

The Medicaid Expansion Choices Ahead for Montana

by Gregg Davis

The dynamics behind the expansion of the Medicaid program and its impact on state budgets is a topic of considerable controversy and differences of opinion. Many states have attempted to estimate the impact of the Medicaid expansion on their rate of uninsured, the health of their population, and the budgetary impact on state finances. There are many moving parts to Medicaid, and no study to date has incorporated all aspects of the Medicaid expansion.

The Supreme Court's early summer ruling on the Affordable Care Act (ACA) makes the expansion of Medicaid programs optional for states without penalty. Under the ruling, federal funding for a state's Medicaid program may not be terminated if the state chooses not to expand Medicaid to all residents with incomes up to 138 percent of the federal poverty level (\$32,000 for a family of four).

Some states, including Florida, Louisiana, Mississippi, South Carolina, Georgia, and Texas, have decided they will not expand the Medicaid programs in their states, claiming it would place an undue burden on their state finances. A number of states are leaning toward the expansion, but the vast majority of states are undecided. Montana is among the undecided.

Medicaid is a health insurance program jointly funded by the federal government and the states. Although states have considerable flexibility in the design and administration of their Medicaid programs, certain groups must be covered for certain categories of services. Generally, eligibility has been restricted to low-income children, women who are pregnant, the parents of dependent children, the elderly, and people with disabilities. Recent changes, however, will now expand eligibility to childless adults.

If states choose to expand, most of their costs for newly eligible adults would begin three years after the expansion and would be capped at 10 percent in 2020 and thereafter. For the first three years of the expansion, the federal government would pay 100 percent of the cost for all newly eligible Medicaid beneficiaries.

The Medicaid expansion represents the single most significant new cost for states under the ACA. But at the same time, the addition of federal dollars will support many jobs and provide additional stimulus to the economy. Lots of uncertainty remains as states attempt to weigh the merits of

the expansion against the financial strain on their budgets. Following is the Bureau's effort to model the Medicaid expansion, but it is in no way conclusive nor inclusive of all the potential new costs or savings.

How Many Montanans Will Be Eligible?

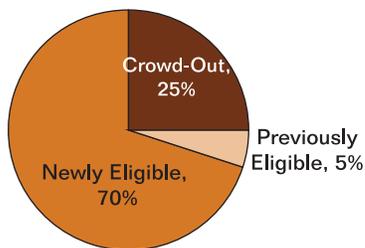
Estimating the number of Montanans eligible for Medicaid under the expansion is subject to some uncertainty. The target population for the expansion is the uninsured with incomes below 138 percent of the federal poverty level. In Montana, that population includes 69,000 people. However, not all of the 69,000 individuals eligible for the expansion will enroll. As shown in the sidebar on page 9, many factors influence the Medicaid-eligible population, including:

- enrollment preferences,
- state outreach efforts,
- financial circumstances,
- coverage under parents' policies,
- crowd-out rates (when employer-sponsored health insurance is dropped in favor of Medicaid)
- take-up rates, and
- enrollment process.

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Figure 1
Sources of New Medicaid Enrollees
with Medicaid Expansion to 138% FPL



Source: Bureau of Business Economic Research, The University of Montana.

Considering all of those factors, the Bureau estimates that about 56,000 total new enrollees could be added under the Medicaid expansion. Nearly 25 percent will be previously insured people who enroll in Medicaid as the result of losing their private coverage. The remaining enrollees (42,000) will be those who now qualify for Medicaid due to the higher income threshold and those previously eligible but not enrolled under traditional Medicaid who now enroll in the program (Figure 1).

Costs of Medicaid Expansion

Estimating the costs of the Medicaid expansion is also subject to risk. Aside from the uncertainties surrounding the potential number of new Medicaid-eligible enrollees, changes in the health status of new enrollees, in per-enrollee Medicaid costs, in the medical rate of inflation used to project future costs, and in the Federal Medical Assistance Percentages (FMAP) could influence the cost of the Medicaid expansion.

