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State Lawmaker's Guide to Evaluating Medicaid Expansion Projections

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In its opinion on the Obamacare case, the Supreme Court found Congress exceeded its Constitutional authority by conditioning existing Medicaid funding on state adoption of the Medicaid expansion in Obamacare. The ruling effectively made the expansion optional.

Supporters of Obamacare, as well as some health care stakeholders—particularly hospitals and clinics—have since contended that states should voluntarily adopt Obamacare's Medicaid expansion. They claim that expanding Medicaid will entail little to no cost to state governments, since the federal government will fund the vast majority of the additional costs. Indeed, some analyses project states achieving savings from adopting the expansion. However, state lawmakers should be wary of accepting such analyses at face value.

This paper, in its entirety, can be found at **http://report.heritage.org/ib3720**

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Question the Assumptions. Setting aside that Obamacare's unnecessary and unaffordable Medicaid expansion will negatively affect their constituents as federal taxpayers; state lawmakers have other reasons to be wary of "free money" arguments. They should closely scrutinize the assumptions behind studies that project favorable state fiscal effects from expanding Medicaid, especially:

Projected Savings from Reduced State Spending on the Uninsured. Hospitals and clinics have proven adept at blocking or reversing cuts to state "supplemental" funding for treating the uninsured. For example, the 2006 Massachusetts health reform legislation, which transformed supplemental payments going to "safety net hospitals" into premium support for the low-income uninsured, achieved near-universal coverage. However, Massachusetts's safety-net hospitals have successfully lobbied to continue receiving over $200 million a year in supplemental payments from state taxpayers.[1]

Under Obamacare, it is even more implausible to assume state savings from cutting uncompensated care payments, since any state payment cuts would have to be imposed in addition to Obamacare's federal payment cuts. Obamacare cuts federal Medicaid "Disproportionate Share Hospital" (DSH) funding by $18.1 billion and Medicare DSH funding by $22.1 billion over the years 2014–2020.[2] Furthermore, the President's Fiscal Year 2013 budget proposed an additional $8.25 billion in Medicaid DSH cuts for 2021 and 2022.[3] Consequently, governors and state legislators should expect their state's hospitals and clinics to lobby them for more—not less—state funding to replace reduced federal supplemental payments.

Estimated Costs Due to the "Woodwork" Effect. The Obamacare exchanges will systematically identify and enroll millions of individuals in either Medicaid or subsidized exchanges. Even if a state does not expand Medicaid, it can expect enrollment and spending to increase in 2014 as a result of what Medicaid officials refer to as the "woodwork" effect: Individuals who qualify under current law for Medicaid, but are not enrolled, coming "out of the woodwork" to enroll. For those individuals, the normal federal Medicaid match rates will still apply.

Any state that adopts the Obamacare Medicaid expansion will

likely reinforce and exacerbate this effect. State lawmakers should probe whether the woodwork effect is fully accounted for in the analyses they are given.

Administrative Cost Estimates. Obamacare's "enhanced" federal match rates for the Medicaid expansion population (100 percent in the first three years; 90 percent in 2020 and thereafter) apply only to benefit spending. Medicaid's existing, separate administrative cost match rates will still apply to any additional administrative spending. Nationally, on average, administrative expenses add 5.5 percent on top of total (federal and state) benefit costs, with states paying about 45 percent of those costs.[4] Thus, every $100 of new Medicaid benefit spending generates about $5.50 in additional administrative costs, of which states pay around $2.48.

States will still have to pay their share of the added administrative costs even during the initial three years of the expansion, when the federal government funds all benefit costs. State lawmakers should ensure the additional administrative costs their state would incur from expanding Medicaid are included in any analysis of state fiscal effects.

Cost to States for Covering Individuals Who Would Otherwise Be Eligible for Exchange Subsidies. The Obamacare Medicaid expansion will enroll all individuals with incomes below 138 percent of the Federal Poverty Level (FPL). If a state does not adopt the expansion, then individuals with incomes at or above 100 percent of FPL will instead qualify for the new federal exchange subsidies. This applies to not only new enrollees that would otherwise be added to the Medicaid rolls by the expansion, but also to existing enrollees with incomes at or above 100 percent of FPL.

