FLORIDA MEDICAID EXPANSION:

Enrollment & Budget Forecasts

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LEAVITT
PARTNERS

SUMMARY

Florida is among the 14 states that have not opted to expand Medicaid up to 138 percent of the federal poverty level (FPL). However, Medicaid expansion continues to garner interest from stakeholders in the state.[1] To inform policymakers and stakeholders of the implications of a Medicaid expansion option, The Commonwealth Fund retained Leavitt Partners to construct an impact model to forecast the five-year enrollment and budgetary implications of Medicaid expansion in Florida beginning in 2020.

Possible budgetary impacts included in this analysis come from two sources: 1) accessing the enhanced federal funds for existing Florida Medicaid populations and 2) fiscal gains—current state spending on other programs replaced with federal funding. This report models the former while outlining separately the possible impacts of the latter.

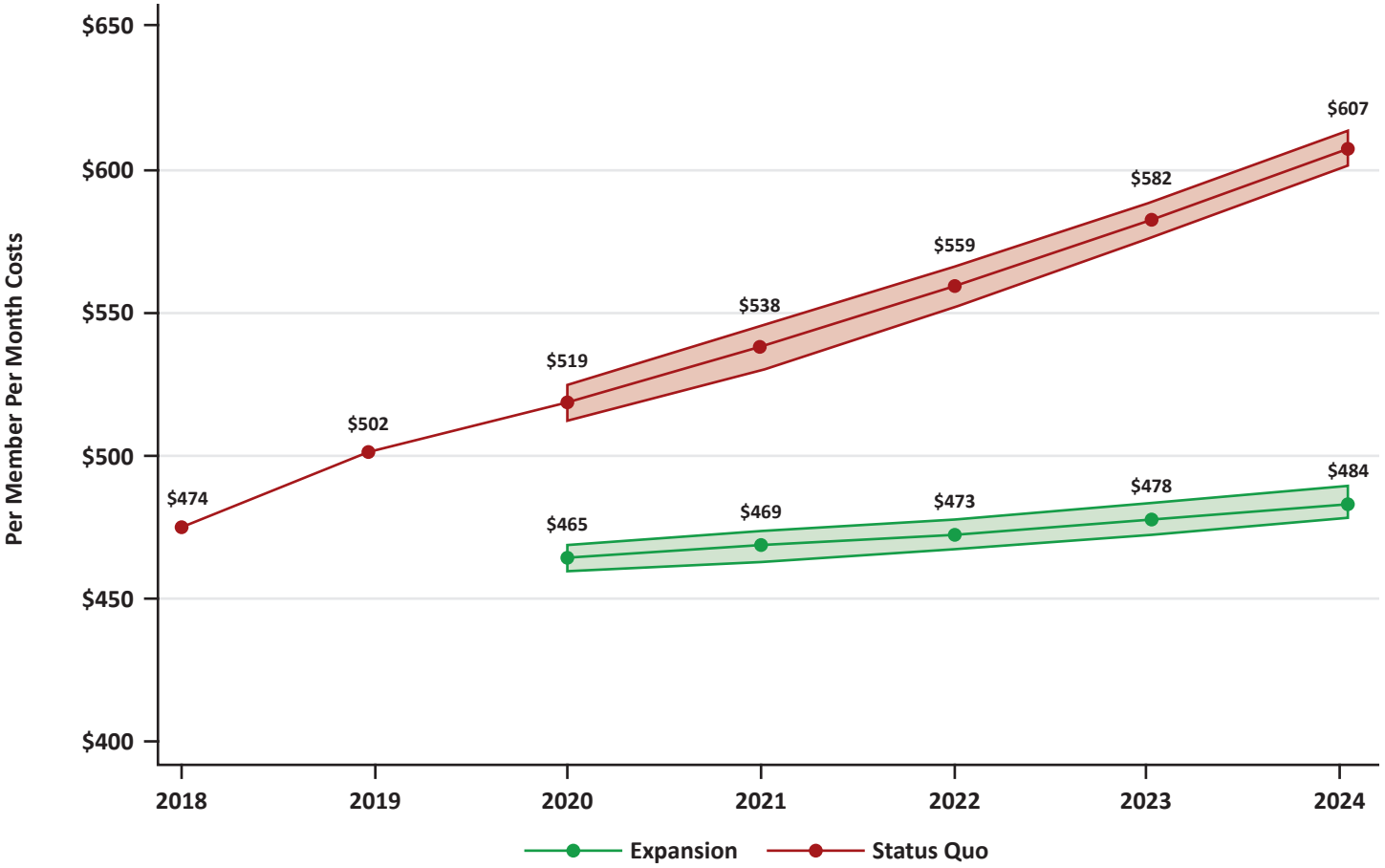
The model estimates that beginning in calendar year 2020, if Florida were to expand Medicaid by extending eligibility to adults with incomes below 138 percent of the FPL, 478,093 adults would newly enroll in Medicaid in that year. In subsequent years, newly eligible enrollees would total 837,514 in 2024. Medicaid expansion in Florida would also yield net new costs to the state of $81.3 million in 2020 which would increase to $170.2 million by 2024. Total expansion costs to the state over the 5-year period are estimated to be $516.4 million.

Key assumptions built into the model include potential savings from an enhanced federal match for Florida's existing Medicaid population and from federal funds replacing state spending on the existing state Medicaid program. On a per member per month (PMPM) basis, the expansion impact model predicts additional state per-enrollee costs of $14.17 per month in 2020, and $16.94 in 2024. Moreover, state average per-member per-month costs are reduced by $54 in 2020 and $123 in 2024 (see Figure 1).

Additional fiscal gains are also possible as new federal funds free up dollars currently paid by the state for services outside of the Medicaid program. These include gains made to the departments of corrections and behavioral health, as well as reduced state spending in the disproportionate share hospital program. In total, these fiscal gains are estimated to be $161.9 million in 2020 and totaling $901 million through 2024. As these funds are separate from the state Medicaid budget, they are not included as savings in the state share of new cost under expansion. The determination of how to assess these funds is not discussed within this report. New federal funds also act as an infusion of fiscal spending into the state economy. While the total projected impact of these new federal dollars on the state economy is not included in this report, the total new federal dollars spent in Florida is estimated to be $2.1 billion in 2020 with $13.8 billion in new dollars through 2024.

The net impact of expansion is projected to increase the number of individuals enrolled in Medicaid while decreasing expenditures on a per person basis. Net increases in state costs may be offset in part or in whole through other program efficiencies due to expansion.

Figure 1: Forecasted Per Member Per Month Expenditures



Source: Leavitt Partners Microsimulation Model Results.

