

# *Medicaid: To Expand or Not?*

## *Key Economic Arguments used on Both Sides*

### *State Policy Report #45*

**August 2013**



#### ***Introduction***

Ever since the U.S. Supreme Court issued its ruling that the Affordable Care Act's (ACA) Medicaid expansion was optional rather than mandatory, political leaders, think tank and research institute experts, advocates, and policy makers have stated their positions supporting and opposing expansion. A central theme from these arguments is the impact of expanding on state economies, state budgets, and employers. Interestingly, however, the same base economic argument is often used to both support and oppose expansion. For example, research has shown that Medicaid expansion will not only have a positive impact on state budgets, but will create a multiplier effect in state economies—resulting in more spending, the generation of new health care related revenue, increased business activity, the creation of new jobs, and increased personal income and state tax revenue. Other studies and reports are used to show that these positive impacts on state budgets are front-loaded, short-term, and can quickly turn into negative impacts—exacerbating the share of state budgets devoted to Medicaid and crowding-out funds directed towards education, transportation, and other critical state needs. Additionally, the multiplier effect touted by some is refuted or minimized by others.

Those advocating Medicaid expansion posit that states choosing not to expand Medicaid could actually lose business, negatively impacting state economic activity in the long run. They highlight the possibility that large employers in those states may have an increased likelihood of receiving a “shared responsibility” penalty because their employees do not have access to affordable or adequate coverage. This could in turn reduce employer net profits and may influence decisions regarding future expansion or business relocation. Those opposed to expansion argue that the “shared responsibility” penalty will result in employers either not adding employees or making sure their current and future employees work less than 30 hours per week. In response, the answer they offer is not to expand Medicaid, but to repeal the employer mandate.

This issue brief will provide a summary of the key economic arguments that have surfaced during 2012 and 2013 as states have made their initial decisions regarding Medicaid expansion. While this brief is not inclusive of all arguments, economic impact arguments in three key areas—state budgets, economies, and business development—are detailed below.

#### ***Impact on State Budgets***

Numerous national and state studies have shown that the Medicaid expansion is expected to have limited impact on total state general fund spending, and that most states could actually experience a net savings from expanding Medicaid. A review of these studies by the National Association of State Mental Health Program Directors (NASMHPD) finds that the net savings emerge as a result of four key factors: 1) increased dollars flowing into the state from the enhanced federal match; 2) shifting some Medicaid-eligible individuals into the exchange; 3) reductions in uncompensated care; and 4)

leveraging federal dollars to pay for state-funded services.<sup>1</sup> Interestingly, opponents of Medicaid expansion focus economic arguments along many of the same themes as those identified by NASMHPD. Examples of arguments using these points to reject or justify the Medicaid expansion are detailed below.

### 1. The enhanced federal match rate.

**Arguments in Support of Expansion:** The new federal match rate will provide 100% federal funding for the care of the newly eligible Medicaid population for three years (2014–2016). After 2016, the funding will be reduced to 90% by 2020 and is expected to hold at 90% thereafter. The 90% level is significantly higher than all current state match rates, which range from a high of 74% to a minimum of 50%. While states' portion of Medicaid costs, as well as total administrative costs, will increase as more individuals enroll in Medicaid, these costs will be partially offset by the enhanced federal funding for the newly eligible population.

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*"Gov. John Hickenlooper announced plans today to save more than \$280 million in Medicaid spending over 10 years, permitting the prudent expansion of coverage in Colorado. Projections show the savings, existing provider fee structure and other health-related revenues will more than cover the cost of the expansion.*

*'We worked diligently over the past several months to find savings in order to expand coverage,' Hickenlooper said. 'Not one dollar from the state's general fund will be used for this expansion, even in 2017 when the federal government begins to reduce its share.'*

*Press release, Gov. John Hickenlooper (Colorado), Jan. 3, 2013.*<sup>2</sup>

<sup>1</sup> "The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States," NASMHPD (January 2013).

<sup>2</sup> To view full press release see:

<http://www.colorado.gov/cs/Satellite?c=Page&childpagename=GovHickenlooper%2FCBONLayout&cid=1251637754987&pagename=CBONWrapper>

### Arkansas

The Arkansas Department of Public Health estimated that the State could save roughly \$362 million over a 12-year period by expanding Medicaid. These savings emerge from: 1) additional state tax revenue generated from the flow of federal dollars into the State; 2) savings from receiving the enhanced federal match to offset state dollars currently spent on optional Medicaid populations (e.g., the Medically needy population); and 3) savings from using the enhanced federal match to offset current state spending on the uninsured (including state payments to hospitals, clinics, and other providers to cover uncompensated care).

These estimates take into account both an increase in Medicaid enrollment from the woodwork population (individuals who are currently eligible, but not enrolled) and an increase administrative cost, as well as an increase in spending on state outreach efforts. Arkansas estimates it would spend \$6.9 million on processing claims and \$10 million on outreach, customer support and processing new claims.

On a year-by-year basis, it is estimated that Arkansas would save money through 2020. Once the enhanced federal match is reduced to 90%, the cost to the State is expected to be \$3.4 million. However, the estimated savings from uncompensated care also continues to grow, helping to offset these costs into the future.

*Source: Estimated Medicaid-related Impact of the ACA with Expansion, Arkansas Department of Public Health (July 27, 2012).*

**Arguments in Opposition to Expansion and Counterpoints:** While not specifically challenging estimates of additional federal revenue a state would receive under the enhanced federal match, opponents of Medicaid expansion question the ability of the federal government to “guarantee” this revenue. However, while it is true that no federal [or state] revenue source comes with an absolute “guarantee,” the fact remains that the enhanced rate is established in statute and any modifications would require Administrative action to endorse such changes through the Presidential signature process and Congressional action to enact the changes. Significant resistance to such changes would be expected.

