Net Effects of the Affordable Care Act on State Budgets

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Introduction and key findings

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) will affect state budgets in many ways. State Medicaid spending on low-income adults will rise, for two reasons. First, the Affordable Care Act is expected to increase enrollment among individuals who currently qualify but have not yet signed up for Medicaid, enrollment for which states must pay their standard share of Medicaid expenses. Second, the legislation requires Medicaid to cover all adults with incomes at or below 133 percent of the federal poverty level (FPL). While the federal government will pay 100 percent of all health care costs for newly eligible adults during 2014-2016, states will begin paying some of these costs in 2017, with the state share gradually rising to 10 percent in 2020 and thereafter. Taking into account both of these factors, prior analyses by the Urban Institute have concluded that, depending on whether participation levels resemble historical averages, as anticipated by the Congressional Budget Office, or significantly exceed those levels, state costs for Medicaid adults with incomes at or below 133 percent of FPL will rise by between $21.1 billion and $43.2 billion during 2014-2019.[1]

To place these costs in context, this paper analyzes potential savings states can achieve under the Affordable Care Act. In sum, we find the following results for 2014-2019:

- By eliminating optional Medicaid coverage for adults over 133 percent of FPL, thus shifting them to federally-funded subsidies in the exchange, states can save between $21.3 billion and $28.2 billion.
- By replacing state and local spending on uncompensated care with federal Medicaid dollars, states and localities can save between $42.6 billion and $85.1 billion.
- By replacing state and local spending on mental health services with federal Medicaid dollars, states and localities can save between $19.9 billion and $39.7 billion.

A worst-case scenario will thus see states realizing net budgetary savings of $40.6 billion during 2014-2019. In a best-case scenario, those gains will reach $131.9 billion (Table 1).

[1] John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, May 2010. The Urban Institute estimates described in this issue brief are based on the Health Insurance Policy Simulation Model (HIPSM), which uses national survey data and economic analyses of individual and business behavior to examine how employer-sponsored insurance, private non-group coverage, and Medicaid and CHIP are likely to change in response to policy modifications. For a description of HIPSM, see Urban Institute Health Policy Center, *The Urban Institute's Health Microsimulation Capabilities*, July 19, 2010, http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf.

Table 1. Worst- and best-case scenarios for state budget effects of various provisions of the Affordable Care Act: 2014-2019 (billions)

	Worst-case scenario	Best-case scenario
Medicaid cost increases for low-income adults	**$43.2**	**$21.1**
Total state savings	**$83.8**	**$153.0**
Savings from shifting Medicaid adults to the exchange	$21.3	$28.2
Uncompensated care savings	$42.6	$85.1
Mental health savings	$19.9	$39.7
Net state fiscal gains:	**$40.6**	**$131.9**

State fiscal effects not considered here include savings on the Children's Health Insurance Program (CHIP) when federal matching rates increase by 23 percentage points in 2016 (and when federal allotments may end, depending on future Congressional decisions); potential savings from new options to combine Medicare and Medicaid dollars into integrated care systems serving individuals who qualify for both programs; potential increases in state revenue that result from higher wages; and effects on state and local costs to provide public employees and retirees with health coverage.

Of course, effects will vary by state. Even if states as a whole gain under the Affordable Care Act, some may lose. And state policy choices will go a long way towards influencing the fiscal impact of the federal legislation. Already, a handful of states have turned down available federal funding, while others have vigorously sought multiple federal grants. State choices will become even more consequential once the major provisions of the ACA become effective in 2014. For example, a state will spend more if it chooses to continue paying Medicare-level reimbursement rates to Medicaid's primary care providers after federal funding targeted to this purpose ends in 2015; a state will spend less if its Medicaid program makes it difficult for eligible individuals to obtain and retain coverage; and a state will experience increased fiscal gains if it aggressively substitutes newly available federal dollars for current state and local health care spending.

No doubt, states will continue to vary in both their objective conditions and their policy choices. Nevertheless, most states will be able to implement the Affordable Care Act in ways that help balance rather than burden state budgets.

