March 2013

Expanding Medicaid in Ohio

Analysis of likely effects

Introduction

The Ohio Medicaid Expansion Study ("study") was conducted to inform Ohio's leaders who must decide whether to expand Medicaid eligibility to Ohio residents with incomes up to 138 percent of the Federal Poverty Level (FPL). We use two different approaches to estimate the health coverage, fiscal and economic effects of Medicaid expansion, but both approaches yield the same conclusions. Medicaid expansion would:

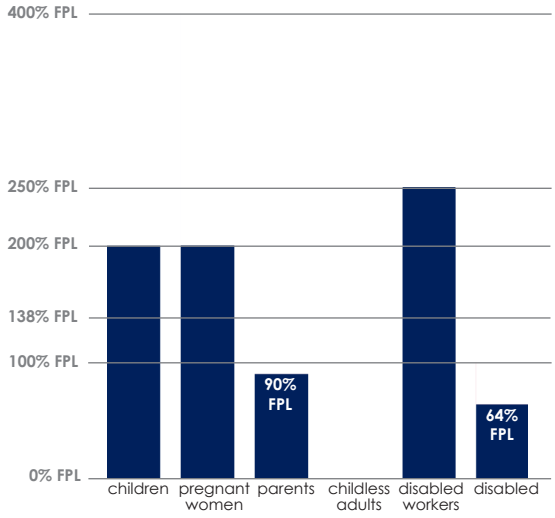
- Increase Medicaid enrollment and, with it, state Medicaid costs
- Create net state budget gains for the next three and a half biennia by generating state budget savings and state revenue that significantly exceed the state's cost of increased enrollment
- Cause state fiscal costs and gains that roughly balance out in fiscal year 2020 and thereafter (although the state is likely to continue receiving small net fiscal benefits from expansion)
- Provide health coverage to hundreds of thousands of Ohio residents who would otherwise be uninsured
- Strengthen Ohio's economy by bringing in federal resources that have already been set aside for Medicaid expansion, creating tens of thousands of jobs within the state's borders
- Reduce health care costs for Ohio's employers and consumers
- Yield significant fiscal gains to Ohio's counties

Background

Medicaid is a state-federal program that provides health coverage to people who meet certain criteria (see figure 1). The financing of the program is shared between the state and federal government through a federal match rate known as FMAP (Federal Medical Assistance Percentage). For Ohio, the current FMAP is generally 63 percent; the state pays the remaining 37 percent of Medicaid costs. The FMAP is higher for certain beneficiary groups, such as children covered under the federal Children's Health Insurance Program (CHIP).

As originally enacted in March 2010, the Patient Protection and Affordable Care Act (ACA) required states to expand Medicaid coverage to people with incomes up to 138 percent of FPL (see chart on page 2). According to this federal law, the federal government will pay 100 percent of the cost for people who are newly eligible for Medicaid from 2014 to 2016, gradually decreasing to 90 percent in 2020 and beyond. In June 2012, the U.S. Supreme Court effectively made expansion of Medicaid under the ACA optional, rather than required.

figure 1. Current Medicaid eligibility



The ACA also provides tax credits and cost-sharing subsidies for people with incomes between 100 percent and 400 percent of FPL who are ineligible for Medicaid to purchase health insurance coverage through health insurance exchanges. Such assistance is limited to residents who lack access to employer-sponsored insurance (ESI) that the ACA classifies as affordable.[1] If Ohio moves forward with Medicaid expansion, most Ohioans with incomes up to 400 percent FPL will have access to subsidized health coverage beginning in 2014. If Ohio does not move forward with Medicaid expansion, thousands of Ohioans below 100 percent FPL will have no subsidized coverage assistance. Citizens and lawfully present immigrants[2] left without coverage include:

- adults without dependent children and incomes between 0 and 100 percent FPL; and
- parents with incomes between 90 and 100 percent FPL. (see chart on page 2)

The Health Foundation of Greater Cincinnati, the Mt. Sinai Health Care Foundation and the George Gund Foundation sponsored this study to provide Ohio's policymakers with neutral and independent analysis on a key policy decision facing the state — namely, whether to expand Medicaid eligibility. The study was conducted

2013 Federal Poverty Level (FPL) Guidelines

(by household size)

	64%	90%	100%	138%	200%	250%	400%
1	$7,354	$10,341	$11,490	$15,856	$22,980	$28,725	$45,960
2	$9,926	$13,959	$15,510	$21,404	$31,020	$38,775	$62,040
3	$12,499	$17,577	$19,530	$26,951	$39,060	$48,825	$78,120
4	$15,072	$21,195	$23,550	$32,499	$47,100	$58,875	$94,200

Note: Annual guidelines for all states except Alaska, Hawaii and DC. For each additional person, add $4,020

Source: *Federal Register*, January 24, 2013

through a partnership of the Health Policy Institute of Ohio (HPIO), The Ohio State University (OSU), the Urban Institute, and Regional Economic Modeling, Inc. (REMI).

The study's primary purpose is to analyze the impact of Medicaid expansion on:

- The state budget
- Ohio economic growth and jobs
- The number of uninsured
- Health coverage, jobs, economic growth, and revenue for regions within the state and some individual counties

The study partners agreed to conduct their analysis based on current federal and state law.

Preliminary findings were released on January 15, 2013 and updated on January 18, 2013. The findings were released with the following caveats:

- Projections inherently involve uncertainty
- Estimates were preliminary and subject to change
- Future analyses would include additional estimates developed using other analytical methods
- While specific preliminary numbers could change, the basic policy implications would likely stay the same

This brief includes refined and additional estimates of costs, savings and revenues associated with a Medicaid expansion. The following additional analyses are reflected in the results presented in this brief:

- Original projections were based in significant part on the Urban Institute's estimated cost and coverage effects of the ACA in Ohio, both with and without a Medicaid expansion. Since then, researchers at OSU have developed an additional set of estimates. As a result, many of the key issues explored here involve two projections rather than one.
- Analysis regarding the state revenue effects of subsidized individual coverage in the exchange, which will generate insurance tax revenue, has been included. As a result, estimated effects of the ACA without a Medicaid expansion include additional revenue compared to the preliminary estimates presented in January. At the same time, estimated revenue effects of the Medicaid expansion now include less managed care tax revenue. Our preliminary revenue estimates were offset with the reduction in insurance taxes that will result if citizens with incomes between 100 and 138 percent FPL receive coverage through Medicaid rather than through the exchange.
- Since the release of the January preliminary report, estimates of state savings involving retroactive Medicaid payments and payments covering the period between application and final eligibility determination were developed. These estimates generated additional state budget savings in our analysis of the effects of Medicaid expansion as well as estimates for the ACA's non-expansion provisions.
- On February 13, the State of Ohio released Mercer's analysis of ACA cost effects, which estimated the impact of the ACA's insurer fee on Ohio's Medicaid managed care costs. We incorporated Mercer's analysis of the fee as a percentage of total managed care costs (minus "ripple" effects on sales and insurance taxes), which increased our estimated cost of the ACA's provisions not including Medicaid expansion and slightly increased our estimated Medicaid expansion costs.

Results from regional and some county level analysis will be available in late February or early March 2013.

Study Questions and Methods

The key questions addressed in the study are:

1. Does a Medicaid expansion generate new state Medicaid costs?
2. Does a Medicaid expansion allow state budget savings?
3. How does a Medicaid expansion affect state revenue?
4. What is a Medicaid expansion's net impact on the state budget?
5. How else does a Medicaid expansion affect Ohioans?
6. What impacts will the state experience from the ACA even if Medicaid is not expanded?

One of the study objectives was to use qualitatively different methods of estimating Medicaid cost and coverage effects — microsimulation models and actuarial-type models — to develop a range of possible outcomes. We found that these different analytic approaches produced similar, though not identical, results.

Three separate models were used to address these questions:

The Urban Institute's Health Insurance Policy Simulation Model (HIPSM)

- HIPSM is a "microsimulation model," like the models used by the Congressional Budget Office, the U.S. Treasury Department, and the U.S. Office of Management and Budget.
- HIPSM uses Census Bureau and other government data to develop a detailed picture of Ohio residents and businesses. In this case, HIPSM's picture of Ohio residents was modified to reflect recent cost and enrollment data from the state's Medicaid program.
- HIPSM estimates how Ohio's residents and employers would react to various policy changes, including the ACA, with and without a Medicaid expansion. These estimates are based on the health economics literature and empirical observations.
- HIPSM is being used to estimate the ACA's cost and enrollment effects by the federal government, a number of states, the Robert Wood Johnson Foundation, the Kaiser Commission on Medicaid and the Uninsured, and the Commonwealth Fund.
- HIPSM's methods are all a matter of public record. See http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf.
- Urban Institute researchers used HIPSM to estimate the effects of ACA implementation in Ohio, both with and without a Medicaid expansion.

Regional Economic Models, Inc. (REMI)'s Tax-PI Model

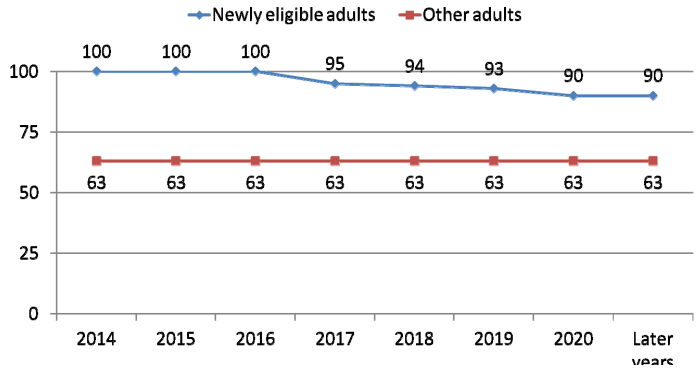
- REMI was founded in 1980, based on the idea that government decision-makers should test the economic effects of policies before implementation. REMI models are used in nearly each U.S. state at all levels of government.
- The Tax-PI model allows users to simulate not only the statewide impact of policy on such variables as jobs, income, gross domestic product, and demographics, but also state revenue and expenditures.
- The REMI model is a structural macro-economic simulation model that integrates input-output, computable general equilibrium, econometric, and new economic geography theories. The model is dynamic and generates year-by-year estimates.
- The model has been used to evaluate the detailed effects of Medicaid expansion in other states and broadly across all 50 states.
- The underlying methods and system of equations have all been peer reviewed and are available at http://www.remi.com/resources/documentation.

