Talking points: The evidence on Medicaid expansion

Expanding Medicaid increases access to care.

Medicaid expansion improves beneficiaries' ability to access needed health care services.

- According to research published in Health Affairs, Medicaid expansion states experienced a 4.9 percentage point increase in the share of low-income adults with a usual source of care.[1] Separate research found an 11.6 percentage point increase in the proportion of low-income adults with chronic conditions who had regularly received care for those conditions, compared to non-expansion states.[2]

- A year after Medicaid expansion was implemented in Michigan more than half of enrollees had visited a primary care physician.[3] Medicaid expansion enrollees also participated in Michigan's voluntary health risk assessment program at twice the rate of privately insured residents.[4]

- Individuals enrolled in Medicaid experience a higher rate of behavioral health conditions than those with private insurance and may have difficulty accessing treatment. According to the Government Accountability Office, expansion states have increased behavioral health treatment availability compared to non-expansion states.[5]

- Recent research found a 5.1 percentage point drop in use of the emergency department as a usual source of care as a result of Medicaid expansion.[6] In Oregon, for example, the rate of patient visits to the emergency department and the rate of non-emergent use of the emergency department have both declined since the state expanded Medicaid eligibility.[7]

Medicaid expansion has drastically reduced the number of uninsured.

- In 2014, states that expanded Medicaid saw a 38 percent decline in uninsurance rates, while states that had not expanded Medicaid saw only a 9 percent decline in uninsurance rates.[8] Ten of the eleven states with the largest decrease in the rate of uninsurance had expanded Medicaid.[9] Arkansas and Kentucky, for example, cut their uninsured rates in half (22.5 to 11.4 percent and from 20.4 to 9.8 percent, respectively) between 2013 and 2014.[10]

- In states that do not expand Medicaid, an estimated 6.7 million residents are likely to remain uninsured in 2016.[11]

Expanding Medicaid improves the lives of working Americans.

Medicaid expansion benefits the working class.

- Sixty-two percent of those who would benefit from Medicaid expansion are in working families.[12] Half are working themselves.[13] Forty-eight percent work for small employers that are

not required to offer health insurance under the Affordable Care Act.[14] Over half of those in the coverage gap are middle-aged (ages 35 to 54) or near elderly (ages 55 to 64).[15]

Medicaid expansion decreases the likelihood that patients delay care because of cost or have trouble paying medical bills.

- Research published in Health Affairs showed the share of low-income adults reporting unmet health care needs because of cost declined 10.5 percent since Medicaid expansion was implemented.[16] Low-income adults also reported a 10.5 percent decline in problems paying family medical bills.[17]

- For example, after expanding Medicaid, Arkansas and Kentucky saw significant reductions in the number of patients skipping medication because of cost (9.9 percentage point reduction) and trouble paying medical bills (8.9 percentage point reduction) relative to Texas, a non-expansion state.[18]

Medicaid expansion improves the health of low-income patients.

- Low-income adults in states that expanded Medicaid face a significant 6.1 percent decrease in mortality (19.6 deaths per 100,000 adults.)[19] Authors in Health Affairs estimated that between 7,115 and 17,104 deaths are attributable to the lack of Medicaid expansion in non-expansion states.[20]

- Researchers estimated that, as of January 2014, Medicaid expansion in states that opted out would have resulted in 712,037 fewer positive screenings for depression, 422,553 more diabetics receiving medication for their illness, 195,492 more mammograms among women age 50-64 years and 443,677 more pap smears among women age 21-64.[21]

- In Oregon, for example, results of their Health Insurance Experiment found that individuals randomly selected to enroll in Medicaid reported improved general health and decreased depression compared to residents not enrolled in Medicaid.[22]

- Longitudinal research has found that individuals eligible for Medicaid since childhood had better health outcomes, and less hospitalizations and emergency room visits in adulthood than their non-eligible peers.[23]

Expanding Medicaid makes good economic sense.

Medicaid expansion grows state economies and creates jobs.

