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Estimating the Economic Gains for States as a Result of Medicaid Coverage Expansions for Adults

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

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Estimating the Economic Gains for States as a Result of Medicaid Coverage Expansions for Adults

Executive Summary

Under pending legislative proposals, Medicaid eligibility would be substantially expanded to cover all low-income adults -- the most likely persons to be uninsured. The House Tri-Committee bill (H.R. 3200) and the Senate Finance Committee proposal would set Medicaid eligibility at 133 percent of the federal poverty level ($24,352 for a family of three in 2009), while the Senate Health, Education, Labor, and Pensions (HELP) Committee bill (S. 1679) would establish Medicaid coverage at 150 percent of the federal poverty level ($27,465 for a family of three in 2009).

New Census Bureau data suggest that under both the House and Senate Finance Committee proposals, about 9.6 million nonelderly adults would gain Medicaid eligibility by 2014. These gains would be the result of eliminating the categorical and financial eligibility restrictions applicable to low-income non-elderly adults since Medicaid's 1965 enactment, as well as the enactment of a coverage mandate coupled with streamlined enrollment procedures. Although the Medicaid expansions involve significant federal and state outlays, we estimate that Medicaid's positive impact on the economy, particularly in medically underserved communities, would be of far greater significance.

Our analysis of the substantial positive economic benefits shows a *return of three dollars in new business activities for every dollar of state Medicaid investment, with gains in new jobs and wages*. These economic gains flow from the fact that Medicaid is a critical source of federal revenue to states, bringing broad economic and employment benefits, as well as an economic "multiplier" effect. With increased federal matching rates through 2010 under the American Recovery and Reinvestment Act, the return on investment in Medicaid for states is even stronger today than in 2007, given that states contribute a lower proportion to the overall Medicaid costs.

Furthermore, because Medicaid is designed to assist both individuals and states with lower incomes, the positive economic effects of a Medicaid expansion will be especially pronounced in southern, southwestern, and Plains states, which tend to be poorer and have more uninsured low-income adults.

A stimulative expenditure may be unachievable if the funds needed to generate the stimulus are not available. Given states' current economic hardships, the Medicaid expansions in health reform should assure full federal funding, at least during the initial five-year period of expansion. This initial full federal stimulus could be followed by an enhanced federal contribution level over the long term. In addition, preserving the American Recovery and Reinvestment Act (ARRA)'s enhanced federal Medicaid payments should be considered an essential short-term investment, particularly since, as this analysis shows, federal Medicaid payments are not only a central strategy for preventing deep Medicaid reductions but also a major source of national and state economic stimulus.

Introduction

Medicaid, the joint federal-state health insurance program for low-income children, adults, seniors, and people with disabilities, plays a critical role in providing access to health coverage and an array of health care services. Extensive research literature documents Medicaid's role in expanding health insurance coverage and improving access to health care.[1] Medicaid's impact on the health of low-income Americans, particularly in the case of people with conditions considered amenable to medical care, also has been significant.[2]

Census Bureau estimates show that in 2008, Medicaid covered 42.6 million children and non-elderly adults. Current health reform legislative proposals pending in Congress would expand Medicaid's reach still further. Specifically, the House Tri-Committee bill (HR 3200) and the Senate Finance Committee proposal would eliminate the categorical restrictions applicable to adults since Medicaid's 1965 enactment, while also establishing an income eligibility standard for adults under age 65 equal to 133 percent of the federal poverty level. (A legislative proposal reported by the Senate HELP Committee, S. 1679 would raise the income eligibility standard for non-elderly adults to 150 percent of the federal poverty level).

In addition, by simplifying enrollment and coupling it with an individual coverage mandate, the Medicaid reforms under consideration would result in improved coverage of children and adults who are eligible under current categorical and financial eligibility rules but not enrolled.

These Medicaid eligibility expansions are projected to be fully effective by 2014.[3,4] The individuals who will particularly benefit from these expansions are low-income parents and nonelderly adults without children or with grown children. The expansions would not only expand Medicaid coverage for millions of persons, but would also eliminate the wide and unpredictable interstate variation in Medicaid eligibility levels.

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[1] Rosenbaum, S. (2002). Medicaid. *New England Journal of Medicine* 346(8): 635-40; Ku, L, Lin, M, and Broaddus M. (2007). "Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP: 2007 Edition." Washington, DC: Center on Budget and Policy Priorities, Jan. Available at: http://www.cbpp.org/cms/index.cfm?fa=view&id=1419.; Gruber, J. (2003). "Medicaid," Means Tested Transfer Programs in the United States, Robert Moffitt, ed., Cambridge, MA: MIT Press.

[2] Ku, L. and Broaddus, M. (2008). Public and private health insurance: Stacking up the costs. *Health Affairs*, 27(4):w318-327. Hadley, J. and Holahan, J. (2004). Is health care spending higher under Medicaid or private insurance? *Inquiry*, 40(4): 323-42; Paradise, J. and Rousseau, D. (2004). "Medicaid: A Lower Cost Approach to Serving a High-Cost Population" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Mar. Available at: http://www.kff.org/medicaid/7057a.cfm.

[3] For this paper, the House proposal is based on the tri-committee version as of July 15, 2009 and the draft Senate plan is the Senate Finance version of September 16, 2009. The Medicaid expansion in the House bill is effective in FY 2013, while the Senate expansion is effective January 1, 2014.

[4] Exceptions exist for certain immigrants. Lawful permanent resident immigrants who have been in the United States for less than five years are not eligible for Medicaid, although states have the option to provide coverage to legal immigrant children and pregnant women. Undocumented immigrants are not eligible for full Medicaid coverage, but can be covered for emergency medical treatment, including labor and delivery, if they meet income and categorical standards. In the draft Senate version, nonelderly non-pregnant adults with incomes between 100 and 133 percent of poverty may choose whether to participate in Medicaid or the health insurance exchanges.

