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# Assessing the Fiscal Impact of Medicaid Expansion Following the Enactment of the American Rescue Plan Act of 2021

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## Background

The Affordable Care Act (ACA) led to major advances in health insurance coverage in the United States. From 2013 to 2019, the uninsured rate fell from approximately 17 percent to 11 percent.[1] A central pillar of the ACA's coverage reforms is the Medicaid expansion, which provides states with the option to cover adults with incomes under 138 percent of the federal poverty level (FPL).[2] A substantial body of evidence indicates that adopting the Medicaid expansion delivers myriad benefits to states and Medicaid enrollees—including reductions in the uninsured rate, improvements in health care access and outcomes, improved financial security among low-income individuals, and increased economic activity and state tax revenue—at a modest cost to states.[3,4,5]

Currently, 12 states have not yet taken up the ACA Medicaid expansion, leaving approximately 2.2 million adults in the so-called "coverage gap" without an affordable source of coverage.[6,7]

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[1] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[2] The ACA established the Medicaid new adult group (or "expansion group") as a mandatory eligibility category. However, the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* (2012) held that the Secretary of Health and Human Services (HHS) may not compel states to adopt the Medicaid expansion. This effectively rendered the group optional.

[3] https://www.shvs.org/finishing-the-job-of-medicaid-expansion/

[4] http://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findingsfrom-a-Literature-Review.pdf

[5] https://www.rwjf.org/en/library/research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-andstate-economies.html

[6] This figure does not include individuals in Missouri and Oklahoma, as these states are slated to expand Medicaid this year.

[7] https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

Objections to expansion in these states have often focused on state costs as the primary reason for not going forward, with some taking the position that covering 10 percent of the cost of expansion (with the federal government covering the remaining 90 percent) is a challenge.[8,9]

While the fiscal benefits of Medicaid expansion to states are strong and well documented, the recent enactment of the American Rescue Plan Act of 2021 (ARP) makes the fiscal case even stronger by providing states that implement expansion after the enactment of ARP with a significant increase in Medicaid funding. Specifically, the law offers a two-year, five percentage point increase in the federal matching rate for most state Medicaid expenditures other than those related to the expansion itself (an unusual approach to providing enhanced federal matching funds). In the following, we describe the ARP matching rate provision in order to assist states in developing their own estimates of the provision. We also assess its fiscal impact for each state using publicly available data, compare the available new federal dollars to the cost of expansion, and identify key factors that will impact how much funding states should expect to receive from the ARP federal medical assistance percentage (FMAP) increase.

## Overview of the ARP Match Rate Increase

ARP provides states that implement a Medicaid expansion after March 11, 2021 (the date of the law's enactment) with a two-year, five percentage point increase in the FMAP that applies to most non-expansion Medicaid populations and activities.[10] The increased matching rate is available at any point after enactment to new expansion states and is tied to when a state begins expending Medicaid funds on the entire adult expansion group.[11] For example, a state with a 60 percent regular FMAP that decides to expand in the fall of 2021 and makes coverage effective on July 1, 2022 will receive the additional five percentage point—or in this case a 65 percent match rate—for most non-expansion Medicaid expenditures incurred between this date and June 30, 2024. Moreover, a state that begins enrolling adults in the Medicaid expansion group during the federal COVID-19 Public Health Emergency (PHE) period will receive ARP's five percentage point FMAP increase on top of the 6.2 percentage point increase authorized by the Families First Coronavirus Response Act (FFCRA).[12] Under this scenario, the state in our example would have a 71.2 percent federal matching rate.

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[8] https://www.newsobserver.com/news/politics-government/article235677772.html

[9] https://www.nbcnews.com/news/us-news/residents-suffer-mississippi-13-other-states-debate-medicaid-expansion-n1075661

[10] American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9814, 135 Stat. 4, 215.

[11] While Missouri and Oklahoma had already formally adopted expansion at the time ARP was enacted, they will be eligible to receive the enhanced matching rate since coverage is not yet effective and the states have not yet expended funds on the expansion group. Wisconsin will also be eligible for enhanced matching funds–despite covering childless adults up to 100 percent of FPL–because the state has not previously covered the entire expansion group.

