

# Economic and Employment Effects of Expanding Medicaid in Iowa

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## Introduction

Under the Patient Protection and Affordable Care Act (ACA, sometimes known as Obamacare), states may decide whether to expand eligibility for their Medicaid programs to non-elderly adults whose family incomes are less than 138 percent of the federal poverty line (an annual income of about \$32,500 for a family of four in 2013). To avoid creating undue financial burdens for states, the federal government will pay 100 percent of the medical costs of serving the newly eligible from 2014 to 2016, but its share will phase down to 90 percent for 2020 and the years thereafter.<sup>1</sup> The original intent of the ACA was that all states undertake this expansion, but the Supreme Court's decision in *National Federation of Independent Businesses v. Sebelius* established that states effectively had the option of whether to expand Medicaid eligibility. States may decide whether and when to implement an expansion, but, if it is adopted, Medicaid eligibility must rise to the 138 percent level.

The purpose of this report is to offer a balanced and comprehensive view of the economic, employment and budgetary effects of the decision of whether or not to expand Medicaid in Iowa. In considering whether to adopt the Medicaid expansion, a state must consider the budgetary and economic consequences of its decision, as well as the health

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<sup>1</sup> States that had already expanded Medicaid coverage will have an enhanced matching rate for childless adults, eventually reaching 90 percent by 2020 and beyond.

This is an independent analysis of the economic impact of a Medicaid expansion, conducted by researchers at Regional Economic Models, Inc. (REMI) and the George Washington University (GW). This report was prepared for the Iowa Hospital Association and funded by the American Hospital Association. All opinions and conclusions in this report are those of the authors and do not represent institutional views of REMI, GW, the American Hospital Association or the Iowa Hospital Association.

consequences. In the normal course of consideration, a state office prepares a budget estimate of the cost to the state of adopting a new policy. While the budget estimates that are usually prepared are important, they often fail to provide a comprehensive view of the effects because they are focused solely on the direct costs that must be borne by the state.

This report offers a more comprehensive view of the total effect of a Medicaid expansion by also looking at the effect on:

- The level of additional federal funds that will be earned in Iowa due to the Medicaid expansion,
- Iowa's economic activity (that is, the gross state product),
- Employment levels in Iowa,
- State tax revenues that would increase due to higher economic activity, and
- Other budgetary savings, such as savings in other health care costs that may occur if Medicaid covers more low-income patients.

It is important to note that this report focuses on the effects of Iowa's decision concerning the Medicaid expansion alone; it does not address the impact of the overall federal health law. Under the Supreme Court decision, other changes required by the ACA, such as the establishment of health insurance exchanges, increases in Medicaid primary care payment rates, or changes in how income is counted in Medicaid, will occur regardless of whether a state expands Medicaid or not. This report examines only the additional consequences of expanding Medicaid and assumes the other changes will take place as specified in the federal law.

## **Iowa's Medicaid Program**

Iowa's Medicaid program currently covers adults with dependent children (i.e., parents or guardians) if their family incomes are below 82 percent of the Federal Poverty Level (FPL), which varies by family size.<sup>2</sup> This percentage equates to roughly \$19,300 in annual income for a family of four in 2013. Limits on assets (e.g., money in savings accounts) also apply. Only adult caregivers such as parents and guardians are eligible; Iowa does not provide Medicaid coverage to any childless adults under age 65 unless they qualify because of a disability. Adults with incomes up to 200 percent of the FPL are eligible for coverage of a more limited set of health care services through the IowaCare waiver program.

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<sup>2</sup> Some documents refer to Iowa's income limit for Medicaid in terms of "net income," which is 32% of the FPL. The gross income standard of 82% of the FPL takes into account income disregarded in computing net income.

Iowa shares the expense of providing Medicaid coverage with the federal government. Today, Iowa is responsible for 40.4% of most Medicaid spending in the state, and the federal government covers the remaining percentage.<sup>3</sup> The ACA substantially increased the federal matching rates for persons who are newly eligible through the Medicaid expansions, which will reduce state costs for this population. From 2014 to 2016, the federal government will fund 100 percent of spending for this population. This enhanced federal match declines to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.

Estimates by the non-partisan Urban Institute indicate that implementation of the Medicaid expansion will increase the number of people in Iowa covered by Medicaid by 72,000 people by 2022.<sup>4</sup> The Urban Institute projects that an additional 43,000 people who are eligible under today's eligibility rules but not currently enrolled will subsequently sign up due to the publicity and outreach related to health reform, even without a Medicaid expansion; sometimes people call this a "woodwork" effect. Iowa will have to pay the regular matching rate (currently 40.4%) for any Medicaid-covered services obtained by these individuals.

