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The Cost of Not Expanding Medicaid: An Updated Analysis

Stan Dorn and Matthew Buettgens

Timely Analysis of Immediate Health Policy Issues

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In-Brief

Nineteen states have not expanded Medicaid eligibility under the Patient Protection and Affordable Care Act (ACA). We estimate that from 2018 through 2027, expansion in these states would increase nominal state costs and federal spending by $59.9 billion and $427.5 billion, respectively, if enrollment is moderate and by $62.9 billion and $487.0 billion if enrollment is high. Each state dollar would thus draw down between $7.14 and $7.75 in net federal funding.

More specifically,

- Medicaid enrollment would grow by between 8 and 9 million,
- higher caseloads would increase state Medicaid spending by $82.5 billion to $90.8 billion,
- caseload growth would increase federal Medicaid funding by $595.8 billion to $664.8 billion,
- federal subsidies in health insurance marketplaces would fall by $132.2 billion to $133.2 billion, and
- reductions in uncompensated care would save states $22.5 billion to $27.9 billion while lowering federal spending by $36.1 billion to $44.6 billion.

We could not estimate other state fiscal effects. However, each comprehensive review in expansion states has found that expansion improved state budget balances. According to those reviews, each state's savings and revenue from expansion have exceeded state cost increases from higher enrollment.

We also find that expanding Medicaid in these 19 states would

- reduce the number of uninsured by between 4.3 million and 5.2 million people, and
- lower out-of-pocket health care costs for state residents by between $84.1 billion and $90.7 billion over 10 years.

Introduction

Nineteen states have not expanded Medicaid eligibility to adults with incomes at or below 138 percent of the federal poverty level (FPL), as provided by the Patient Protection and Affordable Care Act (ACA). In August 2016, we reported on the fiscal and economic effects of state decisions not to expand eligibility.[1] Here, we update and broaden that work, examining the following questions about these 19 states:

- How would Medicaid expansion affect the number of uninsured?
- Over the next 10 years (2018–2027), how would caseload increases resulting from expansion affect state Medicaid costs and federal Medicaid funding?
- With expansion, most adults with incomes between 100 and 138 percent of FPL would no longer qualify for premium tax credits and cost-sharing reductions in health insurance marketplaces. How much of these federal subsidies would states lose if they expanded Medicaid?
- Expansion would reduce the number of uninsured. How would that affect uncompensated care costs? How much would the federal government and states save as a result?
- According to our previous analysis, every expansion state that analyzed the comprehensive fiscal effects of expansion found that, on balance, expansion yielded state budget gains. Since our last report, what new information became available about the effect of coverage expansion on state budgets?
- How would Medicaid expansion affect household health care costs—that is, out-of-pocket spending on premiums and cost-sharing? How would it affect the amount of health care services used by state residents?

To answer these questions, we estimated federal and state costs, uncompensated care expenses, and household effects using the Health Insurance Policy Simulation Model (HIPSM). We simulated Medicaid enrollment under two assumptions about expansion: (1) moderate new enrollment, consistent with previous HIPSM projections, which generally fit observations in most expansion states; and (2) high new enrollment, reflecting participation in states like California, Rhode Island, Kentucky, and Louisiana.[2] We calibrated our model to reproduce the latest available data on marketplace enrollment and second-lowest silver plan premiums in each state. For additional information about our methods, see our August 2016 report.

Results

Coverage Effects of Expansion

Expanding Medicaid would substantially reduce the number of uninsured. If all 19 states expanded Medicaid and participation levels were moderate, the number of uninsured would decline by 4.3 million by 2021 (Table 1). An estimated 5.2 million would gain coverage under the high enrollment scenario.

Not everyone gaining Medicaid coverage under expansion would have been otherwise uninsured.[3] In particular, more than 2 million people with incomes between 100 and 138 percent of FPL, formerly eligible for subsidized marketplace coverage, would move to Medicaid. Medicaid would also cover some who, without expansion, would have received employer-sponsored insurance. With moderate Medicaid take-up, 8.1 million people would gain Medicaid coverage, and the number of uninsured would fall by 4.3 million; with high Medicaid take-up, 9.0 million would gain Medicaid coverage, and the number of uninsured would fall by 5.2 million (Table 1). In the final section below, we analyze the impact of such coverage changes on household out-of-pocket health care costs and receipt of health care services.

