ACA Implementation—Monitoring and Tracking

The Launch of the Affordable Care Act in Selected States: The Financial Impact

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John Holahan
The Urban Institute

Robert Wood Johnson Foundation

Urban Institute

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. Cross-cutting reports and state-specific reports on case study states can be found at **www.rwjf.org** and **www.healthpolicycenter.org.** The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

INTRODUCTION

This brief is one in a series examining what selected states are likely to accomplish in terms of implementing the Affordable Care Act (ACA): expanding health insurance coverage; providing outreach, education, and enrollment assistance; increasing competition in individual and small group insurance markets; reforming insurance market rules; and addressing issues related to provider supply constraints. In this series, we compare eight states: five that have chosen to aggressively participate in all aspects of the ACA (Colorado, Maryland, Minnesota, New York, and Oregon) and three that have taken only a limited or no participation approach (Alabama, Michigan, and Virginia). The focus of this brief is the financial implications of reform for these states and how the ACA will affect state residents and economies.

The study states were chosen from among those participating in a multiyear project funded by the Robert Wood Johnson Foundation (RWJF). The project provides to states in-kind technical support to assist them with implementing the reform components each state has chosen to pursue; the project also provides funds for qualitative and quantitative research to monitor and track ACA implementation at the state and national levels. RWJF selected these states based on their governments' interest in exploring the options related to state involvement in ACA implementation. Some states pursued implementation aggressively, but in others varying degrees of political opposition to the law lessened their involvement. The result is that the variation in state commitment to health reform among the RWJF states reflects the same variation seen nationally.

The first set of states has been actively pro-reform. They have adopted several Medicaid expansions in years preceding the ACA and have also adopted important insurance reforms. They were quick to adopt the ACA, including engaging stakeholders and investing in consumer outreach and education. Very early in the process, they contracted with information technology vendors to develop eligibility and enrollment systems, though not all of them have seen a smooth rollout of their websites. These states have created State-Based Marketplaces (SBMs) and have adopted the optional Medicaid expansion.

In the second set of states, there has been strong opposition to ACA implementation, at least in some quarters. Relative to the first set of states, these states have historically had lower rates of employer-sponsored coverage and higher uninsurance rates. Because of their current circumstances, they have more to gain from health reform than do the other five states. All three rely on the federal government to develop and run their Marketplaces—Federally Facilitated Marketplaces (FFMs)—although Michigan and Virginia have taken on the Marketplace responsibilities associated with plan management. Two of the three—Alabama and Virginia—have not adopted the Medicaid expansion. All rely on the

federal website; however, even as these problems are resolved, these states will still have fewer resources to devote to outreach, education, and enrollment assistance.

FINANCIAL IMPLICATIONS FOR STATE OF THE ACA

Because of the 2012 Supreme Court decision, the Medicaid expansion is now an option for states. Six of the eight states, including all the SBM states, have chosen to expand Medicaid. Alabama and Virginia have chosen not to expand Medicaid at this time. States that have chosen to expand Medicaid under the ACA will benefit from a large amount of new federal revenues. The new eligibles in expansion states have a 100 percent federal match (eventually phasing down to 90 percent in 2020). All states—even those that do not expand Medicaid—will receive pre-ACA federal matching dollars for those eligible under previous rules and an increase of 23 percentage points in the state's federal matching rate for the Children's Health Insurance Program (CHIP). In addition to the new federal matching funds for Medicaid, which make up most of the new revenues, federal dollars are provided for premium and cost-sharing subsidies for those in the 138 percent of the federal poverty level (FPL) to 400 percent of FPL income range who enroll in Health Insurance Marketplace plans.

States that expand Medicaid also benefit if they have state-financed programs that already provide insurance or medical services to individuals who will be newly eligible for Medicaid, as those state-financed programs can be eliminated or scaled back substantially. Also, states that had already covered childless adults with incomes up to 100 percent of FPL through a Medicaid waiver program receive a higher "enhanced" federal matching rate that begins at 75 percent in 2014 and increases to 90 percent in 2020 and beyond.

