subsidy Development and Impact Examples
The impact of removing 546,000 consumers from the ACA market is most notable in the reduction of premium subsidies consumers receive.

Consumers with incomes between 100%-150% are enrolled in a special silver plan that contains enriched benefits to ensure low income consumers have copays and deductibles that are affordable. Previously those enhanced benefits were funded through a separate subsidy program called the "Cost Share Reduction" (CSR) program. However, that subsidy ended in 2017. To adjust for that the silver premium is now blended with all the silver enriched benefit plans created for low income consumers. As a result, the silver premium is now higher than it was previously, which in turn has increased the amount of premium subsidies available for consumers because the premium subsidy is based on the price of the 2nd lowest silver plan. Removing those consumers would reduce the blended silver premium by 2.5%, which will in turn reduce the subsides available for consumers. This should have no net effect on people that have silver plans as the decrease in subsidy will be offset by the decrease in rates. However, for people that used the increased subsidy to purchase a bronze plan, there may be a significant financial impact by reducing the subsidy amount.

For example:

- **A family of 4 in Miami-Dade County earning $54,000 enrolled in the 2nd lowest bronze plan would see their annual premium rise from $282 to $711, a 150% premium increase.**
- **A family of 4 in Hillsborough County earning $54,000 enrolled in the 2nd lowest bronze plan would see their annual premium rise from $196 to $652, a 230% premium increase.**

Note – a family of 4 earning less than $35,000 would be eligible for Medicaid under the expansion.

Why such a large impact on Bronze premium?

The reason for the large impact on bronze is the leveraging effect from subsidies. As we see in the example below, reducing the silver premium 2.5% while keeping bronze premiums flat results in a post subsidy increase of over 150%.

	(a)	(b)=7.09% of AGI	(c) = (a) - (b)	(d)	(e) = (d) - (c)		(a)' = (a) * .975	(b)=7.09% of AGI	(c)' = (a)' - (b)	(d)	(e)' = (d) - (c)'	
	2nd Lowest Silver	FPL Max Premium	Subsidy for Consumer	2nd Lowest Bronze (Unsubsidized)	2nd Lowest Bronze After Subsidy	*Decrease Silver 2.5%*	2nd Lowest Silver	FPL Max Premium	Subsidy for Consumer	2nd Lowest Bronze (Unsubsidized)	2nd Lowest Bronze After Subsidy	Bronze % Change
Miami-Dade	$17,167	$3,829	$13,338	$13,620	$282		$16,738	$3,829	$12,909	$13,620	$711	**152%**
Hillsborough	$18,234	$3,829	$14,406	$14,602	$196		$17,778	$3,829	$13,950	$14,602	$652	**232%**

Enrollment Reduced Between 60,000 and 220,000

The ACA market is extremely price sensitive. In the counties across the state where the second lowest silver premium decreased disproportionately from bronze and gold premiums, we saw those markets lose up to 20% of their enrollment. Those consumers, who are not Medicaid eligible, are presumed to be uninsured. Because of the impact to subsidies, we expect the ACA market to contract between 5% to 20% after removing the new Medicaid eligible consumers. That results in a reduction between 60,000 and 250,000 additional consumers.

Federal Premium Subsidies Reduced Between $4.8 billion and $6.2 billion

To ensure affordability, Florida consumers receive Federal subsidies in the form of premium reduction from the Advanced Premium Tax Credit (APTC). In 2019, Florida consumers received $9.8 billion in APTC dollars. Because premium subsidies are provided on a sliding scale based on income, over half of the APTC is provided to consumers with incomes between 100% and 138% of FPL. By removing those consumers from the ACA market, it is estimated that the amount of premium subsidies provided to Florida will be reduced between $4.8 billion and $6.2 billion. That is to say, instead of receiving $9.8 billion in Federal subsidies, Florida would receive between $3.6 billion and $5.0 billion.

Development of the Ranges
A reduction of $4.8 billion was developed assuming the market does not contract at all, and only the APTC dollars attached to the 546,000 consumers is removed. A reduction of $6.2 billion was developed assuming a 20% contraction on top of the reduction of the APTC dollars attached to the 546,000 consumers being removed. An assumption of a 5% market contraction results in a reduction of Federal premium subsidies of $5.1 billion.

Please let me know if you have any questions or concerns.

Thanks!

Craig H. Wright, ASA, MAAA
Deputy Commissioner and Chief Actuary
Life & Health Insurance
Florida Office of Insurance Regulation
Phone: (850) 413-2409

Tab 11

House Memorandum

MEMORANDUM

To: Carol Gormley
From: Christa Calamas
Date: July 26, 2019
Re: Proposed Ballot Amendment 18-16 Provide Medicaid Coverage to Eligible Low-Income Adults: State Implementation Issues

---

Per your request, House HHS staff put together some preliminary thoughts on the proposed constitutional amendment on Medicaid expansion to the working-age, non-disabled, childless adult population.

While this memorandum is not a complete listing or treatment of the implementation issues that may arise from the proposed amendment, it may deserve consideration in the process of establishing economic and fiscal impacts.

