Center for Health Economics and Policy
INSTITUTE FOR PUBLIC HEALTH AT WASHINGTON UNIVERSITY

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Chairman Hawkins and Members of the House Health and Human Services Committee:

Thank you for the opportunity to testify today as a neutral participant. My name is Dr. Timothy McBride, a Professor and Health Economist at Washington University in St. Louis and Co-Director of the Center for Health Economics and Policy. I am a member of the Rural Policy Research Institute (RUPRI) Rural Health Panel, which provides advice and briefings on rural health issues to the U.S. Congress and other policymakers and I serve as the Chair of the MOHealthNet Oversight committee for Missouri (providing oversight and advice on Medicaid).

I am here to share with you the research that's been done in many of the 31 states that have expanded their Medicaid programs. Because most states accepted expansion in 2014, we now have extensive information on the impact of expansion on coverage, state budgets, and state economies.

Key findings are that states Medicaid expansion contributes to:

- Enhanced economic activity and job growth.
- Increased gross domestic product.
- Increased revenues for health care providers.
- Significant reductions in uncompensated care.
- Net savings in state general funds (increased Medicaid spending more than offset by savings in other state budget items and enhanced revenues).

Medicaid expansion affects state budgets in a number of ways. While there are increased costs associated with the coverage of more people in the Medicaid program, these costs are nominal compared to the costs of coverage in the state's existing Medicaid program. First, the federal matching rate (federal medical assistance percentage, or FMAP) is much higher with expansion. The state of Kansas currently pays about 44% of the cost of Medicaid coverage. With expansion, states pay 5% this year, which gradually phases up to a maximum of 10% in 2020 and beyond (states paid nothing in 2014-2016).

Second, although 75% of people covered by the current Medicaid program are children and parents, the majority (63%) of the costs are incurred from coverage of the disabled and elderly. Medicaid expansion does cover some of the disabled population, but a far larger share than in the current program are relatively healthy adults. The cost of covering these new beneficiaries is less than the costs of covering existing Medicaid beneficiaries.

An expansion of Medicaid has produced savings and increased revenue in participating states. These savings and revenues fall into three major categories:

1. State savings from using new federal funds: States support programs and services for the uninsured, such as mental and behavioral health programs, public health programs, and inpatient health services for prisoners, with state general fund dollars. With expansion, states are able to use federal funds to pay for a much higher share of the spending for these beneficiaries because newly eligible recipients are covered using the higher federal matching rate, as compared to the current lower federal matching rate.

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2. State savings from enhanced federal match: Most states cover some high need individuals through waiver programs and specialized Medicaid eligibility categories. These programs categories include "medically needy" individuals, pregnant women, and the disabled. Kansas' standard federal match applies to these programs, so the state pays 44% of the cost. With expansion, most of these individuals would be eligible for full Medicaid coverage at the enhanced federal match, which never goes below 90%.

3. Revenue gains: Most states raise revenue through assessments and fees on providers and health plans. As provider and health plan revenue and coverage increase with expansion, the state will reap additional revenue through these fees, even if assessments are not raised from current levels. If assessments are increased, revenue increases further.

There are numerous examples of these savings and enhanced revenue that have already been experienced in states that have expanded Medicaid. A few are documented here (the sources included with this testimony contain details of state budget and economic analyses from a wide variety of expansion states):

- Arkansas saved $15.2 million, a decrease in spending of 50%, on coverage of pregnant women in SFY 2015, as women covered through expansion became pregnant and remained in this group. Arkansas projected $24.4 million in savings on this population in SFY 2016.

- Arkansas saved $17.1 million in SFY 2015 and projected savings of $45.4 million in SFY 2016 related to spending on disabled enrollees. Oregon has experienced an 80% drop in the number of individuals seeking disability determinations because they can qualify for Medicaid at a higher income level under expansion and have no need to go through the disability process.

- Colorado saved $136.6 million in CY 2014 and projected savings of $148.4 million in CY 2015 as adults and parents previously enrolled through Medicaid waivers transition to the new eligibility group.

- Kentucky saved $9 million in 6 months of SFY 2014 and projected $21 million in savings in SFY 2015 in state mental health spending.

- Michigan projected a reduction in state correctional spending of $19 million in SFY 2015, as the federal government picks up hospital inpatient costs for incarcerated individuals who are Medicaid-eligible through expansion. Colorado has budgeted savings of $5 million per year for this population.

- Arkansas reduced state spending on community health centers and local health units by $6.4 million in SFY 2015 without reducing services, because these facilities now receive Medicaid payments for services provided to previously uninsured patients who are eligible under expansion.

- New Mexico's premium tax revenues were $30 million greater in CY 2014 due to increased revenue related to the expansion population. The state projects continued revenue gains of $30 million per year.

Medicaid expansion also has significant positive effects on state economies. Enhanced coverage through expansion creates additional health care spending that circulates through local economies, creates jobs in health care and other sectors, and generates local and state tax revenue. For example, Colorado's economy supports more than 31,000 additional jobs due to Medicaid expansion, a total that is expected to grow to 43,000 by FY 2034-35, resulting in total employment that is 1.35% larger than it would be without expansion. Gross Domestic Product (GDP) in Colorado is $3.82 billion larger (1.14%) as a result of expansion, a figure that is projected to grow $8.53 billion in FY 2034-35. Average household earnings are higher as a result of Medicaid expansion. This economic growth, coupled with the types of savings and revenue discussed above, means that the state general fund in Colorado will not incur any expenses as a result of Medicaid expansion.

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Other states have seen similar positive effects. In Arkansas, Medicaid expansion resulted in more than $990 million in new spending and 7,000 new jobs in 2014. Real disposable personal income grew by approximately $245 million and Gross Domestic Product grew by approximately $511 million. Expansion will have a net positive impact of $637 million on the Arkansas state budget between 2017 and 2021. In Kentucky, expansion will add 40,000 jobs and $30 billion to the state's economy through 2021 and a net positive impact of nearly $820 million to state and local government budgets. In Michigan, more than 30,000 jobs have been created and the state costs of expansion will be fully covered through at least 2021. In New Mexico, expansion has created 4,800 jobs and an estimated net gain to the state's general fund of $316 million from 2014-2021.

In summary, despite comments to the contrary about how expensive Medicaid expansion will be for the states, data clearly show that it has a net positive impact on state economies and state budgets, actually reducing (not increasing) the state's share of the Medicaid budget. As a result, governors of both parties from expansion states are aggressively lobbying Congress to retain their expansion programs even as Congress debates a replacement for the Affordable Care Act.

Sources:

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