The Ohio State University Impact of Medicaid Expansion on Ohio model

- The OSU model applies an actuarial approach, generally like that being used by Ohio actuaries who are projecting the ACA's Medicaid cost effects. The OSU model uses data sources and assumptions similar to those in the state's published sources.
- The model uses 2012 Ohio Medicaid Assessment Survey data to estimate the counts and current health coverage status of (a) residents who currently qualify for Medicaid but are not enrolled and (b) residents who will newly qualify for Medicaid if the state implements an expansion.
- The model uses the state's January 2013 to June 2013 Medicaid managed care rates to calculate expected per member per month (PMPM) costs for children, adults, and seniors.
- The model uses the projected annual cost growth and population growth rates currently being used by Ohio Medicaid's actuary to trend PMPM costs and population counts forward (4.6 percent for cost and 1 percent for population growth).
- The model uses the participation rates for each population subgroup that Milliman used in its 2011 Medicaid expansion report for Ohio Medicaid. Milliman assumed that enrollment would gradually rise during 2014 through 2016, reaching final levels by 2017.

- OSU researchers used the model to develop estimates under two scenarios, each with and without inclusion of seniors:
  - A scenario in which Ohio did not expand Medicaid but the ACA's other provisions resulted in increased participation by currently eligible, but not enrolled individuals.
  - A scenario in which Ohio did expand Medicaid, which resulted in both (a) participation by people newly eligible under expansion and (b) participation by some currently eligible, but not enrolled individuals in addition to the increased participation that would result from implementing the ACA without a Medicaid expansion.
- The model is set up as a systems dynamics model that allows for easy changes of input assumptions to examine how those changes alter the projections of spending and number of people covered.

figure 2. Percentage of health care costs paid by the federal government, newly eligible adults vs. other adults; 2014-2020 and beyond

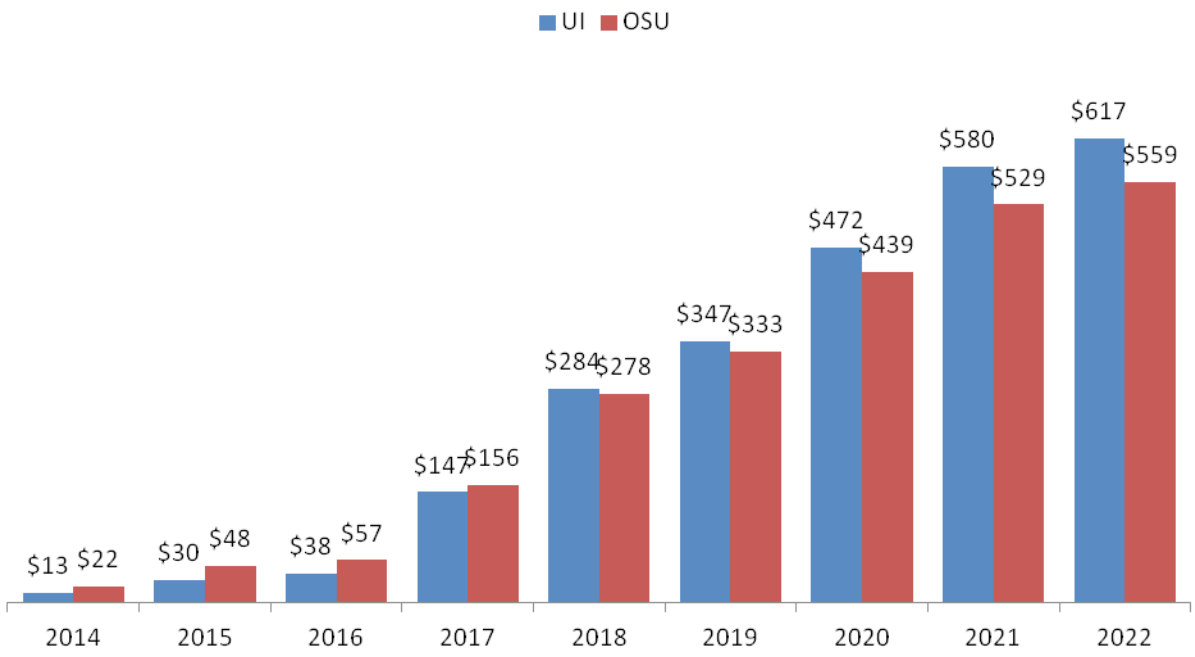


Question 1: Does a Medicaid expansion generate new state Medicaid costs?

New service costs due to increased enrollment

The Medicaid expansion will generate new state service costs, in addition to Medicaid costs that will be incurred under the ACA without a Medicaid expansion. In part, these new costs are due to the state-share obligation to pay for the newly eligible, 19-64 year

figure 3. Impact of Medicaid expansion on state Medicaid costs, Urban Institute (UI) and OSU estimates: SFY 2014-2022 (millions)



Source: Urban Institute HIPSM 2013; OSU 2013.
Note: Estimates include effects of ACA insurance premium fee, Figure does not include higher federal matching rates for certain current-law beneficiaries.

old Ohioans who would be eligible for Medicaid only under an expansion. The federal government will pay 100 percent of these costs from calendar years (CY) 2014 through 2016. After 2016 the state will begin paying some of these costs, with a share that gradually increases to 10 percent by CY 2020, remaining at that percentage thereafter. (see figure 2)

A second new cost is associated with people who are currently eligible for Medicaid, but not enrolled. According to both the Urban Institute's microsimulation model and the assumptions underlying OSU's actuarial-type model, most of the currently eligible, but not enrolled consumers who join Medicaid after 2014 will do so even if there is no expansion. Such increased enrollment will result from the ACA's individual coverage requirement, new subsidies in the HIX, the ACA's new and streamlined systems of Medicaid enrollment, and increased awareness of the availability of health coverage. However, some additional enrollment of people who are currently eligible but not yet enrolled would result from the expansion. We find that roughly 17.5 percent of the total currently eligible but unenrolled people who sign-up for Medicaid under the ACA with an expansion do so only because of the expansion; the remainder join the program with or without a Medicaid eligibility expansion. Ohio will pay its usual state match rate (currently 37 percent) for such people.

Therefore, as Figure 3 shows, the state cost of Medicaid expansion begins at $13 to $22 million in state fiscal year (SFY or FY) 2014 and increases to between $559 to $617 million in SFY 2022. SFY 2021 is the first year when the entire state match for newly eligible adults is at the "steady state" of 10 percent. The costs continue to rise thereafter due to population growth and the general trend of increasing health care costs, assumed to be 1 percent and 4.6 percent per year, respectively, under the OSU analysis.

Administrative costs

Our analysis did not have sufficient data to develop a precise estimate of the effect of Medicaid expansion on state administrative costs. Expansion would both add administrative costs and yield administrative savings; it is not clear whether, on balance, the state fiscal effects are positive or negative.

Many of the ACA's administrative cost effects will occur even if Ohio does not expand Medicaid eligibility. For example:

- Other ACA provisions are likely to increase the number of Medicaid applications, with a corresponding rise in administrative expenses to process those applications.
- Additional administrative costs include major changes to Medicaid eligibility systems, including the implementation of a new Modified Adjusted Gross Income (MAGI) standard, an expanded use of data matching in both establishing and renewing eligibility, and development of systems for coordinating applications, eligibility determination, and redeterminations with the federally facilitated health insurance exchange that will serve Ohio residents. The federal government pays 90 percent of the costs of necessary information technology (IT) development, but the remaining 10 percent must be paid by the state. This major transition also absorbs considerable staff time from state Medicaid officials.
- The new Medicaid eligibility and enrollment system likely will create significant efficiencies, in terms of being less paper intensive, less manual, and more automated. Also, automated eligibility costs will receive a 75 percent federal match, rather than the standard 50 percent match that applies to most administrative costs.
- Other aspects of the ACA require state administrative effort, including the requirement to develop new payment mechanisms to deliver the ACA's federally-funded increase in primary care payments for CY 2013 and 2014.

In addition to the administrative costs the ACA will generate, with or without a Medicaid expansion, the following will generate new administrative costs only if Medicaid is expanded:

- The state would need to process additional applications for people who seek coverage only under an expansion.
- More redeterminations of eligibility would be needed, due to a larger population of Medicaid enrollees.
- The amount of total fee-for-service payments would increase, since new Medicaid participants receive fee-for-service care during the brief time period before selecting a Medicaid managed care organization (MCO). Therefore, the administrative costs of claims processing would rise.
- Increased enrollment in Medicaid managed care plans may raise state administrative costs slightly. For example, the state would need to help more consumers select a plan. However, increased use of Medicaid managed care mainly involves larger payments from the state to insurers, which does not affect administrative costs. The state's purchase on behalf of more covered lives would give the Medicaid program additional negotiating leverage, which might lower the state's overall costs.

Any new costs in the above areas will be offset, to some degree, by the following administrative savings, which involve a 50 percent state share of cost:

- With a Medicaid expansion, many who would have qualified through spend-down — that is, by incurring sufficient medical expenses to qualify as "medically needy" — will instead be enrolled simply on the basis of income. That would avoid the sometimes cumbersome and costly administrative process of verifying that beneficiaries have incurred expenses that meet monthly applicable spend-down requirements, which vary based on each individual's precise income.
- With a Medicaid expansion, many who would have qualified based on disability will instead be eligible based simply on income below 138 percent FPL. This will reduce the number of necessary disability determinations, which can be quite costly.
- A Medicaid expansion should reduce the number of retroactive and backdated eligibility determinations. With continuous coverage between 0 and 138 percent FPL, fewer beneficiaries will have their coverage stop and start based on income fluctuations. Since more will be continuously enrolled, fewer will need to have eligibility established to cover services provided before the date of a new eligibility determination. And fewer will churn on and off the program, forcing redundant eligibility determinations.
- An expansion would reduce the number of requests for fair hearing review of coverage denials. Without an expansion, many people who apply at the exchange will be routed to Medicaid based on income too low for exchange subsidies. Medicaid will deny coverage to those who are not eligible. These applicants have an absolute right, under federal law, to request fair hearings, which the state must provide and fund. By contrast, a Medicaid expansion would cover all applicants with incomes too low for exchange subsidies, resulting in many fewer denials and fair hearings.
- A Medicaid expansion, with a corresponding implementation of the state's proposed eligibility simplification, would reduce the overall complexity of administering a program that, today, maintains over 150 different eligibility groups.

Question 2: Does a Medicaid expansion allow state budget savings?

Medicaid expansion generates new state costs, but that does not mean that Medicaid expansion creates a budget problem for Ohio's state government. Along with the new state Medicaid costs come two possible sources of offsetting budgetary gains:

1. State budget savings that result from or are allowed by Medicaid expansion; and
2. State revenue created by Medicaid expansion.

A Medicaid expansion generates state budget savings in two ways:

1. It shifts existing Medicaid spending from the current state match rate to the enhanced expansion match rate, which begins with full federal funding; and
2. It replaces non-Medicaid spending of state general revenue fund dollars on health care for the poor and near-poor uninsured with federal Medicaid dollars as those people gain Medicaid eligibility.

This analysis quantifies four primary sources of state savings opportunities and several minor savings possibilities. Three of the primary opportunities relate to shifts in current Medicaid spending involving —

- Adults with spend-down coverage;
- Breast and cervical cancer program; and
- Retroactive and backdated fee-for-service spending.