The Urban Institute's estimate of the number of new enrollees due to the Medicaid expansion is somewhat smaller than the estimates by Milliman, Inc. for the Medicaid expansion, ranging from 80,700 to 122,900 used by the Department of Human Services/Iowa Medicaid Enterprise (IME).<sup>5</sup> These discrepancies point out some of the inherent difficulties in projecting responses to future changes, since neither the Urban Institute nor Milliman can be certain of the number of people who would participate under a new program. We do note, however, that the Urban Institute estimates are based on a more sophisticated simulation and were conducted on an independent basis, but it is still difficult to predict whose estimates are more likely to be "correct." Both the Urban Institute and Milliman note that there will be a "woodwork" effect in which current eligibles will increase their participation in Medicaid, because of the additional publicity and other coordinated enrollment requirements in the ACA. Some of the higher enrollment estimates cited by Iowa include this woodwork estimate. Even Milliman acknowledges however, that the woodwork effect will likely occur regardless of whether Iowa

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<sup>3</sup> The 40.4% matching rate applies to expenditures from October 2012 through September 2013.

<sup>4</sup> Holahan, J., Buettgens, M., Carroll, C. and Dorn, S. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Kaiser Commission on Medicaid and the Uninsured. Nov. 2012.

<sup>5</sup> These are the low and moderate estimates for the new Medicaid eligibles, excluding the additional "woodwork" effect which Milliman notes will likely occur even without the Medicaid expansion, because of publicity and other requirements of the ACA which Iowa would have to implement anyway. Milliman, Inc. "Financial Impact Review of the Affordable Care Act as Amended by H.R. 4782, the Reconciliation Act of 2010, and the Supreme Court of the United States June 29, 2012 Decision, on the Iowa Medicaid Budget: Medicaid Expansion to 138% FPL." December 13, 2012.

implements a Medicaid expansion and that they should not be included in estimates of the impact of the decision to expand Medicaid or not.

If Iowa does not expand Medicaid to 138 percent of poverty, some residents with incomes between 100 and 138 percent of poverty may instead get health insurance through the Health Insurance Exchange. These individuals likely will be fewer in number than those who enroll in Medicaid because the Exchanges will require greater contributions from recipients to enroll and to receive health care. Our analyses account for the fact that some in the 100 to 138 percent of poverty bracket will instead enroll in Health Insurance Exchanges if Medicaid is not expanded. Barring changes to the eligibility standards for the Exchanges set forth in the ACA, childless adults with family incomes below 100 percent of poverty (\$23,550 for a family of four in 2013), but above the eligibility level for Iowa's Medicaid program (\$19,300 for a family of four in 2013), will not be eligible for either the Exchange or for Medicaid.

## Methods

The underlying purpose of this report is to illustrate the broad economic and employment consequences of a Medicaid expansion in Iowa. It is fundamental to understand that a Medicaid expansion has very broad economic impact, beyond the state budgetary costs. Since most of the increased costs will be borne by the federal government, there will be a substantial inflow of federal funds to Iowa, although some will also be paid by the state government. These funds will initially be paid to health care providers, such as hospitals, clinics, pharmacies and health insurance plans, as health care payments for Medicaid services. That represents the initial flow of funds. Next, the health care providers distribute these funds as salaries to health care staff, payments for other goods and services (such as the costs of rent, equipment, medical supplies, and other goods and services), and as state and local tax payments. This represents the secondary flow of funds. Finally, these funds flow into the broader state economy as workers and businesses use their income to pay for general goods and services, such as mortgages or rent, utility bills, food bills, transportation and educational services. In turn, the real estate, grocery and other firms distribute these funds as salaries to their employees and to buy other goods and services. Thus, the Medicaid funds trickle through the broader state economy and the total economic impact ends up being larger than the initial amount of Medicaid payments, since the money is recycled through many layers of the state economy. Economists sometimes refer to this phenomenon as the "multiplier effect," although the REMI model uses a more sophisticated approach.

Researchers from the George Washington University (GW) estimated the additional state and federal Medicaid expenditures (or savings) resulting from Medicaid expansion, based on recent estimates published by the Kaiser Commission on Medicaid and the Uninsured, based on

the non-partisan Urban Institute's Health Insurance Policy Simulation Model.<sup>6</sup> The GW experts allocated these estimated expenditures among four healthcare sectors used in the fiscal and economic effects model, described below. The allocations rely on information from several sources, including state Medicaid expenditure data from the Centers on Medicare and Medicaid Services, Medicaid spending and enrollment projections from the Congressional Budget Office, and publicly available reports and projections from the Iowa Medicaid Enterprise.

