

**Medicaid Expansion in Alabama:
Revisiting the Economic Case for Expansion**

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INTRODUCTION

Over six years have now passed since the Supreme Court's landmark decision which upheld the core provisions of the Affordable Care Act (ACA) but left the decision on Medicaid expansion to the states. Despite the generous Federal match rate structure (full federal funding for 3 years, gradually declining to 90% in 2020 and beyond) Alabama was one of 26 states which elected not to participate in Medicaid expansion prior to its inception in January 2014. Since that time, 9 additional states have expanded their programs. Louisiana Democratic Governor John Bel Edwards ran heavily on the issue -- and won -- expanding Medicaid by executive order on his second day of office in 2016. The Republican controlled Virginia legislature voted to expand Medicaid in April 2018, joining a growing list of states that expanded their programs with Republican support. The 2018 midterm elections provided further evidence of broad public support for Medicaid expansion, as voters in three reliably conservative states - Idaho, Utah and Nebraska -- approved ballot measures supporting expansion. Alabama is now one of just 14 states that have taken no action on Medicaid expansion under the ACA¹.

In November 2012 -- over a full year prior to the implementation of expansion -- my former colleague Michael Morrissey and I released a monograph titled *An Economic Evaluation of Medicaid Expansion in Alabama under the Affordable Care Act*². Our report projected the impact of Medicaid expansion in Alabama on new Medicaid enrollment, the uninsured population, costs to the state and Federal Government, economic activity and state tax revenues and presented a strong economic case for expansion. The report focused on the period from 2014 to 2020 and projected that roughly 300,000 Alabamians would be covered under a Medicaid expansion, reducing the state's uninsured population by over 230,000. The state's investment of \$771 million during the initial seven-year period would generate \$20 billion in new economic activity from increased federally funded health spending and spillover effects in other sectors of the state's economy. We concluded that net of the new costs to the state, expansion would yield a \$935 million increase in tax revenues in the state of Alabama.

In October 2016, I drafted a second report that revised and expanded upon the earlier analysis in several important ways³. First, the report updated the earlier core economic impact projections (enrollment, state/federal costs, economic activity and budget impacts) over the period from 2017 to

2020. Since Alabama had already foregone the three year period (2014-2016) with the 100% Federal match rate, this would reduce the aggregate economic windfall from expansion to the state. Second, the report accounted for the fact that Alabama residents with incomes between 100-138% of the Federal poverty level who would have been eligible for Medicaid under expansion have instead enrolled in federally subsidized Marketplace plans. With expansion, these individuals would represent new costs to the state but would not generate new federal health spending in the state. Third, the report provided a more state-centric budgetary impact by distinguishing between tax revenues to state and local governments. Finally, the 2016 report examined the broader budgetary impact of expansion by incorporating estimates from Manatt Health of other potential cost-savings within the existing Medicaid program and other state funded health programs⁴.

The 2012 and 2016 reports provided compelling evidence of the economic case for Medicaid expansion in Alabama. The findings of these Alabama specific *projections* are echoed by the actual *experiences* of states which have expanded their Medicaid programs. Medicaid expansion under the ACA has delivered the largest increases in public insurance coverage since the creation of Medicaid and Medicare under the 1965 Amendments to the Social Security Act. States that expanded Medicaid have experienced 3 to 4 percentage point larger declines in their rates of uninsured⁵. Central to the economic case for expansion, the budgetary savings projected in the prior Alabama studies have materialized in expansion states, including Louisiana which reported almost \$200M in savings in Fiscal Year 2017⁶⁻⁸.

This report updates the 2016 study and projects the direct impact of Medicaid expansion on program enrollment, state/federal costs, economic activity and state tax revenues in FY2020 to FY2023. As of 2020 the long term expansion FMAP of 90% has now been fully phased-in. More recent data on health insurance status from the American Community Survey and marketplace enrollment figures are used to refine the estimates of new Medicaid enrollment and transitions from Marketplace coverage to Medicaid. These new estimates are then combined with revised projections of cost-savings from other state programs generated by Manatt Health to generate comprehensive estimates of the net budgetary impact of expansion. In addition to the aggregate state-level projections, this report also provided estimates of new Medicaid enrollment, Federal Medicaid spending and economic activity by Public Use Microdata Area (PUMA) region, which highlight the broad impact of expansion across the state of Alabama.

SECTION 1: CORE ECONOMIC ANALYSIS OF EXPANSION

The first section of this report updates the 2016 economic analysis of Medicaid expansion with revised estimates of expansion enrollment, state and federal costs, aggregate economic impact and net tax revenues in Alabama over the period from 2020 to 2023. These estimates are constructed using more recent data on macroeconomic conditions, health care spending/growth, and health insurance coverage of the newly eligible population.

New Alabama Medicaid Enrollment under Expansion

Under the ACA's Medicaid expansion, eligibility is extended to adults (19-64) with family incomes less than 138% of the FPL (133% with a 5% income disregard) who are not currently eligible for Medicare or Medicaid. Legal immigrants who have lived in the United States fewer than 5 years, and all undocumented immigrants, are ineligible for Medicaid coverage. The potential Medicaid expansion population in Alabama is estimated using 2012 to 2016 American Community Survey (ACS) data from the University of Minnesota's Integrated Public Use Microdata Series (IPUMS). Income at the "health insurance unit" (HIU) level from the IPUMS data is used to identify the newly eligible population, and the distribution of its current health insurance coverage. As discussed in the data appendix, the HIU is the preferred method for simulating insurance coverage eligibility expansions under the ACA⁹. Of the newly eligible population in Alabama in 2016, approximately 295,000 were uninsured, another 293,000 had employer-sponsored (group) coverage and 99,000 had private non-group health insurance. For the eligible population, non-group coverage increased by roughly 50% between 2012 and 2016. Leveling off of Marketplace enrollments in 2016-2018 suggests that non-group coverage stabilized around 100,000, or just under 10% of the total newly eligible (0-138% FPL) population¹⁰⁻¹². Since it is not possible to differentiate between Marketplace coverage and other forms of non-group coverage in the ACS data, actual Marketplace enrollment data for 2016 from the Center for Medicare and Medicaid Services (CMS) served as the basis for the assumption that 75% of non-group coverage is in subsidized Marketplace plans.

The sub-138% FPL population is then projected forward through FY2023 using population and employment growth forecasts, along with empirical estimates of the proportion of the uninsured that gain private coverage as the economy expands. The newly eligible population includes individuals who have a) no coverage (uninsured) b) private group (employer based) coverage, c) non-group coverage,

and d) non-group marketplace coverage. Total Medicaid expansion enrollment is estimated using the take-up rates reported in Table 1, which come from the Urban Institute’s Health Insurance Policy

Table 1: Take-Up Assumptions

Uninsured	Private Group Coverage	Private Non-Group Coverage	Marketplace Non-Group Coverage
79%	15%	85%	85%

Simulation Model (ACS-HIPSM)¹³. These assumptions do not differentiate between the take-up behavior of individuals with (subsidized) marketplace non-group coverage (100-138% FPL) and individuals with other non-group coverage.