[12] The law also provides targeted increases in Medicaid funding via changes to the matching rate for Medicaid home- and community-based services (HCBS) spending, vaccine purchase and administration, community-based crisis intervention programs, and services provided through the Urban Indian Organizations and Native Hawaiian Health Care Systems.

The extra funding, while time limited, is significant, because ARP's FMAP increase applies to most Medicaid spending (other than spending on the expansion, which already qualifies for an enhanced matching rate). This includes most expenditures on non-expansion eligibility groups (including Medicaid-financed children, parents and caretaker relatives,[13] individuals who are aged, blind, or disabled, and pregnant women), non- Disproportionate Share Hospital (DSH) supplemental payments, payments made through home and community-based services (HCBS) waivers, and other expenditures subject to the FMAP defined under Section 1905(b) of the Social Security Act. As long as the underlying expenditures are eligible under ARP, the FMAP increase applies regardless of whether the expenditure is covered under the state plan or under Section 1115 waiver authority.

Certain expenditures, in addition to those on the expansion group, do not qualify for the ARP FMAP increase. These include DSH payments, CHIP-financed coverage (including coverage for children enrolled in CHIP-financed Medicaid), expenditures on the family planning eligibility group (also subject to an enhanced FMAP), and expenditures in other programs that are tied to the Medicaid FMAP (e.g., child welfare).

By increasing the federal matching rate, the ARP FMAP increase lowers state costs for most of the Medicaid program, freeing up state dollars for other purposes. States will determine how to use these freed up state funds. For example, they could invest these dollars into non-Medicaid priorities or reserve unspent funds for later use. Since the funds are triggered by the adoption of the Medicaid expansion, many states will likely consider using the funds to finance the expansion during and after the expiration of the ARP FMAP increase. Using this strategy, states would able to fully finance the non-federal share of expansion costs for multiple years.

## Analytical Approach

In the following, we estimate both the dollars available under the ARP FMAP provision and costs associated with Medicaid expansion in order to assess the net fiscal impact of expansion. To calculate the value of the ARP FMAP provision, we project forward non-expansion Medicaid expenditures by relying on state-reported enrollment and spending data from CMS and the Medicaid and CHIP Payment and Access Commission (MACPAC).[14,15] We also apply enrollment trends from 2020 through 2021 based on a Manatt analysis of state-specific enrollment during the pandemic.[16] In 2022 and 2023, we assume that the PHE will expire and that enrollment will decline in most states before leveling off in 2024. We derive the rate of enrollment declines in 2022 and 2023 from state budget projections, relying on the midpoint of other states' enrollment projections when were not able to locate state-specific projections. To calculate expansion costs, we project expansion enrollment based on take-up rates observed in other

[13] I.e., those covered under Section 1931 of the Social Security Act.
[14] https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme/data
[15] https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-22.-Medicaid-Benefit-Spending-Per-Full-Year-Equivalent-Enrollee-by-State-and-Eligibility-Group-FY-2018.pdf
[16] https://www.shvs.org/resource/tracking-medicaid-enrollment-growth-during-covid-19-databook/

expansion states. We then assume that expansion adult per capita costs will be equal to non-expansion adult per capita costs as reported by MACPAC for FY 2018.[17] Additional detail on methodology is provided in the appendix.

**We note that our analysis likely overstates the cost of expansion in many states, as it does not account for often significant sources of state savings and revenue increases associated with expansion.** Key sources of savings and revenues that are not accounted for in this analysis include the following:

- States have realized state general fund savings by accessing a higher match rate for certain currently eligible Medicaid enrollees. The most significant source of these savings is for Medicaid enrollees who are pregnant who, under federal rules, remain enrolled in the ACA new adult group until their renewal, thus allowing the state to access the enhanced federal matching rate for a period of time. States have also seen modest reductions in enrollment of individuals through the disability category, suggesting that some choose not to seek a disability determination and instead enroll in the income-based expansion group to receive comprehensive health care benefits (allowing the state to access the enhanced match instead of the regular match).[18]
- When states expand Medicaid, many newly-enrolled individuals who previously would have required state-funded health care services are instead covered by Medicaid, generating federal match for a significant share of spending on some programs– particularly mental health and substance use treatment and certain public health programs.[19]
- Many states finance some or all of the non-federal share of Medicaid expansion costs through assessments or taxes on health care providers. While provider tax structures vary widely across states, some states have seen increases in tax receipts as a result of increasing levels of reimbursable health care utilization.[20]