- The Urban Institute estimated that non-expansion states are missing out on more than $420 billion in federal dollars between 2013 and 2022.[24]

- The influx of federal money reverberates through the state economy. In Kentucky, for example, Medicaid expansion is estimated to contribute to $30.1 billion to the economy by 2021 and have a net positive impact of $919.1 million on the state budget.[25]

- On average, expansion states saw job growth at 2.4 percent in 2014 while non-expansion states saw 1.8 percent job growth.[26] The Bureau of Labor Statistics estimates that Medicaid expansion will spur 22 million jobs by 2022.[27] In Kentucky alone, expansion created 12,000 new jobs in 2014 and is expected to create 40,000 jobs by 2021.[28]

- Research has shown that Medicaid expansion has not resulted in significant changes in employment, job switching, or full- versus part-time status.[29] Another study published in Health Affairs similarly found that Medicaid expansion did not have an effect on employment.[30]

Medicaid expansion saves state budget dollars.

- According to the Kaiser Family Foundation's annual survey of Medicaid directors, twelve states reported that revenues had increased in 2015 or 2016 due to Medicaid expansion.[31] In New Mexico, for example, Medicaid expansion generated over $300 million to the state's general fund.[32]

- The decline in uncompensated care costs incurred by hospitals allows states to invest fewer resources into charity funding programs. Arkansas saved $17.2 million in state funding; California saved $1.4 billion; Kentucky saved $13.5 million; and New Jersey saved $74 million.[33]

- Fifteen states have realized savings because federal funds may now be used in lieu of state funds to pay for inmates' care.[34] Colorado, Michigan, and Ohio, for example, have saved between $5 and $13 million since 2014.[35] Continuity in health care coverage may reduce recidivism by enabling access to substance use and mental health treatment services after prisoners are released.[36]

- Thirteen states reported budget savings related to behavioral health because individuals who previously received state-funded behavioral health services may now receive those services under Medicaid.[37] Michigan, for example, attributed $180 million in savings in 2014 to a drop in demand for state-funded community mental health programs after Medicaid expansion.[38]

- In expansion states, state general fund spending on Medicaid increased on average by 3.4 percent in 2015 compared to 6.9 percent in non-expansion states.[39] The Kaiser Family Foundation attributed the slower growth of general fund spending to the 100 percent federal match for the expansion population.[40] Over two-thirds of expansion states reported that the average per-member-per-month costs were at or below projections for the newly eligible population.[41]

Medicaid expansion protects hospitals.

- Across hospitals in states that expanded Medicaid, charity care provided by hospitals declined 30 percent on average in 2014.[42] In non-expansion states, the average amount of charity care over the same period increased 10 percent.[43] Admissions of uninsured patients plummeted 48 percent in expansion states and only two percent in non-expansion states.[44]

- Hospitals in non-expansion states stand to lose $167.8 billion in Medicaid revenue between 2013 and 2022 that was originally intended to offset major cuts to their Medicare and Medicaid reimbursement in the Affordable Care Act.[45]

- Many rural hospitals are the largest employers in their county and report they are facing layoffs or even closure because of revenue declines.[46] The closure of the sole hospital in the community reduces per-capita income by $703 or 4 percent and increases the unemployment rate by 1.6 percentage points.[47]