Table 2 presents estimates of the numbers of new Alabama Medicaid enrollees from FY2020 to FY2023. The eligibility expansion would lead to over 346,000 new Medicaid enrollees, of which

Table 2: Estimated Number of New Alabama Medicaid Enrollees under ACA Expansion

	FY2020	FY2021	FY2022	FY2023	Average FY2020-23
New Medicaid Enrollees	343,694	346,123	347,592	346,959	346,092
Non-Marketplace New Medicaid Enrollees	283,627	285,632	286,844	286,321	285,606

65% (~223,000) would be newly insured. However, it is important to note that approximately 60,000 of these expansion enrollees would be moving from federally subsidized marketplace plans. For these individuals, the subsidies for private health insurance from the Federal Government would be replaced with Federal funds that support Medicaid expansion. As such, these individuals represent new costs to the state of Alabama but will not generate new federal funds. Additional details on these enrollment projections are shown in the data appendix. This report does not examine the potential impact of Medicaid expansion on individuals who are currently eligible for Medicaid, but not enrolled -- the so-called “woodwork effect”. Given the limited availability of adult Medicaid coverage in Alabama, any woodwork enrollees would almost exclusively be children. Children who are eligible for Medicaid, yet not enrolled, are likely to have limited health care needs and would not represent a significant new cost burden to the state. Additionally, published research has found no evidence of differential Medicaid take-up by previously eligible individuals in expansion vs. non-expansion states¹⁴. These enrollment estimates also assume that all the projected take-up occurs immediately in the first year of expansion. The expansion enrollment estimates reported in Table 2 are at the lower end of the estimated range developed by Alabama Medicaid’s actuary, Optumas, but are higher than 2018 estimates from researchers at the Urban Institute¹⁵⁻¹⁶.

State and Federal Costs of Medicaid Expansion

The counts of new Medicaid enrollees from Table 2, along with estimated per capita health care expenditures and administrative costs, are used to project the state and federal cost of Medicaid expansion from FY2020 to FY2023. The ACA provided a uniform Federal Matching Assistance Percentage (FMAP) to all states of 100% in 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in all years thereafter. Although, Alabama has now missed out on the period with more generous federal funding, Medicaid expansion continues to yield a significantly higher FMAP than the 71.9% that the state is currently receiving for the non-expansion population in FY2019. In addition to its share of the direct costs associated with the coverage expansion, the state of Alabama will also incur new administrative costs related to the expansion. Based on state's share of the current administrative costs for the existing Alabama Medicaid program, administrative costs of the expansion population are assumed to be 1.55 percent of total program benefit costs¹⁷. This approach likely overstates the administrative cost burden of expansion, as the marginal administrative costs for the expansion population are likely to be lower than the average administrative costs of the existing program. See the appendix for details of these administrative cost estimates.

Projections of health spending for the expansion population are derived using the Medical Expenditure Panel Survey (MEPS) from 2014-2016. The MEPS is a national survey of households conducted for the U.S. Agency for Health Care Research and Quality. Since state of residence is unavailable in the public use MEPS data, the expenditure estimates are based upon residents in the full South Census Region. Annual per capita expenditures by current insurance status are calculated for adults with family incomes less than 138% of the FPL. The per capita expenditure estimates are inflated by a factor of 1.10 to account for the well-documented underestimation of expenditures in the MEPS data¹⁸. It is assumed that the expenditures of the Medicaid expansion population will be similar to low-income individuals with private health insurance coverage. As shown in the data appendix, the expenditures of low-income privately insured adults are between those of the uninsured and Medicaid enrollees. Individuals who gain Medicaid coverage will utilize more health care services than when they were uninsured, but will consume fewer services than current adult Medicaid beneficiaries, who are disproportionately disabled. Table 3 presents estimated per capita health expenditures for the expansion population (in 2016 constant dollars) through FY2023 based upon the assumption of 2.6% annual growth in real per capita health care expenditures¹⁹.

Table 3: Estimated Per Capita Expenditure of Expansion Population (2016 \$)

	FY2020	FY2021	FY2022	FY2023
Per capita expenditures	\$6,120	\$6,279	\$6,443	\$6,610

The estimates of new Medicaid enrollment and per capita spending are used to project the aggregate costs of the Medicaid expansion to the state of Alabama and the Federal Government from FY2020 to FY2023. With the enhanced FMAP fully phased in to its long-term 90% as of January 2020, the projected increase in costs to the state after FY2020 is driven by a combination of rising real per capita health care spending and the expected slow-down of the US economy which will lead to increases in unemployment and Medicaid eligibility. The current unemployment rate in the US (and in Alabama) is below the “natural rate” and basic macroeconomic theory would predict that inflationary pressures should lead to a slowing economy and rising unemployment. Over the FY2020-FY2023 period, it is estimated that the state of Alabama would be responsible for \$1.00 billion (10.88%) of the estimated \$9.20 billion in new Medicaid program costs. This figure overstates the net costs of expansion to the state, as it does not capture potential cost-savings in other state health programs and traditional Medicaid. These issues are addressed in Section 2 of this report.

Table 4: Estimated State and Federal Costs Associated with Alabama Medicaid Expansion (in millions)

	FY2020	FY2021	FY2022	FY2023	Total FY2020-23
Alabama Costs	\$227	\$251	\$258	\$265	\$1,001
Federal Costs	\$1,969	\$2,018	\$2,080	\$2,130	\$8,197
Total Costs	\$2,196	\$2,269	\$2,338	\$2,394	\$9,197

Economic Impact of Medicaid Expansion

In order to estimate the economic impact of Medicaid expansion in Alabama, it is first necessary to identify the new “outside” money that would come into the state. In this case, it is the new federal dollars that would finance health care in Alabama as a result of the decision to expand Medicaid. As discussed in the enrollment section, approximately 60,000 of the 346,000 new Medicaid enrollees would be individuals who currently have federally subsidized Marketplace coverage. This population, with incomes between 100-138% of the FPL, receives premium and cost-sharing subsidies that cover 94% of the actuarial cost of their marketplace plans. Since the federal government is already financing the majority of the cost of their health insurance coverage, the federal share of the Medicaid costs for this population cannot be included in the economic impact calculations. In fact, assuming comparable per enrollee spending in Medicaid and Marketplace plans, Federal spending on these enrollees would decline following their transition to Medicaid. As a result, although the federal government would

spend \$1.97B on Medicaid expansion in FY2020, only \$1.62B of this would represent new federal spending in the state. It is important to remember that this increased federal spending on Medicaid expansion (and Marketplace subsidies) will be offset by significant cuts in DSH payments that have been delayed repeatedly and are now slated to begin in FY2020. The consequences of these cuts for hospitals in non-expansion states will be discussed further in Section 4 of this report.