The remaining savings opportunity, inpatient medical costs for state prisoners, shifts non-Medicaid spending that is 100 percent state-financed to Medicaid coverage for newly eligible adults, for whom the federal government pays between 90 and 100 percent of all costs, depending on the year.

Adults with spend-down coverage

Under Ohio's coverage of the "aged, blind, and disabled" (ABD), non-elderly residents with disabilities qualify for Medicaid so long as their incomes do not exceed 64 percent FPL. Residents with incomes above that threshold on the first day of the month can, under Ohio Medicaid's spend-down program, become Medicaid eligible later that month once they incur sufficient medical expenses. Such spend-down adults who do not receive Medicare and have incomes at or below138 percent of FPL would no longer incur

table 1. Net savings on spend-down adults (millions)

Fiscal year	Net savings on spend-down adults
2014*	$36
2015	$74
2016	$78
2017	$80
2018	$82
2019	$86
2020	$87
2021	$91
2022	$96
Total:	**$709**

Source: OSU 2013. **Note:** columns may not total due to rounding.

the medical bills needed for spend-down eligibility. Instead, they would immediately qualify as "newly eligible adults," for whom the state would receive enhanced federal matching funds.

Ohio Medicaid's eligibility simplification draft waiver application (http://1.usa.gov/Zsa6fl) estimated the costs associated with the spend-down population between CY 2014 and CY 2018. According to this document, there would be 8,505 individuals with incomes between 70 percent and 133 percent of poverty in CY 2014 with total spending of $194 million dollars and 8,851 individuals with total spending of $241 million in CY 2018. In our analysis we trended these costs forward using the same growth rate as in Ohio Medicaid's numbers through CY 2022.

When someone moves from eligibility as an adult with spend-down to a newly eligible adult, total Medicaid spending on that person increases, as Medicaid covers the charges previously incurred by the individual to meet spend-down obligations. However, the percentage of Medicaid costs paid by the state falls dramatically. Instead of 37 percent, the state's share of these costs is zero during CY 2014-2016, then gradually rises to 10 percent in CY 2020 and thereafter.

Our analysis trended forward Ohio Medicaid's estimates of both cost effects — namely, total Medicaid costs for these adults and the share paid by the state. We found that Medicaid expansion will generate savings, reflecting the difference between what the state currently spends for these individuals at the regular match rate and what Ohio would spend under the enhanced expansion match rate.

Table 1 shows the net savings, after accounting for the increased spending and the differences in match rates. According to our analysis, the savings will be $36 million in SFY 2014 and grow to $96 million in 2022, with total savings of $709 million over the period of SFY 2014 to SFY 2022.

Breast and cervical cancer program (BCCP)

The breast and cervical cancer program (BCCP) is an optional Medicaid coverage population. To be eligible for BCCP a woman must be uninsured and diagnosed with breast and cervical cancer at a breast and cervical cancer testing site approved by the Centers for Disease Control and Prevention (CDC). The woman must also have an income that is at or below 250 percent of poverty.

With a Medicaid expansion, women not already enrolled would no longer need the BCCP program. Almost all women who otherwise would have qualified for BCCP will instead either be newly eligible adults in Medicaid or qualify for subsidies offered through the health insurance exchange. They will be ineligible for the BCCP program both because they are insured and because, in many cases, they will not receive a diagnosis of cancer from a CDC- approved site.

According to Ohio Medicaid's eligibility simplification waiver application, 610 women are expected to be covered under the BCCP program in CY 2014 at a total cost of $19 million, rising to 634 women and a total cost of $24 million in CY 2018. This total spending equals $7 million state share in 2014 and almost $9 million in 2018, since the state receives enhanced, CHIP-level federal funding for this eligibility group. Our analysis trended these costs forward at the rate of growth used in Ohio Medicaid's own estimates.

Table 2 shows the costs savings to Ohio Medicaid under expansion, assuming that women who otherwise would have enrolled in the BCCP program instead sign up for Medicaid as newly eligible adults. The savings would start at $2 million in SFY 2014 and, as current enrollees gradually leave the program, grow to $7 million in SFY 2022, for a total of $48 million in savings over the period SFY 2014 to SFY 2022. The savings could be even higher if a portion of these costs went entirely away as the women got their coverage through the health insurance exchange rather than Medicaid (although a portion of those savings would be experienced even without a Medicaid expansion).

table 2. BCCP savings (millions)

Fiscal year	BCCP savings
2014*	$2
2015	$5
2016	$5
2017	$5
2018	$6
2019	$6
2020	$6
2021	$6
2022	$7
Total:	$48

Source: OSU 2013. **Note:** The current BCCP program has federal matching rates between standard and ACA levels. Estimates assume that all new BCCP enrollees receive Medicaid as newly eligible adults. If some enroll instead in the exchange, state savings would increase, because the state would not spend anything for their care. However the latter savings would occur with or without expansion.

Retroactive eligibility and backdated eligibility

One attribute of the Medicaid program is that it serves as a kind of high risk pool. Individuals who would not qualify for Medicaid on one day might well qualify on another day if their health status changes significantly enough. Often this change first shows up through a health event that requires expensive medical attention, which may require disposing of liquid assets. Such impoverishment can qualify patients for Medicaid. Also, sometimes a previously eligible person does not undertake the effort required for enrollment until experiencing a medical problem.

For those people whose application is approved, Medicaid will pay costs incurred during the three months before the application date. Such coverage is known as retroactive eligibility. In addition, when there is a delay between the date of application and the ultimate determination of eligibility, Medicaid pays the costs incurred between those two dates. Such coverage is often called "backdated eligibility." Both retroactive and backdated coverage involve fee-for-service claims. People receiving backdated or retroactive coverage enter into managed care plans after they have been found eligible for Medicaid and selected a managed care plan.

Under current Medicaid these individuals either apply for ABD coverage or for Covered Families and Children (CFC) eligibility. The processing time for ABD applications currently averages 3 months, because of the complexities related to completing the disability determination process. The processing time for CFC is typically under one month.

With Medicaid expansion, all individuals aged 19 to 64 with incomes below 138 percent of poverty will qualify, with eligibility based entirely on income, without regard to assets. They will not have to wait for a major health event before obtaining coverage.

table 3. Impact of Medicaid expansion on state costs for retroactive and backdated eligibility: FY 2014-2022 (millions)

Fiscal year	Net savings on retroactive eligibility spending	Net savings on backdated eligibility spending	Total savings on backdated and retroactive eligibility
2014*	$0	$0	$0
2015	$0	$0	$0
2016	$26	$44	$70
2017	$27	$47	$74
2018	$28	$48	$76
2019	$29	$50	$79
2020	$30	$52	$82
2021	$31	$54	$85
2022	$33	$57	$90
Total:	$204	$352	$556

*Assumes savings begin in SFY 16 after full take up has occurred and change in spending is documented and reflected in budgeting process.
Source: OSU 2013. For assumptions, see text.

Coverage will become more continuous for a second reason — namely, with higher income eligibility standards, and the elimination of all categorical restrictions for non-elderly adults with incomes below 138 percent FPL, fewer changes in household circumstances will cause eligibility to end or begin. When applications are required for people with incomes below that threshold, they will be processed much more quickly, because a disability determination will not be necessary. Moreover, as the uninsured gain coverage, the number of months of retroactive and backdated eligibility experience will decline, which will reduce spending on retroactive and backdated eligibility.

These changes should result in two offsets. First, we subtract the estimated reduction in retroactive benefits from the increased Medicaid costs that would result from expansion. Otherwise, those costs will be counted twice: once as "retroactive costs" that will be incurred through the continuation of the present Medicaid program; and a second time as managed care spending on the newly enrolled. In truth, the latter spending will replace current retroactive benefits.

Second, the backdated eligibility costs for people who, today, eventually qualify based on disability should diminish substantially. Such people with incomes at or below 138 percent FPL will qualify quickly based on income, with no need to wait for a disability determination.

As a result, the state should receive enhanced federal match for their care, rather than the standard federal match rate, except for people who seek and qualify for Medicare or disability-based cash assistance. Further, we assume that the state provides newly eligible adults with the same benefits other adults receive. This will ensure that people who qualify as newly eligible adults have no reason to request a disability determination, since such a determination would not provide them with additional coverage.

We limit our estimated savings in this area to the ABD population, since most of the increased enrollment within the CFC group will take place under the ACA without expansion. To estimate retroactive and backdated costs for non-Medicare enrollees within the ABD population, we take the state's current costs and trend them forward, using the state's estimated cost increase of 4.6 percent per year. We begin with a reduction in such costs based on the proportionate decline among uninsured residents with incomes at or below 138 percent FPL, which likely understates the percentage of people with backdated eligibility who would seek to qualify as newly eligible adults. We calculate the resulting savings assuming that only half of these costs would be eliminated by expansion, recognizing that some of these individuals may have incomes above 138 percent FPL and others may apply for and receive cash assistance based on disability, thus falling outside the newly eligible adult category.

We also assume that these will start to accrue in SFY 2016 given the potential costs of pent-up demand during the take up period and the lag in use of spending data to set new rates for managed care. Using these conservative assumptions, we estimate savings of:

- $26 million in SFY 2016 to $33 million in SFY 2022, for a total of $204 million in savings from SFY 2014 to SFY 2022 for retroactive eligibility;
- $44 million in SFY 2016 to $57 million in SFY 2022, for a total savings of $352 million in savings for backdated eligibility from SFY 2014 to SFY 2022.

In-patient medical costs of state prisoners

Under current Medicaid rules, state prisoners can qualify for Medicaid coverage of inpatient and institutional services if they stay outside of the prison setting for at least one night, but only if the prisoners meet all other Medicaid eligibility requirements. Almost all prisoners are ineligible for Medicaid under current law because they are childless adults who fall outside the limited categories of pre-ACA Medicaid eligibility. That will change under Medicaid expansion because eligibility will shift from categorical requirements to eligibility based solely on income below 138 percent of poverty.

As a result, Ohio's prison budget should benefit from a Medicaid expansion. According to the Ohio Department of Rehabilitation and Corrections, in 2012 Ohio spent almost $28 million on prisoners' inpatient costs. Given utilization management strategies used in this system, we assumed a lower cost trend (3 percent) than used in other estimates.[3] Based on these cost trends we estimate that Ohio will spend $30 million in SFY 2014 and $37 million in SFY 2022.

Table 4 shows the estimated savings from shifting inpatient costs of state prisoners from 100 percent funded by the state prison budget to Medicaid funding for newly eligible adults, with the federal government paying between 90 and 100 percent of these costs, depending on the year. Our analysis estimates that this opportunity will result in $15 million dollars of savings in SFY 2014 rising to $34 million in SFY 2022.

table 4. Savings on inpatient care to prisoners (millions)

Fiscal year	Savings on inpatient care to prisoners
2014*	$15
2015	$31
2016	$32
2017	$32
2018	$32
2019	$32
2020	$33
2021	$33
2022	$34
Total:	**$273**

Source: OSU 2013. **Note:** columns may not total due to rounding.