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*“As you know, the state of Oklahoma has rejected the president’s plan for several reasons: First, it is unaffordable for the state. According to a report from the Kaiser Commission on Medicaid and the Uninsured, the proposed expansion of Medicaid would result in a \$689 million increase in state Medicaid costs between 2013 and 2022. Expanding Medicaid as proposed by the president would mean that a huge sum of money would be diverted from other priorities, like education and public safety, as well as existing health care programs.”*

*“In addition to being unaffordable for the state of Oklahoma, President Obama’s plan is unaffordable for the country at a time when we are already experiencing a long-term spending crisis. The same Kaiser Commission report shows Medicaid expansion would cost the federal government \$800 billion nationally. This comes at a time when it is universally acknowledged that Washington must make large cuts in government spending.”*

*Gov. Mary Fallin (Oklahoma) State of the State Address, February 4, 2013<sup>3</sup>*

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Opponents further highlight their belief that as the federal government faces deficit growth year after year, funding necessary for the enhanced Medicaid match rate and other ACA reimbursement enhancements may be targeted for reduction. Cited as proof that even the administration is anticipating cost shifts, opponents point to the proposal for a “blended match rate” that was included in President Obama’s 2013 budget recommendations.<sup>4 5</sup> Again, while there are no guarantees, it should be noted that the federal match for Medicaid services is exempted from the current federal sequestration process and that the Administration withdrew the blended match rate proposal due to the reaction it received from states, elected officials, and other stakeholders.

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<sup>3</sup> Full State of the State Address available at:

<http://www.ok.gov/governor/documents/2013%20State%20of%20the%20State%20-%20Text%20as%20Prepared%20for%20Delivery.pdf>

<sup>4</sup> “State Lawmaker’s Guide to Evaluating Medicaid Expansion Projections,” The Heritage Foundation, Issue Brief No 3720 (September 7, 2012).

<sup>5</sup> In a FAQ released December 10, 2012, CMS stated that it no longer supports the Medicaid blended FMAP proposed in the budget. “Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid,” CMS (December 10, 2012).

*Why I opposed Medicaid expansion. "...contrary to what the president believes, borrowing money from China to expand government spending is not economic development. Every dollar we refuse to spend on Medicaid expansion is one dollar less that we have to borrow from China, not one dollar more that goes to another state. Our refusal to expand Medicaid does in fact help to reduce the growth in federal spending, which is yet another reason why every state should do the same."*

*Op-Ed by Gov. Jindal appearing in The Times Picayune, July 23, 2013<sup>6</sup>*

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Opponents also argue that states will face additional administrative costs that come with expansion—costs which must be covered under regular federal match rates even from 2014 to 2016. It is estimated that administrative costs add an average of 5.5% on top of the costs of benefits and the average state share of these costs is 45%.<sup>7</sup> In addition, ACA modifications to traditional Medicaid eligibility, application, and enrollment requirements will mean that all states, whether they expand or not, will experience increased Medicaid enrollment. Opponents of expansion contend that this “woodwork” effect will be further exacerbated if a state chooses to expand and engages in active marketing and outreach efforts. The services provided to the woodwork population are not eligible for the enhanced match rate, which translates into additional costs for states. However, it can also be argued that this cost is not 100% avoidable even if a state decides not to expand and engages in no ACA-related marketing or outreach efforts. Public education and outreach efforts at a national and state level by health care payers and providers, consumer groups, and other stakeholders, as well as significant media attention, will occur regardless of whether a state actively engages in outreach activities.

Several state analyses have also shown that the economic benefits received from the enhanced federal funding for the newly eligible will more than offset any additional administrative or woodwork costs generated from expanding Medicaid.

## **2. The elimination of Medicaid eligibility for certain adults with income above 138% federal poverty level (FPL) and shifting their costs to the federal government.**

***Arguments in Support of Expansion:*** In 2014, the federal government will provide Advanced Premium Tax Credits (APTC) to persons with income between 100% and 400% FPL. These credits will be available in all states, either through a state-based or federally-facilitated health insurance exchange. States can reduce current Medicaid costs by transitioning eligible individuals with income above 138% FPL (such as adults receiving pregnancy, breast and cervical cancer, and family planning services) to the exchange market and supporting their purchase of commercial insurance with the assistance of APTCs.<sup>8</sup> In addition to reducing state costs for services provided to these populations, transitioning them to the exchange would also reduce the administrative costs associated with this portion of the total Medicaid caseload.

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<sup>6</sup> To view full op-ed see:

[http://www.nola.com/opinions/index.ssf/2013/07/gov\\_bobby\\_jindal\\_why\\_i\\_opposed.html](http://www.nola.com/opinions/index.ssf/2013/07/gov_bobby_jindal_why_i_opposed.html)

<sup>7</sup> “State Lawmaker’s Guide to Evaluating Medicaid Expansion Projections,” The Heritage Foundation, Issue Brief No 3720 (September 7, 2012).

<sup>8</sup> In order for a state to access the 100% federal match rate, it must provide Medicaid coverage up to 138% FPL. CMS has indicated that it will not consider the enhanced match for a demonstration up to 100% FPL.

**Arguments in Opposition to Expansion and Counterpoints:** While expansion supporters focus on transitioning beneficiaries with incomes above 138% FPL, opponents focus their argument on the population between 100% and 138%. They point out that by adopting Medicaid expansion, states will be unable to shift any current costs they incur for serving this population. Once maintenance of efforts requirements, which restrict states from modifying their eligibility requirements for adults, are lifted in January 2014, any costs states currently incur by covering this population can be shifted to the federal government. This is achieved by requiring coverage to be obtained through commercial plans purchased through the exchange. This argument has also been used by those who support “partial” Medicaid expansions—extending eligibility to 100% FPL rather than 138%.

While it is true that individuals at this low-income level are eligible to receive APTCs, the rate at which they would actually purchase insurance through the exchange is likely low—especially given that federal rules have exempted this population from the ACA individual mandate penalty in states that choose not to expand Medicaid. As a result, these individuals may simply remain uninsured and continue to represent uncompensated care costs to the health care system. The opponents’ underlying argument also ignores the population between 100% FPL and the upper level at which a state provides current Medicaid eligibility for working parents. A recent review of current eligibility in the 21 states that affirmatively declined to expand Medicaid in 2014 reveals that the median eligibility limit for this population was 48% FPL; 17 of the 21 states limit eligibility to 60% FPL or less.<sup>9</sup> This population is not eligible for APTCs through the exchange and will have few, if any, options to obtain coverage.