Under current law, uninsured working parents can qualify for Medicaid if their incomes do not exceed an average of 50 percent of the federal poverty level (approximately $9,150 for family of three); at this level, full-time parents who earn the minimum wage fail to qualify in 29 states.[5]

In the case of adults without children or with children who have reached adulthood, the gaps are even more profound, with only six states (Arizona, Delaware, Hawaii, Massachusetts, New York and Vermont) and the District of Columbia providing coverage that equals or approaches Medicaid. Another 21 states offer more limited public coverage to certain groups of low-income childless adults.[6] States with expanded coverage for adults generally have helped defray the cost of coverage expansion using a portion of their federal Children's Health Insurance Fund (CHIP) allotments in combination with other revenues, such as Medicaid disproportionate share hospital payments. However, the 2009 CHIP reauthorization phases out adult coverage using CHIP funds, thereby raising questions regarding the continued availability of such coverage in the absence of further federal reforms.[7]

Medicaid's positive economic impact on individuals and states has been extensively documented.[8] Indeed, it is for this reason, as well as to avert deep Medicaid cuts, that the federal stimulus package included $87 billion in direct federal Medicaid aid to states, as well as another $22 billion in federal Medicaid payments to incentivize the adoption of health information technology (HIT).[9]

Estimating the Impact of Expanded Medicaid Coverage on Workers, the Unemployed, and the National Economy

The effects of a Medicaid expansion on currently uninsured federal and state populations

The starting point for estimating the potential effect of the Medicaid expansions was derived from an analysis of data from the recently released *Current Population Survey* of health insurance coverage. According to these data, in 2008, 9.6 million nonelderly citizens (19 to 64

[5] Cohen, R.D. and Marks, C. (2009). "Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Jan. Available at: http://www.kff.org/medicaid/7855.cfm.

[6] Kaiser Commission on Medicaid and the Uninsured, (2009). "Expanding Health Coverage for Low-income Adults: Filling the Gaps in Medicaid Eligibility." Washington, DC: Kaiser Commission on Medicaid and the Uninsured May. Available at: http://www.kff.org/medicaid/7900.cfm.

[7] Parisi, L. (2009). "What's Next for CHIP-Funded Adult Coverage." Washington, DC: FamiliesUSA, Aug. Available at: http://www.familiesusa.org/assets/pdfs/chipra/adult-coverage.pdf.

[8] Stewart, W. F., Ricci, J. A., Chee, E., Morganstein, D. (2003). Lost productive work time costs from health conditions in the United States: Results from the American Productivity Audit. *Journal of Occupational and Environmental Medicine* 45(12): 1234-1246; Congressional Budget Office. (2002). "The Budget and Economic Outlook: Fiscal Years 2003-2012." Washington, DC: Congress of the United States. Available at: http://www.cbo.gov/ftpdocs/32xx/doc3277/EntireReport.pdf; Cohen, D. and Follette, G. (1999). "The Automatic Fiscal Stabilizers: Quietly Doing Their Thing." Washington, DC: Federal Reserve Board. Available at: http://www.federalreserve.gov/pubs/feds/1999/199964/199964pap.pdf.

9 The American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, 111th Cong., 1st sess. (2009). Available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.txt.pdf.

years old) with incomes at or below 133 percent of the federal poverty level were uninsured.[10] This group constitutes 5.8 percent of all nonelderly adults[11] and all of these individuals should qualify for Medicaid under the proposed expansions. The actual number of participants may differ for a variety of reasons, however, including changes in the private insurance market that may flow from health reform, as well as other, broader, economic and demographic changes. By 2014, the date of full implementation of the Medicaid expansion envisioned in the House and Senate Finance Committee proposals, these changes may mean that not all people who are projected to be eligible for Medicaid may enroll. Nonetheless, the effects of the proposed Medicaid expansion are expected to dramatically reduce the number of uninsured low-income persons.

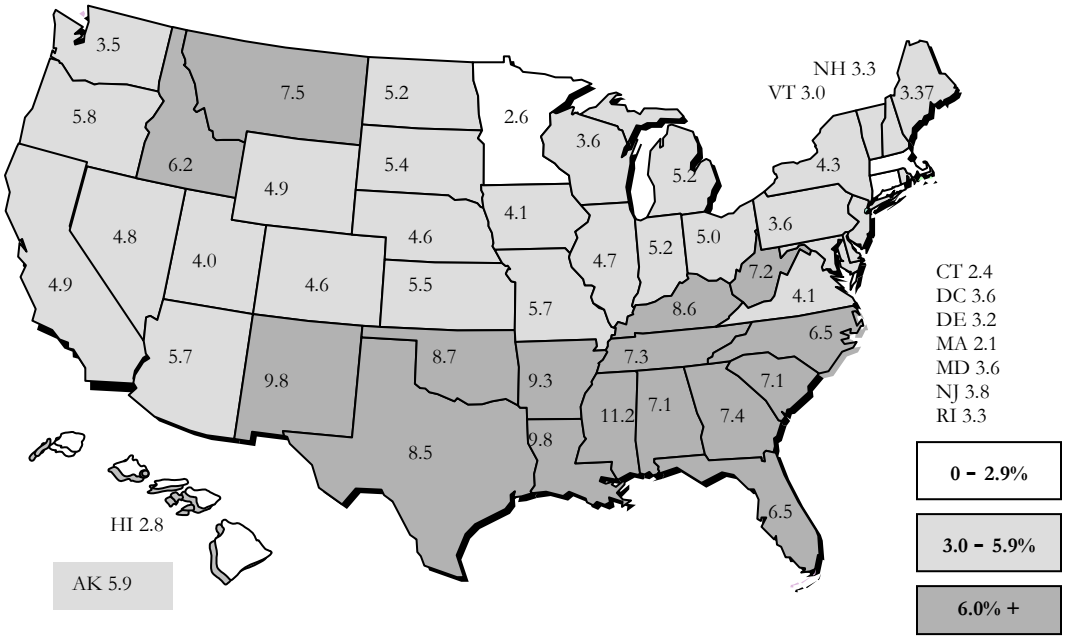
The percentage of nonelderly adult citizens in each state who could gain Medicaid coverage by 2014, should H.R. 3200 or the Senate Finance Committee bill go into effect, is shown in Figure 1 below and in more detail in Appendix Table 1.[12] (These estimates include both the newly-eligible populations as well as those who are already eligible but not currently enrolled.) As these estimates show, states could see a substantial gain in the number and percent of adults covered by Medicaid, with particularly striking gains in southern, southwestern, and Plains states, which tend to have larger impoverished populations and currently less generous Medicaid eligibility standards.

