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Medicaid Expansion Producing State Savings and Connecting Vulnerable Groups to Care

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Health reform's Medicaid expansion has produced net budget savings for many states, new data show, and states such as Arkansas, Kentucky, Louisiana, and New Jersey expect continued net savings in coming years, even after they begin paying a modest part of the expansion's cost. In part, this is because the expansion has lessened the burden on a patchwork of largely state-funded programs that connect people who are experiencing homelessness, have substance use disorders, or have other serious needs with critical health care services.

Medicaid expansion is a good deal for states financially, as the federal government pays the entire cost of covering the new Medicaid enrollees through this year and no less than 90 percent of the cost thereafter. In expansion states there is now less demand for targeted Medicaid programs that serve low-income people with specific health conditions (such as certain women with breast and cervical cancers) but are funded at the state's regular, lower matching rate, and for health programs that are entirely state-funded such as mental and behavioral health programs. Expansion states also are collecting more revenue from their existing taxes on health plans and providers, such as the managed care plans that serve Medicaid beneficiaries in many states, which have experienced a surge in enrollment due to expansion. The combination of these factors has produced savings for many state budgets.

But Medicaid expansion is about more than the impact on state budgets. It also gives states an opportunity to provide needed care to uninsured people whose health conditions have been a barrier to employment. And for those leaving the criminal justice system, particularly those with mental illness or substance use disorders, access to care can reduce recidivism. Connecting these vulnerable populations with needed care can improve health, stabilize housing, and support employment.

State Savings Projected to Continue

The nation has experienced historically large gains in health coverage since health reform's major coverage provisions took effect in 2014, and those gains have been the greatest in the states that

have expanded Medicaid.[1] Medicaid expansion has also produced net budget savings in a diverse group of states such as California, Colorado, Michigan, Oregon, Pennsylvania, and West Virginia.[2]

Critics claim that these savings will be fleeting. Because enrollment has been robust, they argue, expansion will place a burden on state budgets once states must pay part of the cost of covering the newly eligible, starting next year. But four states' projections of the longer-term budgetary impact of expansion suggest this will not necessarily be the case:

- **Arkansas.** The state's "private option" Medicaid expansion will produce net state savings at least through fiscal year 2021, a consultant's report prepared for Governor Asa Hutchinson projects.[3] These savings come from lower payments to hospitals for uncompensated care, lower Medicaid costs for groups that had Medicaid before health reform but were shifted into the new expansion group (with its higher federal matching rate), and higher premium tax revenue due to higher enrollment in the health plans serving the expansion population.
- **Kentucky.** The expansion will save Kentucky money at least through fiscal year 2021, according to a state-commissioned report.[4] These savings reflect lower state spending on behavioral health programs, lower payments to hospitals for uncompensated care, and higher tax revenue.
- **Louisiana.** The expansion will take effect in Louisiana on July 1. Even though the 100 percent federal match for covering new enrollees will only be available for six months, the state projects that expansion will save $677 million over the next five years.[5] These savings will come partly from lower payments to hospitals for uncompensated care and from higher revenue from the state's tax on Medicaid managed care plans.
- **New Jersey.** The expansion will produce net savings of $353 million this fiscal year and $355 million next year, New Jersey estimates.[6] These savings reflect lower payments to hospitals for uncompensated care, higher revenue from the state's tax on health plans serving Medicaid beneficiaries, and lower Medicaid costs for groups covered under a pre-health reform waiver that were shifted into the new expansion group.

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[1] An Urban Institute survey found that the uninsurance rate among adults aged 18 to 64 in expansion states dropped from 15.8 percent to 7.3 percent between September 2013 and March 2016, as compared to a drop from 20.6 percent to 14.1 percent in non-expansion states. Michael Karpman, Sharon K. Long, and Stephen Zuckerman, "Health Insurance Coverage under the ACA as of March 2016," Health Reform Monitoring Survey, Urban Institute, May 25, 2016, http://hrms.urban.org/briefs/health-insurance-coverage-ACA-March-2016.html.

[2] See, for example, Jesse Cross-Call, "Medicaid Expansion Is Producing Large Gains in Health Coverage and Saving States Money," Center on Budget and Policy Priorities, April 28, 2015, http://www.cbpp.org/research/health/medicaid-expansion-is-producing-large-gains-in-health-coverage-and-saving-states; and Deborah Bachrach *et al.,* "States Expanding Medicaid See Significant Budget Savings and Revenue Gains," State Health Reform Assistance Network, Robert Wood Johnson Foundation, March 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.