The aggregate economic impact associated with the new federal spending on Medicaid expansion is estimated using the IMPLAN input-output software model. This software provides industry specific multipliers which can be used to estimate the indirect economic impact of the initial increase in federally financed Medicaid spending. The intuition for a multiplier is that the initial direct Medicaid spending provides revenues to the health care sector which are in turn spent on other goods and services. These purchases yield new revenues to other individuals and firms who increase spending on other goods and services. The process continues with successive rounds of progressively smaller spending increases as the initial spending increase ripples through the economy. The estimates of the indirect impact use health-sector industry specific multipliers (e.g. hospitals, nursing homes, etc) which are weighted by their projected share of annual personal health care expenditures between FY2020 and FY2023. All of the multipliers ranged between 0.65 and 0.75, suggesting that a \$1 increase in federal spending on the Medicaid spending yields an additional 65-75 cents of economic activity.

Table 5 presents the economic impact projections for FY2020-FY2023. In addition to the direct effect of the increase in federal health care spending in Alabama (\$6.75 billion), these flows of new federal dollars would generate an additional \$4.63 billion of new indirect economic activity over the FY2020-FY2023 period. In total, the new federal spending to support the Medicaid expansion (net reductions in marketplace subsidies) would generate \$11.38 billion in new economic activity in Alabama between FY2020 and FY2023.

Table 5: Estimated Economic Impact of Federal Spending on Alabama Medicaid Expansion (in millions)

	FY2020	FY2021	FY2022	FY2023	Total FY2020-23
Direct	\$1,623	\$1,661	\$1,712	\$1,753	\$6,749
Indirect	\$1,114	\$1,139	\$1,173	\$1,201	\$4,628
Total Impact	\$2,737	\$2,800	\$2,885	\$2,954	\$11,377

Budgetary Impact of Medicaid Expansion

Table 6 presents projections of the direct budgetary impact of a potential Medicaid expansion in Alabama over the period from FY2020 to FY2023. These figures do not include important cost-offsets to

the state associated with expansion that will be discussed further in Section 2. The state’s investment of \$1.00 billion in Medicaid expansion would generate \$11.37 billion in increased economic activity between 2020 and 2023, and roughly \$3B billion annually thereafter. The Federation of Tax Administrators (FTA) estimates Alabama’s total tax burden at 8.5 percent of income with an overall state tax rate of 5.3 percent, and an average local tax rate of 3.2 percent²⁰. The budgetary impact of expansion is estimated by applying these tax rates to the increase in economic activity. Conservatively, it is assumed that there is a one-year lag between new Medicaid spending associated with expansion and the resulting increases in tax revenues. As a result, the cost of expansion to the state is significantly higher in year 1 relative to all subsequent years.

Based upon the 5.3 percent state tax, the estimated increase in federal Medicaid spending would generate \$446 million in new tax revenue, leading to a net cost to the state of \$555 million from FY2020-FY2023. Expansion would also generate \$269 million in local tax revenue meaning that over 70 percent of the cost of expansion would be offset by increased state and local tax revenues. The state’s decision to forego expansion during the early years with the 100% federal match, the assumption of lagged tax revenue increases, and the updated analysis of marketplace enrollment that occurred in the absence of Medicaid expansion, explain the less favorable direct budgetary impact relative to the original 2012 study. However, the findings in Table 6 demonstrate that even at the long-term enhanced FMAP of 90%, the annual cost of Medicaid expansion would be almost completely offset by increases in state and local taxes, without accounting for the additional cost-savings associated with expansion which are addressed in the next section.

Table 6: Budgetary Impact of Medicaid Expansion (in millions)

	FY2020	FY2021	FY2022	FY2023	Total FY2020-2023
AL Cost of Expansion	(\$227)	(\$251)	(\$258)	(\$265)	(\$1,001)
New State Tax Revenue	---	\$145	\$148	\$153	\$446
State Budget Impact	(\$227)	(\$106)	(\$110)	(\$112)	(\$555)
New Local Tax Revenue	\$0	\$88	\$90	\$92	\$269
Overall Budget Impact	(\$227)	(\$18)	(\$20)	(\$19)	(\$285)

SECTION 2: INCORPORATING OTHER COST SAVINGS

The previous section provides an incomplete picture of the net budgetary impact of Medicaid expansion in Alabama as the analysis considers only the new costs and tax revenues directly associated with Medicaid expansion, but not potential cost savings in the existing Alabama Medicaid program or other state funded health programs. Studies that have examined the actual experiences of expansion

states have shown significant additional cost savings during the early years of the expansion^{6,21}. These cost savings have been generated by accessing the enhanced FMAP for previously covered groups and by using Medicaid funding to cover services for new enrollees had been financed entirely from state dollars, including mental health and substance abuse programs. Although the nature of these cost savings varies considerably across states based on pre-ACA Medicaid eligibility levels, state FMAP, and investments in other programs (e.g. mental health, uncompensated care pools), all states have experienced cost reductions with expansion.

In 2018, Manatt Health estimated the potential Medicaid and General Fund cost savings associated with Medicaid expansion²². Consistent with the experiences of expansion states, Manatt projected significant savings to the state of Alabama, both from accessing the enhanced FMAP for certain groups of existing Medicaid enrollees, and the use of expansion funding to finance services currently funded from state funds. The Manatt study provides estimates of cost-savings in multiple categories in FY2020 through FY2023. Together with the results from Section 1 of this report, these estimates allow for a more accurate assessment of the net impact of expansion on the state's finances after the phase-in of the long-run FMAP of 90%.

The Manatt report estimates that Medicaid expansion would save the state of Alabama between \$58.9 and \$87.6 million per year between FY2020 and FY2023. These savings come from two sources: 1) higher matching rates for existing Medicaid populations; and 2) the replacement of current state funding of health programs outside of Medicaid with Medicaid matched funding. The state's savings from the enhanced match rate would come primarily from pregnant women and disabled individuals who gain Medicaid coverage on the basis of income under expansion. They predict \$11-\$13 million in annual savings among pregnant women. Currently Alabama is responsible for approximately 28% of the health care costs of women who become eligible for Medicaid on the basis of a pregnancy. Expansion enrollees who become pregnant would remain covered at the enhanced match rate until coverage renewal, during which time the state would be responsible for just 10% of costs. Based on published work from other states, the Manatt estimates assume that 45% of pregnant women would shift from pregnancy-based eligibility to the expansion group. Second, the state would see reductions in costs associated with a decline in the proportion of low-income individuals who are covered on the basis of a disability determination. Based on mixed findings from published studies that examine the effect of eligibility expansions on disability determinations, Manatt projects relatively modest cost savings of \$8-11 million annually. Other populations that would generate savings from the enhanced

match rate include low-include women who are currently covered on the basis of a breast or cervical cancer diagnosis and women receiving family planning services through the Plan First program.