### Ohio

An analysis of expected financial and economic impacts shows that expanding Medicaid eligibility would increase Ohio’s Medicaid costs between \$2.4 and \$2.5 billion over a nine-year period. However, it is also expected that the State could save \$1.6 billion during this same period. These savings would arise from reductions in: 1) state spending on optional Medicaid populations that would qualify for the enhanced federal match; and 2) uncompensated care currently provided to the uninsured.

It is also estimated that expanding Medicaid would generate up to \$2.8 billion in additional state revenue. The additional tax revenue is expected to come from the inflow of federal dollars to the State and the increase in Medicaid enrollment. Increased enrollment will increase the State’s managed care sales and insurance tax revenue as well as increase the State’s receipt of rebates from drug manufacturers.

As a result, the Medicaid expansion is estimated to produce a \$1.9 billion net budget gain to Ohio. The State is expected to realize significant state budget gains for the first seven years of the expansion. Starting in 2021, the expansion’s costs and fiscal gains will roughly balance, although it is estimated that the State will continue to experience small, ongoing net fiscal benefits each following year.

*Source: Expanding Medicaid in Ohio: Analysis of Likely Effects, A study conducted by a research partnership between the Health Policy Institute of Ohio, the Ohio State University, Regional Economic Models, Inc., and the Urban Institute (February 2013).*

<sup>9</sup> “Analyzing the Impact of State Medicaid Expansion,” Kaiser Commission on Medicaid and the Uninsured (July 2013).

*“Improving the quality of the care Medicaid provides, and giving taxpayers better value for the money they spend on it, have been priorities for me as governor. We’ve improved health outcomes through better care coordination and also reduced taxpayer spending by \$2 billion. We followed Ronald Reagan’s lead and found ways to provide a better service at a lower cost. First, Reagan was fiscally responsible, but he was also pragmatic and compassionate.*

*That’s why I have pushed to move forward with a plan to expand Medicaid while protecting Ohio’s economic recovery. Extending health care coverage to 275,000 low-income Ohioans—including 26,000 veterans—builds on what we have done. It spares our hospitals the effects of looming cuts in federal funding for uninsured care, prevents additional projected increases in health insurance costs, and gives low-income workers a hand as they move up and into the workforce.”*

*Op-Ed by Gov. Kasich appearing in USA Today, June 2, 2013<sup>10</sup>*

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### **3. Reductions in uncompensated care.**

**Arguments in Support of Expansion:** When uninsured individuals access health care, it is unfortunately often accessed through the most inefficient means—seeking care in an emergency department for conditions that could have been preventable if earlier care had been received. This results in uncompensated care costs to hospitals and other providers, which are then shifted onto payers, driving up premiums. As a result, the costs are ultimately paid by providers, the state, and the insured public. By decreasing the number of uninsured individuals, and leveraging federal dollars to provide those individuals with health care coverage, it is estimated that on average states can reduce uncompensated care spending by 50%.<sup>11</sup> The reduction would also boost hospital profits, positively impacting state tax revenue and increasing the money flowing within a state economy.

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*“Today, those without health care insurance typically wait until their medical conditions are so severe that they no longer can ignore them, and then they go to an emergency room. That’s an expensive way for them to get care. What’s even worse is they have to suffer with their illnesses. It’s not right, and it’s a failure for our society. That’s a failure for all of us, and we should do something about it.*

*Plus, treating those without insurance places an \$820-million burden for uncompensated care on Michigan’s hospital industry each year. The result is that individuals with insurance and businesses pay higher premiums to cover the cost of uncompensated care. Reducing the amount of uncompensated care will help control medical costs and improve our state’s economy and business climate.”*

*Op-Ed by Gov. Rick Snyder (Michigan) appearing in The Detroit Free Press, June 23, 2013<sup>12</sup>*

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<sup>10</sup> To view full op-ed see: <http://www.usatoday.com/story/opinion/2013/06/02/ohio-governor-reagans-compassionate-medicaid-expansion/2382737/>

<sup>11</sup> “Consider Savings as Well as Costs: State Governments Would Spend at Least \$90 Billion Less With the ACA than Without It from 2014 to 2019,” The Urban Institute (July 2011).

<sup>12</sup> For full op-ed, see: <http://www.michigan.gov/snyder/0,4668,7-277-60279-306849--,00.html>

**Arguments in Opposition to Expansion and Counterpoints:**

Opponents express skepticism that states will be able to actually reduce state spending for uncompensated care—even if they expand Medicaid and reduce the numbers of uninsured. Citing Massachusetts as an example, “hospitals and clinics have proven adept at blocking or reversing cuts to state ‘supplemental’ funding for treating the uninsured” resulting in the continuation of a \$200 million state allocation for covering uncompensated care costs.<sup>13</sup> Other examples cited include Arizona and Maine, where, despite prior expansion efforts, increases in uncompensated and charity care continued.

However, it is important to note that factors influencing state decisions to offset uncompensated care costs by providing funding to hospitals and other health care providers, such as community health centers, are more complex than a singular decision regarding Medicaid eligibility levels. Overall population growth, health care inflation rates, the rate of employers offering employer sponsored insurance, unemployment rates, and trends in where the uninsured access care are among the many factors that may influence these decisions.

Community Health Centers are a case in point. While the number and rate of uninsured in a state such as Massachusetts may have decreased, the number of uninsured who seek care through community health centers has actually risen.<sup>14</sup> As such, the need to address shifts in uncompensated care may continue due to factors unrelated to the expansion.

**New Hampshire**

An analysis completed for the New Hampshire Department of Health and Human Services used a two phase approach to analyze the impact of expanding Medicaid on the State. The first phase looked at the cost of not expanding compared to expanding under several different program design options. The results of the analysis showed that by not expanding Medicaid, the State could save \$66 to \$114 million over a seven-year period. However, the State would also lose \$1.8 to \$2.7 billion in federal revenues over the same period.