[3] The Stephens Group, "The Stephens Group Status Report #3," August 19, 2015, http://posting.arktimes.com/media/pdf/final_august_status_report_sent_to_phil_8-17-19_239.pdf.

[4] Deloitte Consulting, "Commonwealth of Kentucky Medicaid Expansion Report," February 2015.

[5] Kevin Litten, "Medicaid expansion to save Louisiana $677 million over next 5 years," *Times-Picayune* (New Orleans), April 18, 2016, http://www.nola.com/politics/index.ssf/2016/04/john_bel_edwards_medicaid_1.html.

[6] New Jersey Department of Human Services FY 2016-2017, "Discussion Points," http://www.njleg.state.nj.us/legislativepub/budget_2017/DHS_response.pdf.

In each of these states, the projected net savings take into account the costs of expansion, such as state matching costs that begin next year, higher administrative costs, and higher enrollment among people eligible for Medicaid under pre-health reform eligibility rules (who are covered at the regular federal Medicaid matching rate).

Connecting Vulnerable Populations With Needed Care

The Medicaid expansion does more than save states money; it also enables them to help vulnerable populations get needed care and achieve better health outcomes.

Before health reform, only one-fifth of low-income workers had coverage through their employer, and coverage in the individual insurance market was prohibitively expensive for most people, assuming they could obtain coverage at all.[7] Medicaid coverage was not an option for many poor adults; the typical state cut off Medicaid eligibility at 61 percent of the poverty line for working parents and at 37 percent of poverty for parents who were not employed. Moreover, except in a handful of states with federal waivers, non-elderly adults without children could not qualify for Medicaid at all, irrespective of income. By raising eligibility for non-elderly adults up to 138 percent of the poverty line (about $16,400 for an individual and $27,800 for a family of three in 2016), health reform's Medicaid expansion makes coverage available to a group that was largely denied coverage options available to other Americans.

Critics warned that new enrollees would swamp emergency rooms for basic health care and, by getting this care in the costliest setting, drive up states' overall health costs. Yet data from the expansion's first few years show this is not the case; newly eligible enrollees are seeing primary care doctors and obtaining a variety of preventive services. For example, tens of thousands of new enrollees in Kentucky have received cholesterol, diabetes, and cancer screenings and preventive dental services.[8] Similarly, a survey of low-income non-elderly adults in three states found that the share of residents with a primary care physician rose by 8 percentage points *more* in the expansion states (Arkansas and Kentucky) than in the non-expansion state (Texas).[9]

The Medicaid expansion holds particular promise for people with mental health and substance use disorders. Typically, these individuals lack a consistent source of health coverage, instead receiving a patchwork of services through state and local behavioral health programs with limited capacity to meet the demand for care. As a result, they often cannot access basic care such as screenings, assessments, behavioral health treatment, and prescription drugs, which in turn makes it more difficult to manage their conditions.

States are using the Medicaid expansion to better target care to the following populations:

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[7] "If Low-Income Adults Are to Gain Health Coverage, States Must Expand Medicaid," Center on Budget and Policy Priorities, March 13, 2013, http://www.cbpp.org/sites/default/files/atoms/files/Fact-Sheet-Medicaid-Expansion-and-Able-Bodied-Adults.pdf.

[8] Deloitte Consulting, *op cit*.

[9] Benjamin Sommers, Robert Blendon, and E. John Orav, "Both The 'Private Option' And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults," *Health Affairs*, January 2016, http://content.healthaffairs.org/content/35/1/96.abstract.

- **People with behavioral health conditions.** An estimated 20 percent of non-elderly adults had a mental illness in the past year, and 10 percent had a substance use disorder.[10] These conditions are more prevalent among people with low incomes and often go untreated in people who are uninsured. For example, a low-income person with a serious mental illness is 30 percent more likely to get treatment if enrolled in Medicaid than otherwise.[11]

  This population has been left behind in states that have not expanded Medicaid; 1.9 million low-income people with a mental health or substance use disorder remain uninsured because their state has not expanded.[12] States that *have* expanded are saving money in their behavioral health programs because federal dollars are paying for a greater share of services. For example, Michigan saved $190 million in fiscal year 2015 after enrollees in a state-funded program providing services to people with mental illnesses were transitioned into Medicaid. Kentucky saved $30 million in its state mental and behavioral health programs in the first 18 months of expansion.[13] Importantly, states can reinvest some or all of these savings to bolster their state-run programs.

