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CONSIDERHealth

State Medicaid Expansion
Why States Are Reevaluating Whether to Expand Eligibility?

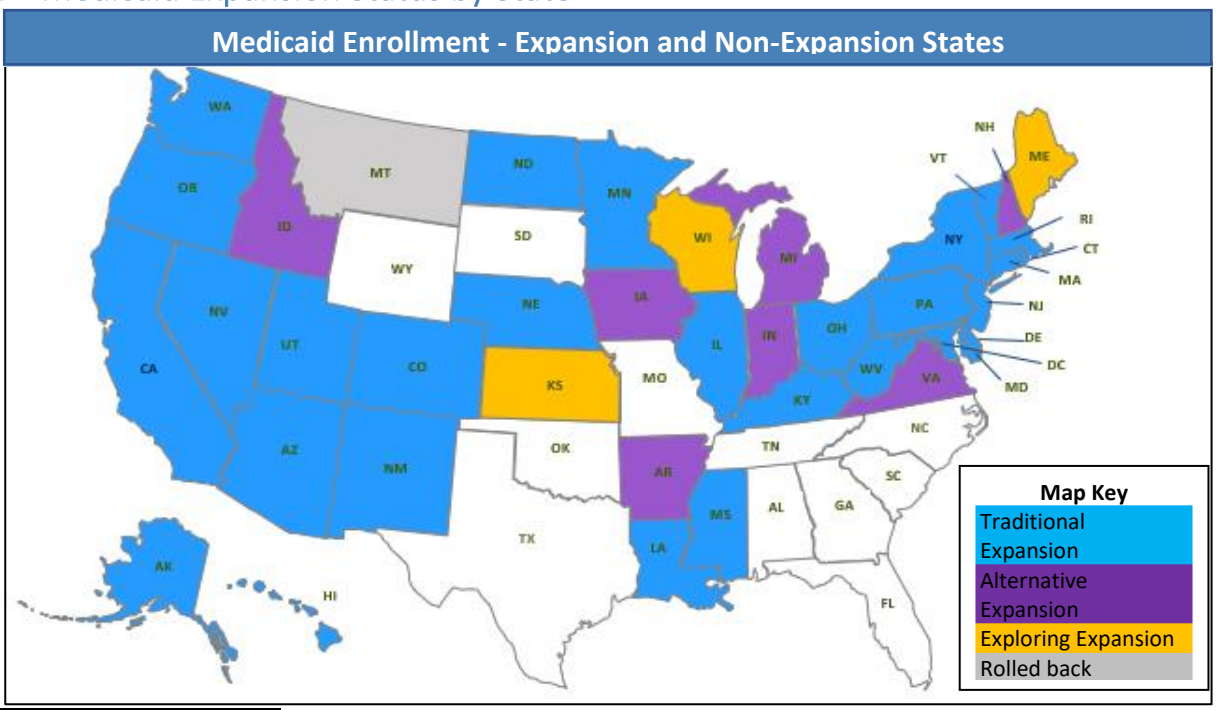
"Softly as if I play piano in the dark" is a line from an iconic OutKast song. It also could be a reference to the growing number of states that are “softly” expanding their Medicaid populations to the Affordable Care Act's (ACA) eligibility income levels. The 2018 mid-term elections saw three additional states vote to expand their Medicaid eligibility by ballot referendum. Residents of Idaho, Nebraska, and Utah voted to expand their Medicaid eligibility up to 138% of the federal poverty income level (FPL). This is expected to increase the total U.S. Medicaid population by at least 300,000.[1]

Those three states bring the total number of states that have expanded Medicaid eligibility to 35 states (not including Montana, who is rolling back expansion) plus the District of Columbia. An estimated 15 million people have gained coverage through Medicaid expansion.[2] These are not all left leaning, avocado toast for breakfast, political states either. In fact, of the states that expanded, several historically right leaning states in the Midwest and Southwest have expanded coverage (See Chart 1 below). In addition, more states are contemplating expanding their eligibility.

So why are states continuing to expand?

1. Healthcare was the number one issue during the mid-terms for voters.[3]
2. The cost to a state to expand coverage is not as much as it seems at first glance.
3. Rural America faces provider shortages and healthcare facility financial pressures that expansion can help.
4. Alternative Medicaid expansion has provided needed flexibility for states to design an expansion plan that is acceptable for them.