The Manatt report also examines the potential impact of Medicaid expansion on other state funded services. The study predicts that expansion would yield \$33.1 million in annual savings on mental health and substance abuse programs, \$12.2 million in annual savings for inpatient hospital care for prisoners, and \$16.5 in annual savings on public health programs. The estimates in the Manatt study appear reasonable and are generally in line with the reported experiences from other states²¹.

Two potential areas of concern with these estimated cost-savings are the uncertainty regarding the eligibility status at renewal for pregnant expansion enrollees and the rate of decline in disability determinations in the long-run following Medicaid expansion. Table 7 presents the full budgetary impact of expansion between FY2020 and FY2023 with these additional savings in Medicaid and other state health programs included. The Manatt estimates allow for a gradual phase-in of the savings associated with existing categories of enrollees transitioning to the enhanced match rate. The assumptions of lagged tax revenue generation and phased-in cost savings create a less favorable budgetary impact in FY2020. Beginning in FY2021, the net cost to the state would be approximately \$25 million per year after accounting for the tax revenues and cost savings that would be generated from Medicaid expansion. When local tax revenues are taken into account, expansion would provide net public budget savings of around \$65-70 million per year.

Table 7: Complete Budget Impact of Medicaid Expansion, FY2020 to FY2023 (in millions)

	FY2020	FY2021	FY2022	FY2023	Total FY2020-2023
AL Cost of Expansion	(\$227)	(\$251)	(\$258)	(\$265)	(\$1,001)
New State Tax Revenue	\$0	\$145	\$148	\$153	\$446
State Cost Savings	\$59	\$83	\$87	\$88	\$316
Net State Budget Impact	(\$168)	(\$23)	(\$23)	(\$24)	(\$239)
New Local Tax Revenue	\$0	\$88	\$90	\$92	\$270
Net Overall Budget Impact	(\$168)	\$64	\$66	\$68	\$31

SECTION 3: REGIONAL IMPACT ANALYSIS

In contrast to most economic development projects supported with state and local incentives, Medicaid expansion would provide benefits across all of Alabama’s 67 counties. This section highlights the breadth of the impact of expansion on Medicaid enrollment, federal health care spending and economic activity across Alabama. The ability to estimate local impacts is limited by the geographic

data available in the ACS public use files. The smallest identifiable geographic area in the ACS is the Public Use Microdata Area (PUMA). The state of Alabama is divided into 34 PUMAs which vary in geographic size by population density. The major cities all have one or more PUMAs, while other PUMA regions are comprised by as many as seven counties. For the five largest metropolitan areas of the state (Birmingham, Huntsville, Mobile, Montgomery and Tuscaloosa), multiple PUMAs were grouped together for ease of interpretation.

The regional analysis follows the same approach as the state-level projections from section 1. First, the ACS data are used to identify the newly eligible population in each PUMA-based region. The expansion population in each region is then estimated using the same take-up assumptions as in the state-level analysis. Table 8 presents the estimated number of new Medicaid enrollees by region for FY2020-FY2023. In FY2020, the number of new expansion enrollees ranges from a high of 40,805 in the 3-county region near Huntsville (Limestone, Madison and Marshall) to a low of 4,825 Etowah County.

Table 8: Alabama Medicaid Expansion Enrollees by PUMA Region

PUMA Regions (Counties)	FY2020	FY2021	FY2022	FY2023
Limestone, Madison and Marshall (HUNTSVILLE)	40,805	41,093	41,267	41,192
Jefferson (BIRMINGHAM)	37,751	38,017	38,179	38,109
MOBILE	30,785	31,002	31,134	31,077
MONTGOMERY, Elmore, Autauga, Lowndes	27,687	27,883	28,001	27,950
TUSCALOOSA and Pickens	17,825	17,951	18,028	17,995
Houston, Dale, Geneva, and Henry	16,077	16,191	16,260	16,230
Russell, Pike, Barbour, Macon and Bullock	13,145	13,238	13,294	13,270
Lee	12,977	13,069	13,124	13,100
Clarke, Choctaw, Conecuh, Escambia, Monroe, Washington, Wilcox	12,262	12,349	12,402	12,379
Lauderdale, Colbert, Franklin and N. Marion	12,132	12,217	12,269	12,247
Shelby	11,587	11,668	11,718	11,697
Baldwin	11,577	11,659	11,709	11,687
Dallas, Bibb, Marengo, Hale, Sumter, Perry and Greene	11,077	11,156	11,203	11,182
Morgan and Lawrence	10,667	10,742	10,788	10,768
Dekalb and Jackson	10,177	10,249	10,292	10,274
Calhoun	9,241	9,306	9,346	9,329
Talladega, Cherokee, Randolph Cleburne, Clay	9,215	9,281	9,320	9,303
Walker, Fayette, Lamar and S. Marion	9,168	9,233	9,272	9,256
Cullman and Winston	9,055	9,119	9,158	9,141
St Clair and Blount	8,684	8,745	8,782	8,766
Chilton, Tallapoosa, Chambers and Coosa	8,666	8,727	8,764	8,748
Coffee, Covington, Butler and Crenshaw	8,308	8,367	8,402	8,387
Etowah County	4,825	4,859	4,880	4,871

Table 9 reports the new Federal spending related to Medicaid expansion by PUMA-based region in 2016 constant dollars. As before, this new spending is determined by the number of expansion enrollees who weren't previously covered through subsidized marketplace plans, per capita expenditures from MEPS, the administrative cost rate, and the enhanced FMAP. Since detailed information on patient flows are not available, it is assumed that all health spending occurs in the PUMA in which enrollees reside. As a result these estimates may understate the spending in the larger metro areas which provide regionalized health services. For example, in Jefferson County, Medicaid expansion would generate over \$175 million in federally financed health care spending annually. Given the significant patient flows from more rural areas to UAB hospital, the economic impact would likely be larger in Jefferson County and lower in areas without hospitals and/or specialized medical services.