States that are adopting the Medicaid expansion will have new expenditure obligations, ones that will increase as the federal matching rates for newly eligible populations decline modestly between 2016 and 2020. However, they will experience offsetting savings in other areas. States will no longer need to fund as much uncompensated care through disproportionate share hospital (DSH) funds, or payments to hospitals and clinics, or support state indigent care programs as a result of falling numbers of uninsured residents. Some groups with incomes above 138 percent of FPL (e.g., pregnant women, medically needy, currently enrolled in Medicaid programs that are jointly financed between the state and the federal government) could be enrolled in the new Marketplace plans, subsidies for which are completely federally financed. Specific services delivered to the low-income population and paid for through state budgets will be covered through Medicaid and Marketplace-based coverage starting in 2014; they include mental health, substance abuse, and some public health services.

States rejecting the expansion will have some new enrollment among those already eligible under pre-ACA rules because of "welcome mat" policies that will guide Medicaid eligibles to enrollment assistance when they contact the new Marketplaces for coverage. In addition, various outreach and enrollment strategies in the ACA should encourage higher rates of participation. However, since outreach and enrollment activities will not be as robust in the states with FFMs, the "welcome mat" effects could be lower than in states with SBMs. The non-expanding states will benefit from increases in the CHIP match but not from the very high federal match on those people who can be made newly eligible under the ACA's rules; these states will have to continue to support uncompensated care through DSH payments and other aid given to hospitals and clinics. Nor will they have the ability to replace state funding with federal funding by allowing Medicaid to absorb substantial costs of care currently financed by state dollars.

For all states, some federal subsidies will support exchange populations. These include both subsidies that reduce the cost of premiums to those with incomes between 138 percent and 400 percent of FPL, and cost-sharing subsidies for those with incomes between 138 percent and 250 percent of FPL.

All states will reap economic benefits from the federal subsidies. Those that expand Medicaid will also benefit from the effects of the increase in federal expenditures on their economies—meaning more employment and higher tax revenues. These effects are, in general, offset by reductions in Medicare provider payment rates,

reductions in Medicaid and Medicare DSH payments, and various new taxes. To the extent these payment reductions or new taxes are distributed differently across the nation, there will be small positive or negative effects on overall economic growth. But positive offsetting revenue flows occur only in states that expand Medicaid. States and their residents will feel the impact of reductions in Medicare and Medicaid spending, together with increased taxes, regardless of whether they adopted the Medicaid expansion. Only if they adopt the Medicaid expansion can they offset the payment reductions with new revenues.

RESULTS

The states that are expanding Medicaid will see significant increases in federal fund inflows, primarily because they have adopted the Medicaid expansion (Tables 1 and 2). Colorado and Oregon will see increases in federal payments of 41.5 percent and 43.3 percent, respectively, relative to their baselines in 2016, and by 36.7 percent and 38.4 percent, respectively, over the 2013–22 period. These large increases reflect the fairly large coverage expansions in these states (see previous section). Maryland will have a 27.9 percent increase in federal payments over its baseline in 2016 and a 24.3 percent increase over the 2013–22 period. This percentage increase is lower than those in Colorado and Oregon because of the broader current Medicaid program in Maryland—particularly through its Primary Adult Care program that has provided outpatient services under Medicaid. The higher federal matching rate paid under the ACA for these previous enrollees provides savings to the state, but the relative change is not as great as for states that had done less for these populations pre-ACA.

Minnesota has even broader current coverage that will lead to state savings as these enrollees are brought into Medicaid as new eligibles. Because the state now receives federal matching payments for many of these individuals, Minnesota's expected increase in federal spending is only 10.8 percent in 2016 and 9.6 percent between 2013 and 2022, relative to the case with no reform. New York will see increased federal spending of $3.9 billion in 2016, or 13.1 percent above its no-reform scenario, and about $27.4 billion, or 9.0 percent, over the 2013–22 period. The coverage expansion in New York is relatively small due to its previous coverage expansions, but the state will receive substantial new revenue from the enhanced match on its expenditures for previously covered childless adults. Because Michigan adopted the Medicaid expansion, federal payments to the state will increase by 27.1 percent in 2016 and 24.3 percent over the 2013–22 period, relative to the baseline.