Chart 1 – Medicaid Expansion Status by State



[1] Medicaid coverage estimate per state. *Healthinsurance.org*. Accessed 11.12.2018. https://www.healthinsurance.org/medicaid/.
[2] “Medicaid Expansion Enrollment FY2016.” *Henry J Kaiser Family Foundation*. Accessed 11/12/2018. https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment.
[3] Newport, Frank. “Top Issues for Voters: Healthcare, Economy, Immigration.” *Gallup.* Published 11/02/2018. Accessed 11/12/2018. https://news.gallup.com/poll/244367/top-issues-voters-healthcare-economy-immigration.aspx..


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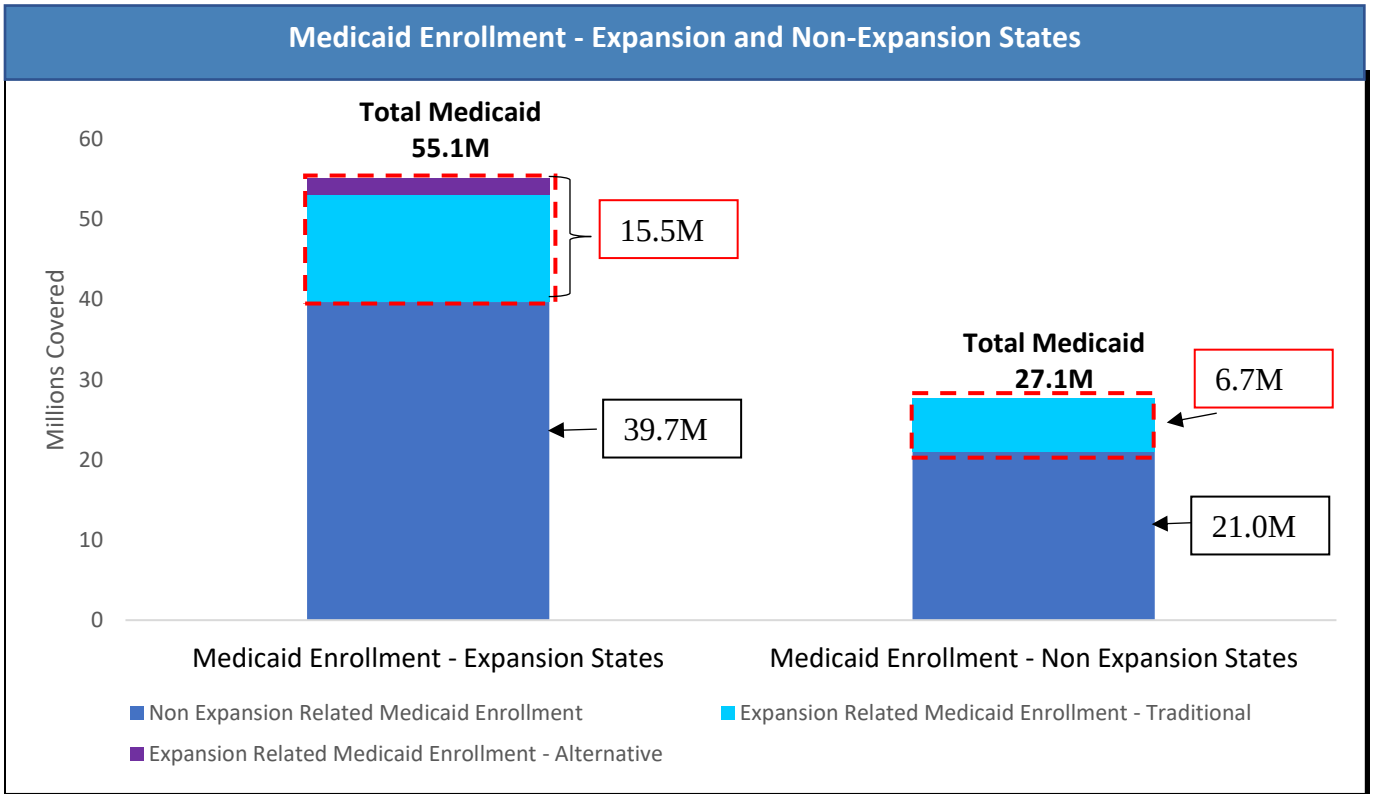
Chart 2 – Medicaid Expansion Status by State[4,5]



If the remaining states were to expand, an estimated 6.7 million individuals would receive coverage. This would represent about an 9% increase in total Medicaid enrollees. At the time of this writing, Kansas, Maine, and Wisconsin are actively pursuing expanding their Medicaid eligibility.

