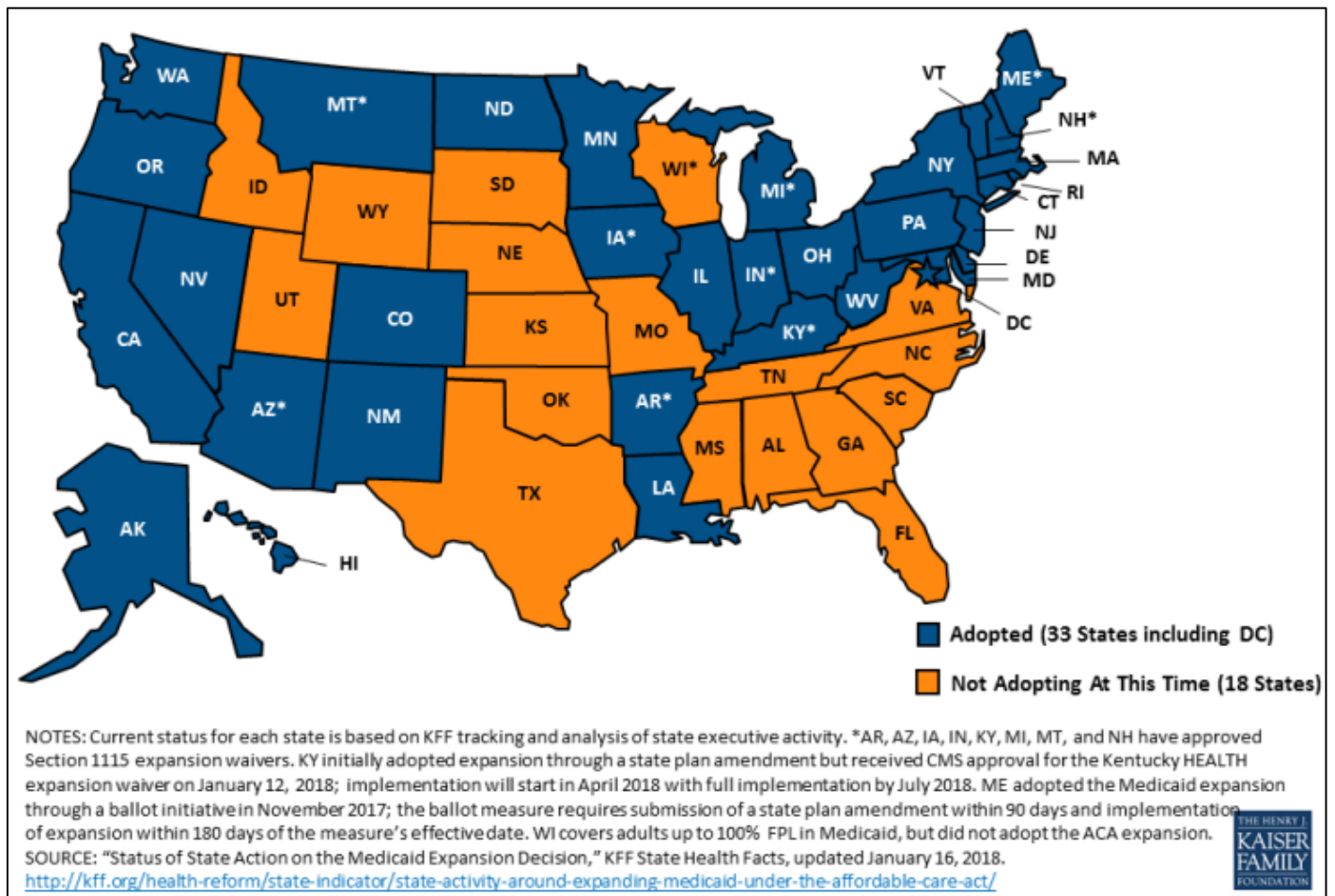


STATE MEDICAID EXPANSION EXPERIENCES

1. INTRODUCTION

The Patient Protection and Affordable Care Act (2010) included a provision that expanded Medicaid enrollment to childless, non-pregnant, non-disabled adults up to 138% of FPL. The Supreme Court ruled (June of 2012) that states have the right to decide if they will adopt this portion of the PPACA. Medicaid expansion coverage started January 1, 2014. As of January 2018 33 states have adopted Medicaid expansion (see map below from the Kaiser Family Foundation).

State Medicaid Expansion Decisions (as of January 2018)



2. ENROLLMENT PATTERNS

Most of the 33 states that have adopted Medicaid expansion initiated enrollment at the beginning of the expansion coverage period (January 1, 2014), and many made the decision to adopt in the 2012-2013 period. Montana's decision to expand Medicaid came later (Medicaid expansion enrollment in Montana began January 1, 2016). As discussed in the Medicaid Monitoring Report, Montana's expansion enrollment is about 91,500 as of January 2018; considerably higher than the enrollment estimate (45,723 by FY 2019 according to the SB 405 fiscal note,¹ 65,319 by FY 2019 according to the fiscal note for another Medicaid expansion bill²) at the time Medicaid expansion was signed into law in Montana. Examining the enrollment patterns in other states indicates Montana's experience of higher-than-expected Medicaid expansion enrollment is not unique.

In March 2015 the Congressional Budget Office (CBO) estimated the PPACA would result in about 10 million additional Medicaid enrollees nationally, with a reduction in uninsured of 17 million. A Centers for Medicare & Medicaid Services (CMS) report from December 2017 indicates an increase of about 16 million Medicaid enrollees in the post-PPACA period, 60% higher than the CBO projection. The Kaiser Family Foundation estimates a national total of 15.1 million Medicaid expansion enrollees in FY 2016³. A recent report from the U.S. Census Bureau (Barnett and Berchick 2017⁴) indicates the reduction of uninsured in the 2013-2016 period was 13.7 million.