Using these inputs, experts at Regional Economic Models, Inc. (REMI) used a structural macroeconomic model to quantify the impact of the ACA on the broader Iowa economy, with and without the Medicaid expansion. Using its Tax-PI software, REMI simulated the statewide net fiscal and economic effects of expansion, and assessed the net effect of the changes in healthcare spending along with the direct costs to the state from additional enrollees, while considering the federal contribution both in the short and longer term. REMI's models have been used in thousands of national and regional economic studies, including studies of health care reform and health care issues around the United States. More information about the Tax-PI model is available in a technical appendix to this report.

The model used in this analysis covers the state of Iowa and includes 70 industry sectors, three of which pertain most closely to the healthcare industry data used in this analysis. The three healthcare sectors used in the model are outlined below with definitions from the U.S. Census Bureau's North American Industry Classification System along with one consumption category:

**Ambulatory Health Care Services:** Establishments in this sector provide health care services directly or indirectly to ambulatory patients and do not usually provide inpatient services. Health practitioners in this sector provide outpatient services, with the facilities and equipment not usually being the most significant part of the production process.

**Hospitals:** This sector provides medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals may also provide outpatient services as a secondary activity. Establishments in the hospitals sector provide inpatient health services, many of which can only be provided using the specialized facilities and equipment that form a significant and integral part of the production process.

**Nursing and Residential Care Facilities:** Industries in the Nursing and Residential Care Facilities subsector provide residential care combined with either nursing, supervisory, or other types of care as required by the residents. In this subsector, the facilities are a significant part of the production process and the care provided is a mix of health and social services with the health services being largely some level of nursing services.

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<sup>6</sup> Holahan et al., Nov. 2012

**Spending on Pharmaceuticals:** Pharmaceutical costs fall into two broad areas: distribution and manufacturing costs. Distribution costs include the retail, wholesale and transportation related costs, which are primarily local in nature. Pharmaceutical manufacturing often occurs in another state. REMI assumes that a portion of manufacturing costs may remain in the state, based on estimates of state manufacturing for pharmaceuticals obtained from other REMI models.

**State Government Spending:** This analysis does not include the state’s share of funding for the Medicaid expansion. Given the balanced budget requirement, any additional dollar spent on Medicaid must come from somewhere else in the state. Revenue can come from economic growth, reallocation from other spending, new revenue sources, and cost savings in other health care programs. The net result of all these spending changes is likely to be negligible and thus it is excluded from this simulation.

Table 1 shows a summary of the estimated annual federal Medicaid expenditures by sector associated with the incremental federal funds received for a Medicaid expansion. These represent the “inputs” to the Tax-PI model. (We do not include the state funds on the assumption that the state would have used these funds on an alternative expenditure which would also have a multiplier impact, whereas the federal funds represent new money that would not otherwise be available to the state.)

**Table 1: Inputs to Tax-PI Rounded (millions of nominal dollars)**

| <u>Detail</u>                             | <u>2014</u>  | <u>2015</u>  | <u>2016</u>  | <u>2017</u>  | <u>2018</u>  | <u>2019</u>  | <u>2020</u>  |
|---|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| <b>Total Federal Spending</b>             | <b>\$257</b> | <b>\$274</b> | <b>\$292</b> | <b>\$311</b> | <b>\$331</b> | <b>\$353</b> | <b>\$376</b> |
| Ambulatory health care services           | \$103        | \$112        | \$120        | \$124        | \$132        | \$141        | \$150        |
| Hospitals                                 | \$113        | \$118        | \$126        | \$137        | \$146        | \$155        | \$165        |
| Nursing and residential care facilities   | \$8          | \$8          | \$9          | \$9          | \$10         | \$11         | \$11         |
| Pharmaceutical and other medical products | \$33         | \$36         | \$38         | \$40         | \$43         | \$46         | \$49         |
| Adjustment for Chemical Mfg Demand        | -\$18        | -\$19        | -\$20        | -\$22        | -\$23        | -\$25        | -\$26        |
| Adjustment for Chemical Mfg Sales         | \$1          | \$1          | \$1          | \$1          | \$1          | \$1          | \$1          |

The REMI model treats the input data as demand variables for the healthcare sectors. The demand variable induces increased growth of those industries, which simulates the effect of expanding government spending on healthcare. We note that only a portion of the health care expenditures result in increased output by state firms. For example, some patients, particularly those living near state borders, may receive care in an out-of-state facility. Consequently, not all of the new Medicaid spending will be in-state. The regional purchase coefficient estimates the amount of demand satisfied locally. (Of course, in turn, if a bordering state expands Medicaid, Iowa health care providers would have increased revenue. But since this report focuses only on

Iowa policies we effectively assume that no bordering states expand Medicaid. In this respect, these estimates may be a conservative representation of increased demand by Iowa health care providers.)