Table 9: New Federal Spending on AL Medicaid Expansion by PUMA Region (millions)

PUMA Regions (Counties)	FY2020	FY2021	FY2022	FY2023
Limestone, Madison and Marshall (HUNTSVILLE)	\$194.3	\$198.9	\$204.9	\$209.9
Jefferson (BIRMINGHAM)	\$177.1	\$181.2	\$186.7	\$191.2
MOBILE	\$154.5	\$158.2	\$163.0	\$167.0
MONTGOMERY, Elmore, Autauga, Lowndes	\$140.1	\$143.5	\$147.9	\$151.4
TUSCALOOSA and Pickens	\$78.1	\$79.9	\$82.4	\$84.4
Houston, Dale, Geneva, and Henry	\$71.3	\$72.8	\$75.0	\$76.9
Russell, Pike, Barbour, Macon and Bullock	\$61.7	\$63.2	\$65.1	\$66.6
Lee	\$57.9	\$59.2	\$61.0	\$62.5
Clarke, Choctaw, Conecuh, Escambia, Monroe, Washington, Wilcox	\$56.7	\$58.1	\$59.9	\$61.3
Lauderdale, Colbert, Franklin and N. Marion	\$55.1	\$56.3	\$58.0	\$59.4
Shelby	\$53.4	\$54.7	\$56.3	\$57.7
Baldwin	\$49.3	\$50.4	\$51.9	\$53.1
Dallas, Bibb, Marengo, Hale, Sumter, Perry and Greene	\$48.7	\$49.8	\$51.3	\$52.6
Morgan and Lawrence	\$48.1	\$49.1	\$50.6	\$51.9
Dekalb and Jackson	\$47.6	\$48.7	\$50.2	\$51.4
Calhoun	\$45.3	\$46.4	\$47.8	\$49.0
Talladega, Cherokee, Randolph Cleburne, Clay	\$45.2	\$46.3	\$47.7	\$48.9
Walker, Fayette, Lamar and S. Marion	\$44.6	\$45.7	\$47.1	\$48.2
Cullman and Winston	\$43.5	\$44.5	\$45.9	\$47.0
St Clair and Blount	\$43.0	\$44.0	\$45.4	\$46.5
Chilton, Tallapoosa, Chambers and Coosa	\$41.0	\$42.0	\$43.3	\$44.3
Coffee, Covington, Butler and Crenshaw	\$40.5	\$41.4	\$42.7	\$43.7
Etowah County	\$26.0	\$26.6	\$27.4	\$28.1

Table 10 shows the total economic impact of Medicaid expansion by PUMA region, which includes the direct health spending and the indirect economic activity generated by the new federal

health spending in Alabama. As with the state totals these estimates were generated using economic multipliers from the IMPLAN software that were applied uniformly to all new health care spending in the state of Alabama. The annual economic impact of Medicaid expansion ranges from \$45-50 million in Etowah County to \$325-350 million in the three county region (Limestone, Madison, Marshall) around Huntsville.

Table 10: Total Economic Impact of AL Medicaid Expansion by PUMA Region (millions)

PUMA Regions (Counties)	FY2020	FY2021	FY2022	FY2023
Limestone, Madison and Marshall (HUNTSVILLE)	\$327.7	\$335.3	\$345.4	\$353.7
Jefferson (BIRMINGHAM)	\$298.6	\$305.5	\$314.7	\$322.3
MOBILE	\$260.5	\$266.7	\$274.8	\$281.4
MONTGOMERY, Elmore, Autauga, Lowndes	\$236.3	\$241.9	\$249.3	\$255.2
TUSCALOOSA and Pickens	\$131.7	\$134.8	\$138.8	\$142.2
Houston, Dale, Geneva, and Henry	\$120.2	\$122.8	\$126.5	\$129.5
Russell, Pike, Barbour, Macon and Bullock	\$104.0	\$106.5	\$109.7	\$112.3
Lee	\$97.7	\$99.9	\$102.9	\$105.3
Clarke, Choctaw, Conecuh, Escambia, Monroe, Washington, Wilcox	\$95.7	\$98.0	\$100.9	\$103.3
Lauderdale, Colbert, Franklin and N. Marion	\$92.8	\$95.0	\$97.8	\$100.2
Shelby	\$90.1	\$92.2	\$95.0	\$97.3
Baldwin	\$83.1	\$84.9	\$87.5	\$89.6
Dallas, Bibb, Marengo, Hale, Sumter, Perry and Greene	\$82.1	\$84.0	\$86.5	\$88.6
Morgan and Lawrence	\$81.2	\$82.8	\$85.3	\$87.4
Dekalb and Jackson	\$80.3	\$82.1	\$84.6	\$86.6
Calhoun	\$76.5	\$78.3	\$80.6	\$82.6
Talladega, Cherokee, Randolph Cleburne, Clay	\$76.3	\$78.1	\$80.4	\$82.4
Walker, Fayette, Lamar and S. Marion	\$75.2	\$77.0	\$79.3	\$81.2
Cullman and Winston	\$73.3	\$75.0	\$77.3	\$79.2
St Clair and Blount	\$72.5	\$74.3	\$76.5	\$78.3
Chilton, Tallapoosa, Chambers and Coosa	\$69.1	\$70.8	\$72.9	\$74.7
Coffee, Covington, Butler and Crenshaw	\$68.2	\$69.8	\$71.9	\$73.7
Etowah County	\$43.8	\$44.9	\$46.2	\$47.4

SECTION 4: OTHER CONSIDERATIONS

The evidence presented in the previous sections focuses exclusively on the narrow short-term economic impact of Medicaid expansion and thus is necessarily incomplete. The state and federal funds that support Medicaid expansion should be viewed as an investment in health and human capital, and there is now broad evidence from other states showing significant returns on investments in expanded health insurance under the ACA. Alongside these additional benefits associated with Medicaid expansion there also may be additional cost-savings beyond the short-term effects identified by the

Manatt report and summarized in section 2. Finally, an analysis of the Medicaid expansion decision cannot ignore potential changes to the status quo with looming cuts to the Medicaid Disproportionate Share (DSH) Program. The rest of this section summarizes each of these issues to provide a more complete picture of the expansion decision in Alabama.

Other Potential Benefits of Expansion

This report does not attempt to place a formal value on the health benefits that would accrue to the 220,000 Alabamians who would gain insurance coverage under Medicaid expansion. However, the ACA has led to a flurry of new research which has found significant health benefits associated with Medicaid expansion and other gains in coverage. Research has shown improvements in self-reported health²³, reductions in depression symptoms²⁴, and reductions in adult²⁵ and infant mortality²⁶. Other studies have found improvements in important quality and access metrics including increased screening and detection of early stage cancers²⁷, and increased identification and treatment of substance abuse disorder²⁸. Medicaid expansion has also been associated with declining crime rates^{29,30}, with some research attributing this to improved access to substance abuse treatment^{24,30} and mental health services. This suggests that the benefits of improved health associated with expansion are not limited to the newly insured.

Beyond these health benefits, research has also shown that Medicaid expansion is associated with significant improvements in financial well-being. A study examining the impact of early Medicaid expansion in certain California counties under an 1115 waiver found significant reductions in payday lending relative to similar counties in states that did not expand early³¹. Other work using credit bureau data and has found that Medicaid expansion is associated with improved credit scores, reductions in medical balances past due and collection balances, and reductions in bankruptcy filings³². These findings are consistent with earlier research showing reductions in medical debt associated with insurance expansions³³. Medicaid expansion has also been shown to decrease non-medical debt to third party collection agencies³⁴. Improvements in credit scores in expansion states have also been associated with better access to credit and lower costs of borrowing³⁵.