The second phase of the project estimated the secondary effects of not expanding compared to expanding Medicaid, taking into account the impact on other state programs, the uninsured, provider groups, the state economy, and the commercial market. Results from the analysis show that by expanding Medicaid, the savings realized by other state programs would total \$47.1 to \$67.1 million from 2014–2020. The study also found the Medicaid expansion to reduce total uncompensated care in the New Hampshire health system by about \$340 million. The expansion is also expected to result in a positive economic impact to the State, increasing gross state product by \$2.8 billion.

*Source: An Evaluation of the Impact of Medicaid Expansion in New Hampshire: Phase II, The Lewin Group (January 2013).*

<sup>13</sup> “State Lawmaker’s Guide to Evaluating Medicaid Expansion Projections,” The Heritage Foundation, Issue Brief No 3720 (September 7, 2012) p. 1.

<sup>14</sup> “How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform,” Kaiser Commission on Medicaid and the Uninsured (March 2009). Data further show that while the overall number of uninsured individuals in the country grew by 28% between 2001 and 2011, the number of uninsured served by CHCs grew by 84%. “A Sketch of Community Health Centers: Chart Book 2013,” National Association of Community Health Centers (2013). Available at: <http://nachc.com/client//Chartbook2013.pdf>

Expansion opponents also argue that the ability to reduce state allocations for uncompensated care is also unlikely when it would occur on top of the planned reductions in federal disproportionate share hospital (DSH) funding scheduled under the ACA. The Obama Administration’s proposal for implementing the planned DSH reductions, which delays the full impact for two years, has also been cited as an argument in favor of states forgoing Medicaid expansion. “In fact, the continued DSH payments will make it marginally easier for states to reject the Medicaid expansion for now, because they will continue to receive federal payments that help compensate for having a large uninsured population.”<sup>15</sup>

However, pushing the impact of the full DSH reductions out two years does not change the fact that DSH reductions will begin for all states in 2014—and the loss of funding will occur in both states that expand and that do not expand. The difference is that in states that do expand, there is an opportunity to offset some or all of the reduction through additional federal Medicaid revenue.

#### **4. Leveraging federal dollars to pay for behavioral health and other state health program services.**

**Arguments in Support of Expansion:** Enrolling uninsured and low-income individuals in Medicaid, and leveraging the enhanced federal funds to pay for their services, can reduce the amount of state and local government dollars that are currently directed toward providing mental health and substance abuse treatment and other state-funded health services. It is estimated states could see financial gains of nearly \$40 billion between 2014 and 2019 by using federal dollars to pay for state-funded behavioral health programs.<sup>16</sup> Other state program efficiencies could be achieved by leveraging the enhanced

### **Utah**

A cost-benefit analysis completed for the State of Utah shows the total costs/savings for the State over a ten-year period under five different scenarios. The first scenario shows the costs if Utah were not to expand its Medicaid program, but still make the mandatory changes required under the ACA. The second and third scenarios assume the state expands to 138% FPL and shows the expected costs/savings using the State’s traditional Medicaid benefit package and an Essential Health Benefits (EHB) package. The fourth and fifth scenarios assume a partial expansion to 100% FPL, and show the costs of expanding using the traditional and EHB benefit packages (the costs are modeled using the State’s regular match rate).

All scenarios take into account any cost reductions to state-funded public assistance programs (average savings of \$15.5 million per year) and optional Medicaid programs (average savings of \$0.7 million per year). While scenarios two and three show an initial savings to state government (an average of \$6.6 million per year for three years), all scenarios result in a direct cost to the State over a ten-year period. This cost increases over time as the enhanced federal match declines from 100% to 90%. However, when factoring in expected savings to state and county-funded public assistance programs, as well as new state and county tax revenue, it is estimated that fully expanding Medicaid will result in total savings to the State over a ten-year period. These savings are increased when factoring the expected reduction in uncompensated care.

*Source: State of Utah Medicaid Expansion Assessment, Impact Analysis: 2014-2023, Public Consulting Group (May 2013).*

<sup>15</sup> Nina Owcharenki, “Obama offers one more reason states shouldn’t rush to expand Medicaid,” *The National Review* (April 15, 2013). Available at: <http://www.nationalreview.com/corner/345604/obama-offers-one-more-reason-states-shouldnt-rush-expand-medicaid-nina-owcharenko>

<sup>16</sup> “Net Effects of the Affordable Care Act on State Budgets,” prepared by the Urban Institute for First Focus (December 2010).

federal funds to pay for the health care of individuals who may be enrolled in uncompensated care pools, state high-risk pools, state-only funded coverage programs, adult correctional facilities,<sup>17</sup> and public health services.

Additional savings may also be realized through better care coordination. More efficient and coordinated care provided to Medicaid and the low-income, uninsured populations has the potential to reduce costs over time as individuals access preventive and appropriate care rather than high-cost care delivered in hospitals and emergency departments.

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*"We have an obligation to provide an adequate level of basic health care services for those most in need in our state. However, we also have an obligation to ensure our state's financial security," Martinez said in a news release. "In deciding to expand Medicaid, I weighed every possible outcome and impact. Ultimately, this decision comes down to what is best for New Mexicans."*

*Gov. Susana Martinez, New Mexico quoted in Huffington Post, January 9, 2013<sup>18</sup>*

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**Arguments in Opposition to Expansion and Counterpoints:** Leveraging federal dollars for behavioral health and other state health programs is not often specifically cited in expansion opposition arguments. However, because it is directly related to accessing additional federal funding, one could expect similar arguments and counterarguments to those listed in point #1 above.

### **Impact on State Economies**

**Arguments in Support of Expansion:** In addition to the estimated state budgetary gains, supporters argue the Medicaid expansion is expected to increase state economic activity, resulting in an overall positive economic impact to the states.

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*"This thoughtful, conservative plan will stimulate the Arizona economy, protect rural and safety-net hospitals and provide quality, cost-effective health care to Arizona's working poor. Passage of Governor Brewer's Medicaid Restoration Plan will: 1) Inject more than \$8 billion into the Arizona economy over the next four years; 2) Preserve safety-net and rural hospitals that have been pushed to the brink by overwhelming costs associated with providing uncompensated care; 3) Keep Arizona tax dollars in Arizona and; 4) Take pressure off our strained State budget."*

*Press release on March 12, 2013, "Gov. Jan Brewer Unveils Draft Legislation to Restore Arizona's Medicaid Program: Plan will Boost Economy, Protect Hospitals and Save Arizona Lives"<sup>19</sup>*

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<sup>17</sup> In 1997, HHS established a general rule allowing Medicaid-eligible inmates who receive treatment at hospitals or other outpatient clinics to have their bills paid for with Medicaid dollars (care received within the correctional facility is not covered). Persons on parole or under house arrest are also eligible to be covered under Medicaid.