First a Little History on Medicaid Funding

Before diving into why states are expanding, a quick review on how Medicaid was administered prior to the ACA (and still is in non-expansion states).

Prior to the ACA passing (and what continues in states that have not expanded), Medicaid was administered by states with federal guidelines (see Appendix Table 2). States had to cover segments of their residents up to mandated income levels or they wouldn't receive federal payment assistance. These income levels were often based on how many children and their ages in a household. After a state covered the Federal mandated minimum, states could decide on their own if they wanted to increase qualifying income levels or population segments to cover more individuals under Medicaid. This led to wide variation in Medicaid income and eligibility by state. Historically, adults without children or with children over 18 faced tremendous hurdles when attempting to qualify for Medicaid, regardless of their need. This remains the same for these adults in the states that have not expanded.

In exchange for covering up to the federal minimums, the Federal Government picked up a portion of the total cost of a state's Medicaid spend through the Federal Matching Assistance Percentage (FMAP). This FMAP varies by state

[4] "Medicaid Expansion Enrollment FY2016." *Henry J Kaiser Family Foundation*. Accessed 11/12/2018. https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment.
[5] Medicaid coverage estimate per state. *Healthinsurance.org*. Accessed 11.12.2018. https://www.healthinsurance.org/medicaid/

based on a state's relative income level but averaged about 66% (remember this number).[6] If little Johnny fell and broke his arm, on average 66% was paid by the Federal government and 34% was paid by the State.

Fast forward to the ACA and expansion guidelines. Under traditional expansion, states need to cover all legal residents who make less than 138% of the FPL. The gains in insured largely come from adult populations that made too much to be eligible for historical Medicaid in most states.

Reasons for State Expansion Detailed

1. Healthcare is #1

In poll after poll, healthcare was the number one issue for midterm voters. 80% of voters in a recent Gallup Survey cited healthcare as important or very important to them.[7] That puts healthcare as the top issue, above the economy and immigration. People are worried that the cost of coverage is too great, and how they are going to afford keeping their families healthy. Republican and Democratic, urban and rural voters - all ranked the issue high on importance.

Further, if you live in a state that has not expanded, a portion of your federal taxes are going to cover Medicaid expansion in other states. You are paying in but not getting any benefit out of it. Companies may be taking note too. Employers, especially those with lower paid workforces, could see improved labor spend in expansion states. The reason is their workforce could be healthier with Medicaid coverage vs. no coverage or they would realize savings from Medicaid covering their workforce vs. the company paying for employee health coverage.

Politicians know their constituents put healthcare #1 and they are in the business of getting reelected. Interestingly, ballot referendums have recently been employed in several states, as the determinant of state expansion instead of working through the state legislature. Utah, Idaho, and Nebraska all passed expansion by ballot referendum during the 2018 midterms. This suggests if the vote is put to the people, some historically apprehensive states could expand.

2. The Cost May Not Be The Cost

I want a Ferrari; we all likely do. I don't buy one because I can't afford it, well that and I have no clue how to drive a stick shift. States that have not expanded have often mentioned the costs of increasing their Medicaid coverage as the reason they have not. The cost of expansion, while indeed likely an additional burden on State finances, may not be as much as originally thought. Let's walk through why.

For a state's additional Medicaid insured population from raising the Medicaid eligibility, starting in 2020 the Federal Government picks up 90%, the state the other 10% of the cost. Remember, traditionally the Federal Government picks up about 66% on average of a state's Medicaid spend through the FMAP (state FMAP ranges from 50% to 76.4% based on per capita income differences). So, a state on average is on the hook for approximately 25% less per Medicaid expansion enrollee compared to traditional enrollees. For scale, the average federal and state spend per full benefit beneficiary was about $6,400 in 2014.[8] In this example, the State would pick up about $640 per year for each new enrollee. If there were 100,000 new enrollees, there would be $64 million in additional state expense but reality may not be that bad. To put in context of total state supplied budget funds, for Kansas this $64 million would increase total State expenses by approximately 1.0%.[9]

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[6] In 2018, the FMAP per state ranges from 50.00% to 76.39%.
[7] Newport, Frank. "Top Issues for Voters: Healthcare, Economy, Immigration." *Gallup.* Published 11/02/2018. Accessed 11/12/2018. https://news.gallup.com/poll/244367/top-issues-voters-healthcare-economy-immigration.aspx.
[8] "Medicaid Spend Per Full Benefit Enrollee FY2014." *Henry J Kaiser Family Foundation.* Accessed 11/12/2018. https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee.
[9] *Kansas Division of the Budget*. Published 08/04/2017. Accessed 11/23/2018. https://budget.kansas.gov/wp-content/uploads/fy2018-comp-rpt-2017-08-04.pdf.