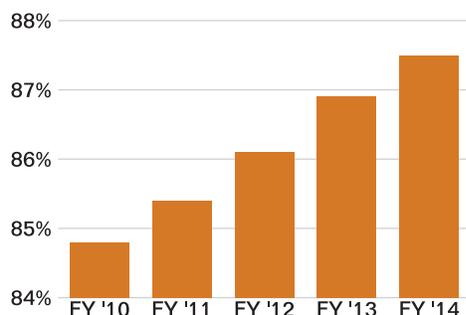
Health status of new enrollees. Adults without children make up 60 percent of the population whose incomes fall below 138 percent of the poverty level and are most likely to account for the majority of people in the Medicaid expansion. Childless adults are more likely to be healthier on average than the Medicaid population in general.

Cost per enrollee. Although the average spending per Medicaid enrollee is \$7,348, it ranges from \$2,900 per enrollee for children to almost \$23,000 per enrollee for the aged. Spending for adults is 60 percent of the average spending per enrollee for all groups, or \$4,382. With respect to those previously eligible for Medicaid who now enroll, the cost per enrollee may be much lower. Since uninsured individuals eligible for health insurance coverage usually obtain insurance when they become ill or develop medical conditions, the average cost per beneficiary of already eligible people who have not yet signed up for Medicaid may be lower than the average cost of those individuals already in the Medicaid program.

Rate of cost inflation per enrollee. Since medical inflation has long outpaced general price inflation, it is important to account for future per-enrollee spending in the Medicaid program. Per-capita personal health care spending by Medicaid enrollees in Montana increased at 5.9 percent annually from 2004 to 2009. This inflation factor is used to estimate costs per enrollee in 2020.

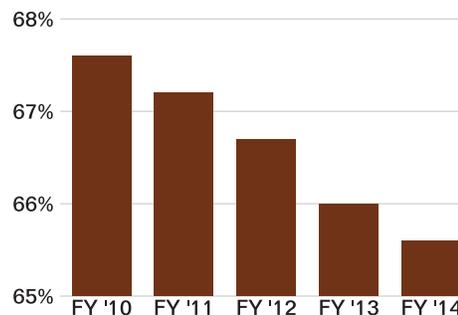
Federal Medical Assistance Percentages. Under the existing Medicaid program, the federal government pays a share of the states' Medicaid costs. States are required to pay the balance to qualify for the federal funds. The federal government's share for most Medicaid services is determined by the Federal Medical Assistance Percentage (FMAP). This percentage is computed by comparing the three-year average of per capita incomes for the state relative to the nation. The formula provides higher federal reimbursement to states with lower incomes and lower reimbursement to states with higher incomes. Statutory requirements limit both upper and lower reimbursements, 83 percent and 50 percent, respectively. The current rate for Montana is 66 percent, which means for every dollar the state contributes to the cost of the Medicaid program, the federal government will contribute \$1.94. As shown in Figure 2, Montana's economy is rebounding better than the national economy. If this trend continues, prospective federal reimbursement rates may be lower in the future than they are today for traditional Medicaid (Figure 3).

Figure 2
Per Capita Income Ratio, Montana to U.S.



Sources: Bureau of Economic Analysis, U.S. Department of Commerce and Bureau of Business Economic Research, The University of Montana.

Figure 3
Estimated FMAP for Traditional Medicaid, Montana



Source: Business Economic Research, The University of Montana.

Factors that Influence the Medicaid-Eligible Population

Montana has 69,000 individuals who are eligible for Medicaid under the expansion. However, a number of those people will not enroll. Following are some factors that influence their enrollment.

Enrollment Preferences. Many people prefer to enroll by mail or online instead of at government offices or community-based organizations. The intensity of state efforts in outreach will also be a significant determining factor in how many will enroll.

The Bubble Population. This population is at risk of cycling into and out of Medicaid as their financial circumstances change and includes individuals with incomes up to 150 percent of the federal poverty level. Including this Medicaid at-risk population would add only another 4,400 uninsured whose incomes are 138 percent to 150 percent of the federal poverty level. If, however, the bubble population extends to uninsured individuals with incomes up to 200 percent of the federal poverty level, the number of uninsured who are at risk of becoming Medicaid-eligible increases substantially. Another 26,000 uninsured Montanans could be at financial risk of becoming eligible for the Medicaid expansion.