[10] Estimates do not include legal and undocumented immigrants.

[11] These analyses include both native and naturalized citizens, but did not include non-citizen immigrants, although some would be eligible for Medicaid coverage. The 2008 estimate is based on the March 2009 *Current Population Survey*.

[12] To generate state-specific estimates, we pooled insurance data from three years (2006 to 2008) in Figure 1 and Appendix Table 1. Because adult uninsurance rates rose from 2006 to 2008, the three-year average is slightly lower than the level in 2008 alone; the three year average was 9.1 million uninsured or 5.5 percent of all nonelderly adult citizens.

Figure 1. Percent of Nonelderly Adults Eligible for Medicaid Under Proposed House and Senate Finance Committee Expansions



Note: Includes nonelderly adults (including childless adults) who are not currently enrolled but would be meet the proposed expansion to 133 percent of the federal poverty level.
Source: GW analyses of March 2007-2009 *Current Population Survey* data.

The cost of the Medicaid expansions

Although expanding Medicaid is a cost-effective way to expand insurance coverage,[13] the costs of the proposed expansion are nonetheless relatively large, particularly given the effects of the present economic downturn on state economies. The Congressional Budget Office (CBO) has estimated the ten-year federal cost of the Medicaid expansion and related changes to be $438 billion under the House Tri-Committee bill.[14] A number of governors have expressed concerns that Medicaid expansions could create serious budget problems for states if costs associated with the expansion are not fully covered by the federal government.[15] The House bill would pay 100 percent of the costs associated with expanded Medicaid eligibility over the FY 2010–2014 time period, with states bearing a share of the cost for newly eligible persons in the later years.[16] The Senate Finance Committee proposal calls for substantial increases in federal matching payments for the expansion populations, using a more complex formula, but would continue to require at

[13] Ku L., Broaddus M. (2008). Public and private health insurance: Stacking up the costs. *op cit*.
[14] Congressional Budget Office, preliminary cost estimate for HR 3200, contained in a Letter to Rep. Charles Rangel, July 17, 2009.
[15] Pettus, E. (2009, September 14) "Governors worry federal health reform could strain budgets in states with many poor, jobless," *Los Angeles Times;* National Governors Association, Health and Human Services Committee, (July 20, 2009) Letter to Sens. Baucus and Grassley about Medicaid expansion.
[16] An amendment passed in the House Energy and Commerce Committee, reduces the Medicaid matching rate to 90 percent in 2015.

least five percent state contribution levels for the expansion populations. States that previously had not expanded coverage would experience a gradual reduction in matching rates from 2014 to 2019, while states that had already expanded coverage would experience a gradual increase in federal contributions over this time period until all states converged on a 32.3 percentage-point increase in their federal contribution rates for the expansion populations by 2019.

Medicaid's positive impact on workers, the unemployed, and the economy

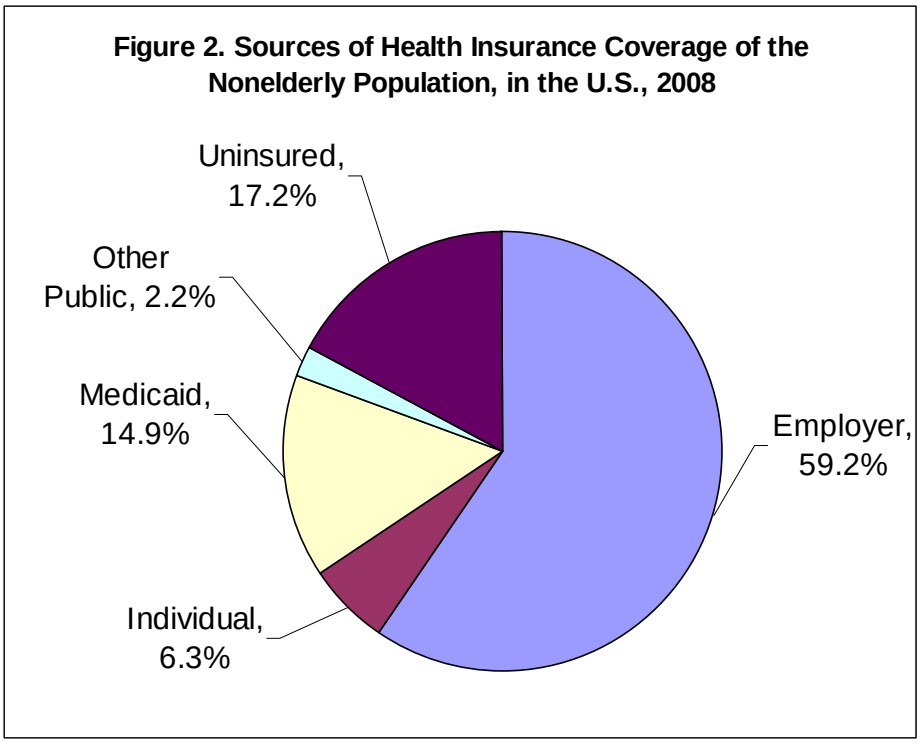
Medicaid's importance to workers

In examining Medicaid's positive economic impact on workers and state economies, it is helpful to provide initial insights into health insurance coverage in the U.S. and to discuss the role of Medicaid in achieving coverage of working-age adults. Figure 2 summarizes the distribution of health insurance coverage for nonelderly adult Americans in 2008, based on the March 2009 *Current Population Survey*.[17] As illustrated, 59.2 percent of the nonelderly adult population was covered by employer-sponsored health insurance in 2008 and some 17 percent of non elderly adults are uninsured.[18] Among this group, 82 percent are employed (71 percent full-time and 11 percent part-time).[19] Lower wage workers represent a disproportionate percent of the uninsured, which is attributable to many factors, including the number of business that do not offer health benefits, the number of lower-wage workers who may fail to qualify for benefits because of waiting periods or limited hours worked, and the number of lower-wage workers who cannot afford their share of health insurance premiums.