**Table 2: Regional Purchase Coefficients - Averages 2014 - 2020**

| <b>Category</b>                         | <b>Average</b> |
|---|----------------|
| Ambulatory health care services         | 75%            |
| Hospitals                               | 63%            |
| Nursing and residential care facilities | 95%            |

**Table 3: Estimated Demand for Health Services In-State and Out-of-State, 2014-2020 (\$ millions)**

| <b><u>Industry</u></b>                  | <b><u>Total Direct Inputs</u></b> | <b><u>Imports from Out of State</u></b> |
|---|-----------------------------------|---|
| Ambulatory health care services         | \$663                             | \$220                                   |
| Hospitals                               | \$607                             | \$353                                   |
| Nursing and residential care facilities | \$62                              | \$4                                     |

## **Results**

Any expansion of Medicaid will have economic impacts. This section estimates the inputs and results, and describes the cause and effect relationship between them. The results reflect the projected economic growth created by the ACA and its expansion of Medicaid coverage in Iowa. These outputs include an array of economic and demographic indicators including total state employment, gross state product, personal income, and total revenues. All the following amounts are in nominal (i.e. not inflation adjusted) dollars.

## State and Federal Expenditures for Expansion

Our estimates of new federal and state spending resulting from Medicaid expansion in Iowa differ from the Milliman, Inc. estimates.<sup>7</sup> For example, this report uses the Urban Institute estimates of \$459 million in direct Medicaid savings from 2014 to 2020 due to the Medicaid expansion, while Milliman estimates that the state will save \$118 to \$206 million, exclusive of the “woodwork” enrollment effect which would occur regardless of whether the state expands Medicaid.<sup>8</sup> While the estimates vary in magnitude, they are similar in that they indicate a net state savings associated with a Medicaid expansion because of the higher federal matching rates for those who are newly eligible in an expansion. In contrast, our estimates for additional federal matching revenues generated by the Medicaid expansion (\$4.1 billion from 2014 to 2020) is in the range of the federal revenue estimates produced by Milliman (\$2.7 to \$4.8 billion), so those are closer. All estimates—others and ours—are approximate since it is impossible to know in advance exactly what the condition will be of the state’s economy, how many people will participate or how high medical costs will be in the future. However, our projections provide a general sense of the overall magnitude and direction of expected economic and budgetary impacts.

## Total Change in Employment and Earnings

One of the most obvious ways that the economy affects people’s lives is through creation of new jobs. The additional spending made necessary by expanding Medicaid will lead to millions of dollars of new money going into the health care industries noted above. Most beneficial to Iowa is the commitment of the federal government to cover 100% of the cost through 2016. Figure 1 shows the expected change in employment resulting from the increase in demand for health care and the ripple effects and these changes. The net increase in overall state employment will be between 2,100 and 2,400 jobs. While the majority of these jobs will be in the health care sector, a substantial share will occur in other economic sectors, reflecting the broad multiplier effect of the Medicaid expansion on many sectors of the state economy. For example, to the extent that health care facilities need to expand to serve the newly covered patients, there will be real estate and construction costs that will boost employment in those sectors as well.