¹ Available at http://leg.mt.gov/bills/2015/FNPDF/SB0405_1.pdf

² Available at http://leg.mt.gov/bills/2015/FNPDF/HB0249_1.pdf

³ All state FY 2016 Medicaid expansion enrollments are available at <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Expansion%20Group%20Enrollment%22,%22sort%22:%22asc%22%7D>

⁴ Available at <https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf>

Given national Medicaid expansion enrollment patterns (considerably higher than CBO projections) it is not surprising that many states have had similar experiences: actual Medicaid expansion enrollments have come in higher than estimate in many, though not all, expansion states. Consider the experiences of some expansion states similar to Montana (some of Montana’s traditional ‘peer states’ [Wyoming, Idaho, South Dakota] have not adopted Medicaid expansion):

| Montana Peer State Medicaid Expansion Enrollment Experiences | | | |
|--|----------------------------|---------------------------|----------------------|
| <u>State</u> | <u>Enrollment Estimate</u> | <u>FY 2016 Enrollment</u> | <u>Adoption Date</u> |
| Alaska ⁵ | 41,000 | 22,900 | September 2015 |
| Colorado ⁶ | 187,000 | 450,000 | January 2014 |
| Iowa ⁷ | 150,000 | 150,000 | January 2014 |
| Nevada ⁸ | 187,000 | 203,900 | January 2014 |
| New Mexico ⁹ | 149,000 | 253,000 | January 2014 |
| North Dakota ¹⁰ | 20,500 | 21,400 | January 2014 |

3. IMPACTS TO THE RATE OF UNINSURED

According to the federal Medicaid and CHIP Payment and Access Commission (MACPAC) several private surveys have indicated a significant relationship exists between a state’s decision to adopt Medicaid expansion and the state’s uninsured rate. Research suggests states that have adopted Medicaid expansion have lower uninsured rates than those that have not. A recent example of this research is the U.S. Census Bureau report mentioned above (Barnett and Berchick 2017) which indicates a lower uninsured rate (6.5%) in expansion states when compared to non-expansion states (11.7%).

4. EVIDENCE OF OTHER MEDICAID EXPANSION IMPACTS

The below paragraphs summarize several peer-reviewed articles on the various impacts of Medicaid expansion. Some caveats are needed: first, this is not a comprehensive review of academic research on this topic, but a sampling of what some researchers have found. Second, this research area is relatively new (recall that Medicaid expansion was not enacted until 2014) so the number of studies is low relative to other areas of research. Finally, the relative recency of the Medicaid expansion research area has not permitted much consensus among researchers to develop, so any research results should be viewed in the proper context.

⁵ Available at https://www.washingtonpost.com/national/health-science/judge-allows-alaska-governor-to-move-ahead-with-medicaid-expansion/2015/08/28/db2266ba-4db1-11e5-bfb9-9736d04fc8e4_story.html?utm_term=.c4955d975478

⁶ Available at http://statebillinfo.com/bills/fiscal/13/SB200_f1.pdf

⁷ Available at https://www.washingtonpost.com/news/post-politics/wp/2013/12/12/iowas-gop-governor-expands-medicaid-program-thursday/?utm_term=.8484a96acb5

⁸ Available at <https://lasvegassun.com/news/2012/dec/11/sandoval-supports-medicaid-expansion-nevada/>

⁹ Available at http://bber.unm.edu/media/publications/Medicaid_Expansion_10-12.pdf

¹⁰ Available at <http://www.grandforksherald.com/news/government-and-politics/3803221-north-dakota-spend-millions-more-originally-projected-medicaid>

Decker et al (2017) find the uninsured rate in expansion state fell by 7.5 percentage points more than the uninsured rate in non-expansion states in 2015. The authors also find Medicaid expansion is associated with an improvement in self-reported 'quality of health coverage' among low-income adults. Choi et al (2017) use state data along with data from the Behavioral Risk Factor Surveillance System and study individual access to and use of health care. The authors conclude Medicaid expansion significantly improved health care access for low-income individuals. Hudson and Moriya (2017) found evidence of the 'welcome mat' effect on low income children: when parents gained access to Medicaid under expansion their children (who were previously eligible) were more likely to enroll in Medicaid.

Ghosh et al (2017) examine the impact of Medicaid expansion on prescription drug use. The authors find expansion adoption is associated with a 19% increase in Medicaid-paid prescriptions. The largest increases in Medicaid-paid prescriptions were for diabetes drugs (24% increase), contraceptives (22%), and cardiovascular drugs (21%). Soni et al (2017) present evidence of a significant relationship between Medicaid expansion and cancer diagnosis: counties with Medicaid expansion had a 3.4% higher number of cancer diagnoses (and 6.4% higher number of early cancer diagnoses) than counties without expansion. McMorrow et al (2017) examined the impact of Medicaid expansion on low-income parents. The authors found expanded eligibility was associated with reduced problems paying medical bills and reduced psychological distress. McMorrow et al did not find significant evidence of a relationship between Medicaid expansion and self-reported perception of general health status.

Nikpay et al (2017) find Medicaid expansion was associated with a higher usage rate for the emergency department (ED): 2.5 more visits per 1,000 persons. The share of ED visits funded by Medicaid increased by 8.8 percentage points in expansion states, while the uninsured share decreased by 5.3 percentage points. Lindrooth et al (2018) examine the relationship between state Medicaid expansion adoption and the likelihood of hospital closures. The authors find state decisions to adopt Medicaid expansion were associated with a lower risk of hospital closure, especially in rural jurisdictions.

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