[17] Some people have more than one type of insurance coverage in a given year. To avoid overlap, we applied a hierarchy of insurance coverage, such that a person with both employer-sponsored health insurance and Medicaid, for example, is shown as having Medicaid.

[18] Doty, M. M., Collins S. R., Rustigi S. D., and Nicholson J. L. (2009). "Out of Options: Why so Many Workers in Small Businesses Lack Affordable Health Insurance, and How Health Care Reform Can Help." New York, NY: The Commonwealth Fund. Available at: http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Sep/Out-of-Options.aspx.

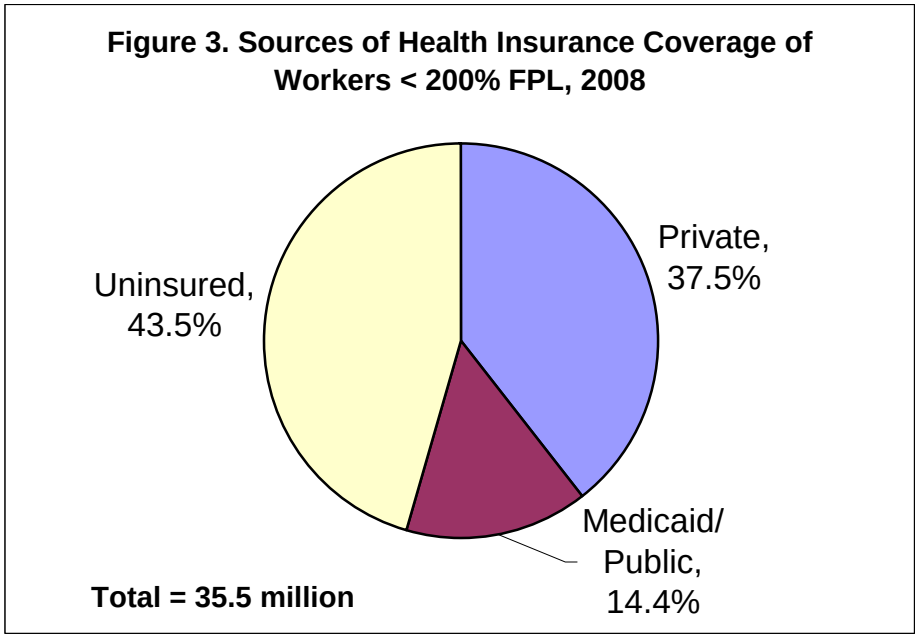
[19] The Kaiser Commission on Medicaid and the Uninsured. (2008). "The Uninsured: A Primer, Key Facts About Americans without Health Insurance." Washington, DC. Available at: http://www.kff.org/uninsured/7451.cfm.



Source: GW calculations based on *CPS* data.

Medicaid growth over the past decade has been the primary factor that has prevented the proportion of uninsured Americans from increasing even further.[20] Medicaid and CHIP have been particularly important for low-income children and pregnant women, with more limited effects for other adults because of historic categorical eligibility restrictions. In 2008, Medicaid covered one in seven workers with family incomes below 200 percent of the federal poverty level (Figure 3).

[20] DeNavas-Walt C., Proctor B. D., and Smith J. C. (2009, September). "Income, Poverty, and Health Insurance Coverage in the United States: 2008." Washington, DC: U.S. Census Bureau. Available at: http://www.census.gov/prod/2009pubs/p60-236.pdf; Holahan, J. and Garrett, A. B. (2009). "Rising Unemployment, Medicaid and the Uninsured." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/uninsured/7850.cfm.



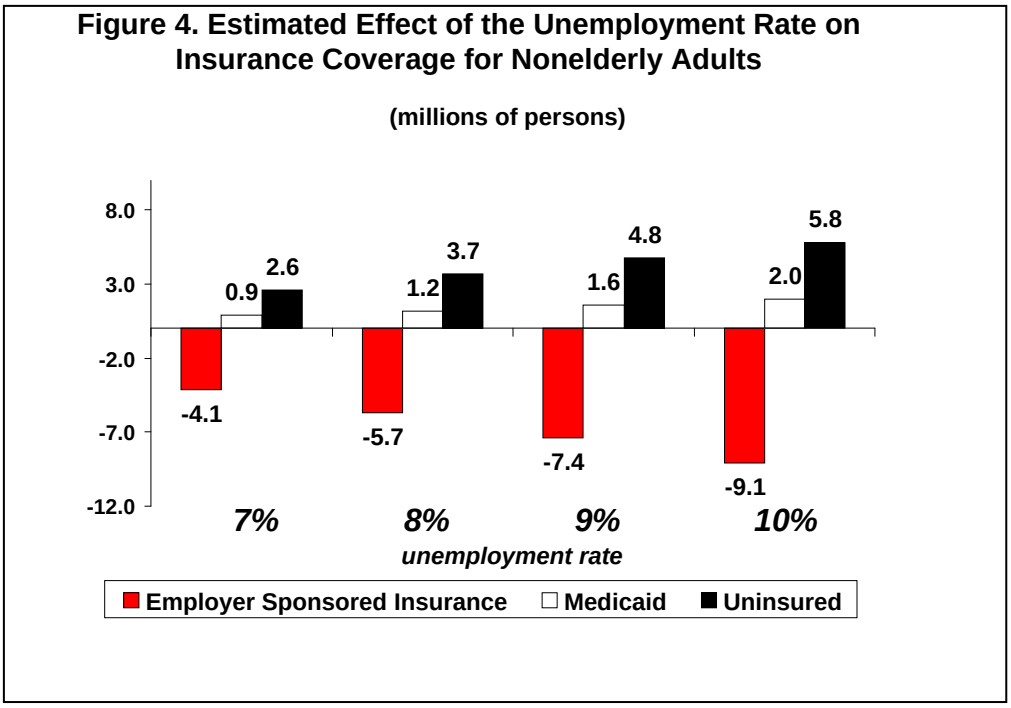
Source: GW calculations based on *CPS* data.