Mental Health and Substance Abuse Treatment

There are several other potential state savings that are challenging to quantify. Most of these savings relate to state spending to assist people who are currently uninsured. Ohio's health-related state agencies, such as the Ohio Departments of Mental Health, Alcohol and Drug Addiction Services and Health, currently fund some health services for people without insurance. Funding typically is distributed to local governmental entities or local agencies that provide these services. Local governmental entities may also have local funding generated through levies that pay for services for people without insurance. An expansion of Medicaid will reduce the number of uninsured and provide federal funding to replace services that are entirely funded by state and local dollars today. These state and local dollars can then be used to provide services to those who will remain uninsured or provide services that are not a part of a Medicaid benefit package, such as housing or employment supports.

In the case of mental health and alcohol and drug addiction spending, estimating the specific amount of state savings, as opposed to local savings, is not possible with existing reporting methods. For instance, in SFY 2011 local governmental entities known as county behavioral health boards "spent $98.3 million on treatment services included in the mental health Medicaid package for the uninsured."[4] Based on the information available to us, we could estimate neither the proportion paid by the state nor the amount spent to serve adults who could qualify as newly eligible based on income at or below 138 percent of FPL. A similar situation exists for funding of alcohol and drug addiction services.

Looking at the issue from a slightly different perspective, in SFY 2013 approximately $60 million dollars in state mental health funding (SFY 2013 MH 335-505 allocation) and approximately $10 million dollars in state alcohol and drug addiction funding (SFY 2013 ADA 401 and 475 allocations) was distributed to local boards. However, with the exception of $14.6 million that was designated for specific mental health purposes, consistent data are not available showing the precise use of these funds. We could not determine, at this time, the proportion that could be replaced by Medicaid funding for newly eligible adults under an expansion.

Other Medicaid program savings

Within the Medicaid program itself there are several other possible sources of savings that we have not included in our estimates of the fiscal impact of expansion:

- *Family Planning Waiver Program:* Ohioans qualifying for this program would become eligible for coverage through Medicaid expansion or on the health insurance exchange. They should prefer either coverage option as the family planning waiver offers a limited benefit package that only covers family planning services. Their pre-ACA coverage consisted of less than full-scope Medicaid, so they can qualify as newly eligible adults if their income does not exceed 138 percent FPL.
- *Transitional Medical Assistance (TMA):* Individuals covered through TMA have experienced an income increase that makes them no longer financially eligible for Medicaid. Current Medicaid rules allow these individuals to maintain their Medicaid coverage for between six months to a year as an incentive for people to seek higher incomes. If the federal Centers for Medicare and Medicaid Services (CMS) permit Ohio to cover these individuals as newly eligible, benefiting from enhanced match, the state would receive additional Medicaid savings of more than $100 million a year.
- *Pregnant Women:* Along similar lines, our estimates do not include savings on pregnant women with incomes at or below 138 percent FPL. In theory, such women who would have qualified for Medicaid under the state's pre-ACA rules should be ineligible for enhanced federal funding

as newly eligible adults. In practice, however, most such women will enroll before they become pregnant. They will receive coverage as newly eligible adults, with enhanced federal funding. CMS has ruled that states do not need to track whether newly eligible adults become pregnant. It is not yet clear whether, as a result, states can simply claim enhanced match for such women among the other newly eligible adults. If they can, Ohio could realize substantial additional savings not shown here.

Question 3: How does a Medicaid expansion affect state revenue?

Along with savings from existing spending, Medicaid spending will increase state revenues in three different ways, including:

- Increased Medicaid managed care tax revenues
- Increased general state revenue dollars
- Increased pharmacy rebate revenues

Medicaid payments to managed care plans are subject to a 1 percent health insuring corporation (HIC) tax and a 5.5 percent sales and usage tax. These payments are also subject to local sales and usage tax, which averages 1.35 percent across all 88 Ohio counties.

This tax applies only on the spending that comes through managed care plans in the form of capitation payments. The tax does not apply to that portion of the capitation payment that reimburses the Medicaid managed care plans for the tax obligation.

In estimating the managed care tax revenue, this analysis estimated the portion of new spending that is expected to go to managed care plans. According to the current Medicaid state budget book, 12 percent of total spending for the CFC population is fee-for-service (FFS) spending and 88 percent is for managed care. Since we expect the expansion population will resemble the CFC population experience much more than the ABD population experience, we projected that 88 percent of total spending would be subject to the managed care tax. Before calculating the tax we then reduced that amount by 7.85 percent to remove the cost of the tax from the amount on which state taxes are levied.

We next calculated the revenues that would be earned under the 1 percent HIC tax, the 5.5 percent state sales and usage tax, and the 1.35 percent local sales and usage tax. In calculating state revenues, we only included the revenues from the 1 percent HIC tax and the 5.5 percent state sales tax. We show the local sales tax revenues in a later section.

In calculating the state revenue, we offset a revenue loss that will result from Medicaid expansion. Such an expansion would reduce the number of people covered in the exchange since it would prevent citizens and qualified immigrants with incomes between 100 and 138 percent of FPL from receiving subsidized coverage in the exchange. The latter coverage generates revenue through either the 1 percent HIC tax or the 1.4 percent insurance premium tax. We therefore subtract this lost revenue from the state's increased receipt of managed care taxes in estimating the net state revenue gains from taxation on insurance premiums. To be conservative in our estimate, we assumed the revenue lost estimate from the higher of the two potentially applicable tax rates.

We do not offset the state's payment, through Medicaid, of part of these managed care tax costs, since those state payments are also included in our estimates of the increased state expenditures that would result from higher enrollment under the Medicaid expansion. To analyze net state budget effects of expansion, managed care costs paid by Medicaid need to be treated in the same way for both the cost analysis and the revenue analysis. We have done this by including these costs in both places, but one could achieve the same result by excluding them from both categories.

Table 5 shows the estimated net state revenues from the Medicaid managed care tax for both the Urban Institute and the OSU model results, which rise from $33 to $279 million under the Urban Institute model and from $46 to $243 million under the OSU model.

table 5. Net increase in state managed care tax revenues resulting from Medicaid expansion, under Urban Institute (UI) and OSU estimates: FY 2014-2022 (millions)

Fiscal year	UI	OSU
2014*	$33	$46
2015	$108	$132
2016	$155	$164
2017	$190	$183
2018	$214	$195
2019	$230	$206
2020	$245	$218
2021	$262	$230
2022	$279	$243
Total:	**$1,717**	**$1,617**

Source: Urban Institute HIPSM 2013; OSU 2013.
Note: columns may not total due to rounding.

State general revenue

A Medicaid expansion would cause the state to receive a large increase in federal dollars as shown in Table 6. These dollars vary between the Urban Institute and OSU models:

- increasing from $1 billion in SFY 2014 to $5 billion in SF 2022 under the Urban Institute model; and
- increasing from $1.3 billion to $4.4 billion under the OSU model.

These new federal Medicaid funds resulting from expansion would be slightly offset by a loss of federal subsidy dollars that otherwise would have funded exchange coverage for citizens and qualified aliens with incomes between 100 and 138 percent FPL. The net result of these two trends is a substantial infusion of additional federal funds to purchase health care services. The health care providers receiving these dollars in turn would buy other goods and services, much of it from Ohio businesses. The resulting increase in economic activity generates increased state revenue from state sales taxes and individual and corporate income taxes.

To estimate these macroeconomic and revenue effects, our analyses used the Tax-PI model from Regional Economic Models, Inc. (REMI). In the past, REMI's modeling has been used by Ohio policymakers to estimate the effects of the Commerical Activity Tax (CAT) changes. REMI's analysis quantifies the health care dollars that are spent within the state's borders and those are that are spent in other states, based on data about prior patterns of health care spending by Ohio residents. Put differently, REMI distinguishes between Ohio residents' increased demand for health care, resulting from Medicaid expansion, and the purchase of health care from Ohio providers. Most such demand, but not all, translates into increased sales of health care goods and services. Likewise, REMI estimates the extent to which health care providers purchase other goods and services within the state, based on historical trend data.

table 6. Increase in federal Medicaid funds resulting from Medicaid expansion, under UI and OSU estimates: FY 2014-2022 (millions)

Fiscal year	UI	OSU
2014	$1,000	$1,339
2015	$2,466	$2,862
2016	$3,282	$3,346
2017	$3,802	$3,598
2018	$4,076	$3,690
2019	$4,295	$3,858
2020	$4,495	$3,991
2021	$4,723	$4,152
2022	$5,026	$4,386
Total:	$33,165	$31,222

Source: Urban Institute HIPSM 2013; OSU 2013.

The economic impact in terms of employment, earnings, and growth is described later. For purposes of the state budget analysis, REMI's analysis found, using the results of both Urban Institute and OSU estimates, that a Medicaid expansion would increase total state general revenue by between $816 million (OSU model) and $857 million (Urban Institute model) from SFY 2014 through SFY 2022 (see Table 7).

table 7. Increased state sales and income tax revenue resulting from Medicaid expansion under UI and OSU cost and coverage estimates and REMI macrosimulation: FY 2014-2022 (millions)

Fiscal year	UI	OSU
2014	$25	$35
2015	$61	$76
2016	$82	$87
2017	$97	$94
2018	$106	$97
2019	$113	$101
2020	$118	$104
2021	$124	$108
2022	$132	$114
Total:	$857	$816

Source: Urban Institute HIPSM 2013; OSU 2013, REMI, 2013.
Note: columns may not total due to rounding.

Prescription drug rebates

Under current Medicaid rules, Ohio receives prescription drug rebates from prescription drug manufacturers for pharmacy spending. According to Ohio Medicaid data, the rebates come to 46.65 percent of prescription drug costs for managed care adults and 21.64 percent for managed care children, and 54.2 percent for fee-for-service adults and 25.14 percent for fee-for-service (FFS) children. There is also a two quarter lag on collections of the rebates.
To calculate the amount of prescription drug savings, this analysis used the expected percent of expenditures for children and adults to be occurring under managed care and FFS payments, as described above, based on the state's prior Covered Families and Children (CFC) experience. The analysis then created a blended per member-per month (PMPM) rate based on these percentages and multiplied that percentage across the estimated spending for pharmaceuticals in each year.

Ohio shares these rebates with the federal government, based on the percentage of Medicaid pharmaceutical costs paid by the federal government.

table 8. Increased prescription drug rebates resulting from Medicaid expansion, under UI and OSU estimates: FY 2014-2022 (millions)

Fiscal year	UI	OSU
2014	$1	$1
2015	$3	$4
2016	$3	$5
2017	$20	$21
2018	$25	$25
2019	$31	$31
2020	$43	$42
2021	$45	$45
2022	$47	$47
Total:	**$218**	**$221**

Source: Urban Institute HIPSM 2013; OSU 2013.