The Medicaid Program

The proposed amendment requires the State to provide Medicaid benefits to low income adults meeting the criteria of Title 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) and Title 42 CFR Part 435, Subpart E, of the federal Social Security Act, as defined in the federal Patient Protection and Affordable Care Act of 2013. It specifically requires the state to provide "Medicaid benefits" to the referenced population. The Medicaid program is a joint state and federal enterprise, under which a state may use state matching funds to draw down federal funds to spend on specified health care services and populations. States are not required to participate in Medicaid.[1]

Mandatory and Optional Populations

Federal law defines the overall structure of the program; it specifies services a state must cover and populations a state must serve for the state to participate in the Medicaid program and use the federal funds. Federal law *requires* state Medicaid programs to cover certain populations, including, for example, children in low-income families, low-income pregnant women, low-income parents with children, children in the state child welfare system, low-income disabled people, and low-income elderly people.[2] Federal law does not require states to cover low-income adults who are not disabled or pregnant and who have no dependent children; that is, the population addressed by the proposed amendment.

Federal law *allows* states to cover other populations, in addition to the mandatory populations, with federal approval.[3] Florida covers several optional populations, including, for example, children, pregnant women, disabled people, and elderly people at higher income levels than the federal requirement, and other optional populations at higher income levels for limited benefits like family planning services, breast and cervical cancer services, and AIDS-related services. The low-income adults addressed by the proposed amendment are an optional population under federal law.[4]

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[1] While the federal Medicaid law was enacted in 1965, the last state to enter the program (Arizona) did so in 1982.
[2] Title 42 U.S.C. § 1396a(a)(10)(i). *See*, Fla. Stat. s. 409.903, for a list of eight Medicaid mandatory categorical coverage groups. Note that "low-income" as used here varies by federally-defined category, and should not be confused with the definition of that term in the proposed amendment.
[3] Title 42 U.S.C. § 1396a(a)(10)(ii). *See*, Fla. Stat. s. 409.904 for a list of optional categorical groups covered by Medicaid in Florida.
[4] Title 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII) makes this population mandatory, but *see*, *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012) (making this low-income adult expansion group an optional population, holding the federal government cannot withhold all federal Medicaid funding for failure to comply with the mandate to expand coverage to this population, and noting Congress' historic and consistent focus on other, more vulnerable, populations, from which this expansion was a significant departure in both type and degree).

Entitlement Nature

Federal law also establishes the entitlement nature of the Medicaid program, by requiring states to serve all those who meet the eligibility criteria in the mandatory populations, and by creating express due process protections for applicants and recipients.

While Medicaid participation is optional, states that choose to participate must meet all the federal requirements. The mandatory coverage requirements, paired with the entitlement nature of the program, mean the state and federal governments must absorb the costs of growth in the eligible populations, service utilization, and service price (inflation). Any expansion of the program, whether by federal mandate or state option, creates a new line of expenditure growth for the future.

The Proposed Amendment

The proposed amendment specifically requires the state to provide "Medicaid benefits" to the referenced population. It does not use broader terms like "health insurance", "health coverage", or even "health care" – it requires Medicaid coverage. The proposed amendment emphasizes this by including requirements for the state Medicaid agency to obtain approval from the federal Medicaid agency to add this new population.

In order for the state to provide Medicaid benefits to this new population, the state must participate in Medicaid. Under federal law, a state cannot offer Medicaid benefits to one group of people unless it agrees to offer benefits to all the federally mandated populations and meet all the federal criteria for the program. While not expressly stated in the proposed amendment or ballot summary, participation in the federal Medicaid program is a precondition that must be met before the proposed constitutional obligation – coverage of a federally optional population - can be met by the state. In fact, the proposed amendment would require Florida to participate in the federal Medicaid program as a matter of constitutional law.

The Florida Constitution confers upon the Legislature the authority to make policy and appropriate funds.[5] Currently, the Legislature may choose to participate in the federal Medicaid program – and appropriate funds to that effect – or not. The proposed amendment appears to remove that authority, instead requiring the Legislature to enact policies - and make appropriations – that allow Florida to continue participating in Medicaid to ensure Medicaid benefits for the proposed expansion population.

For Fiscal Year 2019-2020, the budget for the Florida Medicaid program is approximately $28.4 billion, or 31 percent of the total state budget. State general revenue accounts for approximately $6.9 billion of the total budget, or 20 percent of the state's general revenue. Since participation in Medicaid is optional under current law, the Legislature appropriates those funds at its own discretion and on its own volition. If, however, the proposed amendment were to take effect, the Legislature would no longer have discretion to appropriate funds for Medicaid's federally mandated coverage categories, in addition to the newly required low-income adult category. Put another way, while the proposed amendment would require Florida to cover the people in the new eligibility category, it would effectively also require Florida to cover all the people currently in Medicaid mandatory populations – and all future growth in those populations - which the Florida Constitution does not currently require Florida to cover.

The proposed amendment also appears to limit the Legislature in its policy-making authority in times of economic downturn. Under the proposed amendment, the Legislature would have to prioritize this low-income adult expansion population for service. If paying for the whole Medicaid population became untenable in a time of reduced state revenues, the constitutional priority of this population would mean the Legislature could only apply budget cuts to other federally optional groups – including optional categories of children, pregnant women, the elderly, and those with disabilities – before this able-bodied group of working-age adults.

[5] *See,* Fla. Const. Art. III Sec. 1; Art. III Sec. 19; Art. II Sec. 3.