Additional Cost Savings from Expansion

The 2018 Manatt report estimates the annual cost-savings from Medicaid expansion in Alabama at \$59-\$88 million per year through FY2023. The most uncertain parts of this estimate are the cost

reductions from the transitioning of current enrollees (pregnant women and the disabled) to the enhanced FMAP under expansion. Based on empirical estimates of fairly modest reductions in SSI beneficiaries immediately following Medicaid expansion^{36,37}, Manatt used fairly conservative assumptions in estimating the cost savings for disabled enrollees. Although this is reasonable for the stock of current disabled enrollees, it is likely that the cost savings would rise over time, as the expansion of coverage to childless adults should reduce the flow of Medicaid disability determinations into the future. A second potential source of savings would arise from the relaxing of work disincentives that exist under the current Alabama Medicaid program. Parents and other care givers are currently eligible for Medicaid coverage only up to 16% of FPL. Medicaid expansion would eliminate the incentives to maintain incomes below the low eligibility threshold³⁸, and would provide the state with the enhanced FMAP as these parents/guardians transition to expansion coverage.

DSH Reductions and Access to Care

The ACA initially called for an \$18B cut in Medicaid DSH funding between 2014 and 2020. These reductions were motivated by the expected drop in the uninsured population arising from Medicaid expansion and other coverage expansion provisions of the ACA. The DSH cuts were delayed until 2018 under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Under MACRA, Medicaid DSH payments were to be reduced by \$43B between 2018 and 2025. The cuts were delayed yet again to FY2020 as part of the February 2018 budget bill that extended CHIP funding. Under current law, DSH payments are now scheduled to be reduced by \$4 billion in 2020 and \$8 billion annually between FY2021 and FY2025³⁹. These cuts are slated to occur regardless of whether states have expanded Medicaid, and pose a significant financial threat to hospitals receiving DSH funding in Alabama and other non-expansion states. Although the CMS formula imposes smaller cuts on states with higher uninsured rates (non-expansion states), it penalize states that do not target their DSH payments to hospitals with high Medicaid volume.

Table 11 shows the projected reductions in the Federal Medicaid DSH allotments in Alabama through FY2025. The estimate for FY2020 comes from a 2018 Medicaid and CHIP Payment and Access Commission (MACPAC) report that projected state-level cuts based on the DSH Health Reform Reduction Methodology (DHRM)⁴⁰. The \$111.9 million in cuts in FY2020 corresponds to 30.9% of Alabama's baseline Federal FY2020 DSH allotment or 2.80% of the mandated \$4 billion reduction in DSH payments nationally⁴⁰. Estimated reductions for 2021 through 2025 assume that Alabama's share of

the mandated cuts would remain at 2.80%. The projected cuts of over \$1.23 billion over this six year period will place additional financial pressure on Alabama hospitals and health care providers and threaten access to care for the populations that they serve.

Table 11: Projected Reductions in Federal Medicaid DSH Allotments (in millions)

	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
Change in DSH	(\$111.9)	(\$223.8)	(\$223.8)	(\$223.8)	(\$223.8)	(\$223.8)

CONCLUSIONS

This report gives an updated and more thorough assessment of the potential effects of an expansion of Alabama’s Medicaid program under the Affordable Care Act. The study provides estimates of the number of new expansion enrollees, the costs of the coverage expansion to state and federal governments, the impact of the expansion on the Alabama economy and the budgetary impact on the state during period from FY2020 to FY2023. It is estimated that Medicaid expansion would reduce the state’s uninsured population by approximately 223,000 individuals while generating nearly \$3 billion in new economic activity annually. At the long-run enhanced FMAP of 90%, the costs of expansion to the state would be almost entirely offset by new tax revenues generated by expansion and reductions in existing state spending on current Medicaid enrollees and other health care programs. When the substantial tax benefits to local governments are included, expansion would provide a significant net benefit to the taxpayers of Alabama. Despite having missed out on the early years with extremely generous federal support, this study demonstrates that the economic case for Medicaid expansion in Alabama remains strong.

With Medicaid expansion, the uninsured rate in Alabama would decline from 12% in 2016 to under 8% according to projections from the Urban Institute⁴¹. Without expansion the uninsured rate would remain well above the national average. Adults with incomes below 100% of the FPL would remain caught in the coverage gap, with incomes too high to qualify for Medicaid and too low to qualify for subsidies for Marketplace coverage. In the absence of coverage, research suggests these individuals are likely to suffer both in terms of their health and financial well-being. Without expansion the state’s hospitals will also face intense challenges from scheduled cuts in Federal DSH payments that provide funds to support the provision of indigent care. The pre-ACA “status quo” quite simply does not exist, and without expansion the state will face an exceptionally difficult road going forward.

REFERENCES

1. Kaiser Family Foundation. 2018. "Current Status of State Medicaid Expansion Decisions," accessed 11/10/18 at <https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision>.
2. Becker DJ and Morrissey MA. "An Economic Analysis of Medicaid Expansion under the Affordable Care Act," Nov 2012. Working Paper, Department of HCOP, UAB School of Public Health.
3. Becker DJ. "Medicaid Expansion in Alabama: An Updated Analysis of the Economic Case for Expansion," Mimeo. Nov 2016.
4. Manatt Health. "Alabama Medicaid Expansion: Economic Implications," Mimeo. March 2016
5. Courtemanche C, Marton J, Ukert B, Yelowitz A, Zapata D. "Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States," *Journal of Policy Analysis and Management* 2016;36(1):178-210.
6. Louisiana Department of Health. "Medicaid Expansion Annual Report 2017," Accessed 01/20/2019 at: http://dh.la.gov/assets/HealthyLa/Resources/MdcdExpnAnnRprt_2017_WEB.pdf.
7. Ayanian JZ, Ehrlich GM, Grimes DR, Levy H. "Economic Effects of Medicaid Expansion in Michigan," *New England Journal of Medicine* 2017;376:407-409.
8. Bureau of Business and Economic Research University of Montana. "The Economic Impact of Medicaid Expansion in Montana," April 2018. Accessed 11/15/2018 at <https://mthcf.org/resources/the-economic-impact-of-medicaid-expansion-in-montana>.
9. State Health Access Data Assistance Center. 2012. "Defining "Family" for Studies of Health Insurance Coverage." Issue Brief #27. Minneapolis, MN: University of Minnesota. Accessed 10/25/2018 at: <http://www.shadac.org/publications/defining-family-studies-health-insurance-coverage>
10. Center for Medicare and Medicaid Services. "2016 Qualifying Health Plan Selections by Household Income as a Percent of the Federal Poverty Level and County," accessed 8/28/2016 at <https://data.cms.gov/Marketplace-Qualified-Health-Plan-QHP-/2016-Qualifying-Health-Plan-Selections-by-Househol/n4mh-474r>
11. Center for Medicare and Medicaid Services. "2017 Marketplace Open Enrollment Period Public Use Files," accessed 10/20/2018 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html.
12. Center for Medicare and Medicaid Services. "2018 Marketplace Open Enrollment Period Public Use Files," accessed 10/20/2018 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html.
13. Buettgens M and Kenney GM, 2017 "What if More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured," Urban Institute, Washington D.C. accessed 11/14/2018

at <https://www.urban.org/research/publication/what-if-more-states-expanded-medicaid-2017-changes-eligibility-enrollment-and-uninsured>.

