REQUEST FOR INFORMATION

To: **Equitable Assessment of Costs Related to Medicaid Expansion Legislative Interim Committee**
From: Jared Tatro, Principal Budget & Policy Analyst. Legislative Services Office, Budget & Policy Analysis Division
Date: 09/13/2019
Re: State Share of Medicaid Expansion Funding in Other States

On August 9, 2019, the co-chairs, on behalf of the Equitable Assessment of Costs Related to Medicaid Expansion Legislative Interim Committee, requested information on how other states have funded the state's share of Medicaid expansion.

Summary: As of August 1, 2019, 36 states have expanded Medicaid coverage to those between 0% and 138% of the Federal Poverty Level (FPL).[1] Within these states, 34 rely on the "General Fund" of their state to cover at least some of the state's share of the cost of Medicaid expansion.[2] At least 12 states rely on hospital assessments or hospital fees for at least a portion of the state's cost.[3] Other methods include increases or modifications to a tax (sales, use, other), use of tobacco master settlement moneys, member premiums, savings from work requirements, reduced provider rates, and county generated revenue.[4]

General Fund: 94.4% (34 of 36) of the states that have expanded Medicaid coverage rely at least partially on the states' General Fund to pay the state's share.[5] Of these states, it appears about half use only the General Fund while the other half rely on the General Fund and additional source(s) of funding to cover the state's share of Medicaid expansion. It should be noted that the sources of revenue for a state's General Fund vary and therefore a direct comparison may not be applicable.

Provider Assessment/Tax/Fee: At least 12 states increased or modified its provider assessment to cover the state's share of Medicaid expansion. Most of these states increased the assessment for hospitals.[6] Michigan worked closely with its hospital association and found a compromise-solution for the state and the hospitals that implemented assessments and held revenue for hospitals as neutral as possible. While providers pay these assessments, providers receive more back in assessment financed supplemental payments than what they pay in because the majority of costs are from federal sources. Additionally, Michigan is able to retain a portion of assessment revenue collected to fund Medicaid (both traditional and expansion).[7]

Tax Increase/Redistribution: At least five states relied on a tax increase or redistribution of an existing tax to cover the state's share of Medicaid expansion. California and Indiana use cigarette/tobacco taxes, New Hampshire uses liquor tax revenue, and Utah voters approved a sales tax increase of 0.15%. Oregon uses a portion of tax revenue from marijuana sales to cover substance use expenses associated with expansion (and traditional) populations.[8] Montana voters were asked to fund its Medicaid expansion program with a tobacco tax increase, but the referendum failed.[9]

Premiums: At least eight states have relied on premiums charged to specified groups of members to generate necessary revenue for expansion.[10] At least three more states have submitted plans to institute premiums for expansion populations. Premiums vary by income threshold and by state. Some states use premiums as a personal responsibility tool more than a cost-saving measure.

Work Requirements: At least four states plan to use direct savings from people leaving Medicaid as a result of failing to meet work requirements or by gaining employment and earning enough to leave expansion eligibility. However, no state has been able to actually implement its work requirements program plan without legal challenges, if the loss of Medicaid coverage is a result of not meeting the work requirement. Several states are waiting for additional guidance from the Centers for Medicare

and Medicaid Services (CMS) and the courts on this process. For the state of Kentucky, the district court ruled twice that the work requirements approved by CMS "is arbitrary and capricious because it did not address ... how the project would implicate the 'core' objective of Medicaid: the provision of medical coverage to the needy."[11] Nine states have been approved by CMS for work requirements with seven more states pending approval.[12] Idaho has not submitted its work requirement waiver, but it should be submitted in October.