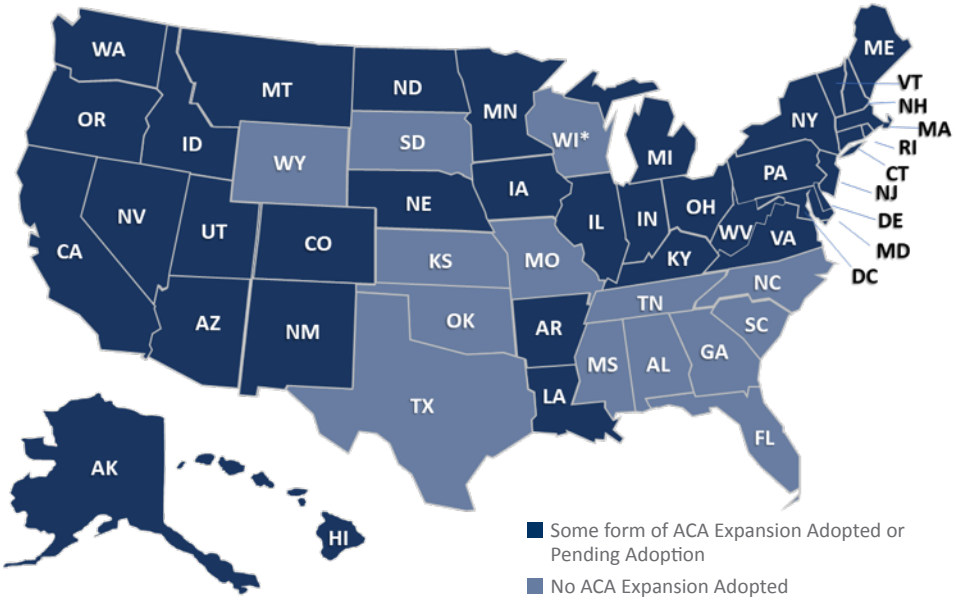
Note: The lower boundary of the shaded area represents the 10th percentile estimate, and the upper boundary of the shaded area represents the 90th percentile estimate.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) (2010) called for Medicaid expansion to previously uncovered adults below 138 percent of the FPL, which became optional for states as a result of Supreme Court rulings on the law in 2012. Under the expansion, states have access to the enhanced federal participation rate for the expansion population—starting at 100 percent in 2014 – 2016 and gradually declining to a steady 90 percent in 2020.[2] 14 states have not opted to expand their Medicaid programs[3] (see Figure 2).

Research investigating the effects of Medicaid expansion suggests that states implementing Medicaid expansion experience coverage gains and reductions in uninsured rates for low-income populations as well as other vulnerable populations.[4]

Figure 2. Medicaid Expansion by State



Source: Leavitt Partners State Policy Tracking, July 2019

*Note: *WI currently covers adults up to 100% of the FPL in Medicaid but did not adopt the ACA expansion.*

Medicaid expansion has also been shown to improve access to care, utilization of services, and the affordability of care and financial security among low-income populations.[5] As enrollment for the newly eligible adult population has increased, total Medicaid spending (combined federal and state) has seen a corresponding increase.[6] However, the enhanced federal match has offset costs to the state, and in some cases the federal match has reduced states' spending on Medicaid.[7]

FLORIDA MEDICAID PROGRAM AND EXPANSION IMPACTS

The Florida Medicaid program currently covers seven categories of working adults, ages 19 - 64 (see Table 1). Medicaid expansion would add adults with incomes up to 138 percent of the FPL that do not qualify under one of these categories. Additionally, program expansion would add enrollment options for existing enrollment groups, including adults who are blind and/or disabled, pregnant women, medically needy, breast and cervical cancer program participants, and family planning program participants. Enrollees of these groups with incomes up to 138 percent of the FPL would be newly eligible for enrollment under the expansion of the program. In some cases, these enrollees may "convert" from the base program to the expansion population, leading to a different federal matching rate for the state program for those beneficiaries.

Table 1. Current State Medicaid Eligibility Categories

Group	2018 Average Monthly Enrollment, Adults Ages 19–64*	Description
SSI (Blind and/or Disabled)*	458,719	Includes working adults, ages 19 - 64 under the FPL who have received a disability determination from the Social Security Administration or state Medicaid agency as a result of a physical or mental impairment, including blindness, that substantially impairs his or her ability to perform labor or services or to engage in a useful occupation.
Pregnant Women	87,490	Includes adult women ages 19 - 64 under 196% of the FPL (191% plus a 5% income disregard) who are currently pregnant.
Parents and Other Caretaker Relatives (1931 Medicaid)	442,880	Includes working adults, ages 19 - 64 who are responsible for a child under 19 years of age; a U.S. national, citizen, legal alien, or permanent resident, with a low income (up to 32% of the FPL when including the 5% income disregard); and are either underemployed, unemployed, or about to become unemployed. Some smaller sub-programs for adults have different eligibility levels and requirements.
Breast and Cervical Cancer Program*	826	Includes working adult women, ages 19 - 64 under 200% of the FPL, with breast or cervical cancer that have been screened under the Breast and Cervical Cancer Early Detection Program and have an abnormal screen, requiring further diagnosis and/or treatment services; have qualifying low income and are not otherwise eligible for Medicaid; and have no other insurance covering breast and cervical cancer (BCC) diagnosis or treatment.
Family Planning Waiver	67,977	Includes women ages 14 - 55 who have lost Medicaid eligibility; are at or below 196% of the FPL (191% plus a 5% income disregard) who would not otherwise be eligible for Medicaid, but require family planning services.[8, 9]
Medically Needy	19,611	Includes working adults, ages 19 - 64 who meet all conditions to qualify for Medicaid, except their monthly income is greater than the Medicaid limit. These individuals generally must pay a share of their medical care costs to reduce their countable income to the Medicaid limit of 18% of the FPL.[10]
Long-term Care*	18,543	Includes working adults, ages 19 - 64 who meet conditions of Medicaid eligibility, who are assessed to have a need for nursing facility services, receive the services in an institutional setting or in the community, and have limited resources and monthly incomes no more than $2,130 (300% of the federal monthly SSI benefit of $710).

Source: AHCA reports and Leavitt Partners calculations from those reports.