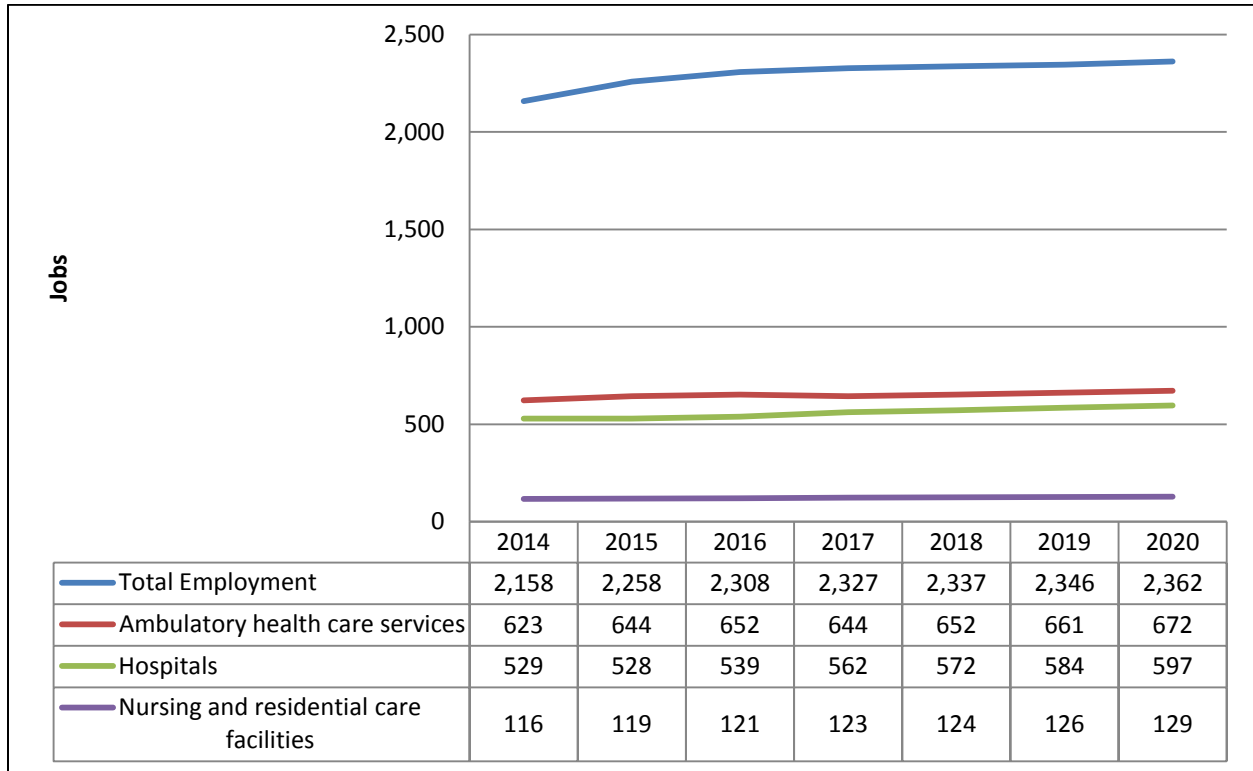
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<sup>7</sup> Milliman, Inc. December 12, 2012.

<sup>8</sup> Memo from Jennifer Vermeer, Medicaid Director, to Charles Palmer, Director, Iowa Dept. of Human Services, Dec. 14, 2012, summarizing analyses by Milliman, Inc. The Milliman estimates including the woodwork effect range from a positive \$117 to \$537 million, but the major reason is because of the increased number of people who are already eligible who would join Medicaid. As Milliman notes, those changes are going to happen because of other ACA requirements and should not be counted as the cost of a Medicaid expansion.