Thus, a state adopting the expansion will not only incur Medicaid costs for a portion of the expansion population that would otherwise receive subsidized exchange coverage (at no cost to the state), it will also be unable to reduce state Medicaid costs by shifting current enrollees with incomes between 100 and 138 percent of FPL into the exchanges. State lawmakers should check that any fiscal projections accurately account for these alternative coverage scenarios.

Projected Increases in State Tax Revenue. In theory, new federal spending from the Obamacare Medicaid expansion will be income to someone (e.g., various health care providers) who will then pay state taxes on that income. Economists calculate such effects by applying what is called an "economic multiplier" to the new spending.

If an analysis uses a multiplier of 1, then the study's author is assuming that every dollar of new spending will generate a dollar of new taxable income. Some believe new government spending produces a multiplier greater than 1, as the recipients in turn spend some of that additional income, generating more economic activity. Others point out that the taxes to pay for the new government spending reduce economic activity, meaning the multiplier should be reduced to reflect that offsetting economic "drag."

Government spending multipliers are highly uncertain. A recent survey of the economic literature found multipliers ranging from 0.5 to 2.0, but concluded that justification was strongest for multipliers of between 0.8 and 1.2.[5]

State lawmakers should question the appropriateness of any economic multiplier assumed in a fiscal analysis. It is highly unlikely that all of the additional federal Medicaid spending will translate into new taxable income or spending within the state. For example, federal Medicaid funds paid to out-of-state providers will not be subject to the state's income tax. Similarly, if some of the additional income is spent outside the state, it will not generate in-state sales or excise tax revenue. Furthermore, any additional state spending associated with the expansion will come from increased taxation, creating an economic "drag."

Uncertainty of Future Federal Medicaid Match Rates. Although Obamacare stipulates the federal government will pay at least 90

1. For more information, including state-level data tables, see U.S. Government Accountability Office, *Medicaid: States Reported Billions More in Supplemental Payments in Recent Years,* GAO-12-694, July 2012.
2. Congressional Budget Office, "Selected CBO Publications Related to Health Care Legislation, 2009–2010," December 2010.
3. U.S. Office of Management and Budget, *Fiscal Year 2013: Cuts, Consolidations, and Savings, Budget of the U.S. Government* (Washington, DC: U.S. Government Printing Office, 2012), p. 169, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/ccs.pdf (accessed August 30, 2012).
4. April Grady, "State Medicaid Program Administration: A Brief Overview," Congressional Research Service, *Report for Congress,* updated May 14, 2008.
5. Valerie Ramey, "Government Spending and Private Activity," National Bureau of Economic Research, January 2012, http://www.nber.org/papers/w17787 (accessed August 29, 2012).

percent of the benefit costs of the Medicaid expansion, state lawmakers have no guarantee future Congresses will keep that promise. Indeed, the Obama Administration has already foreshadowed that possibility in the President's FY2013 budget by proposing to combine the various existing and new Medicaid and Children's Health Insurance Program (CHIP) match rates (including those in Obamacare, which have not taken effect), into a single "blended" match rate for each state.[6] Depending on how a "blended" rate is calculated, the change could result in significant shifts in program costs from the federal government to states.[7]

Skepticism is Key. There is an old adage that if something seems too good to be true, it probably is. When it comes to studies purporting to show positive state fiscal effects from adopting Obamacare's Medicaid expansion, state lawmakers should keep that folk wisdom in mind. They should closely scrutinize the assumptions behind the numbers and decide for themselves whether those assumptions, and the estimates produced using them, are in fact realistic.

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6. U.S. Office of Management and Budget, "Fiscal Year 2013: Cuts, Consolidations, and Savings," p. 169.
7. Drew Gonshorowski, "Medicaid Expansion Will Become More Costly to States," Heritage Foundation *Issue Brief* No. 3709, August 30, 2012, http://www.heritage.org/research/reports/2012/08/medicaid-expansion-will-become-more-costly-to-states (accessed September 7, 2012).