*Note: *The SSI category is exclusive of breast and cervical cancer program and long-term care enrollees.*

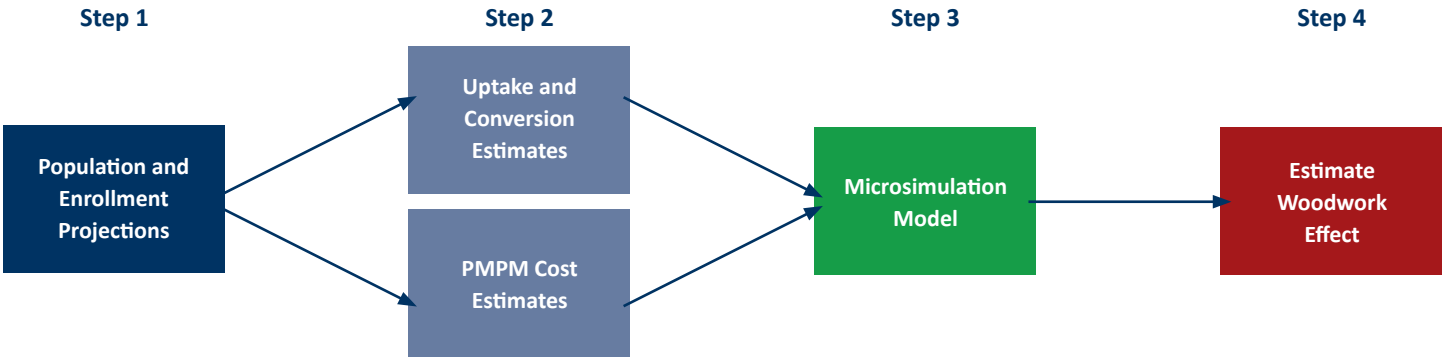
The "conversion" of Medicaid beneficiaries that would be in the base program under the status quo but instead enroll under expansion would lead to the state receiving a higher matching rate from the federal government. Under the current Federal Medical Assistance Percentages (FMAP) for the Florida base Medicaid program, individuals in categories including the blind and/or disabled, medically needy, and pregnant women qualify for a 61.47 percent federal match in 2020, rising to 63.07 percent in 2024.[11] The breast and cervical cancer program is matched at the enhanced FMAP rate, which is 84.53 percent in 2020 and projected to be 73.20 percent in 2021 up to 74.15 percent in 2024.[12 a] Under the expansion program, the FMAP increases to 90 percent for all expansion enrollees. The family planning program is already matched at 90 percent, no savings is modeled for this conversion population. Their increased costs from becoming eligible for full benefits is included in the overall cost estimates.

Florida's Medicaid program is predominantly administered under managed care arrangements. Virtually all Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) (including dual-eligible and long-term care beneficiaries), and pregnant women are covered under managed care plans. The medically needy, family planning, breast and cervical cancer program participants, and some other small groups are carved out of managed care into the program's fee for service component. This research is also based on the assumption that all adults newly enrolling in or converting to the expansion will be enrolled in managed care.[b]

METHODOLOGY

The purpose of this analysis is to estimate the enrollment and budgetary impact of Medicaid expansion in Florida. To do this, Leavitt Partners produced a microsimulation of the Florida population and compared enrollment estimates under expansion against baseline projections of enrollment under status quo conditions across enrollment categories. Estimated PMPM costs and appropriate FMAP rates are then applied to enrollment projections to calculate the direct budgetary impact of expansion. Figure 3 outlines the general approach.

Figure 3. Methodology Process



Multiple data sources were compiled to provide empirical inputs to the relevant models (see Table 2). The microsimulation approach allows for the historical data from multiple sources to influence results simultaneously, increasing model reliability while accommodating natural uncertainties.

[a]The significant decline between 2020 and 2021 is the result of phasing out a period of increased federal CHIP funding provided under the Affordable Care Act. The breast and cervical cancer program match rate is tied directly to the CHIP program's enhanced FMAP.
[b]We generally also apply costs to these populations based on managed care rates, with the exception of BCC and medically needy populations, for which we model rates that reflect their current FFS PMPM costs.

Table 2. Data Sources

Data Source	Description
Florida Agency for Health Care Administration (AHCA) Monthly Medicaid Enrollment and Eligibility Reports[13, 14]	Monthly Medicaid enrollment and eligibility reports from AHCA for January 2014 – February 2019, which includes enrollment breakdowns by age, eligibility category, race, gender, and region.
AHCA Managed Care Rate Data[15]	Managed care rate data by rate cell and region covering the periods from 2016 – 2019.
American Community Survey (ACS) Public Use Microdata Sample[16]	Population demographic data from the American Community Survey (ACS) Public Use Microdata Sample (PUMS), which contains individual-level responses to the ACS for the years 2008 – 2017.
American Community Survey Tables for Health Insurance Coverage[17]	Insurance data by state for 2017 to estimate the reduction in the State Disproportionate Share Hospital (DSH) allocation with decreased rate of uninsured.
Kaiser Family Foundation and Georgetown University Center for Children and Families[18]	Eligibility information compiled from the Federal Register for parents, pregnant women, and other non-disabled adults, 2007 – 2018.
Kaiser Family Foundation and Watts Health Policy[19]	2017 eligibility criteria for the aged, blind, and disabled.
Robert Wood Johnson Foundation State Health Reform Assistance Network[20]	2016 report from Robert Wood Johnson Foundation State Health Reform Assistance Network examining the impact of Medicaid expansion in 11 states and the District of Columbia related to budget savings and revenue gains.
Florida Legislature Office of Economic and Demographic Research[21]	Florida Legislature Office of Economic and Demographic Research report that included estimates of medically needy spending.
Expenditure Reports From MBES/CBES, FY 2016 Financial Management Data[22]	To estimate applicable additional administrative costs for the adult expansion population.
Federal Register, July 28, 2017[23]	Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, A Proposed Rule by the Centers for Medicare & Medicaid Services. Estimates the DSH Allotment Reductions by low-DSH and high DSH states.
Florida Policy Institute Report[24]	Data Estimates of expansion program savings and base program budget numbers. Used for estimate of expenditures for inmate hospital inpatient care expenditures.
Criminal Justice Estimating Conference February 22, 2019[25]	Provides estimates of Florida prison population.
Florida Department of Corrections 2017/2018 Annual Report[26]	Population demographic and other information on the Florida inmate population.
AHCA, Behavioral Health Services Revenue Maximization Plan[27]	To estimate the state general fund in the local entity behavioral health system available for Medicaid match.
Florida Department of Children and Families[28]	Financing data showing distribution of funding across local behavioral health managing entities and how the percent of funding for service type by managing entity.

BASELINE MODEL

A baseline model for program enrollment and expenditures under status quo conditions was required. Projections of enrollment in each eligibility category were developed using Florida population demographics and historical enrollment figures applied to times series models.[c] The model provides estimates for the total program enrollment by current eligibility category.

EXPANSION IMPACT PARAMETER ESTIMATION

Four model parameters were estimated independently prior to simulating the total impact of expansion:

Population Group Sizes – The projected number of Floridians in each population demographic group, as well as the numbers in those groups that are enrolled in Medicaid under the status quo.

Enrollment Uptake – The number of Floridians not currently enrolled in Medicaid that newly enroll after expansion.

Conversion Rates – The aggregate number of Floridians currently enrolled in a Medicaid eligibility category with incomes under 138 percent of the FPL that would "convert" to the expansion population at a higher FMAP. This conversion could be an individual behavioral response or an artifact of changing enrollment patterns at an aggregate level; we do not distinguish between the two in our assumptions, but rather make assumptions only about the resulting distribution. Potential conversion categories include the blind and/or disabled, medically needy, breast and cervical cancer program participants, pregnant women, and family planning enrollees.