Accordingly, during CY 2014 to 2016, the state receives rebate revenue only for the currently eligible but not enrolled individuals who join Medicaid because of an expansion. In later years, as Ohio begins paying a small proportion of costs for newly eligible adults, it begins receiving increased rebate revenue for the prescription drug coverage furnished to those adults. Table 8 shows the following:

- According to Urban Institute estimates, prescription drug rebates resulting from a Medicaid expansion start at $1 million in SFY 2014 and grow to $47 million in SFY 2022. Total prescription rebate revenue is estimated to be $218 million between SFY 2014 and SFY 2022.
- According to OSU's estimates, prescription rebate revenue also starts at $1 million in SFY 2014 and rises to $47 million in SFY 2022. OSU estimates that prescription drug rebate revenue totals $221 million between SFY 2014 and SFY 2022.

Question 4. What would be the net effect of Medicaid expansion on the state budget?

Adding the Medicaid expansion to the rest of the ACA would create state costs, allow state savings, and affect state revenue. Putting all these effects together yields a clear picture of expansion's overall impact on the state budget:

- For the next three and a half biennia — that is, through FY 2020 — the expansion would have an unequivocal positive impact on the state budget. Net fiscal gains would range between $350 million and $400 million during SFY 2014-2015 to between $133 and $142 million in SFY 2020 (Table 9).
- State Fiscal Year 2021 is the first complete fiscal year during which federal funding for newly eligible adults is at the 90 percent level — the

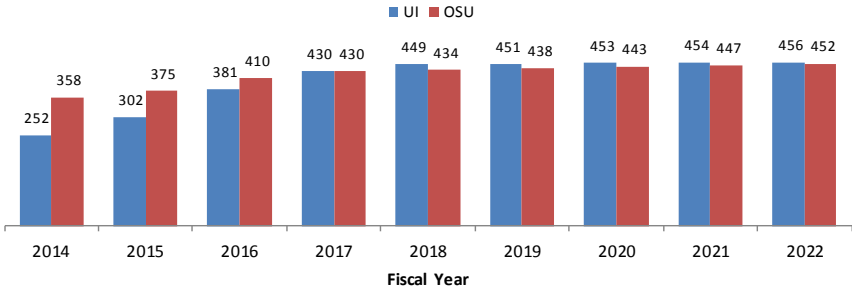
table 9. Overall impact of Medicaid expansion on the state budget, under UI and OSU estimates (millions)

Fiscal year	Increased state costs from more Medicaid enrollment		Savings (spend-down adults, BCCP, inpatient prison costs, retroactive and other pre-MCO costs)	Revenue (taxes on managed care plans, general revenue, drug rebates)		Net state fiscal gains	
	UI	OSU		UI	OSU	UI	OSU
2014	$13	$22	$53	$59	$82	**$99**	**$113**
2015	$30	$48	$110	$172	$212	**$252**	**$274**
2016	$38	$57	$185	$240	$256	**$387**	**$384**
2017	$147	$156	$191	$307	$298	**$351**	**$333**
2018	$284	$278	$196	$345	$317	**$257**	**$235**
2019	$347	$333	$203	$374	$338	**$230**	**$208**
2020	$472	$439	$208	$406	$364	**$142**	**$133**
2021	$580	$529	$215	$431	$383	**$66**	**$69**
2022	$617	$559	$226	$458	$404	**$67**	**$71**
Total:	**$2,529**	**$2,421**	**$1,587**	**$2,792**	**$2,654**	**$1,851**	**$1,820**

Source: OSU 2013; Urban Institute HIPSM 2012; REMI 2013. **Note:** "UI" refers to Urban Institute estimates. Table does not include possible savings from obtaining higher federal matching funds for people with incomes below 138percent FPL who currently receive Medicaid through Transitional Medical Assistance, the family planning waiver, pregnancy-based coverage, or Medicaid Buy-In for Working People with Disabilities. It also does not include savings from existing state spending, other than on inpatient care for prisoners, that goes to provide medical services to the uninsured. Columns may not total due to rounding.

same level where it will stay thereafter, under current federal law. During both SFY 2021 and 2022, the net fiscal gains remain positive, with both the Urban and OSU models estimating net fiscal savings of $67 million to $71 million in both years.

figure 4. The number of Ohio uninsured who would gain coverage from a Medicaid expansion under Urban Institute and OSU estimates (thousands)



Source: Urban Institute HIPSM 2013; OSU 2013. **Note:** FY 2014 results are for January through June 2014. Figure shows the difference between the total number of uninsured, with and without a Medicaid expansion, in each year. It does not show the number of additional uninsured who will gain coverage each year. Figure shows net effects of changes to Medicaid and private coverage. Figure shows the impact of Medicaid expansion. Figure does not include the uninsured who will gain coverage under the ACA's other provisions.

The significance of positive results for FY 2021-22 should not be overstated. The inherent uncertainties of projecting costs and revenues this distance into the future are considerable. That said, what both the Urban Institute and OSU modeling show is that, in the "steady state" that will begin in FY 2021, the state's fiscal gains are roughly comparable to the state's costs of Medicaid expansion, with a reasonable likelihood of ongoing, small net budget gains.

This steady state should not be too surprising in Ohio. As noted above, Ohio's managed care tax brings in revenues that equal 6.5 percent of capitated payments. In effect, the tax raises approximately 60 percent of the state's required 10 percent share of spending for newly eligible adults under the expansion. All the other savings and revenues need cover only the remaining 40 percent of the state's costs.

5. How would a Medicaid expansion affect Ohio residents?

Medicaid expansion would affect state residents in many ways that go beyond the state budget.

Fewer uninsured

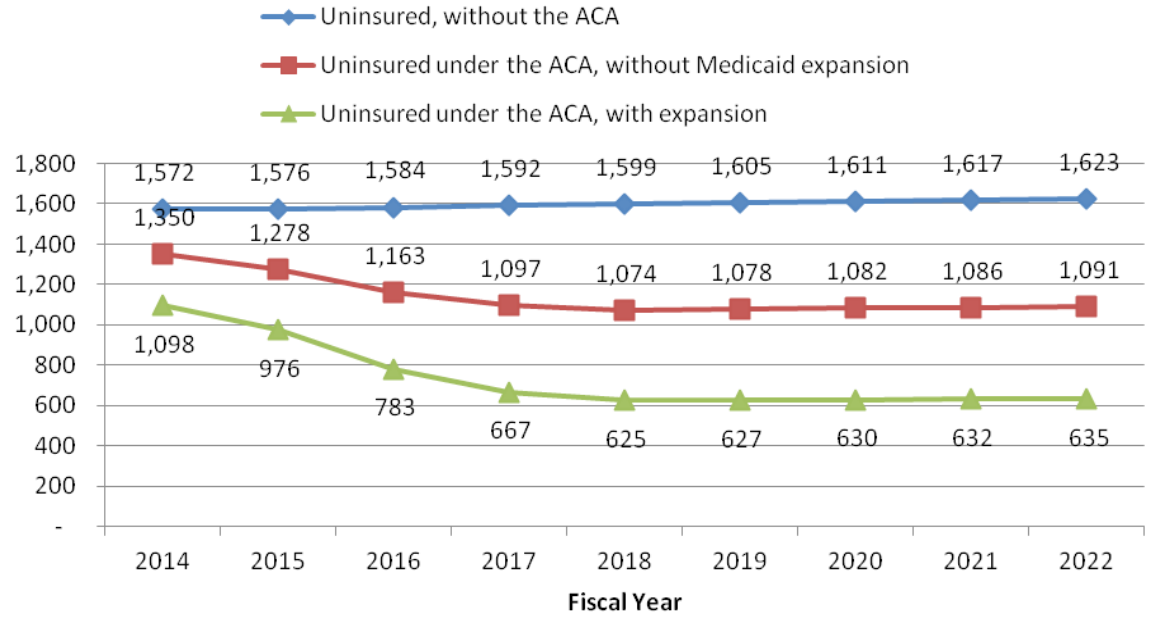
Many more people would be uninsured without a Medicaid expansion. Adults without dependent children with incomes below 100 percent FPL and parents with incomes between 90 and 100 percent FPL would be ineligible for subsidized health coverage. The vast majority of these adults would be uninsured. Further, without a Medicaid expansion, people with incomes between 100 and 138 percent FPL might qualify for subsidized coverage in health insurance exchanges (HIX), rather than Medicaid. Some who would have enrolled in Medicaid would decline HIX coverage, because of higher premium costs or the risk of owing money to the Internal Revenue Service if annual income turns out to exceed projected levels. Further, those who are offered employer-sponsored insurance (ESI) where worker-only coverage costs no more than 9.5 percent of household income will be ineligible for HIX subsidies. The net result of these factors is that, by the time it is fully phased in, the Medicaid expansion would cover, by the end of the nine-year period for which we provide estimates, more than 450,000 Ohio residents who otherwise would be uninsured (Figure 4).

With or without a Medicaid expansion, the ACA will reduce the number of Ohio uninsured. Many will receive subsidized coverage in the HIX. Others who currently qualify for Medicaid but are not enrolled will sign up, for multiple reasons explained above. Still others with incomes too high for any form of help but who have preexisting conditions that prevented them from obtaining individual coverage will be able to purchase insurance due to the ACA's prohibitions of insurance company discrimination against people with health problems. And still others will be motivated to purchase coverage by the ACA's legal requirement for individuals to obtain insurance. The net effect is that, without a Medicaid expansion, the number of uninsured in Ohio will decline by roughly 532,000 as of FY 2022. Adding the Medicaid expansion would cause the number to decline still further, by more than 450,000 people (Figures 5 and 6).