<sup>18</sup> To view full article see: [http://www.huffingtonpost.com/2013/01/09/new-mexico-medicaid-expansion\\_n\\_2442640.html](http://www.huffingtonpost.com/2013/01/09/new-mexico-medicaid-expansion_n_2442640.html)

<sup>19</sup> To view the full press release see: [http://azgovernor.gov/dms/upload/PR\\_031213\\_MedicaidUnveiling.pdf](http://azgovernor.gov/dms/upload/PR_031213_MedicaidUnveiling.pdf)

The Kaiser Commission on Medicaid and the Uninsured compiled findings from 29 studies from 23 states analyzing the impact of the current Medicaid program on state and local economies. All studies found that state Medicaid spending (strengthened by federal match dollars) has had a major impact on state economies—generating jobs, income, and state tax revenues.<sup>20</sup>

Under the expansion, the 90% enhanced federal match rate starting in 2020 means that states will receive \$9 for every \$1 of state money spent on Medicaid services—increasing the total impact of the multiplier effect (between 2014 and 2020 states will receive an even greater return on state dollars as the match rate will be higher than 90%). This is in addition to the match rate states receive for their traditional Medicaid populations.

As such, it can be expected that the Medicaid expansion, particularly the enhanced federal funds, will result in a positive economic impact through a “multiplier effect.”<sup>21</sup> This occurs when an injection of new money into an economy leads to more spending, which creates new demand for services and products.

This in turn results in positive direct, indirect, and induced effects such as increased business activity, the generation of new health care related revenue, the creation of new jobs, and increased personal income and state tax revenue. This process is detailed in Figure 1.

#### **Multiplier Effect Explained**

**Direct effects occur when Medicaid dollars are spent within the industry, such as the federal government paying for a hospital stay.**

**An indirect effect occurs when the industry that is affected directly then interacts with another industry. For example, a hospital with an increase in patient volume will purchase more laundry services from a local laundry company.**

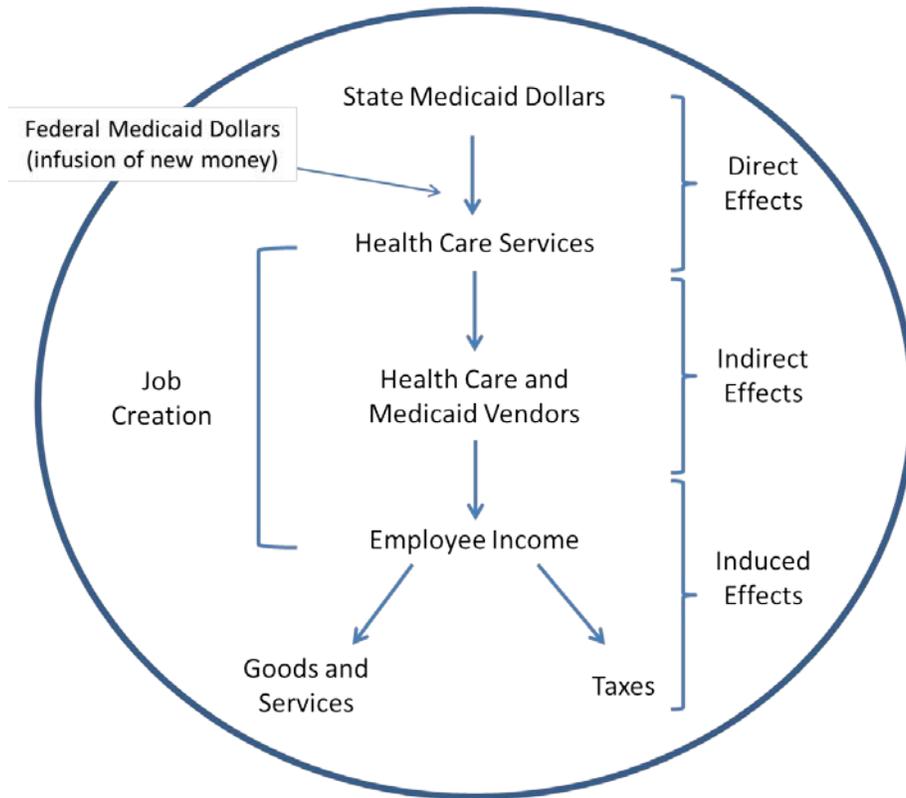
**Induced effects estimate how the additional money spent on the industry will change individual behavior, such as a newly hired worker earning more at the hospital and then spending more money at local retail stores.**

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<sup>20</sup> “The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States,” NASMHPD (January 2013).

<sup>21</sup> Ibid.

**Figure 1: Multiplier Effect from Increased State and Federal Medicaid Dollars**



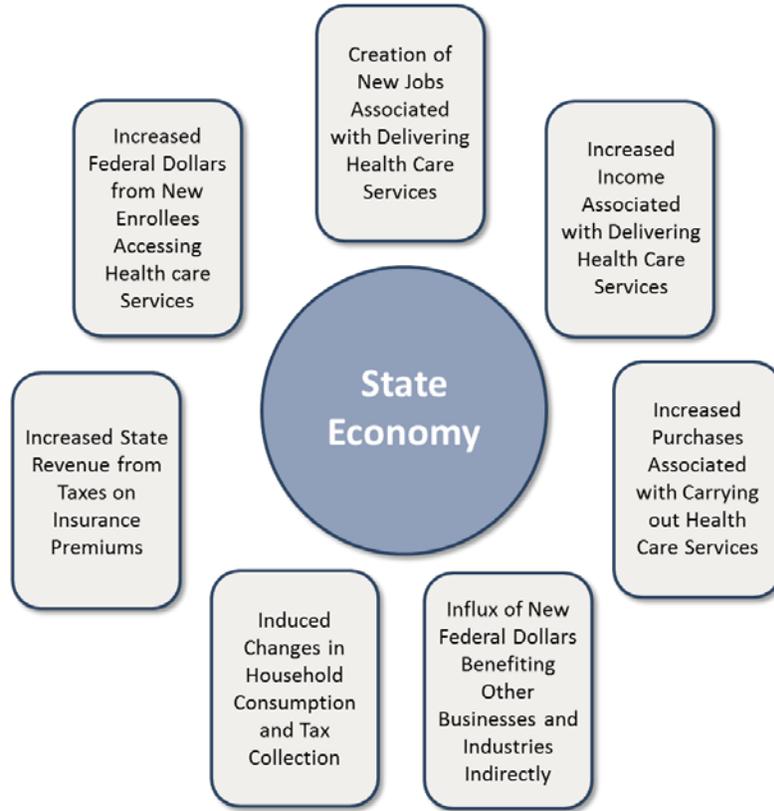
Source: The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States, NASMHPD, January 2013.