Medicaid's importance to the unemployed

The national unemployment rate of 9.8 percent in September 2009 was at its highest point since 1983[21] and is double the 4.9 percent unemployment rate reported in December 2007, at the start of the current recession. Some 7.6 million people have lost their jobs since December 2007 with unemployment figures standing at 15.1 million as of September 30, 2009.[22]

Economic analyses have demonstrated that rising unemployment has a strong effect on the number of people who are uninsured, as well as on the number of Medicaid enrollees. With every one percentage point increase in the unemployment rate, it is estimated that Medicaid and CHIP enrollments rise by one million people; furthermore, despite gains in Medicaid coverage, the number of uninsured people climbs by one million.[23] Figure 4 below illustrates the effects of different unemployment rates on nonelderly adults' coverage under employer-sponsored insurance, Medicaid/CHIP, non-group coverage, and uninsurance as reported in 2009 by John Holahan and Bowen Garrett of the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured.[24] With the current national unemployment rate nearly equal to the 10 percent mark, the model estimates that 9.1 million adults will lose their employer-sponsored insurance, two million will be covered by Medicaid, and nearly six million more will become uninsured.

[21] Bureau of Labor Statistics, U.S. Department of Labor. (2009). Economic News Release, "The Employment Situation - September 2009". Washington, DC: U.S. Dept of Labor, October 2. Available at: http://www.bls.gov/news.release/pdf/empsit.pdf.
[22] *Ibid.*
[23] Holahan, J. and Garrett, A. B. (2009). "Rising Unemployment, Medicaid and the Uninsured." Kaiser Commission on Medicaid and the Uninsured." *op cit.*
[24] *Ibid.*



Source: Holahan and Garrett, Kaiser Commission on Medicaid and the Uninsured.

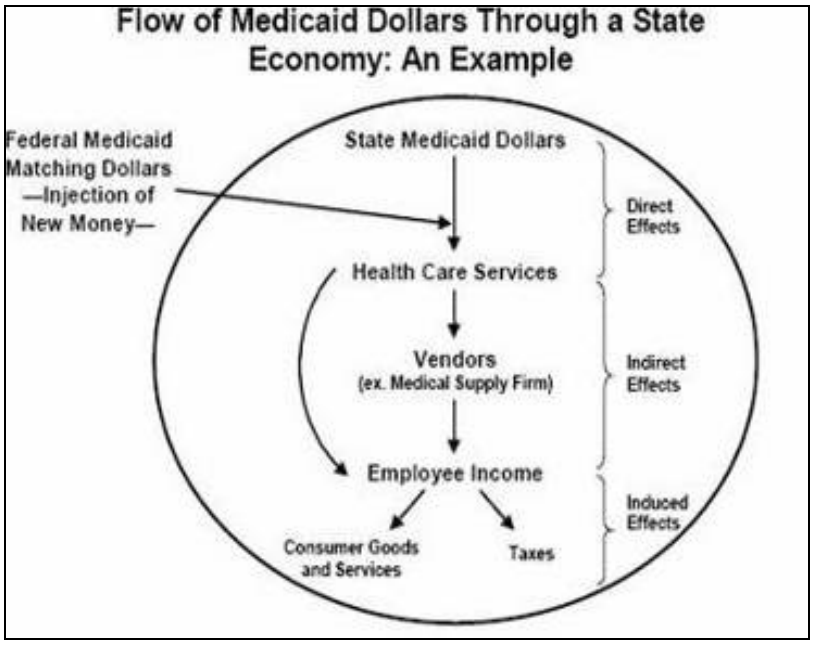
While Medicaid helps offset the loss of employer-sponsored coverage for adults, its effects are blunted because current Medicaid eligibility for low-income adults is so limited, leaving most of those who become unemployed ineligible for Medicaid. Expanding Medicaid to 133 percent of the federal poverty level, while eliminating categorical restrictions applicable to adults, would allow the program to reach the poorest of the unemployed. With improved coverage comes protection against delayed access to health care services of the type that can result in major illness, catastrophic health costs, and lost personal and family productivity.

Medicaid as an engine for state economies

Many analysts view Medicaid from primarily a cost perspective to the federal government and states. This focus, however important, represents only one side of the income statement. Medicaid, when viewed as an enterprise within a state economy, also contributes to state incomes and revenues. This broader view incorporates an understanding of the input-output nature of the U.S. economy; that is, investments in Medicaid (inputs) provide direct, indirect, and induced benefits (outputs) to state and local economies, as illustrated in Figure 5.[25]

[25] Kaiser Commission on Medicaid and the Uninsured. (2009). "The Role of Medicaid in State Economies: A Look at the Research." Washington, D.C. Available at http://www.kff.org/medicaid/7075a.cfm.

Figure 5. Input and Output Effects of Medicaid Expenditures on State Economies



Source: Kaiser Commission on Medicaid and the Uninsured. (2009). "The Role of Medicaid in State Economies: A Look at the Research." Washington, DC.