PMPM Costs – The total cost of medical expenditures for program enrollees in a given month divided by the total number of enrollees in that same month in a given eligibility category.

The first three parameters have to do with the number of individuals that eventually enroll in the Medicaid program under each eligibility category. Enrollment uptake was estimated at the individual level using Florida demographic data and historical enrollment figures from expansion states, then aggregated for total expected enrollment impacts. Various individual and state level factors were included as controls in the model.[d] Conversion rates for individuals moving into the expansion population from the SSI and pregnant women categories were assumed based on previous research (see Table 3).[29, 30 e] For the three other conversion parameters listed in the table, we assume that all enrollees in those categories under 138 percent of the FPL would convert to the expansion program.

[c]See the Forecasting subsection of technical appendix section 4 (Preparing the Simulation Dataset) for more discussion of our ARIMA model specification and statistical results.
[d]See the Uptake subsection of technical appendix section 4 (Preparing the Simulation Dataset) for logistic regression specification and results.
[e]See the Simulation Parameters subsection of technical appendix section 5 (Microsimulation) for more discussion and justification of conversion parameters.

Table 3: Conversion Parameters

Eligibility Group	Timeframe	Percent Converted
Blind and/or Disabled	Year 1	1.25%
	Year 2	3.08%
	Years 3–5	7.40%
Pregnant Women	Year 1	30%
	Years 2–5	45%
Breast and Cervical Cancer	All Years	80.33%*
Family Planning	All Years	85%*
Medically Needy	All Years	44.36%*

*Note: *Percent of program category enrollees with household incomes under 138% of FPL.*

Medicaid expansion may also create a "woodwork" or "welcome mat" effect, referring to the possibility that some people previously eligible for Medicaid will newly enroll because of the increased publicity around the program. While woodwork effects are difficult to estimate, previous research suggests an upper bound of about 2.6 percent for increased enrollment due to woodwork effects.[31] These effects are added to the model through post-hoc estimation after simulation results are generated. Our overall new enrollment and total cost estimates are not affected by this assumption.[f]

Historical medical expenditure data by category was calculated to approximate the cost or savings to the state under expansion (see Table 4). An inflation factor of 2.224 percent annually,[g] equal to the Consumer Price Index for All Urban Consumers (CPI-U) for the southern region,[h] was applied to these base PMPM estimates for projections of base program costs to account for overall inflation over the projected 5-year period.[32] Since available data does not disentangle the PMPM for pregnant women from other parents eligible for TANF, the PMPM for that entire group was used for the base program.[i] Administrative program costs were also estimated and applied to the newly enrolled population using previously estimated blended rate of 62.5 percent or $53.45 per enrollee.[j]

[f]See the Woodwork Effect subsection of technical appendix section 5 (Microsimulation) for more discussion of our treatment of the woodwork effect.
[g]Medicaid PMPM inflation has exhibited slower growth than PMPM rates for commercial payers and Medicare and is therefore more accurately reflected by the CPI-U than by the health care price index.
[h]The southern region includes the following states: AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV
[i]See the Costs per Member per Month subsection of technical appendix section 4 (Preparing the Simulation Dataset) for more discussion of PMPM cost calculation.
[j]See the Administrative Costs subsection of technical appendix section 4 (Preparing the Simulation Dataset) for more discussion of our administrative cost calculation.

Table 4. Estimated PMPM Costs, by Eligibility Category

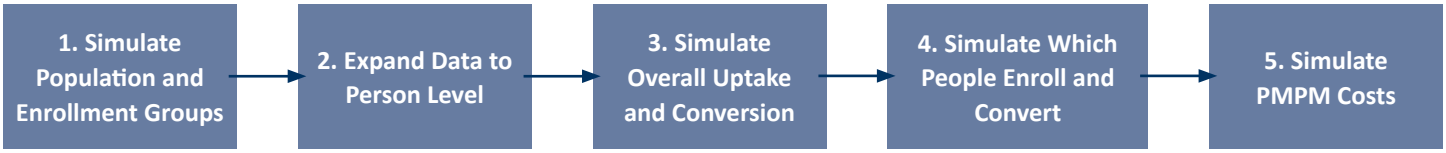
Eligibility Category	PMPM Cost
SSI (blind and/or disabled), Including Dual Eligible	$528.13
TANF Parents	$244.05
Pregnant Women	$745.61
Breast and Cervical Cancer Program	$2,564.05
Family Planning Waiver	$8.46
Medically Needy	$2,495.21
Long-term Care	$4,481.64
Other Adults (Expansion Only)	$311.14
Administrative Cost	$9.65

Source: Leavitt Partners estimates.

SIMULATION MODEL AND TOTAL IMPACT CALCULATION

Estimated parameters from the population and enrollment forecasts, cost data, and an uptake regression model provided an analytical core for a microsimulation of enrollment outcomes. The Monte Carlo microsimulation model was run using the process outlined in Figure 4 for each of 10,000 iterations. The results of each iteration were aggregated across enrollment categories and compared against baseline model projections to calculate the total impact of Medicaid expansion in Florida.[k]

Figure 4. Microsimulation Process



RESULTS

The microsimulation model yielded estimates of the enrollment and direct budgetary impacts to the Medicaid program in Florida. Full results of the simulation by eligibility category are available in section 6 of the technical appendix. In addition to the model results, we also present some calculations and discussion of potential fiscal gains in other state budgets.