14. Frean M, Gruber J, Sommers BD. "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act," *Journal of Health Economics* 2017;53:72-86.
15. Alabama Medicaid Agency. Enrollment projections communicated to Manatt. December 2018.
16. Buettgens M. 2018, "The Implications of Medicaid Expansion in the Remaining States: 2018 Update," Urban Institute, Washington D.C., accessed 01/25/2019 at https://www.urban.org/sites/default/files/publication/98467/the_implications_of_medicaid_expansion_2001838_2.pdf.
17. Alabama Medicaid. "Alabama Medicaid Administrative Costs, Funding and Recoveries" June 9, 2016. http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.5_Media_Library/2.5.1_Slide_Presentations/2.5.1_Budget/2.5.1_Legislative_Budget_Hearing_6-9-16.PDF.
18. Aizcorbe A, Liebman E, Pack S, Cutler DM, Chernew ME, Rosen AB. "Measuring Health Care Costs of Individuals with Employer-Sponsored Health Insurance in the U.S.: A Comparison of Survey and Claims Data," *Statistical journal of the IAOS* 2012;28:43-51.
19. Center for Medicare and Medicaid Services. "National Health Expenditure Projections 2015-2025," accessed 8/20/2016 at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2015.pdf>
20. Federation of Tax Administrators. 2015. "2015 State & Local Revenue as a Percentage of Personal Income," Accessed 08/25/16 at <http://www.taxadmin.org/2015-state-and-local-revenue-as-a-percentage-of-personal-income>.
21. Bachrach D, Boozang P, Herring A, Reyneri DG. "States Expanding Medicaid See Significant Budget Savings and Revenue Gains," RWJF Report 2016. Accessed 8/27/2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097
22. Manatt Health. "Alabama Medicaid Expansion: Summary of Estimated Costs and Savings SFY2020-2023," Report to the Alabama Hospital Association. December 2018.
23. Sommers BD, Maylone B, Blendon RJ, Orav, EJ, Epstein AM. "Three-year Impacts of the Affordable Care Act: Improved Medical Care and Health among Low-Income Adults," *Health Affairs* 2017;36(6):1119-1128.
24. Sommers BD, Gawande AA, Baicker K. "Health Insurance Coverage and Health – What the Recent Evidence Tells Us," *New England Journal of Medicine* 2017;377:586-593.
25. Swaminathan S, Sommers BD, Thorsness R, Mehrotra R, Lee Y, Trivedi AN. "Association of Medicaid Expansion with 1-Year Mortality Among Patients with End-Stage Renal Disease," *JAMA* 2018;320(21):2242-2250.

26. Chintan B. Bhatt and Consuelo M. Beck-Sagué, "Medicaid Expansion and Infant Mortality in the United States," *American Journal of Public Health* 2018;108(4):565–567.
27. Soni A, Simon K, Cawley J, Sabik L. "Effect of Medicaid Expansions of 2014 on Overall and Early-stage Cancer Diagnoses," *American Journal of Public Health* 2018;108(2):216–218.
28. Wen H, Hockenberry JM, Borders TF, Druss BG. "Impact of Medicaid Expansion on Medicaid-covered Utilization of Buprenorphine for Opioid Use Disorder Treatment," *Medical Care* 2017;55(4):336-341.
29. Vogler J. "Access to Health Care and Criminal Behavior: Short-Run Evidence from the ACA Medicaid Expansions," (November 14, 2017). Available at SSRN: <https://ssrn.com/abstract=3042267>.
30. He Q. "The Effect of Health Insurance on Crime: Evidence from the Affordable Care Act Medicaid Expansion," (January 9, 2018). Available at SSRN: <https://ssrn.com/abstract=3087500>.
31. Allen H, Swanson A, Wang J, Gross T. "Early Medicaid Expansion Associated with Reduced Payday Borrowing in California," *Health Affairs* 2017;36(10): 1769–1776.
32. Caswell KJ, Waidmann TA. "The Affordable Care Act Medicaid Expansions and Personal Finance," *Medical Care Research and Review* 2017;
33. Finkelstein A, Taubman S, Wright B, Bernstein M, Gruber J,..., Newhouse JP et al. (Oregon Health Study Group). "The Oregon Health Insurance Experiment: Evidence from the First Year," *Quarterly Journal of Economics* 2012;127:1057-1106.
34. Hu L, Kaestner R, Mazumder B, Miller S, Wong A. "The Effect of the Affordable Care Act Medicaid Expansions on Financial Well-Being," *Journal of Public Economics* 2018;163:99-112.
35. Brevoort K, Grodzicki D, Hackmann MB, Koulayev S. "The Credit Consequences of Unpaid Medical Bills," Working Paper. Accessed 1/10/2019 at https://martinhackmann.files.wordpress.com/2018/07/bgh_draft_2018.pdf
36. Soni A, Burns ME, Dague L, Simon KL. "Medicaid Expansion and State Trends in Supplementary Security Income Program Participation," *Health Affairs* 2017;8:1485-1488.
37. Burns M, Dague L. "The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation," *Journal of Public Economics* 2017;149:20-34.
38. Hall JP, Shartz A, Kurth NK, Thomas KC. "Medicaid Expansion as an Employment Incentive Program for People with Disabilities," *American Journal of Public Health* 2018;108(9):1235-1237.
39. "New Budget Bill Eliminates IPAB, Cuts Prevention Fund, And Delays DSH Payment Cuts, " *Health Affairs Blog*, February 9, 2018. DOI: 10.1377/hblog20180209.194373.
40. MACPAC. 2018. "Report to Congress on Medicaid Disproportionate Share Hospital Payments," accessed 1/10/2019 at <https://www.macpac.gov/wp-content/uploads/2018/03/Annual-Analysis-of-Disproportionate-Share-Hospital-Allotments-to-States.pdf>

41. Buettgens M and Kenney GM. 2016. "What if More states Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured," Urban Institute. Washington, D.C. accessed 11/10/2018 at <http://www.urban.org/research/publication/what-if-more-states-expanded-medicaid-2017-changes-eligibility-enrollment-and-uninsured>.
42. U.S. Census Bureau. "Interim State Projections of Population for Five-Year Age Groups: July 1, 2004 to 2030," accessed 11/10/2018. <http://www.census.gov/population/projections/data/state/projectionsagesex.html>.
43. Cawley J, Moriya AS, and Simon KI. "The Impact of the Macroeconomy on Health Insurance Coverage: Evidence from the Great Recession." *Health Economics* 2015;24(2):206-223.
44. Congressional Budget Office. 2018 "The Budget and Economic Outlook: 2018 to 2028" accessed 11/10/2018 at <https://www.cbo.gov/publication/54318>.