Young Adults Covered by Parents' Policies. There are approximately 26,000 18- to 24-year-olds without health insurance in Montana. Using the proportion of 6- to 17-year-olds with private health insurance, nearly 17,000 young adults may have coverage provided by their parents' policies. Exactly how many of these young adults have incomes below 138 percent of the federal poverty level is not known. For our analysis, the number of young adults with access to their parents' health insurance coverage is included as part of the crowd-out scenario discussed next.

Crowd-Out. Crowd-out occurs because employers may choose to drop health insurance coverage and send their employees into Medicaid for health coverage.

In addition, those with other forms of private health insurance coverage may find the Medicaid option a cheaper alternative for health care coverage. The extent of crowd-out is difficult to ascertain. A recent study estimates the national rate of crowd-out to be as high as 25.8 percent of newly enrolled Medicaid recipients (Holahan, 2010).

According to Bureau survey data, 34,000 individuals below 138 percent of the federal poverty level have some form of private insurance, either through an employer or as an individual policy. However, many of these individuals may not have comprehensive medical insurance. Even though these individuals will likely purchase insurance in the federally facilitated exchange, not all represent true "crowd-out" in the sense of those leaving private coverage for Medicaid. Assuming 57 percent participate in Medicaid, 19,000 Montanans could conceivably enroll in Medicaid.

Another methodology is available to estimate crowd-out that avoids the possible confusion by survey respondents as to what kind of insurance coverage they have. Again assuming a take-up rate of 57 percent and a crowd-out rate of 25.8 percent of newly enrolled, approximately 14,000 Montanans may switch from private coverage to Medicaid.

Woodwork Effect. Some individuals previously eligible for Medicaid may have chosen not to enroll, or they were unaware that they qualified for Medicaid and did not enroll in the program. If the enrollment process is simplified and the state aggressively markets the Medicaid expansion, these previously eligible individuals may now choose to enroll. This "woodwork effect" may also exist because the individual mandate may encourage individuals to enroll rather than face the penalty for having no health insurance. For Montana, this "woodwork effect" is small. Only 4,000 uninsured with incomes below 33 percent of the federal poverty level could now enroll in Medicaid due to a simplified enrollment process.

Montana Take-Up Rates Compared to National Averages

The national Medicaid take-up rate is around 63 percent of newly eligible adults. In Montana, the take-up rate is much lower, 50 to 60 percent of newly eligible adults. The vast majority of newly eligible adults are expected to be childless adults. Childless adults have typically been less likely than other beneficiaries to join. In addition, the ACA eliminates the asset test for eligibility for newly eligible adults. Removing the asset test lowers a barrier to enrollment, so the take-up rate could be higher for newly eligible adults (Davidoff, 2005).

After considering all of the issues, the incremental cost attributable to the Medicaid expansion in Montana is projected to be \$456 million. The state's share of this cost in 2020 will be an estimated \$50 million, with nearly \$406 million paid by the federal government. Remember that the state has little or no obligation for the new Medicaid-eligible from 2014 to 2016. Thereafter, the state's share rises according to the Federal Medical Assistance Percentages phase-down. New state spending for the Medicaid expansion is estimated to be between \$100 million and \$155 million for the period between 2014 and 2019. New federal funds are estimated to be \$2.2 billion to \$2.6 billion, reflecting the 100 percent FMAP during 2014 to 2016 (Holahan, 2010.)

State Costs without Medicaid Expansion

For those states that do not expand Medicaid, additional costs will still be incurred that are not directly attributable to the expansion. Medicaid enrollment will still increase, requiring the state to pay the traditional FMAP for the previously eligible population that now enrolls in Medicaid because of the individual mandate, the outreach of states to enroll individuals to apply for subsidized coverage in the exchanges, and the simplification of Medicaid eligibility procedures. The ACA also requires states to increase Medicaid payments for certain primary care services during 2013 and 2014, regardless of the state's decision to expand or not expand Medicaid.

