Medicaid Expansion in Nebraska under the Affordable Care Act

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SUMMARY

- The estimated number of new Medicaid enrollees in Nebraska under the Affordable Care Act expansion through 2020 ranges from 90,021 to 108,025.
- The estimated cost of Medicaid expansion for the State of Nebraska ranges from $140 million to $168 million.
- The estimated revenue from the federal government coming to the State of Nebraska from the Medicaid expansion ranges from $2.9 billion to $3.5 billion through 2020.
- Without the Medicaid expansion, more than $1 billion in uncompensated care through 2019 would be incurred in Nebraska. With the Medicaid expansion, health care providers would save at least $163 million and as much as $325 million from costs associated with uncompensated care.
- Spending by the federal government on Medicaid expansion would generate at least $700 million in new economic activity every year in Nebraska, which could finance over 10,000 jobs each year through 2020.

Background

On June 28, 2012, the Supreme Court upheld the Affordable Care Act (ACA) but ruled that the ACA provision expanding the Medicaid program for individuals from 100% of the federal poverty level (FPL) to 133% of the FPL is optional, rather than required, of state governments. This decision allows each state to make a decision about the costs and benefits of expanding the Medicaid program.[1] The ACA provides federal tax credits and subsidies for persons to purchase insurance in health insurance exchanges, but these benefits are not available for most people who would be eligible for the Medicaid expansion. States that decide not to expand Medicaid eligibility will face a coverage gap or “doughnut hole” of insurance coverage options for the poor and uninsured. This report provides data for policymakers to consider while deciding whether the State of Nebraska will participate in the ACA’s expanded Medicaid program.

New Medicaid Enrollees under Expansion

Changes in Medicaid eligibility under the ACA will primarily impact adults (age 19-64) without children, who are currently not eligible for Medicaid. Under expansion, nonelderly persons with household income less than 133% FPL will be eligible for Medicaid. The law regarding eligibility disregards 5% of income, thereby increasing FPL eligibility to 138% from 133%. Recent immigrants (5 years or less) and those who are undocumented do not qualify for Medicaid. Based on the new eligibility requirements, Exhibit 1 summarizes 3 estimates of the total number of new enrollees expected under Medicaid expansion, and the following paragraphs discuss the differences in the methods used to calculate the estimates.

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Exhibit 1. Estimated number of new enrollees in Medicaid under ACA expansion in Nebraska

	Low Range	High Range
Center for Health Policy (2014-2020)	90,021	108,025
Urban Institute (2014-2019)	83,898	110,820
Milliman (2014-2020)	107,903	145,297

The UNMC Center for Health Policy estimates (2014-2020) are based on population data from the 2010 American Community Survey for adults (age 19-64 years), after discounting persons with income greater than 138% FPL and recent immigrants. The American Community Survey data is more recent than data used by the Urban Institute and by Milliman. The Center for Health Policy estimates factor in population growth and unemployment based on US Census Bureau projections and on the potential for 15% of persons below 139% FPL with private insurance to switch to Medicaid. The low range in Exhibit 1 assumes a 75% participation rate in Medicaid among the newly eligible, and the high range assumes 90% participation. Currently, the participation rate for Medicaid in Nebraska is approximately 57%, and public programs never have 100% participation. However, it is reasonable to expect that the Medicaid participation rate will be higher than historical averages starting in 2014 in part because of the individual mandate for insurance coverage and also because of a more efficient enrollment system under a state or federally run health insurance exchange.