Data/Methodology Appendix

A. Enrollment Projections

The estimates of the number of new Medicaid enrollees in Table 2 are constructed using the 1-year American Community Survey (ACS) files for 2014 to 2016 from the Integrated Public Use Microdata Series (IPUMS) project at the University of Minnesota. The IPUMS data are used to estimate the size of the newly eligible population (adults 19-64, <138% FPL, resident of US at least 5 years) and to characterize their current distribution of health insurance coverage. As part of the IPUMS project, researchers at the State Health Access Data Assistance Center (SHADAC) added a “health insurance unit” (HIU) identifier to the ACS data which captures distinct family units within the household that are more likely to be the basis for public or private insurance coverage eligibility than the general census definition. Consistent with research done by SHADAC⁹, Appendix Table 1 shows that HIU level income leads to higher estimates of the newly eligible population than the census family income. The newly eligible population declined between 2014 and 2016, due to continued improvement in the Alabama economy.

Appendix Table 1: Potential Alabama Medicaid Expansion Population, SHADAC Health Insurance Unit (2014-16)

	2014	Year 2015	2016
Newly Eligible Population			
Number of Individuals, N	1,078,919	1,079,537	1,025,488
Annual Growth Rate, %	-	0.1%	-5.0%
Insurance Status			
Uninsured Currently (SE)	374,856 (9,550)	336,960 (8,271)	294,251 (8,260)
Private Group (SE)	293,325 (7,538)	301,373 (7,555)	292,734 (7,074)
Private Non-Group (SE)	85,627 (4,068)	88,922 (4,028)	98,785 (3,993)
Public/Other (SE)	325,111 (6,990)	352,282 (9,250)	339,718 (7,434)

Source: Integrated Public Use Microdata Series (IPUMS). IPUMS-USA, University of Minnesota, www.ipums.org. Estimates are based on the population of 19-64 year olds with family incomes below 138% of the Federal Poverty Level, who have resided in the United States for at least 5 years. Standard errors reported in parentheses.

The data on non-group coverage from the ACS, together with Marketplace enrollment data from CMS¹⁰⁻¹² suggest that non-group insurance coverage has leveled off following the significant gains between 2012 and 2016. From the ACS it is not possible to differentiate between subsidized non-group coverage obtained through the marketplace and other non-group coverage. To address the first issue, CMS published data on Marketplace plan selections by income (for 2017 and 2018) are used to motivate the assumption that 75% of non-group enrollees are in subsidized Marketplace plans. Using this approach it is estimated that there were approximately 70,000 Marketplace enrollees in 2018 that would be eligible for Medicaid expansion, which is in-line with published data on marketplace enrollment in Alabama. As discussed in the main body of the report, it is assumed that 85% of non-group enrollees -- including subsidized Marketplace enrollees -- would switch to Medicaid coverage. This assumes that some fraction of subsidy eligible individuals will retain private insurance coverage.

With this 2018 baseline data in place, there are two additional issues that must be addressed to project the Medicaid expansion population into the future: 1) Trends in the working-age population; and 2) The impact of economic recovery on the % eligible for the Medicaid expansion. The Interim State Population Projections from the US Census Bureau are used to project trends in the 19-64 year old population in Alabama through 2023⁴². The working age population in Alabama is projected to decline slightly from 2.83 million in 2018 to 2.79 million individuals in 2023. Based on work by Cawley et al. (2015), it is assumed that a 1% increase in the unemployment rate will lead to a 0.57 percent increase in the share of 19-64 year olds who are eligible for the Medicaid expansion⁴³. National unemployment rate projections from the Congressional Budget Office (2016) are used to

estimate the fraction of the working age population in Alabama who will be eligible for the Medicaid expansion in FY2020-FY2023⁴⁴.

Based on the above methodology the newly eligible population is projected through FY2023. As a simplification, it is assumed that the distribution of health insurance coverage among the newly eligible population observed in 2016 remains constant over time (Uninsured = 28.7%, Private Group = 28.5%, Marketplace Non-Group = 7.2%, Other Non-Group = 2.4%, Other = 33.1%) After projecting the eligible population through FY2023, Medicaid expansion enrollment is estimated using the take up assumptions derived from the Urban Institute’s Health Insurance Policy Simulation Model.

B. Administrative Costs of Medicaid Expansion

The federal match for administrative costs does not vary by state and is set at 50/50 for most functions. However, for some activities including IT investments and family planning the federal government pays 75 percent or more. According to an Alabama Medicaid report from FY2015, total administrative costs were \$257 million or 4.4% of total benefit costs. Overall the state paid 35% (\$90.5 million) of total administrative costs in FY2015¹⁷.

This report assumes that the state’s administrative costs would be the same 1.54% (0.044*0.35) of total benefit costs as under the current program. This approach is conservative and likely overstates the administrative cost burden of expansion since it is based on the average cost of administration rather than a more careful examination of the marginal administrative costs of expansion.

C. Per Capita Expenditures

The estimates of the per capita expenditures of newly eligible Medicaid beneficiaries in Table 2 are derived from the 2014-2016 Medical Expenditure Panel Survey (MEPS) data. The primary assumption in projecting expenditures and total program costs is that expansion Medicaid enrollees will have expenditures similar to those of low-income privately insured individuals. Appendix Table 2 shows the annual MEPS expenditure data by insurance status for 2014 to 2016. Owing to the imprecision of the 1-year MEPS estimates the pooled 2014-2016 mean is used as the baseline per capita expenditure for the Medicaid expansion population. The baseline per capita estimates are further inflated by 10% to account for the underreporting of expenditures in the MEPS data¹⁰. Appendix Table 2 demonstrates the inappropriateness of using the per capita expenditures of the uninsured or the

Appendix Table 2: Per Capita Total Health Expenditures, Expansion Population in South Census Region (2014-16)

Population	Mean Expenditure ¹ (95% CI)		
	2014	2015	2016
Full-year Uninsured	\$1,328 (890,1767)	\$1,196 (792,1599)	\$2,345 (1019,3672)
Ever privately insured in year	\$5,563 (2314,8812)	\$5,124 (1439,8809)	\$4,472 (2807,6138)
Ever publicly insured in year	\$8,499 (6684,10315)	\$7,439 (6118,8759)	\$7,249 (6020,8479)
Overall	\$4,889 (4314,5465)	\$4,719 (4039,5398)	\$4,906 (6974,5838)

Notes: 1) Converted to 2016 dollars using CPI index (all items)

publicly insured population to estimate the cost of the expansion enrollees. Given the limited generosity of adult Medicaid coverage in the South, a large percentage of publicly insured 19-64 year olds are disabled, thus the average expenditures of publicly insured working age adults are much higher than adults with private coverage. With Medicaid coverage, the expenditures among the currently uninsured should become reasonably similar to those of the privately insured population. These expenditures are projected forward through FY2023 based upon the assumption of 2.6% annual growth in real per capita health expenditures.