Table 1. Coverage of Nonelderly People in Nonexpansion States, 2021 (thousands)

	Uninsured without expansion	Expansion with moderate enrollment			Expansion with high enrollment		
		New Medicaid enrollment	Uninsured	Net change in uninsured	New Medicaid enrollment	Uninsured	Net change in uninsured
Alabama	496.5	340.6	312.9	-183.6	379.2	274.3	-222.2
Florida	2,532.1	1,470.7	1,799.7	-732.4	1,635.7	1,634.7	-897.4
Georgia	1,495.6	836.3	1,035.6	-460.0	932.7	939.2	-556.4
Idaho	188.9	120.8	127.9	-61.0	132.3	116.4	-72.4
Kansas	294.5	148.3	214.6	-79.8	163.2	199.7	-94.7
Maine	77.2	50.0	55.4	-21.8	55.3	50.0	-27.2
Mississippi	353.0	233.4	216.9	-136.2	262.3	188.0	-165.0
Missouri	550.7	392.1	348.4	-202.3	439.4	301.1	-249.6
Nebraska	153.8	98.1	109.0	-44.8	106.8	100.3	-53.5
N. Carolina	1,189.8	644.0	868.3	-321.5	713.7	798.6	-391.2
Oklahoma	543.0	274.2	389.8	-153.2	307.8	356.2	-186.8
S. Carolina	623.6	336.1	443.8	-179.9	381.4	398.5	-225.1
S. Dakota	82.5	46.4	54.0	-28.5	53.7	46.6	-35.9
Tennessee	685.7	350.8	502.2	-183.5	396.8	456.2	-229.5
Texas	4,478.2	1,926.2	3,396.2	-1,082.1	2,151.4	3,170.9	-1,307.3
Utah	341.4	174.6	252.6	-88.8	193.0	234.1	-107.3
Virginia	899.7	450.4	676.1	-223.6	501.2	625.3	-274.4
Wisconsin	306.1	152.0	252.9	-53.2	158.6	246.3	-59.9
Wyoming	62.3	29.4	47.0	-15.3	33.0	43.4	-18.8
Total	15,354.7	8,074.4	11,103.2	-4,251.5	8,997.6	10,180.0	-5,174.7

Source: Urban Institute Health Insurance Policy Simulation Model, 2017.

Estimated Fiscal Effects of Expansion

As shown in Tables 2 and 3, states that expand Medicaid will make a small investment of state dollars, drawing down a much larger volume of federal dollars. Several factors are responsible:

- Most additional enrollees under expansion are newly eligible adults, for whom the federal government pays 90 percent or more of all health care costs.
- Both the federal government and state governments save money on payments for uncompensated care. Federal payments include Medicare and Medicaid funds for disproportionate share hospitals (DSH)—those serving large numbers of poor and uninsured patients—as well as supplemental Medicaid payment programs. State and local support includes indigent care hospital financing and state contributions to Medicaid DSH programs. Because a much higher proportion of uncompensated care costs are paid by the federal government than by states and localities (45 percent versus 24 percent),[4] we estimate that federal dollar savings exceed state savings when Medicaid expansion reduces uncompensated care.
- Medicaid expansion ends most eligibility for federal marketplace subsidies among consumers with incomes between 100 and 138 percent of FPL, as explained earlier. The resulting reduction in federal subsidy dollars offsets some of the increase in federal Medicaid funding that results from expansion.

These effects do not show the full fiscal picture because we were unable to estimate certain amounts that vary by state:

1. increased state revenue, either through special revenue sources (such as taxes on insurance premiums and provider receipts) or general revenue sources (resulting from increased economic activity attributable to federal Medicaid dollars buying additional health care within the state);
2. reduced state spending on non-Medicaid programs for the uninsured poor, such as mental health and substance use disorder programs and inpatient care furnished to incarcerated inmates temporarily staying in community hospitals; and
3. lower state Medicaid spending resulting from higher federal matching rates for beneficiaries who, without expansion, would have been covered through pre-ACA eligibility categories.

By August 2016, 14 expansion states had analyzed results in these categories.[1] Each analysis concluded that, on balance, expansion yielded net state budget gains, with state savings and/or revenue gains exceeding the state cost of higher caseload. Ten of these analyses showed fiscal effects through at least 2020, when the state share of expansion costs reaches its final level of 10 percent. The latter effects are as follows:

- Three states projected net gains throughout that extended period.
- Even without factoring in general revenue effects, short-term analyses for five states found state fiscal gains that exceeded 10 percent of total expansion costs (the state share beginning in 2020).
- Two states projected net budget losses in future years. New Mexico's analysis, which characterized its revenue forecasts as conservative, concluded that net fiscal effects could remain positive in future years. The analysis for the other state, Alaska, based its conclusion on the absence of general revenue effects; Alaska is the only state that collects neither sales taxes nor individual income taxes.