Hospitals and healthcare providers receive the $6,400 per Medicaid enrollee as revenue. This money helps to support added labor and pays for needed supplies and equipment for the increased volume of insured. Remaining money flows to business profits. Before expansion, if these same individuals came into a healthcare facility, they would likely be uninsured. The provider would have received little to no reimbursement but would still incur costs for administering care. Medicaid reimbursement leads to more taxes that help to offset the true cost of expansion. This revenue leads to additional state income taxes as the money is paid to labor and the businesses earn profits.[10] In addition, increased state and local sales taxes are incurred as the money is spent. Further still, a healthier population could miss fewer days of work. The result would be more efficient employer operations, leading to higher profits and even more taxes.

There is also some empirical evidence from states that have expanded suggesting expansion impacts on state budgets has been modest. A study published in the New England Journal of Medicine found that Michigan is projected to actually experience a fiscal benefit from expanding factoring all the ancillary benefits.[11]

But There is Still a Cost to a State, Where Does the Money Come From?

To come up with the net state amount states do not necessarily need to raise everyone's taxes, which could be politically toxic. Many have turned to the old piggybank known as "sin" taxes, which are taxes on cigarettes and liquor. Others use provider taxes[12] financed largely by the healthcare facilities that are receiving the expansion benefits.

Of note, sometimes the "sin" tax can create some powerful enemies. Montana expanded Medicaid in 2016 but in the 2018 mid-terms, expansion was rolled back. Big cigarette interests spent significant money in the election in attempts to block the proposed $2 per pack increase to finance expansion in the state.

What if the Federal government changes how much they pay?

This is still a very valid concern for states that are not expanding. If the federal government were to change the 90% to 10% split, that could leave states having to either pick up more of the added costs or scale back on their expansion. Several states have put in safeguards for this that automatically rolls back expansion if the Federal matching rate falls below a certain percentage.

3. Healthcare in Rural America is Struggling

Healthcare in rural America which makes up about a fifth of the country,[13] is struggling. Hospitals located in rural geographies are often barely covering their costs or not at all. The Chartis Group Center for Rural Health found 41% of rural hospitals had a negative margin in 2016 and 80 have closed since 2010.[14] The main culprit is the poor payer mix that exists in these areas. Uninsured rates in rural America are higher than elsewhere. Of the remaining insured, there are few that have high reimbursing commercial coverage. Costs are incurred but needed revenue to balance the books is not coming in.

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[10] Chernew, Michael. "The Economics of Medicaid Expansion." *HealthAffairs.Org*. https://www.healthaffairs.org/do/10.1377/hblog20160321.054035/full/. Published 03/21/2016. Accessed 11/12/2018.

[11] Ayanian, John M.D, M.P.P.; Ehrlich, Gabriel Ph.D.; Grimes, Donald, M.A., and Helen Levy, Ph.D. "Economic Effects of Medicaid Expansion in Michigan." *The New England Journal of Medicine*. Published 02/02/2017. Accessed 11/15/2018. https://www.nejm.org/doi/full/10.1056/NEJMp1613981.

[12] Provider Tax - A health care provider pays a tax or fee to the state government, which then uses the money as the state's necessary matching funds to bring in additional federal Medicaid money according to the individual state's match rate. The total funds are then distributed to health care providers.

[13] About NHRA. National Rural Health Association. Accessed 11/12/2018. https://www.ruralhealthweb.org/about-nrha/about-rural-health-care.

[14] Topchik, Michael. "Rural Relevance 2017: Accessing the State of Rural Healthcare in America." *The Chartis Group, iVantage Analytics*. Accessed 11/12/2018. https://www.chartisforum.com/wp-content/uploads/2017/05/The-Rural-Relevance-Study_2017.pdf.

The problem is likely to get worse. Medicaid Disproportionate Share Hospital[15] payment cuts are slated to begin in 2021. These block Federal funds to states are then allocated to hospitals to assist those with the most challenged payer mixes. The amount of these Medicaid DSH fund cuts are not trivial either. $8 billion of the current $12 billion in Federal DSH funding is slated to go away. Cuts will be greater in states that expanded coverage, as there would be fewer uninsured, but all states are likely to receive some form of cut. For example, I live in Georgia and the state received $295M in Medicaid DSH dollars in 2017. Even if only 20% goes away, about $60M that flows directly to the bottom line for hospitals will vanish overnight. How will Georgia and other states that have not expanded fill the hole that reduced Medicaid DSH dollars could cause?

