



State Health Care Spending

Key findings

The State Health Care Spending Project, an initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, helps policymakers better understand how much money states spend on health care, how and why that amount has changed over time, and which policies are containing costs while maintaining or improving health outcomes. For additional information, visit www.pewtrusts.org.

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Overview

Health care spending presents a complicated set of challenges and financial burdens for states, whose obligations range from caring for the neediest residents—those who cannot afford health care or health insurance on their own—to providing coverage for state employees and retirees who have negotiated it as part of their compensation packages. States spend, in the aggregate, hundreds of billions of dollars a year on various kinds of health care, some of it beyond the control of policymakers. For example, each state’s Medicaid contribution is set by the federal government, and states are legally required to provide care for inmates. Poverty, smoking rates, and an aging population are among external factors that can result in a higher prevalence of chronic health conditions for which states cover treatment. And the same type of care is more expensive in some states than in others, contributing to higher costs for some states.

The Great Recession had the double impact of reducing state revenue while increasing the demand for certain kinds of health care, especially Medicaid coverage, and mental health and substance use disorder services—illustrating that many state-funded responsibilities run counter to the business cycle and that states serve as a safety net for an array of vulnerable populations. Yet while state health care spending is often seen as appropriating money from other priorities such as education and transportation, it also brings billions of federal dollars into the states through matching funds, grants, and payments that help support each state’s health industry.

The State Health Care Spending Project—a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation—produced a series of studies of state health care programs, including Medicaid, the Children’s Health Insurance Program, substance use disorder treatment, mental health services, prison health care, active state government employee benefits, and retired state government employee benefits. Key trends identified in these reports reveal that:

- The amount that individual states spend is not necessarily indicative of either efficiency or waste. Certain states pay higher fees to providers, others are required to pay a larger portion of Medicaid costs; and the residents of some areas require more care than others. Demographics, including poverty rates, the age and health of the population, and the number of prisoners and state retirees, can all influence a state’s health costs. The vibrancy of a state’s economy also plays a major role in determining its health costs.
- States fund and/or directly operate numerous kinds of health services—such as prison health care and treatment for mental illnesses—through a variety of agencies. Although there is often an overlap in clientele, coordination and data-sharing among agencies are rare and sometimes prohibited by privacy laws.
- Many states are taking action to rein in costs within their control, for example by having state employees and retirees assume more of the costs of their health plans, tying provider payments to the provision of high-value care rather than the number of services delivered, and shifting individuals from purely state-funded programs to federal-state programs.
- The Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (Parity Act) are having an impact on state spending in a wide range of programs, including Medicaid, the Children’s Health Insurance Program (CHIP), and treatment for mental illnesses and substance use disorders.
- The lack of timely spending, utilization, and outcomes data, and comparable data across states, as well as the inability to track clients across agencies, all impede program evaluation.

The State Health Care Spending 50-State Report Series

The State Health Care Spending Project, a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, examined seven key areas of state health care spending—Medicaid, the Children’s Health Insurance Program, substance use disorder treatment, mental health services, prison health care, active state government employee benefits, and retired state government employee benefits. The project provided a comprehensive examination of each of these health programs that states fund. The programs vary by state in many ways, so the research highlighted those variations and some of the key factors driving them. The project also released state-by-state data on 20 key health indicators to complement the programmatic spending analysis. For more information, see <http://www.pewtrusts.org/en/projects/state-health-care-spending>.

State health care obligations

States provide health care through a variety of programs, with eligibility ranging from a means-tested entitlement (serving people below certain income levels) to benefits negotiated with state employees, to constitutionally required care for those in correctional facilities. Trends in a population’s age and income, for example, affect programs’ costs, and some states are more expansive than others in programs where eligibility and breadth of coverage is at least partially under their control. The programs studied by the State Health Care Spending Project, which constitute the vast majority of what states spend on health care, include:

- **Medicaid.** Medicaid is the largest health insurance program in the United States, covering both acute and long-term care services for over 66 million low-income Americans. The program is jointly funded by the federal government and the states. In 2012, states spent \$181 billion of their own money on Medicaid¹—an amount second only to state spending on elementary and secondary education.² The federal share of Medicaid is the single biggest influx of federal dollars into state coffers. Federal contributions range from a statutory minimum of 50 percent to a maximum of 83 percent of the cost of the health services (federal contributions to administrative expenses are less), based on a Federal Medical Assistance Percentage (FMAP) derived from the per capita income of states’ residents as compared to the national average.³ The federal government sets minimum eligibility standards and coverage for services, but states have always been able to go further, expanding eligibility and offering optional benefits such as prescription drug coverage or adult dental services. In 2010, jurisdictions with the highest percentage of residents below the federal poverty level—New Mexico, Mississippi, and the District of Columbia—were among those with the highest percentages of residents enrolled in Medicaid; they also received among the highest federal matches.
- **Children’s health.** CHIP was created in 1997 to extend coverage to uninsured children. Compared with insured children, those without coverage tend to have higher rates of preventable hospitalizations and asthma, among other differences.⁴ In fiscal year 2013, CHIP covered 8.1 million children at a total cost of more than \$13 billion.⁵ The program, funded jointly by the federal government and states and administered by the states, has helped reduce the number of uninsured children from 10.7 million (15 percent of the nation’s children) in 1997 to 6.6 million (9 percent) in 2012.⁶
- **Prison health care.** Under the landmark 1976 Supreme Court decision *Estelle v. Gamble*, prisoners were found to have a constitutional right to adequate medical attention. Under the ruling, corrections agency officials may not display “deliberate indifference” to an inmate’s medical needs. States spent a total of \$7.7 billion⁷ on inmate health care in fiscal 2011.

- **Mental health.** States have traditionally been the providers of services to treat mental illness, which in 2013 affected 44 million adults, or about 18.5 percent of the population.⁸ Medically necessary care is delivered through Medicaid programs for enrollees and through services contracted for or delivered by state mental health agencies for all other eligible individuals. These agencies served almost 21 percent of Americans receiving mental health care in 2012.⁹ States spent over \$22 billion of their own funds (excluding state and local contributions to Medicaid) in 2009 for the treatment and prevention of mental illness.¹⁰
- **Substance use disorders.** In 2013, some 22 million Americans had a substance use disorder¹¹—defined as use, abuse, or dependence on alcohol or illicit drugs or misuse of prescription medication—a problem that has a spillover effect on other state concerns such as crime. States spent an aggregate \$7.6 billion¹² across several agencies in 2009 on treatment and prevention of substance use disorders, not including Medicaid spending. Although 2.5 million people were treated in 2013 at a specialty facility, experts estimate that the vast majority of affected individuals receive no treatment.¹³
- **Active state government employee health care.** States provide health insurance for their government employees as part of an overall compensation package, with varying levels of benefits and a range of plans. In 2013, states paid \$25.1 billion toward health insurance premiums for 2.7 million state employee households.¹⁴
- **Retired state government employee health care.** While only 28 percent of large employers in the U.S. offer health benefits to their retired workers, 49 states continue to include these benefits as a key part of state compensation programs, whether it be before they qualify for Medicare (early retirees) or supplemental to Medicare (age 65 and older). States vary in whether they pay their share of such costs on a pay-as-you-go basis or whether they also set aside extra money for future retiree obligations (prefund). In 2013, states paid \$18.4 billion toward their retirees' other post-employment benefits (OPEB), of which health insurance is by far the largest.¹⁵

State health care services often cover overlapping clientele: individuals who are poor, elderly, very young, chronically ill, or incarcerated.

Intersecting programs and populations

State health care services cover overlapping clientele. With the exception of state employee and retiree insurance programs, the health costs borne by states cover populations vulnerable in some way: poor, elderly, very young, chronically ill, or incarcerated. The concentration of need among some of these populations affects spending in disparate programs, in many instances falling across two or more health care programs.

Corrections

State prisons offer a clear example of the interconnection among groups of people covered by state services. Inmates are more likely than the general population to have infectious or chronic diseases such as AIDS or hepatitis C. In 2010, roughly 65 percent of incarcerated individuals met the definition of having an alcohol or drug abuse problem, seven times the rate in the general population. Further, a third suffered from mental illness, and a quarter had some combination of mental illness and substance use disorder.¹⁶ States are obligated to provide health care services to prisoners, but before entering prison and on release such individuals would probably have qualified only for treatment offered to the uninsured under the auspices of the state's mental health and/or substance abuse agency. Now, in states that expand their Medicaid eligibility as allowed under the ACA, released prisoners may qualify for Medicaid coverage of the physical and behavioral health services they need.

Substance use disorders and mental health

Substance use disorder and mental health services also are used by many individuals concurrently. The states' role in substance abuse treatment and prevention came out of their traditional responsibility for caring for the mentally ill. In fact, state substance abuse agencies are often housed in a department of health and human services or a mental or behavioral health agency. Further, most substance abuse treatment is provided in specialty substance abuse and mental health centers and hospitals, including acute, psychiatric, and chemical dependency hospitals.

Approximately 8 million adults with any mental illness also have a substance use disorder.¹⁷ The added burden of these coexisting conditions adds tremendously to the complexity and cost of treating these individuals. The mentally ill are also more likely than the general population to have chronic physical health conditions, largely because mental illness is associated with less-effective preventive care and disease management. For example, individuals with one of 10 common chronic conditions and co-occurring depression or anxiety had physical health care expenditures that were at least 65 percent higher than chronically ill individuals without these mental illnesses.¹⁸

Medicaid and CHIP

Eligibility for both Medicaid and the Children's Health Insurance Program, at least with respect to children, is based on family income in relation to the federal poverty level; small variations in family income will bounce an enrollee between the two programs. There are many "mixed coverage" families in which some members are covered by Medicaid, some by CHIP, and perhaps one parent covered by employer-sponsored insurance.

Some state employees may also be linked to CHIP. Under the Affordable Care Act, states that meet eligibility criteria can cover children of low-income state employees in CHIP, although as of April 2014 only a dozen did so.¹⁹

State government employees and retirees

Although several other state-funded health care programs share clients or see them move among programs, state employees age into state retirees if they continue to work for the state. While each state sets its own "years of service" and other requirements for eligibility for state retiree health insurance, 49 states offer coverage to eligible retirees.²⁰

State spending: The controllable and the uncontrollable

States' spending on health care for residents varies dramatically, with the numbers influenced by more than just a state's commitment to its public's health, deftness in budgeting, or ability to control costs. Because so many state health programs serve as a safety net, the vitality of a state's economy and the characteristics of its private sector play a role in determining total health care expenditures. Contributing factors include federal contributions, which differ from state to state, and provider prices, which can vary dramatically. Characteristics of the population—such as how many people are elderly or poor, or how many smoke—also have an impact on health status and, in turn, on public spending for health care. States can tweak eligibility for certain programs such as Medicaid and CHIP, but some care, such as that in correctional facilities and hospital emergency departments, is guaranteed. Limiting access to care may cause some uninsured individuals to defer care, which can lead to higher costs if they seek services at a more advanced stage of illness.

Variations in Medicaid programs

Although Medicaid is an entitlement for those who meet a state's eligibility criteria, states have the right to provide only the federal minimum required level of benefits to recipients who meet the lowest federal eligibility requirements. Some states go further, however. Prior to the ACA, Vermont, for example, provided full Medicaid benefits to nondisabled adults at a level substantially above the federal minimum requirement.²¹ States either pay for such extensions with state-only funds or obtain federal contributions via a Medicaid waiver if one is granted by the federal government.

Starting in 2014, the states that expanded their Medicaid eligibility under the ACA encouraged newly eligible residents to apply for Medicaid coverage, which will be paid for entirely by federal funds until 2017. Some such individuals had accessed state-funded health services when uninsured, so their enrollment in Medicaid was a financial relief to states. Even in 2020, when the federal share of new Medicaid enrollees levels off, it will continue to pay 90 percent of expenses, far higher than any state's federal Medicaid match for current enrollees.

Variations in CHIP programs

States have more flexibility under CHIP with regard to whom they cover and how they administer their programs. In CHIP, unlike Medicaid, states are allowed to cap enrollment (CHIP is not deemed an entitlement program) and establish waiting lists if demand exceeds their preset budget. As a result, the program's dimensions and costs vary widely among states. Nationally, the program had been growing, with enrollment increasing by 2 million—32 percent—between 2005 and 2012. Funding grew by 5.5 percent during that period.²² But states showed dramatically different trends in spending, ranging from an average annual decrease, calculated over eight years, of 27 percent (Arizona) to an increase of 27 percent (New Mexico).²³ Some of the trends are due to policy changes—for example, Arizona opted to freeze its CHIP enrollment, resulting in a joint federal-state spending drop from \$272.4 million in fiscal 2009 to \$45.7 million in fiscal 2011.²⁴ The health of the state economy can also have an impact, because children whose parents are covered by an employer-sponsored family plan are not generally eligible.

Disability, aging, and health care costs

Several demographic characteristics influence the utilization and cost of health care for states, particularly in their Medicaid programs. The percentage of elderly and disabled people enrolled in any state's Medicaid program—which in 2010 ranged from 16 percent in Arizona to 38 percent in Maine and West Virginia—can affect a state's Medicaid expenses.²⁵ While overall in that year Alaska had the lowest share of people 65 or older (7.7 percent) and Florida the highest (17.3 percent), state Medicaid eligibility decisions (as well as the relative wealth or poverty of its elders) can reduce the potential effect of demographic factors on the state's share of Medicaid.²⁶

Most states are facing the same factors when it comes to providing insurance coverage for state government workers and retirees. On average, these insured populations are older and composed of a greater percentage of females (57 percent versus 51 percent in 2010) than in the private sector (during most phases of a woman's life, her health care costs exceed those of a man of comparable age). Additionally, 36 percent of public sector health plan workers and dependents in 2010 were ages 50 to 64, compared with 26 percent among private firms. Public employees and their dependents also had a greater prevalence of chronic conditions, even when controlling for age and gender.²⁷

Individual behavior

Human behavior contributes to the development and severity of chronic illness and, with it, state health care spending. For example, 43.8 million American adults smoke cigarettes, increasing the likelihood of a variety of ailments.²⁸ Smoking rates vary dramatically among states and demographic groups. In 2010, among those 18 and older, Utah had the lowest rate of cigarette smokers (8.9 percent) and West Virginia the highest (28.1 percent).²⁹ Adult smokers are disproportionately men who live below the poverty level and have less education than nonsmokers.³⁰ State efforts to discourage smoking, for example by levying high taxes on tobacco or limiting smoking in public places, have not proved to have a direct effect on smoking rates. For example, California's cigarette excise tax is low, 0.87 cents a pack, and its smoke-free laws are limited. New York's policies—including an excise tax of \$4.35 a pack and comprehensive smoke-free laws—are more stringent, yet California's smoking rate is 12 percent and New York's is 15.6 percent. Utah's excise tax (\$1.70) is lower than New York's, but so is Utah's smoking rate.³¹

While many employers offer wellness programs and/or incentives to employees to promote healthier habits, evidence is mixed about the value of such investments.³² However, one group for whom it might pay to offer incentives for healthier behavior is state employees, because of their longer-than-average tenure (compared with private sector workers) and because a state's insurance coverage generally stretches into retirement. This longer timespan of responsibility affords states a chance to recoup investments in wellness and smoking-cessation programs.

State variations

Many economic factors affect state health care spending. Whether states pay for services on a fee-for-service basis or negotiate premium rates (capitation) with insurers to cover enrollees, cost-of-living differences and provider wages, provider practice patterns in the delivery of health care, and market power all drive differences in states' bills.

The health of the economy is an ongoing concern for states and can deliver a double hit on finances. High unemployment and shuttered businesses mean lower tax revenue. Those conditions can also lead to a greater number of people whose health care needs are subsidized by states as people lose their employer-sponsored health insurance and become uninsured or eligible for Medicaid or CHIP. Grappling with budget deficits during the Great Recession, funding for mental health services dropped (actual funding levels decreased from state fiscal 2009 to 2010 for the first time in the 30 years it has been tracked), even though demand for state mental health services increased during that period.³³ On average, state funding for substance use disorder services also decreased during the Great Recession from 2008-10, although this varied by state.³⁴

Unexpected health care costs

States are challenged by the unknown and the unexpected, be it a new virus or approach to testing and treatment. Lyme disease and the human papillomavirus, for example, forced states to respond with public education campaigns and to take action to control the spread through enhanced access to treatment. The development of the drug Sovaldi, which cures hepatitis C but is expensive, is forcing states to decide on eligibility criteria for coverage, even if the drug proves to be more cost-effective than other existing treatments in the long run.³⁵ The higher prevalence of hepatitis C in populations for which states are responsible (i.e., the incarcerated, substance users, and Medicaid enrollees) makes the price of Sovaldi a particular concern for states, but cutting-edge cancer medications and new-to-market mood-stabilizing drugs are other examples. And many states, even those choosing not to expand their Medicaid programs under the Affordable Care Act, have experienced a surge in

“woodwork” enrollees, those previously eligible but not enrolled for whom the ACA’s enhanced federal match does not apply.

Containing costs: Managing health care services and delivery

States are exploring myriad ways to slow health care spending, including using technology and data to target resources, requiring state employees to shoulder a greater share of their health care expenses, encouraging the integration of behavioral health care into primary care, and shifting responsibility for providing care within a budget onto accountable care organizations. In addition, in those states expanding the eligibility of their Medicaid programs, newly eligible clients who were previously served by state-funded mental health or substance use treatment services will now obtain those services through Medicaid, thereby sharing costs with the federal government. States are likely to continue being responsible for many health care services for their residents, but by changing the way health care is delivered or by changing certain non-health-related policies, states hope they can increase the value of the services they provide or save money by reducing readmissions, recidivism, or lost productivity.

Shifting patients and costs to Medicaid

Medicaid continues to be a big part of states’ efforts to provide health care to low-income residents, and it is continuing to grow as 31 states and the District of Columbia (as of February 2016) expand their Medicaid programs under the ACA.³⁶ Because health insurance coverage generally encourages attending to one’s health needs early and because all states get at least half of their Medicaid health care spending paid by the federal government, many states have been trying to shift previously uninsured individuals to Medicaid when possible. States that choose to expand Medicaid under the ACA can shift even more of the costs for newly eligible enrollees to the federal government, which picks up 100 percent of the cost of Medicaid expansion payments through 2016, with this contribution gradually decreasing to 90 percent by 2020.

A number of states have made a concerted effort to enroll eligible prisoners in Medicaid so the program can be billed for qualifying health services. Those services are limited to care delivered outside the prison—such as at an off-site hospital or nursing home—when an inmate has been admitted to the health facility for more than 24 hours.³⁷ Although the state remains responsible for as much as half the cost, the amount is likely to be less than the corrections department would otherwise pay because Medicaid typically is the lowest-priced payer. For inmates newly eligible under ACA-driven Medicaid expansion, cost savings are even higher because the federal government will cover a higher proportion of the expenditures. Once out of prison, many inmates in states expanding coverage have qualified for Medicaid, which could not only contribute to improved health for them but also potentially lead to lower crime rates and reduced recidivism among the mentally ill if a successful treatment started during incarceration is maintained after release.

Medicaid expansion and the ACA overall also afford opportunities for states to expand access to substance use disorder and mental health treatment by providing more individuals with insurance and by including both types of care in the list of “essential benefits” all individual and small group health plans must cover.

Using technology to deliver services

Telehealth can cut costs by allowing patients without easy access to medical services or facilities to receive some evaluations and treatment through videoconferencing and remote transmission of clinical data to specialized providers. The strategy is being used with inmates in particular, whose off-site treatment carries the added cost of secure transport.

Corrections reforms

Many states have adopted medical or geriatric parole policies that allow for the release of older, terminally ill or incapacitated inmates who meet certain requirements, although such programs have not been used widely. This is partly due to restrictive eligibility criteria, community opposition, and a lack of facilities willing and available to house released inmates. Because of the high cost of keeping older prisoners with chronic or terminal illnesses incarcerated, granting medical or geriatric parole can achieve notable savings, even if the state retains financial responsibility for parolees' health care costs outside prison, which is likely.

States have increasingly looked to outside partners to provide all or part of their prison health care services at lower costs without sacrificing quality of care. Effective management and oversight—for example, attaching performance standards and tracking systems to contracts or monitoring the timeliness and effectiveness of prisoners' treatment—are critical to the success of these partnerships.

Because of the high cost of keeping older prisoners with chronic or terminal illnesses incarcerated, granting medical or geriatric parole can achieve notable savings.

Changing the delivery and payment system

Reforms to delivery systems can also help streamline services, affecting costs. The ACA provides incentives to improve the quality of mental health care by integrating mental and physical health care treatment. This is done primarily through the development of health homes, which are designed to provide comprehensive care management, better transitional care for those moving from inpatient to outpatient settings, and family and community support. In 2011, the ACA created a Medicaid option in which a health home received a 90 percent federal match during its first two years of existence, with the match subsequently returning to the ordinary state rate.³⁸

States are also examining and tentatively implementing a shift from paying on a fee-for-service basis, in which volume is rewarded, to a capitated and/or incentive basis, in which the provider is paid for achieving a certain outcome. Such outcomes could be a reduction in hospital readmissions, a lowering of emergency department use, or an increase in patients' use of generic drugs.

Shifting the cost burden to workers

States can influence the health benefit costs of government employees through premium contribution strategies. For example, as of 2013 some states, such as North Carolina, based their contribution on the lowest-cost plan and required employees selecting a higher-cost plan to pay the full difference in premiums, which can drive employees to select the cheaper option. Another tactic is to price the "tiers"—such as plans covering spouses and dependent children—in a way that encourages employees to use another source, such as a spouse's health care plan, to cover the rest of the family. In 2013, Mississippi, North Carolina, and Texas, for example, required employees to pay a substantially greater percentage of the cost of coverage of dependents compared with that for a single employee.³⁹

Plans can also be structured to discourage employees from using high-cost treatment options (such as unnecessary emergency room visits) and encourage them to make economical choices, such as generic drugs. High-deductible plans—those that require workers to pay out of pocket at least \$1,300 in 2016 toward covered,

nonpreventive services—are also a way for states to control costs, although state governments have been slower than private sector employers to offer the option. In 2013, 19 states offered health plans with a deductible of at least \$1,500 for employee-only coverage, with eight of those states pairing them with health savings accounts or health reimbursement arrangements to which the states also contributed.

Proponents of high-deductible plans argue that under them patients will be more prudent in their health care decisions and spending. But critics contend that patients lack the information to make data-driven health care decisions, which may result in insufficient care and, ultimately, in higher health care bills as conditions go untreated. A Rand Corp. study found that enrollees in such plans even reduced their use of preventive care despite such costs being fully covered outside the deductible, signaling that some enrollees might not fully understand the rules for these plans.⁴⁰ Other research showed that increased cost-sharing is associated with the reduced use of prescription drugs, including even some very high-value cholesterol-lowering pharmaceuticals. These two unintended and undesirable results indicate that at least for the present, some enrollees of high-deductible plans might not fully understand the rules that govern them and that high cost-sharing might be too blunt an instrument to be effective over the long term.⁴¹

Some states have incorporated value-based insurance design into their employee plans, offering greater subsidies for higher-value treatment. Such therapies include generic prescription drugs to treat hypertension, diabetes, high cholesterol, and asthma, thereby reducing acute episodes and the eventual need for more invasive and expensive care, such as surgical interventions.

While the expenses of these programs tend to be front-loaded, the benefits take time to accumulate, which might make them particularly suitable for states to offer their employees, who tend to stay in state employment and remain covered by state insurance for a longer time than workers in the private sector.

Encouraging healthful living

States cannot force people to exercise, watch their weight, or stop smoking, but they can do things to encourage those behaviors. For example, workplace wellness programs can lead to a healthier state workforce. Strategies include using health-risk surveys to create personalized health improvement plans, and linking an employee's share of premiums to whether they participate in employer wellness programs and/or to various health metrics, such as whether they smoke. Some research has found that these programs can save money. One study discovered that medical costs and those related to absenteeism each fell by about \$3 for every dollar spent on certain wellness programs. Another study was less clear on benefits to both cost and health: Researchers reviewing results of randomized controlled trials found that financial incentives are often ineffective in influencing behavior.⁴² While the expenses of these programs tend to be front-loaded, the benefits take time to accumulate, which might make them particularly suitable for states to offer their employees, who tend to stay in state employment and remain covered by state insurance for a longer time than workers in the private sector.⁴³ Diabetes, hypertension, and weight management, as well as smoking cessation, are good examples—all improve an employee's health and well-being but can take many years to return an investment. States, with their long-term responsibility for their employees' health insurance often through retirement until death, may earn such a return that other employers would not.

What's next? The ACA and the Parity Act

Expanding Medicaid

State spending on health care—indeed, states' entire approach to health care for residents—is changing and will continue to evolve as the Affordable Care Act goes into effect. Its impact on spending is unclear; requirements for minimum coverage may add costs in some areas, for example, but moving toward more universal health insurance coverage may reduce costs in the long run.

Medicaid expansion could have one of the biggest influences on state health care spending, although its effect on states that have not opted to expand the program will be diminished. Before the ACA, few states offered coverage to childless adults without disabilities, regardless of their income, and the eligibility level for parents varied substantially. Now, those younger than 65 in states expanding their Medicaid programs can qualify for coverage if they earn 138 percent of the federal poverty level or less, which in 2014 amounted to approximately \$16,000 for an individual and \$33,000 for a family of four.⁴⁴

Even states that have chosen not to expand Medicaid under the new law are experiencing higher program enrollments because of increased attention to the availability of Medicaid and its less complex application process. (Those new Medicaid enrollees, however, are subsidized at the state's existing Federal Medical Assistance Percentage rate.) States expanding Medicaid coverage are anticipating that costs will ultimately go down as more people receive routine, coordinated care and less frequently seek costly, acute care at emergency rooms. And state prison systems in expansion states stand to benefit if eligible inmates require an inpatient hospitalization, because such stays will be covered under Medicaid rather than paid for entirely by the state corrections agency.

Because the ACA is intended to increase the pool of insured people (either through Medicaid expansion or coverage through the health insurance marketplaces), the federal government is slated to lower its Disproportionate Share Hospital payments, the money offered to hospitals to compensate for taking care of the uninsured. The payments to hospitals will drop even when they are in states that have not expanded Medicaid.⁴⁵

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Enhancing CHIP

The ACA also increases the federal match for CHIP—as much as 23 percentage points as of October 2015—which will greatly reduce or even eliminate the cost of the program to all states. The law also streamlines the guidelines for applying for Medicaid and CHIP, using the same modified adjusted gross income standards. The ACA requires that states operating separate CHIP programs shift children with a family income of up to 138 percent of the poverty level to Medicaid, with its richer coverage, while continuing to receive the higher match from federal CHIP funds. This results in a win-win for both enrollees and state finances. States also must maintain or enhance their current CHIP eligibility levels, as well as enrollment and renewal policies, or risk losing federal Medicaid funds.

Broader coverage for mental health and substance use disorders

Both state-funded substance use disorder treatment and mental health care will be affected by the ACA and by the Mental Health Parity and Addiction Equity Act (Parity Act), because both increase coverage for those conditions. The Parity Act requires an insurance plan's coverage for mental health and substance use disorder treatment, if covered, to be equal to benefits for physical health, including copays, lifetime and annual dollar limits, out-of-pocket expenses, and limits on frequency of treatment.⁴⁶ The ACA, meanwhile, includes both mental health and substance use disorder treatment services as essential health benefits, and extends the parity requirement to plans that previously did not have to cover mental health services. The ACA also mandates that all new health care plans include mental health and substance use disorder coverage and requires health plans to cover mental health-related preventive services, such as depression screenings for adults and behavioral assessments for children.

It is not clear exactly how changes stemming from the ACA will affect state mental health and substance abuse agencies. But because states have shouldered much of the burden for these types of care, their share of spending is expected to decline as more individuals get private health insurance that includes such coverage and as Medicaid coverage expands, extending mental health and substance use disorder care to their enrollees.

Other provisions of the law encourage integration of care between primary care providers and mental health and substance abuse providers. The Parity Act, combined with the ACA, is likely to significantly increase both the number of people receiving benefits and the breadth of services covered. The effect of these laws on state health care spending may well be considerable.

Conclusion

The coming years will usher in tremendous change for state health care programs because of sweeping federal legislation like the Affordable Care Act, the Parity Act, and the inexorable rise of health care spending, especially for pharmaceuticals.

The ACA has brought insurance coverage to millions of previously uninsured individuals and is also transforming some providers' business models. Mental health and substance use disorder providers that were formerly largely financed through state and federal grants, and often did not negotiate with or bill insurers for their services, are now being brought into the fold of insurance. The ACA has also launched dozens of delivery system and payment transformation efforts that often include a state's private sector employers.

States' health care programs and spending vary tremendously owing to many factors, only some of which are under their control. Spending more does not necessarily produce better health outcomes because certain factors—such as age, poverty, and lifestyle—are not mitigated by higher or lower health care spending, and some types of spending are likely to be more effective than others. States have numerous challenges in measuring and tracking the care they provide because of many factors, including agencies that operate separately from each other, outdated reporting requirements, and contractors that do not share robust data. Despite these challenges, states are at the forefront of innovation, constantly piloting new approaches to improve the health of their residents.

Endnotes

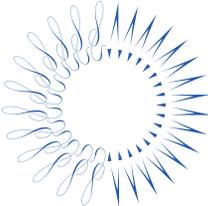
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