Prior research

Our findings are generally consistent with earlier research that examined, not just new costs imposed on states by the Affordable Care Act, but also possible savings. For example, the Council of Economic Advisers (CEA) analyzed the impact of national reform on 16 states,[2] comparing increased state spending on low-income adults with reduced state costs for uncompensated care and public employee coverage. CEA found that each state's budget would

[2] The states were Arkansas, California, Florida, Idaho, Indiana, Iowa, Maine, Michigan, Minnesota, Montana, Nebraska, North Carolina, Oregon, Pennsylvania, Vermont, and Wyoming.

experience net gains, totaling between $3 and $4 billion in annual savings for all 16 states combined.[3]

Along similar lines, The Lewin Group estimated the ACA's effects on state costs for Medicaid and CHIP, savings to state and local safety net programs, costs to furnish public employees and retirees with health insurance, and the revenue impact of wage increases resulting from a slight reduction in employer premium payments. The analysis concluded that, on balance, the Affordable Care Act will save states $106.8 billion during 2010-2019, including $100.6 billion in 2014-2019.[4]

Analysis

Eliminating optional Medicaid coverage for adults over 133 percent of FPL

Beginning in 2014, the Affordable Care Act's maintenance of effort requirements for Medicaid adults will end. As a result, states will be able to eliminate Medicaid eligibility for many adults whose incomes exceed 133 percent FPL without terminating their subsidized coverage. Rather than receive Medicaid, these adults could obtain subsidized coverage in the exchange.[5]

The Urban Institute has projected state and federal Medicaid spending under future scenarios that assume the absence of federal reform. Those costs vary, depending on applicable assumptions about economic conditions, which affect enrollment levels. Two scenarios were modeled, reflecting upper- and lower-bound forecasts of economic growth.[6]

For adults with incomes above 133 percent of FPL whose coverage can be terminated beginning in 2014,[7] states, without the Affordable Care Act, would spend an estimated $21.3 billion from 2014 through 2019 if the economy rebounds vigorously from the current downturn. Such spending would reach $28.2 billion if economic growth remains slow. States can eliminate these costs under the Affordable Care Act, shifting affected adults to subsidies that are funded entirely by the federal government.

Increased federal support for indigent and uncompensated care

States and localities spend considerable sums paying for uncompensated care provided to low-income, uninsured consumers who are now ineligible for Medicaid. Under the Affordable Care Act, most of them will qualify for health coverage.

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[3] Council of Economic Advisers, *The Impact of Health Insurance Reform on State and Local Governments*, September 2009.

[4] The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, Staff Working Paper #11, June 8, 2010.

[5] Some terminated adults will have access to employer-sponsored insurance that makes them ineligible for subsidies in the exchange. Also, some states may implement the Basic Health Program (BH) option provided in Section 1331 of the legislation, in which case adults with incomes at or below 200 percent of FPL would move from Medicaid to BH, rather than to the exchange.

[6] Bowen Garrett, Matthew Buettgens, Lan Doan, Irene Headen, and John Holahan, *The Cost of Failure to Enact Health Reform: 2010–2020*, prepared by the Urban Institute for the Robert Wood Johnson Foundation, March 2010 (updated).

[7] The impact of the ACA's termination of maintenance of effort requirements for adults is described in Matthew Buettgens, Bowen Garrett, and John Holahan, *America under the ACA*, prepared by the Urban Institute for the Robert Wood Johnson Institute (forthcoming).

In 2008, Hadley et al. estimated the amount spent on uncompensated care and the sources of payment.[8] They found that the total amount of uncompensated care in 2008 was $57.4 billion, including $42.9 billion paid by federal, state, and local governments. Government expenditures included Medicare Disproportionate Share Hospital (DSH) payments and Indirect Medical Education payments; Medicaid DSH payments and supplemental provider payments; and state and local tax-based appropriations for hospitals and general assistance health programs. States also fund other programs that support community health centers and clinics.