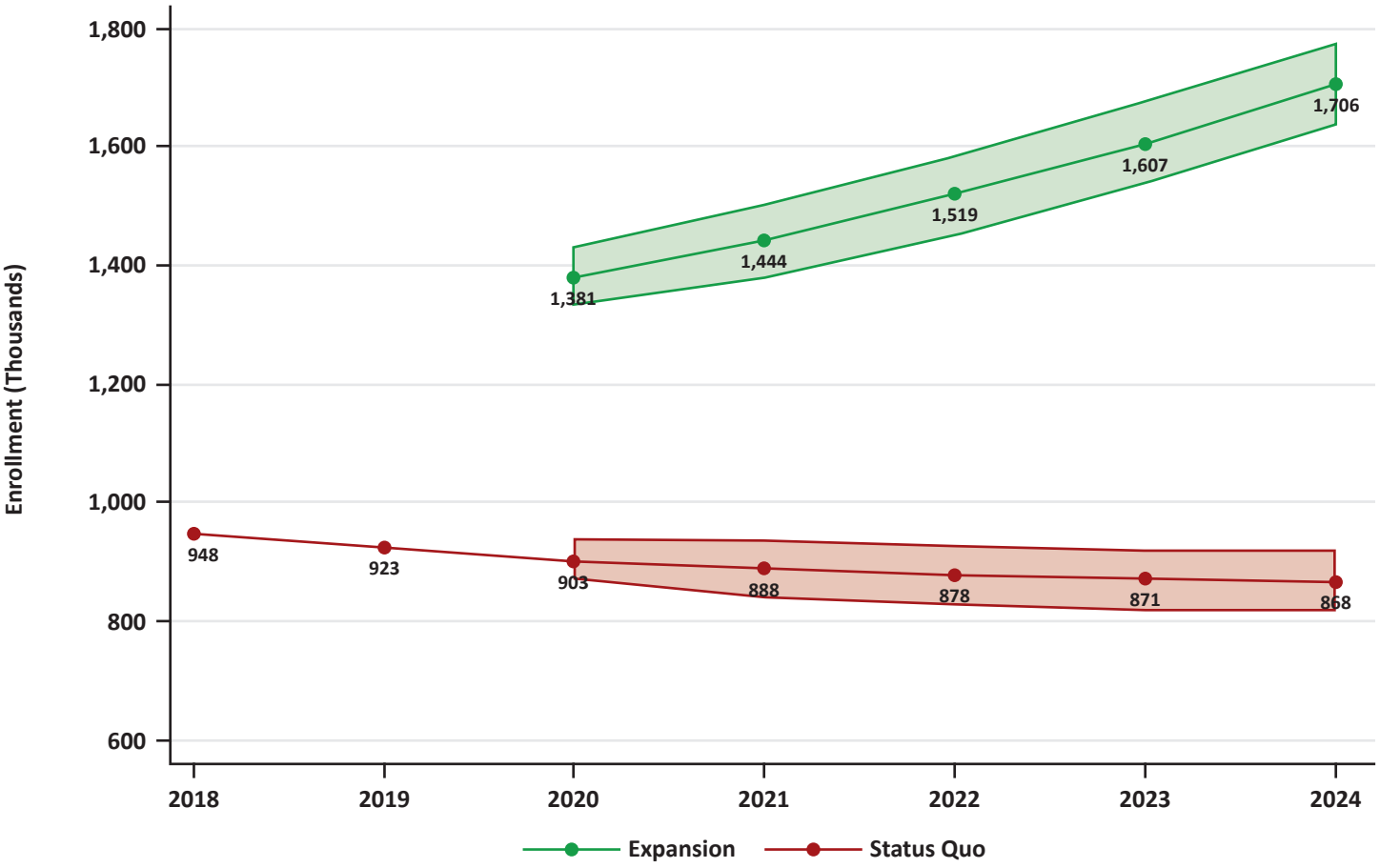
ENROLLMENT PROJECTIONS

Model results indicate that were the status quo Florida Medicaid program maintained, total enrollment in the program for adults ages 19 - 64 would be 902,873 in calendar year 2020 and would slightly decline to 868,471 in 2024. Positive economic growth and lower unemployment may contribute to the declining baseline enrollment, a trend experienced in other states in recent years.[33,34] Given the unpredictability of future economic conditions, the status quo economic conditions are assumed for purposes of model forecasts.

Enrollment in Florida Medicaid under an expansion scenario is projected to increase significantly, as had been the experience in others states that have opted to expand Medicaid (see Figure 5). In 2020, forecasts project that 478,093 (464,650 – 491,566) Floridians will newly enroll in Medicaid in 2020. By 2024, we expect this number to have accumulated to 837,514 (820,550 – 854,534).

[k]See the technical appendix section 5 for more details about the microsimulation process.

Figure 5. Total Medicaid Enrollment—Status Quo vs. Expansion



Source: Leavitt Partners Microsimulation Model Results.

Note: Shaded areas correspond to upper and lower confidence areas from the simulation output. The lower part of the shaded area represents the 10th percentile estimate, and the upper part of the shaded area represents the 90th percentile.

CONVERSION RATE ASSUMPTION

An important consideration is the conversion rate of individuals who would have been eligible to enroll in Medicaid under the base program, who instead enroll through expansion based on income alone. These individuals, including pregnant women and blind and/or disabled individuals, who forgo the more rigorous disability application process, have higher health care costs, on average. An increased federal match for these populations can lead to program savings.

The assumptions made for the blind and/or disabled conversion impact the model results. Estimates used in the model are based on research in other expansion states with similar populations and represent the best estimate for what is likely to happen in an expansion scenario. Leveraging the experience of other states with similar populations to Florida as a parameter to inform the uptake estimates simulated in the model reduces uncertainty. Adjusting this conversion rate upwards or downwards would alter model results. Formula 1 provides the estimation procedure for implementing alternative conversion percent assumptions to the model results for a specific enrollment category.

Formula 1: Conversion Savings Calculation

*Conversion savings = Category enrollment * conversion percent * PMPM * (0.9 - FMAP)*

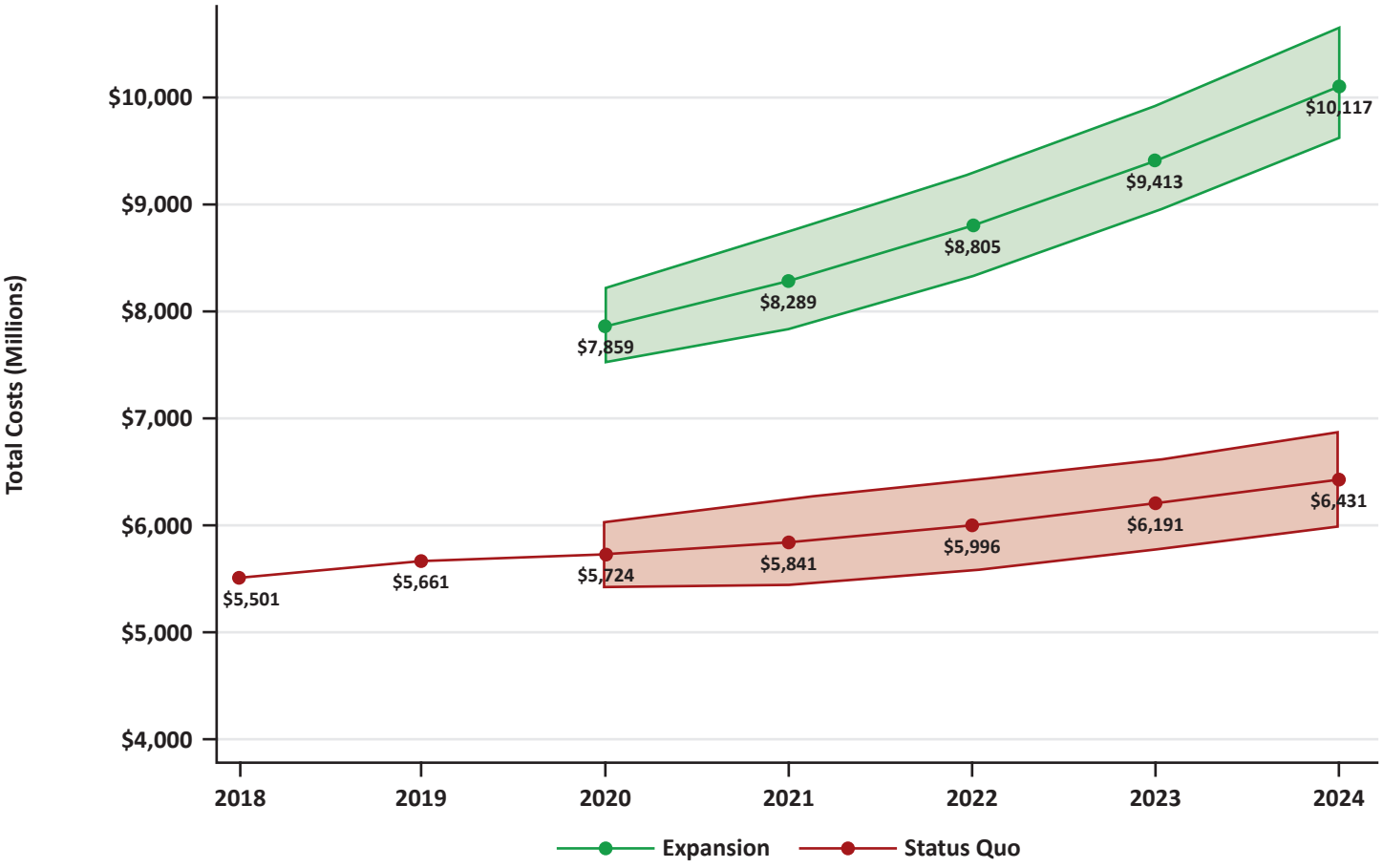
Overall conversion savings can be calculated by applying this formula to all categories in all years. The total and state costs for these categories—base plus conversion—will not change, except as a direct result of the savings.