Three of the states that are expanding Medicaid—Oregon, Colorado, and Minnesota—will face relatively small net increases in state expenditures on Medicaid/CHIP under the ACA, even though federal dollars will increase significantly in each state. State expenditures will increase due to increased enrollment among current eligibles owing to broader outreach and enrollment efforts, and because the states will eventually contribute 10 percent to the costs of Medicaid enrollees made newly eligible under the ACA. Over the 2013–22 period, Colorado will see an increase in state Medicaid/CHIP expenditures relative to the no-reform case in the amount of $1.5 billion, or 5.0 percent, while Oregon will have increased state Medicaid/CHIP expenditures of $803 million, or 3.8 percent. State spending in Minnesota will increase by $1.9 billion, or 2.7 percent, and in Michigan by $4.0 billion, or 7.8 percent.

However, Maryland and New York will experience a decrease in state spending on these programs. Maryland will see savings of $504 million over the 2013–22 period because of a higher federal matching rate for those currently enrolled in its primary care program. The higher match leads to a very large reduction in the state's spending on this population, which more than makes up for increased spending on new eligibles. New York will see savings of $23.0 billion over this period, a 7.7 percent reduction over pre-reform Medicaid expenditures. Again, this is due to the higher federal matching rate the state will receive for childless adults whom the state already covers. Because the newly eligible population in New York is very small due to the state's prior efforts to expand coverage, the savings on the previously eligible individuals because of the "enhanced matching rates" more than offsets spending on new populations.

Each of these states will see reductions in their spending on uncompensated care as the number of uninsured falls. On average, state and local governments pay for about one-third of the costs associated with uncompensated care.[1,2] We assume that states will save one-third of their share of decreased uncompensated care costs associated with declines in the uninsured, presuming that the political difficulty associated with greater reductions of payments to providers would limit potential savings.

Table 1: Increase in Federal and State Medicaid Expenditures Due to the Affordable Care Act, 2016 (in millions)

State	Baseline	ACA		Change		% Change	
	Without ACA	Without Expansion	With Expansion	Without Expansion	With Expansion	Without Expansion	With Expansion
States Expanding Medicaid							
Colorado							
Federal	$2,821		$3,991		$1,170		41.5%
State	$2,654		$2,724		$70		2.6%
Maryland							
Federal	$4,948		$6,328		$1,380		27.9%
State	$4,779		$4,629		-$150		-3.1%
Michigan							
Federal	$9,371		$11,911		$2,540		27.1%
State	$4,597		$4,837		$240		5.2%
Minnesota							
Federal	$6,557		$7,267		$710		10.8%
State	$6,345		$6,495		$150		2.4%
New York							
Federal	$30,071		$34,011		$3,940		13.1%
State	$29,195		$26,677		-$2,518		-8.6%
Oregon							
Federal	$3,421		$4,901		$1,480		43.3%
State	$1,897		$1,877		-$20		-1.1%
States Not Expanding Medicaid							
Alabama							
Federal	$4,687	$4,787	$6,237	$100	$1,550	2.1%	33.1%
State	$2,043	$2,063	$2,073	$20	$30	1.0%	1.5%
Virginia							
Federal	$4,652	$4,821	$6,302	$169	$1,650	3.6%	35.5%
State	$4,456	$4,574	$4,606	$118	$150	2.6%	3.4%

Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.[4]

Based on these data/assumptions, we estimate that savings on uncompensated care spending between 2013 and 2022 will amount to $277 billion in Colorado, $178 billion in Maryland, $351 billion in Michigan, $49 billion in Minnesota, $426 billion in New York, and $280 billion in Oregon.[3] There are other offsetting expenditures, mentioned above, that states have experienced, but we do not have reliable estimates for them.