While states fund a large portion of Medicaid costs (half or less, depending on the federal contribution rate to any particular state matching rate), the majority of funds come from the federal government. Combined federal and state Medicaid payments for health care are directly translated into revenues to physicians, hospitals, clinics, nursing facilities, community drug stores, and other state and community providers of health care. In turn, these local health care providers pay staff, purchase goods and supply vendors, many of whom also are local. Workers and vendors use this income to pay their mortgages, car loans, grocery bills, state and local income and sales taxes, etc. The result is the so-called "multiplier effect" as these funds ripple through the broader state economy. Thus, a medical supply firm that sells supplies to Medicaid providers realizes greater revenues from Medicaid expansions and, in turn, may hire more workers, more fully employ existing workers, or buy more goods from downstream product vendors who, in turn, fare better economically. The resulting cascade of funds raises household spending for consumer goods and eventually leads to increases in state government revenue through income, sales, and property taxes.[26]

A key feature of this ripple effect in the case of Medicaid occurs as a result of the impact of federal revenue transfers to states. The federal government contributes between 50 percent and 76 percent of payments made by states and the District of Columbia for medical assistance costs, as well as between 50 and 90 percent of state expenditures for the cost of administering Medicaid. Because the federal contribution to state payments for medical care (known as the

[26] Fossett, J. W. and Gais, T. L. (2002). "A New Puzzle for Federalism: Different State Responses to Medicaid and Food Stamps." Albany, NY: Rockefeller Institute of Government, State University of New York. Available at: http://www.rockinst.org/publications/federalism/fossett_and_gais_apsa2002withtables.pdf.

federal medical assistance percentage or "FMAP") is tied to a state's per capita income compared to the national average per capita income, poorer states qualify for proportionately higher federal Medicaid contributions and require relatively fewer state dollars. The higher a state's matching rate, the greater the level of federal matching funds and the stronger the multiplier effect of Medicaid on state economies.

A large number of studies have assessed Medicaid's economic impact.[27] Nationally, we estimate that every one dollar invested in Medicaid would generate nearly three dollars in new business activity or a 3:1 return, on average. Using the FamiliesUSA Medicaid Economic Impact online calculator, we estimate the amount of new business activities states can generate for every dollar invested into Medicaid.[28] Table 1 shows the net increases in business activity are substantial and positive. Estimates range from a 6:1 return in Mississippi to little less than a 2:1 return in Wyoming.

[27] A large number of early studies are summarized in Kaiser Commission on Medicaid and the Uninsured. (2009). "The Role of Medicaid in State Economies: A Look at the Research." *op. cit.*

[28] FamiliesUSA. (2008). "Calculate the Impact: Medicaid State Spending and Your State's Economy." Washington, DC: FamilesUSA. Available at: http://www.familiesusa.org/issues/medicaid/other/medicaid-calculator/medicaid-calculator-states-map.html. For a description of the RIMS-II methodology, see: Bureau of Economic Analysis. (1997). The calculator is based on the regional Input-Output Bureau of Economic Analysis (RIMS -II) model created by the U.S. Department of Commerce, Bureau of Economic Analysis. (1997). "Regional Multipliers: A User Handbook for the Regional Input-Output Modeling System (RIMS-II)." Washington, DC: U.S. Department of Commerce.

Table 1. Estimated Rate of Return for Every Dollar Invested in Medicaid by the State, 2007[29]

State	Business Activity Increased	State	Business Activity Increased
National Average: $2.91			
Alabama	$4.33	Montana	$4.23
Alaska	$2.16	Nebraska	$2.75
Arizona	$4.09	Nevada	$2.19
Arkansas	$5.17	New Hampshire	$2.14
California	$2.52	New Jersey	$2.38
Colorado	$2.44	New Mexico	$4.74
Connecticut	$2.11	New York	$2.09
Delaware	$1.92	North Carolina	$3.84
Florida	$2.90	North Dakota	$3.48
Georgia	$4.14	Ohio	$3.45
Hawaii	$2.74	Oklahoma	$4.49
Idaho	$4.64	Oregon	$3.21
Illinois	$2.51	Pennsylvania	$2.77
Indiana	$3.60	Rhode Island	$2.24
Iowa	$3.24	South Carolina	$5.04
Kansas	$3.08	South Dakota	$2.83
Kentucky	$4.67	Tennessee	$3.85
Louisiana	$5.44	Texas	$3.85
Maine	$3.60	Utah	$5.70
Maryland	$2.23	Vermont	$2.65
Massachusetts	$2.19	Virginia	$2.19
Michigan	$2.89	Washington	$2.40
Minnesota	$2.24	West Virginia	$5.08
Mississippi	$6.08	Wisconsin	$2.85
Missouri	$3.62	Wyoming	$1.82

Additional analyses indicate that new jobs would be created as well. For example, a $10 million investment[30] by each state in Medicaid would generate on average 247 jobs in addition to $21.9

[29]These data are derived from FamiliesUSA's Medicaid Calculator, located at http://www.familiesusa.org/issues/medicaid/other/medicaid-calculator/medicaid-calculator-states-map.html. For the methodology, please visit http://www.familiesusa.org/assets/pdfs/medicaid-multiplier-methodology-4-08.pdf. (Data for the District of Columbia are not available online.)

million in new business activities (See Appendix Table 2). The number of new jobs created from a $10 million Medicaid investment of state funds would range from 131 in Delaware to 626 jobs in Mississippi. The ripple effect will mean that job and economic gains will also occur outside the health sector and include other areas of consumer goods and services. Concurrently, such investments are expected to generate significant tax revenues due to increases in salary and wages as rates of disposable income increase with new jobs and higher salaries.

All states can gain a substantial economic boost, but the strongest effects will be experienced by states that have lower per capita incomes (and therefore have higher Medicaid matching rates) or that have more uninsured adults (and therefore will gain more Medicaid enrollees and more federal matching funds). Thus, gains will be particularly strong in southern, southwestern, and Plains states, including Arkansas, Arizona, Louisiana, Mississippi, New Mexico, North Dakota, and West Virginia. These states are likely to experience substantial expansions in health sector investments, providing further resources for health care providers as well as broader economic and employment gains. Moreover, millions of low-income working adults will gain the financial and health security associated with Medicaid coverage, creating additional economic and social improvements.