Whether or not the state implements the Medicaid expansion, the state will continue to have thousands of uninsured residents, for many reasons. For example, according to Urban Institute estimates for CY 2022, under the ACA with a Medicaid expansion (Figure 7):

- 44,000 uninsured will be undocumented immigrants who are ineligible for help;
- 291,000 uninsured will qualify for Medicaid or CHIP but not be enrolled;

figure 5. The number of Ohio uninsured, with and without the ACA, with and without a Medicaid expansion, under Urban Institute estimates (thousands)



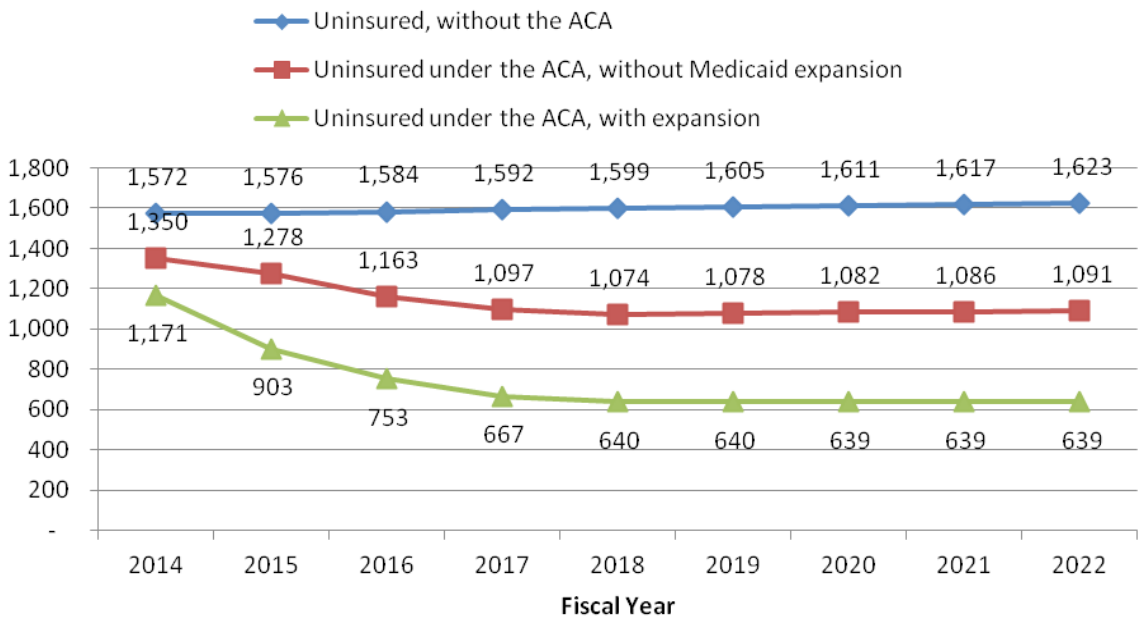
Source: Urban Institute HIPSM 2013. FY 2014 results are for January through June 2014.

- 189,000 uninsured will qualify for HIX subsidies but not be enrolled; and
- 112,000 uninsured will be ineligible for any form of assistance and will not buy unsubsidized coverage. They will be ineligible, either because their income exceeds 400 percent FPL or they are income-eligible for exchange subsidies but disqualified by an offer of ESI that the ACA classifies as affordable.

More employment and economic growth

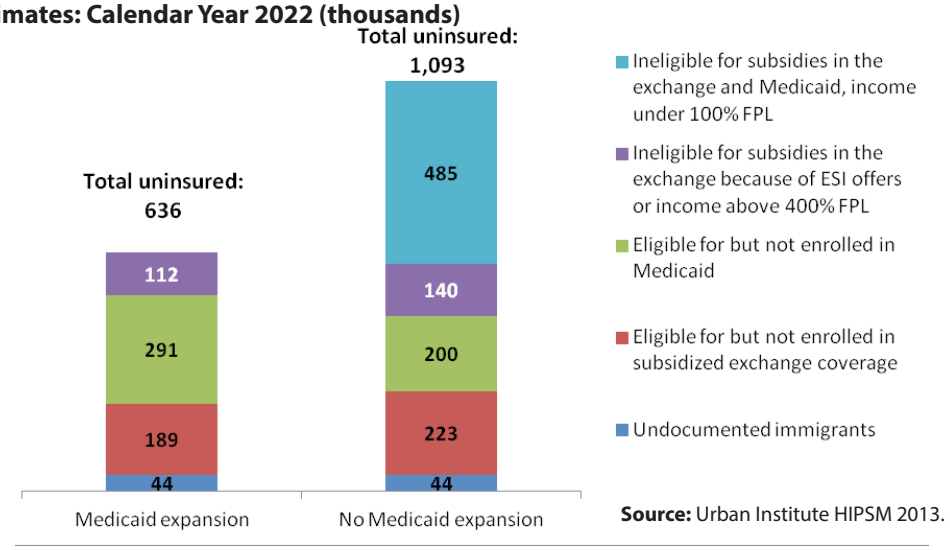
With a Medicaid expansion, many more federal dollars would buy health care from Ohio doctors, nurses, hospitals, and other providers. Those providers will, in turn, purchase other goods and services, much of it from other Ohio businesses. The net result is increased economic activity within the state's borders, creating employment.

figure 6. The number of Ohio uninsured, with and without the ACA, with and without a Medicaid expansion, under OSU estimates (thousands)



Source: OSU 2013. FY 2014 results are for January through June 2014.

figure 7. **Uninsured Ohioans under the ACA, with and without a Medicaid expansion under Urban Institute estimates: Calendar Year 2022 (thousands)**



Source: Urban Institute HIPSM 2013.

To assess these affects accurately, we considered not just the increased federal Medicaid dollars that would result from expansion but also the reduction in federal HIX subsidies, since a Medicaid expansion would eliminate HIX subsidy eligibility for people between 100 and 138 percent FPL. Even taking this into account, we found that a Medicaid expansion would:

- As of FY 2015, the end of the coming biennium, create between 23,000 (Urban) and 28,000 (OSU) new Ohio jobs, both in health care and other industries;
- Increase the earnings of Ohio residents by between $17.5 billion (Urban) and $16.7 billion (OSU) over the entire FY 2014-2022 period; and
- From 2014 to 2022, increase total economic activity in Ohio by between $19.8 billion (Urban) and $18.6 billion (OSU) (Tables 10 and 11).

We did not seek to analyze whether the ACA, as a whole, will help or harm the economy, a hotly contested issue on which opinions differ. Rather, we focused on the narrow question raised by the specific policy choice that is before the state's leadership: namely, if the Medicaid expansion were added to the rest of the ACA, would that strengthen or weaken Ohio's economy? Using two different projection methodologies from the Urban Institute and OSU to "feed into" REMI's macroeconomic model for Ohio, we find a clear positive impact of expansion on the state's employment and economic growth.

Lower health care costs for Ohio businesses and residents

Without a Medicaid expansion, employers will pay more for health care. Some poor or near-poor workers who, under the ACA's original design, were slated to be enrolled in Medicaid will instead sign up for their company's health plan. From FY 2014 through FY 2022, a Medicaid expansion would thus save a total of $1.7 billion for the state's employers (Table 12). Also, under the ACA, employers with over 50 full time employees can experience penalties if they do not offer coverage or offer coverage that is deemed to be unaffordable. The penalty is triggered when an employee receives a premium tax credit for coverage offered through the HIX. Accessing Medicaid coverage does not trigger an employer penalty. Therefore, employers with full time employees with incomes between 100-138 percent FPL could experience increased penalties if Medicaid is not expanded.

An even greater effect will be felt by poor and near-poor state residents. Without a Medicaid expansion, many who would have joined Medicaid instead will remain uninsured or obtain insurance with cost-sharing well above Medicaid levels. As a result, a Medicaid expansion would lower health care costs for Ohio consumers by an estimated $7.4 billion over the next nine years (Table 12).

Fiscal gains for counties

Implementing the Medicaid expansion would reduce some counties' health care costs. Many poor and near-poor uninsured, who now receive care funded by local levies, would instead receive Medicaid for which the state and federal governments share financial responsibility.

We were not able to estimate all of these savings,

table 10. The effects of Medicaid expansion on the Ohio economy under Urban Institute and REMI estimates

Fiscal year	Increased employment	Increased earnings (millions)	Increased economic activity (millions)
2014	9,459	$487	$663
2015	22,657	$1,227	$1,614
2016	28,384	$1,660	$2,077
2017	31,210	$1,963	$2,348
2018	32,033	$2,168	$2,480
2019	31,989	$2,317	$2,550
2020	31,599	$2,429	$2,594
2021	31,401	$2,551	$2,656
2022	31,872	$2,718	$2,779
	Total:	$17,520	$19,761

Source: Urban Institute/HIPSM 2013; REMI 2013. **Note:** Results show the effects of Medicaid expansion, based on increased federal funding buying Ohio health care, including increased federal Medicaid dollars and fewer federal exchange subsidy dollars. Results shown here do not include effects of other ACA provisions.

table 11. The effects of Medicaid expansion on the Ohio economy under OSU and REMI estimates

Fiscal year	Increased employment	Increased earnings (millions)	Increased economic activity (millions)
2014	13,625	$700	$949
2015	28,162	$1,528	$1,990
2016	29,831	$1,770	$2,170
2017	29,712	$1,908	$2,223
2018	28,640	$1,987	$2,206
2019	28,226	$2,087	$2,238
2020	27,435	$2,148	$2,239
2021	26,900	$2,222	$2,262
2022	27,056	$2,340	$2,345
	Total:	$16,689	$18,622

Source: OSU 2013; REMI 2013. **Note:** Results show the effects of Medicaid expansion, based on increased federal funding buying Ohio health care, including increased federal Medicaid dollars and fewer federal exchange subsidy dollars. Results shown here do not include effects of other ACA provisions. Columns may not total due to rounding.

table 12. The effect of not expanding Medicaid on health care costs for Ohio employers and consumers (millions)[5]

Fiscal year	Increased employer costs, without an expansion	Increased consumer costs, without an expansion
2014	$9	$308
2015	$61	$657
2016	$135	$733
2017	$191	$803
2018	$222	$865
2019	$236	$920
2020	$252	$979
2021	$268	$1,042
2022	$285	$1,109
Total:	**$1,659**	**$7,415**

Source: Urban Institute HIPSM 2013. **Note:** Columns may not total due to rounding

which vary greatly among counties. In particular, we could not estimate fiscal gains that would be experienced by the relatively few large, urban counties that currently spend substantial funds providing health care to people who are uninsured and poor. Also, many counties have levies that support mental health and alcohol and drug addiction services. As discussed earlier in this brief, an expansion of Medicaid will reduce the number of uninsured and provide federal funding to cover services that are entirely funded by state and local dollars today. These state and local dollars can then be used to provide services to those who will remain uninsured or provide services that are not a part of a Medicaid benefit package, such as housing or employment supports, or be redirected to other local priorities.

Counties would also achieve revenue gains, only some of which we could estimate. In particular, a

table 13. Impact of Medicaid expansion on county sales tax revenue, under UI and OSU models: FY 2014-2022 (millions)

Fiscal year	UI	OSU
2014	$9	$12
2015	$27	$32
2016	$36	$37
2017	$43	$41
2018	$48	$43
2019	$51	$46
2020	$54	$48
2021	$58	$51
2022	$62	$54
Total:	$387	$364

Source: Urban Institute HIPSM 2013; OSU 2013. Estimates assume the same revenue lags that apply to state sales taxes. **Note:** Columns may not total due to rounding.

Medicaid expansion would increase the amount being spent on Medicaid managed care. Counties as a whole receive sales tax revenue equal to 1.35 percent of such premium payments, as noted earlier. Over the FY 2014-2022 period, these increased revenues would total between $364 and $387 million (Table 13).