## Key Findings

Our analysis shows that the additional federal dollars available through the ARP FMAP provision are substantial because of the breadth of Medicaid expenditures that are subject to the five percentage point FMAP increase. We project the ARP FMAP increase will generate approximately $21.1 billion in additional federal dollars across the remaining 12 non-expansion

[17] https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-22.-Medicaid-Benefit-Spending-Per-Full-Year-Equivalent-Enrollee-by-State-and-Eligibility-Group-FY-2018.pdf
[18] https://www.shvs.org/finishing-the-job-of-medicaid-expansion/#_edn4
[19] https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets
[20] https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets

states (should they expand) and Missouri and Oklahoma (which have already determined to expand), freeing up an equivalent amount of state dollars.[21]

**Table 1: Projected New Federal Dollars from ARP FMAP Increase ($ Millions)***

| STATE | FEDERAL FUNDING FROM ARP FMAP INCREASE |
|---|---|
| ALABAMA | $772 |
| FLORIDA | $3,942 |
| GEORGIA | $1,468 |
| KANSAS | $468 |
| MISSISSIPPI | $739 |
| MISSOURI | $1,471 |
| NORTH CAROLINA | $2,075 |
| OKLAHOMA | $786 |
| SOUTH CAROLINA | $838 |
| SOUTH DAKOTA | $128 |
| TENNESSEE | $1,385 |
| TEXAS | $5,672 |
| WISCONSIN | $1,227 |
| WYOMING | $81 |
| *TOTAL* | ***$21,053*** |

*Note: figures assume non-expansion states implement expansion on January 1, 2022. We assume Oklahoma and Missouri will make expansion coverage effective July 1, 2021 consistent with governing laws in those states.

As explained above, the additional federal Medicaid funds free up state dollars that states would otherwise have spent on Medicaid and those freed up state funds can be used for any purpose. **If those dollars were put toward financing expansion, we estimate that they would fully cover the non-federal share of expansion costs for between 3.1 and 6.5 years depending on the state.**

[21] Missouri and Oklahoma are scheduled to implement Medicaid expansion in 2021 but will have access to the ARP FMAP increase because coverage was not yet effective at the time of the law's enactment.

## Table 2: ARP FMAP Increase vs. Non-Federal Share of Expansion Costs ($ Millions)

| STATE | NON-FEDERAL MEDICAID EXPENDITURES OFFSET BY ARP FMAP INCREASE[i] | NON-FEDERAL COST OF EXPANSION, YEAR 3[ii] | YEARS OF EXPANSION "PAID-FOR"[iii] |
|---|---|---|---|
| ALABAMA | $772 | $182 | 4.8 |
| FLORIDA | $3,942 | $621 | 6.5 |
| GEORGIA | $1,468 | $381 | 4.4 |
| KANSAS | $468 | $147 | 3.8 |
| MISSISSIPPI | $739 | $205 | 4.2 |
| MISSOURI[iv] | $1,471 | $304 | 5.3 |
| NORTH CAROLINA | $2,075 | $662 | 3.8 |
| OKLAHOMA[v] | $786 | $249 | 3.8 |
| SOUTH CAROLINA | $838 | $220 | 4.4 |
| SOUTH DAKOTA | $128 | $33 | 4.5 |
| TENNESSEE | $1,385 | $221 | 6.5 |
| TEXAS | $5,672 | $2,317 | 3.1 |
| WISCONSIN[v] | $1,227 | ($225)[v] | N/A[v] |
| WYOMING | $81 | $26 | 3.8 |
| *TOTAL* | ***$21,053*** | ***$5,342*** | ***N/A*** |

Note: Figures do not account for the significant sources of state savings and revenue increases due to expansion (described above) that have been realized by previous Medicaid expansion states. These savings will allow states to finance expansion for longer than indicated above using dollars freed up by the five percentage point FMAP increase.

i. Represents additional funding for all eight quarters during which a state would be eligible for the ARP FMAP increase, regardless of the expansion start date. We assume that expansion will take effect on January 1, 2022 for all non-expansion states and July 1, 2021 in Missouri and Oklahoma.

