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Strategic Health Policy & Care Coordination Consulting

## Assessment of Medicaid Expansion's Impacts

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## Executive Summary

The purpose of this study is to compare the US states that have adopted the Affordable Care Act's (ACA) Medicaid Expansion to the states that have not done so. The Medicaid Expansion makes people with incomes up to 138 percent of the federal poverty (FPL) line eligible for Medicaid. The US Supreme Court ruling in June 2012 made the Medicaid Expansion, originally intended to be nationwide, optional for states. To date, 37 states and the District of Columbia have implemented this Expansion.

We compare a group of states that adopted the Medicaid population, excluding a few states that had, pre-ACA, already covered most or all of this Expansion population, to those states that had not adopted this Expansion through the end of 2019. We compare these groups of states across the Medicaid Expansion timeframe that was available for analysis (typically 2014-2019). Some of the key components of our assessment included:

- Health Coverage -- particularly impacts on the size of the uninsured population
- Medicaid Costs – overall and at the state and federal level
- Deaths in the under-65 population
- Employment Levels and Unemployment Rates

This study is an objective analysis of the observed impact of Medicaid Expansion on the number of uninsured, Medicaid costs to both states and the federal government, deaths, employment, hospitals' financial situation, and other key outcomes. The intent is to help inform the states that have not yet implemented the Expansion about its likely impact, as well as to demonstrate for Expansion states the aggregated impacts that have occurred.

## Key Findings

Our findings paint a highly – but not completely – favorable picture regarding Medicaid Expansion's impacts.

- More than nine million persons who would otherwise be uninsured have health coverage under the Expansion.
- States' Medicaid costs rose 19.5% from 2013-2019 across states that expanded Medicaid, versus a 26.4% increase in states that had not expanded Medicaid as of 2019. Those states electing to expand Medicaid found a path to cover far more persons and experience modest state-fund cost increases in the process, relative to the Non-Expansion states. This finding suggests that expanding Medicaid has proven to be “better than free” in terms of state Medicaid costs. Our analyses did not calculate some offsetting savings that may have further improved states' fiscal outcomes from adopting Expansion, including savings in mental health and substance use programs, and health services for the incarcerated population. These types of savings are briefly explained in the report.
- A key element of the Medicaid Expansion is its considerable overall cost, which we estimate to be \$80 billion in FFY2019 (for the new enrollees joining Medicaid due to the ACA's passage). This amount equates to \$418 per working age adult in the USA.

- Overall deaths did not appear to have been reduced by Medicaid expansion. We looked specifically at cancer deaths, and these deaths also did not appear to have been affected by Medicaid expansion. However, COVID deaths in the 18-64 age group are lower in the Expansion states (despite being higher in the 65+ age group in the Expansion states).
- Medicaid Expansion has not inhibited employment – and may have led to a slight employment gain. These employment dynamics were assessed in six ways, with all six analyses yielding this same result.
- Personal bankruptcies have decreased across Expansion and Non-Expansion states since 2013, with this reduction being particularly sharp across the Expansion states.
- Hospitals in Expansion states have experienced considerable revenue increases that appear attributable to Medicaid Expansion.

We also estimated the fiscal impacts in the remaining 13 Non-Expansion states if they adopt Medicaid Expansion.

- From a state government perspective, most Non-Expansion states will experience a net savings in the first two years of adopting Medicaid Expansion, and a net cost thereafter. This is due to the enhanced Federal match offered as an incentive to encourage remaining Non-Expansion states to adopt Expansion. The net costs we are projecting for states after Year 2 are conservative as they do not factor in our key finding that implementing Medicaid Expansion appears to be “better than free” in the outyears for states in terms of their overall state-fund Medicaid expenditures.
- Our tabulations indicate that the *residents* of all 13 of the remaining Non-Expansion states would collectively be considerably better off financially if Medicaid Expansion were adopted.
- Collectively, the residents of these states are currently in an adverse position because they are contributing to the cost of other states’ Expansions through their Federal taxes (we estimate this annual cost to Non-Expansion state residents to be \$28.6 billion) – but receiving no health coverage or federal funds infusion in return.
- The broader economic gain from implementing Medicaid Expansion to the residents across the 13 states that have not yet done so is estimated at \$51 billion per year in each of the first two years, and \$44 billion per year thereafter. *This figure of \$44 billion in economic gains is approximately seven times the 13 states’ fund cost of \$6 billion per year.*

## I. Introduction

This report seeks to quantify key outcomes to date of the Affordable Care Act's Medicaid Expansion and estimate the expected impacts that would occur if the remaining Non-Expansion states adopt the Medicaid Expansion. We have assessed Medicaid Expansion's impacts from the following perspectives:

- To what degree has Medicaid Expansion increased health insurance coverage and decreased the number of persons without health insurance?
- What level of overall Medicaid cost increases have occurred? How have these additional costs been distributed between the states and the federal government?
- How much does Medicaid Expansion cost annually in the USA per adult in the 19-64 age group?
- What differences have occurred in employment and unemployment between Expansion states and Non-Expansion states?
- Is there any discernable impact on mortality rates between Expansion and Non-Expansion states in the non-senior adult population, both overall and in certain cause-of-death categories that Medicaid Expansion might be expected to particularly impact (e.g., cancer)?
- What differences have occurred in COVID deaths between Expansion and Non-Expansion states in the 19-64 age group?
- How have hospitals' revenues been impacted by states' decisions to expand Medicaid?
- To what degree has disproportionate share spending in Medicaid decreased due to Medicaid Expansion?
- Is there a discernable impact in health care cost-driven personal bankruptcies?
- How much are taxpayers spending on Medicaid Expansion in the Expansion states versus the Non-Expansion states, taking into consideration federal tax payments for all other states' Expansion populations (and their own state) plus the state share of Expansion costs in their own state (if their state has adopted Expansion).
- What would be the net costs and net gains for each remaining Non-Expansion state to adopt Medicaid Expansion?

## II. Methodology Overview

Our analytic approach primarily involved grouping states based on their Medicaid Expansion dynamics and comparing the progression of each selected metric (Medicaid costs, employment, deaths, etc.) from 2013 to 2019. Because many states that adopted Medicaid Expansion in 2014 were already covering (via Medicaid) significant segments of the Medicaid Expansion population, our analysis has focused primarily on comparing two large groups of states:

- **Group A:** States that had not expanded Medicaid as of 2019. This group includes 17 states: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming. Four of these states have implemented Medicaid Expansion in FFY2020 or FFY021 (Idaho, Nebraska, Utah, and Oklahoma).
- **Group B:** States that expanded Medicaid and where at least 10% of their overall FFY2019 Medicaid expenditures (federal and state share combined) were attributable to persons newly eligible by virtue of adopting Medicaid Expansion. This group includes 27 states and the District of Columbia: Alaska, Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, Nevada, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Virginia, Washington, and West Virginia. These are the states where Medicaid Expansion's impacts should, theoretically, be most visible between 2014 and 2019 relative to the Group A "control group" of Non-Expansion states.

The remaining six states have adopted Medicaid Expansion but primarily already covered their "Expansion populations" in their Medicaid programs prior to 2014. Three of these states – Maine, Massachusetts, and Vermont -- had no FFY2019 Medicaid costs for newly eligible persons due to adopting Expansion. In these states, newly eligible persons' costs represented less than 10% of their overall 2019 Medicaid expenditures. These states were predominantly excluded from our analyses, given that minimal impacts from 2013 to 2019 could be attributed to their adoption of Medicaid Expansion. In these states, little or no new enrollment among Expansion-eligible persons occurred beyond persons who were eligible for Medicaid in these states prior to 2014. We view it to be useful, and arguably important, to exclude these states to discern the impacts of adopting Medicaid Expansion.

In focusing on the changes between 2013 (the last Non-Expansion year) and 2019 between the two groups of states, we also assessed the changes between these groups of states in the years prior to 2013. The degree to which the two groups of states were trending differently prior to 2013 (when Medicaid Expansion could not have been the cause) informs the degree to which the 2013-2019 trend differentials can reasonably be attributed, at least in part, to Medicaid Expansion.

In many of our analyses, it was also possible to compare trends in the 65+ population between the Group A and Group B states. Medicaid Expansion could not have meaningfully affected the senior population, therefore the 65+ population serves to some extent as a "control group" for helping determine whether differences in the 19-64 age cohort's trends from 2013-2019 can reasonably be attributed to Medicaid Expansion impacts.

Our analysis relies on the careful comparison of trends across different groups of states, different populations, and different time periods. Our comparisons between the two large groups of states have the advantage of a massive sample size in each group. We did not use multiple regression analysis or other research models to control for a wide variety of factors beyond the decision to adopt or not to adopt the ACA Medicaid Expansion that could impact various outcomes. That said, we have used different combinations of perspectives and comparison groups that we believe provide a useful picture of the likely impact, or lack of impact, of the Medicaid Expansion on outcomes of interest.

Our methodology, with its appropriate caveats, provides numerous insights strongly suggesting that certain negative effects of the Expansion anticipated by some critics just do not seem to have actually occurred.

Further research could help determine with more certainty the magnitude and a more precise picture of the cause-and-effect nature of the relationships analyzed here.

### III. Coverage Impacts of Medicaid Expansion

Medicaid Expansion has clearly reduced the level of persons without health insurance. **Exhibit A** conveys the degree to which persons in the 19-64 age group have been uninsured in the last year prior to Medicaid Expansion, 2013, and how this figure changed as of 2019. The data are aggregated into state groupings related to Medicaid Expansion as described previously.

**Exhibit A. Trends in Uninsured Persons Age 19-64**

State Grouping	Uninsured Persons, Age 19-64					
	2008	2013	2019	% Change, 2008-2013	% Change, 2013-2019	Net Change, 2013-2019
Group A: 17 states that did not expand Medicaid	14,767,500	16,033,400	12,629,200	9%	-21%	(3,404,200)
Group B: 27 states (plus District of Columbia) that expanded Medicaid and had large 2019 cost impact from newly eligible expansion enrollees	18,213,700	19,413,400	10,226,600	7%	-47%	(9,186,800)

The figures in **Exhibit A** demonstrate that while the uninsured population decreased considerably (by 21%) in the Group A Non-Expansion states from 2013 to 2019, more than twice as large a decrease, 47%, occurred in the Group B Expansion states. The number of uninsured persons across the Group B states decreased by more than 9 million persons from 2013 to 2019.

**Exhibit B** presents the volume of Medicaid Expansion enrollees in each state grouping as of June 2019, at which point nearly 15 million persons were categorized as Medicaid Expansion enrollees. Within these persons, 12 million were newly eligible in their state by virtue of the ACA's passage, and 2.8 million were already eligible in their state. The large decreases in the uninsured population portrayed in **Exhibit A** and the large volume of newly eligible persons in **Exhibit B** both demonstrate that strong health coverage enhancements have occurred due to states' adopting Medicaid Expansion.

**Exhibit B. Medicaid Expansion Enrollment Distributions, June 2019**

State Grouping	Medicaid Expansion Enrollment by State, June 2019					Percentage of Expansion Enrollees who are Newly Eligible
	Total Medicaid Enrollment	Expansion Group Enrollment	Expansion Group -- Newly Eligible Enrollment	Expansion Group -- Not Newly Eligible Enrollment		
Group A: 17 states that did not expand Medicaid	20,516,800	-	-	-		
Group B: 27 states (plus District of Columbia) that expanded Medicaid and had large 2019 cost impact from newly eligible expansion enrollees	42,372,000	12,044,000	11,565,200	478,900		96.0%
Other States: 6 states that adopted Medicaid expansion but which already covered expansion population prior to 2014	9,999,200	2,787,400	438,100	2,349,100		15.7%
<b>Total</b>	<b>72,888,000</b>	<b>14,831,400</b>	<b>12,003,300</b>	<b>2,828,000</b>		<b>80.9%</b>



Note that across the Group B states, 96% of all Medicaid Expansion enrollees were newly eligible. In contrast, only 16% of Expansion enrollees were newly eligible across the remaining six Expansion states (meaning 84% of these states' Expansion enrollees would have been covered according to their state's pre-2014 eligibility criteria). This provides a further rationale for our decision to exclude these six states from our analyses of Medicaid Expansion impacts across the 2014-2019 timeframe.

We also assessed trends in employer-based health coverage in the 19-64 age cohort. These tabulations, summarized in **Exhibit C**, indicate that while the number of adults with employer-based coverage increased by 5% from 2013-2019 across the Group B Expansion states, a sharper increase (12%) occurred across the Group A states that did not adopt Medicaid Expansion.

Based on the above tabulations, we estimate that approximately 2-3 million persons with Medicaid Expansion coverage would have obtained employer-sponsored coverage during 2019 if the Group B states had not adopted Medicaid Expansion. The majority of persons receiving Medicaid Expansion coverage across the Group B states, over 9 million persons, had health insurance *because* their state adopted Medicaid Expansion (and would otherwise have been uninsured).

**Exhibit C. Trends in Employer-Based Coverage, Persons Age 19-64**

State Grouping	Persons with Employer-Based Coverage					
	2008	2013	2019	% Change, 2008-2013	% Change, 2013-2019	Net Change, 2013-2019
Group A: 17 states that did not expand Medicaid	36,652,900	35,833,100	40,253,100	-2%	12%	4,420,000
Group B: 27 states (plus District of Columbia) that expanded Medicaid and had large 2019 cost impact from newly eligible expansion enrollees	62,624,200	60,390,000	63,525,600	-4%	5%	3,135,600
Other States: 6 states that adopted Medicaid expansion but which already covered expansion population prior to 2014	13,519,500	12,873,100	13,253,500	-5%	3%	380,400
<b>Total</b>	<b>112,796,600</b>	<b>109,096,200</b>	<b>117,032,200</b>	<b>-3%</b>	<b>7%</b>	<b>7,936,000</b>

## IV. Cost Impacts of Medicaid Expansion

### A. Overall Costs of Medicaid Expansion

Nationwide Medicaid expenditures during FFY2019 were \$597 billion, an increase of 37.9% over FFY2013 expenditures (\$433 billion). Nationwide Medicaid expenditures for the Expansion population during FFY2019 totaled \$122.9 billion, 20.6% of all Medicaid expenditures during that year. In the Centers for Medicare and Medicaid Services' financial reporting used in our tabulations, the Medicaid Expansion population is referred to as "Group VIII" and costs for this group are specifically shown.

Of the Expansion population's FFY2019 costs of \$122.9 billion, \$80 billion represented persons made newly eligible for Medicaid in their state by virtue of Medicaid Expansion being adopted. This amount represents 13.4% of nationwide FFY2019 Medicaid spending. The remaining \$42.9 billion in Medicaid Expansion expenditures involved persons who were already eligible for Medicaid by virtue of their state offering relatively generous eligibility thresholds prior to 2014. These costs would presumably have occurred during FFY2019 even if the Affordable Care Act (which offered states the Medicaid Expansion option) had never been passed.

Considering just those persons who have become eligible for Medicaid by virtue of their state adopting Medicaid Expansion, the taxpayer cost of Medicaid Expansion in FFY2019 was \$80 billion. This cost represents \$418 per working age adult in the US in that year, as shown in **Exhibit D**. Medicaid as a whole created an FFY2019 cost of \$3,125 per working age adult. Note that these figures do not represent the average personal income tax paid towards Medicaid, as Federal and State governments' tax revenues are acquired through a variety of sources (also including sales taxes, property taxes, corporate taxes, payroll taxes, etc.). However, in some manner the taxpaying population is covering the costs of Medicaid (and all other government programs), and these taxpayers are predominantly in the 18-64 age group.

#### Exhibit D. Medicaid Expansion Costs Per Working Age Adult in the USA, 2019

Medicaid spending during FFY2019, Newly Eligible Group VIII Persons	\$79,999,092,234
USA Adults in 19-64 Age Group, CY2019	191,157,100
FFY2019 Cost of Medicaid Expansion per Working Age Adult	\$418

### B. State and Federal Share of Medicaid Expansion Costs

The costs of Medicaid Expansion are largely borne by the Federal Government. The Federal Government initially paid for 100% of Medicaid Expansion costs, and this percentage phased down to 90% beginning in 2020. States are currently responsible for 10% of their Medicaid Expansion populations' costs. **Exhibit E** summarizes the trajectory of Medicaid costs from 2013 – 2019 nationwide, in the Non-Expansion states described earlier (Group A), and in the Expansion states with a large contingent of newly eligible persons (Group B).

These tabulations are striking in that they suggest that expanding Medicaid appears to be **creating net savings** for the states adopting Expansion. While the states with a large contingent of newly eligible

persons enrolling due to Medicaid Expansion adoption (Group B) experienced a much larger increase in overall Medicaid costs from 2013-2019 than the Non-Expansion states (47.7% versus 28.1%), the state share of spending trended in the opposite direction. The Group A Non-Expansion states collectively experienced a state-fund Medicaid cost increase of 26.4% from 2013 – 2019. The Group B Expansion states experienced a collective state-fund Medicaid spending increase of 19.5% during this same timeframe. *These figures suggest that Medicaid Expansion was “better than free” during 2019 from a state fund perspective, with the Group B states experiencing a favorable differential of 6.9 percentage points.*

During this timeframe, Federal Medicaid spending across the Group B Expansion states increased by 69.8%, **more than double** the rate of increase in Federal Medicaid spending that occurred in the Group A Non-Expansion states (29.0%). *This illustrates the importance to states adopting the Medicaid Expansion of the huge amount of federal funds that flow into these states.*

**Exhibit E. Medicaid Spending Trends from 2013 – 2019, by State Groupings Regarding Expansion**

STATE GROUPING	Net Medicaid Expenditures FFY2013, \$ Billions			Net Medicaid Expenditures FFY2019, \$ Billions			Newly Eligible Group VIII, Total FFY2019 Expenditures (\$ Billions)	Newly Eligible Share of Total FFY2019 Medicaid Expenditures	Percentage Growth in Total Medicaid Spending, 2013-2019		
	Federal	State	Total	Federal	State	Total			Federal	State	Total
USA Total (50 States + DC)	\$247.7	\$183.4	\$431.1	\$383.4	\$207.6	\$590.9	\$80.0	13.5%	54.8%	13.2%	37.1%
USA Total Including Territories	\$248.8	\$184.3	\$433.1	\$386.2	\$211.2	\$597.4	\$80.0	13.4%	55.2%	14.6%	37.9%
GROUP A: Did not Expand Medicaid (17 states -- AL, FL, GA, ID, KA, MI, MO, NE, NC, OK, SC, SD, TN, TX, UT, WI, WY)	\$75.4	\$44.2	\$119.6	\$97.3	\$55.8	\$153.2	\$0.0	0.0%	29.0%	26.4%	28.1%
GROUP B: Expanded Medicaid and Newly Eligible costs 10+% of Total Medicaid Expenditures (27 states + DC)	\$130.1	\$101.7	\$231.8	\$220.9	\$121.5	\$342.3	\$74.3	21.7%	69.8%	19.5%	47.7%

In assessing impacts during the 2013-2019 timeframe, we also conducted a parallel comparison across the prior six-year period (2007-2013) when Medicaid Expansion opportunities at enhanced Federal matching rates did not exist. These comparisons are summarized in **Exhibit F**. Between 2007-2013, the Group B states that ultimately adopted Medicaid Expansion collectively experienced more rapid growth in their Medicaid programs (a 44.6% cost increase) than occurred in the Group A Non-Expansion states (where a 32.3% spending increase occurred). This finding is consistent with the Expansion states’ more general and ongoing interest in broadening Medicaid eligibility beyond minimum Federal requirements.

**Exhibit F. Medicaid Spending Trends from 2007 – 2013 and 2013 – 2019**

STATE GROUPING	Percentage Growth in Total Medicaid Spending, 2007-2013			Percentage Growth in Total Medicaid Spending, 2013-2019		
	Federal	State	Total	Federal	State	Total
USA Total (50 States + DC)	37.9%	35.5%	36.9%	54.8%	13.2%	37.1%
USA Total Including Territories	38.1%	35.7%	37.1%	55.2%	14.6%	37.9%
GROUP A: Did not Expand Medicaid (17 states -- AL, FL, GA, ID, KA, MI, MO, NE, NC, OK, SC, SD, TN, TX, UT, WI, WY)	32.4%	32.3%	32.3%	29.0%	26.4%	28.1%
GROUP B: Expanded Medicaid and Newly Eligible costs 10+% of Total Medicaid Expenditures (27 states + DC)	46.4%	42.4%	44.6%	69.8%	19.5%	47.7%

Unlike the ensuing 2013-2019 period when significant Federal matching fund increases were available, however, during 2007-2013 the state-fund increases across the Group B states rose 42.4%, almost in tandem with their overall Medicaid cost increase. Similarly, the Group A Non-Expansion states experienced a state-fund increase of 32.3% from 2007-2013 that was identical to their overall Medicaid cost increases.

The differences between the 2007-2013 and the 2013-2019 experiences appear to further demonstrate that from a state-fund perspective, Medicaid’s fiscal dynamics changed fundamentally and significantly with the passage of the ACA. *Those states electing to expand Medicaid found a path to cover far more persons and experience modest state-fund cost increases in the process, relative to the Non-Expansion states.*

## V. Mortality Impact Assessment

### A. Overall Mortality Rate Comparisons, Ages 19-64 and 65+ Cohorts

We did not find a reduction in overall deaths among the 19-64 age cohort in the Expansion states relative to Non-Expansion states. As summarized in Exhibit G, death rates for the 19-64 age cohort were lower in the Group B Expansion states than the Group A Non-Expansion states across the 2008 – 2013 timeframe, and this differential did not change meaningfully from 2014 to 2019. Death rates in this age group increased in both state groupings between the two time periods, with the increase being slightly more rapid in the Group B states (5.8%) than the Group A states (4.8%).

The death rates in the 65+ population were also assessed, and these death rates declined considerably between the two time periods for both Group A and Group B and by a similar percentage. Medicaid Expansion could not have impacted death rates in this age cohort – these figures were tabulated to serve as a type of “control group.” However, these comparisons do not provide any evidence that Medicaid Expansion lowered overall death rates.

#### Exhibit G. Overall Annual Mortality Rate Comparisons (Annual Deaths per 100,000 Population)

Time Period	Ages 19-64		Ages 65+	
	Group A (Non-Expansion) States	Group B (Expansion States with Large Newly Eligible Costs)	Group A (Non-Expansion) States	Group B (Expansion States with Large Newly Eligible Costs)
2008-2013 Average	367.0	324.7	4,419.1	4,476.5
2014-2019 Average	384.6	343.4	4,088.0	4,097.5
Percent Change, 2008-2013 and 2014- 2019	4.8%	5.8%	-7.5%	-8.5%

*Data Source Used: Centers for Disease Control and Prevention's Underlying Cause of Death database*

### B. Cancer Mortality Comparisons, Ages 19-64 and 65+ Cohorts

We looked within the overall death rates to ascertain if there is evidence that Medicaid Expansion appears to have reduced cancer deaths in the 19-64 age cohort. We envisioned that Medicaid Expansion coverage could have been particularly valuable in increasing access to early and preventive cancer screenings, and to make appropriate treatments more affordable/accessible for those persons diagnosed with cancer. Again, however, we did not find clear evidence that this has occurred. These tabulations are summarized in Exhibit H.

Annual cancer death rates between 2014-2019 fell by 5.9% in Group B Expansion states compared to their 2008-2013 average, while cancer deaths fell by 5.2% in Non-Expansion states over those same time intervals. This differential is too small to view as sound evidence that a reduction in deaths was in fact attributable to Medicaid Expansion. A similar modest differential occurred with the 65+ population,

where Medicaid Expansion could not have had an impact. These findings further suggest that cancer deaths were not meaningfully reduced by Medicaid Expansion.

**Exhibit H. Cancer Deaths per 100,000 Population from 2008-2019**

Year	Ages 19-64		Ages 65+	
	Group A (Non-Expansion) States	Group B (Expansion States with Large Newly Eligible Costs)	Group A (Non-Expansion) States	Group B (Expansion States with Large Newly Eligible Costs)
2008-2013 Average	98.1	92.1	972.8	1,013.2
2014-2019 Average	93.0	86.7	866.1	890.6
Percent Change, 2008-2013 vs. 2014-2019	-5.2%	-5.9%	-11.0%	-12.1%

Data Source Used: Centers for Disease Control and Prevention’s Provisional COVID-19 Death Counts database

**C. COVID Death Rate Comparisons**

We also assessed per capita (per 100,000 population) deaths attributable to COVID-19 among persons between ages 18 and 64. These tabulations are summarized in **Exhibit I**. Across Group B Expansion states, the death rate of 51.7 per 100,000 was 10.1% below the rate of 57.6 per 100,000 for Non-Expansion states as of May 1, 2021. These states collectively provide a large statistical sample of more than 94,000 COVID deaths in the 18-64 age group. The death rate differential suggests that Medicaid Expansion coverage could have been beneficial in averting COVID deaths in the Medicaid Expansion states.

**Exhibit I. COVID Deaths per 100,000 Population Among Population Ages 18-64 vs Ages 65+**

COVID Deaths per 100,000 Population Through May 1, 2021		
State Grouping	Ages 18-64	Ages 65+
Group A: 17 states that did not expand Medicaid	57.6	783.9
Group B: 27 states (plus District of Columbia) that expanded Medicaid and had large 2019 cost impact from newly eligible expansion enrollees	51.7	814.6
<b>Death Rate Difference, Group B - Group A</b>	-5.9	30.7
<b>Percentage Difference (Group B as Compared to Group A)</b>	-10.1%	3.9%

Data Sources: Centers for Disease Control and Prevention’s Underlying Cause of Death database

This potentially favorable impact of Medicaid Expansion is further indicated by COVID death rate comparisons in the 65+ population in each group of states -- an age group that could not have been impacted by Medicaid Expansion. The Group B Expansion states collectively experienced an average

death rate of 814.6 per 100,000 persons age 65+, 3.9% above the Group A states' collective rate of 783.9 deaths per 100,000.

In summary, the Group B Expansion states experienced a 3.9% higher COVID death rate in the 65+ population relative to the Group A Non-Expansion states, but a 10.1% lower COVID death rate in the 18-64 age cohort which includes essentially all Medicaid Expansion enrollees. It is logical to envision that Medicaid Expansion would make it easier (at minimum in terms of reducing financial barriers) for persons to obtain testing and to access treatment if infected.

Prior studies have also demonstrated a clear correlation between low socio-economic status and relatively high positive COVID infection rates.<sup>1</sup> This all suggests that providing Medicaid coverage (including the system of care advantages of these persons typically being enrolled in Medicaid managed care organizations) can be of significant value in reducing COVID hospitalizations and deaths among this population.

We are therefore inclined to conclude that Medicaid Expansion has favorably impacted (i.e., reduced) COVID deaths in the 19-64 age group.

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<sup>1</sup> “Socio-economic status and COVID-19-related cases and fatalities,” R.B. Hawkins, E.J. Charles, J.H. Mehaffey, Public Health, December 2020.

## VI. Employment and Unemployment Impact Assessments

This section analyzes unemployment and employment measures to assess whether the Medicaid Expansion appears to have served as a disincentive to work. Through examination of the unemployment rate, we find that the Medicaid Expansion may have had a small, but favorable, impact on reducing unemployment in states that opted into the Expansion. Additionally, by looking at the labor force participation rate and the employment-population ratio, we find that expanding Medicaid may have actually encouraged individuals to seek work and successfully secure employment in states that expanded Medicaid. *These findings are contrary to the popular sentiment that expanding Medicaid acts as a disincentive to work.*

### A. Comparison of Employment and Unemployment Trends

A parallel comparison of how unemployment and employment measures trended across the pre-Expansion period (2007-2013) compared to the post-Expansion period (2013-2019) in states that did and did not expand Medicaid is summarized in **Exhibit J**.

The official unemployment rate measures the percentage of the labor force that is unemployed, but actively seeking employment. Although both groups of states' unemployment rates trended upward during the 2007-2013 timeframe and downward during the 2013-2019 timeframe, Group B Expansion states collectively experienced more of a substantial downward turn in their unemployment rates than Group A Non-Expansion states. Group B Expansion states' collective unemployment rate trended worse in the pre-Expansion six-year period, increasing by 2.8 percentage points from 2007 to 2013, relative to Group A's rise of 2.5 percentage points. Subsequently, over the post-Expansion period, Group B's collective unemployment rate decreased by 3.8 percentage points from 2013 to 2019. In contrast, the Group A Non-Expansion states' collective unemployment rate decreased by 3.5 percentage points over the same period. This represents a 6.7 point downward change in how Group B's unemployment rates were trending over the two periods, whereas Group A's unemployment rates experienced a smaller drop of 6.0 percentage points. These findings clearly suggest that expanding Medicaid did not cause a worsening of the unemployment rate. This analysis indicates that Medicaid Expansion may have created a slight decrease (of less than one percentage point) in unemployment.

**Exhibit J. Unemployment Rate, Labor Force Participation Rate and Employment-Population Ratio Trends from 2007 – 2013 and from 2013 – 2019, by State Groupings Regarding Expansion**

State	Unemployment Rate			Labor Force Participation Rate			Employment - Population Ratio		
	Percentage Point Change 2007-2013	Percentage Point Change 2013-2019	Difference in Percentage Point Change from 2007-2013 to 2013-2019	Percentage Point Change 2007-2013	Percentage Point Change 2013-2019	Difference in Percentage Point Change from 2007-2013 to 2013-2019	Percentage Point Change 2007-2013	Percentage Point Change 2013-2019	Difference in Percentage Point Change from 2007-2013 to 2013-2019
USA Total (50 States + DC)	2.8	-3.7	-6.5	-2.8	-0.1	2.6	-4.4	2.2	6.6
Group A: Did not Expand Medicaid (17 states: AL, FL, GA, ID, KA, MI, MO, NE, NC, OK, SC, SD, TN, TX, UT, WI, WY)	2.5	-3.5	-6.0	-2.9	-0.6	2.3	-4.4	1.6	6.0
Group B: Expanded Medicaid and Newly Eligible costs 10+% of Total Medicaid Expenditures (27 states + DC)	2.8	-3.8	-6.7	-2.9	0.1	3.0	-4.6	2.5	7.1

Data Source Used: U.S. Bureau of Labor Statistics



Due to the potential volatility of the unemployment rate, we quantify trends in other employment measures to analyze the impacts of the Medicaid Expansion further. The labor force participation rate measures the percentage of the civilian noninstitutional population that is either working or actively looking for work. In the pre-Expansion period, the labor force participation rate experienced a comparable downward trend in both Expansion and Non-Expansion states. However, an examination of trends in the post-Expansion period shows that the labor force participation rate edged upward by 0.1 percentage point among Group B Expansion states from 2013-2019, while the corresponding figure among Group A Non-Expansion states fell by 0.6 percentage points. This suggests that expanding Medicaid did not discourage individuals from working or actively seeking employment. At minimum, this finding also refutes the common argument that expanding Medicaid has served as a disincentive to work.

The third prong of our employment analysis involves assessing trends in the employment-population ratio. This indicator measures the percentage of the civilian noninstitutional population that is currently working. It provides a valuable indicator of current labor market conditions. Analogous to the labor force participation rate, the employment-population ratio shows a similar downward trend in the pre-Expansion period among Expansion and Non-Expansion states. Then, over the post-Expansion period, the collective employment-population ratio across the Group B Expansion states increased by 2.5 percentage points, whereas that of Group A Non-Expansion states only increased by 1.6 percentage points. Again, this depicts a relatively favorable scenario for Expansion states, in which a larger increase in employment occurred among Group B Expansion states in the post-Expansion period than occurred across the Non-Expansion states.

It is worth noting that both the labor force participation rate and the employment-population ratio are chronically low in the US compared to most other developed nations. This represents a policy challenge nationwide going forward.

#### **B. Comparison of Average Employment and Unemployment Measures**

To protect against volatile changes in any single year that could be distorting the above findings, we also calculated average employment and unemployment measures *every year* from 2008 to 2013 (the pre-Expansion period) and compared those to the averages across *every year* in the 2014-2019 timeframe (the post-Expansion period) for both state groupings. The results of this analysis are summarized in **Exhibit K**. These findings are consistent with those from our employment trend analysis, in which the Medicaid Expansion appeared to have favorable impacts on employment measures in states that opted to expand the program.

The average unemployment rate in Group B Expansion states decreased by 3.6 percentage points in the post-Expansion period, a slightly greater drop than occurred across the Group A Non-Expansion states (3.4%). On the labor force participation front, while both groups of states experienced a decrease in the post-Expansion period, the Group A Non-Expansion states' decrease was slightly larger (1.9 percentage points) than the Group B Expansion states' experienced (1.6%). Finally, the employment-population ratio increased by 0.8 percentage points across the Group B Expansion states, relative to a smaller 0.4 percentage point increase across the Group A Non-Expansion states. While these differences are small, they all point in the same direction.

**Exhibit K. Average Unemployment Rate, Labor Force Participation Rate and Employment-Population Ratio in 2008 – 2013 versus 2014 – 2019, by State Groupings Regarding Expansion**

State	Unemployment Rate			Labor Force Participation Rate			Employment - Population Ratio		
	Average 2008-2013	Average 2014-2019	Percentage Point Change from 2008-2013 to 2014-2019	Average 2008-2013	Average 2014-2019	Percentage Point Change from 2008-2013 to 2014-2019	Average 2008-2013	Average 2014-2019	Percentage Point Change from 2008-2013 to 2014-2019
USA Total (50 States + DC)	8.2%	4.7%	-3.5	64.5%	62.9%	-1.7	59.2%	59.9%	0.7
Group A: Did not Expand Medicaid (17 states: AL, FL, GA, ID, KA, MI, MO, NE, NC, OK, SC, SD, TN, TX, UT, WI, WY)	7.9%	4.5%	-3.4	64.1%	62.2%	-1.9	59.1%	59.5%	0.4
Group B: Expanded Medicaid and Newly Eligible costs 10+% of Total Medicaid Expenditures (27 states + DC)	8.5%	4.9%	-3.6	65.1%	63.5%	-1.6	59.5%	60.4%	0.8

*Data Source Used: U.S. Bureau of Labor Statistics*

This analysis complements our previous findings that the Medicaid Expansion does not appear to serve as a disincentive to work. Rather, the data may indicate that expanding Medicaid does the opposite and has led to a modest increase in employment. While the impacts of improved employment related to the adoption of Medicaid Expansion are not large on a percentage basis, *they were confirmed six times in the six prongs of our analyses.*

## VII. Hospital Impact Estimates

A considerable proportion of Medicaid Expansion expenditures go to hospitals. We crudely estimate that one-third of Medicaid Expansion funds are captured by hospitals across the inpatient and outpatient services rendered. Working with this figure, we estimate that Medicaid Expansion resulted in a \$20.8 billion increase in Medicaid claims payments to hospitals during FFY2019, as derived in Exhibit L.

**Exhibit L. Hospitals' Estimated Revenue Gain from Medicaid Expansion, FFY2019**

	FFY2019 Amount
Medicaid Expenditures for Newly Eligible Persons	\$79,999,092,234
Percentage of Newly Eligible Persons who Would Otherwise Be Uninsured	78.0%
Net Provider Revenue for Newly Eligible Persons	\$62,399,291,943
Estimated Hospital Share of Provider Revenue	33.33%
Estimated Increased Revenue to Hospitals Due to Medicaid Expansion	\$20,799,555,983

We also assessed the degree to which Medicaid disproportionate share payments to hospitals (DSH) have been affected by Medicaid Expansion. DSH payments to hospitals are reported by each state and captured in the annual CMS Financial Management Reports (FMRs). Our tabulations using these FMRs for FFY2013 and FFY2019 are presented in Exhibit M. These tabulations compared collective Medicaid DSH payments between Expansion and Non-Expansion states, between 2013 and 2019.

**Exhibit M. Comparison of Medicaid DSH Payments to Hospitals, FFY2013 and FFY2019**

	Federal	State	Total
<b>Medicaid Disproportionate Share Payments, FFY2013</b>			
Expansion States (33 states plus DC)	\$6,796,663,937	\$5,823,026,015	\$12,619,689,952
Non-Expansion States (17 states)	\$2,437,189,237	\$1,320,380,755	\$3,757,569,992
<b>Total</b>	<b>\$9,233,853,174</b>	<b>\$7,143,406,770</b>	<b>\$16,377,259,944</b>
<b>Medicaid Disproportionate Share Payments, FFY2019</b>			
Expansion States (33 states plus DC)	\$6,688,137,145	\$5,384,939,196	\$12,073,076,341
Non-Expansion States (17 states)	\$3,636,179,981	\$2,024,727,215	\$5,660,907,196
<b>Total</b>	<b>\$10,324,317,126</b>	<b>\$7,409,666,411</b>	<b>\$17,733,983,537</b>
<b>Percent Change in Medicaid Disproportionate Share Payments, FFY2013 - FFY2019</b>			
Expansion States (33 states plus DC)	-1.6%	-7.5%	-4.3%
Non-Expansion States (17 states)	49.2%	53.3%	50.7%
<b>Total</b>	<b>11.8%</b>	<b>3.7%</b>	<b>8.3%</b>

The figures in Exhibit M show that Medicaid DSH payments in Expansion states decreased by 4.3% from 2013 to 2019, whereas the DSH payments increased by 50.7% across the Non-Expansion states during this timeframe. This represents a substantial reduction in Medicaid DSH payments in the Expansion states. This was expected since a main purpose of DSH is to help hospitals offset lost revenues when they treat uninsured patients, and the Expansion greatly reduces the number of uninsured. If the Expansion states had experienced the same increase in Medicaid DSH payments as occurred in the Non-Expansion states (50.7% from 2013-2019), an additional \$6.9 billion in DSH payments would have accrued to hospitals in the Expansion states during FFY2019.

Deducting these DSH reductions of \$6.9 billion from the earlier estimate that hospitals' collective Medicaid claims revenue in the Expansion states increased by \$20.8 billion during FFY2019 (attributable to Medicaid Expansion), we estimate that adoption of Medicaid Expansion collectively increased hospitals' revenues in FFY2019 by \$13.9 billion across the Expansion states.

## VIII. Personal Bankruptcy Analysis

This section analyzes how trends in personal bankruptcies differed across Expansion and Non-Expansion states to determine whether the Medicaid Expansion reduced financial hardship. Our assessments, shown in Exhibits N and O, both suggest that Medicaid Expansion has lowered the degree to which personal bankruptcies are occurring. Exhibit N demonstrates that while the number of personal bankruptcies decreased considerably in the 2013-2019 period from the 2007-2013 period across the nation, this decrease was several percentage points larger across the Group B states (31.3%) which adopted Medicaid Expansion than across the Group A Non-Expansion states (23.8%).

**Exhibit N. Personal Bankruptcy Trends from 2007 – 2013 and from 2013 – 2019, by State Groupings Regarding Expansion**

Personal Bankruptcies (Chapter 7 + Chapter 13)	
State Grouping	% Change in Personal Bankruptcies 2013-2019
USA Total (50 States + DC)	-27.7%
Group A: Did not Expand Medicaid (17 states - AL, FL, GA, ID, KS, MI, MO, NE, NC, OK, SC, SD, TN, TX, UT, WI, WY)	-23.8%
Group B: Expanded Medicaid and Newly Eligible costs 10+% of Total Medicaid Expenditures (27 states + DC)	-31.3%

Data Source Drawn Upon: <https://www.abi.org/newsroom/bankruptcy-statistics>

Exhibit O conveys a similar analysis, grouping the total number of personal bankruptcies across the 2008-2016 timeframe and comparing this volume with the 2014-2019 period. This assessment is perhaps stronger than the Exhibit N analysis, in that it diminishes the importance of the number of bankruptcies occurring within any specific year (e.g., 2013 or 2019) by bundling together six-year timeframes. The findings in Exhibit O confirm those in Exhibit N – the rate of bankruptcies declined more sharply in the Group B Expansion states (by 41.6%) between the two six-year periods than occurred across the Group A Non-Expansion states (31.0%).

**Exhibit O. Total Personal Bankruptcies in 2008 – 2013 versus 2014 – 2019, by State Groupings Regarding Expansion**

State	Personal (Chapter 7 + Chapter 13) Bankruptcies		
	Number of Personal Bankruptcies 2007-2013	Number of Personal Bankruptcies 2013-2019	Percent Change from 2008-2013 to 2014-2019
USA Total (50 States + DC)	7,748,191	4,811,368	-37.9%
Group A: Did not Expand Medicaid (17 states - AL, FL, GA, ID, KA, MI, MO, NE, NC, OK, SC, SD, TN, TX, UT, WI, WY)	2,614,890	1,804,397	-31.0%
Group B: Expanded Medicaid and Newly Eligible costs 10+% of Total Medicaid Expenditures (27 states + DC)	4,514,255	2,636,955	-41.6%

Data Source Drawn Upon: <https://www.abi.org/newsroom/bankruptcy-statistics>

## IX. Cost Impacts of Remaining Non-Expansion States Adopting Expansion

### A. Introduction

The experiences of the states that have not yet adopted Medicaid Expansion have been tracked in many ways throughout this paper. The 17 states that had not implemented Medicaid Expansion as of FFY2019 are depicted as “Group A” in the previous analyses and exhibits. Four of these states have implemented Medicaid Expansion since FFY2019 -- Idaho, Missouri, Oklahoma, and Utah. This chapter estimates the fiscal impacts in the remaining 13 Non-Expansion states if they were to adopt Medicaid Expansion. Our analyses focus on two types of impacts. First, we estimate the net cost (or savings) in state government funds that would occur under Medicaid Expansion. Second, we estimate the net gain/loss the state’s residents as a whole are currently experiencing and how this would change under Medicaid Expansion.

*A key dynamic related to these broader impacts is that the residents of the Non-Expansion states are contributing (through their Federal tax payments) to the costs of the states that have adopted Medicaid Expansion. Collectively, we estimate that the residents of the remaining 13 Non-Expansion states contributed \$32 billion towards the FFY2019 cost of Medicaid Expansion in those states that did expand Medicaid.*

We find that each of the 13 states would experience a net cost in state government funds if they expanded Medicaid. However, our modeling has not factored in our own finding in Section IV that the states that have adopted Medicaid Expansion appear to have *experienced a net savings* in state Medicaid expenditures across 2013-2019 relative to the Non-Expansion states. Therefore, it may well be fiscally advantageous from a state government budget perspective to adopt Medicaid Expansion. More importantly, perhaps, we estimate a large-scale collective financial benefit will occur for the residents *in all 13 Non-Expansion states* if they were to adopt Medicaid Expansion.

Baseline data on the 13 Non-Expansion states is presented in Exhibit P. Collectively, these states pay approximately 26% of all Federal taxes.

Multiplying each state’s share of national Federal tax payments by the nationwide FFY2019 Federal government cost of Medicaid Expansion (approximately \$107 billion) yields the estimated contributions each state’s residents are paying for the Medicaid Expansion programs currently in operation in all other states that have adopted Expansion. This figure totals \$28.6 billion for FFY2019 in all states but is large in each state – ranging from a low of \$145 million in Wyoming to a high of \$8.9 billion in Texas.

These Federal taxes and costs are going to continue to occur whether or not a state adopts Medicaid Expansion. However, residents of the Non-Expansion states find themselves in the adverse position of making considerable Federal tax payments for Medicaid Expansion, but receiving no Medicaid Expansion Federal funds and coverage in return. This is somewhat akin to a state electing not to allow any of its residents to receive Social Security payments, while all its residents continue to pay Social Security taxes. *Medicaid Expansion has to date caused a large-scale redistribution (of approximately \$30 billion annually) in tax revenues from Non-Expansion states to the Expansion states.* This redistribution has been more or less imposed on the residents of these 13 non-expansion states by virtue of their state policymakers not adopting Medicaid Expansion.

**Exhibit P. Non-Expansion State Residents' FFY2019 Payments for Medicaid Expansion**

State	State's Share of National IRS Gross Tax Collections, 2019	State Residents' Costs for Other States' Expansion Programs
Alabama	0.74%	\$808,768,375
Florida	5.89%	\$6,407,186,478
Georgia	2.65%	\$2,876,976,139
Kansas	0.74%	\$803,487,027
Mississippi	0.32%	\$343,910,022
Nebraska	0.72%	\$779,483,343
North Carolina	2.46%	\$2,677,834,388
South Carolina	0.78%	\$850,685,292
South Dakota	0.23%	\$244,950,672
Tennessee	1.96%	\$2,128,442,404
Texas	8.20%	\$8,918,076,302
Wisconsin	1.48%	\$1,612,974,387
Wyoming	0.13%	\$144,724,464
<b>Subtotal, Non-Expansion States</b>	<b>26.30%</b>	<b>\$28,597,499,292</b>

Note: The right-hand column figures will be higher from 2021 forward than in 2019 due to additional states (e.g., Idaho, Missouri, Oklahoma, and Utah) implementing Medicaid expansion.

**B. State Government Impacts of Adopting Medicaid Expansion**

Each state government's fiscal impacts of adopting Medicaid Expansion are derived in Exhibit Q. These figures convey baseline FFY2019 Medicaid costs and then the estimated costs of adopting Medicaid Expansion. Specific derivations are described below:

- The column titled "Total Annual Cost of Medicaid Expansion (in FFY2019 dollars) is derived by multiplying expected Medicaid Expansion enrollment from Exhibit A by a per enrollee cost of \$8,611. This \$8,611 figure represents the average FFY2019 medical cost for Medicaid Expansion enrollees of \$8,201 (derived from our prior tabulations), and an estimated 5% add-on (\$410 per enrollee) for administrative costs.
- The Federal share of the Expansion cost is estimated to be 90% of the medical cost plus 50% of the administrative cost. The remaining state share is estimated to average 13.5% of overall costs for the Expansion population – prior to factoring in the enhanced Federal match that will be provided for the first two years as stipulated in the American Rescue Plan Act enacted in

March 2021. This involves an increase in the federal matching rate of 5 percentage points for the first two years.

- The benefit of this increased Federal match is quantified in the Exhibit Q column titled “Annual State Share Savings From 5% Increase in Federal Match Rate on Base Medicaid Expenditures.” These figures are derived by multiplying total FFY2019 Medicaid expenditures by 0.05.
- The annual impacts of Medicaid Expansion for each state government entity are derived in the last two columns of Exhibit Q. Impacts during the first two years show the state share of Medicaid Expansion costs, less the savings from the five-percentage point enhanced Federal match. Annual impacts for Year 3 and beyond remove the savings from the enhanced Federal match (which would no longer apply).

**Exhibit Q. Derivation of State Government Impacts of Adopting Medicaid Expansion**

State	FFY2019 Medicaid Expenditures	BENEFIT: Total Annual Cost of Medicaid Expansion (in FFY2019 dollars)	COST: State Share Of Medicaid Expansion Cost (if expansion were adopted)	BENEFIT: Annual State Share Savings From 5% Increase in Federal Match Rate on Base Medicaid Expenditures	State Government Fund Cost (negative figure depicts a savings)		State Residents' Collective Net Benefit From Medicaid Expansion	
					Annual Impact, First Two Years	Annual Impact, Year 3 and Beyond	Annual Impact, First Two Years	Annual Impact, Year 3 and Beyond
Alabama	\$5,880,233,770	\$2,789,950,402	\$332,136,953	\$294,011,689	\$38,125,264	\$332,136,953	\$2,751,825,138	\$2,457,813,450
Florida	\$24,384,268,451	\$11,297,576,937	\$1,344,949,635	\$1,219,213,423	\$125,736,213	\$1,344,949,635	\$11,171,840,724	\$9,952,627,302
Georgia	\$10,851,623,393	\$5,562,678,888	\$662,223,677	\$542,581,170	\$119,642,508	\$662,223,677	\$5,443,036,381	\$4,900,455,211
Kansas	\$3,601,873,235	\$1,196,923,166	\$142,490,853	\$180,093,662	-\$37,602,809	\$142,490,853	\$1,234,525,975	\$1,054,432,313
Mississippi	\$5,506,770,865	\$1,782,468,312	\$212,198,609	\$275,338,543	-\$63,139,935	\$212,198,609	\$1,845,608,247	\$1,570,269,704
Nebraska	\$2,141,794,131	\$783,597,181	\$93,285,379	\$107,089,707	-\$13,804,328	\$797,401,509	\$690,311,802	\$93,285,379
North Carolina	\$13,595,881,059	\$5,089,076,196	\$605,842,404	\$679,794,053	-\$73,951,649	\$605,842,404	\$5,163,027,845	\$4,483,233,792
South Carolina	\$6,305,731,666	\$2,833,005,192	\$337,262,523	\$315,286,583	\$21,975,940	\$337,262,523	\$2,811,029,253	\$2,495,742,669
South Dakota	\$899,072,690	\$370,271,195	\$44,079,904	\$44,953,635	-\$873,730	\$44,079,904	\$371,144,926	\$326,191,291
Tennessee	\$10,091,876,637	\$2,781,339,444	\$331,111,839	\$504,593,832	-\$173,481,993	\$331,111,839	\$2,954,821,437	\$2,450,227,606
Texas	\$40,025,676,488	\$14,337,245,122	\$1,706,814,895	\$2,001,283,824	-\$294,468,929	\$1,706,814,895	\$14,631,714,051	\$12,630,430,227
Wisconsin	\$9,132,546,898	\$1,033,314,964	\$123,013,686	\$456,627,345	-\$333,613,659	\$123,013,686	\$1,366,928,622	\$910,301,278
Wyoming	\$584,259,094	\$275,550,657	\$32,803,650	\$29,212,955	\$3,590,695	\$32,803,650	\$271,959,962	\$242,747,007
<b>Subtotal, Non-Expansion States</b>	<b>\$133,001,608,377</b>	<b>\$50,132,997,658</b>	<b>\$5,968,214,007</b>	<b>\$6,650,080,419</b>	<b>(\$681,866,412)</b>	<b>\$5,968,214,007</b>	<b>\$50,707,774,364</b>	<b>\$43,567,757,228</b>

The tabulations in Exhibit Q indicate that 8 of the 13 Non-Expansion states will realize a state government savings during the first two years of implementation, spurred by the Federal match increase during these years. In Year 3 and beyond, all 13 states would experience an increase in state government expenditures due to adopting Medicaid Expansion. These additional annual state government costs range from a low of \$33 million in Wyoming to a high of \$1.7 billion in Texas.

These estimates do not take into account the findings from Section IV of this report, that state funded Medicaid costs appear to have *decreased* as a result of their adopting Medicaid Expansion. Taking those findings into consideration, it is likely that most of the 13 states will realize an ongoing net state government savings from adopting Medicaid Expansion.

In addition, these estimates do not take into account the likely substantial savings that will offset a good portion of states' new outlays under the Medicaid Expansion. In the Non-Expansion states, residents with incomes *above* the Medicaid eligibility level (which in these Non-Expansion states are frequently



below half of the federal poverty line (FPL) and *below* the poverty line have too much income for Medicaid eligibility but not enough income (incomes must be above the FPL) to be eligible for the ACA Marketplace premium and cost sharing subsidies. These people are in the ACA Coverage Gap. Major categories of savings include state outlays for people in the Coverage Gap for mental health and substance abuse disorder treatment and for the incarcerated population. Many such services are paid for with state-only dollars in the absence of the Medicaid Expansion but will receive a 90/10 federal match once the state adopts the Expansion.

In addition, pregnant women living in poverty are eligible for Medicaid even when their incomes exceed the states' eligibility thresholds. For this population, the state is getting the standard Federal Medical Assistance Percentage (FMAP). This is well below the 90 percent federal matching level under the Expansion, and states that newly adopt the Expansion can roll this population into the higher match category (and the mother will be eligible after her baby is born, also at the higher match). Further, many non-elderly adults who qualify for Medicare and SSI and are in the Medicaid "spend-down window" will not end up becoming "dual eligible" by entering Medicaid through this path. Instead, they will be eligible as non-elderly adults under the Expansion, with the higher federal match, and this, too, will generate substantial state savings.

Note that the estimates in Exhibit Q, in using a FFY2019 baseline, do not take into account the increased Medicaid enrollment that has occurred due to the COVID pandemic. This is intentional, as our future modeling presumes that post-pandemic Medicaid enrollment dynamics will gravitate back to pre-COVID levels.

### **C. State Residents' Impacts of Adopting Medicaid Expansion**

State residents' impacts from Medicaid Expansion are also estimated in Exhibit Q and include the following benefits and costs.

- The overall additional cost of implementing Medicaid Expansion in a state's Medicaid program is categorized as an economic benefit to the state (as this figure predominantly represents revenue to medical providers and health plans operating in the state). This will have a "multiplier effect" as those who receive additional revenue will spend a good part of it (e.g. as hospitals and medical groups need more staff, more supplies and equipment, etc.) This should increase state sales tax revenue and income tax revenue for those states that have an income tax.
- The state government's cost of implementing Medicaid Expansion is subtracted from the above figure to yield the net benefit to the state residents of their state implementing Expansion.
- During the first two years of Medicaid Expansion, the increased federal match on baseline Medicaid costs represents a further savings to the residents of each state newly adopting Medicaid Expansion. This advantage, however, does not occur beyond year two.
- As noted earlier, every state's residents contribute to the Medicaid Expansion costs in all the Expansion states (through their Federal tax contributions). However, these costs will continue to occur whether or not the 13 remaining states adopt Expansion, and these costs are not

factored into our assessment of the marginal cost of implementing Expansion. The residents of each Non-Expansion state will face additional Federal tax costs depending on the degree to which the other 13 Non-Expansion states adopt Expansion. For example, if all states adopted Medicaid Expansion, the residents of the 13 current Non-Expansion states would experience approximately a 38% increase in their Medicaid Expansion related Federal tax outlays. However, these increased Federal costs will be based on other states' decisions and should not factor into any given state's policymaking regarding its own economic impacts.

The tabulations in Exhibit Q indicate that the residents of all 13 of the Non-Expansion states would collectively be considerably better off financially if Medicaid Expansion were adopted. Across the 13 states, the net annual benefit is estimated to be \$51 billion in Years 1 and 2 of Expansion and \$44 billion from Year 3 forward. The size of the gain from state to state varies primarily by each state's size. Among the 13 states, the smallest financial gain would occur for the residents of Wyoming -- \$272 million during each of the first two years and \$243 million per year thereafter. *The largest gain would occur in Texas -- \$14.6 billion during each of the first two years and \$12.6 billion per year from Year 3 forward.*

Across the 13 states in Years 3 and beyond, we estimate annual state fund costs would increase by approximately \$6 billion. The broader economic gain from implementing Medicaid Expansion across these 13 states is estimated at \$44 billion – approximately *seven times* the state fund cost.

## X. Summary of Key Findings

Medicaid Expansion is now well into its eighth year of implementation in many states. With many states having adopted Medicaid Expansion and experienced a considerable enrollment influx into their Medicaid program, and several other states not adopting Medicaid Expansion, it is now possible to compare these groups of states on many key measures to assess the impacts Medicaid Expansion has had. We have conducted several such comparisons throughout the previous sections of the report.

Our key findings are summarized in Exhibit R. Medicaid expansion has been highly beneficial financially to both the state governments adopting expansion and to the residents of these states. *It appears to be strongly in the fiscal interests of the remaining 13 Non-Expansion states to implement Medicaid Expansion.*

**Exhibit R. Summary of Findings**

Measurement	Group A: States that Had Not Implemented Medicaid Expansion as of FFY2019 (17 states)	Group B: Medicaid Expansion states where newly eligible members represented at least 10% of total FFY2019 Medicaid expenditures (27 States plus DC)	Comments
Percent change in age 19-64 uninsured population, FFY2013 – FFY2019	21% Decrease	47% Decrease	Across these two findings, we estimate that of the approximately 12 million persons enrolled in Medicaid during FFY2019 due to Medicaid Expansion, <b>over 9 million would otherwise be uninsured.</b> 2-3 million would have employer-sponsored coverage if Medicaid Expansion had not been implemented.
Percent change in age 19-64 employer-based insured population, FFY2013-FFY2019	12% Increase	5% Increase	
Nationwide average cost per working age adult for Medicaid Expansion			Medicaid Expansion costs totaled \$123 billion in FFY2019, 21% of all Medicaid expenditures. \$80 billion of these costs were for persons made eligible due to their state participating in Medicaid Expansion (with the other \$42 billion representing adults covered by a state's Medicaid program anyway before 2014). <b>The \$80 billion represents a cost of \$418 per 19-64 age US resident.</b>
Percentage increase in State Fund Medicaid Expenditures, FFY2013 – FFY2019	26.4%	19.5%	States expanding Medicaid experienced a lower rate of increase in State Fund costs than occurred in Non-Expansion states. <b>This suggests Expansion has turned out to be “better than free” to the Expansion states.</b>
COVID Deaths per 100k Population Through May 1, 2021	57.6 (age 18-64) 783.9 (age 65+)	51.7 (age 18-64) 814.6 (age 65+)	These figures suggest Medicaid Expansion played a role in averting COVID deaths in the Expansion states.

Measurement	Group A: States that Had Not Implemented Medicaid Expansion as of FFY2019 (17 states)	Group B: Medicaid Expansion states where newly eligible members represented at least 10% of total FFY2019 Medicaid expenditures (27 States plus DC)	Comments
			The Group B states had a 4% higher COVID death rate in the 65+ age group relative to Group A (which Medicaid Expansion could not have affected), but a 10% lower COVID death rate in the 18-64 age group.
Additional Death Rate Analyses			We did not find evidence that Medicaid Expansion lowered overall death rates nor cancer death rates.
Unemployment Rate, Percentage Point Change: 2008-2013 versus 2014-2019	-3.4	-3.8	In all the employment analyses, the Expansion states collectively trended more favorably than the Non-Expansion states from 2014-2019. These differentials were small in size but consistent in direction. The findings suggest at a minimum that adopting Medicaid Expansion has not created a loss of employment, and that a modest employment increase may well be attributable to the adoption of Medicaid Expansion.
Labor Force Participation Rate, Percentage Point Change: 2008-2013 versus 2014-2019	-1.9	-1.6	
Employment-to-Population Ratio, Percentage Point Change: 2008-2013 versus 2014-2019	0.4	0.8	
% Change in Personal Bankruptcies, Comparing Total from 2008-2013 with 2014-2019 Timeframe	-31.0%	-41.6%	While personal bankruptcies have decreased considerably in both groups of states across the past several years, this finding suggests Medicaid Expansion may have helped further reduce the volume of personal bankruptcy filings.
Percent Change in Medicaid Disproportionate Share Payments to Hospitals, FFY2013 versus FFY2019	+50.7%	-4.3%	We estimate that disproportionate share payments were \$7 billion lower across the Expansion states versus if they had not expanded. Even after factoring in these reductions, we estimate that hospitals in the Expansion states collectively realized a \$14 billion revenue increase due to Medicaid Expansion during FFY2019.