Under the American Recovery and Reinvestment Act (ARRA), Medicaid matching rates have been temporarily elevated from October 2008 through December 2010, providing an estimated $87 billion in additional federal funding over this period.[31] In addition, state payment incentives to eligible providers for federally recognized HIT adoption activities will be paid fully by the federal government from 2011 through 2021.[32] All states' FMAP rates were increased substantially, but states whose unemployment rates rose more had greater increases, because they were experiencing greater economic distress. Table 2 below shows each state's original and new matching rate for the third quarter in 2009. The initial FMAP increases for FY 2009 range from 6.2 percent point to 13.9 percent. As a result, the return on investment in Medicaid for states is even stronger today than in 2007, given that states contribute a lower proportion to the overall Medicaid costs.

[30] For the purposes of scoring these estimates, $10 million was used to provide consistent job and economic impacts.
[31] States must comply with maintenance of effort requirements to be eligible for the FMAP increase and cannot use the enhanced federal financing for eligibility expansions implemented after July 1, 2008 or for covering disproportionate share hospital (DSH) payments. For more detailed information, see CMS's guidance to states (SMD #9-005, August 19, 2009) http://www.cms.hhs.gov/SMDL/downloads/SMD081909.pdf
[32] ARRA provides $22 billion in additional funding to cover the Medicaid HIT incentive payments.

Table 2. Federal Medicaid Matching Rates: Original FY 2009 and Adjusted Third Quarter 2009 Rates

State	Original Rate	Adjusted 3rd Quarter Rate	Federal contribution increased	State	Original Rate	Adjusted 3rd Quarter Rate	Federal contribution increased
Alabama	68.00%	77.51%	9.51%	Montana	68.00%	77.14%	9.14%
Alaska	50.50%	61.12%	10.62%	Nebraska	59.50%	67.79%	8.29%
Arizona	65.80%	75.93%	10.13%	Nevada	50.00%	63.93%	13.93%
Arkansas	72.80%	80.46%	7.66%	New Hampshire	50.00%	58.78%	8.78%
California	50.00%	61.59%	11.59%	New Jersey	50.00%	61.59%	11.59%
Colorado	50.00%	61.59%	11.59%	New Mexico	70.90%	78.66%	7.76%
Connecticut	50.00%	60.19%	10.19%	New York	50.00%	60.19%	10.19%
Delaware	50.00%	61.59%	11.59%	North Carolina	64.60%	74.51%	9.91%
Florida	55.40%	67.64%	12.24%	North Dakota	63.20%	69.95%	6.75%
Georgia	64.50%	74.42%	9.92%	Ohio	62.10%	72.34%	10.24%
Hawaii	55.10%	67.35%	12.25%	Oklahoma	65.90%	74.94%	9.04%
Idaho	69.80%	79.18%	9.38%	Oregon	62.50%	72.61%	10.11%
Illinois	50.30%	61.88%	11.58%	Pennsylvania	54.50%	64.32%	9.82%
Indiana	64.30%	74.21%	9.91%	Rhode Island	52.60%	63.89%	11.29%
Iowa	62.60%	68.82%	6.22%	South Carolina	70.10%	79.36%	9.26%
Kansas	60.10%	68.31%	8.21%	South Dakota	62.60%	70.64%	8.04%
Kentucky	70.10%	79.41%	9.31%	Tennessee	64.30%	74.23%	9.93%
Louisiana	71.30%	80.01%	8.71%	Texas	59.40%	68.76%	9.36%
Maine	64.40%	74.35%	9.95%	Utah	70.70%	79.98%	9.28%
Maryland	50.00%	60.19%	10.19%	Vermont	59.50%	69.96%	10.46%
Massachusetts	50.00%	60.19%	10.19%	Virginia	50.00%	61.59%	11.59%
Michigan	60.30%	70.68%	10.38%	Washington	50.90%	62.94%	12.04%
Minnesota	50.00%	61.59%	11.59%	West Virginia	73.70%	81.70%	8.00%
Mississippi	75.80%	84.24%	8.44%	Wisconsin	59.40%	68.77%	9.37%
Missouri	63.20%	73.27%	10.07%	Wyoming	50.00%	56.20%	6.20%

Note: District of Columbia also increases from 70% to 79.29%.
Source: *Federal Register*, Aug. 4, 2009

Similarly, the proposed expansions of Medicaid in the House and Senate health reform bills would have a larger economic impact than those whose value was calculated in 2007 before the FMAP increases. Since both bills would substantially increase federal matching funds for the expansions (although at different levels and under different conditions), they would effectively increase the average federal matching rate for states. For example, based on CBO estimates for the draft House bill, we estimate that the average effective federal matching rate for Medicaid would rise from 57 percent in 2007 to 61 percent in 2019.

Conclusion

An important feature of the national health reform plans now under consideration in Congress is a major expansion of Medicaid eligibility for nonelderly adults beginning in 2014, which would provide a national floor for health insurance coverage of 133 percent of the poverty level. This report finds that almost ten million low-income adult citizens who are now uninsured would become eligible for Medicaid coverage, with Medicaid accounting for the greatest proportional gains in reducing the number of uninsured citizens in south, southwest, and plains states as a result of their higher overall poverty rates.

In addition, we find that the positive economic impact of Medicaid on states under health reform will grow significantly. Every dollar invested in Medicaid helps generate two to six dollars in new business activities, a growth impact that serves as an economic offset against state investments. Thus, this analysis underscores that while the final legislation may provide for some state expenditure, the federal funds flow to the states represents a source of hundreds of billions of dollars over the period of investment, with attendant positive economic effects. Equally important, although it is more difficult to quantify, Medicaid's role in improving the health and well-being of previously uninsured individuals and families can be expected to lead to increased productivity, and will ultimately lead to lower health costs as people find regular sources of appropriate preventive and treatment services for acute and chronic conditions.[33]

Finally, it is important to recognize that even a stimulative expenditure may be unachievable if the funds needed to generate the stimulus effect are not available. Given the current economic hardships now being experienced across the states, the Medicaid expansions in health reform therefore ideally would assure full federal funding, at least during the initial five-year period of expansion, as called for in the House legislation. This full federal stimulus could be followed by an enhanced federal contribution level to help sustain state affordability of such efforts. In addition, preserving the enhanced federal Medicaid payment levels established under ARRA should be considered essential in the short term, particularly since, as this analysis shows, federal Medicaid payments must be understood not only as a central strategy for preventing deep Medicaid reductions,[34] but also for their highly stimulative effect on both national and state economies.