A review of studies analyzing the economic impact of the Medicaid expansion found the expansion could impact state economies through seven direct, indirect, and induced effects. These are outlined in Figure 2.<sup>22</sup> All of these factors increase money flowing within a state, positively impacting the states' economy.

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<sup>22</sup> Ibid.

**Figure 2: Key Direct, Indirect, and Induced Impacts Resulting from the Medicaid Expansion**



Source: The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States, NASMHPD, January 2013.

**Arguments in Opposition to Expansion and Counterpoints:** Responding to the “multiplier effect” arguments, opponents of Medicaid expansion caution that “government spending multipliers are highly uncertain.” They question estimates that assume additional federal Medicaid spending will translate into spending only within a state by highlighting the inevitable fact that some of those expenditures will go to purchase goods and services from out-of-state suppliers and will therefore, not generate in-state sales or excise taxes.<sup>23</sup>

Others argue that because the expansion is funded with additional state and federal taxation, it actually results in a negative “drag” on state economies as personal income and business profits are reduced.<sup>24</sup> It is also argued that expanding Medicaid will only add to the federal deficit, which negatively impacts U.S. economic growth over time.

While the factors highlighted by expansion opponents should be considered in economic multiplier calculations, it is unlikely that there would be no effect from the infusion of additional federal funds. This is reiterated by the fact that both state and national-level economic modeling consistently shows a positive economic impact in states that expand Medicaid.

<sup>23</sup> “State Lawmaker’s Guide to Evaluation Medicaid Expansion Projections,” The Heritage Foundation, Issue Brief No 3720 (September 7, 2012).

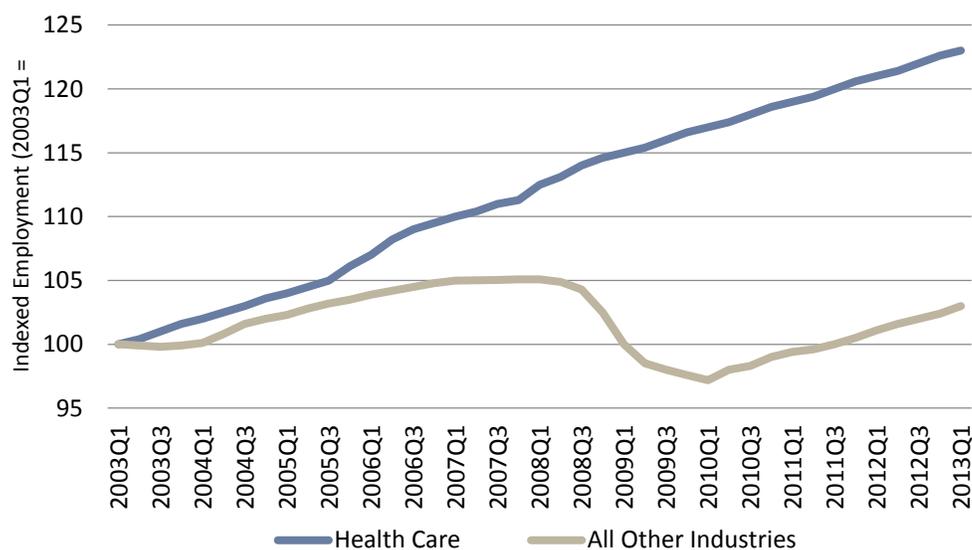
<sup>24</sup> Ibid.

Alternatively, states that choose not to expand Medicaid will be losing out on any potential economic growth that would occur from the infusion of federal funds and resulting multiplier effects. If a state forgoes the expansion then they will also be forgoing \$9 of federal funds for every \$1 dollar of state money spent on covering the low-income, uninsured population. In other words, the state is actually reducing its total Medicaid funds by \$10 in order to save \$1 in state funds.<sup>25</sup> Some would go further and suggest that this potential loss is exacerbated by some states choosing to expand and others choosing to forgo the expansion. States that choose to expand could benefit from a stronger multiplier effect, in turn attracting more businesses and economic activity to their state.

**Impact on Business Development: Health care jobs related to economic recovery**

**Arguments in Support of Expansion:** Supporters of Medicaid expansion point to health care job growth within states as another economic benefit. A report released by The Brookings Institution in July 2013 reports that health care jobs increased 22.7% (2.6 million jobs) over the past ten years.<sup>26</sup> This growth rate compares to 2.1% for all other industries over that same period. Brookings reports that health care employment now accounts for more than 1 of every 10 jobs in the 100 largest U.S. metropolitan areas and represents a “higher share of jobs than before the recession struck” in those areas.<sup>27</sup>

**Figure 3: U.S. Employment Growth in Health Care and All Other Industries, 2003 Q1 – 2013 Q1**



Source: Brookings Institution Healthcare Metro Monitor Supplement, July 1, 2013.

<sup>25</sup> “The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States,” NASMHPD (January 2013).

<sup>26</sup> “Healthcare Metro Monitor Supplement,” Brookings Institution (July 1, 2013).

<sup>27</sup> Ibid.