The Urban Institute estimates (2014-2019) are based on Current Population Survey data, and use a sophisticated analytical technology called the Health Insurance Policy Simulation Model. These estimates of the adult population (age 19-64 years) discount recent immigrants and persons with income greater than 138% FPL. In addition, adjustments were made for census projections of population growth and the impact of unemployment on insurance coverage. The range of participation is assumed to be between 57% and 75%.[2]

The Milliman estimates (2014-2020) are based on Current Population Survey data, and discount persons with income greater than 138% FPL and persons 65 years of age and older; it is not clear whether the estimates discount recent immigrants. It is also not clear whether the estimates are adjusted for census projections of population growth or unemployment. Unlike the Center for Health Policy and the Urban Institute, Milliman includes children in the calculation. The low range assumes a participation rate for uninsured adults of 80%. The high range assumes a consistent 100% participation rate.[3]

State Cost and Federal Revenue from Medicaid Expansion

Based on the projected number of new enrollees, it is possible to generate estimates for the cost of Medicaid expansion and revenue received by the State of Nebraska from the federal government (Exhibit 2). The current Federal Medical Assistance Percentage (FMAP) for the nonexpansion Medicaid population is 57%. The ACA instituted the following FMAP for the Medicaid expansion population: 2014-16 = 100%, 2017 = 95%, 2018 = 94%, 2019 = 93%, and 2020+ = 90%.

Exhibit 2. Estimated monthly cost and revenue of Medicaid expansion per adult enrollee

	2014	2015	2016	2017	2018	2019	2020
Cost per Person	$385.18	$396.10	$407.33	$418.87	$430.75	$442.96	$455.51
State Share	$0	$0	$0	$20.94	$25.84	$31.01	$45.55
Federal Revenue	$385.18	$396.10	$407.33	$397.93	$404.90	$411.95	$409.96

Note: Estimates are for newly eligible adults age 19-64.

The following methodology was used to generate the estimates in Exhibit 2. The Nebraska Medicaid report for 2011 shows that the average monthly medical cost per nonelderly nondisabled adult rose from $423 per person-month in 2008 to $460 in 2011, representing a 2.8% annual increase in cost per adult enrollee. These inflation factors were used to prorate forward to 2014. The benefit package for newly eligible adults is expected to be less generous than for current beneficiaries and more like a managed care insurance policy, which would lower the cost per enrollee. Previous research suggests that the uninsured tend to have lower risks than those currently on Medicaid because current enrollees are typically less healthy than the general population.[4] Therefore, new enrollees who were previously uninsured have been shown to have a 46% lower cost than the current average Medicaid beneficiary because of their lower health risks. For the estimates in Exhibit 2, the discount factor was reduced by half—to a 23% lower cost—to be conservative and to account for pent-up health care demand and some level of adverse selection. The FMAP rate for each year under the new expansion rules was then applied.

These cost-per-person estimates can be applied to the estimated number of new enrollees to generate a total cost to the state and expected federal matching funds received by the state from 2014 to 2020. Exhibit 3 presents estimates of state costs and federal revenue based on the low and high range number of new enrollees provided in Exhibit 1. The Center for Health Policy estimate for federal revenue discounts the payments to be phased out by the federal government from Medicaid Disproportionate Share Hospital (DSH) allotments. Currently, Nebraska receives over $29 million dollars annually in Medicaid DSH allotments, but the ACA cuts these payments over 10 years starting in 2014.[5] Also, the Center estimate for the state adds an estimated 5% administrative overhead cost for Medicaid. The Urban Institute estimate covers a shorter time period, which partially explains the lower federal estimate. Milliman includes estimates of the costs and federal revenue from other public programs along with other projections of costs associated with the Medicaid expansion; however, Milliman did not provide a detailed description of how those numbers were generated.

Exhibit 3. Low and high range estimates of state and federal spending (in millions) for Nebraska Medicaid expansion

	State Cost	Federal Revenue
Center for Health Policy (2014-2020)	$140 - $168	$2,878 - $3,486
Urban Institute (2014-2019)	$106 - $155	$2,345 - $2,732
Milliman (2014-2020)	$526 - $766	$3,977 - $5,495

Note: Estimates do not reflect the potential savings for the state from the Medicaid expansion.