ii. In our model, Year 3 represents the first year of full expansion ramp-up. Accordingly, projected costs are lower in years one and two. Projected costs generally grow after year 3 in most states as medical prices increase over time (we also project enrollment growth after year 3 in some, but not all, states).

iii. Inclusive of the first two years of expansion while the ARP FMAP increase is in effect.

iv. Missouri and Oklahoma were scheduled to implement Medicaid expansion prior to the passage of ARP. This analysis treats expansion costs in these states as new costs, however these states likely already have accounted for these expenditures in budget projections.

v. We project that expanding Medicaid in Wisconsin would reduce non-federal Medicaid expenditures in the state in all years of expansion–regardless of the 5 percentage point ARP FMAP increase–by allowing the state to access the 90 percent enhanced matching rate for over 200,000 childless adults for whom the State currently receives only the State's regular matching rate (66.08% in FY 2022).

In every state, we project that the value of the ARP FMAP increase will cover the non-federal cost of expansion beyond first two years of implementation (i.e., the period during which the ARP FMAP increase will be in effect), and in some states, cover the cost for more than six years. For example, we project that Florida will receive approximately $3.9 billion in additional federal dollars from the ARP FMAP increase. We project that this will offset the non-federal share of expansion costs in 2022 and 2023–$806 million–by over $3.1 billion. If the state were to set aside these freed up state dollars, we project that it could use them to finance the non-federal share of Medicaid expansion for a total of nearly seven years (i.e., into 2028).

**Table 3: Net Fiscal Impact of Medicaid Expansion and the ARP FMAP Increase, Florida, CYs 2022-2030 ($ Millions)**

| | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
|---|---|---|---|---|---|---|---|
| FEDERAL FUNDING FROM ARP FMAP INCREASE | $1,911 | $2,031 | $0 | $0 | $0 | $0 | $0 |
| NON-FEDERAL SHARE OF EXPANSION COSTS | $307 | $499 | $621 | $658 | $695 | $737 | $778 |
| REMAINING FREED UP STATE DOLLARS (ARP FMAP INCREASE MINUS CUMULATIVE EXPANSION COSTS FROM 2022)* | $1,604 | $3,136 | $2,515 | $1,857 | $1,162 | $426 | $0 |

Note: All figures assume state implements expansion beginning on January 1, 2022. Figures do not account for the significant sources of state savings and revenue increases due to expansion (described above) that have been realized by previous Medicaid expansion states. These savings will allow the state to finance expansion for longer than indicated above using dollars freed up by the five percentage point FMAP increase.

*Represents the difference between new federal dollars from the ARP FMAP increase and the non-federal share of expansion costs from that year plus any leftover freed up non-federal funds from the previous year. This assumes that the state sets aside any non-federal funds freed up by the ARP FMAP increase and uses them to finance expansion.

## Key Considerations

A number of factors affect these calculations. States with high non-expansion Medicaid enrollment relative to the number of individuals in the state's coverage gap are likely to be able to fund expansion for the longest period of time using savings from the ARP FMAP increase. This is because states with high non-expansion enrollment will have a larger number of individuals for whom they would be able to claim the ARP FMAP compared to states with fewer non-expansion Medicaid enrollees.

The size of the ARP FMAP increase will also depend on the trajectory of Medicaid enrollment during and after the PHE and the timing of the expansion. Nearly all states have seen significant growth in Medicaid enrollment during the pandemic as a result of the FFCRA continuous coverage provision.[22] However, states may begin to see reductions in enrollment once the PHE

[22] https://www.shvs.org/resource/tracking-medicaid-enrollment-growth-during-covid-19-databook/

expires and they resume regular redeterminations of eligibility. The extent and timing of these enrollment shifts is likely to vary across states. Accordingly, individual states will be best positioned to project the trajectory of their own enrollment following the PHE, and we have not attempted to predict the rate of enrollment decline as part of this analysis (relying instead on assumptions derived from state-specific forecasts or the midpoint of other state forecasts where state-specific figures were not available).

Additionally, as mentioned above, these estimates do not factor in offsetting savings that states will realize when they implement expansion (including savings from currently eligible Medicaid enrollees who enroll through the expansion group and savings on state-funded health care programs). Those savings will mean that the ARP FMAP increase will likely finance expansion for additional years beyond the number estimated here.