COST PROJECTIONS

Under the current Florida Medicaid program, total costs for the target adult population ages 19 – 64, were projected to be $5.66 billion in 2019, funded by both the federal and state government. The state's share of this is $2.20 billion, with the federal government funding $3.46 billion. Assuming no expansion, total program costs for adults ages 19 – 64 would increase through 2024 to about $6.43 billion in that year. The corresponding state cost that year would be $2.40 billion, and the federal cost would be $4.04 billion (see Figure 6 and Table 5).

Under the new FMAP that comes with the expansion enrollment, the projected net increase in state costs is $81.3 million ($46.1 – $114.7 million) in 2020 and the aggregate total between 2020 – 2024 is $516.4 million ($298.8 – $729.8) (see Figure 7 and Table 5). Included in these costs are savings generated from converted populations who would have been enrolled in the base Medicaid program as either blind and/or disabled, medically needy, pregnant women, breast and cervical cancer program participants, or family planning program participants. These savings total $147.4 million ($108.1 – $188.5 million) in 2020 and $1.03 billion ($778.3 million – $1.28 billion) through 2024. With 478,093 newly enrolled individuals in 2020, this corresponds to net new per-beneficiary costs to the state of $170.07 per year ($14.17 per month).

Figure 6. Total Medicaid Costs—Status Quo vs. Expansion, in Millions of Dollars



Source: Leavitt Partners Microsimulation Model Results

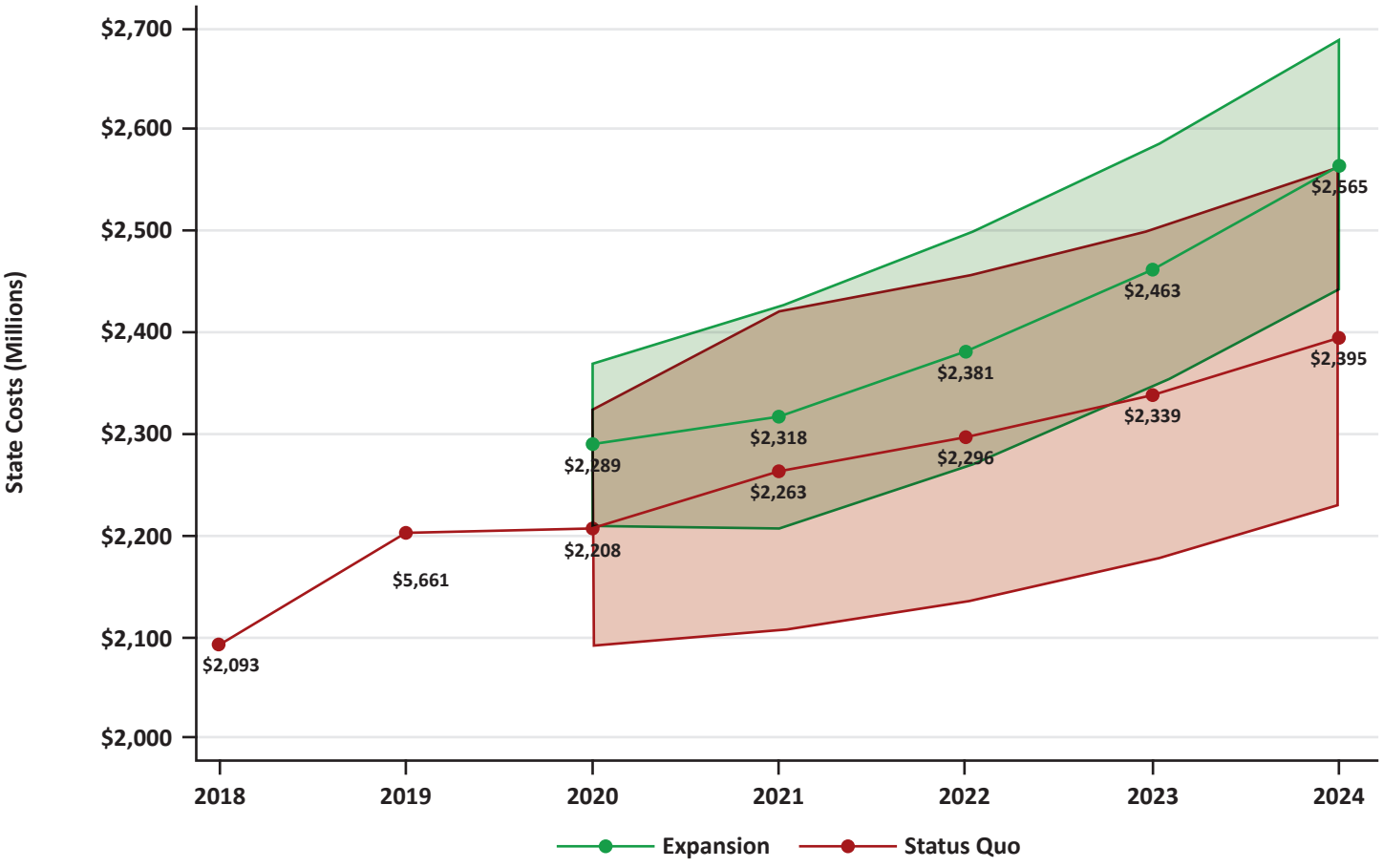
Note: Shaded areas correspond to upper and lower confidence areas from the simulation output. The lower part of the shaded area represents the 10th percentile estimate, and the upper part of the shaded area represents the 90th percentile.