Other observers had reached conclusions similar to those in our August 2016 paper.[5] Since then, new fiscal analyses have continued to show net state budget savings:

- According to an article published in the New England Journal of Medicine, Michigan's Medicaid expansion had generated net state budget gains that would continue to exceed $150 million a year through 2020 and beyond.[6]
- The Arkansas Health Reform Legislative Task Force found that Medicaid expansion would yield $438 million in net state budget gains from fiscal year (FY) 2017 through 2021.[7]
- A one-year analysis commissioned by the Montana Health Foundation concluded that Medicaid expansion yielded $22 million in state savings for FY 2017.[8]
- An independent research organization, New Jersey Policy Perspective, estimated that by 2016, Medicaid expansion had provided more than $1 billion in net state fiscal gains; it also projected that those gains would continue to exceed $400 billion a year in the future.[9]
- A 50-state study published in Health Affairs found that during the first two years of Medicaid expansion, expansion states experienced no significant changes in total state Medicaid spending and no significant reductions in state spending on other priorities, such as education. The study also found some evidence that expansion states were more likely to increase spending on transportation and certain other state budget functions.[10]

Expansion states thus continue to find that expansion improves their budget situation, with cost increases from caseload growth outweighed by state savings and additional revenues.

Table 2. Projected State and Federal Fiscal Effects of Medicaid Expansion, Moderate Enrollment: 2018-27 ($ Billions)

	State effects			Federal effects				Net federal dollars gained for each estimated state dollar
	Higher caseload costs	Uncompensated care savings	Net estimated costs	Spending on higher caseload	Reduced marketplace subsidies	Uncompensated care savings	Net increase in federal funding	
Alabama	1.7	-1.1	0.6	12.0	-5.0	-1.7	5.2	$8.32
Florida	13.4	-3.6	9.8	105.6	-30.8	-5.8	69.1	$7.06
Georgia	7.8	-2.0	5.8	63.8	-12.6	-3.2	48.0	$8.23
Idaho	1.6	-0.3	1.3	14.1	-1.7	-0.5	11.9	$9.21
Kansas	1.6	-0.7	0.9	10.7	-1.9	-1.2	7.7	$8.38
Maine	0.3	-0.2	0.1	2.0	-1.5	-0.3	0.1	$1.30
Mississippi	2.0	-1.0	1.0	16.4	-3.1	-1.6	11.7	$12.09
Missouri	4.0	-1.5	2.5	25.3	-6.6	-2.4	16.4	$6.50
Nebraska	1.1	-0.4	0.7	7.3	-1.6	-0.7	4.9	$7.53
N. Carolina	6.8	-1.4	5.4	54.9	-14.5	-2.2	38.2	$7.08
Oklahoma	2.7	-1.2	1.5	17.1	-2.9	-2.0	12.1	$8.24
S. Carolina	3.1	-1.0	2.2	21.9	-5.3	-1.6	15.0	$6.94
S. Dakota	0.6	-0.3	0.4	4.1	-0.5	-0.4	3.2	$8.35
Tennessee	4.2	-1.3	2.9	34.0	-4.5	-2.0	27.5	$9.43
Texas	22.8	-4.0	18.8	152.8	-25.9	-6.4	120.5	$6.42
Utah	1.6	-0.4	1.2	10.1	-1.7	-0.6	7.8	$6.34
Virginia	5.3	-1.4	3.9	34.2	-7.8	-2.2	24.1	$6.17
Wisconsin	1.3	-0.6	0.7	6.9	-3.2	-0.9	2.7	$3.77
Wyoming	0.4	-0.2	0.3	2.7	-1.0	-0.3	1.4	$5.28
Total	82.5	-22.5	59.9	595.8	-132.2	-36.1	427.5	$7.14

Source: Urban Institute, Health Insurance Policy Simulation Model, 2017

Notes: State cost estimates do not show savings offsets for reduced spending on state-only programs for the uninsured poor (other than for uncompensated care), higher federal matching rates for beneficiaries projected to enroll without expansion, or revenue effects of expansion. Assumed enrollment is comparable to most expansion states.

Table 3. Projected State and Federal Fiscal Effects of Medicaid Expansion, High Enrollment: 2018-27 ($ Billions)