*"The independent report by the Lewin Group has made it clear that moving forward with Medicaid expansion under the Affordable Care Act will inject more than \$2.5 billion in federal dollars into our state, create an estimated 700 jobs, and save Granite Staters more than \$92 million - all while helping working families afford critical health coverage."*

*"By reducing the amount of uncompensated care at our hospitals, the average New Hampshire household will save an estimated \$145 per year, a critical boost during these uncertain economic times."*

Gov. Hassan Press Statement on January 11, 2013<sup>28</sup>

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**Arguments in Opposition to Expansion and Counterpoints:** While supporters use reports, such as the one from Brookings, as evidence of job creation through expanding health care coverage, others use the same data to refute the impact that expanded access under the ACA has on job growth. Most notably, opponents highlight data showing that the growth rate in health care employment has remained unchanged over the last decade, even with the implementation of the ACA in 2010. Since the trend was in place before the law's implementation, they argue the ACA has had minimal to nonexistent effects on employment growth. ACA and Medicaid expansion opponents do not argue that health care job growth has not occurred; rather they suggest that it is more influenced by other factors driving health care—such as the increasing population age 65 and older—rather than any regulatory or even economic changes related to the ACA or expanded coverage.<sup>29</sup>

The commonality between arguments by expansion supporters and opponents on the topic of job growth is that both sides acknowledge that health care job growth has occurred. However, some opponents argue that this type of job growth may not have a positive impact on future local, state, or national economies. For example, increasing health care jobs both results from and contributes to increased health care spending, which may not be sustainable. As a result efforts to "bend the cost curve" of health care and bring increased efficiencies to health care delivery may actually result in the need to slow health-care related employment growth.<sup>30</sup>

### ***Impact on Business Development: Large employers who either do not offer insurance or offer insurance that is not "affordable and adequate"***

The ACA includes what has been termed a "shared responsibility" provision applying to large employers (defined as those with more than 50 full-time equivalent employees (FTE)).<sup>31</sup> "This provision does not

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<sup>28</sup> To view full statement see: <http://governor.nh.gov/media/news/2013/pr-2013-01-11-medicaid-expansion.htm>

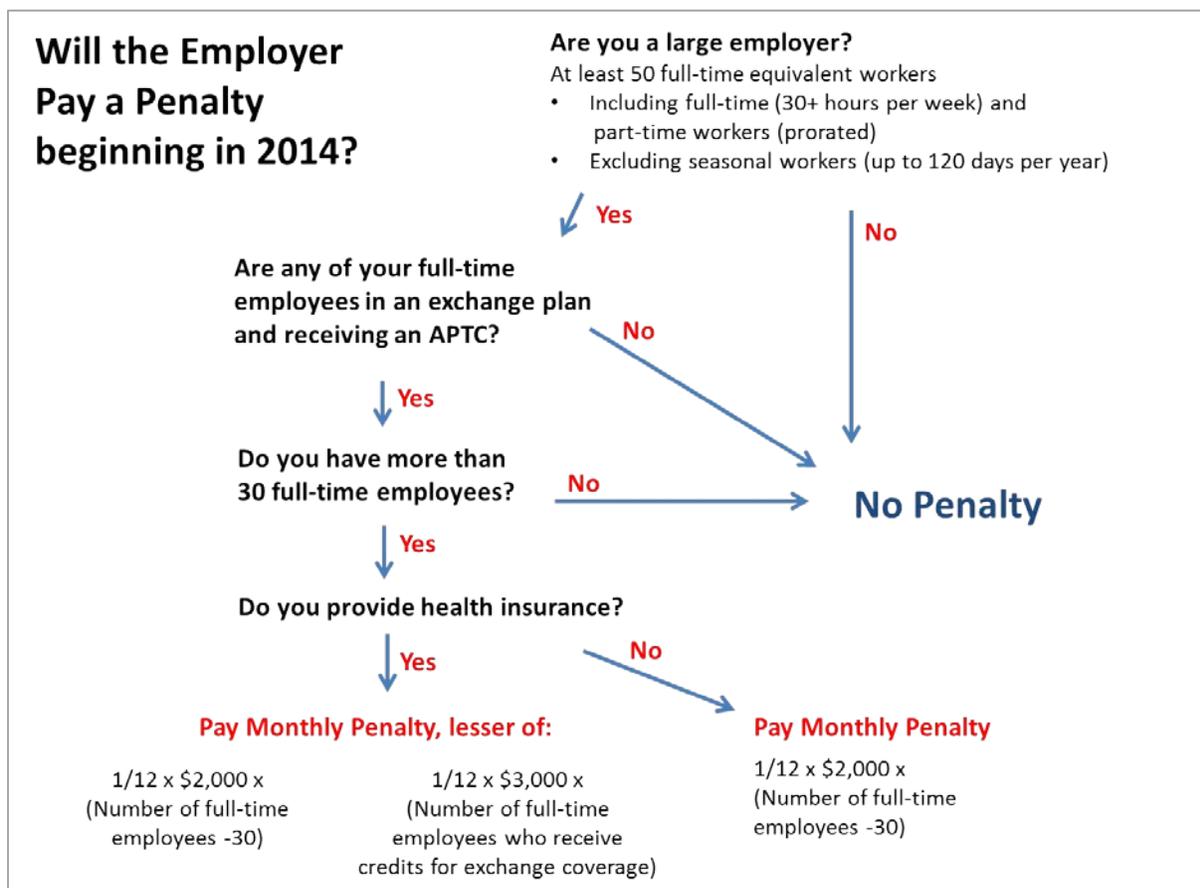
<sup>29</sup> Chris Jacobs, "Obamacare, Health Costs and Jobs," The Foundry, The Heritage Network (July 2, 2013). Available at: <http://blog.heritage.org/2013/07/02/obamacare-health-costs-and-jobs/>

<sup>30</sup> Margot Sanger-Katz, "Health Care: Great for the Economy Today, Terrible Later" National Journal (January 31, 2013). Available at: <http://www.nationaljournal.com/magazine/health-care-great-for-the-economy-today-terrible-later-20130131>

<sup>31</sup> A full-time employee equals an average of at least 30 hours worked per week. To calculate the FTE for part-time employees (working less than 30 hours per week), the total number of hours worked by all part-time employees in a month is divided by 130. Full-time seasonal employees (working under 120 days a year) are excluded from the calculation.