[1] Adele Shartzer, Sharon K. Long & Nathaniel Anderson, *Access to Care and Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain*, 35 Health Affairs 1, 161-168 (Jan. 2016).
[2] Benjamin D. Sommers, Robert J. Blendon & E. John Orav, *Both the Private Option and Traditional Medicaid Expansions Improved Access to Care for Low-Income Adults*, 35 Health Affairs 1, 96-105 (Jan. 2016).
[3] Marianne Udow-Phillips, et al., *The Medicaid Expansion Experience in Michigan*, Health Affairs Blog (Aug. 2015).
[4] *Id*.
[5] United States Government Accountability Office, Behavioral Health. Options for Low-Income Adults to Receive Treatment in Selected States, (Jun. 2015).
[6] Sommers, Blendon & Orav, *supra* note 2.
[7] Oregon Health Authority, Office of Health Analytics, Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update (Jan. 20, 2016).
[8] Sharon K. Long, Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Adele Shartzer, Michael Karpman, & Nathaniel Anderson, Quick Take: Number of Uninsured Adults Continues to Fall under the ACA: Down by 8.0 Million in June 2014, Urban Institute (Jul. 2014).
[9] Dan Witters, *Arkansas, Kentucky See Most Improvement in Uninsured Rates*, Gallup (Feb. 24, 2015).
[10] *Id*.
[11] Dee Mahan & Andrea Callow, Short Analysis: Expanding Medicaid: Better Health, Jobs, and Economic Activity for States, Families USA (Jul. 2014).
[12] Rachel Garfield & Anthony Damico, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid - An Update, Kaiser Family Foundation (Jan. 2016).
[13] *Id*.
[14] *Id*.
[15] *Id*.
[16] Shartzer, Long & Anderson, *supra* note 1.
[17] Shartzer, Long & Anderson, *supra* note 1.
[18] Sommers, Blendon & Orav, *supra* note 2.
[19] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 New England Journal of Medicine 11, 1025-34 (Sep. 2012).
[20] Sam Dickman, David Himmelstein, Danny McCormick & Steffie Woolhandler, *Opting Out Of Medicaid Expansion: The Health And Financial Impacts*, Health Affairs Blog (Jan. 30, 2014).
[21] *Id*.
[22] Sarah L. Taubman, Heidi L. Allen, Bill J. Wright, Katherine Baicker & Amy N. Finkelstein, *Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment*, 343 Science 6168, 263-8 (Jan. 2014).
[23] Alisa Chester & Joan Alker, Center for Children and Families, *Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid*, Georgetown University Health Policy Institute (Jul. 2015).
[24] Stan Dorn, Megan McGrath & John Holahanet, *What is the Result of States Not Expanding Medicaid?* Urban Institute (Aug. 2014).
[25] Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services, Economic Impact of Medicaid Expansion (Mar. 2015).
[26] Bruce Japsen, *Obamacare Jobs Grow Faster in Medicaid Expansion States*, Forbes (Feb. 20, 2015).
[27] Office of the Assistant Secretary for Planning and Evaluation, *supra* note 25.
[28] Press Release, Governor Steve Beshear, Ky's Medicaid Expansion: 40,000 Jobs, $30B Economic Impact (Feb. 12, 2015).
[29] Angshuman Gooptu, Asako S. Moriya, Kosali I. Simon & Benjamin D. Sommers, *Medicaid Expansion Did Not Result in Significant Employment Changes or Job Reductions in 2014*, 35 Health Affairs 1, 111-18 (Jan. 2016).
[30] Bowen Garrett & Robert Kaestner, *Claims That The ACA Would Be A Job Killer Are Not Substantiated By Research*, Health Affairs Blog (Feb. 3, 2016).
[31] Robin Rudowitz, Laura Snyder & Vernon K. Smith, Medicaid Enrollment & Spending Growth: FY 2015 & 2016, The Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation (Oct. 2015).

[32] Lee A. Reynis, Bureau of Business & Economic Research, University of New Mexico, Economic and Fiscal Impacts of the Medicaid Expansion in New Mexico (Feb. 1, 2016).
[33] Deborah Bachrach, Patricia Boozang & Mindy Lupson, Manatt Health Solutions, The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States, State Health Reform
[34] Rudowitz, Snyder & Smith, *supra* note 31.
[35] Jocelyn Guyer, Deborah Bachrach & Naomi Shine, Manatt Health Solutions, Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States, State Health Reform Assistance Network (Nov. 2015).
[36] *Id*.
[37] Rudowitz, Snyder & Smith, *supra* note 31.
[38] Jesse Cross-Call, Medicaid Expansion is Producing Large Gains in Health Coverage and Saving States Money, Center of Budget and Policy Priorities (Apr. 18, 2015).
[39] Rudowitz, Snyder & Smith, *supra* note 31.
[40] *Id*.
[41] *Id*.
[42] Center for Health Information and Data Analytics, Colorado Hospital Association, Impact of Medicaid Expansion on Hospital Volumes (Jun. 2014).
[43] *Id*.
[44] Bachrach, Boozang & Lupson, *supra* note 33.
[45] Dorn, McGrath & Holahanet, *supra* note 24.
[46] iVantage Health Analytics, 2016 Rural Relevance: Vulnerability to Value Study (Feb. 2016).
[47] George M. Holmes, Rebecca T. Slifkin, Randy K. Randolph, & Stephanie Poley, *The Effect of Rural Hospital Closures on Community Economic Health*, 41 Health Services Research 2, 467-85 (Apr. 2006).