Table 5. Total Cost Projections, by State and Federal Share, in Millions of Dollars

Year	Total Costs			State Costs			Federal Costs		
	Status Quo	Expansion	*Diff*	Status Quo	Expansion	*Diff*	Status Quo	Expansion	*Diff*
2018	$5,500.7			$2,093.3			$3,407.4		
2019	$5,660.6			$2,203.1			$3,457.5		
2020	$5,724.1	$7,858.5	$2,134.4	$2,208.0	$2,289.3	$81.3	$3,516.1	$5,569.2	$2,053.1
2021	$5,841.2	$8,289.4	$2,448.2	$2,263.3	$2,317.7	$54.4	$3,577.9	$5,971.7	$2,393.8
2022	$5,996.0	$8,805.1	$2,809.1	$2,295.5	$2,381.0	$85.5	$3,700.5	$6,424.1	$2,723.6
2023	$6,191.2	$9,412.8	$3,221.5	$2,338.5	$2,463.4	$124.9	$3,852.7	$6,949.3	$3,096.6
2024	$6,431.4	$10,117.5	$3,686.0	$2,395.1	$2,565.4	$170.2	$4,036.3	$7,552.1	$3,515.8
2020–2024	**$30,184.0**	**$44,483.3**	**$14,299.2**	**$11,500.5**	**$12,016.9**	**$516.4**	**$18,683.6**	**$32,466.4**	**$13,782.8**

Source: Leavitt Partners Microsimulation Model Results.

Figure 7. State Medicaid Costs—Status Quo vs. Expansion, in Millions of Dollars



Source: Leavitt Partners Microsimulation Model Results

Note: Shaded areas correspond to upper and lower confidence areas from the simulation output. The lower part of the shaded area represents the 10th percentile estimate, and the upper part of the shaded area represents the 90th percentile. Overlapping estimates between status quo and expansion estimates imply that the costs under either scenario are similar.

A woodwork effect of 2.6 percent equates to 12,430 new enrollees in 2020 who were previously eligible for Medicaid but not enrolled, rising to 21,775 by 2024. These new enrollees are matched at the lower base Medicaid FMAP rather than the 90 percent expansion FMAP. This lower match rate translates to an additional $86 million in state costs over the first five years of expansion relative to the scenario in which all new enrollees are expansion-eligible.[l] It is likely that the woodwork effect will be lower than it has been historically, but projecting what exactly the woodwork effect will be extremely difficult to do with any sort of precision. The 2.6 percent assumption is an upper-bound estimate. For comparison, enrollment and total state costs of expansion under this assumption and total state expansion costs under a scenario in which no woodwork effect occurs are given in Table 6.

Table 6. Impact of Woodwork Effect on Net Cost of Expansion to State, in Millions of Dollars

Year	Woodwork Enrollment at 2.6%	State Cost of Expansion with Woodwork at 2.6%	State Cost of Expansion with No Woodwork
2020	12,430	$81.3	$68.5
2021	14,437	$54.4	$39.6
2022	16,667	$85.5	$68.5
2023	19,121	$124.9	$105.4
2024	21,775	$170.2	**$148.0**
Total		**$516.4**	**$430.0**

Source: Leavitt Partners estimates.

TOTAL PMPM COSTS

Due to increased FMAP for conversion populations and relatively lower expected costs of new enrollees, the average cost per Medicaid enrollee is projected to decrease with expansion (see Figure 1 above).

While total costs to the Medicaid program increase in expansion, the PMPM costs reduce overall. Under the status quo, non-administrative PMPM costs are projected to be $518.66 in 2020. Under expansion, this drops to $464.55, an average per-person reduction of $54.11 PMPM. In 2024, the difference increases, with a status quo PMPM of $606.57 and an expansion PMPM of $483.66 before administrative costs.

FISCAL GAINS

In addition to direct Medicaid program expenditures, increased enrollment and a higher FMAP for this population may directly impact the budgets of other state-funded programs (see Table 7). These programs provide services for individuals that may now be funded under the Medicaid program. These fiscal gains could be used to fund the new costs of expansion or other budgetary needs as determined by the state legislature. As such, these savings were analyzed separately from the state Medicaid budget.

Gains to the correction system and behavioral health programs are estimated, based on prior reports,[35] to be as much as $161.9 million in 2020 and $846.3 million through 2024. Other fiscal gains may also be seen through reduced spending on the disproportionate share hospital (DSH) program. We estimate this to be $12.9 million in year two of expansion, increasing to $14.6 million in year five, with total reductions of $54.9 million through 2024.

[l]Total costs are not affected by the woodwork assumption; only the distribution of expenses across Federal and state budgets is affected.

Table 7. Fiscal Gains by Year, in Millions of Dollars

	2020	2021	2022	2023	2024	Total
Corrections	$42.6	$43.5	$44.5	$45.5	$46.5	$222.6
Behavioral Health	$119.3	$122	$124.7	$127.4	$130.3	$623.7
DSH Savings	——	$12.9	$13.4	$14	$14.6	$54.9
Total	**$161.9**	**$178.4**	**$182.6**	**$186.9**	**$191.4**	**$901.2**

Source: Leavitt Partners analysis of prior reports.

Note: The fiscal gains for corrections and behavioral health were calculated for 2020 and then inflated forward using the CPI-U for the southern region, which was 2.224% in 2017.

There are several other programs in the state that could also be impacted by Medicaid expansion (see Table 8). We have not quantified the potential financial gains or losses due to lack of available data, uncertainty around the directionality of the effects, or uncertainty about the policy decisions that would be required to implement any budget reallocations. See section 7 of the technical appendix for more details on the low-income pool and the hospital assessment.

Table 8. Other Potential Areas of Impact

Program Area	Program Description
Low-Income Pool (LIP)	There is a total computable budget allocation of $1.5 billion for this program, with the state share funded through voluntary intergovernmental transfers (IGTs) from local governmental entities. The state share that is required to fund the full amount is $583 million. The future of the LIP and use of the IGTs under Medicaid expansion is uncertain.
Inpatient and Outpatient Hospital Assessments	There is a mandatory provider assessment, the Public Medical Assistance Trust Fund (PMATF), which includes: • a 1.5% assessment of hospital inpatient net operating revenue[m], and a 1.0% assessment of hospital outpatient net operating revenue. • Previously uninsured individuals care paid by Medicaid is counter balanced by the movement of commercially insured Marketplace enrollees with incomes up to 138% FPL to Medicaid—it is not clear what the final impact on assessment revenues will be.
Public Health Programs	Some services funded through state and local appropriations and provided through county health departments to low-income uninsured adults would be covered under Medicaid for newly eligible adults under expansion. Data was not located to quantify the potential Medicaid revenue nor is it clear how any potential gains might be addressed by state and local governments.

INDIRECT IMPACTS

Medicaid expansion is projected to draw down $13.8 billion in federal funds to the state between 2020 – 2024. The influx of federal dollars has led other states that have expanded Medicaid to experience positive economic effects including budget savings, revenue gains, and economic growth; however, the full economic impact of these new dollars are not considered in this report.[36–38]

[m]Net operating revenue is defined in Florida statute as, "gross revenue less deductions from revenue." "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts, contractual adjustments, uncompensated care, administrative, courtesy, and policy discounts and adjustments, and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care." https://www.lawserver.com/law/state/florida/statutes/florida_statutes_395-701

Other indirect effects may also be possible. Further analysis of these and other potential indirect effects on the state budget may be warranted.

DISCUSSION

Evidence from the experience of other expansion states indicates that the projected increased Medicaid enrollment in Florida has potential to help reduce the uninsured rate, improve access to care, and improve the financial security of low-income and other vulnerable populations in the state.[39]

Overall, model outputs suggest that if Florida were to expand Medicaid eligibility to all adults with incomes up to 138 percent of the FPL, both enrollment in Medicaid and total federal and state spending would increase. Our model estimated that 837,514 Floridians would newly enroll in the Medicaid expansion by the fifth year of the expansion. Naturally, total spending on the Medicaid program would also increase, with total cost increases of $14.3 billion over the 5-year time period. The state share of spending would increase but would be largely offset by the enhanced federal matching rate and by conversion of certain base program populations, with a net increase of $516.4 million in state-funded costs through 2024. This corresponds to per-enrollee increases of $14.17 per month in state costs. Almost $13.8 billion of the expansion costs over the five-year period would represent new dollars infused into the Florida economy.

An important consideration is the conversion rate of individuals who would have been eligible to enroll in Medicaid under the base program, who instead enroll through expansion based on income alone. Most prominent here are women who become pregnant after enrolling through expansion, and thus remain at the higher FMAP through at least most of their pregnancy,[n] the blind and/or disabled who may forego a disability determination in favor of easier income-based enrollment in expansion, and the medically needy who would already be eligible for the Medicaid program rather than being required to spend down to the required income and asset levels. These individuals have higher health care costs, on average, and an increased federal match for these populations can lead to significant state savings.

The assumptions made for the blind and/or disabled conversion significantly impact the model results. The estimates used in the model are based on research in other expansion states with similar populations and represent our best estimate for what is likely to happen in an expansion scenario. Leveraging the experience of other states with similar populations to Florida as a parameter to inform the uptake estimates simulated in the model helped reduce uncertainty and bias. However, it is important to note that adjusting this conversion rate upwards or downwards can significantly alter state costs. A lower conversion rate will increase the state's net share of expansion costs, while a higher conversion rate will decrease net expansion costs.

While this report uses appropriate methodologies and the experiences of other states to guide model assumptions, the analysis is limited to the potential Medicaid expansion impacts on program enrollment and program costs. There are other important factors that could also be considered when weighing the impacts of expansion (see Table 9). First, increased enrollment and funding for the expansion Medicaid population will directly impact the department of corrections as well as the behavioral health and public health programs. This is attributable to the increased federal match for new Medicaid enrollees which reduces the state's portion of spending within these programs. Second, due to the decreased uninsured rate following expansion, state spending for uncompensated care to hospitals through DSH payments would also reduce.[o] While these fiscal gains (projected to be $901.4 million through 2024; see Table 7) are attributable to expansion and the enhanced federal match, they are not tied to the Medicaid budget. As such, they are not included as savings in the state's share of cost under expansion. How state policy makers might choose to allocate these fiscal gains is not addressed in this report.

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[n] See *CMS Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing*, 2013, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/FAQ-12-27-13-FMAP-Foster-Care-CHIP.pdf. Women with incomes between the section 1931 coverage income limit and 138% FPL who enroll as an expansion adult before they become pregnant can continue to receive coverage as newly eligible adults with enhanced federal funding until their next scheduled recertification. While states do not have to track the woman's pregnancy status, they do have to provide the choice to enroll in the pregnancy related Medicaid coverage and also review for traditional coverage at time of recertification. Thus, not necessarily all pregnant women would convert to expansion or remain in the expansion category throughout their pregnancy.

[o] It should be noted that most of Florida's DSH payments are funded through inter-government transfers and certified public expenditures, so most of the reductions would not directly affect the state general funds.

Table 9. State Expansion Costs and Potential Fiscal Gains, in Millions of Dollars

Year	Expansion Cost	Fiscal Gains
2020	$81	$162
2021	$54	$178
2022	$86	$183
2023	$125	$187
2024	$170	$191
2020 – 2024	$516	$901

Source: Leavitt Partners estimates.

Finally, with the increased enrollment of the expansion population, there are billons of new federal dollars infused into the state economy ($13.8 billion through 2024). The current report does not address the statewide economic impact of these dollars. Further analysis of economic and indirect state budget implications—such as increased revenues—could be warranted.[39, 40]

This report is not without limitations. First, the study was limited to publicly available data sources on enrollment and costs. Because not all relevant program and demographic breakdowns are publicly available, certain demographic profiles and cost parameters were estimated using the best available data and reasonable assumptions. Second, there is the potential that the percentage of new enrollees converting from the base program varies from our estimates. While experiences from other expansion states were used to guide assumptions, it is impossible to predict the exact conversion percentage with full certainty. To adjust for these limitations, a level of uncertainty was used in the simulation model. Third, our analysis faces the usual limitations of predicting the future based on past performance. It presumes that historical trends in the Medicaid program continue into the known future. Policy changes, such as the zeroing-out of the individual mandate penalty or other fundamental alterations to the Medicaid program, could lead to an experience that differs markedly from our estimates. Macroeconomic conditions will also play a significant role in the actual outcomes. The estimates come at a time of historically low unemployment in Florida and nationally. This research does not attempt to predict changes in these conditions, but cautions that an economic downturn would likely increase enrollment in both the base and expansion programs. Despite these limitations, Leavitt Partners is confident that these results are directionally and proportionally accurate.

CONCLUSION

Impact model projections suggest that the number of Medicaid enrollees under a Medicaid expansion scenario would increase. Overall costs to the state would also increase due to increased enrollment. However, due to enhanced federal matching rates per member costs would decrease, allowing for more purchasing power from the state Medicaid agency. Additionally, indirect fiscal gains associated with efficiencies to other programs may offset some or all of the overall cost increase of Medicaid expansion.

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