Tables 1 and 2 also show the effects of the ACA's Medicaid expansion in states that did not expand. For those states that did not adopt the Medicaid expansion, increases in federal payments are relatively small. Relative to the baseline, federal payments increase by 2.1 percent in Alabama and 3.6 percent in Virginia in 2016 (1.9 percent and 3.3 percent, respectively, over the 2013–22 period). State expenditures will increase modestly because these states will bear the cost of enrolling additional currently eligible Medicaid beneficiaries at their existing matching rates. Thus, state expenditures in Alabama increase by 1.0 percent and in Virginia by 2.6 percent in 2016 (0.9 percent and 2.6 percent between 2013 and 2022).

Tables 1 and 2 also show the amount of revenue forgone in Alabama and Virginia from declining to expand Medicaid. In return for a small increase in state expenditures, a large amount of federal dollars would come to each state. Alabama would have received $15.4 billion and Virginia $16.4 billion in federal funds between

Table 2: Increase in Federal and State Medicaid Expenditures Due to the Affordable Care Act, 2013–22 (in millions)

State	Baseline	ACA		Change		% Change	
	Without ACA	Without Expansion	With Expansion	Without Expansion	With Expansion	Without Expansion	With Expansion
States Expanding Medicaid							
Colorado							
Federal	$31,518		$43,086		$11,568		36.7%
State	$29,658		$31,154		$1,496		5.0%
Maryland							
Federal	$55,564		$69,064		$13,500		24.3%
State	$53,690		$53,187		-$504		-0.9%
Michigan							
Federal	$105,103		$130,659		$25,556		24.3%
State	$51,557		$55,583		$4,026		7.8%
Minnesota							
Federal	$73,633		$80,688		$7,055		9.6%
State	$71,324		$73,255		$1,931		2.7%
New York							
Federal	$305,783		$333,226		$27,443		9.0%
State	$296,882		$273,875		-$23,007		-7.7%
Oregon							
Federal	$38,320		$53,027		$14,707		38.4%
State	$21,284		$22,087		$803		3.8%
States Not Expanding Medicaid							
Alabama							
Federal	$52,137	$53,150	$67,521	$1,013	$15,384	1.9%	29.5%
State	$22,791	$22,990	$24,071	$199	$1,280	0.9%	5.6%
Virginia							
Federal	$52,220	$53,969	$68,633	$1,749	$16,413	3.3%	31.4%
State	$50,066	$51,356	$52,682	$1,290	$2,616	2.6%	5.2%

Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.[4]

2013 and 2022, if they had adopted the expansion—amounts far more than those they are currently set to receive. These forgone increases in federal payments amount to a 29.5 percent increase over baseline in Alabama and a 31.4 percent increase over baseline in Virginia. The state share of payments for new Medicaid eligibles would have increased expenditures by 5.6 percent in Alabama and 5.2 percent in Virginia between 2013 and 2022, compared with the situation with no ACA implementation.

As already noted, federal subsidies will flow into all these states. Because the subsidies do not depend on state decisions, the dollar flows should not vary across SBM and FFM states (though amount of the subsidies could be affected by lower outreach and enrollment efforts, and slower rollout of the federal IT system). Estimates are shown in Table 3. The levels of subsidies are highest, by far, in New York ($2.4 billion in 2016) because of the large size of its subsidized population. Colorado, Maryland, Minnesota, and Oregon will see subsidies of $1.0 billion, $656 million, $615 million, and $865 million, respectively, in 2016. Alabama, Michigan, and Virginia would receive $703 million, $1.7 billion, and $1.2 billion, respectively, in federal payments in 2016—assuming fully functional Marketplaces with effective outreach and enrollment processes. Except in Alabama and Virginia, the federal payments from the Medicaid expansion exceed the subsidy dollars by a considerable amount. The federal subsidies are distributed among these states consistent with the income distribution of expected eligible enrollees and the level of state premiums for the second-

Table 3: Federal Subsidies in Selected States, 2016 (in millions)

State	Premium Subsidies	Cost-Sharing Subsidies	Total Subsidies
SBM States			
Colorado	$971	$42	$1,013
Maryland	$594	$62	$656
Minnesota	$548	$67	$615
New York	$2,160	$263	$2,423
Oregon	$777	$88	$865
FFM States			
Alabama	$638	$65	$703
Michigan	$1,591	$120	$1,711
Virginia	$1,044	$121	$1,165

Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.

lowest-cost silver plan. Areas with more insurance competition or lower medical costs tend to have lower premiums, which reduce federal subsidy spending and, consequently, reduce the size of federal inflows to the state.