Further, it's crucial to consider rural physicians. It is very difficult for rural physicians to make ends meet. The result of this is rural communities suffer from a lack of access to primary and specialty care. Physicians have a hard time justifying practicing in rural areas not because there is not demand for their services but rather there are not enough paying customers to come through the door to satisfy their required return on investment.

Lastly, in rural America, hospitals are often the community's largest employer. If a hospital closes, the local economy greatly suffers due to lost jobs and foregone tax dollars. When the local economy suffers, the health of its residents declines. And rural voters remember this when they go to the ballot box.

Medicaid expansion would convert many uninsured to Medicaid coverage, providing necessary reimbursement to improve rural hospital finances. The added revenue would also help offset pending Medicaid DSH cuts. Improved rural hospital finances would assist these facilities in staying open, thus protecting rural economies.

4. Alternative Expansion Creates Flexibility

States can get creative in how they expand Medicaid coverage, and many have. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to waive provisions of major health and welfare programs authorized under the Act, including certain requirements in Medicaid. 1115 waivers have been around for a while. Seven states have applied and been approved for these waivers in designing a Medicaid expansion program that works for them. Some of the creative design states have employed are:

	Medicaid premiums		Work requirements
	Assistance in purchasing private coverage for the Medicaid eligible		Health savings accounts

While some of the alternative expansion designs are controversial to some e.g. work requirements, alternative expansion has been used to expand in traditional republican leaning states, including Arkansas, Iowa, Idaho, and Indiana.

CHART 3 - Alternative Expansion States

State	Alternative Expansion Detail
Arkansas	• Private insurance as Medicaid • Work requirements
Idaho	• State still in development of alternative expansion specifics

[15] Medicaid Disproportionate share hospital (DSH) payments are statutorily required payments intended to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety-net hospitals.

State	Alternative Expansion Detail
Michigan	• Beneficiary cost sharing • Proposed work requirement • Health savings accounts
Iowa	• Private insurance as Medicaid • Higher premium for those over 50% of FPL
Indiana	• Premium payments with coverage lockout for failure to pay
Virginia	• Work requirement provision • Premiums
New Hampshire	• Private coverage as Medicaid

In Closing

There are a growing number of states that are expanding their Medicaid eligibility. States are doing so for several reasons. It is top of mind for voters. The state's cost of expanding is somewhat offset by downstream factors including increased tax revenues. In addition, expansion can help rural hospitals remain solvent and thus not negatively disrupt rural economies. Lastly, the flexibility afforded to states under 1115 waivers for alternative expansion is being embraced as a way to design a system that works for a state's unique needs.

In evaluating the increased state Medicaid expansion, some questions likely come to mind. Will the remaining non-expansion states expand? Will existing traditional expansion states change to an alternative expansion model? If states expand, what does this mean for healthcare providers, insurers, and the labor market in those states? As a higher percentage of provider and insurer revenues come from the Medicaid population, will this spur innovation and increased provider focus on this segment of the population? Only time will tell, but potentially impacted parties should start to plan for how they would react to these scenarios. This will enable them to quickly take advantage of opportunities if they arise.

About the author

Russell is fascinated with healthcare and how it is delivered, consumed, and paid for. And is infinitely curious to how to improve all of the above. He has extensive experience working for healthcare providers and in healthcare focused management consulting. He also is in constant search for the best tasting fried chicken biscuit. Please contact him about any and all of the above at rautry@considerhealth.com.

APPENDIX

Appendix Table 1 – 100% of Federal Poverty Level by Household Size - 2017

Persons in Household	2017 Federal Poverty Level	Medicaid Eligibility (138% of FPL)
1	$12,060	$16,643
2	$16,240	$22,411
3	$20,420	$28,180
4	$24,600	$33,948

Appendix Table 2 - Required Federal Medicaid Population - Traditional Medicaid

Federal Required Medicaid Populations	Federal Poverty Level Max
Pregnant Women	<=133%
Children Ages 0 to 6[1]	<=133%
Children 6 to 18[1]	<=100%
Supplemental Security Income Recipients (Seniors, Disabled)	<=74%
Parents whose income is within state's welfare reform assistance level	Less than or equal to 50%

1. Children Health Insurance Program (CHIP) funding typically covers children up to 200% or more of the FPL