Total Medicaid spending by the State of Nebraska in fiscal year 2010 was over $1.7 billion. The Center for Health Policy's high range estimate for state costs from the Medicaid expansion ($168 million from 2017-2020) would be a 2.5% annual increase in state Medicaid spending, whereas the Urban Institute estimate suggests a 2.3% increase in Medicaid spending.[2] The estimate from Milliman is not comparable because it includes costs associated with the nonexpansion population.

One of the primary concerns with the size of the uninsured population is the level of uncompensated care that is provided by hospitals and other providers. Typically, these costs are financed by providers, and by the state and federal government.[6-7] Eventually, this cost is shifted to individuals and employers in the form of higher insurance premiums, sometimes referred to as the "silent tax."[7] Exhibit 4 provides an estimate of the impact of the Medicaid expansion on uncompensated care spending.

Exhibit 4. Estimated spending (millions) on uncompensated care in Nebraska, 2014-2019

Without Medicaid Expansion	$1,069
With Medicaid Expansion	$419
Gross Difference in Spending	-$650
Net Savings, Low Estimate	-$163
Net Savings, High Estimate	-$325

Source: Urban Institute Health Insurance Policy Simulation Model 2014-2019.[8]

Note: Low savings: if the federal and state governments, respectively, reduce spending by 25% of the decline in their share of uncompensated care. High savings: if the federal and state governments, respectively, reduce spending by 50% of the decline in their share of uncompensated care.

Spending for the Medicaid expansion will substantially reduce the burden of uncompensated care for providers, but there would continue to be at least $400 million in uncompensated care provided in Nebraska even with the expansion of Medicaid. However, the reduction in uncompensated care spending could reduce (or hold constant) health insurance premiums.

Economic Impact of Medicaid Expansion

Exhibit 5 provides an analysis of the expected economic and employment impact of federal spending from the Medicaid expansion, using estimates of spending produced by the Center for Health Policy. The estimates were generated with the IMPLAN input-output model, which is a standard software package used by governments and private sector entities to estimate the economic and employment impacts of projected spending. Direct spending is the federal money used to provide care to the expanded Medicaid population in Nebraska. The low and high range estimates are those calculated by the Center for Health Policy and shown in Exhibit 3. The federal direct spending provides the health care industry with resources to hire health care workers and to purchase goods and services from suppliers in order to meet the increased demand for health care. These suppliers, in turn, purchase goods and services and hire employees and so on, thereby generating an indirect economic impact from the initial government spending. This direct and indirect hiring and spending also results in higher overall household income and, consequently, spending in the state—an effect called induced economic impact. More details on the methodology of the economic impact analysis can be found in the appendix.

This analysis suggests that Medicaid spending by the federal government would generate, on average, between $701 to $849 million in new economic activity every year in Nebraska. Based on an inflation-adjusted estimate of the total compensation (salary + benefits) in Nebraska ($65,087), the estimated number of jobs that could be financed by the federal dollars annually is at least 10,000 through 2020. A recent report analyzing the impact of the health care sector on Nebraska's economy indicated that the health care sector in Nebraska currently employs more than 117,000 persons and generates more than $8 billion in economic activity every year.[8] Therefore, this analysis suggests that the Medicaid expansion could have a significant impact on the health care sector's economic and labor markets.

Exhibit 5. Estimated economic and employment impact of federal spending (millions) on Medicaid expansion in Nebraska, 2014-2020

	Low	High
Economic		
Direct	$2,878	$3,486
Indirect[1]	$2,028	$2,457
Total	$4,906	$5,943
Average per Year	$701	$849
Employment		
Jobs Financed per Year[2]	10,770	13,044

Source: IMPLAN Economic Input-Output Model, 2009 State Package Data for Nebraska.
[1]Indirect includes induced impact.
[2]Based on inflation-adjusted annual salary data from the Nebraska Department of Labor.