	State effects			Federal effects				Net federal dollars gained for each estimated state dollar
	Higher caseload costs	Uncompensated care savings	Net estimated costs	Spending on higher caseload	Reduced marketplace subsidies	Uncompensated care savings	Net increase in federal funding	
Alabama	1.9	-1.3	0.5	13.3	-5.0	-2.1	6.1	$11.74
Florida	14.7	-4.5	10.2	117.4	-31.0	-7.2	79.2	$7.75
Georgia	8.6	-2.5	6.1	71.1	-12.7	-4.0	54.4	$8.87
Idaho	1.7	-0.4	1.3	15.4	-1.7	-0.7	13.0	$9.97
Kansas	1.8	-0.8	1.0	11.9	-2.0	-1.3	8.7	$8.74
Maine	0.3	-0.2	0.1	2.2	-1.5	-0.4	0.3	$2.60
Mississippi	2.2	-1.2	1.0	18.5	-3.1	-2.0	13.5	$13.33
Missouri	4.4	-1.8	2.6	28.4	-6.7	-2.9	18.8	$7.33
Nebraska	1.2	-0.5	0.7	7.9	-1.7	-0.8	5.4	$7.92
N. Carolina	7.5	-1.7	5.7	60.9	-14.6	-2.8	43.5	$7.58
Oklahoma	3.0	-1.5	1.5	19.2	-3.0	-2.3	13.9	$9.16
S. Carolina	3.5	-1.2	2.3	24.9	-5.4	-2.0	17.6	$7.78
S. Dakota	0.7	-0.3	0.4	4.7	-0.5	-0.5	3.8	$9.29
Tennessee	4.7	-1.6	3.1	38.6	-4.5	-2.5	31.5	$10.17
Texas	25.1	-5.2	19.9	170.7	-26.0	-8.3	136.5	$6.85
Utah	1.8	-0.6	1.2	11.3	-1.7	-0.9	8.7	$7.27
Virginia	5.8	-1.7	4.1	38.2	-7.9	-2.6	27.6	$6.67
Wisconsin	1.4	-0.6	0.8	7.2	-3.3	-1.0	2.9	$3.74
Wyoming	0.5	-0.2	0.3	3.0	-1.0	-0.3	1.7	$6.08
Total	90.8	-27.9	62.9	664.8	-133.2	-44.6	487.0	$7.75

Source: Urban Institute, Health Insurance Policy Simulation Model, 2017

Notes: State cost estimates do not show savings offsets for reduced spending on state-only programs for the uninsured poor (other than for uncompensated care), higher federal matching rates for beneficiaries projected to enroll without expansion, or revenue effects of expansion. Assumed enrollment is comparable to expansion states with high take-up rates (like California, Rhode Island, Kentucky, and Louisiana).

Effects on Household Health Costs

As noted earlier, expansion would result in Medicaid covering both people who are uninsured and those who would otherwise have different coverage. Both groups would experience significant savings. By 2021, out-of-pocket costs for premium payments and cost-sharing would decline by an average of

- $574 for each household joining Medicaid that would otherwise be uninsured (4.2 percent of household income); and
- $1,984 for each Medicaid household that would otherwise receive other forms of coverage (14.6 percent of household income).

At the same time, Medicaid would improve access to care for both groups. The value of additional health care services received by households in each category would average

- $6,120 for each household that would otherwise be uninsured; and
- $1,463 for each household that would otherwise receive other forms of coverage.

If all 19 states expanded eligibility, residents' out-of-pocket health care costs would decline by a total of $84.1 billion to $90.7 billion over 10 years (Table 4).

Table 4. Total Savings in Residents' Out-of-Pocket Health Care Costs if States Expand Medicaid, 2018–2027 ($ millions)

	Moderate take-up	High take-up
Alabama	$3,607.9	$3,869.1
Florida	$18,170.3	$19,345.8
Georgia	$8,234.7	$8,831.9
Idaho	$1,333.0	$1,428.2
Kansas	$1,494.7	$1,593.9
Maine	$717.4	$773.2
Mississippi	$2,317.7	$2,624.2
Missouri	$4,401.6	$4,801.1
Nebraska	$1,162.3	$1,213.9
N. Carolina	$7,400.7	$7,839.4
Oklahoma	$2,371.9	$2,603.7
S. Carolina	$3,324.6	$3,650.6
S. Dakota	$500.8	$561.4
Tennessee	$3,774.3	$4,170.6
Texas	$15,718.0	$17,207.0
Utah	$1,680.8	$1,804.1
Virginia	$5,252.6	$5,633.1
Wisconsin	$2,348.5	$2,368.0
Wyoming	$358.3	$404.1
Total	$84,136.4	$90,685.2

Source: Urban Institute Health Insurance Policy Simulation Model, 2017.

Conclusion

In the 19 states that have not yet expanded Medicaid eligibility, a small investment of state dollars would yield much larger infusions of federal resources, even taking into account offsetting reductions in federal marketplace subsidies and uncompensated care savings. At the same time, the number of uninsured would decline significantly, and state residents would experience significant savings on out-of-pocket health care costs.

Thus far, expansion states have found that state costs resulting from higher caseloads are outweighed by state savings and revenue growth triggered by expansion. For most states with relevant analyses, net fiscal gains are expected for the foreseeable future, even after states begin paying 10 percent of expansion costs.

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ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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5 For example, see: Bachrach D, Boozang PM, Herring A, Reyneri DG. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*. Princeton, NJ: State Health Reform Assistance Network; 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097. Published March 2016. In this 11-state study, the two states that had conducted comprehensive fiscal analyses found net state budget gains from expansion extending into future years, when the state share of expansion costs rose to 10 percent. The other nine states all experienced significant cost offsets and/or special revenue growth as a result of expansion, but they had not completed comprehensive analyses, and other state fiscal gains of expansion were expected to materialize.

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