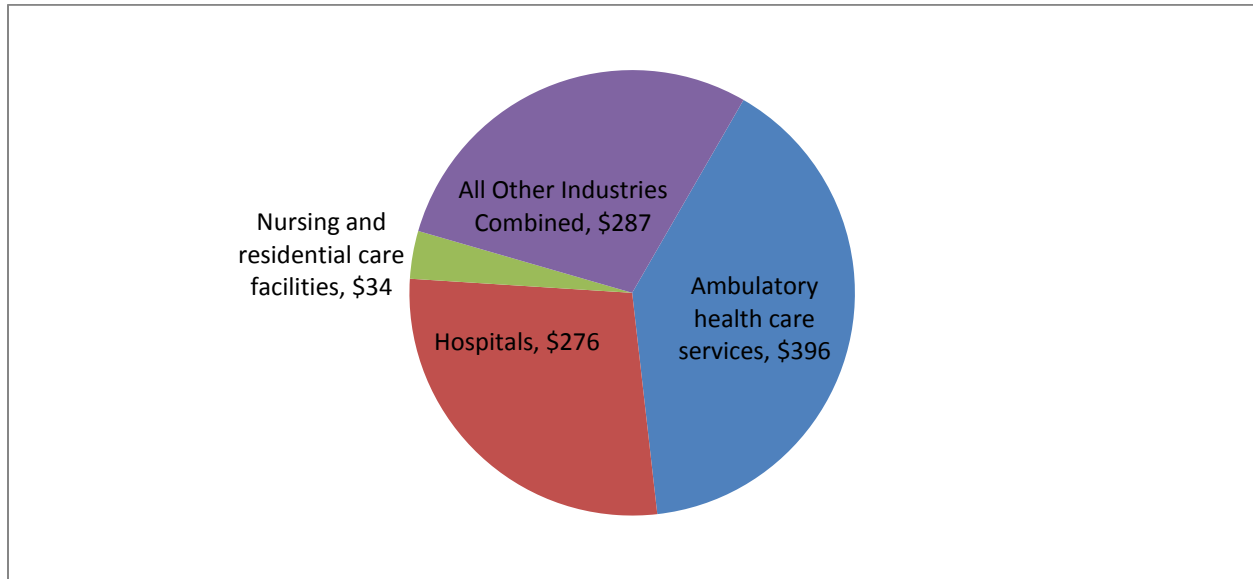


Figure 1: Changes in Employment Levels Due to Medicaid Expansion



Each of the jobs shown in Figure 1 will come with a paycheck. Those paychecks together form Total Earnings by Place of Work, which is the sum of wages, benefits, and proprietors' income paid to employees working in Iowa. These earnings form the basis of Personal Income and increased consumption in the state. As such, they are of primary importance in driving changes in income and sales tax revenues. Figure 2 shows the cumulative change in earnings paid to those employed in Iowa.

Figure 2: Cumulative Earnings (2014-2020) (millions of nominal \$)



## Total Economic Activity

Because there is some leakage out of the state when using the demand variable, it is not a fair assessment of the results to equate the input amounts with the direct, *local* impacts. If we do this, we are underestimating the effect each dollar of local spending has had on the local economy. For example, we estimate that about 37 percent of the inputs in the hospital sector will be received by out-of-state hospitals. Therefore, it is unreasonable to use the full value of spending in the Hospital sector as the increase in revenues going to in-state hospitals.

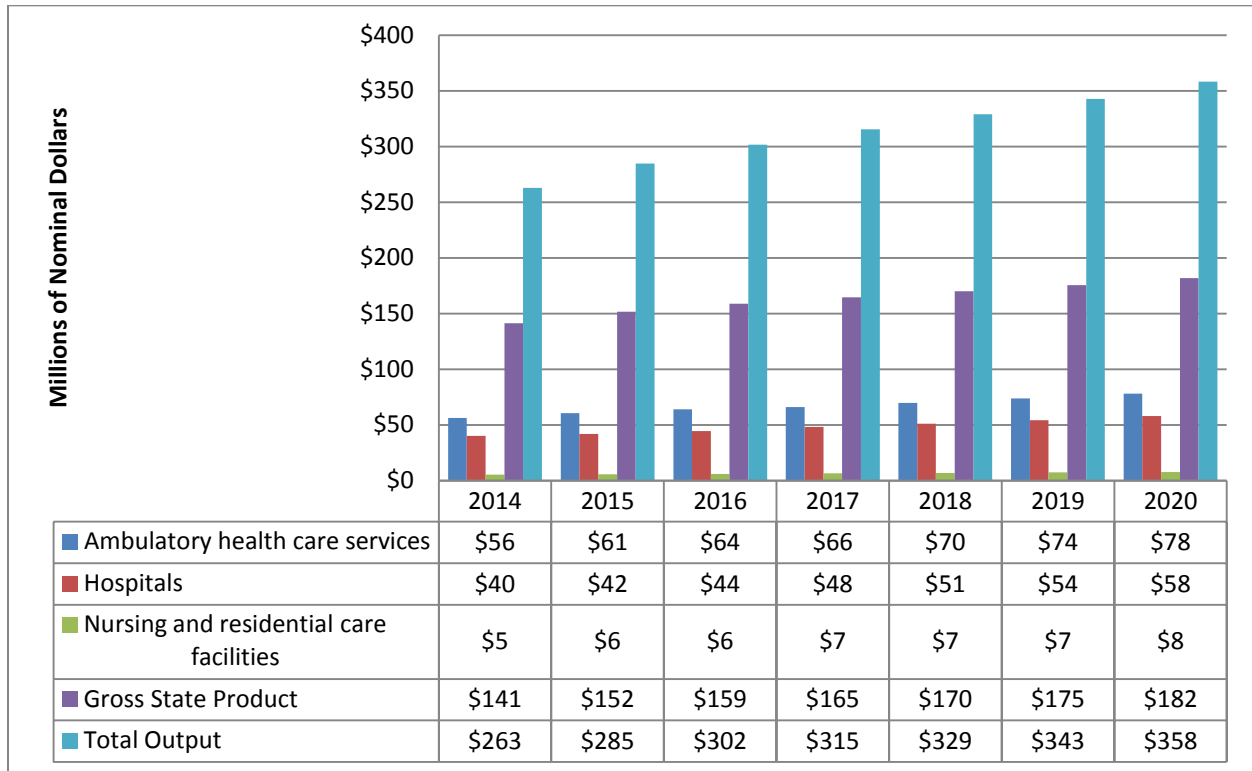
There are two concepts commonly used to quantify economic growth: output and gross state product. Output is the same as revenues so every time a transaction is completed where money is exchanged output increases whether it is a business-to-business sale or one to the household consumer. As a result of the Medicaid expansion, output in Iowa is expected to increase by an average of \$314 million per year for a cumulative increase of \$2.2 billion from 2014 through 2020.