Conclusion

This report provides some evidence of the impact of expanding the Medicaid program in Nebraska. The estimates in this report can be used as a guide for the expected number of new enrollees under expansion, the cost of providing care to the expanded population, the potential revenue from the federal government, the reduced burden of uncompensated care, and projections of the economic and employment impact. Many of the findings in this report are consistent with other studies with regard to expected enrollment, cost, and economic impact, and followed standard guidance.[2,9-12]

However, numerous questions remain to be studied regarding the Medicaid expansion and the impact of other provisions of the ACA on Nebraska. For example, the estimates in this report do not reflect the potential savings for the state from the Medicaid expansion, including reduced health services payments for mental health care, dual eligible savings (Medicare/Medicaid), reduced state spending on the Children's Health Insurance Program after 2015, delivery system reforms, and tax revenue from premiums.[9] The Center for Health Policy conservatively estimates the administrative cost at 5%; however, this cost could be lower (or higher) depending on the implementation of ACA provisions such as the insurance exchanges and electronic record systems and whether the state would apply for federal funds to update its information technology systems. Finally, the decision to expand Medicaid could have a significant impact on the cost of individual and employer health insurance premiums.

Several state governors have expressed concern that the federal government might reduce the FMAP in the future. The data in this report assume that the FMAP will not go lower than 90% by 2020 as mandated by the ACA. If the federal government changed the FMAP, then there would be a need to reanalyze the data to determine the impact on the state. However, the Supreme Court made it clear that the expansion was optional, and therefore a state could initially elect to join the expansion program and later leave the program after several years of participation.

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Conflict of Interest

None.

Disclaimer

The views expressed herein are those of the author and do not necessarily reflect the views of collaborating organizations or funders, or of the Regents of the University of Nebraska.

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Appendix: Economic Impact Analysis Methodology

The US Department of Agriculture in conjunction with the Minnesota IMPLAN Group (MIG) developed (and MIG continues to refine) a complete integrated analysis tool for economic planning efforts called IMPLAN (IMpact analysis for PLANning). IMPLAN is a microcomputer-based system for constructing regional economic models. It generates input-output multipliers by geographic region and by industry, combined with a county/state database (using the North American Industry Classification System (NAICS) developed jointly by the United States, Canada, and Mexico to provide new comparability in statistics about business activity across North America), which allows the assessment of change in overall economic activity. IMPLAN can be used to estimate the impact of organizational projects and expenditures by industry on regional output, household earnings, and jobs, both inside and outside of a given industry.

IMPLAN's output is aggregated based on direct, indirect, and induced economic effects:

- Direct effects: represents the response for a given industry (in this case, the total government spending on the Medicaid expansion population).
- Indirect effects: represents the response by all local industries caused by the iteration of health care spending.
- Induced effects: represents the response by all local industries to the expenditures of new household income generated by the direct and indirect effects.

Direct spending by state and federal governments was allocated using standard guidance provided by the Centers for Medicare and Medicaid Service as shown in Table 1.

Exhibit 1. Centers for Medicare & Medicaid Services' National Personal Health Care Expenditures Projections, 2014-2020

	2014	2015	2016	2017	2018	2019	2020
Professional Services[1]	30.7%	30.6%	30.5%	30.6%	30.6%	30.6%	30.6%
Hospital Services[2]	37.5%	37.4%	37.5%	37.4%	37.3%	37.2%	37.1%
Pharmacy Services[3]	15.6%	15.7%	15.6%	15.7%	15.7%	15.7%	15.7%
Other Health Services[4]	16.2%	16.3%	16.3%	16.4%	16.5%	16.5%	16.6%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Centers for Medicare & Medicaid Services. (2012). National health expenditure projections, 2011 – 2021. Baltimore, MD. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

Expenditure Model Output (2014-2020)

[1]Professional services include physician and clinical, dental, and other professional services.

[2]Hospital services include services provided by inpatient hospitals.

[3]Pharmacy services include retail outlet sales of medical products (e.g., prescription drugs, durable medical equipment, and other non-durable medical products).

[4]Other services include other health, residential and personal care; home health care; and nursing care facilities and continuing care retirement communities.