As mentioned above, the various taxes and provider-payment reductions will occur even with the expansion. Thus, states not adopting the Medicaid expansion will bear all of the pain but receive none of the increased revenue that would have come through the expansion. In addition, the various offsets—such as reductions in state's share of DSH payments and reductions in current budget allocations for mental health, substance abuse, and public health—will not occur because these states did not adopt the Medicaid expansion. Virginia, for example, conducted a detailed analysis of various sources of savings and showed that new state expenditures under a Medicaid expansion would be largely offset by savings on other programs.[5]

It is ironic that Alabama and Virginia conducted detailed analyses of the macroeconomic effects of the Medicaid expansion and found strong positive effects resulting from it. A study conducted by the University of Alabama at Birmingham determined that between 2014 and 2020, there would be $19.8 billion in increased state GDP and an increase in state general revenue of $1.7 billion if the state expanded Medicaid.[6] In Virginia, a study by Chmura Economics and Analytics found that under the Medicaid expansion, the annual average increase in state gross domestic product between 2014 and 2019 would be $3.0 billion, the average increase in employment would be 23.9 thousand, and additional state general revenue would be $29.9 million.[7]

CONCLUSION

This brief has examined the changes in federal and state expenditures from the ACA. We assume all initial problems with the launch of health reform are resolved, and present data on our projected full implementation scenario for 2016. All states will benefit from Marketplace subsidies; how much depends on premiums and income distribution. States that expand will receive significantly larger inflows of federal dollars than those that do not. The Medicaid expansion, with the very high federal matching rates for new eligibles, will bring large amounts of federal dollars into states. These will have positive effects on state economies, significantly offsetting the adverse impacts of Medicare provider payment cuts and Medicaid and Medicare DSH payment cuts. States like Alabama and Virginia that have not adopted the Medicaid expansion are giving up a large amount of federal dollars. Because the cuts in Medicare provider payment rates and Medicaid and Medicare DSH payments will happen regardless of whether the states expand coverage, these states will receive all of the pain and none of the gain from the expansion.

ENDNOTES

1. Hadley, J., J. Holahan , T. Coughlin, and D. Miller. "Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2008.
2. Hadley, J., J. Holahan , T. Coughlin, and D. Miller. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs* 27(5): w399–w415.
3. Holahan, J., M. Buettgens, and S. Dorn. *The Cost of Not Expanding Medicaid*. Washington, DC: The Urban Institute. 2013.
4. These estimates could understate or overstate the effects by state because they were based on a model first employed in 2011. At that time we used the most recent Medicaid Statistical Information System (MSIS) data available on Medicaid enrollment and expenditures – 2007. We inflated 2007 data to hit estimates of Medicaid expenditures by eligibility group for 2013 that we derived from published Congressional Budget Office (CBO) results. For subsequent years, we project all states to increase to be consistent with CBO projections; this method yields baseline enrollment and expenditures for each state. We then used HIPSM to simulate new enrollment both among current and new eligibles and used HIPSM estimates to calculate spending per person. The baseline projections in Tables 1 and 2 can be somewhat high or low in individual states, depending on whether the states have grown faster or slower than projections between 2007 and 2013. This does not affect the estimates of increases or decreases in spending because of the ACA which depend largely on coverage changes. A full description of HIPSM can be found at: http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf.
5. Dorn, S., J. Holahan, C. Carroll and M. McGrath. "Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs." Washington: DC: The Urban Institute. 2013
6. Becker, D. J., and M. A. Morrisey. "An Economic Evaluation of Medicaid Expansion in Alabama under the Affordable Care Act." Department of Health Care Organization and Policy. School of Public Health. University of Alabama at Birmingham. 2012.
7. Chmura Economics and Analytics. *The Economic Impact of the Medicaid Expansion on Virginia's Economy*. Prepared for the Virginia Hospital & Healthcare Association. 2012.

About the Authors and Acknowledgements

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