Gross State Product (GSP) is a subset of output and is the total new value created within Iowa. GSP can be thought of as all net new economic activity or output minus the goods and services used as inputs to production. Which transactions are counted is the key difference between GSP and output: where output counts every transaction, GSP only counts the final transaction. As a result of the Medicaid expansion, GSP in Iowa is expected to increase by an average of \$163 million per year for a cumulative increase of \$1.14 billion from 2014 through 2020.

When choosing between the two concepts output is most appropriate when referring to changes in business activity, as it shows the total amount of new revenues received by all

businesses in the state. However, when referring to new growth or value created in the state's economy, GSP is the best measure to use.

**Figure 3: Contributions to Gross State Product by Industry and Other Totals Due to Medicaid Expansion**



### State Tax Revenue Changes

The economic growth created by expanding Medicaid will create more revenue for the state. A simple way to understand where these revenues come from is to use the output growth shown in Figure 3 as an example. Each of these dollars means greater income for businesses which means more corporate income tax revenue for the state. This example can easily be expanded to understand how economic growth supports greater general tax revenues. Table 4 shows state revenues gained from economic growth.

**Table 4: Change in State Revenues (millions of nominal \$)**

| <u>Category</u> | <u>FY2014</u> | <u>FY2015</u> | <u>FY2016</u> | <u>FY2017</u> | <u>FY2018</u> | <u>FY2019</u> | <u>FY2020</u> | <u>Total</u> |
|-----------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|--------------|
| Total Revenues  | \$3           | \$7           | \$8           | \$9           | \$10          | \$10          | \$11          | \$58         |

## Other State Savings

The expansion of Medicaid eligibility has the potential to reduce other state or local expenditures for health care. There are three areas of potential savings: reduced costs associated with the termination of IowaCare, the state's Medicaid waiver program, community mental health expenditures and reduced charity care costs at state hospitals.

Table 5 illustrates these potential savings. A report from the Iowa Department of Human Services estimates that termination of IowaCare would save about \$8.5 million per year.<sup>9</sup> Next, we assume that a substantial portion of state-funded care for community mental health services (not including inpatient psychiatric or prevention services) would no longer be needed if a large share of low-income uninsured patients could gain mental health services under the Medicaid expansion instead.<sup>10</sup> Similarly, under a Medicaid expansion, there could be a substantial reduction in the level of charity care that is now provided by state public hospitals.<sup>11</sup> For both community mental health services and state public hospitals, we assume that, when fully implemented, about one-third of the expenses could be averted because of care provided under Medicaid instead. However, we also assume that the full level of savings could not be implemented from the start and would need to gradually ramp up in 2014 and 2015.

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<sup>9</sup> Memo from Jennifer Vermeer, Medicaid Director, to Charles Palmer, Director, Iowa Dept. of Human Services, Dec. 14, 2012, summarizing analyses by Milliman, Inc.

<sup>10</sup> Data for state community mental health funding for years 2005 to 2010 came from the National Association of State Mental Health Directors Research Institute and were projected, assuming growth rates comparable to historical levels. This excludes funding for psychiatric hospitals, prevention, research, training and administration costs. Medicaid can cover the costs of ambulatory mental health services, but not inpatient psychiatric costs for adults.

<sup>11</sup> Data about charity care provided by state hospitals was drawn from reports by hospitals in the American Hospital Association's Annual Hospital Survey for 2011, and then conservatively projected with 4% growth per year. This does not include bad debt expenses. After Massachusetts implemented its state health insurance expansion, payments for its uncompensated care program fell by about one-third. Ku, L., Jones, E., Shin, P., Burke, F., and Long, S.. "The Role of the Safety Net After Health Reform: Lessons from Massachusetts." *Archives of Internal Medicine*, 171(15): 1379-84, August 8, 2011.