Counties would also experience general revenue gains from the increased economic activity that would result from expansion. As explained earlier, more federal dollars buying Ohio health care increases the purchasing of goods and services in many different sectors. This increases general revenues for counties and the state alike. At this stage of the project, we were not able to provide estimates of these effects at the county level. A forthcoming analysis will work to project these effects at the regional level and in some specific counties.

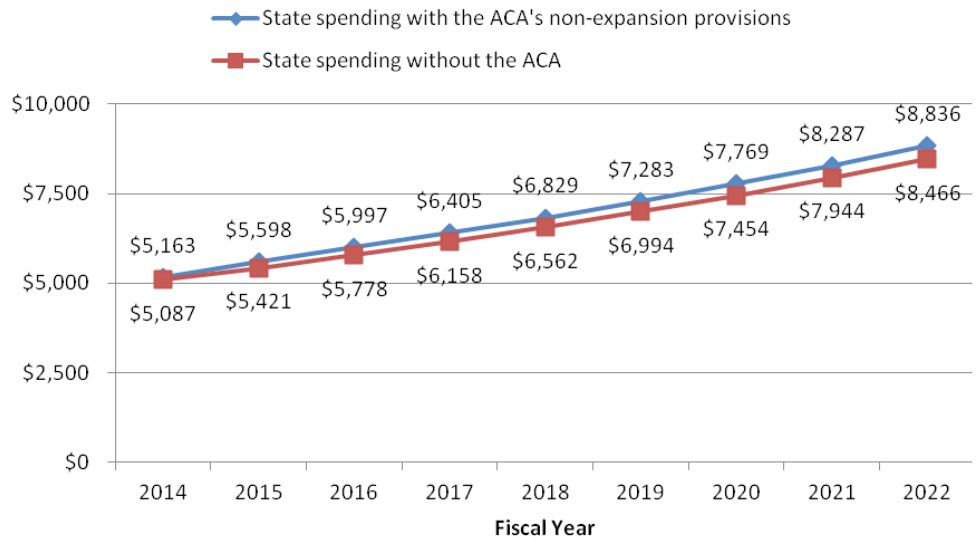
6. What budget effects will the ACA create, even if Medicaid is not expanded?

Without a Medicaid expansion, many of the people who qualify for Medicaid and CHIP but have not enrolled will sign up for coverage, for the reasons described earlier: namely, the ACA's individual coverage requirement; new subsidies in the HIX; increased awareness of the availability of health coverage; the automatic routing of applications from the HIX to Medicaid when applicants appear Medicaid-eligible; other streamlined methods for Medicaid eligibility determination, enrollment, and retention; and general publicity around expanded health coverage.

When currently eligible people enroll in larger numbers, Ohio receives the standard federal matching rate for Medicaid, rather than the highly enhanced rate for newly eligible adults. In addition, the ACA's fee imposed on for-profit insurers will increase state costs for Medicaid managed care arrangements that were in effect regardless of the ACA. Because of these two factors, the state's cost of the ACA, without implementing the expansion, rise from $90 to $119 million in FY 2014 to between $436 and $457 in FY 2022 (Figure10).

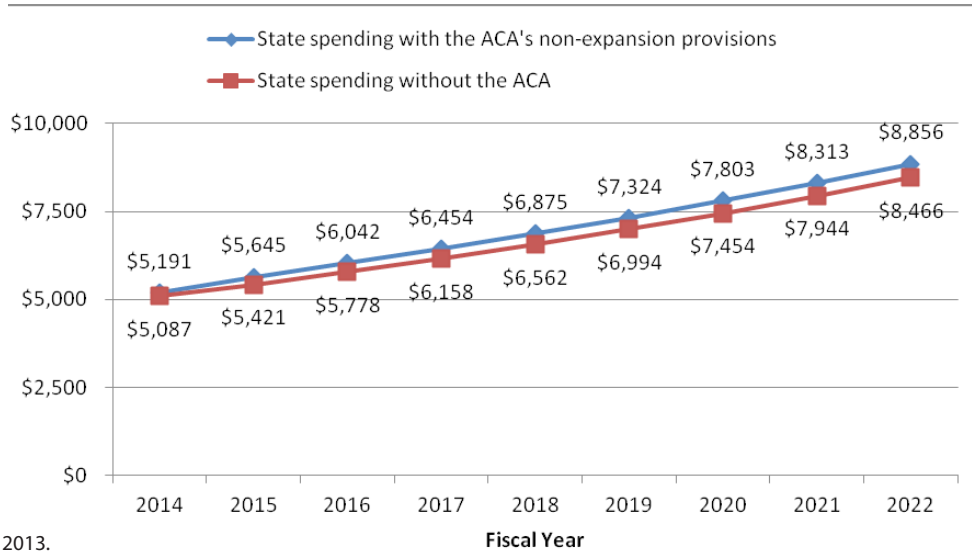
At the same time, the ACA's non-expansion provisions will result in offsetting state budget gains. Most of those gains are like those described above in connection with the expansion:

figure 8. Impact of the ACA's non-expansion provisions on state Medicaid costs resulting from increased participation under Urban Institute estimates (millions)



Source: Urban Institute HIPSM 2013. **Note:** This figure does not include the effects of the ACA insurer fee.

figure 9. Impact of the ACA's non-expansion provisions on state Medicaid costs resulting from increased participation under OSU estimates (millions)



Source: OSU 2013.
Note: These estimates include the Urban Institute's baseline projection of state non-ACA Medicaid costs. This figure does not include the effects of the ACA insurer fee.

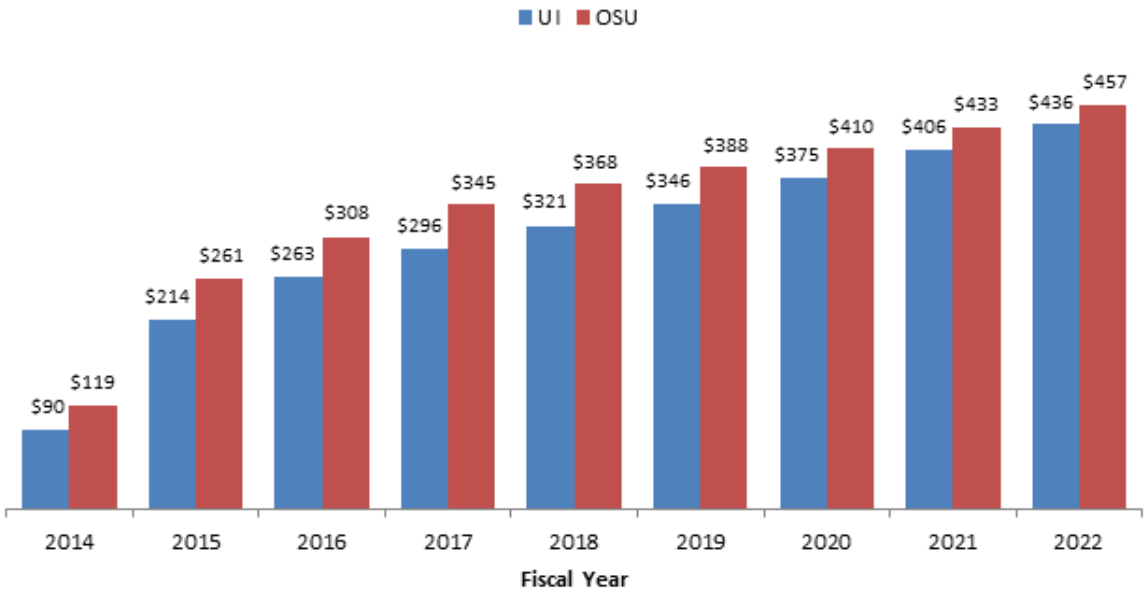
- Increased participation reduces the amount of Medicaid spending on retroactive eligibility;
- When more consumers receive Medicaid, the state receives more prescription drug rebates; and
- With more Medicaid managed care, the state receives additional managed care tax revenue.
-

However, other offsets are either entirely new or different in character from those that apply to the Medicaid expansion:

- The ACA increases federal matching rates for CHIP;
- Subsidized individual coverage in the HIX will provide the state with premium tax revenue; and
- Federal subsidies in the HIX will purchase considerable Ohio health care, generating economic growth and yielding general state revenue.

Other potential costs, savings, and revenues could not be estimated, including the following:

figure 10. State budget impact of ACA's non-expansion provisions: cost of increased participation by currently eligible but not enrolled consumers and ACA insurer fee, under UI and OSU estimates (millions)



Source: Urban Institute HIPSM 2013; OSU 2013.
Note: Figure does not include effects of higher federal matching rates for certain current beneficiaries.

- The administrative cost effects described previously; and
- The potential state savings achieved by moving adults with incomes above 100 percent or 138 percent FPL from Medicaid into subsidized exchange coverage.

Table 14 shows the size of the offsets we could calculate.

Table 15 compares the cost of increased Medicaid enrollment, under the ACA's non-expansion provisions, with the offsets to those costs that result from the increased revenue and state budget savings itemized above. According to both models, the state costs of the ACA's non-expansion provisions are greater than the savings and revenue offsets. For the entire 9-year period covered by our estimates, these costs exceed the total revenues and savings by between $20 million and $185 million from SFY 2014 to SFY 2022.

Taking into account all the above described costs, Table 16 analyzes the impact of the ACA as a whole on the state budget. The first two columns show the effect of the key choice within the control of state officials — namely, whether to expand eligibility. The middle columns show the state budget effects that will occur without an expansion. The two columns on

table 14. Savings and revenue from ACA provisions other than expansion (millions)

Fiscal Year	Retroactive and backdated eligibility	CHIP match increase	Prescription drug rebates		State managed care tax		Premium tax revenue from HIX plans	General state revenue from increased growth		Net offsets to increased costs	
			UI	OSU	UI	OSU		UI	OSU	UI	OSU
2014	$0	$0	$6	$8	$8	$12	$15	$22	$24	**$51**	**$59**
2015	$0	$86	$19	$24	$23	$32	$31	$58	$61	**$217**	**$234**
2016	$16	$90	$24	$28	$30	$40	$33	$85	$89	**$278**	**$296**
2017	$17	$94	$27	$33	$34	$48	$36	$103	$107	**$311**	**$335**
2018	$18	$98	$29	$35	$38	$52	$38	$110	$115	**$331**	**$356**
2019	$19	$102	$32	$37	$41	$55	$40	$118	$122	**$352**	**$375**
2020	$20	$107	$35	$39	$44	$58	$43	$124	$129	**$373**	**$396**
2021	$21	$112	$38	$41	$48	$62	$46	$131	$135	**$396**	**$417**
2022	$22	$117	$41	$43	$52	$65	$48	$138	$141	**$418**	**$436**
Total:	**$ 133**	**$806**	**$251**	**$288**	**$318**	**$424**	**$330**	**$889**	**$923**	$2,727	$2,904