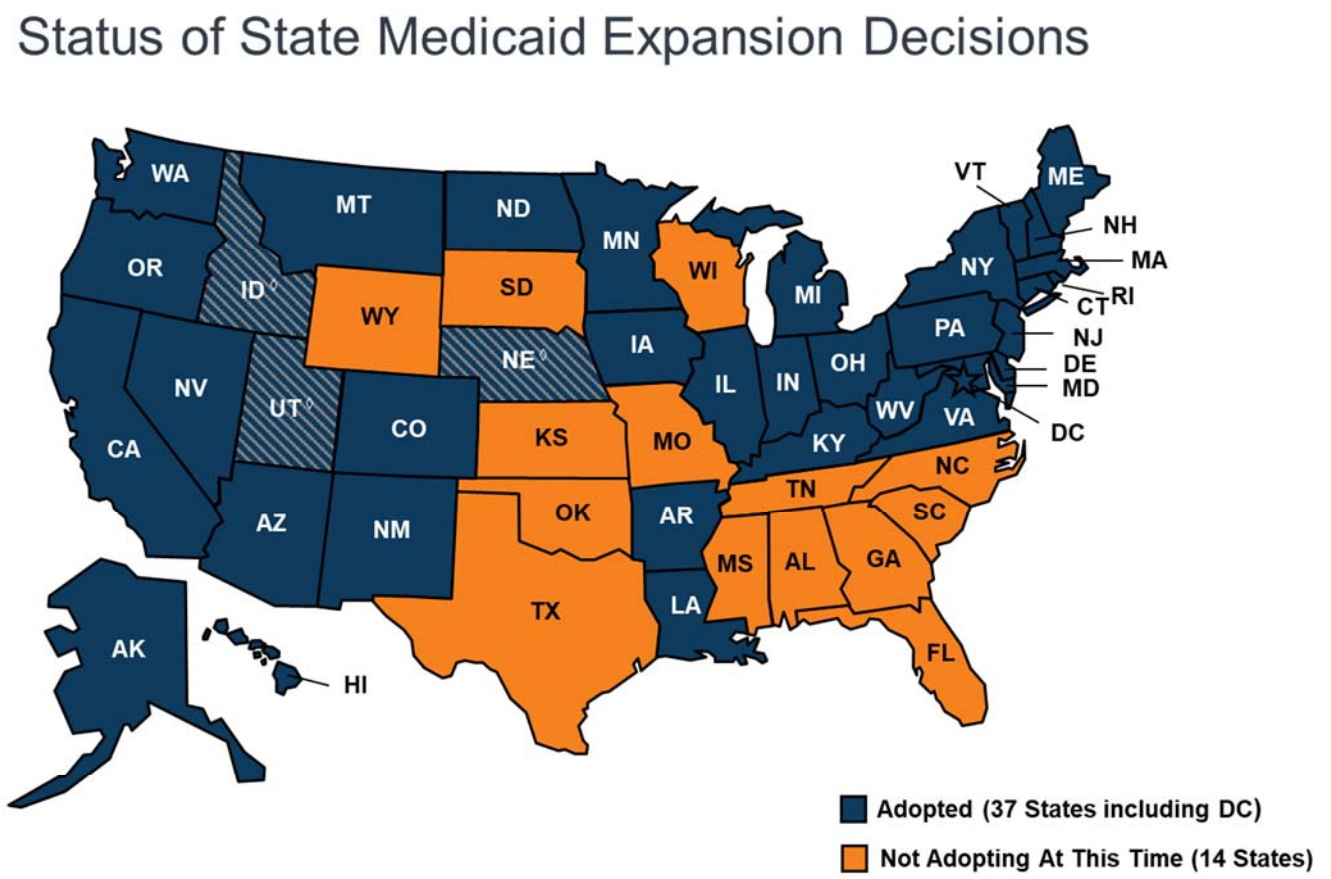
Other Funding Options: There are a variety of options available to fund expansion. Several states have opted to use less common methods to fund Medicaid expansion including: tobacco master settlement agreement moneys; tax on health maintenance organization (HMO) or health insurance plans; copayments; reduced provider rates; and county generated funds. Below is a breakout of five other methods states are using to pay the state's share of Medicaid expansion:

- At least five states, including Idaho, use tobacco funds from the Master Settlement Agreement.[13]
- At least two states have implemented a tax on HMOs or health insurance plans.[14]
- At least six states have relied on copayments for various services (within the maximum allowed by CMS and the Social Security Act). Some examples include copays for a non-emergency use of the emergency department and to purchase brand name pharmaceuticals. Some states use copayments as a personal responsibility tool more than a cost-saving measure.[15]
- North Dakota reduced the rates paid to providers to account for the increased cost to the state with expansion.[16]
- New Mexico uses a county-generated tax (or alternative county revenue source) to cover a portion of the states' costs related to more traditional type Medicaid programs and Medicaid expansion.[17]

Methodology and Report Caveats: To complete this project, online literature reviews from national publications, news sources, and Medicaid.gov were conducted; contacted other states; worked with or relied on information from national organizations such as the National Conference of State Legislatures (NCSL), Kaiser Family Foundations, National Academy for State Health Policy, National Association of State Budget Officers, and the Commonwealth Fund; reviewed appropriation bills and budget documents from various states; and reviewed information from the Idaho Department of Health and Welfare.

Understanding how each state funds its Medicaid expansion program is not always clear, as some states do not track expansion programs separate from traditional Medicaid program(s). Further, not all states follow the same appropriation and budget submission process as Idaho, therefore terminology used in Idaho could mean something different in other states. Because of time and workload constraints, a verification of funding information for all states through personal communication with an agency representative of each state was not feasible and therefore relied on information published by that state, the press, or another organization. Furthermore, the fund source used to pay for the Medicaid expansion program may change from one source to another in any given year, which is true for both Medicaid and non-Medicaid programs.

Medicaid Expansion States: Medicaid has been expanded in 36 states and the District of Columbia. States that have expanded are shown in the graphic below and included here: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia.



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. ◊Expansion is adopted but not yet implemented in ID, NE, and UT. (See link below for additional state-specific notes).
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated August 1, 2019.
https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Endnotes:

[1] 100% of the FPL for a single person is $12,490 in annual modified adjusted gross income and 138% is $17,236.
[2] Colorado relies on assessments and Indiana does not appear to use General Funds to pay the state's share of Medicaid Expansion.
[3] All states except Alaska rely on medical provider assessments to pay for traditional Medicaid and at least 12 states use the assessments for Medicaid expansion claims.
[4] States that are relying on savings from work requirements have not realized savings because of litigation in that state or other states. Counties collect a tax and pay for Medicaid costs in New Mexico.
[5] Calculated from research identified in methodology section and from information obtained from Governing. As Federal Medicaid Money Fades, How are States Funding Expansion?. July 23, 2018. Accessed online 8/1/2019 from https://www.governing.com/topics/health-human-services/gov-medicaid-expansion-funding-states.html
[6] Kaiser Family Foundation, States and Medicaid Provider Taxes or Fees, Published June 27, 2017. Accessed on 9/5/2019 from https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/. Provider taxes are imposed by states on health care services where the burden of the tax falls mostly on providers, such as a tax on inpatient hospital services or nursing facility beds. Provider taxes have become an integral source of financing for Medicaid. For FY 2016, all but one state (Alaska) reported having at least one Medicaid provider tax and two-thirds of states reported three or more provider taxes. Under current regulations, states may not use provider tax revenues for the state share of Medicaid spending unless the tax meets three requirements: must be broad-based, uniformly imposed, and cannot hold providers harmless from the burden of the tax.
[7] Correspondence with Matt Ellsworth, State Administrative Manager, Medical Services Section, Michigan Department of Health and Human Services, 08/22/2019. Providers are assessed collectively by provider types.
[8] Oregon Legislatively Adopted Budget 2017-2019 Detailed Analysis: https://www.oregonlegislature.gov/lfo/Documents/2017-19%20LAB%20Detailed%20Analysis.pdf. The detailed analysis for 2019-2021 was not available. The Summary information reflects the increase in provider assessments and other intergovernmental transfers: https://www.oregonlegislature.gov/lfo/Documents/2019-1%20LAB%20Summary%202019-21.pdf
[9] Billings Gazette, Matt Volz, Associated Press: Montana voters reject paying for Medicaid expansion with tobacco tax, 11/7/2018. Accessed online 09/03/2019 from https://billingsgazette.com/news/state-and-regional/montana/montana-voters-reject-paying-for-medicaid-expansion-with-tobacco-tax/article_02cf2516-79b9-52de-bc2e-ad4f9b931a85.html
[10] Premium: The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance. If you have a Marketplace health plan, you may be able to lower your costs with a premium tax credit. Healthcare.gov, accessed on 9/9/2019, https://www.healthcare.gov/glossary/premium/. Additional information was used from a white paper prepared by the Idaho Department of Health and Welfare, printed on 12/03/2018.
[11] Stewart v. Azar, 313 F.Supp.3d 237, 243 (D.D.C. 2018). This case included four other citing cases: Stewart v Azar, Gresham v. Azar, Philbrick v. Azar, and California v. Ross.
[12] National Academy for State Health Policy (NASHP). A Snapshot of State Proposals to Implement Medicaid Work Requirements Nationwide. Updated 07/29/2019. Accessed online from https://nashp.org/state-proposals-for-medicaid-work-and-community-engagement-requirements/.
[13] The Master Settlement Agreement (MSA) does not have restrictions on the use of the funds.
[14] HMO is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.
[15] Copayments vary by income thresholds and type of service. For those in the expansion population the non-emergency use of the ER would be as much as $8. For pharmaceuticals the copay amount will be as much as $4 for preferred drugs and $8 for non-preferred drugs. https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html. Additional information was used from a white paper prepared by the Idaho Department of Health and Welfare, printed on 12/03/2018.
[16] Governing. As Federal Medicaid Money Fades, How are States Funding Expansion?. July 23, 2018. Accessed online 8/1/2019 from https://www.governing.com/topics/health-human-services/gov-medicaid-expansion-funding-states.html
[17] Section 27-10-2B, New Mexico Code states "The purpose of the county supported Medicaid fund is to leverage existing resources to better address the state's health care needs. The county-supported Medicaid fund will be used to accomplish this purpose by using local revenues solely to expand eligibility for federal Medicaid optional coverages in supplementation to mandated federal Medicaid services…" Section 27-10-3, New Mexico Code creates the county-supported Medicaid fund and provides for distribution limitations and federal-revenue issues. Section 27-10-4 New Mexico Code, states "In the event a county does not enact an ordinance imposing a county health care gross receipts tax pursuant to Section 7-20D-3 [7-20E-18] NMSA 1978, the county shall, by ordinance to be effective July 1, 1993, dedicate to the county-supported Medicaid fund an amount equal to a gross receipts tax rate of one-sixteenth of one percent applied to the taxable gross receipts reported during the prior fiscal year by persons engaging in business in the county. For purposes of this subsection, a county may use funds from any existing authorized revenue source of the county." Section 7-20E-18, New Mexico Code, states "the majority of the members in the governing body of any county may enact an ordinance imposing an excise tax at a rate of one sixteenth (1/16) of one percent (1%) of gross receipts of any person engaging in business in the county for the privilege of engaging in business in the county. Any ordinance imposing an excise tax pursuant to this section shall not be subject to a referendum. The Governing body of a county shall, at the time of enacting an ordinance imposing the tax, dedicate the revenue to the county-supported Medicaid fund." In Section 27-10-4 New Mexico Code it states that in the event a county does not enact an ordinance for the county health care tax and if the county doesn't have sufficient funds in the county indigent claims fund, the county "may use funds from an existing authorized revenue source for the county", exceptions apply. Section 27-5-7-1 New Mexico Code, states that the County Health Care Assistance Fund may be used to meet a county's obligation for 27-10-4 and paying into the county Medicaid fund.