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[33] Kaiser Commission on Medicaid and the Uninsured. (2009). "The Uninsured and the Difference Health Insurance Makes." Fact Sheet. Available at: http://www.kff.org/uninsured/1420.cfm.

[34] Artiga, S. (2009). "Where Are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. October 2, 2009. Available at: http://www.kff.org/medicaid/7993.cfm.

APPENDIX TABLES

Appendix Table 1. Estimated Number of Uninsured Citizens 19-64 With Incomes At or Below 133 Percent of Poverty and Percent of the Nonelderly Citizen Population in Each State, 2006 to 2008

	Number in 1,000s	% of Non-elderly Pop.		Number in 1,000s	% of Non-elderly Pop.
U.S. Total	**9,114**	**5.5%**	Missouri	196	5.7%
Alabama	190	7.1%	Montana	43	7.5%
Alaska	25	5.9%	Nebraska	47	4.6%
Arizona	191	5.7%	Nevada	64	4.8%
Arkansas	153	9.3%	New Hampshire	26	3.3%
California	874	4.9%	New Jersey	170	3.8%
Colorado	133	4.6%	New Mexico	105	9.8%
Connecticut	47	2.4%	New York	443	4.3%
Delaware	16	3.2%	North Carolina	340	6.5%
District of Columbia	12	3.6%	North Dakota	20	5.2%
Florida	604	6.5%	Ohio	342	5.0%
Georgia	404	7.4%	Oklahoma	176	8.7%
Hawaii	19	2.8%	Oregon	127	5.8%
Idaho	52	6.2%	Pennsylvania	262	3.6%
Illinois	337	4.7%	Rhode Island	20	3.3%
Indiana	193	5.2%	South Carolina	182	7.1%
Iowa	72	4.1%	South Dakota	25	5.4%
Kansas	85	5.5%	Tennessee	258	7.3%
Kentucky	214	8.5%	Texas	1,030	8.5%
Louisiana	241	9.8%	Utah	57	4.0%
Maine	27	3.4%	Vermont	12	3.0%
Maryland	112	3.6%	Virginia	181	4.1%
Massachusetts	76	2.1%	Washington	130	3.5%
Michigan	303	5.2%	West Virginia	81	7.2%
Minnesota	79	2.6%	Wisconsin	118	3.6%
Mississippi	188	11.2%	Wyoming	15	4.9%

Source: GW analyses of March 2007 to March 2009 *Current Population Survey* data.

Appendix Table 2.
Estimates of the Effect of Increasing State Expenditures for Medicaid by $10 Million Per State, 2007

State	Business Activity Increased	Jobs Gained	Salary Gains	State	Business Activity Increased	Jobs Gained	Salary Gains
National Average	**$29,100,000**	**247**	**$10,300,000**				
Alabama	$43,300,000	420	$15,800,000	Montana	$42,300,000	447	$15,800,000
Alaska	$21,600,000	185	$7,900,000	Nebraska	$27,500,000	270	$9,900,000
Arizona	$40,900,000	339	$15,400,000	Nevada	$21,900,000	187	$8,000,000
Arkansas	$51,700,000	513	$19,000,000	New Hampshire	$21,400,000	170	$7,300,000
California	$25,200,000	198	$9,000,000	New Jersey	$23,800,000	174	$7,900,000
Colorado	$24,400,000	207	$8,600,000	New Mexico	$47,400,000	464	$17,500,000
Connecticut	$21,100,000	170	$7,600,000	New York	$20,900,000	160	$7,200,000
Delaware	$19,200,000	131	$6,200,000	North Carolina	$38,400,000	360	$14,000,000
Florida	$29,000,000	266	$10,800,000	North Dakota	$34,800,000	348	$12,200,000
Georgia	$41,400,000	333	$14,500,000	Ohio	$34,500,000	310	$12,300,000
Hawaii	$27,400,000	238	$10,200,000	Oklahoma	$44,900,000	454	$16,300,000
Idaho	$46,400,000	476	$17,300,000	Oregon	$32,100,000	286	$11,500,000
Illinois	$25,100,000	202	$8,600,000	Pennsylvania	$27,700,000	223	$9,500,000
Indiana	$36,000,000	315	$12,700,000	Rhode Island	$22,400,000	182	$7,700,000
Iowa	$32,400,000	322	$11,700,000	South Carolina	$50,400,000	488	$18,100,000
Kansas	$30,800,000	279	$10,500,000	South Dakota	$28,300,000	275	$10,500,000
Kentucky	$46,700,000	413	$16,100,000	Tennessee	$38,500,000	311	$13,500,000
Louisiana	$54,440,000	552	$19,800,000	Texas	$38,500,000	331	$13,600,000
Maine	$36,000,000	351	$13,600,000	Utah	$57,000,000	548	$20,500,000
Maryland	$22,300,000	170	$7,700,000	Vermont	$26,500,000	245	$9,800,000
Massachusetts	$21,900,000	170	$7,800,000	Virginia	$21,900,000	181	$7,500,000
Michigan	$28,900,000	263	$10,800,000	Washington	$24,000,000	194	$8,600,000
Minnesota	$22,400,000	187	$8,200,000	West Virginia	$50,800,000	472	$17,800,000
Mississippi	$60,800,000	626	$21,900,000	Wisconsin	$28,500,000	258	$10,500,000
Missouri	$36,200,000	306	$11,900,000	Wyoming	$18,200,000	185	$6,900,000

Source: These data are derived from FamiliesUSA's Medicaid Calculator, located at http://www.familiesusa.org/issues/medicaid/other/medicaid-calculator/medicaid-calculator-states-map.html. For the methodology, please visit http://www.familiesusa.org/assets/pdfs/medicaid-multiplier-methodology-4-08.pdf. (Data for the District of Columbia are not available online.)