To estimate spending by state and local governments in each of these areas, Hadley et al. counted only state general fund dollars, excluding all state payments financed through provider taxes or intergovernmental transfers. They also subtracted out hospital payments to compensate for shortfalls in Medicaid reimbursement. Remaining state and local payments for uncompensated care furnished to the uninsured in 2008 were found to total $17.2 billion.

Projecting this amount forward to 2014-2019, using the Center for Medicare and Medicaid Services (CMS) Office of the Actuary's 6.0 percent estimated increase in annual per capita health care spending, the resulting six-year cost amounts to $170.2 billion. Many of these expenditures will still be necessary even with the Affordable Care Act's expansion of health coverage. There will still be a need to make disproportionate share hospital payments (including state matching dollars), and state and local support for local hospitals, community health centers and clinics will still be required both because of the remaining uninsured population and because of the Affordable Care Act's reduction in overall DSH payment levels. If only a quarter of the $170.2 billion can be saved, state and local uncompensated care spending would drop by $42.6 billion over the six-year period. If 50 percent were reallocated to other purposes, states and localities would save $85.1 billion.

Increased federal support for mental health services

In Fiscal Year 2008, state mental health agencies spent an estimated $36.8 billion. Of this amount, 45.4 percent, or $16.7 billion, represented state and local costs outside Medicaid.[9] Medicaid itself paid for 46 percent of state mental health services, or $16.9 billion.[10] Other funds were provided by Medicare, federal block grants, and additional sources.

The Affordable Care Act's expansion of Medicaid coverage to reach adults with incomes up to 133 percent of FPL will have a major impact on these state-administered systems of care. Among the adults served by state mental health agencies, 79 percent are either unemployed or outside the labor force. Nevertheless, 43 percent of consumers served by these agencies have no Medicaid coverage.[11]

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[8] Jack Hadley John Holahan, Terri Coughlin, and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs*, September/October 2008; 27(5): w399-w415.

[9] This total includes General Fund expenditures (40 percent), other state expenditures outside Medicaid (3 percent), and local expenditures (2.4 percent).

[10] Authors' calculations, Ted Lutterman, *The Impact of the State Fiscal Crisis on State Mental Health Systems: Fall 2010 Update*, NASMHPD Research Institute, Inc (NRI), October 12, 2010.

[11] Theodore C. Lutterman, Bernadette E. Phelan, Ph.D., Azeb Berhane, Robert Shaw, and Verda Rana, *Funding and Characteristics of State Mental Health Agencies, 2007*, prepared by the National Association of State Mental Health Program Directors for the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, HHS Pub. No. (SMA) 09-4424, 2009.

When the Affordable Care Act is fully implemented, Medicaid coverage is expected to increase from 12.4 to 23.3 percent of individuals with mental illness or substance abuse disorders, and Medicaid's mental health spending is projected to rise by 49.7 percent.[12] If the latter increase had applied to state mental health agencies in FY 2008, their Medicaid revenue would have grown by $8.4 billion. Trended forward based on per capita changes in state and local health spending projected by the CMS Office of the Actuary,[13] the increased Medicaid revenue would total $82.7 billion for 2014-2019. Of this amount, $79.4 billion would represent new federal dollars, based on the average federal matching percentage projected for newly eligible adults.[14]

Notwithstanding past patterns through which state policymakers have strategically used increased Medicaid dollars to reduce state budgetary commitments,[15] one should not overstate the extent to which Medicaid dollars can substitute for other resources. Many people served by state mental health agencies will continue to be uninsured. Some will have a connection to the criminal justice system that precludes eligibility for assistance, for example, and others may suffer from cognitive or other impairments that complicate Medicaid enrollment. Further, some important services are not easily reimbursable through Medicaid. Examples include care provided by Institutions for Mental Disease, which Medicaid excludes, and certain types of substance abuse treatment and residential support. And some of these new Medicaid dollars may be used to address unmet needs among the mentally ill, which are likely to grow in the wake of today's state budget shortfalls and the resulting cuts to state-funded mental health services.