explicitly mandate that employers offer their employees acceptable health insurance. However, it does impose penalties on certain firms ... if one or more of their full-time employees obtain a premium tax credit through the newly established health insurance exchanges.”<sup>32</sup> Employees are eligible for the advanced premium tax credits (APTC) if their income is between 100% and 400% FPL and if their employer either does not offer insurance, or the insurance offered is either not affordable or adequate.<sup>33</sup> The penalty varies based on whether the affected employer offers insurance or not and is imposed based on the number of actual full-time employees. The Congressional Research Services has developed the following flow chart reflecting the shared responsibility provision.<sup>34</sup>

**Figure 4: Determining If an Employer Will Pay a “Shared Responsibility” Penalty**



Source: CRS analysis of P.L. 111-148 and P.L. 111-152  
Note: These penalties are for 2014; penalties in future years will be adjusted.

<sup>32</sup> “Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA),” Congressional Research Services (CRS), (April 3, 2013): p.1.

<sup>33</sup> Insurance must be available for the employee and any dependent, defined as children who have not attained the age of 26. Affordability is achieved if the cost of coverage does not exceed 9.5% of annual household income. Adequacy is achieved if the plan’s actuarial value is at least 60%.

<sup>34</sup> CRS: p. 5.

The shared responsibility penalty on large employers was specifically crafted to not apply if their employees and their dependents enroll in Medicaid and/or the Children's Health Insurance Program (CHIP). For states that opt in to the ACA's Medicaid expansion provision, full-time employees of large employers with incomes between 100% and 138% FPL will be eligible for Medicaid. In states that do not opt in to Medicaid expansion, those similarly situated employees will not be eligible for Medicaid, but will be eligible for APTCs through an exchange and thereby will potentially trigger the penalties.

Overall, the Congressional Budget Office (CBO) estimated employers would be subject to \$10 billion in penalties in 2015 and \$140 billion in total penalties during the ten year period of 2014–2023.<sup>35</sup>

**Arguments in Support of Expansion:** In a highly publicized report issued in March 2013, Jackson Hewitt Tax Service detailed its research and findings that employers in states that do not expand Medicaid will face a higher share of responsibility penalties than employers in states that do expand Medicaid.<sup>36</sup> This report provides a range of potential penalties for each state and concludes that for the 22 states they categorized as “opposed,” “leaning against” or “remain undecided,” the employer penalties “... could total \$876 to \$1.3 billion each year...”<sup>37</sup> The Jackson Hewitt study has been widely cited by advocates for Medicaid expansion in their efforts to secure either gubernatorial or legislative support in states that have opposed expansion. It has also been used in efforts to secure support for expansion from business organizations and associations within states.

On July 2, 2013, the Obama Administration announced that they were delaying implementation of ACA mandatory employer and insurer reporting requirements for one year.<sup>38</sup> These requirements provide the informational foundation under which the Internal Revenue Service will calculate whether any full-time employees of a large employer received premium tax credits and any corresponding employer penalty. As announced by the Administration, the one-year transition period was to meet two purposes. “First, it will allow us to consider ways to simplify the new reporting requirements consistent with the law. Second, it will provide time to adapt health coverage and reporting systems while employers are moving toward making health coverage affordable and accessible for their employees.”<sup>39</sup> The advent of this one-year implementation delay may lessen the effectiveness of the “shared responsibility” argument to persuade decisions makers to support Medicaid expansion during 2014.

**Arguments in Opposition to Expansion and Counterpoints:** While some advocates and businesses have argued that the shared responsibility penalty could reduce employer net profits and may influence decisions regarding future business expansion or relocation, those opposed to expansion believe that it will more likely result in employers either not adding employees or making sure their

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<sup>35</sup> CBO estimates available at:

[http://cbo.gov/sites/default/files/cbofiles/attachments/44190\\_EffectsAffordableCareActHealthInsuranceCoverage\\_2.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf)

<sup>36</sup> “The Supreme Court’s ACA Decision and Its Hidden Surprise for Employers: Without Medicaid Expansion, Employers Face higher Tax Penalties Under ACA,” Jackson Hewitt Tax Service Inc. (2013). Available at: <http://www.jacksonhewitt.com/About-Us/Press-Releases/Jackson-Hewitt-Tax-Service-Releases-First-Report-on-Impact-of-Medicaid-Expansion-on-Employers/>

<sup>37</sup> Ibid, p. 1. Estimated penalties for each state is available in the report.

<sup>38</sup> “Continuing to Implement the ACA in a Careful, Thoughtful Manner,” U.S. Dept. of the Treasury, Treasury Notes (July 2, 2013). Available at: <http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx>

<sup>39</sup> Ibid.

current and future employees work less than 30 hours per week. Therefore they argue the ultimate solution is to repeal the employer mandate rather than expand Medicaid. However, there is some evidence that suggests that large numbers of employers do not yet appear to be changing hours in response to the provisions in the ACA.<sup>40</sup>

## ***Conclusion***

The first half of 2013 has seen nearly one-half of all states make the affirmative decision to pursue some form of ACA Medicaid expansion beginning in 2014. The decision to expand or not remains active in six additional states. The decision not to pursue expansion in the remainder of the states has not ceased debate amongst political leaders, health care providers, advocates, and other stakeholders in those states. Debate is sure to continue through the remainder of 2013 and well into 2014.

This issue brief has highlighted some of the most central economic arguments at the heart of the Medicaid expansion debate, including how expansion affects state budgets, economies, and business development efforts. Similar data and information are used on both sides of the argument, by Medicaid expansion supporters and opponents alike. It is this dynamic that heightens the need for individuals interested in health care coverage and services for low-income and vulnerable populations to become familiar with the key arguments and perspectives—both in support and opposition of expansion—in order to better engage in the discussions, debates, and decision making process.

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<sup>40</sup> “The Affordable Care Act: A Hidden Jobs Killer? An Examination of Average Weekly Hours in 2013,” CEPR (July 2013).

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**National Association of Community Health Centers, 2013**

**State Policy Report #45**

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*Key Economic Arguments used on Both Sides*

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