- **People experiencing homelessness.** Individuals experiencing homelessness often suffer from serious physical and mental health conditions such as a substance use disorder, depression, or schizophrenia. Before health reform, individuals experiencing homelessness obtained care from a variety of sources, including state and local health programs. While some states provided Medicaid coverage to some low-income adults, three-quarters of homeless adults eligible for coverage were not enrolled.[14]

  A study examining Health Care for the Homeless projects around the country found that in 2014, coverage among their patients rose 22 percentage points in expansion states (from 45 percent to 67 percent) but just 4 percentage points in non-expansion states (from 26 percent to 30 percent).[15] Providing health coverage to the homeless likely results in better access to care, as well as better financial stability for the clinics and providers serving this vulnerable population.

  The Medicaid expansion is also a critical piece of supportive housing efforts, which pair affordable housing with coordinated services that better equip people to maintain a stable home. States can offer, through Medicaid, personal care services in homes, intensive case management, and help searching for housing and working with landlords if these services help

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[10] Judith Dey *et al.,* "Benefits of Medicaid Expansion for Behavioral Health," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 28, 2016, https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf.

[11] Beth Han *et al.,* "Medicaid Expansion Under the Affordable Care Act: Potential Changes in Receipt of Mental Health Treatment Among Low-Income Nonelderly Adults With Serious Mental Illness," *American Journal of Public Health*, October 2015, http://www.ncbi.nlm.nih.gov/pubmed/25790424.

[12] Dey *et al., op cit.*

[13] Bachrach *et al., op cit.*

[14] Jack Tsai *et al.,* "Medicaid Expansion: Chronically Homeless Adults Will Need Targeted Enrollment And Access To A Broad Range of Services," *Health Affairs*, September 2013, http://content.healthaffairs.org/content/32/9/1552.full.pdf+html.

[15] Matt Warfield, Barbara DiPietro, and Samantha Artiga, "How has the ACA Medicaid Expansion Affected Providers Serving the Homeless Population: Analysis of Coverage, Revenues, and Costs," Kaiser Family Foundation, March 2016, http://files.kff.org/attachment/issue-brief-how-has-the-aca-medicaid-expansion-affected-providers-serving-the-homeless-population.

recipients maintain their health and keep them out of more expensive institutional care. Yet many states do not use this flexibility. And by boosting Medicaid's role in supportive housing, states can reinvest potential savings in such areas as providing rental assistance to more people in need of it.[16]

- **Incarcerated individuals.** People in prisons or jails are more likely to have serious health care needs, such as HIV/AIDS, mental or behavioral health issues, or a substance use disorder. Under federal law, the only services Medicaid will cover when someone is incarcerated are those provided during an inpatient stay at a hospital. For this reason, many states terminate Medicaid eligibility when people become incarcerated, with the result that people are uninsured when they leave prison or jail.

  Various states are now taking either or both of two approaches to help ensure that people have access to health care upon their release. Indiana and New Mexico have recognized that suspending (rather than terminating) Medicaid coverage, which allows the state to resume Medicaid coverage on the day people leave prison or jail, makes it easier for them to get care when released and will likely produce state savings down the road. Arizona and Washington, among other states, allow people to apply for Medicaid coverage before their release so that coverage can begin immediately upon release.[17] People with health coverage when they are released are more likely to receive care for complex medical conditions, which lowers their chances of recidivism — thereby reducing corrections spending — and increases their chances of gaining and maintaining employment.

Conclusion

States that have expanded Medicaid have experienced larger gains in health coverage than non-expansion states. Moreover, many states have experienced net budget savings due to expansion. In addition, the Medicaid expansion is connecting low-income adults — most of whom lacked access to comprehensive health coverage before health reform — with needed care. Many of these individuals have serious physical and behavioral health needs, and Medicaid coverage has allowed them to get care for substance use disorders, mental illness, and a range of other conditions, which can not only improve their health but also support employment and reduce recidivism for many vulnerable individuals.

[16] For more information about supportive housing and the role of Medicaid, see Ehren Dohler *et al.,* "Supportive Housing Helps Vulnerable People Live and Thrive in the Community," Center on Budget and Policy Priorities, May 31, 2016, http://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community.

[17] Catherine McKee *et al.,* "State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration," Kaiser Family Foundation, August 2015, http://files.kff.org/attachment/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration.