Medicaid Expansion Studies: Why Do Net Cost Estimates Differ So Much?

The Hilltop Institute

Morgan Henderson, PhD
mhenderson@hilltop.umbc.edu
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About the Project

States contemplating Medicaid expansion typically conduct studies gauging the projected future impact of expansion on fiscal costs, revenues, and overall net costs. Results from these studies are typically used by policymakers to justify whether or not to support Medicaid expansion.

Mississippi is currently 1 of 12 states that have not expanded its Medicaid program. Three recent studies estimating the effects of a hypothetical Mississippi Medicaid expansion used different methodologies and, as a result, reached different estimates regarding the annual net costs.[1, 2, 3]

We compare these studies in order to better understand (a) what drives differences in Medicaid expansion studies and (b) how future researchers can move toward a more universal methodology for expansion studies in the remaining non-expansion states.

Background and Methodology

Medicaid expansion studies typically quantify the cost of expansion as the product of enrollment estimates and per-participant annual costs, and then:

- **Deduct cost offsets**
  - Within-Medicaid savings as individuals shift from other eligibility groups to the expansion group with its 90% Federal Medical Assistance Percentage (FMAP)
    - Pregnant women
    - Disabled individuals
  - Other state savings as unmatched state expenditure is replaced with matched Medicaid expenditure
    - Mental health and substance use disorders (SUD)
    - Corrections
- **Add additional revenues**
  - Taxes from general economic stimulus
  - Direct taxes (premium or provider taxes)

For each of the three studies in our sample, we selected data from the third year of expansion; where unavailable, we used the average annual value across all study years.

Results

Table 1. Mississippi Medicaid Expansion Study Results

	Study 1	Study 2	Study 3
Enrollment	230,527	217,969	229,000
State Gross Cost ($MM)	$194	$190	$191**
Cost offsets* ($MM)	$215	$92	$84
Additional revenue ($MM)	$40	$95	n/a
Implied Net Cost ($MM)	**-$61**	**$3**	**$107**

* Not including American Rescue Plan (ARP) supplemental FMAP.
** Study 3 includes a ramp-up year, in which the state's gross cost is estimated at $106 million.

Table 2. Detailed Cost Offsets and Revenue Gains ($MM)

	Study 1	Study 2	Study 3
Reduction in spending on pregnant women	$8	$4	$32
Reduction in spending on disabled individuals	$15	$2	$32
Reduction in spending on other Medicaid programs	$8	$7	$2
Reduction in state spending on mental health and SUD	$9	$9	n/a
Reduction in spending on corrections	$8	$9	$18
Reduction in hospital uncompensated care	$167	$61*	n/a
Additional tax revenue due to economic spillovers	$40**	$55	n/a
Additional tax revenue due to premium taxes	n/a	$40	n/a

* Publicly owned hospitals only. ** 2012 dollars.

Takeaway 1: Many states implement expansion via managed care.

To date, **38** states and D.C. have expanded Medicaid.

- **29** have at least 50% of the total Medicaid population in managed care organizations (MCOs).[4]
  - **28** of these have data on MCO enrollment by eligibility group since expansion.[5]
    - **25** of these have at least **80%** of expansion population in managed care
    - Median state (and D.C.) has **94.7%** of expansion population in managed care

Takeaway 2: Premium taxes can be a source of savings.

Medicaid MCOs are typically subject to *premium taxes*.

Premium taxes are included in MCO capitation rates, so the federal government pays a share of state premium tax.[6]

Example: for $100 of additional *federal* premium spending in state *s* with premium tax rate *p*, the state will retain (*p*/100)*$100 in premium tax revenue.

Arkansas estimated that its premium tax led to $27 million in savings in 2021 due to Medicaid expansion.[7]

Table 3. Insurer Premium Tax by State, 2021

State	Premium Tax Rate[8]
AL	1.6%
FL	1.75%
GA	2.25%
KS	2%
MS	**3%**
NC	1.9%
SC	1.25%
SD	2.5%
TN	2.5%
TX	1.75%
WI	-
WY	0.75%

Takeaway 3: Who benefits from reductions in uncompensated care?

Studies have documented 28% - 33% reductions in hospital uncompensated care due to Medicaid expansion.[9,10]

Given the magnitude of uncompensated care in non-expansion states, this is potentially significant in terms of cost savings.

Uncompensated care savings for **publicly owned hospitals** is likely most appropriate as a cost offset.

Table 4. Hospital Uncompensated Care (2019) and % Public Ownership (2020)

State	Uncompensated Care 2019 ($ MM)[11]	% Public Ownership 2020[12]
AL	$773.8	34.7
FL	$4,067.9	9.8
GA	$2,470.9	22.9
KS	$425.1	42.2
MS	**$605.6**	**41.2**
NC	$1,814	25.0
SC	$824.5	27.4
SD	$141.7	7.0
TN	$1,102.2	18.0
TX	$6,937.2	18.9
WI	$449.3	0.8
WY	$101.8	64.3

Takeaway 4: Tax revenue due to economic stimulus is a significant source of additional revenue.

Medicaid expansion entails significant inflow of federal dollars into a state that would not have otherwise occurred, which generates additional economic activity (spillover). This, in turn, is subject to **state and local taxes**.

Shown to be a significant source of additional tax revenue in Michigan.[13]

Study 1 uses REMI; Study 2 uses IMPLAN.

Table 5. Effective Total State and Local Tax Rates 2022[14]

State	Rate	State	Rate
AL	9.8%	SC	8.9%
FL	9.1%	SD	8.4%
GA	8.9%	TN	7.6%
KS	11.2%	TX	8.6%
MS	**9.8%**	WI	10.9%
NC	9.9%	WY	7.5%

Caveats

A large literature has documented additional benefits of Medicaid expansion that we do not attempt to quantify.

Implementation of these cost offsets and sources of additional revenue requires additional modeling; for example, netting out foregone Advanced Premium Tax Credits in the calculation of additional federal expenditure in the state (in order to calculate the tax revenue from economic spillovers due to expansion).

Because every state's Medicaid program and non-Medicaid service offering is unique, it's crucial to incorporate this information in models of the costs, cost offsets, and additional revenue stemming from expansion.

Conclusion

Three recent studies of the effects of a hypothetical Medicaid expansion in Mississippi arrive at different estimates of annual net costs, with a range of $61 million in net *savings* to $107 million in net *costs* (without accounting for ARP Act supplemental payments). Differences are driven by the inclusion of uncompensated hospital care as a cost offset; additional premium tax revenue as a source of revenue; and additional indirect tax revenue due to the increased economic activity resulting from expansion.

Acknowledgments and References

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