**Table 5: Potential Offsetting Health Care Savings If Medicaid is Expanded (millions of nominal \$)**

| <b><u>Category</u></b>      | <b><u>2014</u></b> | <b><u>2015</u></b> | <b><u>2016</u></b> | <b><u>2017</u></b> | <b><u>2018</u></b> | <b><u>2019</u></b> | <b><u>2020</u></b> | <b><u>Total</u></b> |
|-----------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|---------------------|
| IowaCare Savings            | \$8.5              | \$8.5              | \$8.5              | \$8.5              | \$8.5              | \$8.5              | \$8.5              | \$59.5              |
| Community Mental Health     | \$11.2             | \$24.9             | \$41.7             | \$46.6             | \$52.0             | \$58.0             | \$64.8             | \$299.2             |
| State Hospital Charity Care | \$38.2             | \$79.6             | \$124.1            | \$129.1            | \$134.2            | \$139.6            | \$145.2            | \$790.0             |
| Total Potential Savings     | \$49.4             | \$104.5            | \$165.8            | \$175.6            | \$186.2            | \$197.6            | \$210.0            | \$1,089.1           |

It is likely that other savings are possible, such as costs of other miscellaneous state health programs or prison-related care, but we do not have a reasonable basis for providing estimates at this time. We note that such savings may not be possible if there are other needs for these services that are not now being met. For example, it is plausible that there are additional mental health needs that are not now being met by state funds; if a Medicaid expansion reduced the need for some current funding, these funds might instead be used to address other behavioral health needs.

### **Net State Costs**

Table 6 summarizes overall net state costs for the Medicaid expansion. These estimates suggest that the combination of new state revenues and offsetting savings related to Medicaid expansion could actually lead to substantial state savings over the 2014-2020 period of more than \$1.6 billion. Again, we note that these costs are the incremental costs associated with expanding Medicaid vs. not expanding Medicaid. The state will have to cover ongoing Medicaid expenditures and other ACA-related changes, including a significant woodwork effect, regardless of the decision to expand Medicaid eligibility or not. The Department of Health Service’s estimates noted earlier in this report show overall savings to the state attributable to the newly eligible population under Medicaid expansion, exclusive of the other types of potential tax revenues and state savings included in Tables 5 and 6 of this report.

**Table 6: Net State Government Costs of a Medicaid Expansion (in millions of nominal \$)**

| <b>Iowa Fiscal Impacts</b> |  |   |   |  |
|----------------------------|--|---|---|--|
| <b>Year</b>                | <b>Direct State Medicaid Savings (in millions)</b> | <b>New State Revenues (in millions)</b> | <b>Other State Health Savings (in millions)</b> | <b>Net State Savings (in millions)</b> |
| 2014                       | \$76   | \$3                                     | \$49  | \$129                                  |
| 2015                       | \$78   | \$7                                     | \$105   | \$190                                  |
| 2016                       | \$81   | \$8                                     | \$166   | \$255                                  |
| 2017                       | \$69   | \$9                                     | \$176   | \$254                                  |
| 2018                       | \$60   | \$10                                    | \$186   | \$255                                  |
| 2019                       | \$51   | \$10                                    | \$198   | \$259                                  |
| 2020                       | \$44   | \$11                                    | \$210   | \$265                                  |
| <b>Total</b>               | <b>\$459</b>                                       | <b>\$58</b>                             | <b>\$1,089</b>                                  | <b>\$1,606</b>                         |

## **Conclusion**

Expanding Medicaid to non-elderly adults with family incomes up to 138 percent of the federal poverty level will provide considerable economic benefits to Iowans. The estimates provided in this report differ somewhat from those produced by Milliman, Inc. for the Iowa Department of Human Services/Iowa Medicaid Enterprise; but appear to be in the same general direction, even if they differ in magnitude. It is important to remember that projections all have some inherent level of uncertainty and are bound to differ. Our estimates of the economic and employment impact are based on the level of new federal revenue that are generated by a Medicaid expansion and our estimates are more consistent with those of Millman,, so there should be less of a discrepancy in that component of our analysis. Both our estimates, and those of Milliman, indicate that there is a net reduction in state fiscal costs from 2014 to 2020 due to a Medicaid expansion, although there are additional costs that are related to the implementation of the ACA, regardless of whether Medicaid is expanded.

This analysis shows that Medicaid expansion will reduce direct Medicaid costs to the state, and enable the state to draw down billions of dollars in additional federal funding that will support jobs and maintain the state’s healthcare infrastructure. The increases in employment and economic activity will occur both within the health care sector as well as in other sectors of the state economy. While there are some new costs associated with the expansion, these costs can be offset by new state revenue and other health savings that the state will be able to achieve. Overall, the state can substantially reduce its state costs through a Medicaid expansion, while providing 72,000 low-income Iowans with insurance coverage.