Medicaid — and how to pay for it — has become a recurring theme in several current critical policy debates. Fourteen U.S. states have not yet expanded the program under the Affordable Care Act (ACA), mostly because of concerns about the potential impacts on state budgets, and these decisions have left more than 2 million low-income adults without any health care coverage. Meanwhile, earlier this year, the Trump administration invited states to submit proposals to shift Medicaid to a block-grant or per-capita-allotment system with a capped federal contribution. Most recently, the coronavirus epidemic has hit like a thunderbolt, both federal and state policymakers are looking to Medicaid as a central tool in their response to this national emergency.

For all these areas, it has become increasingly important to understand how Medicaid is paid for. Medicaid’s basic financing structure since its creation in 1965 has been a joint state and federal effort. The federal government creates the ground rules for state participation in the program in exchange for large subsidies to the states. Before the ACA, states received a “match rate” (formally the federal medical assistance percentage, or FMAP), which varies by states’ per capita income. Higher-income states such as New York and California have a 50% match rate, while Mississippi — the poorest state in the country — currently has an FMAP of nearly 78%. The states are responsible for the remainder of Medicaid program costs, which they finance through sources including general state revenues and taxes on health care providers. The ACA sweetened the deal for states considerably in its Medicaid expansion, covering newly eligible adults with 100% federal funding from 2014 through 2016, and then scaling back to 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter. So how has this system worked since the creation of the ACA Medicaid expansion, and what does the Covid-19 pandemic mean in terms of the best way to structure the program?

In recent research, we analyzed budget data from all 50 states from 2010 through 2018 to assess the impact of the ACA Medicaid expansion. As expected, we found that expansion states experienced a substantial increase in Medicaid spending since implementation of the expansion, with 24% higher growth than nonexpansion states between 2013 and 2018. Critically, when analyzing the source of funds, we found that this increase in Medicaid spending was subsidized entirely by increased

Paying for Medicaid — State Budgets and the Case for Expansion in the Time of Coronavirus

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federal funding to expansion states, with no significant changes in spending from state revenues associated with Medicaid expansion (see graphs). We also found no evidence that Medicaid expansion forced states to cut back on spending on other priorities, such as education, transportation, or public assistance, despite frequent assertions by opponents of expansion that the policy would inevitably have such harmful effects.

How could states have expanded Medicaid without increasing state spending, when they were on the hook for 5% of the expansion costs in 2017 and 6% in 2018? Our findings in this regard are consistent with case studies from several states showing that they have used federal dollars from the Medicaid expansion to offset other areas of state spending, such as direct subsidies to public hospitals and mental health centers, health care costs for people involved with the justice system, and a more generous match rate for optional groups previously covered by many state Medicaid programs. Thus, Medicaid expansion appears to be a win–win from the states’ perspective — giving health insurance to millions of low-income adults and offering financial support to safety-net hospitals, without any adverse effects on state budgets.

Yet proposals for dramatic changes to the way Medicaid is paid for are in the works, with the Centers for Medicare and Medicaid Services (CMS) recently launching the “Healthy Adult Opportunity” initiative that encourages states to leave behind this system and shift to a fixed federal contribution. The basic economics of the Medicaid match-rate system clarify the potential advantages and drawbacks of such an overhaul. The large subsidy from the federal government leads states to cover far more people under Medicaid than if they were spending only their own funds. Such broadened coverage was the intent of Congress in the 1960s and with the passage of the ACA in 2010. Critics, however, contend that the subsidy leads states to be inefficient in running their programs, producing high costs with what some have called “mediocre” outcomes — despite a large body of evidence showing wide-ranging health benefits of Medicaid expansion. Viewing the program as overly expensive and ineffective, the administration has pushed states to accept caps on federal support for Medicaid in exchange for flexibility to refashion the program in terms of who is eligible, what services are covered, and how care is delivered.

The current Covid-19 crisis highlights a major flaw in this proposal when it comes to unexpected public health shocks. The open-ended nature of the match-
rate subsidy means that states experiencing sudden increases in Medicaid costs continue to receive additional federal support to cover a large portion of those expenses — which is critical, since most states (unlike the federal government) are legally prohibited from going into a budget deficit.

Historically, there have been three main drivers of unexpected cost growth in Medicaid: economic downturns, when many people lose coverage through work and more people need government assistance; natural or public health disasters, such as Hurricane Katrina in 2005, when Medicaid funding was critical to helping Louisiana cope with the disaster, and more recently, the opioid epidemic; and expensive new technologies relevant to the Medicaid population, such as the invention of new antiviral medications for hepatitis C over the past decade.

Unfortunately, all three factors are poised to hit states in 2020. First, the Covid-19 pandemic threatens to overwhelm health care providers and hospitals, especially resource-poor safety-net providers that are heavily reliant on Medicaid in the first place. These providers often care for some of the sickest patients and those who are at highest risk for coronavirus infection, particularly those with disabilities and people living in nursing homes. Second, with sweeping public health measures, state-mandated business closures, and a stock-market crash, a recession is highly likely over the coming months. Third, if and when effective treatments and a vaccine are available for Covid-19, Medicaid will be called on to pay for these new services for tens of millions of beneficiaries.

In the current context, it is hard to imagine a worse policy approach in Medicaid than to cap federal contributions to the program and shift to predetermined block-grant allotments for states. There is simply no way for Congress or CMS, in setting an annual cap for Medicaid, to anticipate or predict the course of this sort of rapidly unfolding disaster, in which Medicaid must be relied on to play a critical role. In recognition of this fact, the first federal Covid-related economic relief package passed in March leaned heavily on the existing Medicaid system, increasing the match rate by 6.2 percentage points until September 2021. This increase is a good start, though a larger boost for a longer period may ultimately be needed.

Given these realities — and the fact that existing Medicaid expansions have not produced the dire effects on state budgets that critics predicted — there is no moment in recent memory more critical than now to bolster Medicaid. Covering more people in Medicaid is a rapid way to bring needed resources into the health care system and infuse federal dollars into state economies on the verge of a major downturn. Medicaid expansion also requires no new infrastructure or federal oversight to achieve, unlike many other types of stimulus spending. Medicaid remains highly popular with voters from both parties. And most important, expanding Medicaid can save lives.

Congress has stepped up with additional support for the program to expand its reach, and now states should do the same. In light of the program’s role in managing the coronavirus epidemic, maximizing long-term health, and helping to stabilize the health care system in a time of crisis, the case for Medicaid expansion in the remaining 14 states has never been stronger.

Disclosure forms provided by the authors are available at NEJM.org.

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