Taking these factors into account, if we assume that only a quarter of increased Medicaid reimbursement will substitute for state and local spending, state and local savings in this area would amount to $19.9 billion during 2014-2019. If half of these Medicaid dollars substitute for state and local spending, savings will reach $39.7 billion.

Other factors

Other effects of the Affordable Care Act are outside this analysis. For example:

- **States may experience savings under CHIP**. After 2015, federal CHIP allotments end, and any remaining federal funds pay for a much higher percentage of health care costs; the applicable federal matching rate for each state rises by 23 percentage points. If Congress does not provide CHIP allotments for 2016 and beyond, state spending on separate CHIP programs will end, and affected children could shift to subsidized coverage in the exchange. If Congress does provide new allotments, the state's share of spending will drop sharply due to the Affordable Care Act's increase in federal matching funds. Either way, state CHIP costs will fall.
- **The Affordable Care Act gives states new options to integrate Medicare and Medicaid funding and service delivery for dual eligibles** (that is, low-income seniors and people with disabilities who qualify for both programs). The Medicare Payment Advisory Commission

[12] Jeffrey A. Buck, *Medicaid Spending for Behavioral Health Treatment Services*, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, June 23, 2010, http://www.nationalgranteeconference.com/presentations/2010/J.%20Buck.pdf.
[13] CMS Office of the Actuary, *National Health Expenditure Projections 2009-2019 (September 2010)*, Table 2.
[14] Authors' calculations, Holahan and Headen, op cit.
[15] Richard G. Frank and Sherry Glied, "Changes In Mental Health Financing Since 1971: Implications For Policymakers And Patients," *Health Affairs*, May/June 2006; 25(3): 601-613.

(MedPAC) explained that, while outcomes research is limited, prior state integration initiatives "demonstrate their ability to reduce institutional and inpatient utilization."[16] Some observers believe such reforms could reduce total spending on dual eligibles by as much as 6 percent.[17] Even cost reductions well below that level could generate significant state savings, since dual eligibles account for 46 percent of all Medicaid spending.[18]

- **The cost of health coverage for public employees and retirees will change**. According to the CEA report described above, such costs will drop. Since fewer Americans will be uninsured, hospital uncompensated care costs will decline, and fewer costs will be shifted to private insurance, resulting in savings to employers (public and private) that pay premiums. Along similar lines, Harvard economist David Cutler and Commonwealth Fund President Karen Davis estimate that, due to lower administrative costs and other delivery system reforms in the Affordable Care Act, employer-sponsored insurance premiums will decline over time relative to baseline projections, reaching a 10 percent savings by 2019.[19] On the other hand, the above-mentioned Lewin Group analysis concluded that state and local costs to cover public employees and retirees will rise because of higher enrollment levels under the Affordable Care Act. We have not included any of these projections in the analysis presented here.

Conclusion

Throughout Medicaid's history, smart and creative state officials have responded to changes in federal law by reconfiguring their programs to maximize fiscal gains and minimize losses. This pattern will surely continue under the Affordable Care Act.

What we have shown is that, even without any state-level creativity, the straightforward implementation of the ACA's coverage expansion is likely to yield state savings that greatly exceed net state costs resulting from increased coverage of low-income adults.

[16] Medicare Payment Advisory Commission (MedPAC), "Chapter 5: Coordinating the care of dual-eligible beneficiaries," *Report to the Congress: Aligning Incentives in Medicare*, June 2010.
[17] The Lewin Group, *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities*, sponsored by the Association for Community Affiliated Plans and Medicaid Health Plans of America, November 2008.
[18] John Holahan, Dawn M. Miller, and David Rousseau, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005*, Urban Institute and Kaiser Commission on Medicaid and the Uninsured, February 2009.
[19] David M. Cutler, Karen Davis, and Kristof Stremikis, *The Impact of Health Reform on Health System Spending*, The Commonwealth Fund, May 2010.

About the authors and acknowledgements

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