Potential Advantages to Medicaid Expansion

The cost of the Medicaid expansion must be compared to the benefits of providing health insurance to nearly 30 percent of Montana's uninsured. The Medicaid expansion will reduce the number of Montanans without health insurance from

20 percent to 16 percent of the civilian non-institutionalized population. Other advantages of expanding Medicaid include:

The donut-hole population would be more likely to have insurance. Perhaps the most vulnerable population if the state chooses not to expand Medicaid is the "donut-hole" population. The donut-hole population is Montanans whose incomes make them too rich for Medicaid (incomes more than 33 percent of the federal poverty level) and too poor for the federal tax credits and cost-sharing subsidies in the federally facilitated exchange (incomes less than 100 percent of the federal poverty level). In Montana, the donut-hole population is 19 percent of all Montana's uninsured, or 37,000 uninsured. Without the expansion of Medicaid, these uninsured may remain without health insurance even though the federally facilitated exchange exists.

Uncompensated care costs should be reduced. Since many of the uninsured will now have Medicaid-covered services, uncompensated care should be reduced. Uncompensated care arises when people don't have insurance and cannot afford to pay. Hospitals, community providers, and physicians all provide care to the uninsured, but hospitals provide 60 percent of the uncompensated care because medical needs requiring hospitalization are the most expensive. Community providers include the Veterans Health Administration, Indian Health Service, Community Health Centers, the National Health Service Corps, and others.

Uncompensated care in Montana's hospitals alone cost taxpayers nearly \$150 million in 2010, excluding all of the free and reduced care provided by Montana's community health centers, physicians, and other medical providers. This uncompensated care results in a cost shift to other health care

payers, primarily the privately insured. In 2011, Montana's 15 community health centers served more than 100,000 patients, 63 percent of whom had incomes below 100 percent of the federal poverty level, at a total cost of \$57 million. The uninsured accounted for half of all patients, and Medicaid patients accounted for 17 percent of the total. Almost \$29 million in federal, state, and local grants went to community health centers in Montana during 2011.

Community-based providers cover almost 42 percent of the uncompensated care provided by hospitals (Hadley, 2008). Office-based physicians provide 22 percent of that care. More than 70 percent of physicians provide some reduced-rate or free care. Applying these ratios to the uncompensated care provided by Montana hospitals, total uncompensated care in Montana could be reduced by nearly \$246 million if the uninsured had health insurance.

Uncompensated care is inefficient spending on health care. Research clearly shows that the uninsured are more likely to delay care and to have unmet health needs. The uninsured are more likely to be hospitalized for medical conditions that can be adequately treated on an outpatient basis instead of an inpatient basis (Kozak, 2001).

Health insurance would reduce mortality. Numerous studies have found that the uninsured are less likely to receive screening and diagnostic tests known to lead to the early detection of cancer, heart disease, and diabetes. Even among the uninsured who know they have hypertension or diabetes, the use of appropriate medications and routine follow-up care is lower than for the insured. Overall, the uninsured receive less preventive and diagnostic care and less therapeutic care even after being diagnosed and, as a result, die earlier and experience greater limitations than otherwise similar people with insurance.

In a *New England Journal of Medicine* article published in 2012, state Medicaid expansions to cover low-income adults were significantly associated with reduced mortality, improved coverage, greater access to care, and significant improvements in self-reported health of "excellent" or "very

good" (Sommers, 2012). The study's findings with respect to reduced mortality are consistent with the Institute of Medicine's estimate that health insurance may reduce adult mortality by 25 percent (Institute of Medicine, 2002).

Workforce would be more productive. Poor health among adults reduces labor force participation, productivity, and earnings. A person in poor health may earn 15-20 percent less than a person in good health. Poor health among family members also reduces the ability to work. Family caregivers work less and earn less. This lost time from work reduces productivity and contributions to the state economy.

Conclusion

Montana faces some tough choices in the very near future about Medicaid expansion. The advantages of providing health insurance to low-income adults must be weighed against the increased strain on state budgets, leaving more than half the states to remain undecided on the fate of the Medicaid expansion. □

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