Source: OSU 2013; Urban Institute HIPSM 2012; REMI 2013. **Note:** "UI" refers to Urban Institute estimates. Table does not include possible savings from administrative simplification and possible revenue from increased federal matching funds for eligibility system and shifting higher-income Medicaid adults into subsidized HIX coverage.

table 15. Overall impact of the ACA's non-expansion provisions on the state budget (millions)

Fiscal year	Increased state costs from more enrollment (Figure 10)		Net offsets to increased costs (Table 14)		Net fiscal impact	
	UI	OSU	UI	OSU	UI	OSU
2014	$90	$119	$51	$59	-$39	-$60
2015	$214	$261	$217	$234	**$3**	-$27
2016	$263	$308	$278	$296	**$15**	-$12
2017	$296	$345	$311	$335	**$15**	-$10
2018	$321	$368	$331	$356	**$10**	-$12
2019	$346	$388	$352	$375	**$6**	-$13
2020	$375	$410	$373	$396	-$2	-$14
2021	$406	$433	$396	$417	-$10	-$16
2022	$436	$457	$418	$436	-$18	-$21
Total:	$2,747	$3,088	$2,727	$2,904	-$20	-$185

Note: columns may not total due to rounding.

table 16. The ACA's impact on the state budget, with and without a Medicaid expansion (millions)

Fiscal year	Impact of the Medicaid expansion (Table 9)		Impact of ACA, without expansion (Table 15)		Net impact of the ACA, with Medicaid expansion	
	UI	OSU	UI	OSU	UI	OSU
2014	$99	$113	-$39	-$60	$60	$53
2015	$252	$274	$3	-$27	$255	$247
2016	$387	$384	$15	-$12	$402	$372
2017	$351	$333	$15	-$10	$366	$323
2018	$257	$235	$10	-$12	$267	$223
2019	$230	$208	$6	-$13	$236	$195
2020	$142	$133	-$2	-$14	$140	$119
2021	$66	$69	-$10	-$16	$56	$53
2022	$67	$71	-$18	-$21	$49	$50
Total:	$1,851	$1,820	-$20	-$185	$1,831	$1,635

the right show the combined impact of all the ACA's provisions, if the state adds the Medicaid expansion to the remainder of the ACA.

This analysis of total budget costs, revenues, and savings shows that the net fiscal effects of the ACA as a whole, if the expansion is added, are positive in every state fiscal year. It also suggests that, without a Medicaid expansion, the remainder of the ACA would increase the state's budget deficit by a small amount during FY 2014; but that adding the Medicaid expansion yields a net fiscal surplus for the state of between $1.6 billion to $1.8 billion between 2014 and 2022.

From the perspective of state policymakers, however, the most important columns are those on the left of the table. These show the state budgetary impact of the only decision within Ohio control — namely, whether or not Ohio should implement Medicaid expansion.

Medicaid enrollment under the ACA, with and without a Medicaid expansion

Ohio's Medicaid enrollment will increase, even if Medicaid eligibility does not expand. As explained earlier, ACA's non-expansion provisions will cause

Why does the Administration project much higher costs from the non-expansion provisions of the ACA?

The main reason the Administration projects much higher costs is that state-contracting actuaries believe that, even though the ACA's coverage expansions and enrollment mechanisms are limited to people under age 65, seniors who currently qualify for Medicaid but are not enrolled will sign up, prompted by the publicity around health reform. This includes those who receive nursing home care from facilities that already have significant financial incentives to enroll patients into Medicaid after they have spent all their resources paying for care.

Neither the Urban Institute team nor the OSU modelers foresee such effects. They have not materialized in the three states that implemented significant state-based expansions over the past decade, Maine, Massachusetts and Wisconsin.[6] Although the rationale used by the state's actuaries would apply throughout the country, such effects are not forecast by the Congressional Budget Office, the Office of Management and Budget, or the CMS Office of the Actuary.

Note that, in addition to serious questions about whether seniors will be spurred to enroll, there are serious questions about the estimated per capita costs of the seniors who would be affected. The costs projected by the state's actuaries include very expensive nursing home residents, for whom it is particularly implausible to imagine a significant increased enrollment resulting from ACA implementation.

table 17. Increased Medicaid enrollment under the ACA, with and without a Medicaid expansion, under UI and OSU models: FY 2014-2022

Fiscal year	Increased enrollment under the ACA, without a Medicaid expansion		Additional enrollment if a Medicaid expansion is added to the rest of the ACA			
			Currently eligible people not enrolled in Medicaid pre-ACA		Newly eligible adults	
	UI	OSU	UI	OSU	UI	OSU
2014	55,626	80,192	11,551	17,011	153,959	260,360
2015	129,316	174,824	27,036	37,084	380,313	550,050
2016	157,785	203,984	33,271	43,270	497,799	609,264
2017	170,236	219,799	36,100	46,624	570,399	642,354
2018	174,760	221,799	37,150	47,090	603,111	648,777
2019	179,687	224,217	38,121	47,561	612,562	655,265
2020	184,353	266,459	38,932	48,036	621,051	661,817
2021	188,864	228,723	39,782	48,516	629,540	668,436
2022	193,525	231,010	40,571	49,003	638,244	675,120

Source: Urban Institute HIPSM 2012; OSU 2013.

some currently eligible people who are not yet enrolled to sign up for Medicaid. A relatively small additional group of such currently eligible people will join the program if a Medicaid expansion is added to the ACA's other provisions. However, the vast majority of new Medicaid enrollees under an expansion will be newly eligible.Table 17 shows the number and characteristics of new Medicaid enrollees, with and without a Medicaid expansion in Ohio.

Conclusion

The purpose of this study is to assess the comprehensive economic and fiscal effects of Medicaid expansion for Ohio. The report also estimates the net fiscal effects that will occur even without expansion.

Our analysis finds that Medicaid expansion creates net positive state fiscal and economic effects for Ohio in all state fiscal years, including in 2020 and beyond, when the state match rates reaches 10 percent. This finding results from the following specific conclusions:

- Medicaid expansion does generate new state costs, even beginning in SFY 2014. Over the SFY 2014-2022 period, these costs total $2.4 billion (OSU) to $2.5 billion (Urban).
- Medicaid expansion also generates substantial state budget savings ($1.6 billion). These savings result from both increased federal matching rates for current Medicaid spending and from reduced non-Medicaid spending on health care for the poor and near-poor uninsured, who would qualify as newly eligible under expansion.
- Medicaid expansion increases state revenue, even after adjusting for any lost general revenue or managed care tax revenue from fewer people obtaining coverage through the health insurance exchange. Over SFY 2014-2022, the net increase in revenue resulting from expansion totals between $2.7 billion (OSU) and $2.8 billion (Urban).
- The combination of budget savings and increased revenues results in Medicaid expansion producing positive net fiscal effects in each state fiscal year, including after the state match rate for newly eligible adults reaches its "steady state" of 10 percent in 2020. The net fiscal gains from expansion, over the 9-year period for which we provide estimates, total between $1.8 billion (OSU) and $1.9 billion (Urban). Put simply, Medicaid expansion pays for itself — and creates a positive state budget impact. In addition to paying for itself and creating a positive state budget impact, Medicaid expansion generates several additional benefits to Ohio's economy and Ohioans that would not occur without the expansion, including more than 450,000 uninsured Ohioans obtaining health coverage and more than 27,000 new jobs for Ohio residents.
- Medicaid expansion also creates local fiscal and economic benefits, including between $364 million (OSU) and $387 million (Urban) in new local managed care tax revenue

If Ohio does not expand Medicaid, other ACA provisions will produce net budget shortfalls. However, if the state adds Medicaid expansion to the remainder of the ACA, the state will experience net positive budget effects in every year from SFY 2014 through SFY 2022.

Many aspects of ACA implementation in Ohio are outside state officials' control. But one key choice is in state policymakers' hands—namely, whether to expand Medicaid. Using two very different methods of estimating the effects of that decision, we found adding expansion to the rest of the ACA would improve the state's budget balance, improve the state's economy, and reduce the number of uninsured.

Notes

1. In addition to premium subsidies, cost-sharing subsidies are available for people with income up to 250 percent of FPL.
2. Lawfully present immigrants fall into two groups: so-called "qualified aliens," whose immigration status permits Medicaid eligibility under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); and other lawfully present non-citizens. The largest number of immigrants in the latter category are immigrants whose status has been lawful for less than five years. Medicaid can cover children and pregnant women in this group, but it cannot cover other adults unless they are "qualified aliens." As noted elsewhere in the text, the ACA generally limits tax credits and other subsidies in the health insurance exchange (HIX) to citizens and lawfully present immigrants who are ineligible for Medicaid and CHIP and who have incomes between 100 and 400 percent FPL. There is one exception to the lower income-eligibility threshold, however. Lawfully present immigrants whose immigration status disqualifies them from Medicaid can qualify for HIX subsidies even though their income would ordinarily be too low for HIX subsidies. Accordingly, if Ohio does not expand Medicaid, "qualified aliens," under PRWORA, like citizens, will be ineligible for any help, whether from Medicaid or HIX subsidies, if they are childless adults under 100 percent FPL or parents with incomes between 90 and 100 percent FPL. At the same time, other "lawfully present immigrants," including those whose authorization to live and work in the U.S. has not lasted long enough to qualify for Medicaid, will receive federally-funded HIX subsidies even though they are childless adults living below poverty or parents with incomes between 90 and 100 percent FPL.
3. This likely underestimates savings. With the availability of federal Medicaid dollars for inpatient and institutional care furnished off prison grounds, the state may change its approach to determining which services are furnished on and off prison grounds.
4. Mental Health Advocacy Coalition and Center for Community Solutions. "By the Numbers 2: Developing a Common Understanding for the Future of Behavioral Health Care." November 2012.
5. In SFY 2015, the top ten sectors that will experience a rise in employment because of Medicaid expansion are: ambulatory services (36.1%); hospitals (19.8%); state and local government (7.8%); retail trade (6.1%); administrative and support services (5.3%); construction (5.3%); insurance carriers and related activities (4.0%); food services and drinking places (2.9%); real estate (2.2%) and professional, scientific, and technical services (2.2%).
6. Laura Snyder, Robin Rudowitz, Eileen Ellis and Dennis Roberts. "Medicaid Enrollment: June 2011 Data Snapshot." Kaiser Commission on Medicaid and the Uninsured and Health Management Associates. June 2012. Eileen R. Ellis, Dennis Roberts, David M. Rousseau, Tanya Schwartz. "Medicaid Enrollment in 50 States: June 2008 Data Update." Kaiser Commission on Medicaid and the Uninsured and Health Management Associates. September 2009.

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About the Ohio Medicaid Expansion Study

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The study was designed to provide an independent, neutral analysis of the impact of potential Medicaid expansion on:

- The state budget
- Ohio economic growth and jobs
- The number of uninsured
- Health coverage, jobs, economic growth, and revenue for regions within the state and some individual counties (to be released in February)