## Conclusion

While Medicaid expansion has always provided significant fiscal advantages for states (in addition to providing a wide range of health and other benefits), the ARP FMAP provision makes the fiscal case even stronger. States will be able to access the additional federal dollars regardless of how they finance the non-federal share of expansion (including through provider assessments, as has been done in many expansion states). States that direct the state savings toward the cost of expansion can expect to fully offset the non-federal share of expansion costs for a minimum of three years, with some states fully offsetting the costs for over six years. The benefits will vary by state driven largely by the state-specific Medicaid enrollment trajectory after the PHE, the timing of expansion, and the size of the state's coverage gap relative to the rest of its Medicaid program. It is, however, clear that the ARP FMAP provision presents an opportunity for states to draw down substantial additional federal dollars and provide coverage and access to care for their residents for at least several years with no or minimal state investment.

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**Appendix: Methodology**

To calculate expansion costs, we first estimate the number of individuals likely to take-up Medicaid expansion coverage. We do this by applying an estimated take-up rate derived from a Manatt analysis of the experience of previous expansion states to estimates of the number of eligible individuals in each non-expansion state from a State Health Data Assistance Center (SHADAC) analysis of the Census Bureau's American Community Survey.[23] For expansion per capita costs, we rely on state-specific non-expansion adult per enrollee expenditures from MACPAC.[24] Finally, we project expansion costs by multiplying estimated enrollment by expected expansion per enrollee costs.

To estimate non-expansion Medicaid enrollment, we rely on CMS Monthly Medicaid and CHIP Enrollment Reports to establish a pre-pandemic baseline.[25] We then apply state-specific enrollment growth rates based on a Manatt analysis of state enrollment data through the end of 2021.[26] Beginning in 2022, we assume that enrollment will decrease for two years following the expiration of the PHE and FFCRA continuous coverage requirement. Depending on availability, we use either state-specific estimates of enrollment declines or apply the median projected decline where state-specific data are not available. Beginning in 2024, we trend forward enrollment by state- and age-specific population growth factors from the AARP Public Policy Institute.[27]

In general, we do not assume any reduction in traditional Medicaid enrollment following the implementation of expansion; the one exception to this is Wisconsin. As of February 2021, Wisconsin covered 231,010 childless adults with incomes up to 100 percent of FPL.[28] We trend enrollment in this group forward through 2021 using the methods described above. We then assume—beginning in 2022—that all childless adults will move into the expansion group (allowing the state to access the enhanced federal matching rate for these individuals).

We estimate traditional Medicaid expenditures by marrying CMS-64 expenditure data with estimates of per capita spending by eligibility group from the MACPAC.[29] We first isolate non-DSH expenditures from 2019 from each state's Form CMS-64.[30] We then adjust 2018 per capita expenditures from MACPAC such that per capita expenditures by eligibility group multiplied by enrollment by eligibility group from MACPAC are equal to total non-DSH expenditures from the CMS-64. To project forward, we apply per enrollee spending growth projections from the Congressional Budget Office.[31] Finally, we estimate total expenditures by multiplying projected traditional Medicaid enrollment by per capita expenditures by eligibility group in each year.

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[23] http://statehealthcompare.shadac.org/Data

[24] https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-22.-Medicaid-Benefit-Spending-Per-Full-Year-Equivalent-Enrollee-by-State-and-Eligibility-Group-FY-2018.pdf

[25] https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme/data

[26] https://www.shvs.org/resource/tracking-medicaid-enrollment-growth-during-covid-19-databook/

[27] https://dataexplorer.aarp.org/

[28] https://www.forwardhealth.wi.gov/wiportal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage

[29] https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-22.-Medicaid-Benefit-Spending-Per-Full-Year-Equivalent-Enrollee-by-State-and-Eligibility-Group-FY-2018.pdf

[30] https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html

[31] https://www.cbo.gov/system/files/2020-03/51301-2020-03-medicaid.pdf

To calculate the value of the ARP FMAP provision, we calculate the difference between federal Medicaid expenditures on non-expansion Medicaid populations with regular FMAP rates applied and the federal share of non-expansion Medicaid expenditures after the application of the ARP FMAP increase.